The Florida Cancer Data System

MonthlyMemo

Monthly Journal of Updates and Information

AUGUST 12

2012-2013 FCDS Educational Webcast Series UPDATE

FCDS is pleased to announce the first in our 6-part series of educational webcasts for 2012 and early 2013.

We encourage all Florida registrars and abstractors to mark their calendars for this entire series of events and plan to participate in all 6 sessions.

The kick-off webcast for our annual series was "What's New for 2012 and More – Annual Meeting Review" which included a recap of the FCDS Annual Meeting, 2012 FCDS Reporting Requirements (What's New) and live demonstrations with instructions on how to use the web-based SEER*Rx Database and the 2012 Hematopoietic Database.

FCDS is pleased to see the great interest and attendance in reference to our 6-part educational series. The webcasts have been tailored to the Florida cancer registrar and cancer case abstractor with emphasis on the 2012 Florida Cancer Reporting Requirements.

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WHAT'S NEW:

The following information is currently available on the FCDS website.

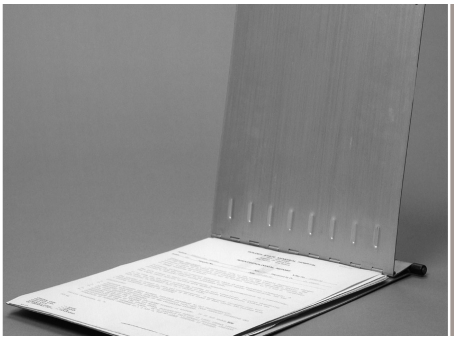
Florida Annual Cancer Report: Incidence and Mortality - 2007

FCDS/NAACCR EDITs Metafile - 12.2B Metafile, posted 06/20/2012 12:44pm, 12.2B Metafile changes, minor changes to Reason No Radiation edits.

FCDS/NAACCR WEBINAR SERIES: NAACCR 2012-2013 CANCER REGISTRY AND SURVEILLANCE WEBINAR SERIES - CODING PITFALLS, 09/06/12, BEING HELD AT 7 FLORIDA FACILITIES AND requires registration.

FCDS Florida Cancer Data System
A Joint Project of the Sylvester Comprehensive Cancer Center and the Florida Department of Health

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



Florida Cancer Data System
Deadlines, Updates, & Reminders

CONSOLIDATED FOLLOW BACK REMINDER

The deadline for completion of your Consolidated Follow Back is fast approaching. Consolidated Follow Back is a combination of AHCA, Ambulatory Surgery Center (AMBI) and the Death Clearance follow back process into a single follow back queue.

The deadline to complete the review and submission of any missed cases is October 15, 2012.

A brief training module has been created to walk through the new Consolidated Follow Back process and can be accessed through our web site at:

http://fcds.med.miami.edu/downloads/Teleconferences/2012/ConsolidatedFollowBack.wmv
Should you have any questions, please contact your Field Coordinator at (305) 243-4600.

"CHANGES WITH THE TIDES"

The Association of NC Cancer Registrars Annual Meeting is being held on September 12-14, 2012 at the Courtyard Marriot Hotel in Carolina Beach, N.C. The event is being hosted by New Hanover Regional Medical Center.

Important Information:

- Continuing Educational Credits– This program has applied for CE credit from NCRA.
- Cancellation Policy– For a full refund of the registration fee, cancellations must be received in writing by August 12, 2012. Cancellations made after this date will be refunded less a $50 administration fee.
- Accommodations–
  Courtyard by Marriott
  100 Charlotte Avenue
  Carolina Beach, N.C. 28428
  Phone: 1-888-321-2211
  Fax: 1-910-458-2050
- Room Rate– All rooms $99 each + 12.75% tax Cut off date for group rate is: August 11, 2012
- For More Information:
  Jo Ann Koch: 866-342-3068
  Joann.loch@nhrmc.org

Target Audience: Cancer Registrars and other health professionals with an interest in oncology data collection and management.

Essential Thrombocythemia versus Refractory Thrombocytopenia - What's the Difference?

FCDS has received several inquiries following the FCDS Annual Meeting asking for additional explanation of the differences between thrombocytopenia versus thrombocythemia; including what is reportable, when they are reportable, and how to code them.

1. Essential (Primary) Thrombocythemia is a reportable myeloproliferative neoplasm characterized by persistent elevated platelet counts of over 750,000 or 1,000,000 with NO KNOWN CAUSE.

IMPORTANT: The terms "essential", "primary", or "idiopathic" are critical in distinguishing reportable neoplastic essential or primary thrombocythemia from reactive (non-neoplastic or secondary) thrombocythemia.

ALTERNATE TERMS: essential thrombocytosis, primary thrombocythemia, primary thrombocytosis, idiopathic thrombocythemia, idiopathic thrombocytosis and hemorrhagic thrombocythemia.

DESCRIPTION: Persistent elevated platelet count over 750,000 or 1,000,000 without any known cause clearly indicates a proliferation or overproduction of platelets. Hence, the classification as myeloproliferative neoplasm. The diagnosis is suspected when a patient has a CBC or peripheral blood smear that shows elevated platelets (clinical diagnosis) and is only made by a hematologist after testing for and excluding a diagnosis of another myeloproliferative neoplasms including; chronic myelogenous leukemia (CML), polycythemia vera (PV), and myelofibrosis. Clinical symptoms include thrombosis (blood clots) and hemorrhage. Treatment is usually low dose aspirin or when platelet counts are extremely high the patient may be treated with hydroxurea or anagrelide. Essential Thrombocythemia may transform to acute myeloid leukemia or primary myelofibrosis.

ICD-9-CM CODES: 238.71 and 238.79 (reportable)

ICD-O CODES: PRIMARY SITE = C42.1

HISTOLOGY = 9962/3

NOTE 1: Thrombocythemia and Thrombocytosis are equivalent terms that indicate a HIGH Platelet Count.

NOTE 2: Thrombocytopenia IS NOT Thrombocythemia or Thrombocytosis.

NOTE 3: Thrombocytopenia indicates a LOW Platelet Count.

2. Reactive (Secondary) Thrombocythemia is not malignant and not reportable. Reactive (Secondary) Thrombocythemia is a temporary inflammatory reaction caused by the body reacting to surgery, overmedication with drugs, inflammatory bowel disease, bacterial infection, absence of spleen (splenectomy), and rheumatoid arthritis.

ICD-9-CM CODE: 287.4 (not reportable)

3. Primary Thrombocytopenia, Secondary Thrombocytopenia, and Thrombocytopenia, NOS are not malignant and not reportable. Thrombocytopenia is an abnormal decrease in the number of platelets. Thrombocytopenia occurs as a result of decreased platelet production as a result of patient exposure to drugs, radiation, congestive heart failure or excess platelet destruction due to spleen malfunction or other cause. Symptoms of thrombocytopenia include small hemorrhages into skin, nosebleed, easy bruising, excess

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Essential Thrombocythemia vs Refractory Thrombocytopenia - What's the Difference?

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menstrual bleeding or other hemorrhage. Treatment may include rest or platelet transfusion.

ICD-9-CM CODES: 287.3, 287.5, 387.4

(not reportable)

NOTE 1: Thrombocythemia and Thrombocytosis are equivalent terms that indicate a HIGH Platelet Count.

NOTE 2: Thrombocytopenia IS NOT Thrombocythemia or Thrombocytosis.

NOTE 3: Thrombocytopenia indicates a LOW Platelet Count.

4. Refractory Thrombocytopenia is a reportable myeloproliferative neoplasm characterized by an abnormal decrease in the number of platelets in the blood (thrombocytopenia) that is unresponsive or "refractory" to treatment with corticosteroids or other therapeutic agents.

IMPORTANT: The distinction between refractory thrombocytopenia and other chronic autoimmune thrombocytopenia is critical and may be difficult to distinguish clinically and/or morphologically. It is imperative that the diagnosis is documented and/or prior treatment failure is documented in the medical record to arrive at the diagnosis of refractory thrombocytopenia.

DESCRIPTION: Thrombocytopenia is an abnormal drop in the number of platelets which are involved in forming blood clots. Symptoms of thrombocytopenia include small hemorrhages into skin, nosebleed, easy bruising, excess menstrual bleeding or other hemorrhage. Refractory Thrombocytopenia is thrombocytopenia that does not respond or has become "refractory" to standard treatment for severe thrombocytopenia which may include: repeated transfusion, systemic corticosteroids, azathioprine, intravenous gamma globulin and even the administration of some chemotherapeutic agents. Refractory thrombocytopenia is characterized by >10% dysplastic megakaryocytes of at least 30 megakaryocytes. Refractory thrombocytopenia may transform to acute myeloid leukemia, NOS or myeloid sarcoma.

ICD-9-CM CODES: 238.72 (reportable)

ICD-O CODES: PRIMARY SITE = C42.1

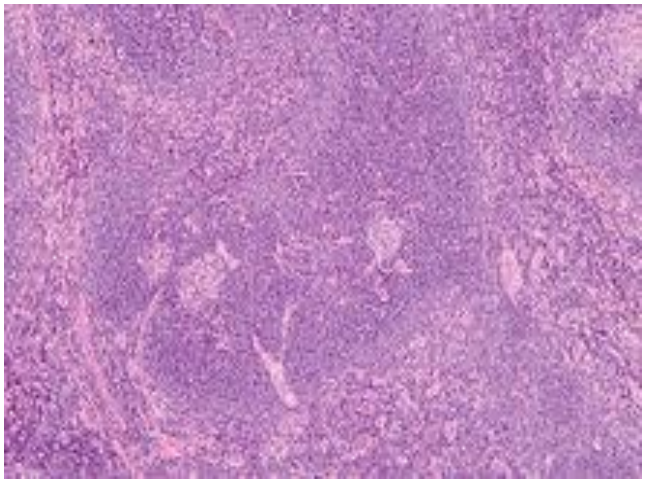
HISTOLOGY = 9992/3

NOTE 1: Thrombocythemia and Thrombocytosis are equivalent terms that indicate a HIGH Platelet Count.

NOTE 2: Thrombocytopenia IS NOT Thrombocythemia or Thrombocytosis.

NOTE 3: Thrombocytopenia indicates a LOW Platelet Count.

Primary Effusion Lymphoma and Lymphoma Arising in HHV8-Associated Castleman Disease



Primary Effusion Lymphoma or PEL (histology code 9678/3) is an aggressive B-cell lymphoma usually confined to one or more body cavities (pleural, pericardial, peritoneal). This lymphoma presents as a serous pleural, pericardial and/or peritoneal effusion(s) with no detectable tumor masses. Usually only one of the body cavities is involved – but there are reported cases where more than one effusion is identified with neoplasm at the time of diagnosis. This type of lymphoma has a very poor prognosis and is usually not responsive to chemotherapy.

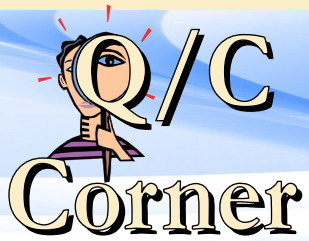
Primary Effusion Lymphoma occurs primarily in patients with advanced HIV disease, profound immunosuppression, and is universally associated with the HHV-8 Kaposi Sarcoma Associated Virus. Again, the only site of disease is in fluid of body cavity(s).

The primary site should be coded C384 (pleura), C380 (pericardium), or C482 (peritoneal cavity). Histology is coded 9678/3.

When the diagnosis is reported as **Castleman Disease with lymphoma**, multicentric Castleman Disease with lymphoma, or **Large B-cell Lymphoma Arising in HHV8-Associated multicentric Castleman Disease,** the lymphoma presents with neoplasm in the lymph nodes and spleen but can also present as diffuse disseminated disease as well as bone marrow and blood involvement. There may also be tumor cells in the body cavity fluids, but there is definite evidence of tumor outside the body cavities.

This neoplasm may also be referred to as plasmablastic HHV8-positive lymphoma or Kaposi Sarcoma Herpes Virus (KSHV)-positive plasmablastic lymphoma and like Primary Effusion Lymphoma is also associated with advanced HIV disease, profound immunosuppression and HHV-8 Kaposi-Associated Virus. There must be neoplasm outside the body cavities of pleural, peritoneum, or pericardium.

The primary site is usually C77* (lymph nodes) or C422 (Spleen). Histology is coded 9738/3.



QUESTIONS? ANSWERS. and CLARIFICATION

QUESTION:
Page 10 and 11 of the 2012 FORDS states that we should not convert Gleason's etc. (special codes) to a histological/differentiating code (i.e. Gleason's 7 = poorly diff = code 3) but should insert a histo code of 9 unless the State requires otherwise. Should we Convert or not Convert?

ANSWER:
FCDS still requires conversion because we do not collect Grade path Value or Grade Path System and do not convert Gleason SSF to grade.

QUESTION:
Is the term "induration" still considered as apparent/ involvement for clinical extension for prostate ca?

ANSWER:
If the term "induration" is used without other demonstrable clinical evidence of disease or statement by physician that there is clinically evident tumor, mass, etc.; induration is not to be used as a term indicative of clinically evident disease.

"Induration" may be a result of the body's reaction to inflammation, hyperemia (excess blood or other fluid), or tumor. Therefore, the term "induration" without other clinical evidence of a mass or tumor should not be used in this case.

The term "induration" is not included anywhere in the CS Extension –Clinical Extension Section of CSv02.03 intentionally, so registrars will not be confused and try to use the term in abstention of demonstrable clinical evidence (palpable tumor or tumor that is visible by imaging).

QUESTION:
Case Scenario: This is a 31-year-old male with increasing abdominal pain starting approximately 24 hours ago. The patient states He has felt fullness in his belly for about a month but nothing significant. He went on to be surgical treated.

7/13/11-CT abdomen; Impression; markedly distended fluid-filled appendix as noted and described above. No associated periappendiceal inflammation. These finding are compatible with a large mucocele of the appendix. 7/14/11-Right hemicolectomy specimen showing; 1. Large intact low grade mucinous cystic tumor of appendix (appendiceal mucocele noninvasive)

Should this case be abstracted?

ANSWER:
This case is not reportable and is based on information provided in the text. A mucocele of the appendix is a benign cyst not an in-situ cancer or a non-invasive polyp with cancer. This was accidentally reported in-situ carcinoma. The term "non-invasive" does not imply "in situ". In this case it refers to a benign cyst. Not reportable and should be deleted. The case passed all edits because it was coded 8010/2 of Appendix – which would be reportable if it was an in-situ carcinoma.

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QUESTION:

Pathology report from two FNA (fine needle aspirates) of the left lung reads: LLL Lung FNA-Positive for malignant cells, consistent with Small Cell Carcinoma and LLL Lung FNA-Small Cell Carcinoma (High Grade Neuroendocrine Carcinoma). Comment: Morphology and stains consistent with High Grade Neuroendocrine Carcinoma from Lung (Small Cell Carcinoma) Should This case be coded 8246/34 (neuroendocrine carcinoma high grade) or 8041/34 (small cell carcinoma high grade)?

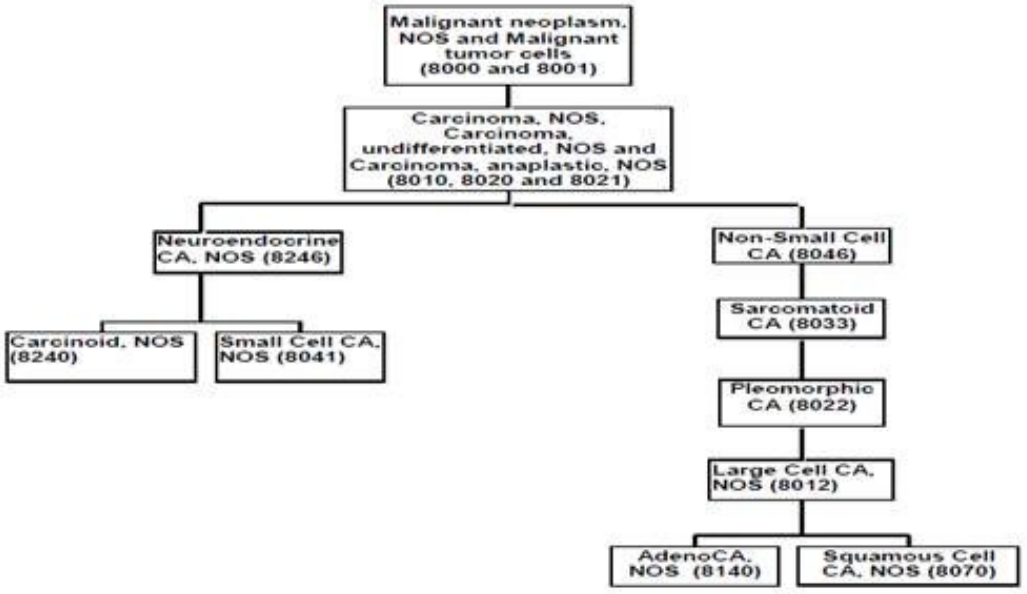
ANSWER:

Small cell carcinoma is a type of neuroendocrine carcinoma – see graphic from MPH Rules – The correct code is 8041/34 (small cell carcinoma, high grade).

Chart 2 – Most Common Lung Histology Groups

Chart Instructions: Use this chart to identify the most common group terms and histology types.

Note: This chart is based on the *WHO Classification of Tumors* for tumors of the lung. The chart is not a complete listing of histologies that may occur in the lung.



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QUESTION:
Pathology Report reads: LLL Small Cell Carcinoma/ Neuroendocrine Carcinoma without grade. Can I use an implied grade of 4 (high grade) for small cell carcinoma? Do I code this case neuroendocrine carcinoma (high grade)?

ANSWER:
Grade of tumor is not implied by the histology "small cell carcinoma" or "neuroendocrine carcinoma." This case should be coded as small cell carcinoma with unknown grade or 8041/39. See above answer to differentiating between small cell carcinoma and neuroendocrine carcinoma coding and refer to the Multiple Primary and Histology Coding Rules (including the charts in the Terms and Definitions) for more information.

QUESTION:
Pathology Report reads: Malignant Carcinoid Tumor/ Neuroendocrine Carcinoma of the Colon with 3/8 nodes positive, grade is not stated. Do I code histology to Carcinoid Tumor (8240/39) or Neuroendocrine Carcinoma a higher code (8246/39)?

ANSWER:
Carcinoid Tumor is a type of Neuroendocrine Neoplasia that is often malignant, therefore reportable to FCDS. Carcinoid tumors can develop anywhere in the GI Tract, Lungs, and other organs. The only carcinoid tumors that are not reportable to FCDS are LOCALIZED carcinoid tumor of the appendix.

The term "neuroendocrine carcinoma" is a broad term that includes many types of cancers that go by various names including; carcinoid tumor, neuroblastoma, schwannoma, Merkel cell carcinoma of the skin, small cell carcinoma, and large-cell neuroendocrine carcinoma to name just a few.

Because "neuroendocrine carcinoma" is a general term and "carcinoid tumor" is a specific type of neuroendocrine carcinoma, you should code carcinoid tumor in this case (8240/39) even though neuroendocrine carcinoma has a higher ICD-O-3 histology code. The same goes for any more specific type of neuroendocrine tumor. If there is both the term "neuroendocrine carcinoma" and a more specific type such as those noted above, code to the more specific type of neuroendocrine carcinoma, regardless of the numerical order of the ICD-O-3 codes.

QUESTION:
Pathology report reads: Transverse colon with Carcinoid Tumor/Low Grade Neuroendocrine Carcinoma. What is the histology and grade? What is the histology and grade for High Grade Neuroendocrine Carcinoma **(CARCINOID TUMOR)**

ANSWER:
Code both cases with the histology 8240/3 (carcinoid tumor) with Grade = 2 (low grade) and Grade = 4 (high grade)

Stated Grade	Grade Code
Low Grade	2
High Grade	4

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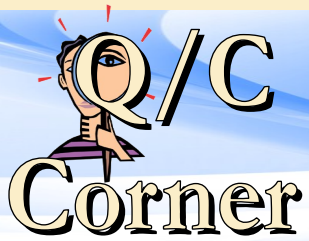

QUESTIONS? ANSWERS. and CLARIFICATION

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QUESTION:
High Grade Dysplasia or Severe Dysplasia of the Esophagus, Colon, and other organs in the Gastrointestinal Tract is considered equivalent to Carcinoma In Situ of these sites per the AJCC TNM Manual, 7th edition. Should we be abstracting cases of high grade dysplasia of the esophagus and colon? What is the correct histology code for these cases?

ANSWER:
The College of American Pathologists and the AJCC in trying to clarify the current use by pathologists of the terms "severe dysplasia," "high grade dysplasia" and "carcinoma in situ" anywhere in the GI Tract (Esophagus, Stomach, Small Intestine, Colon, Rectum, Pancreas, Liver, Biliary System) have made casefinding, abstracting and coding these neoplasms very confusing to registrars. The line between high grade dysplasia (sever dysplasia) and carcinoma in situ (CIS) can be very narrow or even non-existent and the clinical significance and management of these neoplasms is often identical. Both are "precancerous" lesions.

Neither carcinoma in situ or severe dysplasia/high grade dysplasia has any potential to metastasize. It is not until the neoplasms invades the basement membrane (the thin layer of connective tissue the lines the surface epithelium of an organ or lines a body cavity) that the neoplasm is classified as "malignant" and has the potential to metastasize. Once the basement membrane has been breached, malignant cells have access to blood vessels, lymphatic vessels, and nerves along which they can travel and spread (metastasize).

Currently, the guidelines from the Consensus Technical Work Group (SEER, CoC, NPCR) is that "dysplasia is only reportable when it is specified as carcinoma in situ (the pathology report has to include the words carcinoma in situ or CIS). However, hospital registrars may speak with their pathologists to determine whether their use of these terms for specific sites in the GI Tract are consistently synonymous with carcinoma in situ. If the hospital uses more than one pathologist – they all must be in agreement that the terms are used synonymously. If the pathologist(s) are in agreement and/or the facility Cancer Committee wants these cases to be included in your registry as carcinoma in situ – there must be documentation in the abstract text that states "per pathologist – high grade dysplasia = carcinoma in situ" or something similar.

The ICD-O-3 Work Group is trying to address this issue and include clarification in the upcoming release of ICD-O-3 Updates currently slated for 2013. The Work Group has also noted that at this time the only way to identify these cases is by pathology review because there are no ICD-9-CM or ICD-10-CM codes for high grade/severe dysplasia of any organs in the GI Tract. The ICD-O-3 Work Group is working with AHIMA to assess plans to include new codes for ICD-9-CM to identify high grade/severe dysplasia in various organs within the GI Tract.

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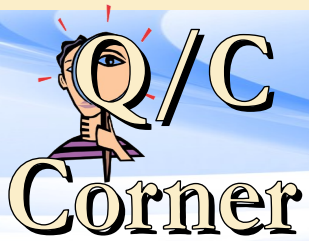
QUESTION:
The terms "Malignant Lymphoma, Diffuse Mixed Large and Small Cell Type" and "Chronic Myeloproliferative Disease" have [obs] next to them in the Hematopoietic Database. Can I still use these codes?

ANSWER:
NO. [obs] or [OBS] next to a hematopoietic or lymphoid neoplasm term and/or code indicates that both the term and code are OBSOLETE and should not be used. Most of the [OBS] codes in the 2012 Hematopoietic Database (http://seer.cancer.gov/seertools/hemelymph) also include a reference to a different histology code that should be referenced and used to code the case. For example; the term chronic myeloproliferative disease [OBS] see 9975/3 appears in the 2012 Hematopoietic Database when you look up chronic myeloproliferative disease or chronic myeloproliferative disorder. This indicates that the new code and current terminology that is used to describe this myeloid neoplasm (which is reportable) is "myelodysplastic/myeloproliferative neoplasm unclassifiable" with histology code 9975/3 and Grade = 9. ALWAYS refer to the 2012 Hematopoietic and Lymphoid Neoplasm Rules and Database when abstracting ANY case with histology 9590/3 or greater. DO NOT USE the ICD-O-3 for any code 9590/3 or greater or you run the risk of coding these neoplasms with outdated rules and obsolete codes which soon will have EDITS in place so you will not be able to use them without getting an edit that cannot be overridden or FORCED.



QUESTIONS? ANSWERS. and CLARIFICATION

Source: *The CoC, NPCR, SEER Technical Workgroup*

A group of data collection experts representing three standard-setting agencies has been meeting regularly via conference call since July 2007. The American College of Surgeons Commission on Cancer (CoC), the Centers for Disease Control and Prevention National Program of Cancer Registries (NPCR), and the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute are collaborating to clarify and explain coding rules and instructions. The group works together to arrive at consensus answers to questions, and to develop agreed-upon approaches to new data collection issues. These are clarifications rather than new coding rules or instructions. This is the second in a series reporting issues discussed and the decisions made by the group.

Issue #1

Guidance needed on how to code diagnostic confirmation for hematopoietic and lymphoid neoplasms when immunophenotyping, genetics, etc. confirm the diagnosis.

Decision

Code 3 is used for hematopoietic and lymphoid cases when three conditions are met: 1) genetic testing and/or immunophenotyping are described in the Hematopoietic Database "Definitive Diagnostic Methods" field AND 2) genetic testing and/or immunophenotyping were done AND 3) the genetic testing and/or immunophenotyping were positive (proved the type of neoplasm being coded).

Issue #2

When coding diagnostic confirmation for hematopoietic and lymphoid neoplasms other than leukemia, is flow cytometry the basis for a positive hematologic findings, including peripheral blood smears, CBC, WBC? There are instructions to assign Code 1 for leukemia only for positive hem findings.
Should these include other hem cases- e.g. JAK-2 or elevated counts for PV, etc.

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Decision
Flow cytometry is a test for immunophenotyping and also for genetic testing. It is coded for hematopoietic and lymphoid neoplasms using the directions in the previous question.

Code 1 is used for leukemia only and records a positive blood count (CBC or peripheral blood).

JAK 2 is a definitive diagnostic method for polycythemia vera and essential thrombocythemia. For coding instructions, see above.

Issue #3
Breast reconstruction may be delayed for valid reasons (e.g., pt too thin at surgery). Should delayed reconstruction be coded in the field "Surgery of Primary Site?"

Decision
If the reconstruction is included in the treatment plan, it is first course of treatment. When a tissue expander is inserted at the time of surgery, code reconstruction.

Issue #4
Bladder primary site surgery reconstruction codes apply to males. Can we agree to drop reference to males and use same codes for all? What about intravesical and BCG installation?

Decision
The code definitions have been rewritten for inclusion in the FORDS. Intravesical and BCG installation will not change until the next version of FORDS is written.

Issue #5
Should donor lymphocyte infusion be coded as treatment?

Decision
Code as immunotherapy. The lymphocyte donation from the original donor creates an immune reaction to the cancer cells.

Issue #6
Are VIN IIIs reportable?

Decision
Yes for SEER and NPCR. No for CoC.
SEE: Table 2. NAACCR Layout Version 12: Comparison of Reportable Cancers: CoC, SEER, NPCR and CCCR in Chapter III of NAACCR Vol II, Fifteenth Edition.

Issue #7
Are bladder papillary urothelial neoplasms of low malignant potential (PUNLMPs) reportable?

Decision
No. These are not reportable. PUNLMPs are premalignant growths in the upper urinary tract (renal pelvis, ureters, urinary bladder, part of the urethra).

Issue #8
Are cervical dysplasia, CIN III, and severe dysplasia of the cervix reportable?

Decision
CIN III and carcinoma of the cervix in situ are no longer reportable to NPCR or CoC and are not reportable for SEER starting with cases diagnosed after

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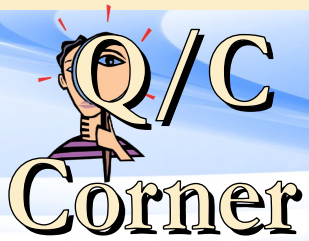

QUESTIONS? ANSWERS. and CLARIFICATION

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Issue #9
Is high-grade dysplasia of the GI tract reportable? The AJCC and CAP protocols say high-grade dysplasia is synonymous with carcinoma in situ.

Decision
Dysplasia is only reportable when it is specified as carcinoma in situ. Refer to the standard setters' manuals and the table in NAACCR Volume II which defines reportability for each of the standard setters.

Issue #10
Should aspirin and phlebotomies still be coded as treatment for hematopoietic neoplasms?

Decision
Yes, continue with current instructions.

Issue #11
How are dates recorded when cancer is diagnosed in utero, or prior to birth?

Decision
Instructions were changed for cases diagnosed 2009 and forward. Record the actual diagnosis and treatment dates even when the dates are prior to date of birth.

Issue #12
Post-transplant patients may develop a malignant myeloproliferative neoplasm. When immunosuppression drugs are stopped, the myeloproliferative neoplasm usually subsides. Is the elimination of immunosuppression treatment codable as other treatment?

Decision
Do not code as a treatment. Record the cessation of immunosuppressive drug treatment in text to explain the patient's change in disease status.

Issue #13
For breast primaries, the SEER manual states "Code the subsite with the invasive tumor when the pathology report identifies invasive tumor in one subsite and in situ tumor in a different subsite or subsites." The FORDS manual does not include this instruction.

Decision
This specific instruction from the SEER manual will also be added to the MP/H manual for all to follow.

Issue #14
A number of hematopoietic diseases were not reportable until 2010, including transformations and newly reportable diseases. If these diseases were diagnosed prior to 2010, are they included in the sequencing?

Decision
If the original hematopoietic disease was not reportable at time of diagnosis, do not include it in the sequencing.

Issue #15
How is neo-adjuvant therapy coded for a second primary discovered at surgery? For example, a patient had neo-adjuvant chemo for rectal ca. An A-P resection revealed intramucosal ca in adenomatous polyp in descending colon which was a second primary.

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Decision
The neo-adjuvant chemotherapy is recorded for both primaries.
For the second primary, use the date of diagnosis as the date of systemic therapy.

Issue # 16
WHO has defined some new brain codes. How will these be handled?

Decision
The new codes will be addressed in the MP/H revision.

Issue # 17
What are the equivalent terms to be used for behavior of /2?

Decision
The list of terms synonymous with "in situ" was reviewed. The term non-invasive will be dropped from the list. Otherwise the list will remain as written in the FORDS and the SEER manual.

Issue # 18
How should high intensity focused ultrasound (HIFU) used to treat prostate cancer be coded?

Decision
Assign surgical code 17 - other method of local tumor destruction. HIFU, sometimes called FUS or HIFUS, is a high-intensity focused ultrasound that heats and destroys tissue.

Issue # 19
When a chemo agent is used for radio-sensitizing, should it be coded as chemotherapy?
For example, Cisplatin used for radio-sensitization.

Decision
Do not code as chemotherapy when documented as being used for radio-sensitization.

Issue # 20
How is the cumulative result of multiple surgeries coded? For example, the first procedure: 'Nipple-sparing' mastectomy with 5 sentinel lymph nodes removed. The second procedure: re-excision left mastectomy with left completion axillary dissection (14 nodes removed). There is a question about the code because the nipple is kept intact. Should this type of scenario be coded to cumulative modified radical mastectomy even though the nipple was not removed? Rationale for this is based upon the ACoS I&R 45322 for skin sparing mastectomy and the fact that this is reflective of the cumulative intent of the surgery (based upon physician statements).

Decision
Code modified radical mastectomy - sparing the nipple is for cosmetic purposes only. Nipple sparing may be done to facilitate immediate reconstructive surgery.

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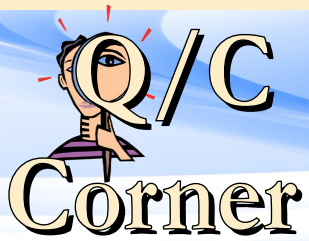

QUESTIONS? ANSWERS. and CLARIFICATION

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Issue # 21

Are stage 1 GIST tumors reportable? In the past, tumor size and mitotic rate were used to determine if malignant, not stage.

Decision

GISTs are to be reported based on the pathologist's designation of tumor behavior, just as with all sites.

Issue # 22

We are collecting some GIST cases at the direction of our pathologists. CoC offered that AJCC's comments can be taken as informational, but they do not define what is required to be reported to any particular standard setter. However, at least from CoC's perspective, any hospital is entitled to collect any non-required cases it chooses, but it may well be that neither NCDB nor the states will want those reported unless they specify in situ or behavior =2.

Decision

GIST is not reportable unless it is identified as being in situ or malignant. This question is an issue of reportability based on behavior and must be reviewed on a case by case basis. Do not enter these cases with a behavior code of /2 unless you have a way to flag them so they are not reported to NCDB or your state as an in situ case.

Issue #23

Code C148 assigned for squamous cell carcinoma diagnosed from lymph node and deemed to be a head and neck primary but specific site could not be identified. Code C148 is based on note in ICD-O-3 indicating it should be used when a code between C000 and C142 cannot be assigned. I & R (46158) indicated it should be coded to C760.

Decision

Assign C148 based on the note in ICD-O-3. C148 is a more specific site code than C760. The I & R answer has been revised.

Issue # 24

We know when suspicious cytology is followed by any of the following: path confirmation, clinical diagnosis by the physician or treatment, the date of the path diagnosis or clinical diagnosis or treatment is used as date of diagnosis. Now we wonder if those "but ifs" should be included in the directions. For example, if diagnosis is supported by other methods or if the doctor treats as malignancy.

Decision

The FORDS manual and SEER manual both have instructions under the data item "Diagnostic Method" that give a hierarchy for coding the type of diagnosis. Both manuals instruct that the diagnostic method code should be changed when, for example, the first diagnosis was clinical and at a later date the cancer was histologically confirmed. The case should not be accessioned based on suspicious cytology, and the date of suspicious cytology should not be used as the date of diagnosis even when proven to be a malignancy at a later date.

Issue #25

Appendix carcinoids should be reported when stated to be malignant in the pathology report or when there are

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discontinuous malignant metastases or metastases to regional lymph nodes. However, the CSv2 slides state clearly that carcinoids are not to be reported unless reportable by agreement.

Decision
The CSv2 slides have been corrected

Issue #26
Suggest adding one or more new codes for subcutaneous mastectomy because it is being used increasingly for breast cancer patients, and it is used specifically in conjunction with immediate reconstruction (to take advantage of sparing the skin). The current instructions identify the procedure as "rarely used for malignancies", and the current code structure does not allow for recording reconstruction. The code for subcutaneous mastectomy is 30, and the other codes in the 30s range are not in use for breast.

Decision
The note “rarely used” was removed. FORDS revised for 2011 states “Cases coded 30 may be considered to have undergone breast reconstruction.”

Issue #27
There are insufficient class-of-case codes for Non-COC, Non-hospital reporting facilities.

Decision
Additional definitions have been incorporated in the FORDS.

Issue #28
Is the following interpretation of first course of treatment correct?

Woman has a biopsy of an enlarged axillary node on 02/01/09. She is informed of a breast cancer diagnosis a few days later. She does not comply with her treatment plan, and the physician loses contact with her. On 05/01/2009 she returns to the physician saying she's ready to be treated. May 10th, she has her lumpectomy/node dissection and makes plans for her radiation therapy.

The case is coded as follows: The first surgical event is the lymph node biopsy. For that surgical event, code Surgery of Primary Site as 00, Scope of Regional Lymph Node Surgery as 1, and Date of First Surgical Procedure as 02/01/2009. For the second surgical event, code Surgery of Primary Site as 22, Scope of Regional Lymph Node Surgery as 3, and Date of Most Definitive Surgical Resection as 05/10/2009.

However, because of the instruction on how to code Date of First Course of Treatment (earliest of Date of First Surgical Procedure, Date Radiation Started, Date Systemic Started, Date Other Tx Started), it is coded as 02/01/2009. In the system, it looks like she started treatment in February when she didn't have any treatment until May.

Decision
This is correct at the present time. It may be evaluated in the future.

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Issue #29

There is some talk in Canada about allowing severe dysplasia of the colon to be equal to in situ cancer of the colon. Canada has a history of collecting /1 behavior neoplasia, so changing the behavior may not have as great an implication there. Yet Canada does want to follow the SEER counting rules and this will greatly increase the number of in situ cancers. SEER still holds to the idea that vocabulary of "dysplasia" is not coded, correct? The case would only be /2 if the words "in situ" also appear, regardless of any reference to dysplasia. Is that still correct? The reasoning was that pathologists did not all agree on the equality of severe dysplasia to in situ disease.

Decision

In the US, the only time severe dysplasia is reportable is when it is documented by the pathologist as being synonymous with carcinoma in situ. Hospital registrars may speak with their pathologists to determine whether their individual diagnosis of severe dysplasia is always equal to in situ. If so, written documentation must be included in the registry procedure manual and those cases would be reportable.

Issue #30

Surgical diagnostic procedures: What is the code for bone marrow (BM) biopsy for stage IV large B-cell lymphoma (LBCL)? 01 is for biopsy to other than primary and 02 is done to primary site or removal of node to diagnose or stage lymphoma.

Decision

In most cases, bone marrow is not the primary site for B-cell lymphomas. However there are a number of B-cell lymphomas and since it is unknown to which B-cell lymphoma you are referring, we will assume that the primary site is not BM. Code the BM biopsy 01 - biopsy of other than primary site.

Issue #31

Suggest evaluation of the use of ambiguous terminology. Medical record coders and registrars do not code the same.

Decision

After reviewing reports generated by CoC, there are a lot of malignancies reported based on ambiguous terminology at diagnosis. Currently no changes are planned for ambiguous terminology. We are using the data items Ambiguous Terminology at diagnosis and Date of Conclusive Diagnosis to evaluate the effect of ambiguous terminology on incidence counts. We need a few more years of data in order to complete this evaluation.

2012-2013 FCDS Educational Webcast Series

DATE/TIME	TOPIC
*8/16/2012	FCDS Annual Meeting Review and What's New for 2012
9/20/2012	FCDS Learning Management System – 2012 New / Annual Testing for FCDS Abstractor Code, Testing / Maintenance Requirements and Using the FCDS On-Line Learning Management System
10/18/2012	GYN Neoplasms - Background/Anatomy/Risk Factors/MPH Rules/CS02.04/ SSF/Tx
11/15/2012	Improving Data Quality Using FCDS Data Quality Reports
1/17/2013	Pediatric Neoplasms - Background/Anatomy/Risk Factors/MPH Rules/CS02.04/ SSF/Tx and introduction of Plans for New Mini-Series for Pediatric Neoplasms (Brain, Sarcoma, Heme/Lymph)
2/21/2013	Genitourinary Neoplasms (Kidney,Renal Pelvis, Urinary Bladder,Prostate) - Background/Anatomy/Risk Factors/MPH Rules/CS02.04/SSF/Tx

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

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, CSv02.04 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 2012 FCDS Annual Meeting in St. Petersburg, 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 .

FCDS has applied for CEU credits (2 hours for each webcast) through NCRA. NCRA CEU numbers and credit hours will ne published in a future monthly memo.

NAACCR 2012-2013 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, 2012-2013 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)**

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.

DATE/TIME	TOPIC
9/06/2012	Coding Pitfalls
10/4/2012	Stomach and Esophagus
11/1/12	Uterus
12/6/12	Pharynx
1/10/13	Bone and Soft Tissue
2/7/13	Central Nervous System
3/7/13	Abstracting and Coding Boot Camp: Cancer Case Scenarios
4/4/13	Breast
5/2/13	Bladder and Renal Pelvis
6/6/13	Kidney
7/11/13	Topics in Geographic Information Systems
8/1/13	Cancer Registry Quality Control
9/5/13	Coding Pitfalls

All NAACCR 2012-2013 Webinars presented in series are available on the FCDS website, on the Downloads page: http://fcds.med.miami.edu/inc/teleconferences.shtml

NAACCR CANCER REGISTRY AND SURVEILLANCE WEBINAR SERIES

Seven Florida facilities will host the 2012-2013 webinar series, *registration is required*

REGISTER FOR THE NEXT WEBINAR

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

Links to each of the webinars within the 2012-2013 NAACCR Webinar series is 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.

Florida Cancer Data System
Cancer Reporting Completeness Report

TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF JULY 31, 2012

Total number of *New Cases* added to the FCDS Master file in July, 2012: **6,572**

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
2012	0	0	0	2,838	0	**Pending**	2,838	**546**
2011	145,906	2,139	96	6,656	0	**Pending**	154,797	**5,338**
2010	164,234	9,420	110	1,602	57	**Pending**	175,423	**688**

		Actual	Expected
% Complete for:	**2012**	**2%**	**8%**
	2011	94%	100%
	2010	100%	100%

Expected % based on 165,000 reported cases/year

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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