“Through the RFP process, contract negotiations and HR transition, the CHAMPS Oncology team has been superb to work with. We are very much looking forward to working together with CHAMPS Oncology to elevate our cancer registry activities to the highest level, while providing us with the timely and high-quality data we need to achieve our mission.”

- Brad Bott, MBA, CCRP | Director, Oncology Clinical Program, Intermountain Healthcare
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The Journal of Registry Management is indexed in the National Library of Medicine’s MEDLINE database. Citations from the articles indexed, the indexing terms (key words), and the English abstract printed in JRM are included and searchable using PubMed.

For your convenience, the Journal of Registry Management is indexed in the 4th issue of each year and on the Web (under “Resources” at http://www.ncra-usa.org/jrm). The 4th issue indexes all articles for that particular year. The Web index is a cumulative index of all JRM articles ever published.
Greetings, colleagues!

In this fall issue of the *Journal of Registry Management*, we are celebrating the life of our colleague April Fritz, who recently passed away. April was an extraordinary pioneer in moving the cancer registry field forward in terms of education and using her gifts to teach and educate all of us. I had the opportunity to attend a few of her education training sessions, most recently her session on pancreatic cancer at the National Cancer Registrars Association (NCRA) 2016 Annual Educational Conference. She contributed to teaching and educating all of us in the registry field about the same cancer she succumbed to.

I would like to share a few words with you regarding celebrating life. I heard a quote that stated life is 10% what happens to us and 90% our reaction to what happens to us. (If I knew who said this, I’d give him/her the proper acknowledgement.) Death is one thing that we know will eventually happen to all of us, right? The timing of when this will definitely happen is unpredictable. However, there are things you can do in the meantime. What are you doing to live your life to the fullest? Are you positively impacting your family and people around you? Are you living in your gifts and passion and sharing them with other people? People don’t always remember hard facts like your date of birth or date of death, but people do remember how you made them feel and whether they were better off before meeting or talking to you versus after meeting or talking to you. Believe it or not, every day you go to work, talk on the phone with a patient, interact with a customer, or meet people in your professional circle, you are undergoing an informal interview. People are taking mental notes on whether they would like to develop a professional working relationship with you. Are you a great person to work with and be around, do you maintain a positive attitude (even in the middle of chaos), are you a dependable team member, are you helpful, polite and courteous in your response to people (verbal and written), do you go the extra mile, or do you complete the minimum required just to get by? Celebrating life involves us living to our maximum capacity in every sense possible. Every day we wake up we have another opportunity to start over and live another day to maximum capacity. What are you doing with your time, talent, and gifts to positively impact the lives of other people?

Following my letter, you will see a letter co-written by two guest editors, Denise Harrison and Louanne Currence, providing a special tribute to April Fritz from the perspective of a friend and colleague. All of the articles in the fall issue represent past articles written by April that we think are still relevant today. There are six articles written by April Fritz entitled, “Surfin’ for Cancer Information,” “It’s Time for an International CTR Exam,” “Planning for the Future,” “Is it Reportable?,” “Case Finding—Now and (Sometime) in the Future,” and “ICD-O-3 Terminology Approved for Use.”

Respectfully,

Vonetta L. Williams, PhD, MPH, CTR
Editor-in-Chief, *Journal of Registry Management*
National Cancer Registrars Association
A Tribute to April Fritz

Guest Editors Denise Harrison, BS, CTR, and Louanne Currence, RHIT, CTR

September 12, 2017, marked the end of an era with the passing of April Fritz, RHIT, CTR. April was known, loved, and admired by many; she was an icon in the cancer surveillance community, and her death has left a huge gap in the training and education of cancer registrars. Her legacy is etched into the hearts and minds of all who knew her, or knew of her, and the stories they share about her.

April’s dedication to the cancer registry profession was evident in everything she did. She was such an accomplished woman. It would take pages upon pages to merely highlight those achievements and the many high honors with which she was recognized. Her curriculum vita is eleven pages long! I don’t think any of us has ever met someone as equally impressive, smart, and grounded as April.

And, she had a world-class sense of humor, which stayed with her until the end. This summer, we told her lots of people were asking me how she was doing; she said to “tell them I am not circling the drain yet.”

Anyone who has ever had the privilege of hearing her speak knows she was a captivating presenter. Who can forget her teaching us staging of lymphoma with the Macarena? One of her last national presentations was the story of her journey with pancreatic cancer at the 2016 NCRA Educational Conference in Las Vegas. The presentation was vintage April: using a personal experience as a teaching moment. The audience was spellbound. She wove together the technical information about the anatomy, staging, and surgical treatment of pancreatic cancer with her personal experience in an interesting and entertaining presentation.

Just before her diagnosis, she held a Principles of Cancer Registry course in Reno, NV. She was jaundiced, itching, tired, and miserable. Being the professional she was, April was there every day, and even helped her friend and neighbor, Patty, prepare the daily lunches for the students. The last night of the class, April and Bob invited some of us up to the casino for dinner and gaming. To this day, we don’t know how she was able to manage that evening. She walked all through the casino and the streets of Reno. She was determined to make sure everyone had a good time. We know that took so much out of her, and we have infinite respect for her for making such an effort. That exemplifies April’s nature. This photo of the Reno The Biggest Little City in the World sign was taken that night in the spring of 2014.

April enjoyed eating and cooking a variety of foods and going to restaurants. One night, while at a barbecue joint in Houston, she put two beers on her tray. She saw we were puzzled, and explained it was so she didn’t have to get up to get a second one! Another evening, she rode with us, asking if we could put the convertible top down, even though it was July-hot here in Houston. She had her elbow out the window and a huge smile on her face. When we think of her, we always try to remember the way she was that night: laughing and talking over a great meal.

April’s contributions to the cancer registry profession and the field of cancer surveillance are innumerable. She was actively involved in the development of many national and international references: ICD-O-3, the AJCC Cancer Staging Manual, Seventh Edition, AJCC Cancer Staging Atlas (published 2006), Collaborative Staging and Coding Manual, SEER Summary Staging Manual 2000, Cancer Registry Management: Principles and Practice, First Edition (NCRA textbook), Workbook for Staging of Cancer (NCRA), and Notes on Anatomy and Oncology. She created her CASEbooks to try to help cancer registrars pull everything together. She wanted so badly to get the third volume of the CASEbooks out, and was working on that book several hours a day until she finally got too weak. She was a determined woman!

We are all going to miss her so much, and have to find a way to honor her memory. April’s mission was to educate us so we could produce high-quality cancer surveillance data, which in turn would lead to earlier diagnoses, better treatments, and improved outcomes. She gave it her all. Now, let us dive into our manuals and rededicate ourselves to capturing outstanding cancer data, data that can be used in the battle against cancer.

And always remember one of her slogans: RTFM—Read the F (insert adjective here) Manual!
So, your best friend (a non-medical type) called and said her brother was just diagnosed with mesothelioma. She wants information, but you know she wouldn’t completely understand any statistics that you generate from the data in your registry. Your friend is probably using a very common coping mechanism that I call “research mode” (finding out everything she can about the diagnosis). How can you help? Easily—and within minutes—if you or your friend has a computer with a modem and access to the Internet.

The Internet is a linkage of computer databases throughout the world. The name is a contraction that describes its purpose: INTERconnected NETworks around the world. Using a modem and Internet access software, you can search for information on mesothelioma or virtually any type of cancer, and be directed to published information on computers in Japan, Germany, Canada, and all over the United States. All this for the price of a phone call to your online service (usually just a local call).

There is a wealth of information about cancer available on the Internet: physician- and health professional-oriented treatment summaries, clinical trials, patient-oriented literature, environmental discussions, psychosocial materials, including tapes and videos, support groups and discussion areas, and alternative medicine information.

The easiest way to get to this information is to “surf” or “browse” databases and message files. In many cases, you can jump from area to area using hypertext connections until you find the information you need. Hypertext is a word or a phrase in a document that contains a link to another document on the same subject or a related one, like a referral footnote in a printed document. The neat thing about hypertext is that if you click on the highlighted phrase, the computer jumps right to the new document, even if it is on a computer halfway across the world. When you find what you want, you can save the file to your hard disk or print it out. There are several methods of moving documents on the Internet to your computer, including the built-in save and print features of online services and the FTP (file transfer protocols) available directly from the Internet.

Now, back to your friend who wants information on mesothelioma in non-technical language. To begin your quest for information, access the Internet via one of the many online services such as America Online, Prodigy, CompuServe, or the new Microsoft Network. Other ways to access the Internet directly include Netscape, OS/2WARP, and “Internet in a box” commercial software programs.

Find the section of the program that allows you to ask for a word search. There are many browse and search engines (as they are called): Gopher, Yahoo, Mosaic, WebCrawler, Aliweb, Lycos, and more. When you enter a keyword or phrase, the computer will search its databases for those words and bring references onto the screen for you to review. Usually the words are part of a brief description of the database; you can access databases on literally thousands of subjects. At this level, if you search on “mesothelioma,” you may not find anything, so try another more general word like “cancer.” Through America Online and the Yahoo search engine, I found 93 references to cancer on the Internet, from treatment of cancer with medicinal herbs to access to the National Cancer Institute’s text files. Through the Gopher search engine, I found 201, plus a message that there were over 2,500 more available.

From the search list on your screen, select a database to explore by clicking on the highlighted hypertext. As you access the cancer databases, use their search engines and try searching for mesothelioma again. For example, Oncolink is the name of the University of Pennsylvania’s web server and Gopher server (see definitions) on the Internet. Oncolink offers an incredible variety of information on cancer. Through the word search routine in Oncolink, I found 40 references to mesothelioma, including online access to the National Cancer Institute’s PDQ statement in patient language on malignant mesothelioma and an essay called “Thoughts from a Mesothelioma Patient.”

In a matter of minutes, you can access, review, and print out patient-oriented information for your friend right from your computer. Charges vary, but even at overtime connection rates, an hour of time—and that’s a lot of browsing—on the Internet costs about three dollars through America Online.

As you and your friend continue to browse through the cancer databases on the Internet, you will find a wide variety of information prepared by medical professionals and by patients on all aspects of cancer. Many databases offer collections of FAQs, or frequently asked questions. These files can be very useful to someone in “research mode” because they save a lot of time browsing for answers to basic questions.

During a browsing session based on a word search for “cancer,” I found two excellent “pages” developed by cancer survivors. A page is a file or group of linked files developed by an individual or organization to convey information about something. Many cancer centers throughout this country have created pages promoting their services. The National Cancer Institute has an extensive presence on the Internet.

In addition to files of prepared information in databases worldwide, the Internet offers access to discussion groups that can be visited electronically by patients and health professionals. Someone can ask a question to a broad audience and, in a matter of hours, get answers, anecdotes, and opinions from a variety of readers around the world.
For a person with an unusual disease, this virtual support group can be a real lifeline. The “sci.med.diseases.cancer” section of the Internet’s Newsgroups is a lively discussion area where users can ask questions and get answers in a supportive environment. From America Online, enter the keyword “Newsgroups” and make your selection from the menu.

Some of the commercial online services have forums where people can discuss cancer. Among them are CompuServe’s forum (GO CANCER); America Online’s live, real-time support group, Living with Cancer (every Sunday night at 7 pm EST, keyword “health,” then click on Medical Health and Chat); and Prodigy’s Medical Bulletin Board.

These are just a few of the resources available online to cancer patients, their families, and the health professionals who try to help them. The world—not just cancer information—is at your fingertips and available for exploration. This review barely skims the surface of what can be found on the Internet. If you don’t have a modem or if you don’t have Internet access, try your facility’s medical library or computer center. Or, try your public library; many have computers with Internet access. Of course, there is a world of cancer information available through the mail by telephoning 1-800-4CANCER. For medical information and many other topics, online research is the wave of the future, and the future is available now.

**URLs to access cancer information**

The following “addresses” are good starting places to look at the variety of information available. Many are interconnected, and most lead to other sites to browse.

At the World Wide Web access point in your online software, type the full address, including the colon, periods, tildes, and slashes.

**Oncolink**
http://oncolink.upenn.edu

**CancerGuide:** Steve Dunn’s cancer information page
http://bcn.boulder.co.us/health/cancer/canguide.html

**Cancer patient resources**
http://www.charm.net/~kkdk

**Cancer guide for patients and families**
http://asa.ugl.lib.umich.edu/chdocs/cancer/cancerguide.html

**Internet Health Forum** (covers cancer, diabetes, Alzheimer’s, and other diseases)
http://www.comed.com

**NCI’s Physician Data Query (PDQ)** site-specific information sheets for health professionals and patients (the same ones you can order through CancerFax) are available from a number of sources. If you want to go directly to the source, use the following address: gopher://gopher.nih.gov/11/clin/cancernet/pdqinfo.

If you want to take a longer electronic trip, the PDQ information sheets are also available from the National Cancer Center of Japan (http://www.ncc.go.jp.cnet.html) and the University of Bonn, Germany (http://imsdd.meb.uni-bonn.de/cancernet/cancernet.html).

**April G. Fritz, ART, CTR, is a data analysis manager at Elm Services, Inc., in Rockville, Maryland.**
This summer I had the opportunity to meet two extraordinary CTRs. Now, it’s true that all CTRs are special people, but I really admire these two and others who have gone to exceptional lengths to become CTRs. I met Asif Mehmood, CTR, and Hye-Young Shim, CTR, when they were attending the summer school on cancer registration at the International Agency for Cancer Research in Lyon, France. Asif is a native of Pakistan who is working in the National Cancer Registry of Saudi Arabia. Hye-Young works for the national cancer registry in Jung-Gu, Republic of Korea. Both have made the effort to study for and pass the US version of the Certification Examination for Tumor Registrars (CTR exam).

According to NCRA records, there are 61 CTRs who live outside of the United States (Table 1). Over 70% are Canadians; the others are in the Middle East, Asia, Central America, and Ireland. All of these folks are to be commended for becoming CTRs, especially those, like the CTRs in French Canada, whose native language is not English. I have also spoken to registrars in Greece, Singapore, Australia, England, and Africa who are interested in formal recognition as cancer data professionals.

We know that becoming a CTR is an accomplishment regardless of where you live, but consider the following:

- The CTR exam is administered only in English, using English language reference books.
- The CTR exam costs as much as two months’ salary in some countries.
- The continuing education for a CTR is much more difficult when you do not have access to registrar association workshops and other avenues to obtain CEs.
- With the implementation of further formal education requirements for eligibility to take the CTR exam, it will be even tougher for non-US registrars to become certified.

To become a CTR when you live outside of the United States requires sacrifice (both financial and time) as well as tremendous dedication to the field.

In my opinion, it’s time that the National Cancer Registrars Association (NCRA) moves forward with an international certification exam for cancer registry professionals. More than three years ago, I was part of a task force to develop a plan for NCRA to offer an international CTR credential. After more than a year of conference calls, the task force presented a complete business plan to the Council on Certification, which took it to the NCRA Board of Directors, which sent it back to another NCRA group called the Specialty Model Task Force (SMTF) to rework using the Canadian model. As I understand it, a Canadian candidate for the CTR exam would have to pass the US version of the exam with all of its US rules and standards, as well as a Canadian module. I think it’s a waste of time—and a deterrent to future international CTRs—to learn US rules and standards that aren’t relevant to the registrars’ activities in their native country. The SMTF has been working on specialty modules but, as of this writing, has yet to present its final recommendations to the Council on Certification and the NCRA Board—and even then it’s only a development proposal, not the exam itself. Meanwhile, there is increasing interest—and pressure—in other countries to develop nation-specific cancer registration proficiency tests without the involvement of the world’s premier cancer registry professional association, NCRA. That would truly be a shame, but if NCRA’s glacially slow pace continues, that may indeed be the reality. If the concern is funding, there are a variety of international agencies and federal programs that could contribute the necessary funding to develop the exam.

Why couldn’t there be a two-part CTR exam for all registry professionals? Many parts of the job and knowledge base are the same regardless of where you live and work. The first part of the exam could cover basic knowledge of oncology (spread of cancer), terminology, anatomy, morphology, statistics, quality control, and database management. The second part of the exam could cover

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information such as COC standards in the United States, NAACCR standards in the United States and Canada, rules for counting multiple primaries (United States vs. international), and unique staging systems (like CS), that are used in a specific country. If that country follows SEER rules (as many do), that information could be tested in the second part of the exam. The successful candidate (who would have to pass both parts) would therefore demonstrate an understanding of the cancer disease process, which is the foundation for our profession, as well as an understanding of national standards.

We know there will be a shortage of registrars in this country in the next few years based on the findings of last year’s NCRA-sponsored Workforce Analysis Study of the Cancer Registry Field, the retirements of colleagues all around us, and the changes in the education requirements for eligibility to take the exam. Let’s not compound that by failing to meet the needs of registrars outside of the United States, whose professional recognition levels are even lower than what we perceive in this country.

Feedback on ICD-9-CM Case-Finding Article

Thank you all for your responses to my piece in the last issue of the Journal of Registry Management regarding the revised ICD-9-CM case-finding codes for the hematopoietic diseases. I had some feedback and clarifications from the National Center for Health Statistics (NCHS) that are important to share with you.

First, while I pointed out that the Federal Register announcement that contains the new ICD-9-CM codes is published by the Centers for Medicare and Medicaid Services (CMS), it is actually the National Center for Health Statistics that is fully responsible for developing and revising the new diagnosis codes that are implemented each year. My apologies for not making that clear.

Second, I stated that the term “cervical intraepithelial neoplasia” had been added to 233.1 as a synonym and that the various grades of CIN are not distinguished. To clarify, CIN III (potentially reportable) is coded as 233.1; the lower grades (not reportable) CIN I and CIN II are coded as 622.11 and 622.12, respectively. NCHS may need to add the phrase “grade III” to the newly added words “cervical intraepithelial neoplasia” to avoid confusion and miscoding of lower CIN grades in 233.1.

Third, I indicated that code 238.7 is no longer in effect, which is true for encoding new cases. When an existing code is expanded in ICD-9-CM, it is correct that the old code is no longer valid, but the old code does remain a valid subcategory for statistical purposes. If codes in 5-digit categories are collapsed for reporting, the older 4- or 3-digit subcategories may still be used in some tabulations. This is a fine, but important, distinction and I am grateful to NCHS for pointing this out.

We have asked NCHS to investigate the correct coding of malignant GIST cases arising in solid organs. Their logic was that GIST not otherwise specified is a borderline tumor in ICD-O-3, so it defaults to the very generic 238.1, neoplasm of uncertain behavior of connective and other soft tissue. Benign GIST defaults to 215.5, benign neoplasm of connective tissue of abdomen, and therefore malignant GIST would default to malignant neoplasm of connective and soft tissue of abdomen. Stay tuned.

Finally, there are more new cancer case-finding codes on the horizon. ICD-9-CM is updated each October, so it is only a few more months until the next round of updates. There are several new codes for specific types of lymphomas (which are really needed) and a new malignant ascites code, as well as some other revisions for VIN and VAIN, all of which will become effective October 1, 2007. The proposed new codes are already posted on the NCHS website if you want to take an advance look. NCHS is working hard to resolve the coding discrepancies between ICD-9-CM and ICD-O-3.

April Fritz, RHIT, CTR, is CEO of A. Fritz and Associates in Reno, Nevada. The opinions in this column are those of the author.
Planning for the Future

April Fritz, RHIT, CTR

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Yes, Virginia, there will be significant changes in registry data collection beginning with cases diagnosed on or after January 1, 2010. These include implementation of the seventh edition of the AJCC Cancer Staging Manual, implementation of the related changes to Collaborative Staging, and implementation of new multiple primary counting and histology coding rules for the hematopoietic diseases and lymphomas. You’ll be reading about them in National Cancer Registrars Association (NCRA) publications and hearing about them at conferences, workshops, webinars, and other trainings during 2009. However—to squelch a rumor that has been widely circulated—I have it on the authority of the International Agency for Research on Cancer that there are no plans to implement a new version of the International Classification of Diseases for Oncology for 2010. We’ll have enough to learn/re-learn without adding an ICD-O-4 to the mix.

As I write this, NCRA and the North American Association of Central Cancer Registries (NAACCR) are seeking abstracts for their 2009 annual conferences. I hope you’ll submit an abstract for a presentation at one or both of these meetings and, moreover, I hope yours will be accepted. What I’d like to discuss is the presentation itself. I’ve had the opportunity to attend a number of state association meetings this year, and I’ve seen presenters show a lot of slides—in my opinion, what you might call “the good, the bad, and the ugly.” Registrars are visually oriented people; they take in much of their information through their eyes. That’s why it is so important to be able to convey your message in good visual style, avoiding the distracting “features” of presentation software programs. So as you plan your future presentation for NCRA or NAACCR, please keep in mind the following guidelines. (These guidelines assume that you are projecting slides from a Microsoft PowerPoint or similar program rather than showing 35 mm slides.)

Planning

- Avoid changing slides sooner than 10 seconds; however, most slides should not remain on the screen longer than two minutes.
- In classic report style: (1) tell them what you are going to tell them—the overview slide; (2) tell them—the body of the presentation; and (3) tell them what you just told them—the summary or conclusion slide.
- Design your message and graphics to be wider than they are high. Maintain a half-inch border on all sides of the text and title. For a computer projection presentation, select “screen” as the template for creating the visuals.
- There are various formulas for the amount of text to put on a slide. These range from a maximum of four lines/four words per line to seven lines/seven words per line. Find a legible format and be consistent from slide to slide.
- Bullet points and short phrases are preferable to long sentences. Quotations can be shortened with ellipses (…).
- In PowerPoint, turn off the AutoFit feature. Do not make the font size smaller just to fit a concept on a single slide. Splitting the information into two or more slides is preferable to tiny print and an illegible slide.
- Keep the title short; one line is best. Remember, less is more when conveying your message. Change the title of the slide to fit the content; avoid using a single title through the entire presentation.
- If the information is complex, it should be on a handout rather than a slide.
- Avoid backing up in slide presentations—it confuses an audience that is trying to follow on a handout. If you need a slide twice, make a duplicate and insert it in the presentation in the appropriate place. If you have a long verbal discussion between two slides, insert a blank slide rather than retaining the previous slide on the screen.
- Remember the KISS principle: “Keep It Simple, Sweetheart.” Your audience will appreciate it.

Backgrounds and Color

- Keep the background simple. A flashy background will detract from both the speaker and the message, and will make it difficult to read the slide. Animated backgrounds (such as shooting stars) distract from the message on the slide. Similarly, avoid flashy transitions between slides.
- Choose colors that are easy to read, pleasing to the eye, and work well together. Graphics software programs offer a variety of background and text color combinations called “palettes” based on what experience has shown works well for slides. Whatever you choose, keep the same background throughout the presentation for consistency.
• Dark colors tend to recede and light colors stand out. A background of solid color, subtle texture, or a gradient sweep fading from one shade of a single color to another shade can be visually interesting without overwhelming the text (or the audience). A small logo on the background throughout your presentation is appropriate. If your facility has a corporate template and palette, you will have to work with that.

• Darker backgrounds with lighter text tend to be easier to read than light backgrounds with dark or black text, especially in a darkened room. However, slides should be clear, with enough contrast to be seen without turning off the room lights.

• Good choices for text on a dark background are white or yellow for slide titles, light colors for borders and graphic accents, and white for text. Yellow on blue will make a slide that is easy to read. Orange and cyan (light blue) are also possibilities for text and accent colors.

• Avoid using black lettering on a blue background or blue text on black because there is not enough contrast between these colors. Many reds, purples, and magentas contrast well with blue, green, and other dark backgrounds, but they are hard on the eyes and often impossible for your audience to read. Use reds for accents, graphic objects, and highlighting rather than for text. Remember that about 10% of the men in your audience are red-green color-blind.

**Text Style**

• The fact that you have 100 or more fonts available in a graphics program is not license to use them all in a single presentation.

• For clarity in projected text, a sans-serif font is best (no “feet” on the letters). Sans-serif fonts include Helvetica, Arial, Futura, Gill Sans, and Century Gothic. Use only one or two fonts for all text and labels on illustrations for consistency through the presentation.

• The minimum font size for any part of the slide, including labels on graphics, is 18 point; 24 or greater is optimal, especially if the slides will be provided as a handout.

• A bold font is easiest to read. Avoid outline, shadow, and underlining to emphasize words. Use italics sparingly.

• Fancy fonts such as script or Old English can detract from the message. If you do choose to use an unusual font, embed it in your presentation software program, because the computer you are projecting from may not have that font installed.

• Upper- and lowercase lettering is most familiar and easiest to read. Use mixed case for titles. Use sentence case for body text. DON’T USE ALL CAPS! IT LOOKS LIKE YOU ARE SHOUTING AND IT IS HARD TO READ!

• Always use tabs—never spaces—to align text because most fonts are proportional (a “W” is wider than an “I”) and spacing can shift from the computer screen to the projector or slide maker. This is particularly important if you are displaying a table of data.

• Center the text on the slide horizontally and vertically. Slides with the text lower than center appear to be falling off the screen.

Two Quick Ways to Check Whether Your Text Is Readable

1. If the slides are made on a computer, measure the diagonal length of your computer screen and divide by three. Put the slide on the screen and stand back from the screen a distance (in feet) equal to that number. For example, if you have a 15-inch screen, stand back five feet (assuming your office is big enough). If you can read the text from that distance, it will be readable by your audience.

2. If you are having printed text photographed, measure the height of the text you plan to photograph and multiply this measurement by seven. Move back from the text a distance (in feet) equal to your answer. For example, if the letters are one-inch high, move back seven feet. Can you read the text at this distance? If you can, then proceed with your photography. If you cannot read it at this distance, your audience will not be able to read the slide.

**Graphics**

• A good graph or graphic can add impact to a slide, simplify the information, and enhance the audience’s understanding of the topic. However, graphics should not distract from the presentation. Graphics should focus, support, clarify, and reinforce the points made orally. A cutesy graphic can diminish the impact of your message and cause your audience to think less of you as an authority. In other words, avoid kittens, bunnies, butterflies, and the like in your presentation.

• Pictures imported from websites, such as .GIF and .JPG file formats, are designed for quick downloading for on-screen presentations and web pages. The quality of the image may be distorted if you stretch or otherwise change the dimensions of the original picture. In addition, imported graphics may appear fuzzy if they are incorporated into 35 mm slides, overhead transparencies, or other types of printed visual aids, so test your output before the presentation.

• If you are scanning an image to include in a slide, save it at no more than 150 dpi or it will create a large graphics file that will take a long time to load in a computer presentation.

• Always cite the source of an illustration that you have taken from a website, book, or other source. Copyright issues apply to graphics, text, and other information used in educational presentations.

• Proofread your slides, use the spelling checker, and have someone else proofread them before you load them into the computer for the final presentation or send them off to be made into handouts.

**During the Presentation**

• Avoid reading slides to your audience. Talk from your slides. They can serve as the outline for you to expand on in your oral presentation and to illustrate what you cannot easily say.

• Never apologize for the quality of a slide. If you don’t like the way it looks, don’t use it.
• Practice giving your presentation with your completed visuals. Practice allows you to incorporate them smoothly into your presentation and means you won’t have to spend time during your presentation figuring out how to use the projector controls.
• If possible, stand on audience’s left. Because we read from left to right, it is our natural tendency to move our eyes from left to right. Standing on the left helps the audience focus on you as the speaker. Avoid standing in front of the screen. The audience will be distracted if they can’t see the screen.
• To view your slides as the audience does, stand at a 45-degree angle to the room—open to the screen and to the audience. Don’t turn your back to the audience. Face the audience when you want to emphasize a point.
• Make eye contact with audience. If it bothers you to look directly at the audience, look just above their eyes. Pick two or three audience members scattered around the room to focus on periodically.
• If you are using a laser pointer, be careful not to point it at your audience. Similarly, avoid gesturing with the pointer on—people get dizzy trying to follow the little red dot on the screen. Use natural movements to emphasize points. Relax your hands at your side or on the podium when you are not gesturing.
• Controlling the slide forwarding yourself by running the computer or using a remote control is better than having another person change the slide and having to say, “Next . . . next . . . next . . .”
• Your voice is important. Vary your pitch, tone, and volume to make your presentation more interesting. Talk loud enough to be heard in the back of the room. One way to do this is to pick someone in the back of the room and speak so they can hear and understand you. Often, speaking slowly helps you speak louder.
• Pronounce your words distinctly. Use words that are easy for you to say. If difficult words are part of the presentation, practice them beforehand.
• Humor goes a long way, especially if you mess something up.
• Smile. It will make you feel comfortable and more confident, and audiences can tell when you enjoy speaking. A smile will help the audience feel comfortable too. Speak with enthusiasm and interest. Be sincere with your audience and they will accept you as the authority you truly are.

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Is It Reportable?

April Fritz, RHIT, CTR

Ever since the publication of the American Joint Committee on Cancer’s *AJCC Cancer Staging Manual, Seventh Edition,* and more so since Collaborative Stage Version 2 (CSv2) has been available, I’ve received questions asking whether certain types of neoplasms are reportable. In particular, I get questions about gastrointestinal stromal tumors (GIST), appendix carcinoids, and, more recently, pancreatic endocrine tumors.

In my opinion, the confusion arises because there are TNM seventh edition (TNM7) chapters and CSv2 schemas that include benign and borderline as well as malignant neoplasms, and sometimes it’s difficult to interpret whether the pathology report says the tumor is malignant or not. The short answer to whether a particular tumor is reportable is, “it depends.”

The stageability-reportability dilemma boils down to two things: what’s important to clinicians and what’s important to population-based cancer registries.

To begin with, the *AJCC Cancer Staging Manual* is a tool for clinicians. When they see an uncommon tumor (or even a common tumor), they want to stage it, as that helps them make their treatment decisions. For this reason, TNM7 includes a number of chapters for malignancies and other conditions of interest to clinicians in their specialty practices, such as GIST, neuroendocrine tumors, skin cancers, and sites that use terminology like “severe dysplasia” or “high-grade dysplasia.” Registrars also use TNM because it is the common language of cancer and allows us to convey information about extent of disease and prognosis in a highly condensed manner.

On the other hand, population-based cancer registries that have perpetually limited resources must focus on their area of interest, which is malignancies of all sites and benign/borderline central nervous system (CNS) tumors. Population-based registries limit reportable tumors to the codes and terminology in the international standard registry reference, the *International Classification of Diseases for Oncology, Third Edition* (ICD-O-3). Doing so allows population-based registries in all nations to compare their data, since everyone uses the same reportability rules.

You might say that facility-based cancer registrars are caught in the middle. They must comply with the requirements of their central registry as well as the wishes of their physicians. It is confusing to the registrar when there is a TNM chapter or CS schema that allows a case to be staged/coded but the site-histology combination is not on the central registry’s reportable list. Some TNM chapters are fairly straightforward—there has been a skin cancer chapter in TNM since the second edition of the AJCC manual—but registrars know that basal and squamous skin cancers are not reportable to the central registry. However, a number of the diagnoses included in the seventh edition are gray areas for reportability.

How to resolve the dilemma? Use the registrar’s tools: ICD-O-3, CSv2, state reporting requirements, and cancer committee guidelines. For example, the final diagnosis on the pathology report says “Distal stomach: gastrointestinal stromal tumor.” The pathologist talks about tumor size and mitotic rate, but the final diagnosis is just that—GIST, not otherwise specified. In CSv2, there are seven schemas for GIST tumors, but is this case actually reportable? The primary reference to use is ICD-O-3. In the index of ICD-O-3, there are three codes for gastrointestinal stromal tumor:

- Gastrointestinal stromal tumor
  - 8936/1 NOS
  - 8936/0 benign
  - 8936/3 malignant
  - 8936/1 uncertain malignant potential

In this example, the pathologist doesn’t specifically say that the GIST is benign or malignant, so we use the default “not otherwise specified” (NOS) code 8936/1. Excluding CNS tumors, cancer registries do not accession /1 (borderline) tumors, so this case is not reportable to the central registry. If the pathologist had said malignant gastrointestinal stromal tumor or gastrointestinal stromal sarcoma, the case would definitely be reportable. The registrar should not use information on tumor size and mitotic rate to make a determination of malignancy—that’s the pathologist’s job. An inquiry to the pathologist would be appropriate, but the criteria for GIST malignancy are somewhat subjective and vary from pathologist to pathologist.

The same concept applies to other newly stageable diagnoses. About 10%–30% of GISTs are malignant, and about 50%–70% of pancreatic endocrine tumors that are now stageable in the pancreas chapter of TNM are malignant. Unless the pathologist states that the tumor is malignant, the registrar has to use the default code as a guide for reportability. If you look up some of these newly stageable diagnoses in ICD-O-3, here’s what you find:
| Term                          | “Default” (NOS) code | Is default reportable?
|-------------------------------|----------------------|-----------------------
| Carcinoid (tumor)            | 8240/3 except of appendix | Yes                  
| Carcinoid of appendix        | 8240/1               | No                    
| Insulinoma                   | 8151/0               | No                    
| Glucagonoma                  | 8152/1               | No                    
| Gastrinoma                   | 8153/1               | No                    
| VIPoma                       | 8155/1               | No                    
| Somatostatinoma              | 8156/1               | No                    
| Pancreatic endocrine tumor*  | 8150/1               | No                    
| Adrenal cortical tumor*      | 8370/0               | No                    

*According to the ICD-O editors, this is the new preferred terminology for islet cell tumor, NOS.

A similar issue affects the newer preferred terminology that is listed in various TNM7 chapters. Examples include “pancreatic intraglandular neoplasia” and “high-grade dysplasia of the esophagus,” which have replaced “carcinoma in situ” of these organs as the preferred terminology used by gastrointestinal and endocrine pathologists. When someone looks up these words in ICD-O to determine reportability, the terms are not there, which implies that they are not reportable. For example, the term “high-grade dysplasia” isn’t in ICD-O so an esophagus case with this diagnosis doesn’t get accessioned, even though many pathologists consider it carcinoma in situ. Consequently, population-based registries may not be receiving these very early, very rare esophageal tumors. Central registries are constrained by what is in the state’s reporting legislation, and that may not be as up-to-date as the pathologists’ changing terminology. Note, too, that not all pathologists agree that intraglandular neoplasia and severe or high-grade dysplasias are equivalent to carcinoma in situ.

Even if the diagnosis is not reportable to your population-based registry, it may be of interest to your physicians. This is a great opportunity for you to market your registry to the medical staff. Take advantage of the situation by discussing these newly stageable cases with the cancer committee. Have them decide whether the cases should be included in the facility registry as reportable-by-agreement and whether they should be followed by the registry. Whatever the decision, be consistent—either include all cases of that type or exclude them from the registry. If the cancer committee decides to make these cases reportable-by-agreement, you won’t be inundated with extra cases. After all, they are uncommon tumors worthy of more study.

Whether a diagnosis is reportable depends on state reporting laws and cancer committee decisions. In some states, carcinoma in situ (/2) of the cervix is still reportable; in others, borderline (/1) tumors of the ovary are still reportable. More likely, however, your cancer committee has indicated that certain diagnoses are of interest to them, above and beyond what the central registry requires.

Keep in mind that the AJCC is not the registry standards setter for reportability. It does not define whether a case should be abstracted, but the AJCC Cancer Staging Manual does provide staging systems for clinicians who see these types of cases. It is important to follow the reportability instructions of your population-based registry and the national standards setters.

Version 2 of the Collaborative Stage Data Collection System includes these diagnoses because it is based on the seventh edition of TNM. But again, do not assume that a case is reportable just because there is a staging schema for it in CSv2.

If you come across a potentially stageable diagnosis not specifically described as malignant and you think it might be reportable, follow these guidelines:

- Check ICD-O to see whether the default NOS code is /2 or /3 for solid organs or in the range /0 to /3 for CNS tumors.
- Check your state registry’s reportable list.
- If the diagnosis is not reportable to the central registry, check with the facility’s cancer committee to determine whether it should be abstracted as reportable-by-agreement.
- If the cancer committee agrees that the diagnosis should be abstracted for local interest, include documentation to that effect in your policy and procedures manual.
- Remember, the existence of a TNM chapter or a schema in CSv2 does not imply that the disease is reportable.

April Fritz, RHIT, CTR, is CEO of A. Fritz and Associates in Reno, Nevada. The opinions in this column are those of the author.
In My Opinion

Case Finding—Now and (Sometime) in the Future

April Fritz, RHIT, CTR

Last July, the Centers for Medicare and Medicaid Services (CMS) published its annual updates to ICD-9-CM that became effective on October 1, 2011, for fiscal year 2012. Included was a short series of new codes that can make your disease index case finding easier. By adding a second decimal digit (also known as the “fifth digit”) to the 173 (malignant neoplasms of skin) codes, health information management coders can distinguish between reportable and non-reportable skin cancers. Table 1 shows the complete list of codes but, to summarize, the following fifth digits have been added to each 173 four-digit rubric:

- 173.0 Unspecified malignant neoplasm
- 173.1 Basal cell carcinoma
- 173.2 Squamous cell carcinoma
- 173.9 Other specified malignant neoplasm

We all know that in most population-based cancer registries in the US, basal cell and squamous cell carcinomas of the skin are not reportable conditions, so the fifth digits...
Table 2. Comparison of ICD-9-CM and ICD-10-CM Lymphoma and Hematopoietic Code Groups

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C81.</td>
<td>Hodgkin lymphoma (was 201._)</td>
</tr>
<tr>
<td>C82.</td>
<td>Follicular lymphoma (was 202.0_, 202.8_)</td>
</tr>
<tr>
<td>C83.</td>
<td>Non-follicular lymphoma</td>
</tr>
<tr>
<td></td>
<td>Includes small B-cell (202.8_), mantle cell (202.4_), diffuse large B-cell (202.0_), lymphoblastic (200.1_), Burkitt (200.2_), other non-follicular (200.3_, 200.5_, and 200.8_), and unspecified non-follicular lymphomas (200.8_)</td>
</tr>
<tr>
<td>C84.</td>
<td>Mature T/NK-cell lymphomas</td>
</tr>
<tr>
<td></td>
<td>Includes mycosis fungoides (202.1_); Sezary disease (202.2_); peripheral T-cell lymphoma, not classified (202.7_); anaplastic large cell lymphoma, ALK-positive (200.6_); anaplastic large cell lymphoma, ALK-negative (200.6_); cutaneous T-cell lymphoma, unspecified (202.8_); other mature T/NK-cell lymphomas (202.8_); and mature T/NK-cell lymphomas, unspecified (202.8_)</td>
</tr>
<tr>
<td>C85.</td>
<td>Other specified and unspecified types of non-Hodgkin lymphoma</td>
</tr>
<tr>
<td></td>
<td>Includes unspecified B-cell lymphoma (202.8_); mediastinal (thymic) large B-cell lymphoma (202.7_, 202.8_); other specified types of non-Hodgkin lymphoma (202.8_); and non-Hodgkin lymphoma unspecified (202.8_)</td>
</tr>
<tr>
<td>C86.</td>
<td>Other specified types of T/NK-cell lymphoma</td>
</tr>
<tr>
<td></td>
<td>Includes extranodal NK/T-cell lymphoma, nasal type (202.81); hepatosplenic T-cell lymphoma (202.87); enteropathy-type T-cell lymphoma (202.83); subcutaneous panniculitis-like T-cell lymphoma (202.83); blastic NK-cell lymphoma (202.80); angioimmunoblastic T-cell lymphoma (200.80); and primary cutaneous CD30-positive T-cell proliferations (200.80)</td>
</tr>
<tr>
<td>C88.</td>
<td>Malignant immunoproliferative diseases and certain other B-cell lymphomas</td>
</tr>
<tr>
<td></td>
<td>Includes Waldenstrom macroglobulinemia (273.3); heavy chain disease (203.80, 203.81); immunoproliferative small intestinal disease (203.80); extranodal marginal zone B-cell lymphoma of mucosa-associated lymphoid tissue (MALT lymphoma) (200.30); other malignant immunoproliferative diseases (203.80, 238.79); and malignant immunoproliferative disease unspecified (203.80)</td>
</tr>
<tr>
<td>C90.</td>
<td>Multiple myeloma and malignant plasma cell neoplasms (was 203._)</td>
</tr>
<tr>
<td>C91.</td>
<td>Lymphoid leukemia (was 204._, 202.40)</td>
</tr>
<tr>
<td>C92.</td>
<td>Myeloid leukemia (was 205._)</td>
</tr>
<tr>
<td>C93.</td>
<td>Monocytic leukemia (was 206._)</td>
</tr>
<tr>
<td>C94.</td>
<td>Other leukemias of specified cell type (was 207._, 238.79)</td>
</tr>
<tr>
<td>C95.</td>
<td>Leukemia of unspecified cell type (was 208._)</td>
</tr>
<tr>
<td>C96.</td>
<td>Other and unspecified malignant neoplasms of lymphoid, hematopoietic and related tissue (was 202.30, 202.50, 202.60, 202.90, 277.89)</td>
</tr>
</tbody>
</table>

1 and 2 can be excluded from computer-generated disease index listings. On the other hand, health records coded with fifth digits 0 and 9 should be reviewed for reportable skin cancers such as adenoid cystic carcinoma, Bowen disease, pilomatrix carcinoma, sweat gland adenocarcinoma, and various sarcomas coded to skin as the primary site. Malignant melanoma cases have long been identified by their own ICD-9-CM code of 172._. Two years ago (for fiscal year 2010), a new code series was added to identify the rare but highly malignant cutaneous Merkel cell carcinomas, 209.3_. The fact that the Merkel cell codes are far outside the numeric sequence of other cutaneous malignancies highlights a developing problem with ICD-9-CM—the neoplasms chapter is running out of empty codes available for use with newly identified or clinically important entities.

If you have not updated your list of case-finding codes for the medical records disease index, it is important that you do so, because when these fifth digit codes were added, the basic 4-digit skin cancer codes (173._) were made obsolete. Also, the 209.3_ codes did not exist prior to October 1, 2009. That means that if your list specifically looks for 173 codes at the decimal level, none will be found. In contrast, if you request every diagnosis in the 140-209 range (plus the straggler malignant codes outside that range), the new 5-digit 173 and 209 codes should appear on the list.

Both CMS and the American Health Information Management Association (AHIMA) indicated that the fiscal year 2012 update would be the last for ICD-9 because of the planned conversion to ICD-10-CM on October 1, 2013.

But that is so last year.

In February 2012, the US Department of Health and Human Services (HHS) announced a delay in implementing ICD-10-CM as the result of pressure from the American Medical Association (AMA), which claims that converting from ICD-9-CM to ICD-10-CM places an undue burden on medical office staffs, not to mention hospital coders. This is the second delay in implementing ICD-10-CM. The original implementation date of October 1, 2011, was extended to 2013 several years ago. HHS officials have not announced a new implementation date. Industry experts believe that the implementation delay will be a minimum of one year, and probably longer. This delay puts AHIMA, which supports
the 2013 implementation date, at odds with the AMA, a vastly larger and more powerful lobbying organization.

From a cancer registry perspective, this is also bad news. ICD-9-CM has been used for health records coding, Medicare claims coding, and DRG grouping since 1983—almost 30 years. Cancer registries successfully made the transition from numeric ICD-9 to alphanumeric ICD-10 with the implementation of the International Classification of Diseases for Oncology, second edition, in 1992. Most currently active registrars probably don’t even remember coding breast primaries as 174 and prostate primaries as 185 in the registry.

The biggest problem with ICD-9-CM is that the lymphoma and leukemia section (200-209) is hopelessly out of date. The terminology in the 200 and 202 codes, such as lymphosarcoma, reticulosarcoma, and Letterer-Siwe disease, dates back to the 1960s, making health record coding a nightmare because lymphoma and leukemia terminology has undergone significant revision and reorganization at least twice in the past two decades. In ICD-9-CM, T-cell and B-cell lymphomas are scattered throughout the lymphoma codes and mixed within individual rubrics. Without a good, annotated ICD-9-CM code book, how can a health record coder know that the largest category of malignant lymphomas, diffuse large B-cell (ICD-O-3 morphology code 9680/3), should be assigned to 200.7, (generic) large cell lymphoma, and that primary cutaneous gamma-delta T-cell lymphoma (9826/3) should be coded to 200.1, lymphosarcoma?

In my opinion, the healthcare field cannot afford another delay in the implementation of ICD-10-CM. Accurate coding of hematopoietic and lymphoid diagnoses would make our registry lives so much easier when it comes to case finding. ICD-10-CM lists many more lymphoma terms and assigns them to an expanded code set. It does a better job of distinguishing separate rubrics for B-cell and T-cell neoplasms as well as other hematopoietic disease entities. Table 2 shows some of the reorganized and more granular codes in the hematopoietic and lymphoid neoplasm ICD-10-CM code range with their corresponding ICD-9-CM codes. It is interesting that as the cancer registry hematopoietic multiple primary and histology coding rules have collapsed all types of Langerhans cell diseases into 9751/3, ICD-10-CM has split them into multifocal/multisystemic, multifocal/unisystemic, and unifocal Langerhans cell histiocytosis codes.


So will we have more ICD-9-CM annual updates? Will ICD-10-CM be implemented in 2013 or later? HHS has made no announcements as of March 1, 2012. Meanwhile, the National Cancer Registrars Association is continuing to work on ICD-10-CM implementation materials and there are US representatives on the international committee already at work on the neoplasms chapter of ICD-11. Stay tuned . . .

April Fritz, BA, RHIT, CTR, is CEO of A. Fritz and Associates in Reno, Nevada. The opinions in this column are those of the author.
ICD-O-3 Terminology Approved for Use with Cases Diagnosed January 1, 2014, and After

April Fritz, CTR

The Change Management Board of the North American Association of Central Cancer Registries (NAACCR) has approved 36 new terms to be added to existing codes in the International Classification of Diseases for Oncology, third edition (ICD-O-3), for use in the United States beginning with cases diagnosed on or after January 1, 2014. Of these terms, 22 are malignant (/3) terms, with the exception of 1 new borderline tumor of the central nervous system, and all of these are reportable. The remaining 14 are benign (/0) or uncertain malignancy (/1) and are not reportable conditions. Table 1 displays the terms approved for use with 2014 diagnoses and forward.

Background

The list of new approved terms is the result of more than 15 months of work by the NAACCR ICD-O-3 Updates Implementation Work Group. In September 2011, the World Health Organization (WHO) published the first update to the ICD-O-3 since its publication in 2000. The update is based on terms and codes approved by the International Agency for Research on Cancer (IARC)/WHO Committee for the International Classification of Diseases for Oncology and incorporated into recently published editions of the WHO Classification of Tumors series, sometimes referred to as the “Blue Books.” These volumes include:

- WHO Classification of Tumors of the Central Nervous System (2007)
- WHO Classification of Tumors of the Hematopoietic and Lymphoid Tissues (2008)
- WHO Classification of Tumors of the Digestive System (2010)

It should be noted that the terms and codes pertaining to the WHO Classification of Tumors of the Hematopoietic and Lymphoid Tissues (fourth edition, 2008) had already been reviewed and accepted by NAACCR and were implemented for use in North America effective with cases diagnosed January 1, 2010. These hematopoietic and lymphoid terms comprised almost half of the terms on the 2011 WHO ICD-O-3 Updates List.

In mid-2012, NAACCR formed the ICD-O-3 Updates Implementation Work Group, which is charged with reviewing the WHO Updates List and determining the possible impact of implementing the new terms and codes. The work group has met about once per month since July 2012 by conference call. On several calls, guest experts were invited to present information about some of the codes and answer questions from the group. Members reviewed the Updates List and drafted the recommendations. Work group members also identified more than 20 files, programs, lists, and other documents that will be affected by the implementation of new codes and terms on the Updates List, including code ranges in both the Collaborative Stage Data Collection System and the AJCC Cancer Staging Manual. The work group presented a report to the NAACCR Change Management Board on April 24, 2013, recommending that a list of new ICD-O-3 terms and codes published by WHO be accepted for inclusion in cancer registry code references for use on and after January 1, 2014. It should be noted that Canada has already implemented the Updates List for their national, provincial, and territorial cancer registries. Work group members from Canada have provided invaluable advice about implementation of the Updates List.

The Need for New Terminology

Changes and improvements in diagnostic technology, such as cytogenetics, immunophenotyping, and immunohistochemistry; new tumor biomarkers; and advances in equipment have increased the understanding of many malignant diseases. As a result, the terminology used to describe these cancers has been evolving for more than a decade. The newer terminology describes specific subsets of cancers when they are clinically unique, sometimes appending to and sometimes replacing existing terminology. When the WHO’s Blue Books are updated and published, the newer terminology becomes mainstream for pathologists and ends up on pathology reports reviewed by cancer registries.

For example, the islet cell tumors of the pancreas (glucagonoma, insulinoma, and others) are now preferably called “pancreatic endocrine tumors” and further subcategorized as functioning and non-functioning. Neuroendocrine tumors of the gastrointestinal tract were called “carcinoids” from 1980 to 2000, then split into well-differentiated endocrine tumors, well-differentiated endocrine carcinoma, and poorly-differentiated endocrine (small cell) carcinoma. Since the 2010 publication of the WHO Digestive System Blue Book, they are now preferably called “neuroendocrine tumor grade 1 (carcinoid)” (8240/3), “neuroendocrine tumor grade 2 (atypical carcinoid)” (8249/3), and “neuroendocrine carcinoma (large cell)” 8246/3;” small cell” 8041/3). The terminology for diffuse adenocarcinoma of the stomach (8145/3) is evolving to “poorly cohesive carcinoma,” a new synonym for “signet ring cell carcinoma” (8490/3).

As pathology terminology evolves, it is necessary to add new terms to our standard references, but this must be done with a carefully considered approach.
Table 1. ICD-O-3 Changes Effective January 1, 2014

<table>
<thead>
<tr>
<th>New preferred term</th>
<th>8150/0 Pancreatic endocrine tumor, benign (C25._)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Move former preferred term to synonym</td>
<td>8150/0 Islet cell adenoma (C25._)</td>
</tr>
<tr>
<td>New related term</td>
<td>8150/0 Pancreatic microadenoma (C25._)</td>
</tr>
<tr>
<td>New preferred term</td>
<td>8150/1 Pancreatic endocrine tumor, NOS (C25._)</td>
</tr>
<tr>
<td>Move former preferred term to synonym</td>
<td>8150/1 Islet cell tumor, NOS (C25._)</td>
</tr>
<tr>
<td>New preferred term</td>
<td>8150/3 Pancreatic endocrine tumor, malignant (C25._)</td>
</tr>
<tr>
<td>Move former preferred term to synonym</td>
<td>8150/3 Islet cell carcinoma (C25._)</td>
</tr>
<tr>
<td>New related term</td>
<td>8150/3 Pancreatic endocrine tumor, nonfunctioning (C25._)</td>
</tr>
<tr>
<td>New related term</td>
<td>8152/1 L-cell tumor</td>
</tr>
<tr>
<td>New related term</td>
<td>8152/1 Glucagon-like peptide-producing tumor (C25._)</td>
</tr>
<tr>
<td>New related term for related term</td>
<td>8152/1 PP/PYY producing tumor</td>
</tr>
<tr>
<td>New preferred term</td>
<td>8154/3 Mixed pancreatic endocrine and exocrine tumor, malignant (C25._)</td>
</tr>
<tr>
<td>New related term</td>
<td>8154/3 Mixed endocrine and exocrine adenocarcinoma (C25._)</td>
</tr>
<tr>
<td>New synonym for related term</td>
<td>8154/3 Mixed islet cell and exocrine adenocarcinoma (C25._)</td>
</tr>
<tr>
<td>New related term</td>
<td>8154/3 Mixed acinar-endocrine-ductal carcinoma</td>
</tr>
<tr>
<td>New synonym</td>
<td>8201/3 Cribriform comedo-type carcinoma (C18._,C19.9, C20.9)</td>
</tr>
<tr>
<td>New synonym to primary term</td>
<td>8201/3 Adenocarcinoma, cribriform comedo-type (C18._,C19.9, C20.9)</td>
</tr>
<tr>
<td>New related term</td>
<td>8213/0 Traditional serrated adenoma</td>
</tr>
<tr>
<td>New related term</td>
<td>8213/0 Sessile serrated adenoma</td>
</tr>
<tr>
<td>New related term</td>
<td>8213/0 Sessile serrated polyp</td>
</tr>
<tr>
<td>New related term</td>
<td>8213/0 Traditional sessile serrated adenoma</td>
</tr>
<tr>
<td>New related term</td>
<td>8240/3 Neuroendocrine tumor, grade 1</td>
</tr>
<tr>
<td>New related term</td>
<td>8240/3 Neuroendocrine carcinoma, low grade</td>
</tr>
<tr>
<td>New related term</td>
<td>8240/3 Neuroendocrine carcinoma, well-differentiated</td>
</tr>
<tr>
<td>New preferred term</td>
<td>8244/3 Mixed adenoneuroendocrine carcinoma</td>
</tr>
<tr>
<td>Move former preferred term to synonym</td>
<td>8244/3 Composite carcinoid</td>
</tr>
<tr>
<td>New synonym</td>
<td>8244/3 Combined/mixed carcinoid and adenocarcinoma</td>
</tr>
<tr>
<td>New synonym</td>
<td>8244/3 MANEC</td>
</tr>
<tr>
<td>New synonym</td>
<td>8249/3 Neuroendocrine tumor, grade 2</td>
</tr>
<tr>
<td>New related term</td>
<td>8249/3 Neuroendocrine carcinoma, moderately differentiated</td>
</tr>
<tr>
<td>New synonym</td>
<td>8263/0 Tubulo-papillary adenoma</td>
</tr>
<tr>
<td>New related term</td>
<td>8290/0 Spindle cell oncocytoma (C75.1)</td>
</tr>
<tr>
<td>New related term</td>
<td>8490/3 Poorly cohesive carcinoma</td>
</tr>
<tr>
<td>New related term</td>
<td>8811/0 Plexiform fibromyxoma</td>
</tr>
<tr>
<td>New related term</td>
<td>8970/3 Hepatoblastoma, epithelioid (C22.0)</td>
</tr>
<tr>
<td>New related term</td>
<td>8970/3 Hepatoblastoma, mixed epithelial-mesenchymal (C22.0)</td>
</tr>
<tr>
<td>New related term</td>
<td>9471/3 Medulloblastoma with extensive nodularity</td>
</tr>
<tr>
<td>New related term</td>
<td>9474/3 Anaplastic medulloblastoma</td>
</tr>
<tr>
<td>New related term</td>
<td>9506/1 Extraventricular neurocytoma</td>
</tr>
</tbody>
</table>

**NOTE:** It is important to understand that cancer registry reportability rules based on behavior code still apply. The addition of a /0 or /1 coded term to ICD-O-3 does not imply that it is now reportable, with the exception of benign and borderline tumors of the central nervous system.
Stepwise Implementation

The Change Management Board approved implementation of a number of terms in the WHO Updates List, but in a stepwise manner. For 2014, only terms added to existing codes have been approved (Table 1). This will minimize the impact on vendors, software developers, and registries to update their programs with new codes and terms. The list includes five new “preferred” terms added to existing reportable codes (replacing the prior bolded term with a new term). In addition, there are many new “related” terms (aligned even with the bolded preferred term in the ICD-O numeric list) and many new “synonyms” (indented under the preferred term or a related term) for both existing codes and new terms and codes. For example, the code 8150/3 exists in ICD-O-3 as “Islet cell carcinoma.” Effective 2014 and forward, the new preferred (bolded) term is “pancreatic endocrine tumor, malignant” and the former preferred term “islet cell carcinoma” is now a synonym (unbolded and indented). In addition, the new related term “pancreatic endocrine tumor, nonfunctioning” is aligned with the preferred term as shown below:

**8150/3 Pancreatic endocrine tumor, malignant (C25._)**

[new preferred term]

- Islet cell carcinoma (C25._)
  [former preferred term, now a synonym]
- Pancreatic endocrine tumor, nonfunctioning (C25._)
  [new related term]

In 2015, 16 new codes and terms will be added to ICD-O-3 (Table 2). Of these, seven are reportable malignant (/3) tumors and five more are reportable borderline (/1) tumors of the central nervous system. Because these are new codes, the terms cannot be used until the codes have been added to registry look-ups and code ranges in software, edits, and/or documentation have been reviewed and updated. Most of these new codes and terms are rare or very site-specific. They are not known to be programmed in any vendor registry software, so trying to use them may result in edit/error messages.

It is important to understand that cancer registry reportability rules based on behavior code still apply. The addition of a /0 or /1 coded term to ICD-O-3 does not imply that it is now reportable, with the exception of benign and borderline tumors of the central nervous system.

### Table 2. ICD-O-3 Changes Effective January 1, 2015

<table>
<thead>
<tr>
<th>Code</th>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>8158/1</td>
<td>Endocrine tumor, functioning, NOS</td>
</tr>
<tr>
<td>8158/1</td>
<td>ACTH-producing tumor</td>
</tr>
<tr>
<td>8163/3</td>
<td>Pancreatobiliary-type carcinoma (C24.1)</td>
</tr>
<tr>
<td>8163/3</td>
<td>Adenocarcinoma, pancreatobiliary type C24.1</td>
</tr>
<tr>
<td>8213/3</td>
<td>Serrated adenocarcinoma</td>
</tr>
<tr>
<td>8265/3</td>
<td>Micropapillary carcinoma, NOS (C18.1, C19.9, C20.9)</td>
</tr>
<tr>
<td>8480/1</td>
<td>Low grade appendiceal mucinous neoplasm (C18.1)</td>
</tr>
<tr>
<td>8552/3</td>
<td>Mixed acinar-ductal carcinoma</td>
</tr>
<tr>
<td>8975/1</td>
<td>Calciying nested epithelial stromal tumor (C22.0)</td>
</tr>
<tr>
<td>9395/3</td>
<td>Papillary tumor of the pineal region</td>
</tr>
<tr>
<td>9425/3</td>
<td>Pilomyxoid astrocytoma</td>
</tr>
<tr>
<td>9431/1</td>
<td>Angiocentric glioma</td>
</tr>
<tr>
<td>9432/1</td>
<td>Pituicytoma</td>
</tr>
<tr>
<td>9509/1</td>
<td>Papillary glioneuronal tumor</td>
</tr>
<tr>
<td>9509/1</td>
<td>Rosette-forming glioneuronal tumor</td>
</tr>
<tr>
<td>9741/1</td>
<td>Indolent systemic mastocytosis</td>
</tr>
</tbody>
</table>

**NOTE:** It is important to understand that cancer registry reportability rules based on behavior code still apply. The addition of a /0 or /1 coded term to ICD-O-3 does not imply that it is now reportable, with the exception of benign and borderline tumors of the central nervous system.

**Make the following reportability change.**

**Behavior code change**

- Delete code and term, 8240/1, Carcinoid tumor, NOS, of appendix (C18.1).
- Code carcinoid tumor, NOS, of appendix to 8240/3.

**Recode the following conditions as shown.**

Recode all cases of enteroglucagonoma, NOS, as 8152/1. Then delete code 8157/1 Enteroglucagonoma, NOS. Enteroglucagonoma is now a related term for glucagonoma. Recode all cases of enteroglucagonoma, malignant, as 8152/3. Then delete code 8157/3 Enteroglucagonoma, malignant.

### Remaining Issues

The publication of this list of approved new terms and its dissemination through the US standard setters does not mean that the job of the ICD-O-3 Updates Implementation Work Group is complete. The group continues to meet to draft an implementation guide and education materials for registrars.

In addition, the review of other terms that were included in the WHO Updates List has not been completed. While the WHO Blue Books reflect current thinking and current terminology among pathologists and specialists, reportability to population-based cancer registries is not clear in many instances. NAACCR is taking a close look at some of the terms and the potential challenges in implementing them as reportable neoplasms in the United States. Most of the problematic terms include the words “high grade neoplasia” or “high grade dysplasia” or “severe dysplasia” in digestive system sites and breast. These dysplasia terms are not included in most states’ reporting legislation. The
The implications of accepting these terms as reportable are being carefully studied, as they may affect not only reporting legislation, but also workload in case ascertainment (case finding), abstracting, follow-up (as applicable) and incidence reporting. The ICD-O-3 Work Group is cooperating with the Cancer Registry Steering Committee and the College of American Pathologists (among others) to make recommendations on the adoption of various dysplasia terminologies for future implementation.

In addition, other issues regarding morphology coding have been identified. These are not within the original scope of the work group but should be addressed sooner rather than later by this or another group established by NAACCR.

- The WHO Classifications of Soft Tissue and Bone; Breast; and Female Genital Organs have been published since 2011. These pathology references include more new terms and codes but they have not been organized into updates lists for future adoption. More updated volumes of WHO Classification are planned. If the current work group is to continue its charge of reviewing new ICD-O terms for potential implementation in the United States, it will need proactive guidance from the standards setters on handling the new codes, designating codes as obsolete, other changes published in these volumes, and timing of implementation.

- Although the new edition of the WHO Lung Classification is not expected until 2015, updated terms for bronchioalveolar carcinoma—including changes in behavior codes—are already in use by pathologists around the United States and Canada. The new terminology should be reviewed and recommendations for interim codes should be disseminated for consistent use in registries long before the WHO Lung Classification is published.

- Reportability guidelines for gastrointestinal stromal (GIST) tumors have been partially addressed in a sentence added to Facility Oncology Registry Data Standards (FORDS) 2013 and the National Cancer Institute’s Surveillance, Epidemiology, and End Results (SEER) 2013 coding and staging manual, which indicate that GIST tumors and thymomas are reportable when there is evidence of multiple foci, lymph node involvement, or metastasis. However, better guidelines for GIST tumors are needed, such as formal interpretation of the risk assessment categories as benign, borderline, or malignant.

Publication of ICD-O-3 2012 Revision

The World Health Organization has announced a 2012 revision of ICD-O-3. This updated printing of ICD-O-3 is in press at the time this article was written and is due to be published in the fall of 2013. Be advised that this new printing includes all the terms added to ICD-O-3 in the 2011 WHO update. Consequently, purchasers of the 2012 revision may be confused by terms added internationally but not yet implemented in the United States. If your ICD-O-3 book is still in reasonably good shape, do not order a replacement yet, as only the terms in Table 1 and Table 2 have been approved in the United States for 2014 and 2015.

Acknowledgements

I gratefully acknowledge the contributions of Shannon Vann, CTR, and the other members of the NAACCR ICD-O-3 Updates Implementation Work Group in the preparation of this article.
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PLANNING FOR THE FUTURE

Quiz Instructions: The multiple choice or true/false quiz below is provided as an alternative method of earning CE credit hours. Refer to the article for the ONE best answer to each question. The questions are based solely on the content of the article. Answer the questions and send the original quiz answer sheet and fee to the NCRA Executive Office before the processing date listed on the answer sheet. Quizzes may not be retaken nor can NCRA staff respond to questions regarding answers. Allow 4–6 weeks for processing following the submission deadline to receive return notification of your completion of the CE process. The CE hour will be dated when it is submitted for grading; that date will determine the CE cycle year.

After reading this article and taking the quiz, the participants will be able to:

• Describe changes in registry data collection beginning with cases diagnosed as of January 1, 2010
• Identify best practices for planning and developing slide presentations
• Discuss ways to enhance a speaker’s presentation

1. Changes in data collection as of January 1, 2010, were based on implementation of:
   a) the sixth edition of the AJCC Cancer Staging Manual
   b) International Classification of Diseases for Oncology, 4th edition
   c) changes to the Collaborative Stage Data Collection System
   d) new multiple primary counting and histology coding rules for solid tumors

2. According to the article, registrars are generally what type of learners?
   a) olfactory
   b) visual
   c) kinesthetic
   d) auditory

3. To maintain an interesting pace and keep the presentation moving along, the article suggests slides be changed every:
   a) 5 to 25 seconds
   b) 30 to 90 seconds
   c) 2 minutes
   d) 5 minutes

4. The article proposes the message and graphics of the presentation should:
   a) be taller than they are wide
   b) be wider than they are tall
   c) have a 1-inch top border
   d) have a 1-inch side border

5. When designing a presentation, which of the following does the author suggest?
   a) 4-7 lines with 4-7 words per line
   b) disabling the auto-fit feature
   c) sentences, rather than phrases
   d) keeping the titles short

<table>
<thead>
<tr>
<th>4-7 lines with 4-7 words per line</th>
<th>disabling the auto-fit feature</th>
<th>sentences, rather than phrases</th>
<th>keeping the titles short</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>b)</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>c)</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>d)</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

6. To help the audience focus on the speaker and the message, the author advises:
   a) a flashy background
   b) an animated background
   c) changing the background color
   d) keeping the background simple

7. To make the presentation easier to read, the author recommends:
   a) black text on a blue background
   b) blue text on a yellow background
   c) darker backgrounds with lighter text
   d) lighter backgrounds with darker text

8. When selecting text styles for a presentation, the author advocates using:
   a) a variety of font styles
   b) a sans-serif font
   c) all capital letters
   d) spaces rather than tab

9. To add impact to a slide, simplify the information, and enhance the audience’s understanding of the topic, the author encourages:

<table>
<thead>
<tr>
<th>cutey graphics such as kittens and bunnies</th>
<th>testing the output before the presentation</th>
<th>using images saved at no more than 150 dpi</th>
<th>proofreading and using spell-check</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>b)</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>c)</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>d)</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

10. According to the article, which of the following demonstrates a good presentation skill?
   a) reading the slides to the audience
   b) avoiding eye contact with the audience
   c) gesturing with the laser pointer
   d) using words that are easy to pronounce
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3 A B C D
4 A B C D
5 A B C D
6 A B C D
7 A B C D
8 A B C D
9 A B C D
10 A B C D

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December 31, 2019

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