The procedures for the processing of FCDS IDEA User Accounts and FCDS Abstractor Codes has been revised.

Please review the following links and information for detailed instructions regarding the renewal of your FCDS Abstractor Code, managing of FCDS IDEA user accounts and the links for accessing FCDS IDEA and the FCDS Learning Management System (LMS).

Please review the recording of the 1/8/2013 teleconference: *FCDS Automated User Account and Using the FCDS On-Line Learning Management System* and download the slides for quick reference. Both are available on our website at: http://fcds.med.miami.edu/inc/teleconferences.shtml

(Continued on page 3)

WHAT'S NEW:

The following information is currently available on the FCDS website.

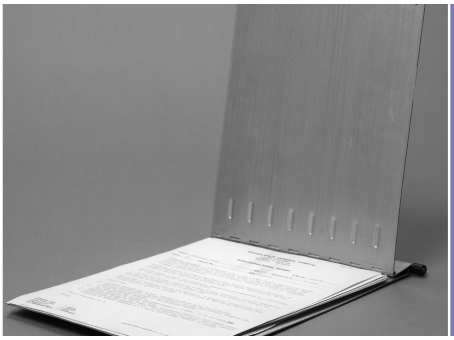
FLORIDA ANNUAL CANCER REPORT: INCIDENCE AND MORTALITY - 2008

FCDS/NAACCR EDITs Metafile - 12.2C Metafile, posted 09/6/2012 1:25pm, 12.2B Metafile changes, minor changes to Reason. No Radiation edits.

FCDS/NAACCR WEBINAR SERIES:

NAACCR 2012-2013 CANCER REGISTRY AND SURVEILLANCE WEBINAR SERIES - ABSTRACTING AND CODING BOOT CAMP: CANCER CASE SCENARIOS 3/7/13, 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.



Florida Cancer Data System

Deadlines, Updates, & Reminders

Save The Date!

Florida Cancer Data System 2013 Annual Conference Registration

The 2013 Florida Cancer Data System Annual Conference is being held July 25-26 at the DoubleTree by Hilton Hotel Sunrise - Sawgrass Mills

The FCRA Annual conference is at the same hotel and precedes the FCDS conference.

Topics /Slides- coming soon

July 25-26, 2013		
July 24th	Early Registration	4:00 PM - 6:00 PM
Day 1		
July 25th	Registration & Continental Breakfast	7:30 AM
	Conference	8:30 AM - 5:00 PM
Day 2		
July 26th	Registration & Continental Breakfast	7:30 AM
	Conference	8:30 AM - 3:00 PM

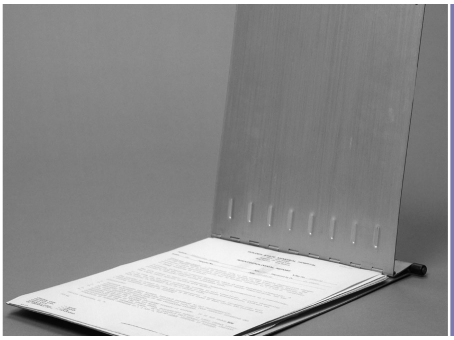
For more information contact:

Bleu Thompson
Florida Cancer Data System
PO Box 016960 (D4-11)
Miami, Florida 33101
bthompson@med.miami.edu
305-243-2635
305-243-4871 (Fax)

Register online Now!

Click here https://fcds.med.miami.edu/scripts/register.pl

Fill out your registration information, press the submit button, print the resulting page, and submit it along with your $50.00 registration check payable to "Florida Cancer Data System".
Our Tax-ID # is 59-0624458. The registration fee is non-refundable.



Florida Cancer Data System

Deadlines, Updates, & Reminders

(Continued from page 1)

QUICK REFERENCE - FCDS IDEA USER ACCOUNTS

- **Existing User Account Instructions:** http://fcds.med.miami.edu/downloads/Teleconferences/2013/User%20Account%20Instructions%20EXISTING%20USER%20_%20ABSTRACTOR.pdf

⇒ *Access the FCDS IDEA :* http://fcds.med.miami.edu/inc/idea.shtml#

- **New User Account Instructions:** http://fcds.med.miami.edu/downloads/Teleconferences/2013/User%20Account%20Instructions%20NEW%20USER%20_%20ABSTRACTOR.pdf

⇒ Create new FCDS IDEA account: https://fcds.med.miami.edu/scripts/fcdswebapp/UserSetup.html

RENEWING YOUR FCDS USER ACCOUNT:

You must renew your FCDS User account annually. Please log into IDEA as usual to review and update your IDEA profile if necessary.

As part of this process you must update your password to renew your account. To do this:

1. Double click in the box titled '**PASSWORD**' hit backspace and change password.
2. Repeat in the box titled '**VERIFY PASSWORD**'
3. Then hit '**SUBMIT**'

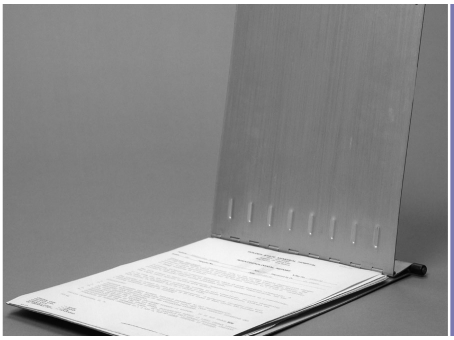
Your user account renewal is now complete.

ABSTRACTOR CODE RENEWAL

Overview of the FCDS Learning Management System (LMS) :
http://fcds.med.miami.edu/downloads/Teleconferences/2013/LMS%20overview%20FCDS.pdf

FCDS: Learning Management System: http://moodle.med.miami.edu

(Continued on page 4)



Florida Cancer Data System

Deadlines, Updates, & Reminders

(Continued from page 3)

FACILITY ACCESS ADMINISTRATOR

EVERY HOSPITAL, AMBULATORY CARE AND RADIATION THERAPY FACILITY MUST HAVE AN FAA. DEADLINE IS MARCH 31, 2013

FCDS has implemented a new web-based facility access system. This system designates one individual at each reporting facility to be the Facility Access Administration (FAA). The FAA will have complete oversight regarding assigning and/or un-assigning reporting personnel from the respective facility. The assigned reporting personnel will have limited or full access to the reporting facility(s) Protected Health Information (PHI) as determined by the FAA.

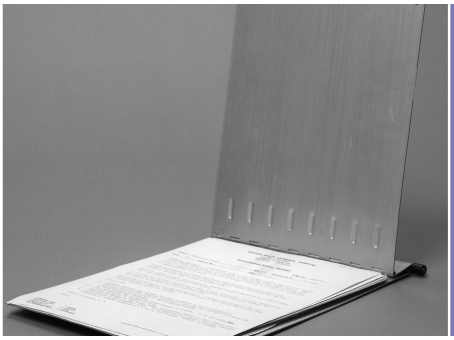
Who is typically the Facility Access Administrator (FAA)?

- Administrator/supervisor of the registry activities who's duties include
    - Assigning and managing abstracting personnel for the facility

Role of the Facility Access Administrator (FAA) for FCDS

- Adds/deletes/modifies abstractor access to the data
- Has complete control of the abstracting activities at their respective facility(s)

* Please note: Contract abstractors **can not** be FAA's. The FAA must be an employee of the facility.



Florida Cancer Data System

Deadlines, Updates, & Reminders

SEER*Rx- Interactive Drug Database / Version 2.1.0 released January 23, 2013

The SEER*Rx Interactive Drug Database was updated on January 23, 2013. This version includes 3 new regimens, 12 new drugs (Phase I, Phase II, or Phase III clinical trials or recently approved by the FDA). 71 drugs currently in the database have been updated to include generic names and or updated information added to the remarks field. 255 drug regimens have been modified. Review of the regimens in SEER*RX noted an ancillary drug (which is not coded) was inadvertently added to these regimens. The drug in question has been deleted.

IMPORTANT UPDATE: Six drugs have changed categories. Please refer to the summary of changes document which is available on the SEER*RX page.

SEER*RX is now available in two formats: a web-based tool and as stand-alone software.

Web-based Version

The SEER*Rx - Interactive Antineoplastic Drugs Database is provided in a web-based format that has several benefits over the software:

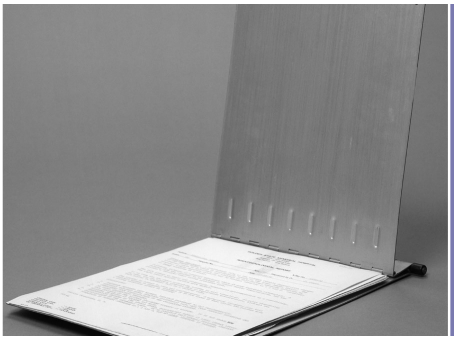
* Updates are automatic: users do not have to install anything to access the latest revisions.
* Allows access from any computer or device with an Internet connection.
* Eliminates problems for users who do not have permission to install software on their work computers.

Download Software Version

The web-based version of the SEER*Rx is the preferred method to access the current data. If you need the software version because of limited Internet access, it is still available for now, but may be phased out in the future. Note that the coding information in the software version of the database can get out-of-date; be sure to check back to this site to install any updates.

Download the SEER*Rx Version 2.1.0 (released January 23, 2013) SEER*RX Version 2.1.0 replaces previous versions. You will need to delete the old version prior to downloading version 2.1.0

(Continued on page 6)



Florida Cancer Data System

Deadlines, Updates, & Reminders

(Continued from page 5)

A comprehensive review of chemotherapeutic drugs currently found in SEER*RX has been completed and in keeping with the FDA, the following drugs listed in the table below have changed categories from Chemotherapy to BRM/Immunotherapy. This change is effective with diagnosis date January 1, 2013 forward. For cases diagnosed prior to January 1, 2013 continue coding these six drugs as chemotherapy. Coding instructions related to this change have been added to the remarks field for the applicable drugs.

Drug Name(s)	Previous Category	New Category	Effective Date
Alemtuzumab/Campath	Chemotherapy	BRM/Immuno	1/1/2013
Bevacizumab/Avastin	Chemotherapy	BRM/Immuno	1/1/2013
Rituximab	Chemotherapy	BRM/Immuno	1/1/2013
Trastuzumab/Herceptin	Chemotherapy	BRM/Immuno	1/1/2013
Pertuzumab/Perjeta	Chemotherapy	BRM/Immuno	1/1/2013
Cetuximab/Erbitux	Chemotherapy	BRM/Immuno	1/1/2013

Summary Report:

- Total number of drugs listed in SEER*RX: 1825
- Total number of Regimens listed in SEER*RX: 853
- Number of drugs added: 12
- Number of drugs modified: 71 (includes spelling and grammar corrections, updated remarks)
- Number of regimens added: 3
- Number of regimens deleted: 1 (duplicate)
- Number of regimens modified: 255
- When SEER*RX was moved to the new format, an ancillary drug, which is not coded, was inadvertently added to 255 regimens. The drug in question has been deleted from these regimens.

Breast Cancer ER/PR/HER2 Testing

⇒ **WHEN AND WHY ARE ER/PR/HER2 TEST(S) PERFORMED AS PART OF CREATING INDIVIDUAL BREAST CANCER PROFILE?**

- Estrogen Receptor (ER)
  - Test routinely performed on invasive cancers
  - Test may be performed on non-invasive (in-situ) cancers
  - Result used to determine whether or not Hormonal Therapy should be considered in 1st course treatment plan

- Progesterone Receptor (PR)
  - Test routinely performed on invasive cancers
  - Test may be performed on non-invasive (in-situ) cancers
  - Result used to determine whether or not Hormonal Therapy should be considered in 1st course treatment plan

- Human Epidermal growth factor Receptor 2 (HER2)
  - Test frequently but not always performed on invasive cancers
  - Test rarely performed on non-invasive (in-situ) cancers at this time
  - Test may be performed using one or more methods (IHC, FISH, CISH, Other)
  - An equivocal or borderline result from IHC HER2 Test may trigger additional testing using FISH or CISH
  - Some facilities bypass IHC HER2 Test and perform FISH HER2 Test as part of routine Breast Cancer Profile
  - Result used to determine whether or not Herceptin (trastuzumab) or Tykerb (lapatinib) should be included in 1st course treatment plan

Favorable Prognostic Factors ER/PR/HER2

- ✓ Estrogen Receptor (ER) **positive** is a favorable prognostic factor.
  - Hormonal Therapy should be considered in 1st course treatment planning.
- ✓ Progesterone Receptor (PR) **positive** is a favorable prognostic factor.
  - Hormonal Therapy should be considered in 1st course treatment planning.
- ✓ **Single Receptor positive** tumors (ER+ only or PR+ only) do exist but are rare with an unfavorable prognosis
  - These tumors are often large in size, are of high grade, are often HER2+, and are often lymph node +
  - Single Receptor positive tumors are usually not treated with Hormonal Therapy
- ✓ Human Epidermal growth factor Receptor 2 (HER2) **positive** is a favorable prognostic factor.
  - Herceptin (trastuzumab) or Tykerb (lapatinib) should be included as part of 1st course treatment plan

(Continued on page 8)

Breast Cancer ER/PR/HER2 Testing

(Continued from page 7)

Unfavorable Prognostic Factors ER, PR, HER2

- Estrogen Receptor (ER) **negative** is an unfavorable prognostic factor.
  - Hormonal Therapy usually not included as part of 1st course treatment plan
- Progesterone Receptor (PR) **negative** is an unfavorable prognostic factor.
  - Hormonal Therapy usually not included as part of 1st course treatment plan
- **Single Receptor negative** tumors (ER- only or PR- only) do exist but are rare with an unfavorable prognosis
  - These tumors are often large in size, are of high grade, are often HER2+, and are often lymph node +
  - Single Receptor negative tumors are usually not treated with Hormonal Therapy
- Human Epidermal growth factor Receptor 2 (HER2) **negative** is an unfavorable prognostic factor.
  - Herceptin (trastuzumab) or Tykerb (lapatinib) usually not included as part of 1st course treatment plan

♦ **Triple Negative** Breast Cancer (ER neg/PR neg/HER2 neg) is a **very unfavorable** prognostic combination.

Test	Value Range	Negative	Borderline	Positive
ER Proportion Score	0%-100%	<5%	5% - 19%	>=20%
ER Intensity Score	None, weak, intermediate, strong	None, weak	intermediate	Strong
PR Proportion Score	0%-100%	<5%	5% - 19%	>=20%
PR Intensity Score	None, weak, intermediate, strong	None, weak	intermediate	Strong
HER2 by IHC	0, 1+, 2+, 3+	0, 1+	2+	3+
HER2 by FISH	Ratio 1.00-9.79 (note decimal point)	<= 1.9	1.90-2.20	>= 2.00
HER2 by CISH	Ratio 1.00-9.79 (note decimal point)	<= 1.9	1.90-2.20	>= 2.00
HER2 by unknown	No value given	Stated by MD	Stated by MD	Stated by MD
Test Not Mentioned in Medical Record - Code as Not Done (998) or Unknown if Done (999)				

American Cancer Society®

THE OFFICIAL SPONSOR OF BIRTHDAYS.®

New Lung Cancer Screening Guidelines for Heavy Smokers

Article date: January 11, 2013

By Stacy Simon

The American Cancer Society has published new guidelines that recommend doctors discuss **lung cancer** screening with people who meet certain criteria that put them at high risk for developing the disease. These high risk patients must be aged 55 to 74 years and in fairly good health, have a smoking history equivalent to a pack a day for 30 years, and currently smoke or have quit within the past 15 years. If people decide to be screened, the recommendation specifies that testing should be done with a low dose **computed tomography (CT)** scan and take place at a **facility with experience in lung cancer screening**. And it emphasizes that screening is not a substitute for quitting smoking. The most effective way to lower lung cancer risk is to **stay away from tobacco**.

The guidelines were published early online January 11, 2013 in *CA: A Cancer Journal for Clinicians*.

Evidence backs guidelines

The recommendations are based on a careful review of several studies that looked at low-dose CT screening. The most significant was the **National Lung Screening Trial** (NLST). This study included more than 50,000 people aged 55 to 74 who were current or former smokers with at least a 30 pack-year history of smoking (equal to smoking a pack a day for 30 years, or 2 packs a day for 15 years). The NLST found that people who got low-dose CT had a 20% lower chance of dying from lung cancer than those who got chest x-rays. However, other trials found no benefit from screening.

The screening in the NLST was done at large teaching hospitals with access to a lot of medical specialists and comprehensive follow-up care. Most were National Cancer Institute cancer centers.

None of the studies included people who never smoked. Although **non-smokers can develop lung cancer**, there is not enough evidence to know whether screening them would be helpful or harmful. Likewise, it is not known if screening would help people who were lighter smokers than those in the studies, or those of different ages. That's why the guideline doesn't recommend screening for these groups.

(Continued on page 10)

(Continued from page 9)

Weighing risks and benefits

The idea of screening for lung cancer is appealing, because it has the potential of finding the cancer earlier, when it's easier to treat. Screening is done in people who do not have any symptoms of cancer. **Lung cancer symptoms** don't usually appear until the cancer is already advanced and not able to be cured. But screening carries risks that may outweigh the benefits for everyone except those at higher than average risk for lung cancer, often heavy smokers. Age is also a risk factor.

One drawback of a low-dose CT scan is that it finds a lot of abnormalities that turn out not to be cancer but that still need to be assessed to be sure. (About 1 out of 4 people in the NLST had such a finding.) This may lead to additional scans or even more-invasive tests such as needle biopsies or even surgery to remove a portion of lung in some people. A small number of people who do not have cancer or have very early stage cancer have died from these tests. There is also a risk that comes with increased exposure to radiation.

Because of these risks, CT scanning is not recommended for people who are less heavy smokers, or who are younger than 55 or older than 74. It is not recommended for people who have other serious diseases that limit their life expectancy. The guidelines say doctors need to discuss all the potential risks, benefits, and limitations of screening with patients who meet the criteria and help them make an informed decision about whether they should get screened. If people do decide to get screened, they should get screened every year through age 74, as long as they are still healthy.

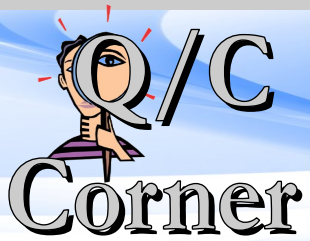
Quitting is still best

The recommendations emphasize that screening for lung cancer is not a substitute for quitting smoking. The most important thing anyone can do to reduce their risk of lung cancer is not smoke or use any form of tobacco. Most lung cancer cases occur in people who smoke or used to smoke.

Besides lung cancer, tobacco use also increases the risk for cancers of the mouth, lips, nose and sinuses, voice box, throat, esophagus, stomach, pancreas, kidney, bladder, uterus, cervix, colon/rectum, ovary, and acute myeloid leukemia. In the US, tobacco use is responsible for nearly 1 in 5 deaths; this equals about 443,000 early deaths each year.

If you smoke and want help quitting, see the American Cancer Society ***Guide to Quitting Smoking*** or call us at 1-800-227-2345.

For More Information go to: **http://www.cancer.org/cancer/news/news/new-lung-cancer-screening-guidelines-for-heavy-smokers**



QUESTIONS? ANSWERS. and CLARIFICATION

QUESTION:
How do I code treatment with aspirin for essential thrombocythemia? The patient was on aspirin prior to diagnosis and continued on it after diagnosis. Should I code this as treatment?

ANSWER:
According to the SEER*Rx version 2.0.1 Aspirin is to be coded as "Other" therapy for essential thrombocythemia ONLY.

QUESTION:
Polycythemia - is it reportable?

ANSWER:
Polycythemia, is a disease in which the percentage of blood made up by red blood cells increases causing the blood to thicken. The increase in the proportion of red blood cells that make up blood may be attributed to overproduction of red blood cells in the bone marrow (myeloproliferative syndrome) or a normal systemic reaction to chronically low oxygen levels in the blood, frequent blood transfusions, or other chronic disease.

Primary Polycythemia or Polycythemia Vera is a reportable myeloproliferative syndrome characterized by the overproduction of red blood cells caused by an abnormality in the bone marrow. This overproduction in red blood cells is not offset by the normal mechanisms that regulate cell maturation or cell death. This overproduction or proliferation of myeloid (red) blood cells due to abnormal bone marrow is called primary polycythemia or polycythemia vera. The diagnosis is often clinical. However, the JAK2 mutation occurs in >96% of patients with PV. So, be sure to look for this test as a confirmation that the patient indeed does have Polycythemia Vera and not some other myeloproliferative malignancy.

Patients with Primary Polycythemia or Polycythemia Vera are most often initially treated with phlebotomy (removal of blood, usually a pint every other day) or the administration of blood thinning agent(s) including aspirin. But, some patients may participate in clinical studies that include administration of chemotherapeutic agents used to treat other myeloid neoplasms. Do not code administration of blood thinning agents as treatment because the intent of this treatment approach is to control the proliferation of red blood cells from the bone marrow – not cure the disease.

NOTE: DO NOT CODE ASPIRIN AS TREATMENT FOR PV. ONLY CODE ASPIRIN AS TREATMENT FOR ESSENTIAL THROMBOCYTHEMIA.

Some patients will undergo a transformation to Acute Myeloid Leukemia (a new primary according to the Heme/Lymph Rules and Database).

Secondary Polycythemia may be caused by; normal adaptation of the body to high altitudes, genetic disorders or even phlebotomy itself. Secondary Polycythemia is not malignant. Therefore, Secondary Polycythemia is not reportable.

Polycythemia as a diagnosis by itself and without additional studies to identify the cause is not malignant and therefore not reportable to FCDS.

(Continued on page 12)

(Continued from page 11)

QUESTION:
If I have an "Intradural, Intramedullary Schwannoma" resected from T5, T6, T7 laminectomy, is the site code 70 meninges, 71 brain or 72 spinal cord? What is the actual site for topo code?

ANSWER:
Intramedullary Schwannoma is a thoracic spinal cord tumor. The fact that it appears to be involving or even perhaps arising in the space between layers of the meninges (intradural) does not convince me that the primary site should be coded to dural meninges.

Schwann Cells comprise part of the nervous system (usually peripheral nerves but can also involve cranial nerves or spinal cord) and produce the myelin that forms the myelin sheath which protects the neural axon and serves as an electrical conduit for associated nerve cells. Intramedullary Schwannoma should always be coded to spinal cord. Primary Site = C720 (spinal cord).

30TH ANNIVERSARY CTR 1983-2013 Certified Tumor Registrar

2013 CTR Certification Exam

Achieve the only credential that demonstrates proficiency and expertise as a cancer registry professional.			
Spring Testing	March 9-23	Fall Testing	September 7-21
Application Deadline	January 31	Application Deadline	July 31
Download the CTR Exam Handbook and Application at: http://www.ctrexam.org			

2012-2013 FCDS Educational Webcast Series

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.

Webcasts are held on Thursdays from 1pm-3pm. Please review the dates below.

EVENT #	DATE/TIME	TOPIC	CE HOURS
2012-157	*10/18/2012	GYN Neoplasms - Background/Anatomy/Risk Factors/MPH Rules/ CS02.04/SSF/Tx	2
2012-158	*11/15/2012	"Improving Data Quality Using FCDS EDITS and Data Quality Reports"	2
2012-157	*1/8/2013	NEW PROCEDURES - FCDS Automated User Account and Using the FCDS On-Line Learning Management System	2
2012-159	*1/17/2013	Pediatric Neoplasms - Background/Anatomy/Risk Factors/MPH Rules/CSv02.04/Site-Specific Factors and Treatment	2
2012-160	*2/28/2013	Genitourinary Neoplasms (Kidney,Renal Pelvis, Urinary Bladder,Prostate) - Background/Anatomy/Risk Factors/MPH Rules/ CS02.04/SSF/Tx	2

* 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

*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.*

Florida Cancer Data System
Cancer Reporting Completeness Report

TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF JANUARY 31, 2013

Total number of *New Cases* added to the FCDS Master file in January, 2013: **16,343**

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	54,508	1,124	40	6,228	0	**Pending**	71,900	**12,556**
2011	161,809	10,853	117	6,857	0	**Pending**	179,636	**3,595**
2010	169,153	10,350	2,494	2,447	57	**2,023**	186,524	**192**

		Actual	Expected
% Complete for:	**2012**	**44%**	**58%**
	2011	100%	100%
	2010	100%	100%

Expected % based on 165,000 reported cases/year

Missed an FCDS or NAACCR Webinar?

Did you know that both FCDS and NAACCR Webinars can be viewed after-the-fact. And, Continuing Education Hours are available to registrars that view recorded webinars? All FCDS Webcasts are recorded and posted on the FCDS Website (Education Tab). FCDS Webcast Recordings are available free of charge and can be viewed anytime/anywhere by anybody. Access to NAACCR Webinar Recordings is available only to registrars with Active/Current FCDS Abstractor Codes. Access to NAACCR Recordings is password protected. Contact FCDS for more information on viewing recorded webinars, or to obtain the password to view individual NAACCR Webcast Recordings.

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 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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