

**New Jersey State Cancer Registry E-Tips**  
**May 2012**



**INDUSTRY AND OCCUPATION CODING AND SUPPORT  
FROM THE CDC AND NIOSH**

**Collection of Industry and Occupation (I&O) Data For  
Cancer Registry Professionals**

**Course Description**

The goal of this training module is to improve both the quality and the quantity of industry and occupation information captured from hospital and clinic records in order to increase the value of using this information for public health surveillance and research with the ultimate goal of decreasing the incidence of cancers related to workplace exposures.

This module contains 3 parts:

- Background on the importance of collecting information on the usual (or longest-held) industry and occupation of cancer patients,
- Guidelines for collecting industry and occupation (or I & O), and
- Examples of adequate and inadequate I & O entries.

There is a test at the end. All of those who complete this activity and pass the test (70% or higher) are eligible for 1.5 CEU from NCRA.

To access the module go to: <http://www.cdc.gov/niosh/topics/coding/courses/cancer/>.

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### **CHILDHOOD CANCER**

Please abstract and submit cases of cancer in people 19 years of age or less as soon as they come to your attention, regardless of the year of diagnosis. Due to the low incidence rate in this age group each case is extremely important. Also, due to the sensitive nature of this disease in this age group, rapid reporting is a necessity. Be certain to use all methods of casefinding since some of these cases, specifically leukemias, may be more difficult to identify.

From the National Cancer Institute Fact Sheet on Childhood Cancers  
<http://www.cancer.gov/cancertopics/factsheet/Sites-Types/childhood>

*In the United States in 2007, approximately 10,400 children under age 15 were diagnosed with cancer and about 1,545 children will die from the disease (1). Although this makes cancer the leading cause of death by disease among U.S. children 1 to 14 years of age, cancer is still relatively rare in this age group. On average, 1 to 2 children develop the disease each year for every 10,000 children in the United States (2)*

*Among the 12 major types of childhood cancers, leukemias (blood cell cancers) and cancers of the brain and central nervous system account for more than half of the new cases. About one-third of childhood cancers are leukemias. The most common type of leukemia in children is acute lymphoblastic leukemia. The most common solid tumors are brain tumors (e.g., gliomas and medulloblastomas), with other solid tumors (e.g., neuroblastomas, Wilms tumors, and sarcomas such as rhabdomyosarcoma and osteosarcoma) being less common.*

### **FOLLOW-UP REPORTS**

The NJSCR is no longer able to provide follow-up reports to hospitals for legal reasons. We are attempting to resolve the issues and hopefully will be able to resume providing these reports in the future. Your patience and understanding is appreciated.

Sent 4/19/2012

## **New Jersey State Cancer Registry E-Tips** **March 2012**



### **CS SSF9, Nodes and Surgery conflict for Head and Neck**

CS Site-Specific Factor 9 (Extracapsular Extension Pathologically, Lymph Nodes for Head and Neck), Regional Nodes Positive, and RX Summ--Scope Reg LN Surg must be coded consistently for Head and Neck schemas.

1. If CS Site-Specific Factor 9 = 000 (no lymph nodes involved pathologically), then Regional Nodes Positive must = 00 (all nodes examined negative).
2. If CS Site-Specific Factor 9 = 998 (no pathologic examination of lymph nodes), then ...
  - a) Regional Nodes Positive must = 95 (positive aspiration or core biopsy of lymph nodes) or 98 (no nodes examined) and
  - b) RX Summ--Scope Reg LN Surg must = 0 (no nodes removed) or 1 (biopsy or aspiration of regional lymph nodes, NOS).
3. If CS Site-Specific Factor 9 = 999 (unknown if regional lymph nodes involved pathologically), then Regional Nodes Positive must = 98 (no nodes examined) or 99 (unknown if nodes are positive).

*Note 1: Extracapsular extension is assessed on histopathologic examination of surgically resected involved regional nodes.*

*Note 2: Code the status of extracapsular extension assessed on histopathologic examination of any involved regional lymph node(s) coded in CS Lymph Nodes. Do not code extracapsular extension for any nodes coded in CS Mets at DX.*

*Note 3: If nodes are involved pathologically but there is no statement of extranodal extension in the pathology report, use code 010.*

*Note 4: Code microscopic or macroscopic extranodal extension as stated in the final diagnosis of the pathology report. If not stated in the final diagnosis, code microscopic if extranodal extension is described only in the microscopic section of the pathology report and macroscopic if extranodal extension is described in the gross section of the pathology report. Macroscopic extension takes priority over microscopic extension.*

*Note 5: Use code 040 if pathologic extracapsular extension is described with no further information and the pathology report is not available for review.*

*Note 6: Use code 040 if pathologic extracapsular extension is described with no further information and the pathology report is not available for review.*

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**New Jersey State Cancer Registry E-Tips**  
**February 2012**



## CARCINOID OF THE APPENDIX

Carcinoid tumors of the appendix are **only** reportable when:

1. the pathologist specifies that it is malignant,
2. the pathologist states regional lymph nodes are positive for malignant carcinoid, or
3. discontinuous metastatic implants or involvement are present and stated to be malignant.

Carcinoid tumors are not reportable if:

1. the lymph nodes are positive for benign carcinoid or NOS, or
2. the implants/involvement are not stated to be malignant or are NOS (many benign tumors will spawn implants that are also benign).

CoC, SEER, and NPCR are all in agreement with the above reporting requirements.