The Florida Cancer Data System's Memo

April 2024

Optic Chiasmatic-Hypothalamic GLIOMAS (OCHGs)
Optic Pathway/Hypothalamic GLIOMAS (OP/HGs)
Optic Pathway GLIOMAS (OPGs)

Optic pathway gliomas can arise anywhere along the length of the **optic nerve**, through the **optic chiasm** and **hypothalamus,** and that is the reason they may be grouped as OCHGs, OP/HGs, or OPGs.

Optic chiasm and hypothalamic gliomas are considered a single entity because no matter where they initially originated whether in the hypothalamus or the optic chiasm, they may infiltrate the other compartment. Sometimes the tumor arises in the hypothalamus and may infiltrate the optic chiasm. Other times the tumor arises in the optic chiasm and may infiltrate the hypothalamus.

To avoid further confusion, we need to go to the basics. We must remember that **GLIO**MAS are derived from **Glia**l cells, also known as **Neuroglia**, whose function is to support and nourish neurons.

Specifically, **Glial** cells or Neuroglia encompass **Astrocytes**, Ependymal cells, Microglia, Satellite cells, Schwann cells, and Oligodendrocyte cells.

Most OCHGs, OP/HGs, or OPGs are benign low-grade **astrocytomas** that arise mostly in the pediatric population. They are predominantly childhood tumors.

Furthermore, 90% of cases are diagnosed in patients <=20 years old. 75% of cases are present in the first decade of life, the peak incidence. And they account for 20% of all pediatric brain tumors in patients who are two years old or younger.

Optic pathway gliomas (OPGs) range from 3% to 6% of pediatric brain tumors. And they account for 2% of all CNS gliomas.

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WHAT'S NEW:

The following information is currently available on the FCDS website.

FCDS Data Acquisition Manual 2024

FCDS RESEARCH JOURNAL PUBLICATIONS REPORT

FCDS State Specific V24 XML Dictionary

FCDS/NAACCR EDITs Metafiles:

V23B Metafile, posted on 11/29/2023

V24 Metafile, posted on 3/18/2024

FCDS Florida Cancer Data System

Florida Statewide Cancer Registry

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Optic Chiasmatic-Hypothalamic GLIOMAS (OCHGs)
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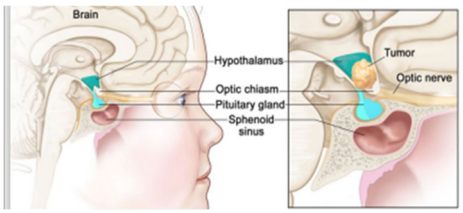

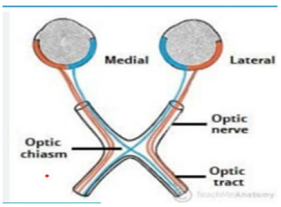

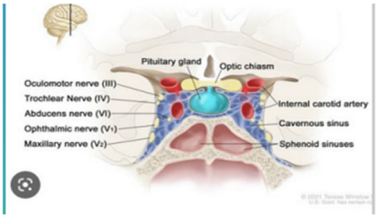

Optic Chiasm: Where the optic nerves cross to the opposite side.

Image credits to their source.

Even though our focus here is OCHGs, OP/HGs, or OPGs, astrocytomas are not exclusive to develop on this optic hypothalamic chiasmatic pathway in the CNS. They may develop in the brain, brainstem, or cerebellum, among other sites.

They are not exclusive to the **pediatric** population either. In **adults**, astrocytomas tend to be high-grade, more aggressive gliomas, such as glioblastoma and anaplastic astrocytomas.

For OCHGs, OP/HGs, or OPGs, the incidence of **gliomas** exclusively of the **optic nerve** is higher in females (F>M).

Nevertheless, the incidence is equally common in both genders when the primary sites are the optic nerve and the optic chiasm (M=F).

Optic pathway/hypothalamic gliomas (OP/HGs) main histological types in the ***pediatric population*** are **pilocytic astrocytoma** (Grade I) and **pilomyxoid astrocytoma** (Grade II).

Unfortunately, pilomyxoid astrocytomas may present with CSF dissemination and spinal metastasis.

They are rare astrocytomas, but for practical reasons, only the most common histologies are named here.

Patients with Optic/Chiasm/Hypothalamic pathway GLIOMAS may present with some of the following:

- Seizures and lethargy are always a possibility in brain tumors. And as the intracranial pressure increases, headaches and projectile vomiting are more common. Once the tumor causes obstruction/imbalance of the CSF, hydrocephalus sets in.
- Visual changes. One may see optic atrophy in a fundoscopy eye exam. Proptosis/ exophthalmos or bouncy eyes known as nystagmus, and strabismus (crossed eyes) may be present. Also, patients may have partial visual field loss which may progress to blindness.
- Babies and young children may present with **Diencephalic syndrome** which includes failure to thrive (especially during the first 3 years of age) as they do not gain a healthy weight for their age per appropriate weight-for-height normal development tables.
- Many of these cases are confused with negligence or abusive parenting. Therefore, their true diagnosis is often delayed, and it is discovered when a Brain MRI is finally done, showing a hypothalamic-optic chiasm neoplasm.
- Obesity may present in other cases. But, why this fluctuation in weight? Because the hypothalamus is the center for regulating hunger and satiety. Thus, depending on how affected the hunger/satiety nuclei are in the hypothalamus, that is how the symptoms will present.

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- Other signs and symptoms of OCHGs, OP/HGs, or OPGs may present due to hormonal dysfunction, as in the case of polyuria/polydipsia, which are symptoms of Diabetes insipidus. Also, rare cases of precocious puberty and short stature may result from hormonal dysfunction.

DIAGNOSIS:

- Brain CT scan, or Brain MRI scan
- Endocrine assessment
- Visual field testing
- Regular Ophthalmologist evaluation in Neurofibromatosis type 1 patients

TREATMENT

Treatment may be a combination of **surgery, chemotherapy, radiation, or immunotherapy**.

Radiation may trigger a newer more aggressive glioma, especially in patients with Neurofibromatosis type 1.

Since radiation is associated with an increased risk of secondary CNS malignancies, chemotherapy may be favored over radiation as first-line treatment.

An example of this is **anaplastic astrocytoma**, which, in many cases, most likely developed malignant degeneration after radiation treatment to a more benign low-grade astrocytoma.

Molecularly targeted drug therapy is currently in clinical trials and addresses blockage to abnormal cellular growth pathways with BRAFV600E BRAF inhibitors (vemurafenib, e.g.) and MEK inhibitors (trametinib, e.g.).

For this type of glioma, the MAPK/ERK pathway is activated. The new drugs target the MAPK/ERK pathway and RAS/MAPK pathway to interrupt abnormal cell growth.

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Consider that those optic gliomas may arise sporadically as a mutation in BRAFv600E or in association with **Neurofibromatosis type** 1 (NF1) or **Noonan Syndrome**. Fortunately, the MAPK/ERK and RAS/MAPK pathways already account for NF1, Noonan Syndrome genetic alterations, and sporadic BRAFV600E mutations.

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PROGNOSIS

Pediatric low-grade gliomas (PLGG) have excellent long-term survival with treatment in contrast with high-grade gliomas.

As mentioned before, Optic gliomas may arise

- **sporadically** as mutations in **BRAFv600E** or
- **in association with Neurofibromatosis type 1** (NF1) or **Noonan Syndrome**.

VON RECKLINGHAUSEN'S disease (Neurofibromatosis type 1)

These patients have a higher risk of developing benign and malignant tumors such as Malignant Peripheral nerve Sheath tumors and Leukemias.

Also, affected patients present other specific features in the eyes (iris Lisch nodules) and the skin (cafe au lait spots and freckles). However, the most distinctive feature for these patients is where prominent nerve neurofibroma tumors cover the body due to a mutation on a tumor suppressor protein called neurofibromin because of a genetic mutation in chromosome 17

In **children** with Neurofibromatosis type 1, there is an increased risk, up to 20%, of developing optic pathway/hypothalamic gliomas. On the other hand, in **adults** with these types of tumors, there is no association with Neurofibromatosis type 1

Furthermore, in patients **with** Von Recklinghausen's disease, the most common site is the **optic nerve**, and the tumor is smaller (in contrast with patients **without** NF1, where the **hypothalamus** and **optic chiasm** are more frequently involved).

NOONAN SYNDROME

The link between **Noonan syndrome** and **Pilocytic Astrocytoma's**.

Noonan syndrome patients are not only at increased risk of developing hematologic malignancies such as ALL and CML, but they may develop brain tumors such as Dysembryoplastic Neuroepithelial Tumors (DNET) and **low-grade astrocytoma's**.

GLIOMAS OF THE OPTIC NERVE / PILOCYTIC ASTROCYTOMAS CODING DISCREPANCIES.

There was some discrepancy in the past about coding them as malignant versus nonmalignant among different official organizations.

This is what the **Journal of Neuro-Ophthalmology** said:

"Consensus opinion now views them as benign neoplasm, although capable of causing significant morbidity. Despite neuro-oncologic judgment of benignancy, the Surveillance, Epidemiology, and End Results **(SEER)** cancer registry had maintained a policy of reporting pilocytic/juvenile astrocytoma's as behavior code/**3 "malignant" until December 2018** when coding of optic nerve astrocytoma's was changed to reflect World Health Organization (**WHO**) guidelines as nonmalignant (behavior code/**1**)"

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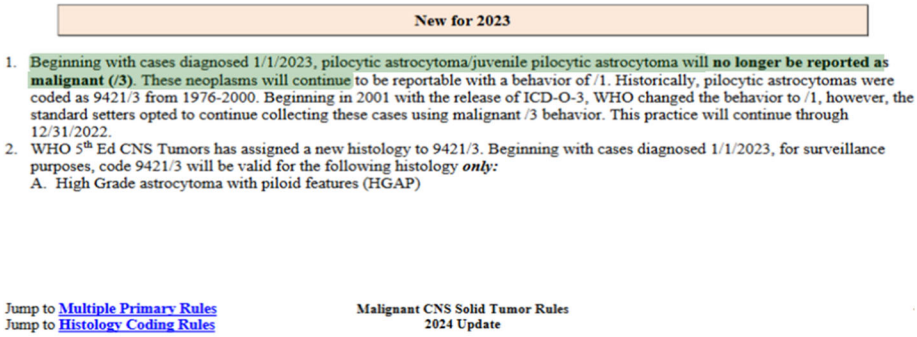
Despite the Surveillance, Epidemiology, and End Results (SEER) and the WORLD Health Organization not agreeing in the past, they finally are on the same common front, and we can see this reflected in the most recent years in the Solid Tumor Rules updates.



New for 2023

1. Beginning with cases diagnosed 1/1/2023, pilocytic astrocytoma/juvenile pilocytic astrocytoma will **no longer be reported as malignant (/3)**. These neoplasms will continue to be reportable with a behavior of /1. Historically, pilocytic astrocytomas were coded as 9421/3 from 1976-2000. Beginning in 2001 with the release of ICD-O-3, WHO changed the behavior to /1, however, the standard setters opted to continue collecting these cases using malignant /3 behavior. This practice will continue through 12/31/2022.
2. WHO 5th Ed CNS Tumors has assigned a new histology to 9421/3. Beginning with cases diagnosed 1/1/2023, for surveillance purposes, code 9421/3 will be valid for the following histology ***only:***
   A. High Grade astrocytoma with piloid features (HGAP)

Jump to Multiple Primary Rules
Jump to Histology Coding Rules

Malignant CNS Solid Tumor Rules
2024 Update

Solid Tumor Rules 2024 Update

Note 5: Pilocytic astrocytoma/juvenile pilocytic astrocytoma:

- For cases diagnosed **prior to 1/1/2023**, these neoplasms are reportable in North America as malignant **9421/3** for all CNS sites with the exception of the optic nerve:
- WHO Classification Tumors of the Central Nervous System and IARC **designate pilocytic astrocytoma as a synonym for optic glioma**
- When the primary site is the optic nerve and the diagnosis is either **optic glioma or pilocytic astrocytoma**, the behavior is non-malignant and coded **9421/1**
- Beginning with cases diagnosed **1/1/2023 forward, pilocytic astrocytoma/juvenile pilocytic astrocytoma are to be reported as 9421/1** for all CNS sites.

Optic glioma/pilocytic astrocytoma 9421/1		

Jump to Multiple Primary Rules
Jump to Histology Coding Rules

Solid Tumor Rules
2023 Update

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Solid Tumor Rules CNS 2024 Update

Note 6: Pilocytic astrocytoma/juvenile pilocytic astrocytoma is reportable in North America as a malignant neoplasm 9421/3.

- See the Non-malignant CNS Rules when the primary site is the optic nerve and the diagnosis is either optic glioma or pilocytic astrocytoma. The behavior for these tumors is non-malignant and coded 9421/**1**.
- IMPORTANT **FOR 2023 FORWARD**: **Beginning 1/1/2023, all cases diagnosed with pilocytic astrocytoma/juvenile pilocytic astrocytoma and new related terminology are to be reported with behavior /1**. They will no longer be collected with malignant behavior (/3). See the Non-malignant CNS Rules.

Non-Malignant CNS Equivalent Terms and Definitions
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 - M9993 and Kaposi sarcoma M9140)

Histology Term and Code	Most Common Intracranial Primary Site
Dysplastic gangliocytoma 9493/0	Cerebellum C716
Juvenile xanthogranuloma 9749/I	Intraventricular C715
Myxopapillary ependymoma 9394/1	4th ventricle C715
Piloctic astrocytoma/juvenile Piloctic astrocytoma 9421/1	Optic nerve C723

Non-Malignant CNS Equivalent Terms and Definitions
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C7
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcom

NOS/Specific Histology Term and Code	Synonyms	Subtypes/Varia
Diffuse astrocytoma, MYB- or MYBL1 altered 9421/1 *Note 1:* Beginning 1/1/2023, diffuse astrocytoma, MYB- or MYBL1 altered is the preferred term for 9421/1. *Note 2:* Beginning 1/1/2023, pilocytic astrocytoma/juvenile pilocytic astrocytoma are coded 9421/1. Cases diagnosed prior to 1/1/2023 are coded 9421/3.	Angiocentric glioma Diffuse low-grade glioma, MAPK pathway-altered Juvenile pilocytic astrocytoma Pilocytic astrocytoma	
9425 3 Preferred Pilomyxoid astrocytoma (C71._)		

Malignant CNS and Peripheral Nerves Equivalent Terms and Definitions
C470-C479, C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Specific and NOS Histology Codes	Synonyms	Subtypes/Variants
Neuroepithelial tumor, malignant 8000/3		
Oligoastrocytoma NOS **9382**	Anaplastic oligoastrocytoma NOS	
Oligodendroglioma NOS **9450** *Note:* Oligodendroglioma NOS is used when molecular markers cannot fully be determined	Oligodendroglioma 1p/19q-codeleted Oligodendroglioma IDH-mutant Oligodendroglioma IDH-mutant and 1p/19q-codeleted, grade 2	Anaplastic oligodendroglioma NOS **9451** IDH-mutant 1p/19q-codeleted IDH-mutant and 1p/19q-codeleted Oligodendroglioma, IDH-mutant and 1p/19q-codeleted, grade 3
Peripheral primitive neuroectodermal tumor **9364**	Ewing sarcoma pPNET	
Pilocytic astrocytoma **9421**		Pilomyxoid astrocytoma **9425**

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Non-Malignant CNS Solid Tumor Rules 2024 Update. P.26

At FCDS, we hope you found this article useful.

Article written by Betty Malanowski

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Annual Reporting Deadline
Reminder Emails to go out in May 2024

Florida law requires that all cancer cases diagnosed/treated for cancer, having a cancer-related health visit while undergoing cancer treatment, or having any evidence of disease at the time of encounter must be abstracted and reported to FCDS within six months of the date of first encounter for cancer. Cancer cases that were seen at your facility in October 2023 must be abstracted and reported to FCDS by April 2024. See the reporting calendar below.

In mid-May 2024, FCDS will notify Facility Administrators and Registrars of those facilities that have reported less than 75% of their total annual caseload for reporting year 2023 that their facility is in jeopardy of missing the state-mandated deadline of June 30th, 2024. FCDS reinforces the 6-month reporting rule with the state-mandated June 30th Deadline each year.

Facilities will be asked to develop a remedial plan to bring the facility back into compliance with state statutes. The plan must also include a statement indicating how the facility plans to stay compliant once the current reporting year has been completed and compliance has been reached for the year in question.

Suppose no action is taken or delinquency continues after the June 30th deadline. In that case, FCDS will notify the Florida Department of Health that the facility is non-compliant, and further action will be taken. The Florida Department of Health and FCDS must approve any remediation or other action plan. FCDS will monitor the plan.

FCDS requires that facilities transmit data at least quarterly. Monthly data submission is highly recommended for large facilities reporting over 500 cases annually.

FCDS Reporting Calendar

Patient Encounter for Cancer	Case Should Be Reported
ALL 2021 CASES WERE DUE 6/30/2022	ALL 2022 CASES WERE DUE 6/30/2023
January 2023	July 2023
February 2023	August 2023
March 2023	September 2023
April 2023	October 2023
May 2023	November 2023
June 2023	December 2023
July 2023	January 2024
August 2023	February 2024
September 2023	March 2024
October 2023	April 2024
November 2023	May 2024
December 2023	June 2024
	ALL 2023 CASES ARE DUE 6/30/2024

FCDS 2024 Educational Webinar Series

FCDS is offering four educational webinars for Florida cancer registrars and cancer case abstractors.

FCDS 2024 Educational Webinar Series will take place between March and December 2024.The four webinars will consist of two site-specific topics on lung and gynecological malignancies and two on reviewing and coding the four grade fields and the QC Visual Review findings. The webinars will provide essential background and directed instruction on 2024 data collection requirements for FCDS with specific coding instructions and feedback. Each Cancer Site Educational Webinar will provide background and instructions for registrars to understand the anatomy and surrounding structures for each cancer site, risk factors associated with cancers of each site, signs, and symptoms of disease, how to use and apply the Solid Tumor Rules, Summary Staging, SSDI and Grade coding, NCCN or other published clinical practice guidelines for establishing a diagnosis, staging, marker studies and other tests used for treatment planning for each site. In addition to addressing abstracting, coding, staging, and treatment for each cancer site, FCDS QC Staff will discuss findings from routine processing of EDITS plus Visual Editing to target specific problem areas for Florida registrars.

SCHEDULE: Each webinar will be held Wednesday from 10 am - 12 pm. Please use the links below to register.

FCDS Webcast Title	Date	Time	Registration Link	NCRA# 2 Cat A CEUs
FCDS QC Visual Review Findings and Feedback	3/13/24	10 am - 12 pm	https://miami.zoom.us/webinar/register/WN_9Zoweg0AQKa_qliUZFyKmg	2024-031
Lung Cancer	6/12/24	10 am - 12 pm	https://miami.zoom.us/webinar/register/WN_x2RsqrgFRMudoQ5MWZeTkA	2024-032
The Complexity of Coding Grade	9/11/24	10 am - 12 pm	https://miami.zoom.us/webinar/register/WN_YT9IFo3eScWA6DhxOWesBQ	2024-033
GYN Site Group Cancer	12/11/24	10 am - 12 pm	https://miami.zoom.us/webinar/register/WN_2zZfOsBVTJ6s3X3AGd6fXw	2024-034

The webinars will be recorded and posted to the FLccSC website. Please join us for this informative, educational webinar series

Radiation Treatment Facilities-Reporting Deadline

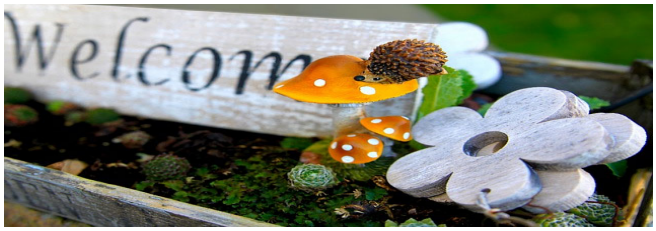
IDENTIFICATION OF CANCER CASES DIAGNOSED *AND/OR TREATED AT RADIATION TREATMENT FACILITIES BETWEEN JANUARY 1, 2023 AND DECEMBER 31, 2023*

*The Florida Cancer Data System is requesting at this time that Radiation Treatment facilities identify and report the cancer cases that were diagnosed and/or treated at their facility between **January 1, 2023 and December 31, 2023**.*

The deadline to submit the list of cancer cases is June 30, 2024. After the June 30th deadline, FCDS will match the submitted records with the FCDS database. FCDS will request a full cancer case abstract for each patient not found through the match.

State law requires the information requested. Facilities that fail to meet state-mandated cancer incidence data reporting requirements 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," per Section 385.202 F.S.

For questions, please call Saskia Angel at (305) 243-2636 or email at sangel@med.miami.edu.



New Staff

Dawn Mason, BS, ODS, Sr. Field Coordinator, effective March 2024
Dawn Mason began her cancer registry career in 2013.She has worked in a multi-facility hospital system for the past six years. She was promoted to Lead Cancer Registrar, where she was responsible for overseeing clinical registry operations, cancer reporting, establishing quality standards, and mentoring newly credentialed cancer registrars. She is a member of the FCRA and the NCRA. Dawn is happy to join the FCDS team.

Rhonda Buchenhain, BS, RHIA, ODS-Certified, Sr. Field Coordinator, effective March 2024
Rhonda Buchenhain has 22 years of experience in the cancer registry field. She has a broad background in Cancer Registry Management, monitoring NAPBC compliance, maintaining compliance with state reporting, and monitoring compliance with the CoC Cancer Program Standards. She received her AS degree from SUNY Empire State College in Business, Management & Economics in 1987, and a BS degree from SUNY Institute of Technology in Health Information Management/Health Services Management in 1997. She was previously employed at Ascension Seton Healthcare for 9.5 years as the Network Cancer Registry Manager for 11 facilities in Austin, TX, and as Lead Quality Abstractor for four states (AL, IL, NY & TX). Rhonda is also active in state and national organizations such as NCRA, FCRA, and TxTRA. She is a former Ways & Means Chair with FCRA, volunteering for 10 years, and former President of the TX Tumor Registrars Association (TxTRA). Rhonda is passionate about helping others achieve their goals in the registry: mentoring, training, answering questions, and providing education and resources. She finds it rewarding and encouraging to see the new CTRs connect the dots and understand the overall picture of how Central and Cancer Registries work. She is very happy to be part of the FCDS family and is eager to embark on the new journey!

Historical Case

FCDS requires reporting historical cancers even when the patient has no evidence the historical cancer is active.

Suppose a patient has had at least one primary reportable neoplasm that is currently active or under treatment. In that case, all other primary reportable neoplasms the patient has ever had (active or inactive), regardless of the date of diagnosis, must be reported. Each case of cancer must be abstracted and reported separately. These historical cancers are to be reported only once for a patient, not every time a currently active cancer is reported. New cancers for cases with old Accession Numbers must include the old Accession Number. Multiple submissions of the same cancer will fail edit checks. Without an active cancer, a historical cancer alone does not need to be reported.

FCDS recommends that Registrars use the Facility Alpha Listing found in the FCDS Reports Menu in IDEA to avoid duplicate case submissions to FCDS. This report is updated every time cases are submitted to FCDS. It is a complete reference of all cases ever reported to FCDS from your facility since 1981.

Information about the historical cancer may be vague. The abstractor should attempt to complete an abstract with as much information as is available in the medical record.

Abstracting Historical Cases

There are two methods for reporting a Historical Case:

1. Historical cases reported as full abstracts or

2. Reported using the minimal dataset as specified below:

A. For every abstract submitted, the record layout will allow for the entry of up to five historical cases.

B. The fields required for each of the five cases include:

   1. Sequence Number
   2. Diagnosis Date
   3. Primary Site
   4. Histology

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Historical Cases

5. Behavior

6. Laterality

7. State of Residence at Diagnosis (State Abbreviation)

8. County of Residence at Diagnosis (FIPS County Code)

9. Schema Discriminator 1

10. Schema Discriminator 2

C. These fields will be edited at the time of transmission.

D. These fields should only be used when abstracting a historical case with insufficient information.

E. A complete abstract must be reported to FCDS for cases with sufficient information in the patient's medical record or when the patient has evidence of the historical cancer at the time of patient en-counter (persistent disease, progression of disease or disease recurrence.

F. The minimal dataset only applies to Class of Case 33 Historical Cases with insufficient information. All other Non-Analytical cases, including Class of Case 33 historical cases with enough information, require a full abstract to be reported to FCDS.

G. Historical Cases should not include Unknown Primary Cancers (C80 or C76).

QC Visual Review Findings Overview March 13, 2024 Q&A

1. I was not able to download the slides as it was not given permission to download from FCDS web-site. Will they be updated after the session to provide permission to download?

   The slides can be downloaded here FCDS Webcast QC Coding Pitfalls (miami.edu).

2. Isn't grade supposed to be assigned based on the primary site only (or a metastatic site), not on a biopsy of a lymph node?

   Yes, the grade must be coded from the primary tumor only. Do not code grade based on metastatic tumor or recurrence.

3. If TURBT is considered a clinical diagnosis, shouldn't the clinical grade be 3 and the pathological grade 9?

   For urothelial cancers use codes L, H and 9; if only grades G1-G3 are documented, code 9 and TURBT qualifies for a clinical grade only.

4. If you code an 8046 in most software, you will get an edit.

   FCDS has one specific edit related to using the histology code 8046 (non-small cell carcinoma). This edit allows for an edit override (a force), meaning that it will fail the edit but will be allowed to be transmitted.

   All cases that fail a site/histology combination edit check will allow for an edit override (a force).

5. Highly suggestive is not in the ambiguous terminology.

   Correct. Highly suggestive is not an ambiguous term that constitutes a diagnosis of cancer.

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6. There continues to be confusion about using BIRADS as diagnosis.

   Instructions by all standard setters have never been clear. Additional clarifications are included in the FCDS DAM 2024 and the April 2024 Monthly Memo.

7. Breast case - This was not "suspicious", it was very suggestive. Does it make any difference?

   The highly suggestive refers to the category of the Bi-Rads. Category 5 is "Highly Suggestive of Ma lignancy." "Suggestive" is not reportable ambiguous terminology. ACR states that Category 5 has a "very high probability" of malignancy, but it is not diagnostic.

8. When did we go back to using BIRADS as diagnosis?

   Instructions in the FCDS 2023 DAM state that A positive/suspicious mammogram date should be used as the date of diagnosis ONLY when the patient goes on to subsequently have a positive biopsy and/or resection that confirms the suspicious abnormality is, in fact, a malignancy and not to use the RADS standards as the date of diagnosis until and unless SEER published instructions in the manuals.

   RADS rules will apply starting with diagnosis year 2024 forward. Please see the FCDS DAM 2024 for more instructions.

9. BIRADS 4 BREAST WOULD COUNT?

   The American College of Radiology defines Category 4 as “Suspicious.” Category 4, 4a, 4b, and 4c descriptions are not diagnostic of malignancy. They all represent a percentage of likelihood, the highest being 4c which is greater than 50% but less than 95% likelihood of malignancy. The ACR states, "This category is reserved for findings that do not have the classic appearance of malignancy but are suffi- ciently suspicious to justify a recommendation for biopsy."

10. What if Bi-Rads 5 on breast US, bx negative, but resection positive. Do we use Bi-Rads as DX date?

    Yes, use the Bi-Rads for the diagnosis date. The surgery confirmed the imaging results.

11. If FCDS and SEER manuals differ regarding the breast dx date scenario - which one of those 2 should be used to report correctly?

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FCDS and SEER agree.

12.I did a DCIS case today, : screening mamo on 8.7.23 states "indeterminant micro CALS++." on 8.28.23 a diagnostic mamo states "LOQ CALS++, amorphous appearance." POSITIVE biopsy 8.31.23. 8.31.23 is the correct DOD, correct?

Yes, the date of diagnosis is 8/31/23 if there is no mention of BI-rads 4A-4C,5.

13.So CoC & SEER agree with date of dx being the date of bx for the Birads 4-5 cases, FCDS is deviating from the rest of the country, are you sticking to those rules 2024+?

FCDS agrees with SEER. FCDS is not deviating from the rest of the country. Use the date of the BI-RADS if confirmed with a positive biopsy. Clarifications are included in the FCDS DAM 2024 and the April 2024 Monthly Memo.

14.You want info from the surgery text but if the tumor size extent of disease in op note is not in the op note do you want it from the path report?

FCDS requires supporting text documentation in the operative report data item, which can include observations at surgery, findings from resection, tumor size, extent of involvement, or primary or metastatic sites not resected or biopsied. Refer to FCDS DAM for more information on which data items require text.

15.Do TRUS bxs of prostate need to be entered in Operative text?

Suggested text can include dates and descriptions of biopsies and all other surgical procedures.

16.Does ethnicity need to be indicated in Exam Text box even though it is coded in Ethn data item?

Yes, the patient's age, sex, race, marital status, and ethnicity must be supported in your text documentation.

17.Please clarify when not to re-use the accession number. Do not re-use accession number if a case is deleted or reported to FCDS but determined not to be reportable?

(Continued on page 16)

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Each patient receives only one accession number from your facility for a lifetime, regardless of the facility's "reference date," number of primary cancers reported, or alternate numbering assignment. Accession numbers are never reassigned, even if a patient is removed from your facility registry.

QUESTION PT HAS HX OF BL CA 15 YRS AGO, PT HAS TUMOR SUSPICIOUS FOR RECURRENT UROTHELIAL BL CA, PT REFUSED ANY FURTHER WORKUP, NO CYSTOSCOPY OR PATH. IS IT REPORTABLE BASED ON TERM W NO PATH?

If a patient presents to your facility with a historical case with active disease, progression or recurrence, this is considered reportable to FCDS.

19.If I have a patient who was already reported to FCDS, and now has a new diagnosis, however while gathering this information for this new dx I found a historical case seq 02 and the new one is seq 03. I am getting a State edit sequence error; how do I fix this?

Please get in touch with FCDS with the specific edit number so that we can help you. Clarifications on how to report historical cancers to FCDS are included in the April 2024 Monthly Memo.

20.And these RADS rules will apply starting what year/date?

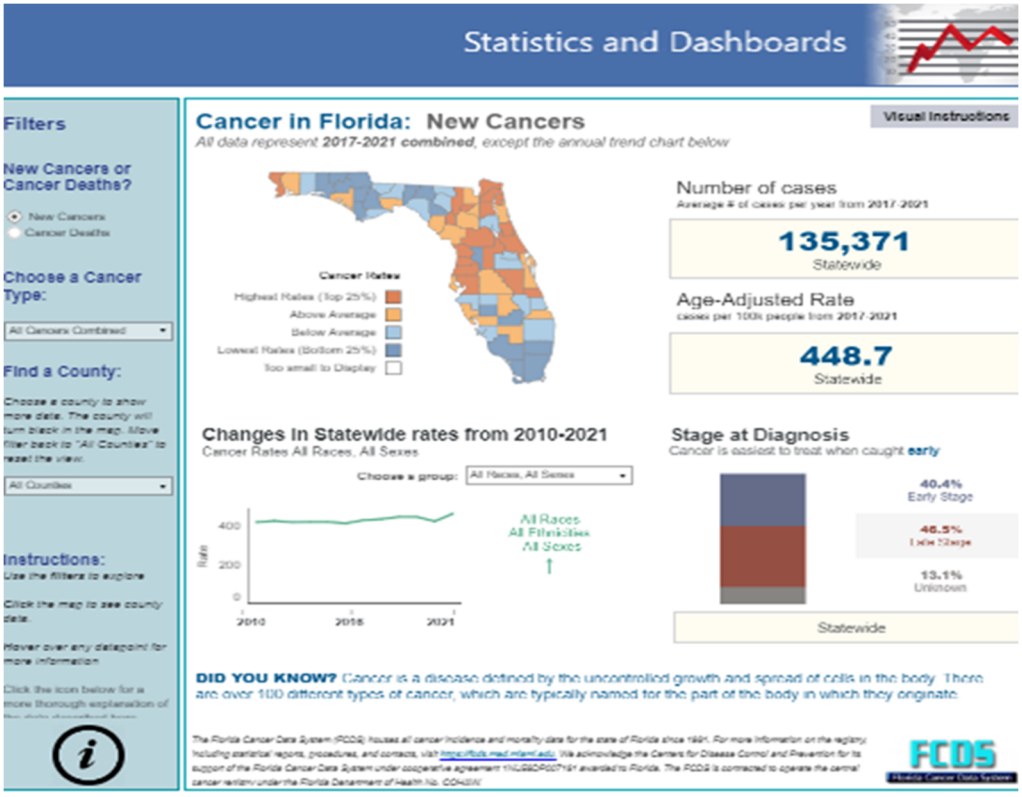
Instructions in the FCDS 2023 DAM state that A positive/suspicious mammogram date should be used as the date of diagnosis ONLY when the patient goes on to subsequently have a positive biopsy and/or resection that confirms the suspicious abnormality is, in fact, a malignancy and not to use the RADS standards as the date of diagnosis until and unless SEER published instructions in the manuals.

RADS rules will apply starting with diagnosis year 2024 forward. Please see the FCDS DAM 2024 for more instructions.

21.Why does FCDS still require Height and Weight? What useful conclusions has FCDS reported or found with this information?

NPCR requires these data items.

Updated FCDS Data Visualization Dashboard
now with 2021 Data



The Florida Cancer Data System is pleased to announce updates to the Data Visualization Dashboard, which now includes 2021 data.

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

The Data Visualization Dashboard was developed to make statistics on the top cancers in Florida more accessible to the public. Statewide and county statistics are available for new cancers, cancer deaths and stage of disease. Statewide cancer trend data are available dating back to 2010.

How is this dashboard different from our other statistical dashboards? This dashboard contains helpful tips on the meaning of each statistic and is developed to be user-friendly. It is an interactive tool that we hope will allow users to better understand what is happening with cancers in the state.

If you have any questions or comments you can contact Monique Hernandez, at FCDS for more information. Mhernandez5@med.miami.edu

2023-2024 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.

NAACCR is providing FCDS with 110 live attendance portals for 110 Florida registrars.

For registrars who do not make the short list for the live sessions, FCDS offers every NAACCR Webinar as a recorded session in FLccSC. You can still earn 3 CEUs per webinar in FLccSC. Recordings appear in FLccSC within a week or two following the live session

The 2023-2024 NAACCR Webinar Series begins on October 5, 2023 and continues through September 4, 2024. The 2023-2024 Webinar Series Schedule is provided below.

FCDS and NAACCR have an established agreement whereby any Florida FLccSC User MUST have *at least* one 'Active' User Permission or User Access Role in at least one Florida facility in IDEA to view NAACCR Webinar Recordings. All other recordings are available to any user with or without a FCDS IDEA User Role. User Roles must be updated every 6 months. 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). If you do not have current access to at least one facility you will not be given permission to access the NAACCR Recordings. The recordings will not even show up in your FLccSC Available Courses Menu.

DATE	TOPIC
10/5/23 9am & 2pm	**Lung 2023 Part 1** **Co-host: Wilson Apollo** Part 1 of the Lung webinar will focus on the treatment of lung cancer. We will discuss the surgery, lymph node related data items, systemic treatment, and radiation.
11/1/23 2pm 11/2/23 9am	**Lung 2023 Part 2** **Co-host: Denise Harrison** Part 2 of the Lung webinar will focus on SSDIs and staging. Examples, quizzes, and case scenarios included.
12/7/23 9am & 2pm	**Radiology and Radiation (R&R)** **Co-host: Wilson Apollo** During the webinar we will focus on imaging tools used to diagnose and stage and radiation tools used for treatment. We will discuss using information from radiology and radiation reports when abstracting.
1/10/24 2pm 1/11/24 9pm	**Liver and Bile Ducts 2024** **Co-host: Denise Harrison** This webinar will cover anatomy, solid tumor rules, staging and treatment of liver and bile duct primary malignancies. Examples, quizzes, and case scenarios included.
1/31/24 2pm 2/1/24 9am	**Pancreas 2024** **Co-host: Vicki Hawhee** This webinar will cover anatomy, solid tumor rules, staging and treatment of pancreatic primary malignancies. Examples, quizzes, and case scenarios included.
3/6/24 2pm 3/7/24 9am	**Boot Camp 1 2024** **Co-host: Juliet Wilkins** We will have 2 boot camps this year! This will allow us to spend more time on core casefinding and abstracting activities. We will spend most of our time completing and reviewing quizzes, exercises, and case scenarios. There will be minimal lecture.
4/3/24 2pm 4/4/24 9am	**Boot Camp 2 2024** **Co-host: Nancy Etzold** We will have 2 boot camps this year! This will allow us to spend more time on core casefinding and abstracting activities. We will spend most of our time completing and reviewing quizzes, exercises, and case scenarios. There will be minimal lecture.
5/1/24 2pm 5/2/24 9am	**Ovary 2024** **Co-host: Connie Boone** This webinar will cover anatomy, solid tumor rules, staging and treatment of ovarian primary malignancies. Examples, quizzes, and case scenarios included.
6/5/24 2pm 6/6/24 9am	**Thyroid 2024** **Guest Presenters: Amy Bamburg and Gillian Howell** This webinar will cover anatomy, solid tumor rules, staging and treatment of thyroid primary malignancies. Examples, quizzes, and case scenarios included
7/10/24 2pm 7/11/24 9am	**Life in a CoC Accredited Facility in 2024** **Guest Presenters: Jennie Jones and Kim Rodriguez** **Join us for a discussion of life in a CoC accredited facility and how registrars help maintain accreditation. Kim and Jennie will discuss how they prepare for survey, quality control, RCRS, and much more!**
7/31/24 2pm 8/1/24 9am	**CNS 2024** **Co-host: Carol Kruchko and Jennifer Ruhl** This webinar will cover anatomy, solid tumor rules, staging and treatment for benign and malignant primaries of the central nervous system. We will also see how the Central Brain Tumor Registry of the United States is using our data to perform research. Examples, quizzes, and case scenarios included
9/4/24 2pm 9/5/24 9am	**Coding Pitfalls 2024** **Co-host: Janet Vogel** During this webinar we will review problematic coding issues identified through quality control of registry data.

Florida Cancer Data System

Cancer Reporting Completeness Report

TOTAL NUMBER OF CASES IN THE FCDS MASTER FILE AS OF MARCH 31,2024

Total number of *New Cases* added to the FCDS Master file in March, 2024 9,579
Recurrence Abstracts Received to Date:

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	Tumors
2023	120,467	2,550	359	13,720	225	**Pending**	137,321	**6,489**	**70,952**
2022	242,146	5,579	725	13,750	22,505	**Pending**	284,705	**2,859**	**152,017**
2021	247,773	7,330	2,402	12,783	35,529	**2,297**	308,114	**231**	**171,110**

% Complete for:	Actual	Expected
2023	**55%**	**75%**
2022	100%	100%
2021	100%	100%

Expected	
2023	**55%**
2022	**100%**
2021	**100%**

Expected % based on 250,000 reported cases per year
Tumor Expected % based on 130,000 tumors per year as of 12/14/2023 9:19:33 AM (based on DX Date)

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