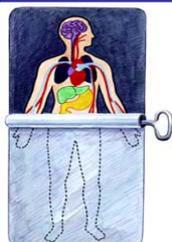




HAPPY FOURTH OF JULY

FLORIDA CANCER DATA SYSTEM

JULY/AUGUST 2004 MONTHLY MEMO



UGI Tract Cancer

Seer Training Website: http://training.seer.cancer.gov/ss_module07_ugi/00_ugi_home.html

WHAT'S NEW:

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

- FCDS REGISTER VOL. 24
- FCDS JUNE 2004 MONTHLY MEMO
- 6/24/2004: FCDS CHANGES FOR HOSPITALS SUBMITTING FULL CANCER ABSTRACTS FOR NAACCR V10.1 (Does not pertain to Pathology Data or Radiation Therapy ID Data)

On the Web:

- **FLORIDA STATUTES AND CONSTITUTION**
<http://www.flsenate.gov/Welcome/index.cfm>
- **THE NATIONAL COMMITTEE ON VITAL HEALTH STATISTICS**
<http://ncvhs.hhs.gov/>
- **CDC'S DIVISION OF CANCER PREVENTION AND CONTROL'S (DCPC)**
<http://www.cdc.gov/cancer/>
- **INTERNATIONAL AGENCY FOR RESEARCH ON CANCER**
<http://www.iarc.fr/>
- **SEER TRAINING WEB SITE**
<http://training.seer.cancer.gov/>

INTRODUCTION TO UGI TRACT CANCER

Collectively, cancers of the esophagus, stomach, and small intestine are referred to as upper gastrointestinal tract (UGI) cancers. UGI cancers represent the second most common site and cause of death among the digestive system cancers.

Esophagus Cancer

The American Cancer Society estimates that during 2003, approximately 13,900 new esophageal cancer cases will be diagnosed in the United States (10,600 men and 3,300 women). This disease is about 3 times more common among men than women and almost 3 times more common among African Americans than whites.

There are two main types of esophageal cancer: squamous cell carcinoma and adenocarcinoma. The majority of cancers in the upper two thirds of the esophagus are squamous cell carcinoma in nature. 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 esophagus.

Squamous cell carcinoma is the most common type of cancer of the esophagus among African Americans, while adenocarcinoma is more common in whites. Cancer of the esophagus is much more common in some regions of the world. For example, esophageal cancer rates in Iran, northern China, India, and southern Africa are 10 to 100 times higher than in the United States.

Stomach Cancer

Stomach cancer (also called gastric cancer) can develop in any part of the stomach and may spread throughout the stomach and to other organs. It may grow along the stomach wall into the esophagus or small intestine. It also may extend through the stomach wall and spread to nearby lymph nodes and to organs such as the liver, pancreas, and colon. Stomach cancer also may spread to distant organs, such as the lungs, the lymph nodes above the collar bone, and the ovaries. Each year, about 24,000 people in the United States are diagnosed with

cancer of the stomach.

Most of stomach cancers are adenocarcinomas, arising in the glandular cells in the stomach lining. These glandular cells normally produce mucus and digestive enzymes. Other stomach cancers may include squamous cells cancers, lymphomas, sarcomas, and neuroendocrine tumors.

Small Intestine Cancer

Cancer of the small intestine, a rare cancer, is a disease in which cancer cells are found in the tissues of the small intestine. Each year US doctors diagnose about 1,200 malignant small intestine tumors. This is a small number relative to the frequency of tumors in other parts of the GI tract.

The majority of cancers of the small intestine are adenocarcinomas (50% or more) and commonly start in the duodenum, jejunum, and the part of the small intestine nearest the stomach. These cancers often grow and obstruct the bowel.

Leiomyosarcomas, another type of small intestine cancer,

(Continued on page 2)

(Continued from page 1)

occur most often in the ileum. Some 20% of malignant lesions of the small intestine are carcinoid tumors, which occur more frequently in the ileum than in the duodenum or jejunum. It is uncommon to find malignant lymphoma as a solitary small intestinal lesion.

FIVE-YEAR SURVIVAL RATES

(from the National Cancer Institute's Physician Data Query system, July 2003)

Esophageal cancer is lethal because the esophagus has no serosa; any tumor extension beyond the esophagus can spread rapidly. Overall, the five-year survival rate is less than 10% for all stages combined.

ANATOMY

Esophagus

The esophagus is a muscular tube about ten inches (25 cm.) long extending from the hypopharynx to the stomach. The esophagus lies posterior to the trachea and the heart, and passes through the mediastinum and the hiatus, an opening in the diaphragm, in its descent from the thoracic to the abdominal cavity. The esophagus has no serosal layer; tissue around the esophagus is called adventitia.

There are two subsite descriptions for the esophagus and they are not equivalent.

Subsite Description 1

Cervical

Cervical begins at the lower end of pharynx (level of 6th vertebra or lower border of cricoid cartilage) and extends to the thoracic inlet (suprasternal notch); 18 cm from incisors.

Thoracic

Upper thoracic: from thoracic inlet to level of tracheal bifurcation; 18-23 cm.

Mid thoracic: from tracheal bifurcation midway to gastroesophageal junction; 24-32 cm.

Lower thoracic: from midway between tracheal bifurcation and gastroesophageal junction to GE junction, including abdominal esophagus; 32-40 cm.

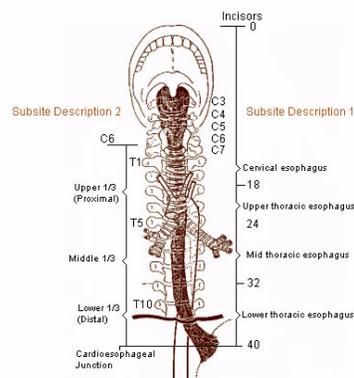
Abdominal

Considered part of lower thoracic esophagus; 32-40 cm.

Subsite Description 2

Upper third (10% of esophageal cancers)
 Middle third (40%)
 Lower third (50%)

The figure below illustrates the correlation between subsite descriptions of the esophagus.



Esophagus	
Stage 0	Excellent
Stage I	> 65%
Stage IIA	30%
Stage IIB	15%
Stage III	< 10%
Stage IV	Rare
Stomach	
Stage 0	> 90%
Stage I	50 - 70% for distal cancers; 10 - 15% for proximal cancers
Stage II	> 25% for T1/T2 Node positive cases; < 25% for T3 cases
Stage III	15% for distal cancers
Stage IV	< 5%
Small Intestine	
Stage 0	not reported
Stage I	60-70%
Stage II	45-55%
Stage III	15%
Stage IV	<10%
Carcinoid	< 40%

(Continued on page 3)

(Continued from page 2)

Stomach

The stomach lies just below the diaphragm in the upper part of the abdominal cavity primarily to the left of the midline under a portion of the liver. The main divisions of the stomach are the following:

Cardia

The cardia is the portion of the stomach surrounding the cardioesophageal junction, or cardiac orifice (the opening of the esophagus into the stomach). Tumors of the cardioesophageal junction are usually coded to stomach.

Fundus

The fundus is the enlarged portion to the left and above the cardiac orifice.

Body

The body, or corpus, is the central part of the stomach.

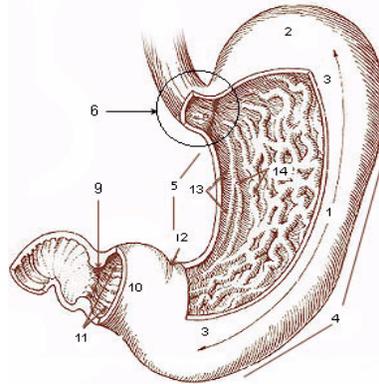
Pyloric antrum

The pyloric antrum is the lower or distal portion above the duodenum. The opening between the stomach and the small intestine is the pylorus, and the very powerful sphincter which regulates the passage of chyme into the duodenum is called the pyloric sphincter.

The stomach is suspended from the abdominal wall by the lesser omentum. The greater omentum attaches the stomach to the transverse colon, spleen and diaphragm.

The common mesentery suspends the small intestine. The parietal peritoneum lies over the duodenum and other structures, such as the abdominal aorta. Because they lie behind the peritoneum, they are called retroperitoneal structures.

The figure below shows the anatomy of the stomach.



1. Body of stomach
2. Fundus
3. Anterior wall
4. Greater curvature
5. Lesser curvature
6. Cardia
9. Pyloric sphincter
10. Pyloric antrum
11. Pyloric canal
12. Angular notch
13. Gastric Canal
14. Rugal folds

Small Intestine

The small intestine is a tube measuring about 2.5 cm in diameter. The complete small intestine is approximately 600 cm (20 feet) long and coiled in loops, which fill most of the abdominal cavity. It extends from the pyloric sphincter to the ileocecal valve, where it joins the large intestine and is comprised of three parts:

Duodenum-- approximately 25 cm long; proximal end of small intestine; joined to stomach by the pyloric sphincter.

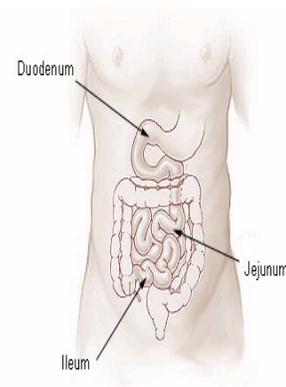
Jejunum-- approximately 200 cm long.

Ileum-- approximately 300 cm long; joins the cecum at the ileocecal valve.

Peyer patches-- lymphoid tissue in lamina propria primarily in distal ileum; primary site for lymphomas.

Meckel diverticulum--congenital anomaly of the ileum, a diverticulum analogous to the appendix of the cecum; a potential site for malignancy.

Anatomy of the Small Intestine

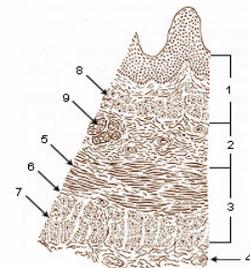


Layers of UGI Organs

Layers of Esophageal Wall

The esophageal wall contains four layers:

- mucosa -- surface epithelium, lamina propria, and glands
- submucosa -- connective tissue, blood vessels, and glands
- muscularis (middle layer)
 - o upper third, striated muscle
 - o middle third, striated and smooth
 - o lower third, smooth muscle
- adventitia -- connective tissue that merges with connective tissue of surrounding structures



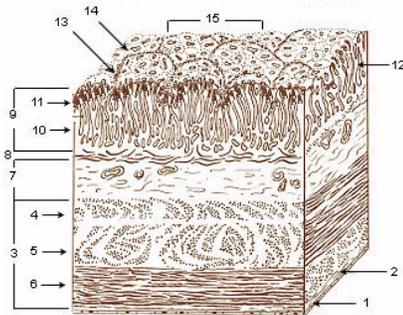
1. Mucosa
2. Submucosa
3. Muscularis
4. Adventitia
5. Striated muscle
6. Striated and smooth
7. Smooth muscle
8. Laminamuscularis mucosae
9. Esophageal glands

(Continued on page 4)

(Continued from page 3)

Layers of Stomach Wall

Layers of the stomach wall, among others, include serosa, muscularis, submucosa, mucosa. The three layers of smooth muscle consist of the outer longitudinal, the middle circular, and the inner oblique muscles. Construction of these muscles helps mix and break the contents into a suspension of nutrients called chyme and propels it into the duodenum.



1. Serosa
2. Tela subserosa
3. Muscularis
4. Oblique fibers of muscle wall
5. Circular muscle layer
6. Longitudinal muscle layer
7. Submucosa
8. Lamina muscularis Mucosae
9. Mucosa
10. Lamina propria
11. Epithelium
12. Gastric glands
13. Gastric pits
14. Villous folds
15. Gastric areas (gastric surface)

REGIONAL LYMPH NODES

Esophagus

Cervical:

Superior mediastinal, anterior deep cervical (internal jugular), upper cervical, periesophageal, supraclavicular, lowest paratracheal (azygos), cervical NOS

Thoracic (upper and middle):

Internal jugular, tracheobronchial, peritracheal, perigastric, carinal, hilar, posterior mediastinal, periesophageal

Thoracic (lower):

Left gastric, cardinal, perigastric, NOS, posterior mediastinal, nodes of lesser curvature

Stomach

Inferior (right) gastric:

Greater curvature, greater omental, gastroduodenal, gastrocolic, gastroepiploic (right or NOS), gastrohepatic, pyloric (including subpyloric and infrapyloric), pancreaticoduodenal

Splenic:

Gastroepiploic (left), pancreaticolienal, peripancreatic, splenic hilar

Superior (left) gastric:

Lesser curvature, lesser omental, gastropancreatic (left), gastric (left), paracardial, cardinal, cardioesophageal

Perigastric, NOS

Celiac

Hepatic

Small Intestine

Duodenum:

Hepatic (pancreaticoduodenal, infrapyloric, gastroduodenal)

Jejunum:

Superior mesenteric

Ileum:

Posterior cecal and ileocolic (for terminal ileum)
Superior mesenteric

ICD-O CODES FOR UGI TRACT CANCER

RELATED TERMS AND ADJECTIVES

Esophagus	esophageal, esophago-
Stomach	gastric, gastro-
Small intestine	small bowel, entero-, duodeno-, jejuno-, ileo-
Esophagus, stomach and small intestine	upper gastrointestinal (UGI), esophagogastrod uodeno-

ICD-O-3 TERM

Esophagus

- C15.0 Cervical esophagus
- C15.1 Thoracic esophagus
- C15.2 Abdominal esophagus
- C15.3 Upper third of esophagus
- C15.4 Middle third of esophagus
- C15.5 Lower third of esophagus
- C15.8 Overlapping lesion of esophagus
- C15.9 Esophagus, NOS

Stomach

- C16.0 Cardia, NOS
- C16.1 Fundus of stomach
- C16.2 Body of stomach
- C16.3 Gastric antrum

(Continued on page 6)



DEADLINES AND REMINDERS



PATH LAB REPORTING

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

January 1, 2004 through June 30, 2004 data are due December 31, 2004.



FCDS Q & A

SEER INQUIRY SYSTEM:

[HTTP://SEER.CANCER.GOV/SEERINQUIRY/](http://seer.cancer.gov/seer inquiry/)



References

CS Manual, Part II ;pgs 549-551 (Vers 1.0, Jan 1, 2004)

Question

CS extension--Bladder: How would extension be coded for a bladder case that states: papillary transitional cell carcinoma with no invasion into the submucosa or deep muscularis. There is focal extension of tumor into bladder diverticula.

Answer

Assign extension code 01 [Papillary transitional cell carcinoma stated to be noninvasive]. Extension into bladder diverticula does not change the code. Diverticula are pouches in the mucosa (mucous membrane).

References

1. CS Manual, Part I ;pgs 27 (Vers 1.0, Jan. 1, 2004)
2. CS Manual, Part II ;pgs 458 (Vers. 1.0, Jan. 1, 2004)

Question

CS Tumor Size--Breast: When the diagnosis is inflammatory carcinoma of the breast, must the CS tumor size always be 998?

Answer

No. For inflammatory carcinoma, code the size of the tumor in CS tumor size. Use code 998 [diffuse] when the tumor is stated to be "diffuse."

Page 27 in Part I of the CS manual will be corrected to define code 998 for breast as only "diffuse." The errata should be distributed in July 2004.

(Continued from page 4)

Stomach (Cont'd)

- C16.4 Pylorus
- C16.5 Lesser curvature of stomach, NOS (not classifiable to C16.1 to C16.4)
- C16.6 Greater curvature of stomach, NOS (not classifiable to C16.0 to C16.4)
- C16.8 Overlapping lesion of stomach
- C16.9 Stomach, NOS

Small Intestine

- C17.0 Duodenum
- C17.1 Jejunum
- C17.2 Ileum (excludes ileocecal valve C18.0)
- C17.3 Meckel diverticulum (site of neoplasm)
- C17.8 Overlapping lesion of small intestine
- C17.9 Small intestine, NOS

MORPHOLOGY AND GRADE

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

Esophagus

Squamous cell carcinoma (The majority of cancers in the upper two thirds of the esophagus are squamous cell carcinoma in nature. Adenocarcinomas, which also arise in the esophagus, are more prevalent in the lower third of the esophagus.)

Adenocarcinoma (in Barrett esophagus)

Key words: Barrett esophagus--gastric mucosa (glandular) continuing into esophagus

Stomach

Adenocarcinoma (81403; 95% of all gastric cancers; subtypes: ulcerative 70%, polypoid 10%, scirrhous/diffusely spreading/ linitis plastica 10%, superficially spreading 5%)

Signet ring adenocarcinoma (84903)
Linitis plastica (81423) -- complete involvement of the stomach; leathery appearance

Krukenberg tumor (84906) -- metastatic signet ring carcinoma in the ovaries; most likely from stomach or intestinal primary

Lymphoma (many morphology codes)
Leiomyosarcoma (88903, 88913, 88963; 1% of all gastric cancers)

Small Intestine

Adenocarcinoma (81403)
Lymphoma (many morphology codes)
Leiomyosarcoma (88903, 88913, 88963)
Carcinoids (82403, 82413, 82433, 82443)

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

EXTENT OF DISEASE FOR UGI CANCER

COMMON METASTATIC SITES

SPREAD	PRIMARY SITE/METS
LYMPHATIC SPREAD	Most common for esophageal and stomach cancers; distant lymph nodes include supraclavicular, retropancreatic, hepatoduodenal, aortic, portal, retroperitoneal, mesenteric and inguinal
INTRACAVITARY SPREAD	From stomach--peritoneal seeding; also submucosal extension into esophagus or duodenum; direct extension into liver, transverse colon, pancreas or diaphragm
HEMATOGENOUS SPREAD	Esophagus--liver, lung, pleura, kidney; Stomach--liver, lung, peritoneum, bone; Small intestine--liver, lung

EXTENT OF DISEASE EVALUATION

(Parentheses enclose the names of the organs for which the diagnostic study is useful.)

DEFINITIONS

Key words/involvement:

Terms which indicate tumor is present. Common terms are provided, but the list is not all-inclusive.

(Continued on page 7)

(Continued from page 6)

Other words/no involvement:

Other terms seen in reports which indicate an abnormality but do not indicate tumor is present. Common terms are provided, but the list is not all-inclusive.

Key information:

Information to look for in the report of the study. Key information helps define the extent of disease.

DIAGNOSTIC STUDIES

- PHYSICAL EXAM
- LABORATORY TESTS
- IMAGING
- TUMOR MARKERS
- ENDOSCOPIES
- OPERATIVE REPORT
- PATHOLOGY

UGI CANCER STAGING

Criteria for TNM Clinical Staging:

Physical examination and history; pathologic examination of biopsy specimen to establish a diagnosis of cancer, endoscopies and imaging procedures, surgical exploration of primary site.

Criteria for TNM Pathologic Staging:

Examination of surgically resected specimen and lymph nodes.

Notes on TNM Staging for Stomach

Tumor that involves the gastrocolic or gastrohepatic ligaments or penetrates into the greater or lesser omentum without perforating the visceral peritoneum covering these structures is coded T2. Any perforation of the visceral peritoneum covering the gastric ligaments or omentum is classified T3.

Extension of tumor along the stomach wall into the duodenum or esophagus is classified by the greatest depth of invasion at any of these sites, including the stomach.

Adjacent structures of the stomach are the spleen, transverse colon, liver, diaphragm, pancreas, abdominal wall, adrenal gland, kidney, small intestine, and retroperitoneum.

BRIEF SUMMARIES OF 6th EDITION CATEGORIES

ESOPHAGUS

T1 Lamina propria or submucosa
 T2 Muscularis propria
 T3 Adventitia
 T4 Adjacent structures

N1 Regional lymph node metastases

Lower thoracic esophagus

M1a Celiac lymph nodes
 M1b Other distant metastasis

Upper thoracic esophagus

M1a Cervical lymph nodes
 M1b Other distant metastases

Mid-thoracic esophagus

M1a Not applicable
 M1b Non-regional lymph nodes or other distant metastases

SMALL INTESTINE

T1 Lamina propria or submucosa
 T2 Muscularis propria
 T3 Subserosa, non-peritonealized perimuscular tissues (mesentery, retroperitoneum) = 2 cm
 T4 Visceral peritoneum, other organs/structures (including mesentery, retroperitoneum) > 2 cm

N1 Regional lymph node metastases

M1 Distant metastasis

STOMACH

T1 Lamina propria or submucosa
 T2 Muscularis propria or subserosa
 T2a – Tumor invades muscularis propria
 T2b – Tumor invades subserosa
 T3 Penetrates serosa
 T4 Adjacent structures

N1 1 - 6 nodes
 N2 7 - 15 nodes
 N3 > 15 nodes

M1 Distant metastases

TREATMENT

Surgery (Stomach)

Surgery is the treatment of choice for stomach cancer, as long as adequate margins (5-6 cm) around the tumor can be obtained and regional lymph nodes are removed. Total gastrectomy does not improve survival, compared to subtotal or partial gastrectomy.

(Continued on page 8)

(Continued from page 7)

Types of Surgery	Key: X = complete * = partial o = optional • = see note under procedure -----Tissue Removed -----				
	Lesion	Stomach (Upper)	Stomach (Lower)	Lymph Nodes	Other Organs#
Local surgical excision Includes excision of ulcer, other lesions or stomach tissue with evidence of tumor	X				
Polypectomy	X				
Partial/subtotal/hemigastrectomy --upper (proximal) portion Includes sleeve resection of stomach may include part of esophagus		*		X	•
Antrectomy		X		X	
Partial/subtotal/hemigastrectomy --lower (distal) portion. Includes sleeve resection of stomach may include part of duodenum			X	X	•
Gastropylorctomy			X	X	
Billroth I includes part of duodenum			X	X	•
Billroth II includes duodenum			X	X	•
Partial/subtotal/hemigastrectomy, not otherwise specified Includes sleeve resection of stomach, resection of portion of stomach, NOS		* / °	* / °	°	°
Total/near total gastrectomy (more than 80%) Includes resection with pouch left for anastomosis, total gastrectomy following previous partial resection for other reason		X	X	X	°
Hofmeister-Finsterer operation		X	X	X	
Gastrectomy, not otherwise specified		* / X	* / X	X	°
Gastrectomy (partial/total/radical) with partial/total removal of other organs		* / X	* / X	X	*
Surgery of regional/distant sites/nodes only				* / X	* / X

May include spleen, momentum, mesentery, or mesocolon

(Continued on page 9)

(Continued from page 8)

Surgery (Esophagus & Small Intestine)

Operative treatment of esophageal cancer carries up to a 40% mortality rate and 10% five year survival. Surgery is most effective for esophageal cancers in the distal half. Maintaining nutrition is extremely important; however, esophageal feeding tubes, colonic interpositioning, and feeding gastrostomies are each accompanied by high morbidity.

Laser surgery can help to maintain an open passageway for nutrition.

For carcinoid tumors less than 1 cm in diameter, local resection is the treatment of choice. If the tumor is larger than 1 cm, the resection should include regional lymph nodes from the mesentery.

Other Therapies

RADIATION THERAPY

Radiation therapy is most effective for carcinomas of the upper third of the esophagus (cervical portion) and for Stage III and IV cancers. Radiation is also used to maintain patency of the lumen and to treat metastases. More recently, there has been research on the benefits of radiation combined with 5-FU and Mitomycin C chemotherapy for local control of dysphagia. Adenocarcinomas of the esophagus are not as radiosensitive as squamous cell carcinomas.

Gastric cancer does not respond readily to radiation therapy for cure, although it can be used for palliative treatment, metastases to bone or brain, or to deter gastric hemorrhage.

SYSTEMIC THERAPY

DRUGS COMMONLY USED FOR TREATING UPPER GASTROINTESTINAL CANCERS

Chemotherapy for esophageal cancer

Combinations using CisPlatinum (under clinical evaluation)

Examples

Cisplatinum, mitomycin C, bleomycin

Cisplatinum plus 5-FU

Cisplatinum, vindesine, bleomycin

Cisplatinum, methotrexate, bleomycin

Chemotherapy for stomach cancer

Combinations using 5-FU, adriamycin, mitomycin C, cisplatin, nitrosoureas (BCNU, CCNU)

Examples:

FAM (5-FU, adriamycin, mitomycin C)

5-FU plus methyl CCNU

5-FU plus adriamycin

EAP (Etoposide, adriamycin, cisplatin)

FAP (5-FU, adriamycin, cisplatin)

FAB (5-FU, adriamycin, carmustine)

Chemotherapy for cancer of small intestine

Streptozotocin plus 5-FU

Adriamycin plus 5-FU

Hormones (not shown to be effective for esophagus, stomach or small bowel cancers)

Biological Response Modifiers (under clinical evaluation)

Alpha interferon has been tried for metastatic carcinoid tumor, but the toxicity is significant.

(Continued on page 10)

TYPES OF SURGERY	Key: X = complete * = partial o = optional = see note under procedure				
	-----Tissue Removed -----				
	Tumor destruction	Tumor only	Organ	Lymph Nodes	Other Organs
Cryosurgery	*				
Cautery, fulguration (without specimen)	*				
Laser surgery with specimen		*/X			
Excisional biopsy			*		
Polypectomy			*		
Excision of lesion			*		
Partial/simple surgical removal, primary site no lymph node dissection			X		
Partial/simple surgical removal, primary site with lymph node dissection			X	X	
Debulking procedure (so stated) with or without lymph node dissection	X		*/o	o	
Radical surgery, primary site		X	X	o	
Surgery of regional/distant sites/nodes only					o

(Continued from page 9)

Keys to Abstracting

The stomach (all sections) is considered a single organ. The esophagus (entire length) is considered a single organ. The small intestine is considered three organs: duodenum, jejunum, ileum.

Gastric ulcers in patients with achlorhydria are malignant until proven otherwise.

Debulking is surgical removal of as much macroscopic tumor as possible in the abdomen. The principle behind debulking is to reduce the size of the largest residual tumor to less than 2.0 cm in greatest dimension so that the patient's total tumor mass is minimal. The effectiveness of postoperative adjuvant radiation and chemotherapy is increased when the tumor burden is smallest. Also called: tumor reduction surgery, cytoreductive surgery.

Record circumferential lesion (entire circumference) of the esophagus as 998 in the field "Size of Tumor."

Record 998 in "Size of Tumor" field if involvement of stomach is described as 3/4 or more of stomach, diffuse, linitis plastica, or widespread.

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

Do not add together the sizes of pieces of tumor removed at biopsy and at resection. 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."

For esophageal cancer, disregard extension within the wall (intraluminal) to adjacent segments of esophagus and code the maximum depth of invasion through the esophageal wall or extra-esophageal spread wherever it occurs.

For stomach cancer, disregard extension within the wall (intraluminal) to esophagus or duodenum and code the maximum depth of invasion through the stomach wall or extra-gastric spread wherever it occurs.

For small bowel cancer, disregard extension within the wall (intraluminal) to adjacent segments of small intestine and code the maximum depth of invasion or spread beyond small bowel wall wherever it occurs.

If a partial resection of the stomach is performed for diagnosis and a more complete procedure, such as a Billroth II, is done as cancer-directed surgery, code the more complete surgical procedure. The surgical code should indicate the status of the primary organ at the completion of the procedure.

Congratulations to Florida's Newest Certified Tumor Registrars



Marie Cranmer, CTR - Sanford
Melissa A. Schuster, CTR - Cape Coral
Jason D. Strader, CTR - West Palm Beach
Daniel P. Vargo, CTR - SW Ranches

EDUCATION AND TRAINING

PRINCIPLES OF ONCOLOGY FOR CANCER REGISTRY PROFESSIONALS

December 6 - 10, 2004
Bolger Center for Leadership Development
Potomac, Maryland
Registration fee: \$695.00*

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

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.

Class size will be limited to 25 registrants.

CANCER REGISTRATION & SURVEILLANCE TRAINING PROGRAMS

The Fullmer Institute is pleased to announce:

- **Principles and Practice of Cancer Registration and Surveillance**
- November 1-5, 2004
(and more dates in 2005!)
- **Advanced Topics in Cancer Registration and Surveillance**
October 18-20, 2004
May 4-6, 2005
August 10-12, 2005

For further information and registration go to:
<http://www.fullmerinstitute.org>

2005 CTR EXAM CONTENT

<http://www.ctrexam.org/>

The content of the 2005 CTR Examinations will be drawn in part from the publications of several national standard-setting organizations, including:

- **International Classification of Diseases for Oncology 3rd Edition (ICD-O-3);**
- **Facility Oncology Registry Data Standards "FORDS: Revised for 2004";**
- **AJCC Cancer Staging Manual 6th Edition;**
- **CoC Cancer Program Standards 2004**
- **Collaborative Staging Manual and Coding Instructions, version 1.0.**

The Collaborative Staging (CS) will test on the following data fields and sites.

CS DATA FIELDS:

1. CS Extension
2. CS Lymph nodes
3. CS Metastasis at Diagnosis

Specific CS FIELD SITES:

1. Breast
2. Lung
3. Colon Rectal
4. Bladder
5. Kidney
6. Melanoma
7. Ovary
8. Corpus Uteri (Endometrium)
9. Pancreas
10. Thyroid

Please note that Summary Stage 2000 is no longer tested. Plus, the exam content excludes any clarifications posted in the SEER SINC and Commission on Cancer's Inquiry and Response system.

The 2005 Handbook for Candidates will be posted here in late 2004.



FLORIDA CANCER DATA SYSTEM Path Reporting and Radiation Therapy Reporting

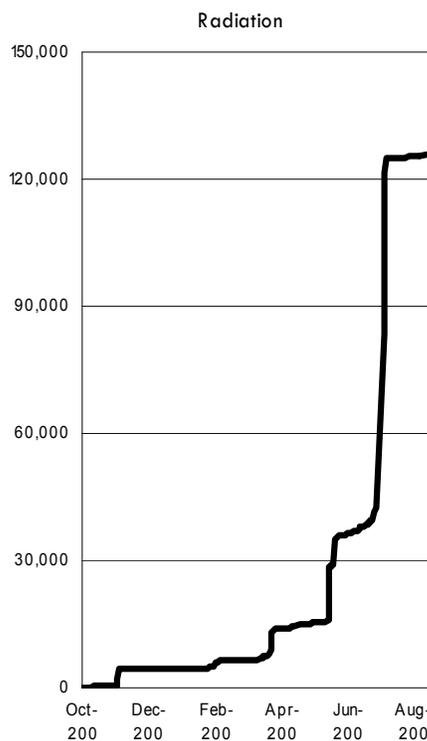
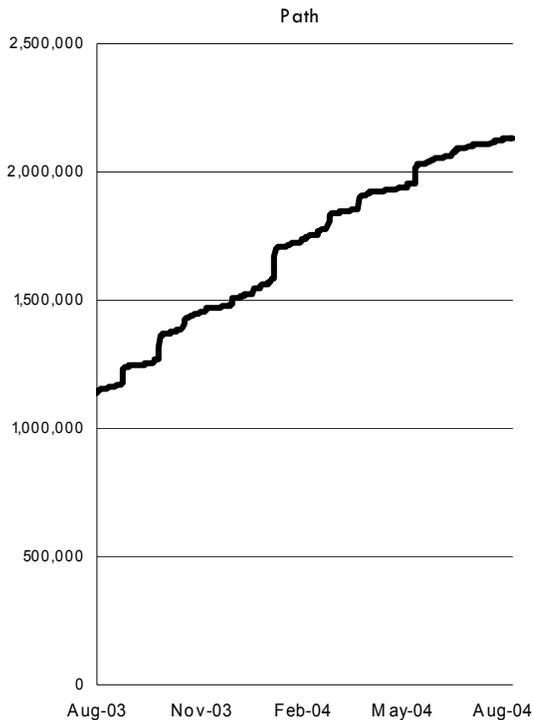


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