FCDS MONTHLY MEMO

OCTOBER 2000

The SEER Summary Staging Manual 2000 (SSSM2K) is currently in the final stages of being edited and published. – Steven Roffers, PA, CTR, Co-Editor, SEER Summary Staging Manual 2000

Current plans are to have a PDF ("Portable Document Format") file of the SSSM2K available on the SEER WebSite on November 1, 2000. The published hard-copy version of SSSM2K, complete with anatomical drawing and illustrations, will be available by March 1, 2001.

Printed copies of the SSSM2K will be free of charge and available from SEER in the usual manner.

The Uniform Data Standards (UDS) committee of NAACCR has approved the use of SSSM2K **starting with January 1, 2001** diagnosis and forward. The NAACCR Record Layout version 9 is ready to accommodate the SSSM2K code. The codes will be stored in a separate location than the SEER Summary Stage 1977 (SSG77 - old SEER Summary Stage) codes.

A major change from the Summary Staging Guide 1977 (SSG77) to the SEER Summary Staging Manual 2000 is the change in the "time rule" from the "two month rule" used in conjunction with SSG77 to the below "time rule" in SSSM2K. *(NOTE: The NAACCR Record Layout version 9 contains an erroneous definition of the "time rule" for SSSM2K.)*

The CORRECT "time rule" for SSSM2K is as follows:

> *Summary stage should include all information available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer.*

The following is a list of changes and noteworthy items regarding the new **SEER Summary Staging Manual 2000** (SSSM2K):

1. EVERY anatomic site now has a staging scheme;

2. It's now a MANUAL with rules, definitions, and standardized codes;

3. The colon subsite schemes in SSG77 are now lumped into one colon scheme in SSSM2K;

4. Pleural effusion is now specifically stated under Distant for lung;

5. For the lymphomas, the code choices are 1 for Stage I, 5 for Stage II and 7 for Stage III and Stage IV. The use of code 5 for Stage II lymphomas alleviates the confusion of using code 2 (Reg DE), code 3 (Reg LN), or code 4 (Reg DE and LN)

6. For breast cases, some cases will shift from Localized to Regional Direct Extension

In SSG77, a note reads as follows:

Skin changes such as dimpling, tethering, attachment, fixation, induration and thickening or Paget's disease of the nipple do not alter the classification.

Due to the fact that dimpling, tethering and nipple retraction are caused by tension on Cooper's ligament(s), and not by actual skin involvement, the new note in SSSM2K reads as follows:

Adherence, attachment, fixation, induration, and thickening are clinical evidence of extension to skin or subcutaneous tissue and are to be coded Regional Direct Extension.

7. There are marks denoting those things that are now different than the Historical Stage (#) and those things that are now different from the SSG77 (*)

Two examples illustrate this:

Mandible is marked with a # notation in the soft palate (C05.1) scheme because extension to the mandible is now staged "Distant" in SSSM2K, whereas it was considered regional in the Historical Stage.

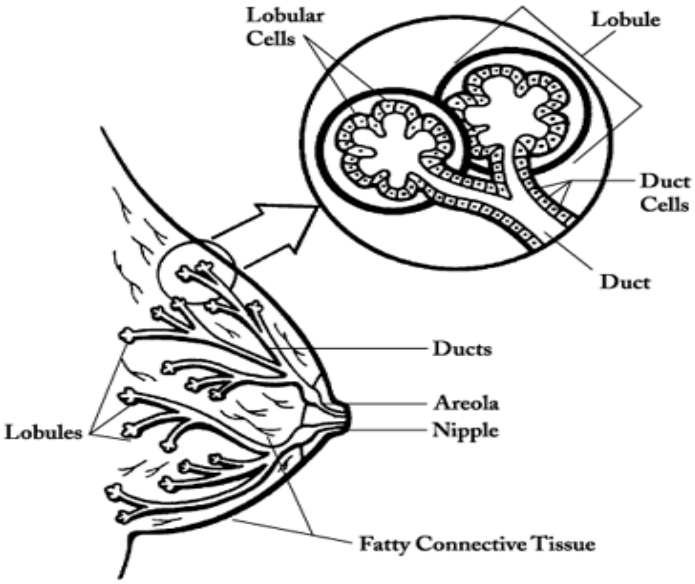
Diaphragm is marked with a * notation in the lung (C34.9) scheme because extension to the diaphragm is now staged "Regional by Direct Extension" in SSSM2K, whereas it was considered "Distant" in the SSG77.

BREAST CANCER AWARNESS MONTH

In 1993, President Clinton proclaimed October as the National Breast Cancer Awareness month.

What Is Breast Cancer?
Breast cancer begins in the breast tissue. Women are more likely than men to get breast cancer, but men can also get breast cancer, although this is rare.

The inside structure of the breast is glands that produce and release milk after a woman



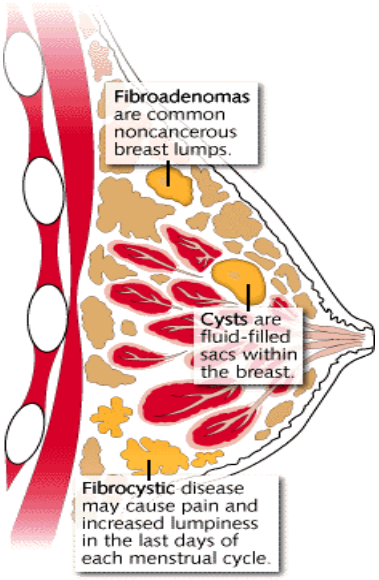
has a baby. The glands that make the milk are called *lobules* and the tubes that connect them to the nipple are called *ducts.* What makes the breast itself is lobules, ducts, and fatty, connective, and lymphatic tissue.

Lymph is a clear fluid that contains immune system cells. The fluid is carried in lymph vessels that lead to small, pea-sized collections of tissue called lymph nodes. Most lymphatic vessels of the breast lead to lymph nodes under the arm known as the *axillary nodes.*

If breast cancer cells reach the underarm lymph nodes, they can continue to grow, causing the nodes to swell. When cancer cells have reached these nodes, they are more likely to spread to other organs of the body as well.

HISTOLOGIC TYPES OF BREAST TUMORS

There are several types of breast tumors. Most are benign; that is, they are not cancer. These lumps are often caused by fibrocystic changes. Cysts are fluid-filled sacs, and *fibrosis* refers to the forming of connective tissue or scar tissue. Fibrocystic changes can cause breast swelling and pain. The breasts may feel lumpy and sometimes there is a clear or slightly cloudy nipple discharge. Benign breast tumors are abnormal growths, but they do not spread outside of the breast and they are not life threatening. For more



information, refer to the American Cancer Society document "Benign Breast Conditions." Breast cancer, on the other hand, involves malignant tumors. Some terms that describe the most common types of breast cancer are **Ductal carcinoma in situ** (DCIS): This is breast cancer at its earliest stage (stage 0). DCIS is confined to the ducts and nearly 100% of women with cancer at this stage are curable. Early detection with a mammogram is the best way to find DCIS.

Infiltrating (invasive) **ductal carcinoma** (IDC) starts in a milk passage or duct, breaks through the wall of the duct, and invades the fatty tissue of the breast. From there it can spread to other parts of the body. Infiltrating Ductal Carcinoma is the most common type of breast cancer that accounts for nearly 80% of breast cancer.

Lobular carcinoma in situ (LCIS): A tumor that hasn't spread beyond the area where it began is called *in situ*. Although not a true cancer, LCIS increases a woman's risk of developing cancer later. For this reason, it's important for women with LCIS to have a physical exam two or three times a year, as well as a mammogram every year.
Infiltrating (invasive) **lobular carcinoma** (ILC): This cancer starts in the milk glands (lobules). It can spread to other parts of the body. Between 10% and 15% of breast cancers are of this type.

Note: there are several other less common types of breast cancer. If you have one of these, you can get more information from the American Cancer Society.

Diagnosing Breast Cancer

A biopsy is done first, followed by a decision concerning treatment. The biopsy can be done in the doctor's office, outpatient basis in the hospital, or freestanding centers.

The tissue removed during the biopsy is examined in the pathology laboratory to determine whether the cancer is invasive or not, what is the histologic type of cancer, and grade. The grade helps predict the outcome (prognosis) for the woman because cancers that closely resemble normal breast tissue tend to grow and spread more slowly. In general, a lower grade number means a slower-growing cancer, while a higher number means a faster-growing cancer.

The biopsy sample can also be tested to see whether it has receptors for certain hormones such as estrogen (ER) and progesterone (PR). If it does, it is often referred to as ER-positive or PR-positive. Such cancers with ER & PR positive tend to have a better outlook than cancers without these receptors and are much more likely to respond to hormonal therapy. There are several other tests used to help predict how fast the cancer is growing.

Stage Information

Once breast cancer is 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 breast cancer, a surgical procedure will need to be preformed. Knowing the stage of the disease will assist the doctor in effectively planning further treatment. Stages should preferably defined by the AJCC, American Joint Committee on Cancer AJCC system also called the TNM system. The following stages are used for Breast Cancer:

Stage 0 (Non-invasive or carcinoma in-situ)
The cancer is confined to the ducts of the breast and it is detected very early.

Stage I (Localized)
The cancer has not spread beyond the breast. The tumor size is smaller than 2 centimeters in diameter (three fourths of an inch or less).

Stage II (Localized or Regional nodal involvement)
The cancer measures larger than 2 centimeters in diameter and/or has spread to lymph nodes under the arm on the same side as the breast cancer. Lymph nodes have not yet adhered to one another or to the surrounding tissues.

Stage III A or IIIB (Localized or Regional direct extension with nodal involvement)
Stage IIIA:
The cancer measures larger than 5 centimeters (over 2 inches) in diameter and/or has spread to lymph nodes that adhere to one another or surrounding tissue.
Stage IIIB:
Breast cancers of any size that have spread to the skin, chest wall, or internal mammary lymph nodes (located beneath the breast and inside the chest).

Stage IV (Distant)
The cancer, regardless of its size, has spread (metastasized) to distant sites such as bones or lungs, or to lymph nodes not near the breast.

Recurrent
Recurrent disease means that the cancer has come back (recurred) after it has been treated. It may come back in the skin of the breast or in another part of the body. Recurrent cancer of the breast is often found in the skin, bone, lung, and brain.

BREAST TNM definitions, Primary tumor (T)

AJCC Cancer Staging Manual, Fifth Edition, Chapter

Primary Tumor (T)

TX: Primary tumor cannot be assessed
T0: No evidence of primary tumor
Tis: Carcinoma *insitu*: Intraductal carcinoma, lobular carcinoma *in situ*, or Paget's disease of the nipple with no tumor
T1 Tumor 2cm or less in greatest dimension
T1mic Microinvasion 0.1cm or less in greatest dimension
T1a Tumor more than 0.1cm but not more than 0.5cm in greatest dimension
T1b More than 0.5cm but not more than 1cm in greatest dimension
T1c More than 1cm but not more than 2cm in greatest dimension
T2 Tumor more than 2cm but not more than 5cm in greatest dimension
T3 Tumor more than 5cm in greatest dimension
T4 Tumor of any size with direct extension to (a) chest wall or (b) skin, only as described below
T4a Extension to chest wall
T4b Edema (including peau d'orange) or ulceration of the skin of the breast or satellite skin nodules confined to the same breast
T4c Both (T4a and T4b)
T4d Inflammatory carcinoma

Note: Paget's disease associated with a tumor is classified according to the size of the tumor.

Regional Lymph nodes (N)

NX Regional lymph nodes cannot be assessed (e.g., previously removed)
N0 No regional lymph nodes metastasis
N1 Metastasis to movable ipsilateral axillary lymph node(s)
N2 Metastasis to ipsilateral axillary lymph node(s) fixed to one another or to other structures
N3 Metastasis to ipsilateral internal mammary lymph node(s)

Distant Metastasis (M)

MX Distant Metastasis cannot be assessed
MO No distant metastasis
M1 Distant metastasis (include metastasis to ipsilateral supraclavicular lymph node(s)

Staging Grouping

Stage 0	Tis	N0	M0
Stage 1	T1*	N0	M0
Stage IIA	T0	N1	M0
	T1*	N1**	M0
	T2	N0	M0
Stage IIB	T2	N1	M0
	T3	N0	M0
Stage IIIA	T0	N2	M0
	T1*	N2	M0
	T2	N2	M0
	T3	N1	M0
	T3	N2	M0
Stage IIIB	T4	Any N	M0
	Any T	N3	M0
Stage IV	Any T	Any N	M1

***Note: T1 includes T1mic**

****Note: The prognosis of patients with N1a is similar to that of patients with pN0**

Treatment Option Overview
There are treatments for all patients with breast cancer. 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)
- bonemarrow transplant

Surgery is the most common treatment of all stages of cancer of the breast. A doctor may take out the breast cancer using the following: **Breast-conserving surgery** (BCS) -- Removing the cancerous lump in the breast and some of the surrounding tissue. The surgery is usually followed by radiation therapy.

Lumpectomy: Removal of only the breast lump and a rim of normal tissue. Lumpectomy is almost always followed by about six weeks of radiation therapy.

Partial mastectomy: Removal of up to one-quarter or more of the breast. Six to seven weeks of external beam radiation therapy is usually given following this surgery. For most women with breast cancer, lumpectomy or partial mastectomy is as effective as mastectomy. There is no difference in survival rates of women treated with these two approaches. Other factors, though, can affect which type of surgery is best for a woman.

Simple or total mastectomy: In this surgery the entire breast is removed but not the lymph nodes from under the arm nor muscle tissue from beneath the breast.

Modified radical mastectomy: Removal of the entire breast and some of the lymph nodes under the arm.

Radical mastectomy: Extensive removal of entire breast, lymph nodes, and the chest wall muscles under the breast. This surgery is rarely done now because modified radical mastectomy has proven to be just as effective with less disfigurement and fewer side effects.

Axillary Dissection: Removal of underarm (axillary) lymph nodes to find out whether the cancer has spread to these nodes. Knowing whether there are cancer cells in the lymph nodes can help guide other treatment decisions.

Sentinel lymph node biopsy: A radioactive substance or a dye is injected into the region of the tumor and the substance is carried by the lymph system to the first (sentinel) node. This node is the one most likely to contain cancer cells if the cancer has spread. If the sentinel node contains cancer, probably more lymph nodes will be removed. If the sentinel node is free of cancer, further lymph node surgery might not be needed.

Radiation therapy Using x-rays or other high-energy rays to kill cancer cells and shrink tumors. This is usually given following surgery to control any remaining tumor and to reduce the chance of recurrence. There are several ways radiation is given but for breast cancer the most common is a machine outside the body (external radiation therapy). Depending on the stage of the breast cancer radiation can be used alone or in addition to surgery and/or chemotherapy.

Chemotherapy is called a systemic treatment because the drugs enter the bloodstream, travel through the body and kill cancer cells. Chemotherapy may be given in a form of a pill, or it may be administered 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. Patient's that have liver metastasis may be given chemotherapy directly into the artery going to the liver. During surgery 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 behind. Adjuvant chemotherapy therapy is given after an operation to a person who has no cancer cells that can be seen.
Chemotherapy is given in cycles, with each period of treatment followed by a recovery period. The total course lasts three to six months. It is often more effective to use combination drugs rather than a single drug alone. The most commonly used combinations are:

- cyclophosphamide, methotrexate, and fluorouracil (CMF)
- cyclophosphamide, doxorubicin (Adriamycin), and fluorouracil (CAF)
- doxorubicin (Adriamycin) and cyclophosphamide (AC), with or without paclitaxel (Taxol)
- doxorubicin (Adriamycin), followed by CMF

Hormone therapy -- Using drugs that change the way hormones work or removing the organs that produce hormones, such as the ovaries. Chemotherapy and hormone therapy can be used together to reduce symptoms if the cancer has spread.

Immunotherapy or Biological response modified (BRM) is another form of treatment that tries to get the body to fight cancer and it uses materials made by the body or made in a laboratory to boost, direct, or restore the body's natural defenses against disease. Trastuzumab (Herceptin) is a drug that attaches to a growth-promoting protein known as HER2/nue, which is present in small amounts on the surface of normal breast cells and most breast cancers. Some breast cancers have too much of this protein which can cause the cancer to grow and spread faster. Herceptin can stop the HER2/nue protein from causing breast cancer cell growth and it may also help the immune system to better attack the cancer.
Herceptin is generally started after standard hormonal or chemotherapy is no longer working, but studies are going on now to see if it should be added to the first course of chemotherapy. The side effects of this drug are fairly mild; they may include fever and chills, weakness, nausea, vomiting, cough, diarrhea, and headache.

Autologous Bone Marrow Transplantation or Peripheral Blood Stem Cell Transplantation

While it is possible to use very high doses of chemotherapy or radiation to kill cancer cells, such treatments also kill blood-producing stem cells in the patient's bone marrow. Damage to bone marrow stem cells lowers the white blood cell count, which makes the patient more likely to get serious, even fatal, infections. Bone marrow transplantation (BMT) or peripheral blood stem cell (PBSC) transplantation can be used to restore the patient's blood-producing stem cells to a healthy level after high-dose chemotherapy.
In these procedures, some of the patient's stem cells are removed before the chemotherapy begins. Stem cells can be taken from either the circulating (peripheral) blood or from the bone marrow. They are returned to the patient after chemotherapy. The stem cells soon re-establish themselves and restore the body's ability to produce blood cells.

Peripheral blood stem cell transplantation offers some advantages over bone marrow transplantation because PBSC can be used even when cancer cells have spread to the bone marrow. In most cases, the stem cells can be collected in an outpatient setting and the patient will not need general anesthesia.
Bone marrow or peripheral blood stem cell transplantation may be used as adjuvant therapy in some women with a high risk of recurrence, or for treatment of advanced disease. The effectiveness of this treatment is still being studied. At this time these procedures are best done as part of a clinical trial.

Clinical Trials
Clinical trials are studies promising new treatments that are done only when there is some reason to believe that the new treatment may be of value to the patient. Treatments used in clinical trials are often found to have real benefits. Anyone interested in clinical trials can get a current list by calling the National Cancer Institute (NCI) at 1-800-4-CANCER or visiting the NCI clinical trials web site for patients at cancertrials.nci.nih.gov.

The National Comprehensive Cancer Network (NCCN) makes neither representation nor warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in anyway. The guidelines set by NCCN are statement of consensus of its authors regarding their views of currently accepted approaches to treatment. Any clinician wanting to apply or consult using these guidelines is expected to use independent medical judgement in the context of individual clinical circumstances to determine any patient's care or treatment.

TREATMENT BY STAGE
Stage 0, Breast Cancer, Tis
NCCN:
Stage 0- LCIS –
Observation is preferred treatment but in special circumstances bilateral mastectomies are performed with or without reconstruction
TREATMENT BY STAGE
Stage 0, Breast Cancer, Tis; NCCN, continued
Tamoxifen should be considered at-least 5 five years for prevention. Follow-up with a physical examination every 6 six months for 5 five years, then have yearly checkup XM. Yearly mammography (XM) is recommended.
Stage 0- DCIS – Tis N0 M0

- DCIS that is widespread (present in two or more quadrants perform a Total Mastectomy without nodal dissection with or without breast reconstruction.
- DCIS is more limited (present in only one quadrant) and margins are negative (that is, no cancer is found at the edges of the initial surgical excision) either a total mastectomy without lymph node dissection or excision plus radiation therapy is recommended.
- DCIS with only one quadrant involvement, small (<0.5cm), unicentric, low grade, negative margins should have a Lumpectomy with radiation or Total Mastectomy without nodal dissection with or without breast reconstruction; Lumpectomy alone with post-excision & post XM documented as a complete tumor excision.

Tamoxifen should be considered for LCIS or DCIS for (5) five years for prevention. Follow-up with a physical examination every (6) six months for (5) five years, then have yearly mammography is recommended.

Stage I Breast Cancer: T1N0M0; Stage II A Breast Cancer, T0N1M0, T1*N1M0, T2N0M0; Stage IIB Breast Cancer: T2N1M0, T3N0M0**

*Note T1 includes T1mic

**Note: The prognosis of patients with N1a is similar to that of patients with pN0

NCCN Recommendation for treatment:

Work-up that includes laboratory test of (complete blood & platelet count, and a liver function test), CXR, mammography of both breasts, ultrasound as necessary; ER-estrogen/PR-progesterone-receptor tests to check whether the tumor is hormone-driven, and to what extent; a HER2/*neu* test to help predict the response to certain drugs; an S-phase or other test of the biopsy to determine the tumor's rate of growth; and a bone scan, if warranted with localized symptoms or elevated alkaline phosphatase.

- Lumpectomy plus axillary node dissection or sentinal node dissection with radiation therapy, or lumpectomy without radiation.
- If the nodes are clear, or negative, and the tumor measures half a centimeter or smaller, the patient needs no adjuvant (post-surgery) chemotherapy
- Tubular, Colloid, Medullary, or Adenoid cystic types of tumors that measure smaller than 1 centimeter need no additional treatment. But if such a tumor measures 1 to 2.9 centimeters in diameter, the guidelines recommend that patients is post-surgery chemotherapy; and if this type of tumor has grown to 3 centimeters or larger, then the guidelines recommend adjuvant chemotherapy.

Stage I Breast Cancer: T1*N0M0; Stage II A Breast Cancer: T0N1M0, T1*N1M0, T2N0M0; Stage IIB Breast Cancer: T2N1M0, T3N0M0**

*Note T1 includes T1mic

**Note: The prognosis of patients with N1a is similar to that of patients with pN0

NCCN Recommendation for treatment:

- Node-negative patients with invasive ductal or invasive lobular cancers, when the tumor is 0.6 to 1 centimeter without such unfavorable features as high-grade angiolymphyatic invasion or high S-phase (or elevated results of other tests of how fast the tumor cells are dividing), then no adjuvant chemotherapy is needed. But if the tumor measures 0.6 to 1 centimeter with one or more unfavorable features, the patient, in consultation with her physician, should consider adjuvant chemotherapy or hormonal.
- If the tumor has grown larger than 1 centimeter and hormone-receptor tests are negative, the guidelines counsel adjuvant chemotherapy. On the other hand, if the tumor proves hormone-receptor positive, there are two possibilities: (1) when the tumor measures up to 3 centimeters, take Tamoxifen, with or without chemotherapy; or (2) when the tumor measures larger than 3 centimeters, take chemotherapy plus Tamoxifen.
- Node-positive patients, the guidelines recommend that those with hormone receptor-negative tumors receive adjuvant chemotherapy. Those with hormone receptor-positive tumors should receive adjuvant chemotherapy plus Tamoxifen.

Modified Radical Mastectomy recommended when:

- if the tumor is larger than 5 centimeters or shows positive margins (that is, abnormal cells at the boundary around the tumor).
- the cancer has spread to four or more lymph nodes,

Premenopausal women with tumors smaller than 5 centimeters and no cancer spread to the lymph nodes do not need radiation. Premenopausal women with cancer spread in up to three lymph nodes should consider radiation therapy after surgery plus chemotherapy.

Adjuvant chemotherapy or hormonal therapy is based on the status of axillary (underarm) lymph nodes, the size of the cancer, and its histologic type. If the nodes are clear, or negative, and the tumor measures half a centimeter or smaller, the patient needs no adjuvant therapy.

Postmenopausal women with tumors smaller than 5 centimeters and cancer in fewer than four nodes, no radiation therapy recommended.

Stage IIA, IIB node positive with hormone-receptor negative should receive adjuvant chemotherapy and treatment should be individualized with consideration of comorbid conditions. Stage IIA, IIB node positive with positive hormone-receptor should receive adjuvant chemotherapy plus tamoxifen. There is evidence now to support that the surgical or radiation ovarian ablation in premenopausal women with hormone receptor-positive breast cancer is similar to that achieved with combination chemotherapy and ovarian ablation may be considered an option. Treatment should be individualized with consideration of comorbid conditions

Stage IIIA Breast Cancer:T0,N2,M0; T1*N2M0; T2N2M0; T3N1M0; T3N2M0;
Stage IIIB Breast Cancer: T4 Any N M0; Any TN3M0 –
Regional nodal involvement or Regional direct extension with or without nodal involvement
NCCN Recommendations for treatment are:
Recommended work-up for stage IIIA and IIIB includes laboratory test of (complete blood & platelet counts, and a liver function test); (CXR) chest x-ray; (XM) mammography of both breasts; a breast ultrasound test if necessary to further clarify the findings; 2nd opinion on the pathology review; (ER) estrogen & (PR) progesterone-receptor tests to check whether the tumor is hormone-driven, and to what extent; a HER2/*neu* test to help predict the response to certain drug. Further workup is recommended to include a bone scan, CT, MRI or ultrasound scan of the abdomen.

Stage IIIA Breast Cancer:T0N2M0; T1*N2M0; T2N2M0; T3N1M0; T3N2M0;
Stage IIIB Breast Cancer: T4 Any N M0; Any T N3 M0
Regional nodal involvement or Regional direct extension with or without nodal involvement
NCCN Recommendations for treatment are:
Lumpectomy patients should receive chemotherapy after their surgery.

- If hormone-receptor status is positive or unknown, then therapy with Tamoxifen is appropriate.

Modified radical mastectomy (MRM), with or without breast reconstruction

- If the tumor is hormone receptor negative, adjuvant treatment involves chemotherapy after surgery. Radiation to the chest & the area above the collarbone should follow.
- If hormone-receptor status is positive or unknown, then therapy with Tamoxifen is appropriate.

Stage IIIB Breast Cancer: T4 Any N M0; Any T N3 M0 should use the same as for Stage IIIA-
Regional nodal involvement or Regional direct extension with or without nodal involvement
NCCN recommendations for treatment are:
Neoadjuvant chemotherapy (given prior to surgery) with our without tamoxifen

- If the tumor shrinks enough to be considered operable follow by MRM with or without breast reconstruction or lumpectomy with axillary node dissection followed by radiation therapy
- Additional adjuvant chemotherapy and tamoxifen should be considered if hormone receptor-positive or uncertain after surgery.
- If tumor is still inoperable after neoadjuvant therapy there needs to be an individualized therapy

Stage IV- Distant Breast Cancer: Any T Any N M1 or Recurrence
NCCN recommendations for treatment are:
Work-up for stage IV including laboratory test of (complete blood & platelet counts, and a liver function test); (CXR) chest x-ray; (XM) mammography of both breasts; a breast ultrasound test if necessary to further clarify the findings; 2nd opinion on the pathology review; (ER) estrogen & (PR) progesterone-receptor tests to check whether the tumor is hormone-driven, and to what extent; a HER2/*neu* test to help predict the response to certain drug. Further workup is recommended to include a bone scan, CT, MRI or ultrasound scan of the abdomen.

- ER/PR positive patient as well as those who only have bone or soft tissue distant spread with prior hormonal therapy within the last year should try different hormonal therapy and if there is a good response continue with the hormone treatment
- If no prior hormonal therapy or hormonal therapy was given for more than 1 year ago use standard hormonal therapy and if there is good response continue with the hormonal therapy.
- If there is poor response to the hormonal therapy give chemotherapy
- If primary regimen is no longer effective, another chemotherapy protocol is tried.

Stage IV- Distant Breast Cancer: Any T Any N M1 or Recurrence
NCCN recommendations are:

- If tests of the tumor tissue show high levels of HER-2/neu, giving Herceptin along with Taxol is an option.
- If there is no response to this treatment, then only supportive care should be given and focus on relieving the symptoms.
- If metastasis is to the brain, spinal cord or meninges (membranes covering the brain and spinal cord), methotrexate may be injected directly into the spinal fluid, or the metastasis can be treated with radiation therapy.

- If there is bone metastasis this can be treated with radiation therapy or Aredia which is a drug that slows destruction of the bone by the cancer.

For more information contact or lookup WebSite: National Cancer Institutes, Cancer Information Service 1-800-4-CANCER, 1-800/332-8615 (TTY) or http://www.nci.nih.gov; American Cancer Society 800/ACS-2345 or http://www.cancer.org; NCCN-http://www.nccn.org; National Alliance of Breast Cancer Organizations (NABCO) Telephone: 212-719-0154 Internet Address: http://www.nabco.org. Other WebSite: http://www.ama-assn.org/insight/spec_con/patient/pat041.htm.

EDUCATION

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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October 13, 2000, The Jackson Memorial Hospital (JMH) in Miami, FL will sponsor an FCRA Regional Oncology Workshop. Location JMH/ Diagnostic Treatment Center, Second Floor, Room 259 at 1900 NW 12 Avenue, Miami, FL, from 7:30 a.m.-1:15p.m. The objectives is to provide an overview of Gastrointestinal malignancies incidence, FL vs National Indexes; overview of unique features, diagnostic evaluation, and new directions for treatment of esophagogastric tumors; exploring important areas in the clinical and surgical care of patients with colorectal cancer; analysis of the clinical and pathological aspect of GI stromal tumors Vs Leoimyosarcomas. For more information contact: Lisette Acosta (305) 585-6533. *CEU's applied for.*

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, RHIT, 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

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March 5-9, 2001, 2001 BASIC CANCER REGISTRY TRAINING in Chicago. Registration for the program will begin January 2, 2001 and the fee for the five-day course is $500. For more information and details, contact Pat Tary at ptary@facs.org.

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

Hospitals should now be reporting April 2000 cases.

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)