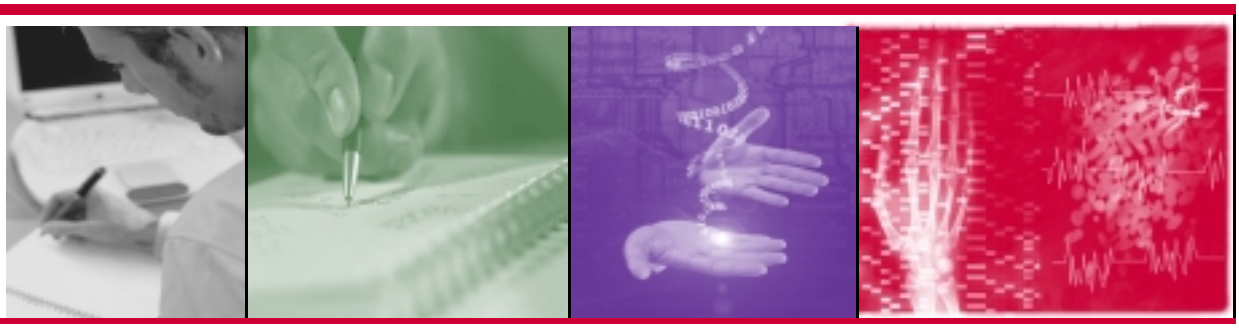
FLORIDA CANCER DATA SYSTEM

December 2002 Monthly Memo

Seasons Greetings



CODING COMPLEX MORPHOLOGIC DIAGNOSES

CODING COMPLEX BREAST HISTOLOGIES

Apply these guidelines in priority order. Use the first guideline that applies and stop.

Single Tumors with Complex Histology

1. If the diagnosis is both lobular and ductal (in situ or invasive or a combination), use code 8522.
Examples: Duct carcinoma and lobular carcinoma in situ -- code as 8522/3.
LCIS and DCIS -- code as 8522/2.

2. If the diagnosis is mixed invasive and in situ, code the invasive diagnosis.
Examples: Ductal carcinoma with extensive cribriforming DCIS -- code as 8500/3
Mucinous carcinoma in a background of ductal carcinoma in situ -- code as 8480/3
Infiltrating ductal carcinoma with DCIS, solid, cribriform and comedo type – code as ductal carcinoma, 8500/3.

3. Use a combination code if the diagnosis is duct carcinoma or lobular carcinoma mixed with another type of carcinoma.

Look for "and" or "mixed" in the diagnosis.
a. If the diagnosis is duct carcinoma mixed with another type of carcinoma (excluding lobular), use code 8523/_.

Examples: Duct carcinoma **and** tubular carcinoma – code as 8523/3.
DCIS and cribriform carcinoma in situ -- code as 8523/2

b. If the diagnosis is lobular carcinoma mixed with another type of carcinoma (excluding ductal), use code 8524.
Examples: Lobular and adenoid cystic carcinoma -- code as 8524/3
Tubular carcinoma and lobular carcinoma -- code as 8524/3

4. Code the specific type if the diagnosis is
• Duct carcinoma, _____ type
• Duct carcinoma, predominantly _____
• Duct carcinoma with features of _____
Code the stated type (subtype) even if the code is lower than 8500.
Look for the term "type," "subtype," or "variant" or terms that indicate the majority of the tumor.
Examples: Duct carcinoma, tubular type -- code as tubular carcinoma, 8211
Duct carcinoma with apocrine features -- code as apocrine carcinoma, 8401/3

5. If the diagnosis includes more than one subtype, use a combination code.
Examples: Duct carcinoma, cribriform and comedo types – code as 8523/3.
Duct carcinoma in situ, showing both solid and cribriforming subtypes -- code as 8523/2

(Continued on page 2)

(Continued from page 1)

Separate Tumors of Different Histologies in One Breast

6. If different histologies occur in separate tumors in the same breast, use a combination code if possible and count the case as a single primary.
Examples: LCIS UIQ right breast and duct carcinoma LIQ -- code as 8522/3
Paget disease of nipple and intraductal carcinoma, UOQ -- code as 8543/3

HISTOLOGY CODES FOR INVASIVE BREAST CANCERS

Histology code must reflect the invasive tumor; terms include invasion, infiltrating, infiltration

I. Invasive only, single type, no in situ component
Invasive carcinoma 8010/3
Invasive adenocarcinoma 8140/3
Invasive ductal (duct) carcinoma 8500/3
Invasive lobular carcinoma (NOS and subtypes) 8520/3
Tubular carcinoma 8211/3
Mucinous (colloid) carcinoma 8480/3
Medullary carcinoma 8510/3
Adenoid cystic carcinoma 8200/3
Intraductal papillary carcinoma with invasion 8503/3
Apocrine adenocarcinoma 8401/3
Metaplastic carcinoma 8575/3

Other rare types
Paget disease (rare without underlying carcinoma, 8540/3 which is usually invasive, but may be DCIS only)

II. Invasive only, 2 or more types, no in situ component
Invasive ductal and lobular 8522/3
Invasive ductal and mucinous (colloid) 8523/3
Invasive ductal and tubular 8523/3
Invasive ductal and cribriform (cribriform also invasive) 8523/3
Invasive lobular and other types (except ductal) 8524/3

III. Invasive, one type, with DCIS or/and LCIS present
Invasive ductal and DCIS (loses the DCIS) 8500/3
Invasive lobular and DCIS 8522/3
Invasive ductal and LCIS 8522/3
Invasive lobular and LCIS (loses the LCIS) 8520/3

IV. Invasive, 2 or more types, with DCIS or/and LCIS
Code as in category II; the CIS will be lost

HISTOLOGY CODES FOR NON-INVASIVE BREAST CANCERS

No invasion present (DCIS and/or LCIS only)

I. Intraductal (ductal carcinoma in situ, DCIS) only 8500/2

II. Intraductal, with one subtype specified
DCIS papillary (intraductal papillary) 8503/2
DCIS micropapillary or clinging 8507/2
DCIS cribriform 8201/2
DCIS solid 8230/2
DCIS comedo 8501/2

III. Intraductal, with two or more subtypes specified 8523/2

IV. Intralobular (lobular carcinoma in situ, LCIS) 8520/2

V. Both DCIS and LCIS (any DCIS subtypes will be lost) 8522/2

Examples of Complex Breast Diagnoses (coded, with comments)

Assume these examples are single primaries.

8401/3 Core needle breast bx: PD infiltrating ductal carcinoma with aprocrine subtype of ductal ca. *Code the stated subtype of the invasive component.*

8500/3 FNA L breast mass, UIQ: Atypical hyperplasia with clusters suspicious for carcinoma.

Needle localization (L breast, UOQ) followed by exc bx: Scirrhous ductal carcinoma and DCIS (comedo pattern); TS = 1.8 x 2.0 x 2.0 cm; extensive cribriforming noted. Margins of resection are clean.

Code the invasive component. "Scirrhous" is an adjective meaning "hard" Although it has a code in ICD-O-3, ductal carcinoma is the more precise term. According to our medical advisor, ignore "scirrhous" when it is used in combination with another histologic descriptor. If the term is "scirrhous carcinoma," code as 8141/3.

8507/3 Infiltrating ductal ca; focal micropapillary invasive pattern and intralymphatic tumor are additional features.

Use the "micropapillary invasive" information to code the more specific term.

8520/3 Infiltrating lobular ca, pleomorphic variant, measuring 5.4 cm.

A pleomorphic variant (subtype) of lobular carcinoma is not the same as pleomorphic carcinoma. Code as lobular carcinoma, NOS.

8522/2 Right breast lumpectomy specimen: Extensive in situ carcinoma with mixed ductal and lobular features and the following characteristics:

1) Two foci suspicious but not definitive for invasion.

2) Solid and cribriform histologic patterns.

Use the guidelines in order. Code the ductal and lobular combination. For coding purposes, any ductal carcinoma subtype should be treated as ductal carcinoma when seen in combination with lobular carcinoma or LCIS.

(Continued on page 5)

Release of 2003 Implementation Guidelines and Recommendation

The North American Association of Central Cancer Registries' 2003 Implementation Workgroup has completed its task and is pleased to announce the release of the "2003 Implementation Guidelines and Recommendations." In coordination with NAACCR, this document should be available January 9 on the American College of Surgeons Web site at: http://www.facs.org/dept/cancer/coc/standards.html, and will be available from the NAACCR Web site on Monday, January 13, 2003.

The "2003 Implementation Guidelines and Recommendations" were developed by a group that included representatives from the CoC, SEER, NPCR, NCRA, state central cancer registries, and cancer registry software vendors. This collaboration was necessary to ensure that the "Guidelines and Recommendations" were developed to assist all levels of cancer registry activity and to help ease the transition from ROADS to FORDS (NAACCR Version 9.1 to Version 10 standards). The goal of the "Guidelines and Recommendations" is to ensure that data transmission standards are consistently maintained among all facility and central registries and that these standards be implemented in a planned and timely manner.

The CoC understands that cancer registry software providers/ developers will likely be able to deliver FORDS compatible software before the end of the second quarter of 2003--this is contingent upon deliverables per the "2003 Implementation Guidelines and Recommendations." Completion of the software updates is dependent on a number of factors including: 1) the release of the "2003 Implementation Guidelines and Recommendations;" 2) revisions to the CoC's conversion rules and computer algorithm which facilitates the ROADS to FORDS transition; and 3) the availability of the necessary Version 10 EDITS metafiles. This delay has been unavoidable and beyond the immediate control of the software providers.

Cases diagnosed on or after 01/01/2003 should be entered into a suspense file until your FORDS compatible software upgrade becomes available. After the ROADS to FORDS conversion is complete, suspended cases can be coded and completed using FORDS. Vendors have been advised to provide training on the software upgrades. State central cancer registries have been advised to distribute their implementation plans and timelines to facility registries and vendors as early as possible.

Inquiries about specific FORDS data items and conversions should be referred to the CoC. Any comments/questions about the "2003 Implementation Guidelines and Recommendations" can be submitted to Andrew Stewart at astewart@facs.org.

FCDS *Q & A*

Question: COC #5708
If a patient is diagnosed with multiple myeloma and receives Melphalan and Prednisone, is Prednisone coded to hormone treatment?

Answer: COC
Record Prednisone as hormonal therapy when administered in combination with chemotherapy. See page 238 in ROADS, Vol II.

Question: COC #5737
When Prednisone is used in combination with Leukeran for treatment of a lymphoma, is Leukeran coded to a single agent with Prednisone considered an axillary drug?

Answer: COC
Record Prednisone as hormonal therapy when administered in combination with chemotherapy. See page 238 in ROADS, Vol II. Leukeran would be coded as a single chemotherapeutic drug.

1 - Is cystic duct node for Head of Pancreas, regional or distant?
The cystic duct node is in the area between the gallbladder and the commonbile duct along the cystic duct. In my interpretation of the pictures and definitions, this is just outside the regional lymph node area; in otherwords I think the cystic duct node is distant.

2 - If you have a needle bx of poorly diff lobular insitu and at lumpectomy is mod diff inf ductal what morph/ grade do you use?
Grade of tumor is independent of histology. Use the grade of the invasive tumor. In this case use mod diff because it is attached to the inf ductal CA. and since needle bx is lobular insitu and lumpectomy is only infiltrating ductal you use the combination code of 8522/3

Seer Updates

Table 24 Errata

Table 24 replaces ICD-0-3, page 36.

http://training.seer.cancer.gov/module_ido3/downloadables/new_table_24.pdf

Table 24 in the ICD-O-3 is incorrect. The correct Table 24 is as below:

Table 24. Groups of Topography Codes from the Second and Third Editions of ICD-O Considered a Single Site in the Definition of Multiple Cancers

ICD-O-2/-3	Site Groupings
C01	Base of tongue
C02	Other and unspecified parts of tongue
C05	Palate
C06	Other and unspecified parts of mouth
C07	Parotid gland
C08	Other and unspecified major salivary glands
C09	Tonsil
C10	Oropharynx
C12	Pyriform sinus
C13	Hypopharynx
C23	Gallbladder
C24	Other and unspecified parts of biliary tract
C30	Nasal cavity and middle ear
C31	Accessory sinuses
C33	Trachea
C34	Bronchus and lung
C37	Thymus
C38.0	Heart
C38.1-.3	Mediastinum
C38.8	Overlapping lesion of heart, mediastinum, and pleura
C38.4	Pleura (visceral, parietal, NOS)
C51	Vulva
C52	Vagina
C57.7	Other specified female genital organs
C57.8-.9	Unspecified female genital organs
C56	Ovary
C57.0	Fallopian tube
C57.1	Broad ligament
C57.2	Round ligament
C57.3	Parametrium
C57.4	Uterine adnexa
C60	Penis
C63	Other and unspecified male genital organs
C64	Kidney
C65	Renal pelvis
C66	Ureter
C68	Other and unspecified urinary organs
C74	Adrenal gland
C75	Other endocrine glands and related structures

Site/Histo Comparison Table

The new site histo comparison table is available on the SEER Website at: http://seer.cancer.gov/icd-o-3/.

ICD-O-3 SEER Site/Histology Validation List (6/14/2001 - updated from 2/9/2001)

The listing is provided in both PDF (*.pdf) and Excel (*.xls) formats. The PDF file is intended as a reference file for ICD-O-3 only. Although based on the 2/9/2001 validation list, it has been stripped of redlining and strikeouts.

Also available an Errata for ICD-0-3 Site/Type Validation List dated 9/16/02

FCDS Incidence Abstracting Workshop

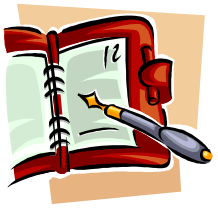
FCDS
Incidence Abstracting Workshop
March 26-28, 2003
at the
Double Tree Hotel
Coconut Grove, FL

Registration fee: $100.00

For more information please contact Mayra Alvarez at 305-243-4603.

15 CEU'S AWARDED FROM AHIMA

2003 CTR EXAM



Application Deadline
February 01, 2003

Examination Date
March 15, 2003

MARK YOUR CALENDAR

(Continued from page 2)

8522/2 Excision bx right breast: Ductal carcinoma in situ with the following haracteristics:
1) cribriform and solid subtype.
2) lobular carcinoma in situ.

Use the guidelines in order. Code the ductal and lobular combination.

8522/2 Left breast core needle bx: ductal carcinoma in situ with the following features:

1) Histologic type: cribriform and solid.
Excisional bx:
1) Lobular carcinoma in situ.
2) Rare microscopic foci of ductal carcinoma in situ with the following features:
a) Histologic type: cribriform.
3) Microcalcifications associated with DCIS and LCIS.
Use the guidelines in order. Code the ductal and lobular combination.

8522/2 Stereotactic breast bx: DCIS with the following features:
Pattern: cribriform and solid.
Excision bx: residual ductal carcinoma in situ with the following features:
Histologic type: Solid and cribriform types.
Medial margin: Rare foci reaching minimal criteria for lobular carcinoma in situ. Negative for invasive ca.
Code as ductal and lobular.

8522/3 Infiltrating duct ca with focal lobular features and focal mucinous features. There is cribriform DCIS with focal comedonecrosis adajacent to the infiltrating component.

Use a combination code for the invasive component. Use the first guideline and code the lobular and ductal combination.

8522/3 Right breast excisional biopsy: infiltrating ductal carcinoma with areas of metaplastic carcinoma with associated DCIS, cribriform histologic type and multiple foci of lobular carcinoma in situ.

Code the combination of invasive ductal and lobular in situ. "With areas of" does not constitute a majority of tumor.

8522/3 Left breast mass excision:
1) Infiltrating carcinoma with the following features:
Histologic type: infiltrating ductal carcinoma of apocrine type.
2) Ductal carcinoma in situ with the following features:
1) Histologic type: Apocrine cell type with papillary and solid architecture.
2) Scattered foci of lobular carcinoma in situ.
Use the combination of ductal and lobular.

8522/3 Ductal and papillary carcinoma with separate foci of lobular ca

Code ductal and lobular combination.

8522/3 Ductal ca, mucinous type, and LCIS.
Use the guidelines in order. Use the combination code of ductal and lobular.

8523/3 Mammogun bxs, R breast, 6 specimens:
Specimen #1, UIQ: Ductal carcinoma, in situ, cribriforming type, BR Score 3
Specimen #2, UOQ: NED
Specimen #3, LIQ: Infiltrating papillary ductal carcinoma, well differentiated
Specimen #4, LOQ: NED
Specimen #5: Central breast: NED
Specimen #6: Nipple complex: NED, flaky nipple observation on physical examination is
negative for Paget's disease.
R MRM w/R axill LN dissect: Ductal carcinoma, in situ and infiltrating, cribriform and papillary features observed; BR Score 3 to 4. 16 of 23 R axillary LNs with papillary ductal carcinoma present.

Use a combination code to include the cribriform and papillary features.

8523/2 Exc bx, R breast, UOQ: DCIS, cribriform (comedocarcinoma) and micropapillary, nuclear gr. 3.
Codes as multiple subtypes of DCIS.

8523/2 Stereotactic bx left breast: cribriform ductal carcinoma in situ.
Excisional bx: residual ductal carcinoma in situ, solid type.
Use information from both procedures. Code as multiple subtypes of DCIS.

Deadlines & Reminders

DEATH CERTIFICATE NOTIFICATION

FCDS mailed the Death Certificate Request Forms for 2001 the first week of December. All forms were to be returned to FCDS no later than January 15, 2003. The information on the forms was obtained from the official Florida Vital Statistics Death Certificate. Each form identifies a Florida resident who expired with a cancer-related cause of death and does not match with any record already in the FCDS database. **If you have any questions, please contact your Field Coordinator at (305) 243-4600 or 1-800-906-3034.**

PATH LABS

Every anatomic pathology laboratory that reads biopsy and surgical resection specimens collected from patient encounters within the State of Florida MUST electronically submit the specified data for every malignant cancer case. **Specimens read between January 1, 2002 and June 30, 2002 were due to FCDS on December 31, 2002.**

Specimen read between July 1, 2002 and December 31, 2002 are due June 30, 2003.

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

667369

FLORIDA CANCER DATA SYSTEM

P. O. BOX 016960 (D4-11)
MIAMI, FL 33101

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

PROJECT DIRECTOR:
Lora Fleming, MD, PhD

ADMINISTRATIVE DIRECTOR:
Jill Mackinnon, CTR

EDITORIAL STAFF:
Mayra Alvarez, RHIT, CTR
Melissa K. Williams

CONTRIBUTORS:
Megsys Cuadra, CTR

UMSylvester Comprehensive Cancer Center
University of Miami
Florida Department of Health