

The Florida Cancer Data System

Monthly Memo

Monthly Journal of Updates and Information

NOV/ DEC 2011



New FCDS Edit for Prostate

A large hole has identified within the Prostate edits that is now being identified and corrected with **FCDS EDIT #5862**.

1. When coding CS Ext (Clinical Stage) and SSF3 (Pathologic Stage) the registrar **MUST** know the difference between a FNA, Needle core biopsy TURP and a (total) prostatectomy.

2. **ONLY** prostatectomy and/or autopsy findings should be coded in SSF3. **DO NOT REPEAT WHAT YOU CODED IN CS Extent (clinical stage) in SSF3.**

3. Our **NEW FCDS EDIT 5862** verifies that, for cases using the CS Prostate schema, if no prostatectomy is coded in the surgery field, CS Site-Specific Factor 3 must also show no prostatectomy.

4. **MANY CASES ARE FAILIING THIS EDIT** and we have been trying to explain this to our registrars over and over.

5. If RX Summ--Surg Prim Site = 50 (Radical prostatectomy, NOS; total prostatectomy, NOS) or 70 (Prostatectomy WITH resection in continuity with other organs; pelvic exenteration), then CS Site-Specific Factor 3 must not = 960(unknown if "prostatec

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WHAT'S NEW:

The following information is currently available on the FCDS website.

FCDS 2011 EDUCATIONAL WEBCAST SERIES: BRAIN & CNS TUMORS - 2012 MPH RULES/CSV02.03/ SITE SPECIFIC FACTORS AND TREATMENT, JANUARY 19, 2012 REGISTER

FCDS/NAACCR EDITs Metafile - compatible with NAACCR 12.1B version - 11/28/2011, 12.1B Metafile changes, *removes* edit 1261.

FCDS/NAACCR WEBINAR SERIES: COLLECTING CANCER DATA: LUNG, 02/02/2012, BEING HELD AT 7 FLORIDA FACILITIES AND [requires registration.](#)



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

Deadlines, Updates, & Reminders

QC Visual Review Sampling of Every 25th Record

FCDS Quality Control staff visually review at least one of every 25 records submitted by each reporting facility. The Quality Control Visual Review is a three step process designed to visually (manually) validate abstracted data (codes) and text to make sure they make sense together and are in reasonable chronology (timeline) in terms of order of first course of treatment. QC also checks for appropriateness of treatment as compared to stage of disease documented to ensure the stage and treatment make sense as coded.

Abstracts with questionable coding discrepancies, text versus code discrepancies, or coded data items with omitted supporting required text are sent to each reporting medical facility via FCDS IDEA with comments and questions as needed.

FCDS emails these QC Review Notifications of records that need to be reviewed or require more information for code clarification.

Reviewers at the facility must be granted specific access to these cases or they will not be able to view the cases or the notes. Nor will they be able to respond to the inquiries or deadlines indicated on the notification – administrative access permission is required.

If you do not have the FCDS IDEA DISCREPANCY REVIEW menu, you may request it or delegate it to another person (if you are a facility administrator or designated cancer registry manager).

Go to the FCDS IDEA and select User Account Request Form:

<http://fcds.med.miami.edu/downloads/FCDSLoginRequestForm.pdf>

Also, If you receive an email stating that there are records with discrepant data available for review. You must sign in to FCDS IDEA and review and return the discrepancy Review to FCDS before the deadline. This does count as a deadline for Jean Byers Award.

NOTE: When responding to FCDS Feedback on data quality, comments or questions: Please do not simply state that you “agree” or “disagree” with the reviewer. Provide text to support your answer and/or corrected data with text to backup what you would like to have changed, updated or otherwise changed. Otherwise, you have not completed the request and may get it right back again. Please be specific – or if you do not understand the question, please state so.

The deadline to complete the review is two weeks from the date of the email. Please contact the Quality Control Field Coordinator if you have any questions about the QC Visual review of every 25th process at 305-243-4600.

Deadlines, Updates, & Reminders

New FCDS Edit for Prostate

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Tomy”, 970 (no prostatectomy in first course of treatment), 980 (prostatectomy performed, but not first course of treatment), or 985 (autopsy performed, but extension unknown).

6. Finally, The registrar **MUST** know that CSExt Eval = 4 **ONLY** for prostatectomy or autopsy.

7. Please join us for the GU (Kidney, Renal Pelvis, Ureter, Bladder, Prostate) FCDS Web Broadcast on Thursday, December 15 from 9am-11am Eastern. You must register to join the broadcast.

8. Register under What's New on the FCDS Website - <http://fcds.med.miami.edu>





2011 FCDS Educational Webcast Series

FCDS is pleased to see the great interest and attendance in reference to our 8-part educational series. The webcasts have been tailored to the Florida cancer registrar and cancer case abstractor with emphasis on the 2011 Florida Cancer Reporting Requirements. The first webcast presented in mid August focused on 2011 FCDS Cancer Reporting Requirements (including enhanced text requirements and new CS Site Specific Factors), QC Visual Editing for 2011, and an Introduction to CSv02.03.02. The series will continue with concentration on specific cancer sites or site groups. Webcasts are held on Thursdays from 9am-11am. Please review the dates below.

DATE	TITLE	NCRA Program Recognition Number
*8/18/11	FCDS 2011 Text Documentation/Visual Editing and Introduction to CSv02.03.02	2011-162
*9/15/11	Colon/Rectum Cancer - 2011 MPH Rules/CSv02.03/Site Specific Factors and Treatment	2011-167
*9/29/11	Breast Cancer - 2011 MPH Rules/CSv02.03/Site Specific Factors and Treatment	2011-168
*11/02/11	Myeloid Neoplasms (CML/AML/MDS) - 2011 MPH Rules/CSv02.03/Site Specific Factors and Treatment	2011-169
*11/17/11	Lung Cancer - 2011 MPH Rules/CSv02.03/Site Specific Factors and Treatment	2011-170
*12/15/11	Genitourinary (Kidney, Bladder, Prostate) - 2011 MPH Rules/CSv02.03/Site Specific Factors and Treatment	2011-171
1/19/12	Brain and CNS Tumors - 2012 MPH Rules/CSv02.03/Site Specific Factors and Treatment	2011-172
2/16/12	Head and Neck Cancers - 2012 MPH Rules/CSv02.03/Site Specific Factors and Treatment	2011-173

* - Indicates webinar has been presented, recorded, and is available on the FCDS website.

Each webcast will provide background and instruction sufficient for registrars to understand the anatomy and surrounding structures for each cancer site/site group, risk factors associated with cancers of each site/site group, CSv02.03.02 coding for each site/site group, and ASCO/NCCN Clinical Practice Guidelines for Treatment of each site/site group. This series builds upon information presented at the 2011 FCDS Annual Meeting in Tampa, Florida in July. There is no fee and each 2-hour webcast will be recorded and available on the FCDS website, <http://fcds.med.miami.edu/inc/teleconferences.shtml>. **NCRA approved CEUs (2 each)**, note the program recognition numbers in the above chart.

CSv02.03 FAQs

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

REFERENCE #	SCHEMA NAME	CS FIELD(S)	DESCRIPTION
#351	Part I		Lymph-Vascular Invasion code 8, not applicable, is only used for those histologies where lymph vascular invasion is not possible or the standard-setter does not require collection for the schema. These histologies are noted in Part I, Section 1, and include the lymphomas, leukemias and the myelodysplastic syndromes. If your standard-setter does not require collection of this data item for particular schemas, use code 8. For those cases where there is no information/documentation from the pathology report or other sources, use code 9. 6/30/11 - Revised 8/29/11
#45	Part I, 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
#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 CorpusCarcinoma schema. This will be fixed in CSv0204. Do NOT try to fix these cases before CSv0204. 6/3/2011
#531	EsophagusGEJunction	CS Extension	Esophagus GE Junction Extension: For extension to transverse colon (including flexures), previously coded 600, use code 605. This description was left off in v02.03 and will be added back at a later date. (8/9/11)
#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 ased 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

Bladder Cancer Treatment Often Haphazard

By Crystal Phend, Senior Staff Writer, MedPage Today

Source: MedPageToday (www.medpagetoday.com)



MedPage Today Action Points

Explain that the vast majority of physicians do not follow all of the published guidelines for the treatment of high-grade, non-muscle-invasive bladder cancer.

Note that the only adherence measures that improved significantly after the guidelines came out were use of radiographic imaging and immunotherapy.

Review

Guidelines for treating bladder cancer are largely ignored, according to a study showing that only 1% of providers delivered the full gamut of recommended care to at least one patient in their practice.

Only one bladder cancer patient out of 4,545 received the full number of recommended cystoscopies and cytologies as well as intravesical chemotherapy and immunotherapy, Karim Chamie, MD, MSHS, of the University of California Los Angeles, and colleagues found.

These results from the national Surveillance, Epidemiology and End Results (SEER) database linked with Medicare claims were reported online in *Cancer*.

The SEER patients in this study had high-grade, non-muscle-invasive bladder cancer diagnosed from 1992 to 2002. The patients had to have survived at least two years without definitive treatment.

Differences in adherence from one provider to the next appeared to account for a substantial proportion of the variation in how well the American Urological Association (AUA) and National Comprehensive Cancer Network (NCCN) guidelines were applied:

- 59% for cytology
- 45% for perioperative intravesical chemotherapy
- 26% for postoperative instillation of Bacillus Calmette-Guérin (BCG) immunotherapy
- 25% for cystoscopy

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



REGISTER FOR THE
NEXT WEBINAR

FCDS is now the host site for Miami, FL with space for 25-30 participants.

Links to each of the webinars within the 2010-2011 NAACCR Webinar series is now available on the FCDS website. You may access the recording, copy of the slides, Q&A, and CE Certificate for each webinar from the series. A CE Certificate has been provided for those viewing the recording of the webinars.



NAACCR 2011-2012 Webinar Series

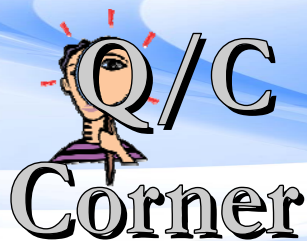
The Florida Cancer Data System is happy to announce that for another year we will be presenting the NAACCR Cancer Registry and Surveillance Webinar, 2011-2012 series at seven locations throughout Florida:

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

DATE/TIME	TOPIC
02/02/2012	Collecting Cancer Data: Lung
03/01/2012	Abstracting and Coding Boot Camp: Cancer Case Scenarios
04/05/2012	Collecting Cancer Data: Lower Digestive System
05/03/2012	Collecting Cancer Data: Hematopoietic
06/14/2012	Using and Interpreting Data Quality Indicators
07/12/2012	ICD-10-CM and Cancer Surveillance
08/02/2012	Collecting Cancer Data: Melanoma of Skin
09/06/2012	Coding Pitfalls

Special thanks to the hosting facilities for their participation and support. For a complete description of the webinars, click here: https://fcds.med.miami.edu/scripts/naaccr_webinar.pl

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 Steve Peace at 305-243-4601 or speace@med.miami.edu.



QUESTIONS? ANSWERS.

QUESTION:

The term Lymphoid Granulomatosis is not in the Hematopoietic data base, but I know I read somewhere that is now considered to be the same as low grade leukemia. In the ICDO it is a borderline tumor. Was I dreaming or is this true? I remember highlighting it, but still can't find it. Is this diagnosis one we need to report?

ANSWER:

While the most recent literature and perhaps even some local pathologists, Lymphoid Granulomatosis is displayed as not reportable in the Heme DB, has no ICD-O-3 code and is not a synonym for another reportable condition. To remain consistent with the rest of the country and with utilization of the Heme DB and Heme/Lymph Rules, we have to stay with the DB until WHO or somebody else asks us to change this. I do not see lymphoid granulomatosis noted as a synonym for low grade lymphoma. I am not sure if this will change in any upcoming revision to the Heme DB – but will forward this on the NCI SEER as an issue to discuss when upgrading/modifying the DB entries.

QUESTION:

Patient came here for BMT that had previous outside bx of sclerotic sacral mass felt to be plasmacytoma with severe polyneuropathy and monoclonal spike of IgG lambda in blood and urine. A bone survey had multiple sclerotic lesions and endocrinopathies and skin changes consistent with diagnosis of sclerotic myeloma.

Physician noted that sclerotic myeloma accounts for 1% of all myelomas and is a rare condition with BMT outcomes better than osteolytic myeloma.

I could not find anything about sclerotic myeloma or POEMS syndrome in the Hematopoietic database as a point of reference.

Am I just dealing with a plasmacytoma that transforms to a multiple myeloma?

ANSWER:

The likelihood of any individual with one or more plasmacytomas (intra or extra osseous) to transform to full blown multiple myeloma is estimated at 10-25% of all cases. This case is more than MGUS (monoclonal gammopathy with unknown significance) because the plasma cells have already begun to proliferate and behave in malignant fashion as shown by the monoclonal spike of IgG. While POEMS and Myeloma are closely related, POEMS syndrome alone is malignant by definition. There is almost always an M-spike in the M-protein and the patient may also have Castleman's Disease – which is reportable. Additionally, this is always treated as though malignant disease is present even if dry tap on bone marrow – because prognosis is poor (less than 5 years in most cases) so they get BMT, etc. We recommend, you code this case as multiple myeloma, NOS with advanced disease.

Bladder Cancer Treatment Often Haphazard

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Source: MedPageToday (www.medpagetoday.com)

"We could do a better job standardizing our management of bladder cancer," agreed J. Stuart Wolf, Jr., MD, of the University of Michigan in Ann Arbor and chair of the AUA practice guidelines committee.

The AUA needs to improve dissemination of its guidelines, likely through getting local "champions" involved and providing physician feedback on performance, he suggested in an interview with *MedPage Today*.

Unless such a broad quality improvement initiative is implemented to provide clinically effective care, "many more unnecessary disease recurrences, procedures, and deaths will be realized," Chamie's group warned in the paper.

However, the study may have somewhat overstated the problem, Wolf argued. "I think their criteria for compliance may have been a bit too rigorous," he said.

Based on guidelines from the NCCN in 1998, AUA in 1999, and European Association of Urology in 2002, which had only slight variation among them, the researchers determined bladder cancer patients should have received:

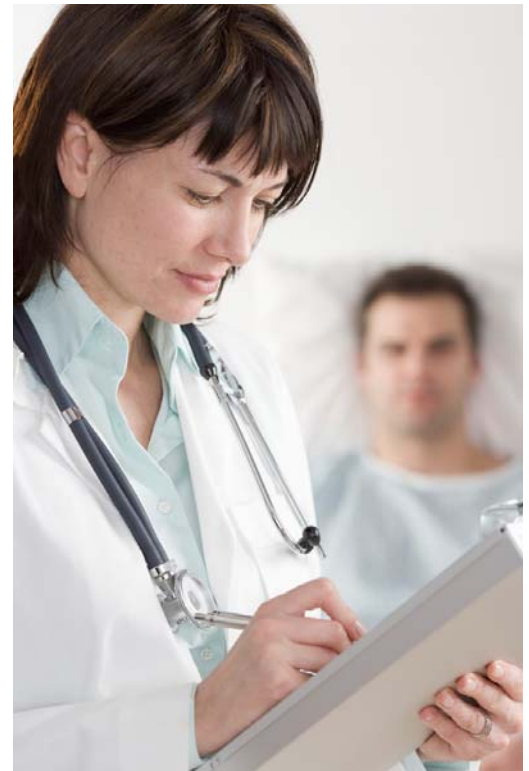
- Frequent surveillance to detect recurrence and progression with cystoscopy and urine cytology every three months for the first two years after diagnosis.
- Upper tract imaging at diagnosis and at least every two years thereafter for a total of at least eight cystoscopies, eight cytologies, and two upper tract imaging studies.
- At least one treatment with intravesical chemotherapy in the form of perioperative mitomycin C (Mutamycin) after transurethral urethral resection of the bladder tumor.
- At least six instillations of BCG immunotherapy postoperatively to minimize recurrence and progression.

Wolf cautioned that the data on perioperative mitomycin was only beginning to come out in the mid- to late-1990s, which may have played a role in lower adherence during the study period.

Even excluding the mitomycin and upper tract imaging requirements, 99% of physicians did not provide the full number of other treatments to a single patient.

While 99% noncompliance is "hard to fathom," eight cystoscopies in two years might be excessive for some patients, Wolf noted, calling it a high bar for compliance.

Yet further relaxing the definition for compliance still yielded poor results.



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Bladder Cancer Treatment Often Haphazard

Source: MedPageToday (www.medpagetoday.com)

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In the study, 42% of physicians did not perform at least one cystoscopy, one cytology, and one instillation of immunotherapy for even a single patient in their practice in the first two years after diagnosis.

The criteria had to drop to requiring only one cystoscopy and one BCG immunotherapy instillation before what at least half of patients received could be considered compliant care (53.6%).

The only patient or provider adherence measures that improved significantly after the guidelines came out were use of radiographic imaging (odds ratio 1.19, 95% confidence interval 1.03 to 1.37)



and immunotherapy (OR 1.67, 95% CI 1.39 to 2.01).

The researchers suggested that physicians have little excuse for poor compliance, since cystoscopy, cytology, and intravesical treatments for bladder cancer are office-based procedures.

"By limiting our cohort to those patients with high-grade disease, we expected preference-sensitive variation to err on the side of overuse, not gross underuse," they chided in the paper.

The group cautioned, though, that their observational study may have been confounded by patient preferences for surveillance and treatment and lack of data on who withdrew from therapy due to side effects, as well as limited in generalizability to patients under age 65 or with private insurance.

The study was supported by the American Cancer Society, Ruth L. Kirschstein National Research Service Award Extramural, Jonsson Comprehensive Cancer Center Seed Grant, and National Institute of Diabetes and Digestive and Kidney Diseases.

The researchers reported having no conflicts of interest to declare.

Wolf reported having no conflicts of interest to declare.

Source reference:

Chamie K, et al "Compliance with guidelines for patients with bladder cancer variation in the delivery of care" *Cancer* 2011; DOI: 10.1002/cncr.26198.

Florida Cancer Data System

Cancer Reporting Completeness Report



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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TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF OCTOBER 31, 2011

Total number of *New Cases* added to the FCDS Master file in October, 2011: **19,631**

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
2011	19,472	220	36	3,172	0	Pending	22,900	11,794
2010	154,733	3,603	103	1,365	57	Pending	159,861	7,523
2009	172,014	9,998	3,375	3,143	73	Pending	188,603	314

		<u>Actual</u>	<u>Expected</u>
% Complete for:	2011	14%	33%
	2010	97%	100%
	2009	100%	100%

**Expected % based on 165,000 reported cases/year*

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

Total number of *New Cases* added to the FCDS Master file in November, 2011: **16,843**

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
2011	31,401	220	56	4,005	0	Pending	35,682	12,782
2010	156,484	3,603	103	1,373	57	Pending	161,620	1,759
2009	172,111	9,998	3,375	3,148	73	2,200	190,905	2,302

		<u>Actual</u>	<u>Expected</u>
% Complete for:	2011	22%	41%
	2010	98%	100%
	2009	100%	100%

**Expected % based on 165,000 reported cases/year*