SEPTEMBER 2010

Florida Cancer Data System

MONTHLY JOURNAL OF UPDATES AND INFORMATION

Monthly Memo

FCDS Address Requirements

What's New:

The following information is currently available on the FCDS website.

FCDS has received a number of calls regarding our new Address Edits which are now working correctly. We felt it was important to share the 2010 FCDS address field requirements with everybody – so you understand the requirements and the associated edits. Vendors were sent a blast email notifying them of this FCDS requirement.

Our primary focus continues to be on Florida residents, Florida Zip Codes, and Florida County Codes, and has always been used to identify ways to simplify data collection and to simplify how data is interpreted by researchers and other non-registry people. Most of the people who use our data have limited understanding or interest in learning about the inter-field relationships between our standard address fields (which states and counties and zip codes go together). They just want to use the data. We avoid this problem by limiting allowable codes for out of Florida counties and by not allowing the use of country codes in the county field.

While the FCDS field and code set requirements have changed, our requirements conceptually follow a long-standing policy.

- Different requirements are in place for the Address at DX and Address Current fields.
- FCDS Address at DX requirements are dependent upon Class of Case.
- Florida residents have specific requirements.
- Out of Florida residents may have different requirements and allowable values than Florida residents.

Below are the Tables we use in our programs to verify Address fields for reference:

Address Current - State	Class of Case	Address Status	County	Zip Code
FL	00-99	Full Known Address Required	Valid FL	Valid FL
Non-FL exclude XX,YY,ZZ,AA, AP,AE and Canada	00-99	Full Known Address Required	998	State Zip
XX,YY	00-99	Unknown Permitted	998	88888
ZZ (NOT ALLOWED)				
Canada,AA,AP,AE	00-99	Unknown Permitted	998	99999

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Address At Dx - State	Class of Case	Address Status	County	Zip Code
FL	00-30,34-43	Full Address Required	Valid FL	Valid FL
FL	31-33	Full Address allowed but Unknown is permitted	Valid FL,999	Valid FL, 99999
Non-FL exclude XX,YY,ZZ,AA, AP,AE and Canada	00-34,34,35,38,40,41,42	Full Known Address Required	998	State Zip
Non-FL exclude XX,YY,ZZ,AA, AP,AE and Canada	20-33,36-37,43	Full Address allowed but Unknown is permitted	998	State Zip, 99999
XX,YY	00-99	Unknown Permitted	998	88888
ZZ	00-99	Unknown Permitted	999	99999
Canada,AA,AP,AE	00-99	Unknown Permitted	998	99999

This is a summary of what the tables mean – in (hopefully) a somewhat easier to understand language.

- **COUNTY CODES - FCDS only allows Florida County Codes – if any residence is out of Florida – the county must = 998 or 999.**

- **The requirements for Address at DX differ depending on the Class of Case (see the table for details).**
  - **If the patient is diagnosed or diagnosed and treated in Florida – FCDS requires a complete Address at DX – regardless if Florida resident or not.**
    - No unknowns allowed. There are rules in place for unknown residence – refer to the FCDS DAM.
    - Florida residents have specific requirements
    - Non-Florida residents have different requirements
  - **But, if a patient is only treated or the case is historical or the case represents a recurrence – Address at DX information *can* include "unknowns".**
    - Unknowns are allowed
    - Florida residents have specific requirements
    - Non-Florida residents have different requirements
    - If the address is unknown – some specific codes must be used
  - **If the Address at DX information is known – regardless of class of case – then we expect it to pass the address edits that are in place.**

- **The requirements for Current Address DO NOT depend on Class of Case (see the table for details)**
  - **No unknowns are allowed.** There are rules in place for unknown residence – refer to the FCDS DAM.
  - Florida residents have specific requirements.
  - Non-Florida residents have specific requirements

Lung Webcast Q&A: 7/29/2010

The following Q&A are enhanced answers to questions asked during the July 29, 2010 FCDS Educational Webcast on Collaborative Stage (CSv2) Data Collection Requirements for Lung Cancers. The recorded webcast is available on the FCDS website along with presentation slides, practice cases, and answers to the cases with supporting rationale. Please visit us at http://fcds.med.miami.edu

1. **Question:** When should information from a cytology/pathology report and/or radiology report (diagnostic imaging) be used to confirm a positive or negative pleural (pericardial) effusion?

   Answer: CSv2 Notes for Lung: *"Pleural effusion and pericardial effusion are coded under CS Mets at DX. Most pleural (and pericardial) effusions with lung cancer are due to tumor. In a few patients, however, multiple cyto-pathologic examinations of pleural (pericardial) fluid are negative for tumor, and the fluid is non-bloody and is not an exudates. Where these elements and clinical judgment dictate that the effusion is not related to the tumor, the effusion should be excluded as a staging element and the tumor should be classified M0."*

   Pleural effusion or the accumulation of fluid between the two layers of pleura, visceral (covering the lungs) and parietal (lining the chest wall and covering the diaphragm), is a common symptom of lung cancer spread. Pericardial effusion is the accumulation of fluid within the pericardial cavity (around the heart). Pleural or pericardial effusion may be due to inflammation, infection (viral, bacterial, and fungal) or can result from the accumulation of fluid following surgery. Pleural and pericardial effusion(s) can also be attributed to treatment with certain chemotherapy agents including cyclophosphamide (cytoxan) and doxorubicin.

   However, when a patient has a new diagnosis of lung cancer and has pericardial and/or pleural effusion at the time of diagnosis; the effusion is presumed malignant until proven negative. A single negative examination of pleural or pericardial fluid is insufficient to rule out tumor involvement. Proving that the fluid is NOT involved when there is clinical, symptomatic, and/or radiologic evidence of effusion requires repeated examination of pleural (pericardial) fluid with consistently (ALL) negative results. Any confirmation of malignant cells in the pleural (pericardial) fluid confirms positive effusion.

   Clinical symptoms of both pleural and pericardial effusion are vague and include; shortness of breath, painful breathing, cough, dizziness, and chest pain. Symptoms usually lead a physician to order some type of diagnostic imaging. Therefore, pleural and/or pericardial effusions are usually identified on diagnostic imaging (x-ray, CT, PET, MRI, or ultrasound). Once identified on imaging, pleural or pericardial fluid may be removed (tap) to relieve symptoms related to the accumulation of fluid and/or to verify fluid involvement by tumor.

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Bloody pleural or pericardial fluid is a visual clue and clinical indicator that the fluid will likely be positive for malignant cells if examined under the microscope. However, not all pleural (pericardial) exudates are bloody. *Note: Exudates are essentially any type of oozed fluid composed of serum, fibrin, and white blood cells that escapes from blood vessels.*

Therefore, medical record documentation of positive pleural effusion most often includes clinical symptoms with the relevant information confirming the presence of effusion noted on diagnostic imaging reports (x-ray, CT, PET, or MRI scan), followed by positive cytologic or pathologic examination of fluid, or a physician's reference to involvement. Negative results require rigorous and repeated microscopic examination with all results negative for tumor.

2. **Question:** When should we use CS Mets at DX Code = 18 (malignant pleural effusion, NOS)? How can a person possibly code malignant pleural effusion if it is not verified?

   Answer: CSv2 includes codes which indicate the extent of pleural effusion (i.e. ipsilateral (involving the same side as the primary tumor), contralateral (involving the opposite side of the primary tumor), or bilateral involvement (both sides of the chest/lung/pleura) by pleural effusion. When you cannot determine the degree of pleural involvement (unilateral, contralateral, or bilateral); code to pleural effusion, NOS.

15	Malignant pleural effusion, ipsilateral or same lung
16	Malignant pleural effusion, contralateral or different lung
17	Malignant pleural effusion, ipsilateral and contralateral lung (bilateral pleural effusion)
18	Malignant pleural effusion, unknown if ipsilateral or contralateral lung
20	Malignant pericardial effusion

3. **Question:** So regardless of whether the pleural fluid is negative unless there are TWO or more NEGATIVE cytology reports, we still code it as positive pleural effusion?

   Answer: CORRECT

4. **Question:** When there is clinical and/or radiological evidence of pleural effusion and the physician stages the case as a T1 should we assume the pleural effusion is negative?

   Answer: Do not presume the pleural effusion is negative if the patient has clinical symptoms and/or radiological evidence of pleural effusion at the time of diagnosis, regardless of how the physician staged the case. If you are a CoC-accredited facility, you can record the physician staging in the designated field(s) in your abstract. But, record the Collaborative Stage elements based upon the information in the medical record. If you have no other information about CS Extension, you may record CS Extension = 125 (stated as T1, NOS). You should record the pleural effusion under CS Mets at DX based on the information in

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the medical record and using code 15, 16, 17, or 18, depending on the information available.

5. **Question:** Please explain the difference between rib invasion and rib metastasis (e.g. when do you code CS Extension (invasion to adjacent rib) and CS Mets at DX (bone metastasis).

   Answer: Many non-small cell lung cancers (adenocarcinoma and large cell carcinoma) originate in the peripheral lung (along or near the lung surface). Squamous cell carcinoma more often presents as a central lesion. Small cell carcinomas of the lung are often centrally located and cause airway obstruction via bronchial infiltration and early mediastinal nodal involvement. All can metastasize to bone including ribs.

   Peripheral lung cancers are anatomically located close to the ribs. Large tumors or even small tumors growing near ribs may invade directly into one or more ribs by direct extension. This type of tumor spread may be confirmed by x-ray or CT scan and described on imaging as rib invasion, rib destruction or rib erosion. This type of tumor spread is often referred to as loco-regional spread as it involves invasion of the rib directly from the primary tumor. There is direct involvement between the primary tumor and the rib or ribs in a large tumor.

   Rib metastasis on the other hand are a result of tumor spread to the bone (rib) via a completely different route, the circulatory system (blood). Rib metastases are not directly connected to the primary tumor . Rib metastases are often multiple in nature and other bones may be involved in addition to the ribs. A diagnosis of bone metastasis is usually made on bone scan, often includes numerous osseous deposits within a single rib and/or multiple rib involvement in addition to involvement of other bones such as vertebral column.

   Loco-regional extension of the primary tumor with rib erosion, destruction, or invasion is coded in the CS Extension field with CS Extension = 730. Rib metastases are coded in the CS Mets at Diagnosis field to indicate disseminated disease via blood borne metastasis.

6. **Question:** The CS Ext code 400, description mentions "without pleural effusion." When there is both atelectasis and pleural effusion can we use code 400? Also, if there is direct extension to the rib or chest wall – do you code this under CS Mets at Diagnosis? What if you do not know if the rib involvement is by direct extension or metastatic spread?

   Answer: CS Extension Code 400 includes; "Atelectasis/obstructive pneumonitis that extends to the hilar region but does not involve the entire lung (or atelectasis/obstructive pneumonitis, NOS) WITHOUT pleural effusion." CS Extension Code 500 includes; "Atelectasis/obstructive pneumonitis involving entire lung." CS Extension Code 730 includes; invasion of "adjacent rib" and was described in our response to Question 5 above. Pleural effusion is coded under CS Mets at Diagnosis NOT CS Extension.

   If you know the patient had atelectasis you would assign the code indicating atelectasis in the

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SEER*Rx - Interactive Antineoplastic Drugs Database Version 1.5.0 released September 27, 2010

The SEER*Rx Interactive Drug Database was updated on **September 27, 2010**. Version 1.5.0 includes 5 new regimens, 3 drugs recently approved by the FDA, and 26 new drugs. All of the newly added drugs are currently in clinical trials (Phase I, Phase II, or Phase III) and have not received final FDA approval as accepted treatment for cancer. Three drugs currently in the database have been updated to include brand names. Two drugs have changed categories: Thalidomide and Lenalidomide have both changed categories from chemotherapy to immunotherapy.

You can download the new SEER*Rx database at: ,http://seer.cancer.gov/tools/seerrx/

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CS Extension field, regardless of whether there was pleural effusion or not. Code the pleural effusion separately in CS Mets at Diagnosis. Use the information available in the medical record to record each component separately, unless there is a combination code that represents use of multiple codes within the same category (CS Ext or CS Mets at DX).

7. **Question:** Should we use the CS fields based on when a case was diagnosed or do we follow the CSv2 instructions for all cases reported from this point in time forward?

   Answer: Use the latest edition of Collaborative Stage (CSv2) for all cases. Do not go back and use the old CSv1 manual or instructions for any cases, period.

8. **Question:** There is a statement in the report that states there are "additional nodules too small to characterize". Do we ignore this statement?

   Answer: Do not ignore the statement, investigate it further. Generally speaking, lung nodules that are too small to characterize should not be confused with tumor nodules or metastatic disease. There must be additional radiographic or pathologic testing to confirm or rule out tumor involvement and/or a physician statement that the nodules are felt to be related to tumor spread or metastasis.

   Lung nodules are simply small masses of tissue in the lung and are quite common. They may be as small as a few millimeters and are not diagnostic until they grow to 2 or more centimeters in size. The larger the nodule, the more likely it may be malignant. Lung nodules can often be further characterized by their number, size, shape, and density. Lung nodules can be anything from an inflammatory response to infection, tuberculosis or bacteria, fibrosis, cysts, hemangioma, or even pulmonary embolism. A nodule or multiple nodules, therefore, should not be inferred as being related to the primary tumor or to tumor spread. Do not code "nodules too small to characterize" as tumor involvement unless further workup or physician statement indicate the nodule(s) are felt to be solitary or multiple metastasis or otherwise related to the lung cancer or metastasis.

Breast Webcast Q&A: 8/12/2010

The following Q&A are enhanced answers to questions asked during the August 12, 2010 FCDS Educational Webcast on Collaborative Stage (CSv2) Data Collection Requirements for Breast Cancers. The recorded webcast is available on the FCDS website along with presentation slides, practice cases, and answers to the cases with supporting rationale at http://fcds.med.miami.edu.

1. **Question:** Where can we find reference lab values for tumor markers and other lab tests?

   Answer: This information can be found in the Collaborative Stage Data Collection System Coding Manual and Instructions Part I Section 2: Lab tests, Tumor Markers, and Site-Specific Factor Notes.

   CS Manual: RECORDING LAB TESTS AND TUMOR MARKERS IN SITE-SPECIFIC FACTORS – IMPORTANT NOTES

   The following information is intended as a guide to help the registrar locate the test in the medical record and to identify which lab test results should be coded in the CS site-specific factors.

   1. The results of many tumor markers and laboratory tests vary according to the laboratory conducting the test. The normal reference range and notes are included in the tumor marker comments as background information only.
      a. Whenever possible, code the clinician's/pathologist's interpretation of the lab test.
      b. In the absence of a doctor's interpretation of the test, if the reference range for the lab is listed on the test report, the registrar can use that information to assign the appropriate code.
      c. Only when there is no clinician/pathologist interpretation of the lab test and no description of the reference range in the medical record should the registrar use the background information listed in the tumor marker notes to code the SSF.

   To Download the CS Manuals go to http://www.cancerstaging.org/cstage/manuals/index.html:

   - CS Manual Part I Section 1: General Instructions
   - CS Manual Part I Section 2: Lab Tests, Tumor Markers, and Site-Specific Factor Notes
   - Part II of the CS "Manual" is the Site Specific Schemas
     - Site Specific Schema are in XML table format
     - http://www.cancerstaging.org/cstage/schema.html

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- PDF versions of groups of schemas are available
  - Individual Site-Specific Schema are not available in PDF
  - Not interactive or web-based
  - Grouped schemas are large PDF files
  - Not recommended for routine reference
  - Registrars may not know when the interactive XML tables are updated. Therefore, registrars may not be aware when the PDF files get updated.

2. **Question:** Oncotype DX test results include an 'intermediate risk' category. How do we code 'intermediate risk'?

   Answer: Multigene testing is usually ordered for node-negative patients and used to predict risk of recurrence within or to predict the likelihood that the patient will respond to specific types of chemotherapy. These are usually proprietary testing methods and may be called; genomic profiling, Oncotype Dx, MammaPrint, multigene testing, multigene assay, microarray assay, or molecular diagnostics for treatment planning. Data are collected in two site-specific factors; SSF22 - Multigene Signature Method and SSF23 - Result/Score of Multigene Signature. The methods field is where you record the type of test performed. The result/score is where you record the result. The preferred result/score is the actual value or "score" with results ranging from 1-100 or 100+. Do not record the category of "risk" if you have the actual score. If you do not have a score and the risk is reported as "intermediate" use code 200 to indicate "low risk of recurrence" in keeping with the general rule of "down-staging". A recommendation to add a specific code for "intermediate" risk has been forwarded to the CSv2 Breast Team.

3. **Question:** For SSF18 - Disseminated Tumor Cells (DTC) and Method of Detection, is code "130 - Other Test Type" used to record that a test for DTC was done but the type of test is not listed under code "110 - RT-PCR" or code "120 - IHC"?

   Answer: YES. This site-specific factor is designed to capture not one but two pieces of information about the presence or absence of disseminated tumor cells (DTC) in the bone marrow: whether they are present and what test was used to detect them. In this three-digit field, the first digit codes whether the test was negative (0), positive (1), or borderline (2). The second digit codes the type of test.

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The most common methods to detect DTC in the bone marrow are by reverse transcriptase-polymerase chain reaction (RT-PCR) or immunihistocytochemical test (IHC). RT-PCR is a gene-amplification test used for a number of other purposes including FISH and CISH tests for HER2 and sometimes for detection of isolated tumor cells in sentinel nodes. IHC is IHC is also widely used in to understand the distribution and localization of biomarkers and certain expressed proteins in tissue. Other testing methods are being investigated to isolate DTCs, but are not in widespread use. Therefore, this SSF currently includes codes for only two specific testing methods (RT-PCR and IHC), a code for "other test method" to record non-standard testing, and an "unknown type of test" code. Use the code that best represents the type of testing method used, and the result of the test (positive, negative, borderline, unk).

4. **Question:** For SSF18 - Disseminated Tumor Cells (DTC) and Method of Detection, is code "140 - Unknown Test Type" used to record that a test for DTC was done but the type of test is not is unknown or not specified?

   Answer: YES. This site-specific factor is designed to capture not one but two pieces of information about the presence or absence of disseminated tumor cells (DTC) in the bone marrow: whether they are present and what test was used to detect them. In this three-digit field, the first digit codes whether the test was negative (0), positive (1), or borderline (2). The second digit codes the type of test.

   The most common methods to detect DTC in the bone marrow are by reverse transcriptase-polymerase chain reaction (RT-PCR) or immunohistochemistry test (IHC). RT-PCR is a gene-amplification test used for a number of other purposes including FISH and CISH tests for HER2 and sometimes for detection of isolated tumor cells in sentinel nodes. IHC is also widely used in to report certain biomarkers and certain expressed proteins in tissue. Other testing methods are being investigated to isolate DTCs in both the circulating blood and bone marrow, but no other testing methods are in widespread use. This SSF includes codes for only the two specific testing methods (RT-PCR and IHC) that are in widespread use. There are also codes for "other test method" to record non-standard testing (not IHC and not RT-PCR), and an "unknown type of test" code (test done, method unknown). Use the code that best represents the type of testing method used and the result of the test (positive, negative, borderline, unk).

5. **Question:** In Practice Case Number 2 shouldn't the two (multiple) tumors in the same breast and reported as a single primary be coded to topography code C50.9 (Breast, NOS) rather than C50.8 (Overlapping lesion of breast)?

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Answer: YES. There is an error in the answer key. The topography code C50.8 or any topography C**.8 should only be used for a SINGLE tumor that overlaps two adjacent anatomic sub-sites. This is an often misused sub-site code and should always be used cautiously.

- Use Code C50.9 when there are multiple tumors the same breast
- Use Code C50.9 when there are multiple tumors in different sub-sites of the same breast
- Use Code C50.8 when a single tumor overlaps adjacent sub-sites of the same breast
- Use code C50.8 when a single tumor is located in the 3, 6, 9, or 12 o'clock position and no more specific information is given about the point of origin. Example: Upper breast, NOS; Outer breast NOS; Inner breast, NOS; Lateral breast, NOS; Lower breast, NOS; Inferior breast, NOS; Medial breast, NOS; Midline breast NOS; and Superior breast, NOS.

AJCC Seventh Edition Cancer Staging Manual and Handbook 7th Edition Errata

Since the publication of the seventh edition of the AJCC Cancer Staging Manual, important updates and clarifications have been noted, as well as some unintended technical inaccuracies and typographical errors. Corrected pages for both the manual and the handbook are available on the AJCC website http://cancerstaging.org/products/errata.html.

The changes fall into the following categories:

- Typographical errors
- Histology and topography code changes
- Revisions to clarify concepts

Most of the identified problems are minor typos, such as printing "the the" when we meant "the." But some are more serious errors that could cause misunderstanding or an error in staging or data collection. Content changes that affect staging are few and include the following:

- Colon and Rectum: The circumferential resection margin image was mislabeled and should be T3;R2 on the right side.
- Prostate: For stage IIA, add T2a N0 M0 PSA≥10<20 Gleasons≤6 and change the T2a line to read T2a N0 M0 PSA<20 Gleason7.
- Testis: The serum tumor markers used in staging should all be measured post-orchiectomy.

A list of the corrections is also available in a table format for easy reference or for use in making the corrections in your copy of the publication

FCDS/NAACCR 2010-2011 Webinars Schedule

The Florida Cancer Data System is happy to announce that for another year we will be presenting the NAACCR 2010-2011 Webinar Series at six locations throughout Florida:

- Boca Raton Community Hospital (Boca Raton, FL)
- Moffitt Cancer Center (Tampa, FL)
- M.D. Anderson Cancer Center Orlando (Orlando, FL)
- Shands University of Florida (Gainesville, FL)
- Gulf Coast Medical Center (Panama City, FL)
- Baptist Regional Cancer Center (Jacksonville, FL)

Special thanks to the hosting facilities for their participation and support.

2010-2011 NAACCR Webinar Series Schedule and Course Description

Collecting Cancer Data: Hematopoietic Disease
11/4/10

This 3-hour class will present the following information for hematopoietic: anatomical information needed to abstract and code the cases; how to determine the number of primary tumors; how to code topography and histology; how to code the CSv2 data items; and the treatments and how to code them.

Collecting Cancer Data: Liver and Biliary Tract
12/2/10

This 3-hour class will present the following information for liver and biliary tract: anatomical information needed to abstract and code the cases; how to determine the number of primary tumors; how to code topography and histology; how to code the CSv2 data items; and the treatments and how to code them.

Collecting Tumor Data: Brain and Central Nervous System
1/6/11

This 3-hour class will present the following information for liver brain and central nervous system: anatomical information needed to abstract and code the cases; how to determine the number of primary tumors; how to code topography and histology; how to code the CSv2 data items; and the treatments and how to code them.

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Collecting Cancer Data: Testis
2/3/11

This 3-hour class will present the following information for testis: anatomical information needed to abstract and code the cases; how to determine the number of primary tumors; how to code topography and histology; how to code the CSv2 data items; and the treatments and how to code them.

Collecting Cancer Data: Bladder
3/3/11

This 3-hour class will present the following information for bladder: anatomical information needed to abstract and code the cases; how to determine the number of primary tumors; how to code topography and histology; how to code the CSv2 data items; and the treatments and how to code them.

Collecting Cancer Data: Breast
4/7/11

This 3-hour class will present the following information for breast: anatomical information needed to abstract and code the cases; how to determine the number of primary tumors; how to code topography and histology; how to code the CSv2 data items; and the treatments and how to code them.

Collecting Cancer Data: Prostate
5/5/11

This 3-hour class will present the following information for prostate: anatomical information needed to abstract and code the cases; how to determine the number of primary tumors; how to code topography and histology; how to code the CSv2 data items; and the treatments and how to code them.

Best Practices for Developing and Working with Survival Data
6/2/11

This 3-hour class will address the work of the NAACCR Survival Analysis Work Group with population-based survival data.

Complete Case Identification and Ascertainment
7/7/11

This 3-hour class will present current reportability requirements; developing case identification and assessment procedures; assessing completeness of case ascertainment; concurrent abstracting – pro's & con's.

NAACCR Interoperability Activities and the Electronic Health Record
8/4/11

This 3-hour class will present national initiatives and cancer specific activities in reference to the electronic health record and activities of the NAACCR Pathology Data Work Group

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2010 D.A.M. Prostate Cancer Grading

General Reference: The primary pattern is the pattern occupying greater than 50% of the cancer, and is usually indicated by the first number of the Gleason's grade or "3" in our example of Gleason 3+4/10. The secondary pattern is usually indicted by the second number or "4" in our example. These two numbers are added together to create a pattern score, ranging from 2 to 10. So, our score is 7 in the example - 7 out of a possible 10. Interestingly, and just to help drive home our message of primary and secondary pattern. A Gleason 3+4 with a primary pattern of 3 has a better prognosis than a Gleason 4+3 where pattern 4 is the primary pattern.

1. **When coding Gleason Grade data (Gleason Pattern and Gleason Score) in SSF 7-11:** Follow the instruction in the CSv2 Manual. If only one number is given, and it is less than or equal to 5, assume that the number describes the primary pattern. Record the number as the Gleason Primary Pattern and code the Gleason Secondary Pattern as '9'. Gleason Score will be unknown in this case, because you only have a primary pattern. If only one number is given, and it is greater than 5, assume that it the Gleason Score for example 7/10. In this case you will not have a primary or secondary pattern, only the Gleason Score.

2. **When coding Tumor Grade in the traditional Grade field (not a CS field):** Follow the instruction in the 2010 FCDS DAM for coding Grade. Per 2010 FCDS DAM – Grade: If there is only one number and it is less than or equal to 5, assume a pattern. Double it to determine the score. If there is only one number and it is greater than 5, assume a score. If there are two numbers, assume two patterns (the first number being the primary and the second number being the secondary) and add them to obtain the score.

If Gleason's score (2-10) is given, code as follows:

Gleason's score	Grading
2,3,4	I Well Differentiated
5,6	II Moderately Differentiated
7,8,9,10	III Poorly Differentiated

If Gleason's pattern (1-5) is given, code as follows:

Gleason's pattern	Grading
1,2	I Well Differentiated
3	II Moderately Differentiated
4,5	III Poorly Differentiated

2008 Death Clearance is now Past due (September 30th, 2010)

The FCDS 2007 Death Clearance Follow Back records are available for online review. FCDS sent email notifications of follow back records to review instead of mailing paper. If you do not have the FCDS IDEA Death Clearance menu, you may request it or delegate it to another person (if you are a facility administrator/cancer registry manager). See the FCDS IDEA User Account Request Form: http://fcds.med.miami.edu/downloads/FCDSLoginRequestForm.pdf.

The deadline to complete the online review and submission of any missed cases were due September 30, 2010.

2008 AHCA Followback is now Past Due (June 30th)

The FCDS 2008 AHCA Follow Back is now past due. If you facility has not completed this activity we encourage you to get this done immediately.

The Florida Department of Health (DOH) in an effort to decrease the number of reporting facilities that do not meet the required data submission deadlines, is monitoring the AHCA and Death Clearance process. Facilities failing to meet the reporting requirements will be reported to DOH for non-compliance. Should you have any questions, please contact your Field Coordinator at (305) 243-4600.

New Eligibility Routes for CTR Exam Candidates

CTR EXAMINATION: The National Cancer Registrars Association's (NCRA) Council on Certification promotes standardization in the collection and use of cancer data through examination and certification of Cancer Registrars and other cancer data specialists. The CTR®, Certified Tumor Registrar, credential marks achievement, fosters professional pride, and is nationally recognized in recruitment and retention of registry personnel. Exam Application Forms, Registration Deadlines, Examination Handbooks, and other information is available on the NCRA Council on Certification Website http://www.ctrexam.org.

2011 CTR EXAMINATION DATES

- March 5-19, 2011 (Application due by January 31, 2011)
- September 10-24, 2011 (Application due by July 31, 2011)

ELIGIBILITY: Candidates for the CTR examination must meet eligibility requirements that include a combination of experience in a CTR-staffed cancer registry and education in an NCR-accredited program or allied health degree. Candidates must meet all requirements in one or more of the following eligibility routes:

Route A:

Experience: Successful completion of 160 hours of work practicum in a CTR-staffed cancer registry.

Education: NCRA-Accredited Associate Degree Program or successful completion of an NCRA-Accredited Formal Education Program and successful completion of a minimum of an Associate degree or equivalent.

Route B:

Experience: Minimum one year full-time (12 months or 1,950 hours) or equivalent experience in the Cancer Registry field.

Education: Successful completion of an Associate degree or equivalent in an approved college level curriculum in a recognized allied health field as determined by NCRA's Council on Certification.

Route C:

Experience: Minimum one year full-time (12 months or 1,950 hours) or equivalent experience in the Cancer Registry field.

Education: Successful completion of a minimum of an Associate degree or equivalent and license or certification in a recognized allied health field as determined by NXCXRA's Council on Certification.

Route D:

Experience: Minimum one year full-ti9me (12 months or 1,950 hours) or equivalent experience in the Cancer Registry field.

Education: Successful completion of a Master's level or higher college level curriculum in a recognized allied health field.

(Continued from page 12), 2010-2011 NAACCR Webinar Series Schedule and Course Description

Coding Pitfalls
9/1/11

This 3-hour class will address coding dilemmas identified through quality control of registry data and present solutions with rationale for determining the number of primary tumors using the MP/H rules revised for 2011, assigning ICD-O-3 topography and histology codes using the ICD-O-3 Manual, completing the appropriate data items using CSv2, and completing treatment data items as required by all standard setters.

Please go to the FCDS website to register online for your location of choice. Registration link is: https://fcds.med.miami.edu/scripts/naaccr_webinar.pl. A separate registration will be required for each webinar. The number of participants allowed to be registered for each webinar will be dependent on space availability. For more information, please contact Melissa Williams at 305-243-2641 or melissa_williams@miami.edu.

PROJECT DIRECTOR:
Jill A. Mackinnon, PhD, CTR

ADMINISTRATIVE DIRECTOR:
Gary M. Levin, BA, CTR

EDITORIAL STAFF:
Melissa K. Williams

CONTRIBUTORS:
Steven Peace, BS, CTR.

Florida Cancer Data System
Cancer Reporting Completeness Report

TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF SEPTEMBER 17, 2010

Total number of *New Cases* added to the FCDS Master file in August 2010: 725

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

Admission Year	Hospital	Radiation	Ambi/Surg	Physician	Derm Path	DCO	Total	New
2010	412	0	9	0	0	**Pending**	421	421
2009	163,521	3,449	65	3,148	19	**Pending**	170,202	252
2008	171,691	8,636	2,568	4,746	42	**Pending**	187,683	52

		Actual	Expected
% Complete for:	2010	0%	17%
	2009	100%	100%
	2008	100%	100%

Expected % based on 165,000 reported cases/year