Welcome

We're Glad You Are Here

Florida Cancer Data System

A JOINT PROJECT OF THE SYLVESTER COMPREHENSIVE CANCER CENTER AND THE FLORIDA DEPARTMENT OF HEALTH

What's New for 2013 and More

FCDS Annual Meeting Review

MILLER SCHOOL OF MEDICINE UNIVERSITY OF MIAMI

2013-2014 FCDS Webcast Series

Steven Peace, CTR

FCDS Staff and Guest Speakers

August 22, 2013

NPCR NATIONAL PROGRAM OF CANCER REGISTRIES

Florida HEALTH

The Winds of Change .....
Florida Cancer Data System Annual Meeting
Day 1 - Thursday, July 25, 2013

Registration	
Welcome and Introduction • Florida Department of Health • University of Miami Miller School of Medicine	
DOH Update	Dr. Youjie Huang and Tara H
FCDS Updates - State of the State	Dr. Jill MacKinnon
Audit Results (CER, NPCR,FCDS)	Steve Peace
Comprehensive Cancer Control	Tara Hylton for Sue Higgins
Physician Office Reporting – What this means to you	**Dr. Jill MacKinnon**
Data Quality Indicators – What they mean	**Brad Wohler**
Break	
Automated User Account System and FCDS Learning Management System	Dr. Jill MacKinnon and Melis
Florida's CER Project	**Dr. Monique Hernandez**
Florida's Environmental Public Health Tracking Program	Melissa Murray Jordan
Patient/Tumor Consolidation – Benefits to Registries	Gary Levin
V13 Changes	Steve Peace
Lunch on your own	
United Health Care/FCDS Collaboration	Brad Wohler
Florida System for Cancer Research and Collaboration	**Dr. Robert Hood**
Proactive Physician Reporting and Tx data	**Dr. Monique Hernandez**
FCDS Linkage with National Health Interview Survey	Dr. David Lee
Data Acquisition – Evolution and Growth	Michael Thiry
Break	
Jean Byers Presentation	Mike Thiry, Betty Fernandez
Round Table Discussion	DOH/FCDS Staff and Attendees
Wrap Up and Adjourn	

The Winds of Change .....
Florida Cancer Data System Annual Meeting
Day 2 – Friday, July 26, 2013

Registration	
ICD-O-3 Updates for 2014	Steve Peace
2013 SEER*Rx and Heme/Lymph DB Updates	Gema Midence
Clinical Edit Checks – What Are They and Why Are They?	Steve Peace
Break	
News from the NCCN 18th Annual Conference: "Advancing the Standard of Cancer Care™"	Mayra Espino and Judy Bonner
What's New in Cancer Care: • Updates to National Screening Guidelines • Diagnostic Testing and Clinical Staging • Tumor Markers and Cancer Genetics Testing • Updates to Treatment Recommendations • Text Documentation for All of the Above	Steve Peace and FCDS Staff
Adjourn	

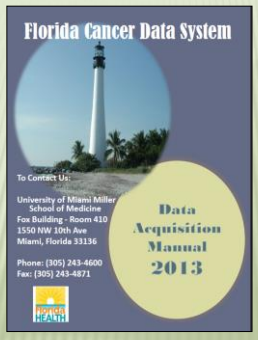
Source: Life's Crazy at http://lifescrazy.com/game-7

WHAT'S NEW FOR 2013 AND V13

FCDS Annual Meeting
July 26, 2013
Sunrise, Florida

Steven Peace, CTR
Gary Levin, CTR

2013 FCDS DATA ACQUISITION MANUAL



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2013 FCDS DATA ACQUISITION MANUAL

Newly reportable data items required to be collected

- Standard Data Item added FCDS CORE (Required for ALL Cases)

NAACCR Item #	Item Name	Start Position	Stop Position	Length
102	Addr at DX – Country	436	438	3
252	Birthplace State	442	443	2
254	Birthplace Country	444	446	3
1832	Addr Current – Country	439	441	3

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2013 FCDS DATA ACQUISITION MANUAL

Newly reportable data items required to be collected – con't

- CS Site Specific Factor Added Back into Required Data Items – JAK 2 HemeRetic
- State-Specific Data Item (NAACCR Item #2200) Retained as FCDS CORE (Required for ALL Cases) but moved to NPCR-Specific Field (NAACCR Item #3720)

NAACCR Item #	Item Name	2013 Start Position	2013 Stop Position	Length
3720	Height at Diagnosis	1315	1316	2
3720	Weight at Diagnosis	1317	1319	3
3720	Tobacco Use – Cigarette	1320	1320	1
3720	Tobacco Use – OthSmoke	1321	1321	1
3720	Tobacco Use – SmokelessTob	1322	1322	1
3720	Tobacco Use – NOS	1323	1323	1

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FCDS ABSTRACTOR CODE POLICY

SECTION I: GUIDELINES FOR CANCER DATA REPORTING 14

C. ABSTRACTING

1. Personnel Requirements

Trained personnel must perform abstracting. FCDS provides basic incidence abstracting training via web-based modules. In addition, FCDS performs on-site regional workshops on an ad hoc basis.

Every registrar/abstractor planning to work in the State of Florida is required to obtain an individual FCDS Abstractor Code. This code is assigned by FCDS to persons who successfully pass the FCDS Abstractor Code On-Line Examination, regardless of certification by NCRA as a CTR, experience in the registry industry, or other factors. As of January 1, 2013 any individual planning to acquire a New FCDS Abstractor Code or planning to Renew an Existing FCDS Abstractor Code must take and pass the FCDS Abstractor Code Exam.

The FCDS Abstractor Code Requirement has been FCDS Policy for many years and applies to every cancer registrar working in the state of Florida (CTR or non-CTR, Florida resident or out-of-state contractor, regardless of number of years' experience). FCDS will not accept cases from individuals without an *Active/Current* FCDS Abstractor Code.

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FCDS ABSTRACTOR CODE POLICY

Questions are electronically selected at random from a pool of nearly 500 questions covering 6 major topic areas. No two exams will be alike.

The 6 topic areas include:

- General Abstracting Knowledge
- General Abstracting Rules and Florida-Specific Rules
- Primary Site/Histology/Grade
- Stage at Diagnosis (Collaborative Stage Data Collection System and Site Specific Factors)
- Latest Rule Changes
- Treatment and Survival

WHO NEEDS TO TAKE THE FCDS ABSTRACTOR CODE EXAM?

✓ Individuals hoping to acquire a *NEW* FCDS Abstractor Code will need to take the New FCDS Abstractor Code Exam.

✓ If an individual's FCDS Abstractor Code has been expired for greater than 2 years, the individual must re-apply and take and pass the New FCDS Abstractor Code Exam.

WHO NEEDS TO TAKE THE FCDS ABSTRACTOR CODE RENEWAL EXAM?

✓ Individuals with an *ACTIVE* (not yet expired) FCDS Abstractor Code will be required to take and pass the FCDS Abstractor Code Renewal Exam once their code has expired.

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FCDS ABSTRACTOR CODE POLICY

- This test is NOT a substitute for the CTR Examination
- CTRs and non-CTRs MUST take the FCDS Abstractor Code Test
- Every person who abstracts must have their own FCDS Code

- New to Florida Abstractors (no existing FCDS Abstractor Code) will take a test with 20 questions with no time limit
- Annual Renewal tests are 15 questions with 1 hour time limit
- If you fail the test twice – you must wait 7 days to take it again
- If you fail twice – you should not abstract cases until you pass
- A score of 80% is required to pass

- NEVER share your FCDS Abstractor Code

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FCDS ABSTRACTOR CODE POLICY

✓ Sources for FCDS Abstractor Code Test Questions:

- Current FCDS Data Acquisition Manual
- SEER Self Instructional Manuals
  - Book 2 – Cancer Characteristics and Selection of Cases
  - Book 3 – Tumor Registrar Vocabulary: The Composition of Medical Terms
  - Book 4 – Human Anatomy as Related to Tumor Formation
- Collaborative Stage Data Collection System
  - Collaborative Stage Core Data Items
  - Site-Specific Factors
- ICD-O-3 and Updates
- Multiple Primary and Histology Coding Rules – Solid Tumors
- Hematopoietic and Lymphoid Neoplasms – MPH Rules and Data Base
- Any NEW Rules, Tools, Instructions, Data Items, etc.

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APPENDIX A-P

Appendix A: Florida Healthcare Facilities Currently Reporting to FCDS
Appendix B: Florida FIPS, USPS State Abbreviations and ISO Country Codes - NEW
Appendix C: Glossary and Standard Abbreviations - Updated
Appendix D: Race Coding Instructions and Race and Nationality Descriptions
Appendix E: Census List of Spanish Surnames
Appendix F: Site-Specific Surgery Codes
Appendix G: FCDS 2013 Record Layout (NAACCR Version 13)
Appendix H: 2013 FCDS Required CSv02.04 Site Specific Factors (SSFs)
Appendix I: Free-Standing Radiation Therapy Centers Cancer Case Identification Program
Appendix J: Height Conversion Tables - Converting Feet to Inches
Appendix K: Weight Conversion Tables - Converting Kilograms to Pounds
Appendix L: FCDS Text Documentation Requirements - Updated
Appendix M: Hematopoietic and Lymphoid Neoplasm Master Code Lists (alpha/numeric)
Appendix N: 2013 FCDS Casefinding List for Reportable Tumors
Appendix O: 2013 Resources for Registrars
Appendix P: FCDS Frequently Asked Questions (FAQ)

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APPENDIX B – ALL NEW

APPENDIX B
NEW

International Organization for Standardization (ISO) Country Codes

United States Postal Service (USPS) State Abbreviation Codes

United States Territory and Possessions Abbreviation Codes

Canadian Province and Territory Abbreviation Codes

Florida Federal Information Processing Standards (FIPS) County Codes

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APPENDIX B – ALL NEW

APPENDIX B
International Organization for Standardization (ISO) Country Codes – Country Alpha Order

Code	Label
AFG	Afghanistan
ZZF	Africa, NOS
XIF	African Coastal Islands (prev. in South Africa, NOS) [Pre-2013 cases only]
ALA	Aland Islands
ALB	Albania
DZA	Algeria
ASM	American Samoa
AND	Andorra
AGO	Angola
AIA	Anguilla
ATA	Antarctica
ATG	Antigua and Barbuda
XAP	Arabian Peninsula [Pre-2013 cases only]
ARG	Argentina
USA	Armed Forces Americas
USA	Armed Forces Canada, Europe, Middle East, Africa
USA	Armed Forces Pacific
ARM	Armenia
ABW	Aruba

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APPENDIX B – ALL NEW

APPENDIX B
United States Postal Service State Abbreviation Codes
Canadian Province Abbreviation Codes
United States Territory Abbreviation Codes

NAME	STATE/PROVINCE CODE	COUNTRY CODE
Alabama	AL	USA
Alaska	AK	USA
Alberta	AB	CAN
American Samoa	AS	ASM
Arizona	AZ	USA
Arkansas	AR	USA
Armed Forces Americas	AA	USA
Armed Forces Canada, Europe, Middle East, Africa	AE	USA
Armed Forces Pacific	AP	USA
British Columbia	BC	CAN
California	CA	USA
Canada	CD	CAN
Colorado	CO	USA
Connecticut	CT	USA
Delaware	DE	USA
District of Columbia	DC	USA
Florida	FL	USA
Georgia	GA	USA
Guam	GU	GUM
Hawaii	HI	USA
Idaho	ID	USA
Illinois	IL	USA
Indiana	IN	USA
Iowa	IA	USA
Johnston Atoll	UM	UM
Kansas	KS	USA
Kentucky	KY	USA
Louisiana	LA	USA
Maine	ME	USA
Manitoba	MB	CAN
Mariana Islands (Trust Territory of Pacific Islands)	MP	MNP
Marshall Islands (Trust Territory Pacific Islands)	MH	MHL
Maryland	MD	USA
Massachusetts	MA	USA
Michigan	MI	USA
Micronesia (Fed States of) (Caroline, Trust Terr of Pacific)	FM	FSM
Midway Islands	UM	UM
Minnesota	MN	USA
Mississippi	MS	USA
Missouri	MO	USA
Montana	MT	USA
Nebraska	NE	USA
Nevada	NV	USA
New Brunswick	NB	CAN

APPENDIX B
Federal Information Processing Standards (FIPS) County Codes for FLORIDA

County Name	FIPS Code
ALACHUA	001
BAKER	003
BAY	005
BRADFORD	007
BREVARD	009
BROWARD	011
CALHOUN	013
CHARLOTTE	015
CITRUS	017
CLAY	019
COLLIER	021
COLUMBIA	023
DADE	025
DESOTO	027
DIXIE	029
DUVAL	031
ESCAMBIA	033
FLAGLER	035
FRANKLIN	037
GADSDEN	039
GILCHRIST	041
GLADES	043
GULF	045
HAMILTON	047
HARDEE	049
HENDRY	051
HERNANDO	053
HIGHLANDS	055
HILLSBOROUGH	057
HOLMES	059
INDIAN RIVER	061
JACKSON	063
JEFFERSON	065
LAFAYETTE	067
LAKE	069
LEE	071
LEON	073
LEVY	075
LIBERTY	077
MADISON	079

County Name	FIPS Code
MANATEE	081
MARION	083
MARTIN	085
MONROE	087
NASSAU	089
OKALOOSA	091
OKEECHOBEE	093
ORANGE	095
OSCEOLA	097
PALM BEACH	099
PASCO	101
PINELLAS	103
POLK	105
PUTNAM	107
SANTA ROSA	113
SARASOTA	115
SEMINOLE	117
ST. JOHNS	109
ST. LUCIE	111
SUMTER	119
SUWANNEE	121
TAYLOR	123
UNION	125
VOLUSIA	127
WAKULLA	129
WALTON	131
WASHINGTON	133

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APPENDIX C - UPDATED

APPENDIX C

BREAST CANCER PROFILE EXPLAINING ER/PR/HER2 PROGNOSTIC FACTORS

SEER PROGRAM CODING AND STAGING MANUAL 2013
LINK TO CODING GUIDELINES FOR SPECIFIED SITES

GLOSSARY OF COMMON TERMS

STANDARD ABBREVIATIONS

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APPENDIX C - UPDATED

When and Why are ER/PR/HER2 Test(s) Performed as Part of Creating Individual Breast Cancer Profile?

- Estrogen Receptor (ER)
  - Test routinely performed on invasive cancers
  - Test may be performed on non-invasive (in-situ) cancers
  - Result used to determine whether or not Hormonal Therapy should be considered in 1st course treatment plan
- Progesterone Receptor (PR)
  - Test routinely performed on invasive cancers
  - Test may be performed on non-invasive (in-situ) cancers
  - Result used to determine whether or not Hormonal Therapy should be considered in 1st course treatment plan
- Human Epidermal growth factor Receptor 2 (HER2)
  - Test frequently but not always performed on invasive cancers
  - Test rarely performed on non-invasive (in-situ) cancers at this time
  - Test may be performed using one or more methods (IHC, FISH, CISH, Other)
  - An equivocal or borderline result from IHC HER2 Test may trigger additional testing using FISH or CISH
  - Some facilities bypass IHC HER2 Test and perform FISH HER2 Test as part of routine Breast Cancer Profile
  - Result used to determine whether or not Herceptin (trastuzumab) or Tykerb (lapatinib) should be included in 1st course treatment plan

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APPENDIX C - UPDATED

Favorable Prognostic Factors ER/PR/HER2

- ✓ Estrogen Receptor (ER) **positive** is a favorable prognostic factor.
  - Hormonal Therapy should be considered in 1st course treatment planning.
- ✓ Progesterone Receptor (PR) **positive** is a favorable prognostic factor.
  - Hormonal Therapy should be considered in 1st course treatment planning.
- ✓ **Single Receptor positive** tumors (ER+ only or PR+ only) do exist but are rare with an unfavorable prognosis
  - These tumors are often large in size, are of high grade, are often HER2+, and are often lymph node +
  - Single Receptor positive tumors are usually not treated with Hormonal Therapy
- ✓ Human Epidermal growth factor Receptor 2 (HER2) **positive** is a favorable prognostic factor.
  - Herceptin (trastuzumab) or Tykerb (lapatinib) should be included as part of 1st course treatment plan

Unfavorable Prognostic Factors ER, PR, HER2

- Estrogen Receptor (ER) **negative** is an unfavorable prognostic factor.
  - Hormonal Therapy usually not included as part of 1st course treatment plan
- Progesterone Receptor (PR) **negative** is an unfavorable prognostic factor.
  - Hormonal Therapy usually not included as part of 1st course treatment plan
- **Single Receptor negative** tumors (ER- only or PR- only) do exist but are rare with an unfavorable prognosis
  - These tumors are often large in size, are of high grade, are often HER2+, and are often lymph node +
  - Single Receptor negative tumors are usually not treated with Hormonal Therapy
- Human Epidermal growth factor Receptor 2 (HER2) **negative** is an unfavorable prognostic factor.
  - Herceptin (trastuzumab) or Tykerb (lapatinib) usually not included as part of 1st course treatment plan
- **Triple Negative Breast Cancer** (ER neg/PR neg/HER2 neg) is a **very unfavorable** prognostic combination.

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APPENDIX C - UPDATED

Test	Value Range	Negative	Borderline	Positive
ER Proportion Score	0%-100%	<5%	5% - 19%	>=20%
ER Intensity Score	None, weak, intermediate, strong	None, weak	intermediate	Strong
PR Proportion Score	0%-100%	<5%	5% - 19%	>=20%
PR Intensity Score	None, weak, intermediate, strong	None, weak	intermediate	Strong
HER2 by IHC	0, 1+, 2+, 3+	0, 1+	2+	3+
HER2 by FISH	Ratio 1.00-9.79 (note decimal point)	<= 1.9	1.90-2.20	>= 2.00
HER2 by CISH	Ratio 1.00-9.79 (note decimal point)	<= 1.9	1.90-2.20	>= 2.00
HER2 by unknown	No value given	Stated by MD	Stated by MD	Stated by MD
Test Not Mentioned in Medical Record - Code as Not Done (998) or Unknown if Done (999)				

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APPENDIX L – TEXT DOCUMENTATION

Below is a list of FCDS Required Data Items that carry an additional requirement of complete and accurate text documentation. See Table on Following Page for Specific Examples for each Text Area.

DATA ITEMS REQUIRING COMPLETE TEXT DOCUMENTATION	
Date of DX	RX Summ – Surg Prim Site
Seq No	RX Summ – Scope Reg LN Surgery
Sex	RX Summ – Surg Oth Reg/Distant
Primary Site	RX Date – Surgery
Subsite	RX Summ – Radiation
Laterality	Rad Rx Modality
Histologic Type	RX Date – Radiation
Behavior Code	RX Summ – Chemo
Grade	RX Date – Chemo
	RX Summ – Hormone
CS Tumor Size	RX Date – Hormone
CS Ext	RX Summ – BRM/Immunotherapy
CS Tumor Ext/Eval	RX Date – BRM/Immunotherapy
Regional Nodes Positive	RX Summ – Transplant/Endocrine
Regional Nodes Examined	RX Date – Transplant/Endocrine
CS LN	RX Summ – Other
CS LN Eval	RX Date - Other
CS Mets	
CS Mets Eval	Any Unusual Case Characteristics
All FCDS Req'd SSFs	Any Pertinent Patient/Family History

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APPENDIX L – TEXT DOCUMENTATION

Text documentation should always include the following components:

- Date(s) – include date(s) references – this allows the reviewer to determine event chronology
- Date(s) – note when date(s) are estimated [i.e. Date of DX 3/15/2011 (est.)]
- Location – include facility/physician/other location where the event occurred (test/study/treatment/other)
- Description – include description of the event (test/study/treatment/other) – include positive/negative results
- Details – include as much detail as possible – document treatment plan even if treatment is initiated as planned
- Include "relevant-to-this-person/cancer" information only – edit your text documentation
- DO NOT REPEAT INFORMATION from section to section
- DO USE Standard Abbreviations (Appendix B)
- DO NOT USE non-standard or stylistic shorthand
- Enter "N/A" or "not available" when no information is available related to any specific text area.

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APPENDIX L – TEXT DOCUMENTATION

APPENDIX L FCDS TEXT DOCUMENTATION REQUIREMENTS

Text Data Item Name NAACCR Item # Field Length	Text Documentation Source and Item Description *FCDS Required Text Documentation* Example:
Text - Physical Exam H&P NAACCR Item #2520 Field Length = 1000	Enter text information from history and physical exams. *History and physical examination findings that relate to family history or personal history of cancer diagnosis, physical findings on examination, type and duration of symptoms, reason for admission.* **Example: Hx RCC Rt Kidney – Dx 9/2007 in Georgia. Adm c/o fever and night sweats. Adm for w/u.**
Text - X-rays/Scans NAACCR Item #2530 Field Length = 1000	Enter text information from diagnostic imaging reports, including x-rays, CT, MRI, and PET scans, ultrasound and other imaging studies. *Date, facility where procedure was performed, type of procedure, detailed findings (primary site, size of tumor, location of tumor, nodes, metastatic sites), clinical assessment, positive/negative results* **Example: 4/12/13 (Breast Center xyz) Mammo - Rt Breast w/1.5cm mass at 12:00 o'clock**
Text - Scopes NAACCR Item #2540 Field Length = 1000	Enter text information from diagnostic endoscopic examinations. *Date of Procedure, facility where procedure was performed, type of procedure, detailed findings (primary site, extent of tumor spread, satellite lesions), clinical assessment, positive/ negative results* **Example: 4/12/13 (Endoscopy Ctr xyz) EGD: gastric mucosa w/ evidence of large tumor occupying half of the stomach. Numerous satellite tumors seen on opposite wall of the stomach**
Text - Lab Tests NAACCR Item #2550 Field Length = 1000	Enter text information from diagnostic/prognostic laboratory tests (not cytology or histopathology). **Text for Collaborative Stage Site Specific Factor or SSF documentation.** *Date(s) of Test(s), facility where test was performed, type of test(s), test results (value and assessment)* **Example: 4/12/13 (Hosp xyz) ER +, PR - , HER2 neg by IHC method, PSA 5.3 (elevated)**
Text - Operative Report	Enter text information from surgical operative reports (not diagnostic needle, incisional biopsy). Include observations at surgery, tumor size, and extent of involvement of primary or metastatic sites.

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APPENDIX M – HEME/LYMPH CODE LIST

2012 Hematopoietic and Lymphoid ICD-O Codes - Numerical List
THIS TABLE REPLACES ALL ICD-O-3 Codes 9590-9989

Preferred Histologic Term - updated for 2012 Heme/Lymph NOTE: DO NOT USE [OBS] Codes Beginning 1/1/2010 - [OBS] Codes are OBSOLETE	Histology
Malignant lymphoma, NOS	9590/3
Non-Hodgkin lymphoma, NOS	9591/3
B-cell lymphoma, unclassifiable, with features intermediate between diffuse large B-cell lymphoma and classical Hodgkin lymphoma	9596/3
Primary cutaneous follicle centre lymphoma	9597/3
Classical Hodgkin lymphoma	9650/3
Lymphocyte-rich classical Hodgkin lymphoma	9651/3
Mixed cellularity classical Hodgkin lymphoma	9652/3
Lymphocyte-depleted classical Hodgkin lymphoma	9653/3
~~Hodgkin lymphoma, lymphocyte depletion, diffuse fibrosis~~ [OBS]	~~9654/3~~
Hodgkin lymphoma, lymphocyte depletion, reticular	9655/3
~~Hodgkin disease, lymphocytic predominance, NOS~~ [OBS] See 9651/3	~~9657/3~~
~~Hodgkin disease, lymphocytic predominance, diffuse~~ [OBS] See 9651/3	~~9658/3~~
Nodular lymphocyte predominant Hodgkin lymphoma	9659/3
~~Hodgkin granuloma~~ [OBS]	~~9660/3~~
~~Hodgkin sarcoma~~ [OBS]	~~9662/3~~
Nodular sclerosis classical Hodgkin lymphoma	9663/3
~~Hodgkin lymphoma, nodular sclerosis, cellular phase~~ [OBS] See 9663/3	~~9664/3~~
~~Hodgkin lymphoma, nodular sclerosis, grade 1~~ [OBS] See 9663/3	~~9665/3~~
~~Hodgkin lymphoma, nodular sclerosis, grade 2~~ [OBS] See 9663/3	~~9667/3~~
~~Malignant lymphoma, small B lymphocytic, NOS~~ [OBS] See 9823/3	~~9670/3~~

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APPENDIX O – 2013 RESOURCES

APPENDIX O - RESOURCES FOR REGISTRARS – updated May 2013

Reference Book/Manual for Abstracting Web Address For Source Notes		
2013 FCDS (Florida Cancer Data System) Data Acquisition Manual	http://www.fcds.med.miami.edu/inc/DAM.shtml	Details cancer data reporting guidelines and casefinding mechanisms for identifying reportable cancers.
2013 CoC FORDS Manual (Facility Oncology Data Standards)	http://www.facs.org/cancer/coc/standards.html	FORDS errata is issued quarterly and posted on the website.
SEER Program Coding and Staging Manual 2012	http://seer.cancer.gov/tools/codingmanuals/	The 2012 Surveillance, Epidemiology and End Results (SEER) Program Coding and Staging Manual is effective for cases diagnosed January 1, 2012, and forward. Previous editions of this manual are available on the SEER website.
MPH Rules - Solid Tumors, rev Aug 24, 2012	http://www.seer.cancer.gov/tools/mphrules/index.html	On the home page click on "Information for Cancer Registrars", MPH Rules
MPH Rules - Heme/Lymph Neoplasms and Interactive HemeLymph Database	http://seer.cancer.gov/seertools/hemelymph/	On the home page click on "Information for Cancer Registrars", Hematopoietic & Lymphoid Neoplasm Project
ICD-O-3 Coding Materials	http://www.seer.cancer.gov/icd-o-3/index.html	On the home page click "Data Collection Tools", Errata and Clarifications
Collaborative Stage Data Collection System	http://www.cancerstaging.org/cstage	On the home page click the link "news" to see if there are updates
SEER*Rx - Interactive Drug Database	http://seer.cancer.gov/seertools/seerrx/	A one-step lookup for coding oncology drug and regimen treatment categories in cancer registries
Cancer Registry Management – Principles and Practice for Hospitals and Central Registries, 3rd ed	http://hcia-usa.org/ or http://www.kendallhunt.com	Kendall/Hunt (publisher) ISBN 978-0-7575-6965-5
AJCC Staging Manual 7th Edition (plus errata)	http://www.springer.com/medicine	Springer (publishers) ISBN: 978-0-387-88440-0
Education and Training Materials Web Address For Training Materials Notes		
FCDS Education & Training On-Line Abstractor Training Course and Recorded Webcasts - PLUS Registration Portal to access FCDS-sponsored Educational Events and FCDS-hosted Events	http://www.fcds.med.miami.edu/inc/training.shtml and http://www.fcds.med.miami.edu/inc/webconferences.shtml	On-Line Abstractor Training Course, Recorded FCDS Educational Webcasts, Annual Meeting Presentations, Special Announcements, and more
SEER Cancer Registar Training Modules	http://www.seer.cancer.gov/training/index.html	Self Instruction Modules on many abstracting topics including Collaborative Staging and Multiple Primary and Histology Coding Rules.
CoC/AJCC Online Education	http://www.ao2.commpartners.com/users/sso	On-Demand Webinars, CLP Education
NAACCR Webinars	http://www.naaccrtra.webex.com/mw0306/mywebex/	FCDS sponsors 6 host locations across Florida for the monthly educational webinars.
Brain Tumor Registry Reporting Training Materials	http://www.cdc.gov/cancer/npcr/training	This includes a Power Point presentation on Benign Brain and CNS Tumors along with speaker notes. It also has exercises with answers provided.
Newsletters Web Address Notes		
FCDS Monthly Memo	http://www.fcds.med.miami.edu/inc/newsletters.shtml	Florida Cancer Data System's monthly memo written especially for registrars. Used as a source for updates/replacement pages to manuals.
FCDS Register (Quarterly Newsletter)	http://www.fcds.med.miami.edu/inc/newsletters.shtml	Florida Cancer Data System's newsletter
COC Flash	http://www.facs.org/cancer/coc/flash.html	Commission on Cancer's newsletter

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APPENDIX P – FCDS IDEA AND ACCOUNTS

Frequently Asked Questions

- Do I need an FCDS IDEA User Account?
- How do I create an FCDS IDEA User Account?
- Procedure for Lost User ID/Password?
- How do I renew my FCDS User Account?
- Who can be a Facility Access Administrator (FAA)?
- Which Facilities are Required to Establish an FAA Account?
- How do I apply for the FAA Role?
- How do I Manage User Role Assignments?
- What is an FCDS Abstractor Code?
- Do I need an FCDS Abstractor Code?
- How do I obtain an FCDS Abstractor Code?

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FCDS EDITS V13A METAFILE

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NEW FCDS EDITS METAFILE V13A

Changes Made To NAACCR v13 Metafile		Released: Dec. 17, 2012
Green = deleted		
Yellow = new edits		
Blue = edit name/field name changes		
New Edit Name	**Old Edit Name**	**Comments**
Addr at DX--Country (COC)		New edit
Addr at DX--Country (NAACCR)		New edit
Addr at DX--Country, Date of Diagnosis (COC)		New edit
Addr at DX--Country, Date of Diagnosis (NAACCR)		New edit
Addr at DX--Country, State (NAACCR)		New edit
Addr Current--Country (COC)		New edit
Addr Current--Country (NAACCR)		New edit
Addr Current--Country, Date of Diagnosis (COC)		New edit
Addr Current--Country, Date of Diagnosis (NAACCR)		New edit
Addr Current--Country, State (NAACCR)		New edit
Obsolete Histology ICDO3, Date of DX (SEER)		New edit

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NEW FCDS EDITS METAFILE V13A

CS Ext, Surg, TS/Ext Eval, Prostate (CS)		New edit
CS Ext,TS/Ext Eval, SSF 1, MelanomaConjunc (CS)		New edit
CS Extension, Histology, Grade, Thyroid (CS)		New edit
CS Extension, SSF 1, Conjunctiva Schema (CS)		New edit
CS Extension, SSF 2, KidneyRenalPelvis (CS)		New edit
CS Extension, SSF 2, Lung Schema (CS)		New edit
CS Extension, SSF 2, MelanomaChoroid (CS)		New edit
CS Extension, SSF 2, MelanomaCiliaryBody (CS)		New edit
CS Extension, SSF 3, MelanomaChoroid (CS)		New edit
CS Extension, SSF 3, MelanomaCiliaryBody (CS)		New edit
CS Extension, Tumor Size, Lung Schema (CS)		New edit
CS SSF 2, Ext, KidneyRenalPelvis (CS)		New edit
CS SSF 2, Lymph Nodes, Bladder (CS)		New edit
CS SSF 2, Lymph Nodes, Vagina (CS)		New edit
CS SSF 2, Mets at DX, Vagina (CS)		New edit
CS SSF 2, Pleura (CS)		Deleted
CS SSF 2, RX Summ--Surg, Oth, DX/Stg, Lung (CS		New edit
CS SSF 2, SSF 3, Vagina (CS)		New edit
CS SSF 2, Surg, KidneyRenalPelvis (CS)		New edit
CS SSF 2L, Surg/Rad Seq, Sur/Sys Seq, Breast (CS)		Deleted
CS SSF 3, Lymph Nodes, Bladder (CS)		New edit
CS SSF 3, RX Summ--Scope Reg LN Sur, Vagina (CS)		New edit

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COMING ATTRACTIONS

- 2014 - ICD-0-3 Updates – PENDING
- 2014 - MPH Rules and Data Base for Solid Tumors
- 2014 - ICD-10-CM Implementation
- 2014 - CSv02.05 – no major changes, fewer SSFs required
- 2014 - More CS EDITS

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IMPORTANT REMINDERS

- ✓ Diagnosis Date is often date of imaging not date of biopsy
- ✓ Only ONE Accession Number per Patient – Alt Acc # Field
- ✓ All sequences must be reported when reporting any case with multiple primaries – Historical Grid for inactive cancers
- ✓ Completeness and Consolidated Follow-Back
- ✓ Timliness: Each facility must report at least quarterly
- ✓ Facilities reporting >500 cases/year should report monthly

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IMPORTANT REMINDERS

- ✓ Astractors must have access to and use available resources such as Heme DB and SEER*Rx and new MPH DB
- ✓ Please refer to MPH Rules and Heme MPH Rules
- ✓ Please refer to Heme DB for coding Heme/Lymph Histology
- ✓ Check your drop-down selections - not a substitute for rules
- ✓ Contact FCDS with abstracting and coding questions

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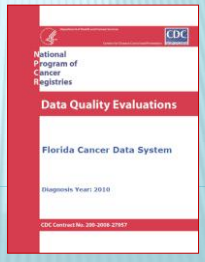
2013 NPCR DATA QUALITY EVALUATION: RESULTS AND RECOMMENDATIONS

FCDS Annual Meeting
July 26, 2013
Sunrise, Florida

Steven Peace, CTR
Megsys Herna, CTR
FCDS Data Quality Staff



PURPOSE OF NPCR DQE

- Assess the quality of the data of NPCR-funded, statewide, population-based cancer registries.
- These data are a crucial part of cancer surveillance systems because they are used for planning, operating, funding, and evaluating cancer control programs.
- Complete and accurate data are essential to estimate variations in and changes among population subgroups over time.
- The evaluation assessment is based on the existence of appropriate policies and procedures for the following:
  - Data consolidation
  - Assessment of data quality
  - Text documentation

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ELEMENTS OF DQE

- Visual Editing
- Consolidation Validation
- NPCR Clinical Edit Checks
- FCDS Policy and Procedures Manual
- Final Report to NPCR and FCDS
- Recommendations

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DQE METHODOLOGY – VISUAL EDITING

- Evaluator reviewed all data elements included in the evaluation as well as the corresponding text for each abstract-level case.
- Any abstract-level codes not substantiated by text were recoded
- Errors resulted when there was 1) a complete lack of text to support the coded data element or, 2) the text was available but the coded data element was incorrect.

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DATA ELEMENTS REVIEWED

Cancer Identification	Collaborative Staging	Treatment 1st Course
Primary Site	CS Tumor Size	Date of Initial RxSEER
Subsite	CS Extension	Rx Summ--Surg Prim Site
Laterality	CS Tumor Size Extent Eval.	Rx Summ--Scope Reg LN Sur
Histology	CS Lymph Nodes	Rx Summ--Surg Oth Reg/Dis
Behavior	CS Mets at Dx	Rad--Regional Rx Modality
Grade	CS Site-Specific Factor 1	Rx Summ- Chemo
Date of Diagnosis	CS Site-Specific Factor 2	Rx Summ-Hormone
Sequence Number--Central	CS Site-Specific Factor 3	Rx Summ-BRM
	Derived SS2000	Rx Summ-Transplnt/Endocr
		Rx Summ-Other

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DATA ELEMENTS REVIEWED

Collaborative Staging SSFs for Female Breast
CS Site-Specific Factor 1
CS Site-Specific Factor 2
CS Site-Specific Factor 8
CS Site-Specific Factor 9
CS Site-Specific Factor 10
CS Site-Specific Factor 11
CS Site-Specific Factor 12
CS Site-Specific Factor 13
CS Site-Specific Factor 14

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DQE METHODOLOGY – CONSOLIDATION

- A total of 200 cases were reconsolidated.
- A total of 5,483 data elements could have had errors
- 181 data elements were found to have errors.

Site	Number of Elements Reviewed	Number of Elements With Errors	Number of Elements Without Errors	Accuracy Rate
Colon	480	17	463	96.46%
Rectum	216	7	209	96.76%
Lung	1,800	53	1,747	97.06%
Female Breast	1,536	49	1,487	96.81%
Corpus Uteri	300	2	298	99.33%
Prostate	575	23	552	96.00%
Total	**4,907**	**151**	**4,756**	**96.92%**

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2013 DQE RESULTS

- **Overall Accuracy Rate = 96.9% - Commendation**
- **Visual Editing Accuracy Rate = 96.0% - Commendation**
- **Reconsolidation Accuracy Rate = 96.0% - Commendation**
- FCDS is encouraged to continue conducting visual editing to maintain data quality in the State, in addition to reviewing basic abstracting principles with staff and data reporters and emphasizing to all reporting facilities that text documentation to support data element code selection is required.
- Text documentation should support all coding decisions.
- Text documentation should support all consolidation decisions.

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CONGRATULATIONS AND THANK YOU

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NPCR DQE RECOMMENDATIONS

1. Provide an overview of abstracting principles to staff and data reporters.
2. State training should include a focus on the following data items:
   - *CS Extension* and *CS Metastasis at Diagnosis*
   - *CS Tumor Size, CS Extension,* and *CS Lymph Nodes* when neoadjuvant treatment is administered
   - *RX Summary Surgery Primary Site* and *RX Summary Scope Regional Lymph Node Surgery* particularly as they apply to breast cancer and sentinel lymph nodes
   - *Date of Diagnosis* Review diagnostic language, including ambiguous terminology
   - Rules for coding Site-Specific Factors including training regarding text documentation

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NPCR DQE RECOMMENDATIONS

2. State training should include a focus on the following data items:
   - Grade Conversion Tables, particularly as it applies to Gleason Grade for prostate cancer – discussion tomorrow morning
   - *Date of Initial RX* — *SEER* rules and providing training on the importance of including dates with text documentation
   - Rules for coding *Radiation Regional RX Modality*, including training regarding text documentation of modality and energy
3. Visual Editing Review and Consolidation:
   - Educating all reporting facilities that text documentation, with dates, is required for all data elements, preferably using hands-on training

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FCDS FOLLOW-UP PLAN

- Share NPCR Audit Results with Reporters
- Introduce Clinical Edit Checks to Registrars
- Reinforce Text Documentation Requirements
- Reinforce FCDS QC Review/Visual Editing Rationale
- Incorporate Recommendations into 2013 FCDS Webcast Series
- Reinforce FCDS QC Review/Visual Editing Feedback Procedures
- Standardize Format for FCDS Policy and Procedures Manual
- Annual Review of FCDS Policy and Procedures Manual

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NPCR CLINICAL EDIT CHECKS

FCDS Annual Meeting
July 26, 2013
Sunrise, Florida

Steven Peace, CTR
FCDS Data Quality Staff

FCDS Florida Cancer Data System
A Joint Project of the Sylvester Comprehensive Cancer Center and the Florida Department of Health

PURPOSE OF CLINICAL EDIT CHECKS

- The primary purpose of the Clinical Check edits is to evaluate reported prognostic and treatment items for cancer cases with specific tumor characteristics.
  - Missing/Incomplete Tumor Characteristics (site/type/stage)
  - Missing/Incomplete Site-Specific Factors (prognostic factors)
  - Missing/Incomplete First Course Treatment
- Clinical Checks are based on consensus measures for quality of cancer care developed by CoC and NPCR for specified cancers.
- Endorsed by National Quality Forum, CoC, ASCO, and NCCN.
- If the reported treatment does not appear to be consistent with widely recognized standards of care **or** cases fail to contain known prognostic characteristics, a warning is generated.

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NPCR AUDIT INCLUDED CLINICAL CHECKS

NPCR Clinical Check Edits—2010 Data	Total Eligible Cases	Total Cases With Warning Messages	Total Cases Without Warning Messages	Percentage of Cases Without Warning Messages
Prognostic and Staging Info, Breast (Clin2)	3,646	1,323	2,323	63.71%
Prognostic and Staging Info, Colon (Clin2)	960	590	370	38.54%
Radiation With Breast-Conserving Surg (Clin2)	1,326	614	712	53.70%
Radiation With Rectal Cancer Surgery (Clin2)	115	115	0	0.00%
Surgically Treated Non-metastatic Colon Canc (Clin2)	520	209	311	59.81%
Systemic Treatment With Breast Surgery (Clin2)	1,048	621	427	40.74%

Any discrepancy generated warning that standard treatment not captured or recorded.

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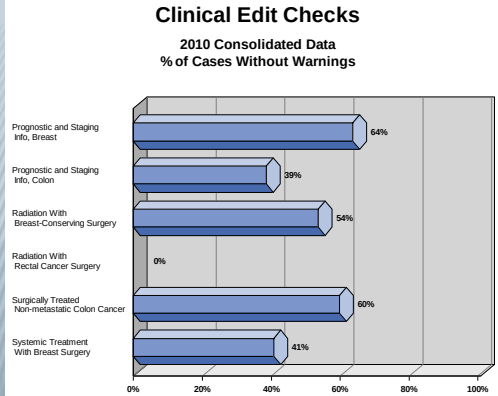


ENVIRONMENTAL PUBLIC HEALTH TRACKING NETWORK & CANCER SURVEILLANCE

Florida HEALTH

Melissa Jordan, MS
Florida Department of Health/Bureau of Epidemiology

Florida Tracking Program Overview

- Environmental Public Health Tracking (Tracking) focuses on surveillance of environmental factors and related health outcomes
  - Examples of environmental factors: drinking water contaminants, ozone, particulate matter, community design
  - Examples of health outcomes: asthma, birth defects, cancer, cardiovascular disease, heat-related illness, birth outcomes
- Funded through a cooperative agreement with CDC since 2003

Tracking Web Portal – www.floridatracking.com

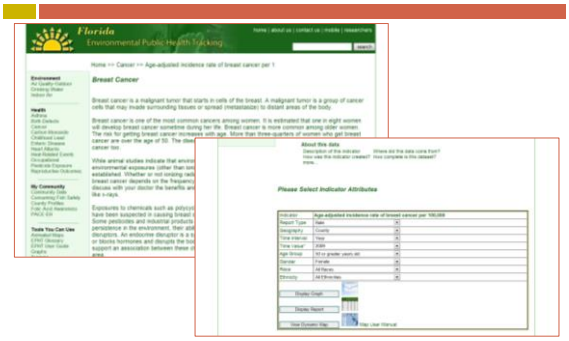
Cancer – Core Indicators

- Nationally Consistent Data Measures (NCDMs) – indicators displayed by all Tracking grantees
  - Bladder
  - Brain & other Nervous Systems
  - Breast
  - Leukemia (Acute Lymphocytic, Acute Myeloid, Chronic Lymphocytic)
  - Lung & Bronchus
  - Non-Hodgkin's Lymphoma
  - Thyroid

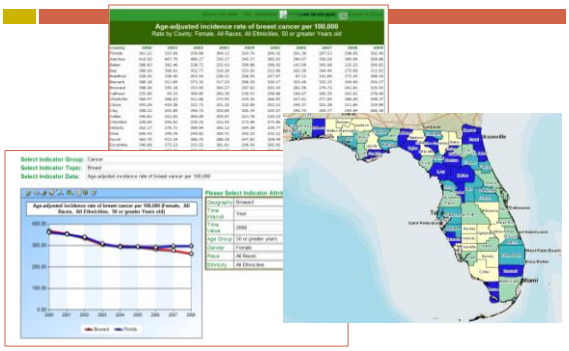
Cancer – Core Indicators (New)

- New NCDMs
  - Kidney & Renal Pelvis
  - Liver & Intrahepatic Bile Duct
  - Melanoma of the Skin
  - Mesothelioma
  - Tobacco Related
    - Esophagus
    - Larynx
    - Oral Cavity & Pharynx
    - Pancreas

Data Reports & Tools



Data Reports & Tools (continued)



Florida's System for Cancer Research & Collaboration

Robert Hood, Ph.D.
Manager, Florida System of Cancer Research and Collaboration
robert_hood@doh.state.fl.us (850) 245-4585

Protect, promote and improve the health of all people in Florida.

FL System for Cancer Research & Collaboration

- Use existing state structures
  - C-CRAB, BRAC, registry
  - Bankhead-Coley, King
- Establish state cancer research agenda
- Enhance collaborations between researchers and develop research networks
- Develop metrics to evaluate health impact of research

Protect, promote and improve the health of all people in Florida.

Cancer Center of Excellence Award

- Establishes a Cancer Center of Excellence Award (381.925 *F.S.*)
  - Encourage excellence in patient-centered, coordinated cancer care
  - Attract and retain the best care providers
  - Help Florida providers to be recognized nationally as a preferred destination for quality cancer care
- After January 1, 2014 DOH will conduct two application cycles annually

Protect, promote and improve the health of all people in Florida.

Florida Department of Health
Division of Community Health Promotion
Bureau of Chronic Disease Prevention

Sue Higgins, MPH
Director, Comprehensive Cancer Control Program

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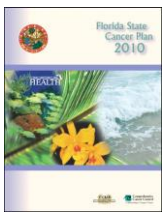
- Goal I: Infrastructure
- Goal II: Prevention
- Goal III: Treatment/Access to Care
- **Goal IV: Survivorship**
  "Floridians affected by cancer are aware of and have access to quality, appropriate services for quality of life, palliative care, and survivorship



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American College of Surgeons
Commission on Cancer
Standard 3.3 Survivorship Care Plan
The cancer committee develops and implements a process to disseminate a comprehensive care summary and follow-up plan to patients with cancer who are completing cancer treatment. The process is monitored, evaluated, and presented at least annually to the cancer committee and documented in minutes.

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Cancer Control and Research Advisory Council (CCRAB)

Goal 4: Survivorship Committee

Created a brochure to help explain what cancer treatment summaries and survivorship care plans are and why are they important

61

Success through Collaboration: Enhancing surveillance data with insurance claims

Brad Wohler
Florida Cancer Data System
FCDS Annual Meeting 2013

Protect, promote and improve the health of all people in Florida.

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PHYSICIAN OFFICE REPORTING WHAT THIS MEANS TO YOU

Dr. Jill A. MacKinnon
FCDS Project Director

Pro-Active Reporting of Physician Medical Claims Data: Capturing Complete and Missed Treatment Data

MONIQUE HERNANDEZ, PHD
FLORIDA CANCER DATA SYSTEM

ANNUAL MEETING
SUNRISE, FL
JULY 25-26, 2013

The Model is Changing

65

- The management of cancer has evolved and no longer fits the model implemented in the late 1970's when FCDS was designed
  - Diagnosis and treatment of many cancers shift from the hospital to the private practitioner's office
- As more and more cancer patients become cancer survivors, more information is needed by the medical community to improve the quality of life for our cancer survivors
- Survival is no longer the only salient endpoint

Ramifications of old Model on Cancer Surveillance and Data on the Cancer Patient

66

- Underestimates of incidence of certain cancers
  - Dx/Tx taking outside of hospital
- Treatment incomplete
  - Not capturing full course of treatment, especially chemo
- Data used by policy makers
  - Misallocation of funds and services
  - Unable to identify areas/subgroups in need
- Data Used by Researchers
  - Sampling frame for patient studies
  - Data for hypothesis driven research
  - Trends over time

New Model

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Physician reporting via medical claims data

Incorporate/Operationalize Medical Claim Form Electronic Data

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- National standard record layout currently used by every private practitioner in the nation
  - 837 Record, Version 5010
- Using existing insurance industry standard record layout (837 record)
  - Patient demographics
  - Patient diagnosis codes
  - Procedure codes -- Cancer directed treatment
  - Date of last contact

HICFA 1500 -- Demographics

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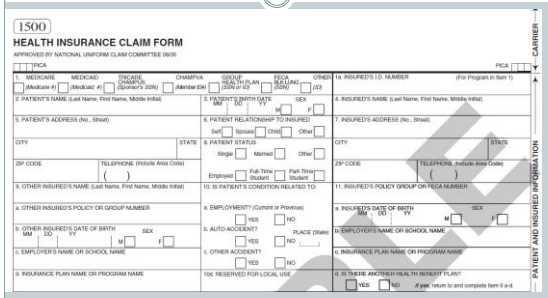
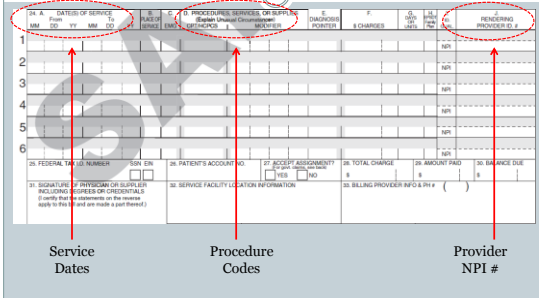


HICFA 1500 – Diagnosis and Procedures

70



Physician Office Reporting Using Medical Claims Data

71

- Data submitted to FCDS at the same time physician's normal insurance submission
- Crosswalk/derive treatment/procedure codes to cancer registry codes
  - CPT – Current Procedural Terminology
  - HCPC – Healthcare Common Procedure Coding System
  - Anti-neoplastic agents, RT, Hormones
  - Ancillary therapies to enhance chemo tolerance

FCDS Partnerships and Special Projects

72

- Florida Cancer Specialists – Pilot
  - Largest privately owned oncology/hematology practice
    - 120 physicians - 70 nurse practitioners
    - 60 clinical offices
      - Located in 33 of Florida's 67 counties
      - Captures roughly 40% of market in Florida
- Zexion -- Dr. Lynne Penberthy and Mr. Davis Gentry
- CDC's CER Project – Special data collection of additional treatment information for Dx 2011

Broad Learning Objectives

73

- How effective are claims data in augmenting registry records?
- How use of this new data source can assist the hospital based registrar?
- Is there potential for creating a 'virtual abstract' from disparate data streams?

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Data Capture and Evaluation a Florida Pilot Project

Data Capture

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Data capture via multiple methods

- CER -- Comparative Effectiveness Research Project
  - Expanded treatment captured by CTR from Florida Cancer Specialists' electronic medical record system
- Florida Cancer Specialist Data submitted via 837 claim feed since July of 2012. Goes back to 2011.
- Routine capture using consolidated hospital abstracts – Registry Core Record

General Descriptive Analysis

76

Objectives:

- To compare summary chemo treatment information from claims records against core treatment records using CER as a gold standard.
- This will help us answer two main questions…

Answer Two Questions

77

1. Can the claims data produce incident Tx data according to NAACCR standards (first course chemo)?

   Chemo given yes/no

2. Can the claims data augment the existing NAACCR standard treatment data?

   Chemo single/multiple agents

Methods for Identifying Study Sample

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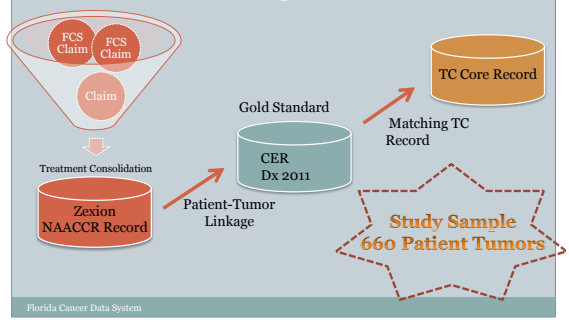
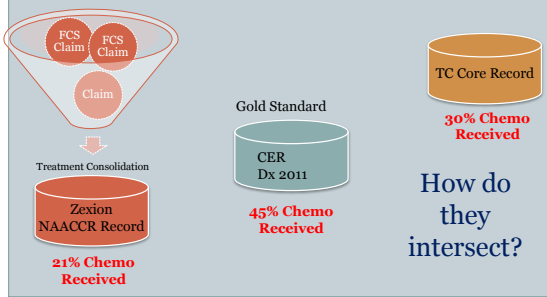


Chemo Treatment by Dataset (N=660)

79



Q1: Can the claims data produce incident Tx data according to NAACCR standards (first course chemo)?

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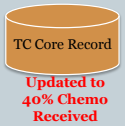
Core FCDS Incident Tx Data	Claim Treatment Data		
	Yes	No	Total
Yes	67	127	194
No	71	395	466
Total	138	522	660

- Study sample N=660
- 70% agreement on Treatment
- 71 records from core Tx No to Tx Yes
- Existing FCDS Chemo Tx given went from 30% to 40%
- Treatment data validated by CER (82%)
- Limitations: claims records have gaps in services

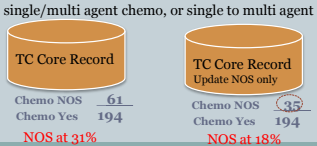


Q2: Can the claims data augment the existing NAACCR standard treatment data where treatment is given?

81

Core FCDS Incident Tx Data	Incident Tx Data Computed from Claim Records is greater than*		
	Yes	No	Total
Yes	0	19	19
No	26	22 (same code)	48
Total	26	41	67

*NOS to single/multi agent chemo, or single to multi agent chemo



Data Enhancement

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- Date of Last Contact
  - 94% of matched records updated
- Treatment
  - Chemo treatment changed by 37%
  - Treatment NOS went down from 31% to 18%
- 21% Granular Tx detail (chemo agents)

Two Questions

83

1. Can the claims data produce incident Tx data according to NAACCR standards (first course chemo)?

   YES!

2. Can the claims data augment the existing NAACCR standard treatment data?

   YES!

What Does This Mean to You?

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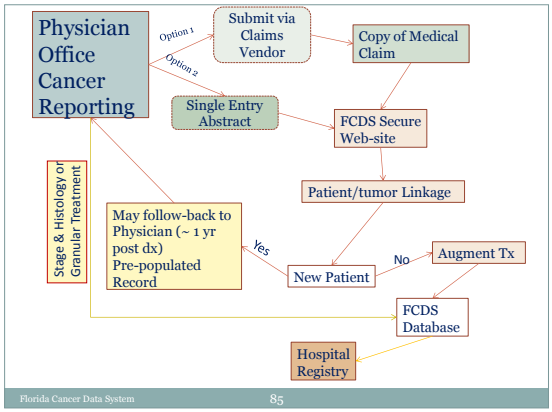
- Once fully operational
  - FCDS can and will provide you with
    - Detailed treatment and dates
    - Dates of last contact
    - Patient status



Your Responsibility

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- Download F/U files from FCDS
- Modify registry software to integrate new data
- Should greatly minimize - eliminate your follow-up burden

ICD-O-3 UPDATES - PENDING

FCDS Annual Meeting
July 26, 2013
Sunrise, Florida

Steven Peace, CTR
ICD-O-3 Work Group

2011 ICD-O-3 UPDATES SUMMARY

- 29 non-CNS benign and borderline entities
- 8 new reportable terms
- 31 hematopoietic and lymphoid terms – approved 2010
- 18 new histology/behavior including word "dysplasia" behavior = 2.
- The term "in-situ" ino longer used in to describe neoplasms arising in the GI tract – now called "glandular dysplasia high grade," "high grade dysplasia" or "intraepithelial neoplasia, high grade"
- Carcinoid of Appendix changes to a Reportable Malignancy
- Clarification/Explanation of two confusing heme codes
- 5 new preferred terms replace outaded ICD-O-3 terms
- Many related terms and synonyms added to existing codes

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ICD-O-3 WORK GROUP – SCOPE OF WORK

1. Review WHO ICD-O-3 Update list
2. Heme/Lymph New Codes already accepted
3. Determine possible impact of new terms/codes
4. Canada has already implemented WHO ICD-O-3 Update
5. Utilize Guest Experts in Pathology and WHO Classification of Diseases for Oncology
6. Identify associated files, lists, programs, and documents that will be affected by changes
7. The ICD-O-3 Work Group recommends implementation of the non-controversial terms and the few completely new codes as soon as possible.

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WHO CLASSIFICATION OF DISEASES

- Completed Fourth Edition Updates Include:
- 2007 – Tumors of Central Nervous System
- 2008 – Tumors of Hematopoietic and Lymphoid Tissues
- 2010 – Tumors of Digestive System
- 2011 – Tumors of Breast
- 2012 – Tumors of Soft Tissue and Bone

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WHO CLASSIFICATION OF DISEASES

- PENDING Fourth Edition Updates Include:
- Tumors of Head and Neck
- Tumors of Urinary System
- Tumors of Skin
- Tumors of Lung, Pleura, Thymus, Heart
- Tumors of Female Genital System
- Tumors of Male Genital System

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ICD-O-3 WORK GROUP – NOT IN SCOPE

1. New terminology and behavior for bronchioloalveolar carcinoma. Note: Terms are already in use by pathologists around the US and Canada.
2. Reportability guidelines for GIST tumors. Note: This has been partially addressed in a sentence added to FORDS 2013 and the SEER 2013 Coding Manual, which indicate that GIST and thymoma are reportable when there is evidence of multiple foci, lymph node involvement, or metastasis.
3. WHO Classifications of Soft Tissue and Bone as well as Breast have been published since 2011, and more updated volumes of the WHO Classification are planned.
4. NAACCR needs to be proactive in deciding how to handle new codes, obsolete codes, and other changes published in these volumes.

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HGD/IEN/CIS AND IMC OF GI TRACT

- IEN/HGD/CIS of Genital Sites - Squamous Epithelium
- IEN/HGD/CIS of GI Tract – Glandular Epithelium

- IEN – Intra-Epithelial Neoplasia
- HGD – High Grade Dysplasia
- CIS – Carcinoma In Situ

- IMC of GI Tract – Intramucosal Carcinoma
  - Invades lamina propria with no involvement of muscularis mucosa

- Non-Invasive (in-situ) Neoplasms DO NOT Metastasize
- Retire "polyp" in-situ codes (8210/2, 8261/2, 8263/2)

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GI TRACT TOPGRAPHY CODES

- C15.* - Esophagus
- C16.* - Stomach
- C17.* - Small Intestine
- C18.* - Colon (includes appendix)
- C19.* - Rectosigmoid Colon
- C20.* - Rectum
- C23.* - Gall Bladder
- C24.* - Bile Ducts
- C25.* - Pancreas
- Excludes: Anus (C21.*) and Liver (C22.*)

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ICD-O-3 WORK GROUP RECOMMENDATIONS

- Reportability Changes
  - 8240/3 – Carcinoid Tumor, NOS of Appendix (C18.1)
- Accept All Heme/Lymph Changes in Heme DB
- Correct a few Heme/Lymph Terms or Codes in Heme DB
  - 9960/3 – Myeloproliferative Neoplasm, NOS
  - 9971/1 – Post Transplant Lymphoproliferative Disorder, NOS
  - 9571/3 – Polymorphic Post Transplant Lymphoproliferative Disorder

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ICD-O-3 WORK GROUP RECOMMENDATIONS

DO NOT USE [OBS] or (obs) Codes

Obsolete ICD-O Codes Neoplasms of Hematopoietic and Lymphoid Tissue		
9654	9675	9753
9661	9684	9754
9662	9728	9760
9664	9835	9764
9665	9836	9805
9667	9729	9960
9670	9733	9984
	9750	9987

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ICD-O-3 WORK GROUP RECOMMENDATIONS

- **NO ACTION AT THIS TIME** - The ICD-O-3 Update Implementation Work Group recommends NO ACTION for the following codes and terms in the WHO Update until the impact of a reportability change for terminology that includes "dysplasia" can be further assessed.
- **Current reportability legislation affects these codes/terms**
  - All new codes/terms w/reference to high grade intraepithelial neoplasia or dysplasia of GI Tract (esophagus, colon, pancreas, biliary, other GI Tract)
    - Squamous Neoplasms
    - Glandular (adeno) Neoplasms
    - Mucinous cystic neoplasms
    - Papillary neoplasms

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ICD-O-3 WORK GROUP RECOMMENDATIONS

- **NO ACTION AT THIS TIME** - continued

8077/2	**Squamous intraepithelial neoplasia, high grade**
8077/2	Esophageal squamous intraepithelial neoplasia (dysplasia), high grade (C15._)
8148/2	**Glandular intraepithelial neoplasia, high grade**
8148/2	Flat intraepithelial glandular neoplasia, high grade (C24.1)
8148/2	Biliary intraepithelial neoplasia, high grade
8148/2	Esophageal glandular dysplasia (intraepithelial neoplasia), high grade (C16._)
8163/2	**Papillary neoplasm, pancreatobiliary-type, with high grade intraepithelial neoplasia (**
8453/2	**Intraductal papillary mucinous neoplasm with high grade dysplasia**
8453/3	Intraductal papillary mucinous neoplasm with an associated invasive carcinoma
8470/2	**Mucinous cystic tumor with high-grade dysplasia (C25._)**
8470/2	Mucinous cystic neoplasm with high-grade intraepithelial neoplasia (C22._)
8470/2	Mucinous cystic neoplasm with high-grade dysplasia (C25._)
8470/3	**Mucinous cystic tumor with an associated invasive carcinoma (C25._)**
8470/3	Mucinous cystic neoplasm with an associated invasive carcinoma (C25._)
8503/2	**Intraductal papillary neoplasm with high grade intraepithelial neoplasia**
8503/2	Intraductal tubular-papillary neoplasm, high grade
8503/3	**Intraductal papillary neoplasm with associated invasive carcinoma**

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IMPACT ON CANCER REGISTRARS?

- Adoption Delay will create confusion pathology/cancer registry
- Many proposed Update CodesTerms and pending 4th edition Blue Books reflect current terminology already in use by pathologists
  - 8148/2 - Glandular intraepithelial neoplasia (dysplasia), high grade when the term in-situ is not used in conjunction with the diagnosis
  - 8453/2 – Intraductal papillary mucinous neoplasm with high grade intraepithelial neoplasia/high grade dysplasia (no invasive tumor)
  - No New ICD-O-Codes Yet Proposed by WHO to reflect Changes in Bronchoalveolar Lung Adenocarcinoma using Travis Classification
    - All BAC now called something else
    - Adenocarcinoma in situ (formerly BAC)
    - Mucinous Adenocarcinoma with Lepidic Pattern (formerly mucinous BAC)
    - Adenocarcinoma Lepidic Predominant (formerly non-mucinous BAC)
    - Colloid Adenocarcinoma (formerly mucinous cyst-adenocarcinoma)
    - Enteric Adenocarcinoma (similar to colorectal adenocarcinoma)
- All proposed changes in turn effect CS, TNM, Tx, etc

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SYNCHRONIZED UPDATES REQUIRED

1. FORDS/SEER/State Coding Manual Updates
2. Volume II Reportable Case Matrix (high grade dysplasia for GI cancers)
3. Casefinding List Review (are there any specific ICD-9-CM diagnosis and/or procedure codes associated with the new histologies)
4. SEER Site/Type Table Update
5. CoC Site-Specific Surgery Codes – Histology-Driven "Sites"
6. MPH Rules Solid and Hematopoietic/Lymphoid Neoplasms – Histology-Driven "Rules" and Resources (DB and web-resources)
7. AJCC/TNM – Histology Inclusion Tables and Histology-Driven Chapters
8. Collaborative Stage Data Collection – Histology Inclusion Tables
9. Collaborative Stage Data Collection – any special SSFs included/excluded
10. Automated/Manual Tumor Consolidation Histology Pairs Tables
11. Standard EDITS and State-Specific EDITS
12. SEER Incidence Site Recode ICD-O-3 –Histology-Driven Recodes
13. SEER Lymphoma Subtype Recodes – Histology-Driven Recodes
14. International Classification of Childhood Cancer (ICCC) Recodes – Histology-Driven Recodes
15. Histology Code Conversion(s) if any are required
16. Software-related: Site/Histo grouping updates as required where available for ad-hoc reports
17. Software-related: Updates to scoped lookups (based on site/histo)
18. Revisions: Does that include codes being added, deleted, converted?
19. Registry Plus Online Help resource

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CODING GRADE/DIFFERENTIATION

- ✓ 2010 - Immunophenotype Lymphoid Neoplasms
- ✓ 2010 - Immunophenotype Myeloid Neoplasms
- ✓ 2013 - Discontinue Grade Path Value
- ✓ 2013 - Discontinue Grade Path System
- ✓ **2013 - CONSENSUS GUIDELINES PROPOSED**
- ❑ **FINAL REVISIONS PENDING**
  - ❑ Clarify Grade for In-Situ Tumors
  - ❑ Implied Grade for Brain Tumors
  - ❑ Implied Grade for Solid Tumors
  - ❑ Site-Specific Factors for Grade
  - ❑ Grade Conversion Tables
  - ❑ Conversion Algorithms

SEER

COLLABORATIVE STAGE DATA COLLECTION SYSTEM

Commission on Cancer

NPCR NATIONAL PROGRAM OF CANCER REGISTRIES

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GRADE CLARIFICATIONS

Special Grade Systems for Solid Tumors	
CS Schema	**Special Grade System**
Breast	**Nottingham or Bloom-Richardson Score/Grade**
Prostate	**Gleason Score on Needle Core Biopsy/TURP**
Prostate	**Gleason Score on Prostatectomy/Autopsy**
HeartMediastinum	**Grade for Sarcomas**
Peritoneum	**Grade for Sarcomas**
Retroperitoneum	**Grade for Sarcomas**
SoftTissue	**Grade for Sarcomas**
KidneyParenchyma	**Fuhrman Nuclear Grade**

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GRADE CLARIFICATIONS

2 Grade System

Code	Terminology	Histologic Grade
2	Low grade	1/2
4	High grade	2/2

3 Grade System

Code	Terminology	Histologic Grade
2	Low grade, well to moderately differentiated	I/III or 1/3
3	Medium grade, moderately undifferentiated, relatively undifferentiated	II/III or 2/3
4	High grade, poorly differentiated to undifferentiated	III/III or 3/3

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GRADE CLARIFICATIONS

Description	CS Code	Grade Code	AJCC 7th	SEER 2003-2013	AJCC 6th	SEER prior to 2003
Gleason Score						
2	002	1	G1	G1	G1	G1
3	003	1	G1	G1	G1	G1
4	004	1	G1	G1	G1	G1
5	005	1	G1	G2	G2	G2
6	006	1	G1	G2	G2	G2
7	007	2	G2	G3	G3	G2
8	008	3	G3	G3	G3	G3
9	009	3	G3	G3	G3	G3
10	010	3	G3	G3	G3	G3

Analyses of prostate grade before 2014 based solely on the grade field is not recommended

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GRADE CLARIFICATIONS

Current Conversion
FCDS DAM Update

Code	Gleason's score	Terminology	Histologic Grade
1	2, 3, 4	Well Differentiated	I
2	5, 6	Moderately Differentiated	II
3	7, 8, 9, 10	Poorly Differentiated	III

AJCC 7th edition
2014 Proposed
Conversion

Code	Gleason's score	Terminology	Histologic Grade
1	2, 3, 4, 5, 6	Well Differentiated	I
2	7	Moderately Differentiated	II
3	8, 9, 10	Poorly Differentiated	III

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CLOSING REMARKS

- FCDS has already begin utilizing edits for [OBS] codes
- FCDS will not allow any facility to use proposed ICD-O Codes
- DO NOT USE GRADE CODING GUIDELINES UNTIL APPROVED
- > 20 critical cancer registry reference manuals, tables, algorithms, and coding instruction documents to be updated – IMPACT ???
- How to schedule and coordinate updates to multiple references
- All Staff Must Use - current manuals, versions, updates, etc.
- Please Do Not Use Outdated Materials – put them away
- MANAGERS/FAA: Please share QC feedback and QC Review Findings and any other Field Coordinator and Quality Review corrections and comments with their staff – especially when new rules and tools and manuals or manual updates are introduced.

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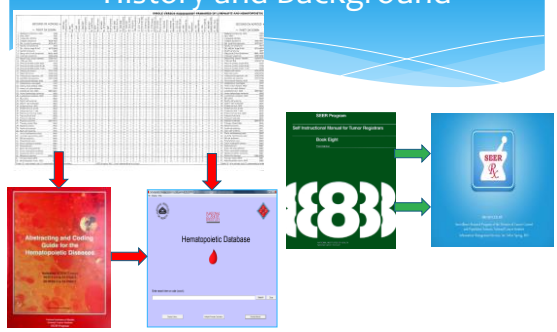
FCDS Florida Cancer Data System

2013 SEER Rx and Heme/Lymph Database Updates

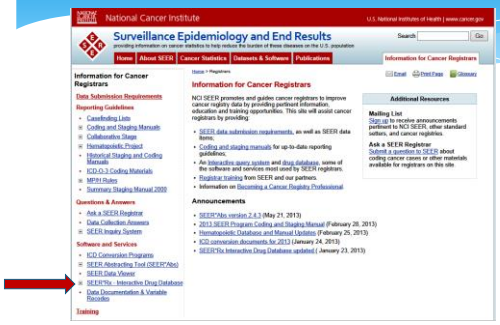
Background
Rules and Instructions
Tips and Tools

Gema G. Midence, MBA, CTR
Steven Peace, CTR
Florida Cancer Data System Annual Meeting
Friday, July 26, 2013
Sunrise, Florida

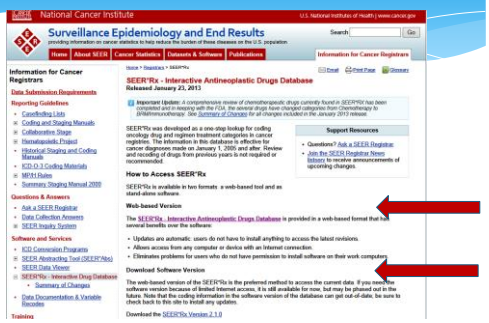
History and Background



Information for Cancer Registrars



SEER*Rx



Summary of Changes in 2013

- Total number of drugs listed in SEER*RX: **1825**
- Total number of Regimens listed in SEER*RX: **853**
- Number of drugs added: **12**
- Number of drugs modified: **71**
- Number of regimens added: **3**
- Number of regimens deleted: **1 (duplicate)**
- Number of regimens modified: **255**

Summary of Changes in 2013

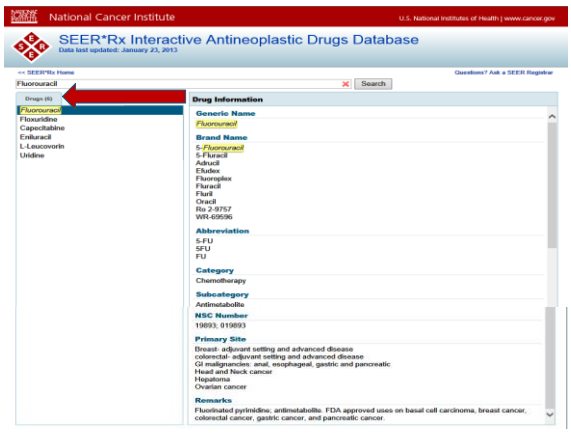
Prior to 2013, targeted therapies that invoke an immune response, such as Herceptin, had been coded as chemotherapy.

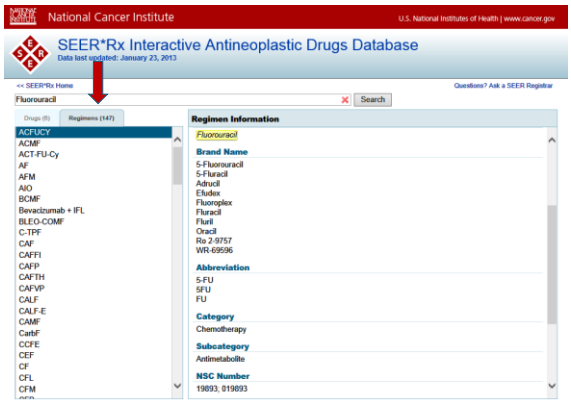
Effective with cases diagnosed January 1, 2013 and forward these therapies are classified as biological response modifiers.

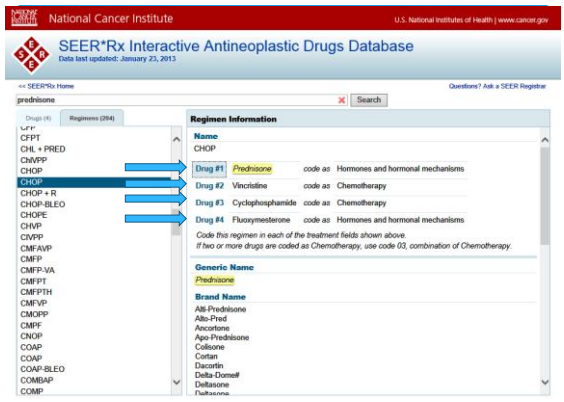
Coding instructions for these changes have been added to the remarks field for the applicable drugs in the SEER*RX Interactive Drug Database

Summary of Changes in 2013

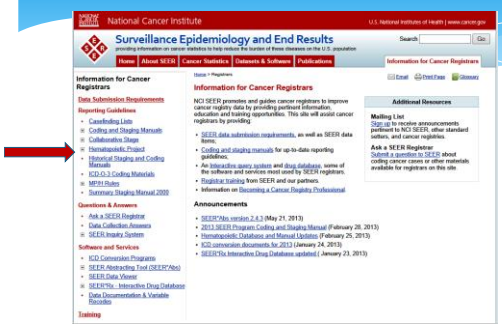
Drug Name(s)	Previous Category	New Category	Effective Date
Alemtuzumab/Campath	Chemotherapy	BRM/Immuno	1/1/2013
Bevacizumab/Avastin	Chemotherapy	BRM/Immuno	1/1/2013
Rituximab	Chemotherapy	BRM/Immuno	1/1/2013
Trastuzumab/Herceptin	Chemotherapy	BRM/Immuno	1/1/2013
Pertuzumab/Perjeta	Chemotherapy	BRM/Immuno	1/1/2013
Cetuximab/Erbitux	Chemotherapy	BRM/Immuno	1/1/2013



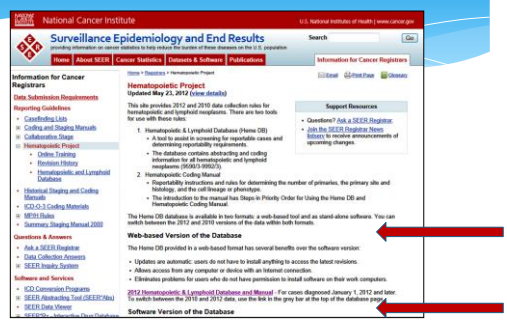




Information for Cancer Registrars



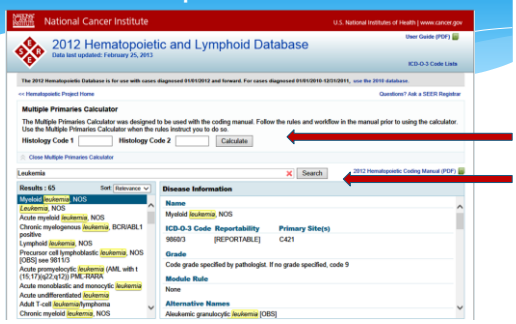
Information for Cancer Registrars



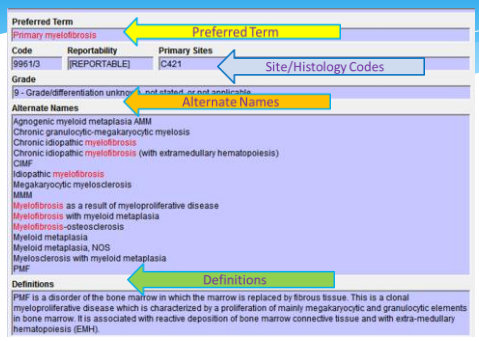
What's In The Manual/Database?

Manual	Database
Introduction	Neoplasm Definition
Reportable Instructions	Neoplasm Synonyms
Multiple Primary Rules	MP Calculator
Primary Site Coding Rules	Diagnostic Method(s)
Histology Coding Rules	Genetic Tests
Grade Coding Rules	Immunophenotype
Glossary	Treatment
Appendices (A-E)	Transformation
	Abstractor Notes
	ICD-O/ICD-9/ICD-10 Codes

Hematopoietic Database



What's in the DB?



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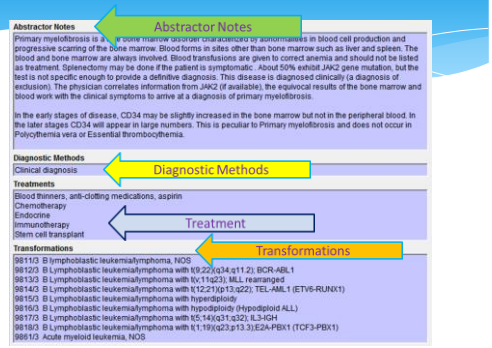

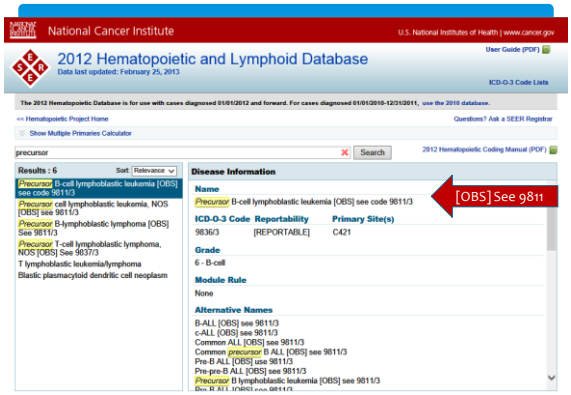

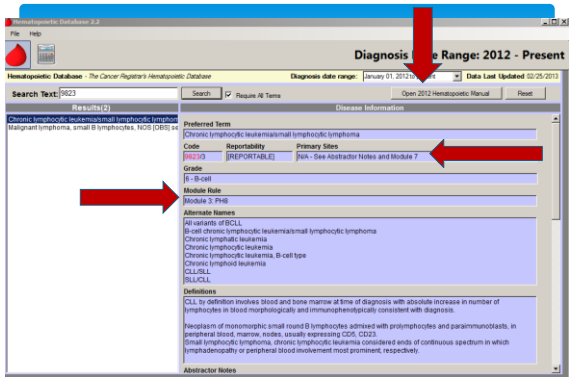

WHAT'S NEW IN CANCER CARE

FCDS Annual Meeting
July 26, 2013
Sunrise, Florida

Steven Peace, CTR
FCDS Data Quality Staff

Prevention → Detection → Treatment → Recovery → Palliation

WHAT'S NEW IN CANCER CARE?

- Targeting At Risk and High Risk Populations
  - Cancer Screening Guidelines
  - New Screening Methods
- Profiling Individual and Tumor Characteristics
  - Prognostic Indicators
  - Molecular Testing
  - Genetic Testing
  - Staging Factors
- Targeting Treatment
  - Patient/Tumor Profile
  - Treatment Guidelines
  - Quality of Life and End of Life Care
- New Methods for Drug Delivery

Source: hetdex.com

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CANCER SCREENING GUIDELINES - LUNG

- August 2011 - National Lung Screening Trial (NLST) Results
- Screening with low-dose spiral CT compared to CXR reduced lung cancer deaths among older heavy smokers by 20%.
- Improved detection of lung cancer at earlier stages is key to increased survival and improved mortality due to lung cancer.
- Weigh Benefits/Risk of lung cancer screening using CT scan
- Recommend Screening in High Risk Population:
  - Current/Former Smoker
  - Age 55-74 Years
  - Smoking History of at least 20-30 pack-years (varies by organization)
  - No personal history of lung cancer
- Frequency of Screening not included in All Recommendations
  - Annual
  - Once Every 3 Years
  - Other

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CANCER SCREENING GUIDELINES - LUNG

- Endorsement/Adoption of Guideline
  - American Cancer Society (ACS)
  - American Lung Association (ALA)
  - American College of Chest Physicians (ACCP)
  - American Association for Thoracic Surgery (AATS)
  - ASCO/NCCN Clinical Practice Guidelines (ASCO/NCCN)
- Pending Endorsement
  - United States Preventative Services Task Force
    - 2004 - Last update to USPS TF Lung Cancer Screening

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CANCER SCREENING GUIDELINES - LUNG

American Lung Association Recommendations

- The best way to prevent lung cancer caused by tobacco use is to never start smoking or to quit smoking.
- Low-dose CT screening should be recommended for those people who meet NLST criteria:
  - Current or former smokers aged 55 to 74 years
  - A smoking history of at least 30 pack-years
  - No history of lung cancer
- Individuals should not receive a chest X-ray for lung cancer screening
- Low-dose CT screening should NOT be recommended for everyone
- Patients should be referred to a facility that uses "best practices" for CT screening

The complete report can be found at www.Lung.org.

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CANCER SCREENING GUIDELINES - LUNG

- ALA Developing an Educational Portfolio for Patients to Explain:
  - **The difference between a screening process and a diagnostic test**
    - ***Cancer Screening is testing for cancer before there are any symptoms***
  - **The benefits, risks and costs (emotional, physical and economic)**
  - **That not all lung cancers will be detected through use of low dose CT scanning**
- ALA issued a Call to Action for Hospitals and Screening Centers to:
  - **Establish ethical policies for advertising/promoting lung cancer screening svcs**
  - **Develop educational materials to assist patients in having thoughtful discussions between patients and physicians regarding lung cancer screening**
  - **Provide lung cancer screening services with access to multidisciplinary teams that can deliver the needed follow-up for evaluation of nodules.**

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CANCER SCREENING GUIDELINES - PROSTATE

- PSA screening in men under age 40 years is not recommended.
- Routine screening in men between ages 40 to 54 years at average risk is not recommended.
- For men ages 55 to 69 years, the decision to undergo PSA screening involves weighing the benefits of preventing prostate cancer mortality in 1 man for every 1,000 men screened over a decade against the known potential harms associated with screening and treatment. For this reason, shared decision-making is recommended for men age 55 to 69 years that are considering PSA screening, and proceeding based on patients' values and preferences.
- **To reduce the harms of screening, a routine screening interval of two years or more may be preferred over annual screening** in those men who have participated in shared decision-making and decided on screening. As compared to annual screening, it is expected that screening intervals of two years preserve the majority of the benefits and reduce over diagnosis and false positives.
- Routine PSA screening is not recommended in men over age 70 or any man with less than a 10-15 year life expectancy.

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CANCER SCREENING GUIDELINES - PROSTATE

- What do the guidelines actually mean?
- Men of any age should not be routinely screened using PSA until evidence demonstrates mortality benefit of screening
- Men ages 55 to 69 are urged to talk with their doctors about benefits and harms of testing and treatment
- The best available evidence suggests that following these guidelines will lead to an improved benefit-to-harm ratio.
- What will this mean for cancer registry programs?
- What will this mean for cancer treatment centers?

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CANCER SCREENING GUIDELINES - PROSTATE

- Endorsement/Adoption of Guideline
  - American Cancer Society (ACS)
  - American College of Physicians (ACP)
  - American Urological Association (AUA)
  - American Society for Radiation Oncology (ASTRO)
  - ASCO/NCCN Clinical Practice Guidelines (ASCO/NCCN)
  - United States Preventative Services Task Force (USPSTF)

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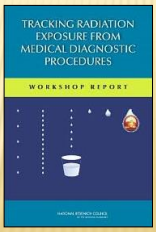
NEW CANCER SCREENING METHODS

- Need to Track Radiation Exposures from Screening
- Need to Track Radiation Exposure from non-screen CTs
- Screening Risk from Radiation Exposure Hypothesis Testing



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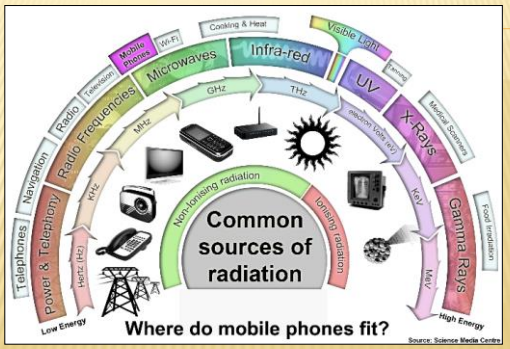

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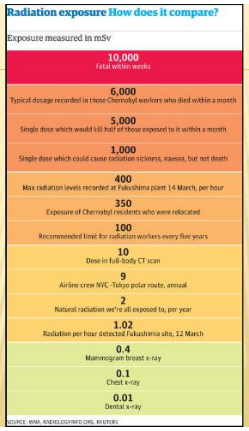

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NEW TREATMENT DELIVERY METHODS

- Transition from infusion chemotherapy to oral administration
- New Inhalable chemotherapeutic agents using "nanostructured lipid nanocarriers" can transport antineoplastic agents at full strength directly into lungs or other organs – highly efficient.
- Nanoparticles also carry small interfering RNA (siRNA) molecules which helps control and repress certain genes to eliminate "pump" resistance (when tumor cells actively expel chemo agent(s) before the chemo can work) and "non-pump" resistance, which keeps cancer cell from dying.
- MRI-Guided Focused/Concentrated Ultrasound Therapy

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NEW TREATMENT DELIVERY METHODS

- Photo-Dynamic Therapy (PDT)
  - Approved for airway malignancy, Barrett's esophagus with high grade dysplasia and non-melanoma skin cancers
  - Investigational for high-grade glioma, oral and laryngeal neoplasms, inoperable cholangiocarcinoma, and mesothelioma
- New Embolization Techniques
  - Code as Chemo or Radiation plus Other Therapy
  - Trans-Arterial Chemo Embolization (TACE) – direct administration of chemo into liver or other organ then embolization of artery
  - Drug Eluting Bead Therapy – administration of beads impregnated with chemo agent(s) through catheter with timed release of agent(s)
  - Ytrium-90 Microsphere Therapy – administration of spheres with low levels of radio-isotope Ytrium-90 attached – direct radiation to liver
    - Code as brachytherapy not radio-isotope per CoC

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NEW TREATMENT DELIVERY METHODS

- HIPEC Chemotherapy – Heated Intra-peritoneal Chemotherapy
  - Chemotherapy solution heated to 107.6 degrees before administration
  - Chemotherapy solution kept at 107.6 degrees and recirculated throughout peritoneal cavity for at least two hours by going through a heating chamber
- Proton Therapy Increases Precision and Reduces Side Effects
- Focusing not only on direct treatment to tumor burden but also reducing side effects from treatment and collateral tissue damage
- Also focusing on long-term /secondary effects from treatment(s)

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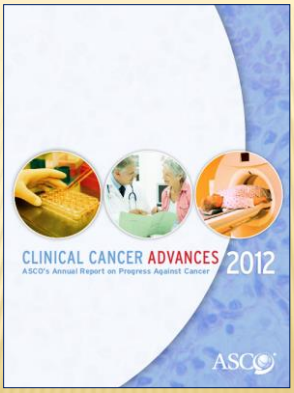

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FOCUS AREAS IN CANCER RESEARCH

- Cancer Screening Risks and Benefits
- No Two Tumors Are Alike
- Precision Medicine – Personalized Medicine
- Targeting Molecular Pathways
- Targeting Genetic Alterations
- FDA and New Drug Approvals
- Management of Clinical Trials
- Overcoming Treatment Resistance
- Quality of Life and Survivorship Issues
- End of Life Care

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FDA APPROVALS OF ANTICANCER AGENTS

Newly Approved Agents

Generic Name	Trade Name	Indications	Date of Approval
Axitinib	Inlyta	For treatment patients with advanced kidney cancer (renal cell carcinoma) who have not responded to other treatments for this type of cancer	January 27, 2012
Vismodegib	Erivedge	For use in patients with locally advanced basal cell cancer who are not candidates for surgery or radiation and for patients whose cancer has metastasized.	January 30, 2012
Pertuzumab	Perjeta	For use in combination with trastuzumab and docetaxel as a first-line treatment for patients with HER2-positive metastatic breast cancer	June 8, 2012
Carfilzomib	Kyprolis	For treatment of patients with multiple myeloma whose disease progressed despite at least two prior therapies, including bortezomib and an immunomodulatory agent	July 20, 2012
Ziv-Aflibercept	Zaltrap	For use in combination with 5-fluorouracil, leucovorin, irinotecan (FOLFIRI) for the treatment of patients with metastatic colorectal cancer that is resistant to or has progressed following an oxaliplatin containing regimen	August 3, 2012
Enzalutamide	Xtandi	For treatment of patients with metastatic castration-resistant prostate cancer who have previously received docetaxel	August 31, 2012
Regorafenib	Stivarga	For treatment of patients with metastatic colorectal cancer that has progressed despite standard treatments	September 27, 2012

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FDA APPROVALS OF ANTICANCER AGENTS

Expanded Indications for Existing Agents

Generic Name	Trade Name	Indications	Date of Approval
Imatinib mesylate	Gleevec	For the adjuvant treatment of adult patients following complete gross resection of Kit (CD117) positive gastrointestinal stromal tumors (GIST)	January 31, 2012
Pazopanib	Votrient	For treatment of patients with advanced soft tissue sarcoma who have received prior chemotherapy.	April 26, 2012
Cetuximab	Erbitux	For use in combination with FOLFIRI (irinotecan, 5-fluorouracil, leucovorin) chemotherapy for first-line treatment of patients with KRAS mutation-negative, epidermal growth factor receptor (EGFR)-expressing metastatic colorectal cancer	July 6, 2012
Everolimus	Afinitor	For use in combination with exemestane to treat certain postmenopausal women with advanced hormone-receptor positive, HER2-negative breast cancer	July 20, 2012
Vincristine sulfate liposome injection	Marqubo	For treatment of adult patients with Ph- acute lymphocytic leukemia in second or greater relapse or whose disease has progressed following two or more anti-leukemia therapies	August 9, 2012

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MAJOR CLINICAL ADVANCES IN YEAR 2012

- Breast Cancer
  - Chemo - Everolimus (Afinitor) for hormone-receptor + breast
  - Chemo - Trastuzumab-DM1 for HER2-positive metastatic breast
  - BRM - Pertuzumab (Perjeta) for HER2-positive metastatic breast
- Lung Cancer
  - Combination Chemo - Carboplatin and Pemetrexed for non-small cell lung cancer

Prevention → Detection → Treatment → Recovery → Palliation

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MAJOR CLINICAL ADVANCES IN YEAR 2012

- Prostate Cancer
  - Hormone - Enzalutamide (Xtandi) for late stage prostate cancer
- Esophageal Cancer
  - Neoadjuvant chemo plus XRT then surgery for esophagus and gastroesophageal junction tumors

Prevention | Detection | Treatment | Recovery | Palliation

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MAJOR CLINICAL ADVANCES IN YEAR 2012

- Multiple Myeloma
  - BRM - Lenalidomide (Revlimid) maintenance delays relapse after stem cell transplant
  - BRM Agents for MM – Thalidomide, Velcade, Kyprolis, Pomalyst
- Soft Tissue Sarcoma
  - Chemo - Pazopanib (Votrient) for soft tissue sarcoma – 1st new drug in decades for soft tissue sarcoma

Prevention | Detection | Treatment | Recovery | Palliation

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MAJOR CLINICAL ADVANCES IN YEAR 2012

- Thyroid Cancer
  - Chemo - Cabozantinib (Cometriq) in medullary thyroid cancer
- Colorectal Cancer
  - Chemo - Regorafenib (Stivarga) in metastatic colorectal cancer
- Ovarian Cancer
  - BRM - Bevacizumab (Avastin) in recurrent ovarian cancer

Prevention | Detection | Treatment | Recovery | Palliation

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MAJOR CLINICAL ADVANCES IN YEAR 2012

- Colorectal Cancer Screening
  - Flexible sigmoidoscopy reduces colorectal cancer incidence and deaths – where does it fit into screening paradigm?
  - Flexible sigmoidoscopy results are comparable to colonoscopy

Prevention | Detection | Treatment | Recovery | Palliation

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MAJOR CLINICAL ADVANCES IN YEAR 2012

- Factors increase risk of death in elderly chemo population
  - Geriatric assessment for patients > 70 yrs of age
  - Advanced disease
  - Low nutritional assessment score
  - Poor mobility
- Chemo-induced Nausea and Vomiting
  - Ancillary - Olanzapine (Zyprexa) for breakthrough nausea/vomiting

Prevention | Detection | Treatment | Recovery | Palliation

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MAJOR CLINICAL ADVANCES IN YEAR 2012

- Predicting risk for adverse effects of chemo in elderly
  - New model introduced scoring system and risk-stratification
  - Low-Risk / Intermediate-Risk / High-Risk
- Chemo-induced Peripheral Neuropathy
  - Ancillary - Duloxetine (Cymbalta) for alleviating pain from chemo-induced neuropathy

Prevention | Detection | Treatment | Recovery | Palliation

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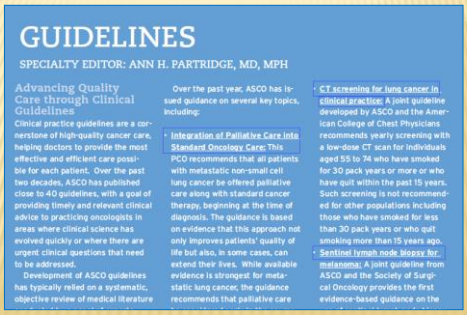
WHY CLINICAL GUIDELINES?



GUIDELINES

SPECIALTY EDITOR: ANN H. PARTRIDGE, MD, MPH

Advancing Quality Care through Clinical Guidelines

Clinical practice guidelines are a cornerstone of high-quality cancer care, helping doctors to provide the most effective and efficient care possible for each patient. Over the past two decades, ASCO has published close to 40 guidelines, with a goal of providing timely and relevant clinical advice to practicing oncologists in areas where clinical science has evolved quickly or where there are urgent clinical questions that need to be addressed.

Development of ASCO guidelines has typically relied on a systematic, objective review of medical literature

Over the past year, ASCO has issued guidance on several key topics, including:

- **Integration of Palliative Care into Standard Oncology Care:** This PCO recommends that all patients with metastatic non-small cell lung cancer be offered palliative care along with standard cancer therapy, beginning at the time of diagnosis. The guidance is based on evidence that this approach not only improves patients' quality of life but also, in some cases, can extend their lives. While available evidence is strongest for metastatic lung cancer, the guidance recommends that palliative care

- **CT screening for lung cancer in clinical practice:** A joint guideline developed by ASCO and the American College of Chest Physicians recommends yearly screening with a low-dose CT scan for individuals aged 55 to 74 who have smoked for 30 pack years or more or who have quit within the past 15 years. Such screening is not recommended for other populations including those who have smoked for less than 30 pack years or who quit smoking more than 15 years ago.
- **Sentinel lymph node biopsy for melanoma:** A joint guideline from ASCO and the Society of Surgical Oncology provides the first evidence-based guidance on the

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QUALITY INDICATORS

- Risk Stratification TX Early Stage Bladder Cancer (example):
- Low-Risk Group: Ta Low Grade/Low Volume Non-Muscle Invasive Bladder Cancer – single dose Intravesical Chemotherapy using Epirubicin or Mitomycin
- High-Risk Group: Ta High Grade/High Volume Non-Muscle Invasive and T1 Bladder Cancer – Intravesical BCG (Bacillus Calmette-Guerin – Tuberculosis)

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