

# The Florida Cancer Data System's Memo

MAY 13

## SAVE THE DATE!



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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.

**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.

### WHAT'S NEW:

*The following information is currently available on the FCDS website.*

**FLORIDA ANNUAL CANCER REPORT: INCIDENCE AND MORTALITY - 2008**

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

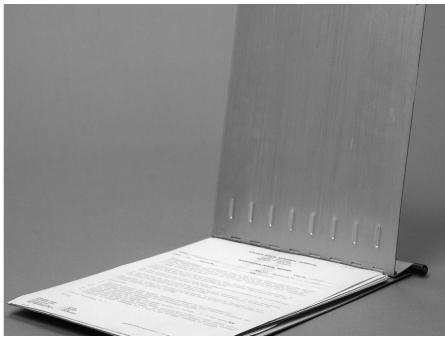
**FCDS/NAACCR**

**WEBINAR SERIES:**

NAACCR 2012-2013 CANCER REGISTRY AND SURVEILLANCE WEBINAR SERIES - KIDNEY 6/6/13, 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

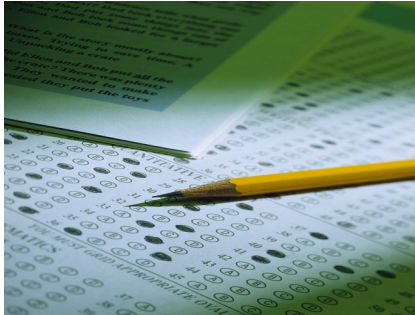
The Florida Cancer Data System (FCDS) is Florida's statewide, population-based cancer registry and has been collecting incidence data since 1981.



# Florida Cancer Data System

## Deadlines, Updates, & Reminders

### NAACCR CTR EXAM PREPARATION AND REVIEW WEBINAR SERIES (7/9/13-9/24/13)



In keeping with FCDS' long-standing commitment to provide Florida registrars with opportunity for early and continuing education and our collaboration with FCRA to "Grow CTRs in Florida", FCDS is pleased to announce the availability of a special NAACCR Webinar Series to be offered to Florida CTR Candidates planning to sit for the CTR Exam in September 2013.

The NAACCR CTR Exam Preparation and Review Webinar Series will include nine 2-hour live webinar sessions that follow the CTR exam content outline. A syllabus is provided below. This is a dedicated CTR Prep Course. Sessions are presented by experienced instructors and include lectures, Q&A sessions, study materials, on-line discussions, interactive quizzes, and a timed CTR Exam practice test.

NOTE: This is not a beginning abstractor course...it is a CTR Exam Prep Course. Please do not register for this "course" if you do not plan to sit for the CTR Examination in September 2013. Thank you.

This series has strict registration and attendance requirements, and is being offered free of charge to Florida CTR Candidates. Potential "course" candidates will be pre-screened prior to official registration with NAACCR. FCDS hopes to be able to provide this course to Florida CTR Candidates on an on-going twice-a-year basis depending on level of interest and participation.

A special registration portal will be posted on the FCDS NAACCR Webinar Registration Site. Once approved, students will be provided instruction for creating a MyNAACCR account. Once you are registered, NAACCR will communicate directly with you via e-mail and MyNAACCR with student syllabus, schedule, assignments, etc.

Should a participant miss a session or want to review again prior to sitting for the CTR Exam, recordings of each session will be made available to registered participants. Again, live participation is encouraged to pro-

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# Florida Cancer Data System

## Deadlines, Updates, & Reminders

NAACCR CTR Exam Preparation and Review Webinar Series (7/9/13-9/24/13)

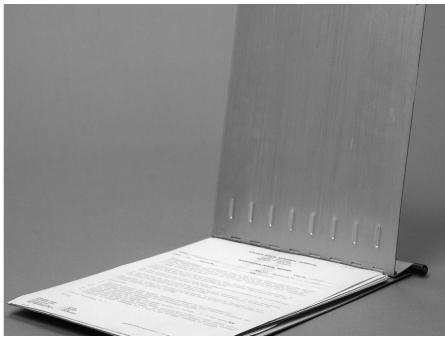
*(Continued from page 2)*

vide the best learning experience and for the participant to actively join in on-line discussion groups with fellow classmates.

Please contact Steven Peace, CTR at FCDS for more information on the course or to pre-register. Steve's direct phone is (305) 243-4601 or e-mail [speace@med.miami.edu](mailto:speace@med.miami.edu).

Do not contact NAACCR directly to register.

<u><b>Date</b></u>	<u><b>Time</b></u>	<u><b>Topic</b></u>
7/9/13	1 pm—3pm	Introduction to the exam format /Registry organization and operations
7/16/13	1 pm—3pm	Registry organization and operations
7/23/13	1 pm—3pm	Data Analysis and interpretation
7/30/13	1 pm—3pm	Concepts of abstracting , coding, & follow– up /Anatomy and physiology
8/6/13	1 pm—3pm	Concepts of abstracting , coding, & follow– up /Case finding and ascertainment, abstracting & coding principles
8/13/13	1 pm—3pm	ICD-O-3 Coding /Multiple primary and histology coding rules
8/20/13	1 pm—3pm	Hematopoietic and lymphoid neoplasm coding /AJCC Staging
8/27/13	1 pm—3pm	Collaborative Stage coding principles
9/3/13	1 pm—3pm	Timed test; Overview; Test taking tips; Q & A
<b>9/7/13-9/21/13</b>	<b>1 pm—3pm</b>	<b>CTR Exam Testing Window</b>
9/24/13	1 pm—3pm	Feedback from students



# Florida Cancer Data System

## Deadlines, Updates, & Reminders

### FCDS IDEA USER ACCOUNTS AND FCDS ABTRACTOR CODES

The procedures for the processing of FCDS IDEA User Accounts and FCDS Abtractor Codes has been revised as of 1/1/2013.

Please review the following links and information for detailed instructions regarding the renewal of your FCDS Abtractor 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>

### 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](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](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. Log into IDEA as usual.
2. Go to the IDEA User menu
3. Select Account Manager
4. Double click in the box titled 'PASSWORD' hit backspace and change password.

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# Florida Cancer Data System

## Deadlines, Updates, & Reminders

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4.Repeat in the box titled ‘**VERIFY PASSWORD**’  
Then click ‘**SUBMIT**’  
Your renewal will be 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>

### **FACILITY ACCESS ADMINISTRATOR**

**EVERY HOSPITAL, AMBULATORY CARE AND RADIATION THERAPY FACILITY MUST HAVE AN FAA.**

FCDS has implemented a new web-based facility access system as of 1/1/2013. 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.



### **REMINDER!**

FCDS will not accept any 2013 cases (Admission or diagnosis) until after July 1, 2013 due to NAACCR v13 implementation and data conversion requirements.



# Florida Cancer Data System Deadlines, Updates, & Reminders

## CONGRATULATIONS NEW FLORIDA CTRs



**JACQUELINE BRICE**

**TINA COLEMAN**

**JOAN GALBICSEK**

**EDITH KNAPP**

**BARBARA LORENTSON**

**TODD SOPLINSKI**

**BRYAN STEVENS**

**ANN THOMPSON**



## 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>

# 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 1<sup>st</sup> 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 1<sup>st</sup> 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 1<sup>st</sup> course treatment plan

## Favorable Prognostic Factors ER/PR/HER2

- ✓ Estrogen Receptor (ER) **positive** is a favorable prognostic factor.
  - Hormonal Therapy should be considered in 1<sup>st</sup> course treatment planning.
- ✓ Progesterone Receptor (PR) **positive** is a favorable prognostic factor.
  - Hormonal Therapy should be considered in 1<sup>st</sup> 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 1<sup>st</sup> course treatment plan

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# 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 1<sup>st</sup> course treatment plan
  - Progesterone Receptor (PR) **negative** is an unfavorable prognostic factor.
    - Hormonal Therapy usually not included as part of 1<sup>st</sup> 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 1<sup>st</sup> 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)				



"to educate,"  
from



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.

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### **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**

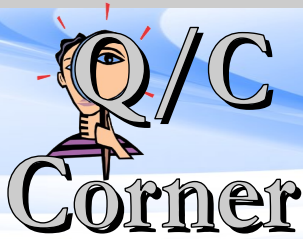
The recommendations emphasize that screening for lung cancer is not a substitute for quitting smoking. The most important thing anyone can do to reduce their risk of lung cancer is not smoke or use any form of tobacco. Most lung cancer cases occur in people who smoke or used to smoke.

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:**

What is TACE and how do I code it?

## **ANSWER:**

TACE, Drug Eluting Bead Therapy and Yttrium-90 Microsphere Therapy are all used to treat primary liver cancer as well as primary cancers of other sites that have metastasized to the liver forming large liver masses. Each of the three therapies involve direct administration of chemo and/or radiation to the primary tumor or large liver metastasis to cut off the blood supply and intentionally trap chemotherapeutic agents within the embolized artery and primary organ (liver) for targeted delivery of drug/radiation therapy to liver.

TACE stands for “trans-arterial chemo embolization”. Transarterial chemo embolization therapy involves administration of chemotherapy directly to the liver tumor via a catheter. With this technique, the chemotherapy targets the tumor while sparing the patient many side effects of traditional chemotherapy that is given to the whole body. Following chemotherapy, the physician will embolize (cut off) the blood supply to the tumors. In this manner, the tumor is treated using two different techniques. If necessary, TACE can be performed multiple times to achieve the desired response in the tumor. Code this as treatment under chemotherapy and other therapy, both.

Drug Eluting Bead Therapy involves the administration of beads that have been impregnated with the chemotherapy agent. The drug eluting beads are given via catheter directly to the liver tumor. Giving chemotherapy with the beads may provide an additional benefit as the chemotherapy is slowly released from the beads, destroying the tumor over a greater period of time. Code this as treatment under chemotherapy and other therapy, both.

Yttrium-90 Microsphere Therapy involves the administration of spheres that have low levels of radioactivity attached to them. The radioactivity destroys the liver tumor without affecting other parts of your body. Code this as treatment as radioactive isotope administration of radiation therapy and other therapy, both.

## **QUESTION:**

I have a renal cell carcinoma, Furman grade is a 2, what would I put for grade/differentiation of this cases?

## **ANSWER:**

Nuclear grade of the tumor is the most important prognostic factor after size of the primary tumor and overall anatomic stage. The Fuhrman grade originally published in 1992 is unique to renal cell carcinomas. It is a nuclear, not histologic, grade and is based on nuclear size and shape and the prominence of nucleoli in the tumor cells.

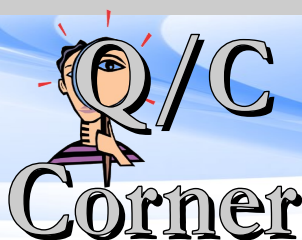
Differentiation has priority over nuclear grade when both are specified. Example: Liver biopsy histology described as "well differentiated hepatocellular carcinoma, nuclear grade 2/4." Code the tumor grade as grade 1 (SEER).

The Fuhrman nuclear grade used to be converted into the ICD-O grade/differentiation (6th digit) code. Refer to FORDS 2010 for the conversion table. But, this is no longer recommended by the COC.

COC recommends coding Fuhrman only in site specific factor 6 which FCDS does not require.

COC also instructs registrar not to use the Fuhrman nuclear grade to code the fields Grade Path System

*(Continued on page 12)*



# QUESTIONS? ANSWERS. and CLARIFICATION

*(Continued from page 11)*

and Grade Path Value (two other field FCDS does not require.

So, if you only have Fuhrman grade for kidney cancer – code 9 in Grade/Differentiation, do not code grade path value/system and code Fuhrman in SSF6 in you are a COC—approved program.

## **QUESTION:**

“First course of treatment” sometimes take longer than 240 days,(for instance Neo adjuvant treatment) but in that scenario the System don’t allow to validate the abstract and we are forced to code it as second course, which changes the case from Analytical to Non analytical. How should this be handled?

## **ANSWER:**

You are not “forced to” record therapy started >240 days after dx (or >365 days for breast or prostate) as subsequent therapy.

The 240/365 day edit is “Forceable” (Force=Y). So, any true first course therapy that fails the 240/365 day edit can be overridden.

So, if you document in your text that all treatment was planned first course – and you document that there has not been disease progression or recurrence in the time period since treatment started – FCDS will override the edit and allow the treatment to be captured and coded as first course therapy.

Do not change from analytic to non-analytic based on the start of treatment as long as it is planned 1st course. Record Class of Case that best describes SCCC involvement in the dx/tx/follow-up/recurrence/death for each patient.

## **QUESTION:**

The pathology states that it’s has 8 + lymph node and N2b. How do I handle this?

Pathology Report:

Regional Lymph Nodes (pN) - pN2b: Metastasis in 7 or more regional lymph nodes

Number of Lymph Nodes Examined: Specify: 12

Number of Lymph Nodes Involved: Specify: 8

## **ANSWER:**

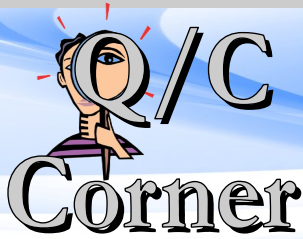
This is kicking back to you because you HAVE information about the number of nodes involved and you coded this information in nodes positive/nodes examined.

CS Lymph Nodes for Colon, Note 4 (below) instructs the abstractor to use codes 110-300 when you do have information on nodes positive and nodes examined... and the edit is looking at these data and sees they are there. The Note also states NOT to use codes 400-480.

Note 4: The number of positive regional nodes is required to calculate the correct N category for this schema. Use codes 400-480 when the pathology report assigns an N1 or N2 category but does not specify the number of nodes involved, or the record identifies an N1 or N2 category but the specific information about number of nodes involved is not available. Use codes 110-300 rather than codes 400-480 when information about the number of positive nodes is available, or when nodes are clinically positive but not removed for examination.

*(Continued on page 13)*





# QUESTIONS? ANSWERS. and CLARIFICATION

*(Continued from page 12)*

Only use “Stated As” codes when you **DO NOT** have other information to assign a representative code. Text / Code must match.

ANSWER: Code CS Lymph Nodes = 210

## QUESTION:

I have a patient with diffuse large B-cell lymphoma (40%) arising out of a follicular lymphoma Gr 3/3 (60%). How do I code that? Is there a combination code? Do I code the larger, ie follicular lymphoma?

## ANSWER:

You must use the Heme rule and database for instructions on how to handle these cases.

Rule PH16 Code the primary site to the site of origin, lymph node region(s), tissue(s), or organ(s) and code the histology diffuse large B-cell lymphoma (DLBCL) 9680/3 when DLBCL 9680/3 AND follicular lymphoma (NOS, grade 1, grade 2, or grade 3) are present in the same lymph node region(s), organ(s), tissue(s) or bone marrow.

FL includes the following

- FL, NOS 9690/3 OR
- FL grade 1 9695/3 OR
- FL grade 2 9691/3, OR
- FL grade 3 9698/3

**Note 1:** The original pathology may identify only DLBCL although both DLBCL and follicular lymphoma are present. The DLBCL is much more aggressive than the follicular lymphoma and often masks the follicular lymphoma during the initial work-up. Because it is more aggressive, the DLBCL will respond more rapidly to treatment so the post-treatment biopsy may show a combination of DLBCL and follicular lymphoma or the post-treatment biopsy may be positive for only follicular lymphoma. The follicular lymphoma was present from the beginning but was hidden. Do not change the histology; it should remain 9680/3

**Note 2:** Use this rule when the diagnosis of DLBCL and FL are synchronous/simultaneous OR when the FL is diagnosed in a post-treatment biopsy. The timing for a post-treatment biopsy would be within or equal to 60 days after the completion of initial treatment.

**Note 3:** Do not simply code the site of a biopsy; use the information available from scans to determine the cor-

*(Continued on page 14)*



# QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 13)

rect primary site. See Primary Site Coding Instructions and Module 7 for more information on coding primary site for lymphoma.

**Note 4:** See Appendix C for help identifying lymph node names, chains, regions and codes.

## INSTRUCTIONS:

First go to the Heme DB and look up DLBCL. Below is what you will see. Under “Module Rule” – the DB refers you to go to MPH Rule M5 and PH Module 6 Rules PH16, PH17, PH18, PH20 for specific rules on this type of lymphoma. From there you find the appropriate rule that meets your case scenario.

Hematopoietic Database 2.1

File Help

Hematopoietic Database - The Cancer Registrar's Hematopoietic Database

Diagnosis date range: January 01, 2012 to present Data Last Updated 05/23/2012

Search Text: dlbcl Search ☒ Require All Terms Open 2012 Hematopoietic Manual Reset

Results(2)	Disease Information						
<p><b>Diffuse large B-cell lymphoma (DLBCL)</b></p> <p>Primary mediastinal (thymic) large B-cell lymphoma</p>	<p><b>Preferred Term</b></p> <p>Diffuse large B-cell lymphoma (DLBCL)</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Reportability</th> <th>Primary Sites</th> </tr> </thead> <tbody> <tr> <td>9680/3</td> <td>[REPORTABLE]</td> <td>N/A - See Abstractor Notes and Module 7.</td> </tr> </tbody> </table> <p><b>Grade</b></p> <p>5 - B-cell</p> <p><b>Module Rule</b></p> <p>M5 Module 6: PH16, PH17, PH19, PH20</p> <p><b>Alternate Names</b></p> <p>Age-related EBV+ lymphoproliferative disorder            Anaplastic large B-cell lymphoma            Angioendotheliomatosis [OBS] see 97152/3            Angiotropic lymphoma [OBS] see 9712/3            Diffuse large B-cell lymphoma, NOS            Diffuse large B-cell lymphoma, NOS anaplastic variant            Diffuse large B-cell lymphoma, NOS centroblastic variant            Diffuse large B-cell lymphoma, NOS immunoblastic variant            Diffuse large B-cell lymphoma/intravascular large B-cell lymphoma  <b>DLBCL</b>            DLBCL associated with chronic inflammation            EBV Positive DLBCL of the elderly            EBV-associated B-cell lymphoproliferative disorder of the elderly            Germinal centre B-cell-like GCB            Histocyte-rich large B-cell lymphoma [OBS] see 9688/3            Hodgkin-like anaplastic large cell lymphoma            Intravascular B-cell lymphoma [OBS] see 97142/3            Intravascular large B-cell lymphoma [OBS] see 9712/3            Malignant lymphoma, centroblastic, diffuse, NOS</p>	Code	Reportability	Primary Sites	9680/3	[REPORTABLE]	N/A - See Abstractor Notes and Module 7.
Code	Reportability	Primary Sites					
9680/3	[REPORTABLE]	N/A - See Abstractor Notes and Module 7.					

# 2013-2014 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 2013 Florida Cancer Reporting Requirements.

Tentative 2013 FCDS Webcast Series – 3 <sup>rd</sup> Thursday from 1pm-3pm	
August 22, 2013	What's New for 2013 and More – Annual Meeting Review
September 19, 2013	Lung Neoplasms – Background/Anatomy/Risk Factors/MPH Rules/CSv02.04/Site Specific Factors and Treatment
October 24, 2013	New Developments in FCDS Quality Improvement – FCDS Abstractor Code, NPCR Audit Outcome, FCDS Validation Studies, New QC Reports
November 21, 2013	Breast Neoplasms: Background/Anatomy/Risk Factors/MPH Rules/CSv02.04/Site Specific Factors and Treatment
December 12, 2013	Colon/Rectum Neoplasms: Background/Anatomy/Risk Factors/MPH Rules/CSv02.04/Site Specific Factors and Treatment
January 23, 2014	FCDS Learning Management System – What's New for 2014
February 20, 2014	Lymphoid Neoplasms: Background/Anatomy/Risk Factors/MPH Rules/CSv02.04/Site Specific Factors and Treatment

\* 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 be 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/naacccr\\_webinar.pl](https://fcds.med.miami.edu/scripts/naacccr_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/naacccr\\_webinar.pl](https://fcds.med.miami.edu/scripts/naacccr_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](mailto: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



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 APRIL 30, 2013

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

**15,966**

*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	108,810	2,375	73	6,959	0	Pending	118,217	<b>14,901</b>
2011	165,500	11,192	117	7,172	0	Pending	183,981	<b>806</b>
2010	169,597	10,377	2,594	2,494	57	<b>2,012</b>	187,131	<b>259</b>

		<u>Actual</u>	<u>Expected</u>
% Complete for:	2012	<b>62%</b>	<b>83%</b>
	2011	97%	100%
	2010	98%	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.