# FCDS MONTHLY MEMO
# SEPTEMBER 2000

FCDS would like to thank all those registrars who attended the FCDS annual meeting at Melbourne. Also, thanks to those who completed the meeting evaluation. The evaluation provides a valuable method by which to assess your responses to the topics presented. Overall, one area that FCDS has been stressing is text documentation. For some, this might seem very elementary but for others it is quite useful. Even though some considered the session too elementary, everyone must remember that the text information collected by the registrar needs to support the coding. The FCDS Quality Control procedures follows the North American Association of Cancer Registries (NAACCR), which has set the following guidelines for visual editing that should support your codes with text.

Physical exam:
Record and date any pertinent information related only to the malignancy. Important diagnostic statements are generally located at the end of the physical exam. This may give clues about what diagnostic procedures are planned for the patient, i.e., x-rays, labs, scopes, etc.

X-Rays/Scans/Scopes:
Record and date any pertinent finding with respect to the malignancy, whether it refers to location of the primary site, regional or distant involvement by tumor.

Laboratory Tests:
Record and date any pertinent findings with respect to the malignancy, for example: PSA level for prostate cancer, Blood cell counts for leukemia, etc.

Surgery Reports:
Record the date of surgery, the procedure, primary site, tumor size, metastasis and lymph node involvement, or spread of disease to tissues that were not excised. For example, for a colon cancer you would check in the operative report for any liver metastasis and document the findings whether they are positive or negative for metastasis.

Pathology Report:
Record the date and name of report, source of specimen, primary site, histologic diagnosis including grade, extent of disease, node involvement, tumor markers. (If there is a discrepancy between the surgery report and pathology report, the pathology report takes precedence)

Treatment Information:
Record dates, all methods of therapy recorded in the treatment plan and administered to the patient.

Text documentation should give FCDS the whole picture on all cases no matter what class they are even for those class 3 cases.

**In the FCDS Data Acquisition Manual the following areas require text documentation:**
See Section II-34 and II-35
Enter sufficient text to document and substantiate the coding of each of the following items; Item 27 - Primary Site, Item 33 - Morphology/Histology, Item 34 - Behavior, Item 35 - Grade, Item 36 - Summary Stage at Diagnosis and Item 37 - FCDS Stage at First Contact.

Results from diagnostic tests (x-rays, ultrasound, CT scans, MRI, etc.), laboratory tests, physical examinations, operative reports, surgical pathology reports and any other pertinent information that is documented in the record can be used to document these data items. Both positive and negative cancer findings are equally important in documenting the stage.

Text documentation with regard to first course of therapy or subsequent courses of therapy can also be helpful and may be included here. Documenting therapy can be particularly helpful when the first course of therapy extends beyond 240 days from the date of diagnosis (365 days for breast and prostate cancers).

***NOTE: For cases seen 1/1/2001 and after, CDC/NPCR will require additional text under the fields Physical Exam, Diagnostic Procedures and Surgery bringing the total number of required text fields to 9.***

## *September is Gynecological Cancer Awareness Month*

Gynecologic cancers are the fourth most common cancers among American women today. Cancer of the cervix, ovaries, uterus, vagina, vulva, and fallopian tubes are gynecologic cancers. One in twenty women in the United States will be diagnosed with a gynecologic cancer in her lifetime. Early detection is the key to a greater chance of survival. More treatment options and routine care are the best ways to reduce the risks of gynecologic cancers.

Genetic risks for ovarian cancer can be transmitted through either the mother or father. The most significant risk factor for ovarian cancer is family predisposition. Therefore, women should know their family history so that preventative measures can be taken and so they can educate themselves about gynecologic cancer.

The six warning signs of reproductive cancers that all women should be aware of are: unusual vaginal bleeding or discharge, sores that do not heal, pain or pressure in the pelvic area, persistent change in bowel or bladder habits, frequent indigestion or abdominal bloating and a lump that either causes pain or that is visible to sight and touch. Some gynecologic cancers have no symptoms and can only be detected by a visit to a gynecologist. All women should have an annual appointment for a gynecological exam and Pap test. Having a regular healthcare routine is critical to maintaining good health and for early detection of health problems.

# Gynecologic Cancer Awareness Month Fact

www.wcn.org/publicity/factsheet.rtf; www.hrsa.dhhs.gov/WomensHealth/gyncan.htm; www.wcn.org

***What is gynecologic cancer?***

Gynecologic cancer is the uncontrolled growth and spread of abnormal cells originating in the female reproductive organs, including the cervix, ovaries, uterus, fallopian tubes, vagina and vulva.

***What causes gynecologic cancer?***

Biomedical research has discovered that some genes, called oncogenes and tumor suppressor genes, promote the growth of cancer. You can acquire these genetic mutations during life (e.g. through smoking, aging or environmental influences) or you can inherit these mutations from your parents or grandparents.

***Can gynecologic cancer be prevented?***

Diet, exercise and lifestyle choices play a significant role in the prevention of cancer. Additionally, knowing your family history can increase your chance of early diagnosis and can help you take action towards prevention. Screening and self-examinations, conducted regularly can result in the detection of certain types of gynecologic cancers in their earlier stages.

***Who should treat gynecologic cancer?***

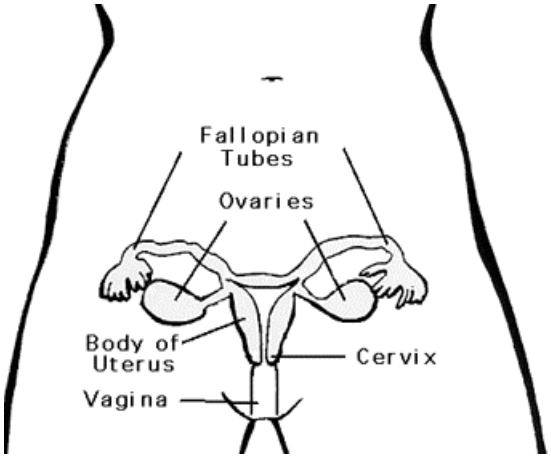
Gynecologic cancers require a cancer specialist. A gynecologic oncologist is a board certified OB/GYN who has taken training which entails an additional 3-4 years specializing in treating gynecologic cancers.

***How is gynecologic cancer treated****?*

Surgery, radiation therapy, chemotherapy and experimental treatments can treat gynecologic cancer.

***Who is at risk?***

Each year approximately 82,000 women in the United States are diagnosed with cancers affecting the reproductive organs.



***Types of gynecologic cancers:***

***Ovarian Cancer -http://www.ovarian.org/***
Ovarian cancer, the most serious of the gynecologic malignancies, usually arises on the surface of the ovary. Although there are very few specific symptoms, the most common ones are a pressure or fullness in the pelvis, abdominal bloating or changes in bowel and bladder patterns that are constant and progressive.

The risk of ovarian cancer increases with age, especially around the time of menopause. A family history of ovarian cancer is one of the most important risk factors. Infertility and not bearing children are also risk factors, whereas pregnancy can decrease the risk of developing ovarian cancer.

Ovarian cancer ranks fifth as a cause of cancer deaths among women, and causes more deaths than any other cancer of the female reproductive system. It is estimated that there will be 25,200 new cases diagnosed and approximately 14,500 deaths from ovarian cancer in the United States during 1999.

There are three main types of ovarian tumors. They are named after the type of cells they start from. The most common type of tumor begins in the cells that cover the surface of the ovary, called the *epithelial* cells. Most epithelial ovarian tumors are harmless, but some are cancerous. Most ovarian cancers are the of epithelial type.

The second kind of tumor starts in the *germ cells* that form the eggs in the ovary. The word *germ* refers to an early or seed cell and most germ cell tumors are also benign, although some are cancerous. Germ cell cancers account for about 5% of ovarian cancers.
The third type of tumor starts from the tissue that holds the ovary together and produces female hormones. These are called *stromal cell tumors.* Stromal tumors are fairly rare, accounting for only about 5% of ovarian cancers.

***Uterine Cancer***
Most uterine cancers begin in the lining of the uterus (endometrium) after menopause, when a woman's menstrual cycle ends and the endometrium flattens out. Those cells in the lining that grow out of control and invade the muscle of the uterus are typically responsible for uterine cancer. e symptoms include signs of any bleeding after menopause, or irregular vaginal bleeding before menopause.

The risk factors include obesity, hypertension, diabetes, inappropriate estrogen use, tamoxifen use and late menopause. Women who have not been pregnant have a slightly higher risk.
Cancer of the endometrium is the most common cancer of the female reproductive organs. It is estimated that 37,400 new cases will be diagnosed and 6,400 women will die from uterine cancer in 1999.

***Cervical Cancer***
Cervical cancer is caused by abnormal cellular changes in the cervix and is the only gynecologic cancer that can be prevented by regular screening. The symptom are bleeding after intercourse,

***Cervical Cancer, continued***
excessive discharge and abnormal bleeding between periods. Risk factors are failure to receive regular examinations which often eliminates the opportunity for early diagnosis by Pap smear screening. Smoking, a high number of sexual partners, HIV, HPV (wart virus) infection and early age of first intercourse are other risk factors.

According to the American Cancer Society, 12,800 new cases of cervical cancer will be diagnosed, and approximately 4,600 American women will die of the disease in 2000.
According to the National Cancer Institute, cervical cancer is tied with colon cancer as the second-leading cause of cancer deaths among women worldwide (breast cancer is first).
However, between 1955 and 1992, the number of cervical cancer deaths in the United States declined by 74% due to the increased use of the Pap test, a screening procedure that permits diagnosis of pre-cancerous changes in the cervix.

***Vulvar Cancer***
Vulvar cancer appears as lesions on the surface of the vulvar or labia. The symptoms are itching in the vulvar area. Risk factors include diabetes, advanced age (70's, 80's and 90's) and chronic vulvar irritation. This is a very curable type of cancer, usually with surgical removal of the vulvar lesions and the groin lymph nodes.

***Vaginal Cancer***
Vaginal cancers are very rare. They are usually diagnosed in elderly women with abnormal bleeding and are treated with radiation.

***Cancer of the Fallopian Tubes***
The fallopian tubes will rarely develop cancer. Treatments and risk factors for fallopian tube cancer are similar to ovarian cancer.

## GYNECOLOGICAL QUESTIONS & ANSWERS

**Q.** Cervical cancer primary, Clinically stage T3b/Figo 3b by the radiation oncology and gynecologic-oncology physicians, but a CT pelvis diagnosis reporting clinically positive regional pelvic nodes. This pt was treated with XRT with no surgical resection. Is the clinical stage T3b N1 or Nx or N0? Can that CT info information be used for staging?
**A.** ROADS: If the pelvic CT Scan was done to establish stage and/or determine treatment, it may be used to clinically stage lymph nodes. If it was done after the original stage was assigned, it may not be used.

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**Q.** Ovary tumor ruptured intra-operatively. Since the tumor ruptured is the patient free of disease postoperatively or with residual disease postoperatively?
**A**. ROADS: The rupture of an ovarian tumor is not the basis to determine if there is residual disease. The surgeon should include in the operative report if there is residual disease, or that all gross residual disease has been removed.

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**Q**. Coding of "endometrioid carcinoma" of the endometrium: The pathologists here insist that this is a valid histology, even though the ICD-0 coding rules state that this histology can only apply the ovary. What histology code should I use for "endometrioid carcinoma" of the endometrium?

**GYNECOLOGICAL QUESTIONS & ANSWERS, continued**

**A**. ROADS: The ICD-O-2 attaches the T code for ovary to endometroid adenocarcinoma because most endometrioid adenocarcinoma arises in the ovaries. Endometroid adenocarcinoma can also arise in the endometrium. Following the rules in the ICDO 2, endometrioid adenocarcinoma would be sited to ovary if the site of origin was not clear. You can use the code 8380/3. Previously, this was an edit with the state cancer registry. If it comes up as an edit, ask your state cancer registry representative to contact April Fritz at SEER

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**Q**. Bilateral Salpingoophorectomy (BSO) along with excision of the pelvic mass was done. Pathology read as an abdominal mass resection with malignant mesodermal mixed tumor, heterologous, spindle cell Carcinoma & chondrosarcoma (carcinosarcoma), 14.0 cm. Liver biopsy: negative for tumor. R Ovary w/ fallopian tube: Microscopic foci of CA on the surface of ovary, fallopian tube WNL. Omentum section: Mets CA. Appendix: negative for malignant. Left Ovary w/ fallopian tube: negative for malignant L Pelvic LNs: 3 pelvic nodes negative for tumor. Sigmoid epiploic fat: Positive for mets CA. R Pelvic LNs: 4 nodes negative for malignant. Comment: This is a highly malignant mixed tumor showing epithelial and sarcomatous element. These tumors usually arise in the uteri of elderly women. This pt has a history of uterine removal in the late 1960's. The tumor is thought to be of mullerian origin and could arise from any mullerian ducts or surface including old endometriosis. The attending MD & consulting oncologist call this carcinosarcoma of mullerian epithelium. In the ICD-O mullerian mixed tumor shows uterus as the primary site. Can one code a primary site that has been previously removed? If not, what will be the primary site? The histology doesn't fit under uterine nor soft tissue sarcoma so will I be able to stage this right? What is the correct histology?

**A**. ROADS: This should be coded to 8980/3 Carcinosarcoma. You can code the site to Peritoneum, NOS. This case was discussed with April Fritz, CTR from NCI/SEER.

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**Q**. When coding "endometroid/endometrioid" adenocarcinoma, that the primary site is always ovary. It even gives us the ovary site designation in our ICD-0 book next to the diagnosis term. Our pathologists at this institution also use the endometrioid adenocarcinoma for the endometrium. The Chairman of our Pathology Dept. uses the AFIP classification for carcinomas of the endometrium.

**A**. ROADS: Endometrioid Adenocarcinoma frequently arises in the endometrium. SEER has changed their edit to allow this.

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**Q**. I have an adenosarcoma of the endometrium with focal sarcomatous overgrowth. Lesion confined within the inner 1/3 of the myometrium. Would you code this to soft tissue or to the endometrium?

**A**. ROADS: The site code would be C54.2 - myometrium

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**Q**. A person is diagnosed with CIS of the cervix after we were no longer required to collect CIS cases refuses further treatment and follow-up and eventually is diagnosed with infiltrative Squamous Cell Carcinoma (SCC). What is the diagnosis date? Do we backdate to the date the CIS was diagnosed or is the diagnosis date the date the invasive SCC was diagnosed?

**A**. ROADS: The date of diagnosis for this case is the date they were diagnosed with invasive SCCA. Since Carcinoma insitu (CIS) of Cervix is not reportable, this case does not become reportable until it becomes invasive.

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**GYNECOLOGICAL QUESTIONS & ANSWERS, continued**

**Q**. It is stated that "carcinoma-in-situ of the cervix" is not reportable. This is a bit ambiguous. Does this include squamous cell carcinoma in situ as well as adenocarcinoma in situ of the cervix?

**A**. ROADS: Yes. This covers all carcinomas in situ of the cervix.

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**Q**. Should the histology code for microinvasive Squamous Cell Carcinoma be used only for cervix, or can it be used for any GYN site?

**A**. ROADS: If Squamous Cell Carcinoma is microinvasive or invasive, it is reportable no matter what the site.

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**Q**. Are all cervical in situ cancers non-reportable regardless of histology? Should a case with a primary site of cervix and histology of 8560\2 be reported?

**A**. ROADS: All cases of Carcinoma in-situ of cervix are non-reportable

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**Q**. Can you use histology code 80762 for all GYN sites, or only the cervix?

**A**. ROADS: The topography code assigned to the morphologic terms should be used when the topographic site is not given in the diagnosis. See Rule 8. ICD-0, P. xxx.

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**Q**. What is the histology code for adenoid basal carcinoma of the cervix?

**A**. ROADS: Adenoid basal cell carcinoma will have a new code 8098/3 in ICD-O-3. For now, code to basal cell carcinoma, NOS, 8090/3. This would be a reportable case.

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**Q**. If the path report states that the sarcoma arose from the uterus is this stageable at all?

**A**. ROADS: You can stage a sarcoma of the uterus with Summary Stage but not with AJCC TNM Staging.

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**NAACCR WebSite EDUCATION &TRAINING WebSite links**
**www.naaccr.org/Training/Guidelines.html**

**Confidentiality Issues**

- Confidentiality Policy Statement
- Anatomy of a Rumor
- Challenges to Data Confidentiality: From Rumor to Court Order
- Confidentiality and the Cancer Registry
- Massachusetts Confidential
- Recent Data Privacy Legislation in Minnesota

**Guidelines**

♦ Team Building to Enhance Data Quality (PDF)

**Health Level 7 (HL7)**

- Adopting the HL7 Standard for Cancer Registry Work by T Tucker, H Howe, B Kohler and JP Fulton

**Cancer Registry Management Report**

- Report

**Timeliness of Cancer Reporting: Assessment and Improvement**

- Part 1 of 3
- Part 2 of 3
- Part 3 of 3

**EDUCATION, continued**

**University of Southern California Cancer Surveillance Program** Co-sponsored by Southern California Cancer Registrars Association a Cancer Registrar Training Program 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 at (323) 442-2334. E-mail: dmorrell@hsc.usc.edu

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**September 18-22, 2000 –** The Commission on Cancer will conduct a Basic Cancer Registry Data Collection workshop at the Headquarters of the American College of Surgeons, 633 N. Saint Clair Street, 28th Floor, Chicago, Illinois, 60611, (312) 202-5085. Registration Fee is $400 that includes the course materials only. If you have any questions about the class, please contact Pat Tary at 312/202-5410 or ptary@facs.org

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**September 19, 2000**, The Jackson Memorial Hospital in Miami, FL at the Town Hall Meeting will address Colorectal Cancer Awareness and prevention from 11am to 2pm. For more information please, contact Maribel Fuentes at (305) 585-5074 or (305) 585-6142; email at mfuentes@med.miami.edu

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**September 25 – 26, 2000**, NAACCR 2000 - E-Toolkit Workshop being held at the Double Tree Hotel Seattle, Washington at 205 Strander Blvd, Seattle, WA 98188. 1-800-222-8733. Topics will focus on how to run EDITS, writing your own edits and encrypting your registry data for submission, how to use new epidemiological transmission tools, a special round table on death clearance, duplicate protocols, and registry certification process, procedures for the Call-for-Data 2001 will be outlined as well. For more information contact: Joellyn Hotes (217) 698-0800 Ext. 3. WebSite: www.naaccr.org/News/index.html

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**October 13, 2000,** The Jackson Memorial Hospital (JMH) in Miami, FL will sponsor an Oncology Workshop. Location JMH, Diagnostic Treatment Center from 7:30 a.m.-1:00p.m. For more information contact: Lisette Acosta (305)(305)585-6533. *CEU's applied for*

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**October 25-27, 2000, Miami, FL -** FCDS Incidence Abstracting Workshop. The cost is $100. Please contact Betty Fernandez or Bleu Herrard at (305) 243-4600 for information and registration

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**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.friz|@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.

**February 5-6, 2001**, The Florida Cancer Registrars Association will be having a CTR Exam Review Workshop at the at Mayo Clinic Jacksonville, FL. The cost is $100. Please contact FCRA Education Chairman for more information and registration, Mary O'Leary, RHIT, CTR at (305) 243-4961, Fax: (305) 243-5239 or e-mail: moleary@med.miami.edu

**May 22-25**, **2001** - National Cancer Registrars Association -NCRA Annual Conference will be held at the Hilton in the Walt Disney World Village, Orlando, Florida. Carol Johnson, president-elect is 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.johnson@NIH.gov or contact Edie Kutlus (302) 798-3978, email at Ekutlus@cppsinc.com. NCRA (913) 438-6272 or email NCRA at: ncra-info@goamp.com. WebSite: www.ncra-usa.org.

# DEADLINES

## HOSPITALS

**ALL 1999 cases were DUE June 30, 2000**

**Hospitals should now be reporting March 2000 cases.**

**ALL 1998 Death Certificate Notification (DCN) cases were due July 15, 2000**

## AMBULATORY CANCER CARE REPORTING PROGRAM (AARCP)

**ALL 1997 & 1998 Cases were DUE June 30, 2000**
**(this includes all AHCA Unmatched Cancer Records Listings and Abstracting)**