

The Florida Cancer Data System's Memo

JANUARY 2016

Congratulations to Florida CTRs Summer 2015

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WHAT'S NEW:

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

**FLORIDA ANNUAL
CANCER REPORT:
INCIDENCE AND
MORTALITY - 2012**

**FCDS/NAACCR EDIT's
Metafile** - 15A Metafile,
posted 1/6/2016
at 8:00 AM

**FCDS/NAACCR
WEBINAR SERIES:**
NAACCR 2015-2016
Cancer Registry and
Surveillance Webinar series -
Collecting Cancer Data: Breast
2/4/16, being held at
7 Florida facilities and
requires registration.

**FCDS EDUCATIONAL
WEBCAST SERIES:**
2014-2015 – 2/18/2016
Colon (incl. Appendix) and Rec-
tum Neoplasms: Background,
Anatomy, Risk Factors, Signs
and Symptoms, MPH Rules,
Anatomic Staging (TNM,
SS2000, SSFs) and TX



**Florida Statewide
Cancer Registry**

2016 MEETINGS

SAVE THE DATE



Boca Raton Marriott
5150 Town Center
Circle
Boca Raton, FL
33486
Hotel Rate: \$109.00

JULY 25TH—26TH

FCRA 38TH ANNUAL CONFERENCE

“THE REGISTRY & CANCER DATA CONTAINMENT”

FCRA REGISTRATION FEE: \$225.00

Additional Information will be provided in the

SunTimes & the FCRA Website: <http://www.fcra.org>

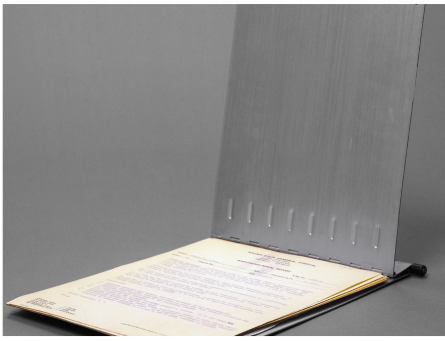
JULY 27TH—28TH

FCDS ANNUAL MEETING

FCDS REGISTRATION FEE: \$100.00

Registration Information will be available soon on the

FCDS Website: fcds.med.miami.edu



FCDS EDITSv15A Metafile Release

First Name Sex DOB Validation Utility

UPDATE

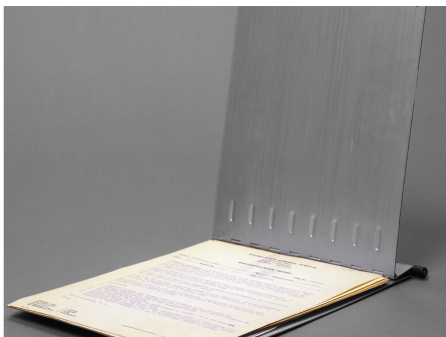
FCDS released the FCDS EDITSv15A Metafile on January 4, 2016 @ 1:00pm. The new metafile includes administrative updates to the standard NAACCR EDITSv15A Metafile plus the usual Florida-specific edits. Also included in the v15A metafile is the NEW Sex Code Validation Utility which is run as a mini-Edit Set to check the First Name, Sex and Date of Birth for each abstract sent to FCDS. Currently, the Sex Code Validation Utility min-EDIT Set only takes into account first names given to children born in the United States between 1890-2009. The utility is based on an algorithm initially created by the New York Cancer Registry in August 2011.

The purpose of this edit is to identify likely errors in the coding of the patient's Sex based on First Name. The edit compares the patient's First Name against a list of known First Name/Sex pairs and the Birth Decade for which they are most common. If a match on name and decade is found but the sex code differs, a WARNING is generated (WARNING: Check name/sex/decade).

Note: You cannot override a WARNING. You DO need to review the WARNING to make sure the first name is spelled correctly, the sex is coded correctly, and the date of birth has been entered correctly...AND you need to make sure that for any case failing this edit, that you have documented the patient's sex in the abstract text.

FCDS is encouraged by the results of this new utility and envision that it will help correct what has been an increasing trend over the past 15 years where registrars are miscoding sex for non-reproductive system cancers that would not otherwise be identified without a First Name check. We anticipate nationwide adoption of this utility and standard EDIT in the next few years and expect this will soon lead to a shift from WARNING to full-fledged EDIT with override required before 2018.

An original article entitled, "Misclassification of Sex in Central Cancer Registries" was published in the Journal of Registry Management 2014 Volume 41 Number 3. The article describes the national scope of the problem of miscoding patient sex in cancer registration, effect of miscoded sex on published statistics and research that incorrect assignment of sex impacts, and the methodology and results of applying this utility in the cancer registry setting (hospital and central registry).



Florida Cancer Data System

Deadlines, Updates, & Reminders



2016 CTR EXAM DATES

The National Cancer Registrars Association's (NCRA) Council on Certification promotes standardization in the collection and use of cancer data through examination and certification of Cancer Registrars and other cancer data specialists. The CTR®, Certified Tumor Registrar, credential marks achievement, fosters professional pride, and is nationally recognized in recruitment and retention of registry personnel.

February 27 – March 19

Application deadline = January 29

June 18 – July 9

Application deadline = May 20

October 15 – November 5

Application deadline = September 16

Change in Pathology Laboratories Submission File Layout

Attention: All Pathology Laboratories in the State of Florida

Effective April 1, 2016, the Florida Cancer Data System (FCDS) will be changing the requirements of the pathology laboratory file layout submission criteria. At that time, the patient address, patient city/town, patient state, and patient zip code will all be required fields. Previously, these fields were optional. The revised record layout specification is attached to this notification for your reference. Please understand the collection of these data fields are essential in ensuring data completeness and quality (accuracy); that the cancer registry is not missing a reportable cancer due to the lack of confirmation of a Florida resident as result of missing patient address information.

The FCDS will display a warning message on all uploads and single entry pathology input between now and the effective date to remind pathology laboratories of this upcoming change.

Please feel free to contact Carlos Alvarez, your Field Coordinator or Mike Thiry, Manager Data Acquisition if you have any questions or concerns. Carlos can be reached at calvarez1@med.miami.edu or 305-243-2638. Mike can be reached at mthiry@med.miami.edu or 305-243-2639.

Reporting Pancreatic Neoplasms

IMPORTANT

CLARIFICATION FOR REPORTING PANCREATIC NEOPLASMS

The classification and reporting of tumors of the pancreas can be confusing in part due to the latest terminology associated with tumors arising in the pancreas, and complicated by the mixed nature of benign, borderline, in-situ and invasive neoplasms and various histologic subtypes associated with pancreatic neoplasms. Classification of pancreatic tumors is often rooted in the functional components of the pancreas [(neuro)endocrine or exocrine] as well as in the cellular origin and/or architecture of the tumor. And, with advancements in diagnostic imaging technology, cystic lesions of the pancreas are being detected with increased frequency, may be associated with pancreatitis, are often malignant cystic neoplasms in elderly populations, and are predictors of malignant potential from benign cystic neoplasms to invasive malignant tumors in general adult populations. Asymptomatic tumors are usually identified incidentally on imaging for other reason.

In 2010 the World Health Organization (WHO) published the latest WHO Classification of Tumors of the Pancreas. This latest classification includes both exocrine and (neuro)endocrine neoplasms of the pancreas with ductal adenocarcinoma still the most common and the most clinically relevant malignant tumor arising in the pancreas. Other ductal tumors [mucinous cystic neoplasms (MCN) and intraductal papillary mucinous neoplasms (IPMN)] are classified as neoplasms with various grades of dysplasia up to invasive carcinoma. High grade dysplastic tumors are now considered precursor neoplasms. A new subtype of IPMN, intraductal tubule-papillary neoplasm (ITPN), has been characterized and newly added to the IPMN group. Serous and acinar tumors are also classified as neoplasms with varying grades of dysplasia. Solid pseudo-papillary neoplasm (SPN) is regarded as malignant (low grade) as a matter of principle because of its inherent potential to metastasize. Serous cystadenomas, solid and cystic papillary (Hamoudi) tumors, lympho-epithelial cysts and simple cysts are all benign, whereas mucinous cystic neoplasms, intraductal papillary mucinous neoplasm, cystic neuroendocrine tumors, and cystadenocarcinomas are considered to be premalignant or malignant. Neuroendocrine neoplasms are characterized as Grade 1 or Grade 2 neuroendocrine tumors (NET) or high grade neuroendocrine carcinomas (NEC). Syndromic low grade NETs are described and named according to their hormone expression pattern.

The ICD-O-3 which is published and maintained by the WHO did publish an updated in 2011 which included new terminology and new histology codes for some of these more recently characterized neoplasms. Unfortunately, the United States has not fully implemented all of the new histology codes included in the 2011 ICD-O-3 Update. This does not mean that ALL in-situ and invasive neoplasms of the pancreas are not reportable... they are still reportable. The NCI SEER Program has published some clarifications on the reportability of some of these neoplasms (below). Additionally, FCDS and the Florida Department of Health are considering a proposal to add other precursor neoplasms of the pancreas to Florida cancer reporting requirements in an effort to monitor expected increases in the diagnosis and treatment of pancreatic neoplasms of all types as related to increases in weight and obesity related cancers as well as diabetes related neoplasms.



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Reporting Pancreatic Neoplasms

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- 1) Report All Histologies with Behavior Code of /2 (in-situ) or /3 (invasive) in the International Classification of Disease for Oncology, 3rd ed (ICD-O-3)
- 2) The term Mucinous Cystic Neoplasm (MCN) of the pancreas with high-grade dysplasia replaces the term mucinous cystadenocarcinoma, non-invasive
- 3) Non-invasive Mucinous Cystic Neoplasm (MCN) of the pancreas with high-grade dysplasia is reportable with histology 8470/2
- 4) Mucinous Cystic Neoplasm (MCN) of the pancreas with invasive carcinoma is reportable with histology 8470/3
- 5) Mucinous Cystadenocarcinoma of the pancreas is reportable with histology 8470/3
- 6) Solid Pseudo-papillary Neoplasm (SPN) of the pancreas is reportable with histology 8452/3.
- 7) Cystic Pancreatic Endocrine Neoplasm (CPEN) is reportable with histology 8150/3
- 8) Cystadenocarcinoma of the pancreas is reportable with histology 8440/3
- 9) Neuroendocrine Tumor, Grade 1 (NET GR1) of the pancreas is reportable with histology 8240/3
- 10) Neuroendocrine Tumor, Grade 2 (NET GR2) of the pancreas is reportable with histology 8249/3
- 11) Neuroendocrine Carcinoma of the pancreas is reportable with histology 8246/3
- 12) Infiltrating Duct Carcinoma of the pancreas is reportable with histology 8500/3
- 13) Intraductal Papillary Mucinous Neoplasms (IPNM) of the pancreas is reportable with histology 8453/2
- 14) Intraductal Papillary Mucinous Neoplasm (IPNM) with invasive carcinoma is reportable with histology 8453/3
- 15) Papillary Mucinous Cystadenocarcinoma of the pancreas is reportable with histology 8471/3
- 16) Intraductal Tubule-Papillary Neoplasm (ITPN) of the pancreas is reportable with histology 8503/2
- 17) Intraductal Tubule-Papillary Neoplasm (ITPN) with invasive carcinoma is reportable with histology 8503/3
- 18) Serous cystadenomas, solid and cystic papillary (Hamoudi) tumors, lympho-epithelial cysts and simple cysts are all benign and not reportable
- 19) TWO NEW HISTOLOGY CODES NOT YET IMPLEMENTED IN THE UNITED STATES – THESE NEOPLASMS ARE REPORTABLE
 - a. 8552/3 – Mixed acinar-ductal carcinoma
 - b. 8163/2 – Papillary neoplasm, pancreatobiliary-type, with high grade intraepithelial neoplasia
 - c. 8163/3 – Pancreatobiliary-type carcinoma
- 20) Not Reportable: Histologies with Behavior Code of /0 (benign) or /1 (borderline) in the International Classification of Disease for Oncology, 3rd ed (ICD-O-3)

References: 2010 WHO Classification of Tumours of the Pancreas; Pathologe. 2011 Nov;32 Suppl 2:332-6. doi: 10.1007/s00292-011-1515-2; Ann Surg. 2004 May; 239(5): 651–659), 2011 ICD-O-3 Updates, 2015 SEER Program Coding and Staging Manual, and NCI SEER Ask A SEER Registrar.

AJCC and NCDB Announce:

December 3, 2016

AJCC and NCDB Announce:
New AJCC T, N, and M Categories to be Implemented in 2016



The primary considerations when assigning American Joint Committee on Cancer (AJCC) staging classifications is timeframe and criteria. The clinical staging (or classification) timeframe includes information obtained from the time of diagnosis throughout the diagnostic workup and ends at the initiation of definitive treatment. Within the clinical staging timeframe, criteria include physical exam, imaging, endoscopies, and diagnostic biopsies. It is important to emphasize that the mere existence of a pathology report that includes microscopic assessment does not exclude it from the clinical staging criteria. If the assessment was a part of the diagnostic workup, it has occurred within the clinical timeframe and can be used for clinical staging.

The pathologic staging/classification timeframe includes information obtained from the moment of diagnosis and throughout the diagnostic workup (i.e., all information from clinical classification), the operative findings and pathology report from the definitive surgery. Within the pathologic staging timeframe, criteria include all of the clinical staging criteria, operative findings from the surgeon, and the pathology report for the resected specimen. Observations from the surgeon in the operative findings that are not accompanied by a biopsy are included in the pathologic staging criteria (e.g., observation of extension without a tissue sample for pathologic review). Similarly, involvement found on imaging is considered in the pathologic staging criteria even in the absence of tissue biopsy.

According to the AJCC manual and trainings, the appropriate T, N, and M categories should be assigned based on the above AJCC rules. This may entail allowing, e.g., the pathologic staging M category to be properly assigned as cM1. However, cancer registry abstracting software is currently set up to code two separate and mutually exclusive clinical and pathologic strings of T, N, M, and stage categories, with an implied "c" in the clinical TNM string, and an implied "p" in the pathologic TNM string. Upon abstraction, the registrar has no way of recording the appropriate M category for the pathologic stage if it is cM1. This discrepancy between registry software data items and AJCC staging classification rules causes a dilemma for registrars when abstracting the T, N, and M data items and results in inconsistent coding practices and data loss.

As a result, this issue will be addressed upon implementation of NAACCR version 16-compliant software with the addition of new AJCC T, N, and M categories for the AJCC T, N, and M data items [940, 950, 960, 880, 890, and 900]. The new categories have been generated by adding the prefixes of 'c' and 'p' to existing valid clinical and pathologic T, N, and M categories respectively, and by modifying, add-

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AJCC and NCDB Announce:

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ing, and deleting specific existing categories newly prefixed with a 'c' or 'p'. For example, the addition of pTis to the clinical classification T category will enable its use for in situ patients in accordance with the AJCC rules (serves as a reminder that the in situ diagnosis cannot be made on imaging alone). FORDS Revised for 2016, due to be released later this month, will include listings of valid categories and instructions for coding.

The Commission on Cancer (CoC) will require CoC-approved cancer programs to use the new T, N, and M categories and convert historical data upon upgrading to NAACCR version 16-compliant software (Please see the NAACCR 2016 Implementation Guidelines for complete details). The new category options will be implemented for cases of all diagnosis years abstracted using NAACCR version 16-compliant software. Conversion of historical data for the diagnosis years of 2015 and earlier is being carried out for the purposes of formatting the data to accommodate consistent viewing, abstraction, and editing of the data across all diagnosis years. Please note that the prefixes included in the new categories are only intended to reflect clinical significance for cases diagnosed January 1, 2016 and later, and should not be analyzed in any fashion for cases diagnosed earlier.

This implementation will allow registrars to comply with AJCC rules while abstracting, thus reducing stage assignment confusion and increasing registrar confidence in assigning AJCC stage, increasing data integrity, and reducing the time and resources registrars and AJCC and CoC staff currently spend addressing these issues. The CoC would like to whole-heartedly thank registrars for their persistence in reporting this issue to AJCC and National Cancer Data Base (NCDB) and in pursuing answers to your questions.

The AJCC supports the new AJCC T, N, and M category options for the data items within cancer registry software. AJCC has updated the "Explaining Blanks and X" presentation, and added a new presentation "AJCC T, N, and M Category Options for Registry Data Items in 2016." These are available on the AJCC website under the Cancer Staging Education – Registrar – Presentations tab. In addition registrars are encouraged to review the AJCC Curriculum for Registrars, which provides further details about the new categories as well as comprehensive instruction on AJCC staging.



Coding Reminders

HISTORICAL CASES

REMINDER: Historical Cases should not include Unknown Primary Cancers (C80.9 or C76.*)

FCDS has noticed an increase in the number of Historical Cases being submitted with an Unknown Primary Cancers (C80.9 or C76.*) diagnosed before a diagnosis of a known or recent cancer. While it is remotely possible that a patient may have a history of an unknown primary cancer with a new known primary cancer with a current diagnosis/treatment, the likelihood that a patient has survived long enough following an unknown primary diagnosis either with or without treatment is low. Most patients with unknown primary have a fairly short survival time after the diagnosis, regardless of treatment. Please confirm historical cancers as best you can and remember that historical cases should not include and should not be assigned designation as unknown primary (C80.9 or C76.*) just because you don't have information on the earlier primary. Also, please remember that for some histologic types an NOS Primary Site can be assigned. For example: metastatic melanoma without a known primary tumor is not coded as C80.9 but rather to C44.9 (skin, NOS). Likewise for lymphoma cases with unknown primary...the primary site should be assigned C77.9 and not C80.9 in these cases. Various other site-inferred neoplasms can be assigned a primary site not = C80.9 based solely on the histologic type. Please refer to the FCDS DAM Primary Site Coding Instructions for additional instructions and always consult the ICD-O-3 for site-specified histologies. The table below is included in the FCDS DAM and should be used for reference when assigning primary site for site-specific histologies.

Histologic Type Codes	Histologic Types	Preferred Site Codes for Ill-Defined Primary Sites
8720-8790	Melanoma	C44. __, Skin
8800-8811, 8813-8830, 8840-8921, 9040-9044	Sarcoma except periosteal fibrosarcoma and dermatofibrosarcoma	C49. __, Connective, Subcutaneous and Other Soft Tissues
8990-8991	Mesenchymoma	C49. __, Connective Subcutaneous and Other Soft Tissues
8940-8941	Mixed tumor, salivary gland type	C07. __, for Parotid Gland; C08. __, for Other and Unspecified Major Salivary glands
9120-9170	Blood vessels tumors, Lymphatic vessel tumors	C49. __, Connective Subcutaneous and other Soft tissues
9240-9252	Mesenchymal chondrosarcoma and giant cell tumors	C40. __, C41. __ for bone and cartilage C49. __, Connective, Subcutaneous, and Other Soft tissues
9580-9582	Granular cell tumor and alveolar soft part sarcoma	C49. __, Connective, Subcutaneous and Other Soft Tissues

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Coding Reminders

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LANGERHANS HISTIOCYTOSIS

Langerhans Histiocytosis - Unifocal, Multifocal or Systemic

Langerhans cell histiocytosis is a rare disease involving proliferation of Langerhans cells, immune system cells found in the skin and mucosal sites that help protect us from microbial antigens that may enter the body through the skin, oral mucosa, or genital mucosa. The cells can also be found in other tissues or may aggregate in other tissues such as lymph nodes, bone and even circulating blood, particularly with an evolving or full-fledged Langerhans Cell Histiocytosis occurs and too many of these cells are being produced and have nowhere else to go in the body. The condition Langerhans Cell Histiocytosis has gone by several other names over the years adding to confusion as far as whether or not these cases are reportable, what is the correct primary site, and when to abstract cases. Other names have included; Histiocytosis X, Letterer-Siwe Disease, and Hand-Schuller-Christian Disease. The current nomenclature is “Langerhans Cell Histiocytosis”.

There are 4 known classifications or “stages” of disease, most of which are reportable as “malignancy” but not all.

When the condition is localized to a single site such as 1 region of the skin or bone - is not reportable. However, once it has begun to show evidence of involvement in multiple locations (multiple regions of skin involvement, lymph node involvement, bone involvement or bone marrow involvement), the condition is reportable.

Pulmonary Langerhans Cell Histiocytosis is when the condition only appears in the lungs that occurs almost exclusively in cigarette smokers. It is not reportable.

Multifocal Unisystem Disease is usually found in children and includes description when the condition appears in multiple areas of a single body system – such as multiple bones or multiple skin sites with diffuse eruptions on the scalp and in the ear canals. Diabetes insipidus is also related to this form of the disease.

Multifocal Multisystem Disease (Letterer-Siwe Disease) is when the condition appears in multiple organ systems – skin and lymph nodes – and is very aggressive with less than 50% 5-year survival. This form of the disease is often found in young children under age 2. The prognosis is quite poor even with aggressive therapy.

Please keep these parameters in mind when you review these cases. They can be tricky and we have been seeing some cases reported that should not be.

LYMPHOMA

We have noticed that more registrars are having problems assigning primary site for lymphoma cases, both Hodgkin Lymphoma and Non-Hodgkin Lymphoma. Both of these general classifications for lymphoma are most often identified first in the lymphatic system (lymph nodes, tonsils, spleen, etc.). Most of the time lymphoma will be assigned primary site of lymph nodes in the range C77.0-C77.9. Only about 20% of Non-Hodgkin Lymphoma arise in extranodal or Extranodal lymphatic sites. The percent is much lower for Hodgkin Lymphoma. When multiple lymph node re-

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Coding Reminders

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gions are involved the primary site is C77.8 (multiple lymph node regions). This is not based on which lymph nodes were biopsied but which nodal areas are involved.

When a physician or imaging study indicates “mediastinal mass” or “retroperitoneal mass” without reference to “lymph nodes”, they are most likely referring to a mass of lymph nodes. When the case is a lymphoma, the primary site should be assigned the correct lymph node region(s) not generalized to “mediastinum” or “retroperitoneum”. Sometimes you cannot determine a primary site with a lymphoma diagnosis because you do not have imaging or other reference. In these cases...the primary site should be assigned “lymph nodes, NOS” – not the site of the biopsy.

Finally, some lymphomas present with bone marrow involvement (leukemic phase – lymphoid leukemia). These cases can be assigned a primary site of lymph nodes, NOS or (sparingly) bone marrow to indicate lymphoma/leukemia. But, some of the newest edits for lymphoma might redirect you to assign C77.9.

Finally, when you run across a splenic marginal zone lymphoma, whether it is confined to the spleen or involves spleen and other site(s)...the primary site is spleen and the histology is splenic marginal zone lymphoma – not just marginal zone lymphoma.

Please take care when determining primary site for these important neoplasms.

MENINGIOMA

FCDS has noticed that many registrars are still auto-

matically assigning a primary site code of C70.9 (meninges, NOS) rather than determining if the meningioma is located in the spinal meninges (C70.1 – unlikely/rare) or cranial/cerebral meninges (C70.0 – most likely/common). Please take care when assigning primary site for meningioma. C70.9 is a non-specific primary site code whereas C70.0 is more specific. When FCDS recodes the primary site, we also have to restage the case.

SURGICAL TREATMENT FIELD

FCDS has noticed a significant increase over the past 3 years in the number of cases submitted to FCDS with incorrectly coded and incorrect use of the surgical treatment field, “Surgery Other Regional/Distant Sites”. This data item was created for registrars to be able to code the resection of non-primary (metastatic) tissue or organ(s) that were removed because the surgeon suspected involvement or intentionally resecting to remove a metastasis to distant lymph node(s), distant metastasis such as resection of a single lung nodule metastasis or a single liver metastasis, or if there is suspected involvement of a non-standard regional site of metastasis that is not included in the Surgery of Primary Site codes.

Another example where you would not use this data item to code a surgery would be TAH/BSO for cervical cancer. The TAH is clearly surgical treatment of the primary site. You do not additionally code the BSO (removal of ovaries and fallopian tubes) under Surgery of Other Regional or Distant Sites just because ... unless the BSO found metastasis in the ovary(s) or was

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Coding Reminders

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meant to debulk metastasis. The BSO in combination with the TAH is a standard surgical procedure performed at the same time as TAH/BSO. The BSO is an “incidental” removal of non-primary tissue and organs (ovaries and tubes) that was performed as part of the Surg of Primary Site (TAH/BSO) procedure – and the TAH was already coded in Surgery of Primary Site.

The tissue or organ removed must have been suspected or proven to be involved with malignancy (even if the pathology is negative)...surgical treatment of a distant site”

The reason for this clarification is that when you enter a code in this field it appears the patient has had surgery to remove metastasis when in fact the surgery was standard treatment with no suspicion of metastasis to any of the incidental organs or tissues removed. This looks like over-treatment. The current Surgery of Primary Site codes include most standard surgical procedures and may be extensive surgery such as “debulking” which may include removal of other organs that may or may not be involved. This is still standard of care surgical treatment for the primary site and not removal of a distant lymph node or distant metastatic organ or site meant to control what is usually a single metastasis or to rule out metastasis.

Remember that most surgeries performed in the first course of treatment are intended to remove the primary site plus or minus regional lymph nodes. And Surgery of Primary Site codes include debulking. However, on occasion there may be suspected metastasis in a single distant organ or distant lymph node area outside the primary site’s local/regional anatomy. This type of surgical procedure is what registrars should be coding in the field “Surgery Other Regional/Distant Site”...not

debulking, not incidental removal of organs, not extended surgery.

Registrars should not be entering surgical resection of incidental tissues or organs that are part of the surgical treatment of the primary site or regional lymph nodes.

Registrars should not be double-entering debulking procedures that have already been coded in the surgery of primary site field.

Registrars should not enter surgical resection of other regional or distant tissue or organs unless they are related to assessment of suspected metastasis to the organ(s) or tissue(s) removed and the surgical procedure is not included under surgery of primary site codes.

Please take care when coding this data item keeping in mind these are related to treatment for the patients cancer and not just a surgical procedure performed on the patient, NOS.

DATE OF 1ST CONTACT

“Date of 1st Contact” is not the same as “Date of Initial Diagnosis” though they may be the same value in some instances.

“Date of 1st Contact” and “Date of Admission” may be the same. But, FCDS does not collect “Date of Admission” or “Date of First Patient Encounter”.

“Date of 1st Contact” is not the same as “date of best or first diagnostic confirmation” either. There is no standard data item to code a “date of first or best diagnostic confirmation”. We only collect “Date of Initial Diagnosis” (regardless of method of diagnosis or diagnostic confirmation). We have been seeing a lot of registrars

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Coding Reminders

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entering the date of the first radiographic evidence or the date of best diagnostic confirmation in “Date of 1st Contact”, even when in the middle of a hospital admission for workup or tx of suspected cancer. This is incorrect.

“Date of 1st Contact” is “the patient’s first contact with the reporting facility for the diagnosis and/or treatment of the tumor, whether as an inpatient or an outpatient for diagnosis and/or first course treatment. The date may represent the date of an outpatient visit for a biopsy, x-ray, scan, or laboratory test, the date of admission to the facility, or the date of a pathology specimen that was collected as an outpatient or as part of surgical resection or biopsy performed during a long-term in-patient admission.”

If a patient was admitted for noncancer-related reason(s), the “Date of 1st Contact” is the date the cancer was first suspected during the hospitalization. This is a non-suspected cancer.

“Date of 1st Contact” should not be a date in the middle of a hospital admission when the patient has been admitted with any suspicion that they have cancer. “When a diagnosis of cancer is made during a patient’s long-term stay for another condition, the date the patient was first examined for the cancer-related problem should be used as the Date of First Contact. If the case was initially diagnosed “incidentally” at autopsy, the Date of Death should be used as the Date of First Contact as well as for the Date of Diagnosis.”

“Date of 1st Contact” may occur the middle of a hospital admission on rare occasion when the patient has an extended hospitalization and cancer is identified incidentally when the patient had no signs or symptoms or any suspicion that they might have cancer prior to admission. Again, “when a diagnosis of cancer is made during a patient’s long-term stay for another condition, the date the patient was first examined for the cancer-related problem should be used as the Date of First Contact. If the case was initially diagnosed “incidentally” at autopsy, the Date of Death should be used as the Date of First Contact as well as for the Date of Diagnosis.”

And finally, please remember that an error is issued if the Date of First Contact precedes the Date of Diagnosis by more than thirty days. This is a rare occurrence in our current healthcare environment. Few patients have long-term hospital admissions for any reason anymore. Please take care when assigning “Date of 1st Contact”.

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Coding Reminders

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WATCH YOUR DECIMAL POINT

FCDS wants to remind everybody to Watch Your Decimal Point when coding tumor size and Site Specific Factor values where the standard placement of a decimal point might be implied or an item might have a decimal point that is often overlooked or rounded up. While FCDS can correct many of the errors from incorrect entry of specific values based on text documentation, we do not have the luxury of visually reviewing every record you submit. Some decimal points for some variables can indicate significant or critical differences in the value such as depth of invasion for melanoma cases. There tends to be a larger problem with coding smaller numbers or whole numbers, particularly when the decimal point is implied in the item (PSA value). Some vendors provide a visual display of decimal point placement. But, this is not universal and usually not for all data items with decimal points. FCDS will continue to monitor this and provide updates on specific data items where the coding of a size or value is highly dependent upon decimal placement as a reminder to recheck these items as you complete your abstracts.

CS Tumor Size: XXX

6.5 mm = 007

1.4 mm = 001

8.0 mm = 008

2.5 cm = 25 mm = 025

4 cm = 40 mm = 040

Melanoma Breslow SSF 1: X.XX

0.02 mm = 002

0.50 mm = 050

0.74 mm = 074

1.07 mm = 107

1.50 mm = 150

Prostate PSA SSF 1: XX.X

Colon/Rectum CEA SSF 3: XX.X

0.1 ng/ml or less = 001

0.08 ng/ml = 001

0.2 ng/ml = 002

4.8 ng/ml = 048

12.4 ng/ml = 124

98.0 or more = 980

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Coding Reminders

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LINAC RADIOSURGERY/CYBERKNIFE/ GAMMAKNIFE/PROTON BEAM

Various Types of Radiation Modalities can be used to target brain tumors. They are similar but different in type of radiation source and method of delivery.

LINAC Radiosurgery is the same thing as high-energy stereotactic (3-D) radiosurgery using a Linear Accelerator...same AS CYBERKNIFE.

Most Linacs are built for conventional fractionated radiotherapy and require additional technology and expertise to become dedicated radiosurgery tools.

CyberKnife is brand of Linac machine that is dedicated to radiosurgery, only. It uses a small Linac machine mounted onto a robotic arm that moves around the patient and radiates the tumor from a large set of fixed positions, mimicking the Gamma Knife concept...but, the GammaKnife points radiation thru a helmet.

Gamma Knife is also a specialized machine that is dedicated to radiosurgery. But, Gamma Knife uses low-

dose radioisotopes not high energy as seen in the Linac.

CyberKnife is often compared to Gamma Knife therapy, but it does not use radioisotopes and thus by definition, does not use gamma rays.

Linear acceleratory based therapies differ from Gamma Knife in several ways.

Gamma Knife has over 200 gamma radioisotope sources arrayed in a helmet to deliver a variety of treatment angles.

On a LINAC, the machine moves around the patient to change the delivery angle and delivers high-dose photon therapy.

Gamma Knife uses cobalt-60 and low-energy gamma rays (1.25MeV)

CyberKnife uses high-energy x-rays (6MV photons)

Proton Therapy is in the same general class of radiation therapy as Stereotactic Radiosurgery, Linac Radiosurgery, and Gamma Knife but utilizes high energy proton beams produced by a particle accelerator which charges the atomic particles – different than electrons or radioisotopes – all use different radiation sources.

Coding Radiation Modality (NAACCR Item #1570)

40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.

NAACCR 2015-2016 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, 2015-2016 series at seven locations throughout Florida. Be sure to mark your calendars for each of these timely and informative NAACCR webinars.

- 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. All webinars start at 9am.

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	TOPIC
*10/1/15	Collecting Cancer Data: Unusual Sites and Histologies
*11/5/15	Collecting Cancer Data: Pharynx
*12/3/15	Directly Coded Cancer Stage (AJCC and Summary Stage)
*1/7/16	Collecting Cancer Data: Bone and Soft Tissue
2/4/16	Collecting Cancer Data: Breast
3/3/16	Abstracting and Coding Boot Camp
4/7/16	Collecting Cancer Data: Ovary
5/5/16	Collecting Cancer Data: Kidney
6/2/16	Collecting Cancer Data: Prostate
7/7/16	Patient Outcomes
8/4/16	Collecting Cancer Data: Bladder
9/1/16	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/educationtraining.shtml>

NAACCR CANCER REGISTRY AND SURVEILLANCE WEBINAR SERIES

Seven Florida facilities
will host the 2015-2016
webinar series,
registration is required



**REGISTER FOR THE
NEXT WEBINAR**

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

CEU information for the 2015 FCDS Annual Conference:

CE Hours: 8.75

*NCRA Recognition
Number: 2015-077*

CEU information for the 2014 FCDS Annual Conference:

CE Hours: 8.25

*NCRA Recognition
Number: 2014-113*

2015-2016 FCDS Educational Webcast Series

FCDS is pleased to announce the 2015-2016 FCDS Webcast Series schedule and topics. This year FCDS will be concentrating on preparing registrars and abstractors for direct-assignment of SEER Summary Stage 2000 (SS2000) and AJCC TNM, 7th edition. The SS2000 entry is a requirement for all 2015> cases. The AJCC TNM entry will be a requirement for all 2016> cases. FCDS does not plan to cover the basics of SS2000 or AJCC TNM staging as there are resources for self-instruction currently available. FCDS strongly recommends that registrars and abstractors attend ALL of the AJCC Self-Instruction Modules I-IV as well as work practice cases until they are comfortable assigning AJCC TNM for general use cases. FCDS will be covering site-specific stage.

NCRA CEU#	Date	Time Schedule 3 rd Thursday	Presentation Title	CEU Hours
2015-115	*8/20/2015	1:00pm – 3:00pm	2015 Reporting Requirements: FCDS Annual Meeting Highlights	2
2015-114	*9/17/2015	1:00pm – 3:00pm	Lung and Pleural Neoplasms: Background, Anatomy, Risk Factors, Signs and Symptoms, MPH Rules, Anatomic Staging (TNM, SS2000, SSFs) and TX	2
2015-113	*10/15/2015	1:00pm – 3:00pm	Brain and CNS Tumors: Background, Anatomy, Risk Factors, Signs and Symptoms, MPH Rules, Anatomic Staging (TNM, SS2000, SSFs) and TX	2
2015-117	*11/19/2015	1:00pm – 3:00pm	Prostate and Bladder Neoplasms: Background, Anatomy, Risk Factors, Signs and Symptoms, MPH Rules, Anatomic Staging (TNM, SS2000, SSFs) and TX	2
-	December	N/A	No Webcast Scheduled	-
2015-116	*1/21/2016	1:00pm – 3:00pm	Breast Neoplasms: Background, Anatomy, Risk Factors, Signs and Symptoms, MPH Rules, Anatomic Staging (TNM, SS2000, SSFs) and TX	2
2015-112	2/18/2016	1:00pm – 3:00pm	Colon (incl. Appendix) and Rectum Neoplasms: Background, Anatomy, Risk Factors, Signs and Symptoms, MPH Rules, Anatomic Staging (TNM, SS2000, SSFs) and TX	2

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

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>. Webcast materials are also available on the FCDS website.

Florida Cancer Data System

Cancer Reporting Completeness Report



TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF DECEMBER 31, 2015

Total number of *New Cases* added to the FCDS Master file in DECEMBER, 2015: **18,209**

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
2015	60,551	467	52	7,368	0	Pending	68,438	14,846
2014	178,264	5,050	73	9,848	0	Pending	193,235	3,142
2013	183,121	8,224	2,059	9,518	0	2,096	205,018	221
						<u>Actual</u>	<u>Expected</u>	
% Complete for:		2015		36%		50%		
		2014		100%		100%		
		2013		100%		100%		

**Expected % based on 190,000 reported cases per year*

Reminder:

The facility Quarterly Reporting Status is always available in IDEA under the Reports/Inquiries tab. Please remember to look at your current reporting status at least quarterly. Also, prior reporting quarters are available.

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 Web-site (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.

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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