

FCDS March 2002 MONTHLY MEMO



March is National Colorectal Cancer Awareness



In 2000, the U.S. Senate declared March as National Colorectal Cancer Awareness Month by passing S. Res. 108, a resolution sponsored by Senators John Breaux (LA), Connie Mack (FL), Frank Murkowski (AK), and Tim Johnson (SD). Through passage of this resolution, not only did we create a platform for discussion about colorectal cancer during the month of March, but we were successful in raising awareness among our Federal legislators. Additionally, a Sense of Congress Resolution, H. Con. Res. 133 was introduced in the House, and a Presidential Proclamation was issued by the White House also declaring March as National Colorectal Cancer Awareness Month.

March 2002 begins the third annual nationwide effort to educate the public about steps that can protect against colorectal cancer and reduce the number of people who die each year from the disease. National Colorectal Cancer Awareness Month was founded by the Cancer Research Foundation of America in collaboration with the American Society for Gastrointestinal Endoscopy, the Foundation for Digestive Health and Nutrition and the National Colorectal Cancer Roundtable.

For more information on National Colorectal Cancer Awareness Month, contact:
Cancer Research Foundation of America
1600 Duke Street, Suite 110
Alexandria, VA 22314
1-800-227-CRFA
703-836-4412; Fax: 703-836-4413



National Cancer Registrars Week: April 8 - 12, 2002

On behalf of the Florida Cancer Data System (FCDS) we would like to take this opportunity to sincerely thank all of the registrars for their participation and support of the Florida's Statewide Cancer Registry. Your dedication and support has made Florida one of the best registries in the nation.

Cancer registrars provide information to FCDS by collecting data from the facilities' medical records, pathology labs, physicians, and death certificates. The data is used by a variety of medical professionals and others concerned about cancer. Congratulations during the National Cancer Registrar Week, we salute you in your special week of recognition. It is a time to reflect and thank all FL registrars for their hard work and dedication to the field of cancer research.



FCDS TELECONFERENCE

FCDS hosted our 1st teleconference of the year on Thursday, February 21, 2002 from 2-3PM. The objective of the conference was to provide registrars with their own "Technical Expertise - Web Tools and Resources for Everyday Abstracting". The fast-paced teleconference provided participants with hands-on navigation of important websites for the everyday abstractor. If you missed the conference, the power-point slide presentation is still available on the FCDS Website.

Question & Answer Sessions:

- Q. Are the FCDS Training modules available in hard copy or on the website.
A. The PowerPoint presentations from the teleconferences are available on our website complete with presenter notes. The Incidence Abstracting Workshop is not online, yet.
- Q. Will there be an update to SEER Book 8 Chemotherapy Drugs and will it be interactive and available online?
A. Book 8 is currently being redesigned to be an online, interactive look-up reference available through SEER. The release date has yet to be announced, but we will let you know as soon as we hear something.

Staging for Colon Cancer

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

Stage 0 or carcinoma in situ

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

Stage I

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

Stage II

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

Stage III

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

Stage IV

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

Staging for Colon CA, cont.

Recurrent

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



Treatment Options

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

- ◆ surgery (taking out the cancer)
- ◆ radiation therapy (using high-dose x-rays or other high-energy rays to kill cancer cells)
- ◆ chemotherapy (using drugs to kill cancer cells)
- ◆ biological response modifier (using drugs that tries to get the body to fight cancer)

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

If the cancer is found at a very early stage, the doctor may take out the cancer without cutting into the abdomen. Instead, the doctor may put a tube through the rectum into the colon and cut the tumor out. This is called a local excision.

If the cancer is found in a small bulging piece of tissue (called a polyp), the operation is called a polypectomy.

If the cancer is larger, the doctor will take out the cancer and a small amount of healthy tissue around it

Treatment Options

The healthy parts of the colon are then sewn together (anastomosis). The doctor will also take out lymph nodes near the intestine and look at them under the microscope to see if they contain cancer.

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

This bag does not show under clothing, and most people take care of these bags themselves.

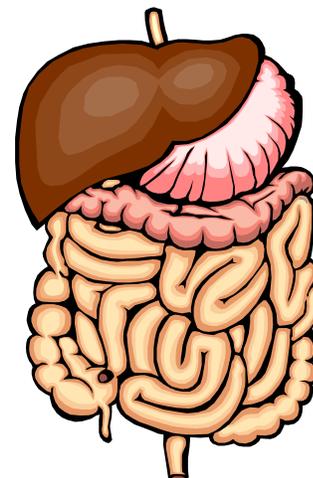
Radiation therapy is the use of x-rays or other high-energy rays to kill cancer cells and shrink tumors. There are several ways radiation is given. From a machine outside the body (external radiation therapy) or from putting materials that contain radiation through thin plastic tubes (internal radiation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

Chemotherapy is the use of drugs to kill cancer cells. Chemotherapy may be taken by pill, or it may be put into the body by inserting a needle into a vein. A patient may be given chemotherapy through a tube that will be left in the vein

while a small pump gives the patient constant treatment over a period of weeks.

Chemotherapy is called a systemic treatment because the drug enters the blood-stream, travels through the body, and can kill cancer cells outside the colon. If the cancer has spread to the liver, the patient may be given chemotherapy directly into the artery going to the liver. If the doctor removes all the cancer that can be seen at the time of the operation, the patient may be given chemotherapy after surgery to kill any cancer cells that are left. Chemotherapy given after an operation to a person who has no cancer cells that can be seen is called adjuvant chemotherapy.

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



Treatment by stage

Treatments for cancer of the colon depend on the stage of the disease and the patient's general health.

Standard treatment may be considered because of its effectiveness in patients in past studies, or participation in a clinical trial may be considered. Not all patients are cured with standard therapy and some standard treatments may have more side effects than are desired. For these reasons, clinical trials are designed to find better ways to treat cancer patients and are based on the most up-to-date information. Clinical trials are ongoing in most parts of the country for most stages of cancer of the colon. To learn more about clinical trials, call the Cancer Information Service at 1-800-4-CANCER (1-800-422-6237); TTY at 1-800-332-8615.

Treatment information has been obtained from NCI, NCCN and ACS.

The most up-to date-guidelines for cancer care are available on the websites of the ACS (www.cancer.org), NCI (www.cancer.gov) and NCCN (www.nccn.org).

You may also phone the ACS at 1-800-4-CANCER or NCCN at 1-888-909-NCCN for more information.

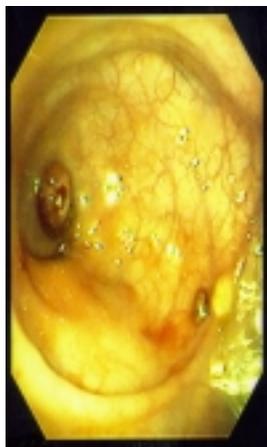
Note: NCCN provides patients and the general public with cancer treatment information. NCCN guidelines are to assist patients and physicians in making treatment decisions and do not replace the expertise and clinical judgment of a physician.

Stage 0 Colon Cancer, Tis

Treatment may be one of the following:

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

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



Polyp
An abnormal, often precancerous growth of tissue (colorectal polyps are growths of tissue inside the intestine).
<http://www.cdc.gov/cancer/screenforlife/terms.htm#screening>
<http://www.gastrolab.net/pawelcom.htm>

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

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

NCCN: Surgery: none if **Tis** or **T1** single specimen and villous adenoma or villoglandular adenoma with cancer. Hemicolectomy or laparoscopic surgery per protocol if fragmented specimen is villous adenoma or villoglandular adenoma with cancer, **T2**, or ulcerative/invasive, nonobstructing.

Hemicolectomy for obstructing, unprepped bowel. Diverting colostomy with limited resection if possible for unresectable lesion. Adjuvant: none

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

NCI-Treatment may be one of the following:

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

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

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

NCI-Treatment may be one of the following:

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

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

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

NCI-Treatment may be one of the following:

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

Clinical trials of chemotherapy or biological therapy.

NCCN Treatment Guidelines: Liver metastasis: Surgery: hemicolectomy + liver resection ± cryosurgery or hemicolectomy + in 6 wk liver resection ± cryosurgery for resectable 1-4 discrete hepatic metastasis. Hemicolectomy for symptomatic with high liver burden. No treatment is give a asymptomatic with high liver burden.

Resectable liver metastasis give adjuvant Chemotherapy with 5fu/leucovorin or HA1, CIV5FU or clinical trial.

Stage IV Colon CA

NCCN Treatment Guidelines:

Unresectable liver metastasis –Asymptomatic R colon lesion with high liver burden no surgery.

Unresectable liver metastasis – Symptomatic with high liver burden perform only a limited bowel resection

- ◆ Lung metastasis: Surgery: hemicolectomy, then thoractomy for 1-3 lung nodules and chemotherapy with 5fu/leucovorin or HA1, CIV5FU or clinical trial. Hemicolectomy alone with multiple lung metastasis.

Abdominal metastasis: Surgery: hemicolectomy if resectable.

Unresectable abdominal metastasis, only have a limited bowel resection or diverting colostomy performed.

http://nccn.org/patient_gls/english/_colon/index.htm

Rectal Cancer

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

Rectal cancer 5cm or closer to anal verge:

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

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

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

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

Rectal cancer 5cm or further from anal verge:

Stage 0 (Tis, N0, M0); Stage I rectal cancer (T1, N0, M0), Stage A,

Stage I (T2, N0, M0), Stage B1: Anterior Resection and no Adjuvant therapy.

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

1. Anterior resection followed by 5-FU ± leucovorin x2, XRT +%FU CIV, 5-FU ± leucovorin.
 2. Neoadjuvant chemotherapy + radiation followed by LA or AP resection.
- T4, Any rectal lesion (T4, No-2, M0) Stage B3, C: Neoadjuvant chemotherapy + radiation followed by LA or AP resection, Adjuvant: 5-FU/leucovorin.

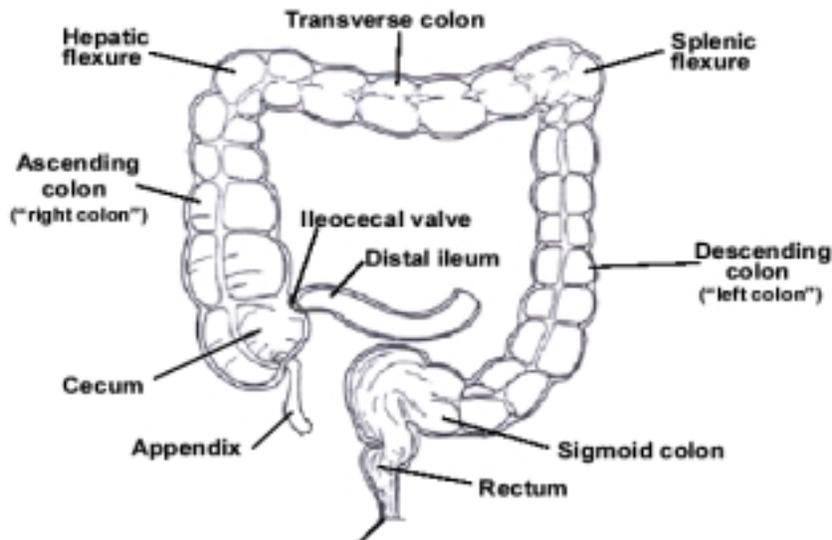
Metastatic (any T, any N, M1) Stage D

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

Recurrent Colon Cancer

Stage II rectal cancer (T3, N0,M0) Stage B2, Stage III rectal cancer T1-3, N1-2, M0, Stage C
 NCI-If the cancer has come back (recurred) in only one part of the body, treatment may consist of an operation to take out the cancer. If the cancer has spread to several parts of the body, a doctor may give a patient either chemotherapy or radiation therapy. The patient may also choose to participate in a clinical trial testing new chemotherapy drugs or biological therapy.

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



SEER Summary Stage 2000



References: 1. SEER Program Manual ; pgs 97

Brief: We are having a difficult time interpreting the rule about coding histology for colon cases when they are first found in polyps and then also found in the resection (SEER Program Manual, page 97, "Multiple Lesions, considered Single Primary - #2).

Question: 1.) If the cancer was found in a polyp, should the histology be coded as carcinoma in a polyp or should the histology be coded to adenocarcinoma if the resection shows malignancy in the colon not just in the polyp?

2) If there is residual tumor in the same place where the polyp was do you code it as "in a polyp" or not?

Answer: *Final*

1). If there is one lesion, adenocarcinoma that arises in a polyp that has extended to invade the colon, code as arising in a polyp. If there are two tumors, one arising in a polyp and a frank adenocarcinoma arising in the colon wall, code the histology as adenocarcinoma, NOS.

2.) If there is residual tumor, read the pathology report carefully. If the pathology describes the residual tumor as being the same place where the polyp was located (where the polyp's stalk was resected), and describes the residual as further extension from the cancer in the polyp, code as adenocarcinoma or carcinoma in a polyp. If there was no invasion of the stalk of the polyp or if the pathology report from the colon resection says the cancer did not arise in a polyp, code the histology to adenocarcinoma, NOS or carcinoma, NOS.

COLORECTAL TNM definitions, Primary tumor (T)

AJCC Cancer Staging Manual, Fifth Edition, Chapter 12

Primary Tumor (T)

TX: Primary tumor cannot be assessed

T0: No evidence of primary tumor

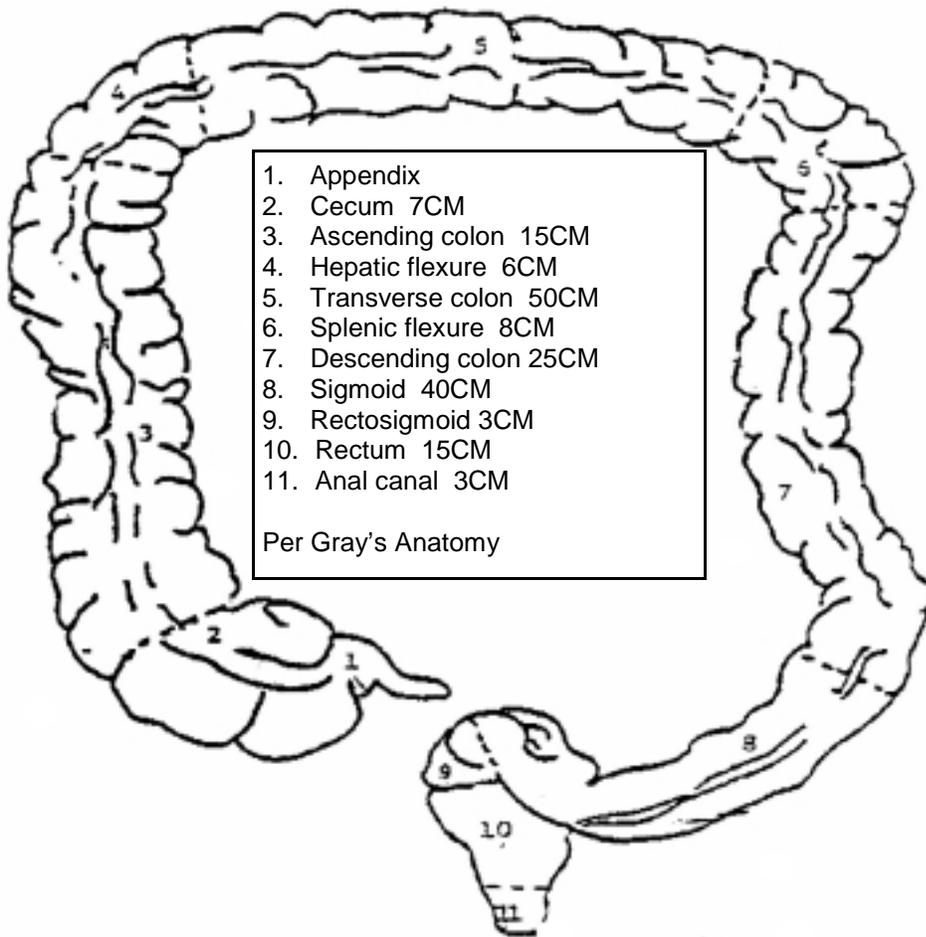
Tis: Carcinoma *in situ*: intraepithelial or invasion of the lamina propria* It has not gone beyond the mucosa (inner layer) of the colon or rectum

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

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

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

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



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

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

Regional lymph nodes (N)

Regional Lymph Node Involvement (N)

NX: Regional nodes cannot be assessed

N0: No regional lymph node metastasis

N1: Metastasis in 1 to 3 regional lymph nodes

N2: Metastasis in 4 or more regional lymph nodes

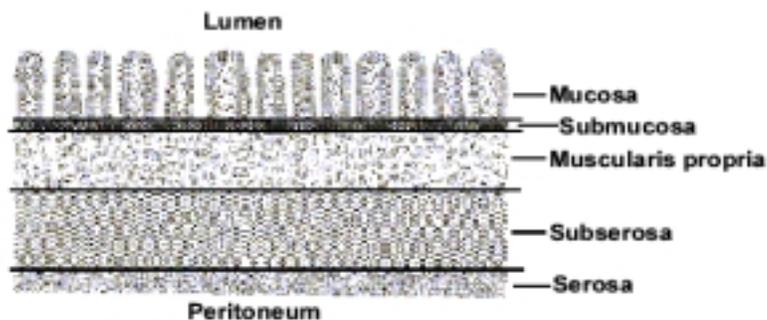
A tumor nodule greater than 3 mm in diameter in the perirectal or pericolic fat without histologic evidence of a residual node in the nodule is classified as regional perirectal or pericolic lymph node metastasis. A tumor nodule 3 mm or less in diameter is classified in the T category as a noncontiguous extension, that is T3.¹

Distant Metastasis (M)

MX: Distant metastasis cannot be assessed

M0: No distant metastasis

M1: Distant metastasis



LAYERS OF THE COLON WALL OF COLON

SEER Summary Stage 2000

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



Q. Is Arimidex (anastrozole) a chemotherapy drug and what is it used for?

A. Arimidex is a nonsteroidal compound in a new class of 3rd generation selective oral aromatase inhibitors. Inhibition of aromatase reduces the production of estrogen. Because there is not direct hormonal manipulation, any aromatase inhibitor should be coded under biological response modifier.

Arimidex was approved in 1996 as a treatment for advanced breast cancer in postmenopausal women whose disease has progress following therapy with tamoxifen.

www.centerwatch.com



1998 FCDS ANNUAL REPORT

The 1998 FCDS Annual Cancer Report is now available on line at FCDS.med.miami.edu. The annual report publications began in 1995, providing updates on cancer incidence and mortality in Florida. The purpose of this report is to provide researchers, policy makers, health professionals and the public with an overview of the status of cancer in Florida.

The series was developed by the Bureau of Epidemiology of the Florida Department of Health in collaboration with the Florida Cancer Data System (FCDS) at the University of Miami School of Medicine, Sylvester Comprehensive Cancer Center. For more details visit our website at <http://FCDS.med.miami.edu>.



2001 FDA New drug

In 2001 FDA approved the following drugs:

Campath; Injectable treatment of B-cell chronic lymphocytic leukemia; Berlex Laboratories; Approved May 2001. **Code under chemotherapy**

Femara (letrozole) Tablets; First-line treatment of postmenopausal women with locally advanced or metastatic breast cancer; Novartis; Approved January 2001. Non-steroidal aromatase inhibitor. **Code under Biological Response Modifier.**

Gleevec; Oral therapy for the treatment of chronic myeloid leukemia; Novartis; Approved May 2001 Protein Kinase inhibitor. **Code under Biological Response Modifier**

Trelstar LA; Intramuscular injection for the treatment of advanced stage prostate cancer; Debiopharm S.A.; Approved June 2001. Effect of Castration. **Code under Hormone.**

Xeloda; Oral chemotherapy for the treatment of metastatic colorectal cancer; Hoffman-La Roche; Approved May 2001. **Code under Chemotherapy.**

Breast Cancer Patient bill proposal



The Breast Cancer Patient Protection Act if passed will require insurance companies to cover a minimum 48-hour hospital stay for patients undergoing a mastectomy. It will eliminate the "drive-through mastectomy" where women are forced to go home hours after surgery against the wishes of their doctor, still groggy from anesthesia and sometimes with drainage tubes still attached.

Lifetime Television has put this pending bill on their web page with a petition drive to allow you to show your support. Last year over half the House signed on.

PLEASE Sign the petition by clicking on the web site below and help women living with breast cancer get the care they need and deserve!

http://www.lifetimetv.com/health/breast_mastectomy_pledge.html



FCDS IDEA UPDATE

If you are using the FCDS IDEA for data entry and make a mistake entering the facility number, please contact your field coordinator. If the case is left uncorrected, your facility will not receive credit for the case. DO NOT re-enter the abstract!

Please notify your field coordinator immediately so that the appropriate facility number is reassigned to the case.

Also, when a list is generated of cases that you have entered using the *FCDS Single Abstract Entry* (data can be printed until it has been batched) the listing will contain the facility number and the cases entered by the username.

FCDS Field Coordinators:
 Edith Alvin 305-243-4601
 Kelly Large 305-243-2642
 Mae Whitehead 305-243-2641

Education & Training

SEER Update — <http://seer.cancer.gov>

SEER recently introduced several new web-based training modules on their website with additional modules under development. When the site is completed it will contain 12 individual training modules, each covering a particular area of cancer registration.

The following SEER training modules are currently available:

SEER TRAINING MODULES

- ◆ SEER Summary Stage 2000
- ◆ ICD-O-3 Training module
- ◆ Cancer Registration
- ◆ Cancer Treatment
- ◆ Cancer as a Disease
- ◆ Casefinding
- ◆ Anatomy & Physiology & Diagnostic Test- **coming soon!**



INFORMATIONAL MODULES

- ◆ ICD-O-3 Satellite Training Video
- ◆ Summary Staging 2000 Manual



Future CTR Exam Dates	
<u>Application Deadline</u>	<u>Exam Date</u>
February 1, 2002	March 16, 2002
August 1, 2002	Sept. 14 2002

Education & Training

CoC March 2002 Workshop Canceled

The year 2003 will have many important changes related to the CoC's standards, "FORDS," and the AJCC Collaborative Stage and TNM staging. For this reason, the CoC has decided that it would be more beneficial to their course participants to wait until these changes are finalized and nearing implementation before they continue any further instructional courses. While COC still plans to offer instructional presentations of these changes during the NCRA meeting, they will postpone more complete educational courses until a later date. The CoC will contact those who have already registered for the March Workshop, and a full refund will be provided. If you have any questions regarding the refund, please contact Mary Ann Marts at mmarts@facs.org.

FCDS INCIDENCE ABSTRACTING WORKSHOP, April 17-19, 2002

Mark your calendar for the next FCDS Incidence Abstracting Workshop! FCDS conducts semi-annual workshops in incidence cancer case reporting. The three-day intensive course covers only the basics of cancer reporting for Florida. The April 17-19, 2002 workshop will cover all of the 2001 reporting requirements. The cost of this workshop is \$100.00. The workshop will be held in Double Tree in Coconut Grove, FL. For more information please contact Bleu Herard 800-906-3034 / 305-243-2635 or Betty Fernandez at (305) 243-2629.

NCRA Annual Educational Conference, May 21 - 24 2002

The [National Cancer Registrars Association](http://www.nkra-usa.org) will host the **Annual NCRA Educational Conference** at the Opryland Hotel in Nashville, TN on May 21-24, 2002. The theme is "Data Driven, Knowledge Bound, Destiny: The Cure" Visit the NCRA website: www.nkra-usa.org for more information and a PowerPoint on the internet. Email may be sent as follows: info@ncra-usa.org. NCRA telephone numbers are 703-299-6640 (phone); 703-299-6620 (fax).



We're on the Web!
FCDS.med.miami.edu

NAACCR Annual Conference, June 11 - 13, 2002

The 2002 meeting of the North American Association of Central Cancer Registries will be held at the Westin Harbour Castle Hotel in Toronto, Ontario, Canada from June 11-13, 2002. The theme is "Achieving Equity in Cancer Control." In addition to the main conference, there will be some pre- and post-workshops on registries operations, research and medical informatics. Watch the News & Events section of NAACCR web site for more details as they become available, <http://www.naacr.org>, or you can contact Darlene Dale at Cancer Care Ontario, (416) 217-1228, or email Dale@cancercare.on.ca.

FCRA/FCDS Combined Annual Conference, July 31 - August 2, 2002

The Florida Cancer Registrars Association (FCRA) and the Florida Cancer Data System (FCDS) will co-host a combined Annual Educational Conference at the Hyatt Sarasota on Sarasota Bay from July 31, 2002 to August 2, 2002. The cost of the conference is \$75. For more information, please contact Jamie Suarez, CTR, FCRA Program Chair at jsuarez@uhs.com or Bleu Herard, FCDS at 305-243-4600. Program registration and flyers will be mailed to all FCRA members as well as all FCDS-identified facilities, contractors and courtesy mailing parties in March.

Advanced Cancer Registry Training Program, August 5 - 7, 2002

The **Advanced Cancer Registry Training Program** specifically covers: abstracting, staging, and coding really difficult cancer cases; bizarre, rare, and unusual cancer cases; calculating incidence, prevalence, age-adjusted, survival, and other rates; using registry data (preparation, analysis, annual reports, etc.); and using the Internet to locate comparable data and useful cancer information and resources. Participants must have attended the website www.sph.emory.edu/GCCS/training/practice/index prior to registering for this advanced training (or have at least one year of experience working in a cancer registry). Registration Fee: \$500. The course will be held on the campus of Emory University in the Rita Anne Rollins Conference Room located on the 8th Floor of the Rollins School of Public Health, 1518 Clifton Road, NE, Atlanta, GA 30322. For further information about the training program, accommodations or travel arrangements, contact: Steven Roffers, PA, CTR, Phone: 404-727-4535, Fax: 404-727-7261, E-mail: sroffer@sph.emory.edu

Principles and Practice of Cancer Registration, Surveillance, and Control, November 4-8, 2002

Principles and Practice of Cancer Registrations, Surveillance, and Cancer Control will be held at the Emory University in Atlanta, Georgia November 4-8, 2002.

A staff of recognized experts in cancer registration, surveillance, and cancer control teaches this intensive and comprehensive training program.

The instructors are accomplished adult trainers and are internationally recognized as leaders in their fields.

Complete details are available on the training program web site at <http://cancer.sph.emory.edu> or contact Steven Roffers, PA, CTR at (404) 727-4535.



QUALITY CONTROL - Every 25th Record Sampling Report

The FCDS QC staff is currently reviewing reports from the 3rd & 4th Quarter for the **Every 25th Record Sampling Report**. These reports provide FCDS & you with a visual review of at least every 25th record that FCDS receives from every facility. The report contains all the data downloaded to FCDS by your facility. A copy of each of the cases reviewed will be mailed to you. FCDS asks that you review each case report and provide us with feedback on any comments or questions noted on any of the reports.

The QC staff is also currently performing on-site re-abstracting audits in randomly selected facilities.

You will be contacted if your facility has been selected for an audit.

669401



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**UPDATE - 2001 FCDS
 DATA ACQUISITION**

A few minor errors/data item changes & clarifications have been identified. The 2002 DAM Errata will be mailed out soon. Thanks.



DEADLINES

HOSPITALS

Hospitals should now be reporting September 2001 cancer cases

Reminder: All Hospitals should be at least for 80 % complete for the 2001 Reporting Year by the end of March, 2002

AMBULATORY CENTERS CANCER REPORTING PROGRAM (ACCRP)

Ambulatory Centers can expect AHCA 2000 patient encounters sometime early this summer.



Hospital submission for 2000 and 2001 cancer cases

