Florida Cancer Data System

September/October 2007 Monthly Memo

WHAT'S NEW :

The following information is currently available on the FCDS website.

- NAACCR Webinar: Abstracting Gynecologic Cancer Incidence and Treatment Data on November 8. (*Registration required*)
- FCDS Register Vol. 36

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

News & Information

UPDATE The Collaborative Staging (CS) Update

The Collaborative Staging (CS) Steering Committee is currently working on an update to the Collaborative Staging System that will be released on October 31, 2007 as Version 01.04.00.

An announcement detailing the changes included in this release will be made on October 31, 2007. It will include effective dates for this version as defined by each standard-setting agency. Cancer registry software vendors have been made aware of this expected release date and will be updating their products accordingly.

Version 01.04.00 will encompass minor changes identified through the CS Reliability Study, concerns identified through case abstracting, and questions from the CoC I&R and SEER SINQ systems. This release clarifies coding issues identified by registrars, but does not contain major changes.

As of October 31, the CS Web site, http://cancerstaging.org/cstage/index.html, will include resources required to implement the new version, and the AJCC will be hosting national Web conferences to review the changes. Details will be provided in CoC Flash and posted on the CS Web site. Questions should be sent to the AJCC at AJCC@facs.org.

News & Information

NEW! New FCDS Edits

461- If Type of Reporting Source = 6 (autopsy only), then RX Summ-Radiation must = 0, RX Summ-BRM must = 00, RX Summ-Chemo must = 00, RX Summ-Hormone must = 00, RX Summ-Other must = 0, and RX Summ-Transplnt/Endocr = 00

462- If Type of Reporting Source is 6 (autopsy only), then RX Summ--Surg Prim Site must = 00 or 98

463- If Primary Sites = C700-C729 or C809 or Morphology = 9590-9989, and if Type of Reporting Source is 6 (autopsy only), then RX Summ--Scope Reg LN Sur and RX Summ--Surg Oth Reg/Dis must = 0 or 9

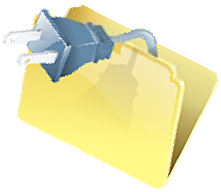
464- If Type of Reporting Source is 6 (autopsy only), then RX Summ--Scope Reg LN Sur and RX Summ--Surg Oth Reg/Dis must = 0

465- If Type of Reporting Source is 6 (autopsy only), Reason for No Surgery must = 9

466- If Type of Reporting Source is 6 (autopsy only), then RX Summ--Systemic/Sur Seq must = 0

News & Information

The complete 2007 FCDS Data Acquisition Manual is now available on the FCDS website http://fcds.med.miami.edu under Downloads.



FCDS WILL NOT BE DISTRIBUTING HARD COPIES OF THIS MANUAL.

News & Information

Brain and CNS Multiple Primary and Histology Coding Rules– *Rule M6 Clarification*

Rule M6- A glioblastoma or glioblastoma multiforme (9440) following a glial tumor is a single primary* (See Chart 1).

In other words, all glial tumors listed below Glioma, NOS (9380) are considered a single primary with Glioblastoma, NOS and Glioblastoma Multiforme (9440). In this rule, it does not matter if the histologies are on the same branch of Chart 1 or not as long as they are under Glial Tumors. Rule M6 is the exception to Rule M7 and M8.

FCDS Casefinding List for Reportable Tumors-

Revised October 2007

FCDS has revised the Casefinding List. The list of ICD-9– CM codes is to be used to identify reportable tumor diagnoses effective with October 1, 2006 encounters and discharges. Please note that the following codes are still reportable to FCDS and fall under the range of 235.0-238.9 in the new list:

236.0 Endometrial stroma, low grade (8931/3

237.5 Ependymoma (epithelial) (malignant) (9391/3)

237.6 Papillary Meningioma (9538/3)

You may find the revised list on the FCDS website http://fcds.med.miami.edu under What's New and Downloads, 2007 Data Acquisition Manual. If you have any questions, please feel free to contact FCDS at (305) 243-4600.

FCDS Casefinding List for Reportable Tumors- *Revised October 2007*

*** Required +Optional *****International Classification of Diseases, Ninth Revision, Clinical Modification.*** **U.S. Dept. of Health and Human Services, Public Health Service - Health Care Finance Administration; DHHS**

* 042	AIDS (review cases for AIDS-related malignancies)
* 140.0-208.9	Malignant neoplasms
* 225.0-225.9	Benign neoplasm of brain and spinal cord neoplasm
* 227.3-227.4	Benign neoplasm of pituitary gland, pineal body, and other intracranial endocrine-related structures
* 230.0-234.9	Carcinoma in situ (excluding cervix – 233.1)
* 235.0-238.9	Neoplasms of uncertain behavior
* 238.4	Polycythemia vera (9950/3)
* 238.6	Solitary plasmacytoma (9731/3), Extramedullary plasmacytoma (9734/3)
* 238.71	Essential thrombocythemia (9962/3)
* 238.72	Low grade myelodysplastic syndrome lesions (9980/3, 9982/3), 9985/3)
* 238.73	High grade myelodysplastic syndrome lesions (9983/3
* 238.74	Myelodysplastic syndrome with 5q deletion (9986/3)
* 238.75	Myelodysplastic syndrome, unspecified (9985/3)
* 238.76	Myelofibrosis with myeloid metaplasia (9961/3)
* 238.79	Other lymphatic and hematopoitic tissues (includes 9931/3, 9960/3, 9961/3,)
+ 239.0-239.9	Neoplasms of unspecified behavior
* 259.2	Carcinoid Syndrome
* 273.2	Gamma heavy chain disease (9762/3); Franklin's disease (9762/3)
* 273.3	Waldenstrom's macroglobulinemia (9761/3)
+ 273.9	Unspecified disorder of immune mechanism (screen for potential 273.3 miscodes)
* 288.3	Hypereosinophilic syndrome (9964/3)
*289.83	Myelofibrosis NOS (9961/3)
* V07.3	Other prophylactic chemotherapy (screen carefully for miscoded malignancies)
+ V07.8	Other specified prophylactic measure
+ V10.0-V10.9	Personal history of malignancy (review these for recurrences, subsequent primaries, and/or subsequent treatment)
* V58.0	Admission for radiotherapy
* V58.11	Admission for chemotherapy
* V58.12	Admission for antineoplastic immunotherapy
+ V66.1	Convalescence following radiotherapy
+ V66.2	Convalescence following chemotherapy
+ V67.1	Radiation therapy follow-up
+ V67.2	Chemotherapy follow-up
+ V71.1	Observation for suspected malignant neoplasm
+ V76.0 - V76.9	Special screening for malignant neoplasm

Q/C Corner

Q & A Section

QUESTION :

MP/H Rules--Prostate:

Please see the case details in "Discussion." How many primaries and what is (are) the correct histology code(s)?

DISCUSSION:

Patient has TURP. Final path diagnosis is adenocarcinoma in 20% of tissue and sarcoma in 50% of tissue. Since it is unknown if single or multiple tumors, rule M1 (Other Sites) is used which instructs to abstract as a single primary. Single invasive histology rules are followed to rule H16, but table 2 does not contain a mixed code for this situation, even though ICD-O-3 has a code 8933/3 for "adenosarcoma". Therefore, rule H17 is applied that states to use the highest code, which in this case would be 8800/3, Sarcoma, NOS. Is this correct?

ANSWER:

Code as two primaries, one adenocarcinoma the other sarcoma.

This is two tumors (adenocarcinoma and separate sarcoma) until proven otherwise. Do not code as adenosarcoma, as this is a gyn-specific diagnosis; adenosarcoma of the prostate is not a recognized entity in the WHO classification of prostate tumors.

Reference:

2007 SEER Manual;
pgs C-1127 (Appendix C)

Question taken from SEER Inquiry & Response ID: #20071068

QUESTION:

A patient had three tumors, left colon tumor invasive well-diff mucinous adenoca arising in tubulovillous adenoma with pericolonic subserosal fat invasion 8.5cm. An infiltrative mod-diff colonic adenoca with invasion of muscularis propria 4cm and an invasive mod-diff colonic adenoca with invasion of muscularis propria, 1/69 nodes positive. We used M8 for one primary, but M10 contradicts; and H13 coding rule 8263/3.

ANSWER:

Assuming that all tumors are in the left colon, there are three tumors:

1. Mucinous adenocarcinoma arising in a villous adenoma
2. Colonic adenocarcinoma
3. Colonic adenocarcinoma

Multiple Primary Determination

In the colon MP rules go to the multiple tumors module. Start with M3. Stop at M7 and abstract as a single primary.

Histology Code

Go to the histology coding rules, multiple tumors module, and start with H15. Stop at H20 which tells you to code the most invasive tumor. Tumor 1 is the most invasive according to the definition of most invasive in the 2007 SEER Manual, page C-271. Code 8263/3 [Adenocarcinoma in tubulovillous adenoma].

Reference:

2007 SEER Manual;
pgs C-271, C-303 - C-310 (Appendix C)

Question taken from SEER Inquiry & Response ID: #20071077

Education and Training

Education and Training

NAACCR Webinar: Abstracting Gynecologic Cancer Incidence

NAACCR November 8th webinar: Abstracting Gynecologic Cancer Incidence and Treatment Data Registration for the webinar on Abstracting Gynecologic Cancer Incidence and Treatment Data" is now open.

The Florida Cancer Data System (FCDS) and the Florida Cancer Registrars Association (FCRA) are now accepting registrations for the second webinar of the 2007-2008 NAACCR Hospital Registrar Webinar Series presented by NAACCR. The Abstracting Gynecologic Cancer Incidence and Treatment Data webinar is scheduled for **November 8, 2007, 9AM-1PM EST**. It will be presented at **Boca Raton Community Hospital** (Boca Raton), **Moffitt Cancer Center** (Tampa), and **Shands University of Florida** (Gainesville).

Please go to the FCDS website https://fcds.med.miami.edu/scripts/naaccr_webinar.pl to register online for your location of choice. If you have any questions, please contact: Meg Herna, BA, CTR, 305-243-2625.

Principles of Oncology for Cancer Registry Professionals

December 10-14, 2007 in Reno, NV
Registration fee: $949.00

A Fritz and Associates, LLC
Preparing Cancer Registry Professionals for the Future

Principles of Oncology is a concentrated five-day training program in cancer registry operations and procedures emphasizing accurate data collection methods. The training program includes extensive site-specific, hands-on case coding, abstracting and staging sessions using practice cases that are representative of the many situations registrars may face.

Class size will be limited to 20 registrants.

Participants are responsible for their own travel, hotel, meals, and incidental expenses, except as noted above.

For further information about the Principles of Oncology training program please visit A. Fritz and Associates website at: http://afritz.org/index.html

Deadlines & Reminders

Deadlines & Reminders

2005 Death Certificate Notification Process

The FCDS staff is currently working on the Death Certificate Clearance process for the 2005 hospital and non-hospital deaths. The deadline to report the "missed cases" and to return the *Mortality Follow Back Request Forms* was September 21, 2007. Please return the forms to your Field Coordinator. Please contact your Field Coordinator for additional information or if you have any questions at 305-243-4600.

QC Sampling Reports

The QC Sampling Report is designed to visually edit abstracted data not detected by the computerized FCDS edit checks. The QC sampling report allows for a visual review of the record to detect discrepancies, deficiencies and inconsistent coding. It is also used to identify lack of understanding in abstracting concepts, data definitions, and coding selections that may require additional training.

The QC Sampling Report automatically selects at least one of every 50th case that successfully passes the FCDS edit checks and makes it into the FCDS master file. For facilities reporting fewer than 50 cases, at least one record is selected at random. Each case selected is placed in a file to be reviewed and printed. The report is printed monthly and is sorted by Medical Facility.

Abstracts with questionable coding discrepancies, text versus code discrepancies, or coded data items with omitted supporting required text will be mailed to each reporting medical facility. Some cases will require additional documentation to verify/validate the coding. Please contact the Quality Control Field Coordinators if you have any questions about the reports at 305-243-4600.

FCDS 2007 Quality Assurance Audit- Reconciliation Process

All the facilities that are currently being audited in October will receive a packet containing the Reconciliation Request forms as part of the Quality Assurance Audit Reconciliation Process once all the audits are completed. The Reconciliation Request forms summarize the comparison of data items coded by the auditor to the data originally submitted to FCDS by the audited facility through the regular cancer reporting process. If any discrepancies are found, the field on the report containing the discrepant data item will be preceded with one asterisk (*) indicating the discrepancy. The facilities must review all forms and reply in the following way:

If the original submission to FCDS was in error, you would write **AGREE** on the Reconciliation Request form OR

If you disagree with the auditor, perhaps because your source documents may have been more complete than the ones reviewed by the auditor, write **DISAGREE** on the Reconciliation Request form and provide a brief explanation indicating the source of any supporting information, such as, pathology reports, Op reports, etc.

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Happy Columbus Day

Observed: October 8th

FCRA FCDS

For any questions or suggestions, please contact the taskforce at taskforce@fcra.org.

Florida Cancer Data System

Cancer Reporting Completeness Report

TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF SEPTEMBER 30, 2007

Total number of *New Cases* added to the FCDS Master file in September 2007: 14,088

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
2007	19,686	485	148	0	55	**Pending**	20,374	10,727
2006	154,349	4,787	528	0	788	**Pending**	160,452	2,756
2005	158,849	2,726	4	932	676	171,191	605	383

		Actual	Expected
% Complete for:	2007	12%	25%
	2006	97%	100%
	2005	100%	100%

**Expected % based on 165,000 reported cases/year*