FLORIDA CANCER DATA SYSTEM

Happy Fourth of July

JUNE / JULY 2003 MONTHLY MEMO

National Cancer Survivors Month

Staging A Cancer Case

SEER's Training Website: http://training.seer.cancer.gov/module_staging_cancer/unit01_sec01_staging_defined.html

STAGING DEFINED

The concept of describing disease by stage or extent was introduced in 1929 by the League of Nation's World Health Organization. Staging is a common language developed by medical professionals to communicate information about a disease to others. The disease can be any acute or chronic disease such as cancer, diabetes, acquired immunodeficiency syndrome (AIDS), cardiovascular disease, or rheumatoid arthritis. The first primary site so described was cancer of the cervix.

Staging for cancer has evolved over many years. Many groups have developed different staging systems. Some staging systems cover all sites; others are limited to particular ages of patients, histology, sites, study groups, or medical specialties. This learning module briefly discusses common staging schemes and classifications. The three most common staging systems used in hospital and central registries are discussed in detail.

Staging is a shorthand method for describing disease. A coded format, such as a numerical system with increasing values meaning more involvement or severity, allows electronic analysis of cases with similar characteristics.

A short definition for staging is "the grouping of cases into broad categories based on extent of disease." Extent of disease is a detailed description of how far the tumor has spread from organ or site of origin (the primary site). Extent of disease is an anatomic categorization using descriptors to group individual cases in relation to the human body.

As stated in the National Cancer Registrars Association Workbook for Staging Cancer: *Classification is the process of grouping cases based on specific criteria. Classification is an orderly arrangement showing relationships among groups. Classification does not necessarily imply a prognosis.*

The relationship between staging, extent of disease and classification is: extent of disease is a type of classification (based on human anatomy) and pertains to an individual case. Staging is

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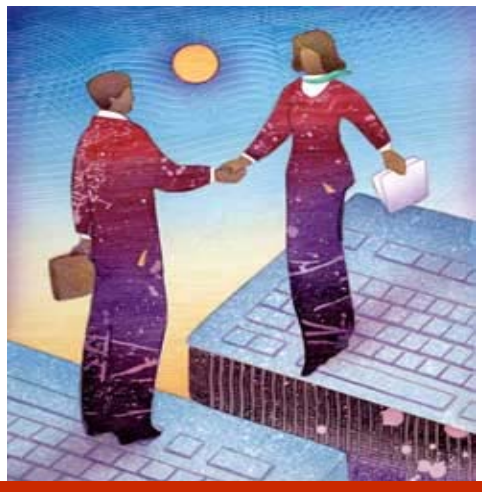

REMINDER:

All Hospital and Freestanding Abstractors

Path labs <u>do not</u> need abstractor codes.

TO: FCDS Cancer Abstractors

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 **<u>may not</u>** 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 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. **On and after July 1, 2003, no records will be accepted with an incorrect abstractor code**.

You may return the form via Fax (305) 243-4871 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

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coded shorthand or a notation describing disease in more general terms. By staging, characteristics about a case (precise extent of disease information) can be grouped into categories. Thus staging translates extent of disease classification about individual cancers into groups that can be studied or evaluated for prognostic significance.

Elements to be considered in any staging system are the primary tumor site, tumor size, multiplicity (number of tumors), depth of invasion and extension to regional or distant tissues, involvement of regional lymph nodes, and distant metastases.

PURPOSE OF STAGING

There are several reasons for staging cancer cases. One reason is that the need for staging places a responsibility on the medical practitioner to adequately assess the extent of cancer in order to treat the disease in the most appropriate manner. Another reason is that knowing the extent of disease helps the physician determine the most appropriate treatment to cure the disease, decrease the tumor burden, or relieve symptoms.

Staging is also used to indicate prognosis for an individual patient. Data from historical sources can provide an estimate of the expected survival rate for a particular cancer with a corresponding extent of disease. Of course, histology and grade of tumor, patient demographics such as age, sex, and race, and the efficacy of therapy all play a part in determining the patient's prognosis and quality of survival.

Staging provides a means of comparing local treatment results with national data based on common criteria for the extent of disease. Staging expedites the exchange of data and assists in the continuing research on cancer. Health information records are the primary source of documentation for staging information.

STAGING SOURCES

Many sources in the health information record must be examined to determine the extent of disease. These sources are part of the diagnostic workup for the disease. These tests may be done on an outpatient basis or in a physician's office. Below is a list of staging sources:

- Physical Exam
- Radiologic Procedures
  - X-rays
  - Scans
  - Endoscopies
- Tumor Markers
- Pathologic Exams
- Surgical Reports
- Progress Notes and Discharge Summaries

STAGING SYSTEM

The Surveillance, Epidemiology and End Results (SEER) Program of the National Cancer Institute collects cancer data from designated populated-based cancer registries in various areas of the country. There are two staging classifications developed by SEER: extent of disease and summary stage. Extent of disease (EOD) coding is required for all SEER programs funded through the National Cancer Institute.

The Commission on Cancer (CoC) of the American College of Surgeons requires that the American Joint Committee on Cancer (AJCC) staging system be completed on all applicable sites and histologies. The CoC and NPCR require summary staging on the sites or histologies not included in AJCC staging.

General Guidelines for Staging all Schemes

- Stage grouping can only be applied to cancers that are alike in site, histology, or both.
- Accurate and complete assessment of the cancer is necessary before staging.
- Rule out distant disease first. When metastatic disease is documented, there may be no need to look for information about the primary tumor and regional lymph node status.
- A few cases are unstageable. The "unstageable" category should be assigned only after all efforts to identify the extent of the disease have been exhausted or the site or histology does not meet criteria for staging.
- It is mandatory to stage uniformly using the same staging classification in order to compare data or results.
- If staging information is unclear, it is important to seek further

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information in order to ensure the quality of data.

SUMMARY STAGING

What is Summary Staging

Summary staging is based on the theory of cancer growth previously described in Unit One, Section Three, "Disease Process of Cancer." Summary staging is also called General Staging, California Staging, SEER Staging. It is the most basic staging system and is applicable to all anatomic sites (solid tumors, not leukemias). Summary Staging uses all information available in the medical record, clinical, and pathological. It is frequently used by tumor registries, but not always understood by physicians.

There are limitations for the staging system: categories are so broad that there is a wide variety of cases included; detailed analysis of a case with specific characteristics is sometimes not possible.

Listed below are the five main categories of Summary Staging:

- In situ
- Localized
- Regionalized
- Distant
- Unknown

Guidelines For Summary Staging

1. Rule out distant disease first. If metastases can be documented, there is no need to spend a great deal of time identifying local or regional spread.

2. Carcinomas and melanomas are the only types of cancer that can be classified as in situ.

Sarcomas are never described as in situ.

3. If there is any evidence of invasion, nodal involvement or metastatic spread, the case is not in situ even if the pathology report so states. This is a common error in staging cervical cancer where the path report states that the cancer is "in situ with microinvasion"--such a case would be staged as localized.

4. In order for a lesion to be classified as localized, it must not extend beyond the outer limits of the organ and there must be no evidence of metastases anywhere else.

5. For carcinomas, if there are lymph nodes involved with the tumor, the stage is at least regionalized.

6. If a specific chain of lymph nodes is not named and there is no indication in the chart of its location, assume that the nodes are regional.

7. If nodes, organs, or adjacent tissues are not specifically mentioned in the description of the various categories, attempt to cross-reference the term you have with those outlined. If there is no match, assume the site in question represents distant disease.

8. If there is not enough information in the record to categorize a case, it must be recorded as unstageable.

TIME FRAMES CONSIDERATIONS IN STAGING

The Surveillance, Epidemiology and End Results (SEER) Extent of Disease coding is limited to all information available within four months of diagnosis in the absence of disease progression or through completion of surgery(ies) in first course of treatment, whichever is longer.

For SEER Summary Stage 2000, the stage should include all information available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer.

The American Joint Committee on Cancer (AJCC) clinical staging is determined after the staging workup is completed and before any treatment has started. AJCC pathologic staging is completed after the resection of the primary tumor and regional lymph nodes,

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before additional treatment is initiated. There is no predetermined time limit for assigning AJCC clinical or pathological stage.

COMMON CONCERNS FOR STAGING

Some common concerns about staging are the following:

The stage of a cancer is sometimes confused with the grade of a tumor by new registrars. Terms such as well differentiated and undifferentiated are tumor grades.

The rules for each staging scheme must be reviewed for each site and histology. The AJCC staging systems and summary staging systems list the sites and histologies to which specific staging schemes apply. The term microinvasion implies invasion through the basement membrane (an anatomic landmark), indicating that the stage is invasive instead of in-situ.

Some cases of cancer are difficult to stage appropriately. Problem situations include the following:

- Diagnostic tests done on an outpatient basis with results not documented in the hospital health information record.
- Tests and biopsies done in a physician's office and sent to freestanding laboratories for assessment.
- Conflicting information about the exact location, size, and involvement of the tumor.

There are many resources available for staging cancers. The registry should have adequate access to appropriate references. Staging manuals for the most commonly used systems (summary staging, AJCC staging, and SEER extent of disease) provide comprehensive guidelines. These should be routinely reviewed at the time of abstracting to verify the staging classification.

The Commission on Cancer of the American College of Surgeons requires that staging be done by the managing physician and recorded in the patient's health information record. This requirement does not negate the need for the registrar to understand staging. Verification is necessary at the registry level to ensure the accuracy and completeness of data. It is imperative that staging be correct, when registry data are reported and analyzed.

The patient's treatment is based on the extent of the disease. The prognosis of the disease can be estimated by the stage and other factors such as age, aggressiveness of tumor, and the presence or absence of other medical conditions. In certain stages of disease, quality of life issues may influence treatment decisions. The stage of disease is used in research studies and in the analysis of cancers.

FCDS Q & A

LEUKEMIA

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

References
SEER Program Code Man, 3rd Ed ;pgs 102, 104 Brief

Question
Grade, Differentiation--Lymphoma/Leukemia: What code is used to represent this field for a lymph node biopsy that reveals "well differentiated lymphocytic lymphoma" and a bone marrow biopsy that reveals "chronic lymphocytic leukemia/well differentiated lymphocytic lymphoma"?

Answer
Code the Grade, Differentiation field to 1 [Grade 1] for both of these cases because there is no mention of T-cell, B-cell, null cell, or NK cell involvement. Both cases have a pathologic description of well differentiated, not the descriptors "high grade," "low grade," or "intermediate grade" which must be ignored when coding grade for lymphomas.

For lymphomas, you cannot code the descriptions "high grade," "low grade," and "intermediate grade" in the Grade, Differentiation field because these terms refer to categories in the Working Formulation and not to histologic grade. However, you can code terms such as "well differentiated", "moderately differentiated" and "poorly differentiated" for lymphoma histologies.

References
Agents Not Listed in SEER Bk 8 ;pgs 4 (May 2002) Brief

Question
First Course of Cancer-Directed Therapy--All Sites: How do we code retinoic acid?

Answer
The code for retinoic acid depends upon the primary site and histology of the tumor. Code retinoic acid (also called Vitamin A, tretinoin, ATRA, all-transretinoic acid or Vesanoid) in the Immunotherapy field as 01 [Immuno administered as first course therapy] for acute promyelocytic leukemia. This drug is given to patients as an alternative to chemotherapy.

For all other sites/histologies, code retinoic acid in the Other Cancer-Directed Therapy Field. Use code 2 [Other experimental cancer-directed therapy] or 3 [Double-blind clinical trial, code not yet broken] if the drug is given as part of a protocol. If the drug isn't being given as part of a protocol or you don't know whether it is part of a protocol, use code 1 [Other cancer-directed therapy].

References
ICD-O-3 ;pgs 102, 147, 156... Brief

Question
Reportability/Behavior Code--Bone Marrow: Is T-cell large granular lymphocytic leukemia SEER reportable? Pages 102, 147, 156, 160-162 and 167 of the ICD-O-3 list it as 9831/1, but on page 17 this is listed as 9831/3.

Answer
T-cell large granular lymphocytic leukemia [9831] is a very indolent form of leukemia. It was assigned a behavior code of 1 by the editors of ICD-O-3 (as noted on pages 102, 147, 156 160-162, and 167 of the ICD-O-3 manual). The table on page 17 is the World Health Organization list of hematopoietic and lymphoid tumors. WHO recognizes TCLGLL as a malignancy. The disease is infrequently symptomatic enough to be diagnosed, but when it is called TCLGLL or one of the other terms included under histology 9831/1, it should be reported to SEER as a malignancy with a behavior code of /3.

References
ICD-O-3 ;pgs 102-103 Brief

Currently, in both the numerical and the alphabetic listings of the ICD-O-3, code 9895/3 (acute myeloid leukemia with multilineage dysplasia) has two other definitions that seem to contradict each other. "Acute myeloid leukemia with prior myelodysplastic syndrome" and "Acute myeloid leukemia without

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prior myelodysplastic syndrome." A 12-31-01 SEER e-mail stated that AML with multilineage dysplasia can develop in two ways, in patients with prior MDS and in patients without prior MDS. The characteristics of this disease (the multilineage dysplasia) are different from regular single clonal AML. 9895/3 was recognized as a distinct entity in the WHO classification of hematopoietic diseases but there were too few cases of the subtypes (with and without prior MDS) to warrant separate codes for each of them.

Question

For code 9895/3, should the wording for the non-bold definitions in the ICD-O be changed to the following in both the alpha and numeric sections:

AML with multilineage dysplasia and prior MDS

AML with multilineage dysplasia and without prior MDS

Answer

To assign code 9895, it is important that the diagnosis includes "multilineage dysplasia." Use code 9895 when the diagnosis is with or without prior (not concurrent) myelodysplastic syndrome AND multilineage dysplasia. Acute myeloid leukemia without prior myelodysplastic syndrome and without multilineage dysplasia is coded 9861 [Acute myeloid leukemia, NOS]. Although the wording of 9895 cannot be changed, coders can make a note that the synonyms are intended to include:
-Acute myeloid leukemia WITH multilineage dysplasia with prior myelodysplastic syndrome
and
-Acute myeloid leukemia WITH multilineage dysplasia without prior myelodysplastic syndrome.
The histology code for the case example is 9861/3 [Acute myeloid leukemia, NOS].

Question

Where would you put a NK Cell Lymphoma/Leukemia that was detected in bone marrow?

Answer

If it was described anywhere in the record as 'aggressive' or if the patient is Asian and/or up to young adult in age, code as 9948. If they are expecting an indolent course, code as 9801/38. Aggressive NK cell [lymphoma/] leukemia is rare, aggressive and usually fatal. Code site to bone marrow C42.1.

Question

When a splenectomy is done for hairy cell leukemia, how is this coded under surgery?

Answer

If the splenectomy is part of 1st course of therapy for a hairy cell leukemia, code 4 under the surgery of other regional site(s) or distant lymph nodes (NAACCR item #1294).

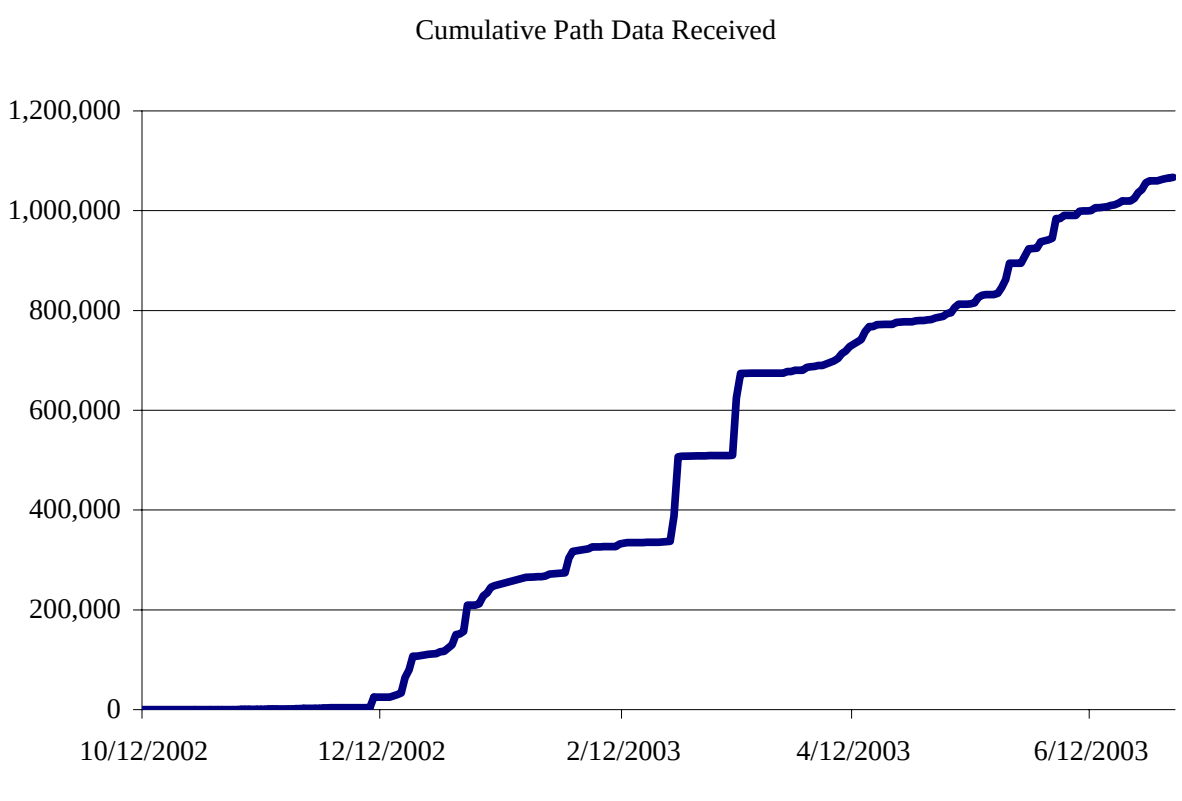
Question

We have a patient that was treated for Idiopathic Thrombocytopenia Purpura (ITP). Is ITP reportable?

Answer

Idiopathic Thrombocytopenia Purpura (ITP) is not reportable. Do not acession thrombocytopenia; this is not the same condition as thrombocythemia. Refer to the Abstracting and Coding guide for Hematopoietic diseases, page 32.

Path Reporting



EDUCATION AND TRAINING

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 Belleview 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

PRINCIPLES AND PRACTICE OF CANCER REGISTRATION, SURVEILLANCE, AND CONTROL

The Principles and Practice of Cancer Registration, Surveillance, and Control Program will be held at the Holiday Inn Select Hotel and Suites, 2183 North Decatur Road, Decatur, Georgia 30033, located in the Atlanta-Emory University area on August 18-22, 2003.

Participants **must** be familiar with (at a minimum) the contents of the *Self-Instructional Manual for Tumor Registrars, Book One (Objectives and Functions of a Tumor Registry)* and *Book Three (Tumor Registrar Vocabulary: the Composition of Medical Terms)*. These *Self-Instruction Manuals* are available free from the National Cancer Institute's SEER Program (phone 1-301-496-8510 or fax 1-301-496-9949).

Registration fee: $1000.00

CANCER CASE ABSTRACTING, STAGING, AND CODING

The Cancer Case Abstracting, Staging, and Coding program will be held at the Holiday Inn Select Hotel and Suites, 2183 North Decatur Road, Decatur, Georgia 30033, located in the Atlanta-Emory University area on August 25-29, 2003.

Participants must have attended the Principles and Practice of Cancer Registration, Surveillance, and Control training program, or have at least six months of cancer registry.

Registration fee: $1000.00

Approved by NCRA for 35 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.

CERTIFIED TUMOR REGISTRAR (CTR) EXAMINATION

Application Deadline: August 1, 2003

Fall Examination Date: September 13, 2003

The 2004 CTR Exams will be based on FORDS and AJCC 6th edition. Also, the 2004 CTR Exams will be computerized and offered at over 600 computerized testing centers.

EXAM APPLICATION FEES
NCRA Members - $200.00

More information on the CTR Examination is available on the National Cancer Registrars Association website, http://www.ncra-usa.org/ certification/exam.htm#sub2.

FLORIDA CANCER DATA SYSTEM INCIDENCE ABSTRACTING WORKSHOP

The FCDS Incidence Abstracting Workshop will be held at the Double Tree Hotel in Miami, Florida on October 29-31, 2003.

Registration fee: $100.00

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

15 CEU'S AWARDED BY AHIMA

Deadlines & Reminders

JUNE 30TH DEADLINE

FCDS has received several inquiries from hospitals and pathology labs regarding an extension to the June 30, 2003 reporting deadline. FCDS is not in the position to grant extensions. After June 30th, FCDS will forward the list of facilities found to be delinquent in reporting to the Florida Department of Health. The DOH will then assume the responsibility of bringing the delinquent reporting facilities into compliance by working with facility administrators to develop action plans to meet the statutory requirement as outlined in the Florida Statutes and Administrative Rules. Facilities that fail to comply with cancer case reporting to FCDS may be subject to their operating license being suspended or revoked, as stated in the Florida Statutes. FCDS will work closely with the facilities experiencing delays in reporting and make every attempt to support all facilities in the state of Florida.

If you feel that your facility will be late in reporting cancer cases to FCDS, please take time to evaluate the reporting needs of your facility. Please contact FCDS in writing suggesting an action plan that can be used to bring your facility into compliance. FCDS will forward your action plan to the DOH should your facility be found to be delinquent on June 30, 2003.

FCDS CONVERTING TO NAACCR VERSION 10 JULY 1-15, 2003

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. This does not apply to Path Labs, which may continue to upload data.

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). **Path labs need to continue using the NAACCR Path 9.1 tab separated format or the single entry format.**

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 were due to FCDS on June 30, 2003.**

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

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