Florida Cancer Data System

August 2006 Monthly Memo

WHAT'S NEW :

The following information is currently available on the FCDS website.

- **FLORIDA ANNUAL CANCER REPORT: 2002 INCIDENCE AND MORTALITY**
- **FCDS 2006 DAM**
- **FCDS 2006 IMPLEMENTATION GUIDE FOR NAACCR V. 11 (REVISED 6/30/2006) -** *APPLIES TO FACILITIES SUBMITTING FULL CANCER ABSTRACTS, NOT PATH OR RT IDENTIFICATION DATA*
- **FLORIDA DEPT. OF HEALTH MEDICAL LICENSE SEARCH** *USEFUL FOR CASE FOLLOW-UP*
- **FCDS MONOGRAPH: 2004**

FCDS MAILING INFORMATION

US Postal Service mail including Express mail, Priority mail, and Certified mail should be sent to the following PO Box address:

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

FCDS STREET ADDRESS SHOULD ONLY BE USED FOR COURIER PACKAGES
(Federal Express, UPS, Airborne Express)

FCDS/University of Miami
Miller School of Medicine
1550 NW 10th Ave, Fox Bldg, Room 410
Miami, FL 33136

FCDS Quality Assurance Audit

FCDS will conduct its annual Quality Assurance Audit during the month of October 2006, which will include a re-abstracting audit of selected 2004 analytical cases. Twenty-nine hospitals were selected at random to participate in the audit. Medical records will be audited by a FCDS auditor. Comparison will be made between the audited data and the data originally submitted by the hospital. These audits allow assessment with regard to standardized interpretation of data definitions, coding rules and guidelines, policies and procedures and serve to identify areas that may require further education and training.

Arrangements will need to be made with the Health Information Management/ Medical Records Department to make ALL the medical records identified on the list available for review as well as arrangements for a workspace large enough to accommodate one or two persons.

FCDS will present a teleconference to all participating hospitals on Tuesday, September 12, 2006.

FCDS TELECONFERENCE INFORMATION:

Date: Tuesday, September 12, 2006
Time: 2:00 p.m. – 4:00 p.m. EDT
Dial In Number: (888) 622-5357
Participant Code: 286683

If you have any questions about the audit process, please contact Megsys Herna at (305) 243-2625

Inflammatory Breast Cancer & CS Rules

Q/C Corner

By: Mayra B. Alvarez, RHIT, CTR

As a reminder registrars need to know that inflammatory breast cancer is a clinical diagnosis not a histologic type of breast cancer. Therefore, because it is a clinical observation of extent and type of tumor spread, it is being collected under the Breast Collaborative Stage CS Extension Schema. Only if you have in the pathology report with the statement of an inflammatory breast carcinoma then you use M8530/3. Otherwise, if the pathologist did not state inflammatory breast carcinoma the new CS instruction for registrars is to NEVER code it M8530/3.

The following is from the CS Breast chapter, CS Extension Note 5 and 6. Also, within the coding structure - see Codes 20, 40, 51, 61, 62, 71, and 73.

http://web.facs.org/cstage/breast/Breastcsextensiontable.html

- Note 5: Inflammatory Carcinoma. AJCC includes the following text in the 6th edition Staging Manual (p. 225-6), "Inflammatory carcinoma is a clinicopathologic entity characterized by diffuse erythema and edema (peau d'orange) of the breast, often without an underlying palpable mass. These clinical findings should involve the majority of the skin of the breast. Classically, the skin changes arise quickly in the affected breast. Thus the term of inflammatory carcinoma should not be applied to a patient with neglected locally advanced cancer of the breast presenting late in the course of her disease. On imaging, there may be a detectable mass and characteristic thickening of the skin over the breast. This clinical presentation is due to tumor emboli within dermal lymphatics, which may or may not be apparent on skin biopsy. The tumor of inflammatory carcinoma is classified T4d. It is important to remember that inflammatory carcinoma is primarily a clinical diagnosis. Involvement of the dermal lymphatics alone does not indicate inflammatory carcinoma in the absence of clinical findings. In addition to the clinical picture, however, a biopsy is still necessary to demonstrate cancer either within the dermal lymphatics or in the breast parenchyma itself."

- Note 6: For Collaborative Staging, the abstractor should record a stated diagnosis of inflammatory carcinoma, and also record any clinical statement of the character and extent of skin involvement in the text area. Code 71 should be used if there is a stated diagnosis of inflammatory carcinoma and a clinical description of the skin involvement in less than 50% of the skin of the breast. Code 73 should be used if there is a stated diagnosis of inflammatory carcinoma and a clinical description of the skin involvement in more than 50% (majority) of the skin of the breast. Cases with a stated diagnosis of inflammatory carcinoma but no such clinical description should be coded 71. A clinical description of inflammation, erythema, edema, peau d'orange, etc. without a stated diagnosis of inflammatory carcinoma should be coded 51 or 52, depending on described extent of the condition.

(Continued on page 3)

Inflammatory Breast Cancer & CS Rules

Q/C Corner

By: Mayra B. Alvarez, RHIT, CTR

(Continued from page 2)

BREAST COLLABORATIVE STAGE DATA SET - *Revised 02/04/2005*

CS EXTENSION

CODE	DESCRIPTION	TNM MAPPING	SS77 MAP-	SS2000 MAPPING
20	Invasion of subcutaneous tissue Local infiltration of dermal lymphatics adjacent to primary tumor involving skin by direct extension **Skin infiltration** of primary breast including skin of nipple and/or areola	*	RE	RE
40	Invasion of (or fixation to): **Chest wall** Intercostal or serratus anterior muscle(s) Rib(s)	T4a	RE	RE
51	Extensive **skin involvement**, including: Satellite nodule(s) in skin of primary breast Ulceration of skin of breast Any of the following conditions described as involving not more than 50% of the breast, or amount or percent of involvement not stated: Edema of skin En cuirasse Erythema **Inflammation of skin** **Peau d'orange** ("pigskin")	T4b	RE	RE
61	(40) + (51)	T4c	RE	RE
62	(40) + (52)	T4c	RE	RE
71	Diagnosis of **inflammatory carcinoma** WITH a clinical description of inflammation, erythema, edema, peau d'orange, etc., involving not more than 50% of the skin of the breast, or percent of involvement not stated, WITH or WITHOUT dermal lymphatic infiltration Inflammatory carcinoma, NOS	T4d	RE	RE
73	Diagnosis of **inflammatory carcinoma** WITH a clinical description of inflammation, erythema, edema, peau d'orange, etc., of more than 50% of the skin of the breast, WITH or WITHOUT dermal lymphatic infiltration	T4d	RE	RE

Q&A

Section

Q/C Corner

By: Sarah Manson, BS, RHIT, CTR

QUESTION #1
Multiple primaries/Histology--Breast: Is this a multiple primary for 2005 or would histology code 8524 be appropriate for the following case? Please see discussion.

SCENARIO:
Patient has a 4.5 cm. invasive lobular carcinoma of the right breast and also a tiny focus of intraepidermal tumor cells (Paget's disease of nipple).

ANSWER:
There are two primaries:
1. invasive lobular carcinoma [8520/3]
2. in situ Paget disease of nipple [8540/2].
There is no combination code for lobular carcinoma and Paget disease.

SOURCE:
1. 2004 SEER Manual ; pgs 13 (Rule 6)
2. ICD-O-3

QUESTION #2
Primary site--Unknown & ill-defined site: The following cases were submitted with an unknown primary site. Should we change to a more specific site? Please see discussion.

SCENARIO:
Case 1 - CT: Mult pulm nodules, bilat pleural effusions; paraaortic, paracaval, celiac lymphadenopathy. Lytic lesions L4&L5.

Bx L3: Met pd adenoca. Based on the histopathologic features and the results of the immunostains, cholangiocarcinoma is regarded as the most likely primary. However, other possible primaries include pancreas, stomach, and (remotely) lung.

Should primary be coded as C26.9, digestive organ, NOS?

Case 2 - CT: Mult liver masses. Liver Bx: Mod diff adenoca. The most likely primary sites include cholangiocarcinoma, stomach and pancreas.

FDx per attending: Met adenocarcinoma to the liver, probably biliary origin.
What primary site code do we use?

Case 3 - Admitting Dx: Unknown primary with mets to lungs, liver and cerebellar area. Liver Bx: Met adenoca. The combination of morphological and immunohistochemical staining favor a colon primary. However other possibilities include cholangiocarcinoma and pancreatic ca.
Should we code site as C18.9 or C26.9?

ANSWER:
Code the primary site according to the physician's opinion. An ill-defined site code or an NOS code for the organ system is preferred over C809 [Unknown primary site] whenever possible. Code C809 only when there is not enough information to use an ill-defined or NOS code.

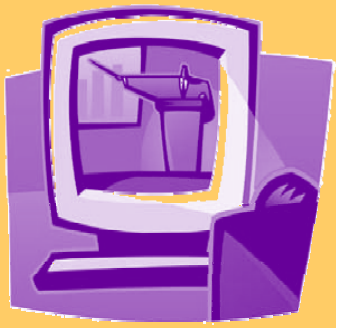
Case 1 and Case 2 - Assign code C249 [Biliary tract, NOS]. Based on the available information, the physicians believe these are most likely biliary primaries.

Case 3 - Assign code C189 [Colon]. According to the available information, the physician believes this is most likely a colon primary.

SOURCE:
1. 2004 SEER Manual ;pgs 74-75 (#7)
2. ICD-O-3

Education and Training

HOSPITAL REGISTRARS AND CANCER REPORTERS WEBINARS



Abstracting Cancer Incidence and Treatment Data Hospital Tumor Reporting Webinar Series

The North American Association of Central Cancer Registries (NAACCR) is presenting a series of web seminars (webinars) for cancer data collectors. A webinar includes a presentation by an instructor with an audio portion (telephone) and a visual portion (computer through the Internet). Both are needed to participate in this interactive education, although in many locations the connection allows multiple participants to attend for one low cost! Participants are able to ask questions and answers will be provided during the session.

COURSE DESCRIPTION

Each webinar will address cancer data collection for a specific site and will include information on anatomy, multiple primary and histology coding rules, collaborative staging, and treatment data items as required by the American College of Surgeons (ACoS) Commission on Cancer (CoC). Didactic exercises will be completed and answers with rationale will be presented. There will also be a question and answer session.

TENTATIVE SCHEDULE

DATE	TITLE
October 12, 2006	Abstracting Head and Neck Cancer Incidence and Treatment Data
December 14, 2006	Abstracting Central Nervous System Tumor Incidence and Treatment Data
January 11, 2007	Abstracting Urinary System Cancer Incidence and Treatment Data
February 8, 2007	Abstracting Lymphoma Cancer Incidence and Treatment Data
March 8, 2007	Abstracting Colon and Rectum Cancer Incidence and Treatment Data
May 10, 2007	Abstracting Prostate Cancer Incidence and Treatment Data
June 14, 2007	Abstracting Lung Cancer Incidence and Treatment Data
September 13, 2007	Abstracting Breast Cancer Incidence and Treatment Data

Webinar series includes: Eight webinars and each will be four hours long. The series will begin in October 2006 and end in September 2007.

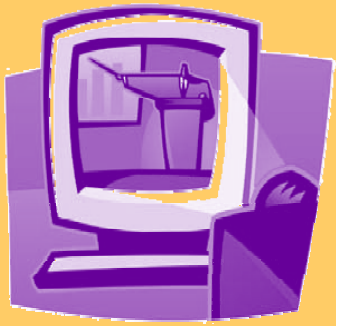
Subscriptions: Only $800 to subscribe to the entire series. Limited availability in each of the webinars can be purchased for $175 per session after the subscription period closes.

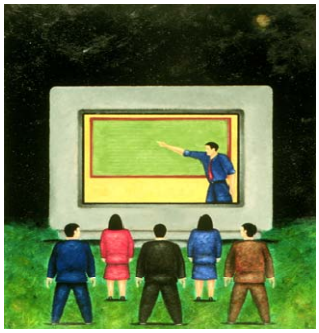
Registration Period: June 1, 2006 through August 15, 2006.

Contact the NAACCR program manager of education and training, Shannon Vann, CTR, at svann@naaccr.org or 315/682-6543 for answers to your questions about the webinar series. For more information about training opportunities through NAACCR, Inc., check the NAACCR website at www.naaccr.org.

Education and Training

CTR Examination Review & Basic Skills Workshops





FLORIDA CANCER REGISTRARS ASSOCIATION WORKSHOP

AUGUST 24-25, 2006
SARASOTA MEMORIAL HOSPITAL
WALDERMERE BUILDING, CYPRESS ROOM
SARASOTA, FLORIDA

WORKSHOPS OBJECTIVES

CTR Exam Review Workshop: Purpose is to assist participants to prepare to write the Certification Examination for Cancer Registrars, to review the fundamentals of cancer data management and ACoS/Commission on Cancer Standards and to identify areas requiring concentrated study. Presentations will be based upon the Exam Contents outline identified in the Handbook for Candidates, distributed by the Professional Testing Corporation and the NCRA Council for Certification.

ATTENDEES MUST BRING THE FOLLOWING REFERENCES:

International Classification of Diseases for Oncology - Third Edition (ICD-O 3rd Ed.)
AJCC Cancer Staging Manual – 6th Ed.

ALSO RECOMMENDED TO BRING:

Facility Oncology Registry Data Standards (FORDS)
CoC Cancer Program Standards 2004

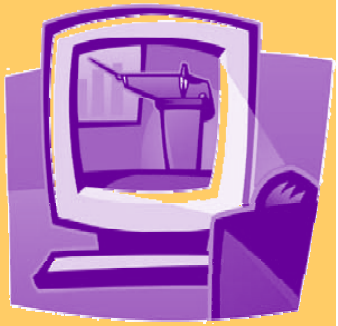
BASIC SKILLS WORKSHOP:

Purpose is to introduce new cancer registrars to cancer registry functions and the skills required by these functions. Bringing the above references, especially ICDO-3 is strongly recommended but not required.

REGISTRATION DEADLINE: August 15, 2006
REGISTRATION FEE: $100.00

For brochure and registration information please visit the FCRA website at::
http://fcra.org/index.shtml

Education and Training



NAACCR Education and Workshops

NAACCR CTR Exam Readiness Institute
August 15-16, 2006
Nashville, Tennessee

Goals

- Prepare eligible candidates to take the Certified Tumor Registrar (CTR) exam.
- Increase participants knowledge and under standing of
  - Cancer registry organization and operation
  - Anatomy, physiology, and histology
  - Abstracting and coding
  - Statistics and epidemiology
  - Computer principles
  - ICD-O-3
  - Staging systems
    - Collaborative Staging
    - AJCC Cancer Staging, 6th Edition
- Answer participants questions about the CTR exam

Target Audience

- CTR eligible cancer registrars and cancer incidence reporters
- CTR eligible allied health professionals
- CTR eligible public health professionals
- Basic Knowledge/Skills/Prerequisites
- CTR Eligibility

For further details please contact:
Ms. Shannon Vann
Phone Number: (315) 682-6543
Fax: Number: (217) 698-0188
Email: svann@naaccr.org

NAACCR 2006 Toolkit Workshop: Technical Tools For Data Use And Research

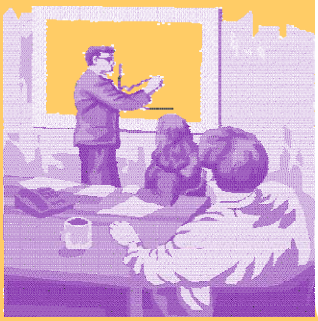
SEPTEMBER 25, 26, AND 27TH 2006
WILLIS CONFERENCE CENTER
NASHVILLE, TENNESSEE

TOPICS INCLUDE:

- Basic SEER*Stat
- Advanced SEER*Stat
- NAACCR Call for Data Refresher
- NAACCR Method to Calculate Completeness
- Geographic Information Systems

Check the NAACCR Website, www.naaccr.org, for more details.

Sponsored by NAACCR and NCI



Congratulations!

Please join us in wishing two of the FCDS staff farewell.

Mae Whitehead, who has been with FCDS for 12 years will be joining the American Cancer Society. She has been a Field Coordinator for hospital sources as well as involved in Incidence Training and Regional Workshops.

Sharonda Boone will remain with the University of Miami, Miller School of Medicine joining the Office of Patient Protection and Risk Management. She has been with FCDS for four years.

The FCDS staff is sad to see them leave, and wish them much success and happiness in their new endeavors!

FCDS Florida Cancer Data System

PROJECT DIRECTOR:
Lora E. Fleming, MD, PhD

DEPUTY PROJECT DIRECTOR:
Jill A. Mackinnon, PhD, CTR

ADMINISTRATIVE DIRECTOR:
Gary M. Levin, CTR

EDITORIAL STAFF:
Melissa K. Williams

CONTRIBUTORS:
Mayra Alvarez, RHIT, CTR
Megsys C. Herna, BA, CTR
Sarah J. Manson, BS, RHIT, CTR

Florida Cancer Data System

Cancer Reporting Completeness Report

TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF JULY 31, 2006

Total number of *New Cases* added to the FCDS Master file in July 2006: 4,154

The figures shown below reflect initial patient encounters (admissions) for cancer by year.

Admission Year	Hospital	Radiation	Ambi/Surg	Physician Office	Derm Path	DCO	Total Cases	New Cases
2006	2,152	173	44	0	1	**Pending**	2,370	2,327
2005	144,130	4,160	549	0	606	**Pending**	149,467	1,478
2004	151,505	3,303	3,044	0	729	**Pending**	161,590	349

		Actual	Expected
% Complete for:	2006	2%	8%
	2005	98%	100%
	2004	100%	100%

**Expected % based on 152,000 reported cases/year*