The Florida Cancer Data System's Memo

JANUARY 2017

2017 CTR Exam Dates

The 2017 CTR Exam dates and application deadlines are noted below.

To request the 2017 CTR Exam Candidates Handbook & Application, e-mail ctrexam@ncra-usa.org.

February 11-March 1, 2017
Application deadline: January 31

June 17-July 8, 2017
Application deadline: May 19

October 14-November 4, 2017
Application deadline: September 15

WHAT'S NEW:

The following information is currently available on the FCDS website.

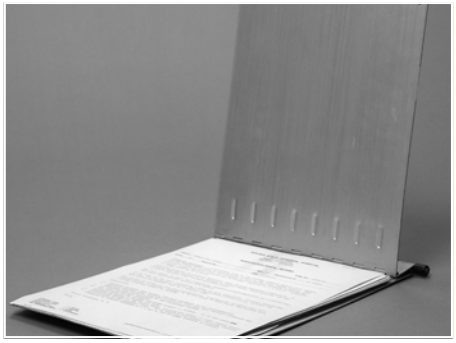
FLORIDA ANNUAL CANCER REPORT: INCIDENCE AND MORTALITY - 2013

FCDS/NAACCR EDITs Metafile
16C Metafile, posted on 10/26/2016.

FCDS/NAACCR WEBINAR SERIES:
NAACCR 2016-2017 Cancer Registry and Surveillance Webinar series - Collecting Cancer Data: Colon 2/2/17, being held at 7 Florida facilities and requires registration.

FCDS Florida Cancer Data System

Florida Statewide Cancer Registry



Florida Cancer Data System
Deadlines, Updates, & Reminders

FCDS Annual Conference

July 26-27, 2017

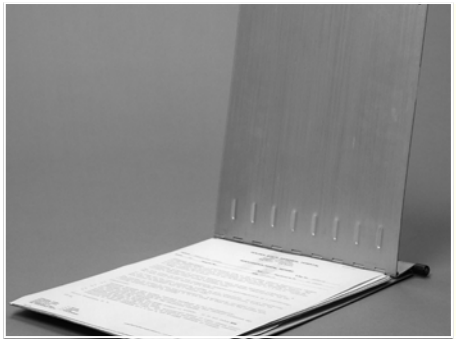
Wyndham Grand Orlando Resort
Bonnet Creek

Room Rates: $129.00 - Single/Double

Conference Registration Fee: $100.00

Hotel Reservaions can be made at the following website:
https://aws.passkey.com/e/16431649

Hotel link: wyndhamgrandorlando.com More information coming soon.



Florida Cancer Data System
Deadlines, Updates, & Reminders

CONGRATULATIONS
to New Florida CTRs

Deana Duarte, Cape Coral,

Wedly Sylvain, Jacksonville

Sharon Whitfield, Milton

FCDS Facility Follow-Up Report/Inquiry Update

FCDS announced the FCDS Facility Follow-Up Report/ Inquiry System over a year ago. This system provides your registry with a consolidated case summary of cases that you share with other facility(s) in the state. Data from multiple case reports (abstracts) are combined during the FCDS Tumor Consolidation Process - selecting the most correct data from all records to be combined into a single Consolidated Tumor Record. Records may be queried at the individual level or via a batch processing method if you want to check hundreds of cases against the FCDS Consolidated Tumor Record. FCDS Follow-Up is available in FCDS IDEA - Inquiry.

The benefits for using the FCDS Facility Follow-Up Report/Inquiry System include; the most current Date of Last Contact anywhere in the state, new or updated First Course of Treatment data (surgery items, radiation items, chemotherapy, immunotherapy, biological therapy, hormonal therapy, etc.) - this is treatment data that was given at a facility or physician office other than your own facility (treatment you were not aware had actually been given), and more.

Originally, FCDS was able to provide you with just a simple summary that included Date of Last Contact and Consolidated Treatment Data from hospitals - only.

More recently, FCDS began incorporating several years' worth of Physician Office Treatment Data, primarily from medical oncology practices. This includes updates to tens of thousands of Consolidated Tumor Records in the FCDS master files. The addition of the physician office treatment data is significant and should significantly enhance completeness of First Course of Treatment to add various types of treatment given at the physician's office or from any other actively reporting cancer diagnosis and treatment center in the state of Florida. This treatment has been verified by specific ICD Diagnosis Codes and CPT/HCPCS Codes.

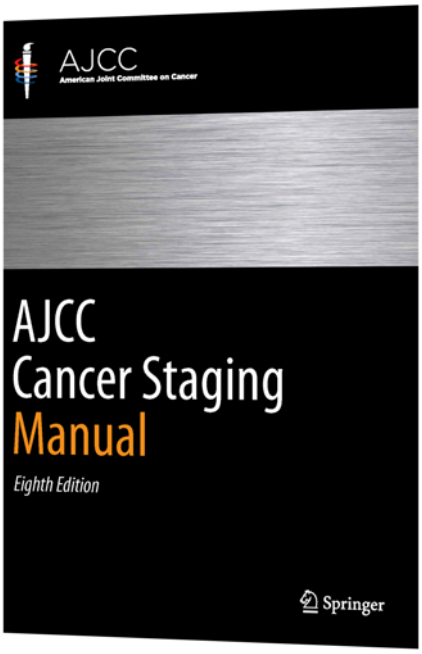
Overall, you can expect to see a more complete picture of the entire First Course of Treatment - regardless of where that treatment may have been delivered - in the hospital, in a free-standing treatment center, or in a private physician's office.

FCDS continues to work with all reporting entities throughout the state of Florida to complete the entire picture for each patient and each patient/tumor we see.

Thank you for your contributions…and please give the FCDS Facility Follow-Up Report/Inquiry System a try to enhance your facility-level data.

AJCC
American Joint Committee on Cancer
Validating science. Improving patient care.

The American Joint Committee on Cancer (AJCC) has been working closely with all of its member organizations throughout the development of the recently published 8th Edition Cancer Staging Manual. The coordination of the implementation for a new staging system is critically important to ensure that all partners in patient care and cancer data collection are working in synchrony.



In order to ensure that the cancer care community has the necessary infrastructure in place for documenting 8th Edition stage, the AJCC Executive Committee, in dialogue with the National Cancer Institute (NCI-SEER), Centers for Disease Control and Prevention (CDC), the College of American Pathologists (CAP), the National Comprehensive Cancer Network (NCCN, the National Cancer Data Base (NCDB), and the Commission on Cancer (CoC), made the decision to delay the implementation of the 8th Edition Cancer Staging System to **January 1, 2018**.

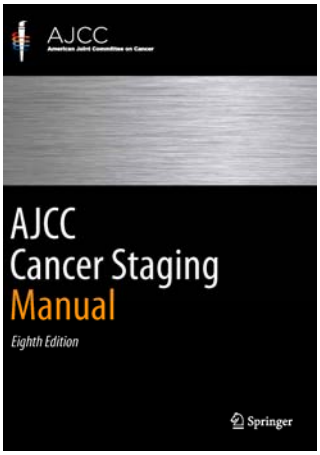
DO NOT USE THE 8TH EDITION MANUAL UNTIL 1/1/2018.

Clinicians will continue to use the latest information for patient care, including scientific content of the 8th Edition Manual. All newly diagnosed cases through December 31st 2017 should be staged with the 7th edition. The time extension will allow all partners to develop and update protocols and guidelines and for software vendors to develop, test, and deploy their products in time for the data collection and implementation of the 8th edition in 2018.

The AJCC is working together with all of its members as well as software vendors to make this transition as smooth as possible for the oncology community. More communication will follow from the AJCC and the member organizations over the coming weeks.

The latest information regarding the AJCC 8th Edition Cancer Staging System can be found at www.cancerstaging.org

Clarification on AJCC 8th edition Content and Distribution



Errata

This list contains important errata identified in the first printing of the AJCC Cancer Staging Manual, 8th Edition, and is effective for hard copy manuals purchased from September 2016 to present. This list includes errors of omission and only critical errata that affect the meaning of a cancer staging system. Errata are tracked by staff and updated weekly. If you have identified an erratum not listed here, please emaillaurameyer@facs.org.

All of the major errata are published on http://sxc.cancerstaging.org/references-tools/deskreferences/Pages/default.aspx . This is updated every Friday morning.

Chapter or Part No.	Chapter or Part Title	Section	Page	Column	Before Correction	After Correction
55	Ovary, Fallopian Tube and Primary Peritoneal Carcinoma	AJCC Prognostic Stage Groups	688	2	When T is T3a, T3b, T3c, N is N0, N1	When T is T3a, T3b, T3c, N is NX, N0, N1
58	Prostate	Definition of Histologic Grade Group	724	1	Grade Group 4, Gleason Score 8, Gleason Pattern 4+4	Grade Group 4, Gleason Score 8, Gleason Pattern 4+4, 3+5, 5+3
58	Prostate	AJCC Prognostic Stage Groups	724	2	cT1a-c, cT2a N0 M0 PSA ≥ 10 < 20 G1 IIA	cT1a-c, cT2a, pT2 N0 M0 PSA ≥ 10 < 20 G1 IIA
58	Prostate	AJCC Prognostic Stage Groups	724	2	Any T, N0, M1, Any PSA, Any G, IVB	Any T, Any N, M1, Any PSA, Any G, IVB
60	Kidney	AJCC Prognostic Stage Groups	744	1	T3 N0 M0 III	T3 NX, N0 M0 III
61	Renal Pelvis and Ureter	AJCC Prognostic Stage Groups	754	1	T4 N0 M0 Stage IV	T4 NX, N0 M0 Stage IV
67	Uveal Melanoma	Definition of Regional Lymph Node (N)	812	2	No definition for NX and N0	NX Regional lymph nodes cannot be assessed N0 No regional lymph node involvement
73	Thyroid - Differentiated and Anaplastic	Imaging	877	2	Most patients will be clinical MX, as routine use of cross-sectional or functional (RAI)…	Most patients will be clinical M0, as routine use of cross-sectional or functional (RAI)…
II	Head and Neck	Members of the Head and Neck Expert Panel	53	1	Panel member name omitted	Shirley Jordan Seay, PhD, OCN, CTR - Data Collection Core Representative
52	Cervix Uteri	Author List	649	n/a	…Ian S. Hagemann, Esther Oliva, Lorraine Portelance…	…Ian S. Hageman, Lorraine Portelance…
54	Corpus Uteri - Sarcoma	Author List	671	n/a	…Ian S. Hagemann, Matthew A. Powell…	...Ian S. Hagemann, Esther Oliva, Matthew A. Powell…

QUESTIONS? ANSWERS. and CLARIFICATION

QUESTION:
Define Progression?

ANSWER:
The NCI Dictionary of Cancer Terms defines "progression" as "the course of a disease, such as cancer, as it becomes worse or spreads in the body" - but that doesn't help much. Progression is any advancement of the cancer with or without treatment…advancement of the primary tumor, new or more involved lymph nodes, or new or more involved metastatic disease…any advancement of any of the T, N, or M is disease progression. It doesn't even have to be a change in the actual code given for T, N, or M…for example; you can see progression of primary tumor with increase in tumor size - but, still coded to the same T-category code.

Time to Progression or the length of time from the date of diagnosis or the start of treatment until the disease starts to get worse or spread to other parts of the body (progression). But, this time has no limit…progression is still based on advancement of disease.

Progression and Tumor Response in a clinical trial gets even more confusing….and, of course in a clinical trial, measuring the time to progression is one way to see how well a new treatment works with disease progression being an endpoint in many/most cancer tx clinical trials. So, for many clinical trials they include a specific definition of progression for that specific clinical trial - so there is no confusion…and they usually base these on a measurement of tumor burden (primary tumor size or invasion PLUS or MINUS the presence/absence or measurement of one or more metastasis - to see if the antineoplastic agent has any anti-tumor effect.

Progression of disease may not indicate treatment failure because the treatment may actually be keeping the tumor tamped down…just not enough to stop it.

So, in clinical trials a "tumor response" is distinct from "disease progression" for solid tumors…and both may be endpoints in research. More info from NCI below.

Criteria for progression remain loosely based on those outlined in the original WHO guidelines published in the year 1981. This landmark set of guidelines also included recommendations on performance status reporting and toxicity grading, although the recommendations were mostly based on a consensus agreement instead of data. The WHO criterion for partial response (a 50% decrease in the bi-dimensional measurement) was derived from an earlier study that quantified the variability of manual tumor measurement. In contrast, the definition of progressive disease (a 25% increase in the size of one or more measurable lesions or the appearance of new lesions) was an educated guess and not based on any specific published data.

(Continued on page 7)

(Continued from page 6)

The Southwest Oncology Group (SWOG) later proposed a larger criterion for progression (a 50% increase in the sum of tumor measurements) because of concern about the poor reproducibility of the WHO criterion for progression. In the year 2000, the Response Evaluation Criteria in Solid Tumors (RECIST) group then established the current criterion for progression—a 20% increase in unidimensional measurement or appearance of new lesions. Mathematically, the RECIST criterion is equivalent to a 73% increase in the volume of a spherical tumor mass, which is somewhat less than the SWOG criterion (a 84% increase in volume) and greater than the WHO criterion (a 40% increase in volume).

The waxing and waning criteria for progression over the past decades contrasts with the criteria for response, which have consistently represented a 65% decrease in volume of a spherical tumor mass despite changes in the measurement technique.

PMC full text: J Natl Cancer Inst. 2012 Oct 17; 104(20): 1534–1541.
Published online 2012 Aug 23. doi: 10.1093/jnci/djs353

Table 1.

The evolution of criteria for determining response and progression in solid tumor oncology

	Study and year published				
Criteria	Zubrod et al. (1), 1960	WHO (2), 1980	SWOG (15), 1992	RECIST 1.0 (17), 2000	RECIST 1.1 (20), 2009
Response characteristics					
Measurement method	Not described	Bidimensional	Bidimensional	Unidimensional	Unidimensional
Response criteria, % change	Investigator consensus	50	50	30	30
Equivalent % volume change*	NA	65	65	66	66
Response confirmation required	Yes	Yes	Yes	Yes†	Yes†
Considers "clinical response"	Yes	Yes	No	No	No
Progression characteristics					
Progression criteria, % change	Two consecutive increases	25	50	20	20
Equivalent % volume change*	NA	40	84	73	73
New lesions count as progression	Yes	Yes	Yes	Yes	Yes
Trial endpoints discussed					
Response rate	Yes	Yes	Yes	Yes	Yes
Duration of response	Yes	Yes	Yes	Yes	Yes
Time to progression and progression- free survival	No	No	Yes	Yes‡	Yes‡

* This calculation assumes a spherical tumor mass. NA = not applicable.

† Note that response confirmation is not always required, such as when response is a secondary endpoint or for randomized trials.

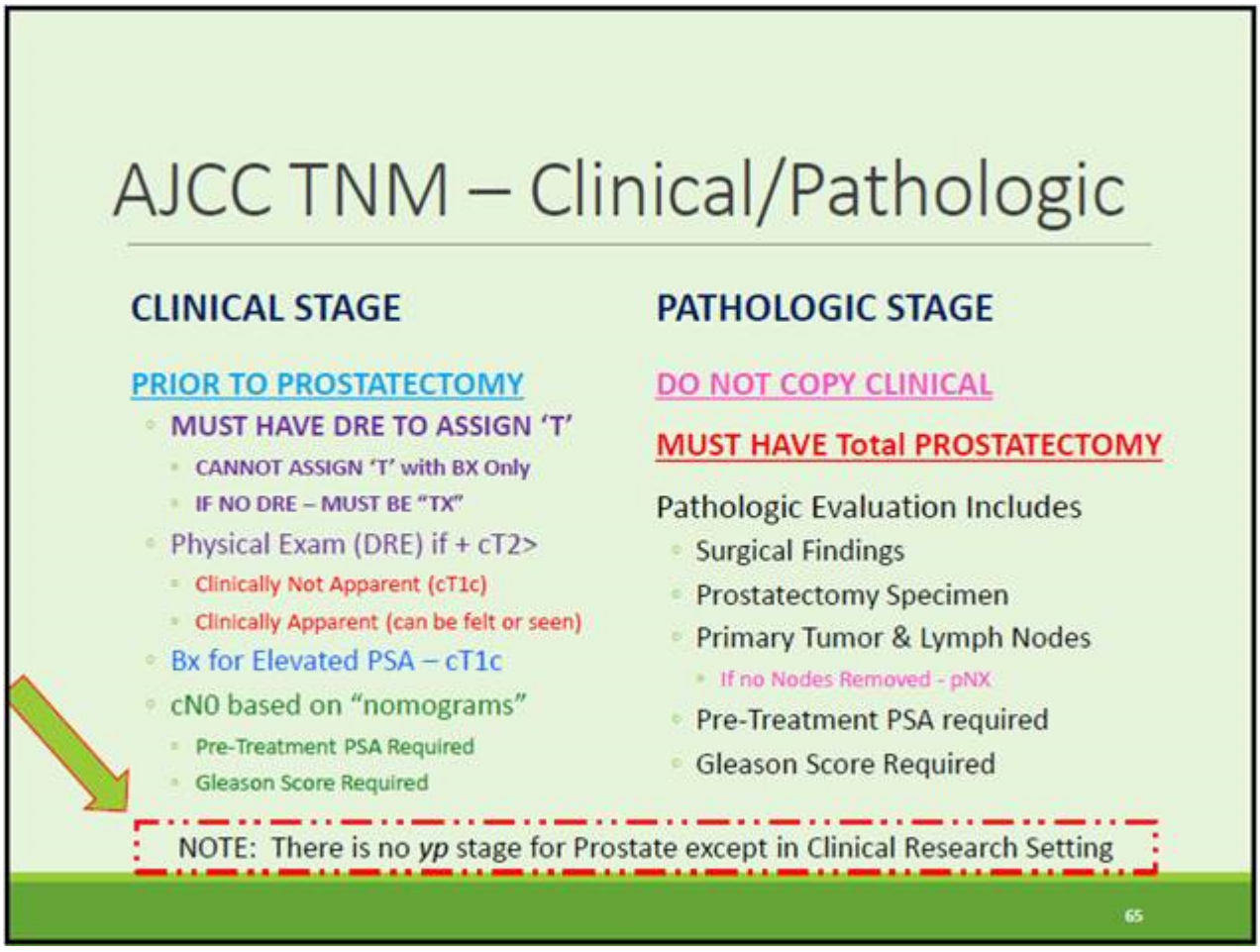
‡ The criteria were mentioned but not defined.

(Continued on page 8)

(Continued from page 7)

QUESTION:
The pt chose active surveillance as first course RX 4/2015, and now comes for prostatectomy because a subsequent bx revealed a more aggressive cancer, should the path stage be "y"?

ANSWER:
There is no such thing as yp staging for prostate. since active surveillance was first treatment - prostatectomy is not first course and not used for path staging.



(Continued on page 9)

(Continued from page 8)

QUESTION:
PATH - A. "Sacral bone lesion bx": Plasma cell neoplasm consistent with plasmacytoma. B and C. "Bone marrow, aspirate smears, clot section and core biopsy": Plasma cell neoplasm consistent with plasma cell myeloma.
Is this considered 2 primaries?

ANSWER:
One of the shortcomings of the hematopoietic database is the multiple primaries calculator and tables that support the primarily histology-based MP rules.

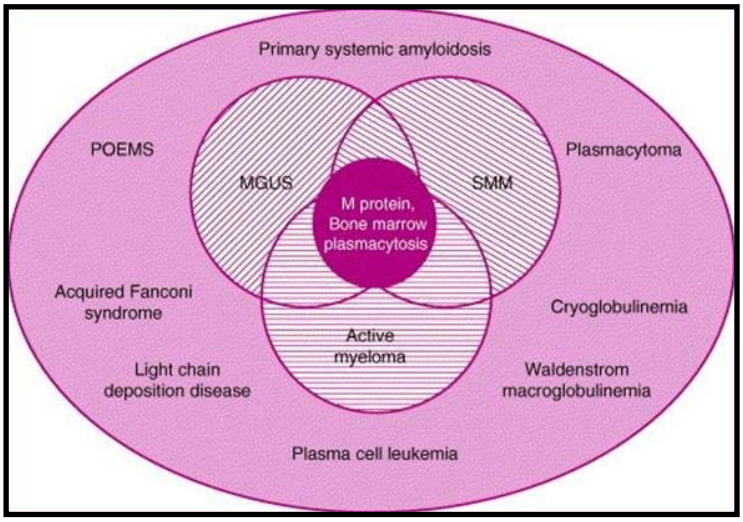
Plasma cell neoplasms are classified on a continuum or spectrum of diseases…becoming more invasive and life-threatening at each new disease classification.

Plasma Cell Dyscrasia > Monoclonal Gammopathy of Undetermined Significance (MGUS) > Solitary Plasmacytoma > Plasma Cell Myeloma (multiple myeloma)

Most plasmacytoma are solitary and asymptomatic. When multiple plasmacytoma and/or lytic bone lesions are noted there is often bone marrow involvement and the diagnosis changes to MM. I often think of the spectrum of plasma cell diseases as progression of neoplasia up to multiple myeloma..but each is different diagnosis. Solitary Plasmacytoma is reportable if it appears first…then a second primary of multiple myeloma may occur as "progression" - but some folks go right to plasma cell myeloma - their plasmacytoma "stage" was completely asymptomatic and they did not make a diagnosis until the patient had systemic disease.

Persons with MGUS are at risk for development of solitary plasmacytoma or MM - and a significant % of patients with solitary plasmacytoma progress to MM within 2-10 years of diagnosis of the original plasma cell disorder - whether it is MGUS, solitary plasmacytoma or a combination of monoclonal gammopathy (Ig).

Your case started out with dx of solitary plasmacytoma but the entire clinical picture and full workup demonstrated systemic disease and plasma cell myeloma.



(Continued on page 10)

(Continued from page 9)

QUESTION:
Has Lupron been approved for patients with pre-menopausal breast cancer?

ANSWER:
December 2016 Update: Lupron as ovarian suppressor in pre-menopausal breast cancer has been approved by the FDA per NCI. Beginning with cases diagnosed 1/1/2017 forward, code as hormone therapy.

Lupron is a gonadotropin-releasing hormone analogue. FDA approved its use on prostate cancer and should be coded as hormone therapy.

FOR BREAST CASES DIAGNOSED PRIOR TO 1/1/2017:
The effectiveness of Lupron on patients with breast cancer was being studied in one clinical trial. This trial was looking at extended endocrine therapy for pre-menopausal women with breast cancer. This trial is looking at the drug combination of letrozole and leuprolide for women who have taken Tamoxifen for at least 4-5 years. This drug combination is used in the treatment for metastatic breast cancer and is sometimes used for treatment of early stage breast cancer. However, as of early December 2016 it has not been accepted as a standard of care treatment and had not yet received FDA approval for treatment of breast cancer. While it may not have received FDA approval, it can be used "off label" for other conditions. Lupron should be coded as "Other Therapy" until such time that it receives FDA approval.

https://seer.cancer.gov/seertools/seerrx/rx/53c44afa102c1290262dc318/?regimen_field=score&rx_type=drug&drug_offset=0&regimen_offset=0&q=lupron&limit=25&drug_field=score&search_mode=&drug_direction=UP&regimen_direction=UP&mode=

NAACCR 2016-2017 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, 2016-2017 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
*10/6/16	Collecting Cancer Data: Melanoma
*11/3/16	Collecting Cancer Data: Hematopoietic and Lymphoid Neoplasm
*12/1/16	Collecting Cancer Data: Lung
*1/12/17	AJCC Staging
2/2/17	Collecting Cancer Data: Colon
3/2/17	Abstracting and Coding Boot Camp: Cancer Case Scenarios
4/13/17	Collecting Cancer Data: Lip and Oral Cavity
5/4/17	Multiple Primary and Histology Rules
6/1/17	Collecting Cancer Data: Liver and Bile Ducts
7/13/17	Hospital Cancer Registry Operations□Topic TBD
8/3/17	Collecting Cancer Data: Central Nervous System
9/7/17	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 2016-2017 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 DECEMBER 31, 2016

Total number of *New Cases* added to the FCDS Master file in DECEMBER, 2016: **26,715**

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
2016	49,228	929	49	8,815	98	**Pending**	59,119	**22,545**
2015	183,132	7,767	175	11,081	7,831	**Pending**	209,986	**3,563**
2014	186,625	9,104	1,939	11,016	15,582	**2,186**	226,452	**607**

		Actual	Expected
% Complete for:	**2016**	**31%**	**50%**
	2015	100%	100%
	2014	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 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.

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