

# Register

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

Division of Cancer Prevention and Control

Volume 45 – October, 2009

## 2009 FCDS Annual Meeting Jacksonville, FL - July 23-24, 2009

The FCDS 2009 Annual Conference took place this year at the Hyatt Regency Jacksonville Riverfront Hotel in Jacksonville, Florida July 23<sup>rd</sup> -24<sup>th</sup>. The hotel's location along the St. John's River and adjacent to Jacksonville Landings Entertainment & Shopping Complex provided guests with both dining and shopping amenities for the duration of their stay. FCDS was very pleased with the attendance this year of 83 registrants.

The day and a half conference was full of interesting and educational topics for all the attendees. The morning session commenced with the "Welcome and Introduction" chaired by Dr. MacKinnon, Dr. Huang and Dr. Fleming. In support of "going green", Dr. MacKinnon announced only the agenda and evaluations would be provided at this year's conference, informing the audience that the

presentations would be available on the FCDS website after the meeting.

Next on the agenda, Dr. MacKinnon presented "FCDS Updates" providing information on the 2009 year in review, and announcing FCDS "Gold" status again this year. Congratulations to all! As new FCDS Staff members were welcomed and introduced (Mr. Mike Thiry, Sr. Database Analyst and Ms. Christine Castro, Office Assistant), Dr. MacKinnon also announced the retirement of our beloved Edith, special and dear to us all. We will miss her very much and wish her all the best in this new phase in her life!



Implementation" providing an insight on the 2009 implementation guideline, data submission and overview of the modified and new edit checks. Next, Dr. MacKinnon's presentation on "Enhancing Passive F/U" introduced the process and benefits associated with this project. Up next, Gary Levin's presentation "NAACCR Version 12 - A Glimpse of the Future" had the audience's attention and participation in a "Who Wants to be a Millionaire" format with Q&A's on the future of the 2010 NAACCR v12. The next presentation by Dr. Monique Hernandez on "FCDS

Linkage to the National Death Index and Effects on Survival" concluded

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Following, Ms. Tara Hylton provided information on the important role FCDS plays in cancer surveillance in her presentation "FCDS The Centerpiece of the Puzzle". The next two presentations on data linkage: "NPCR & NDI Linkage NY & FL Experience" by Mr. Brad Wohler and "FCDS/NCHS Data Linkage Project" by Dr. David Lee were both very interesting and informative.

After the mid-morning break Ms. Meg Herna continued with "NAACCR v11.3

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the first part of a very productive and informative morning.

Following the lunch break, Dr. Lora Flemings' presentation on "Statewide Monographs" provided information and objectives of the Florida monographs. The next two presentations "QC Updates" and "2008 Re-abstracting Audit" was chaired by Ms. Sarah Manson and Ms. Mayra Alvarez, these presentations provided a summary of the findings on the QC review for the period of March – June, 2009 and the results of the 2008 re-abstracting audits performed for the 2006 cases. Continuing with the afternoon sessions, up next were presentations by Dr. Jill MacKinnon and Ms. Recinda Sherman "Bladder Cancer and Arsenic Contamination" and "A Geographic Approach to Data Quality".

The day concluded with the "Process Improvement" session, chaired by Mr. Gary Levin, Ms. Tara Hylton and Dr. Jill MacKinnon. Mr. Levin began by

reviewing the results from last years' conference. Afterwards, all the attendees formed groups to propose ideas and suggestions for future development. As part of this session Dr. MacKinnons' presentation on "Handling of Protected Information" stressed the responsibility we all have in protecting and securing the data. The meeting adjourned at 5:00 p.m., after a full day of informative and interesting topics.

Day two of the conference introduced two hands-on educational trainings, "Abstracting for Beginners - Basic Incidence Abstracting Training" chaired by Ms. Betty Hallo and Ms. Mayra Alvarez and "Advanced Training – Head and Neck" chaired by Ms. Meg Herna and Ms. Sarah Manson. Guests interested in attending these trainings chose their preference at the time of registration. Both trainings were simultaneous and concluded at noon.

We would like to thank all of the presenters for their contribution in making our meeting a success! Special

thanks to our guest speakers Dr. Youjie Huang, Ms. Tara Hylton, Dr. Lora Fleming and Dr. David Lee for taking the time out of their busy schedules to be a part of our conference. And last but certainly not least, thanks to all the guests who attended, your hard work and commitment makes all that we do possible.

For your convenience, the presentations from the annual conference are available on our web site at: <http://fcfs.med.miami.edu/inc/downloads.shtml#annual>.

**NCRA approved the program for 9.0 CE hours. NCRA Recognition number is 2009-080.**

Next years' meeting will be at the Renaissance Orlando Hotel at SeaWorld! We look forward to seeing you there!

## Congratulations & Best Wishes on your Retirement, Edith!



*As a chapter closes in your life,  
And a new one starts for you,  
May your years be filled with all the  
things you're looking forward to!*

*Author unknown*





# Notes from the Statistical Unit

## DATA IN ACTION

By RECINDA SHERMAN, MPH, CTR

An article in last month's *Register* highlighted the tremendous national and international attention given to Dr. Pinheiro's journal article "Cancer Incidence in First Generation US Hispanics: Cubans, Mexicans, Puerto Ricans, and New Latinos" published online ahead of print in *Cancer Epidemiology and Biomarkers*. This month's article puts the research in context.

The analysis is descriptive using FCDS data—the statistics describe the burden of cancer by race and ethnicity. The article compared cancer rates in Hispanic sub-groups to each other and to non-Hispanic Blacks and Whites in Florida. The study also compared rates in Hispanic sub-groups in Florida to rates in their home countries. The analysis established that not all Hispanic sub-groups have the same cancer profile despite sharing a common language, the experience of immigration, and a culture with attitudes and values that tend to differ from those of "mainstream" English-language culture of non-Hispanic whites. Further, the data showed that rates of most

cancers are markedly higher for Hispanic Floridians compared to the Hispanics in their native countries. These findings highlight an area of tremendous value for further study.



Cancer surveillance systems like FCDS are designed to generate descriptive analyses, and the results are intended to create hypotheses about cancer risk.

Why do rates differ among these population groups? Is it modifiable? What type of public health intervention would be most effective? In the prevention/public health field, much of what we know about what causes cancers is the modifiable or behavioral factors, such as diet, screening adherence, alcohol and tobacco use, and level of physical activity. For instance, the study indicated that among Hispanics, Cuban men were burdened most by tobacco-affiliated cancers (lung, larynx, bladder, kidney, and pancreas). Cuban women had the highest rates of colorectal cancer, believed to be a diet

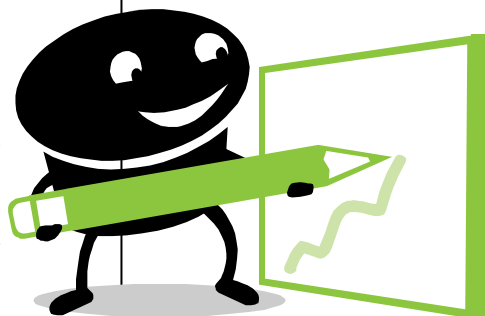
related cancer, among Hispanic women. The study also indicated Puerto Ricans generally had the highest rates of cancer among all Hispanics, and Puerto Rican men had the highest rates of two alcohol-related cancers (oral cavity and liver). Mexicans had the lowest cancer rates among Hispanics but had much higher rates of typical "minority" cancers than whites (stomach, cervix, and liver). Understanding that cancers affect ethnic sub-populations differently is important in targeting both prevention and screening programs.

It is well documented that life in the mainland US, despite potential financial and other social advantages, is less healthy for many immigrant groups than living in their native, and often socioeconomically disadvantaged, countries. This has been demonstrated with specific cancer sites for multiple ethnic and racial groups. Numerous studies corroborate this current work by demonstrating that cancer incidence is higher among Puerto Ricans living in the US than among Puerto Ricans living on the island. Similar

(Continued on page 4)

work starting in the 1960's showed similar results among Asian sub-populations in California particularly around female breast cancer. And such patterns are seen outside the field of cancer to include life expectancy, morbidity, and mortality.

In general, first generation (adult) immigrant populations are initially healthier than the general US population (Notable exceptions here are short-term/seasonal migrants, such as farm workers, and refugee immigrants). Particularly for Hispanics who generally have lower socioeconomic status than the rest of the nation, this is considered a paradox, i.e., The Hispanic Paradox. This is theorized as being due to the Healthy Migrant Effect—only those healthy enough to make the journey will immigrate. In general, this self-selected group is healthier than the general population of the home country as well; intuitively it would be particularly true for those who have undergone health evaluations by immigration. However, there is research to suggest that The Hispanic Paradox, specifically for Mexicans, is mainly driven by the Salmon Effect—the tendency for Mexicans to return to their home country when they fall ill. Other explanations revolve around poor data collection and incomplete identification of race and ethnicity in health and vital statistics data.



But this health advantage erodes with subsequent generations. The longer an immigrant group has resided in the US, the more their general health,

particularly for chronic disease, resembles the host population. This is the Theory of Acculturation—as individuals and their off-spring embrace the “western” lifestyle their rates of chronic disease rise to match their new neighbors. But this pattern seems to apply differently based on race and ethnicity. White, European immigrants show improved health after living five or more years in the US while the majority of others, blacks and Hispanics particularly, show a decrease in health status using a variety of end-points (BMI, life expectancy, chronic disease).

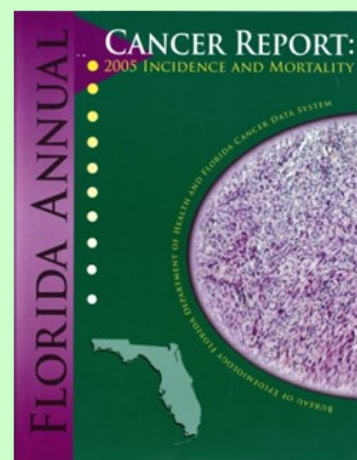
The root of these patterns appears as complex as the patterns themselves. For instance, Canada is a country that struggles less with race and immigration issues than the US, and it is a country with universal health care. Yet the trends hold true there as well with white immigrants maintaining or improving health while blacks get sicker. The fate of Hispanics is unknown because of the relatively low number of Hispanic

immigrants to Canada. It is likely that the gene/environment interaction is a driving force in these disparities. Research in immigrant health is particularly beneficial because a well designed follow-up study can evaluate both genetic and modifiable risk factors that can have significant implications for the population as a whole.

Related reading:

1. Dey AN, Lucas JW. Physical and Mental Health Characteristics of US-and Foreign-Born Adults: United States, 1998-2003 Advance data from vital and health statistics; no 369. Hayattsville, MD: National Center for Health Statistics. 2006.
2. Ginh GK. Health, Life Expectancy, and Mortality Patterns among Immigrant Populations in the United States *Revue Canadienne de Sante Publique* 2004 May-June; 95(3):I-14-I-21.
3. Palloni A, Arias E. Paradox Lost: Explaining the Hispanic Adult Mortality Advantage *Demography* 2004 August; 41(3):385-415.

NOW AVAILABLE ON LINE AT:  
<http://fcds.med.miami.edu/>





# CALENDAR OF EVENTS

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### NAACCR CANCER REGISTRY & SURVEILLANCE WEBINAR SERIES 2009-2010

**Time:** 9:00 am—12:00 pm  
**Locations:** Baptist Regional Cancer Center (Jacksonville, FL) *New Site*  
 Boca Raton Community Hospital (Boca Raton, FL)  
 Gulf Coast Medical Center (Panama City, FL)  
 H. Lee Moffitt Cancer Center (Tampa, FL)  
 M.D. Anderson Cancer Center (Orlando, FL) *New Site*  
 Shands University of Florida (Gainesville, FL)  
**Contact:** Meg Herna at 305-243-2625 or mherna@med.miami.edu  
**To Register:** <http://fcfs.med.miami.edu>

Date	Topic
10/01/2009	2010 Cancer Data Collection Updates: Standards Volume II, Version 12
11/05/2009	Collecting Cancer Data: Colon/Rectum/Appendix
12/03/2009	Collecting Cancer Data: Lung
01/07/2010	Change Management in the Cancer Registry
02/04/2010	Collecting Cancer Data: Soft Tissue Sarcoma and Gastrointestinal Stromal Sarcoma (GIST)
03/04/2010	Collecting Cancer Data: Kidney
04/01/2010	Collecting Cancer Data: Skin Malignancies
05/06/2010	Using Geographic Information Systems (GIS) for Mapping and Spatial Analysis
06/03/2010	Collecting Cancer Data: Esophagus and Stomach
07/01/2010	Using CINA Data in Cancer Surveillance Activities
08/05/2010	Collecting Cancer Data: Lip and Oral Cavity
09/02/2010	Coding Pitfalls

### COLLABORATIVE STAGE VERSION 2—ADVANCED WEBINAR SERIES

**Date:** September 2009—March 2010  
**Website:** <http://www.ncra-usa.org>

### PRINCIPLES OF ONCOLOGY FOR CANCER REGISTRY PROFESSIONALS

**Date:** November 16-20, 2009  
**Location:** Reno, NV  
**Website:** <http://www.afritz.org>



**NATIONAL BREAST CANCER AWARENESS MONTH**  
**CELEBRATING 25 YEARS OF AWARENESS,**  
**EDUCATION, AND EMPOWERMENT**

# NATIONAL BREAST CANCER AWARENESS MONTH, 2009

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

## A PROCLAMATION

In 2009, more than 190,000 women are expected to be diagnosed with breast cancer, and more than 40,000 women are expected to die from this disease. It is the most common non-skin cancer and the second leading cause of cancer-related death among women in the United States. As we observe National Breast Cancer Awareness Month, we salute the brave Americans who are fighting this disease, including families and friends, advocates, researchers, and health care providers. We also pause to remember and pray for those we have lost to breast cancer.

Many Americans know someone who survived breast cancer due to early detection or improved treatment, and we must continue to discover ways to prevent, detect, and treat this disease. For us to better understand how breast cancer develops, to prevent recurrence, and to enhance the quality of life for survivors, we must support critical research programs. The National Institutes of Health, Department of Defense, and the Centers for Disease Control and Prevention will invest over \$1 billion in research this year. Strengthening our knowledge of breast cancer development can lead to improvements in prevention and treatment.

Screening and early detection are essential to our Nation's fight against breast cancer. The National Cancer Institute recommends that women age 40 and older have mammograms every 1 to 2 years. Women who are at greater risk should talk with their health care providers about whether to have mammograms before age 40 and how often to have them. My Administration is committed to requiring insurance companies to cover mammograms with no extra charges, and prohibiting the denial of coverage based on pre-existing conditions, including breast cancer.

Breast cancer health disparities also present a serious challenge. White women have the highest breast cancer incidence rates, and African American women have higher mortality rates than other racial or ethnic groups in the United States. There is also evidence lesbian women are at a greater risk of developing breast cancer than heterosexual women. Every day, we are improving programs that address the issues women encounter in obtaining appropriate and timely treatment. As a Nation, we will overcome the financial and physical restraints of underserved populations and ensure access to quality health care.

Our Nation has made significant progress in the fight against breast cancer, and we remain firm in our commitment to do more. This month, we reaffirm our commitment to reduce the burden of breast cancer and our support for those who are living with this devastating disease. By raising awareness of this disease and supporting research, we can usher in a new era in our struggle against breast cancer.

NOW, THEREFORE, I, BARACK OBAMA, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim October 2009, as National Breast Cancer Awareness Month. I encourage citizens, Government agencies, private businesses, nonprofit organizations, and other interested groups to join in activities that will help Americans understand what they can do to prevent and control breast cancer.

IN WITNESS WHEREOF, I have hereunto set my hand this thirtieth day of September, in the year of our Lord two thousand nine, and of the Independence of the United States of America the two hundred and thirty-fourth.

BARACK OBAMA

*Source: [http://www.whitehouse.gov/the\\_press\\_office/Presidential-Proclamation-National-Breast-Cancer-Awareness-Month/](http://www.whitehouse.gov/the_press_office/Presidential-Proclamation-National-Breast-Cancer-Awareness-Month/)*



**FCDS CASEFINDING LIST FOR REPORTABLE TUMORS**  
**REVISED SEPTEMBER 2009- EFFECTIVE WITH 2009 CASES**  
**(REVISIONS ARE IN BOLD)**

The following ICD-9-CM list is to be used to identify potentially reportable tumors. Some ICD-9-CM codes contain conditions that are not considered reportable. These records will need to be reviewed and assessed individually to verify whether or not they are reportable to FCDS. Casefinding must include both primary diagnoses and any subsequent or secondary diagnoses.

* 042	AIDS (review cases for AIDS-related malignancies)
* 140.0-208.9	Malignant neoplasms (excluding skin 173.0-173.9 with morphology codes 8000-8110)
* 209.0-209.2	Malignant carcinoid tumors of the small and large intestines, rectum, and of other and unspecified sites
* 209.30	Malignant poorly differentiated neuroendocrine tumors, any site
* 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
* 227.9	Benign neoplasm; endocrine gland, site unspecified
* 228.02	Hemangioma; of intracranial structures
* 230.0-234.9	Carcinoma in situ (excluding cervix – 233.1)
+ 235.0-238.9	Neoplasms of uncertain behavior
* 236.0	Endometrial stroma, low grade (8931/3)
* 237.5	Ependymoma (epithelial) (malignant) (9391/3)
* 237.6	Papillary Meningioma (9538/3)
* 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)
* 238.77	Post transplant lymphoproliferative disorder (9987/3)
* 238.79	Other lymphatic and hematopoietic 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)
* 288.3	Hypereosinophilic syndrome (9964/3)
* 289.83	Myelofibrosis NOS (9961/3)
* 511.81	Malignant pleural effusion (code first malignant neoplasm if known)
* 789.51	Malignant ascites (code the first malignant neoplasm if known)
* 795.06	Papanicolaou smear of cervix with cytologic evidence of malignancy
* 795.16	Papanicolaou smear of vagina with cytologic evidence of malignancy
* <b>796.76</b>	<b>Papanicolaou smear of anus with cytologic evidence of malignancy</b>
+ 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	Encounter for radiotherapy
* V58.1	Encounter for chemotherapy and 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

\* = Required for review

+ = Optional for review

## COMPLETENESS REPORT—2009 CASE REPORTING

Month	Complete	Expected
July 2009	4%	8%
August 2009	9%	17%
<b>September 2009</b>	<b>17%</b>	<b>25%</b>



**In 1939, President Franklin D. Roosevelt proclaimed the fourth Thursday of every November as the day to celebrate Thanksgiving Day. The tradition continues still and millions in the world look forward to celebrating this wonderful occasion every November. Happy Thanksgiving to you and your family!**

# Register

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

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The FCRA/FCDS Task Force is actively working on many issues that all registrars are facing. If you have any questions, issues or suggestions that you would like the task force to review, please email them to [taskforce@fcra.org](mailto:taskforce@fcra.org).

The task force meets the first Thursday of every month. We will respond back to your inquiries as quickly as possible.



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