

FCDS MONTHLY MEMO

MARCH/APRIL 2000

Colon Cancer

NATIONAL COLORECTAL CANCER AWARENESS MONTH, 2000

The President of the United States of America proclaimed March 2000 as National Colorectal Cancer Awareness Month. Health care providers, advocacy groups, policymakers, and concerned citizens across the country are encouraged to help raise public awareness of the risks and methods of prevention of colorectal cancer and to use the power of our knowledge to defeat this disease.

What is cancer of the colon?

Cancer of the colon, a common form of cancer, is a disease in which cancer (malignant) cells are found in the tissues of the colon. The colon is part of the body's digestive system. The purpose of the digestive system is to remove nutrients (vitamins, minerals, carbohydrates, fats, proteins, and water) from the foods eaten and to store the waste until it passes out of the body. The digestive system is made up of the esophagus, stomach, and the small and large intestines. The last 6 feet of intestine is called the large bowel or colon.

Genes are markers in cells associated with hereditary traits. Abnormal genes have been found in patients with some forms of colon and rectal cancer. Tests are being developed to determine who carries these genes in the hope that tests can be developed to identify at risk individuals long before cancers may appear.

Screening tests (such as a fecal occult blood test (FOBT), digital rectal examination (DRE), double contrast barium enema) may be done regularly in patients who are at higher risk for developing cancers. A special procedure such as a proctoscopy, and colonoscopy may be done to look inside the rectum and lower colon. Proctoscopies find about half of all colon and rectal cancers. The test is usually done in a doctor's office. The doctor may also want to look inside the rectum and the entire colon (colonoscopy) with a special tool called a colonoscope. This test is also done in a doctor's office. If tissue that is not normal is found, the doctor will need to cut out a small piece and look at it under the microscope to see if there are any cancer cells. This is called a biopsy. Biopsies are usually done during the proctoscopy or colonoscopy, in a doctor's office, freestanding facility, GI centers, or in a hospital as an outpatient. If a biopsy is positive, a colon and rectal cancer workup evaluation should be done to evaluate the extent of the spread of the disease. This workup might include a blood test (to measure amounts of Carcinoembryonic antigen (CEA) in the blood) and x-rays such as an Endorectal ultrasound, Intraoperative ultrasound, CT scans of the abdomen/pelvis, and chest x-rays.

The prognosis (chance of recovery) and choice of treatment depend on the stage of the cancer (whether it is just in the inner lining of the colon or if it has spread to other places) and the patient's general state of health. Additional diagnostic workup may be needed to evaluate metastasis such as CT guided needle biopsy, Magnetic resonance imaging (MRI) Positron emission tomography(PET), angiography . After treatment, a blood test (to measure amounts of Carcinoembryonic antigen (CEA) in the blood) and x-rays may be done to see if the cancer has come back (recurred)

Stage Information

Stages of cancer of the colon

Once cancer of the colon is found (diagnosed), more tests will be done to find out if cancer cells have spread to other parts of the body (staging). In order to stage colon cancer, a surgical procedure will need to be performed. Knowing the stage of the disease will assist the doctor in effectively planning further treatment. Treatment decisions have also been made usually in reference to the older Dukes classification or the Astler-Coller classification schema. Stages should preferably be defined by the AJCC, American Joint Committee on Cancer AJCC system, also called the TNM system. The following stages are used for cancer of the colon:

Stage 0 or carcinoma in situ

Stage 0 cancer of the colon is very early cancer. The cancer is found only in the innermost lining of the colon.

Stage I

The cancer has spread beyond the innermost lining of the colon to the second and third layers and involves the inside wall of the colon, but has not spread to the outer wall of the colon or outside the colon. Stage I colon cancer is sometimes called Dukes A colon cancer.

Stage II

Cancer has spread outside the colon to nearby tissue, but it has not gone into the lymph nodes. (Lymph nodes are small, bean-shaped structures that are found throughout the body. They produce and store cells that fight infection.) Stage II colon cancer is sometimes called Dukes B colon cancer.

Stage III

Cancer has spread to nearby lymph nodes, but it has not spread to other parts of the body. (Stage III colon cancer is sometimes called Dukes C colon cancer.

Stage IV

Cancer has spread to other parts of the body. Stage IV colon cancer is sometimes called Dukes D colon cancer.

Recurrent

Recurrent disease means that the cancer has come back (recurred) after it has been treated. It may come back in the colon or in another part of the body. Recurrent cancer of the colon is often found in the liver and/or lungs.

Treatment Option Overview

There are treatments for all patients with cancer of the colon. Three kinds of treatments are available:

- ◆ surgery (taking out the cancer)
- ◆ radiation therapy (using high-dose x-rays or other high-energy rays to kill cancer cells)
- ◆ chemotherapy (using drugs to kill cancer cells)

Surgery is the most common treatment of all stages of cancer of the colon. A doctor may take out the cancer from the colon using one of the following:

If the cancer is found at a very early stage, the doctor may take out the cancer without cutting into the abdomen. Instead, the doctor may put a tube through the rectum into the colon and cut the tumor out. This is called a local excision. If the cancer is found in a small bulging piece of tissue (called a polyp), the operation is called a polypectomy.

If the cancer is larger, the doctor will take out the cancer and a small amount of healthy tissue around it (bowel or colon resection). The healthy parts of the colon are then sewn together (anastomosis). The doctor will also take out lymph nodes near the intestine and look at them under the microscope to see if they contain cancer.

If the doctor is not able to sew the colon back together, he or she will make an opening (stoma) on the outside of the body for waste to pass out of the body. This is called a colostomy. Sometimes, the colostomy is only needed until the colon has healed, and then it can be reversed. However, the doctor may have to take out the entire lower colon and the colostomy is permanent. If a patient has a colostomy, a special bag will need to be worn to collect body wastes. This special bag, which sticks to the skin around the stoma with a special glue, can be thrown away after it is used. This bag does not show under clothing, and most people take care of these bags themselves.

Radiation therapy is the use of x-rays or other high-energy rays to kill cancer cells and shrink tumors. There are several ways radiation is given. From a machine outside the body (external radiation therapy) or from putting materials that contain radiation through thin plastic tubes (internal radiation therapy) in the intestine area. Radiation can be used alone or in addition to surgery and/or chemotherapy.

Chemotherapy is the use of drugs to kill cancer cells. Chemotherapy may be taken by pill, or it may be put into the body by inserting a needle into a vein. A patient may be given chemotherapy through a tube that will be left in the vein while a small pump gives the patient constant treatment over a period of weeks. Chemotherapy is called a systemic treatment because the drug enters the bloodstream, travels through the body, and can kill cancer cells outside the colon. If the cancer has spread to the liver, the patient may be given chemotherapy directly into the artery going to the liver. If the doctor removes all the cancer that can be seen at the time of the operation, the patient may be given chemotherapy after surgery to kill any cancer cells that are left. Chemotherapy given after an operation to a person who has no cancer cells that can be seen is called adjuvant chemotherapy.

Another form of treatment that tries to get the body to fight cancer is the Biological response modifier (BRM) therapy or Immunotherapy. It uses materials made by the body or made in a laboratory to boost, direct, or restore the body's natural defenses against disease.

Treatment by stage

Treatments for cancer of the colon depend on the stage of the disease and the patient's general health. Standard treatment may be considered because of its effectiveness in patients in past studies, or participation in a clinical trial may be considered. Not all patients are cured with standard therapy and some standard treatments may have more side effects than are desired. For these reasons, clinical trials are designed to find better ways to treat cancer patients and are based on the most up-to-date information. Clinical trials are ongoing in most parts of the country for most stages of cancer of the colon. To learn more about clinical trials, call the Cancer Information Service at 1-800-4-CANCER (1-800-422-6237); TTY at 1-800-332-8615. Treatment information has been obtained from NCI, NCCN, ACS. The National Comprehensive Cancer Network (NCCN) have set treatment cancer guidelines and the American Cancer Society (ACS) have made a partnership to provide patients and the general public with cancer treatment information. NCCN guidelines is to assist and does not replace the expertise and clinical judgement of a physician.

The most up-to date-guidelines are available on the websites of the ACS (www.cancer.org) or NCCN (www.nccn.org) Also to obtain the most recent information anyone can the NCCN at 1-888-909-NCCN or the ACS at 1-800-ACS-2345. Website to browse: www3.cancer.org/cancerinfo; cancernet.nci.nih.gov/; www.nci.nih.gov/; www.whitehouse.gov/WH/New/html/20000301_1.html

Stage 0 Colon Cancer, Tis

Treatment may be one of the following:

1. Local excision or simple polypectomy to remove all the cancer.
2. Bowel resection.

NCCN: **Tis**: Adenomatous polyp with cancer at polypectomy. No Surgery **Tis** if polyp is superficial and completely removed. Hemicolectomy or laparoscopic surgery per protocol if 1 or more of the following: polyp has deep invasion into stalk or adverse pathologic findings such as high-grade, lymphatic invasion. Adjuvant therapy: none

Stage I Colon Cancer, T1N0M0 (Duke A) and T2, N0, M0 (Dukes B1)

Treatment is usually surgery (bowel resection) to remove the cancer and join the cut ends of the bowel.

NCCN: Surgery: none if **Tis** or **T1** single specimen and villous adenoma or villoglandular adenoma with cancer. Hemicolectomy or laparoscopic surgery per protocol if fragmented specimen is villous adenoma or villoglandular adenoma with cancer, **T2**, or ulcerative/invasive, nonobstructing. Hemicolectomy for obstructing, unprepped bowel. Diverting colostomy with limited resection if possible for unresectable lesion. Adjuvant: none

Stage II Colon Cancer, T3 or 4, N0, M0 (Dukes B2)

NCI-Treatment may be one of the following:

1. Treatment is usually surgery (bowel resection) to remove the cancer.
2. Clinical trials of chemotherapy, radiation therapy, or biological therapy following surgery.
3. If the tumor has spread to nearby tissue, a patient may also receive chemotherapy and/or radiation therapy following surgery.

NCCN Cancer Guidelines: Surgery: Hemicolectomy or laparoscopic surgery per protocol if ulcerative/invasive, nonobstructing. Hemicolectomy for obstructing, unprepped bowel, diverting colostomy with limited resection if possible for unresectable lesion. Adjuvant: none. Clinical trial or 5FU/levamisole or 5FU/leucovorin for \pm radiation or other adjuvant therapy. 5FU/leucovorin for B2 with obstruction or perforation (hole in colon wall), Cancer not completely removed from colon or uncertain about completeness of cancer removal treat with Clinical trial and/or 5FU/levamisole or 5FU/leucovorin for \pm radiation or other adjuvant therapy. 5FU/leucovorin

Stage III Colon Cancer, (T1-3, N1-2, M0 Dukes C1/C2) or T4, N1-2, M0 (Dukes C3)

NCI-Treatment may be one of the following:

1. Treatment is usually surgery (bowel resection) to remove the cancer followed by chemotherapy.
2. Clinical trials of chemotherapy, radiation therapy, and/or biological therapy following surgery.

NCCN Cancer guidelines: Surgery: Hemicolectomy or laparoscopic surgery per protocol if ulcerative/invasive, nonobstructing. Hemicolectomy for obstructing, unprepped bowel. Diverting colostomy with limited resection if possible for unresectable lesion. Adjuvant: Clinical trial or 5FU/leucovorin, or 5FU/leucovorin for Stage III and T4, N0, M0 (Dukes B3) chemotherapy 5FU and leucovorin, or 5-FU and leucovorin \pm radiation.

Stage IV Colon Cancer, T1-4, N1-3, M1 (Dukes D)

NCI-Treatment may be one of the following:

1. Surgery (bowel resection) to remove the cancer or to make the colon go around the cancer so that it can still work.
2. Surgery to remove parts of other organs such as the liver, lungs, and ovaries, where the cancer may have spread.
3. Radiation therapy to relieve symptoms.
4. Chemotherapy to relieve symptoms.
5. Clinical trials of chemotherapy or biological therapy.

continued

NCCN Treatment Guidelines:

- ◆ Liver metastasis: Surgery: hemicolectomy + liver resection ± cryosurgery or hemicolectomy + in 6 wk liver resection ± cryosurgery for resectable 1-4 discrete hepatic metastasis. Hemicolectomy for symptomatic with high liver burden. No treatment is given to asymptomatic with high liver burden. Resectable liver metastasis given adjuvant Chemotherapy with 5fu/leucovorin or HA1, CIV5FU or clinical trial.
Unresectable liver metastasis – Asymptomatic R colon lesion with high liver burden no surgery.
Unresectable liver metastasis – Symptomatic with high liver burden perform only a limited bowel resection
- ◆ Lung metastasis: Surgery: hemicolectomy, then thoractomy for 1-3 lung nodules and chemotherapy with 5fu/leucovorin or HA1, CIV5FU or clinical trial. Hemicolectomy alone with multiple lung metastasis.
- ◆ Abdominal metastasis: Surgery: hemicolectomy if resectable. Unresectable abdominal metastasis, only have a limited bowel resection or diverting colostomy performed.

Rectal Cancer staging see Colon Cancer TNM staging. The following treatment options:

NCCN treatment guidelines:

Rectal cancer 5cm or closer to anal verge:

Stage 0 rectal cancer (Tis, N0, M0); Stage 1 rectal cancer (T1, N0, M0, Stage A: Transanal or posterior local excision or if well differentiated, nonulcerated, endocavitary radiotherapy. No adjuvant therapy.

Stage I rectal cancer (T2, N0, M0), Stage B1, -Low anterior (LA) anterior resection or Abdominal perineal resection (AP resection), with no adjuvant therapy.

Stage II rectal cancer (T3, N0,M0) Stage B2, Stage III rectal cancer T1-3, N1-2, M0, Stage C:

1. LA or AP resection, neoadjuvant prior to surgery 5-Fu N
2. Neoadjuvant therapy after LA or AP resection with 5-FU ± leucovorin, XRT, and additional 5FU + leucovorin.

Rectal cancer 5cm or further from anal verge:

Stage 0 rectal cancer (Tis, N0, M0); Stage 1 rectal cancer (T1, N0, M0), Stage A, Stage I rectal cancer (T2, N0, M0), Stage B1: Anterior Resection and no Adjuvant therapy.

Stage II rectal cancer (T3, N0,M0) Stage B2, Stage III rectal cancer T1-3, N1-2, M0, Stage C

1. Anterior resection followed by 5-FU ± leucovorin x2, XRT + %FU CIV, 5-FU ± leucovorin.
2. Neoadjuvant chemotherapy + radiation followed by LA or AP resection.

T4, Any rectal lesion (T4, N0-2, M0) Stage B3, C: Neoadjuvant chemotherapy + radiation followed by LA or AP resection, Adjuvant: 5-FU/leucovorin.

Metastatic (any T, any N, M1) Stage D

1. All metastases resectable, resect metastases and anterior or AP resection. Adjuvant: Chemotherapy and radiation. *Adjuvant combined Modality therapy for rectal cancer is combining 5-Fu, leucovorin, radiation therapy*
2. If metastases unresectable: anterior or AP resection, Salvage therapy.

Recurrent Colon Cancer

Stage II rectal cancer (T3, N0,M0) Stage B2, Stage III rectal cancer T1-3, N1-2, M0, Stage C

NCI-If the cancer has come back (recurred) in only one part of the body, treatment may consist of an operation to take out the cancer. If the cancer has spread to several parts of the body, a doctor may give a patient either chemotherapy or radiation therapy. The patient may also choose to participate in a clinical trial testing new chemotherapy drugs or biological therapy.

NCCN: Resection of liver metastasis in selected patients (5-year cure rate for resection of solitary or combination metastases exceeds 20%) 2. Resection of isolated pulmonary or ovarian metastases. 3. Palliative radiotherapy and or chemotherapy. 4. Biological therapy protocols. 5 Chemotherapy protocols in phase I and II clinical trials.

COLORECTAL TNM definitions, Primary tumor (T)

AJCC Cancer Staging Manual, Fifth Edition, Chapter 12

Primary Tumor (T)

TX: Primary tumor cannot be assessed

T0: No evidence of primary tumor

Tis: Carcinoma *in situ*: intraepithelial or invasion of the lamina propria* It has not gone beyond the mucosa(inner layer) of the colon or rectum

T1: Tumor invades submucosa (cancer has grown through the mucosa and the next layer, the muscularis mucosae, and extends into the submucosa

T2: Tumor invades muscularis propria (cancer has grown through the mucosa, the muscularis mucosae, the submucosa, and extends into the muscularis propria

T3: Tumor invades through the muscularis propria into the subserosa, or into nonperitonealized pericolic or perirectal tissues(cancer has grown through mucosa, the muscularis mucosae, the submucosa, and completely through the muscularis propria. The tumor has spread to the subserosa but not to any neighboring organs or tissue

T4: Tumor directly invades other organs or structures, and/or perforates visceral peritoneum (cancer has spread completely through the wall of the colon or rectum into nearby tissues or organs visceral peritoneum **

*Note: Tis includes cancer cells confined within the glandular basement membrane (intraepithelial) or lamina Propria (intramucosal) with no extension through the muscularis mucosae into the submucosa.

**Note: Direct invasion in T4 includes invasion of other segments of the colorectum by way of the serosa; for example, invasion of the sigmoid colon by a carcinoma of the cecum.

Regional lymph nodes (N)

Regional Lymph Node Involvement (N)

NX: Regional nodes cannot be assessed

N0: No regional lymph node metastasis

N1: Metastasis in 1 to 3 regional lymph nodes

N2: Metastasis in 4 or more regional lymph nodes

A tumor nodule greater than 3 mm in diameter in the perirectal or pericolic fat without histologic evidence of a residual node in the nodule is classified as regional perirectal or pericolic lymph node metastasis. A tumor nodule 3 mm or less in diameter is classified in the T category as a noncontiguous extension, that is T3.

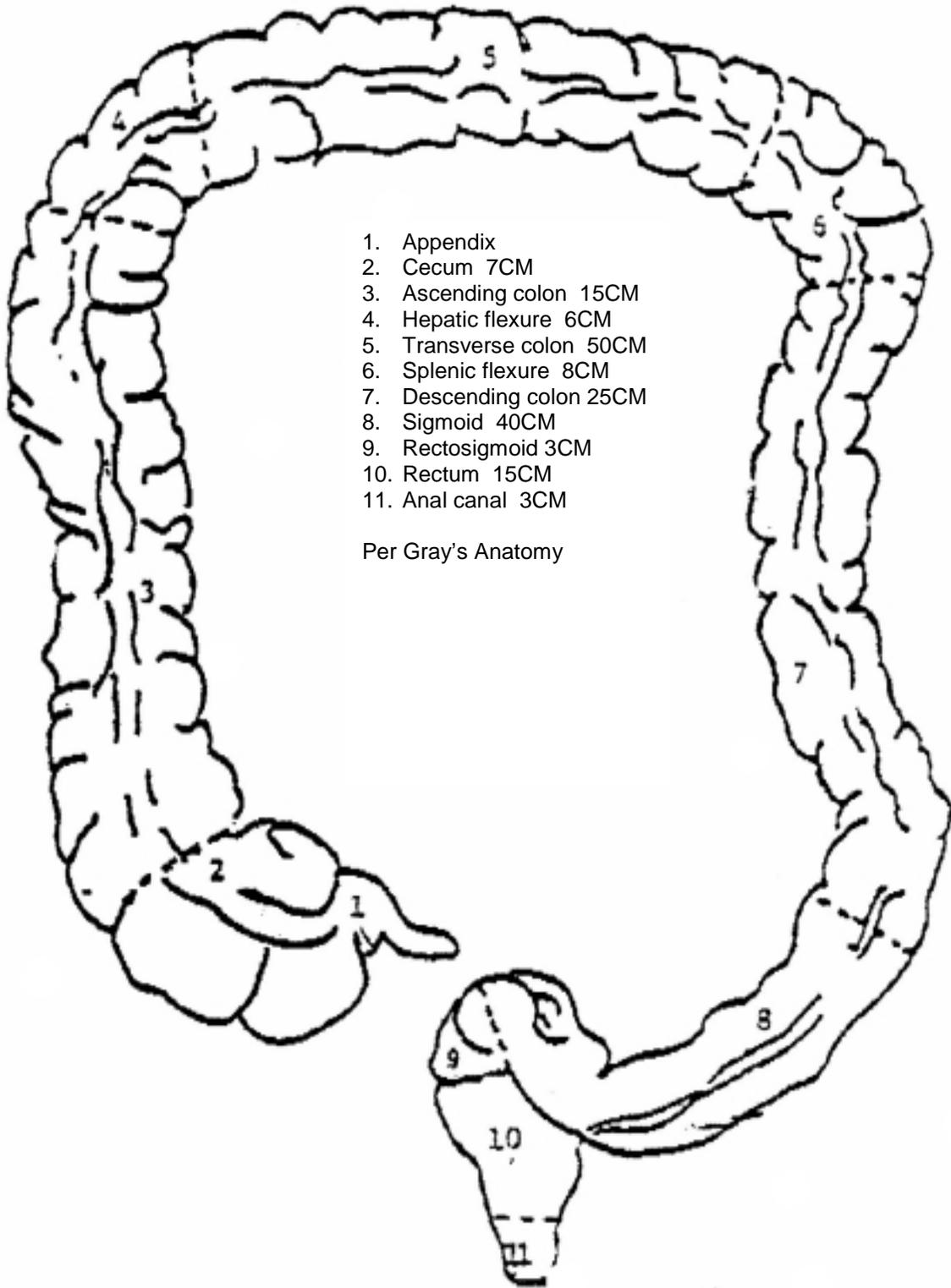
Distant Metastasis (M)

MX: Distant metastasis cannot be assessed

M0: No distant metastasis

M1: Distant metastasis

TNM grouping	AJCC/TNM	Dukes	Astler-Coller
Stage 0: Tis, N0 M0	0	-	-
Stage I: T1,N0M0 T2,N0,M0	I	A	A,B1
Stage II: T3,N0,M0 T4, N0, M0	II	B	B2, B3
Stage III: Any T, N1, M0 Any T, N2, M0	III	C	C1, C2, C3
Stage IV: Any T, Any N, M1	IV	-	D



NAACCR WebPages–Questions & Answers - Summary Staging
www.naacr.org/techhelp/faq.html

Q. What Summary staging scheme should be used for cutaneous lymphoma (9700/3-9708/3)?

A. Use the “Skin, other than Melanoma” scheme.

Q. What Summary stage should be assigned for Paget’s Disease of the nipple with underlying intraductal carcinoma? The AJCC Manual for Staging assigns an in-situ stage, should the Summary stage also be in-situ?

A. Summary stage should be local.

Q. Pathology report reads: Parotid: Carcinoma in-situ, ex pleomorphic adenoma of parotid (malignant mixed tumor). How should summary stage be coded?

A. Ask the pathologist about the carcinoma in-situ. Sarcoma (mixed malignant tumor) cannot be in-situ. In the absence of further information, assign a summary stage of 1, localized.

Q. How should Summary stage be coded for a bladder tumor that spreads rather than invades? The pathology report shows in-situ bladder cancer involving Von Barunn’s nest and a prostatic duct. Urine cytology is positive for transitional carcinoma.

A. Summary stage is coded in-situ. For all staging systems, mucosal spread of in-situ cancer does not change the stage. An in-situ classification is based on invasion, not mucosal spread.

Q. At original submission, a bilateral testicular lymphoma was staged as local. We restaged to regional, NOS. Is this the correct Summary stage?

A. Summary stage guidelines would place this case into Stage IE. Please refer to TMN supplement 1993, page 46 “Involvement of both organs of a paired site is considered as involvement of a single organ.”

Q. A local cancer registry publication had an article that said to code Summary stage as unknown for all cases with non-specific primary sites (those site codes ending in . Is this statement correct?

A. No, .8 indicates that the lesion overlaps two sites or two subsites and many of these lesions can be staged. For example, if a breast lesion is described as 12 o’clock, the site code would be C50.8, but the case can still be staged.

ANNOUNCEMENT

National Cancer Registrar Week April 10-14, 2000

On behalf of the Florida Cancer Data System (FCDS) we would like to take this opportunity to sincerely thank all of the registrars for their participation and support of the Florida’s Statewide Cancer Registry. With your dedication and support has made Florida one of the best registries in the Nation. Congratulations during the National Cancer Registrar Week and salute you in your special week of recognition.

NEW Staff Member

FCDS is pleased to welcome *Reidel Oviedo*, CTR to our staff. Reidel will be working with Lydia Voti, Manager of Quality Control and Joy Houlahan, CTR.

FYI - FCDS plans to revise certain sections of the FCDS Data Acquisition Manual – DAM. This is expected to be completed by the first of the year. We plan to more clearly define the FCDS policies and procedures that effect reporting facilities, update some fields to include new 2000 ROADS codes, and enhance the content wherever we can. If you have any suggestions on the content, format, etc. for the DAM...please call Mayra Alvarez, at 305-243-2603 or write us with details. Thanks

Clarification regarding the reporting of Carcinoma of the Cervix. *In Situ Carcinoma* of the cervix is **not reportable to FCDS**. Invasive carcinoma of the cervix is reportable to FCDS. However, *in situ* of the cervix with **other histology is reportable such as *in situ* adenocarcinoma**. It may be necessary for you to contact your pathologist for clarification when both terms are used on a surgical pathology report.

DISK/CD MAILER

Please make sure when mailing any disk to FCDS that you use an appropriate **disk mailer**, a Batch Transmittal form and a list of the cases you submitted. Disk mailers provide a safe, secure and economical way to mail a floppy disk.

QUALITY CONTROL

1998 AHCA In-Patient Unmatched Cases Report.

FCDS mailed the 1998 AHCA In-Patient Unmatched Cases Report to Florida in-patient facilities early in April. This report lists any 1998 in-patient record with a cancer diagnosis that was not reported by a hospital. FCDS requires that you document the reason that each case not reported to FCDS. If any of these unmatched cases meet the Florida Cancer reporting requirements, the registrar **MUST** abstract them. Abstracting/Submitting these missed cases will be a reporting priority, as they should have been submitted with the 1998 cases.

VITAL STATISTIC RECORDS

FCDS has completed matching Florida deaths from 1998 to the FCDS Masterfile. Death Certificate Notification Forms for cases documented as cancer related hospital deaths, by the Vital Statistics Department, will be mailed to all facilities in early May. The Death Certificate Notification Forms (DCN) are part of each facility's accounting for case completeness and must be returned to FCDS on the abstract form and within the timeframe allotted.

EVERY 50TH RECORD SAMPLING REPORT

The QC staff has been working on reviewing the first quarter of 2000 **Every 50th Record Sampling Report**. This report provides FCDS and you with a visual review of at least every 50th record that FCDS receives from any facility. The report contains all the data downloaded to FCDS by your facility. A copy of the case will be mailed and FCDS will ask that you please review the reports and provide us with feedback on any comments or questions noted on each case report.

EDUCATION

FCDS EDUCATION & TRAINING – FCDS Incidence Training Workshop, May 22-24, 2000

The next FCDS Incidence Training Workshop will be held May 22-24, 2000 in Miami at the Holiday Inn, Coral Gables. This three-day intensive course covers only the basics of cancer reporting for Florida. This additional workshop will be offered in the spring, 2000 to assist in orienting and training new ambulatory patient care facilities so that they can meet the June 30, 2000 reporting deadline.. The cost of this workshop is \$100.00. Please contact Bleu Herard at FCDS for further information at (305) 243-2635.

University of Southern California Cancer Surveillance Program This program is co-sponsored by Southern California Cancer Registrars Association. The objective of the USC Cancer Registrar Training Program, established in 1976, is to prepare individuals to be employed as cancer registrars with the basic skills necessary to initiate and operate a cancer registry as part of a hospital cancer program. The 24-day program is presented each Spring, with classes held two days per week for 12 consecutive weeks. The subject matter is presented in six modules: Introduction to Cancer, Abstracting, Biostatistics & Epidemiology, Follow-Up, Computerization, and Cancer Program Management. Contact: Donna Morrell, CTR, Director. Phone: (323) 442-2334. E-mail: dmorrell@hsc.usc.edu

April 15, 2000 - SEER*Stat Course

The National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) program has developed two Windows-based systems for analyzing cancer registry data for use in cancer surveillance and control. The first, SEER*Stat, allows for the calculation of rates (age-adjusted and crude), trends, frequencies, and survival rates (relative and observed). The second, SEER*Prep, permits a user to format databases containing individual tumor records for use in SEER*Stat.

April 15, 2000 - SEER*Stat Course

Objectives: Course will be taught from a hands-on perspective with each participant working through a series of structured examples on individual PC's. Upon completion, participants should be able to use SEER*Stat to analyze data to address questions pertaining to cancer surveillance and control.

Requirements: Class participants must supply their own laptop computer, which must be a Pentium with at least 21 MB RAM, running Windows 95, 98 or NT, and have either an internal or external CD-ROM drive. Content: SEER*Stat, Set-up and systems requirements, Production of counts and frequencies, Incidence rates Trends, Survival rates. Course organizer: Carol Kosary, MA, National Cancer Institute

Faculty: Faculty will consist of experts from the National Cancer Institute and Information Management Services, Inc. who were involved in the design and development of the system.

Registration: The course fee of \$100 includes course materials and two snacks. This course is a Pre-Conference Workshop of the NAACCR 2000 Annual Conference to be held at the Hilton Riverside in New Orleans. To register, use the conference registration form and payment instructions. Class size is limited. For more information contact June A. Harnacke, NAACCR Office Manager. Email: jharnack@naaccr.org

April 16, 2000 NAACCR Short Course, Central Cancer Registries: Design, Management, and Use

Course objectives and description:

- To provide training in the design and management of central cancer registries and in the use of population-based data
- To increase the knowledge and confidence of personnel already active in central cancer registries
- To prepare other interested professionals with little experience in central cancer registries

This course is offered over two days preceding the NAACCR Annual Meeting to be held at the Hilton Riverside in New Orleans. It follows a format of lectures and discussions, utilizing a textbook compiled for the course.

Course content: Types of registries, Data set planning, Administration of central registries, Computerization, Case finding and abstracting, Death clearance, Quality control and data editing, Follow-up, Calculation and assessment of incidence rates, Calculation and assessment of survival analysis, Research uses of registry data, Use of registry data for cancer prevention and control

Course organizers: Herman R. Menck, MBA, Thomas C. Tucker, MPH, Kentucky Cancer Registry, Jerri Linn Phillips, CTR, National Cancer Data Base, Commission on Cancer. Faculty is drawn from subject experts within NAACCR.

Registration fee of \$275 includes all course materials and two snack per day. To register, use the conference registration form and payment instructions. Class size is limited. For more information contact June A. Harnacke, NAACCR Office Manager. Email: jharnack@naaccr.org

April 18-20, 2000 – North American Association of Central Cancer Registries Annual Meeting

The NAACCR 2000 Annual Meeting will be held in New Orleans, Louisiana at the Hilton Riverside. For more information contact June Harnacke, Office Manager, NAACCR, 2121 West White Oaks Drive, Suite C, Springfield, IL 62704-6495. For reservations call the Hilton Riverside Hotel call directly, (504) 561-0500.

April 16, 2000 - NAACCR -Year 2000 Pop! Advanced Workshop - 8:30 a.m. - 5 p.m.

Training for the change to the Year 2000 population standard -- clear presentations of age-adjustment, their impact on cancer rates, and train-the-trainer approach to handling questions from consumers of cancer data. For more information contact June Harnacke, Office Manager, NAACCR, 2121 West White Oaks Drive, Suite C, Springfield, IL 62704-6495

April 16, 2000 - SEER*Prep Course - 12:30 p.m. - 5 p.m.

The National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) program has developed two Windows-based systems for analyzing cancer registry data. The first, SEER*Stat, allows for the calculation of rates, trends, frequencies, and survival rates. The second, SEER*Prep, is a data preparation tool that permits a user to format databases in SEER250 or NAACCR Analytic format containing individual tumor records for use in SEER*Stat.

Objectives: The course will be taught from a hands-on perspective with each participant working through a series of structured examples on individual PC's. Upon completion, participants should be able to use SEER*Prep to prepare their own registry data and state mortality data for use in SEER*Stat.

Requirements: Class participants must supply their own laptop computer, which must be Pentium with at least 21 MB RAM, running Windows 95, 98 or NT, and have either an internal or external CD-ROM drive. If possible, participants are encouraged to bring a data file from their registry for preparation in the class. Participants will be contacted before the class to ensure the data they provide are formatted correctly and contain an appropriate number of records. Content: SEER*Prep, Preparing and formatting incidence data, SEER 250 format, NAACCR format, Preparing and formatting

mortality data, Using resulting database in SEER*Stat. Course organizer: Carol Kosary, MA, National Cancer Institute. Faculty: Faculty will consist of experts from the National Cancer Institute and Information Management Services, Inc. who were involved in the design and development of the system.

Registration: The course fee of \$50 includes course materials and an afternoon snack. To register, use the NAACCR 2000 Annual Conference Registration Form and payment instructions. This course is a Pre-Conference Workshop to the NAACCR 2000 Annual Conference to be held at the Hilton Riverside in New Orleans. Class size is limited. For more information contact June A. Harnacke, NAACCR Office Manager, Email:jharnack@naaccr.org

May 9-12, 2000 - National Cancer Registrar Association (NCRA) - 26TH ANNUAL EDUCATIONAL CONFERENCE, in Albuquerque, New Mexico. For more information contact NCRA (913) 438-6272 or email NCRA at: ncra-info@applmeapro.com

June 19-21, 2000 - Emory University in Atlanta, Georgia - Advanced Cancer Registry Training Program.

A staff of recognized experts in cancer registration, surveillance, and control teaches this intensive and comprehensive training program. This Advanced Cancer Registry Training Program will focus on abstracting, staging, and coding really difficult; bizarre, rare, and unusual cancer cases; calculating incidence, prevalence, age-adjusted survival, and other rates; using registry data (preparation, analysis, annual reports, etc.); and using the Internet to locate comparable data and useful cancer information and resources. Participants must have attended the Principles Practice training program prior to registering for this advanced training (or have at least one year of experience working in a cancer registry). For complete details search the training program WebSite at cancer.sph.emory.edu or contact Steven Roffers, PA, CTR at (404) 727-4535.

July 24-28, 2000 & December 4-8, 2000 - The National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) program, Principles of Oncology for Cancer Registry Professionals presented by Bolger Center for Leadership Development Potomac, Maryland. Registration fee: \$595.00. Principles of Oncology is a five-day training program in cancer registry operations and procedures emphasizing accurate data collection. The training program includes extensive site-specific, hands-on case abstracting and coding sessions using both full medical records and abstracts that demonstrate the many situations that registrars may face. Faculty includes April Fritz, BA, ART, CTR, Manager of Data Quality at the National Cancer Institute's SEER Program, april.fritz@nih.gov - For more information, contact the National Cancer Institute at (301) 496-8510 or contact April Fritz, ART, CTR, 6130 Executive Blvd, Room EPN343J, Rockville, MD 20852, phone: 301 402-1625, fax: 301 496-9949.

August 14-15, 2000 - The Florida Cancer Data System (FCDS) Annual Conference once again will be held in conjunction with Florida Cancer Registrar Association (FCRA) Annual Conference at the Melbourne Beach Hilton Oceanfront, Melbourne, FL. The Hilton is located just 10 minutes from Melbourne's International Airport at 3003 North Highway A1A, Indialantic, Florida 32903-2133. Tel: (407) 777-5000, Fax: (407) 777-3713. Registration fee is the same as last year, \$25.00. For registration information please contact Betty Fernandez or Bleu Herard at (305) 243-4600.

August 16-18, 2000 - FCRA Annual Conference will be at the Melbourne Beach Hilton, Oceanfront, Melbourne, FL, 3003 North Highway A1A, Indialantic, Florida 32903-2133 Tel: 1/407/777-5000, Fax: 1/407/777-3713. The cost of the conference is \$150 for FCRA Members registering before August 5, 2000 and \$175 for FCRA Members registering after August 5, 2000. Non-members registration is \$175 before August 5, 2000 and \$200 after August 5, 2000. For more information please, contact Lynn McGuill, at (321) 799-7125.

August 14-18, 2000 and November 6-10, 2000, Emory University in Atlanta, Georgia will conduct a training course entitled Principles and Practice of Cancer Registration, Surveillance, and Control. A staff of recognized experts in cancer registration, surveillance, and control teaches this intensive and comprehensive training program. The instructors are internationally recognized as leaders in their fields. Complete details are available on the training program web site at cancer.sph.emory.edu or contact Steven Roffers, PA, CTR at (404) 727-4535.

May 22-25, 2001 - National Cancer Registrar Association -NCRA Annual Conference will be held at the Hilton in the Walt Disney World Village, Orlando, Florida. Carol Johnson, president-elect is now looking for Florida Registrars and Central Registry volunteers to help staff the hospitality & registration booths as well as the cocktail reception. Any suggestions for local speakers, and volunteers are welcomed. Contact Carol Johnson, 301-402-6226, carol.jonson@NIH.gov or contact Edie Kutlus (302) 798-3978, Ekutlus@cppsinc.com, NCRA (913) 438-6272 or email NCRA at: ncra-info@applmeapro.com

DEADLINES

HOSPITALS

OCTOBER 1999 cases are DUE by the end of APRIL 2000

FREESTANDING FACILITIES

**ALL AHCA Unmatched Cancer Records Listings and Abstracting Must be Completed by
JUNE 30, 2000**

REMINDER

FCDS requires that all facilities submit cases at least quarterly.
