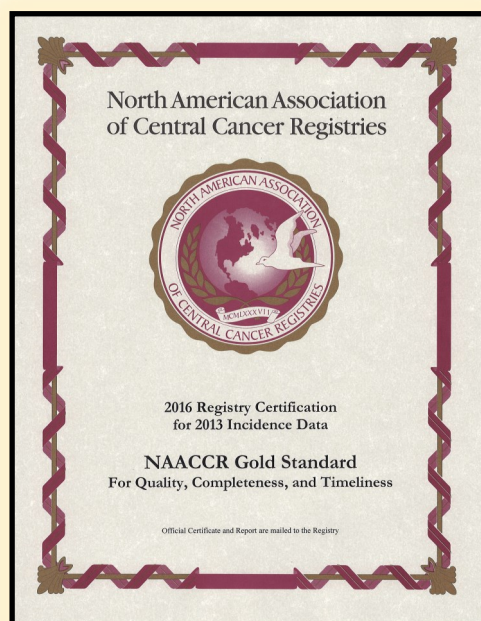


# The Florida Cancer Data System's Memo

JULY 2016

## NAACCR GOLD 14th consecutive year!



*Florida Cancer Data System has been recognized nationally at the highest level of certification, NAACCR GOLD, for the 14th consecutive year.*

### WHAT'S NEW:

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

**FLORIDA ANNUAL  
CANCER REPORT:  
INCIDENCE AND  
MORTALITY - 2013**

**FCDS/NAACCR  
EDITs Metafile**  
V16 Metafile,  
will be posted on or  
around 8/1/2016.

**FCDS/NAACCR  
WEBINAR SERIES:**  
NAACCR 2015-2016  
Cancer Registry and  
Surveillance Webinar  
series - Collecting Cancer  
Data: Bladder 8/4/16,  
being held at 7 Florida  
facilities and  
requires registration.

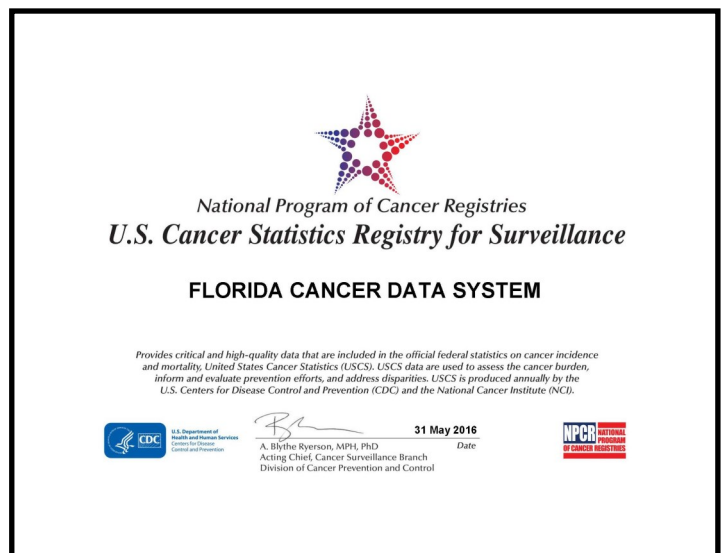


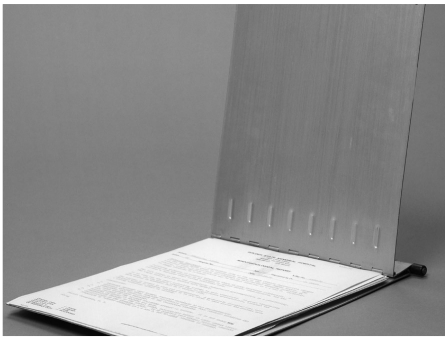
Florida Statewide  
Cancer Registry

# Florida Cancer Data Systems Recognized for Excellence

*FCDS has been recognized by CDC NPCR for 2015 as a Registry of Excellence and a U.S. Cancer Statistics Registry for Surveillance. We are one of 22 registries nationwide to receive this level of certification. This recognition indicates that FCDS has met the CDC NPCR National Completeness and Quality Standard. This recognizes that the data we have submitted as part of our 2015 call for data is considered of the highest quality and will be used in the United States Cancer Statistics report as well as other analytic data sets for use by cancer prevention and control activities, research and the monitoring of cancer trends at the local, regional, and national level.*

*Thank you all for your dedication and hard work to maintain the high standards that Florida sets at the national level. We all really appreciate your efforts!*





# Florida Cancer Data System Deadlines, Updates, & Reminders



## **2015 Cases will be still accepted until 7/24/2016** **in NAACCRv15 format**

Due to the extremely late release by NAACCR of the national EDITS metafile (late last Tuesday) and the still pending release of the CDC/NPCR TNM algorithm, FCDS and the Florida Department of Health have decided to modify our normal year end schedule. The Annual Reporting Deadline of 6/30/2016 will still be the official date for on-time reporting. However, this year the FCDS will allow 2015 cases to still be reported until midnight on Sunday, 7/24/2016. 2016 Cases will not be accepted until the FCDS is fully functional with NAACCRv16 which includes the new AJCC TNM Staging requirements. FCDS plans to begin 2016 reporting 8/1/2016.

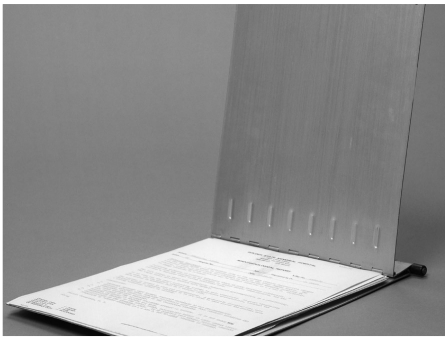
FCDS has extended 2015 reporting to allow reporters to abstract and report “late” 2015 cases using their current software while they wait for 2016 updates from their vendors. FCDS anticipates most Florida facilities will have 2016 reporting software available in August 2016. Delays are being felt on a national scale by all central cancer registries and vendors.

Please review the detailed timeline below.

1. FCDS Annual Reporting Deadline remains 6/30/2016. (2015 cases received after 6/30/2016 will be counted as “late” reports)
2. FCDS will continue to accept 2015 cases in NAACCRv15 format until Sunday 7/24 @ midnight.
3. FCDS will not accept any 2016 cases until we are fully functional in the NAACCRv16 format.
4. FCDS IDEA will be shut down from 7/25/2016-7/31/2016 to finish processing 2015 cases, upgrade to NAACCRv16 and for annual system maintenance.
5. FCDS will begin accepting 2016 cases in the NAACCRv16 format on Monday 8/1/2016.
6. FCDS IDEA will be available for reporting 2016 cases on Monday 8/1/2016 (FCDS IDEA Single Entry and batch file uploads in NAACCRv16 format, only. Cases abstracted and/or reported in NAACCRv15 format will no longer be accepted after midnight on 7/24/2016).
7. FCDS EDITS Metafile will be posted as early as possible sometime after 7/15/2016.
8. This timeline is subject to change dependent on the delivery of the Florida EDITS Metafile and the CDC/NPCR TNM algorithm DLL.

If you have any questions or concerns please contact your Field Coordinator at FCDS.

Thank you in advance for all your hard work in meeting this updated reporting timeline.



# Florida Cancer Data System Deadlines, Updates, & Reminders

## **2016 Update to FCDS Abstractor Code Test Question Bank**

To All Florida Cancer Registry Professionals:

FCDS recently reviewed and updated the FCDS Abstractor Code Test Question Bank. The revised question bank includes 300 questions and referenced answers in 5 categories. The revisions are already in place. FCDS continues to improve upon the FCDS Abstractor Code Test Question Bank. If you have questions you would like to submit for addition to the question bank, please email your question(s) and answer(s) with complete reference to Steven Peace at [speace@med.miami.edu](mailto:speace@med.miami.edu).

Review Process: All questions have been reviewed for correctness. A few questions have been slightly revised. Answers and rationale have been revised for some questions to bring references back up-to-date. A few questions have been removed as they were deemed “no longer timely” or “relevant” by the reviewer team. All of the Collaborative Stage Data Collection Instructions and Coding questions have been removed. Questions about Site Specific Factors are still included. New AJCC Cancer Staging Manual, 7th edition, 2016 Staging Instructions and 2016 New Codes for T, N, and M Categories and Stage/Prognostic Group have been added.



## **FCDS Annual Meeting July 27 – 28, 2016**



**[DRAFT Agenda](#)**

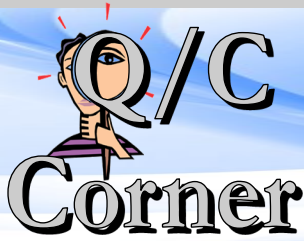
**[The Boca Raton Marriott at Boca Center](#)**

**[Register online!](#)**

**[Reservation page for FCDS](#)**

**[FCDS payment page](#)**





## QUESTIONS? ANSWERS. and CLARIFICATION

### **QUESTION:**

Scenario: 1st person: TURB done. Assume they got it all. Pt is NED. Cysto is for surveillance. If positive, then list as a recurrence and if a TURB is done, that is considered subsequent treatment.

2nd person: TURB done. Don't know margins (code as 9), so using the 3 month cysto as a gauge for cancer status. If cysto is positive, then the patient was never NED and it's not a recurrence. Is this TURB considered subsequent tx? How should we be looking at all this?

### **ANSWER:**

TURB often does not get all of primary cancer - particularly since there are possibly other papillary neoplasms that were not treated when they did the TURB. And, because they just fulgurate the tumor bed which can leave residual. This is why treatment recommendations are to always follow with Intravesical treatment with either BCG for higher-grade and Mitomycin for lower grade lesions. This is also why AJCC requires complete cystectomy for pathologic staging...TURB is in many cases just a glorified biopsy just like a TURP for prostate cancer...they confirm presence of disease and remove tumor..but, margins are always in question and it is even questionable that this should be considered treatment because it is so superficial scraping and cauterization of the wall of the bladder.

Also, follow-up guidelines for bladder cancer is to follow and do cysto at 3 months to check for regrowth or anything that might have been missed. So, I would never use the initial 3-6 month first follow-up cysto as a recurrence date...just as part of initial course of therapy. When NCCN looks at "post-treatment" for cTa, cT1, or Tis tumor – it is to be used that post-treatment is not just TURBT but also post-TURBT Intravesical tx.

So, the answer is – it depends – on whether the patient got Mitomycin or BCG after the initial TURBT...if they got Intravesical tx and had tumor at 3 months – then this is persistent cancer, still not recurrence. If the patient did not get Intravesical tx and had tumor at 3 months...Treat this all as first course without recurrence. If the follow-up cysto that shows tumor at 6-12 months or later...then treat as recurrence.

### **QUESTION:**

"November 18, 2010: Received FDA approved for the prevention of skeletal related events in Pt's with bone mets from solid tumors. Phase II for Multiple Myeloma & Osteoclastogenesis inhibitor factor. Amgen."

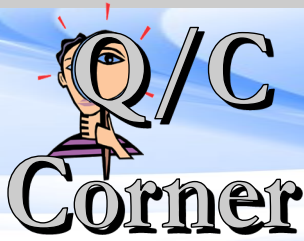
In the top paragraph it states "for all other conditions do not code and in the second paragraph it states approved for the prevention of skeletal related events in Pt's with bone mets from solid tumors. Phase II for Multiple Myeloma & Osteoclastogenesis inhibitor factor. Amgen. Does the part " Pt's with bone mets from solid tumors." mean it is to be coded when used for i.e. Prostate & Breast cases w/bone mets and with Phase II for Multiple Myeloma? And, what does "Osteoclastogenesis inhibitor factor. Amgen." mean?

### **ANSWER:**

Yes, this particular agent has been and is still being prescribed (sometimes off label) as treatment for bone mets prior to FDA approval for treatment of bone mets for solid tumors that have metastasized to bone. It is FDA approved as primary treatment for giant cell tumors of the bone. FDA has approved the drug to be used to treat hypercalcemia related to bone mets or to prevent bone mets...but, not approved as treatment for bone mets.

Xgeva (denosumab) is a RANK ligand (RANKL) inhibitor indicated for the prevention of skeletal-related events in patients with bone metastases from solid tumors, and for the treatment of giant cell tumor of the bone. It is not coded as treatment for bone mets – why? Because it can be used to prevent bone mets or to treat hypercalcemia for bone mets...but not to treat the metastasis...only to prevent or to treat symptoms.

*(Continued on page 6)*



## QUESTIONS? ANSWERS. and CLARIFICATION

*(Continued from page 5)*

Xgeva is only coded as treatment for giant cell tumor of bone. So, when it is used as treatment for giant cell tumor of bone it is coded as treatment.

### **QUESTION:**

The path report states that 5 sentinel lymph nodes were removed plus 5 non-sentinel nodes. We coded scope of lymph nodes surgery to a 6. The surgeon states that is wrong because she only did sentinel node biopsy and that she took extra axillary tissue and the additional 5 nodes were found. She stated this is routinely done and that all the cases where an extra axillary tissue is taken should be a code 2, sentinel lymph nodes biopsy only, because she didn't plan an axillary dissection. My question is: what do I call the other (5) nodes that were taken from the axillary tissue?

### **ANSWER:**

Code 6 includes both the SLN and extra regional nodes – you coded it correctly according to the instructions. Code 6 does not state “axillary node dissection” – only that SLN Bx was done and additional regional nodes were removed at the same time. A lot of folks infer that this means a complete axillary node dissection – but it does not. You coded this correctly.

### **QUESTION:**

A breast case where the pathology class this a pT1c (tumor is 1.6 cm). The tumor is also described on the path report as skin with invasive md ductal carcinoma in the dermis, (on bx). Mastectomy path describes subareolar invasive ductal carcinoma, 1.6 cm, Nottingham grade 2 invading the dermis also with dermal lymphatics and perineural invasion. Should not this be staged a pT4?

### **ANSWER:**

Dermal invasion of the primary tumor invading into the skin of the breast – just by itself – does not qualify as T4...even some dermal lymphatic invasion is not T4.

Most inflammatory carcinoma of the breast that is assigned a T4b or T4d is based on the clinical diagnosis and not necessarily pathologic evidence. In this case, the dermal lymphatic invasion has to be reviewed carefully and somewhat differently that we are used to – we often just go right for the inflammatory based on dermal lymphatic involvement – but not so fast.

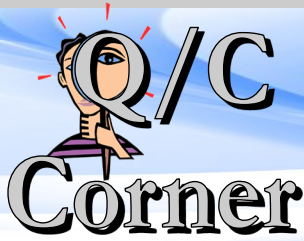
First you have to look at this patient's clinical presentation. Inflammatory carcinoma is a clinical diagnosis even more so than it is a pathologic diagnosis.... And, the AJCC Cancer Staging Manual specifically addresses the possibility that locally advanced breast cancers can directly invade the dermis or have ulceration of the skin with no clinical skin changes (specifically edema and erythema – redness/swelling/peau d'orange) and even with the presence of tumor emboli in the dermal lymphatics – do not automatically qualify as inflammatory carcinoma. The diagnosis and the staging both depend upon the clinical presentation of inflammatory.

If there is no evidence of the tell-tale skin changes – you stage the case based upon the size of tumor and it is not classified or staged as inflammatory carcinoma.

There must be a clinical diagnosis of edema and erythema – redness/swelling/peau d'orange – to classify and stage the case as inflammatory T4d. Even T4b calls out specifics for ulceration and satellite nodules and/or edema – insufficient to meet criteria for inflammatory carcinoma (involving at least 1/3 of breast)

So, if there were skin changes (edema and erythema) then this could be assigned cT4d. The patient would likely get pre-surgical treatment so, ypT can vary.

*(Continued on page 7)*



## QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 6)

If there were no skin changes (even with dermal invasion and/or tumor emboli in dermal lymphatics) this is a cT1c and apparently also a pT1c

Most of this is discussed on page 354 of the AJCC Staging Manual, 7th edition under the definition of Inflammatory Carcinoma. This is also why we always recommend referencing your manuals for situations like this for more information...If you rely on a drop down menu selection – you don't get the whole picture.

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### **1999-2013 United States Cancer Statistics Report Released**

The [\*1999–2013 United States Cancer Statistics \(USCS\): Incidence and Mortality Web-based Report\*](#) includes the official federal statistics on cancer incidence from registries that have high-quality data, and cancer mortality statistics. It is produced by the Centers for Disease Control and Prevention (CDC) and the National Cancer Institute (NCI). This report shows that in 2013, 1,536,119 Americans received a new diagnosis of invasive cancer, and 584,872 Americans died of this disease (these counts do not include *in situ* cancers or the more than 1 million cases of basal and squamous cell skin cancers diagnosed each year).

This year's report features information on invasive cancer cases diagnosed during 2013, the most recent year of incidence data available, among residents of 49 states, six metropolitan areas, and the District of Columbia—geographic areas in which about 99% of the U.S. population resides. Incidence data are from CDC's National Program of Cancer Registries (NPCR) and NCI's Surveillance, Epidemiology, and End Results (SEER) Program. Data from population-based central cancer registries in these states and metropolitan areas meet the criteria for inclusion in this report.

The report also provides cancer mortality data collected and processed by CDC's National Center for Health Statistics. Mortality statistics, based on records of deaths that occurred during 2013, are available for all 50 states and the District of Columbia.

The report also includes incidence rates and counts for Puerto Rico for 2009 through 2013 by sex and age, as well brain tumor and childhood cancer data.

USCS data are presented in the following applications

- [United States Cancer Statistics \(USCS\)](#)
- [Interactive Cancer Atlas \(InCA\)](#)
- [State Cancer Facts](#)

# 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](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](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](mailto: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  
10 participants.*

## CEU information for the 2016 FCDS Annual Conference:

*CE Hours: 8.25*

*NCRA Recognition  
Number: 2016-056*

## CEU information for the 2015 FCDS Annual Conference:

*CE Hours: 8.75*

*NCRA Recognition  
Number: 2015-077*



# Florida Cancer Data System

## Cancer Reporting Completeness Report



### TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF JUNE 30, 2016

Total number of *New Cases* added to the FCDS Master file in JUNE, 2016: **32,732**

*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	167,908	2,974	160	10,183	0	Pending	181,225	<b>31,322</b>
2014	181,887	8,732	153	10,045	0	Pending	200,817	<b>1,192</b>
2013	184,264	8,564	2,309	9,569	0	<b>2,067</b>	206,773	<b>218</b>

		<u>Actual</u>	<u>Expected</u>
% Complete for:	2015	<b>95%</b>	<b>100%</b>
	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 Website (Education Tab). FCDS Webcast Record-

ings 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.

#### PROJECT DIRECTOR:

David Lee, PhD

#### DEPUTY PROJECT DIRECTOR:

Gary M. Levin, BA, CTR

#### EDITORS:

Gary M. Levin, BA, CTR  
Steven Peace, BS, CTR  
Melissa K. Williams

#### EDITOR ASSISTANT/ GRAPHICS DESIGNER:

Aja M. Scott, BA

#### CONTRIBUTORS:

Steven Peace, BS, CTR

#### FCDS

PO Box 016960 (D4-11)  
Miami, FL 33101

Phone: 305-243-4600

800-906-3034

Fax: 305-243-4871

<http://fcds.med.miami.edu>