The Florida Cancer Data System's Memo

October 2022

2022 FCDS Virtual Annual Conference

FCDS held the 2022 FCDS Annual Conference virtually again this year. The 4 two-hour sessions were attended by more than 325 registrars at every session. Our usual in-person attendance is only one-third the attendance we have enjoyed since going virtual during the pandemic. NCRA awarded the conference 7 CEUs with 4 Category A hours.

Full Session Recordings are available on the FCDS Website. And, you can still download the Attendance CEU Certificate from the FCDS Website @ https://fcds.med.miami.edu/inc/educationtraining.shtml.

The conference followed the usual FCDS Annual Meeting format with Session 1 consisting of updates from the Florida Department of Health's Interim Manager of Registries and Surveillance, Heather Lake-Burger, and FCDS Deputy Project Director, Gary Levin. Mr. Levin shared FCDS progress on numerous fronts include awards and certifications, FCDS involvement in NPCR Data Modernization Initiatives, our involvement with the National Childhood Cancer Registry at NCI's Surveillance Research Program, highlights from CCRAB and the Florida Cancer Plan and various other projects.

Dr. Jordan Baeker Bispo then presented on Social Determinants of Health. She demonstrated various categories of cancer disparities by race and ethnicity, by geography, by nativity and by sexual orientation and pointed out that social determinants drive cancer disparities along the entire continuum of cancer care from prevention to early detection to treatment and survivorship. Collection of addition of metrics for social determinants of health are included in the CCRAB 2020-2025 Cancer Plan. So, you will be hearing more about this important topic in the coming months and years.

Our next guest speaker was Dr Eric Durbin, Director of the Kentucky Cancer Registry at the University of Kentucky. Dr Durbin provided a 'genetics primer' that included the rationale for collecting genomic tumor data in a central cancer registry and why it is not reasonable for cancer registrars to attempt to collect literally hundreds of genetic mutation test results on each cancer patient to be used in research. Rather it is more practical for the central cancer registry to provide a solid infrastructure to reach out to providers of next generation sequencing multi-gene targeted test panels who can provide these data electronically and then linked to the patients and tumors already captured at the central registry. The explosion of treatment options now available based on genetic mutation targeted therapies is changing the entire landscape of cancer care for some cancers.

(Continued on page 2)

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 8/2/2022

FCDS/NAACCR WEBINAR SERIES:
NAACCR 2021-2022 Cancer Registry and Surveillance Webinar Series 10/6/2022– Solid Tumor Breast 2022 Part 1 ***
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

(Continued from page 1)

We have moved beyond simple approaches to treatment and are now able to provide more directed therapies targeted to correct mutations or kill cells that harbor mutations. Single mutations have slowly been added to site-specific data items. However, the speed and volume of next generation sequencing and multi-gene testing panels prohibits registrars from finding and manually coding hundreds of gene mutations for every cancer case. This large-scale approach is something that FCDS is working with CCRAB to build infrastructure to support.

Dr Monique Hernandez provided the audience with a visual display of various new FCDS Data Visualization Platforms available on the FCDS Website for exploring and displaying Florida cancer data. These tools have been developed by FCDS and include the latest complete data available from FCDS.

Our next speaker was Dr David Lee. Dr Lee presented us with an update on the important Florida Firefighters Project in which he has been integrally involved for many years. This year the update was on Lung Cancer Survival Among Male Florida Career and Volunteer Firefighters. Dr Lee also informed the audience that the World Health Organization and the International Agency for Research on Cancer recently added Firefighters to the list of carcinogenic careers as they are exposed to various toxic substances by the inhalation of particulate matter and gasses as well as dermal exposure routes throughout the course of their careers. Interestingly male firefighters who develop lung cancers tend to have improved survivorship compared to non-firefighters. This is likely driven at least in part by a 'healthy worker effect' with more consistent access to health insurance coverage during their lifetimes.

The first session ended with Barbara Dearmon-Neyland, CTR extraordinaire providing us with an update on the NCRA Clinical Practicum and CTR Exam Core Competencies from the NCRA Education Committee. The clinical practicum has become an increasingly challenging prerequisite to writing the CTR Exam as it has become increasingly difficult to find host sites to support candidate CTRs before writing the exam. NCRA has approved new approaches to virtual and in-person clinical practicum with the goal of each practicum option focusing on the same Core Competencies for gaining experience in critical knowledge areas including casefinding, abstracting, coding and staging, data analysis and usage, registry organization, follow-up and data quality assurance and cancer program accreditation. Now candidate CTRs can use one or more of the practicum activity options including virtual, in-person, or a hybrid to complete the 160-hour practicum equivalent. NCRA hosts a Practicum Portal that will assist students in accomplishing these goals and help support our candidate CTRs to become fully credentialed CTRs.

Session 2 of the conference was all about FCDS Activities over the past year (Data Acquisition, Completeness of Reporting, Data Quality and Audits, NPCR Audits, etc.) and FCDS Cancer Reporting Requirements for 2022, including the 2022 Education and Training Plan to help registrars meet the 2022 requirements. Recordings for these sessions cover all the details for these mission-critical operations. FCDS currently receives over 290,000 abstracts each year from registrars. These abstracts are in turn supplemented and linked to electronic pathology reports, physician office reports, death certificates, in-patient and ambulatory patient encounters statewide, and numerous other data sources to complete each patient/tumor consolidated abstract stored at FCDS. Cancer Registrar abstracted cases have always formed the foundation for FCDS data. The numerous additional sources that now number in the millions of records every single year are used to supplement and add data to incomplete abstracts to cover the full first course of therapy, other patient encounters for other reasons, and span the course of each patient's life and the full course of each patient's cancer(s). Meg Herna provided a detailed view of the 2022 Cancer Reporting Requirements including new histologic terms and codes, new reportable cancers, new data items, changes to standard reference manuals, and updates to the FCDS DAM. The session concluded with a detailed explanation of the FCDS Education and Training Plan which will again offer more than 65 FREE CEUs for Florida Cancer Registrars to help them keep up with the fast-paced changes in technology and cancer care. A shout out the FCRA/FCDS Task Force and the special projects the Task Force is working on currently. And, 61 Honorable Mention Awards were given out for 2021.

(Continued on page 3)

Florida Cancer Data System Deadlines, Updates, & Reminders

(Continued from page 2)

Session 3 was split into 2 one-hour sessions. The first session was all about the National Childhood Cancer Registry, part of the new Childhood Cancer Data Initiative in the NCI Surveillance Research Program and the CDC STAR Project, Survivorship, Treatment, Access and Research. Both programs grew out of the Childhood Cancer Data Initiative. Dr Johanna Goderre from NCI shared the goals and progress of the NCCR including building a community centered around childhood cancer care and research data that includes clinical data, treatment data, outcomes, molecular and biospecimen data and other data.

This is a part of the Cancer Moonshot Initiative. The NCCN which includes Florida pediatric and young adult cancers has an initial goal of include 70% of the U.S. population of childhood cancers with numerous linkage projects for clinical trials, biospecimen research, social determinants of health, molecular pathology and much more. FCDS is proud to be a part of this important initiative. Dr Loria Pollack from the CDC shared information about the STAR Act and the CDC initiative to 'enhance and expand infrastructure to track the epidemiology of cancer in children, adolescents, and young adults." The STAR Project is keenly focused on Rapid Case Reporting of laboratory and state-based central cancer registry case data to a National Oncology Rapid Ascertainment Hub beginning with patients aged 0-29. This is a huge effort to central rapid case reporting of pediatric and young adult cancers to a single location for rapid reporting and use by researchers including enrollment in patient cancer clinical trials.

The second half of this session was devoted to 'What's New in Cancer Care' and provided a glimpse of multiple cancer research professional association annual reports on cancer trends and progress against cancer including new cancer drug approvals and new developments in diagnostic tools and treatments. The session also pointed out new observations and trends in endometrial cancer, brain and central nervous system cancers, pancreatic cancer screening, MCED or multi-cancer early detection tests which include molecular biomarkers and next generation sequencing multi-gene panel testing and liquid biopsy tests, and other new developments in tumor classification and biomarker testing. New approaches to radiation therapy were discussed including 'Flash Therapy' and Artificial Intelligence in Radiotherapy. New image-guided radiotherapy systems were also highlighted as well as new diagnostic imaging tools and management systems. The technology continues to push forward with rapid acceleration on all fronts from early detection to diagnosis and classification of disease to treatment and follow-up to managing recurrence and disease progression.

The 4th and final session was dedicated to Lymphoid and Myeloid Neoplasms. Steven Peace gave a fast-paced introduction to both Lymphoid and Myeloid Neoplasms. He also introduced the Inaugural WHO Classification of Pediatric Tumors and the 5th edition of the WHO Classification of Hematolymphoid Neoplasms both of which are scheduled for release later this year. Mr Peace covered the anatomy and physiology of the blood and marrow circulatory system and the lymphatic circulatory system and where they overlap. He also discussed several areas of both myeloid and lymphoid 'overlap syndromes' which are always confusing for registrars. And, he covered the chronic conditions that are always reportable even when stated to be in remission because the remission is only clinical, and patients are never completely free of disease unless they have a bone marrow or stem cell transplant (or more than one transplant). This topic is coming at a critical time in disease classification for these malignancies as the classification for 'histology' is shifting from microscopic observation of cellular features and cellular functions to cell surface proteins and tumor markers and now quite critically to molecular pathology using genetic mutations as markers and as targets to develop new anti-neoplastic agents that hone in specifically on genetic mutations to target cancer cells without harming normal cells. The 5th edition WHO Classification has many new 'histologic' descriptions that are genetic mutation profiles for cancers. Knowing the difference between a histology and a biomarker and a genetic profile will be critical for registrars to understand so we can correctly apply the new ICD-O histology codes to these neoplasms. This 2-hour session will be followed in January and February 2023 by 2 two-hour sessions with more advanced information for registrars and new updates from WHO next year. There will be a major FCDS Audit of lymphoid and myeloid neoplasms sandwiched in between the educational sessions. The intent of this 6-month project focusing on lymphoid and myeloid neoplasms is to emphasize to registrars that all of us must know how to use and must actually use the SEER Hematopoietic Database and the Hematopoietic Manual when abstracting lymphoma, leukemia, myelodysplastic syndrome and myeloproliferative neoplasms or we will be missing critical information as we move forward with genetic profiling and targeted antineoplastic agents for these important cancer specialties.

Florida Cancer Data System Deadlines, Updates, & Reminders

REMINDER - 2022 New Reportable Neoplasms/Reclassified Tumors

a. LAMN – low grade appendiceal mucinous neoplasm (C18.1)
b. HAMN – high grade appendiceal mucinous neoplasm (HAMN (C18.1)
c. Serrated dysplasia, high grade (C160-C166, C168-C169, C170-C173, C178-C179)
d. Adenomatous polyp, high grade dysplasia (C160-C166, C168-C169, C170-C173, C178-C179)
e. Intestinal-type adenoma, high grade (C160-C166, C168-C169, C170-C173, C178-C179)
f. Chondrosarcoma, grade 1
g. 9 New Histology Codes with Associated New Histology Terms
    - ❍ 8455/3 - Intraductal oncocytic papillary neoplasm with associated invasive carcinoma (C250 -C254, C257-C259)
    - ❍8483/3 - Adenocarcinoma, HPV-associated C530-C531, C538-C539)
    - ❍8484/3 - Adenocarcinoma, HPV-independent, NOS C530-C531, C538-C539)
    - ❍8859/3 - Myxoid pleomorphic liposarcoma
    - ❍8976/3 - Gastroblastoma (C16.0 – C16.9)
    - ❍9111/3 - Mesonephric-like adenocarcinoma
    - ❍9366/3 - Round cell sarcoma with EWSR1-non-ETS fusions
    - ❍9367/3 - CIC-rearranged sarcoma
    - ❍9368/3 - Sarcoma with BCOR genetic alterations

PLEASE REFERENCE APPENDIX R for the Complete Set of Changes for 2022 New Reportable Histology Codes, Retired Codes, New/Changes to Behavior and Reportability of Neoplasms.

CORRECTION TO 2022 FCDS DAM

8323/3 – clear cell papillary renal cell carcinoma of kidney has been reclassified as a ISUP Grade 1 (low grade neoplasm) which is not malignant. HOWEVER, United States Registries (SEER, NPCR, FCDS) still want cancer registrars to continue to report these neoplasms using the historical histology/behavior code 8323/3. Please continue to report these neoplasms.

SEER*Educate Latest Training Module Releases

Summer 2022 Update.

New Coding Practice Modules
Dx Year 2022

Eight additional sites (cervix, melanoma, Merkel cell, ovary, stomach, testis, vagina, and vulva) have been released in the SEER*Educate "Mash-Up" series which provides EOD, Summary Stage, Grade and SSDI coding practice for both new and experienced CTRs. All training modules for these primary sites qualify for Category A continuing education (CE) credits approved by NCRA. The number of CEs awarded is based on the average time it takes to code the cases and review the answers and training rationales.

The number of free **Category A** CEs awarded for each training module completed is indicated in the table below. The Program Recognition number to use when preparing your biannual CE submission is also provided to facilitate completing the NCRA documentation required to maintain your CTR credential.

NCRA Program Recognition #	Program Title Dx 2021-2022 EOD, Summary Stage, Grade, SSDI	Number of cases	CE Ending Date	Category A CEs Approved	Released on SEER*Educate
2022-042	Cervix	5	12/31/2025	3	Jul-22
2021-108	Melanoma 06-10	5	12/31/2024	2.75	May-22
2021-227	Merkel Cell Carcinoma	5	12/31/2024	2.5	Jul-22
2021-230	Ovary 06-10	5	12/31/2024	2.5	May-22
2021-233	Stomach	5	12/31/2024	2.25	Jun-22
2021-234	Testis	5	12/31/2024	3.5	Jun-22
2022-047	Vagina	5	12/31/2025	3	Jul-22
2022-048	Vulva	5	12/31/2025	2.75	Jul-22

Log in or sign up at **SEER*Educate** today by visiting https://educate.fredhutch.org/ and **Learn by Doing**! If you need help finding the exercises mentioned in this announcement, see the next few pages.

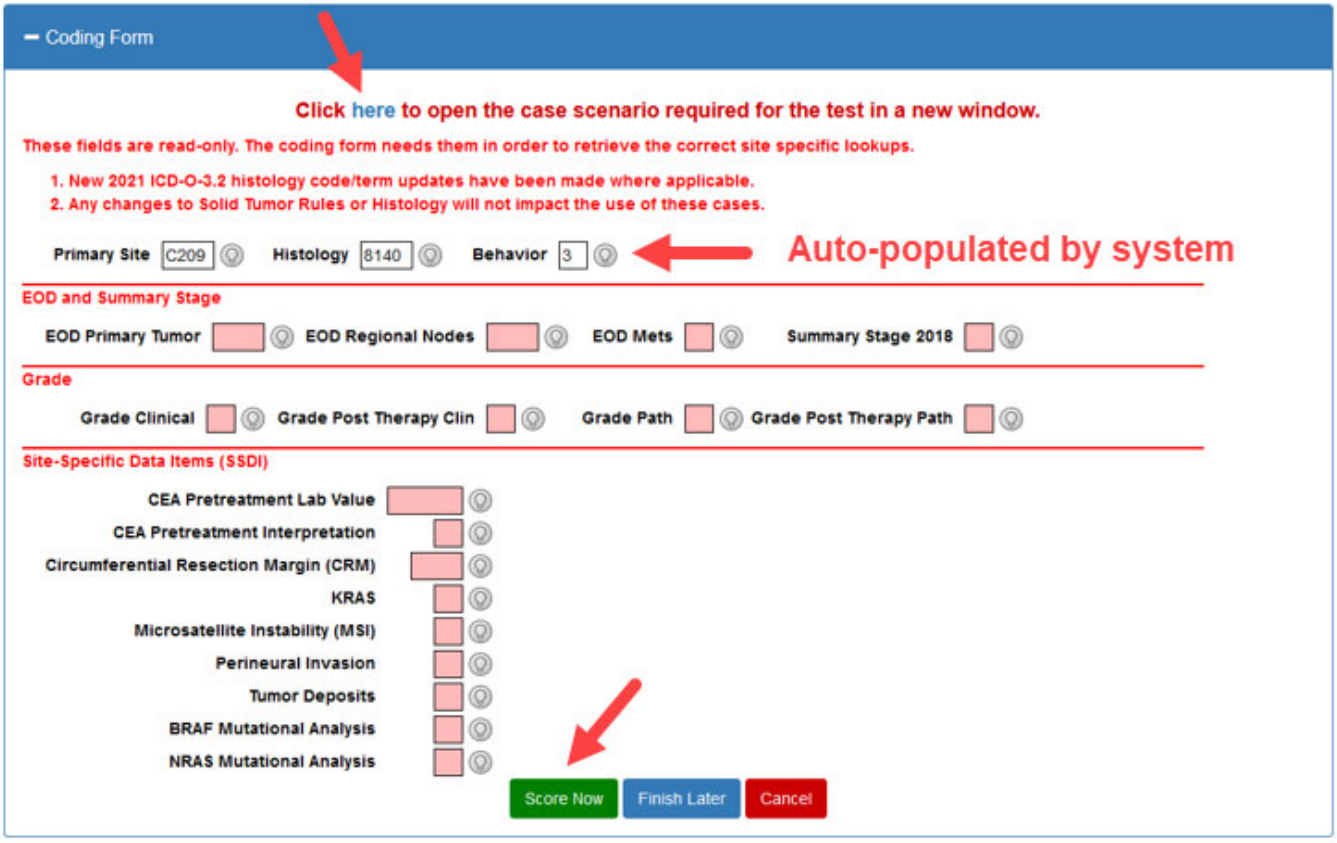
(Continued on page 6)

(Continued from page 5)

More about the Mash-Ups

We created a site-specific "mash-up" coding form to facilitate assessing coding accuracy for the Dx Year 2022 changes to EOD, Summary Stage, Grade, and SSDI.

There is a case scenario (the "Click here" link) and we provide the read-only coding for site, histology, and behavior to ensure that the correct data items and drop-downs are retrieved from the SEER*RSA. These are the same drop-downs vendor software will display to registrars. However, the page that displays before the coding form provides links to the various relevant manuals which you should also have open and available to complete these exercises.



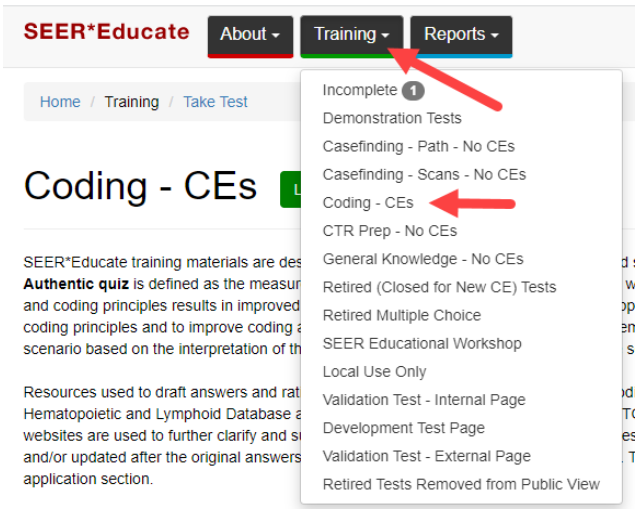
After you complete the coding form, click the Score Now button to compare your coding to the preferred answers and detailed rationales for each data item.

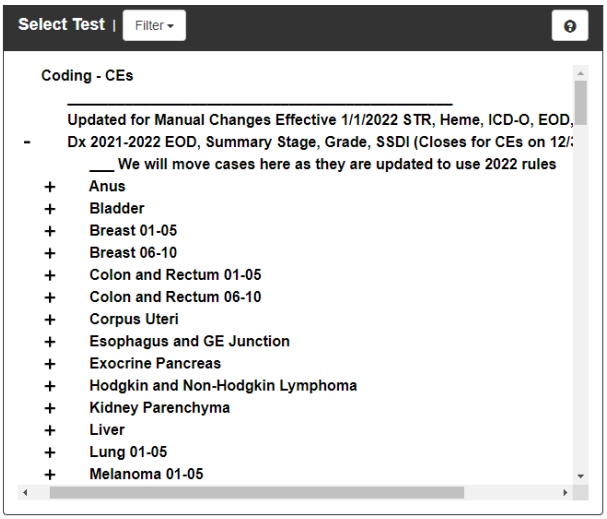
(Continued on page 7)

(Continued from page 6)

Quick reference on how to access new Dx Year 2022 exercises and the CE report

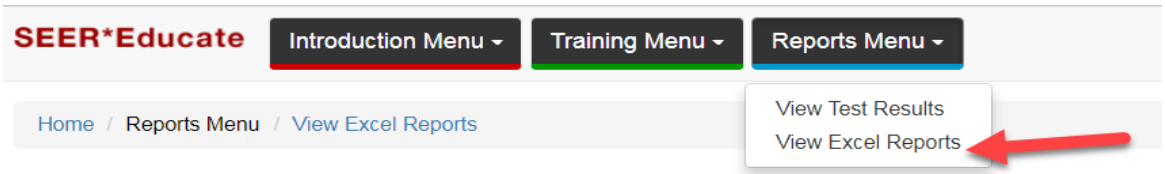
To access the exercises, click on Training and then Coding – CEs to display the page with the test menu.





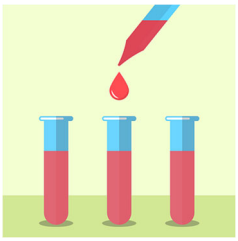
Click on the + sign to expand the Dx 2021-2022 EOD line to display the sites.

To print a report demonstrating completion of the CEs, click on Reports Menu and then View Excel Reports.



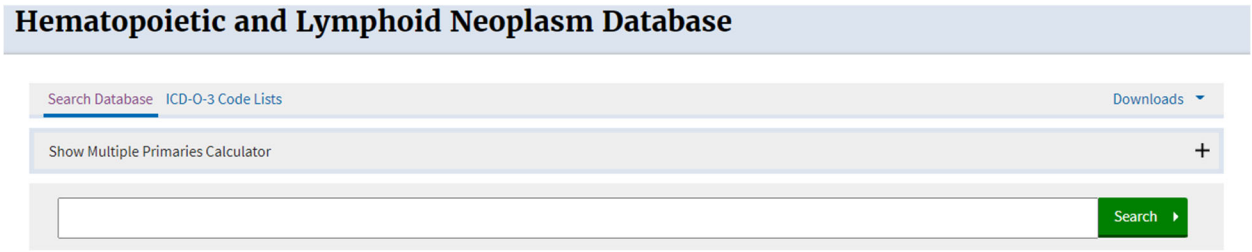
Click on the + sign to expand **CE Reports** section and click on **Dx Year 2021-2022 EOD, Summary Stage, Grade, SSDI** row. Change the start date to a date prior to when you began this material, such as 4/1/2022 and change the end date to today's date.

If no results are returned, you may need to retake a specific exercise where you originally scored less than 70%. We recommend waiting at least two days before retaking an exercise so that you know you are testing your knowledge of what you learned from your first attempt versus your immediate short-term recall of reading the rationale.



Clarifications for Diagnostic Confirmation

For hematopoietic and lymphoid neoplasms always use the Hematopoietic Manual as your diagnostic confirmation reference. This manual can be found under Downloads on the Hematopoietic Database Website – the manual is updated annually - https://seer.cancer.gov/seertools/hemelymph/



1. Code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy or D&C or from aspiration of biopsy of bone marrow specimens. Code 1 is the preferred coding for Fine Needle Aspiration (FNA).

   NOTE: Pathologists may refer to FNA as 'FNA Cytology' – however, 'cytology' for cancer registry purposes indicates cells suspended in body fluids such as washings, spinal fluid, pleural fluid or peritoneal fluid. FNA does not meet this definition.

   For leukemia only, code 1 when the diagnosis is based only on the complete blood count (CBC), white blood count (WBC) or peripheral blood smear.

   Use code 1 for FNA cytology, bone marrow, peripheral blood, or blood smear for leukemia.

   Do not use code 1 if the diagnosis was based on immunophenotyping or genetic testing using tissue, bone marrow, or blood.

2. Code 2 when the microscopic diagnosis is based on cytologic examination of *cells suspended in body fluids* such as sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. **FNA is not classified as 'cytology' in cancer registry**. FNA is treated as a biopsy Code 1.

(Continued on page 9)

(Continued from page 8)

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

Cases with positive histology for the neoplasm being abstracted (including acceptable ambiguous terminology and provisional diagnosis) **AND** immunophenotyping, genetic testing, or JAK2 is listed in the Definitive Diagnosis in the Heme DB **AND** the testing

a.Confirms the neoplasm OR

b.Identifies a more specific histology (not preceded by ambiguous terminology)

Note 1: Do not use code 3 for positive immunophenotyping or genetic testing identifying a more specific histology when preceded by ambiguous terminology.

Note 2: Do not use code 3 for positive immunophenotyping or genetic testing identifying a more specific histology when the test result is preceded by "patchy weak staining."

c.Peripheral blood smear followed by flow cytometry (most commonly done with CLL/SLL, 9823/3)

Note: Flow cytometry studies are normally done based on an abnormal blood smear. If unable to find documentation that a peripheral blood smear was done first, assume that it was and code 3

Note 1: 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 2: 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.

4. Code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer. To date there is **only one** laboratory test that can be used to confirm any patient has evidence of cancer without diagnostic imaging and/or biopsy to support the diagnosis. The Hematopoietic Manual suggests the test for Bence Jones Protein in Urine and possibly in Serum may be a lab test that fits the definition for use of Code 5. However, you must use this code with caution. Proteinemia can be cause by other than cancer and must be ruled out for other causes. Plasma Cell Neoplasms usually have a bone marrow or bone biopsy plus or minus imaging as better Dx Confirmation. Therefore, **Code 5 should be used sparingly if at all.**

5. Code 6 when the diagnosis is based only on the surgeon's operative report from a surgical exploration or endoscopy or from gross autopsy findings in the absence of tissue or cytological findings.

6. Code 7 is used when the diagnosis is based only on an imaging report finding of primary tumor and/or metastatic tumor on imaging study.

7. Code 8 when the case was diagnosed by any clinical method that cannot be coded as 6 or 7.

8. Code 9 should not be used unless there is absolutely no information or inference of confirmation method used to confirm the patient's cancer. Do not use this code. You can usually find a better code to use than '9'. Dx Confirmation by Histology can always be inferred when you have a histologic description or when surgery was performed. MOST cancers have histologic confirmation – even historical ones.

Chronic Lymphoid and Myeloid Neoplasms
ALL MPN, ALL MDS, ALL Mast Cell Neoplasms, ALL Chronic Leukemia
These neoplasms are always reportable with evidence of cancer even when stated 'in remission'.

- Chronic lymphocytic leukemia/small lymphocytolytic lymphoma
- Chronic Lymphoproliferative Disorder of NK Cells
- Follicular lymphoma
- Chronic Myeloid Leukemia, BCR-ABL Positive
- Atypical Chronic Myeloid Leukemia BCR-ABL1 Negative
- Juvenile Myelomonocytic Leukemia
- Chronic Myelomonocytic Leukemia
- Chronic Neutrophilic Leukemia
- Chronic Eosinophilic Leukemia, NOS

Table B1: Myeloproliferative Neoplasms

WHO Preferred Term	ICD-O
Chronic eosinophilic leukemia, NOS	9964/3
Chronic myeloid leukemia, *BCR-ABL1*-positive	9875/3
Chronic neutrophilic leukemia	9963/3
Essential thrombocythemia	9962/3
Myeloproliferative neoplasm, unclassifiable	9975/3
Polycythemia vera	9950/3
Primary myelofibrosis	9961/3

Table B2: Mastocytosis

WHO Preferred Term	ICD-O
Aggressive systemic mastocytosis	9741/3
Cutaneous mastocytosis	9740/1
Indolent systemic mastocytosis	9741/1
Mast cell leukemia	9742/3
Mast cell sarcoma	9740/3
Systemic mastocytosis with an associated hematological neoplasm	9741/3

Table B4: Myelodysplastic/Myeloproliferative Neoplasms

WHO Preferred Term	ICD-O
Atypical chronic myeloid leukemia, *BCR-ABL1*-negative	9876/3
Chronic myelomonocytic leukemia	9945/3
Juvenile myelomonocytic leukemia	9946/3
Myelodysplastic/myeloproliferative neoplasm, unclassifiable	9975/3
Myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis	9982/3

Table B5: Myelodysplastic Syndromes

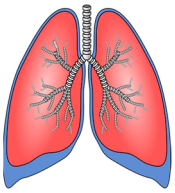
WHO Preferred Term	ICD-O
Myelodysplastic syndrome with isolated del(5q)	9986/3
Myelodysplastic syndrome, unclassifiable	9989/3
Myelodysplastic syndrome with single lineage dysplasia - Refractory neutropenia (2021+) - Refractory thrombocythemia (2021+)	9980/3 9980/3 9980/3
Myelodysplastic syndrome with excess blasts	9983/3
Myelodysplastic syndrome with ring sideroblasts and single lineage dysplasia	9982/3
Myelodysplastic syndrome with ring sideroblasts and multilineage dysplasia (2021+)	9993/3*
Myelodysplastic syndrome with multilineage dysplasia	9985/3
Refractory cytopenia of childhood	9985/3
Refractory neutropenia (2010-2020) (see code 9980 for 2021+)	9991/3
Refractory thrombocythemia (2010-2020) (see code 9980 for 2021+)	9992/3

ICD-10-CM Casefinding List for Reportable Tumors – *Oct 1, 2021 and later encounters*

The following ICD-10-CM list is to be used to identify potentially reportable tumors. Some ICD-10-CM codes contain conditions that are not reportable. These records should be reviewed and assessed individually to verify whether or not they are reportable to FCDS. ICD-10-CM implementation is expected nationwide October 1, 2021 for all hospitals. A complete listing of ALL Required ICD-10-CM Code is in Appendix O of this manual.

ICD-10-CM	Description
C00.0 – C43.9	Malignant neoplasms
C44.13.1 – C44.13.92	Sebaceous Cell Carcinoma of Skin of Eyelid, Including Canthus
C45.0 – C96.9	Malignant neoplasms
C4A.0 – C4A.9	Merkel cell carcinoma
C49.A0 – C49.A9	GI stromal tumor
C7A.0 – C7A.8	Malignant carcinoid tumors
C84.A0 – C84.A9	Cutaneous T-cell lymphoma
C84.Z0 – C84.Z9	Other Mature T/NK-cell lymphoma
C91.A0 – C91.A2	Mature B-cell leukemia Burkitt-type
C91.Z0 – C91.Z2	Other lymphoid leukemia
C92.A0 – C92.A2	Acute myeloid leukemia with multi-lineage dysplasia
C92.Z0 – C92.Z2	Other myeloid leukemia
C93.Z0 – C93.Z2	Other monocytic leukemia
C96.A	Histiocytic sarcoma
C96.Z	Other specified malignant neoplasm of lymphoid, hematopoietic and related tissue
D00.0 – D09.9	Carcinoma in situ (exclude: skin, cervix and prostate– D04._, D06._ and D07.5)
D18.2	Hemangioma of intracranial structures
D32.0 – D32.9	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33.0 – D33.9	Benign neoplasm of brain and other parts of central nervous system
D35.2, D35.3, D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42.0, D43.9	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 – D44.5	Neoplasm of uncertain behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3)
D46.1 – D46.22, D46.4, D46.9	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
D46.A – D46.Z	Other myelodysplastic syndromes
D47.02, D47.1-D47.9	Myeloproliferative diseases (9931, 9740, 9741, 9742, 9960, 9961, 9962, 9963, 9965, 9966, 9967, 9970, 9971, 9975, 9987)
D47.Z – D47.Z9	Post-transplant lymphoproliferative disorder (PTLD)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
D72.110 – D72.1119	Hypereosinophilic Syndrome

Note: Pilocytic/juvenile astrocytoma (M-9421) is reported with the behavior coded /3 (9421/3 not 9421/1).



New FDA Approvals for Lung Cancer – Source National Cancer Institute

FDA Approves First Targeted Therapy for HER2-Mutant Lung Cancer

On August 11, the Food and Drug Administration (FDA) gave accelerated approval to trastuzumab deruxtecan (Enhertu) for adults with NSCLC that has a certain kind of mutation in the HER2 gene (called an "activating" mutation). Around 3% of people with NSCLC have this kind of HER2 mutation.

People who have never smoked, are female, and are of Asian descent are more likely to have a HER2 mutation in their lung tumors

To be eligible for treatment with Enhertu, patients must also have cancer that can't be removed by surgery (unresectable) or has spread to other parts of the body (metastatic), and they must have already received one or more cancer therapies.

Alongside Enhertu, FDA approved two companion diagnostic tests that check for HER2 gene mutations: Guardant360 CDx, which uses a blood sample, and Oncomine Dx Target Test, which uses a sample of tumor tissue.

Capmatinib Approved for MET-Mutant Lung Cancer

On August 10, FDA gave full approval to capmatinib (Tabrecta) for treatment of metastatic NSCLC that has a mutation in the MET gene called "exon 14 skipping." Around 3% to 4% of people with NSCLC have tumors with this type of gene mutation.

Another drug, called tepotinib (Tepmetko), is also FDA-approved for people with NSCLC that carries a MET exon 14 skipping mutation.

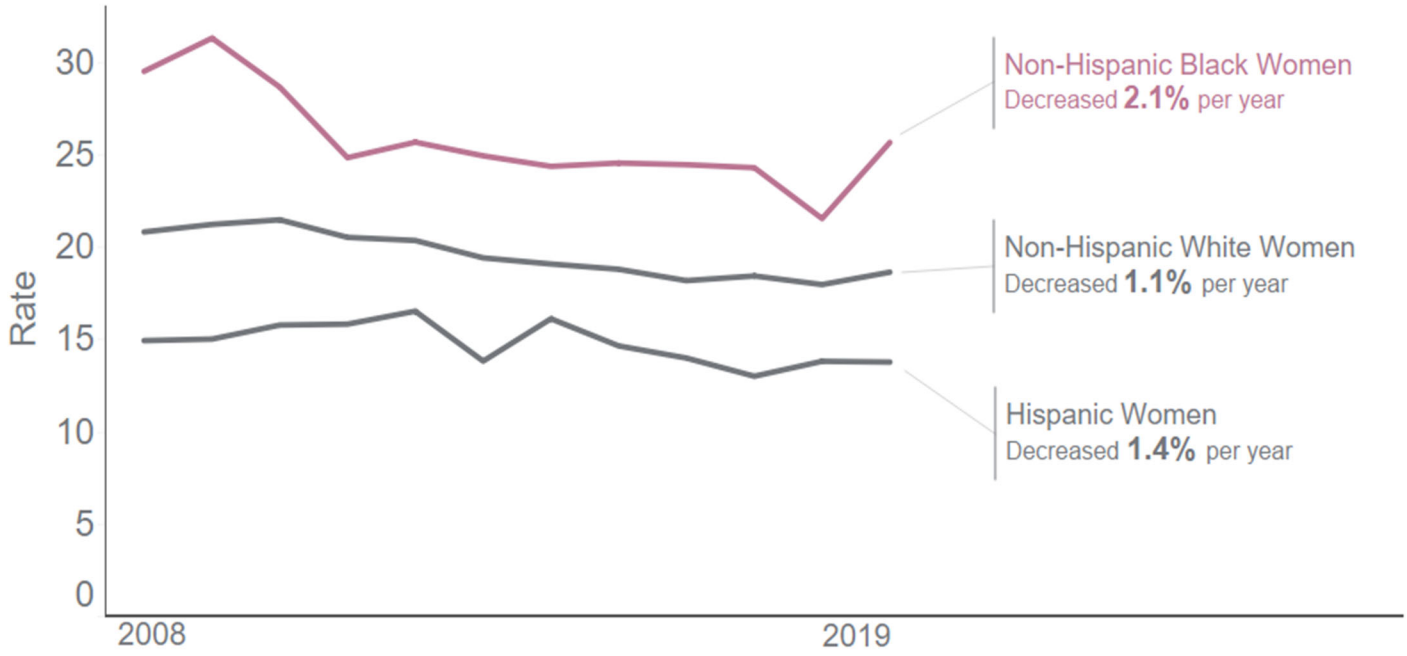
Florida New CTRs
March 2022 Exam

Melanie Grillone, ***Saint Petersburg***
Miriah Livingston, ***Winter Garden***
Dina McAllister, ***Bradenton***
Ebony Michel, ***Orlando***
Bradley Vanserke, ***Parrish***
Cathy Walker, ***Destin***

Breast Mortality

Mortality Rates from Breast Cancer are Dropping in Florida

2008 to 2019, by Race/ Ethnicity



Mortality rates are declining for breast cancer across racial and ethnic groups, and they are decreasing most rapidly for Non-Hispanic Black women. However, rates are still highest in that population. More work is needed to eliminate this disparity.

If you or someone you know needs help accessing screening services, visit https://www.floridahealth.gov/diseases-and-conditions/cancer/breast-cancer/bccedp.html

To learn more about breast cancer, visit the Centers for Disease Prevention and Control (CDC):
https://www.cdc.gov/cancer/dcpc/resources/features/breastcancerawareness/index.htm

The Florida Cancer Data System (FCDS) houses all cancer incidence and mortality data for the state of Florida since 1981. For more information on the registry, including statistical reports, procedures, and contacts, visit https://fcds.med.miami.edu. We acknowledge the Centers for Disease Control and Prevention, for its support of the Florida Cancer Data System, and the publication and distribution of the Florida Annual Cancer Report under cooperative agreement 1NU58DP006350 awarded to Florida.

https://fcds.med.miami.edu/inc/statistics_breastCancerMortalitybyrace.shtml

FLccSC - Restricted Access to NAACCR Webinar Recordings

FCDS reminds our Florida FLccSC Users that access to the NAACCR Webinar Recordings is restricted to "registry staff and facilities that report to the NPCR Central Registry that purchased the series."

FCDS recently introduced automation of access permissions that will check your individual access permission status every time you log into FLccSC regardless of how you access FLccSC (via IDEA or web).

The new automation has cutoff access to some of our Florida FLccSC Users who do not work in Florida.

The automation process now verifies that upon login each user must have current/active User Role in at least one Florida reporting facility by accessing your User Role and Facility Access Status in FCDS IDEA.

If you do not have current access to at least one facility you will not be given permission to access to the NAACCR Recordings. The recordings will not even show up in your FLccSC Available Courses Menu.

You can always check your User Role(s), Facility Access and Status (active/expired) for each User Role for each Facility by running the 'Your Access Summary' report from the Idea User Menu in FCDS IDEA.

Facility Access and User Roles are renewed semi-annually by the Facility Access Administrator (FAA) from each facility that grants you permission to access their facility data, upload data, make corrections, respond to QC Inquiries and Field Coordinator Inquiries, run reports, participate in FCDS Audits, etc.

All FLccSC Users will continue to have full access to all FCDS-produced webinar recordings. It is only the NAACCR Webinar Recordings where access will be restricted due to our agreement with NAACCR.

"NAACCR gives permission for NPCR Central Cancer Registries who have purchased a NAACCR Branded Monthly Webinar Series to post materials and recordings for the series on the FLccSC LMS. The NPCR Central Cancer Registries that purchase the series will be responsible for limiting access to the materials from the series to registry staff and facilities that report to the NPCR Central Registry that purchased the series."

CLARIIFICATION for BI-RADS4 and BI-RADS5
This is in the FCDS DAM, too!!

Both SEER and the NCDB CoC are coming around to the FCDS clarifications of how to use Bi-RADS4 and Bi-RADS5 when abstracting cases. FCDS has used the same criteria for many years – and everybody asks and asks where they can find it in STORE or SEER. Well, the ancient instructions that people remember about use of Bi-RADS4 and Bi-RADS5 is not to use it for anything – but, that has never been in any manual. We have for decades asked them to clarify in a manual so we can reference the instruction when we do QC or when registrars call and ask if they can use the date and under what circumstances.

SEER went halfway with a clarification in the 2022 SEER Coding Manual.

The NCDB/CoC validated that the FCDS Clarification was correct.

The confusion comes about because there are actually several questions asked here.

1. Is Bi-RADS4 and/or Bi-RADS5 on breast imaging reportable (2D (conventional film), digital (electronic) 3D (breast tomosynthesis or enhanced electronics with computer assisted diagnostics), (contrast-enhanced spectral mammography or CESM), positron emission mammography (PEM), and even breast MRI is read out in Bi-RADS), – do you abstract the case? NO – imaging only diagnosis with Bi-RADS4 or Bi-RADS5 is insufficient to establish a positive diagnosis – per SEER and NCDB/CoC. Other types of breast testing such as Ultrasound or Thermography are not rated using the American College of Radiology Bi-RADS system. So, these other types of tests do not fit into the formula.

2. The other questions related to this are – can you use the BI-RADS4 or BI-RADS5 imaging date as the date of diagnosis when it is followed by a positive biopsy from the same area of the 'abnormal' breast? ABSOLUTELY. The imaging date followed by a confirmation biopsy affirms the abnormality was in fact a tumor that must be reported. And, the first date it was felt to be a tumor was the date of the Abnormal Mammogram/MRI.

3. If you can use the Bi-RADS4 or Bi-RADS5 date as the date of diagnosis – how do you code the Diagnostic Confirmation? Diagnostic Confirmation is totally separate from Date of Diagnosis. The Diagnostic Confirmation is the BEST METHOD used to confirm the diagnosis – not the first method. So, the biopsy (anatomic pathology or histology) is the BEST METHOD. We may soon have additional criteria in Diagnostic Confirmation to qualify which solid tumors were assigned a subtype based on molecular pathology in the same way we use Dx Confirmation = 3 for Hematopoietic Cases. But, we have yet to establish that new code and it will take some time to write instructions.

◊ If you only have a BIRADS4 or BIRADS5 from screening without a biopsy – the case is not reportable as imaging, only diagnosis – no other information.

(Continued on page 16)

(Continued from page 15)

◊ If BIRAD4 or BIRADS imaging is followed by + biopsy – the Date of Dx is the date of imaging – Diagnostic Confirmation is still = 1 (histology – because of the bx)

We should have started capturing the difference in days between diagnostic or screening mammography's and the first positive biopsy since the 1980s.

This is how you measure the effectiveness of a breast screening program. It shows how many positivde or suspicious mammoraphs turned out to be malignant (or in-situ). These were the days when it was not uncommon to see a 5cm breast tumor and many women had positive nodes. The tumors we find now are often less than 0.5mm.

The comparison of these dates is also how you identify 'access to care issues' and other 'social determinants of health' that keep people from seeking treatment. Such as when individuals know they have a breast tumor and still must wait long periods of time to follow-up on a known abnormal mammograph. They may not have insurance or money or are scared – so many reasons to postpone.

This should all be captured in the cancer registry. We should have been able to show this difference since screening mammography took off in the 1980s…we just didn't.

There was an old instruction emphasized back in the 1990s that registrars were never to use Bi-RADS for anything…and it stuck in everybody's head. It was only half the rule. But, it was based on pre-digital mammography before we had superfast imaging machines and computers to run them and to run Computer Assisted Diagnostics and Artificial Intelligence to identify suspicious lesions.

We still had no clear way to measure the time between imaging and biopsy without capturing the imaging data. Some hospital/research/network hospital system registries capture these data as part of their Breast Programs. But, the data belong in the cancer registry. FCDS is asked this question frequently. We just have to say, 'we don't collect that data' in our routine data collection practice.

We hopt this helps registrars understand that screening mammography is really important, we really need the dates and the text – and that a Bi-RADS4 or Bi-RADS5 followed by a biopsy that proves breast cancer is present confirms that the first date of diagnosis was the imaging/Bi-RADS date.

Page 31 of 2023 STORE Manual

STORE 2023 *STORE 2023 Summary of Changes*

STORE 2023 Page Number	Section or NAACCR Data Item Number	Data Item Name	Changes/Comments/Clarifications
45	Overview of Coding Principles	Case Eligibility	Added: PI Rads, BI Rads, LI Rads alone are not reportable for CoC. PI Rads, BI Rads, LI Rads confirmed with biopsy or physician statement are reportable to CoC. Date of diagnosis is the date PI Rads, BI Rads, LI Rads imaging. The biopsy makes it reportable to CoC however the date of diagnosis is the date of the imaging.

Scope of Regional Lymph Node Surgery = 1 (FNA) Still Must Be Coded

We have identified a very clear pattern from QC Review where many registrars have completely stopped using Code = 1 (FNA Regional Lymph Node) in the field 'Scope of Regional Lymph Node Surgery'. Yes, the NCDB/CoC decided in 2021 to include it in Diagnostic Work 'section' instead of the Treatment 'section' just like a sentinel lymph node biopsy…they made the procedure not 'count' as treatment.

But that doesn't mean that you stop coding it completely. We need the FNA of Lymph Node Procedure.

Scope Reg LN Surg = 1 is still used to verify pre-surgical regional node disease without reading every abstract. And without this code the regional nodes appear to have been clinically diagnosed instead of histologically. Biopsy-proven regional nodes are an important indicator for treatment patterns.

Please remember that if the regional node is positive, you also code Regional Nodes Positive = 95 and Regional Nodes Examined = 95. This is still the same. Except you can code 00/95 if the node is negative.

All the NCDB/CoC did was make it so you do not have code Treatment Given = 1 (Yes) when only an FNA of a regional lymph node was performed and you don't have to sequence this FNA procedure with other treatment given (before or after chemo/rad/etc.).

FNA is not and never has been 'treatment'. All the NCDB/CoC did is acknowledge that in Treatment Given Field and Sequence with other Treatment fields. The procedure is important in research.

It is possible that your vendor no longer sends this treatment item to FCDS as Scope Reg LN Surg = 1. We have not checked with any individual vendors as we did not notice a 'vendor pattern' only a coding one.

PLEASE continue to code the FNA procedure in Scope Reg LN Surg. You don't need a, just code = 1. So simple and so easy to overlook. I think folks are just skipping over it since it is no longer counted as treatment. But that never meant to stop using the code or the 95/95 for nodes examined/positive.

Prostate Cancer Transformation To Small Cell

Question:

I have a case where the radiation oncologist and medical oncologist are calling this a prostate cancer that turned into a small cell carcinoma that is now metastatic to the lung, liver, bone. I've never had a prostate adenocarcinoma "turn into" something else. Do I have 1 primary - Prostate, or do I have 2 primaries - Prostate? Or is this an unknown new primary?

From Medical Oncologist office note: Patient diagnosed high risk, stage IVA (cT4 cN1 M0), Gleason 4+5 = 9, PSA 35, prostate adenocarcinoma status post definitive radiation with ongoing ADT (androgen deprivation therapy). Patient now presents with biopsy- proven metastatic small cell carcinoma to the liver. He also has bone and nodal metastases.

Both Oncologists are treating this as metastatic small cell carcinoma from the prostate.

Answer:

This 'transformation' has been discussed in the literature in the past several years and is called 'treatment-emergent small-cell neuroendocrine prostate cancer' or t-SCNC. It is a distinct entity separate and apart from the original adenocarcinoma of the prostate.

Scientists think something happens during treatment with abiraterone or enzalutamide that causes this transformation at the molecular level. So, these are always genetically distinct from the original adenocarcinoma of the prostate. Therefore, they must be a new primary.

The best correlation for abstracting as a new primary is that it is like any other genetic level transformation like CML to AML or CLL/SLL to ALL. But this is a solid tumor not a lymphoma or a leukemia. We currently do not have any 'transformation' rules for solid tumors.

It is possible that there were neuroendocrine features or mixed adeno and small cell at the time of original diagnosis. But we don't have any instructions how to abstract these as mixed tumors or instructions to code these to small cell neuroendocrine carcinoma - unless they are 100% small cell carcinoma. So, the current histology rules have not caught up with the science, yet.

(Continued on page 19)

(Continued from page 18)

WHO just published the 5th edition, Volume 8 Classification for Urinary and Male Genital Tumors in June of 2022. It includes several new subtypes for both prostate and urinary system cancers. So, SEER has just started working on updating the Solid Tumor Rules to revise the prostate and bladder multiple primary and histology coding rules. We will see new rules come out in 2024. SEER wants to be sure that they are clear and consistent with WHO Classification.

The new small cell carcinoma neuroendocrine carcinoma will usually have a low PSA and will not be hormone responsive. It is a lethal and highly aggressive form of prostate cancer and it is usually metastatic and castrate-resistant/hormone resistant. It is estimated as many as 20% of prostate cancers might have the potential to 'transform' into aggressive small cell carcinoma.

A conversation with SEER indicated that we should abstract as a new and 2nd prostate cancer and include the term 'treatment-emergent small-cell neuroendocrine prostate cancer'.

Historically we have instructed registrars a patient can have only 1 prostate adenocarcinoma in a lifetime. So, this case will fail edits and create havoc in our system and maybe yours for now.

The more we learn about molecular pathology the more we will learn about subtypes for cancers. Prostate adenocarcinoma is usually a microscopic histology diagnosis and not a molecular pathology diagnosis. But new science is emerging that does identify various subtypes of adenocarcinoma of the prostate – even subtypes of acinar adenocarcinoma – and the Solid Tumor Rules will eventually 'catch up' with the science.

Please report these cases as a new diagnosis of metastatic small cell of the prostate. Let FCDS work with edits to FORCE the case in as a new prostate primary. It is definitely a new primary.

Tumor Mutational Burden or TMB

QUESTION:
Would Tumor Mutation Burden be documented at the KRAS, BRAF, EGFR etc. in a lung path report. I know we collect those mutation results, but it is the same as the tumor mutational burden.

ANSWER:
The short answer is 'no'.

The basic translation of the formal definition below is that 'tumor gene mutation burden is the approximate amount of gene mutation that occurs in the genome of a cancer cell.'

Cancers with low mutation burden have fewer mutations – this decreases the chance that any mutations present will activate the immune system response.

(Continued on page 20)

(Continued from page 19)

Cancers with high tumor mutation burden have more mutations – this increases the chance that at least one mutation will activate an immune system response.

The higher the tumor mutation burden the more likely the tumor will respond to treatment because the immune system has a better opportunity for recognizing at least one of the mutations to trigger a response. But it is not a guarantee by any means…it is still increasing/decreasing possibility of response.

TMB is measured by next-generation sequencing of tumor tissue looking for all different kinds of mutations. Cancers with TMN of 10 mut/Mb or greater may be more likely to respond to immune checkpoint inhibitors which help activate the immune system to better recognize cancer cells.

Next-generation sequence multi-gene panel assays are not FISH or IHC or Flow Cytometry. They are test such as Guardant360 CDx or FoundationOne CDx or Carls Life Sciences 592 gene panel. They are not a routine part of any pathology report. Just like FISH, IHC or Flow Cytometry – they are separate reports.

Only a few NGS multi-gene panels are FDA approved at this time. So, you must look for the report and the interpretation of the results on that report. The interpretation may be an addendum to the anatomical pathology report. But the pathology report is just the tissue and cellular observations not the results of specialty testing like FISH, IHC, Flow Cytometry or Molecular Genetic Testing using NGS.

Definition from NCI: Tumor mutational burden (TMB) is a numeric index that expresses the number of mutations per megabase (mut/Mb) harbored by tumor cells in a neoplasm. TMB can be determined using different approaches based on next-generation sequencing. In the case of high values, it indicates a potential response to immunotherapy.

Which human cancers have the highest mutation burden? The magnitude of TMB also varies across different tumor types, with the highest levels reported in melanoma and other skin cancers (where ultraviolet light is the dominant mutational process), followed by non-small cell lung cancer and other squamous carcinomas.

2022-2023 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.

DATE	TOPIC
*10/6/21	**Breast 2022 Part 1** Co-host: Wilson Apollo Part 1 of the Breast webinar will focus on treatment of breast cancer. We will discuss the new breast surgery codes, reconstruction, lymph node related data items, systemic treatment, and radiation.
11/3/21	**Breast 2022 Part 2** Co-host: Denise Harrison Part 2 of the Breast webinar will focus on SSDIs and staging. Examples, quizzes, and case scenarios included.
12/1/21	**Esophagus 2022** Co-host: Wilson Apollo This webinar will focus on anatomy, SSDIs, staging, and treatment with an emphasis on radiation. Examples, quizzes, and case scenarios included
1/12/23	**Head and Neck 2023** Co-host: Vicki Hawhee This webinar will cover the anatomy, solid tumor rules, staging and treatment of Head & Neck cancers. Examples, quizzes, and case scenarios included.
2/2/23	**Data Item Relationships** Co-host: Jennifer Ruhl and Angela Costantini We will take an in-depth look at how codes for one data item impact codes for other data items. Examples, quizzes, and case scenarios included.
3/2/23	**Boot Camp 2023** Guest Hosts: Nancy Etzold and Elaine Bomberger-Schmotzer This Boot Camp webinar will involve completing multiple quizzes with minimal lecture.
4/6/23	**Prostate 2023** Co-host: Gillain Howell and Amy Bramburg This webinar will focus on the anatomy, SSDIs, staging, and treatment of prostate cancer. Examples, quizzes, and case scenarios included.
5/4/23	**Lower GI 2023 Part 1** Co-host: Denise Harrison Part 1 of the Lower GI webinar will focus on colon, appendix, and anus. We will look at anatomy, solid tumor rules, and SSDIs for these sites. Examples, quizzes, and case scenarios included.
6/1/23	**Lower GI 2023 Part 2** Co-host: Denise Harrison Part 2 of the Lower GI webinar we will discuss stage and treatment for colon, appendix, and anus. Examples, quizzes, and case scenarios included.
7/13/23	**IT Worked for Me: In"FUN"matics in the Cancer Registry** Co-host: Ronda Broome, Lisa Landvogt, Kelli Merriman This webinar features a variety of professional perspectives on how best to mix technology with data and utilizing the outcome to share relevant and valuable data analysis (informatics). This is THE next level for CTR's on the career ladder. We have spent decades on mastering the input of data, NOW is the time to take "IT" to the next level. Join us on our journey, "IT" is truly the fruit of our labor, from beginning to end.
8/3/23	**Melanoma 2023** Co-host: Janine Smith We will look at solid tumor rules, staging, SSDIs, and new skin surgery codes for Melanoma. Examples, quizzes, and case scenarios included
9/7/23	**Coding Pitfalls 2023** Co-host: Janet Vogel During this webinar we will review problematic coding issues identified through quality control of registry data

CEU information for the 2022 FCDS Annual Conference:

CE Hours: 7.5

4 Hrs Category A

NCRA Recognition Number: 2022-127

2022-2023 FCDS Annual Educational Webcast Series
All Webcasts Occur on the 3rd Thursday of each Month from 1pm-3pm

FCDS offers a 6-session annual educational webcast series every year for over 10 years as one component of the overall FCDS Education and Training Plan. The six sessions are intended to provide registrars with the latest information on the latest cancer registry topics. The sessions kickoff during the FCDS Annual Conference held in the late summer of each year. This is when topics are introduced for the coming year including webcasts, audits, use of new manuals, etc. The annual conference and webcast sessions combined with the monthly NAACCR Cancer Surveillance Webinar Series provide nearly 60 NCRA-approved CEUs for Florida Cancer Registrars every single year. Here is the 2022-2023 schedule.

Date	2022-2023 FCDS Webcast Series - Topics
9/22/2022	FCDS Annual Conference Summary – 2022 Requirements
10/20/2022	Lung & Thoracic Neoplasms – WHO 5th edition Classification, Volume 5; 2021
11/17/2022	Brain & CNS Neoplasms (includes pediatric) – WHO 5th ed Classification, Volume 6; 2021
12/15/2022	Common Registrar Technical Questions and Clarifications from Visual Editing
1/19/2023	Myeloid Neoplasms – 2022 Updates & 2022 Audit Findings
2/16/2023	Lymphoid Neoplasms – 2022 Updates & 2022 Audit Findings

Florida Cancer Data System

Cancer Reporting Completeness Report

TOTAL NUMBER OF CASES IN THE FCDS MASTER FILE AS OF SEPTEMBER 30, 2022

Total number of *New Cases* added to the FCDS Master file in September, 2022 **22,015**

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	23,202	613	103	6,963	18	**Pending**	30,899	**9,190**
2021	187,028	2,316	450	12,164	6,205	**Pending**	208,163	**9,818**
2020	218,149	5,808	1,408	12,446	25,373	**Pending**	263,184	**3,007**

		Actual	Expected
% Complete for:	**2022**	**12%**	**25%**
	2021	83%	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.

FCDS
PO Box 016960 (D4-11)
Miami, FL 33101

Phone: 305-243-4600
800-906-3034
Fax: 305-243-4871

http://fcds.med.miami.edu