



FLORIDA CANCER DATA SYSTEM MAY 2004 MONTHLY MEMO

WHAT'S NEW:
The following Newsletters and Reports are currently available from the FCDS website:

- **UPDATED 5/18/2004:**
(NEW FIELDS ADDED FOR COLLABORATIVE STAGING REQUIREMENTS AND NON-MANDATORY FIELD CHANGES AFTER JULY 1, 2004)
APPENDIX F OF THE 2004 FCDS DATA ACQUISITION MANUAL
- FCDS 2004 ANNUAL MEETING BROCHURE
- FCDS REGISTER VOL. 23
- FCDS APRIL 2004 MONTHLY MEMO
- CTR ATTESTATION FORM

On the Web:

- **AMERICAN COLLEGE OF SURGEONS (ACoS)**
<http://www.facs.org>
- **FACILITY ONCOLOGY REGISTRY DATA STANDARDS (FORDS) MANUAL UPDATES FROM AMERICAN COLLEGE OF SURGEONS COMMISSION ON CANCER (CoS)**
<http://www.facs.org/dept/cancer/coc/fordsmanual.html>
- **NATIONAL CANCER DATABASE (NCDB)**
<http://www.facs.org/dept/cancer/ncdb>
- **NATIONAL CANCER INSTITUTE (NCI)**
<http://www.nci.nih.gov>
- **NATIONAL CENTER FOR HEALTH STATISTICS (NCHS)**
<http://www.cdc.gov/nchs/default.htm>
- **NATIONAL CANCER REGISTRARS ASSOCIATION**
<http://ncra-usa.org>



ESOPHAGUS CANCER

American Cancer Society Website: http://www.cancer.org/docroot/CRI/content/CRI_2_2_3X_How_is_esophagus_cancer_found_12.asp?rnav=cri

What Is Esophagus Cancer?

The *esophagus* is a muscular tube that connects the mouth to the stomach and carries food into the stomach. The esophagus is usually between 10 to 13 inches long. The normal adult esophagus is roughly three-fourths of an inch across at its smallest point.

The wall of the esophagus has several layers. Cancers of the esophagus start from its inner layer and grow outward. The innermost layer of the esophagus is called the *mucosa*. The mucosa has 2 parts: the *epithelium* and the *lamina propria*. The epithelium forms the lining of the esophagus and is made up of flat, thin cells called *squamous cells*. The lamina propria is a thin layer of connective tissue right under the epithelium.

There is a thin layer of muscle tissue under the mucosa called the *muscularis mucosae*. The next layer is the *submucosa*. Some parts of the esophagus have mucus-secreting glands in this layer. The layer under the submucosa is a thick band of muscle called the *muscularis propria*. This layer of muscle contracts in a coordinated, rhythmic way to force food along the esophagus from the throat to the stomach. The outermost layer of the esophagus is formed by connective tissue. It is called the *adventitia*.

The upper part of the esophagus has a special area of muscle at its beginning that relaxes to open the esophagus when it senses food or liquid coming toward it. This muscle is called the *upper esophageal sphincter*. The lower part of the esophagus that connects to the stomach is called the *gastroesophageal junction*, or *GE junction*. There is a special area of muscle near the GE junction called the *lower esophageal sphincter*. The lower esophageal sphincter controls the movement of food from the esophagus into the stomach and it keeps the stomach's acid and digestive enzymes out of the esophagus.

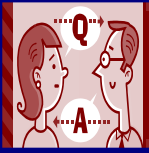
The stomach has strong acid and enzymes that digest food. The epithelium or lining of the stomach is made of glandular cells that release acid, enzymes, and mucus. These cells have special features that protect them from the stomach's acid and digestive enzymes.

If acid escapes from the stomach into the esophagus, patients can feel a burning sensation called heartburn in the middle of their chest. The medical term for the escape of acid from the stomach back into the esophagus is *reflux*. If the reflux of

stomach acid into the lower esophagus continues for a long time, the acid can cause glandular cells to replace the squamous cells that usually line the esophagus. These glandular cells usually look like the cells that line the stomach and are more resistant to stomach acid. If these glandular cells extend farther than 3 centimeters (about 1¼ inches) above the GE junction, the patient has a condition called *Barrett's esophagus*. These new glandular cells that make up Barrett's esophagus can later develop into a cancer so people found to have Barrett's esophagus should be closely watched by a doctor. Barrett's esophagus is very common, particularly in people with reflux. But people with no symptoms can also have Barrett's esophagus.

There are 2 main types of esophageal cancer: *squamous cell carcinoma* and *adenocarcinoma*. At one time, squamous cell carcinoma was by far the more common of the two cancers and was responsible for almost 90% of all esophageal cancers. However, more recent medical studies show that squamous

(Continued on page 3)



FCDS Q & A

SEER INQUIRY SYSTEM
<http://seer.cancer.gov/seer inquiry/>



References

SEER Book 4 ;pgs 203, 204 (Figures 30 &31)

Question

Primary Site--Esophagus: What is the difference between C15.5 [Lower third of esophagus] and C15.2 [Abdominal esophagus]?

Answer

These descriptions represent the use of two different ways the esophagus can be divided anatomically. The two different systems used are illustrated in the SEER Self Instruction Manual for Tumor Registrars: Book 4. Assign the primary site code that describes the location of the tumor in the same way the tumor's location is described in the medical record.

FDA APPROVES NEW INDICATION FOR TAXOTERE PROSTATE CANCER



The Food and Drug Administration (FDA) May 19 approved Taxotere

(docetaxel), injection in combination with prednisone (a steroid), for the treatment of patients with advanced metastatic prostate cancer. This is the first drug approved for hormone refractory prostate cancer that has shown a survival benefit.

“We consider this approval an important advance in the treatment of prostate cancer because it can help some patients live longer. Patients need as many effective treatment options as possible and Taxotere, in combination with prednisone, offers hope to certain patients who have not responded to other treatments,” said Dr. Lester M. Crawford, Acting FDA Commissioner.

Prostate cancer is the second leading cause of cancer death in men and for those patients who have not responded to hormone therapy, Taxotere, in combination with prednisone, is a

new treatment option that has now shown a survival advantage.

Taxotere works by inhibiting tubulin, a protein essential to cell division, thus preventing cancer cells from dividing and growing in number.

The safety and effectiveness of Taxotere was established in a randomized, multi-center global clinical trial with over 1,000 patients comparing chemotherapy with taxotere and prednisone to mitoxantrone and prednisone in men with metastatic, hormone -- refractory prostate cancer. Taxotere, in combination with prednisone, given every three weeks showed a survival advantage of approximately 2.5 months over the control group in the trial.

The most common adverse events reported were nausea, alopecia (hair loss), and bone marrow suppression. In addition, fluid retention and peripheral neuropathy (tingling sensations in the extremities), known effects of taxotere, were also observed.

The American Cancer Society estimates there will be about 230,900 new cases of prostate cancer in the United States in 2004. About 29,900 men will die of this disease this year alone

The NAACCR Washington Report
 May 27, 2004 Volume 5, Number 11

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cell cancers make up less than 50% of esophageal cancers today. Since the entire esophagus is normally lined with squamous cells, squamous cell carcinoma can occur anywhere along the length of the esophagus.

The other common type of esophageal cancer, *adenocarcinoma*, starts in glandular tissue, which normally does not cover the esophagus. It usually occurs in the lower esophagus, near the stomach. Before an adenocarcinoma can develop, glandular cells must replace an area of squamous cells, for example as in Barrett's esophagus. Although at one time it was rare, adenocarcinoma of the esophagus has become the most common type in white men.

How Many People Get Esophagus Cancer?

In the United States, the American Cancer Society estimates that there will be about 14,250 new cases of this cancer in 2004. About 13,300 people will die of the disease. This cancer is about three times more common among men than among women and three times more common among African Americans than among whites. Some countries such as Iran, northern China, India, and southern Africa have rates that are 10-100 times higher than that of the United States.

How Is Esophagus Cancer Found?

In most cases, this type of cancer is found because of the symptoms it causes. But often these symptoms don't appear until the cancer is advanced, making cure less likely. If the cancer is found early, it is often a result of tests done for other reasons.

Below are the most common symptoms of this type of cancer:

Trouble with swallowing (dysphagia: dis-**FAY**-jee-uh): This is the most common symptom of cancer of the esophagus. It means that you feel as if food is lodged in the chest. By this time, if cancer is present it has grown to fill about half the opening of the esophagus. Solid foods like bread and meat often get stuck. People with dysphagia often switch to softer foods or even liquids to help with swallowing.

Pain: Rarely, pain in the mid-chest, or a feeling of pressure or burning, can be a sign of cancer. But these symptoms can also be caused by something else, such as heartburn. Pain while swallowing is usually a late sign of cancer.

Weight loss: About half of people with esophageal cancer lose weight without trying. This is because they are not getting enough food since they have trouble swallowing. Also, they may find they have less appetite.

Other symptoms: Hoarseness, hiccups, pneumonia, and high calcium levels are usually signs of more advanced cancer. Of course, these symptoms can be caused by other diseases as well.

If Cancer is Suspected

If certain symptoms suggest esophageal cancer, a doctor will use one or more methods to find out if the disease is really present. After taking your medical history and doing a physical exam, the doctor will tell the patient which of the following tests they will need.

Barium swallow: This is a series of x-rays taken after the patient swallows barium, a dense liquid. Barium coats the surface of the esophagus and helps create a good picture. Any lumps on the lining of the esophagus show up on the x-ray. A barium swallow is often the first test to be done if this cancer is suspected.

Endoscopy (en-**DOS**-kuh-pe) An endoscope is a flexible tube with a light and video camera on the end. The doctor uses this to "see" into the esophagus and the stomach. The patient is given a sedative before the tube is passed down through the mouth and esophagus into the stomach.

This test is useful because:

- The doctor can see the esophagus clearly.
- A tissue sample can be taken to find out if there is cancer and the type.
- If the cancer is blocking the opening of the esophagus, the opening can be made bigger.

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- The doctor can learn more about whether the cancer can be removed with surgery.

CT scan (Computed tomography): CT scanners take x-ray pictures from many angles to give an accurate picture of organs inside the body. CT scans can be helpful in finding out the extent of the cancer, which in turn can help guide choices about surgery.

Endoscopic ultrasound: This new test uses an endoscope with a small ultrasound probe attached. It can show how far the cancer has grown into the esophagus to aid in making choices about surgery.

Bronchoscopy (bron-KOS-kuh-pe): This test is somewhat like an endoscopy except that the doctor looks into the windpipe and the tubes leading into the lungs to see if the cancer has spread there. The patient will be made drowsy for this test.

PET scan (positron emission tomography): For this test, a special radioactive sugar is injected into a vein. The tissues with cancer quickly take up the sugar. Then a scanner can spot those areas. This test is still being studied, is useful for spotting cancer that has spread beyond the place where it started. It may help in staging the cancer.

Thoracoscopy (thor-uh-COS-kuh-pe) **and laparoscopy** (lap-uh-ROS-kuh-pe) : These are methods that allow the doctor to see lymph nodes inside the chest or abdomen with a hollow lighted tube. The doctor can also remove lymph nodes for testing through the same tube. This information is helpful in telling whether surgery is a good option.

After The Tests: Staging

Staging is the process of finding out how far cancer has spread. This is very important because treatment and the outlook for recovery depend on the stage of the cancer.

Doctor will start with a barium swallow and/or endoscopy to find out the size of the tumor. Then a CT scan will help answer the following questions:

- Has the cancer spread to lymph nodes or to the lungs?
- Does the tumor extend into the windpipe?
- Has the tumor spread to distant organs such as the liver?

Sometimes endoscopic ultrasound is used as well to find out how deep the cancer goes into the tissue of the esophagus.

Once the doctor has the answers to these questions, the stage of the cancer can be determined. Stages are often labeled using Roman numerals 0 through IV (0-4). In general, the lower the

number, the less the cancer has spread. A higher number, such as stage IV (4), means a more serious cancer.

Treatment for Esophagus Cancer

There is a lot to think about when choosing the best way to treat or manage cancer. There may be more than one treatment to choose from. Patients may feel that they need to make a decision quickly. But patients need time to absorb the information learned.

A patient may want to get a second opinion. The doctor should not mind doing this. In fact, some insurance companies require the patient to get a second opinion.

Surgery, chemotherapy, and radiation are used to treat cancer of the esophagus. Other treatments (palliative) can be used to help relieve pain but are not meant to cure the cancer.

The best choice will depend on the stage of the cancer as well as the general health of the patient. Each of these treatments might have some side effects.

Surgery

How much surgery is done depends on the stage of the cancer. Surgery can also be used along with other treatments such as chemotherapy and radiation treatment.

There are two common types of operations for this cancer. In one, esophagectomy (ee-sof-uh-JEK-tuh-me), the esophagus and nearby lymph nodes are removed. The esophagus is re-connected to the stomach, either directly or by adding a piece taken from the large intestine.

The other surgery, esophagogastrectomy (ee-sof-uh-go-gas-TREK-tuh-me), is done to remove part of the lower esophagus, nearby lymph nodes, and the upper part of the stomach. The esophagus is again connected to the stomach.

Both of these operations are complex. Surgeons who do this surgery must be quite expert. The success rate is greater when the surgery is done in a hospital where it is done more often.

Most people stay in the hospital for 2 weeks after surgery. And there can be risks and side effects. For example, after the operation the stomach may empty very slowly, causing nausea and vomiting. The place where the esophagus connects to the stomach can become more narrow, making it hard for the person to swallow. Also, acid from the stomach can enter the esophagus causing heartburn.

Anyone who has problems with side effects should talk with their doctor or nurse as there are often ways to help.

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Chemotherapy

Chemotherapy refers to the use of drugs to kill cancer cells. Usually the drugs are given into a vein or by mouth. Once the drugs enter the bloodstream, they spread throughout the body.

Chemotherapy alone cannot cure cancer of the esophagus unless radiation treatment (and in some cases surgery) are also used. Chemotherapy is used in 3 ways: it can be given along with radiation to shrink the cancer; it can be used before surgery to shrink a tumor; it can be used to ease the symptoms of advanced cancer.

Chemotherapy can have some side effects. These side effects will depend on the type of drugs given, the amount taken, and how long treatment lasts. The most common side effects can include:

- Nausea and vomiting
- Loss of appetite
- Hair loss
- Mouth sores
- Increased chance of infection
- Bleeding or bruising after minor cuts or injuries
- Tiredness or shortness of breath

Most side effects go away once treatment is over. Anyone who has problems with side effects should talk with their doctor or nurse as there are often ways to help.

span class="t8"> Radiation Therapy

Radiation therapy is treatment with high energy rays (such as x-rays) to kill or shrink cancer cells. External radiation uses a beam from outside the body. This is the kind most often used for cancer of the esophagus. For internal or implant radiation, radioactive material is placed directly inside the body near the cancer.

Radiation therapy by itself will not cure esophageal cancer. Often it is combined with surgery and/or chemotherapy. It is also used to relieve problems with swallowing, pain, or other symptoms of this cancer.

Side effects of radiation treatment may include skin problems, upset stomach, diarrhea, and fatigue. Often these side effects go away when treatment ends. Radiation to the chest may cause lung damage and lead to trouble breathing and shortness of breath.

PDT (photodynamic therapy): This method may be used when the cancer has come back after radiation treatment. First, a harmless chemical is injected into the bloodstream. It collects in the tumor for a few days. Then a special type of laser light is focused on the cancer through an endoscope. The light changes the chemical into a new chemical that can kill cancer cells.

PDT is useful because it can kill cancer cells with very little harm to normal cells. But because the light must be used, it can reach only cancers near the surface of the esophagus. It doesn't work for cancers that have spread deeper or into other organs.

Survival Rates

Side effects of PDT include redness or discoloration of the skin and sensitivity to the sun or other light sources. Because of this, people having this treatment may be told to stay indoors for 6 weeks. Because this cancer is usually found at an advanced stage, most people will die of the disease. But survival rates have been getting better. The cancer care team can answer questions about the patient's chances of a cure, or how long the patient's survival.

LUNG CANCER CASES THAT PRESENT WITH PLEURAL EFFUSION

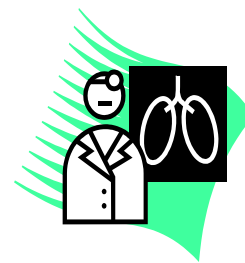
Lung cancer cases that present with pleural effusion can often be confusing and tricky to stage. We have taken the liberty of reprinting the following information that should help.

In the SEER Summary Staging Manual 2000 on page 151, the following reference is made regarding pleural effusion:

"Ignore pleural effusion which is negative for tumor. Assume that a pleural effusion is negative if a resection is done".

The AJCC Staging Manual 6th Edition contains the following reference to pleural effusion on page 171:

"Most pleural effusions associated with lung cancer are due to tumor. However, there are a few patients in whom multiple cytopathologic examinations of pleural fluid are negative for tumor. When these elements and clinical judgement dictate that the effusion is not related to the tumor, the effusion should be excluded as a staging element and the patient should be staged T1, T2 or T3."



EDUCATION AND TRAINING



FLORIDA CANCER DATA SYSTEM 2004 ANNUAL MEETING

DATE: July 27-28, 2004

LOCATION: Embassy Suites Hotel,
Tampa, Florida

For further information visit the FCDS website at <http://fcds.med.miami.edu> and click What's New tab.



FLORIDA CANCER REGISTRARS ASSOCIATION 2004 ANNUAL MEETING

“PROMOTING CANCER CARE AND RESEARCH”

July 28 –30, 2004

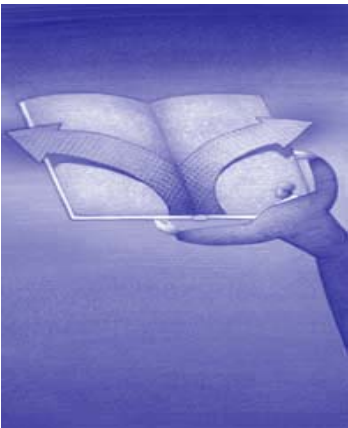
Embassy Suites Hotel
Tampa, Florida

CME credits are pending approval

FOR ADDITIONAL INFORMATION CONTACT:

2004 FCRA Chair: Barbara Dearmon, CTR
Voice: (813) 632-1479
Fax: (813) 632-1435
Email: dearmobj@moffitt.usf.edu

Or visit the FCRA website at http://fcra.org/conference_overview.shtml



PRINCIPLES OF ONCOLOGY FOR CANCER REGISTRY PROFESSIONALS

July 26-30, 2004
December 6-10, 2004

Bolger Center for Leadership Development
Potomac, Maryland
Registration fee: \$695.00 *

Principles of Oncology is an intensive five-day training program in cancer registry operations and procedures emphasizing accurate data collection. The training program includes extensive site-specific, hands-on case abstracting and coding sessions using both full medical records and abstracts that are representative of the many situations registrars may face. This program is endorsed by the National Cancer Registrars Association (NCRA) and the North American Association of Central Cancer Registries (NAACCR). NAACCR also serves as the fiscal agent for this program.

*The registration fee is reduced for participants who stay at the conference center.

For further information visit the SEER website at <http://seer.cancer.gov/training/oncology/>

CERTIFIED TUMOR REGISTRAR EXAMINATION

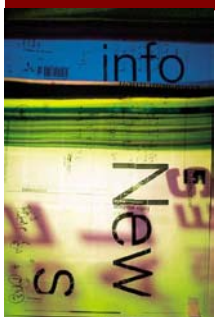


Certified Tumor Registrar Examination

Application Deadline: July 31, 2004
Testing Begins: September 11, 2004
Testing Ends: September 25, 2004

The Certification will be administered during two week periods on a daily basis, Monday through Saturday, excluding holidays, at Laser Grade Computer Testing Inc.'s computer-based testing facilities managed by Professional Testing Corporation.

For more information on the CTR Exam , go to www.ctrexam.org.

**ABSTRACTING****CLARIFICATIONS**

Edit #190, ICD-O-3 morphology not valid with site or non-reportable to FCDS. This edit will no longer appear for those cases coded to a breast primary (C500-C509) with a morphology of 8523 (Infiltrating Duct mixed with other types of Carcinoma) and a behavior code of 2 (in-situ).

Theraspheres are currently being used as initial treatment of patients with unresectable hepatocellular carcinoma. A therasphere delivers radiation to tumors in the liver using

glass beads called microspheres. The microspheres are embedded with the radioactive element yttrium90. Theraspheres should be coded in the Radiation field as a 3' (Radioisotopes).

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.

EDITS

All FCDS Edits are 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.

Edit #0032 was revised from a warning to an override. *Patient has multiple primaries and DX confirmation is not equal to 1, 2, 4, or 5 on all sequences.*



June 9, 2004

TO: All Facility Administrators, Managers, Registrars and Contractors

FROM: Jill A. MacKinnon
Administrative Director

RE: Submission Requirements for 2003 and 2004 Cases

Due to the fact that the Commission on Cancer has extended the abstracting deadline for their approved hospital-based programs, the FCDS had modified the submission requirements for the 2003 and 2004 cases. There are two components to the modified requirements:

1. The June 30, 2004 deadline for receipt of all your 2003 cases HAS NOT been extended. Therefore, as always, to be eligible for the Jean Byers Award, all your 2003 cases must be received by June 30th. The Department of Health and the Agency for Health Care Administration WILL NOT be notified until October 1st of any late reporting.
2. Conversion of the FCDS database to NAACCR v10.1 will be implemented on October 1, 2004. All 2003 records received by September 30th may be submitted in the current format, using the existing single entry and batch upload procedures. For any facility or contractor that would like to begin entering or batch uploading 2004 cases in the new NAACCR v10.1 format (which includes all the collaborative stage elements) may do so beginning July 1. Explicit instructions will be posted on the FCDS web site.

I am sorry for this late notice, but we were just notified of the COC actions by Joyce Allen your FCRA liaison on May 21st and forwarded it to CDC for guidance. We just received approval of our plan from DOH and CDC today.

Should you have any questions please contact your field coordinator. As always, I thank you for your dedication to the FCDS and the cancer surveillance efforts in Florida.



DEADLINES AND REMINDERS

POLICIES AND PROCEDURES

FCDS is revising certain sections of the *FCDS Data Acquisition Manual (DAM)* to incorporate the NAACCR V10.1 revisions that effect cases admitted on or after January 1, 2004. Any facility planning to submit 2004 cases prior to October 1, 2004 must use the revised *DAM*. A draft copy of the *DAM* will be available on the FCDS web site on July 1.

If you have any questions or suggestions on the content, format, etc. please contact Mayra Alvarez at 305 243-4603 or e-mail her at Mayra_alvarez@miami.edu.

ABTRACTOR CODE RENEWAL DEADLINE

FCDS Cancer Abtractor Codes expire on June 30th, 2004. You must fill out a new form to continue submitting work to FCDS. Completed forms should be sent to your Field Coordinator during the month of June, 2004.

On July 1, during the database conversion work (v.10 to v.10.1), we will take all requested Abtractor Renewal forms and renew the expiration date to June 30, 2005.

The renewal form is located on the FCDS IDEA page of our website:
<http://fcds.med.miami.edu/inc/idea.shtml>.

Please note: This is the 3 letter/number code (ex: 3GV) coded on the abstract. This is not the FCDS IDEA user id (ex: mrudolph). The Pathology and Radiation users don't need the 3 letter abtractor 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 from Florida patient encounters 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 are due to FCDS on June 30, 2004. All 2003 data should be reported on June 30, 2004.**

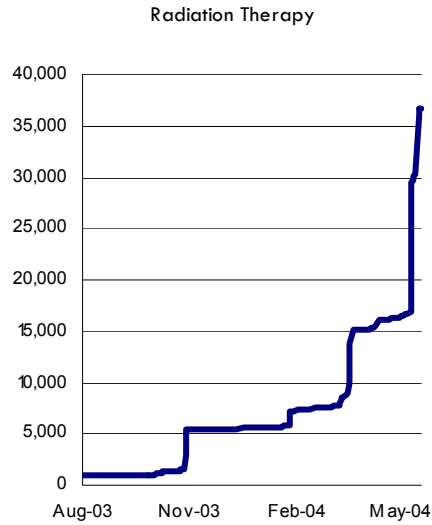
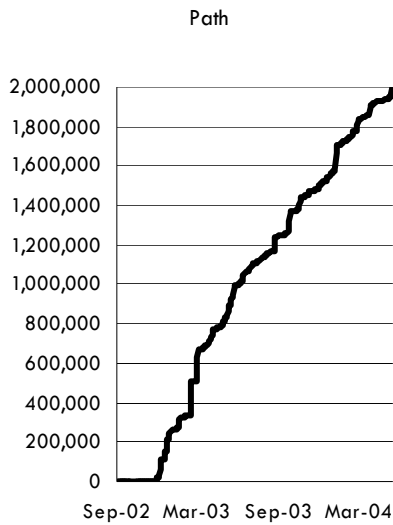
(July 1, 2004 through December 31, 2004 data are due June 30, 2005.)



FLORIDA CANCER DATA SYSTEM

Path Reporting and Radiation Therapy Reporting

Cumulative Data Received



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

PROJECT DIRECTOR:
Lora Fleming, MD, PhD

ADMINISTRATIVE DIRECTOR:
Jill Mackinnon, CTR

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

CONTRIBUTORS:
Betty Fernandez
Stuart Herna, CTR
Kelly Large, CTR

UMSylvester
FLORIDA DEPARTMENT OF HEALTH
UNIVERSITY OF MIAMI
SCHOOL OF MEDICINE