Florida Cancer Data System's

DECEMBER 2010

MONTHLY JOURNAL OF UPDATES AND INFORMATION

Monthly Memo

FCDS/NAACCR 2010-2011 Webinars Schedule

What's New:

The following information is currently available on the FCDS website.

FCDS 2010 EDUCATIONAL WEBCAST SERIES RECORDINGS:
Malignant Melanoma and Other Skin Cancers

FCDS Reportable: 2010 Casefinding and the NEW Class of Case Codes

Heme/Lymph Part II

FCDS/NAACCR WEBINAR SERIES:
COLLECTING CANCER DATA: TESTIS, 2/03/2011, BEING HELD AT 6 FLORIDA FACILITIES AND requires registration

CANCER AMONG PERSONS OF AFRICAN DESCENT MONOGRAPH

FCDS REGISTER,

VOL. 49

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: 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.

(Continued on page 5)

Deadlines, Updates & Reminders

Job Opportunity with FCDS!

FLORIDA CENTRAL CANCER REGISTRY SPECIALIST

Position Numbers 034100 and 022518

The University of Miami, Miller School of Medicine has two opportunities available for a Central Cancer Registry Specialist located on our Medical Campus in Miami, Florida. This individual will be responsible to be the primary point of contact between the Florida Cancer Data System (FCDS), Florida's statewide population based cancer registry, and our reporting sources (hospitals, physician offices, radiation treatment centers and surgery centers). Primary duties include the processing, review and correction of submitted cancer abstracts by the reporting sources, developing relationships with each assigned facility and being the primary contact for questions and issues.

Position requirements are: 1) A minimum of two years experience in a cancer registry; 2) NCRA certification as a Certified Tumor Registrar (CTR) or CTR eligible with cancer abstracting. Send resumes to mthiry@med.miami.edu or call 305-243-2639 for more information.

FCDS Implementation of CSv02.03.02 - July 2011

The Collaborative Stage Management Team recently announced the release of CSv02.03.02. The new CS release includes new schema, new codes, retired/obsolete codes, new definitions, and numerous other updates. FLORIDA REGISTRARS should not use CSv02.03.02 schema, manuals, or codes until FCDS has implemented NAACCRv12.1 and CSv02.03.02. The earliest FCDS plans to accept any 2011 cases or cases staged using CSv02.03.02 will be July 2011.

FCDS will not accept any cases abstracted in CSv02.03.02 until we begin collecting 2011 cases. If you have any questions, please contact your Field Coordinator or Steven Peace. FCDS will provide vendors and registrars with plenty of advanced notice for planning related to Florida's implementation of NAACCR V12.1 and CSv02.03.02.

Deadlines, Updates & Reminders

FCDS EDITS Metafile - latest release is 12/4/2010

The latest release of the FCDS EDITS Metafile is dated 12/4/2010.

If you or your vendor have not updated your FCDS Metafile, please visit the FCDS website and download the current version.

Go to http://www.fcds.med.miami.edu/ and look under "Downloads".

Florida Cancer Data System

Cancer Reporting Completeness Report

TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF NOVEMBER 30, 2010

Total number of *New Cases* added to the FCDS Master file in November 2010: 15,345

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	23,133	1	15	159	0	**Pending**	23,308	11,375
2009	165,790	3,571	74	3,361	19	**Pending**	172,815	799
2008	171,966	8,679	2,758	5,099	42	2,950	191,494	3,171

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

Expected % based on 165,000 reported cases/year

NEW Subtype of Acute Myeloid Leukemia Identified

By profiling epigenetic changes in the genomes of patients with acute myeloid leukemia (AML), researchers have identified a biologically distinct subtype of the disease that could be amenable to new forms of molecularly targeted therapy. Epigenetic changes, such as DNA methylation, include chemical modifications to DNA that alter the activity of genes without changing their coding sequence. In this study, patients whose tumors had mutations in the genes IDH1 or IDH2 showed widespread DNA methylation changes, including changes to key genes associated with leukemias, the researchers reported online in Cancer Cell on December 2.

The research team, co-led by Dr. Ari Melnick of the Sackler Center for Biomedical and Physical Sciences at Weill Cornell Medical College, were surprised by the results because IDH1 and IDH2 are involved in cell metabolism and have not been linked previously to epigenetic changes. But once these genes are mutated, the researchers found, they encode abnormal proteins that produce an aberrant metabolite that, in turn, increases DNA methylation. This increased methylation causes genes to function abnormally and causes hematopoietic cells to develop leukemic features.

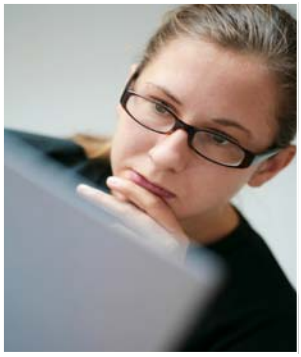
To make the discovery, the researchers compared gene activity and DNA methylation patterns in tumors from 750 patients with AML. They also sequenced selected genes, including IDH1 and IDH2, which have been implicated in AML and in glioma, a form of brain cancer. The gene-expression patterns of patients with IDH1 or IDH2 mutations were not distinct from those of other AML patients, but clear differences were seen in the epigenetic profiles.

In additional experiments, the researchers found that the abnormal metabolite produced by the mutant IDH1 and IDH2 proteins disrupts the functions of a factor called TET2 that can otherwise reduce DNA methylation. They also showed that some AML patients have genetic mutations that inactivate the TET2 gene, and this causes the same abnormal patterns of DNA methylation as IDH1 and IDH2 mutations.

"This study marks the first time that genes involved in energy balance and abnormalities in cancer epigenetic programming have been linked," said Dr. Melnick, who led the work with Drs. Craig Thompson and Ross Levine of Memorial Sloan-Kettering Cancer Center. The study further suggests that a gene can acquire an entirely new function when it is mutated. "In these kinds of studies, it is important to expect the unexpected," Dr. Melnick added.

Source: NCI Cancer Bulletin, December 14, 2010 • Volume 7 / Number 24

(Continued from page 1) 2010-2011 NAACCR Webinar Series Schedule and Course Description



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

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.

When do you code an excisional biopsy of a lymph node(s) as surgical treatment for lymphoma?

We are finding that a lot of registrars are incorrectly coding an excisional biopsy of one or more lymph nodes as surgical treatment for lymphoma. In nearly every case the excisional biopsy was performed to establish a diagnosis. This is not treatment for the lymphoma. Adding to the confusion is the availability of Code 25 under Surgery for Lymphoma which gives a code for excision of one, two or three lymph nodes (less than a chain). The intent of surgery is key to coding these correctly.

Surgical treatment for lymphoma is a rare treatment approach, even for extranodal lymphoma presenting in a solid organ. . Just because a lymph node was excised does not mean that the excision was intended to treat the lymphoma. In nearly every case this type of excision is to establish the diagnosis – not treat the malignancy. The role of surgery for staging and treatment of lymphoma has been replaced by PET scan and other imaging studies. While we can acknowledge that often registrars must rely on limited information in the medical record that does not include the intent of the surgical procedure. We also most rely on the experience and knowledge of the registrar to correctly code treatment. In nearly every lymphoma case, an excision of a lymph node (or 2 or 3) is the first step in establishing a lymphoma diagnosis and is therefore diagnostic in intent (not intended to treat the lymphoma). Treatment planning does not even begin until the diagnosis has been established.

Example: Patient has extensive adenopathy. The surgeon removes a lymph node by excisional biopsy. The patient is referred to medical oncology.

Discussion Questions:

1. Is this a biopsy procedure to establish a diagnosis or is this a surgical procedure coded in the surgery treatment section of the abstract?
2. If this is not coded in the surgery section when do you use the code 25 local tumor excision, NOS?

Answer:

DO NOT CODE THIS DIAGNOSTIC PROCEDURE AS SURGICAL TREATMENT. Code Surgery of the Primary Site =25 only if the procedure was performed for treatment. For CoC Hospitals – you should code Diagnostic and Staging Procedure = 01 since this excisional biopsy was performed for diagnosis and/or staging.

CAUTION: Use Code 25 (local tumor excision, excision of less than a full chain, includes an excisional biopsy of a single lymph node) only in the rare instance where the only site of involvement of lymphoma is this one lymph node or local area and that the area was fully treated – no chemo, nothing else done. If you have no other information other than the excision of a lymph node – do not use code 25 as treatment…the biopsy was most likely diagnostic not therapeutic.

Coding Site and Histology for "precursor cell lymphoblastic lymphoma"

QUESTION:

Morph code 9727/3 Precursor cell Lymphoblastic Lymphoma - the nodule is on the skin - is the correct code skin? If so, does it require a surgery code of 98? FCDS wants the 98 regardless of the topography code - what is the correct answer?

ANSWER:

This is an interesting group of heme/lymph conditions with the associated series of histology codes not entirely in synch with current nomenclature, state of the science, and ICD-O-3 is out of synch with the heme/lymph rules, new codes, and database. The 9727/3, 9728/3,and 9729/3 codes will eventually be "retired" from ICD-O-3 and replaced with the series 9811/3-9818/3 for the B-cell group. The NOS group and T-cell group will be managed somewhat differently. And, UNFORTUNATELY, the Hematopoietic Database and Rules have a couple of "hidden" rules in the Abstractor Notes section for these conditions that haven't made it into hardcoded rules just yet. SEER is aware that these are missed by registrars and need to be brought into greater awareness with specific rules added. In the interim, this is what we are supposed to do with these cases…specifically with regard to surgery and coding histology:

Use the Heme/Lymph Database to determine immunophenotype (B-cell or T-cell origin). If of B-cell origin use the 9811/3-9818/3 codes for B-lymphoblastic leukemia/lymphoma. Code the primary site based on where disease is found (see PH Rules) – in this case skin. Surgery of Primary Site coding is based on primary site – not histology. So, if primary site is skin then surgery can be coded as treatment for the lymphoma if resection is treatment-oriented not just diagnostic biopsy or excisional biopsy. If the condition is found in bone marrow – then 98 is correct for surgery code. This appears to be a lymphoma/leukemia of the skin.

ICD-O-3 CODE	ICD-O-3 TERM	WHO TERM	COMMENT
9727/3	Precursor-cell lymphoblastic lymphoma	Blastic plasmacytoid dendritic cell neoplasm	This is now classified as a precursor myeloid neoplasm. WHO uses the same code as ICD-O-3 but with new terminology – not new condition
9728/3 – DOES NOT EXIST IN WHO	Precursor B-cell lymphoblastic lymphoma	A single term for this set of conditions does not exist in WHO per se	The codes 9811/3-90818/3 (precursor lymphoid neoplasms) replace 9728/3 in WHO
9729/3 – DOES NOT EXIST IN WHO	Precursor T-cell lymphoblastic lymphoma	T Lymphoblastic leukemia/lymphoma	Use code9837/3 for these cases of T-cell origin

Coding Thyroid Treatment

Coding Thyroid Treatment can be tricky at times, especially when a patient receives hormonal therapy pre-operatively, post-operatively, or following I-131 radioisotope ablation of the thyroid. This can be even more confusing for CoC facilities that need to enter and document more details of radiation therapy than incidence-only abstractors who only need to capture the type of radiation therapy and the date the therapy was initiated.

Thyroid Ablation with I-131 or Radioactive Iodine should be coded as radioisotope treatment for thyroid neoplasms or RX Summ-Radiation = 3. The CoC field Radiation Treatment Volume identifies the volume or anatomic target of the most clinically significant regional radiation therapy delivered. I-131 is a radioactive pill that is swallowed and it exposes the whole body to isotope irradiation. According to the CoC Inquiry and Response System, I-131 radio-isotope ablation should be coded with Radiation Treatment Volume = 33 to indicate radiation was systemic to the whole body. The thyroid does uptake most of the iodine but not all. Code 33 indicates that more than just the thyroid is exposed to radiation. The CoC field Regional Treatment Modality should be coded using code = 60, Radioisotopes, NOS.

Hormone Replacement as First Course Therapy: Code Hormone therapy = 01 [Hormone therapy administered as first course therapy] when thyroid replacement therapy is part of the first course of treatment for follicular or papillary thyroid cancer following total thyroidectomy or following radioisotope ablation of the thyroid with I-131.

Thyroid hormone replacement therapy has a treatment effect on differentiated (follicular and papillary) carcinomas of the thyroid. This treatment effect is not seen for most medullary and undifferentiated thyroid cancers.

Hormone Replacement for Hypothyroidism: Do not code hormone replacement given to treat hypothyroidism as cancer treatment.

December 1st

December 21st

December 25th

December 26th - January 1st

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Florida Cancer Data System
Cancer Reporting Completeness Report

TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF DECEMBER 31, 2010

Total number of *New Cases* added to the FCDS Master file in December 2010: 15,410

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	37,539	16	46	262	0	**Pending**	37,863	14,555
2009	166,356	3,591	116	3,383	19	**Pending**	173,445	630
2008	172,130	8,679	2,817	5,101	42	2,950	191,719	225

		Actual	Expected
% Complete for:	2010	23%	58%
	2009	100%	100%
	2008	100%	100%

Expected % based on 165,000 reported cases/year