

# REGISTER

## Changing Times (and other Things)

As you are well aware by now, the FCDS data requirements, file structure and submission modalities are undergoing some major changes beginning with cases diagnosed January 1, 2001 and after. Why? That is a wonderful question, one we here at FCDS ask ourselves on a daily basis. Change is often difficult and time consuming but it is essential. We here at FCDS are following the national standards in everything we do.

The most logical answer, and one we must strive to remember, is that the diagnosis, treatment and overall management of cancer is ever changing. In order for data at all levels (hospital based and central) to be of the highest quality and value to the research, cancer surveillance and control community, we must all change with the times. To address these changes, the national standard setters such as SEER and the American College of Surgeon's CoC working through the North American Association of Central Cancer



Registries (NAACCR), have revised some data items and included additional ones. As a result of the national changes, the standards for the CDC's National Program of Cancer Registries (NPCR) require the collection of additional data in accordance with SEER and CoC.

Each of the major changes is reviewed below.

**Additional Data Items to be Collected:**

- *The four additional race fields* are required in order to be consistent with the U.S. Census Bureau.
- *Summary Stage 2000* is required for all cases diagnosed January 1, 2001 and forward.
- *Detailed and specific text* is required to be broken out in different fields.
- 1998 Surgery Fields.

**Changes in Coding Definitions:**

- *ICD-O-3* is the coding convention for all cancer diagnosed January

1, 2001 and forward.

- *Summary Stage 1977* will be collected for cases diagnosed prior to January 1, 2001.
- *Summary Stage 2000* will be collected for cases diagnosed January 1, 2001 and forward.

**Operational Changes- Data Abstracting and Submission:**

- *Record layout* is changed effective July 1, 2001. All data submitted on or after that date must be in NAACCR version 9 layout (this version accommodates all the above mentioned revisions).
- *FCDS will no longer accept*

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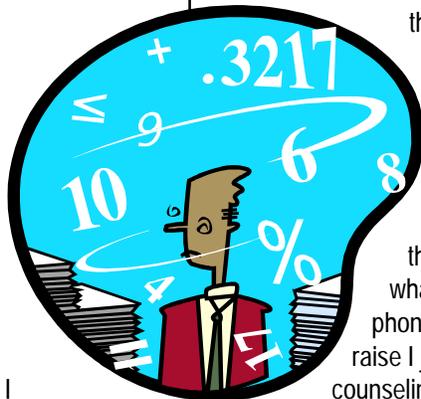
## Bad Cancer Statistics - Good Cancer Statistics.... From the desk of a frustrated statistician...

Author's note: I have exercised my author's prerogative and have taken poetic license in this article to make my point. This article is a compilation of real and made up experiences rolled into one purely fictitious story. I hope you enjoy it and that it provides a clearer picture of good data use and interpretation.

It is 3 PM when the phone rings. It is a newspaper reporter conducting an investigation on health hazards and cancer incidence in his county and he is eager to know everything about cancer statistics. However, as the conversation continues it is apparent that, although he may be a good investigative journalist, he is not a cancer epidemiologist or researcher. Additionally, I get the impression that he has been assigned this by his editor and therefore wants to write a sweat-free article. Whether I like it or not... this gives me no choice but to attempt delivery of a one hour crash course on the cancer and statistical knowledge I have gained in 4 years of college, 8 of graduate school and 10 years of work experience. I take a deep breath and forge ahead.

An hour and a half later, I have a dry mouth from talking and most of all from taking deep breaths. *Breathe in, breathe out...relax... I remind myself.* He is inquisitive like a puppy and he is pounding me restlessly with questions before I can catch my breath. He finally says the magic words: " Oh, OK I understand now why I SHOULD NOT use

zip codes for....." *Oh well* I think to myself, when I hang up the phone: *I'm exhausted... but an abuse of statistics and of the registry's data was just avoided. Thank goodness another disaster averted!* A thank you e-mail follows saying: "Thanks for your time yesterday. I will take your advice and will use zip codes for my article." Did I advise him that?? Maybe I have split personality and my other self says different things than the self I am "wearing" now.... Maybe I'm a sleepwalker and emailed him at night something stating the exact opposite of what I told him on the phone.... I think that this raise I just got will go for counseling fees...



To cut the long story short, I emailed him back clarifying certain things, crossed my fingers and kept hoping... Two months later an article with misleading cancer statistics appears, crashing my hopes. Following publication of the article, it was not long before the Department of Health and FCDS staff were working frantically to diffuse the near panic generated by one journalist's poor interpretation of cancer statistics. A couple of days later and several thousand of tax dollars poorer in wasted personnel time, phone calls etc., I found myself wandering why I never wrote something up to assist the reader, registrars, journalists or general 'cancer epidemiologist-wanna-bes' how to use and interpret cancer statistics. So I dropped the original article I had in

mind and here I am trying to compile an easy to read article with the bare minimum information on some commonly used epidemiological measures.

### Definitions of commonly used epidemiological measures and some comments on them

**Cancer Incidence:** It is the number of new cancer cases diagnosed among previously unaffected individuals (population at risk). Specifying the time period and the geographic region are essential in order to determine the referent population, that is, the population at risk to develop cancer. Then the number of new cancers diagnosed in that population can be counted.

**Crude Cancer Incidence Rate:** When incidence is expressed as a rate, it is the number of new cases per standard unit of population during a time period. To compute incidence rates you basically need to consider three things: person, place and time. The idea is that unless you define the place and the time you can not determine the referent population and count the new cancers among them. Cancer registries usually express this as the number of new cancer cases diagnosed per 100,000 population at risk. Don't worry, this is not rocket science. You simply divide the number of new cases by the population at risk and multiply the result by 100,000 (120 cases/75,000 people persons at risk X 100,000 = a crude rate of 160 per 100,000 population)

This number reflects the burden of cancer to the referent population but it

does not take into account the age distribution of the population. The crude rate can be used as a comparison figure for the burden of cancer between, counties, zip codes etc. BUT YOU MUST BE CAREFUL. If for example in zip code X you have 5 retirement communities, the number of elderly people is disproportional to zip code Y where most residents are more evenly distributed in terms of age. The more older people, the more cancer cases will be diagnosed, so chances are that the crude incidence rate in zip code X will be higher than that of zip code Y, by virtue of the age and not because zip code X is cursed and zip code Y is blessed! So please be aware of the danger of this kind of comparisons.

**Age Specific Cancer Incidence Rate:**

It is a Crude Incidence Rate within a specific age group of the population (for instance in 1999 there were 137 women of all races in Dade County, in the age group 45 to 49 that were diagnosed with breast cancer. In addition, the female residents of Dade County in 1999, of ages 45-49 were 80,220. Therefore as with the crude rate above  $(137/80,220) \times 100,000 = 170.8$ ). It reflects the burden of new cancers in a specific age group. This measure enables you to compare the cancer incidence in age groups of interest over time.

There is a catch when trying to compute incidence rates at the zip code level: the zip codes change as often as twice a year based on the needs of the US Postal Office for the mail distribution. This means that there are no credible population data for the age groups of interest and therefore no credible incidence rates can be computed. The stability of the population estimates is a very important factor in computing any rates. This is why rates at the zip code level often times are misleading and incorrect.

**Age-Adjusted Incidence Rate:** As we mentioned earlier, the Crude Incidence Rate does not take into account the age composition of the population. The

measure that does take it into account is the age-adjusted rate, which is in essence, a Crude rate that has been adjusted to reduce the effects of the differences in the age distributions of the populations compared. So, it is a weighted age specific incidence rate, freed of the anomalies of the age distribution of different populations. This is accomplished by weighting the different age groups differently or in more technical terms, weighting the age-specific rates in the population of interest, by the proportions of persons of a standard population, usually the 1970 US, or the 2000 US population, in order to reflect the age group composition.



This quantity, convoluted as it might sound, enables us to compare apples to apples: we can compare the cancer incidence of various US populations, no matter how much they differ in terms of age, and see how much higher or lower the incidence is among them. You may want to think of this as a quantity that allows you to compare your county with another county in Florida or compare your state to another state etc. In addition, some rates are presented adjusted to the world standard population, permitting comparisons of rates in any area with those from other countries that have also published rates adjusted to the world standard.

**Mortality Rate:** Mortality rates are expressed in the same terms as incidence rates (crude, specific and adjusted). The only difference here is that the number of deaths is substituted for the number of newly diagnosed cases. Everything else is the same. It is the number of deaths for a specific cancer or for all cancers combined during a specific time period. When expressed as a rate, it is the number of

deaths during a specific time period per 100,000 persons.

Having said all that, I think it is time to stop the preaching and show you some cancer statistics. I hope you will put all this information in good use and it will help you to un-encrypt and avoid being misled by inaccurate articles about cancer statistics.

**Cancer in the 67 Florida Counties – 1999 Update**

Florida's 15.6 million population, as of 1999, pose a challenge for the demographer in terms of its age distribution among other things. Unlike other states, it is clearly skewed towards the older age groups, with almost 28% of its residents being over 55 years old.

This might be the most important reason that cancer, a disease affecting disproportionately the older age groups, is the 2<sup>nd</sup> leading cause of death in Florida.

In 1999 162,122 deaths occurred among Florida residents, with 38,182 of those being cancer related (24%). At the same time, 85,524 new primary cancers were diagnosed, bringing the **Crude Incidence Rate of Cancer** to 555.5 cases per 100,000 population (the highest in the nation). However, when adjusting for the effects of the skewed age distribution of the state, the figures look less frightening. The **Age-adjusted Incidence Rate** in Florida, in 1999 was 427.5 per 100,000, compared to 428.5 in 1998 and 388.6 the national rate (1996 was the latest year I found national cancer incidence data for). This tells the researcher that Florida looks roughly the same as the nation.

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**Internet Access will  
be required for any  
data submitted after  
July 1, 2001.**

## Q. C. Corner - *By Joy Houlahan, CTR and Steven Peace, CTR*

### **Abstracting tidbits derived from the every 50<sup>th</sup> (soon to be every 25<sup>th</sup>) Edit.**

1. Hormones are seldom used alone as a Cancer-Directed Therapy (except in Breast and Prostate cancer). FCDS frequently identifies miscoding of hormones as cancer-directed therapy. Usually the miscoding centers on the use of prednisone and megace.

If a patient is given prednisone or megace alone, it is probably intended to treat symptoms related to the patient's cancer rather than the cancer itself. Prednisone is given for a variety of reasons and for a wide variety of conditions other than treating malignant lymphoma, leukemia and multiple myeloma. Other conditions where Prednisone is frequently used include treating allergies, arthritis, inflammatory bowel disease, lupus and even infertility. Prednisone acts by reducing inflammation. Megace is often prescribed to stimulate appetite. Rarely is Megace prescribed as cancer-directed therapy for any cancer.

2. If during the patient's first course of treatment there has been NO surgery performed where lymph nodes are removed, then the data item Regional Lymph Nodes Positive must be coded '98' and the number of Regional Lymph Nodes Removed must be coded '00'.

*Example:* TURP for prostate cancer is a surgical procedure where a simple resection of the prostate is performed. No lymph nodes are removed during the procedure. In this instance, Regional Lymph Nodes Positive should be coded '98' and Regional Lymph Nodes Examined should be coded '00'.

*Some Exceptions:* Brain Tumors, Leukemia, Lymphoma, Multiple Myeloma and Unknown primary. Always code these malignancies with Regional Lymph Nodes Positive '99' and Lymph Nodes Examined '99'.

3. If a tumor is staged using the AJCC Staging System with a "T4" lesion, then it is most likely not a localized tumor in the SEER Summary Staging System. T4 lesions are locally aggressive tumors that have spread beyond the natural boundaries of the primary site. In the SEER Summary Staging System, most T4 lesions have spread to at least the regional direct extension category and sometimes there is distant spread by direct extension.
4. For lung cancers, pleural effusion (unless, pathologically proven to be negative) indicates distant disease. According to the AJCC Staging System and the NEW SEER Summary Stage 2000 - most pleural effusions associated with lung cancer are due to tumor and should be staged as distant disease. However, there are a few patients in whom multiple cytopathologic examinations of pleural fluid are negative for tumor. In these cases, fluid is non-bloody and is not an exudate. If the patient has bloody pleural fluid, then it is most likely positive. When these elements and clinical judgment dictate that the effusion is not related to the tumor, the effusion should be excluded as a staging element and the patient should be staged T1, T2, or T3 in the AJCC Staging System and will not be staged distant in the SEER Summary Staging System.
5. For breast cancers, even if the path report says infiltrating ductal, but the breast has involvement of

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# SEER Summary Staging Manual 2000

The SEER Summary Staging Manual 2000 – Codes and Coding Instructions is now available on the SEER website <http://www-seer.ims.nci.nih.gov>. This manual must be used to code SEER Summary Stage at Diagnosis and FCDS Stage at First Contact for any admission on or after January 1, 2001. Please be sure not to use the DRAFT document for coding SEER Summary Stage 2000 as it contains some errors that have since been corrected.

The new manual contains detailed instructions, illustrations and definitions that make the task of assigning summary stage much easier. All sites now have a summary staging schema.

FCDS will not include this new manual in the revised 2001 FCDS Data Acquisition Manual. You must either order your copy directly from SEER or download the PDF from the SEER website. There is no charge for the manuals. ☺

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the dermal lymphatics in the skin, inflammation and other symptoms of Inflammatory Carcinoma, or the physician calls it Inflammatory Carcinoma, then you should code the morphology 8530 not 8500. An inflammatory carcinoma diagnosis is based on a combination of BOTH clinical and pathologic factors. It is the only tumor where this is the case. Therefore, you must consider both clinical and pathologic findings when determining the correct morphology for these cases.

6. For malignant lymphoma, a low-grade lymphoma does not mean you are supposed to code the grade to 5. The pathology report or physician statement must clearly state that the lymphoma is a T-cell lymphoma to code grade to 5.
7. I-131 is Radioactive Iodine isotope used to treat Thyroid Cancer and not a BRM (Biological Response Modifier) and should be coded to RX Summ - Radiation code of 3.
8. If a patient has an excisional biopsy (bx) with residual disease at your facility and goes elsewhere for chemotherapy or radiation (XRT) your class of case is 1 and not 0.
9. If a patient has a lung primary with multiple masses/nodules confined to one lobe of the lung or mainstem bronchus, this is summary stage 1 (localized), for cases Dx up until December '00. See Summary Stage 2000 draft page 154, for those cases Dx 1/1/01 and beyond. It changes to Regional direct extension. <http://seer.cancer.gov/Publications/SummaryStage>
10. If a patient has pre-op chemotherapy and/or radiation therapy, then Tumor Size should be coded from the clinical tumor size (if available, from x-ray, CT, MRI or direct visualization) prior to treatment with chemotherapy, radiation therapy or subsequent surgery and NOT from the pathology report. Regional Nodes Positive should be coded '99' when the patient was treated with radiation, chemotherapy, hormone therapy, or BRM (immunotherapy) prior to definitive cancer-directed surgery. ☺

## FCDS COMPLETENESS REPORT APRIL 1, 2001

CALENDAR YEAR 2000 ADMISSIONS  
63% COMPLETE - 75% EXPECTED

(REMINDER: ALL 2000 CASES  
ARE DUE JUNE 30, 2001)

## CALENDAR OF EVENTS

### 27th Annual NCRA Conference

May 21 - 26, 2001

Hilton Walt Disney Work Village  
Orlando, FL

Contact:

Carol Johnson 301-402-6226

<http://www.ncra-usa.org>



### NAACCR Annual Conference

June 5 - 7, 2001

Sheraton Bal Harbour Beach Resort  
Miami Beach, FL

Contact:

Megsys Cuadra 305-243-4600

<http://www.naacr.org>



### Principles and Practice of Cancer Registration, Surveillance, and Control

July 9 - 13, 2001

Contact:

Steven Roffers, PA, CTR 404-727-4535

[sroffer@sph.emory.edu](mailto:sroffer@sph.emory.edu)

<http://cancer.sph.emory.edu>



### FCRA/FCDS Combined Conference

August 1 - 3, 2001

Sheraton Suites  
Plantation, FL

Contact:

Donna Acosta 561-362-5156

Mary O'Leary 305-243-4600



### 2001 CDC Cancer Conference

September 5 - 7, 2001

Marriott Marquis Hotel  
Atlanta, GA

*"Using Science to Build Comprehensive Cancer  
Programs: A 2001 Odyssey"*

<http://www.cdc.gov/cancer/>



## Tips for Internet Use

Steven Roffers, PA, CTR

Development Team Leader, SEER Training Web Site

<http://www.training.seer.cancer.gov>

There's no doubt about it... we are in an electronic age. And the largest and fastest growing segment of the electronic age is the Internet.

Cancer registries and cancer registry associations, organizations, and cancer-related agencies all have web sites, and there is an amazing amount of information to access via those web sites. And now, the cancer registry world-at-large has access to web-based instructional and informational materials and training modules. But unless you know how to "surf the Internet", you may end up frustrated and left behind.



Many of our registry colleagues have Internet access and have e-mail capacity and connections. However, many just do not know how to use the Internet effectively and efficiently. I have received many messages like "I know how to double click on the Netscape icon and the Netscape window opens, but then what do I do?". The same is true for those who choose to use Internet Explorer. Plus, once on a web site, some people confront the "okay, now how do I..." paralysis. So, in an effort to bring everyone further along on the Information Super Highway (and to hopefully reduce the paralysis), here are some fundamental yet useful items of information and some tutorials to help.

But first, some terms and definitions:

- BROWSER: A browser is a program that enables you to "browse" the Internet. The two most common browsers are Netscape and Internet Explorer. According to the W3C (World Wide Web Consortium), about 55% of the "online world" uses Netscape and about 44% uses Internet Explorer (with the remaining 1% using other configurations via non-traditional non-PC and non-Macintosh equipment and systems).
- URL: Hey man, what's your URL? URL = Uniform Resource Locator. The URL is the address of the web site. For example, <http://www.naacr.org> is the URL, or web site address

or location, of the NAACCR web site.

- HTTP: What's that goofy "http" in the URL? HTTP = Hyper Text Transfer Protocol. This is the set of instructions (or "protocol") that tells the server (that which "serves" the web pages and info) what to send to the client (the computer that is receiving the web pages and info).
- WWW: Although our colleagues who connect via a modem at a slow baud rate think WWW stands for the World Wide Wait, it actually stands for World Wide Web. The WWW is a global (World Wide) hypertext system that uses the Internet as it's transport mechanism. In a hypertext system, you navigate by clicking hyperlinks, which display another document or another page which may also contain hyperlinks.
- Hyperlink: The text you find on a Web site which can be "clicked on" with a mouse which in turn will take you to another Web page or a different area of the same Web page. Hyperlinks are created or "coded" in HTML. Your arrow will turn to a pointing finger when dragged over a hyperlink. HTML: Oh, good gravy, not another set of initials!
- HTML = Hyper Text Mark-up Language. HTML is the lingua franca for publishing hypertext on the Internet. Domain: The domain is the type, or general category, of the site. Using the <http://www.naacccr.org> as an example, the domain is ".org" signifying that it is a non-profit organization.

Other common domains are:

.com = Commercial ; .net = Network;  
.edu = Educational ; .gov = Government;  
.mil = Military and there are others...  
There is an organization called InterNIC that registers domain names for a small fee and keeps people from registering the same name. Most recently, more domain names will be allowed due to new suffixes coming out. These are: .arts = Arts and cultural entities; .firm = Business; .info = Information services; .non = Individuals; .rec = Recreation and entertainment; .store = Merchants; .web = Web services. Onward... you can double-

click on your browser and the browser window opens... now what? Well, point your arrow/cursor in the Netsite (Netscape)/ Address (Internet Explorer) box and click to enter a URL in that box. After you type the URL, hit ENTER. Your browser will take you to the web site of the URL that you just entered (this assumes that you are connected to the Internet via a modem connection to an online service or via a direct communication connection in your office at work). Now, you want to learn more, right? You want to learn how to access all that the world has to offer on the Internet efficiently and effectively, right? So go to these web sites for online tutorials on how to use Netscape and how to use Internet Explorer to surf the Internet and obtain the info that you are looking for: Netscape Tutorial URL = <http://home.netscape.com/eng/mozilla/1.1/handbook> > Internet Explorer Tutorial URL = <http://www.microsoft.com/windows/ie/tour> > Note: You can type, or just copy and paste, the URL into your browser and then go there that way, or better yet, most e-mail systems hyperlink the URL so you can just click on the hyperlink directly and it will open your browser window for you and go to that web site automatically.

One last thing and then I'll leave you alone so you can get on with the tutorials (or get back to work). Current versions of the browsers (Netscape 4.5 and higher / Internet Explorer 5.0) are "smart enough" to recognize a URL such that you don't even need to type the "http", nor the ":", nor the two slashes "://", nor the "www" (if there is a www). For example, just typing naaccr.org in your browser will bring you to NAACCR's web site just as typing the full URL (<http://www.naacccr.org>) does. I hope this information, and those tutorials, are of use. Happy surfin'! ☺

NAACCR & FCDS are  
pleased to invite you to  
the  
NAACCR 2001  
Annual  
Conference

WHEN:  
JUNE 5 -7, 2001

WHERE:  
SHERATON BAL HARBOUR  
BEACH RESORT  
MIAMI BEACH, FLORIDA

CONTACT:  
MEG SYS C. CUADRA AT  
305-243-2625  
FOR FURTHER INFORMATION, VISIT  
THE NAACCR WEBSITE AT  
[HTTP://WWW.NAACCR.ORG](http://www.naacccr.org)

THE REGISTRATION FEE FOR  
FLORIDA HOSPITAL REGISTRARS  
IS \$225.00. ACCORDING TO  
NAACCR POLICY, IF A STATE IS  
A MEMBER OF THE ORGANIZA-  
TION, THEN HOSPITAL REGIS-  
TRARS PAY REGISTRATION AT  
MEMBER LEVEL TOO. PROGRAMS  
HAVE BEEN MAILED OUT TO ALL  
HOSPITALS.

**FYI**

*Registrars will be required to submit 10 cases from each facility both printed and over Internet to assure that we are getting what we require after July 1, 2001. Details to follow...*

In Florida's 67 counties, the burden of cancer varies. Table 1. describes the number of newly diagnosed cancers in 1999 and the corresponding Age-adjusted incidence rate for each county. In addition to that, the population is presented to provide the reader with a point of reference.

**Table 1. Florida's Population in 1999 and the Newly Diagnosed Cancers, by County**

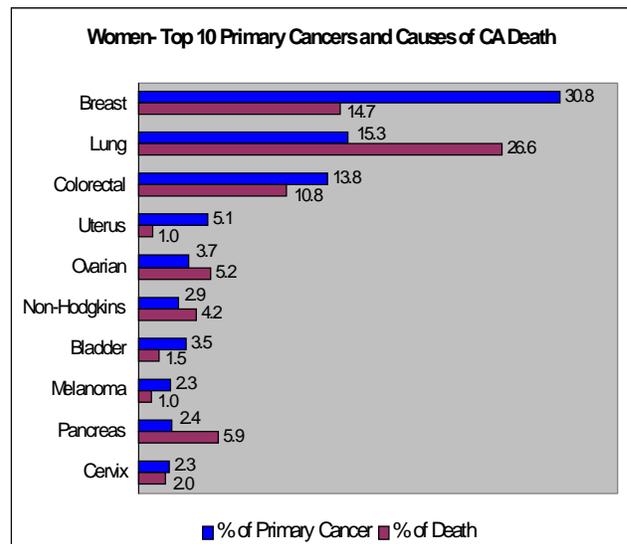
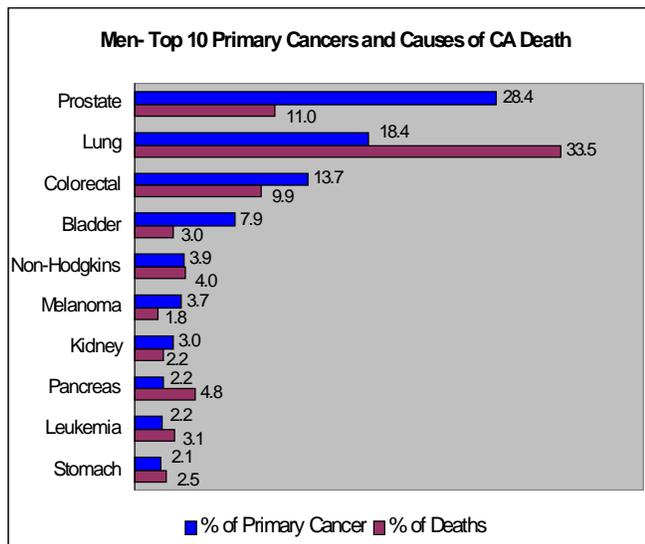
	Males			Females			Both sexes combined		
	Population	Number of Primary Cancers	Age Adjusted Incidence Rate	Population	Number of Primary Cancers	Age Adjusted Incidence Rate	Population	Number of Primary Cancers	Age Adjusted Incidence Rate
Alachua	109,569	365	512.3	111,264	460	491.5	220,833	825	500.7
Baker	12,089	45	517.4	10,585	34	369.2	22,674	79	453.6
Bay	75,240	357	487.8	77,684	320	372.4	152,924	677	433.2
Bradford	14,457	58	461.4	11,373	47	361.6	25,830	105	416.8
Brevard	238,102	1,465	507.6	248,046	1,280	376.7	486,148	2,745	446.5
Broward	731,060	4,184	492.4	787,075	4,383	408.2	1,518,135	8,567	449.3
Calhoun	7,716	27	382.0	6,733	24	290.6	14,449	51	339.0
Charlotte	67,953	630	466.3	73,678	508	350.9	141,631	1,138	414.8
Citrus	56,147	499	441.2	62,072	438	372.5	118,219	937	409.1
Clay	70,589	274	462.7	72,312	267	380.9	142,901	541	422.4
Collier	110,620	864	503.5	116,685	648	358.8	227,305	1,512	441.5
Columbia	30,406	135	475.8	28,285	120	383.1	58,691	255	432.2
Dade	1,045,780	5,011	506.9	1,113,817	4,601	364.8	2,159,597	9,612	438.9
Desoto	15,545	82	468.6	13,642	60	330.1	29,187	142	410.1
Dixie	7,189	40	441.7	6,773	32	344.4	13,962	72	398.5
Duval	379,239	1,633	542.2	395,465	1,556	394.0	774,704	3,189	469.9
Escambia	153,798	782	579.5	156,074	627	364.1	309,872	1,409	483.6
Flagler	22,981	257	590.1	25,141	214	471.4	48,122	471	536.2
Franklin	5,382	22	273.0	5,707	27	324.4	11,089	49	301.3
Gadsden	26,257	114	538.8	26,602	76	279.6	52,859	190	435.1
Gilchrist	7,391	28	383.5	6,564	35	456.1	13,955	63	423.8
Glades	5,563	18	282.7	4,695	9	123.5	10,258	27	229.6
Gulf	8,169	34	453.3	6,790	25	288.2	14,959	59	383.3
Hamilton	8,606	20	302.7	6,617	14	208.9	15,223	34	264.1
Hardee	12,114	67	578.6	10,625	48	374.4	22,739	115	493.4
Hendry	16,267	78	603.0	15,294	60	417.9	31,561	138	522.6
Hernando	62,821	780	623.4	69,004	529	427.1	131,825	1,309	544.1
Highlands	39,204	435	558.0	44,199	320	359.2	83,403	755	473.7
Hillsborough	481,491	2,246	493.2	503,390	2,130	381.3	984,881	4,376	438.7
Holmes	10,055	16	152.7	9,096	20	185.1	19,151	36	170.7
Indian River	53,875	404	443.1	58,547	372	362.4	112,422	776	404.4
Jackson	26,668	73	327.2	23,785	55	194.4	50,453	128	270.2
Jefferson	6,568	23	329.1	8,129	23	261.8	14,697	46	295.5
Lafayette	4,230	6	179.4	3,114	5	140.5	7,344	11	161.7
Lake	100,082	936	533.3	109,602	738	371.5	209,684	1,674	462.0
Lee	206,350	1,648	516.8	221,919	1,322	354.6	428,269	2,970	444.6
Leon	117,873	366	470.1	126,244	369	373.7	244,117	735	421.7
Levy	16,350	114	487.4	18,059	105	411.7	34,409	219	451.1
Liberty	4,952	8	239.2	3,529	13	351.0	8,481	21	308.4
Madison	10,462	34	405.5	9,587	25	229.5	20,049	59	330.9
Manatee	123,101	903	469.4	135,564	875	370.0	258,665	1,778	420.5
Marion	123,356	1,019	536.5	134,103	938	437.4	257,459	1,957	489.0
Martin	60,621	572	561.4	64,000	478	444.2	124,621	1,050	508.0

	Males			Females			Both sexes combined		
	Population	Number of Primary Cancers	Age Adjusted Incidence Rate	Population	Number of Primary Cancers	Age Adjusted Incidence Rate	Population	Number of Primary Cancers	Age Adjusted Incidence Rate
Monroe	44,474	251	486.1	43,789	168	307.8	88,263	419	414.6
Nassau	29,062	152	601.7	29,689	120	391.9	58,751	272	509.1
Okaloosa	91,817	370	483.8	92,203	326	363.4	184,020	696	427.4
Okeechobee	18,986	104	463.7	17,527	74	346.3	36,513	178	414.9
Orange	429,600	1,699	491.7	440,238	1,491	344.9	869,838	3,190	423.1
Osceola	80,399	351	442.9	83,321	315	335.3	163,720	666	392.0
Palm Beach	513,363	3,983	539.3	555,791	3,653	415.2	1,069,154	7,636	480.0
Pasco	157,790	1,299	457.2	175,620	1,125	350.0	333,410	2,424	407.4
Pinellas	430,181	3,041	487.6	477,145	3,210	408.0	907,326	6,251	446.8
Polk	233,889	1,270	421.9	249,735	1,228	359.8	483,624	2,498	391.4
Putnam	35,771	215	476.5	37,975	164	304.4	73,746	379	402.1
St. Johns	57,394	312	452.2	60,409	314	391.3	117,803	626	421.7
St. Lucie	93,428	663	518.9	99,223	605	414.6	192,651	1,268	469.1
Santa Rosa	58,186	262	517.8	57,714	230	389.5	115,900	492	457.8
Sarasota	153,810	1,199	423.5	173,694	1,234	381.4	327,504	2,433	402.1
Seminole	179,273	701	474.9	185,001	610	328.4	364,274	1,311	406.7
Sumter	28,145	123	338.4	23,849	118	282.1	51,994	241	310.8
Suwannee	17,272	98	469.4	18,316	84	365.7	35,588	182	421.6
Taylor	11,232	39	404.2	9,471	34	311.0	20,703	73	360.8
Union	9,366	68	931.8	5,016	24	458.9	14,382	92	808.4
Volusia	210,832	1,572	537.0	225,106	1,427	404.1	435,938	2,999	473.8
Wakulla	11,155	52	512.3	10,377	26	232.3	21,532	78	419.0
Walton	20,924	75	275.2	20,597	72	232.6	41,521	147	254.3
Washingt.	11,486	38	307.3	10,829	33	253.8	22,315	71	282.4
State's Total	7,614,123	44,609	497.6	8,044,104	40,915	378.5	15,658,227	85,524	427.5

### Top 10 sites for 1999

The top 10 sites for 1999, in terms of incidence have not changed for the past few years. Prostate is the number one cancer diagnosed among men as breast cancer is among women. However, lung cancer continues to be the leading cause of cancer deaths in Florida, as it has been for years.

**Table 2.**



To be continued in the next FCDS Register, Volume XII....

Continued from page 1: Changing Times (and other Things)

*diskette submission.* All data submitted on or after July 1, 2001 will be via encrypted Internet transmission.

- *FCDS will not update the PC-based abstracting software.* The free software needed to abstract data from facilities will be Internet-based. No submissions from the current FCDS software will be accepted after July 1, 2001. Contractors and facilities using this software must have an Internet connection in order to abstract data.

Remember, In order to abstract or submit any data to FCDS after July 1, 2001 all facilities and contractors must have Internet access.

FCDS is relying on national coding manuals and rules. As many of you know the manuals and rules necessary to implement these changes are just becoming available to the registry community. We are all in the same boat..... The FCDS staff are working very hard to finalize the revise the *Data Acquisition Manual* and Internet abstracting software. As products and manuals are finalized, we will notify you.

**Remember, with all the data and file layout changes taking place, all abstracts submitted after June 30, 2001 must be in the new format using the new data gathering rules (regardless of the diagnosis date).**

No matter how we look at this transition, it is formidable. We are trying to take it one issue at time. With your help and patience we will get through this as we have gotten through so much in the past. As always, I look forward to our collective success and improved data usage. 🍷

*Jill A. MacKinnon, CTR*  
Administrative Director



## REGISTER

A joint project of the Sylvester Comprehensive Cancer Center and the Florida Department of Health



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## SEVERELY DELINQUENT LETTERS WILL BE MAILED MAY 1, 2001

Letters informing facility administrators that their facility is delinquent in reporting year 2000 cases will be mailed May 1, 2001. A copy of the letter will be mailed to the registrar or contractor responsible for abstracting and reporting in that facility. A letter will be mailed to any facility identified as having reported less than 55% of the estimated annual caseload for the facility.



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

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