OCTOBER/
NOVEMBER
2010

MONTHLY
JOURNAL OF
UPDATES AND
INFORMATION

Florida
Cancer Data
System's

Monthly Memo

FCDS 2010 Educational Webcast Series

What's New:

The following information is currently available on the FCDS website.

FCDS is pleased to announce the re-scheduled dates for our final two webcasts in the 2010 FCDS Educational Webcast Series. The two final webcasts will be held on November 11, 2010 and December 16, 2010.

PURPOSE:

The 2010 series has provided groundwork training for Florida registrars and cancer case abstractors providing essential instruction and background on 2010 data collection requirements for FCDS with specific coding instruction in the use of the new Collaborative Stage Data Collection System (CSv2) for Lung, Breast, Colon, Rectum, Prostate, and Bladder Cancers as well as new information on the 2010 Hematopoetic and Lymphoid Neoplasm Rules, Manual, and Database.

The final two webcasts will continue this effort with a focus on Collaborative Stage for Melanoma and Other Skin Cancers as well as Clarification of the 2010 Case Reporting Rules, Casefinding Instruction and Using the NEW Class of Case Codes.

WEBCAST SCHEDULE:

The webcasts will be held on a Thursday from 10am-12pm on dates noted below.

HOW TO JOIN THE WEBCAST:

The same dial-in number, access code, and web link will be used for the 2 webcasts.

Meeting Name:

FCDS 2010 Educational Webcast Series

Date (s):

***11/11/2010 -**

FCDS Reportable: 2010 Casefinding NEW Class of Case Codes

12/16/2010 -

Collaborative Stage: Malignant Melanoma and Other Skin Cancers

Time:

(Continued on page 2)

(Continued from page 1), 2010 FCDS Educational Webcast Series

10am-12pm EDT

Dial-in Number:

877-807-5706

Participant Code:

261452

Link to web session:

https://webmeeting.med.miami.edu/fcds2010educationseriesA/

ALL WEBCASTS WILL BE RECORDED:

Each webcast will be recorded electronically and posted to the FCDS website.

NCRA Log #	2010-105	Name of Event	Approved
2010-105A	7/29/2010	Collaborative Stage Lung	2
2010-105B	8/12/2010	Collaborative Stage Breast	2
2010-105C	8/26/2010	Collaborative Stage Prostate	2
2010-105D	9/9/2010	Collaborative Stage Colon	2
2010-105E	9/23/2010	Heme/Lymph Part I	2
2010-105F	9/30/2010	Heme/Lymph Part II	2
2010-140A	11/11/2010	2010 Casefinding **NEW** Class of Case Codes	2
2010-140B	12/16/2010	Collaborative Stage: Malignant Melanoma and Other Skin Cancers	2

Genitourinary (Prostate and Bladder Cancers) Webcast Q&A : 08/26/2010

The following Q&A are enhanced answers to questions asked during the August 26, 2010 FCDS Educational Webcast on Collaborative Stage (CSv2) Data Collection Requirements for Prostate and Bladder 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 a physician does not specifically state that s/he performed a digital rectal examination (DRE) on a patient being evaluated for prostate cancer, but there is phrasing in the H&P that indicates a DRE was performed (i.e. description of size, shape, firmness, or nodularity in the prostate gland), can we assume that a DRE was performed as part of the patient's physical examination?

   Answer: Yes. The urologist uses digital rectal examination or DRE to palpate or feel the prostate gland (edges, lobes, peri-prostatic region, etc.) to evaluate the overall health of the patient's prostate as well as to check for abnormalities such as lumps, hard nodules or firmness. Any description that includes reference to size, shape, firmness, abnormality or lack of abnormality in the palpated prostate gland is a report of findings from a digital rectal examination or DRE. Neither the PSA test nor ultrasound can replace palpation of the gland by a trained urologist. None of these tests provides sufficient proof without additional testing to rule out presence or absence of malignancy in the prostate gland. This is why a biopsy is performed following positive DRA, PSA, or ultrasound.

2. **Question:** In the April 29, 2010 version of CSv2 schema for prostate, microscopic involvement of bladder neck is included under code 482. Should this be coded 440 instead?

   Answer: Microscopic bladder neck involvement is coded 440.

3. **Question:** On page 78 of 2009 D.A.M. it states for prostate grade that if there is only one number and it is less than or less than 5, then we are to assume a pattern and double it to determine the Gleason score. Is this correct? Can you please clarify?

   Answer: The instructions for coding the standard data item "Grade" (NAACCR Item #440) are slightly different that the instructions for coding Gleason Score in the CSv2 Prostate Schema for Site Specific Factors SSF7-SSF11. We have not updated the instructions for coding "Grade" to be consistent with the instructions for coding Gleason Score per the CSv2 instructions. Instructions for coding the two new data items Grade Coding System and Grade Coding Value have separate instructions that should be followed. It may be determined at some future date that the traditional "Grade" field is no longer relevant given all of

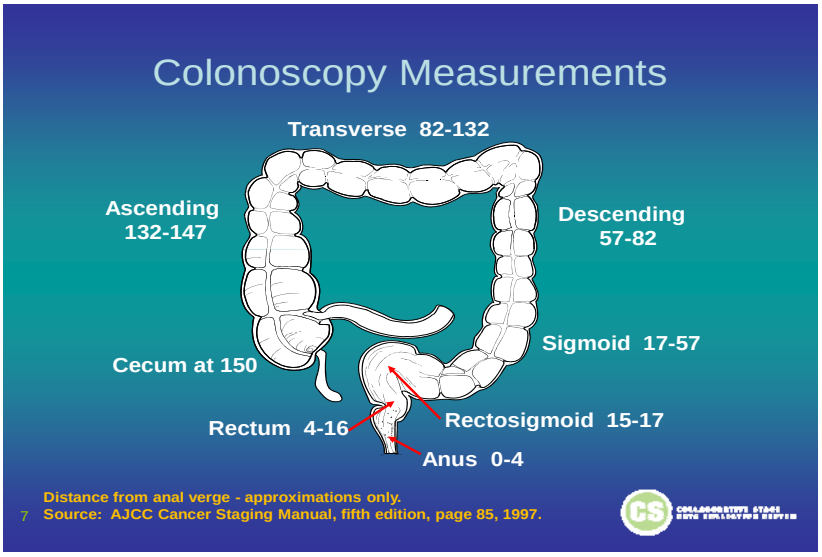
(Continued on page 6)

Colon, Rectum, Appendix Webcast Q&A : 09/09/2010

The following Q&A are enhanced answers to questions asked during the September 9, 2010 FCDS Educational Webcast on Collaborative Stage (CSv2) Data Collection Requirements for Colon, Rectum, and Appendix 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:** Where can we get copies of the pictures you used, i.e. colonoscopy measurement?

   Answer: The diagram showing approximate distance measured in centimeters from the anal verge corresponding to colon and rectum anatomy was used with permission from AJCC. The source is the AJCC Cancer Staging manual, 5th edition, page 85, 1997. SEER also has included this diagram in the SEER Training Modules for Colorectal Cancer. Please remember that the measurements are not exact. The measurements are approximations only.



2. **Question:** If there are Regional Lymph Nodes examined and positive, and an unspecified number of peri-tumoral deposits; are Regional Lymph Nodes Examined = 97 or 98? And Regional Lymph Nodes Positive = 97? In other words, are we counting the tumoral deposits as lymph nodes if unspecified?

   Answer Part A: CSv2 Notes for Colon CS Lymph Nodes Field: Note 2: One or more malignant satellite peritumoral nodules in the pericolorectal adipose tissue of a primary carcinoma without histologic evidence of residual lymph node in the nodule may represent discontinous spread, venous invasion with extravascular spread or a totally replaced lymph node. The total number of tumor deposits must also be coded in SSF4. If there are tumor deposits and node involvement, code the information on node involvement. That is, do not use code 050.

(Continued on page 5)

(Continued from page 4), Colon, Rectum, Appendix Webcast Q&A : 9/09/2010

Answer Part B: CSv2 Notes for Colon CS SSF4 Tumor Deposits: Note 2: Record the number of of tumor deposits whether or not there are positive lymph nodes.

Answer Part C: Therefore, Regional Lymph Nodes Positive and Regional Lymph Nodes Examined are coded independently from Tumor Deposits. Do not presume the tumor deposits are lymph nodes or vice versa.

3. **Question:** In regards to carcinoid tumor of appendix, these cases are reportable when metastatic lesions or positive lymph nodes are identified. Is the histology code 8240/3?

   Answer: Yes, malignant carcinoid tumor of the appendix showing evidence of metastatic disease including liver metastasis and/or positive lymph nodes are reportable as malignant carcinoid tumor with histology code = 8240/3.

4. **Question:** Would you please explain CRM again?

   Answer: CSv2 Notes for CRM: Please refer to the Collaborative Stage Data Collection System Coding Manual and Instructions, Part I Section 2: Site-Specific Notes for more information on the Circumferential Resection Margin or CRM which is coded for Colon and Rectum primary cancers. Information on CRM is found in the pathology report.

   The CRM is also referred to as the radial margin or the mesenteric resection margin is the measurement of the distance from the deepest invasion of the tumor to the closest soft tissue margin of the specimen (see Figure I-2-5). In other words, the CRM is the width of the surgical margin at the deepest part of the tumor in an area of the large intestine or rectum without serosa (non-peritonealized rectum below the peritoneal reflection) or only partly covered by serosa (upper rectum, posterior aspects of ascending and descending colon). The CRM is not the same as the distance to the proximal and distal margins of the colon specimen. For rectal cancers, the circumferential resection margin is the most important predictor of local recurrence.

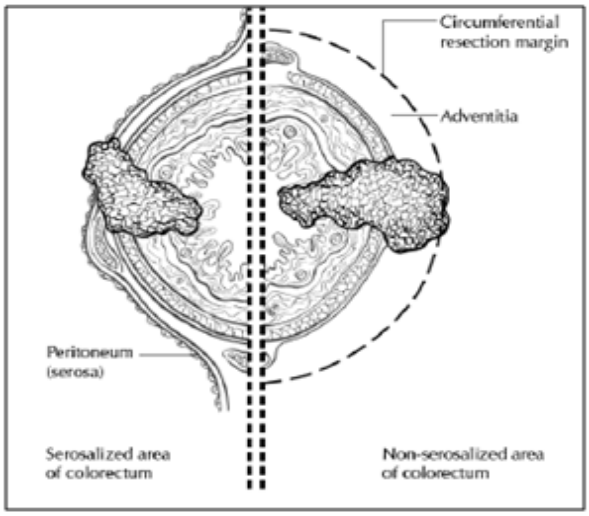


Figure I-2-5. Circumferential Resection Margin. Used with permission of the American Joint Committee on Cancer (AJCC), Chicago, Ill. The original source for this material is the AJCC Cancer Staging Atlas (2006) edited by Greene et al and published by Springer Science and Business Media, LLC, www.springerlink.com.

(Continued on page 6)

(Continued from page 3) Genitourinary (Prostate and Bladder Cancers) Webcast Q&A : 08/26/2010

the specialized grading systems in use and collected with CSv2. Until that time, hospital and central registries will continue to follow standard instructions for these data items.

When coding "Grade" please follow the most current FCDS DAM instructions (October 2010 not 2009). An excerpt from the section entitled, "Coding Grade for Prostate Cancers" informs the abstractor; "Usually prostate cancers are graded using Gleason's score or pattern. Prostate cancer generally shows two main histologic patterns. The primary pattern, the pattern occupying greater than 50% of the cancer, is usually indicated by the first number of the Gleason's grade, and the secondary pattern is usually indicated by the second number. These two numbers are added together to create a score, ranging from 2 to 10."

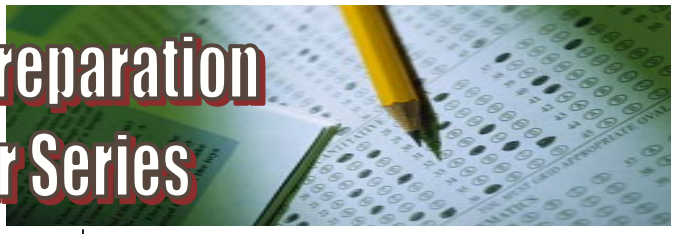
The DAM then goes on to instruct the abstractor; "If there is only one number and it is less than or equal to 5, assume a pattern. Double it to determine the score. If there is only one number and it is greater than 5, assume a score. If there are two numbers, assume two patterns (the first number being the primary and the second number being the secondary) and add them to obtain the score. If expressed as a specific number out of a total of 10, the first number given is the score, e.g., Gleason's 3/10 would be a score of 3."

(Continued from page 5), Colon, Rectum, Appendix Webcast Q&A : 9/09/2010

5. **Question:** On page 155 of the 7th edition AJCC Manual regarding M1a and M1b; the AJCC Manual specifies "non-regional node" for M1a, only. The CSV2 states M1A = single lymph node CHAIN and M1b for more than one distant lymph node CHAIN. Should there be an update to AJCC to be in line with CSV2?

Answer: The latest version of CSv2 site schema and algorithm should be aligned with the 7th edition AJCC Cancer Staging Manual. The AJCC Site Teams and the CSv2 Mapping Teams have worked closely to align both sets of criteria. The annotation regarding metastatic involvement of a single non-regional lymph node chain versus metastatic involvement of more than one non-regional lymph node chain is consistent with the notion that non-regional lymph node involvement constitutes distant involvement. It is also consistent with the notion that M1a designates a single area of metastasis (in this case a non-regional lymph node chain) versus M1b for multiple areas of metastasis (multiple non-regional lymph node chains). CSv2 follows AJCC TNM rather than the other way around. We have forwarded this inconsistency along to the CSv2 Mapping Team who will in turn share it with AJCC.

NAACCR CTR Exam Preparation and Review Webinar Series



The NAACCR CTR Exam Preparation and Review Webinar Series (March 2011 exam) offers online interactive instruction with live instructors. The Webinar Series includes eight 2-hour sessions carefully prepared to reflect the changes to the 2011 CTR exam as well as a short follow-up post exam session. It includes "live" lectures presented by experienced instructors, Q&A sessions, study materials, take home tests and a timed practice test.

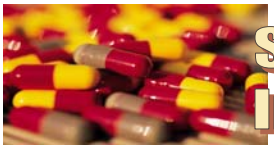
The subscription is $400. This includes "live" lectures presented by experienced instructors, Q&A sessions, study materials, take home tests and a timed practice test. If a participant is unable to attend one of the live sessions, they may download the session and view it at their convenience (limit of 2 recordings per participant). Follow the links listed below for a full syllabus, study resources and technical requirements. More than one person may view the sessions (please limit 3-4 individuals per subscription), but they must all view the session from the same computer.

Syllabus: http://www.naaccr.org/LinkClick.aspx?fileticket=HcSrc7KXh8A%3d

Study Resources: http://www.naaccr.org/LinkClick.aspx?fileticket=1X7twcvFJA8%3d

Technical Requirements: http://www.naaccr.org/LinkClick.aspx?fileticket=jacSwmb8O5g%3d

Please contact Jim Hofferkamp, jhofferkamp@naaccr.org or Shannon Vann, svann@naaccr.org, for more information or if you have any questions.



SEER*Rx, The Cancer Registrar's Interactive Antineoplastic Drug

SEER*Rx, The Cancer Registrar's Interactive Antineoplastic Drug Database, was last updated on September 27, 2010. The latest version can be downloaded at http://seer.cancer.gov/tools/seerrx/index.html. Be sure to sign up for e-mail update notifications to stay up-to-date with this useful abstracting tool. While many registrars rely on their memory or personal interpretation of which category a particular drug is coded, categories and classification of drugs do change. Please use the latest version and reference the database to verify antineoplastic agent categories and whether or not treatment should be coded for certain ancillary drugs.

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.

Finally, aspirin as treatment for certain hematopoietic malignancies was downgraded in an earlier release of SEER*Rx and should only be coded for one condition, essential thrombocythemia (ET). You will get an error in the new FCDS Edits if you try to code aspirin under Other Therapy for conditions other than ET. Note: In order to code aspirin as treatment for ET a specified dose must be documented. The therapeutic dose for essential thrombocythemia is in the range of 70-100 mg/day.

Heme/Lymph Part I Webcast Q&A : 09/23/2010

The following Q&A are enhanced answers to questions asked during the September 23, 2010 FCDS Educational Webcast of Part I – Hematopoietic and Lymphoid Neoplasm. 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: Diagnostic Confirmation: Please clarify when we are to use code 1 versus code 3?

   Answer: A new Diagnostic Confirmation Code and brand new coding instructions were introduced for use with hematopoietic and lymphoid neoplasms abstracted and coded using the **2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and Hematopoietic Database**. There are now two sets of instructions for prioritizing and assigning Diagnostic Confirmation; one for solid tumors and one for hematopoietic and lymphoid neoplasms). All state and national standards organizations have agreed on the introduction and use of the new set of codes and coding instructions. Please refer to the 2010 FCDS Data Acquisition Manual (FCDS DAM) for specific instructions.

   Below are several excerpts from the 2010 Heme/Lymph Coding Manual and the FCDS DAM that should help clarify coding priority and use of new codes for Diagnostic Confirmation for hematopoietic and lymphoid neoplasms.

   - **Code 1** (Positive Histology) should still be used to code positive bone marrow aspiration, bone marrow biopsy, CBC, and peripheral blood smear;
   - **Do not give preference to assigning Code 1** (Histologic Confirmation) over Code 3 or Code 5 for the hematopoietic and lymphoid neoplasms. For these neoplasms, the genetic testing and immunophenotyping are needed to identify the specific histology. Consequently, Codes 3 and 5 have higher priority for any histology 9590/3-9992/3.
   - **Code 3** (Positive Histology PLUS Positive Immunophenotyping and/or Positive Genetic Studies) is used when there is a positive histology for malignancy **and** positive immunophenotyping **and/or** positive genetic test that confirms the diagnosis. Do not use code 3 for neoplasms diagnosed prior to January 1, 2010.
   - **Code 3 NOTE:** Most lymphoid and myeloid neoplasms have some type of immunophenotype and/or genetic test performed to rule out or rule in specific types and subtypes of lymphoma, leukemia, myeloma, etc. You MUST verify that the specific test (immunophenotype or genetic test) is confirmatory for the specific type of neoplasm and not just that a test was done. In other words, if the type of lymphoma you are abstracting requires that CD4, CD8, CD24 are positive but your record shows that the study was done but they are negative – you should not use this code just to document testing was done. The test must confirm the dx.

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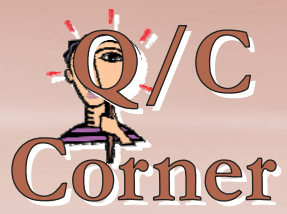
- **Code 3 Clarification:** Do we need the positive results of BOTH Genetics Data and Immunophenotype to use code 3 in this example? NO – one and/or the other…both are not necessary.
- **Code 5** (Positive laboratory test/marker study) is used **ONLY when** the Hematopoietic DB lists genetic testing, immunophenotyping, or any other variation of laboratory testing is the definitive diagnostic method **and** any one or more of the specific tests was performed and positively confirm the histologic type.
- **Code 5 NOTE:** Molecular Tumor Markers come in many forms from serum protein markers to Tissue Microarrays to Polymerase Chain Reaction. Based on the acronym or label for the test, it is difficult to discern between many of the tests that may be conducted as immunophenotyping, tumor marker, or genetic testing. You cannot rely simply on recognition of the test abbreviation, acronym, or label. Always check the Hematopoitic Database for more information about each of these types of tests. Be sure to verify the type of test with each specific hematopoietic and/or lymphoid neoplasm or condition before using this code. Code 5 indicates the positive test or marker study was THE definitive diagnostic method for the case.
- **Diagnosis of Exclusion/Inclusion:** A number of hematopoietic and lymphoid neoplasms are diagnosed or "confirmed" by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation. These should not be confused with positive test results that confirm a diagnosis.
- **Use the Hematopoietic Database:** Query the Database to determine which Diagnostic Method(s) is definitive and/or diagnostic for each specific condition.

2. Question: On a Leukemia that was diagnosed by bone marrow biopsy and Flow Cytometry and when coding the Diagnostic Confirmation would it be correct to code this as Positive Histology?

   Answer: Flow Cytometry is one testing method used to assess immunophenotype or concentrations of certain characteristic proteins that are expressed by cells. Immunophenotype evaluates or designates proliferation for myeloid/lymphoid cells and also evaluates or designates differentiation or category of malignancy. Other methods include; RT-PCR or reverse transcriptase polymerase chain reaction which displays various "cluster designations" or CD concentrations found in the examined tissue reported in a laboratory report; IHC or immunohistochemistry is another method commonly used to determine immunophenotype. FISH or other in-situ hybridization test results are often used in conjunction with or as an adjunct to cytogenetic immunophenotype test results to correlate the immunophenotype with other genetic abnormalities found during FISH testing.

   Bone marrow biopsy PLUS POSITIVE flow cytometry result used to confirm or clarify a diagnosis of a specific type of leukemia should be coded with Dx Confirmation = 3. Be sure to check the Hematopoietic DB to confirm the preferred diagnostic confirmation method and specific type of Cluster Designation findings or other result required to confirm each specific condition.

(Continued on page 13)



Code Histology from Final Dx on the Pathology Report or CAP Synoptic Report

ABSTRACTING POINTER FOR CODING HISTOLOGY FROM "FINAL DIAGNOSIS": Since the 2007 release of the MPH Rules for Solid Tumors registrars have been somewhat confused about whether they should be coding tumor histology from the Final Diagnosis on the narrative Pathology Report or from the CAP Synoptic Report. While these should be the same, registrars have reported that frequently they are not. The revisions to the MPH rules will include instructions to "code the final diagnosis from the pathology report and/or the CAP synopsis/report". The CAP checklist and synoptic report provide a more clear picture of microscopic and other findings from examination of surgical pathology specimens. Many times the CAP report will also include tumor marker information and special testing results. Eventually, pathologists and pathology labs will recognize that both the synoptic report and the pathology report narrative need to be identical when it comes to documenting a diagnosis rather than including optional diagnoses and other pertinent information in comments. Until that time, if you are fortunate enough to have a CAP checklist and synoptic report, this is likely the best option for coding histology. If you do not have a CAP report, please use the Final Diagnosis from the narrative pathology report as you have for many years.

MPH Manual - Replacement Pages posted

Replacement pages for the MPH Manual were placed on the SEER website in October.

If you have already downloaded and printed an earlier version of the manual, you can access the replacement pages from the link below separately to insert into your copy.

*Data Items - released 10/14/2010 (155 KB)

To download the pages, go to http://seer.cancer.gov/tools/mphrules/download.html.

NPCR Data Quality Audit January 5-20, 2011

All NPCR-funded States including Florida are required to participate in an audit of compliance with NPCR standards on cancer registry data quality every 5 years. This is an audit of the state central registry (FCDS) and not the individual reporting facility. The audit involves re-abstracting primary source medical records at selected reporting facilities (hospitals) and comparing the re-abstracted field audit data to the FCDS Master File data. Inconsistent data are "reconciled" back to the facility through FCDS to ensure the most correct data are provided to the audit team. The last time Florida was audited by NPCR was during the 2004-2005 audit year.

NPCR Data Quality Audits are designed to evaluate the quality of the data, including correctness and completeness of coding for all types of reportable neoplasms, including hematopoietic neoplasms and benign or borderline brain tumor cases. Data abstracted include primary site, histology, CS, etc. This is an audit of 2008 cases, only. The intent of these audits is to assess the quality of the data within the central cancer Registry (FCDS) with an emphasis on the existence of appropriate policies and procedures for data quality assessment, statewide, and also in aggregate for comparison of Florida's data quality to the data quality findings in other states.

NPCR will conduct this audit in 12 Florida Hospitals between January 5 and January 20, 2011. Each facility has been asked to provide access to 33 medical records (electronic and/or paper) corresponding to 33 analytic cases randomly pre-selected by NPCR. Selected facilities have already been contacted regarding their participation. Your NPCR Auditor is Janice Gregoire, MSHS, CTR. She works for ICF Macro under contract with CDC NPCR conducting audits across the U.S.

Facilities selected for the NPCR Audit are excluded from the FCDS audit cycle for this year. FCDS would like to thank the 12 Florida Hospitals participating in the NPCR Data Quality Audit. We appreciate the time and attention required to accommodate the audit team before, during and after the audit, including reconciliation.

Selected Facilities Include:

- St Luke's Hospital – Jacksonville
- Bert Fish Medical Center – New Smyrna Beach
- Florida Hospital Cancer Institute South – Orlando
- Orlando Regional Lucerne Hospital – Orlando
- Westside Regional medical Center – Plantation
- Kendall Medical Center – Miami
- Peace River Regional Medical Center – Port Charlotte
- Northside Hospital heart Institute – St. Petersburg
- Tampa General Hospital – Tampa
- Mease Countryside Hospital – Safety Harbor
- Memorial Hospital of Tampa – Tampa
- Lakeland Regional Medical Center – Lakeland

Deadlines, Updates & Reminders

Please join FCDS in wishing Beatriz Hallo farewell.

Beatriz was with FCDS for 10 years. She has joined James Jackson Memorial Hospital as Cancer Registry Manager. The FCDS staff was sad to see her leave, and wish her much success and happiness in her new position!

Please join us in welcoming Gema Midence, CTR to FCDS.

Gema is joining the QC and Education/Training Team as a Senior Regulatory Analyst.

Gema is a CTR with an undergraduate degree in Biology from the University of Miami and an MBA from Florida International University. Most recently Gema was the Cancer Registry Manager at Aventura Hospital. Before managing the Aventura Cancer Registry she was the senior cancer registrar and interim manager for the Cedars Medical Center Cancer Registry before UM bought out Cedars.

Welcome Gema!

Congratulations! To Florida's Newest Certified Tumor Registrars

Abelardo De La Rua
Martha Duran
Angela Simmons

(Continued from page 9) Heme/Lymph Part I Webcast Q&A : 09/23/2010

3. **Question:** Please give the new range of codes for hematopoietic and lymphoid neoplasms in ICD -O-3.

   Answer: DO NOT USE THE ICD-O-3 for coding histology for hematopoietic and lymphoid neoplasms 1/1/2010 and forward. YOU MUST USE the Master Code List found in Appendix F of the **2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and Hematopoietic Database** to code histology for any neoplasm in the range 9590/3 to 9992/3. Many of the new codes do not appear in the ICD-O-3 and many of the ICD-O-3 codes have new instructions on how they are to be used. Do not go directly to ICD-O-3 for codes 9590/3-9992/3.

4. **Question:** Can the HemeDatabase be used instead of the new 2010 Heme and Lymphoid Neoplastic Coding Manual? Can we use the Multiple Primaries Calculator alone?

   Answer: NO. BOTH MUST BE USED TOGETHER – they are interdependent. DO NOT USE THE Multiple Primaries CALCULATOR before you use the Multiple Primary Rules found in the Manual.

5. **Question:** Can the PDF version of manuals be "marked up" with personal notes and highlighting? How?

   Answer: Currently, all of the electronic reference manuals have the capability of inserting annotations using Notes and/or Highlight among other personal use features. The easiest way to enable these features is to click on the "Advanced" menu when you are in Adobe Acrobat and then select "Extend Features in Adobe Reader." This should provide you with markup features enabled for individual documents. Remember that when a new version comes out you will have to transfer your notes to the new manual and if the page numbers change – you might need to figure out where your old note goes with the new page numbering. FCDS will be providing additional instruction on these extended features for Adobe Reader in the future.

6. **Question:** Should we use the 2010 Hematopoietic and Lymphoid Neoplasm Manual and Rules with an older (pre 2010 established case) when trying to determine if there's a possible new primary in 2010?

   Answer: Yes, use the new manual and rules for all cases abstracted 1/1/2010 and forward, regardless of the date of diagnosis. This includes assessing an older diagnosis with a new or potentially new diagnosis for new primary. FCDS does not require registrars to use two sets of rules based on the date of diagnosis. Use only the 2010 Rules.

October 31st

November 25th

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Florida Cancer Data System
Cancer Reporting Completeness Report

TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF DECEMBER 06, 2010

Total number of *New Cases* added to the FCDS Master file in November 2010: 15,253

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
2010	22,952	1	11	154	0	**Pending**	23,118	11,288
2009	165,721	3,566	66	3,354	26	**Pending**	172,733	781
2008	171,954	8,675	2,751	5,099	42	2,972	191,493	3,184

		Actual	Expected
% Complete for:	2010	14%	41%
	2009	100%	100%
	2008	100%	100%

Expected % based on 165,000 reported cases/year