The Florida Cancer Data System

MonthlyMemo

Monthly Journal of Updates and Information

JULY/AUGUST 11

WHAT'S NEW:

The following information is currently available on the FCDS website.

- **ADDING SEARCHABLE NOTES AND HIGHLIGHTED TEXT TO PDF FILES SUCH AS THE FCDS 2011 DAM**
- **FCDS 2011 DATA ACQUISTION MANUAL**
- **FCDS 2011 IMPLEMENTATION GUIDE**
- **FCDS TEXT DOCUMENTATION REQUIREMENTS**
- **FCDS/NAACCR EDITs Metafile - compatible with NAACCR 12.1 version - 7/07/2011, 12:45pm Metafile changes.**
- **FCDS/NAACCR WEBINAR SERIES: CODING PITFALLS, 09/01/2011 BEING HELD AT 7 FLORIDA FACILITIES AND requires registration.**

2011 FCDS Educational Webcast Series

FCDS is hosting a series of educational webcasts for Florida cancer registrars and cancer case abstractors between 6/15/11 and 1/19/12. There are eight (8) different webcasts in the series. Please join us for this informative and timely educational series.

We encourage all Florida registrars and abstractors to mark their calendars for this entire series of events and plan to participate in all 8 sessions.

WEBCAST SCHEDULE:

Each webcast will be held on a Thursday from 9am-11am on dates noted below.

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The Florida Cancer Data System (FCDS) is Florida's statewide, population-based cancer registry and has been collecting incidence data since 1981.

Job Opportunities with the Florida Cancer Data System

- **Florida Central Cancer Registry Specialists**
- **Senior Regulatory Analyst/ Quality Control Coordinator**

FLORIDA CENTRAL CANCER REGISTRY SPECIALIST

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.

SR. REGULATORY ANALYST/QUALITY CONTROL COORDINATOR

FCDS, Florida's population-based state-wide cancer registry, has an exciting job opportunity for an experienced CTR as a Senior Regulatory Analyst/Quality Control Coordinator. The QC Coordinator will work directly with the Manager of Data Quality and Education and Training and the FCDS Data Quality Team. The FCDS Data Quality Team is involved in the overall planning and delivery of various data quality studies across the state of Florida (reporting completeness, abstracting completeness, and coding accuracy) as well as ad hoc data quality and quality improvement activities that combine to make-up the FCDS

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Quality Control Plan. The FCDS Data Quality Team is also actively involved in the development and delivery of high quality education and training programs geared toward both new and experience cancer registrars. This is a challenging and rewarding position for a highly motivated CTR. FCDS is a busy hub of activity that includes cancer reporting from many types of report sources.

Routine responsibilities include: the Quality Control of abstracted/coded data to ensure that all cases received by FCDS are accurate and reliable and that data meet or exceed national data quality standards; re-casefinding and re-abstracting field audits and audit reconciliation activities; response to technical inquiries from in-the-field registrars, and serving as a subject matter expert to both hospital registry staff and the staff at the central registry. Experience with electronic data capture, e-path, and other electronic health records including EMRs is also highly desirable.

Qualified individuals should have a bachelor's degree and at least three years relevant work experience in a cancer registry as a CTR. Applicants must demonstrate a working knowledge of ICD-O-3, ICD-9-CM, ICD-10 including ICD-10-CM/PCS, and HCPCS/CPT coding. Understanding of national cancer case abstraction and cancer registry coding standards and related best practices is a requirement. Experience in epidemiological and/or clinical research studies is a plus.

The University of Miami, Miller School of Medicine is proud to offer those who lead with us competitive salaries, medical; and dental benefits, tuition remission, vacation, university paid holidays and much, much more. The University of Miami is an Equal Opportunity/Affirmative Action Employer. Please send cover letter and resume/CV to Steven Peace at speace@med.miami.edu.

New FCDS IDEA Feature: Reconnect

In the past, if your internet connection was interrupted, you would have to re-login to FCDS IDEA and possibly lose work. Now, if FCDS IDEA senses a loss of internet access, the system will try 10 times to 'reconnect'. If it can't it will print out an error message which you should email to Mark Rudolph, at mrudolph@med.miami.edu. **Please remember not to email screen-prints containing confidential information**.

FCDS Staff UPDATE

We are pleased to welcome two new employees to our Field Services team. Leslie Beaubrun and Saskia (Sam) Angel joined our staff in May and both will be working on our Collaborative Effectiveness Research Project (CER).

Leslie joins us from Canada where she worked as a Human Resources professional and Sam comes to us from another department within University of Miami where she worked as an Administrative Assistant.

Please join us in welcoming them to our team!

Deadlines, Updates, & Reminders

Just a reminder - the deadline for the FCDS Death Clearance Follow Back processing is October 24, 2011. Please remember to clear all of your cases.

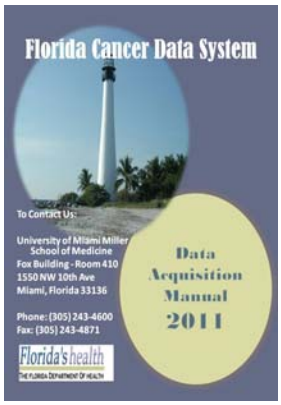
FCDS IDEA was successfully upgraded to allow V12.0 and V12.1 Upload and Single Entry Options. These options have been available for use since July 5, 2011.

While the deadline for submission of 2010 cases was June 30, 2011, FCDS continues to make available an option for registrars to use BOTH Single Entry and Batch V12.0 Upload until 8/31.

A separate option in the FCDS Menu will guide you to the V12.1 Single Entry and Batch Upload options which are also now available. Please ensure that you have completed your 2010 cases prior to converting your database and software to V12.1 you cannot go back once you convert.

Updates Summary:

1. V12.0 Uploads and Single Entry remain open until 8/31 unless otherwise noted.
2. V12.1 Uploads and Single Entry are now open and will edit any submissions .
3. Full processing of V12.1 abstracts by FCDS field staff will not occur until after the entire FCDS database undergoes V12.1 conversion currently scheduled to be completed by 9/15.
4. Please remember that the V12.1 conversion for BOTH hospitals and FCDS includes required manual reviews of cases; this may be time consuming for both small and large registries and includes nearly 5000 cases to be reviewed by FCDS at the central registry level.
5. 2011 FCDS DAM is now on the FCDS website.
6. We will keep you posted of any changes in the timelines.



THE 2011 FCDS DAM IS AVAILABLE ON THE FCDS WEBSITE.

FCDS is pleased to announce the availability of the 2011 FCDS Data Acquisition Manual (FCDS DAM). The manual includes important information about Florida cancer reporting requirements for 2011, instructions for coding new and changed data items, and has links to references and resources used daily when abstracting cancer cases.

Download a copy to your computer desktop for easy reference or for printing at http://fcds.med.miami.edu under Downloads.

Collaborative Stage FAQ Document with Known Issues for v02.03

The Collaborative Stage (CS) Team is preparing for the next release of CS in Fall 2011. In the meantime, the CS team has developed a known issue document that can be useful when coding in CSv02.03. This document contains important information for a few schemas and fields where there is a known issue with CSv02.03 that will be resolved in the upcoming release. This document was created to let you know that we are aware of the issues you may be encountering with these few fields in CSv02.03 and they will be resolved in CSv02.04.

Please take a moment to download or print this document as a reference to use when coding these fields. The FAQ document can be found at http://cancerstaging.org/cstage/csv2/faqs.html.

CSv02.03 FAQs

The following report summarizes FAQs. Coding guidance is provided where appropriate.

REFERENCE #	SCHEMA NAME	CS FIELD(S)	DESCRIPTION
#351	Part I		Use Lymph-Vascular Invasion code 8 only for Hematopoietic and Lymphoid disorders. Use code 9 for non-Hematopoietic and Lymphoid disorders where there is no microscopic examination of a primary tissue specimen. See CS Manual, Part I, Section 1, page 83 for CS v0203. This use of code 9 is a change from the definition in CS v0202, but a conversion from code 8 to code 9 for appropriate cases is NOT automatically applied in the upgrade to CS v0203. If you wish to do your own conversion, search for 2010+ diagnosis cases with Lymph-Vascular Invasion code 8 and all histology codes less than 9590/3, and change 8 to 9. 06/30/11
#251	Colon, Rectum	CS Extension	We will modify the notes in v0204 to clarify that code "050" may be used when there are tumor deposits without lymph node metastasis in T1, T2, T3 and T4 cases. Previously, the v0203 instructions stated that you could only use this code for T1 and T2 cases. 6/3/2011
#423	Colon, Rectum	CS Site-Specific Factor 2, Extra Table	Code 030 is not relevant for SSF2 and we will be making it obsolete in the next version. This is because tumor deposits are identified histologically and SSF2 is used to code the clinical assessment of regional lymph nodes. We are not supposed to include information from surgical observation or lymph node biopsies in this SSF. Cases that were abstracted with this code will need to be reviewed and corrected. 6/3/2011
#268	CorpusCarcinoma, CorpusSarcoma	Schema Page	For corpus uterine/uterus NOS primaries, histology codes 8950 and 8951 should have been included in the Corpus Carcinoma schema. This will be fixed in CSv0204. Do NOT try to fix these cases before CSv0204. 6/3/2011
#45	KidneyParenchyma	CS Site-Specific Factor 3	For Kidney Parenchyma SSF 3, code 998 for "No histologic examination to determine ipsilateral adrenal gland involvement", will be added. In the meantime, code 999 should be used for cases without histologic examination that determines ipsilateral adrenal gland involvement. 6/10/11

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DATE	DAIL-IN NUMBER	PARTICIPANT CODE	HOST CODE	TITLE
*6/15/11	877-322-9652	358762	687543	2011 FCDS Reporting Requirements - Vendors
8/18/11	888-296-1938	619968	749704	Text Documentation/Visual Editing and Introduction to CSv02.03.02
9/15/11	888-296-1938	619968	749704	Colon/Rectum Cancer - 2011 MPH Rules/CSv02.03/Site
9/29/11	888-296-1938	619968	749704	Breast Cancer - 2011 MPH Rules/ CSv02.03/Site Specific
10/20/11	888-296-1938	619968	749704	Myeloid Neoplasms (CML/AML/ MDS) - 2011 MPH
11/17/11	888-296-1938	619968	749704	Lung Cancer - 2011 MPH Rules/ CSv02.03/Site Specific
12/15/11	888-296-1938	619968	749704	Genitourinary (Kidney, Bladder, Prostate) - 2011 MPH
1/19/12	888-296-1938	619968	749704	Brain and CNS Tumors - 2012 MPH Rules/CSv02.03/Site

* Webcasts available on the FCDS website, on the Downloads page: http://fcds.med.miami.edu/inc/teleconferences.shtml

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CSv02.03 FAQs

#353	Lung	CS Extension , Extra Table	A tumor involving the carina, regardless of size, should be a T4, per AJCC. If you code 250, for confined to carina, you will derive based on tumor size. "Confined to carina" will be moved to a T4 (in a future version.) For now, the best code to use is code 700, which includes the description extension to carina and will derive a T4. In your abstract you can note this situation. The confusion arises since Summary Stage focuses strictly on how big or how many structures are involved, making a tumor strictly in the carina a localized tumor. Whereas AJCC assign stage based on treatment guidelines and prognosis (survival). We know that a tumor in the carina, even if it is small and strictly confined to the carina, will be unresectable and will have poor outcome, since the tumor can easily spread to both lungs due to the location (tumor can spread from the carina down BOTH mainstem bronchus into both lungs) it has a very poor prognosis (survival). 6/30/11
#271	Testis	CS Site-Specific Factor 8, CS Site-Specific Factor 14	The measurements in SSFs 8 & 14 were incorrectly entered as ng/ml and will be updated to mIU/ml in v0204. 6/3/2011

NAACCR CANCER REGISTRY AND SURVEILLANCE WEBINAR SERIES

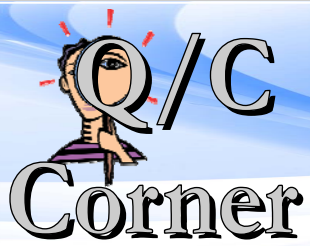
Seven Florida facilities will host the 2011-2012 webinar series, *registration is required*

FCDS *is now hosting the webinars with space for 25-30 participants.*

The recording, a copy of the slides, the case scenarios, answers, and Q&A and clarifications from the NAACCR Webinars on Collecting Cancer Data: Prostate, 5/5/2011 and the Best Practices for Developing and Working with Survival Data, on 6/2/2011, have been posted to the NAACCR website. A CE Certificate has been provided for those viewing the recording of the webinar.

You may download the Prostate recording at *http://www.naaccr.org/Webinars/tabid/140/ctl/Details/mid/671/ent_i/b8506f56891d4803a996886dc9d5fe36/view/1/Default.aspx*

You may download the Best Practices for Developing and Working with Survival Data recording at *http://www.naaccr.org/Webinars/tabid/140/ctl/Details/mid/671/ent_i/2809844d841f4b65924be83a20697f08/view/1/Default.aspx*



2010 Feedback on QC Review (Visual Editing)

2010 Feedback on QC Review (Visual Editing)

3-step process

1. Initial QC or Visual Editing Review Takes Place - reviewer makes notes or asks question to registrar/abstractor.
2. Registrar/Abstractor Responds to QC Review Note/Question
3. Final Visual Editing Review Takes Place - final reviewer reads case, reviews text, reviews QC Reviewer notes, reviews Abstractor reply to notes and makes final decisions based n all information available.

#1 Problem:	Inadequate/Insufficient Text Documentation to Validate Coded Information or to Adequately Explain Rationale for Making Key Coding Decisions
#2 Problem:	Editor and /or Abstractor writes and inadequate question/response to five FCDS enough information to correct the case - "corrected" is not an appropriate or adequate answer
#3 Problem:	Dates/Place not included in text to provide chronology and location of events that occurred

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BEST FIELDS -	Pathology - but not in all cases - some abbreviate far too much, some do not include dates
BAD FIELDS -	Radiology Labs - no dates ever included, findings often vague, interpretation or details missing or miss important key information by copy and pasting with editing.
PROBLEM FIELDS -	CS and Other STAGING FIELDS INCLUDING Site Specific Factors (SSFS)

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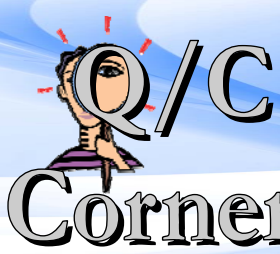
1. Why are the reviewers asking who staged the case? Answer: Because "Stated As" Codes are to be used as last resort when coding Collaborative Stage data items. Please use "Stated As" sparingly - and document who did the staging. Also, often no other information is including in staging to provide staging background such as diagnostic imaging, pathology details, or other staging criteria.
2. If I don't understand the reviewer' question or registrars reply - what should I do? Answer: Provide FCDS examples of unclear questions and answers so we can clear it up. Two-way conversation.
3. Why has Grade become such a problem and confusing field(s) to code? Answer: Grade is no longer as simple or straight forward as it used to be. This is why we have SSFs that address Grade specifically for Prostate, Brain Tumors, Breast Tumors, Renal Cancer, and other specialized grade of tumor. The two new Path Grade Value and Path Grade System fields required by CoC are still not required by FCDS until they work out the bugs for coding these fields. Nuclear Grade, 2,3,4 grade systems.



QUESTIONS? AND ANSWERS.

Question:

On a case of an unknown head and neck primary, what topography code should be used?

This specific question has two responses in 2010 (I&R). The question has not been asked again since the CA?nswer Forum went up. I would be happy to post it there for re-review, but the I&R response would dictate that it be coded C76.0 until restated/updated/revised in the CA Forum.

Answer:

According to the 2007 MPH Rules for Head and Neck (this is in the section entitled Equivalent Terms, Definitions, Charts, Tables and Illustrations), Page 18.

When the point of origin **cannot be determined**, use a topography code for overlapping sites:

- C02.8 Overlapping lesion of tongue
- C08.8 Overlapping lesion of major salivary glands
- C14.8 Overlapping lesion of lip, oral cavity, and pharynx.

Question:

I have searched for what the term “spent” phase means in reporting of hematopoietic disease and cannot find a reference except in relation to polycythemia.

Example: Patient with hx of Essential Thrombocythemia in 2006 and txd with hydrea. 8/4/10 bm bx dxd as c/w spent-phase of myeloprolifertaive neoplasm (hx ET) and then referred to by physicians as having myelofibrosisi & tsc with chemo. Then in 12/08/10 bm bx + acute myelogenous leukemia w/mds related changes and treated w / CLAG.

Can you direct me to the where to find the answer in the manual please?

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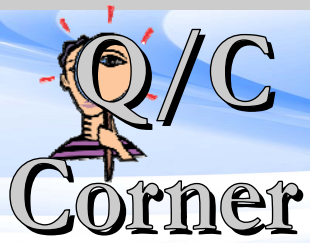

QUESTIONS? AND ANSWERS.

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Answer:

The term "spent" is an example of disease progression. The disease has become more severe, but remain the same cell type. For ET, the bone marrow biopsy resembles primary mylofibrosis. The patient has cytopenias, bone marrow hpoplasia and fibrosis. The patient, however, still has the same disease. The term "spent-phase" used for myeloproliferative neoplasms is similar to stating that a solid tumor has progressed to a more advanced stage.

A genetic transformation is when a neoplasm with a different cell is diagnosed. For example, a patient with ET (disease of hemotopoietic stem cells) is diagnosed with acute myeloid leukemia (a disease of the myeloid line of white blood cells). How do you know this? Use the hematopoietic Database(DB). Always look up the historic case first. Enter ET into the Heme DB. Display ET, look at the transformation box which infoms you that Et transforms to AML. That means you have a chronic neoplasm (ET) and an acute neoplasm (AML) diagnosed more than 21 days apart. Go to the Multiple Primary Rules, M10 and abstract the AML as a second primary.

Question:

The dermatology-only entry module automatically enters both accession or sequence numbers. These are not visible to the person doing the case entry. When FCDS receives the case, there are sometimes conflicts with understanding the number of primary cancers being reported. The case below is one such example where it appears the patient has two melanoma in-situ with the same primary site (scalp), and IDEA has assigned two different accession numbers. This triggered an edit suggesting the case as a possible duplicate. FCDS staff reviewed the pathology report and were presented with the following options to process the case:

1. Accept the case as a single primary and delete the duplicate case with latest accession number
2. Accept the case as a multiple primary (two primaries) then move the case into our database's pending file, then change the sequence to one. Then change the accession from the incoming new case and add the sequence tow and process the case as a force for the 2nd sequence.

Answer:

Despite the fact that this patient clearly has two tumors on the same side of the scalp, each of which is in-situ melanoma, and the they were diagnosed at the time (within 60 days per rule), for purposes of cancer surveillance and according to the MPH Rules this is a single primary. A physician will call this two primaries, which it clearly is for clinical purposes. However when we "count" tumors using our standardized MPH Rules - sometimes the clinical picture does not quite fit into the rules we have laid out for counting tumors for cancer surveillance. Another example is the European example which only allows one tumor per person for lifetime in many of the European registries.

Unfortunately, we currently do not have the means to distinguish between the two tumors noted above because the characteristics are identical and no coding system currently in place can differentiate between the two. Therefore, we count these as a single primary.

Florida Cancer Data System
Cancer Reporting Completeness Report

TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF JUNE 30, 2011

Total number of *New Cases* added to the FCDS Master file in June, 2011: 37,465

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	132,258	2,687	101	1,070	23	**Pending**	136,139	33,087
2009	171,357	7,814	2,668	3,814	73	**Pending**	185,726	4,078
2008	172,638	8,728	2,906	5,070	79	2,945	192,366	300

		Actual	Expected
% Complete for:	2010	83%	100%
	2009	100%	100%
	2008	100%	100%

Expected % based on 165,000 reported cases/year

Congratulations to Florida's

The Florida Cancer Data System (FCDS) is Florida's statewide, population-based cancer registry and has been collecting incidence data since 1981 when it was contracted by the State of Florida Department of Health in 1978 to design and implement the registry. The University of Miami Miller School of Medicine has been maintaining FCDS (http://fcds.med.miami.edu) since that time.

The FCDS is wholly supported by the State of Florida Department of Health, the National Program of Cancer Registries (NPCR) of the Centers for Disease Control and Prevention (CDC) and the Sylvester Comprehensive Cancer Center at the University of Miami Miller School of Medicine.

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