July 2022

2022 FCDS Virtual Annual Meeting Registration Announcement - Thursdays @ 1pm-3pm from 8/11/2022 - 9/1/2022

FCDS and FCRA have been working together to bring you a series of 'current topic' webinars starting in August 2021 and concluding in early September 2021.

This announcement and the webinar registration links are for the FCDS Thursday Sessions, only; 8/11/2022-9/1/2022.

The FCRA Conference Agenda and Registration will sent under a separate announcement.

FCDS will host 4 sessions beginning August 11. The FCDS sessions will include 1 webinar each week every Thursday from August 11 – September 1 from 1pm-3pm.

Participants must register for each of the sessions you plan to attend rather than one single registration for the entire 4-part series.

FCDS encourages ALL Florida Registrars including Florida Interim Staffing Companies and Individual Contractors to attend ALL 4 Sessions.

Each session will provide an entirely different set of information. All sessions are equally relevant and timely. Each webinar will be FREE of Charge.

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What's New:

The following information is currently available on the FCDS website.

Weight-Related Cancers in Florida 1992-2013 Monographs

FCDS Research Journal Publications Report

FCDS/NAACCR EDITs Metafile
V22b Metafile,
posted on 6/15/2022

FCDS/NAACCR WEBINAR SERIES:
NAACCR 2021-2022 Cancer Registry and Surveillance Webinar Series 8/4/2022– Solid Tumor Rules 2022 ***** In person attendance cancelled until further notice. Please Login to FCDS IDEA->Education->FLccSC Learning Management 2 weeks after webinar to watch recordings and get CEUs *****

FCDS Florida Cancer Data System

Florida Statewide Cancer Registry

Florida Cancer Data System Deadlines, Updates, & Reminders

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CEUs: FCDS will offer 4 webinars for up to 8 FREE CEU Hours. Each webinar will be awarded CEUs separately by NCRA. The conference series will be recorded.

2022 FCRA and FCDS Virtual Educational Conferences:

- FCRA Virtual Annual Conference – August 1, 2022 and August 2, 2022
- FCDS Virtual Annual Conference – August 11, 2022 – September 1, 2022
- FCDS Annual Educational Webinar Series – 9/22/2022 – 2/16/2023 – Every Thursday from 1pm-3pm

Session	Date/Time	Estimated Time	2022 FCDS Virtual Annual Conference - Topic	Registration Link
FCDS Session 1	8/11/2022 1pm-3pm	1:00pm-1:10pm	Welcome to the 2022 FCDS Virtual Annual Meeting Webinar Series	https://miami.zoom.us/webinar/register/WN_ItcYWZ1hT0KFWynH3vtphg
		1:10pm-1:30pm	DOH and FCDS Updates – State of the State	
		1:30pm-1:50pm	Social Determinants of Health	
		1:50:pm-2:10pm	Genetics Primer – Genetics for Central Cancer Registry	
		2:10pm-2:30pm	Data Visualization Platforms	
		2:30pm-2:45pm	Lung Cancer Survival Among Male Florida Career/Volunteer Firefighters	
		2:45pm-3:00pm	Becoming a CTR – NCRA Clinical Practicum & CTR Exam Core Competencies	
FCDS Session 2	8/18/2022 1 pm-3pm	1:00pm-1:15pm	2020-2021 Data Acquisition Summary & 2022 Completeness of Reporting	https://miami.zoom.us/webinar/register/WN_CuavsScfSuyRrKi3atWOBQ
		1:15pm-1:30pm	2021 QC Activity Summary & Findings (Audits/QC Review/NPCR DQE)	
		1:30pm-2:00pm	2022 Audits – 2019 DX NET/NEC - 2020 DX Myeloid/Lymphoid Neoplasms	
		2:00pm-2:30pm	What's New in 2022? 2022 Florida Cancer Reporting Requirements	
		2:30pm-2:40pm	FCRA/FCDS Task Force – Florida Guide for Contracted Abstracting Services	
		2:40pm-2:50pm	2022-2023 FCDS Education and Training Plan	
		2:50pm-3:00pm	Annual FCDS Jean Byers and Pat Strait Awards	
FCDS Session 3	8/25/2022 1pm-3pm	1:00pm-2:00pm	NCCR & STAR Projects – Pediatric, Adolescent and Young Adult Cancers	https://miami.zoom.us/webinar/register/WN_3XWR4L01TsWvSe-oqH59UQ
		2:00pm-3:00pm	What's New in Cancer Care –Diagnosis, Workup, Tumor Markers, TX	
FCDS Session 4	9/01/2022 1pm-3pm	1:00pm-2:00pm	Myeloid Neoplasms – MPN, MDS, Acute/Chronic Myeloid Leukemia	https://miami.zoom.us/webinar/register/WN_xz1YBm9cTVeXxlfHxbq48g
		2:00pm-3:00pm	Lymphoid Neoplasms – Nodal/Extra-Nodal Lymphoma, Plasma Cell Neoplasms, Lymphoid Leukemia, and the Lymphoma/Leukemia Classification Group	

Florida Cancer Data System Deadlines, Updates, & Reminders

FCDS Conversion and Maintenance Schedule

FCDS will be performing data conversion to the NAACCR Version 22 and performing system maintenance in the upcoming weeks. Please carefully read the schedule below. We anticipate all processes to go as planned. We ask that you check FCDS IDEA regularly for updates.

1. June 30, 2022, at midnight through Monday, July 18, 2022- IDEA will be disabled
2. July 1, 2022, thorough July 18, 2022- NAACCR V22 Conversion and FCDS system maintenance

V21 XML and V22 XML Data Submission

FCDS will allow data uploads in V21 XML in conjunction with V22 XML. Data uploads in V21 XML will be allowed until September 30, 2022. FCDS will extend this date if necessary.

Effective October 1, 2022, all data uploads will need to be using V22 XML only.

FCDS EDITSv22B

The FCDS EDITSv22B metafile dated 6/14/22 is available on the FCDS Website under Downloads, and it has also been posted to the NAACCR Repository. Data submitted in V22 XML must use the FCDS EDITSv22B metafile. Please be sure to let FCDS know if you find any problems with any old or new edits.

The metafile and associated files include all new and revised standard and Florida-specific edits. These are the three ancillary excel files also posted:

- FCDS v22B Change Spreadsheet
- FCDS New Error Messages v22B
- FCDS Metafile v22B Error Messages Report

FLccSC

FLccSC will not be available July 5, 2022 only. During conversion and system maintenance FLccSC will remain available, but it will not allow users to access FLccSC via the FCDS IDEA. In addition, Abstractor Codes that expire during the two-week period from 7/1-7/18 will be extended 15 days.

2021 Jean Byers Memorial Awards

FCDS presents the Jean Byers Memorial Award for Excellence in Cancer Registration each year to those facilities that have met or exceeded the national quality standards for timeliness and completeness in cancer reporting. However, we recognize that the cancer registry community has gone through many challenges these past few years since 2018 and through the pandemic which has impeded many registries to fully meet these national quality benchmarks. These challenges were industry related and others were out of our control.

FCDS has made the decision to cancel the 2021 Jean Byers Memorial Award for the 2019 data. Future awards will be evaluated next year.

We would like to recognize the sixty-one reporting facilities below because despite the many difficulties, they met or even exceeded the national quality standards for timeliness and completeness in cancer reporting. FCDS appreciates the commitment and effort that these facilities place in meeting these critical goals.

Criteria:

- Met the 2019 Annual Reporting Deadline of 9/30/20
- No more than 5% of the 2019 cancer case admissions reported to FCDS within 2 months (60 days) following the 9/30/20 deadline
- No more than 10% of the 2019 cancer case admissions reported to FCDS within 12 months following the 9/30/20 deadline

Honorable Mention

1100-SHANDS UNIVERSITY OF FLORIDA

1306-BAY MEDICAL CENTER

1609-IMPERIAL POINT MEDICAL CENTER

1636-HOLY CROSS HOSPITAL

1645-BROWARD HEALTH CORAL SPRINGS

1686-FLORIDA MEDICAL CENTER

1800-FAWCETT MEMORIAL HOSPITAL

2205-SHANDS LAKE SHORE REGIONAL MED CTR

2307-WEST KENDALL BAPTIST HOSPITAL

2348-DOCTORS HOSPITAL

2349-HIALEAH HOSPITAL

2353-NORTH SHORE MEDICAL CENTER

2359-NICKLAUS CHILDREN'S HOSPITAL

2372-U OF MIAMI HOSPITAL CLINICS

2376-SOUTH MIAMI HOSPITAL

2377-WESTCHESTER GENERAL HOSPITAL

2383-PALMETTO GENERAL HOSPITAL

2605-BAPTIST MEDICAL CENTER BEACHES

2606-SHANDS JACKSONVILLE MEDICAL CENTER

2636-BAPTIST MEDICAL CTR JACKSONVILLE

2640-BAPTIST MEDICAL CENTER SOUTH

2647-NEMOURS CHILDREN'S HOSPITAL

2648-MEMORIAL HOSPITAL JACKSONVILLE

2672-WOLFSON CHILDREN'S HOSP NCC

2738-ASCENSION SACRED HEART

3300-ASCENSION SACRED HEART ON THE GULF

3906-TAMPA GENERAL HOSPITAL

3907-ADVENTHEALTH TAMPA

3932-H LEE MOFFITT CANCER CENTER

3938-SOUTH FLORIDA BAPTIST HOSPITAL

3978-HCA FLORIDA WEST TAMPA HOSPITAL

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4105-CLEVELAND CLINIC INDIAN RIVER HOSP

4516-LEESBURG REGIONAL MEDICAL CENTER

4547-ADVENTHEALTH WATERMAN

4601-CAPE CORAL HOSPITAL

4605-LEE MEMORIAL HEALTH SYSTEM

4645-REG CANCER CTR GULF COAST HOSPITAL

4647-LEHIGH REGIONAL MEDICAL CENTER

4690-LEE MEMORIAL HOSPITAL HEALTHPARK

5100-BLAKE MEDICAL CENTER

5446-FISHERMENS HOSPITAL

5471-MARINERS HOSPITAL

5505-BAPTIST MEDICAL CENTER NASSAU

5610-ASCENSION SACRED HEART EMERALD COAST

6003-DELRAY MEDICAL CENTER

6007-LAKESIDE MEDICAL CENTER

6036-ST MARY'S MEDICAL CENTER

6206-HCA FLORIDA LARGO HOSPITAL

6246-JOHN HOPKINS ALL CHILDREN'S HOSPITAL

6251-ST ANTHONY HOSPITAL

6305-LAKELAND REGIONAL MEDICAL CENTER

6346-BARTOW REGIONAL MEDICAL CENTER

6347-ADVENTHEALTH HEART OF FLORIDA

6348-ADVENTHEALTH LAKE WALES HOSPITAL

6349-WINTER HAVEN HOSPITAL

6570-FLAGLER HOSPITAL

6707-SANTA ROSA MEDICAL CENTER

6846-SHOREPOINT HEALTH VENICE

6905-CENTRAL FLORIDA REGIONAL HOSPITAL

7005-VILLAGES REGIONAL HOSPITAL

7105-LAKE CITY MED CTR SUWANNEE

CLARIFICATION FROM APRIL 2022 MEMO – RQRS/RCRS & COMPLETED CASES

Apparently, the last FCDS Memo caused some confusion with regard to submitting cases to FCDS when the RQRS/RCRS Complete First Course of Treatment had not been completed according to the treatment plan on or before the June 30th FCDS Annual Reporting Deadline. This should be an exceedingly rare case – but, this is what you need to do.

If your RCRS/RQRS Case has not yet been completed on or before the June 30th FCDS Annual Reporting Deadline, you should report the case as 'Incomplete' – BUT, you need to record the treatment from the Treatment Plan that has yet to be started as 'treatment recommended'. Then report the case. It is as simple as that. No need to complicate things and create 'what if' problems that do not exist. If the treatment has already started – just enter the start date. If the treatment has yet to begin and is part of the documented Treatment Plan – record it as 'recommended unknown if given.'

This should be a rare case. The cases required to be reported by June 30th would be between 6 months and 18 months out from the date of diagnosis and the start of treatment. When planned first course of treatment is still pending at the time of FCDS Deadline – please submit the case with treatment recommended according to the physician recorded treatment plan. Keep it simple, please.

FCDS 2020 Consolidated Follow Back Records Available for Review

FCDS completed the matching of the 2020 In-Patient and Out-Patient Discharges reported by Florida reporting hospitals' and ambulatory surgery centers' Finance-Billing/Medical Records Department to the Agency for Health Care Administration (AHCA). All records with principal or secondary diagnosis of cancer were linked to the FCDS database. A match was also completed of the Florida Vital Statistics Death Certificates for 2020. All non-matching records have been placed in IDEA for review.

Each case on the queue must be reviewed online. If the case is found to not be reportable, assign the appropriate disposition code; if the record was previously reported to FCDS assign disposition code 07, accession number, and sequence number, then press the Submit button. In addition, any case found to meet the FCDS Cancer Case Reporting Requirements outlined in Section I of the FCDS DAM and found to not have been previously reported must be reported to FCDS using IDEA. These are considered missed cases. Assign a disposition code of 01, accession number, and sequence number to the reportable cases and press the Submit button. **These disposition code 01 records (missed cases) must be electronically reported to FCDS within 30 days of assigning the disposition code, otherwise, after the 30 days, the record(s) will be placed back in the queue and marked as incomplete.**

The deadline to complete the review and submission of any missed cases is September 1, 2022.

Please keep in mind that all audits conducted by FCDS are dictated and closely monitored by the Florida Department of Health. Facilities failing to meet the reporting requirements will be reported to DOH for non-compliance. Should you have any questions, please contact your Field Coordinator at (305) 243-4600.

Active Surveillance or Watchful Waiting Is there a difference? YES

Cancer Registries started recording the data item "Treatment Status" back in 2010. This was the first time we were given an opportunity or a place to record 'active surveillance/watchful waiting' for prostate cancers. It had been nearly 20 years since the PSA became a 'first-line screening test' for prostate cancer. Population-Based Screening Guidelines were developed and promoted as the way to find prostate cancer early and to treat it definitively when found. These screening guidelines were adopted far and wide resulting in improved survival and mortality. PSA Screening was a huge success.

During the years 1990-2010 many thousands of men were screened for prostate cancer with the combination of PSA and DRE (digital rectal examination). And, many thousands of prostate cancers were identified and treated with prostatectomy and/or radiation therapy.

PSA Screening resulted in the identification of many cancers (early and late stage), treatment of many cancers (early and late stage), and these in turn helped to improve survival and mortality for prostate cancers across the board. But, at the same time we were improving survival and mortality from prostate cancer, we were also learning more about the risk versus benefit of finding and treating early cancers based on an elevated PSA.

By the early 2010s, population-based PSA screening was being called into question because of concerns that the benefits of screening may not justify the risks of overdiagnosis and overtreatment of potentially harmless prostate cancers. Were we really improving and extending the lives of all men diagnosed and treated for their prostate cancer?

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Or, were we finding and treating far more prostate cancers than needed treatment for their disease (overdiagnosis and overtreatment)? And, was that a negative risk?

So, our research began to focus on trying to find a balance between the benefits of treatment for early diagnosis and the potential harms of overtreatment (providing treatment when it would not truly benefit the patient by extending his life or improving his life – only treat the cancer). This was accomplished by identifying strategic 'risk groups' for treatment stratification. And then modifying screening guidelines based on the best treatment options available for these strategic risk groupings.

The current Prostate Cancer Risk Groups are based on a combination of the PSA prior to biopsy, the Gleason Score and Grade, and the expected lifetime of the patient. Treatment has become more individualized and 'very early' prostate cancer patients are now given the option of receiving treatment or not receiving treatment based on the overall profile of their cancer. Additionally, prostate cancer screening guidelines have changed multiple times between 1990-2020.

So now we have a group of individuals who may be prescribed a 'watch and wait' approach or an 'active surveillance' approach to treatment. Both approaches delay treatment of the cancer. But the differences are somewhat nuanced.

We as registrars have 1 field under Treatment Status to record 'Active Surveillance'. However, most registrars do not recognize the difference between 'watch and wait' and 'active surveillance' and use this field value for both, incorrectly.

"Active Surveillance" involves actively monitoring the course of disease with the expectation to intervene with treatment for a curative intent if the cancer progresses. Life expectancy is a key determinant when deciding on 'active surveillance' as the primary treatment plan. These are generally younger patients with life expectancy greater than 10 years and with very low risk disease. Some patients with intermediate risk disease and a life expectancy greater than 10 years may opt for 'active surveillance' as well. The intent is to begin treatment to cure the patient once the cancer begins to show signs of progression. This is not simply observation of their disease – it is active surveillance.

A patient in "Active Surveillance" will have frequent PSA (at least once every 6 months), DRE (at least once a year), repeat biopsy at least once a year, repeat imaging at least once a year, etc. There is a schedule to the activities used to surveille or keep an active eye on the cancer for signs of progression. This is a decision to delay curative treatment.

"Watch and Wait" on the other hand is just 'Observation'. Observation or 'NO TREATMENT' is the treatment of choice when a patient has a life expectancy less than 10 years and has low to very high risk of disease progression or already has regional or metastatic prostate cancer and a life expectancy less than 5 years. Treatment of any kind is postponed until the patient becomes symptomatic. Once the patient becomes symptomatic, he may qualify for definitive therapy or for palliative care depending on the progression and re-stage of disease and patient choice to treat or not to treat. But, the patient with a shorter life expectancy can avoid the possible side effects of unnecessary confirmatory testing and definitive therapy when he undergoes a true 'watch and wait' plan to treat only once symptoms occur.

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Treatment Status should only be coded as 'active surveillance' when you know there is a treatment plan to actively monitor and regularly test the patient to check for disease activity that will serve as a trigger to begin definitive therapy.

"Watch and Wait" on the other hand should be coded as 'NO TREATMENT' because it is 'observation only'.

Below is a table from the NCCN Guidelines that further elucidates Risk Stratification and Staging Workup for Prostate Cancer. This may help registrars better understand the various risk groups and why certain decisions to delay treatment, only observe the patient, or immediately treat the patient is recommended.

TABLE. Risk Stratification and Staging Workup of Prostate Cancer[1]

Risk Group	Clinical/Pathologic Features	Imaging	Molecular Testing of Tumor	Genetic Testing of Tumor
Very low	All of the following: • T1c • Gleason score ≤6/grade group 1 • PSA <10ng/mL • <3 prostate biopsy fragments/ cores positive, ≤50% cancer in each fragment/core • PSA density <0.15 ng/mL/g	Not indicated	Not indicated	Consider if there's a strong family history
Low	All of the following: • T1-T2a • Gleason score ≤6/grade group 1 • PSA <10ng/mL	Not indicated	Consider if life expectancy is ≥10 years	Consider if there's a strong family history
Intermediate-favorable	Any of the following: • T2b-T2c • Gleason score 3+4=7/grade group 2 • PSA 10-20 ng/mL PLUS percentage of positive biopsy cores <50%	• Bone imaging: not recommended for staging • Pelvic ± abdominal imaging: recommended if nomogram predicts >10% probability of pelvic lymph node involvement	Consider if life expectancy is ≥10 years	Consider if there's a strong family history
Intermediate-unfavorable	Any of the following: • T2b-T2c • Gleason score 3+4=7/grade group 2 or Gleason score 4+3=7/grade group 3 • PSA 10-20 ng/mL	• Bone imaging: recommended if T2 and PSA >10 ng/mL • Pelvic ± abdominal imaging: recommended if nomogram predicts >10% probability of pelvic lymph node involvement	Not routinely recommended	Consider if there's a strong family history
High	Any of the following: • T3a • Gleason score 8/grade group 4 or Gleason score 4+5=9/grade group 5 • PSA >20 ng/mL	• Bone imaging: recommended • Pelvic ± abdominal imaging: recommended if nomogram predicts >10% probability of pelvic lymph node involvement	Not routinely recommended	Consider
Very high	Any of the following: • T3b-T4 • Primary Gleason pattern 5 • >4 cores with Gleason core 8-10/ grade group 4 or 5	• Bone imaging: recommended • Pelvic ± abdominal imaging: recommended if nomogram predicts >10% probability of pelvic lymph node involvement	Not routinely recommended	Consider
Regional	Any T, N1, M0	Already performed	Consider tumor testing for: • homologous recombination gene mutations • MSI/dMMR	Consider
Metastatic	Any T, any N, M1	Already performed	Consider tumor testing for: • homologous recombination gene mutations • MSI/dMMR	Consider

dMMR indicates mismatch repair deficiency; MSI, microsatellite instability; PSA, prostate-specific antigen.

Also New in the SEER Hematopoietic and Lymphoid Neoplasms Coding Manual

When you MUST assign DX Confirmation = 3 and when you NEVER assign DX Confirmation = 3 (9590/3-9993/3)

You can find the 2022 Revision to the ***SEER Hematopoietic and Lymphoid Neoplasms Coding Manual*** on the SEER Heme Data Base under Downloads at; https://seer.cancer.gov/seertools/hemelymph/)

See the 'Diagnostic Confirmation Coding Instructions' Section of the ***SEER Hematopoietic and Lymphoid Neoplasms Coding Manual*** **for critical clarifications on coding DX Confirmation (p18-20 of the manual).**

Below are a highlights from Section for codes 1, 2 and 3 that are worth noting – for ALL registrars.

There is no priority order or hierarchy for coding the Diagnostic Confirmation for hematopoietic or lymphoid neoplasms. Frequently, a bone marrow biopsy provides provisional diagnoses and the specific histologic type is determined through immunophenotyping or genetic testing.

- Use code 1 when ONLY the tissue, bone marrow, or blood was used to diagnose the specific histology.
- Do not use code 1 if the provisional diagnosis was based on tissue, bone marrow, or blood and the immunophenotyping or genetic testing on that same tissue, bone marrow, or blood identified the specific disease (see Code 3).

Code 1: Positive Histology

Code 1 includes a provisional diagnosis and/or several provisional (differential) diagnoses which may or may not be preceded by approved ambiguous terminology.

Assign code 1 for

1) **Tissue from lymph node(s), organ(s) or other tissue specimens** from biopsy, frozen section, surgery, or autopsy
2) **Bone marrow specimens (aspiration and biopsy)**
3) **Peripheral blood smear**
   Can be used as a histological diagnosis for any of the hematopoietic histologies (9590/3-9993/
4) **Leukemia only (9800/3-9948/3): positive histology also includes**

a) Complete blood count (CBC)

b) **White blood count (WBC)**

c) **Immunophenotyping, genetic testing,** or JAK2 **not done OR** Immunophenotyping, genetic testing, or JAK2 **done but negative (non-diagnostic)**

5) IHC studies are done, but the patient has a provisional (NOS) diagnosis or one or more provisional diagnoses.
6) Historical cases not already in the database if information states that there was histologic confirmation

Code 2: Positive Cytology

Code 2 is RARELY used for Hematopoietic and Lymphoid Neoplasms.

1) Examination of fluid such as spinal fluid, peritoneal fluid, or pleural fluid
2) Paraffin block specimens from concentrated spinal fluid, peritoneal fluid, or pleural fluid
3) A specimen that fails to provide enough tissue to do a histologic examination - in this case, the report will be a cytology report rather than a pathology report

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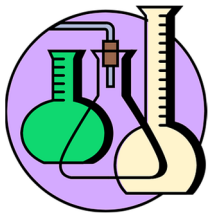
Code 3: Positive histology *PLUS* positive immunophenotyping or genetic testing

Code 3 can be used for cases diagnosed **2010+** with histologic confirmation (see code 1) **AND** immunophenotyping, genetic testing, or JAK2 confirmation

Note 1: While every attempt is made to keep the Hematopoietic database updated, it is impossible to keep the Hematopoietic database updated with all the immunophenotyping or genetics that can be done for a specific histology since clinical medicine continues to evolve. If immunophenotyping or genetics are used by the pathologist/managing physician to identify a **specific** neoplasm that are not included in the Hematopoietic database, and genetic testing and/or immunophenotyping are listed as Definitive Diagnostic methods for that histology, go ahead and use these.

Note 2: The following histologies are diagnosed based on immunophenotyping or genetics and therefore **should only be diagnostic confirmation 3**: 9806/3, 9807/3, 9808/3, 9809/3, 9812/3, 9813/3, 9814/3, 9815/3, 9816/3, 9817/3, 9818/3, 9819/3, 9865/3, 9866/3, 9869/3, 9871/3, 9877/3, 9878/3, 9879/3, 9896/3, 9897/3, 9911/3, 9912/3, 9965/3, 9966/3, 9967/3, 9968/3, 9986/3.

Note 3: The following histologies **should never be assigned diagnostic confirmation 3** since they are non specific codes and neither genetic testing or immunophenotyping are listed as Definitive Diagnostic Methods for these histologies. If there is immunophenotyping or genetics available, then a more specific histology code may be able to be assigned: 9590/3, 9655/3, 9800/3, 9820/3, 9860/3, 9863/3, 9980/3, 9982/3, 9989/3, 9991/3.



Diagnostic Confirmation = 5 (Lab Test) CORRECTION to January 2021 FCDS Memo

According to the 2022 Revisions to the 'Diagnostic Confirmation' Section of the **SEER Hematopoietic and Lymphoid Neoplasms Coding Manual** there **ONE** hematopoietic neoplasm that can be diagnosed by a lab test, only DX Conf = 5. This test has been around for a long time. But the clarification is new.

The 2022 Revision to the **SEER Hematopoietic and Lymphoid Neoplasms Coding Manual** (see the SEER Heme Data Base website under Downloads at; https://seer.cancer.gov/seertools/hemelymph/) states that **a positive result from a Urine or Serum Protein Electrophoresis Laboratory Test can be sufficient to diagnose a case of plasma cell myeloma**.

In Plasma Cell Myeloma, Bone Marrow Biopsy is still the preferred method for Diagnostic Confirmation.
But, there are times when in a patient with plasma cell myeloma has bone marrow that is so 'clogged' with plasma cells' that the suction from a bone marrow biopsy cannot pull out marrow for a diagnosis.

This is followed by the second most preferred method, a skeletal or bone survey (not a bone scan), that identifies LYTIC (not blastic) lesions. Lytic lesions result from neoplastic plasma cells building up in the marrow. This type of bone metastasis destroys bone material and cannot be healed. Lytic lesions appear as 'punched-out' lesions in the bone, particularly large bones. Blastic bone lesions fill the bone with extra cells where new bone grows out of old bone without breaking down the old bone first.

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There are times when a plasma cell diagnosis may be suspected, but the patient has a 'dry tap bone marrow biopsy' with no marrow in the sample. And, the patient shows no lytic lesions.

However, the patient may have an elevated serum protein with an elevated globulin level relative to albumin or possibly symptoms of underlying plasma cell disorder (bone pain, recurring infections, fractures, etc.).

The combination of abnormal labs and symptoms may suggest the patient has plasma cell spectrum neoplasm (plasma cell myeloma, primary amyloidosis, Waldenstrom macroglobulinemia).

A simple, non-invasive, blood or urine test, an electrophoresis test, may be performed to measure the amount of specific large proteins called 'globulins' there are in the circulating blood or in the urine. There are other reasons than neoplasm when a patient may have elevated proteins in the blood or urine. The electrophoresis is used to examine different types of proteins to see if there are protein spikes of certain types of protein. If there is a monoclonal spike or a bi-clonal spike, plasma cell neoplasia is suspected. Furthermore, large amounts of protein in urine may indicate kidney disease. Kidney disease and plasma cell neoplasia go hand-in-hand in most patients with theses conditions.

SEER has determined when just a serum or protein electrophoresis is positive in a setting with symptoms of plasma cell neoplasia; this lab test is sufficient to diagnosis plasma cell myeloma.

Please refer to the **SEER Hematopoietic and Lymphoid Neoplasms Coding Manual** for further clarifications on coding Diagnostic Confirmation for Hematopoietic and Lymphoid Neoplasms. *These instructions/ clarificationsf for coding Diagnostic Confirmation do not appear in the STORE Manual.*

RADIATION TREATMENT FACILITIES 2021 CANCER CASES SUBMISSION

IDENTIFICATION OF CANCER CASES DIAGNOSED AND/OR TREATED AT YOUR RADIATION TREATMENT FACILITY BETWEEN JANUARY 1, 2021 AND DECEMBER 31, 2021

The Florida Cancer Data System is requesting at this time that you identify and report the cancer cases that were diagnosed and/or treated at your facility between January 1, 2021 and December 31, 2021.

Please login to the FCDS IDEA web portal to either use the option of single entry or upload to report the cases. The deadline to submit your list of cancer cases is **June 30, 2022** . After the June 30th deadline, FCDS will perform a match of the records that you submitted with the FCDS database. FCDS will request a full cancer case abstract for each of the patients not found through the match.

State law requires the information requested. Facilities that fail to meet state-mandated cancer incidence data reporting requirement to the FCDS are referred to the Florida Department of Health for non-compliance. Please note that "failure to comply with this requirement may be cause for registration or licensure suspension or revocation," in accordance with Section 385.202 F.S.

First Course of Therapy or Not

Question:

Patient was initiated on FOLFOX and after 5 cycles was discontinued due to intolerance. The patient was then switched to FOLFIRI. Since this added a different drug, would this be considered a change from the initial treatment plan and considered subsequent treatment?

Answer:

The reference you are looking for is in the SEER Program Coding and Staging Manual (SEER is the originator of SEER*Rx). You will not find a reference in the STORE or in any other reference manual – so hang on to this reference – we will try to remember to put it into the 2023 FCDS DAM so we have it in our documentation, also. See Section VII: First Course of Therapy on pages 210 and 211 of the 2022 SEER Program Coding and Staging Manual – and you also must reference SEER*Rx to identify the Subcategory of the Chemotherapy for Oxaliplatin and Irinotecan to confirm answer.

3. The physician may change a drug during the first course of therapy because the patient cannot tolerate the original agent
   a. This is a continuation of the first course of therapy when the chemotherapeutic agent that is substituted belongs to the same group (alkylating, antimetabolites, natural products, targeted therapy, or other miscellaneous)
   b. Do **not** code the new agent as first course therapy when the original chemotherapeutic agent is changed to one that is NOT in the same group. Code only the original agent as first course. When the new agent is in a different group, it is **second course therapy**.
   c. Use SEER*Rx and compare the subcategory of each chemotherapy agent to determine whether or not they belong to the same group (subcategory). See "Chemotherapeutic Agents" below for the groups and their definitions.

Oxaliplatin is Subcategory Platinum Analog and Irinotecan is Subcategory Topoisomerase Inhibitor. The change in the Subcategory of chemotherapy (found in SEER*Rx) indicates they do not belong in the same 'group' or 'subcategory'. So, when they changed from FOLFOX to FOLFIRI – they swapped out 1 drug in 1 subcategory for a different drug in a different subcategory. Therefore, the First Course of Therapy ended when they started the FOLFIRI and the Irinotecan…even when the reason for the switch is because the patient cannot tolerate the original agent. It doesn't matter how many cycles of FOLFOX the patient got. Once they switched to FOLFIRI – they changed the First Course of Treatment – and all treatment that followed is to be coded as Subsequent Treatment.

2021-2022 Monthly NAACCR Cancer Surveillance Webinar Series

FCDS is pleased to offer another year of the Monthly NAACCR Cancer Registry and Surveillance Webinar Series - Free of Charge to Florida Registrars in Recorded Sessions.

This year in response to the Covid Pandemic, NAACCR provided FCDS with 42 'live attendance portals' for 42 lucky Florida Registrars to attend the 2021-2022 Webinar Series 'live'.

FCDS worked with our traditional 7 host sites to identify 6 registrars from each site-region who attended the NAACCR webinars routinely at their host site. These registrars were offered the 'live' attendance seats for Florida. Unfortunately, FCDS was unable to purchase 200-250 'live' attendee spots…but, we are fortunate to have acquired 42 slots for the 2021-2022 NAACCR Webinar Series.

For registrars who do not make the short list for the 'live' spots, FCDS offers every NAACCR Webinar as a 'recorded session' in FLccSC.

You can still earn 3 CEUs per webinar in FLccSC...just like we have for many years. Recordings appear in FLccSC within a week or two following the 'live' session.

And, old webinars can still be viewed – up to 2 years in arears. So, registrars can still gain 3 CEU credits for attendance at any NAACCR Webinar that is up to 2 years old.

The 2021-2022 NAACCR Webinar Series begins on October 7, 2021 and continues through September 1, 2022. The 2021-2022 Webinar Series Schedule is provided below.

Please visit FLccSC to view recordings and earn your CEUs.

DATE	TOPIC
*10/7/21	Uterus
* 11/4/21	Bladder
* 12/2/21	Treatment
* 1/6/22	Lung
* 2/3/22	Data Item Relationships
*3/3/22	Boot Camp
*4/4/22	Hematopoietic and Lymphocytic Neoplasms
*5/5/22	Colon
* 6/2/22	CNS
*7/7/22	Back to the Future: What year is it and what did I miss?
8/4/22	Solid Tumor Rules
9/1/22	Coding Pitfalls

CEU information for the 2021 FCDS Annual

Conference:

CE Hours: 7.5

4 Hrs Category A

NCRA Recognition Number: 2021-124

Florida Cancer Data System

Cancer Reporting Completeness Report

TOTAL NUMBER OF CASES IN THE FCDS MASTER FILE AS OF JULY 31,2022

Total number of *New Cases* added to the FCDS Master file in July, 2022 **3,010**

The figures shown below reflect initial patient encounters (admissions) for cancer by year.

Admission Year	Hospital	Radiation	Ambi/ Surg	Dermatology	Physicians Claims	DCO	Total Cases	New Cases
2022	688	0	0	3,895	0	**Pending**	4,583	**823**
2021	162,738	1,348	421	11,775	600	**Pending**	176,882	**1,497**
2020	211,171	4,771	371	12,201	24,145	**Pending**	252,659	**690**

		Actual	Expected
% Complete for:	**2022**	**2%**	**8%**
	2021	71%	100%
	2020	100%	100%

Expected % based on 250,000 reported cases per year

Missed an FCDS or NAACCR Webinar?

Did you know that FCDS Webcasts and NAACCR Webinars can be viewed after-the -fact?

FCDS Webcasts and NAACCR Webinars are recorded and posted on the FCDS FLccSC LMS Site.

The FCDS Webcast recordings are available free of charge and can be viewed anytime/anywhere by anybody. NAACCR Webinars are restricted approved Florida FLccSC Users per FCDS/NAACCR agreement.

FCDS holds all FCDS/NAACCR recordings for 2 years before 'retiring' them due to outdated information.

Registrars must have an active Florida FLccSC Account and must take and pass the CEU Quiz as required to obtain some of the CEUs for certain FCDS Webcasts... always to obtain a Certificate of Attendance.

NAACCR Webinars have their own CEU award mechanism whether viewed live or via a recorded session.

Only Florida registrars with Active/Current FCDS Abstractor Codes can access the NAACCR Webinars.

Please contact FCDS for more information on viewing recorded webinars.

FCDS Florida Cancer Data System

The Florida Cancer Data System (FCDS) is Florida's statewide, population-based cancer registry and has been collecting incidence data since 1981 when it was contracted by the State of Florida Department of Health in 1978 to design and implement the registry. The University of Miami Miller School of Medicine has been maintaining FCDS (http://fcds.med.miami.edu) since that time.

The FCDS is wholly supported by the State of Florida Department of Health, the National Program of Cancer Registries (NPCR) of the Centers for Disease Control and Prevention (CDC) and the Sylvester Comprehensive Cancer Center at the University of Miami Miller School of Medicine.

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