WHAT'S NEW:

The Following newsletters and reports are currently available from the FCDS website:

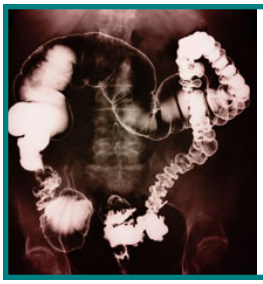
- THE MARCH 2004 MONTHLY MEMO
- DRAFT APPENDIX F 2004 DATA ACQUISITION MANUAL ERRATA
- FCDS REGISTER VOL. 23
- CTR ATTESTATION FORM

On the Web:

- **FLORIDA COMPREHENSIVE CANCER CONTROL INITIATIVE** http://fccci.med.miami.edu
- **C-CRAB: FLORIDA CANCER CONTROL & RESEARCH ADVISORY COUNCIL** http://ccrab.moffitt.usf.edu
- **HIPAA LEGISLATION** http://fcds.med.miami.edu/inc/links.shtml#priv

FLORIDA CANCER DATA SYSTEM

APRIL 2004 MONTHLY MEMO



Colorectal and Anal Cancer

SEER Training Website: http://training.seer.cancer.gov/ss_module04_colon/00_cc_home.html

INTRODUCTION

Although colorectal cancer is the third most common cancer -- with an estimated 147,500 new cases expected to be diagnosed in 2003 (72,800 men and 74,700 women) -- its incidence among Americans is decreasing. The mortality rate is also decreasing, which may reflect advances in detection and screening as well as the increasing use of combination therapies. Nevertheless, recurrence continues to be a serious problem.

Cancer can affect the colon or the rectum, the last 20-25 centimeters of the colon. Because cancer often affects both areas, it is frequently referred to as colorectal cancer. Anal cancer is an uncommon disease in which malignant cells are found in the anus. The anus is the opening at the end of the rectum (the end part of the large intestine) through which body waste passes. Cancer in the outer part of the anus is more likely to occur in men; cancer of the inner part of the rectum (anal canal) is more likely to occur in women.

Americans have about a one in 20 lifetime risk of developing colorectal cancer. It affects primarily those over 65, but risk starts increasing at age 40. Only about 3 percent of these malignancies occur in patients under 40. Incidence of colorectal cancer is

(Continued on page 3)

NATIONAL CANCER REGISTRARS WEEK: APRIL 5 - 9, 2004

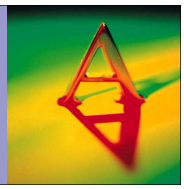
NCRA's National Cancer Registrars Week (NCRW) observed April 5-9, 2004.

This year's NCRW theme is
"Cancer Registrars Seize the Day...
. . .as experts of cancer data management for a cure!"

FCDS Q & A:

COLORECTAL CANCER

Seer Inquiry System: http://www.seer.cancer.gov/cgi-bin/seerinquiry/index.pl



Q&A #1

REFERENCES
SEER EOD-88 3rd Ed ;pgs 3

QUESTION
Histology--Colon: What code is used to represent histology when the surgeon describes a sessile polyp and the final path diagnosis is stated as: "Rectal sessile polyp: Invasive moderately differentiated adenocarcinoma" (pathologist does not state that it is "arising in a sessile polyp")?

ANSWER
Code the Histology field to 8210/3 [adenocarcinoma arising in a polyp]. The structure in which this adenocarcinoma is arising, is a polyp

Q&A #2.

Question
Histology--Colon: What code is used to represent the histology "adenocarcinoma arising in a papillary adenomatous polyp"?

Answer
Code the Histology field to 8261/3 [adenocarcinoma in a villous adenoma]. In describing colon polyps, papillary and villous are equivalent terms.

Q&A #3

References
SEER Program Code Man, 3rd Ed ;pgs 12, 97

Question
Multiple Primaries/Histology--Colon: Would one primary be reported when adenocarcinoma arising in a polyp NOS [8210/3] and adenocarcinoma arising in a tubulovillous adenoma [8263/3] were simultaneously diagnosed in the sigmoid colon (first 3-digits of the histology are different

Answer
Code as one primary. Code the Histology field to 8263/3 [Adenocarcinoma in tubulovillous adenoma].

Count as a single primary and code the more specific term when simultaneous lesions are present and one lesion is an "NOS" term and the other is a more specific term. "Polyp" is considered an NOS term. Adenoma is an associated term, but is considered more specific(Tubulovillous adenoma is more specific than "polyp").

(Continued from page 1)

nearly the same among men and women until age 50, when it becomes slightly higher among men.

The exact cause of colorectal cancer is unknown, however at least eight different genes involved can be traced to dietary fat, particularly animal fat. During fat metabolism, bacteria in the bowel form carcinogens (cancer-causing agents) that can irritate the intestinal lining. It is believed that polyps form in response to this irritation. These are often a precursor of cancer.

A high-fiber diet is thought to be somewhat protective, because it helps accelerate the rate at which fats pass through the bowel, and/or dilutes the concentration of fats, reducing the exposure of the large intestine to carcinogens. This theory is based on various epidemiological studies. However, clinical trials are underway that are designed to demonstrate whether there is any benefit, such as preventing polyps, from increasing the fiber content of the diet.

TYPES OF COLORECTAL CANCER

Adenocarcinomas account for 90 to 95 percent of all large bowel tumors. They typically originate in the mucosa from a benign growth or adenoma. Adenomatous polyps look like grapes on the surface of the bowel's inner wall. The larger their size and the greater the degree of dysplasia (abnormally developed cells), the more likely the polyps are to progress to cancer.

On the right side of the colon near the cecum, cancers usually grow into the space within the colon. They can become large enough to be painful and are likely to cause bleeding. In these cases anemia from chronic blood loss is often the first sign and is why a stool test for occult, or hidden, blood is important (guaiac).

Most polyps and cancers appear on the left side of the colon. In the left or descending colon, where the channel is narrow, the cancer usually grows around the colon wall and encircles it. Left-sided colon cancer typically constricts the bowel channel, causing partial blockage. Typical symptoms include constipation, change in bowel habits, and narrow, ribbon-shaped stool when a cancer is low in the rectum.

In general, colorectal cancers tend to be slow growing, gradually enlarging and eventually penetrating the bowel wall. When they do spread, it is usually through invasion of nearby lymph nodes. In fact, cancer cells may enter a lymph node even before the tumor penetrates through the intestinal wall. The most common sites of distant metastasis are the liver, lungs, and brain.

Rectal cancer can spread to adjacent organs in the pelvic region, such as the ovaries or the prostate. Bone metastases can occur in the pelvis or other bones.

FIVE YEAR SURVIVAL RATES

(from the National Cancer Institute's Physician Data Query system, July 2002)

Prognosis is related to the degree of tumor penetration through the bowel wall and the presence of involved lymph nodes.

Survival Rates: Colon and Rectum		
Stage 0	>96%	
Stage I	80-95%	
Stage II	55-80%	
Stage III	35-55%	involved lymph nodes
Stage IV	< 15%	distant metastases

Survival Rates: Anus	
Stage 0	100%
Stage I	> 98%
Stage II	80%
Stage IIIA	65%
Stage IIIB	15%
Stage IV	Unusual

ANATOMY OF THE COLON AND RECTUM

The entire colon is about 5 feet (150 cm) long, and is divided into five major segments. The rectum is the last anatomic segment before the anus.

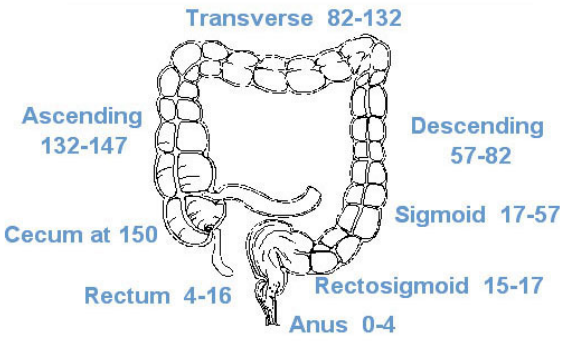
The ascending and descending colon are supported by peritoneal folds called mesentery.

The right colon consists of the cecum, ascending colon, hepatic flexure and the right half of the transverse colon. The left colon consists of the left half of the transverse colon, splenic flexure, descending colon, and sigmoid.

(Continued on page 4)

(Continued from page 3)

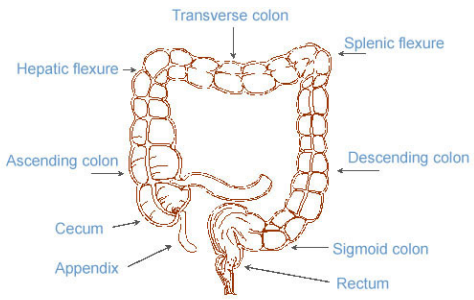
FIGURE 1: COLONSCOPY MEASUTEMENTS FROM ANAL VERGE



PARTS OF COLON AND RECTUM

Cecum (proximal right colon)--6 x 9 cm pouch covered with peritoneum
Appendix--a vermiform (wormlike) diverticulum located in the lower cecum
Ascending colon--20-25 cm long, located behind the peritoneum
Hepatic flexure--lies under right lobe of liver
Transverse colon--lies anterior in abdomen, attached to gastrocolic ligament
Splenic flexure--near tail of pancreas and spleen
Descending colon--10-15 cm long, located behind the peritoneum
Sigmoid colon--loop extending distally from border of left posterior major psoas muscle
Rectosigmoid segment--between 10 and 15 cm from anal verge
Rectum--12 cm long; upper third covered by peritoneum; no peritoneum on lower third which is also called the rectal ampulla. About 10 cm of the rectum lies below the lower edge of the peritoneum (below the peritoneal reflection), outside the peritoneal cavity.
Anal canal--most distal 4-5 cm to anal verge

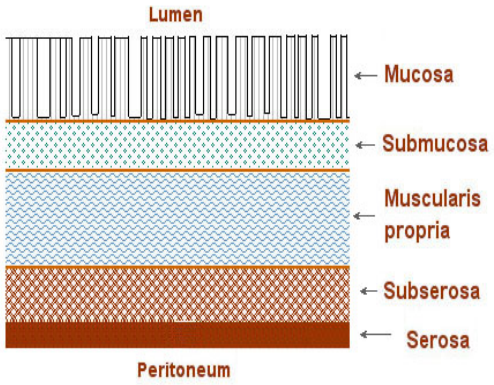
FIGURE 2: ANATOMY OF COLON AND RECTUM



LAYERS OF THE BOWEL WALL

Lumen (interior surface of colon "tube")
Mucosa
Surface epithelium
Lamina propria or basement membrane--dividing line between in situ and invasive lesions
Muscularis mucosae
Submucosa--lymphatics; potential for metastases increases
Muscularis propria
Circular layer
Longitudinal layer--in three bands called taenia coli
Subserosa--sometimes called pericolic fat or subserosal fat
Serosa--present on ascending, transverse, sigmoid only (also called the visceral peritoneum)
Retroperitoneal fat (also called pericolic fat)
Mesenteric fat (also called pericolic fat)

FIGURE 4: LAYERS OF BOWEL WALL



REGIONAL LYMPH NODES

There are between 100 and 150 lymph nodes in the mesentery of the colon. Regional lymph nodes are the nodes along the colon, plus the nodes along the major arteries that supply blood to that particular colon segment.

SEGMENT	REGIONAL LYMPH NODES
Cecum	Pericolic, anterior cecal, posterior cecal, ileocolic, right colic
Ascending colon	Pericolic, ileocolic, right colic, middle colic
Hepatic flexure	Pericolic, middle colic, right colic
Transverse colon	Pericolic, middle colic

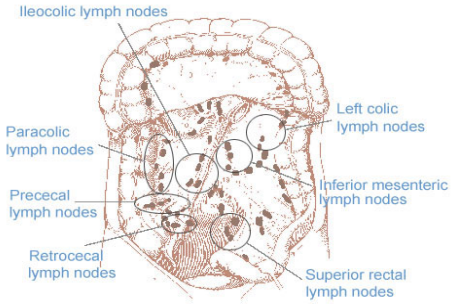
(Continued on page 5)

(Continued from page 4)

SEGMENT (CONT'D)	REGIONAL LYMPH NODES (CONT'D)
Splenic flexure	Pericolic, middle colic, left colic, inferior mesenteric
Descending colon	Pericolic, left colic, inferior mesenteric, sigmoid
Sigmoid colon	Pericolic, inferior mesenteric, superior rectal, superior hemorrhoidal, sigmoidal, sigmoid mesenteric
Rectosigmoid	Perirectal, left colic, sigmoid mesenteric, sigmoidal, inferior mesenteric, superior rectal, superior hemorrhoidal, middle hemorrhoidal
Rectum	Perirectal, sigmoid mesenteric, inferior mesenteric, lateral sacral, presacral, internal iliac, sacral promontory (Gerota's) superior hemorrhoidal, inferior hemorrhoidal
Anus	Perirectal, anorectal, superficial inguinal, internal iliac, hypogastric, femoral, lateral sacral

Lymph nodes along a "named vascular trunk" (as defined by the fourth edition of the AJCC staging manual) are those along a vein or artery that carries blood to a specific part of the colon, for example, the inferior and superior mesenteric arteries, sigmoidal artery, left or right colic artery. In the fifth and sixth editions, the location of the nodes does not affect assignment of the N category.

FIGURE 3: REGIONALLYMPH NODES



ABSTRACTING, CODING, AND STAGING THE COLON AND RECTUM

ICD-O CODES

RELATED ADJECTIVES
Colon--colo, colono-
Rectum--rectal, recto-
Anus--procto-, ano-
Colon and rectum--large bowel, large intestine, colorectal

ICD-O-2/3 CODES

ICD-O-2/3	TERM
Colon	
C18.0	Cecum
C18.1	Appendix
C18.2	Ascending colon; Right colon
C18.3	Hepatic flexure of colon
C18.4	Transverse colon
C18.5	Splenic flexure of colon
C18.6	Descending colon; Left colon
C18.7	Sigmoid colon
C18.8	Overlapping lesion of colon
C18.9	Colon, NOS
Rectosigmoid junction	
C19.9	Rectosigmoid junction
Rectum	
C20.9	Rectum, NOS
Anus and Anal canal	
C21.0	Anus, NOS (excludes Skin of anus and Perianal skin C44.5)
C21.1	Anal canal
C21.2	Cloacogenic zone
C21.8	Overlapping lesion of rectum, anus and anal canal

Each ICD-O four-digit subsite within the colon and rectum is considered a separate primary site.

MORPHOLOGY & GRADE

ICD-O MORPHOLOGY CODES

If the diagnostic term in the pathology report is not in the following list, be sure to consult your ICD-O manual.

(Continued on page 6)

(Continued from page 5)

COLON and RECTUM

Adenocarcinoma (814_3; 98% of tumors above anal verge)
Mucinous (colloid) adenocarcinoma (84803)
Signet ring adenocarcinoma (84903)
Adenocarcinoma in adenomatous polyps (82103)
Adenocarcinoma in adenomatous polyposis coli (82203)
Adenocarcinoma in villous adenoma (82613)
Other carcinomas
Lymphoma (many cell types)

APPENDIX

Carcinoids (82401)

ANAL CANCER

Squamous cell carcinoma of the anus (807_ 3)
Cloacogenic (81243; transitional cell 81203; or basaloid 81233) carcinoma of ano-rectal junction
Basal cell cancer (809_3)
Extramammary Paget disease (85423)
Bowen disease (80812)
Malignant melanoma (872_3)
Sarcomas and lymphomas of the perianal soft tissues

Synonyms for in situ carcinoma: (adeno)carcinoma in an adenomatous polyp with no invasion of stalk, confined to epithelium, noninfiltrating, intraepithelial, intraepidermal (anus), involvement up to but not including the basement membrane, noninvasive, no stromal involvement, papillary noninfiltrating.

EXTENT OF DISEASE FOR COLORECTAL CANCER

COMMON METASTATIC SITES

LYMPHATIC SPREAD: distant lymph nodes

HEMATOGENOUS SPREAD: liver, lungs, bone

EXTENT OF DISEASE (EOD) EVALUATION

DEFINITIONS
Key words/involvement: terms which indicate possible involvement by tumor. Common terms are provided but the list is not all-inclusive.

Other words/no involvement: other terms seen in reports which indicate an abnormality but do not indicate a neoplastic process. Common terms are provided, but the list is not all-inclusive.

Key information: words or phrases to look for in the report of the study. Key information helps define the extent of disease.

DIAGNOSTIC STUDIES--PHYSICAL EXAM

Examination of Abdomen
Key information: masses and enlarged organs (organomegaly; hepatomegaly; splenomegaly); palpable lymph nodes; jaundice (yellowing of skin and eyes due to blockage of bile ducts).

Rectal Examination
Key information: (digital, manual) for obvious bleeding, palpable tumor, fixation.

DIAGNOSTIC STUDIES--LABORATORY TESTS

Fecal Occult Blood (Guaiac)
Carcinoembryonic Antigen See CEA in Tumor Markers section.
Liver Function Tests (LFTs): SGOT, SGPT, T Bili, D Bili, Alk Phos

DIAGNOSTIC STUDIES--IMAGING

Key information: size and location of primary tumor, involvement of adjacent organs and/or distant sites

Barium Enema
Small Bowel Series
Chest X-ray
Imaging, Abdomen/pelvis
Imaging, Liver/spleen
Imaging, Brain
Imaging, Bone

DIAGNOSTIC STUDIES--TUMOR MARKERS

Key information: prognosis (what treatment to use if the tumor should recur)

CEA (Carcinoembryonic Antigen)--a blood test measuring the presence of an antigen in malignancies arising in endodermal (embryonic) or gastrointestinal tissue. Persistent elevated levels indicate residual or recurrent metastatic carcinoma. CEA assay

(Continued on page 7)

is non-specific for identifying a primary site, but it does indicate the presence of malignancy. Smokers may have an elevated CEA without malignant disease.

Normal range: < 2.5 ng/ml. Normal range may vary somewhat depending on the brand of assay used. Levels > 10 ng/ml suggest extensive disease and levels > 20 ng/ml suggest metastatic disease.

OTHER TUMOR MARKERS

CA 19-9 (Cancer Antigen 19-9)--monitors post-therapeutic gastrointestinal cancer for recurrence; non-specific to colorectal cancer

CA 195 (Cancer Antigen 195)--detects colon cancer; changing level indicates progression or regression of tumor load

DIAGNOSTIC STUDIES--ENDOSCOPIES

Colonoscopy
Sigmoidoscopy
Cystoscopy

DIAGNOSTIC STUDIES--OPERATIVE REPORT

Key information: anatomic site and name of all involved lymph nodes, especially those not removed during the resection; site and description of any gross tumor not removed

DIAGNOSTIC STUDIES--PATHOLOGY

Key information: cell type, whether tumor arose in adenomatous polyp, villous adenoma or tubular adenoma, exact size of lesion, location within colon, distance from tumor to edge of resected specimen, extension of primary tumor into blood vessels or lymph channels, presence of multiple tumors in other parts of colon/rectum, intraluminal extension (extension along inner surface to contiguous segments of colon), location and number of lymph nodes positive and number of nodes pathologically examined, extension to adjacent tissues (peritoneum, serosa, omentum, adjacent fat, adjacent organs), depth of penetration of tumor through bowel wall (Dukes' staging), biopsy results of any additional tumor sites identified during operation

Cytology Reports

STAGING

Criteria for TNM Clinical Staging: Physical examination and history; histologic type; imaging (barium enema, chest x-ray, and so forth), endoscopy, and studies to determine presence or absence of distant metastases

Criteria for TNM Pathologic Staging: Information from clinical staging; surgical exploration; pathologic examination of resected specimen, including depth of penetration into wall of bowel; evaluation of number and location of involved lymph nodes

Synonyms for in situ carcinoma: Stage 0, non-infiltrating, superficial, no invasion of lamina propria, limited to mucosa, non-invasive, no penetration of the basement membrane

The staging for carcinoma of the anal canal is different from that for colon and rectal cancer.

BRIEF SUMMARIES OF 5th and 6th EDITION T CATEGORIES

COLON AND RECTUM

T1 Invades submucosa
T2 Invades muscularis propria
T3 Invades subserosa, non-peritonealized pericolic/perirectal tissues
T4 Invades other organs or structures/visceral peritoneum

N1 1- 3 nodes
N2 >3 nodes

ANAL CANAL

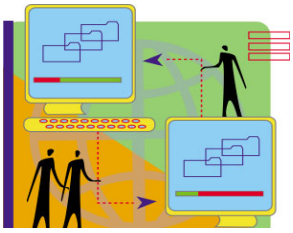
T1 < 2 cm
T2 2 cm to 5 cm
T3 > 5 cm
T4 Invades adjacent organs, such as vagina, urethra, bladder

N1 Perirectal lymph node(s)
N2 Unilateral interal iliac and/or inguinal node(s)
N3 Perirectal and inguinal nodes and/or bilateral internal iliac and/or inguinal nodes

(Continued on page 9)

EDUCATION AND TRAINING

MAY 2004



Privacy Specialty Advancement — H0PSA, HOPINST, H035 Specialty Advancement Program

In response to industry demands for HIPAA Privacy Training, AHIMA has developed an online Specialty Advancement Program in Privacy. Specialty Advancement Training will prepare participants to assume roles of greater responsibility or enhance current job skills by exploring professional practice issues above and beyond the basic HIPAA curriculum or available job experience for the candidates.

The Program includes three courses and a one-day face-to-face Institute.

- Privacy Practices
- Managing Access, Amendment, and Disclosures
- The Organization's Responsibilities
- Privacy Institute

Those who complete all three courses and attend the Privacy Specialty Advancement Institute obtain a Certificate of Completion in Privacy Specialty Advancement that can be used to demonstrate added qualifications within the profession.

For complete information on this program please visit the AHIMA website at http://campus.ahima.org/campus/course_info/PSA/PSA_info.htm.

Upcoming Training, Workshops, & Seminars 2004

NAACCR ANNUAL CONFERENCE
"New Frontiers in Cancer Surveillance"

Date:
June 8-9, 2004

Location:
Salt Lake City, Utah

For further information about the NAACCR Annual Conference visit the NAACCR website at
http://www.naaccr.org

FLORIDA CANCER DATA SYSTEM ANNUAL MEETING

Date:
July 27-28, 2004

Location:
Embassy Suites Hotel
USF/Busch Gardens
Tampa, FL

FLORIDA CANCER REGISTRARS ASSOCIATION ANNUAL MEETING

Date:
July 29-30, 2004

Location:
Embassy Suites Hotel
USF/Busch Gardens
Tampa, FL

(Continued from page 7)

TREATMENT

COLORECTAL CANCER TREATMENT
Surgery is the primary treatment for both colon and rectal cancer. There is no standard therapy for patients with widespread disease. Adjuvant chemotherapy is recommended for Stage III colon cancer.

For Stage II and III rectal cancer, the recommended therapy is surgery, high-dose pelvic irradiation, and chemotherapy.

SURGERY
Types of Surgery - Colon

TYPES OF SURGERY--COLON
X = complete * = partial o = optional

	------Tissues Removed-----			
	Segment	Colon	Lymph nodes	Other Organs#
Local tumor destruction without specimen Includes cryosurgery, fulguration, laser surgery (vaporization), electrocautery	*			
Local excision with pathologic specimen Includes endoscopic snare, excisional laser surgery, polypectomy	*			
Partial (subtotal) colectomy but less than hemicolectomy; includes wedge resection, segmental resection, cecectomy (cecum), transverse colectomy, sigmoidectomy (sigmoid), ileocolectomy, enterocolectomy, partial resection of a colonic flexure	X	*	X	o
Hemicolectomy but less than total colectomy total colectomy Includes colectomy (right/ascending or left/ descending) from mid-transverse laterally		*	X	o
Total colectomy Includes cecum through to sigmoid/ rectosigmoid or part of rectum		X	X	o
Colectomy, Not Otherwise Specified, NOS	*/X	*	X	o
Colectomy of any type plus partial/total removal of other organs		*/X	X	o
Surgery of regional and/or distant sitesor nodes				*

Other organs includes mesentery, mesocolon, peritoneum, omentum, and/or terminal ileum

THE REGISTRAR'S KEY TO ABSTRACTING

Figure 1: IMAGE GUIDED ENDOSCOPY PARTIAL COLECTOMY (CECETOMY)

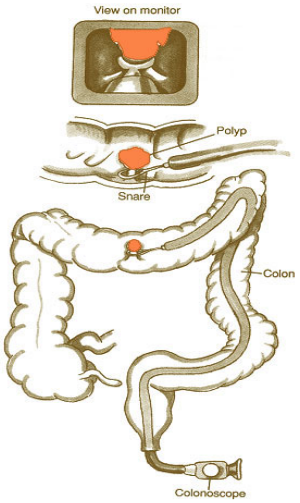


Figure 2: PARTIAL COLECTOMY (CECECTOMY)

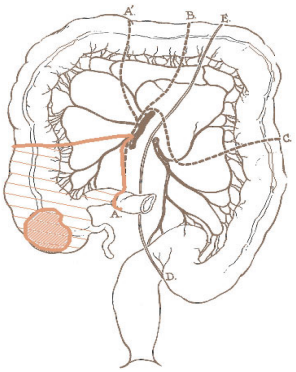


Figure 3: RIGHT HEMICOLECTOMY FOR HEPATIC FLEXURE CA

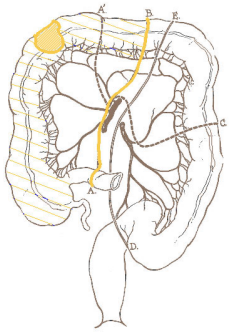


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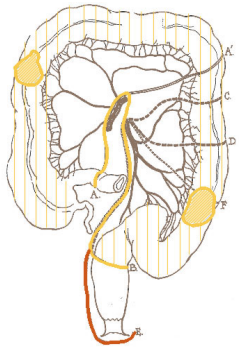
Figure 4: RIGHT HEMICOLECTOMY with lower line: TOTAL PROCTOCOLECTOMY



Types of Surgery - Rectum

TYPES OF SURGERY--RECTUM

X = complete * = partial o = optional • = see note under procedure

------Tissues Removed-----

	Rectum	Recto-sigmoid	Lymph nodes	Sphincter	Other Organs#	Permanent Colostomy
Local tumor destruction without specimen Includes cryosurgery, fulguration, laser surgery (vaporization), electrocautery	*					
Local excision with pathologic specimen Includes endoscopic snare, excisional laser surgery, polypectomy	*					
Partial proctectomy	X					
Rectal resection, Not Otherwise Specified	X	X	X	o		
Wedge or segmental resection	X	o	o			
Transsacral rectosigmoidectomy	X	X	X			
Hartmann's operation	X	X	X	rectal-pouch	descending	
Anterior/posterior resection	X	X	X			
Pull-through resection with sphincter preservation; includes: Altemeier's operation, Soave's submucosal resection	X	o	X			
Duhamel's operation	X	X	X		sigmoid	

(Continued on page 11)

(Continued from page 10)

Types of Surgery - Rectum (Cont'd)

TYPES OF SURGERY--RECTUM

X = complete * = partial o = optional • = see note under procedure

------Tissues Removed-----

	Rectum	Recto-sigmoid	Lymph nodes	Sphincter	Other Organs#	Permanent Colostomy
Swenson's procedure	X	X	X	*		
Turnbull procedure	X	o	X	preserved		
Abdomino-perineal resection (complete proctectomy) descending • anus, perineal skin, fat and nerves	X	X	X	X	•	X
Miles' operation • perianal excision of rectum and anus	X	X	X	X	•	X descending
Rankin's operation	X	o	X	X		X
Pelvic exenteration (partial or total)	X	o	X	X	X	X
Surgery of regional and/or distant sites or nodes				*/X		

Other organs may include bladder, prostate, pelvic contents, bony pelvis, pelvic blood vessels, ligamentous attachments

AP Resections--how to tell what the initials mean

There is no published guideline for determining whether this abbreviation refers to Anterior/Posterior or Abdominoperineal resections, but some of the distinguishing characteristics are listed below.

Abdominoperineal resection is performed for very low lesions in the rectum (lower third--within 5 cm of anal verge). An abdominoperineal resection, in addition to removing the entire rectum, most of the sigmoid colon, the mesocolon and its regional lymph nodes, removes the anal sphincter and leaves the patient with a permanent colostomy. Because of the resulting colostomy, this procedure is done only in circumstances where it is absolutely necessary. This procedure may also be called a Miles' or a Rankin's procedure. Review the x-rays, endoscopy, op report and/or path report for an indication that the tumor is very low in the rectum or that the path specimen contained the anal sphincter muscle. An enterostomal therapist report may also give you some indication that the patient will have a permanent colostomy.

Anterior/Posterior resection is performed for other lesions in the rectum and rectosigmoid (above 5 cm from anal verge). This procedure is usually called a low anterior resection, but may have a posterior approach in certain situations. An Anterior/ Posterior resection preserves the anal sphincter and preserves bowel continuity by creating an anastomosis after the segment of bowel containing the tumor is removed. You will see references to autosuture devices or intraluminal stapling devices in the op report as the anastomosis is constructed. The patient may have a temporary colostomy which is closed at a later date.

(Continued on page 12)

(Continued from page 11)

The general guideline is to look at the location of the tumor: if it is below 5 cm from the anal verge, AP probably stands for Abdominoperineal; if it is above 5 cm, it probably means Anterior/Posterior.

RADIATION THERAPY

Radiation therapy is a primary treatment for anal and distal rectal lesions when the patient is a poor risk for primary surgery.

Postoperative radiation therapy may be useful for Stage II or III colon cancer that is fixed or adherent to adjacent structures, or had complete obstruction or perforation.

Radiation therapy is more useful for rectal lesions than for colon lesions. Both pre-operative and post-operative irradiation are used to prevent local recurrence from rectal lesions. High-dose preoperative radiation may permit resection of primary tumor with preservation of sphincter function.

Hepatic radiation for known or suspected liver metastases (under clinical evaluation)

Intracavitary radiation may be used in selected rectal cancer patients (well-differentiated tumor < 2 cm in size, no fixation or palpable lymph nodes).

Intraoperative radiation is an option (where available) for locally advanced rectal disease.

DRUGS COMMONLY USED

Chemotherapy--recommended as adjuvant for Stage III disease (positive lymph nodes)
5-FU alone
5-FU and levamisole (Biological Response Modifier)
5-FU and leucovorin (under clinical evaluation)-ancillary drug
5-FU plus radiation therapy for rectal cancer
Portal vein infusion of 5-FU for known or suspected liver metastases (under clinical evaluation--has shown improvement in palliation but not in survival)

Combinations

MOF--5-FU, Methyl-CCNU and vincristine (no longer considered to be appropriate adjuvant treatment per NCI because of M-CCNU's renal toxicity and leukemogenic effect)

Hormones (not useful for colorectal cancer)

Biological Response Modifiers (under clinical evaluation)

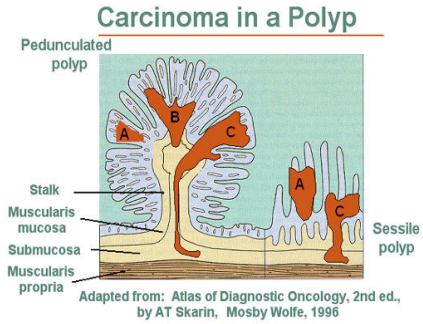
KEYS TO ABSTRACTING

In situ carcinomas may arise in either flat mucosa or in a polyp. If tumor arises in a polyp, it is important to determine whether the stalk is invaded. If it is, the tumor is assigned to T1.

Most colorectal cancers appear to arise in polyps. The risk of cancer increases with the size of the polyp; 30-50% of polyps over 2 cm in size are malignant.

FIGURE 3. Tumor Invasion of Polyps

The figure below is a pedunculated adenoma or polyp. The figure on the right is a sessile, or flat, adenomatous polyp. The dark areas A, B, and C represent zones of carcinoma. Area A shows no invasion and is therefore in situ. Note that any invasion below the muscularis mucosae (Areas B and C) in a sessile lesion represents invasion into the submucosa of the bowel wall. In contrast, invasive carcinoma in a pedunculated adenoma (left) must traverse a considerable distance before it reaches the submucosa of the underlying bowel wall. Although more pedunculated adenomas have a tubular pattern and most sessile adenomas are villous, exceptions to this generalization occur.



About 70% of all cancers of the large intestine occur below the mid point of the descending colon (descending 10%, sigmoid 10%, rectum 50%). The remainder are in the right, middle and upper descending colon (29.5%).

Independent simultaneous colon primaries in more than one segment of the colon should be abstracted separately. The surgical codes for all primaries should reflect the complete extent of the resection.

Nodules in pericolic or perirectal fat are considered to be lymph nodes containing metastases. If the nodule has the contour and form of a lymph node it is considered as lymph node metastasis and if the nodule has an irregular contour, it should be classified in the T category.

The number of lymph nodes involved has prognostic importance: patients with 1-3 nodes positive have a better survival than those with 4 or more nodes positive.

The ileocecal valve is considered part of the large bowel (cecum), not the small intestine (ileum).

(Continued on page 13)

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"Bowel wall" means different things to different medical professionals. To some, it is the muscular layers of the intestine only; to others, it is the entire thickness of the intestine, from inside to outside. Thus the term "through the bowel wall" could be different stages. If "bowel wall" is the muscular layers only, extension through the bowel wall would be into the subserosal fat but still within the thickness of the intestine (localized). If "bowel wall" is the entire intestinal thickness, invasion through it would extend tumor outside the organ and therefore it would be at least regionalized by direct extension. It is important to define "bowel wall" at your facility, so that you can correctly stage the tumor based on the pathologic description.

The serosa of the colon (outside layer) is one cell layer thick; therefore, involvement of the serosa indicates that the tumor has broken through the serosa and may spread by extension from there.

The serosa is also called the visceral layer of the peritoneum, so serosal invasion is considered regional stage unless there is definite evidence of distant spread.

Do not add together the sizes of pieces of tumor removed at biopsy and at resection unless it is done/stated by the pathologist or surgeon. Use the largest size of tumor, even if this is from the biopsy specimen. If no size is stated, record as 999 in the field "Size of Tumor."

If a wedge resection of a segment of the colon is done for diagnosis and a more complete procedure, such as a hemicolectomy, is done as cancer directed surgery, code the more complete surgical procedure. If a right hemicolectomy was done in the past for a previous primary and a left hemicolectomy is now being performed for a new primary, code the left hemicolectomy to "complete excision of the colon." The surgical code should indicate the status of the primary organ.

Abdominal-perineal resection is usually performed only for rectal tumors within 6-8 cm of the anal verge.

Liver involvement may be a direct extension from a tumor in the hepatic flexure and would be regional disease; otherwise it is considered hematogenous (blood-borne) distant metastasis. If the liver metastases can be resected, the patient has a better survival.

The sigmoid colon is the most common site for cancer of the colon. Rectal carcinoma is the most common cancer of the lower gastrointestinal tract.

One of the determining factors for preservation of the anus is how close the tumor is to the sphincter. If sufficient distal rectum permits low anterior resection or colo-anal anastomosis, this treatment is preferred to a permanent colostomy.

AJCC staging applies to carcinomas only; lymphomas, carcinoids and sarcomas are not to be included in this staging system.

Use TX if the primary tumor was excised at another facility and no information about tumor size is available.

There have been several modifications of the Dukes' staging for colon and rectal cancers. It is important to find out which modification is being referred to and to use that system consistently when analyzing data.

The parts of a two-stage procedure are:
1) decompression of bowel obstruction through a colostomy and removal of tumor; and
2) reanastomosis of bowel and removal of colostomy at a later date
In such a case, the closure of the colostomy is not coded as part of cancer directed treatment.

For carcinoma of the anal canal, size of tumor must be recorded in order to stage the case by the AJCC system.

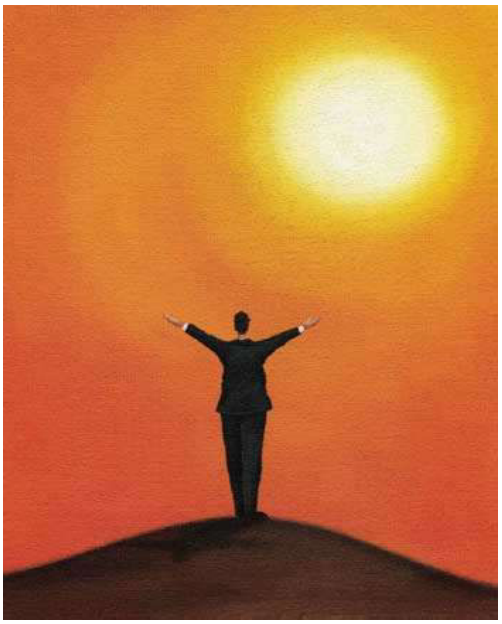
ATTENTION REGISTRY SOFTWARE VENDORS STATE AND CENTRAL REGISTRY STAFF

The Collaborative Staging Task Force discovered a problem with the CS calculation during the CS implementation process. Rest assured that when problems are detected, we will fix and test them, and then release a notice to public. The current problem has been fixed and has already passed several rounds of testing.

The current problem only affected prostate with a blank SSF3. It did not affect any other data.

It is imperative that Vendors switch to the new version as soon as possible. The revised version of cstage.dll is already posted on the CS Web pages at www.cancerstaging.org. Click on Collaborative Staging, and then on the Software Vendor button. The version number for this revision of cstage.dll is Version 010002.

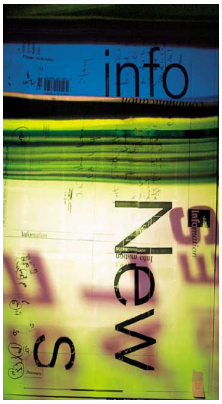
If you have any questions, please feel free to e-mail Valerie Vesich at ajcc@facs.org or Tom Rawson from CDC at trk2@cdc.gov



CONGRATULATIONS!

Please join us in wishing Mary O'leary, CTR, the best on her new position with the Baptist Healthcare Systems. She has been part of FCDS for the past 4 years.

The FCDS staff is sad to see her leave, and wish her much success and happiness!



DISTRIBUTION OF THE COLLABORATIVE STAGING MANUAL AND CODING INSTRUCTION:

FCDS has received the published copies sent by the Center for Disease Control (CDC) of the Collaborative Staging (CS) Manual and Coding Instructions. FCDS has mailed copies of the CS manual to non-ACoS hospitals and freestanding facilities.

If you need additional copies, the Collaborative Staging Manual and Coding Instructions are available electronically and can be printed and downloaded from the CS Web page at www.cancerstaging.org/personnelinfo.html or visit the FCDS website under "what's new?"

If you did not receive your complimentary copy of the CS manual from FCDS, please contact Melissa Williams, at 305-243-4600.

ICD-O-3 PRIMARY BRAIN AND CNS SITE/HISTOLOGY LIST

The ICD-O-3 Primary brain and CNS site/histology list indicates the site and corresponding 4 digit histology codes for benign, borderline intracranial and CNS and malignant tumors. To download a copy visit the FCDS website under FCDS 2004 DAM and select the NAACCR 2004 implementation guidelines, see Appendix D.

ANNUAL FCDS QC SITE VISITS

FCDS has been performing On-Site Quality Control Audits in randomly selected Florida hospitals. QC Audits have included Casefinding and Reabstracting Audits of 2002 admission data at end-results registries and data.

CDC SITE VISITS

FCDS is one of the registries picked by the Centers of Disease Control (CDC) for a casefinding and reabstracting Audit. Nine facilities were selected in the CDC's random sample for this audit which covered the 2001 admissions data and the site visits were carried out in collaboration with FCDS during the month of March 2004.

SEQUENCE NUMBERS

Primary non-malignant tumors diagnosed on or after January 1, 2004 are to be sequenced in the range of 60-87.

POLICIES AND PROCEDURES

FYI - ***FCDS plans to revise certain sections of the FCDS Data Acquisition Manual – DAM.*** *This is expected to be completed by June, 2004. We plan to include the new NAACCR V10.1 updating some fields and deleting a few fields.*

If you have any suggestions on the content, format, etc. for the DAM...please call Mayra Alvarez, at 305-243-2603 or write us with details. Thanks

EDITS

All FCDS Edits are currently being reviewed and updated to meet the NAACCR Version 10.1 standards. You can expect a number of new edits after July 15, 2004. Reminder: FCDS has Modified Edit 0171- "2004 Cases Are Not Being Accepted At This Time". This edit was added to avoid having any facility report 2004 cases before July 1, 2004. FCDS will begin accepting 2004 cases on July 15, 2004.

DEADLINES AND REMINDERS

DEADLINES- SERIOUSLY DELINQUENT LETTER

Facilities that have 55% or less of their 2003 total annual caseload reported to FCDS by the end of April will receive a "Seriously Delinquent" letter. The letter will be mailed the first week of May 2004 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, 2004 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."

DOH continues to work with individual facilities under extenuating circumstances. Please contact your Field Coordinator immediately at (305) 243-4600 to discuss your plans to meet the reporting deadline of June 30, 2004.

This deadline does not apply to non-hospital facilities.

QUARTERLY ACTIVITY REPORTS FOR JANUARY THROUGH MARCH 2004

FCDS generated the Quarterly Activity Reports for the first quarter of 2004, January through March. The reports were mailed the first week of April. All reporting facilities are expected to be 75% complete reporting their 2003 cancer cases.

COMPLETENESS REPORT

The number of new cases added to the FCDS Masterfile in March 2004 is 17,462.

As of March 31, 2004, 49% of the 2003 Cancer Admissions have been reported to FCDS. 75% is expected from all reporting facilities.

NEW PROCEDURE FOR ACTIVE CTR'S APPLYING FOR THE FIRST TIME FOR AN FCDS ABSTRACTOR CODE

(* MOST ABSTRACTOR CODES WILL EXPIRE JUNE 30, 2004. PLEASE RENEW.)

As of March 1st, 2004, any active CTR applying for the first time for an FCDS Abstractor Code will NO longer be required to submit 25 cases. They must complete and submit the following documentation to FCDS:

a) A photocopy of their most current CTR Certificate indicating active certification from NCRA.
b) A completed FCDS Cancer Abstractor Code Request Form (can be downloaded from the FCDS Web site under FCDS IDEA).
c) A signed and completed copy of the CTR attestation (can be downloaded from the FCDS Web site under FCDS IDEA).

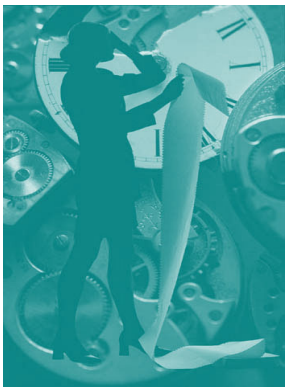
All non CTR's applying for permission to submit cancer cases to FCDS must continue to submit 25 abstracts in hard copy form for review and approval to obtain an FCDS Cancer Abstractor Code.

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 Betty Hallo at (305) 243-2627 for additional information.

PATH LAB REPORTING

Every anatomic pathology laboratory that reads biopsy and surgical resection specimens collected within the state of Florida MUST electronically submit the specified data for every malignant cancer case. Specimens read between July 1, 2003 and December 31, 2003 must be submitted to FCDS on or before June 30, 2004.

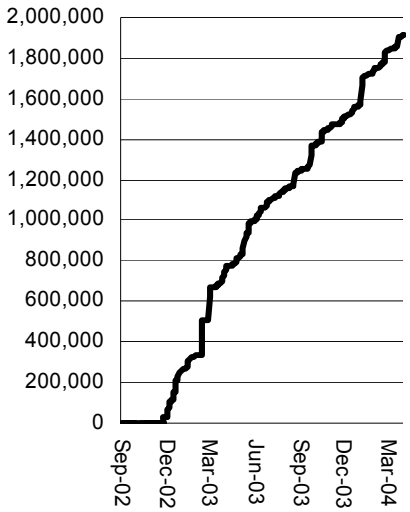


FLORIDA CANCER DATA SYSTEM

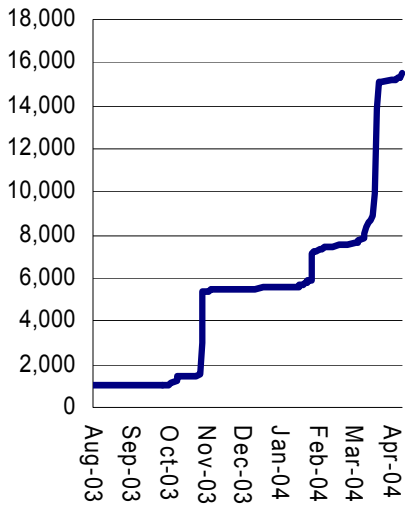
Path Reporting and Radiation Therapy Reporting

Cumulative Data Received

Path



Radiation Therapy Center



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

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