Cancer Registry Casefinding
Learning Objectives

Recognize cancer diagnoses by analyzing oncology-related terms
Use ICD-O-3 behavior codes as a guide to case eligibility
Apply national and state reporting guidelines to determine case reportability
Identify casefinding sources
Recognize appropriate casefinding methods
Use a suspense file for case management
Identify quality monitors for assuring completeness of casefinding.
Eligible cases are new or historical cases that are potentially reportable based on behavior and/or primary site.

Reportable cases are the eligible cases which, after review, cannot be excluded from reporting because of circumstances surrounding the diagnosis and treatment of the case.

- All /2 and /3 behaviors and CNS primaries are eligible to be reported and must be identified through casefinding.

However, not all eligible cases are ultimately reportable.
Casefinding is the systematic process of identifying all cases eligible to be included in a cancer registry database. Cancer registry personnel use medical terminology skills, knowledge of health records, and knowledge of national and state reporting requirements to ensure that all eligible cases are reported to the Florida Cancer Data System.
Casefinders’ Tasks:

1. Screen health records for potentially reportable diagnoses.
2. Apply specific reporting guidelines to determine the actual reportability of cases to the Florida Cancer Data Systems (FCDS).
3. Implement procedures to assure that casefinding is complete and accurate.
To insure consistency in identification and reporting of cancers, standards for casefinding have been established by national organizations that oversee cancer prevention and control efforts in the United States.
The national standard setting organization for hospital cancer registries is the American College of Surgeons’ Commission on Cancer (CoC).

CoC approved hospital registries must comply with the casefinding standards documented in the CoC’s Facility Oncology Registry Data Standards (FORDS) manual.
The national standard setters for state central registries such as the Florida Cancer Data System (FCDS) are the National Program of Cancer Registries (NPCR) and SEER (Surveillance, Epidemiology and End Results).

Individual states, in turn, use the NPCR and SEER standards to develop specific guidelines for cancer reporting in each state.

The guidelines for reporting cancer to the FCDS are documented in the FCDS Data Acquisition Manual, 2008.
Whenever questions arise regarding the reportability of cases to the FCDS, the Data Acquisition Manual is the “go to” resource for specific guidance.

The manual is online at http://fcds.med.miami.edu/inc/downloads.shtml#dam.
Recognizing Cancer Diagnoses - General Terms

Not all tumors are cancer, and not all cancers are reportable.

The following are general terms used in pathology reports and other medical reports.

- **Neoplasm**
  New and abnormal growth. Neoplasms may be benign or malignant.

- **Tumor**
  Literally means swelling, synonymous with neoplasm.

- **Mass**
  Abnormal lump of cells or tissue that may or may not indicate a tumor.

- **Malignant**
  Cancerous. Having the properties of invasiveness and metastasis.

- **Benign**
  Literally means non-threatening or good. Not cancer.
Examples:

MRI brain: 12 mm area right frontal lobe likely representing indeterminate neoplasm. (not cancer)

Patient history: Patient had a nephrectomy some years ago for kidney tumor of unknown type. (not cancer)

Report of pelvic Ultrasound: 7.4 cm hypoechoic pelvic mass. (not cancer)

Pleural fluid cytology: Atypical cells most consistent with metastatic malignancy. (cancer)

Patient history: Patient reports a resection of a benign brain tumor several years ago, with no evidence of recurrence. (not cancer)
Registrars recognize potentially reportable cases by analyzing the terminology used in the diagnosis statement.

Medical terms are built from roots, prefixes and suffixes (often Latin or Greek) that represent anatomic sites, body tissues, medical conditions, and therapeutic procedures.
For Example:

<table>
<thead>
<tr>
<th>Root</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oste = Bone</td>
<td>-itis = Inflammation</td>
</tr>
<tr>
<td>Nephr = Kidney</td>
<td>-osis = condition or disease</td>
</tr>
<tr>
<td>Encephal = Brain</td>
<td>-oma = tumor</td>
</tr>
<tr>
<td>Oste / oma</td>
<td>= Bone tumor</td>
</tr>
<tr>
<td>Nephr / osis</td>
<td>= Kidney disease</td>
</tr>
<tr>
<td>Encephal / itis</td>
<td>= Brain inflammation</td>
</tr>
</tbody>
</table>

**Note:** All terms that include the suffix –oma should catch the attention of cancer registry casefinders.
Tumors (suffix -oma) are usually named either by the organ of origin or by the type of tissue that gives rise to the tumor.

These are examples of tumors that are named by the organ of origin: Note that the terms themselves may not indicate whether the tumor is benign or malignant. To determine whether a term represents a malignancy or not, look up the term in ICD-O-3.

<table>
<thead>
<tr>
<th>Root/Suffix</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nephr/oma</td>
<td>Kidney tumor</td>
</tr>
<tr>
<td>Encephal/oma</td>
<td>Brain tumor</td>
</tr>
<tr>
<td>Thym/oma</td>
<td>Thymus tumor</td>
</tr>
<tr>
<td>Hepat/oma</td>
<td>Liver tumor</td>
</tr>
<tr>
<td>Chrondr/oma</td>
<td>Cartilage tumor</td>
</tr>
<tr>
<td>Neur/oma</td>
<td>Nerve tumor</td>
</tr>
</tbody>
</table>
Major categories of malignant tumors (cancers) are named by the type of tissue that gives rise to the tumor.

Any disease that includes the terms carcinoma, sarcoma, lymphoma or leukemia are malignant and are eligible to be reported.

<table>
<thead>
<tr>
<th>Carcinoma:</th>
<th>Malignant tumors of epithelial tissue. The vast majority of cancers are carcinomas. There are many types of carcinoma named for the specific epithelial tissue of origin. For example: Choriocarcinoma (originates in placental tissue), cholangiocarcinoma (originates in bile ducts).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarcoma:</td>
<td>Tumors of connective tissues such as bone, fat, tendons, and muscles. Sarcomas are named for specific connective tissue of origin, such as osteosarcoma (bone), liposarcoma (fat).</td>
</tr>
<tr>
<td>Lymphoma:</td>
<td>Cancer of the lymph nodes and lymphatic tissue, may be specifically named for the cell type origin (B-cell or T-cell lymphomas).</td>
</tr>
<tr>
<td>Leukemia:</td>
<td>Cancer of bone marrow, specifically resulting in overproduction of white blood cells. Leuk (white) + emia (blood condition).</td>
</tr>
</tbody>
</table>

FLORIDA CANCER DATA SYSTEM
It would be impossible to memorize all the terms used to name and describe tumors. The ICD-O-3 is a complete classification with indexing of all neoplasms. Casefinders must be very familiar with how to use the classification for determining whether specific diseases are eligible to be reported to the FCDS. All beginning casefinders should complete the FCDS training module on ICD-O-3.
ICD-O-3 Codes are the Key to Reportability

ICD-O-3 provides numeric codes for the three components of a complete diagnosis:

1. The anatomic site of the primary tumor
2. The morphology (tissue of origin) of the tumor
3. The behavior of the tumor
Three Components of an ICD-O-3 Code

- **C34.1 8140/3**
  
<table>
<thead>
<tr>
<th>Primary Site</th>
<th>Morphology</th>
<th>Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>C34.1</td>
<td>8140</td>
<td>/3</td>
</tr>
<tr>
<td>Upper lobe of lung</td>
<td>Adenocarcinoma</td>
<td>Malignant</td>
</tr>
</tbody>
</table>

- **C50.9 8500/3**
  
<table>
<thead>
<tr>
<th>Primary Site</th>
<th>Morphology</th>
<th>Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>C50.9</td>
<td>8500</td>
<td>/2</td>
</tr>
<tr>
<td>Breast</td>
<td>Infiltrating duct carcinoma</td>
<td>In Situ</td>
</tr>
</tbody>
</table>

- All diagnoses with a behavior code of /2 or /3 are potentially reportable to the FCDS and must be identified through the casefinding procedure. The cases will be further evaluated to determine whether they meet specific FCDS criteria for reportability.
Tumor Behavior

Tumors act or behave in the body in different ways that can affect the treatment and prognosis of the disease.

The ICD-O-3 tumor behavior code is an indicator of the ability of a tumor to spread from the tissue of origin to other tissues or organs in the body, a process called metastasis.

Diagnoses are determined to be reportable primarily on the basis of the ICD-O-3 behavior code, although morphologic type and anatomic site also affect reportability.
• Tumors that grow in place without the potential for spreading to other tissues or organs. Benign tumors may remain harmless for long periods of time, but may grow to significant size, creating pressure or abnormal function in surrounding tissues.
  • For example: C73.9 8330/0 Follicular adenoma of the thyroid

• Tumors that have some morphologic characteristics of benign tumors, but may occasionally behave more aggressively, even to the extent that they may metastasize. Their behavior is unpredictable.
  • For example: C34.9 8140/1 Bronchial adenoma
Carcinoma in situ

- Tumors that are still growing in place, but are capable of spreading to other tissues or organs (metastasizing). In situ is a Latin term meaning, “in the place.” These tumors are malignant, but are considered to be early stage of disease and usually have a favorable prognosis when completely removed.
  - For example: C50.9  8500/2 Ductal carcinoma in situ of the breast
  - Pathologists may use any of the following synonyms for carcinoma in situ: Noninvasive, non-infiltrating, intraductal, intraepithelial, intraepidermal, intracystic, Stage 0, no stromal involvement, lobular neoplasia, confined to epithelium.
• Tumors that are capable of metastasizing and are no longer growing in place. In other words, they are no longer “in situ.” Malignant tumors are invasive cancers that often require post-surgical chemotherapy and/or radiation to treat potential microscopic spread of the disease and to prevent future metastasis or recurrence.
• For example: C18.7 8140/3 Adenocarcinoma of the sigmoid colon
Behavior Codes Not Used by Cancer Registries

/6* Malignant, metastatic site

- Tumors that are growing in a secondary site, having metastasized from the primary site of the tumor.
- For example: 8140/6 represents metastatic adenocarcinoma.

/9* Malignant, uncertain whether primary or metastatic site

- Not used in cancer registries.
*NOTE:

- Behavior codes /6 and /9 are not used by cancer registries, but may be used in pathology laboratories to code and track tissue specimens.
- A case identified by either /6 or /9 would require further investigation to determine whether it should be considered eligible for reporting.
Neoplasms Eligible to be Reported to the FCDS

1. All primary in situ (ICD-O-3 behavior /2) and invasive (ICD-O-3 behavior /3) malignancies except:

- Carcinoma in situ of the cervix (CIS)
- Cervical intraepithelial neoplasia, Grade 3 (CIN III)
- Prostatic intraepithelial neoplasia, Grade 3 (PIN III)
- Basal cell and squamous cell carcinoma of non-genital skin sites (C44._). These skin cancers, M 8000-M 8110, are not reported because of the frequency of incidence and very low risk of morbidity and mortality.
2. All primary intracranial and CNS neoplasms, regardless of behavior code, diagnosed on or after 1/1/04.

- All primary tumors of the brain and central nervous system are required to be reported to the FCDS, including ICD-O-3 behavior codes /0 (benign), /1 (borderline), /2 (in situ) and /3 (malignant).
- Intracranial and CNS malignancies have always been reportable to the FCDS, however the requirement for reporting benign and borderline tumors became effective for cases diagnosed on or after 1/1/04.
- Tumors of any type of behavior occurring within the skull can create pressure on surrounding tissue and disturb neurologic function.
- The exact location of intracranial tumors is an important prognostic factor, as well as the morphology of the tumors.
## Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors

<table>
<thead>
<tr>
<th>General Term</th>
<th>Specific Sites</th>
<th>ICD-O-3 Topography Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meninges</strong></td>
<td>Cerebral meninges</td>
<td>C700</td>
</tr>
<tr>
<td></td>
<td>Spinal meninges</td>
<td>C701</td>
</tr>
<tr>
<td></td>
<td>Meninges, NOS</td>
<td>C709</td>
</tr>
<tr>
<td><strong>Brain</strong></td>
<td>Cerebrum</td>
<td>C710</td>
</tr>
<tr>
<td></td>
<td>Frontal lobe</td>
<td>C711</td>
</tr>
<tr>
<td></td>
<td>Temporal lobe</td>
<td>C712</td>
</tr>
<tr>
<td></td>
<td>Parietal lobe</td>
<td>C713</td>
</tr>
<tr>
<td></td>
<td>Occipital lobe</td>
<td>C714</td>
</tr>
<tr>
<td></td>
<td>Ventricle, NOS</td>
<td>C715</td>
</tr>
<tr>
<td></td>
<td>Cerebellum, NOS</td>
<td>C716</td>
</tr>
<tr>
<td></td>
<td>Brain stem</td>
<td>C717</td>
</tr>
<tr>
<td></td>
<td>Overlapping lesion of brain</td>
<td>C718</td>
</tr>
<tr>
<td></td>
<td>Brain, NOS</td>
<td>C719</td>
</tr>
<tr>
<td><strong>Spinal cord, cranial nerves, and other parts of the central nervous system</strong></td>
<td>Spinal cord</td>
<td>C720</td>
</tr>
<tr>
<td></td>
<td>Cauda equine</td>
<td>C721</td>
</tr>
<tr>
<td></td>
<td>Olfactory nerve</td>
<td>C722</td>
</tr>
<tr>
<td></td>
<td>Optic nerve</td>
<td>C723</td>
</tr>
<tr>
<td></td>
<td>Acoustic nerve</td>
<td>C724</td>
</tr>
<tr>
<td></td>
<td>Cranial nerve, NOS</td>
<td>C725</td>
</tr>
<tr>
<td></td>
<td>Overlapping lesion of brain and central nervous system</td>
<td>C728</td>
</tr>
<tr>
<td></td>
<td>Nervous system, NOS</td>
<td>C729</td>
</tr>
<tr>
<td><strong>Pituitary, craniopharyngeal duct and pineal gland</strong></td>
<td>Pituitary gland</td>
<td>C751</td>
</tr>
<tr>
<td></td>
<td>Craniopharyngeal duct</td>
<td>C752</td>
</tr>
<tr>
<td></td>
<td>Pineal gland</td>
<td>C753</td>
</tr>
</tbody>
</table>

**Note:** Benign and borderline tumors of the cranial bones (C410) are **not reportable.**
Neoplasms Eligible to be Reported to the FCDS

3. Basal and squamous cell carcinomas of the genitalia

- Basal and squamous cell carcinomas of these genital sites must be reported to the FCDS.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C51.0 – C51.1</td>
<td>Labia</td>
</tr>
<tr>
<td>C51.8 – C51.9</td>
<td>Vulva</td>
</tr>
<tr>
<td>C51.2</td>
<td>Clitoris</td>
</tr>
<tr>
<td>C52.9</td>
<td>Vagina</td>
</tr>
<tr>
<td>C60.0</td>
<td>Prepuce</td>
</tr>
<tr>
<td>C60.9</td>
<td>Penis</td>
</tr>
<tr>
<td>C63.2</td>
<td>Scrotum</td>
</tr>
</tbody>
</table>
Pathologically confirmed diagnoses and clinically confirmed diagnoses are eligible to be reported to FCDS.
The vast majority of reportable diagnoses are pathologically proven by either **histology** (microscopic examination of removed tissue as in a biopsy), or **cytology** (microscopic examination of cells present in body fluids like sputum or cerebrospinal fluid).

Histologic and cytologic diagnoses are collectively referred to as “pathologic diagnoses.”

In most instances, a pathologic diagnosis takes precedence over a clinical diagnosis.

The exception is when there is a clinical diagnosis of a malignancy and a biopsy is negative, but the physician treats the patient for cancer in spite of the negative biopsy.
Sometimes tissue or cells may not be available for microscopic examination, so diagnoses are made based only on available clinical information:

- **Radiologic imaging** (CT scan, MRI, PET scan, Bone scan) For example: Intracranial tumors such as pituitary adenomas or meningiomas are usually diagnosed by CT scan or MRI of the head.
- **Direct visualization.** (Endoscopy or exploratory surgical procedures without tissue removal) For example: Malignancies of the larynx and oropharynx may be clinically diagnosed by the appearance of the lesion on endoscopic examination.
- **Laboratory tests/markers.** For example: Liver lesions that are evident on imaging may be clinically diagnosed as malignancies based on the radiologic appearance of the lesion and elevated alpha-fetoprotein (AFP) values.
- **Physician assessment.** For example: A bone marrow biopsy that does not meet all of the criteria for a pathologic diagnosis of multiple myeloma may be documented as “smoldering myeloma” by the medical oncologist, based on all available pathologic data, lab data and physical data.
A diagnosis at autopsy is made when a malignancy or CNS tumor is discovered at autopsy, with no prior clinical or pathologic diagnosis of the tumor.

For example: A patient who experienced neurologic symptoms, but had no diagnostic workup and no documented clinical suspicion or diagnosis of CNS tumor expires suddenly following a fall.

Microscopic exam of a brain tumor discovered at autopsy reveals glioblastoma multiforme.

A diagnosis at autopsy is usually pathologically confirmed, rather than clinically confirmed.
FCDS Historical Cases

FCDS requires the collection and reporting of certain historical neoplasms in order to effectively research and report cancer incidence.

Historical cases are defined as those primary reportable neoplasms (malignant or benign/borderline brain/CNS) that are not active and not currently receiving any treatment AND the patient is seen at the reporting facility for another cancer/benign reportable neoplasm that IS active and/or undergoing treatment.
If a patient has at least one primary reportable neoplasm which is active or under treatment at the reporting facility, all other primary reportable neoplasms the patient has ever had (active or inactive), regardless of the date of diagnosis or treatment facility, must be reported.

If a patient has no reportable neoplasms that are currently active or under treatment, no other prior neoplasms the patient has ever had need to be reported.
Patient with a newly diagnosed lung cancer in 2008 in treatment at the reporting facility has a history of breast cancer diagnosed in 1995 with no current evidence of disease.

*Both the 2008 lung cancer and the 1995 breast cancer are reportable to FCDS.*
Example 2:

Patient admitted to the reporting facility in 2008 for cardiac evaluation has a history of breast cancer diagnosed in 1995 with no current evidence of disease.

This breast cancer is not reportable because the patient has no currently active neoplasms.
FCDS historical cases include:

/o, /1 behavior for brain or CNS diagnosed prior to 1/1/04 when accompanied by another active reportable primary diagnosed on or after 1/1/04.

Squamous intraepithelial neoplasia grade III of vulva (VIN III), vagina (VAIN III) and anus (AIN III) and are reportable as historical cases, when diagnosed prior to 1/1/01, AND the patient has another active reportable neoplasm.
Morphologies as listed below* if diagnosed prior to 1/1/01 AND patient has another active reportable neoplasm. (These cases should be reported with behavior code of /1 if diagnosed prior to 1/1/01).

*Most of these morphologies are chronic myeloproliferative disorders or myelodysplastic syndromes that had been coded as /1 behaviors in ICD-O-2, but changed to /3 behaviors with the implementation of ICD-O-3 for cases diagnosed as of January 1, 2001.

<table>
<thead>
<tr>
<th>Code</th>
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<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>8931</td>
<td>9960</td>
<td>9980</td>
<td>9983</td>
</tr>
<tr>
<td>9393</td>
<td>9961</td>
<td>9981</td>
<td>9984</td>
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<tr>
<td>9538</td>
<td>9962</td>
<td>9982</td>
<td>9989</td>
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<td>9950</td>
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</tbody>
</table>
Summary and Review of FCDS Eligibility Criteria

Cases eligible for reporting to the FCDS will either meet all of the following criteria:

- First seen at the reporting facility after 1/1/81 (7/1/97 for freestanding treatment centers)
- Address must be a Florida address
- Inpatient, outpatient, or ambulatory care center patient
- /2, /3 behavior OR /0, /1, /2, /3 behavior for brain or CNS diagnosed on or after 1/1/04.
- Currently active tumor
- Diagnosed clinically or pathologically (including autopsy)
- Either in treatment or not
Or meet these any of these criteria as an FCDS historical case:

- Reportable neoplasm NOT currently active or receiving treatment AND patient is seen as an inpatient or outpatient at the reporting facility for another reportable neoplasm that IS active and/or undergoing treatment
- /0, /1 behavior for brain or CNS diagnosed prior to 1/1/04 when accompanied by another reportable primary diagnosed on or after 1/1/04 OR.
Squamous intraepithelial neoplasia grade III of vulva (VIN III), vagina (VAIN III) and anus (AIN III), even if diagnosed prior to 1/1/01, AND the patient has another active reportable neoplasm.

Morphology as listed below if diagnosed prior to 1/1/01 AND patient has another active reportable neoplasm. These cases should be reported with behavior code of /1.

<table>
<thead>
<tr>
<th>Code</th>
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<td>9989</td>
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<tr>
<td>9950</td>
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</tr>
</tbody>
</table>
A registry’s reference date is the date that data collection began.

The FCDS reference date is January 1, 1981, for hospitals.

For free-standing/ambulatory diagnostic and treatment centers, the reference date is July 1, 1997.

Inpatients, outpatients and ambulatory care patients first seen at the reporting facility on or after January 1, 1981 (July 1, 1997) who meet the diagnostic criteria, whether in active treatment or not, must be considered eligible for reporting.
Not all cases that are “eligible” for inclusion in the FCDS database are ultimately “reportable” to the FCDS.

Some cases may meet the diagnostic eligibility criteria, but may be non-reportable due to circumstances surrounding the diagnosis and treatment of the cancer.
Non-Reportable Patients

Patients first seen at the reporting facility prior to January 1, 1981 (July 1, 1997 for free-standing centers) and returning after that date for the same primary neoplasm.

• For example: A patient diagnosed by biopsy at the reporting facility December 11, 1979 and returns periodically after 1/1/81 for treatment of recurrent disease would not be reportable to FCDS.

Patients seen only in consultation to confirm a diagnosis or a treatment plan.

• For example: A patient with carcinoma of the lung diagnosed at another facility, then seen by a medical oncologist at the reporting facility for a second opinion regarding the treatment plan prescribed at the diagnosing facility would not be reportable to FCDS.
Non-Reportable Patients

Patients in remission (NED – No Evidence of Disease) and not receiving prophylactic or adjuvant therapy.

- For example: A leukemia patient diagnosed and treated at another facility 5 years ago, now being seen in follow-up at the reporting facility in complete remission with no plans for further treatment would not be reportable to FCDS.

Patients who receive transient care to avoid interrupting a course of therapy started elsewhere.

- For example: A patient who began a course of radiation treatment at Facility X, but was referred to the reporting facility for completion of treatment due to flood damage at Facility X would not be reportable to the FCDS.
Non-Reportable Patients

Primary skin tumors (C44._) with histology codes 8000 – 8110

Carcinoma in situ of the cervix (CIS)

Intraepithelial neoplasia, Grade III, of the cervix (CIN III) and prostate (PIN III)
FCDS and CoC Reporting Requirements are Different

FCDS requires reporting of certain cases that hospital cancer registries are not required to accession or abstract by ACoS/CoC standards.

Casefinding procedures must be in place to identify these reportable cases that are not usually submitted to FCDS by the hospital registries.

By review of the FCDS/CoC comparison table, you will see that these include:

- Historical cases
- Non-analytic cases
- VIN III, VAIN III, AIN III
Non-analytic (Class of Case 3) cases are those in which the reporting hospital did not play a role in the patient’s diagnosis or first course of treatment, or the patient was diagnosed or had initial treatment at the reporting facility prior to its reference date.
In addition, these types of cases are considered non-analytic (Class 3) by hospital registries:

- Diagnosed at autopsy.
- Diagnosis and all initial treatment completed by a staff physician in the office setting.
- Pathology reports “Sent in” or “Brought in” from physician offices or other facilities for review by the reporting facility’s pathology department, but the patient is never admitted to the reporting facility as an inpatient or outpatient.
Cases that are Class of Case 3 (non-analytic) to a hospital registry must be reported to the FCDS even though the hospital registry is not required to accession or abstract them.

Refer to the CoC FORDS manual, page 83 for complete descriptions of Class of Case codes.
## Comparison Table
### FCDS Requirements to COC/ACoS Requirements

<table>
<thead>
<tr>
<th>TYPE OF CASE</th>
<th>COC</th>
<th></th>
<th></th>
<th>Follow-up</th>
<th>FCDS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All malignant cancers (ICD-O behavior /2 &amp; /3)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Analytic (Class of case 0, 1, 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Historical case (see Sect. 1 pg. 1-2, 6, 12-14)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-analytic (Class of case 3, 4, 5, 8, 9)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Intraepithelial neoplasia Grade III of cervix and prostate (CIN III, PIN III)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Squamous Intraepithelial neoplasia Grade III of vulva, vagina and anus (VIN III, VAIN III, AIN III) (See Sect. 1, Pg. 12)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Terms that changed from borderline to malignant as of 1/1/01 (i.e., Myelodyplastic Syndrome) (See Sect. 1, Pg. 12)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Carcinoma in-situ of the vagina, vulva, prostate</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Carcinoma in-situ of other sites (except skin)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Basal &amp; Squamous cell carcinoma of the skin (See Sect. 1, Pg. 2-3)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Basal &amp; Squamous cell carcinoma of mucocutaneous sites (See Sect. 1, Pg. 2-3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basal &amp; Squamous cell carcinoma of genital sites (See Sect. 1, Pg. 2-3)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Other skin cancers (See Sect. 1, Pg. 3)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Benign, borderline brain and CNS tumors (See Sect. 1, Pg. 1, 3, 5, 6, 13)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Foreign residents</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

X – Indicates Required
A definitive diagnosis of malignancy is not always possible.

A clinical method of diagnosis or a pathology specimen received in poor condition may not provide enough information for a definitive diagnosis, so the diagnostic statement may include ambiguous terminology.

The following table must be used to insure consistency in interpreting ambiguous diagnostic statements.
<table>
<thead>
<tr>
<th>Terms that constitute a diagnosis of Cancer (Reportable)</th>
<th>Terms that without additional information do not constitute a diagnosis of Cancer (Not reportable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apparent(ly)</td>
<td>Cannot be ruled out</td>
</tr>
<tr>
<td>Appears</td>
<td>Equivocal</td>
</tr>
<tr>
<td>Comparable with</td>
<td>Possible</td>
</tr>
<tr>
<td>Compatible with</td>
<td>Potentially malignant</td>
</tr>
<tr>
<td>Consistent with</td>
<td>Questionable</td>
</tr>
<tr>
<td>Favors</td>
<td>Rule out</td>
</tr>
<tr>
<td>Features of</td>
<td>Suggests</td>
</tr>
<tr>
<td>Malignant appearing</td>
<td>Worrisome</td>
</tr>
<tr>
<td>Most likely</td>
<td></td>
</tr>
<tr>
<td>Neoplasm *(for CNS only)</td>
<td></td>
</tr>
<tr>
<td>Presumed</td>
<td></td>
</tr>
<tr>
<td>Probable/Probably</td>
<td></td>
</tr>
<tr>
<td>Suspect(ed)</td>
<td></td>
</tr>
<tr>
<td>Suspicious (for histology &amp; peripheral smear)</td>
<td></td>
</tr>
<tr>
<td>Tumor *(for CNS only)</td>
<td></td>
</tr>
<tr>
<td>Typical of</td>
<td></td>
</tr>
</tbody>
</table>
If any of the reportable ambiguous terms precede a reportable in situ or invasive diagnosis or precede a word that is synonymous with an in situ or invasive tumor (e.g. cancer, carcinoma, malignancy, etc), the case is reportable.

* “Neoplasm” and “Tumor” do not imply malignancy, and should be reported only for intracranial and central nervous system sites.
These rules apply to eligible in situ (/2) and invasive (/3) malignancies and to benign (/0) and borderline (/1) primary intracranial and CNS tumor.

1. Ambiguous terminology rules should be used for screening diagnoses on pathology reports, operative reports, imaging reports and other diagnostic testing other than tumor markers.

- Example: Consultation report: Elevated CA-125, pelvic mass, consistent with ovarian malignancy. Not reportable because ambiguous terminology rules do not apply to tumor markers.
2. If the ambiguous word or an equivalent term does not appear on the list of reportable ambiguous terms, the term is not diagnostic of cancer and should not be reported.

3. Forms of reportable ambiguous terms should be accepted as reportable.

- Example: “Favored” rather than “Favor(s) or Appeared to be” rather than “appears.”
4. Do not interpret suspicious cytology as a diagnosis of cancer. Report the case only if a positive biopsy or physician’s clinical impression of cancer supports the cytology findings.

- Example: Pleural fluid cytology: Atypical cells present, suspicious for malignancy. Do not report this case.
- Example: Pleural fluid cytology: Atypical cells present, suspicious for malignancy AND biopsy of lung confirms adenocarcinoma. This case is reportable.
5. If an ambiguous diagnosis is proven to be not reportable by biopsy, cytology or physician’s clinical assessment, do not report the case.

- Example: Mammogram report states Birads score 5: Highly suspicious of malignancy, but breast biopsy of the suspicious area is negative for malignancy. Do not report the case.
The casefinding cycle is a series of processes that must take place to insure complete and accurate identification of all eligible cases in a registry.

These processes take place in hospital registries and in central registries, although the implementation methods may vary according to the reporting requirements of the registry.
1. “Where do we look to find cancer diagnoses/eligible diagnoses in our facility?”

2. “What is the most accurate and efficient way to access the source data?”

3. “What happens to the identified eligible cases?”

4. “How can we be sure we haven’t missed any cases?”

1. Identify casefinding sources

2. Determine appropriate casefinding methods

3. Link identified cases

4. Monitor completeness of casefinding
1. Identify casefinding sources

“Where do we look to find eligible diagnoses in our facility?”

Look specifically at each of these important casefinding sources:

- Pathology Reports
- Health Information Disease Index
- Outpatient Treatment Centers
- Billing Records
Pathology reports are the most accurate and reliable source documents for cancer registry casefinding.

All tissues and cells removed from patients during diagnosis, treatment or at autopsy must be microscopically examined by a pathologist.

Pathology reports document the specific morphology and behavior of tumors based on the microscopic exam of the tissue or cytology specimen.
All pathology reports generated at each facility must be screened for potentially reportable diagnoses.

If a facility’s pathology department provides SNo-MED morphology and behavior codes on the pathology reports, reportable malignancies can be identified by automated screening of the pathology reports.

If automated screening is not possible, all pathology reports must be visually screened by registry staff.
### Types of pathology reports

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical pathology</td>
<td>Examination of tissue removed during surgical treatment</td>
</tr>
<tr>
<td>Cytology</td>
<td>Examination of cells withdrawn with body fluids (Sputum, pleural fluid, bronchial brushings and washings, spinal fluid, cervical and vaginal smears, breast secretions, etc.)</td>
</tr>
<tr>
<td>Bone marrow biopsy</td>
<td>Examination of bone marrow, usually for diagnosis of leukemias and other myelodysplastic disorders, and for lymphoma staging</td>
</tr>
<tr>
<td>Autopsy</td>
<td>Examination of tissues sampled at autopsy</td>
</tr>
</tbody>
</table>
For casefinding, it’s particularly important to distinguish cytology reports from all other types of pathology reports because the guidelines for use of “ambiguous terminology” are different for cytology.

Remember that a cytology result reported as “suspicious” is not to be considered diagnostic of cancer since examination of exfoliated or “shed” cells is not as accurate an indicator of malignancy as an examination of a tissue specimen.
**Example of Surgical Pathology Diagnosis**

<table>
<thead>
<tr>
<th>Specimen type:</th>
<th>Radical mastectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lymph node sampling:</td>
<td>Axillary dissection</td>
</tr>
<tr>
<td>Laterality:</td>
<td>Left</td>
</tr>
<tr>
<td>Tumor Site:</td>
<td>Upper Outer Quadrant</td>
</tr>
<tr>
<td>Size of invasive Component:</td>
<td>1.1 cm x 1.5 cm x 0.5 cm</td>
</tr>
<tr>
<td>Histologic type:</td>
<td>Infiltrating duct carcinoma</td>
</tr>
<tr>
<td>Histologic grade:</td>
<td>Nottingham score 4, histologic grade 1/3</td>
</tr>
<tr>
<td>Regional Lymph Nodes:</td>
<td>Negative for malignancy</td>
</tr>
<tr>
<td>Margins:</td>
<td>Uninvolved by invasive carcinoma</td>
</tr>
<tr>
<td>AJCC Pathologic stage:</td>
<td>T1c No MX</td>
</tr>
</tbody>
</table>

FLORIDA CANCER DATA SYSTEM
Example of a Cytology Report

Endobronchial brushing: Negative for malignancy.

Endobronchial washing: Atypical cells consistent with non-small cell carcinoma.
In some facilities, autopsy reports may be filed separately from pathology reports, and require additional casefinding procedures to ensure that all malignancies initially diagnosed at the time of autopsy are reported.

Autopsy reports must be thoroughly reviewed from start to finish because malignancies may be noted incidentally and not listed as the cause of death.
The hospital Health Information Management department (HIM) disease index contains the ICD-9-CM codes for the primary diagnosis and all secondary diagnoses for all hospital inpatients and outpatient visits.

The HIM disease index must be screened for ICD-9-CM codes that represent cancer diagnoses or cancer related admissions/visits.

Because of the large volume of coded diseases contained in the index, automated screening of the index is usually the first step in using the disease index for casefinding.

Many ICD-9-CM neoplasm codes include diagnoses that are not reportable to FCDS as well as diagnoses that are reportable.

Potential cases identified by screening the disease index must be reviewed manually to determine whether they are reportable to the FCDS.
ICD-9-CM codes that should be used for screening the HIM disease index.
Casefinding List for Reportable Tumors

The following ICD-9-CM** list is to be used to identify potentially reportable tumors. Some ICD-9-CM** codes contain conditions that are not considered reportable. These records will need to be reviewed and assessed individually to verify whether or not they are reportable to FCDS. Casefinding must include both primary diagnoses and any subsequent or secondary diagnoses.

- 642.9 AIDS (review cases for AIDS-related malignancies)
- *140.0-208.9 Malignant neoplasms
- *225.0-225.9 Benign neoplasm of brain and spinal cord neoplasm
- *227.3-227.4 Benign neoplasm of pituitary gland, pleural body, and other intracranial endocrine-related structures
- *230.0-234.9 Carcinoma in situ (excluding cervix – 233.1)
- *235.0-238.9 Neoplasms of uncertain behavior
- 236.9 Endometrial sarcoma, low grade (991/3)
- 237.5 Ependymoma (epithelial) (malignant) (9391/3)
- 237.6 Papillary Meningioma (9353/3)
- 238.4 Polycythemia vera (9950/3)
- 238.6 Solitary plasmacytoma (9731/3), Extramedullary plasmacytoma (9734/3)
- 238.71 Essential thrombocytopenia (9962/3)
- 238.72 Low grade myelodysplastic syndrome lesions (9980/3, 9982/3, 9985/3)
- 238.73 High grade myelodysplastic syndrome lesions (9983/3)
- 238.74 Myelodysplastic syndrome with 5q deletion (9986/3)
- 238.75 Myelodysplastic syndrome, unspecified (9985/3)
- 238.76 Myelofibrosis with myeloid metaplasia (9961/3)
- 238.79 Other lymphatic and hematopoietic diseases (Includes 9931/3, 9960/3, 9961/3)
- +239.0-239.9 Neoplasms of unspecified behavior
- 239.2 Carcinoid Syndrome
- 273.2 Gamma heavy chain disease (9762/3), Franklin's disease (9762/3)
- 273.3 Waldenstrom's macroglobulinemia (9761/3)
- +273.9 Unspecified disorder of immune mechanism (screen for potential 273.3 miscodes)
- 288.3 Hyperesinophilic syndrome (9964/3)
- 289.83 Myelofibrosis NOS (9961/3)
- *V07.3 Other prophylactic chemotherapy (screen carefully for miscoded malignancies)
- *V07.8 Other specified prophylactic measure
- +V10.0-V10.9 Personal history of malignancy (review these for recurrences, subsequent primaries, and/or subsequent treatment)
- *V58.0 Admission for radiotherapy
- *V58.1 Admission for chemotherapy
- *V58.12 Admission for antineoplastic immunotherapy
- +V66.1 Convalescence following radiotherapy
- +V66.2 Convalescence following chemotherapy
- +V67.1 Radiation therapy follow-up
- +V67.2 Chemotherapy follow-up
- +V71.1 Observation for suspected malignant neoplasm
- +V76.0 Special screening for malignant neoplasm
- V76.9

## Example of HIM Casefinding Report

<table>
<thead>
<tr>
<th>Encounter</th>
<th>Patient DOB – MRN</th>
<th>Type/Service</th>
<th>Admit/Dsch</th>
</tr>
</thead>
<tbody>
<tr>
<td>006651489</td>
<td>APPEL, ROBERT R Bd: 06/12/1932 – mrn: 051492</td>
<td>IP/CARD</td>
<td>03/11/200x 03/16/200x</td>
</tr>
</tbody>
</table>

### Diagnoses

- [P] 238.75 Myelodysplastic syndrome, unspec
  - [01] 276.7 Hyperpotassemia
  - [02] 284.1 Pancytopenia
  - [03] 276.51 Dehydration
  - [04] 250.80 DMII Oth nt st uncontrolled
- [05] 185 Malignant neopl prostate
  - [06] 401.9 Hypertension
  - [07] 780.79 Malaise and fatigue NEC

### Procedures

- [P] 41.31 Bone marrow biopsy
  - [01] 99.04 Packed cell transfusion
## Example of HIM Casefinding Report

<table>
<thead>
<tr>
<th>Encounter</th>
<th>Patient DOB – MRN</th>
<th>Type/Service</th>
<th>Admit/Dsch</th>
</tr>
</thead>
<tbody>
<tr>
<td>006657264</td>
<td>APPLE, EATON bd: 11/23/1948 – mrn: 029385</td>
<td>OBSER/ONC</td>
<td>04/15/200x 04/16/200x</td>
</tr>
</tbody>
</table>

### Diagnoses

- [P] V58.11 Antineoplastic chem other uncetr
- [01] 205.00 Act myl leuk w/o remission
- [02] 250.00 DMII wo cmp nt st uncntr
- [03] V58.69 Long term use meds NEC

### Procedures

- [P] 99.25 Inject ca chemother NEC
### Example of HIM Casefinding Report

<table>
<thead>
<tr>
<th>Encounter</th>
<th>Patient DOB – MRN</th>
<th>Type/Service</th>
<th>Admit/Dsch</th>
</tr>
</thead>
<tbody>
<tr>
<td>006659250</td>
<td>APPLE, EATON bd: 11/23/1948 – mrn: 029385</td>
<td>IP/ONC</td>
<td>06/10/200x 06/14/200x</td>
</tr>
</tbody>
</table>

**Diagnoses**

- [P] 288.04 Neutropenia due to infection
- [01] 284.89 Aplastic anemias NEC
- [02] 054.9 Herpes simplex NOS
- [03] 682.6 Cellulitis of leg
- **[04] 205.01 Act myl leuk w remission**
- [05] 780.6 Fever
- [06] 250.00 DMII wo cmp nt st uncetr
- [07] E933.1 Adv effect antineoplastic

**Procedures**

- [P] 99.04 Packed cell transfusion
- [01] 99.05 Platelet transfusion
Outpatient Treatment Centers

Hospital outpatient medical records may be integrated with inpatient records to create a unified medical record, or are sometimes maintained separately within the outpatient center.

Patient records in independent treatment centers, however, are separate from hospital records and require separate casefinding procedures within the treatment centers.

Outpatient treatment centers usually maintain treatment logs or billing records that should be reviewed at routine intervals for potentially reportable cases.
Procedures should be in place for casefinding at these types of outpatient treatment centers, regardless of whether hospital-owned or independent centers:

<table>
<thead>
<tr>
<th>Type of Center</th>
<th>Casefinding Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy or infusion centers</td>
<td>Check medical oncology consultations, infusion records, billing records.</td>
</tr>
<tr>
<td>Same day surgery centers</td>
<td>Check surgery schedules, operative reports, pathology reports, billing records.</td>
</tr>
<tr>
<td>Radiation therapy centers</td>
<td>Check radiation oncology consultations, radiation treatment summaries, radiation treatment logs or billing records.</td>
</tr>
<tr>
<td>Specialty clinics such as dermatology clinics, urology clinics, breast centers or endoscopy centers</td>
<td>May maintain a variety of rich casefinding sources such as pathology reports, treatment records, diagnostic indices, or billing records.</td>
</tr>
</tbody>
</table>
Documentation and information management methods can vary greatly among different facilities.

It’s important to consider all of the departments/facilities where patients receive cancer diagnosis, treatment, or palliative care as potential sources for casefinding.

The next step is to work with those departments/facilities to develop procedures that will insure that all eligible cases are identified.
Automated casefinding from outpatient billing records may be accomplished using the coded information on the billing records that describes the diagnoses or the reason for the outpatient encounter.

This should be an automated procedure similar to HIM disease index casefinding in hospitals, where potentially eligible cases are identified by ICD-9-CM code, then manually reviewed to determine reportability.
The Casefinding Cycle:

2. Determine casefinding methods

“What is the most accurate and efficient way to access the source data?”

Three methods of casefinding are commonly used:

• a. Active
• b. Passive
• c. Combined active and passive
a. Active casefinding

Involves cancer registry personnel screening source documents for potentially reportable diagnoses.

Manual review of pathology reports is an example of active casefinding.

Because registry staffs are most knowledgeable about specific cancer reporting requirements, active casefinding is the most thorough and accurate method.

However, active casefinding is time consuming and costly since all source documents, whether cancer related or not, must be reviewed.
b. Passive casefinding

Uses non-registry personnel or exclusively automated methods to screen for reportable diagnoses.

Screening by non-registry personnel may result in incomplete casefinding because non-registrars may not be familiar with specific reporting requirements.

- For example: Gamma heavy chain disease or Paget’s disease of the breast may be overlooked because the terms don’t contain the typical word roots that indicate tumor or malignancy.

Automated screening is the computerized selection of reportable cases based on diagnosis or procedure codes generated by other departments such as Health Information Management, Pathology or Billing departments.
Automated casefinding is a lower cost means of reporting because the labor costs associated with active reporting are eliminated.

However, casefinding done exclusively by automated methods will result in over-reporting of cases because the selection criteria must be broad enough to encompass all potentially reportable diagnoses, but cannot be exclusive enough to weed out the specifically non-reportable cases.
Most registries use a combination of active and passive casefinding methods in order to maximize completeness and accuracy and to minimize the cost of casefinding.

- For example, radiation therapy consultation reports and treatment summaries may be screened by radiation therapy staff for cancer-related diagnoses (passive), and copies of those reports will be forwarded to the cancer registry for final determination of reportability (active).
- Another example: Cases selected by automated screening of the HIM disease index (passive) or automated screening of pathology SNoMED codes (passive) must be reviewed by registry staff (active) to insure that excludable cases do not get reported.
“What happens to the identified eligible cases?”

Cases identified as potentially reportable are routed to the suspense file for temporary storage.

Cases in suspense are then reviewed by registry personnel who make the final determination as to whether or not the cases are reportable.
Suspense files may be manual or electronic.

Most cancer registry software includes an automated suspense system which collects a minimum amount of data on eligible cases, usually patient name, medical record number, date of diagnosis or date of first contact, and primary site.

A manual suspense file may contain the source documents, usually the pathology reports, radiation treatment summaries, and/or chemotherapy treatment records of identified eligible patients.

Cases in suspense that meet all of the criteria for reporting are eventually either abstracted and entered into the cancer registry database (Master patient index) as a new primary cancer, or they provide important follow-up information on primary cancers that already exist in the database.
The Not Reportable List

If, after review, a suspense case does not meet all of the eligibility criteria for reporting as a new primary, identifying information on the case should be entered into a Not Reportable List.

The Not Reportable List documents the reasons cases are not reportable to FCDS, expediting future review and problem-solving when patients are repeatedly seen for the same primary cancer.

- CIS, CIN III, PIN III, Basal cell carcinoma & Squamous cell carcinoma of skin
- Diagnosed prior to reference date, returning now for treatment for same primary
- Consultation only at your facility to confirm a diagnosis or treatment plan
- Patients with no current evidence of prior disease (NED), not receiving treatment
- Treatment given at your facility to avoid interruption of a course of treatment started at another facility
The Casefinding Cycle:

4. Monitoring Completeness of Casefinding

“How can I be sure I haven’t missed any cases?”

Reportable cases can slip through the casefinding net because of inadequate casefinding policies and procedures, inadequate staff training, or because of procedural changes in information handling in other departments involved in casefinding.

It’s important to routinely monitor casefinding results, so that potential problems can be identified and quickly corrected to insure continuing completeness of reporting.

It’s costly and inconvenient for everyone when a registry has to spend time backtracking through source documents to identify missing cases.
Because pathology reports are the primary resource for casefinding, it’s very important that no pathology report escapes review.

Whether pathology reports are screened manually or electronically, a tracking system must be in place to verify that every report generated from the pathology lab has been screened.

All specimens examined in a pathology lab are numbered sequentially, and the reports should be screened in sequential order, making it possible to note reports that are missing during review.

Missing reports should be documented and follow-up must be done to make sure all pathology reports are eventually reviewed.
<table>
<thead>
<tr>
<th>Review Date</th>
<th>FROM Pathology #</th>
<th>TO Pathology #</th>
<th>Missing Pathology #</th>
<th>Reviewer</th>
<th>Report Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/4/08</td>
<td>S04-16394</td>
<td>S04-17925</td>
<td>S04-16825</td>
<td>MLB</td>
<td>8/12/08</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>S04-17320</td>
<td></td>
<td>8/12/08</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>S04-17583</td>
<td></td>
<td>8/25/08</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>S04-18587</td>
<td></td>
<td>8/12/08</td>
</tr>
<tr>
<td>9/5/08</td>
<td>S04-17926</td>
<td>S04-19012</td>
<td>S04-18142</td>
<td>TPT</td>
<td>9/29/08</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>S04-18533</td>
<td></td>
<td>9/29/08</td>
</tr>
</tbody>
</table>
Monitoring the completeness of casefinding in other sources such as Radiation Therapy logs, Nuclear Medicine visits, Medical oncology visits, etc. can be a bit more complex.

Reports of patient encounters in these areas are not numbered sequentially, so it’s not as easy to know if any reports from these areas have escaped review.

Internal audits of these casefinding sources should be performed periodically whether the casefinding has been done manually or electronically, by active or passive methods.

- For example: A single month’s activity in the Radiation Therapy department may be selected as the target for a casefinding audit on an annual or semi-annual basis.
Monitoring Casefinding Progress

Documenting the number of cases identified per month or per quarter for each of the casefinding sources in a facility creates a tool for comparing current casefinding volume to the volume of cases identified during comparable periods in the past.

Comparison of monthly casefinding volumes over time may show unexpected decreases or increases in the number of identified cases, prompting investigation of potential reasons for the fluctuation.

What might be some reasons for significant fluctuation in casefinding numbers from month to month or year to year? Additional services added, higher patient volumes, loss of oncologists, competition from another facility’s new cancer center, or perhaps a breakdown in casefinding procedures.

Documented monitoring of casefinding volumes is not required by any of the registry standard setters, but a routinely maintained “completeness log” can be an early indicator that casefinding procedures need to be reviewed and updated.
### Facility XYZ: Cases Identified per Month

<table>
<thead>
<tr>
<th>2008</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Path Review</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiation Log</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Med Onc</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
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<td>HIM Index</td>
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NPCR, NAACCR and FCDS require that 95% of a facility’s cases be abstracted and reported within six months of the date of service.

Therefore, screening for eligible cases and determination of reportability is a critical registry function that cannot be neglected.

Casefinding must be a part of the daily routine in hospital registries.
FCDS conducts casefinding audits periodically at all of its reporting facilities.

FCDS auditors visit each reporting facility and review all casefinding sources for eligible cases.

Identified eligible cases are matched to the FCDS master patient index.

For any cases missing from the FCDS master patient index, registries must provide reasons the cases were not abstracted and reported to the FCDS.

The registry’s Non-Reportable List, when accurately maintained, should quickly provide the reasons cases were not reported.
Florida’s Agency for Health Care Administration (AHCA) Match

FCDS annually matches its master file of reported cases to the AHCA database of inpatient and outpatient encounters.

Names reported to AHCA with cancer-related encounters who do not have a match in the FCDS master file will be reported back to the registries with a request for further case review and rationale.
Florida’s Bureau of Vital Statistics database is also annually matched to the FCDS master file to identify people whose death certificates list cancer as a cause of death, but who have not been reported to the FCDS.

The FCDS will request the registries to review any missing cases and provide rationale for not reporting the cases.
FCDS Reportability Dates

**FCDS Reference Date for Hospitals**

- **January 1, 1981**
- **July 1, 1997**
- **January 1, 2001**
- **January 1, 2004**

**FCDS Reference Date for free-standing treatment centers**

ICD-O-3 is implemented, changing the reportability status of ovarian, hematopoietic, and some in situ tumors.

- /0, /1 Benign and Borderline tumors of brain and CNS become reportable to FCDS
- /1 Borderline, un certain malignant potential tumors of ovary no longer reportable to FCDS
- 8931, 9960, 9983, 9393, 9961, 9981, 9984, 9538, 9962, 9982, 9989 and 9950 become reportable as historical cases.
- VAIN III, VIN III and AIN III become reportable as historical cases.

See FCDS Data Acquisition manual pages 12 & 13 for specific instructions.
Most cancers, as well as benign and borderline tumors of brain and central nervous system in Florida residents are reportable by Florida law.

The Florida Cancer Data System (FCDS), in cooperation with ACoS and NPCR/NAACCR, is the standard setter for cancer reporting in Florida facilities.

Command of the terminology of cancer and the principles of ICD-O-3 are essential for accurate and complete identification of reportable cases.

The FCDS Reportable List, the FCDS list of Non-Reportable Patients, and the FCDS List of Ambiguous Terminology, as published in the current edition of the FCDS Data Acquisition Manual, are the primary guides to case reportability in Florida.
The primary sources for casefinding are the histologic diagnoses from individual pathology reports and the ICD-9-CM diagnostic codes from the HIM disease index.

However, multiple sources of documentation must be screened to achieve complete case ascertainment.

Casefinding may be accomplished manually or electronically, actively or passively, or through a combination of methods.

Casefinding monitors must be in place to assure completeness and timeliness of casefinding.