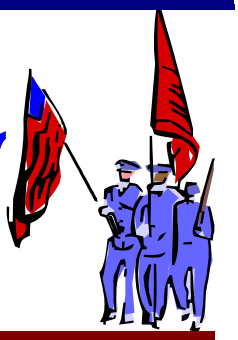
FLORIDA CANCER DATA SYSTEM

May 2003 Monthly Memo

Happy Memorial Day



MELANOMA & SKIN CANCER AWARENESS MONTH

What You Need To Know About Melanoma

National Cancer Institute (NCI) website:
http://www.nci.nih.gov/cancerinfo/wyntk/melanoma

Introduction

Melanoma is the most serious type of cancer of the skin. Each year in the United States, more than 53,600 people learn they have melanoma.

In some parts of the world, especially among Western countries, melanoma is becoming more common every year. In the United States, for example, the percentage of people who develop melanoma has more than doubled in the past 30 years.

The National Cancer Institute (NCI) has written this booklet to help people with melanoma and their families and friends better understand this disease. We hope others will read it as well to learn more about melanoma. This booklet discusses risks and prevention, symptoms, diagnosis, treatment, and follow-up care. It also has information about resources and sources of support to help patients cope with melanoma.

Research continues to teach us more about melanoma. Scientists are learning more about its causes. They are exploring new ways to prevent, find, and treat this disease. Because of research, people with melanoma can look forward to a better quality of life and less chance of dying from this disease.

What Is Melanoma?

Melanoma is a type of skin cancer. It begins in *cells* in the skin called melanocytes. To understand melanoma, it is helpful to know about the skin and about melanocytes—what they do, how they grow, and what happens when they become cancerous.

The Skin

The skin is the body's largest organ. It protects against heat, sunlight, injury, and infection. It helps regulate body temperature, stores water and fat, and produces vitamin D.

(Continued on page 6)

NOTICE FOR ALL HOSPITAL AND FREESTANDING CODERS

(PATHLABS EXEMPT)

Florida Cancer Data System

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

May 15, 2003

TO: FCDS Cancer Abstractors

FROM: Jill MacKinnon

RE: FCDS Cancer Abstractor Code

Effective July 1, 2003 'abstractor initials' will no longer be accepted on abstract forms. All abstracts must have an approved '**cancer abstractor code**' in this field. The abstractor code will be part of the edit process, therefore, if a code is incorrect, the abstracts (or batch) will be returned unprocessed.

This code **may not** be shared with other abstractors. Each abstractor that submits work to FCDS in a hospital-based registry must have their own unique abstractor code. (Individuals or Contractors abstracting for multiple facilities need only one abstractor code). The three digit abstractor codes will be generated using a mixture of letters and numbers. The abstractor codes will be renewed each year on July 1st.

The attached Abstractor Code Request form must be completed and returned to your Field Coordinator as soon as possible. Once you receive your code you may begin using it prior to July 1, 2003. **However, on and after July 1, 2003, no records will be accepted with an incorrect abstractor code**.

You may return the form via Fax or US mail. Should you have any questions please contact your Field Coordinator. You will receive your abstractor code in return mail to the address you listed on the form.

Thank you,

cc: Field Coordinator

Enclosure: Cancer Abstractor Code Request Form

Florida Cancer Data System
Cancer Abstractor Code
Request Form

Please mail or Fax this form to your FCDS Field Coordinator

First Name: _____

Last Name: _____

Middle Initial: _____

Mailing Address: _____

_____

City: _____ State: _____ Zip Code: _____

Day Phone: (_____) _____

E-Mail Address: _____

Are you a Certified Tumor Registrar (CTR)? *Please check one*:

___ Yes – Year certified _____

___ No

How many years have you been abstracting cancer information? _____

I attest the above information is true and correct; that I will not share my abstractor code with any one and that I know and understand the codes, policies and procedures for abstracting cancer cases for the Florida Cancer Data System.

Signature: _____/ Date_____

For FCDS Use Only:

Abstractor Code: _____ Expiration Date: _____

DIAGNOSTIC CONFIRMATION

SEER Inquiry System
http://seer.cancer.gov/seerinquiry/

FCDS Q & A

Question
Would this case be reportable, if so, what would the diagnostic confirmation be? Path report from shave bx of mid upper chest states: "compound nevus w/adjacent markedly atypical junctional melanocytic proliferation. Changes highly suggestive of early melanoma arising adjacent to superficial congenital nevus." The re-excision path says "biopsy proven melanoma" in the "Clinical History" section of the report (referencing the original shave bx). The re-excis path says "no evid of melanoma." The abstract had a statement from the physician that states he feels it is a melanoma. Should it be reported? Should it be a DC "1" or "8?"

Answer
The case is reportable because the physician documented a clinical diagnosis of malignant melanoma. The field "Diagnostic Confirmation" should be coded 8, clinical dx (physician).

Question
Question, can we use code 1 (histology) for diagnostic confirmation for all hemotologic diseases being diagnosed by just peripheral blood smear? For instance on page 111 of SEER Code Manual it states in 'Code 1' that positive hematologic findings relate. to leukemia, include. peripheral blood smears....It looks like we can only use code 1 for leukemia diagnosed that way.

Answer
Hemotologic diseases diagnosed by peripheral blood smear and by bone marrow are coded as histologic confirmation (code 1).

References
SEER Program Code Manual ;pgs 111

Question
On PE, the patient has a mass in his right testicle and the testicular antigen was positive. Patient had a right orchiectomy and the pathology was negative. The final diagnosis on the chart was testicular cancer. Do we code diagnostic confirmation as 5, positive marker?

Answer
Use code 5, positive marker. The disease was confirmed both clinically and by a positive marker. Code 8, clinical diagnosis only, is used when the diagnosis is based on information other than that coded in 5, 6, or 7 (positive lab test/marker study, visualization, and radiography or other imaging techniques). Code 8 is rarely used.

Question
Do we code "5" (positive laboratory test/ marker study) for prostate cases when there is an elevated PSA with no other work-up?

Answer
Yes. Use code 5 to indicate the diagnosis is based upon an abnormal PSA tumor marker if the physician uses the PSA as a basis for diagnosing prostate cancer.

DEADLINES- Seriously Delinquent Letter

Facilities that have fewer than 55% of their 2002 total annual caseload reported to FCDS by the end of April will receive a Seriously Delinquent letter. The letter was mailed the first week of May 2003 to the facility Administrator with a copy to the Tumor Registrar or Health Information Management Director. The intent of the letter is to inform the facility that state mandated reporting of cancer cases to the Florida Cancer Data System (FCDS) is seriously delinquent and that the facility has 60 days in which to complete the reporting.

Facilities failing to meet state cancer reporting requirements by June 30, 2003 will be referred to the Florida Agency for Health Care Administration (AHCA), Healthcare Facilities Licensing and, in accordance with Florida Statute 385.202, are subject to "registration or licensure suspension or revocation."

FCDS continues to work with individual facilities under extenuating circumstances.

This deadline does not apply to non-hospital facilities.

2001 AHCA In-Patient Audit –Deadline May 30, 2003

On April 22, 2003, FCDS completed the matching of the **2001** In-Patient Discharges reported by all Florida hospital's Finance-Billing/Medical Records Department to the Agency for Health Care Administration (AHCA). All records with principal or secondary diagnoses of cancer were linked to the FCDS database. Each AHCA record that did not match with a case in the FCDS Master file is identified on the AHCA Unmatched Cancer Records Request listing. Any case found on the report to meet the FCDS Cancer Case Reporting Requirements outlined in Section I of the *FCDS DAM* and found not to have been previously reported must be reported to FCDS. Please check your 'Cases Reviewed But Not Reported To FCDS' listing to determine why the case was not reported.

All Forms and Abstracts must be completed and submitted to FCDS according to the current reporting guidelines and record layout no later than May 30, 2003.

All audits conducted by FCDS are dictated and closely monitored by the Department of Health. Should you have any questions, please contact your Field Coordinator at (305) 243-4600. Thank you.

Ambulatory Care Centers Cancer Reporting Program - 2001 AHCA audit– Deadline May 30, 2003

The matching of the 2001 outpatient discharges reported by Florida Ambulatory Patient Care Centers' Finance-Billing/Medical Records Department to the Agency for Health Care Administration (AHCA) was also completed on April 22, 2003. All records with principal or secondary diagnoses of cancer were linked to the FCDS database. Only records reported to AHCA but not matched to an FCDS record will appear on the lists titled "AHCA Ambi Unmatched Cancer Records Request." The centers will only receive notification for cases that have never been reported from any other source to FCDS.

Facilities With Fewer Than 35 Cancer Cases Identified On The "AHCA Ambi Unmatched Cancer Records Request" List - Copies Of Records Only

Any facility with fewer than 35 cancer cases identified on the "AHCA Ambi Unmatched Cancer Records Request" list need only submit copies of patient records to FCDS for each of the cases on the list. A Batch Transmittal Form must be included with any chart copies submitted.

The following reports (if available) from each patient record must be submitted before August 15, 2003: Face sheet, Summary, History & Physical, Operative Reports, Consultation Reports, Pathology Reports, Radiology Reports, Laboratory Reports and all other pertinent reports.

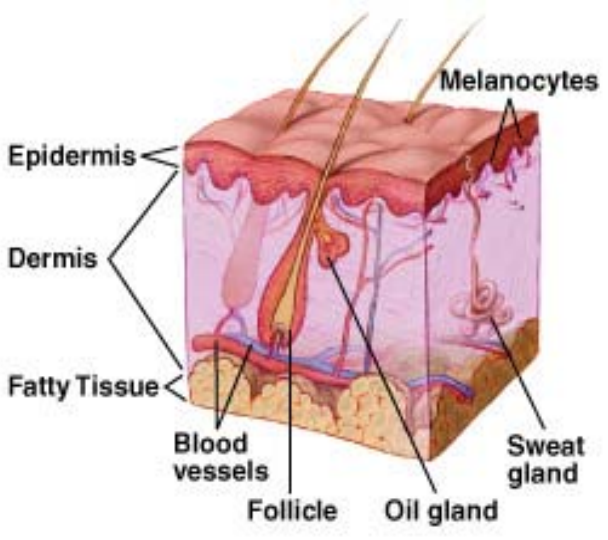
Facilities With Greater Than 35 Cancer Cases On The "AHCA Ambi Unmatched Cancer Records Request" List - Full Case Reporting Required

The facility must determine whether or not each of the identified case records must be reported to the FCDS by referring to the FCDS reporting criteria outlined in Section I of the *FCDS Data Acquisition Manual*. If the case meets the FCDS reporting criteria, a full case abstract must be submitted to FCDS. All data submitted to FCDS must be via

(Continued on page 12)

Deadlines & Reminders

(Continued from page 1)



The skin has two main layers: the outer epidermis and the inner dermis.

The epidermis is mostly made up of flat, scale like cells called squamous cells. Round cells called basal cells lie under the squamous cells in the epidermis. The lower part of the epidermis also contains melanocytes.

The dermis contains blood vessels, lymph vessels, hair follicles, and glands. Some of these glands produce sweat, which helps regulate body temperature. Other glands produce sebum, an oily substance that helps keep the skin from drying out. Sweat and sebum reach the skin's surface through tiny openings called pores.

Melanocytes and Moles

Melanocytes produce melanin, the pigment that gives skin its natural color. When skin is exposed to the sun, melanocytes produce more pigment, causing the skin to tan, or darken.

Sometimes, clusters of melanocytes and surrounding tissue form noncancerous growths called moles. (Doctors also call a mole a nevus; the plural is nevi.) Moles are very common. Most people have between 10 and 40 moles. Moles may be pink, tan, brown, or a color that is very close to the person's normal skin tone. People who have dark skin tend to have dark moles. Moles can be flat or raised. They are usually round or oval and smaller than a pencil eraser. They may be present at birth or may appear later on—usually before age 40. They tend to fade away in older people. When moles are surgically removed, they normally do not return.

Melanoma

Melanoma occurs when melanocytes (pigment cells) become malignant. Most pigment cells are in the skin; when melanoma starts in the skin, the disease is called cutaneous melanoma. Melanoma may also occur in the eye (ocular melanoma or intraocular melanoma). Rarely, melanoma may arise in the meninges, the digestive tract, lymph nodes, or other areas where melanocytes are found. Melanomas that begin in areas other than the skin are not discussed in this booklet. The Cancer Information Service (1-800-4-CANCER) can provide information about these types of melanoma.

Melanoma is one of the most common cancers. The chance of developing it increases with age, but this disease affects people of all ages. It can occur on any skin surface. In men, melanoma is often found on the trunk (the area between the shoulders and the hips) or the head and neck. In women, it often develops on the lower legs. Melanoma is rare in black people and others with dark skin. When it does develop in dark-skinned people, it tends to occur under the fingernails or toenails, or on the palms or soles.

When melanoma spreads, cancer cells may show up in nearby lymph nodes. Groups of lymph nodes are found throughout the body. Lymph nodes trap bacteria, cancer cells, or other harmful substances that may be in the lymphatic system. If the cancer has reached the lymph nodes, it may mean that cancer cells have spread to other parts of the body such as the liver, lungs, or brain. In such cases, the cancer cells in the new tumor are still melanoma cells, and the disease is called metastatic melanoma, not liver, lung, or brain cancer.

Melanoma: Who's at Risk?

No one knows the exact causes of melanoma. Doctors can seldom explain why one person gets melanoma and another does not.

However, research has shown that people with certain risk factors are more likely than others to develop melanoma. A risk factor is anything that increases a person's chance of developing a disease. Still, many who do get this disease have no known risk factors.

Studies have found the following risk factors for melanoma:

Dysplastic nevi: Dysplastic nevi are more likely than ordinary moles to become cancerous. Dysplastic nevi are common, and many people have a few of these abnormal moles. The risk of melanoma is greatest for people who have a large number of dysplastic nevi. The risk is

(Continued on page 7)

(Continued from page 6)
especially high for people with a family history of both dysplastic nevi and melanoma.

Many (more than 50) ordinary moles: Having many moles increases the risk of developing melanoma.

Fair skin: Melanoma occurs more frequently in people who have fair skin that burns or freckles easily (these people also usually have red or blond hair and blue eyes) than in people with dark skin. White people get melanoma far more often than do black people, probably because light skin is more easily damaged by the sun.

Personal history of melanoma or skin cancer: People who have been treated for melanoma have a high risk of a second melanoma. Some people develop more than two melanomas. People who had one or more of the common skin cancers (basal cell carcinoma or squamous cell carcinoma) are at increased risk of melanoma.

Family history of melanoma: Melanoma sometimes runs in families. Having two or more close relatives who have had this disease is a risk factor. About 10 percent of all patients with melanoma have a family member with this disease. When melanoma runs in a family, all family members should be checked regularly by a doctor.

Weakened immune system: People whose immune system is weakened by certain cancers, by drugs given following organ transplantation, or by HIV are at increased risk of developing melanoma.

Severe, blistering sunburns: People who have had at least one severe, blistering sunburn as a child or teenager are at increased risk of melanoma. Because of this, doctors advise that parents protect children's skin from the sun. Such protection may reduce the risk of melanoma later in life. Sunburns in adulthood are also a risk factor for melanoma.

Ultraviolet (UV) radiation: Experts believe that much of the worldwide increase in melanoma is related to an increase in the amount of time people spend in the sun. This disease is also more common in people who live in areas that get large amounts of UV radiation from the sun. In the United States, for example, melanoma is more common in Texas than in Minnesota, where the sun is not as strong. UV radiation from the sun causes premature aging of the skin and skin damage that can lead to melanoma. Artificial sources of UV radiation, such as sunlamps and tanning booths, also can cause skin damage and increase the risk of melanoma. Doctors encourage people to limit their exposure to natural UV radiation and to avoid artificial sources.

People who are concerned about developing melanoma should talk with their doctor about the disease, the symptoms to watch for, and an appropriate schedule for checkups. The doctor's advice will be based on the person's personal and family history, medical history, and other risk factors.

Signs and Symptoms

Often, the first sign of melanoma is a change in the size, shape, color, or feel of an existing mole. Most melanomas have a black or blue-black area. Melanoma also may appear as a new mole. It may be black, abnormal, or "ugly looking." ***(See Picture Box, p. 8)***

If you have a question or concern about something on your skin, see your doctor. Do not use the pictures shown at left to try to diagnose it yourself. Pictures are useful examples, but they cannot take the place of a doctor's examination.

Melanomas in an early *stage* may be found when an existing mole changes slightly, for example, when a new black area forms. Newly formed fine scales and itching in a mole also are common symptoms of early melanoma. In more advanced melanoma, the texture of the mole may change. For example, it may become hard or lumpy. Melanomas may feel different from regular moles. More advanced tumors may itch, ooze, or bleed. But melanomas usually do not cause pain.

A skin examination is often part of a routine checkup by a health care provider. People also can check their own skin for new growths or other changes. (The "How To Do a Skin Self-Exam" section on pg. 9 has a simple guide on how to do this skin self-exam.) Changes in the skin, such as a change in a mole, should be reported to the health care provider right away. The person may be referred to a dermatologist, a doctor who specializes in diseases of the skin.

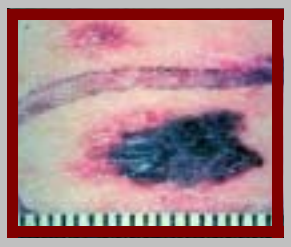
Melanoma can be cured if it is diagnosed and treated when the tumor is thin and has not deeply invaded the skin. However, if a melanoma is not removed at its early stages, cancer cells may grow downward from the skin surface and invade healthy tissue. When a melanoma becomes thick and deep, the disease often spreads to other parts of the body and is difficult to control.

People who have had melanoma have a high risk of developing a new melanoma. People at risk for any reason should check their skin regularly and have regular skin

(Continued on page 8)

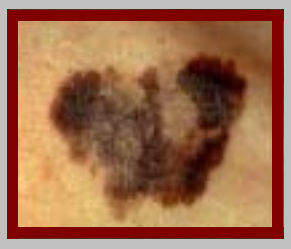
Thinking of "ABCD" can help you remember what to watch for:

ASYMMETRY—The shape of one half does not match the other.



BORDER—The edges are often ragged, notched, blurred, or irregular in outline; the pigment may spread into the surrounding skin.

COLOR—The color is uneven. Shades of black, brown, and tan may be present. Areas of white, grey, red, pink, or blue also may be seen.



DIAMETER—There is a change in size, usually an increase. Melanomas are usually larger than the eraser of a pencil (1/4 inch or 5 millimeters).

(Continued from page 7)

exams by a health care provider.

Dysplastic Nevi

Some people have certain abnormal-looking moles (called dysplastic nevi or atypical moles) that are more likely than normal moles to develop into melanoma. Most people with dysplastic nevi have just a few of these abnormal moles; some people have many. People with dysplastic nevi and their health care provider should examine these moles regularly to watch for changes. (Additional information about moles and dysplastic nevi and melanoma risk is available on the NCI website and in the NCI booklet *What You Need To Know About Moles and Dysplastic Nevi*, http://www.nci.nih.gov/cancerinfo/wyntk/moles-and-dysplastic-nevi .)

Dysplastic nevi often look very much like melanoma. Doctors with special training in skin diseases are in the best position to decide whether an abnormal-looking mole should be closely watched or removed and checked for cancer.

In some families, many members have a large number of dysplastic nevi, and some have had melanoma. Members of these families have a very high risk of melanoma. Doctors often recommend that they have frequent checkups (every 3 to 6 months) so that any problems can be detected early. The doctor may take pictures of a person's skin to help show when changes occur.

Diagnosis

If the doctor suspects that a spot on the skin is melanoma, the patient will need to have a biopsy. A biopsy is the only way to make a definite diagnosis. In this procedure, the doctor tries to remove all of the suspicious-looking growth. This is an excisional biopsy. If the growth is too large to be removed entirely, the doctor removes a sample of the tissue. The doctor will never "shave off" or cauterize a growth that might be melanoma.

A biopsy can usually be done in the doctor's office using local anesthesia. A pathologist then examines the tissue under a microscope to check for cancer cells. Sometimes it is helpful for more than one pathologist to check the tissue for cancer cells.

Staging

If the diagnosis is melanoma, the doctor needs to learn the extent, or stage, of the disease before planning treatment. Staging is a careful attempt to learn how thick the tumor is, how deeply the melanoma has invaded the skin, and whether melanoma cells have spread to nearby lymph nodes or other parts of the body. The doctor may remove nearby lymph nodes to check for cancer cells. (Such surgery may be considered part of the treatment because removing cancerous lymph nodes may help control the disease.) The doctor

(Continued on page 9)

(Continued from page 8)
also does a careful physical exam and, if the tumor is thick, may order chest x-rays, blood tests, and scans of the liver, bones, and brain.

Stages of Melanoma

The following stages are used for melanoma:

Stage 0: In stage 0, the melanoma cells are found only in the outer layer of skin cells and have not invaded deeper tissues.

Stage I*:* Melanoma in stage I is thin:

The tumor is no more than 1 millimeter (1/25 inch) thick. The outer layer (epidermis) of skin may appear scraped. (This is called an ulceration).

Or, the tumor is between 1 and 2 millimeters (1/12 inch) thick. There is no ulceration.

The melanoma cells have not spread to nearby lymph nodes.

Stage II: The tumor is at least 1 millimeter thick:

The tumor is between 1 and 2 millimeters thick. There is ulceration.

Or, the thickness of the tumor is more than 2 millimeters. There may be ulceration.

The melanoma cells have not spread to nearby lymph nodes.

Stage III: The melanoma cells have spread to nearby tissues:

The melanoma cells have spread to one or more nearby lymph nodes.

Or, the melanoma cells have spread to tissues just outside the original tumor but not to any lymph nodes.

Stage IV: The melanoma cells have spread to other organs, to lymph nodes, or to skin areas far away from the original tumor.

Recurrent: Recurrent disease means that the cancer has come back (recurred) after it has been treated. It may have come back in the original site or in another part of the body.

Treatment

The doctor can describe treatment choices and discuss the

(Continued on page 10)

How To Do a Skin Self-Exam

Your doctor or nurse may recommend that you do a regular skin self-exam. If your doctor has taken photos of your skin, comparing your skin to the photos can help you check for changes.

The best time to do a skin self-exam is after a shower or bath. You should check your skin in a well-lighted room using a full-length mirror and a hand-held mirror. It's best to begin by learning where your birthmarks, moles, and blemishes are and what they usually look and feel like.

Check for anything new:

- A new mole (that looks abnormal)
- A change in the size, shape, color, or texture of a mole
- A sore that does not heal

Check yourself from head to toe. Don't forget to check all areas of the skin, including the back, the scalp, between the buttocks, and the genital area.

- Look at your face, neck, ears, and scalp. You may want to use a comb or a blow dryer to move your hair so that you can see better. You also may want to have a relative or friend check through your hair because this is difficult to do yourself.
- Look at the front and back of your body in the mirror, then raise your arms and look at your left and right sides.
- Bend your elbows and look carefully at your fingernails, palms, forearms (including the undersides), and upper arms.
- Examine the back, front, and sides of your legs. Also look between your buttocks and around your genital area.
- Sit and closely examine your feet, including the toenails, the soles, and the spaces between the toes.

By checking your skin regularly, you will become familiar with what is normal for you. It may be helpful to record the dates of your skin exams and to write notes about the way your skin looks. If you find anything unusual, see your doctor right away.

Source:National Cancer Institute (NCI)
http://www.nci.nih.gov

results expected with each treatment option. The doctor and patient can work together to develop a treatment plan that fits the patient's needs. Treatment for melanoma depends on the extent of the disease, the patient's age and general health, and other factors.

People with melanoma are often treated by a team of specialists. The team may include a dermatologist, surgeon, medical oncologist, radiation oncologist, and plastic surgeon.

Getting a Second Opinion

Before starting treatment, the patient might want a second opinion about the diagnosis and the treatment plan. Some insurance companies require a second opinion; others may cover a second opinion if the patient or doctor requests it.

There are a number of ways to find a doctor for a second opinion:

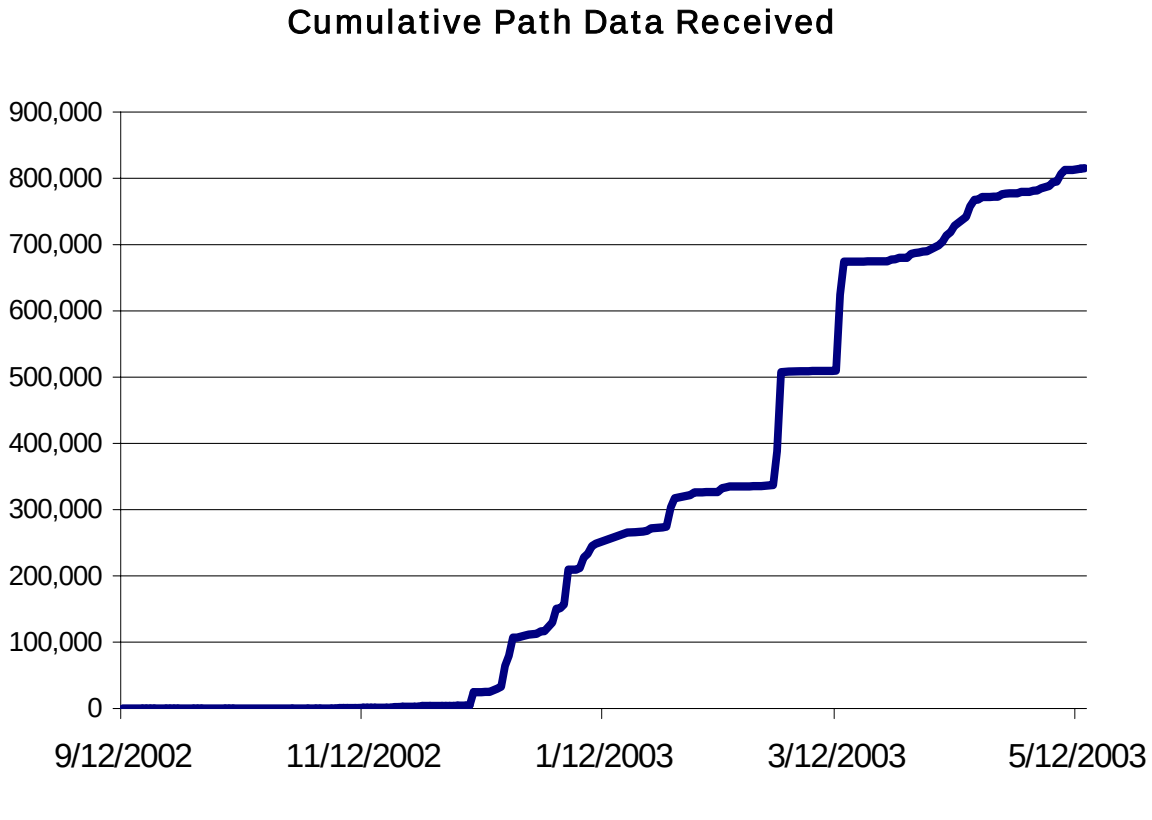
The patient's doctor may refer the patient to one or more specialists. At cancer centers, several specialists often work together as a team.

The Cancer Information Service, at 1-800-4-CANCER, can tell callers about nearby treatment centers.

A local or state medical society, a nearby hospital, or a medical school can usually provide the names of specialists.

The *Official ABMS Directory of Board Certified Medical Specialists* lists doctors' names along with their specialty and their educational background. Board-certified doctors have met specific education and training requirements and have passed an examination given by a specialty board. The directory is available in most public libraries. The American Board of Medical Specialties (ABMS) also offers information about board certification by telephone and on the Internet. The toll-free telephone number is 1-866-ASK-ABMS (1-866-275-2267). The Internet address is **http://www.abms.org/newsearch.asp**.

Path Reporting



EDUCATION AND TRAINING

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 (*http://www.ilikaihotel.com)* in Honolulu, Hawaii, June 10-12, 2003.

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

FCDS EDUCATIONAL TELECONFERENCE

CODING COMPLEX MORPHOLOGIC DIAGNOSES

Presented by:
April Fritz, RHIT, CTR,
Manager of Data Quality, NCI SEER Program

Dates: July 9, 2003
Time: 2:00 p.m. - 4:00 p.m.
Dial In Number: 800-486-2726
Participant Code: 182834

FCDS 2003 ANNUAL MEETING

The Florida Cancer Data System 2003 Annual Meeting will be held at the Belleview Biltmore Resort & Spa (*http://www.belleviewbiltmore.com)* in Clearwater, Florida on July 30, 2003.

Registration fee: $25.00

For more information please contact Betty Fernandez or 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.

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

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

2003 EMORY UNIVERSITY SESSIONS

ADVANCE CANCER REGISTRATION TRAINING PROGRAM

The Advanced Cancer Registry Training Program will focus on 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.

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 July 9-11, 2003.

Participants **must** have attended the Principles and Practice training program prior to registering for this advanced training or have at least one year of experience working in a cancer registry.

Registration fee: $500 for the full 3 day training

Approved by NCRA for 20.5 CE hours

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*.

Deadlines & Reminders

(Continued from page 5)

the encrypted Internet transmission, FCDS IDEA. For further information, visit the FCDS website at **http://fcds.med.miami.edu.** If the case does not meet the FCDS reporting criteria, the appropriate Disposition Code must be documented on the "AHCA Ambi Unmatched Cancer Records Request" list and returned to FCDS.

FCDS will be converting the state registry database to the NAACCR version 10 record layout from July 1, 2003 through July 15, 2003. No data will be accepted during this period.

Due to the conversion, please be aware of the following dates. The dates will affect your workload.

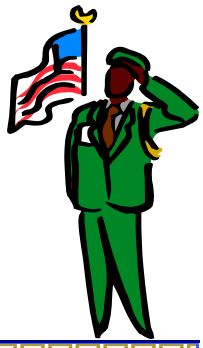
Cases received by FCDS on or before June 30, 2003- All abstracts must be submitted according to the current reporting guidelines and record layout (NAACCR version 9).

Cases received by FCDS after July 15, 2003- All abstracts must be submitted according to the new reporting guidelines and new NAACCR version 10 record layout (This includes the new data items).

If after reviewing the "AHCA Unmatched Cancer Records Request" list, the facility has fewer than 35 reportable cases, you need only submit copies of patient records to FCDS for each of the cases on the list. A Batch Transmittal Form must be included with any chart copies submitted. The following reports (if available) must be submitted from each patient record: Face sheet, Summary, History & Physical, Operative Reports, Consultation Reports, Pathology Reports, Radiology Reports, Laboratory Reports and all other pertinent reports.

August 15, 2003 is the final deadline for completing all forms and abstracts, or for submitting copies of patient records.

All audits conducted by FCDS are dictated and closely monitored by the Department of Health. If you have any questions, please contact Megsys Casuso at (305) 243-2625 or Megsys_Casuso@miami.edu.



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.**

FCDS Florida Cancer Data System

667369

FLORIDA CANCER DATA SYSTEM

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

FCDS Florida Cancer Data System

PROJECT DIRECTOR:
Lora Fleming, MD, PhD

ADMINISTRATIVE DIRECTOR:
Jill Mackinnon, CTR

EDITORIAL STAFF:
Mark Rudolph, M.S.
Mayra Alvarez, RHIT, CTR
Melissa K. Williams

CONTRIBUTORS:
Megsys Cuadra, CTR
Betty Fernandez

UMSylvester Miami HEALTH