



**HAPPY
HALLOWEEN**

WHAT'S NEW:

Download the following reports and lists from the FCDS web-site:

- Facility Alpha List*
- Yearly Mortality Match*
- Quarterly Mortality Match*
- 2002 Mortality Data has arrived
- 2001 FCDS Monograph of Cancer In Florida

*In order to obtain access to the Facility Alpha list and Quarterly Mortality Match the facility must complete the FCDS IDEA User Account Request Form and a Web-Based Report Access Authorization and Account Request Memo and return to your field coordinator.

On the Web:

- AJCC Collaborative Staging Release information
<http://www.cancerstaging.org/collab.html>
- NAACCR Data Dictionary version 10.1 GIS Handbook
<http://www.naaccr.org/Stats/CINAPubs.html>
- HIPAA Legislation
<https://fcds.med.miami.edu/inc/links.shtml#priv>

FLORIDA CANCER DATA SYSTEM

OCTOBER 2003 MONTHLY MEMO

What is Collaborative Staging?

SEER Training Website: http://training.seer.cancer.gov/module_collab_stage/xp_unit01_sec01_what.html

Cancer stage historically has been collected using three different staging systems having three different purposes, data sets and rules. The American Joint Committee on Cancer (AJCC), in collaboration with North American standards setters, has developed a unified data set that will combine and standardize the information needed to assign stage in the AJCC (TNM), SEER (EOD) and Summary Stage (SS) 1977 and 2000 systems and to derive the T, N, M, stage group, Extent

of Disease (EOD), and SS applicable to each cancer site. Collaborative Stage (CS) allows combined pathological and clinical "mixed" or "best" stage to be captured. Additional data elements have been incorporated into the CS data set to support and enhance the description of the cancer stage.

Collaborative Stage provides the advantages of a unified data collection system designed to provide a common goal,

to meet all the needs of the three staging systems, TNM, EOD, SS. It

(Continued on page 3)

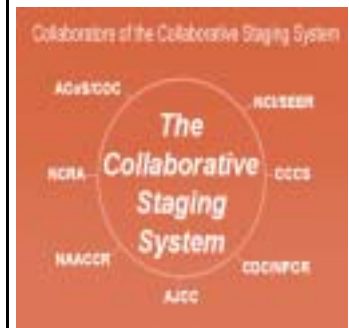


Image shows the true collaboration between agencies involved in cancer data collection to create a system that will allow the different staging systems to join together--as ONE

Benign Brain Tumor Implementation: Update on Task Force Formation and Progress to Date

Excerpt, NAACCR Newsletter Summer 2003 Edition

Lori Havener, NAACCR staff, has established a workgroup on benign brain tumor implementation. The major standard-setting organizations, CBTRUS representatives, and vendors are represented and an initial conference call was held in mid-July. The committee will utilize a template developed by NAACCR that identifies all of the key imple-

mentation issues to be addressed. This effort will be coordinated with the Collaborative Staging implementation so that one document covering all 2004 implementation guidelines can be disseminated. There was further discussion to determine which strategy should be adopted for benign brain tumor reporting be-

ginning in 2004. Various groups have been working to define reporting rules. Three strategies to support the implementation of reporting rules for benign brain tumors were reviewed by the NAACCR Board and SMOs. Although each of the strategies was discussed in detail, no resolution was requested or made by this group. Further deliberations continue to take place.



FCDS Q & A

Q&A #1	Q&A #2	Q&A #3
<p>Q: Which primary payer code is used for a Medicare Replacement Policy?</p> <p>A: 10 - Insurance, NOS. The type of insurance is unknown.</p>	<p>Q: A patient comes into my facility for a wide local excision of a melanoma. The patient has already had the biopsy at another facility. The wide local excision shows no evidence of residual disease. Do I abstract this case?</p> <p>A: Yes. Although there is no evidence of residual disease, the wide local excision is considered first course of treatment. This is a class of case 2, treatment only.</p>	<p>Q: Which primary payer code is used for a Medipass policy?</p> <p>A: Medipass stands for Medicaid Provider Access System. The primary payer code is 31 - Medicaid.</p>

REPORTING CLARIFICATIONS

Place of Diagnosis-Text Field

Please enter text information about the facility where the diagnosis was made. This includes facility or physician name **AND** city, state, and/or county. This text field is used to justify codes and for quality control purposes.

Tumor Size for Melanoma

For melanomas of the skin, vulva, penis, scrotum and conjunctiva, the depth of invasion is recorded for the tumor size. This number is recorded in hundredths of millimeters. A melanoma with a depth of .5mm is recorded as 050, and a 1mm depth is recorded as 100.

Coding Grade for Prostate Cancer

The grading system for prostate cancers has changed slightly with the implementation of the FORDS manual. Please note: A Gleason's score of '7' is now recorded as a grade '3', poorly differentiated.

Code	Gleason's Score	Pattern	Grades/Description
1	2, 3, 4	1, 2	I Well differentiated
2	5, 6	3	II Moderately differentiated
3	7, 8, 9, 10	4, 5	III Poorly differentiated

Introduction to Collaborative Staging (Cont'd)

(Continued from page 1)

also provides a comprehensive system to improve data quality by standardizing rules for timing, clinical and pathologic assessments, and compatibility of descriptions across all of these systems for all cancer sites

The Commission on Cancer (CoC) approvals program will require that the registrar record the T, N, M and stage groups as the physician has documented them in the medical record. This will enable comparison of CS and physician stage and allow the CoC to assess the need for physician education in staging.

REVIEW OF STAGING SYSTEMS

Tumor, Regional Lymph Nodes, & Distant Metastasis (TNM)

The concept of a classification scheme that would encompass all aspects of cancer distribution in terms of primary tumor (T), regional lymph nodes (N), and distant metastasis (M) was first introduced by the International Union Against Cancer, or Union Internationale Contre le Cancer (UICC), in 1958 for worldwide use. The American Joint Committee for Cancer Staging and End Results Reporting (AJC) was established in 1959. The AJC changed its name to the American Joint Committee on Cancer (AJCC) in 1980. Staging schemes were developed to be consistent with the practice of medicine in America and used the basic premise of the TNM system: cancers of similar histology or site of origin share similar patterns of growth and extension. This group published a series of site-specific staging schemes from 1962 until 1974. The American Joint Committee on Cancer (AJCC) published the first edition

of the Manual for Staging of Cancer in 1977. About every five years, a new edition is published with updates and new schemes for additional cancer sites.

The SEER Extent of Disease (EOD)

The SEER Extent of Disease (EOD) coding system initially begun in 1988 has gone through several revisions and now includes schemes for all sites and histologies of cancer. The EOD coding scheme consists of a ten-digit code. It incorporates three digits for the size and/or involvement of the primary tumor, two for the extension of the tumor, and one as a general code for lymph node involvement. Four more digits are used after these six: two for the number of pathologically positive regional lymph nodes and two for the number of regional lymph nodes that are pathologically examined. The system is based on clinical, operative, and pathological diagnoses of the cancer. The size of tumor recorded is the size before systemic (i.e., chemotherapy) or radiation therapy.

SEER Summary Staging (SS)

Summary staging is a required data item for facilities and central registries participating in the National Program of Cancer Registries (NPCR) of the Centers for Disease Control and Prevention (CDC). Many cancer registries report their data using summary stage because the staging categories are broad enough to measure the success of cancer control and other epidemiologic efforts.

Summary staging is based on the the-

(Continued on page 4)



CANCER STAGE SYSTEM COLLABORATORS

AJCC: American Joint Committee on Cancer

ACoS/CoC: American College of Surgeon Commission on Cancer

NCRA: National Cancer Registrars Association

NCI/SEER: National Cancer Institute/SEER Program

CDC/NPCR: Centers for Disease Control and Prevention/ National Program of Central Registries

NAACCR: North American Association of Central Cancer Registries

CCCS: Canadian Council on Cancer Staging

Introduction to Collaborative Staging (Cont'd)

(Continued from page 3)

ory of cancer growth. Intraepithelial, noninvasive, or non-infiltrating cancer is described as "in situ." In situ tumors fulfill all microscopic criteria for malignancy except invasion of the basement membrane of the organ. A "localized" tumor is confined to the organ of origin without extension beyond the primary organ. "Regional extension" of tumor can be by direct extension to adjacent organs or structures or by spread to regional lymph nodes. If the cancer has spread to parts of the body remote from the primary tumor, it is recorded as "distant" stage. Sometimes there is insufficient information to assign a stage, such as in cases without thorough diagnostic workups or cases in which there is ambiguous or contradictory information.

Background: Meeting a Data Collection Need

Cancer stage is currently collected using three different staging systems with three different purposes and three different sets of rules. Different needs exist for different agencies; for example, TNM provides forward flexibility and clinical utility, SEER EOD provides longitudinal stability for epidemiological studies, and SEER Summary Staging provides data population surveillance.

The three staging systems use different rules for data collection. Timing of data is different among the three systems, and so are rules for integrating clinical and pathological data.

The three staging systems use different rules for data collection. Timing of data is different among the three systems, and so are rules for integrating clinical and pathological data.

Using three different systems could affect the quality of data, especially when there are conflicting rules. In addition, duplication of effort occurs when multiple data sets on the same patient are collected. Finally, physician staging and cancer registrar staging cannot be compared consistently. Registrars have always reviewed physician staging and revised it when necessary, which increases cost and labor.

These disadvantages will be eliminated with CS, a unified data collection system. Collaborative Staging is designed to provide a common data set to meet the needs of all three staging systems, TNM, SEER EOD, SEER SS and provide a comprehensive system to improve data quality by standardizing rules for timing, clinical and pathologic assessments, and compatibility across all of these systems for all cancer sites.

Collaborative Stage makes it possible for all registries to collect a unified data set and report to central agencies such as the National Cancer Data Base (NCDB) of the Commission on Cancer (COC), the SEER Program of the National Cancer Institute, and the National Program of Cancer Registries of the Centers for Disease Control and Prevention. Collaborative Staging system converts "objective" data into information that each agency can use in its own way.

The Commission on Cancer approvals program continues to require that the registrar record the stage as the physician has documented in the medical record. This will allow the CoC to assess the need for physician education in staging. It also requires less time for the registrar to abstract.

CS Data Set and Collection

Collaborative Stage is a coding system, not a staging system. The structure of CS is adapted from SEER Extent of Disease Coding (EOD) using the AJCC 6th edition and SEER Summary Stage 2000. The final Stage is derived by computer algorithm provided in the cancer registry software program.

In Collaborative Staging, registrars code the "facts" about a case, including all elements to derive TNM and Summary Stage.

(Continued on page 5)

Introduction to Collaborative Staging (Cont'd)

(Continued from page 4)

The computer algorithm is designed to generate the corresponding stage from the CS coded fields, using primary site code, histology code specific schemes based on ICD-O-3, as well as site-specific factors.

The same computer algorithms are used at both the hospital registry and the central registry to derive the stage from CS data elements

Clinical and Pathologic Staging Basis

Collaborative Stage coding provides the information to generate staging TNM as pathological, clinical, or mixed stage.

Clinical and pathological data is not combined and as a result there are too many cases with unknown stage. There are two problems with this data collection method.

1. Output must be "pure" clinical, "pure" pathological or unstageable.
2. The Registry stores interpreted data, not facts.

On the other hand, with Collaborative Staging, clinical and pathological information can be combined to come up with a mixed or best stage.

Method of Evaluation as a Basis for Determining Stage

Collaborative Staging has added data items that capture the method used for the evaluation of the individual T, N, and M elements.

Collaborative Stage codes describe the facts about how the T, N, and M were determined, based on coded levels of pathologic and clinical information. For example, the abstractor codes that the T category was based on complete surgical resection (pathologic), CAT scan imaging or physical examination (clinical).

Collaborative Stage coding rules enable the regis-

try to store fact-based codes, minimizing the variability that results from coding interpreted data.

Site Specific Factors have been added to record the additional details necessary to derive the T, N, M, and Stage Group and the Summary Stage. For some sites, the site-specific factors expand the use of anatomic and prognostic factors specific to cancer sites and histologies that affect the cancer stage. Each of the six site specific factors has a three digit data field.

Collaborative Staging Data Items

There are fifteen items in CS data set. In addition to five existing data items (tumor size, extension, and lymph node items), there are ten new data items including metastases at diagnosis, three "methods of evaluation (TNM)," and six site specific factors.

Three new fields were used to identify the method of staging (clinical vs. pathological). Site specific factors allow for the collection of biomarkers and other factors in staging, for example, A/B symptoms in lymphoma, or LDH levels in Melanoma.

Collaborative Staging and Coding Manual

To access the Collaborative Staging and Coding Manual and other useful items visit The Collaborative Stage Rollout site at <http://www.edits.cx/cs/>.

EDUCATION AND TRAINING

NOVEMBER 2003



EMORY UNIVERSITY TRAINING PROGRAMS

PRINCIPLES AND PRACTICE OF CANCER REGISTRATION, SURVEILLANCE, AND CONTROL

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

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 November 10-14, 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 for the weeklong training

CANCER CASE ABSTRACTING, STAGING, AND CODING PROGRAM

The Cancer Case Abstracting, Staging, and Coding 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 November 17-21, 2003.

Participants should 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 for the weeklong training

Approved by NCRA for 35 C.E. hours

DECEMBER 2003



ADVANCED CANCER REGISTRY TRAINING PROGRAM

This advanced training program will specifically address: 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. The course will be held at the Holiday Inn Express Hotel & Suites, 2183 North Decatur Road, Decatur, Georgia 30033, located in the Atlanta-Emory University Area.

Registration Fee: \$500 for the full 3 day training

Approved by NCRA for 20.5 CE hours

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

2004

2004 CTR EXAM REVIEW & BASIC SKILLS WORKSHOPS

Plans are underway to provide concurrent CTR Examination Review & Basic Skills Workshops at the Moffitt Cancer Center, February 12-13, 2004. Moffitt is located on the campus of the University of South Florida, Tampa, Florida. Details on registration, curriculum and lodging will be distributed shortly. Meanwhile, information is available by contacting Helen Lewis, BS, CTR, Moffitt Cancer Registry. Phone: 813-632-1305 or toll-free 1-800-456-3434x1305. E-mail address: lewishl@moffitt.usf.edu.

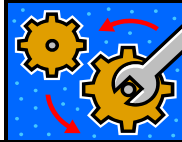
PRINCIPLES AND PRACTICE OF CANCER REGISTRATION, SURVEILLANCE, AND CONTROL

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 March 29-April 2, 2004

CANCER CASE ABSTRACTING, STAGING, AND CODING PROGRAM

The Cancer Case Abstracting, Staging, and Coding 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 April 5-9, 2004

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



ICD-O-3 ERRATA SITE/TYPE VALIDATION LIST

SEER Website: http://seer.cancer.gov/icd-o-3/sitetype_errata.d10102003.pdf

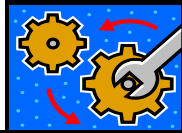
Please update your manual with the site histology list. The following site histology list is also available on the FCDS website under Downloads at: <https://fcds.med.miami.edu/inc/downloads.shtml#dam>

October 10, 2003

Errata for ICD-O-3 Site/Type Validation List

The following site/histology combinations were added to the list.

C239-C249		8162/3 Klatskin tumor
C250-C259	GRANULAR CARCINOMA	832 8323/3 Mixed cell adenocarcinoma
C440-C449 !	PAPILLARY SEROUS CYSTADENOCA	846 8461/3 Serous surface papillary carcinoma
C510-C518, C529	!GRANULAR CARCINOMA	832 8323/3 Mixed cell adenocarcinoma
C519	!GRANULAR CARCINOMA	832 8323/3 Mixed cell adenocarcinoma
C530-C539	!GRANULAR CARCINOMA	832 8323/3 Mixed cell adenocarcinoma
C570-C579	!GRANULAR CARCINOMA	832 8323/3 Mixed cell adenocarcinoma
C809	MALIGNANT LYMPHOMA, NOS	959 9590/3 Malignant lymphoma, NOS 9591/3 Malignant lymphoma, non-Hodgkin 9596/3 Composite Hodgkin and non-Hodgkin lymphoma
	HODGKIN LYMPHOMA	965 9650/3 Hodgkin lymphoma, NOS 9651/3 Hodgkin lymphoma, lymphocyte-rich 9652/3 Hodgkin lymphoma, mixed cellularity, NOS 9653/3 Hodgkin lymphoma, lymphocytic deplet., NOS 9654/3 Hodgkin lymph., lymphocyt. deplet., diffuse fibrosis 9655/3 Hodgkin lymphoma, lymphocyt. deplet., reticular 9659/3 Hodgkin lymph., nodular lymphocyte predom.
	HODGKIN LYMPHOMA, NOD. SCLER.	966 9661/3 Hodgkin granuloma [obs] 9662/3 Hodgkin sarcoma [obs] 9663/3 Hodgkin lymphoma, nodular sclerosis, NOS 9664/3 Hodgkin lymphoma, nod. scler., cellular phase 9665/3 Hodgkin lymphoma, nod. scler., grade 1 9667/3 Hodgkin lymphoma, nod. scler., grade 2
	ML, SMALL B-CELL LYMPHOCYTIC	967 9670/3 ML, small B lymphocytic, NOS 9671/3 ML, lymphoplasmacytic 9673/3 Mantle cell lymphoma 9675/3 ML, mixed sm. and Ig. cell, diffuse 9678/3 Primary effusion lymphoma 9679/3 Mediastinal large B-cell lymphoma
	ML, LARGE B-CELL, DIFFUSE	968 9680/3 ML, large B-cell, diffuse 9684/3 ML, large B-cell, diffuse, immunoblastic, NOS 9687/3 Burkitt lymphoma, NOS 9689/3 Splenic marginal zone B-cell lymphoma



ICD-O-3 ERRATA SITE/TYPE VALIDATION LIST

Errata for ICD-O-3 Site/Type Validation List (Cont'd)

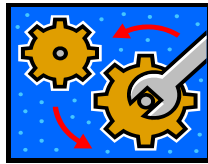
The following site/histology combinations were added to the list

FOLLIC. & MARGINAL LYMPH, NOS	969	9690/3 Follicular lymphoma, NOS	
		9691/3 Follicular lymphoma, grade 2	9695/3
		Follicular lymphoma, grade 1	9698/3
		Follicular lymphoma, grade 3	
		9699/3 Marginal zone B-cell lymphoma, NOS	
!T-CELL LYMPHOMAS	970	9702/3 Mature T-cell lymphoma, NOS	
		9705/3 Angioimmunoblastic T-cell lymphoma	
		9708/3 Subcutaneous panniculitis-like T-cell lymphoma	
!OTHER SPEC. NON-HODGKIN LYMPHOMA	971	9714/3 Anaplastic large cell lymphoma, T-cell and Null cell type	
		9716/3 Hepatosplenic gamma-delta cell lymphoma	
		9717/3 Intestinal T-cell lymphoma	
		9719/3 NK/T-cell lymphoma, nasal and nasal-type	
PRECURS. CELL LYMPHOBLASTIC LYMPH.	972	9727/3 Precursor cell lymphoblastic lymphoma, NOS	
		9728/3 Precursor B-cell lymphoblastic lymphoma	
		9729/3 Precursor T-cell lymphoblastic lymphoma	

CONGRATULATIONS TO FLORIDA'S NEWEST CERTIFIED TUMOR REGISTRARS



TAMALA H BUNZE, CTR
DENISE M. COLBURN, CTR
RANDIE DAVIS, CTR
LORETTA GATES, CTR
EMMA HART, CTR
PAULA LANDRY-GRINER, CTR
MARGARITA B. MENA, CTR
KAREN L MYERS, CTR
MAUD Y. SMITH, CTR
PAULETTE Y. THOMAS, CTR



ICD-O-3 ERRATA AND CLARIFICATIONS SET #2

Please update your manual with the following *International Classification of Diseases for Oncology, Third Edition* (ICDO-3) errata and clarifications. These errata and clarifications are in addition to the first set of errata and clarifications available at: <http://www.seer.cancer.gov/icd-o-3/errata.d05222001.pdf>

Errata

1. Page 160; left column Lymphoblastic, Acute, NOS; replace the M-9685/3 in parentheses with 9727/3
2. Page 170; right column Lymphoma, Small, T-cell, NOS, Cutaneous (C44._); replace the code M-9702/3 with 9709/3
3. Page 205; right column Supratentorial PNET; replace the code M-9373/3 with M-9473/3
4. Page 212; left column Tumor, follicular dendritic cell; replace the code M-9756/3 with M-9758/3
5. Page 239, far left column Add code 9989/1 in the far left column for the Preleukemia row as well as for the Preleukemic syndrome row

Clarifications

1. **Krukenberg Tumor** (page 79 and page 156)

Metastatic tumors to the ovary are uncommon, but there is one situation in which a metastatic adenocarcinoma to the ovary appears as a large mass and resembles a primary tumor: a so-called "Krukenberg" tumor of the ovary which has a signet ring histologic pattern and usually is metastatic from a primary in the gastrointestinal (GI) tract (most often, stomach). Since cancer registries typically only collect and report the in situ (/2 in the behavior code) and invasive cancers (/3 in the behavior code), the /6 in the behavior code of the Krukenberg tumor morphology code on page 79 and again on page 156 often confuses inexperienced registrars. The /6 behavior code accurately indicates that Krukenberg tumor is a metastasis, and the suggested site code (the C56.9 in parentheses) accurately indicates that the metastasis presents itself in the ovary. However, registrars should report the primary tumor, not the metastatic tumor. So, the code for a Krukenberg tumor in most registries would be M-8490/3 and the primary site code should indicate where in the GI tract the tumor is thought to have originated. A careful review of the source documents will generally reveal the precise location of the tumor in the GI tract. In the absence of a precise location in the GI tract, the site should be coded to Gastrointestinal Tract, NOS, C26.9.

2. **Organ/Island of Reil** (page 183 and page 194)

The organ of Reil is another name for the Island of Reil, which is sometimes referred to only as the Reil. All of these eponyms are synonyms for Insula, a part of the brain coded to C71.0.

On page 183, add C71.0 Organ of Reil.

On page 194, add the following lines: C71.0 Reil; C71.0 Reil, Island of; and C71.0 Reil organ of.

3. **Table 24** (page 36)

Add the following group of primary sites to the table as ICD-O-2/3 codes that are considered a single site in ICD-O-1:

C56	Ovary	183.0
C57.0	Fallopian tube	183.2
C57.1	Broad ligament	183.3
C57.2	Round ligament	183.5
C57.3	Parametrium	183.4
C57.4	Uterine adnexa	183.9



DEADLINES AND REMINDERS

Quarterly Activity Status Report

FCDS is not generating the third Quarterly Status Report for the period of July 1, 2003 through September 30, 2003 as some facilities are experiencing downloading delays that are beyond their control. The delays have resulted from several software vendors not completing the download module in a timely fashion. We understand the data are being abstracted, but until the vendor download software is available, the data cannot be transmitted to FCDS.

FCDS is planning to generate and mail the fourth Quarterly Status Report for the period of October 1, 2003 through December 31, 2003 the first week of January 2004.

If you are still experiencing downloading difficulties, please contact your Field Coordinator immediately.

Radiation Therapy Centers Cancer Case Identification Program

Beginning with the 2003 patient encounters, Radiation Therapy Centers are responsible for identifying and reporting all of their cancer cases to the Florida Cancer Data System using the FCDS-IDEA Single Entry or the File Upload modules. The deadline to submit the cases is June 30, 2004. Please log on to the FCDS website fcds.med.miami.edu or call Megsys Casuso Herna at (305) 243-2625 for additional information.

DELINQUENT LETTER FOR PATH LABS

Pathology labs with fewer than 50% of their 2003 total annual caseload reported to the Florida Cancer Data System (FCDS) by June 30, 2003 have been sent a **delinquent** letter. The letters went out on September 29, 2003. The intent of this letter is to inform the laboratory that **no** cases have been received.

If your laboratory has diagnosed no reportable cancer cases excluding basal and squamous cell carcinoma of the skin, please send a letter to Mayra Alvarez at PO Box 016960 (D4-11), Miami, FL 33101. If your laboratory has diagnosed cancer cases submit all of your 2002 cancer cases to FCDS by **October 31, 2003**.

Facilities failing to meet state of Florida's cancer reporting requirements for pathology laboratory cancer case reporting will be referred to the Florida Department of Health (DOH) on November 1, 2003.

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

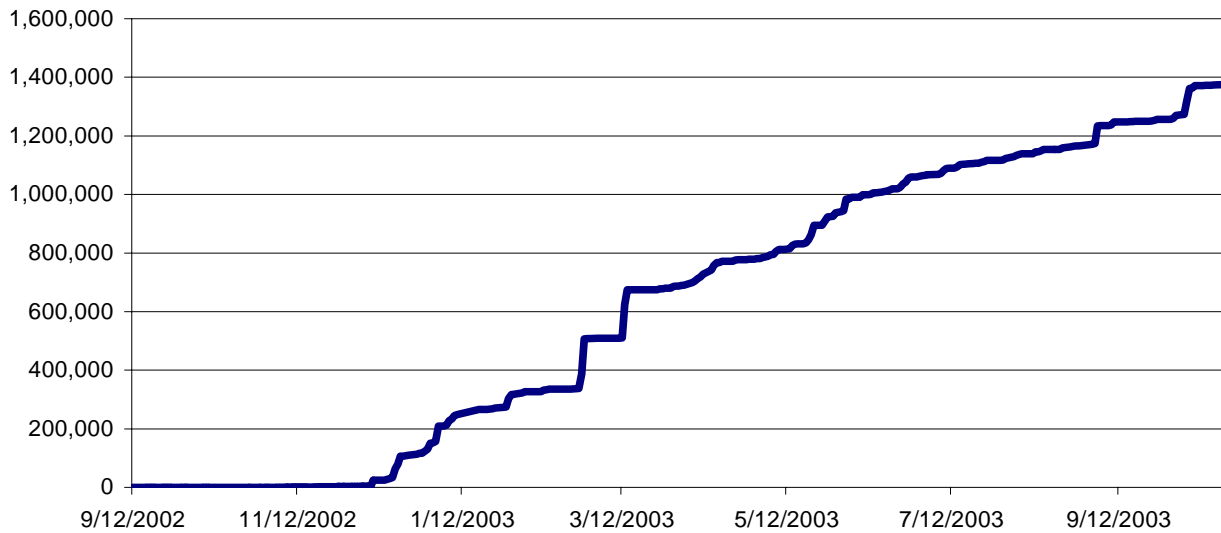
(July 1, 2003 through December 31, 2003 data are due June 30, 2004.)



FLORIDA CANCER DATA SYSTEM

Path Reporting

Cumulative Path Data Received



662826

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



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