

Collecting Cancer Data: Melanoma

NAACCR 2016-2017 Webinar Series

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Q&A

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



••• Fabulous Prizes



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••• Agenda

- Overview
- Epi Moment
- Treatment
- Quiz 1
- Staging
- Quiz 2
- Case Scenarios

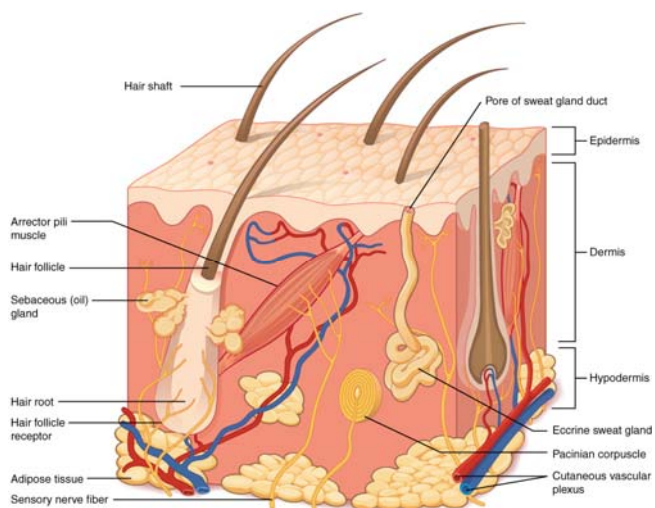
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Melanoma

Overview

Layer of Skin

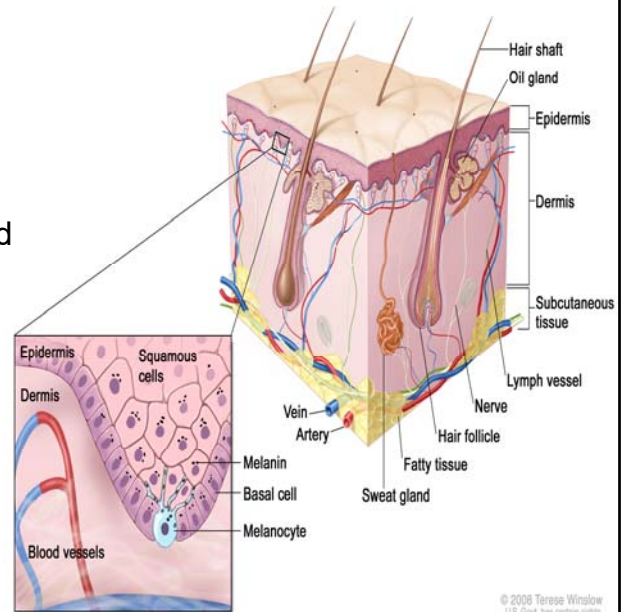
- Epidermis
- Dermis
- Subcutaneous



Anatomy & Physiology, Connexions Web site. <http://cnx.org/content/col11496/1.6/>, Jun 19, 2013.

••• Skin Cells

- Squamous
 - Flat cells
 - Outer part of epidermis
- Basal
 - Divide to replace squamous cells that shed
 - Lower part of epidermis
- Melanocytes
 - Melanin
 - Protects deeper layers of skin
 - Exposed to sun make more pigment



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••• Melanoma Skin Cancers

- Less common than basal and squamous cell cancer
- More dangerous because can spread
- Men: Trunk; Women: Legs
- Less common areas: eyes, mouth, genitals and anal area
- Palms of hands, soles of feet, under nails: African Americans, Asians, Hispanics

Types of Melanoma

- Superficial Spreading Melanoma (8743)
- Nodular Melanoma (8721)
- Lentigo Maligna Melanoma (8742)
- Acral Lentiginous Melanoma (8744)
- Malignant melanoma, NOS (8720)



Possible Signs of Melanoma - ABCDE

- Asymmetry
- Border
- Color
- Diameter
- Evolving



••• Possible Signs of Melanoma – Other Signs

- Sore doesn't heal
- Spread of pigment
- Redness or new swelling beyond border of the mole
- Change in sensation, itchiness, tenderness or pain
- Change in surface of mole



••• Laterality

- Draw a line from mid forehead to mid pelvis and from mid skull to mid buttocks – divides body into right and left half
 - Right
 - Left
 - midline



Multiple Primary and Histology Rules

- M3 – Topography codes different at second (Cxx.x), third (Cxx.x) or Fourth character (Cxx.x) are multiple primaries
- Example
 - Patient has invasive melanoma on right leg (C44.7) and an invasive melanoma on right arm (C44.6)



Multiple Primary and Histology Rules

- M4 – Different laterality are multiple primaries
- Example
 - Patient has invasive melanoma on right trunk (C44.5) and an invasive melanoma on midline trunk (C44.5)



Multiple Primary and Histology Rules

- M5 – Histology codes different at first (xxxx), second (xxxx) or third number (xxxx) are multiple primaries
- Example
 - Patient has invasive melanoma (8720/3) on right leg (C44.7) and another invasive superficial spreading melanoma (8743/3) on right leg (C44.7)



Multiple Primary and Histology Rules

- M6 – Invasive melanoma more than 60 days after an insitu melanoma is a multiple primary
- M7 – melanomas more than 60 days apart multiple primaries



••• Multiple Primary and Histology Rules

- H5 – Code histologic type when diagnosis is regressing melanoma and a histologic type
- H6 – Code 8723 (malignant melanoma, regressing) when diagnosis is regressing melanoma



••• Multiple Primary and Histology Rules

- H7 – Code histologic type when diagnosis is lentigo maligna melanoma and a histologic type
- H8 – Code 8742 (lentigo maligna melanoma) when the diagnosis is lentigo maligna melanoma



Multiple Primary and Histology Rules

- H9 – Code most specific histology term: melanoma, NOS with a single specific type
 - In situ lesions
 - » Pattern, architecture, type, subtype, predominantly, with features of , major or with ____ differentiation
 - Invasive lesions
 - » Type, subtype, predominantly, with features of , major or with ____ differentiation



Epi Moment

Melanoma

Theme song:

Theme from Endless



••• Epidemiology of Malignant Melanoma

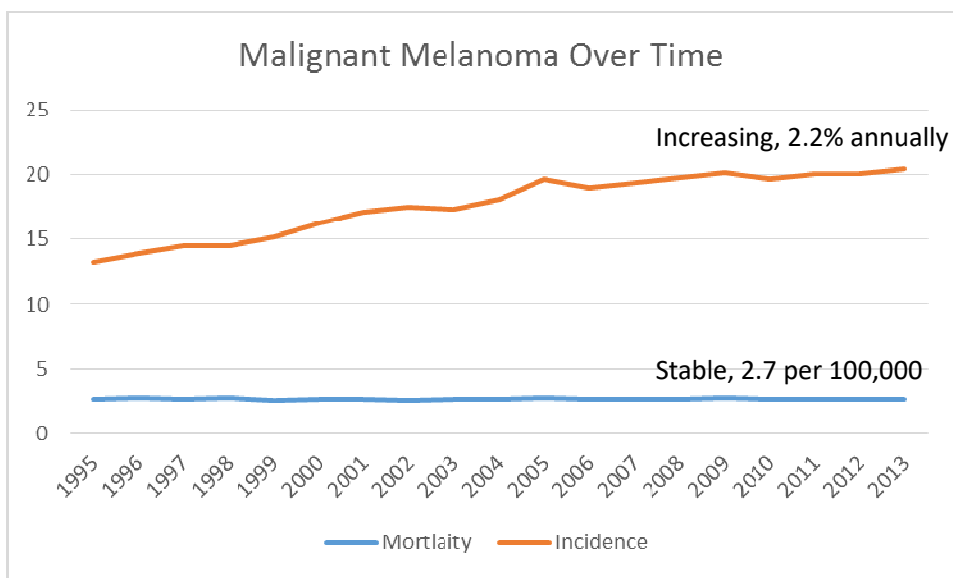
- Increasing worldwide
 - 3-7% annually for whites
 - Highest in Australia/New Zealand
 - 2x NA (climate, demographics, & location/ozone)
 - Influenced by geography (UV exposure)
- Higher among men than women
 - 25.7 versus 16.0 incidence
 - 4.1 versus 1.7 mortality
- Higher among whites
 - 22.9 versus 4.8 AI/ANs; 1.3 APIs, 1.0 blacks incidence
 - 3.1 versus <1 mortality
- Higher among non-Hispanics
 - 25.6 versus 4.5 incidence
 - 2.9 versus <1 mortality



Lifetime risk of melanoma 1 in 63 (invasive)
 Median age at dx 52; 25% < 45

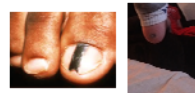


••• Malignant Melanoma Trends, 1995-2013



●●● Cutaneous Melanoma

- Treatment similar for all types
- Superficial spreading melanoma
 - 70% of all cases, common in young people
 - Common on upper back & trunk in men, legs in women
 - Flat or slightly raised discolored patch with irregular borders; often in moles, Spreads superficially
- Nodular melanoma
 - 10-15% of all cases, common in elderly
 - Generally invasive at dx, aggressive
 - Black or other discoloration, bump on trunk, legs & arms
- Lentigo maligna
 - 10% of all cases, In situ, common in elderly (Hawai'i)
 - Flat or slightly elevated tan or brown discoloration, Spreads superficially & slow
 - Sun-exposed, damaged skin on face, ears, arms & upper trunk
 - Invasive = lentigo maligna melanoma
- Acral lentiginous melanoma
 - <5% of all cases, common in blacks, Asians (not whites)
 - Spreads superficially but quickly
 - Black or brown discoloration under the nails (subungal) or on the soles of the feet or palms of the hands
- Amelanotic melanoma
 - <5% of all cases, “without melanin”, can be difficult to diagnosis due to lack of color



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●●● Extra- or Non-cutaneous Melanoma

- Do not develop in skin cells; 4-5% of all melanomas; poor prognosis
- Mucosal melanoma <2% of all cases
 - Generally advanced stage at dx (location not easily seen)
 - Located in mucosal membranes lining respiratory, gastrointestinal and urogenital tract
 - Surgery main tx; movement away from radical surgery, Radiation does not improve survival
- Ocular melanoma
 - Most common extracutaneous type
 - Uveal (choroidal—most common, iris, ciliary body) & conjunctival
 - Surgery or Radiation or both
- Leptomeningeal
 - Worst prognosis—median survival 6-8 weeks
 - Not usually a primary cancer, a metastatic
- Internal organs
 - Rare, also often metastatic



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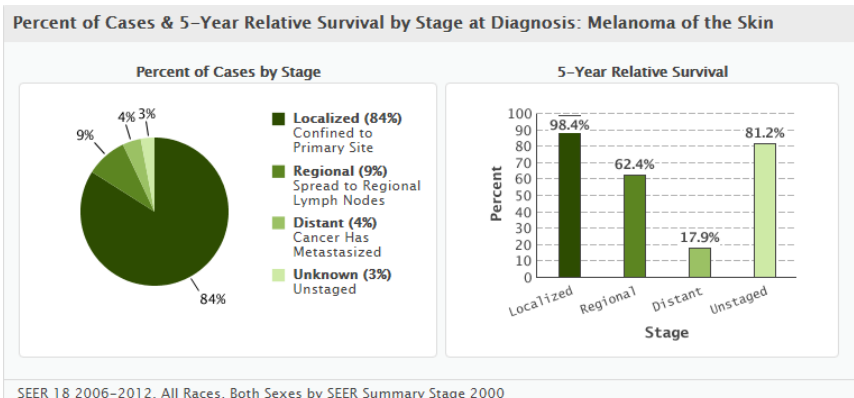
Risk Factors for Melanoma

- Age, Moles (nevus)
- Fair skin, freckles, light hair
- Family history
 - Shared exposures; skin tone
 - No genetic testing currently recommended
 - Xeroderma pigmentosum (rare, inherited, can't repair DNA damage to skin cells)
- Previous melanoma, Weakened immune system
- UV exposure (sunlight, tanning beds)
 - UV small % of sun's rays but damages DNA, causes cancer when DNA of genes controlling skin cell growth are damaged
 - Frequent sunburns, esp childhood (intermittent not occupational)
 - Risk for cutaneous and ocular; not a risk for other types
 - 2009: more tanning salons than coffee shops
 - Newer devices modified to decrease sun burn; still classed as carcinogen
- Occupational exposures



Melanoma Survival

- 90%, 5 year relative
- Survival rates ↑
- Lower
 - Blacks
 - Older age
- Type, stage



Issues with melanoma screening

- Incidence increasing
 - Better detection or more sun exposure?
- Survival rates increasing but mortality no change
 - No true progress against disease
- Self-examination, clinical skin exams
 - Common at community health fairs
 - Regular exams (self & clinical) promoted by ACS and other adv
- 7/22/16 USPSTF
 - Insufficient evidence to assess benefits versus harms of visual skin exams to screen for melanoma
 - Visual skin examination modest sensitivity and specificity for detecting melanoma
- Harms: misdiagnosis, over-diagnosis
 - More limited than other cancers (i.e. removal of mole) but can lead to adverse effects, both cosmetic & occasionally functional

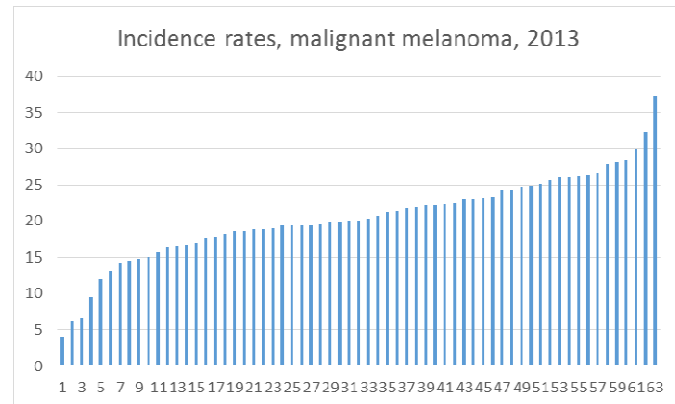


"I don't know what these dots are ...
but ya mind if I connect 'em?"

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Issues with melanoma reporting

- Underreported
 - Due to decentralization of diagnosis
 - Outside hospital system
- **BUT** rates ↑, over-diagnosis!
 - Increasing screening
 - % early stable since 1995, likely a factor prior
 - Increasing risk
 - Increasing ascertainment
 - % path & % phys reporting ↑ since 1995
 - 6 → 11% path; 8 → 19% phys
 - Rates very highly correlated with % path/phys
- Reporting inconsistent by geography
- Caution when comparing rates over time or between geographies
 - Large differences unlikely to represent large changes in risk



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Melanoma Research

- Focus on sun protection, indoor tanning
 - Healthy behaviors; impact of health campaigns
 - Impact of regulation
 - Targeting minorities (Hispanics)
- Additional risk factors
 - SES, diet
- CiNA
 - *Solar ultraviolet-B exposure and cancer incidence and mortality in the United States, 1993-2002*
Boscoe FP, Schymura MJ., BMC Cancer, 2006
 - *The relationship between area poverty rate and site-specific cancer incidence in the United States*
Boscoe FP, Johnson CJ, Sherman RL, Stinchcomb DG, Lin G, Henry KA. Cancer, 2014
- Melanoma Monograph
 - J Am Acad Dermatolo 2011
- Rad Tech
 - NOT RISK FACTORS: height, weight, BMI, age at menarche, menopausal status, HRT, parity, or contraceptive use
 - BUT BRCA2 is a risk
 - Modest increase of risk prior to 1950 or if not using lead aprons/shields



Standard Scenario

- Patient or physician identifies a suspicious lesion and excises the tumor.
 - Tries to get close margins.
 - Thorough physical exam is performed.
- Tumor comes back as melanoma.
 - If necessary, imaging is performed.
- Definitive surgery is performed. Usually, some form of wide excision
 - If warranted, sentinel lymph node biopsy is performed.
 - If warranted, lymph node dissection
- Based on stage, patient may have adjuvant treatment.
- Follow-up plan.



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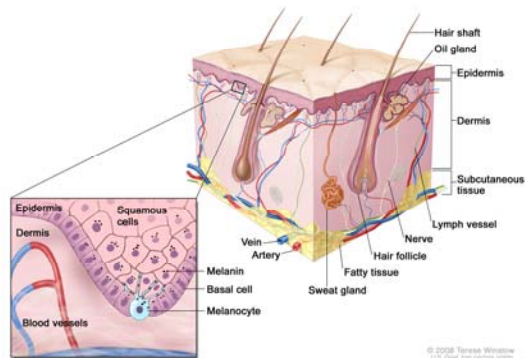
Diagnostic Staging Procedure

- Tumor is very large
- Tumor in a site that is difficult to biopsy
- Margins will be grossly positive on pathology
- Code as a diagnostic staging procedure code 02.

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Biopsies

- Excisional
- Punch
- Shave



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Wide Excision

- Follows the excisional biopsy
- Removes a margin of healthy tissue from around the melanoma site.
- If the margin of healthy tissue is 1cm or less, or the margin of healthy tissue is not stated
- code this procedure using codes 30-33.

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••• Surgery Codes

- Code 30 – original excisional biopsy or technique was not indicated
- Code 31 – original excisional biopsy was a shave biopsy
- Code 32 – original excisional biopsy was a punch biopsy
- Code 33 – original incisional biopsy and then wide excision was done*

*incisional biopsy coded as diagnostic staging procedure



••• Surgery Codes

- Code 45 – wide excision with margins more than 1 cm but not documented if more or less than 2 cms
- Code 46 – wide excision with margins more than 1 cm or equal to or less than 2 cms
- Code 47 – wide excision and margins are more than 2 cms



A 3x2 grid of colored rectangles. The top row has a green rectangle on the left containing the text 'Melanoma' and a blue rectangle on the right. The middle row has a blue rectangle on the left and a green rectangle on the right. The bottom row has a green rectangle on the left and a blue rectangle on the right containing the text 'Quiz 1'.

A 3x2 grid of colored rectangles. The top row has a green rectangle on the left containing the text 'Melanoma' and a blue rectangle on the right. The middle row has a blue rectangle on the left and a green rectangle on the right containing the text 'Summary Stage'. The bottom row has a green rectangle on the left and a blue rectangle on the right containing the text 'TNM Staging'.

Standard Scenario

- Patient or physician identifies a suspicious lesion and excises the tumor.
 - Tries to get close margins.
 - Thorough physical exam is performed.
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Melanoma

Summary Stage

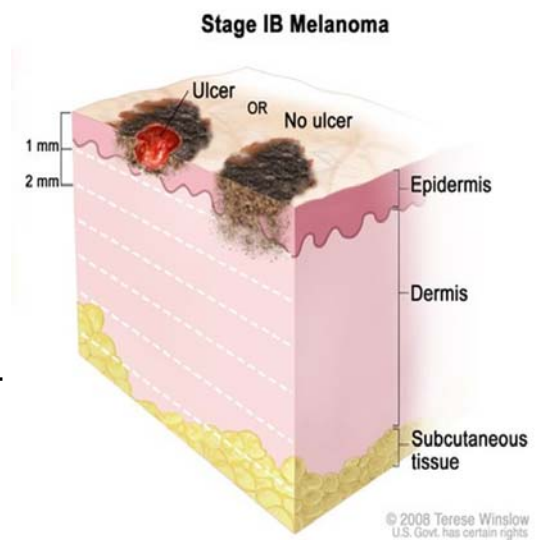
TNM Staging



Summary Stage

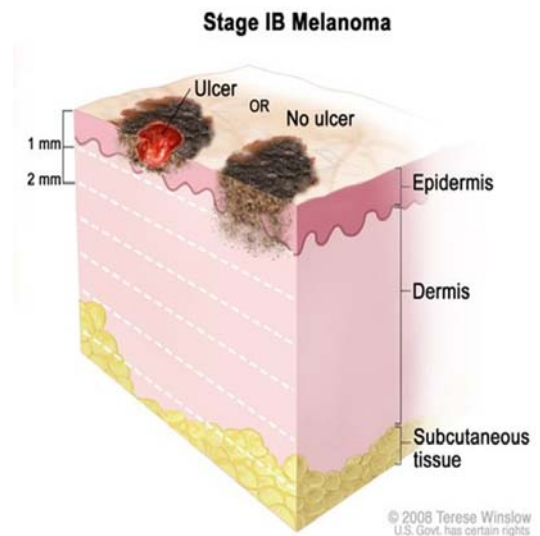
Summary Stage

- **0 In situ:**
 - Noninvasive; intraepithelial
 - Basement membrane of the epidermis is intact; intraepidermal
 - Clark's level I
- **1 Localized only**
 - Papillary dermis invaded-Clark's level II
 - Papillary-reticular dermal interface invaded-Clark's level III
 - Reticular dermis invaded-Clark's level IV
 - Skin/dermis, NOS
 - Localized, NOS



Summary Stage

- **2 Regional by direct extension only**
 - Subcutaneous tissue invaded (through entire dermis)
 - Clark's level V
 - Satellite nodule(s), NOS
 - Satellite nodule(s) < 2 cm from primary tumor
- **3 Regional lymph node(s) involved only**
 - REGIONAL Lymph Nodes by primary site
 - **All sites:**
 - In-transit metastasis (satellite nodules >2 cm from primary tumor)
 - Regional lymph node(s), NOS



Summary Stage

- **4 Regional by BOTH direct extension AND regional lymph node(s) involved**
- **5 Regional, NOS**
- **7 Distant site(s)/lymph node(s) involved**
- **9 Unknown if extension or metastasis**

Summary Stage: Notes

- Note 1: For melanoma of sites other than those above, use site-specific schemes.
- Note 2: If there is a discrepancy between the Clark's level and the pathologic description of extent, use the higher Summary Stage code.
- Note 3: Skin ulceration does not alter the classification. Skin ulceration was considered regional in Historic Stage.
- Note 4: In-transit metastasis was considered regional by direct extension in Historic Stage and Summary Stage 1977



TNM Stage

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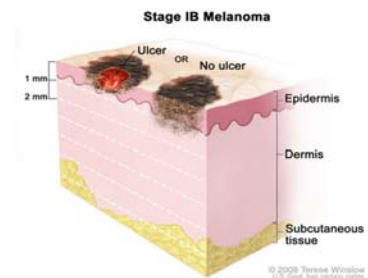
Rules for Classification

- Clinical
 - Complete excision of the primary tumor
 - Clinical assessment (*physical exam and imaging only*) of the regional lymph nodes and intralymphatic metastasis.
- Pathologic
 - Wide-excision/re-excision is considered definitive treatment
 - Pathologic assessment of regional nodes after sentinel lymph node biopsy and/or complete regional lymphadenopathy.
 - Pathologic confirmation of intralymphatic (satellite or in-transit metastasis).
 - Would be highly unusual to have pathologically confirmed intralymphatic metastasis and no lymph nodes removed.



Primary Tumor

- “T” value is based on
 - Breslow’s depth
 - Ulceration (*cannot assume no ulceration if not mention of ulceration*)
 - Mitotic rate (sometimes)
- Excision of the primary tumor is part of the clinical evaluation.
- Wide excision or re-excision are a definitive surgeries that meet the criteria for pathologic stage



(see page 335)



Pop Quiz 1

- A patient present for annual screening by a dermatologist and is found to have a 6mm suspicious lesion on her calf. The lesion is removed. No additional abnormalities were seen during the physical exam.
- Pathology revealed a malignant melanoma.
 - Breslow's depth: 1.3 mm.
 - No ulceration was identified.
- The patient did not return for any additional work-up or treatment.

Data Item	Value
Clinical T	cT2a
Clinical N	cN0
Clinical M	cM0
Clinical Stage	1B
Pathologic T	
Pathologic N	
Pathologic M	
Pathologic Stage	99



Pop Quiz 2

- A patient presented for an annual screening and was found to have a 6mm suspicious lesion on her calf. The lesion was removed. No additional abnormalities were seen during the physical exam.
- Pathology revealed a malignant melanoma.
 - Breslow's depth: 1.3 mm.
 - No ulceration was identified.
- The patient returned for a wide excision that was negative for residual carcinoma. No additional surgery was performed.

Data Item	Value
Clinical T	cT2a
Clinical N	cN0
Clinical M	cM0
Clinical Stage	1B
Pathologic T	pT2a
Pathologic N	pNX
Pathologic M	cM0
Pathologic Stage	99



Pop Quiz 3

- A patient has a suspicious mole removed at her physician's office.
- Pathology confirmed a melanoma with Breslow's depth of 1.2mm.
- Physical exam did not show enlarged lymph nodes.
- A sentinel lymph node biopsy showed no metastasis in 3 lymph nodes.
- A wide excision did not reveal an residual disease.
- She then had a lymphadenectomy with removal of 12 lymph nodes that were all negative for malignancy.
- No further treatment was done.

Data Item	Value
Clinical T	cT2
Clinical N	cN0
Clinical M	cM0
Clinical Stage	99
Pathologic T	pT2
Pathologic N	pN0
Pathologic M	cM0
Pathologic Stage	99



Pop Quiz 3 cont

- Same scenario, path report documented no ulceration.
 - What is the cT and pT?
 - What are the cStage and pStage?
- Same scenario, path report documented ulceration was present.
 - What is the cT and pT?
 - What are the cStage and pStage?

Data Item	Case 1	Case 2	Case 3
Clinical T	cT2	cT2a	cT2b
Clinical N	cN0	cN0	cN0
Clinical M	cM0	cM0	cM0
Clinical Stage	99	1B	2A
Pathologic T	pT2	pT2a	pT2b
Pathologic N	pN0	pN0	pN0
Pathologic M	cM0	cM0	cM0
Pathologic Stage	99	1B	2A



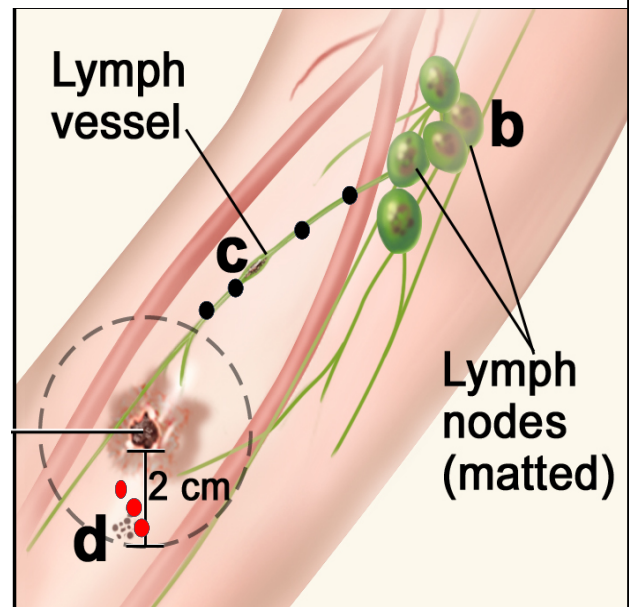
••• cN Regional Lymph Nodes

- Based on imaging and physical done prior to definitive surgery (wide excision).
 - cNX - Cannot be assessed
 - cN0 - No evidence of regional node metastasis
 - cN1- 1 or more clinically apparent metastasis
 - cN2- 2-3 clinically apparent lymph nodes
 - cN2c - In-transit or satellite metastasis (no positive lymph nodes)
 - cN3
 - 1 or more clinically apparent nodes and in-transit or satellite metastasis or
 - More than 3 positive lymph nodes



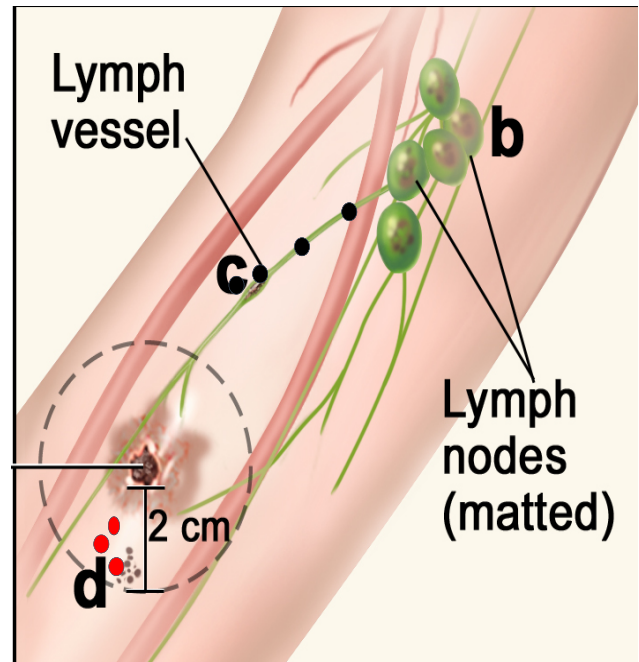
••• Intralymphatic Metastasis

- Satellites (microsatellite)
 - Nodules occurring in the lymphatic channels within 2cm of the primary lesion
- In-transit metastasis
 - Metastasis in the lymph lymphatic channel occurring between the primary and the lymphatic basin



••• Intralymphatic Metastasis

- cN2c
 - Satellite or In-transit mets identified prior to definitive surgery.
- pN2c
 - Pathologically confirmed.



••• pN Regional Lymph Nodes

- Surgically removed regional lymph nodes
 - pN1 – 1 node with positive lymph nodes
 - pN1a micrometastasis
 - pN1b macrometastasis
 - pN2 – 2-3 positive lymph nodes
 - pN2a micrometastasis
 - pN2b macrometastasis
 - pN2c in-transit/satellite metastasis **without** lymph node metastasis
 - pN3 – 4 or more metastatic nodes **or** matted nodes **or** in-transit metastasis/satellite metastasis **with** metastatic nodes
- A and B categories only
For pN

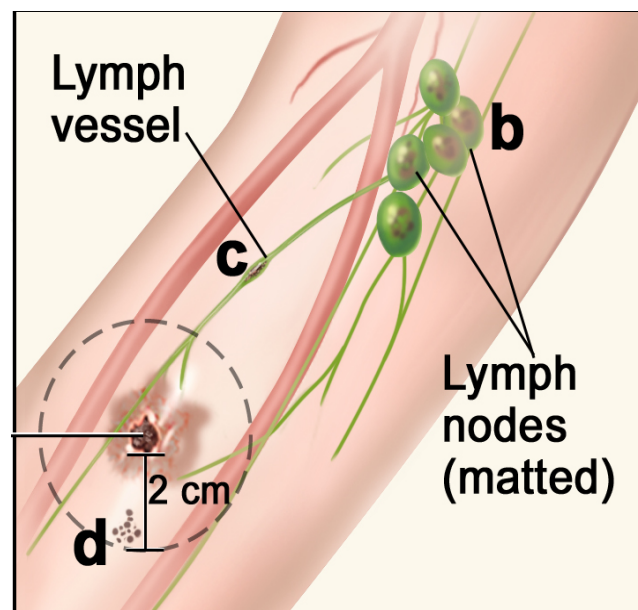
••• Micrometastasis vs Macrometastasis

- Comparing cN with pN
- Micrometastasis
 - cN0
 - Not enough tumor in a lymph node to be felt during physical exam or seen on imaging.
 - Lymph nodes positive for malignancy on surgical exam.
 - Clinically occult
- Macrometastasis
 - Clinically apparent lymph node metastasis
 - Enough tumor is present in the lymph nodes to make them palpable or to appear malignant on imaging



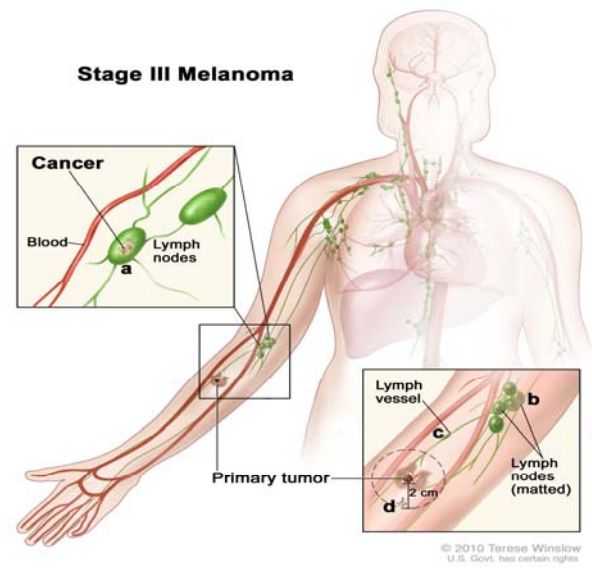
••• Sentinel Node Biopsy

- Usually done on cN0 patients with cT1b or higher.
- Radioactive dye is injected around the site of the melanoma
- Dye is traced to nodes that the tumor drains to.
- May be multiple nodes in multiple basins



Metastasis from an Unknown Primary

- If a patient presents with a positive lymph node and an adequate work-up fails to reveal a primary tumor, code the lymph node as regional.



Pop Quiz 4

- A patient present with an enlarged cervical lymph node.
- An excisional biopsy is done and confirms metastatic melanoma.
- A thorough physical exam is conducted and no primary tumor is identified. Imaging does not show any additional abnormalities.

Data Item	Value
Clinical T	cT0
Clinical N	cN1
Clinical M	cM0
Clinical Stage	3
Pathologic T	
Pathologic N	
Pathologic M	
Pathologic Stage	99

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Pop Quiz 5

- A patient presents for annual screening and is found to have a suspicious mole. The mole is excised and found to be malignant melanoma (cT1b). No palpable lymph nodes were present.
- The patient returned two weeks later for a sentinel lymph node biopsy and wide excision.
- Pathology
 - Wide excision: Negative for residual melanoma
 - Sentinel node biopsy:
 - 4 lymph nodes removed. Micrometastasis measuring less than 0.1mm in a single lymph node. 3 lymph nodes negative for metastasis.

Data Item	Value
Clinical T	cT1b
Clinical N	cN0
Clinical M	cM0
Clinical Stage	3
Pathologic T	pT1b
Pathologic N	pN1a
Pathologic M	cM0
Pathologic Stage	3A

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pStage III

- Stage group 3A
 - pT1a, pT2a, pT3a, or pT4a
 - pN1a or pN2a
 - cM0
- Stage group 3B
 - pT1b, pT2b, pT3b, or pT4b
 - pN1a, pN1b, pN2a, pN2b, or pN2c
 - cM0

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••• Distant Metastasis

- M1a
 - Metastasis to the skin, subcutaneous tissue, or distant lymph nodes
- M1b
 - Metastasis to the lung
- M1c
 - Metastasis to any other “visceral” sites
 - Distant metastases to any site combined with an elevated LDH



••• Serum lactate dehydrogenase (LDH)

- Blood test
- Elevated LDH can help predict survival for patients with distant metastasis.
- Can be a good indicator of recurrent disease.
- LDH is not an effective test to diagnose melanoma
- LDH is not an effective test to identify regional or distant metastasis



Pop Quiz 6

- A patient was found to have cT3b melanoma.
- Imaging and physical exam did not show any suspicious lymph nodes, but did show a malignant appearing mass in the left lung.
- A bronchoscopy with biopsy was positive for malignant metastatic melanoma.
- The LDH was elevated.
- The patient then had a sentinel node biopsy and wide excision.
 - Sentinel node biopsy showed two positive lymph nodes.
 - Wide excision was negative for residual metastasis.

Data Item	Value
Clinical T	cT3b
Clinical N	cN0
Clinical M	pM1c
Clinical Stage	4
Pathologic T	pT3b
Pathologic N	pN2a
Pathologic M	pM1c
Pathologic Stage	4



Pop Quiz

- A patient presents with a solitary brain metastasis.
- A biopsy confirmed malignant melanoma.
- Work-up revealed no primary site no other disease
- The LDH was normal.

Data Item	Value
Clinical T	cT0
Clinical N	cN0
Clinical M	pM1c
Clinical Stage	4
Pathologic T	
Pathologic N	
Pathologic M	pM1c
Pathologic Stage	4





Questions?

SSF1

- Measured Thickness (Depth), Breslow Measurement
 - Documents depth of invasion of primary melanoma
 - Predicts risk of nodal metastasis
 - Is a factor in determining T category
 - Record to hundredths of mm as documented in path report
 - Record greatest measurement from any procedure whether biopsy or excision

SSSF2

- Ulceration
 - Is the absence of intact epidermis over the melanoma
 - Is an important adverse prognostic factor
 - Record presence or absence of ulceration as documented in path report
 - Code as 000 (no ulceration present) if there is no documentation or mention of ulceration in path report
 - Caution...this is not the same rule we use to assign the a and b subcategories for the T value!

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SSSF3

- Clinical Status of Lymph Node Mets
 - Tumor burden in regional nodes is an important prognostic factor
 - Micrometastases
 - Clinically inapparent metastasis histologically diagnosed after sentinel node biopsy and lymphadenectomy (if performed)
 - Macrometastases
 - Clinically detected nodal metastasis confirmed by lymphadenectomy or nodal metastasis with gross extracapsular extension

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SSSF4

- Serum Lactate Dehydrogenase (LDH)
 - Is a significant predictor of survival among patients who present with or develop distant metastasis
 - Record range for positive LDH prior to treatment or within 6 weeks of diagnosis
 - First positive test is priority
 - Is a factor in determining M category
 - Use same test to code SSSF4, SSSF5, and SSSF6

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SSSF4

- Positive LDH results from 2 lab tests required to code as positive
 - Assign code 000 (within normal limits) if 1st test positive and 2nd test negative
 - Assign code 998 (test not done) if 1st test positive and no 2nd test performed
 - Assign code 999 (unknown) if 1st test positive and no information about 2nd test
 - Assign code 000 if only 1 test performed and it is within normal limits

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SSF7

- Primary Tumor Mitotic Count/Rate
 - Increasing mitotic rate correlates with decline in survival
 - Based on number of mitoses in one square mm surrounding a 'hot spot' or a field with representative mitosis
 - Is a factor in determining T category
 - Record mitotic rate/count as documented in path report

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Questions?

Coming Up...

- Collecting Cancer Data: Hematopoietic and Lymphoid Neoplasm
– 11/3/2016
- Collecting Cancer Data: Lung
– 12/1/2016



Fabulous Prizes



CE Certificate Quiz/Survey

- Phrase
- Link
 - <http://www.surveygizmo.com/s3/3081649/Melanoma-2016>



Thank You!

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