

FLORIDA CANCER DATA SYSTEM

November 2004 Monthly Memo

WHAT'S NEW:

THE FOLLOWING IS CURRENTLY AVAILABLE ON THE FCDS WEBSITE.

- **2003 FLORIDA ANNUAL CANCER REPORT: INCIDENCE AND MORTALITY FOR 2000**
- **EDUCATION AND TRAINING WEB MODULES** (Under Edu and Training)
- **FCDS REGISTER VOL. 25**

ON THE WEB:

- **COLLABORATIVE STAGING**
<http://www.cancerstaging.org/cstage/index.html>
- **ALLIANCE FOR LUNG CANCER ADVOCACY, SUPPORT, AND EDUCATION**
<http://www.alcase.org>
- **LUNG CANCER.ORG**
<http://www.lungcancer.org>
- **LUNG CANCER ONLINE**
<http://www.lungcanceronline.org>



Determining and Counting Multiple Primaries

SEER Training Website: http://training.seer.cancer.gov/module_bbt/unit02_sec05_f_multiple_primaries.html

In determining multiple primaries, separate rules are used for non-malignant and malignant brain tumors. Rules are based on the specific data elements.

Timing (assuming same site and same histology)

- Malignant: 2 months
- Non-malignant: no limitation

The current timing rule for determining multiple primary tumors applies to malignant CNS tumors only. If two or more primary

malignant intracranial or CNS tumors are diagnosed in the same site within two months of the diagnosis of the first primary, the tumors are counted as one primary. If multiple tumors of the same site are diagnosed more than two months apart, the tumors are counted as separate primary sites.

The current 2 month rule does not apply to non-malignant CNS tumors. Non-malignant tumors may recur in the same location. If they recur, even after 20 years, they are still the same tumor.

Site

- Malignant: 3 character level
- Non-malignant: 4 character level

For non-malignant CNS tumors, sites are different when there is a difference in the 4th digit of the site code, but the first 3 digits are the same. For example, spinal meninges (C70.1) and cerebral meninges (C70.0) are considered different primaries. (The exception is when the difference

(Continued on page 7)

November is Lung Cancer Awareness Month



"It's Time To Focus On Lung Cancer," is a campaign promoted nationally by three leading cancer organizations:

Cancer Care, Oncology Nursing Society, and The CHEST Foundation. The goal of this campaign, which culminates during Lung Cancer Awareness Week (the third week in November), is to raise awareness of the disease, encourage early diagnosis, share new treatment developments and screening methods, and offer support to lung cancer patients and their loved ones.

VALUABLE RESOURCES FOR INFORMATION YEAR-ROUND:

Lung Cancer Toll Free Information Line 1-877-646-LUNG (5864): Oncology social workers are available to answer questions and offer support.

EDUCATION AND AWARENESS PROGRAMS HOSTED BY:

Cancer Care – www.cancercare.org

Oncology Nursing Society – www.ons.org

The CHEST Foundation – www.chestfoundation.org

FCDS Q & A



MULTIPLE PRIMARIES

SEER Inquiry System

(<http://seer.cancer.gov/seer inquiry/>)



References

SEER Prog Code Man, 3rd Ed ;pgs 8, 12 (Jan 1998)

QUESTION

Multiple primaries--Kidney: How many primaries should be abstracted in this situation? In June 2003, a right kidney was removed and found to have a 6.3 cm tumor of renal cell carcinoma (clear cell type) and a separate 0.5cm incidental renal cell carcinoma, granular cell type.

ANSWER

Abstract two primaries. This is an example of two tumors with different histologic types in the same site (Rule 5.a on page 12 of the SEER Program Code Manual, 3rd Edition) -- Right kidney with two separate tumors, one renal cell carcinoma (clear cell type) and the other renal cell carcinoma (granular cell type).

References

SEER Prog Code Man, 3rd Ed ;pgs 12-13 (January 1998)

QUESTION

Multiple Primaries/Histology--Thyroid: How many primaries should be coded and what are the histology and grade codes for an anaplastic carcinoma and papillary carcinoma occurring as two separate lesions in the thyroid? Please see below.

ANSWER

Accession and code as two thyroid primaries:

Anaplastic carcinoma [8021/34]

Papillary carcinoma [8260/39]

QUESTION

Multiple primaries--Colon: What is the number of primaries for a case of familial polyposis with at least three separate tumors having invasive adenocarcinoma, one in the rectum? Please see discussion.

ANSWER

Familial polyposis is always a single primary. Code the primary site for the case example above to C199 [colon and rectum].

References

Sngl vs Sbsq Prim Lymph & Hem (02/28/2001)

QUESTION

Multiple primaries--Lymphoma: How many primaries should we abstract when Single Versus Subsequent Primaries table indicates one primary and special studies indicate two primaries? Please

see discussion below.

ANSWER

Abstract the example above as two primaries. Hematologic malignancies (including lymphoma) and solid tumors are handled differently when determining the number of primaries. For hematologic malignancies, take the physician's opinion into account. Use the

Single Versus Subsequent Primaries of Lymphatic and Hematopoietic Diseases table as an aid when there is insufficient information available. For solid tumors, follow the multiple primary rules in the SEER Program Code Manual.

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FCDS Q & A

(Continued from page 2)

References

SEER Prog Code Man, 3rd Ed ;pgs 5, 8, 11 (January 1998)

QUESTION

Multiple primaries/Date of diagnosis: A non-invasive papillary transitional cell carcinoma is removed by TURB in May 2002. In January 2003, a bone biopsy reveals metastatic transitional cell carcinoma consistent with bladder primary. Is this a second primary with date of diagnosis January 2003?

ANSWER

Code a second bladder primary diagnosed in January 2003.

References

SEER Prog Code Man, 3rd ed ;pgs 11 (January 1998)

QUESTION

Multiple primaries--Thyroid: Would a papillary carcinoma of the right lobe of the thyroid approximately 2 1/2 years after a papillary carcinoma of the left lobe be a second primary?

Answer

Yes, this is a second primary. The second papillary carcinoma was more than 2 months after the first and not specified as recurrent or metastatic.

References

1. ICD-O-3
2. SEER Prog Code Manual, 3rd ed ;pgs 8, 12 (January 1998)

QUESTION

Multiple primaries--Breast: How should we code the following - one primary? Two primaries? Histology?
Please see discussion.

ANSWER

Code as one primary. Code the histology 8522/3 [Infiltrating duct and lobular carcinoma].

This is a single primary because there are two lesions of the same histologic type within the same site:

1. Upper outer quadrant, moderately differentiated infiltrating ductal carcinoma with lobular features [8522/3].
2. Upper inner quadrant, well differentiated tubulolobular carcinoma [8522/3]. According to the ICD-O-3 editors, Tubulolobular carcinoma is a mix of ductal and lobular carcinoma. Code tubulolobular as 8522.

The entity in the 6:00 position is not a definite malignancy. Do not code it.

News and Information

CLARIFICATION ON COLLABORATIVE STAGING



1. **New Rule For Inaccessible Sites** - Since evidence of regional lymph node involvement or metastatic disease would alter the treatment approach chosen by the physician in the care of a patient, for inaccessible primary sites, meaning sites such as lung or pancreas that cannot be examined by palpation, observation, physical examination or other clinical methods, Collaborative Staging allows data collectors to record regional lymph nodes and distant metastases as negative rather than unknown when there is no mention of regional lymph node involvement or distant metastases in the patient's record and the patient receives usual or standard treatment to the primary site.

-These inaccessible rules apply to early stage (T1, T2, localized) tumors.

-Unknown should be coded when there is reasonable doubt that the tumor is no longer localized. For example, when there is clinical evidence that a prostate cancer has spread through the capsule into surrounding tissues, and no mention is

made of regional lymph node or metastatic involvement, it would be correct to code regional lymph node involvement and metastases at diagnosis as unknown in the absence of any specific information regarding nodes or metastases.

2. The field **CS Mets Eval** records how the code for "CS Mets at DX" was determined based upon the diagnostic methods employed. Select the CS Mets Eval code that documents the report or procedure from which the information was obtained *about metastatic involvement or non involvement farthest from the primary site*. For example, a patient with colon cancer has a CT scan showing normal lungs. During the resection the surgeon palpates the liver and determines it to be normal. Code "0" for CS Mets Eval, evaluation based on imaging, since the CT scan shows potential metastatic sites outside of the surgical field were negative. The CT scan of the chest was used to determine metastatic involvement or non-involvement farther from the primary site than observation at surgery and that is why it is coded here.

HISTORICAL CASES

Although the American College of Surgeons/Commission on Cancer does not require accredited facilities to abstract historical cases, FCDS does require the collection and reporting of historical cancers. A population-based cancer registry such as FCDS must record all cancers meeting FCDS reporting requirements, regardless of class of case, place of diagnosis or date of diagnosis. If a patient has at least one primary reportable neoplasm which is active or under treatment, all other primary reportable neoplasms the patient has ever had, active or inactive, must be reported.

Each case of cancer must be abstracted and reported separately. FCDS realizes

that much of the information about the original diagnosis, staging and treatment of non-analytic and historical cancers may be sketchy. The abstractor should attempt to complete each abstract with as much information as is available in the medical record.

The following morphology terms of borderline behavior are reportable to FCDS as historical cases if they were diagnosed prior to 1/1/01 and the patient has another active reportable neoplasm on or after 1/1/01:

| | | |
|--------|--------|--------|
| 8931/1 | 9960/1 | 9981/1 |
| 9989/1 | 9393/1 | 9961/1 |
| 9982/1 | 9538/1 | 9962/1 |
| 9983/1 | 9950/1 | 9980/1 |
| 9984/1 | | |

Benign and borderline brain and central nervous system tumors are reportable as historical cases to FCDS if they were diagnosed prior to 1/1/04 and the patient has another active reportable neoplasm on or after 1/1/04. Benign and borderline brain and central nervous system tumors diagnosed on or after 1/1/04 must be reported to FCDS.

Since these cases are not malignant they need to be sequenced in the sequence number range of 60-88. Sequencing rules for benign cases follow the same pattern as rules for malignant cases. A single, solitary benign case is sequenced 60. The first of two or more benign cases is sequenced 61, the second 62, etc.



2004 Jean Byers Award for Excellence in Center Registration

In accordance with national standards for evaluating completeness, FCDS will be awarding the 2004 Jean Byers Award for Excellence in Cancer Registration in November 2004. All facilities eligible for the award will be notified and an announcement will be made in the *FCDS Monthly Memo* and *The Register*. In order for reporting facilities (excluding Freestanding Ambulatory Patient Care Centers and Pathology Labs) to receive the Jean Byers Award for Excellence in Cancer Registration for the 2002 cancer case admissions, they must meet the following criteria:

1. Timeliness- All deadlines met with respect to the 2002 cancer case admissions
 - 2002 Annual Caseload Submission Deadline- June 30, 2003
 - 2002 Death Certificate Notification Deadline- December 19, 2003
 - 2002 AHCA Audit Deadline – August 30, 2004
 - No more than 5% (or 35 cases, whichever number is greater) of the 2002 cancer case admissions reported to FCDS within 2

months (60 days) following the June 30, 2003 deadline (late reporting of 2002 cancer case admissions)

2. Completeness- All cases reported to FCDS
 - No more than 10% of the 2002 cancer case admissions reported to FCDS within 12 months following the June 30, 2003 reporting deadline. (Due to delinquent 2002 case reporting, missed cases found on Death Certificate Notification or missed cases found on AHCA Completeness Audit)

2004 Facility Annual Evaluation

FCDS will be generating the 2004 Facility Annual Evaluation for all reporting facilities in Florida (excluding Free-standing Ambulatory Patient Care Centers and Pathology Labs) in November 2004. The intent of the Facility Annual Evaluation is to provide a summary of the timeliness and quality of your data for the last three complete reporting years (2000 – 2002) and the completeness of your data for the 2002 reporting year. In 2003, FCDS generated the reports for all reporting facilities for the first time, which is why only the Registrars or the Health Information Management Directors received a copy. However, this year FCDS plans to also make a copy of the evaluations available to Hospital Administrators. Should you have questions or concerns about the report, please feel free to contact your Field Coordinator or Megsys C. Herna at (305) 243-4600.

Pathology Lab

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

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





FCDS WEB-MODULES

- **Reporting Requirements for Intracranial and CNS Tumors,**
Presented by Stuart Herna
- **Data Access for Dept. of Health Personnel and Approved Researchers,**
Presented by Jill MacKinnon
- **Collaborative Staging Part 1 & 2 ,** Presented by Stuart Herna
- **Correct/Delete Single Entry Records,** Presented by Mark Rudolph
- **Interactive Web-Based Edits,** Presented by Jill Mackinnon

The Florida Cancer Data System (FCDS) is pleased to announce the FCDS Web Training Modules, now available on the FCDS website at <http://fcds.med.miami.edu>, under Education and Training. The modules are designed to assist registrars and their staff with clarification on rules, reporting requirements, data definitions, policies, and procedures.

NCI/The Rollins INSTITUTE WEB-MODULES

The National Cancer Institute in collaboration with the Rollins School of Public Health at Emory University is pleased to announce the availability of a new web-based training module on **Pancreatic and Biliary Cancer.**

This new training module is now available at:
<http://www.training.seer.cancer.gov>

PRINCIPLES OF ONCOLOGY FOR CANCER REGISTRY PROFESSIONALS

PRINCIPLES OF ONCOLOGY FOR CANCER REGISTRY PROFESSIONALS

December 6-10, 2004
Potomac, Maryland

Registration fee: 695.00*

*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/>

FCDS MAILING INFORMATION



For those facilities and physician offices that need to mail patient(s) medical records, please use our general mailing information listed below.

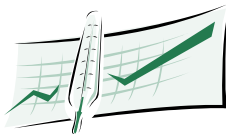
In order to protect and properly handle all packages, particularly those containing confidential patient information, we ask that US Postal Service mail including Express mail, Priority mail, and Certified mail be sent to the PO Box address below:

FCDS/University of Miami School of Medicine
P. O. Box 016960 (D4-11)
Miami, FL 33101

FCDS STREET ADDRESS SHOULD ONLY BE USED FOR COURIER PACKAGES

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Miami, FL 33136



Determining and Counting Multiple Primaries (Cont'd)

(Continued from page 1)

in the 4th digit occurs because the 4th digit of one site code is 9, which indicates a non-specific code.)

Malignant tumors remain as they are currently defined with differences only at the 3 digit level. Therefore, separate malignant tumors occurring in the cerebral meninges and in the spinal meninges (both C70) are not considered different primaries.

Laterality

Laterality should be coded for both non-malignant and malignant brain tumors. Further, laterality is to be considered when determining multiple primaries for non-malignant tumors but not for malignant brain tumors.

CNS sites to be coded with laterality:

- Cerebral meninges, NOS (C70.0)
- Cerebrum (C71.0)
- Frontal lobe (C71.1)
- Temporal lobe (C71.2)
- Parietal lobe (C71.3)
- Occipital lobe (C71.4)
- Olfactory nerve (C72.2)
- Optic nerve (C72.3)
- Acoustic nerve (C72.4)
- Cranial nerve, NOS (C72.5)

Code laterality using codes 1 through 4 or 9 (paired site but lateral origin unknown; midline tumor). The laterality for all other CNS sites is coded 0 (not a paired organ).

Histology

- Malignant: 3 digit level
- Non-malignant: Histology Groups Table

The histology rules for counting multiple primaries have to be modified to count tumors at a level other than the first three digits of the morphology code.

The evolution and grading of brain tumors is such that a tumor may recur at a higher grade which has a different ICD-O-3 code number. In such cases, the new tumor is not counted as a new primary (except if it progresses or transforms from benign or borderline to malignant). The various four-digit histologies within each of these histologic groups will be counted as one primary. Thus the patient could have one glioma and one ependymoma, but not a low grade astrocytoma followed by a glioblastoma multiforme at the same site.

For counting non-malignant primaries, each of the following groups is considered ONE primary.

B = Benign M = Malignant

| | |
|---------------------------------------|--|
| Gliomas* | 9380, 9381, 9382, 9400, 9401, 9410, 9411, 9420, 9421, 9423, 9424, 9430, 9440, 9441, 9442 |
| Subependymomas | 9383, 9384 |
| Choroid plexus neoplasms | 9390 |
| Ependymomas | 9391, 9392, 9393, 9394, 9444 |
| Neuronal and neuronal-glial neoplasms | 9412, 9413, 9505, 9506 |
| Oligodendrogliomas | 9450, 9451, 9460. |

*includes gliomas, astrocytomas, astroblastomas and glioblastomas

Please use the two reference tables below to count malignant and non-malignant primaries.

Counting Malignant Primaries

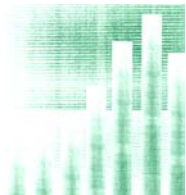
| Same Histology | | * unless stated to be metastatic or recurrent | | | | | |
|----------------|--------|---|------------|-----------|----------------|------------|-----------|
| Tumor | Timing | Same Site | | | Different Site | | |
| 1st | 2nd | Same side | Other side | Unkn side | Same side | Other side | Unkn side |
| M | M | < 2 | 1 | 1 | 2* | 2* | 2* |
| M | M | 2 + | 2* | 2* | 2* | 2* | 2* |
| M | B | NA | 2 | 2 | 2 | 2 | 2 |

| Different Histology | | ** unless one histology is a specific subtype of the other | | | | | |
|---------------------|--------|--|------------|-----------|----------------|------------|-----------|
| Tumor | Timing | Same Site | | | Different Site | | |
| 1st | 2nd | Same side | Other side | Unkn side | Same side | Other side | Unkn side |
| M | M | < 2 | 2** | 2** | 2 | 2 | 2 |
| M | M | 2 + | 2 | 2 | 2 | 2 | 2 |
| M | B | NA | 2 | 2 | 2 | 2 | 2 |

Counting Non-malignant Primaries

| Same Histology | | | | | | | |
|----------------|--------|-----------|------------|-----------|----------------|------------|-----------|
| Tumor | Timing | Same Site | | | Different Site | | |
| 1st | 2nd | Same side | Other side | Unkn side | Same side | Other side | Unkn side |
| B | B | NA | 1 | 1 | 2 | 2 | 2 |
| B | M | < 2 | 2 | 2 | 2 | 2 | 2 |
| B | M | 2 + | 2 | 2 | 2 | 2 | 2 |

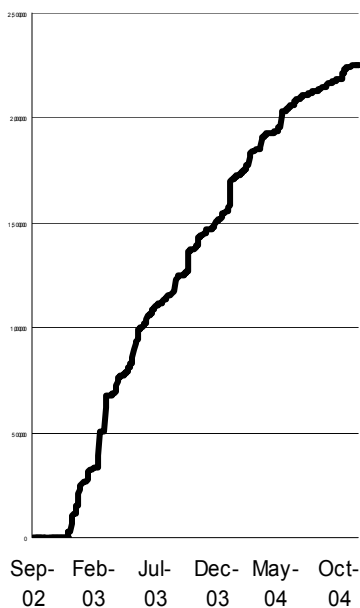
| Different Histology | | | | | | | |
|---------------------|--------|-----------|------------|-----------|----------------|------------|-----------|
| Tumor | Timing | Same Site | | | Different Site | | |
| 1st | 2nd | Same side | Other side | Unkn side | Same side | Other side | Unkn side |
| B | B | NA | 2 | 2 | 2 | 2 | 2 |
| B | M | < 2 | 2 | 2 | 2 | 2 | 2 |
| B | M | 2 + | 2 | 2 | 2 | 2 | 2 |



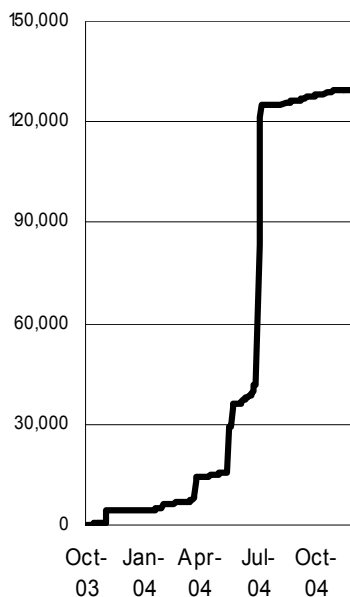
FLORIDA CANCER DATA SYSTEM

Pathology & Radiation Reporting

Path



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