UMSylvester Comprehensive Cancer Center

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

FLORIDA DEPARTMENT OF HEALTH

Register

A joint project of the Sylvester Comprehensive Cancer and Center and the Florida Department of Health

Division of Cancer Prevention and Control

Volume 23, 2004

Overview of New Reporting Requirements For 2004

By Stuart Herna, CTR

Beginning with cases diagnosed on or after January 1, 2004, implementation of new rules, regulations and reporting requirements will be employed that will dramatically change not only how we collect and stage our cases, but the very nature of the type of cases that we collect as well. These new reporting requirements, effective July 1, 2004, will focus on reporting of benign brain tumors and a change to the staging scheme used by FCDS.

Benign Brain: New legislation passed by both the House and the Senate in October of 2002 enacted the **Benign Brain Tumor Cancer Registries Act** (Public Law 107-260). This act requires the abstracting and reporting of non-malignant primary intracranial and Central Nervous System tumors by the National Program of Cancer Registries (NPCR). The Commission on Cancer (CoC) and the Surveillance, Epidemiology, and End Results Program (SEER) added benign and borderline intracranial and Central Nervous System tumors to their case definitions soon thereafter.

Collaborative Staging: This new staging system was designed to eliminate duplicate data collection by registrars reporting to facility based and central registries, to address the concerns of clinicians for more accurate and complete data, and to provide greater parity and reduce discrepancies between the three major staging systems used in

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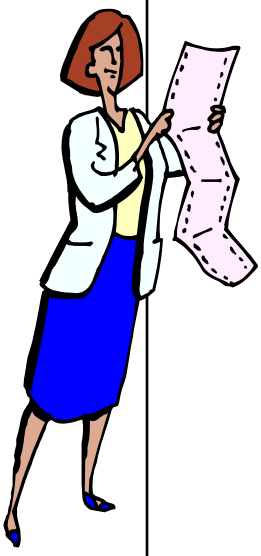
the United States (SEER, TNM and EOD). Beginning with cases diagnosed January 1, 2004, FCDS will collect all 15 items of the collaborative staging scheme. Because of the change in the record layout, no 2004 cases will be accepted prior to July 1, 2004. And as with all previous conversions, any 2003 cases not reported by the FCDS deadline of June 30, 2004 must be submitted to FCDS in the new NAACCR v10.1 format and must include all 15 items of the collaborative staging scheme.

Impact On Registries Of New Reporting Requirements For 2004

Caseload/Workload:
Benign and **borderline** intracranial and CNS tumor incidence is estimated to be equivalent to **malignant** intracranial and CNS tumors. Cancer Registries can get a rough estimate of the increase in volume that will result from collection of these tumors by doubling the number of their reported malignant intracranial and CNS tumors for a given year.



Collaborative Staging will allow the registrar to collect factual, objective information without having to refer to two or more staging schemes to complete an abstract. This will save time since the Registrar will no longer need to reference different staging manuals, separate books, documents or help screens in order to make decisions to assign stage.

Software will need to be modified to allow for the collection of new or revised data fields.

The Site/Histology Validation List, the Case Finding List, the Reportable List and the Policy and Procedure Manual all need to be updated to include benign and borderline CNS and intracranial tumors, Collaborative Staging data elements and the new rules and regulations for data collection and reporting.

Edits need to be modified to accommodate non-malignant behavior codes and sequence numbers and to handle the Collaborative Staging data items.

Changes to the criteria for determining the data reported to Central Registries will be necessary to allow for the transmission of benign and borderline CNS and intracranial tumors with a Behavior Code of 0 or 1 and the Collaborative Staging data elements.

A slight learning curve is anticipated for new data fields and codes.

Training and Educational Resources

The next FCDS *Monthly Memo* will go into great detail about data collection methodology and specifics concerning the data fields. Additionally, FCDS will be presenting a series of teleconferences covering both Collaborative Staging and reporting of benign and borderline CNS and intracranial tumors. The first, on Thursday February 25th, 2004 from 2:00 – 3:00 P.M., will provide a general overview and discussion of new reporting requirements for 2004. The second, on Wednesday March 24th, 2004 from 2:00 – 4:00 P.M., will cover Part I of Collaborative Staging — General Instructions: How The Collaborating Staging Works . The third, on Wednesday April 14th, 2004 from 2:00 – 4:00 P.M., will cover Part II of Collaborative Staging —Coding Instructions. All are welcome to participate. For additional information please access the FCDS website at http://fcds.med.Miami.edu and click on '**What's New'**.

The following sources were used for this article: NAACCR, Inc., 2004 Implementation Guidelines; Collaborative Staging Manual and Coding Instructions, version 1.0

Completeness Report

As of January 31, 2004
Calendar Year 2003 Admissions
27% Completed
58% Expected

March is National Colorectal Cancer Awareness Month

National Colorectal Cancer Awareness Month was founded by the Cancer Research and Prevention Foundation (formerly the Cancer Research Foundation of America) in collaboration with the American Society for Gastrointestinal Endoscopy, the Foundation for Digestive Health and Nutrition and the National Colorectal Cancer Roundtable. These founding partners have joined with 50 collaborating partners to educate about colorectal cancer year-round, focusing their energies and resources on the annual awareness campaign that takes place each March. All across the nation, organizations sponsor activities to bring the public information about colorectal cancer.

Important points about Colorectal Cancer:

- Colorectal cancer can be prevented.
- No matter what your age, know the risk factors, know the symptoms, know your family history.
- Starting at age 50, men and women who are at average risk for colorectal cancer should get screened. Men and women who have a higher risk of the disease may need to be tested earlier and should talk to their health care professional about when.
- Colorectal cancer is treatable — know your options.
- Talk to your health care professional today.

MYTHS & REALITY ABOUT COLORECTAL CANCER

Colorectal cancer has long been a disease cloaked in embarrassment and misunderstandings. Some people think that colorectal cancer is not preventable so they do not go to be screened. Other people avoid screening because they believe that if they do get tested and diagnosed with colorectal cancer they are going to die. Some women think that they do not have to worry about *this* disease because only men get it.

Below some of the common myths about colorectal cancer are exposed. Protect yourself by learning the actual realities of the disease.

MYTH: *There is nothing I can do about getting colorectal cancer.*

REALITY: Colorectal cancer can be prevented. Screening tests can detect polyps (grape-like growths on the lining of the colon or rectum) that can turn into cancer. Removing these polyps can prevent colorectal cancer from ever occurring. **Starting at age 50, men and women who are at average risk should be screened regularly for colorectal cancer. Men and women who are at high risk of the disease may need to be tested earlier and should talk to their health care professional**

MYTH: *Colorectal cancer is usually fatal.*

REALITY: Colorectal cancer is usually curable when detected early. More than 90 percent of patients with localized colorectal cancer confined to the colon or rectum are alive five years after diagnosis.

MYTH: *Colorectal cancer is a disease of older, white men.*

REALITY: An equal number of women and men get colorectal cancer. An estimated 74,700 women and 72,800 men will be diagnosed with colorectal cancer in 2003. African-Americans are more likely to be diagnosed with colorectal cancer at later stages of the disease.

MYTH: *Screening tests are necessary only for individuals who have symptoms.*

REALITY: Since symptoms of colorectal cancer are often silent, it is important to get screened regularly. Screenings test for a disease even if the patient has no symptoms. About 75 percent of all new cases of colorectal cancer occur in individuals with no known risk factors for the disease, other than being 50 or older. If you have a personal or family history of colorectal cancer, polyps or inflammatory bowel disease you may need to be screened before age 50. Talk with your health care professional.

Source: Cancer Research and Prevention Foundation – website: http://www.preventcancer.org/

ERRATA LIST FOR THE 2003 FCDS DATA ACQUISITION MANUAL

Errata for the Data Acquisition Manual, 2003 has also been posted on our website under "What's New". Please visit the FCDS website at http://fcds.med.miami.edu/ to download a copy.

Pages	Changes
Page II-31, Typo	**MODIFY** 9120-**91770** **REPLACE** 9120-**9170**
Page II-48, Typo	**MODIFY** 8021/34 Carcinoma, **aplastic**, NOS (Under Terms In **ICD-O-3** That Carry An Implied Statement Of Grade) **REPLACE** 8021/34 Carcinoma, **anaplastic**, NOS (Under Terms In **ICD-O-3** That Carry An Implied Statement Of Grade)
Page II-55, Missed Word	**MODIFY** Paragraph # 6 – **Summary Stage** is based on a combination of pathologic, operative and clinical assessments. **REPLACE** **SEER Summary Stage** is based on a combination of pathologic, operative and clinical assessments.
Page II-57, Missed Word	**MODIFY** ***NOTE:*** For Stage Code for Lymph Nodes and Lymphoid Tissue, Kaposi Sarcoma, Sezary Disease, and Hematopoietic refer to ***SEER Summary Manual 2000***. **REPLACE** ***NOTE:*** For Stage Code for Lymph Nodes and Lymphoid Tissue, Kaposi Sarcoma, Sezary Disease, and Hematopoietic refer to ***SEER Summary Staging Manual 2000***.
Page II-58, Incorrect Website	**MODIFY** This information can be found online at **http://www.seer.cancer.gov/Publications/SummaryStage/** **REPLACE** This information can be found online by going to **http://www.seer.cancer.gov** then clicking on Order SEER Publications.
Page II-63, Typo	**MODIFY** Please refer to either the *SEER Program Code Manual, 3rd Edition, 1998* or the *Standards of the Commission on Cancer, Volume II: **Standards Registry Operations and Data Standards (ROADS)**, Appendix D, 1/98 revision.* **REPLACE** Please refer to either the *SEER Program Code Manual, 3rd Edition, 1998* or the *Standards of the Commission on Cancer, Volume II: **Registry Operations and Data Standards (ROADS)**, Appendix D, 1/98 revision.*
Page II-64, Repeated Sentences	**THESE TWO SENTENCES ARE REPEATED IN EXAMPLE #2** Ignore the surgical approach when coding procedures. Ignore the surgical margins when coding procedures.
Page II-66, Typo	**MODIFY** C07.9-**08.9** **REPLACE** C07.9-**C08.9**
Page II-68, Typo	**MODIFY** For Hodgkin and non-Hodgkin Lymphoma, with a lymph primary *(Primary Site **(C770-C779)*** and Histology *ICD-O-2 (M-9590-9595, 9650-9698, 9702-9717, 9727-9729),* code **9**. **REPLACE** For Hodgkin and non-Hodgkin Lymphoma, with a lymph primary *(Primary Site = **C77.0-C77.9**)* and Histology *ICD-O-2 (M-9590-9595, 9650-9698, 9702-9717, 9727-9729),* code **9**.
Page II-68, Typo	**MODIFY** A sentinel node is the first lymph **nodes** or nodes that drain a defined area of tissue within the body. It is identified by the injection of a dye or radio label at the site of the primary tumor. **REPLACE** A sentinel node is the first lymph **node** or nodes that drain a defined area of tissue within the body. It is identified by the injection of a dye or radio label at the site of the primary tumor.
Page II-69, Typo	**MODIFY** **Code 1-8** have priority over codes **0** and **9**. **REPLACE** **Codes 1-8** have priority over codes **0** and **9**.
Page II-72, Typo	**MODIFY** **C770-**C77.9 **REPLACE** **C77.0-**C77.9
Page II-74, Typo	**MODIFY** A sentinel node is the first lymph **nodes** or nodes that drain a defined area of tissue within the body. It is identified by the injection of a dye or radio label at the site of the primary tumor. **REPLACE** A sentinel node is the first lymph **node** or nodes that drain a defined area of tissue within the body. It is identified by the injection of a dye or radio label at the site of the primary tumor.

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Pages	Changes
Page II-74, Repeated Sentence	**DELETE THE SECOND OCCURRENCE** For primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system *(C70.0-C70.9, C71.0-C71.9, C72.0-C72.9),* code **9**.
Page II-77, Typo	**MODIFY** Nonprimary surgical procedure to distant lymph **nodes(s)** Resection of *distant lymph **nodes(s)*** **REPLACE** Nonprimary surgical procedure to distant lymph **node(s)** Resection of *distant lymph **node(s)***
Page II-77, Typo	**MODIFY** If Rx **Sum**-Surg Prim Site (NAACCR Item 1290) is "Unknown" and/or if any cancer-directed surgery performed, date unknown, or death certificate only case, enter Surgery date as **99999999.** **REPLACE** If Rx **Summ**-Surg Prim Site (NAACCR Item 1290) is "Unknown" and/or if any cancer-directed surgery performed, date unknown, or death certificate only case, enter Surgery date as **99999999.**
Page II-81, Misspelled word	**MODIFY** A patient with Stage III colon cancer is treated with a combination of fluorouracil and levamisole. Code the administration of **fluorouacil** as single agent chemotherapy, and levamisole as an immunotherapeutic agent. **REPLACE** A patient with Stage III colon cancer is treated with a combination of fluorouracil and levamisole. Code the administration of **fluorouracil** as single agent chemotherapy, and levamisole as an immunotherapeutic agent.
Page II-82, Grammatical Error	**MODIFY** A patient has breast cancer with positive nodes. All detectable **tumor is** removed by a modified radical mastectomy. **REPLACE** A patient has breast cancer with positive nodes. All detectable **tumors are** removed by a modified radical mastectomy.
Page II-82, Incorrect Website	**MODIFY** Refer to SEER website or at **http://seer.cancer.gov/tools.approveddrugs.pdf** for the FDA approved oncology agents not listed in SEER Book 8. **REPLACE** Refer to SEER website or at **http://seer.cancer.gov/tools/** for the FDA approved oncology agents not listed in SEER Book 8.
Page II-83, Missing Word	**MODIFY** Hormone was not administered because the patient died prior to planned or recommended therapy. **REPLACE** Hormone **therapy** was not administered because the patient died prior to planned or recommended therapy.
Page II-83, Missing Word	**MODIFY** Hormone was not administered; it was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was noted in the patient record **REPLACE** Hormone **therapy** was not administered; it was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was noted in the patient record
Page II-84, Incorrect Website	**MODIFY** Refer to SEER website or at **http://seer.cancer.gov/tools/approveddrugs.pdf** for the FDA approved oncology agents not listed in SEER Book 8. **REPLACE** Refer to SEER website or at **http://seer.cancer.gov/tools/** for the FDA approved oncology agents not listed in SEER Book 8.
Page II-84, Missing Word	**MODIFY** If hormone was not administered because the patient died prior to planned or recommended therapy. **REPLACE** If hormone **therapy** was not administered because the patient died prior to planned or recommended therapy.
Page II-84, Missing Word	**MODIFY** If hormone was not administered; it was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was noted in the patient record **REPLACE** If hormone **therapy** was not administered; it was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was noted in the patient record
Page II-93, Repeated	**DELETE THE SECOND OCCURRENCE** Prostate Cancer: PSA

Reminder

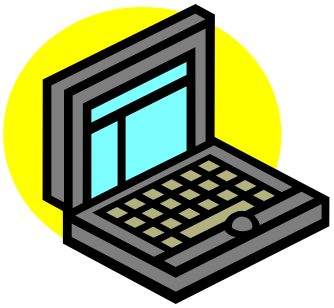
FCDS will no longer run the Facility Alpha List or Quarterly/Yearly Mortality Match reports for hospitals as of January 31, 2004.

These reports can be downloaded from the FCDS website:

- **Facility Alpha List***
- **Quarterly/Yearly Mortality Match***
- **Quarterly 2003 Deaths are now available***

****To run these reports, be sure to obtain access by completing the FCDS IDEA User Account Request Form and the Web-based Report Access Authorization Form. Both of these forms can be downloaded from the FCDS website at: http://fcds.med.miami.edu***

Plans underway for Incidence Training Workshop On-Line



New Year brings enhancement! FCDS is very excited about the new plans for providing the Incidence Abstracting Workshop on-line. Mark Rudolph, FCDS System Analyst is working diligently with the QC Education & Training staff on the development of the on-line educational module. Individuals interested in the cancer registry field will soon be able to take the course on-line, saving both money and time spent away from the workplace. Online training will be very cost effective for both the facilities and individuals.

As with the Incidence Abstracting Workshop, an individual must have knowledge of medical terminology, anatomy and physiology, clinical medicine and disease processes, as well as all the educational tools (DAM; SEER books 1-8, SEER Summary Stage 2000 etc.). More details about the program will be forthcoming in the very near future!

Quarterly Activity Status Report

FCDS has generated the Quarterly Status Report for the period of October 1, 2003 through December 31, 2003. The report was sent out January 12, 2004. The report consists of two sections:

1) **Quarterly Activity Summary**

The Quarterly Activity Summary reflects the FCDS file activity and data submissions for each facility on a quarterly basis. It highlights information about the total number of cases submitted and the quality of the data. FCDS requires that inpatient facilities submit data at least every quarter. Monthly submissions are recommended for facilities with an annual caseload greater than 500. All facilities should show some activity quarterly.

2) **Annual Case Summary**

The Annual Case Summary reflects all cases submitted to FCDS by the facility during the past four reporting years.

Please contact Meg Herna at (305) 243-2625 should you have any questions about the report.

Collaborative Stage

Reporting facilities should not be submitting any cases diagnosed from January 1, 2004 or later until the computerized modules for Collaborative Stage are in place (on or about July 1, 2004). FCDS will keep you informed of training and implementation of the Collaborative Stage variables.

CALENDAR OF EVENTS

FCDS 2004 TELECONFERENCE SERIES

Date: March 24, 2004
Topic: **Collaborative Staging Part I**
Time: 2:00 p.m. – 4:00 p.m.
Dial-in No: (888) 476-3762 (toll free)
Call-in Code: 359957

Date: April 14, 2004
Topic: **Collaborative Staging Part II**
Time: 2:00 p.m. – 4:00 p.m.
Dial-in No: (888) 422-7137 (toll free)
Call-in Code: 175525

Power point presentation slides on the above teleconferences can be accessed through the "Downloads" button on the FCDS website a few days before the Teleconferences.

FLORIDA CANCER REGISTRARS ASSOCIATION REGIONAL WORKSHOP

"Data Collection of Primary Central Nervous System Tumors"
Date: March 20, 2004 – Orlando, FL.
Contact: Patricia Bentley, CTR, Program Chair, *patbentley@cfl.rr.com*.

NCRA 30TH ANNUAL EDUCATIONAL CONFERENCE

Date: April 20-23, 2004
Location: Portland, Oregon
Website: http://www.ncra-usa.org

NAACCR ANNUAL CONFERENCE

Date: June 8-10, 2004
Location: Salt Lake City, Utah
Website: http://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

CTR EXAM INFORMATION

Application Deadline:
July 31, 2004

Testing Begins:
September 11, 2004

Testing Ends:
September 25, 2004

The Certification Examination will be administered during two 2-week testing periods on a daily basis, Monday through Saturday, excluding holidays, at *LaserGrade Computer Testing Inc.'s* computer-based testing facilities managed by Professional Testing Corporation. Visit the NCRA website at: www.ncra-usa.org for additional information.

ABSTRACTOR CODES:

FCDS Cancer Abstractor Codes expire on June 30th, 2004.

The abstractor Request form and memo is posted on the website under FCDS IDEA. 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.

THE WEBSITES LISTED BELOW ARE JUST A FEW THAT PROVIDE A WEALTH OF INFORMATION TO ALL IN THE CANCER REGISTRY FIELD:

- ACoS Commission on Cancer: *http://web.facs.org/coc/*
- American Cancer Society: *http:www.cancer.org/*
- American College of Surgeons: *http://www.facs.org/*
- CDC's Cancer Control Planet: *http://cancercontrolplanet.cancer.gov/*
- Centers for Disease Control (CDC): *http://www.cdc.gov/*
- FDA Drug list: (List of approved Oncology drugs with approved indications) *http:www.accessdata.fda.gov/scripts/cder/onctools/druglist.cfm*
- FDA: *http://www.fda.gov*
- Florida Department of Health: *http://doh.state.fl.us*
- Florida Statutes: *http:www.leg.state.fl.us/*
- NAACCR: *http://www.naaccr.org/*
- NCI's SEER Program*: http://seer.cancer.gov/*
- University of Kansas Medical Center: *http://www2.kumc.edu/kci/registrylinks*
- US Dept of Health & Human Services: *http://www.dhhs.gov/*

ADDITIONAL SITES CAN BE ACCESSED ON THE "LINKS" BUTTON WHEN YOU VISIT THE FCDS WEBSITE AT HTTP://FCDS.MED.MIAMI.EDU/

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...A New Season...Spring!

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