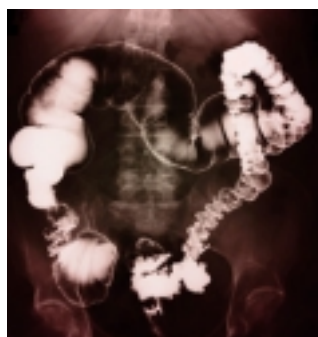




National Colorectal Cancer Awareness Month



Colon and Rectum: U.S. Racial/Ethnic Cancer Patterns

<http://cancer.gov/statistics/cancertype/colon-and-rectum-racial-ethnic>

Cancers of the colon and rectum are the fourth most commonly diagnosed cancers and rank second among cancer deaths in the United States. The incidence rates show wide divergence by racial/ethnic group, with rates in the Alaska Native population that are over four times as high as rates in the American Indian population (New Mexico) for both men and women. There are only minor differences, between men and women, in the order of incidence rates by racial/ethnic group. After Alaska Natives, the next highest rates in men are among Japanese, black and non-Hispanic white populations. These are followed by Chinese, Hawaiians and white Hispanics; and then Filipinos, Koreans and Vietnamese. In women, Alaska Natives are followed by black, Japanese and white non-Hispanic Americans. Next are Chinese,

Hawaiians, and Vietnamese; and finally white Hispanics, Koreans, and Filipinos. Incidence rates for both men and women are substantially lower among American Indians in New Mexico (18.6 per 100,000 in men, 15.3 per 100,000 in women). In each racial/ethnic group, incidence rates for cancers of the colon and rectum among women are lower than those among men. Although the pattern of incidence rates by race/ethnicity is similar for each sex, the ratio of male-to-female rates varies. Among Filipinos and Japanese, men experience an excess of greater than 60%, while among American Indians, Alaska Natives and Vietnamese the male excess is much lower at only 13-22%. It is interesting that, although the Alaska Natives have the highest colorectal cancer incidence rates of

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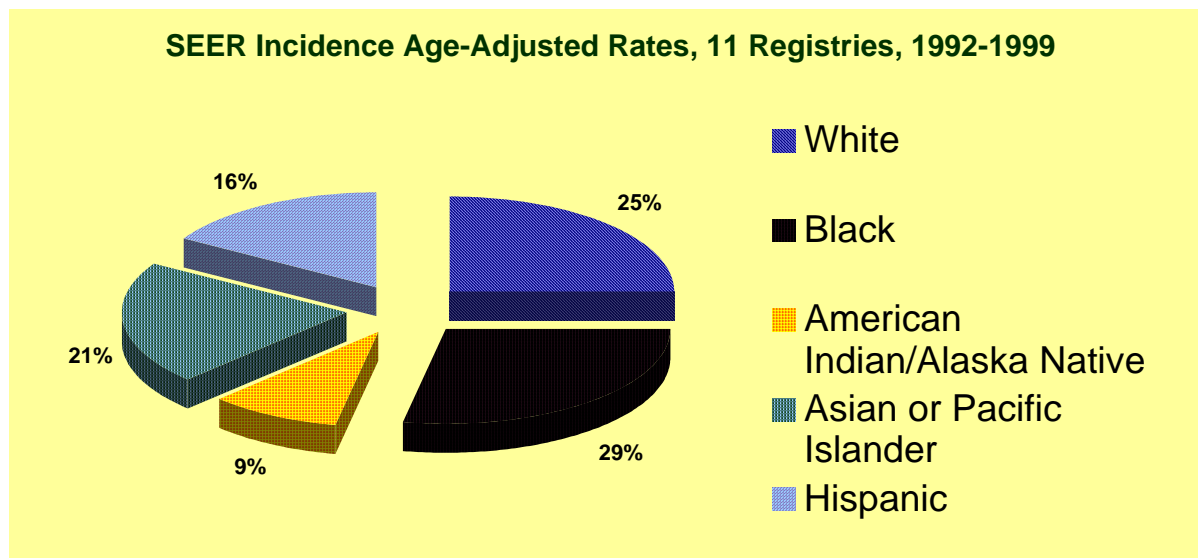
(Continued from page 1)

all groups and the American Indians experience the lowest, the gender ratios of these two native American groups are similar.

Mortality patterns by race/ethnicity for cancers of the colon and rectum are similar to those for incidence, with several notable exceptions. Black, Alaska Native, and white non-Hispanic men and women, as well as Hawaiian and Japanese men, have comparatively high mortality rates. The high mortality rates among Alaska Natives and Japanese men are consistent with the high incidence rates in these groups. However, the mortality rates among white non-Hispanic and black men and women, and among Hawaiian men, appear disproportionately high.

Colon cancer accounts for 59% (Korean men) to 81% (Alaska Native men) of the combined colon and rectum cancer incidence rates. This is reflected in a racial/ethnic pattern for colon cancer incidence rates that is quite similar to the pattern for both sites combined. Incidence and mortality rates for cancers of the colon and rectum increase with age. Interestingly, the incidence rate for Hawaiian men is highest in the 55-69 year age group, and their mortality rate is second only to black men in this age group.

Migrant and other studies have provided very strong evidence that colorectal cancer risk is modifiable, and that differences in population rates may therefore be explained by lifestyle or environmental factors. Dietary factors and exercise appear to be very important. Migrants to the United States (from Japan and other countries where rates of colon and rectal cancer are lower than in the U.S.) have higher rates than do those who remain in their native country. Studies have shown that first and second generation American offspring from these migrant groups develop these cancers at rates reaching or exceeding those of the United States white population.



Graph showing incidence and mortality for specific racial and ethnic groups including information that may not be discussed in the text, is available at the NCI's Surveillance, Epidemiology, and End Results (SEER) Web site at: <http://seer.cancer.gov/>.

Source: Miller BA, Kolonel LN, Bernstein L, Young, Jr. JL, Swanson GM, West D, Key CR, Liff JM, Glover CS, Alexander GA, et al. (eds). Racial/Ethnic Patterns of Cancer in the United States 1988-1992, National Cancer Institute. NIH Pub. No. 96-4104. Bethesda, MD, 1996.

CANCER REPORTING AND HIPAA

Implication of HIPAA for Central Cancer Registries

Administrators of all Hospitals, Ambulatory Surgical and Radiation Therapy Centers, and Path Labs in Florida. Under the new HIPAA regulations, all facilities will be allowed to report cancer data to FCDS. The documents mentioned in the letter may be found at these websites:

- <http://naaccr.org/Training/files/AcademicLetterInterpretingHIPAA.pdf>
- <http://naaccr.org/Training/files/LegalLetterInterpretingHIPAA.pdf>
- <http://naaccr.org/Training/files/FAQsRegardingHIPAAandCancerRegistries.pdf>



Dear Tumor Registrar/Administrator:

The Health Insurance Portability and Accountability act of 1996 (HIPAA) became law April 14, 2001. While most organizations have two full years – until April 14, 2003 – to comply, questions regarding how this new law impacts cancer reporting have arisen.

The North American Association of Central Cancer Registries (NAACCR) has provided materials that address these questions. As you will see, HIPAA regulations only minimally impact current state cancer reporting procedures. Specifically,

HIPAA allows for the reporting of identifiable cancer data to public health entities. Because the Florida Cancer Data System falls under the definition of a public health entity, HIPAA allows your facility to continue to report data to us in compliance with state law. Written informed consent from each cancer patient reported to public health entities is not required under HIPAA; rather hospitals must simply document that reporting has occurred.

Enclosed please find a copy of a letter from the NAACCR legal counsel, an academic interpretation of HIPAA from Professor James G. Hodge, Jr., J.D., LL.M., of the Georgetown University Law Center, and a list of frequently asked questions and answers.

We hope this material is beneficial in your understanding the HIPAA requirements regarding cancer incidence reporting.

Sincerely,

Jill A. MacKinnon
Administrative Director, FCDS

cc: Dr. Youjie Huang, DOH



EDUCATION AND TRAINING

HEALTH LEVEL 7 (HL7) WORKING GROUP MEETING

HL7 working group meeting will be held at the Renaissance Cleveland Hotel in Cleveland, Ohio April 28 - May 2, 2003.

The Cleveland Working Group Meeting will offer 23 educational opportunities. Sessions will cover a full range of HL7-specific topics.

Contact: meetinginfo@hl7.org
Phone number: 800-Hotels-1

Early Bird Registration & Hotel cutoff date is March 27, 2003.

NATIONAL CANCER REGISTRARS ASSOCIATION (NCRA) 29TH ANNUAL CONFERENCE

“NETWORKS OF STEEL: BUILDING A WORLD FREE OF CANCER”

The NCRA Annual Conference will be held at the innovative new David L. Lawrence Convention Center in Pittsburgh, Pennsylvania, May 13-16, 2003.

Continuing education hours for Certified Tumor Registries are being requested from the NCRA Program Recognition Committee. Approximately 18 CEs will be available. Additional CEs will be available through the pre/post-conference workshops.

Complete conference registration and information is available on the NCRA website at www.ncra-usa.org.

NAACCR 2003 ANNUAL MEETING

“HARMONY AND DIVERSITY IN CANCER REGISTRATION AND SURVEILLANCE: MEETING COMMUNITY HEALTH NEEDS”

The NAACCR Annual Meeting will be held at the Renaissance Ilikai Waikiki Hotel in Honolulu, Hawaii, June 10-12, 2003.

Register before May 1, 2003 for the Early Bird discounted registration fee.

Visit the NAACCR website at <http://www.naacccr.org/News/ameeting.html>, for further information.

FCDS 2003 ANNUAL MEETING

The Florida Cancer Data System 2003 Annual Meeting will be held at the Bellview Biltmore Resort & Spa in Clearwater, Florida on July 30, 2003.

Registration fee: \$25.00

For more information please contact Betty Fernandez and Bleu Herard at 305-243-4600.

FCRA 2003 ANNUAL MEETING

Celebrating its twenty-fifth anniversary, the Florida Cancer Registrars Association Annual Meeting will be held at the Bellview Biltmore Resort & Spa in Clearwater, Florida July 31- August 1, 2003.

For more information please contact Denise Colburn at 727-518-2522.

Registration fee :
\$100.00 for members
\$125.00 for non-members

2003 EMORY UNIVERSITY SESSIONS

ADVANCE CANCER REGISTRATION TRAINING PROGRAM

This intensive and comprehensive training program will be held at the Holiday Inn Express Hotel and Suites, 2183 North Decatur Road, Decatur, Georgia 30033, located in the Atlanta-Emory University area on March 24-28, 2003.

(Continued on page 5)

(Continued from page 4)

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

ON-LINE CANCER REGISTRY PROGRAM

Program is approved by NCRA

Orange County Community College, Institute for Business, Industry and Government is now offering an on-line Cancer Registry Management Program.

Visit their website for additional information at www.sunyorangecape.org.

AJCC VIDEOCONFERENCE VIDEOTAPE NOW AVAILABLE

A complimentary videotape from the American Joint Committee on Cancer's two-hour videoconference held on November 21, 2002, is now available.

Complimentary videotapes have already been sent to facilities that hosted the live videoconference. For those facilities that were unable to participate and would like a copy, please print the order form located on the AJCC's Web site at <http://www.cancerstaging.org> and fax the completed form to (312)202-5009. **No phone or e-mail orders will be taken. The quantity of videos is limited. Only one copy will be provided to each inquiring facility on a first come, first serve basis.**

Two Category 2 continuing medical education (CME) credit hours have been approved by the American College of Surgeons for viewing the videotape. The National Cancer Registrars Association (NCRA) has also approved this program for two continuing education (CE) hours.

The presentation contains the new concepts of TNM followed by the staging systems for breast, head and neck, GI, renal tumors, and melanoma and concludes with a question and answer session. The faculty includes Frederick L. Greene, MD, FACS, chair of the American Joint Committee on Cancer; Charles M. Balch, MD, FACS, executive vice president and CEO of the American Society of Clinical Oncology; and S. Eva Singletary, MD, FACS, professor of surgery at MD Anderson Cancer Center.

Source: CoC Flash February 2003



- HEALTH LEVEL 7 (HL7) WORKING GROUP MEETING, April 28 - May 2, 2003
- NATIONAL CANCER REGISTRARS ASSOCIATION (NCRA) 29TH ANNUAL CONFERENCE, May 13-16, 2003
- NAACCR 2003 ANNUAL MEETING, June 10- 12, 2003
- FLORIDA CANCER DATA SYSTEM 2003 ANNUAL MEETING, July 30, 2003
- FLORIDA CANCER REGISTRARS ASSOCIATION ANNUAL MEETING, July 31- August 1, 2003

Emory University Sessions

- ADVANCE CANCER REGISTRATION TRAINING PROGRAM, March 24-28, 2003



FCDS Q & A

Reason for No Cancer Directed Surgery

Source : <http://seer.cancer.gov/seerinqury/>

Question

How should we code Reason for No Cancer-Directed Surgery?

Answer

Code as 1, Cancer-Directed Surgery Not Recommended

Question

A patient with prostate cancer undergoes only a pelvic lymph node dissection. No surgery of primary site undertaken. What is the code for "reason for no cancer-directed surgery"?

Answer

Use code 0, (surgery performed) when a surgery is entered in any of the three surgery fields, "Surgery of Primary Site," "Scope of Regional LN Surgery," and "Surgery of other..reg/dist sites, dist LN."

Question

In general, is there a priority order for coding Reason for No Site Specific Surgery? See example below.

Answer

SEER has not established a priority for assigning the Reason for No Surgery of Primary Site codes. Assign the code which best describes the reason surgery was not performed.

Example: Assign code 2, Contraindicated due to patient risk factors. According to the physician, this is the reason that surgery was not performed.

Question

If no surgery is performed on the primary site, and "scope of regional lymph node surgery" and/or "surgery of other regional/distant site" is done, do we code "0" in the "reason for no cancer-directed surgery field?"

Answer

Yes, you would use Code 0, surgery performed. Surgery of Primary Site, Scope of Regional LN Surgery, and Surgery of Other Reg/Dist Sites are all surgical procedures, if any of these fields have a valid procedure code, reason for no surgery must be coded as 0.

Question

If the patient refuses treatment, it is not always clear how to code the treatment field.

Answer

1. Use code 7 when chemotherapy was discussed and recommended but the patient refused treatment.
2. Code 7 for radiation and chemotherapy if a combination of chemotherapy and radiation was the recommendation. If only one modality (either chemotherapy or radiation) was recommended, code 7 for the modality that was recommended and code 0 for the modality that was not recommended.
3. Code 00, no surgical procedure and code 1 in reason no cancer-directed surgery.



FORDS Revisions

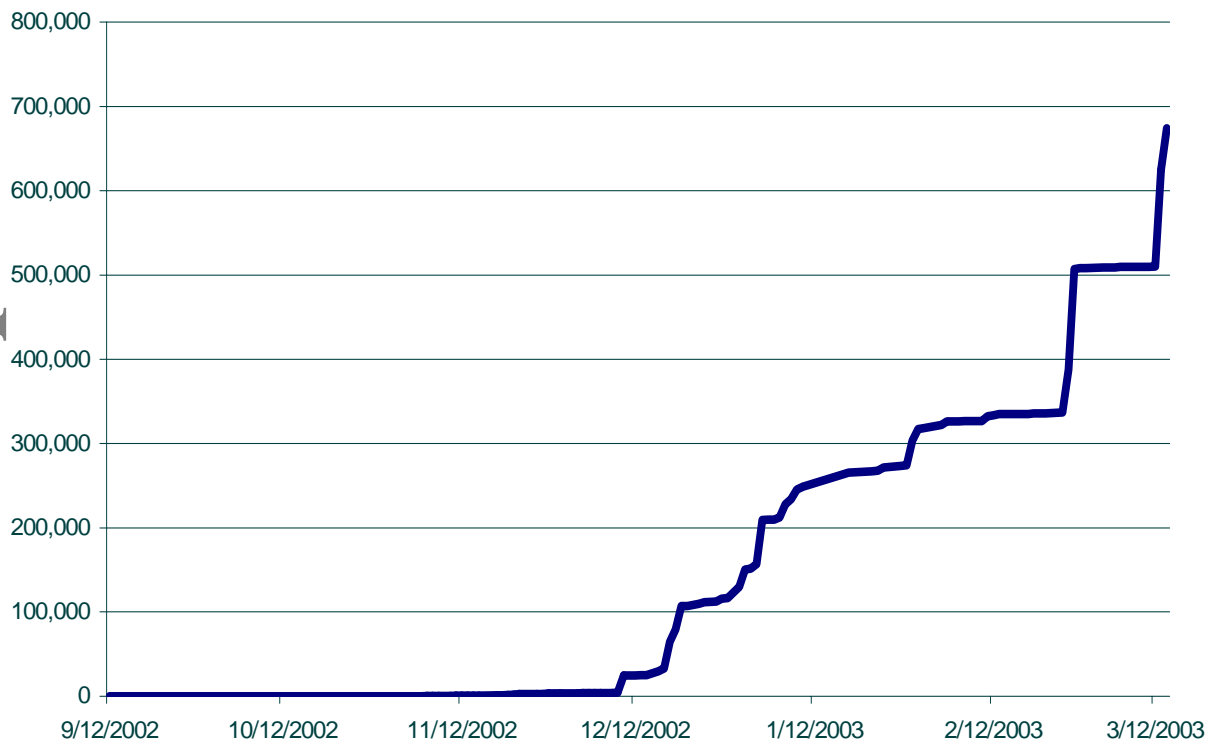
On February 10, the CoC made some minor corrections to *FORDS* files that were previously posted. These changes are indicated by the phrase "Revised and reposted 2/10/03" on the *FORDS* menu page. Please note that they have also specifically indicated the pages that were changed.

Therefore, you need only to print the pages indicated for your paper copy of the *FORDS* manual. You will also find a new "Individual Page Corrections" file dated 2/10/03. If you have already printed or purchased a copy of the *FORDS* manual, we encourage you to replace the current pages with just the corrected pages found in the PDF file located at <http://www.facs.org/dept/cancer/coc/fordspatientid0122.pdf>. For those who have downloaded the manual from the Web to your computer desktop, we encourage you to replace your current files with the revised PDFs for the individual sections of Patient Identification and First Course of Treatment.

Source: Commission on Cancer Web site: <http://www.facs.org/dept/cancer/coc/fordsmanual.html>

Path Reporting

Cumulative Path Data Received





Deadlines & Reminders

COMPLETENESS REPORT

The number of new cases added to the FCDS Masterfile in February 2003 is 9,351.

REMINDER

75% of the 2002 Cancer Admissions are due by March 31, 2003.

ANNUAL MAIL FILE REVIEW

The Annual Mail File Review forms were mailed to all FCDS mail recipients on February 20, 2003. Please be sure to review the document. In an effort to efficiently correspond with you, please make any and all corrections to the information provided directly on the form itself. Forms were to be returned to FCDS by March 14, 2003. You may fax the form to 305-243-4871. Please feel free to contact FCDS anytime throughout the year to inform us of any changes.

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 July 1, 2002 and December 31, 2002 must be submitted to FCDS on or before June 30, 2003.



FLORIDA CANCER DATA SYSTEM

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