The Florida Cancer Data System's Memo

JANUARY 2020

The Florida Department of Health and Florida Cancer Data System 2019 Cancer Reporting Deadline Announcement

The Florida Department of Health's Florida Cancer Data System (FCDS) **reporting deadline for the 2019 cases is September 30, 2020.** This affects healthcare facilities such as hospitals and medical centers submitting full cancer abstracts. Radiation Therapy Centers and Ambulatory Surgical Centers follow a unique reporting schedule, which will be announced at a later date. Claims and E-Path reporting is separate, however, they should adhere to this deadline.

CASES: The term 'cases' includes 'analytic' and 'non-analytic' cases in equal measure.

The Deadline for reporting all of 2019 cases is September 30, 2020.

FCDS will allow the reporting of 2019 cases beginning February 13, 2020.

The Deadline for reporting all 2018 cases remains March 31, 2020.

The FCDS will continue to monitor facility submissions with the understanding that facilities are still dealing with all of the new complexities of the 2018 Reporting Standards. Abstractors should be reasonably familiar with the 2018 requirements. There have been no changes to the 2019 reporting requirements and by this time productivity should be much improved for 2019 abstracting and reporting as we all continue to get back on schedule.

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WHAT'S NEW:

The following information is currently available on the FCDS website.

WEIGHT-RELATED CANCERS IN FLORIDA 1992-2013 MONOGRAPHS

FCDS RESEARCH JOURNAL PUBLICATIONS REPORT

FCDS/NAACCR EDITs Metafile
18D Metafile,
posted on 10/25/2019.

FCDS/NAACCR WEBINAR SERIES:
NAACCR 2019-2020 Cancer Registry and Surveillance Webinar Series - Abstracting and Coding Boot Camp 2020 on 3/05/2020, being held at 7 Florida facilities and requires registration.

Florida Statewide Cancer Registry

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As stated earlier, it is vitally important for everyone to take the necessary time to learn the new requirements and to provide quality abstracts to the state.

Remember, we are all trying to manage the situation of catching-up to our previous annual standard for meeting our cancer reporting requirements together as a state. Together we will work to navigate these uncharted waters.

New Florida CTRS

Neil Dungca, Pembroke Pines

Pedro Hernandez, Tampa

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Chad Williams, Boca Raton

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Florida Cancer Data System Deadlines, Updates, & Reminders

Why Are Registrars Using Diagnostic Confirmation Code 4, 5 or 9?

FCDS has seen a very odd uptick in cases being coded with a Diagnostic Confirmation Code of 5 and 9. There is not one single anatomic site and/or neoplasm histology that should even allow a Diagnostic Confirmation of 5. And, 9 is absolutely worthless and should never be used as a default value even when the original diagnosis information is lacking. This is actually an important data item that really needs to be coded correctly…please.

Diagnostic Confirmation is used to distinguish the basis for the diagnosis of cancer – not how you determined the best histology code.

Diagnostic Confirmation Code 5 may be expanded in the future to include molecular genetic testing and/or diagnostic laboratory tests. But today this code is used in only two specific instances; AFP used to diagnose hepatocellular carcinoma in liver or serum/urine electrophoresis used to diagnose plasma cell myeloma. These tests are rarely used in 2020 to establish a diagnosis. Today, these cancers are diagnosed by other means.

The only Diagnostic Confirmation Codes FCDS expects you to use are 1, 2, 3, or 7. Code 3 is a special code used only for myeloid or lymphoid neoplasms. Codes 6 and 8 may be used on rare occasions. But, registrars need to understand when they are used instead of other available codes. Codes 4, 5 and 9 should almost never be used. There are better codes to use than 4, 5 or 9 in every single case.

That said, FCDS does not limit use of codes 4 or 5 or 9. But, we know of only a few instances when these codes need ever be used if registrars understand the rationale behind the use of the other available codes and the hierarchy rule and coding instructions. So, let's review.

INSTRUCTIONS: The codes are in priority order; code 1 has the highest priority. Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple diagnostic methods. This data item must be changed to the lower (higher priority) code if a more definitive method confirms the diagnosis at any time during the course of the disease.

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Code	Description	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined).
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
3	Positive histology PLUS • Positive immunophenotyping AND/OR • Positive genetic studies	Histology is positive for cancer, and there are also positive immunophenotyping and/or genetic test results to refine or confirm a specific diagnosis. For example, bone marrow examination is positive for acute myeloid leukemia. (9861/3) Genetic testing shows AML with inv(16) (p13.1q22) (9871/3).
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/ marker studies which are clinically diagnostic for cancer. Examples include alpha-fetoprotein for liver cancer and abnormal electrophoretic spike for multiple myeloma. Elevated PSA is not diagnostic of cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only, other than 5, 6 or 7	The malignancy was reported by the physician in the medical record.
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually nonanalytic).

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Diagnostic Confirmation = 1 is used when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy or D&C or from aspiration of biopsy of bone marrow specimens. Code 1 is the preferred coding for Fine Needle Aspiration (FNA). Code 1 is also used for leukemia when the diagnosis is based only on the complete blood count (CBC), white blood count (WBC) or peripheral blood smear. Do not use code 1 if the diagnosis is based on tissue, bone marrow aspiration, blood test, immunophenotype test, or genetic testing.

Diagnostic Confirmation = 2 is used when the microscopic diagnosis is based on cytologic examination of cells that are held in body fluids such as sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluids. Do not use this code for Fine Needle Aspiration (FNA) as the FNA is not held in body fluids or mixed with body fluids during extraction of tumor cells.

Diagnostic Confirmation = 3 is used only for Hematopoietic or Lymphoid Neoplasms (ICD-O-3 Histology Codes M9590-9992). This code is used when there is a histology positive for cancer AND positive immunophenotyping and/or positive genetic testing results. This code should not be used when testing only provides the means to a more clear histology to code. You cannot use code 3 for neoplasms diagnosed prior to January 1, 2010.

Diagnostic Confirmation = 4 should NOT be USED. Codes 1, 2 or 3 should be used instead. You should be able to figure out whether code 1, 2 or 3 was used to establish a cancer diagnosis. There is essentially no reason to use this code if you understand the cancer diagnosis process and rules.

Diagnostic Confirmation = 5 should NOT be USED with two rare exceptions; positive alpha--fetoprotein for liver cancer without biopsy or abnormal protein electrophoresis spike for multiple myeloma. These tests are very rarely used in the absence of positive biopsy and/or imaging. And, today we see these two types of neoplasms almost always with a positive biopsy or positive imaging – and almost never with only a lab test. We are seeing this code being assigned with increased frequency when registrars think one of the new genetic tests

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or other some clarifying but non-diagnostic lab tests suggests a cancer is present or a more specific histology should be coded. Cancers are very rarely diagnosed only on a laboratory test or genetic testing. This may change in the future. But today, these tests only provide clarification of histologic type or subtype and are not the means for establishing the diagnosis of cancer…only a way to clarify or establish a better histology code. Please be cautious when using this particular code.

Diagnostic Confirmation = 6 is used when there is only a direct visualization of the tumor – but, the tumor is not biopsied or resected for microscopic exam. This may be used during endoscopic visual exam, EUS or other direct visualization of a tumor without a biopsy or tissue or fluid examination. Code 6 is used when the diagnosis is based only on the surgeon's operative report from a surgical exploration or endoscopy or from gross autopsy findings in the absence of tissue or cytological findings.

Diagnostic Confirmation = 7 is used when there is only a positive imaging study as the diagnostic method without a biopsy or tissue examination or an examination of body fluids. Diagnostic Imaging includes x-ray, CT scan, MRI study, PET scan, or hybrid imaging such as CT/PET or MRI/PET scans. Diagnostic Confirmation 7 cases are often benign brain or CNS tumors or solid tumors that are never treated due to patient comorbidities or age.

Diagnostic Confirmation = 8 is used when the cancer was diagnosed by any clinical method that cannot be coded as 6 or 7. Please remember these codes are to be used in a hierarchy and code 8 is nearly last on the list of preferred codes.

Diagnostic Confirmation = 9 is used only when you have no idea how a cancer was diagnosed – and you cannot figure it out from other clues in the medical record. DO NOT USED CODE 9 as a DEFAULT for any cases, including non-analytic cases. When a patient has a histologic type designated in a history, summary, consultation or other report…the patient had a biopsy. You might not know when or where. But, the patient had a biopsy of some type to identify the histology and code 1 should be used. If the report gives you a tumor location, the patient at least had imaging. Sometimes you have to look for the clues to determine a better Diagnostic Confirmation code to use…but, please do not used code 9 as a default or pass-thru.

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Coding Grade for 2018 and Later Diagnosed Cases

FCDS continues to see error after error on visual editing (QC Review) when it comes to correctly coding the 3 new Grade Fields. It isn't that difficult to follow these instructions, and we are somewhat baffled as to why these errors keep coming in in droves. It must be that registrars are only using their memory and the drop down pick list in their software to 'pick' a code, rather than understanding the differences in which codes are best to use for your particular case. Grade is a very important data item and has become very cancer-specific and behavior-specific. You have to pay attention to both when selecting the code from your pick list as some codes are more accurate than others and some should only be used for 'non-invasive' tumors and some only for 'invasive' tumors. These specifics for coding the grade fields do not appear in your pick list – so, please use the manual.

- PLEASE - DO NOT RELY ON YOUR MEMORY TO CODE GRADE.
- CODING GRADE FOR MANY CANCERS HAS BECOME CANCER TYPE SPECIFIC.
- The codes for each cancer-specific grading system are to be used in hierarchy from top to bottom.
- The cancer-specific grading will always appear at the top of the grading hierarchy for that cancer site.
- The terms high/low grade are generally used only for non-invasive/in-situ cancers – but, can be used when this is the best information you have.
- The terms well differentiated, moderately differentiated, poorly differentiated and undifferentiated generally fall at the bottom of the selection list for all cancer-specific grading systems and are to be used when this is the only grade information provided on the pathology report.

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- Do not convert the terminology to a code based on the old grade tables – assign them literally from the text.

- A biopsy or resection of a metastatic site can never be used as the specimen for coding grade – only code the grade of the primary site.

- If the patient has a biopsy before the resection of the primary site -- then clinical grade = biopsy grade (first grade identified).

- If the patient has a biopsy and does not have a resection of the primary site -- then clinical grade = biopsy grade (first grade identified) and the pathological grade = 9.

- If the patient does not have a biopsy but does have a resection of the primary - then clinical grade = 9 and the pathological grade = resection of the primary site grade.

- If the patient does not have a biopsy but does have a resection of primary site – then the clinical grade = 9 and the pathologic grade = resection of primary site grade.

- If the patient has a biopsy assign the biopsy grade, and a resection assign the pathologic grade.

- If the biopsy/clinical grade is higher than the resection/pathological grade – assign the pathological grade to both the clinical and pathological grade. (IMPORTANT: BUT – don't do the reverse of this and recode the clinical grade to a higher code when the pathological grade is higher.)

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Code	Grade Description
1	Site-specific grade system category
2	Site-specific grade system category
3	Site-specific grade system category
4	Site-specific grade system category
5	Site-specific grade system category
8	Not applicable (Hematopoeitic neoplasms only)
9	Grade cannot be assessed, Unknown
A	Well differentiated
B	Moderately differentiated
C	Poorly differentiated
D	Undifferentiated and anaplastic
E	Site-specific grade system category
H	High grade
L	Low grade
M	Site-specific grade system category
s	Site-specific grade system category
Blank	(Post therapy only)

Codes 1-5, H, L, M, S, and 9 all represent AJCC recommended grading systems.

Categories L and H are applicable for the AJCC recommended grading systems of "low grade" and "high grade" for those cancers for which these are used (e.g. urinary cancers with urothelial histologies). It also includes

M for intermediate grade to be used with L and H for breast in situ cancers.

S is utilized for sarcomatous overgrowth in corpus uteri adenosarcoma, an AJCC registry data collection variable.

Codes A-E are the generic grade categories (definitions) that have been used by the cancer surveillance community for many years. Codes A-E are not available for all cancers since although many AJCC chapters continue to use the traditional grade terms, many of the chapters now use a three-grade system, instead of the four-grade system.

Clarifications on the Class of Case

FCDS gets TONS of questions about 'How to Code Class of Case' on the Abstract. And, for some reason Registrars often agonize over coding this data item. It is easy to figure out once you understand the coding structure. The codes and definitions were 'updated' in 2010 and the revised definitions for Class of Case became confusing. But, if you stick to the basics, you will be able to code Class of Case easily and correctly – most of the time.

The CoC STORE Manual includes descriptions of all Classes of Case and a history of this data item. Changes have been made over time to try to accommodate changes in healthcare delivery systems, small and large networks of intertwined healthcare partners, and for care provided in an ambulatory setting and in physician practices. We know these affiliations and relationships change frequently, adding to confusion over code usage.

Class of Case describes the nature of your facility's involvement with the diagnosis/treatment of a patient and the patient's cancer. Your facility may be involved in the screening, diagnosis, workup, 2nd opinion review, surgical or other treatment, or follow-up for recurrence or progression of disease over the course of the patient's lifetime – and the lifetime of the patient's cancer should it return after treatment, lead to further disease or complications from therapy, and until death.

1. **Do not use Class of Case = 99 as a Default on Any Cases for Florida** (central registry use only)

2. Class of Case can be Grouped into "Diagnosis-Only", "Analytic" and "Non-Analytic" Classes

3. **Group 00 Class of Case is the "Diagnosis-Only" group.** It is used when your facility is responsible only for the diagnosis of the case; whether by imaging, or by biopsy, endoscopy or surgery. Again, your facility only diagnosed the case. Nobody from your staff took part in writing up a workup-plan and/or a treatment plan and/or your facility did not provide any treatment for the cancer, whatsoever.

a) Please remember that when your facility takes part in the initial workup and non-surgical staging of a patient's cancer; you are involved in the diagnostic/staging process. More than one facility can use the Class of Case 00 when the diagnosis/non-surgical staging occurs in more than one location or across healthcare networks during the early workup for a patient's cancer.

b) When the CoC redesigned the codes back in 2010 they moved this group of cases from Class of Case 00 (involved in workup and part of diagnosis/staging) they created a lot of confusion as to whether code 00 or code 30 should be used when a facility participates only in diagnostic workup. FCDS has always taken issue with this change in code 00 and 30 definitions and now allows either code 00 or 30 to be used in these cases.

c) These cases are considered 'non-analytic' and excluded from your CoC reports because the only information you know about the cancer has been obtained from a screening or diagnostic image, or perhaps an endoscopy or biopsy specimen. There is no context as to treatment options or planning.

4. **Group 10-20 Class of Case** is used when your facility takes part in the initial diagnosis and all or part of the first course of treatment for a patient/cancer. These are referred to as 'analytic cases' because these are the primary cases used when looking at quality patient care at your institution. Your facility was involved in the initial cancer care for the patient. When your facility takes part in treatment for cancer, you are involved in treatment.

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a) **The 10-14 Group** consists of cases where your facility participated in both the diagnosis and first course of therapy for cancer. Participation in first course of therapy may be that your facility only provided a treatment plan, and the treatment was given at a physician practice or another facility of some kind – but, your facility or one of your staff physicians participated in both diagnosis and treatment planning and/or deliver of therapy during the initial course of treatment for cancer.

i) Parsing the 10-14 group is where folks seem to get most confused for some reason. When in doubt, you can always just assign the code 10 and the case stays in the same group of 10-14 without agonizing over the minor differences between codes 11, 12, 13, and 14.

ii) It is often difficult to determine the status of individual physicians and their relationship with your primary facility. Some facilities have closer relationships with physician practices than others have and consider the physician practice to be an extension of the primary facility. In addition, some facilities actually employ many physicians. How your facility treats these cases is up to your Cancer Committee. When registrars do not understand these relationships there are inconsistencies in this 10-14 code group.

b) **The 20-22 Group** consists of cases where your facility participated in all or part of the first course of therapy for cancer – but the patient came to your facility from outside your physician base and the diagnosis was not made at your facility or one of its associates. These cases are also considered 'analytic' cases because your facility played an integral role in the early treatment of this patient's cancer.

i) Similar to parsing the 10-14 group; when you try to parse the 20-22 group you need to understand the relationship between the physician practice or endoscopy center or wherever the patient was originally diagnosed by imaging and/or biopsy before you can determine whether or not your 'facility' in the broader sense participated in diagnosis and/or first course of cancer therapy. A code 20 may suffice if you are not sure the exact code to use but know your case belongs in the 20-22 Group.

ii) Sometimes it is obvious the patient came to your facility from outside your healthcare network for treatment by your hospital or specialty clinic. Other times it is not as obvious because of the relationships between your facility, the primary or referring physician, and what may/may not be a totally separate 3rd party location or practice that established the initial diagnosis. Therefore, these cases can be tricky, too…especially as these relationships change over time with ambulatory centers, hospitals, and physician practices going thru mergers, acquisitions and divestitures.

5) **The 30-38 Group** consists of cases seen at your facility after the initial diagnosis and first course of treatment but, have had recurrence or progression of their primary cancer that may or may not be treated at your facility or elsewhere. These are 'non-analytic' cases because your facility did not participate in the initial care of the patient and their cancer… but rather, your facility is participating in secondary or tertiary or end-of-life care for the patient due to cancer recurrence, progression, or other complications from their cancer.

Note: Florida also requires that non-analytic cases in these categories without evidence of the historical cancer must still be reported in the historical cancer grid to account for all cancer sequences the patient has ever encountered. These non-analytic 'no evidence of cancer' cases are placeholder mini-abstracts that help Florida keep track of all cancers for every cancer patient when at least one of the cancers is 'active'. That said many of these cases turn out to be 'analytic' for FCDS. The central registry and hospital registry treat this 30-38 group differently.

a) Registrars don't really like to abstract these cases because all too often there is limited information in the history or consultation regarding the initial diagnosis (histology, stage, etc.) and initial treatment or the information may be entirely missing from the medical record. Every state in the country requires by law that these cases are abstracted when reporting cases with 'active cancer' is part of the state legal cancer-reporting requirement.

b) Code 30 Clarification – While the CoC maintains that Class of Case = 30 cases include patients seen for consultation only, treatment planning only, or staging workup only; FCDS has always treated the patient receiving part or all of staging workup as 00 cases. Either code 00 or 30 is correct. However, FCDS retains the claim that when a facility participates in the initial staging workup – they are also participating in diagnostics. Hence, the use of either code is acceptable – code 00 is preferred in this case. These cases are still 'analytic' for Florida; even if they are non-analytic for your facility because your facility took part in the non-surgical diagnostic/staging workup for the cancer.

c) The remainder of the code 30-38 group are self-explanatory and for special use. You will not find occasion to use these codes other than 30, 31, 32, 33 very often. But, you may need to use code 34 for example in the case where you are reporting VIN III, VAIN III, or other state-reportable neoplasms that are not required by the CoC and should not be sent to the NCDB as part of the NCDB Annual Call for Data.

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6. **The 40-49 Group** is not used by registrars unless there is a special arrangement between physician practices and the primary facility to report physician-office only cases including path-only cases. These codes are '**for central registry use – only**.'

7. **Code 99 should never be used – period.** You should always be able to determine what relationship your facility has with the patient, their cancer, the diagnosis, first or subsequent course of therapy and follow-up. While FCDS does accept code 99 – it should never be used by anybody for any cases.

Google AI - Breast Cancer Screening

You may have heard about this over the weekend – but, this is where healthcare imaging including screening for cancers technology is headed – just like I told folks on our December 19, 2019 Webcast it was coming – it is here – it is AI and 3D and holograms for screening and evaluation of cancers - wow!!! I told them on the webinar about computer assisted diagnostics and this new Google Artificial Intelligent System is exactly that…with CAD plus AI – and outcomes are better than using trained radiologists to do readings. We are there folks…now we will see a big rush in CAD plus AI for other cancers. I suspect lung will be a big one for screening…but, the CAD plus AI is truly a technological breakthrough – expected and now arrived.

There is always a reader variability when it comes to radiologist' interpretation of images – so computer assistance and artificial intelligence are prime for decreasing this variability and can rely on huge image databases to look at abnormalities and assess them uniformly without reader interpretation. The CAD and AI work together to build an enormous database of tumor characteristics and compare the incoming image to other images (and the outcomes from those images – were they cancer or something else – and can include time studies of changes in 'tumor' over time.

We were also working on this when I was involved in the National Lung Cancer Screening Trial (NLST) for CAD/AI for lung cancer screening.

The CAD/AI DBMS examines tumor size, shape, texture, location, edges, smoothness, roundness, micro calcifications, nearby structures and other factors and compares them to other images and diagnoses held in the CAD database to look for similarities and differences to other tumors.

https://www.cnn.com/2020/01/02/tech/google-health-breast-cancer/index.html

More AI in Medicine in the News

As a follow-up to the 12/19/2019 FCDS Webcast on Technological Advances in Medical Imaging – FCDS has provided several January 2020 news articles about Computer-Assisted Diagnostics and Artificial Intelligence Advances in Diagnostic Imaging. We wanted to reinforce the facts that these advances are here now and that the rapid pace of development of these new tools will greatly change our work as well as our services for patients.

New Study Shows Artificial Intelligence Provides Game-Changing Intraoperative Brain Tumor Diagnostics

New cutting-edge technology that uses artificial intelligence along with optical imaging is providing neurosurgeons a near real-time method of diagnosing brain tumors during surgery, according to a recent study.

The collaborative study, co-authored by neurosurgeons with Sylvester Comprehensive Cancer Center, part of the University of Miami Miller School of Medicine, was published on January 6 in the journal *Nature Medicine*.

"It's really a step forward in providing rapid intraoperative diagnoses of malignant and benign tumors, which is essential information needed to make critical decisions during safe and effective brain tumor surgery," said Sylvester neurosurgeon and study co-author Michael Ivan, M.D., M.B.S., who played a major role in developing the Stimulated Raman Histology (SRH) technology with leading collaborators at New York University and the University of Michigan. "This digitized process provides surgical teams a diagnosis in less than three minutes as opposed to a 20-30 minute wait time during a traditional process."

Accurate histopathologic diagnosis is crucial for planning during the actual surgical removal of brain tumors. Conventional methods for intraoperative histology are time consuming and require sectioning and freezing and necessitate tissue transport to a pathology laboratory, specimen processing, slide preparation by highly trained technicians, and interpretation by pathologists, with each step representing a potential barrier to delivering safe, timely, and effective surgical care.

Titled "Near Real-time Intraoperative Brain Tumor Diagnosis Using Stimulated Raman Histology and Deep

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Neural Networks," the study examined the diagnostic accuracy of brain tumor image classification through machine learning, compared with the accuracy of conventional histologic images interpreted by pathologists. The results for both methods were comparable: the AI-based diagnosis was 94.6% accurate, compared with 93.9% for the pathologist-based interpretation on a frozen specimen.

One of the most significant advantages of Stimulated Raman Histology is ensuring more precision in completely removing cancerous brain tumors, said Dr. Ivan, who is leader of the Neuro-oncology Site Disease Group at Sylvester and assistant professor of neurological surgery at the Miller School of Medicine.

"In many of our surgeries on malignant tumors, the ability to remove all of the tumor makes a difference in a patient's overall survival," said Dr. Ivan. "Artificial intelligence provides more rapid and frequent information to the surgeon while operating to ensure the boundaries of the surgical resection are clear of cancer."

This game-changing technology is an exciting step forward in the management of brain tumors, said Sylvester neurosurgeon Ricardo Komotar, M.D., who also served as a study co-author and is the director of surgical neuro-oncology and the Brain Tumor Initiative at Sylvester.

How Stimulated Raman Histology Works

The pioneering imaging technique reveals tumor infiltration in human tissue by collecting scattered laser light that illuminates essential features not typically seen in standard histologic images.

The microscopic images are then processed and analyzed with artificial intelligence, and in under two and a half minutes, surgeons are able to see a predicted brain tumor diagnosis. Using the same technology, after the resection, they were able to accurately detect and remove otherwise undetectable tumor.

"This is a very complex AI system, which looks at patterns, intensity, and coloration of the specimen's digital image to provide an instantaneous diagnosis," said Dr. Ivan.

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How The Study Was Conducted

To build the tool, researchers designed an artificial intelligence model trained on over 2.5 million images — a deep convolutional neural network (CNN) composed of 415 patient samples to classify tissue into 13 histologic categories that represent the most common brain tumors, including malignant glioma, lymphoma, metastatic tumors, and meningioma.

In order to validate the CNN, Dr. Ivan and researchers and neurosurgeons at two other sites enrolled 278 patients undergoing brain tumor resection or epilepsy surgery in the clinical study. Brain tumor specimens were biopsied from patients, split intraoperatively into sister specimens and randomly assigned to the control or experimental arm.

Specimens routed through the control group — the current standard practice — were transported to a pathology laboratory and went through conventional specimen processing. The experimental group was performed intraoperatively, from image acquisition and processing to diagnostic prediction via CNN.

The study showed that the diagnostic errors in the experimental group were unique from the errors in the control group, suggesting that a pathologist using the novel technique could achieve close to 100 percent accuracy. The system's precise diagnostic capacity could also be beneficial to centers that lack access to expert neuropathologists.

"As surgeons, we're limited to acting on what we can see; this technology allows us to see what would otherwise be invisible, to improve speed and accuracy in the OR, and reduce the risk of misdiagnosis," said senior author Daniel A. Orringer, M.D., associate professor of neurosurgery at NYU Grossman School of Medicine, who helped develop SRH and co-led the study with colleagues at the University of Michigan. "With this imaging technology, cancer operations are safer and more effective than ever before."

In addition to accelerating the workflow of pathologists, researchers conclude that the technology can be used in other medical settings that depend on the expert analysis of tumor samples obtained during surgery.

"The combination of artificial intelligence and surgical experience is an example of what separates Sylvester Comprehensive Cancer Center from other centers in the state of Florida," said Dr. Komotar.

100 More Casefinding Exercises Available

Path Practicum 07 Released January 13, 2020

Mary Potts, RHIA, CPA, CTR

Director, SEER*Educate

Fred Hutchinson Cancer Research Center, Cancer Surveillance System

Learn by Doing: Casefinding

When it comes to casefinding, we could all use a good map.

A guided tour would be even better.

Under the Training Menu in SEER*Educate is a Casefinding Page with pathology reports for training in the application of SEER's reportability rules using additional references of Solid Tumor Rules, Heme Rules, and ICD-O-3 codes.

During 2019, the first six practicums (600 exercises) were released. On January 13, 2020, we released Path Practicum 07 (100 exercises). During 2020, we will release Path Practicums 08 through 12 for a total of 1,200 path casefinding exercises.

This selection of pathology reports is based on the **types of actual reports** that both trainees and sometimes experienced staff at our registry misclassified as to the potential number of primaries (0 for not reportable and then 1, 2, or 3 for reportable primaries).

These pathology reports are not intended to be trick questions, but are intended to challenge people. After you declare the number of potentially reportable primaries, you are prompted to code the primary site(s), if any. These exercises provide many opportunities for students and registry staff to practice primary site coding in addition to learning casefinding and how to apply the Solid Tumor Rules and Heme Rules.

Casefinding is always done in context of a facility's reporting requirements for State reporting, CoC reporting (if the facility is ACoS-approved), and per the facility's own Cancer Committee requests. For this purpose, we created SEER*Educate Memorial Hospital. This hospital registry uses a Casefinding Overview document, General Guidelines document, and then a Facility-Specific Path Casefinding Rules document, and these documents are available on the Casefinding Page. Each user needs to read these documents before starting these exercises and then reference the documents as needed throughout the exercises.

The National Cancer Registrars Association (NCRA) recognizes 9 practicum hours for the casefinding requirement for students who complete a set of 100 path reports achieving 85% accuracy across the cases. Although users can immediately repeat a test to improve one's score, we recommend cycling through all 100 in a set before repeating any

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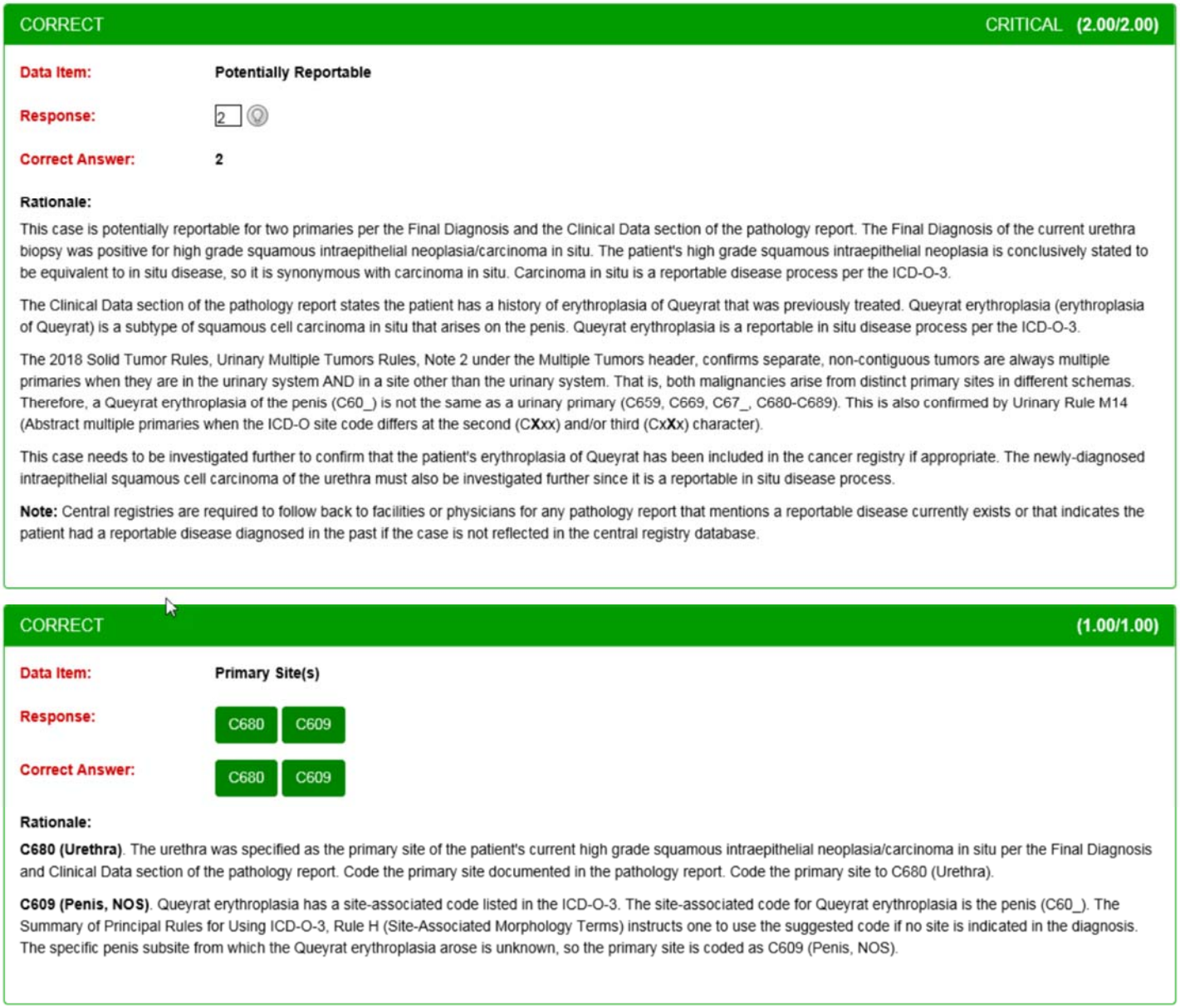
tests to improve your actual understanding of the casefinding guidelines, reportability rules and resources, and primary site coding.

An example of the detail provided in the rationales is shown below. Reading the rationales and learning the concepts that are repeated throughout these exercises is the transferable skill students and registrars need to acquire to perform highly accurate casefinding.

Example Answer/Rationale for a Pathology Report



CORRECT — CRITICAL (2.00/2.00)

Data Item: Potentially Reportable

Response: 2

Correct Answer: 2

Rationale:

This case is potentially reportable for two primaries per the Final Diagnosis and the Clinical Data section of the pathology report. The Final Diagnosis of the current urethra biopsy was positive for high grade squamous intraepithelial neoplasia/carcinoma in situ. The patient's high grade squamous intraepithelial neoplasia is conclusively stated to be equivalent to in situ disease, so it is synonymous with carcinoma in situ. Carcinoma in situ is a reportable disease process per the ICD-O-3.

The Clinical Data section of the pathology report states the patient has a history of erythroplasia of Queyrat that was previously treated. Queyrat erythroplasia (erythroplasia of Queyrat) is a subtype of squamous cell carcinoma in situ that arises on the penis. Queyrat erythroplasia is a reportable in situ disease process per the ICD-O-3.

The 2018 Solid Tumor Rules, Urinary Multiple Tumors Rules, Note 2 under the Multiple Tumors header, confirms separate, non-contiguous tumors are always multiple primaries when they are in the urinary system AND in a site other than the urinary system. That is, both malignancies arise from distinct primary sites in different schemas. Therefore, a Queyrat erythroplasia of the penis (C60_) is not the same as a urinary primary (C659, C669, C67_, C680-C689). This is also confirmed by Urinary Rule M14 (Abstract multiple primaries when the ICD-O site code differs at the second (C**X**xx) and/or third (Cx**X**x) character).

This case needs to be investigated further to confirm that the patient's erythroplasia of Queyrat has been included in the cancer registry if appropriate. The newly-diagnosed intraepithelial squamous cell carcinoma of the urethra must also be investigated further since it is a reportable in situ disease process.

Note: Central registries are required to follow back to facilities or physicians for any pathology report that mentions a reportable disease currently exists or that indicates the patient had a reportable disease diagnosed in the past if the case is not reflected in the central registry database.

CORRECT — (1.00/1.00)

Data Item: Primary Site(s)

Response: C680 C609

Correct Answer: C680 C609

Rationale:

C680 (Urethra). The urethra was specified as the primary site of the patient's current high grade squamous intraepithelial neoplasia/carcinoma in situ per the Final Diagnosis and Clinical Data section of the pathology report. Code the primary site documented in the pathology report. Code the primary site to C680 (Urethra).

C609 (Penis, NOS). Queyrat erythroplasia has a site-associated code listed in the ICD-O-3. The site-associated code for Queyrat erythroplasia is the penis (C60_). The Summary of Principal Rules for Using ICD-O-3, Rule H (Site-Associated Morphology Terms) instructs one to use the suggested code if no site is indicated in the diagnosis. The specific penis subsite from which the Queyrat erythroplasia arose is unknown, so the primary site is coded as C609 (Penis, NOS).

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SEER*Educate is funded by Surveillance, Epidemiology and End Results (SEER) of the National Cancer Institute (NCI) and the Fred Hutchinson Cancer Research Center. (NCI Contract Number HHSN261201800004I)

Mammograms and Reportability (decrypt)

BIRADS5 IMAGING DATE AS DX DATE – PLEASE FORWARD TO ME and WE CAN AGAIN RECONSIDER THIS VERY OLD AND OUTDATED COC "RULE" THAT WE HAVE BEEN UNABLE TO FIND THE SOURCE

This has been an area of concern for decades and does not need to be. The original intent of distance of time between identification of an imaging abnormality and biopsy confirmation of cancer was key. Now, we have reduced this amount of time greatly due to enhanced imaging techniques, better scheduling, clearer images, access to care, etc.

FCDS could not find any reference to use or no use of BIRADS in any of the CoC/STORE/NCDB/SEER/NPCR/NAACCR or other standards that restricted the use an abnormal mammography date as a date of diagnosis. Therefore, FCDS has rescinded these date restrictions and made clarifications that mammography imaging can indeed be used as a date of initial cancer diagnosis when the abnormality is later confirmed to be cancer on biopsy.

It is really quite easy. A low radiation screening mammogram (2D, 3D, film or digital) that shows an abnormality of BIRADS 4 or BIRADS 5, readings which are highly suspicious and/or diagnostic of breast cancer on imaging, and that abnormality is later biopsied and confirmed to be cancer, regardless of behavior, then the first indication the patient had any sign of cancer was the screening mammography date.

We have gone round and round on this for years and can no longer find a solid reference not to use the BIRADS4 or BIRADS5 mammography date as the initial date the a physician referred to abnormality as 'cancer'…but, clearly mammography imaging has come a long way since this old rule.

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The tricky part here is that in the rare instance where a patient ONLY has a mammogram with BIRADS 4 or BIRADS 5 still is not reportable, alone.

We are still requiring that the imaging be confirmed with a biopsy because tumors are so small these days when found on imaging they could be cancer even when the abnormality is found only to be a couple of millimeters in size.

When biopsy of the noted BIRADS4 or BIRADS5 abnormality of the breast does result in confirmation of cancer – then you can use imaging date as the date of diagnosis – just like any other imaging report like a CT Scan of the Lung can be used as the diagnosis of lung cancer before biopsy.

Don't let date of diagnosis be confused with best method of diagnostic confirmation – the best Diagnostic Confirmation for the case is still a biopsy.

So, the cancer can be diagnosed on imaging but we require a biopsy as a better diagnostic confirmation to validate these small tumors are in fact cancer – particularly when imaging is confirmed with biopsy as it is for lung, colon or other cancers. Best practices do dictate biopsy follows these radiological findings when a BIRADS 4 or BIRADS 5 lesion is noted – biopsy is recommended…and when biopsy is positive…the date of dx is the mammography date, not the date of the biopsy.

Do not report a breast cancer based on an abnormal mammogram only, regardless of BIRAD status.

QUESTIONS? ANSWERS. and CLARIFICATION

JAK2 positive case

Question:

So I have this case where the person is stated by med onc to have "Jak2 positive myeloproliferative disorder" with a (+) Jak2 v617f test. Was also stated to have erythrocytosis and thrombocytosis but nothing more specific. Patient was started on hydroxyurea and has phlebotomies prn.

Would you say this is reportable and if so, what histology would you use?

Answer:

The patient most likely has Polycythemia Vera (PV – 9950/3) with JAK2+ MPN – 90% of PV cases have JAK2 V617F mutation. Especially since there is trilineage proliferation of white, red and platelet cells. This is also called panmyelosis. However, Essential Thrombocythemia (ET - 9962/3) and Primary Myelofibrosis (PMF – 9961/3) also show JAK2+ in about 50% of cases. All are myeloproliferative neoplasms (MPN). Transformations from PV to PMF or ET do occur as do transformations to acute myeloid leukemia. It is unclear what triggers these transformations.

There was a lot of talk about JAK2 when it was first identified and it was thought to be marker for single disease – PV – But, it turns out it was marker for multiple related diseases. Unless a physician designates a subtype of Myeloproliferative Disease as PV, ET, or PMF – all we can code is the myeloproliferative neoplasm, NOS with the information available and document the JAK2+ and the CBC before treatment for white, red, platelets.

Bone Marrow Primary (C42.1) with histology code 9975/3: Myelodysplastic/myeloproliferative neoplasm, unclassifiable

Treatment: Hydroxyurea is used to decrease the proliferation of the bone marrow's overproduction of red cells, white cells and platelets that are hallmarks of these conditions. Hydrea is not a cure as there is no cure for any of these chronic conditions. Hydrea is used when patients become symptomatic or for folks who have higher risk of developing blood clots caused by the overproduction of blood cells in the proliferative phase of these conditions. This is also why they do phlebotomy – to decrease the volume of blood that is being overproduced by the bone marrow and reduce the risk for developing blood clots or other problems with overproduction of the 3 blood components in the circulating blood.

And, of course a percentage of these cases will go on to develop AML in a blast crisis and that changes everything.

Malignant Granular Cell Tumor of the Breast

Question:

The Path on excision shows 4.4cm tumor size, 8/15 axillary lymph nodes with mets.

Do you have any other cases like this or some insight into if this should be soft tissue primary vs. a C50._ primary ?

Answer:

It depends on how long you have been in the business and how you may interpret some old coding rules that I don't think are in any manuals, anymore. Fortunately, if anybody wants to research these tumors they look them up by histology and not by primary site – they are quite rare in the breast and they are not always malignant which makes it even more confusing – rare and not always reportable/malignant tumors. They are tumors of the nerve sheath of Schwann cells in the breast.

This one clearly is reportable and malignant. And, you reported it the way it should be reported – as a breast cancer primary not soft tissue.

Technically though…it is a type of connective tissue nerve cell sarcoma, usually low grade, that arises in the nerve cells of the peripheral nervous system (not the central nervous system or brain) and originates in the covering of the Schwann cells – the nerve sheath. We usually see benign schwannoma in the cranial nerves (acoustic and optic usually) within the cranium – also called acoustic neuroma or optic neuroma. But, the peripheral nerve tumors can also become malignant and difficult to control as they progress and de-differentiate and de-grade like this one did.

Many years ago it was decided to report unusual tumors of 'organs' like breast to the 'organ of origin' breast in this case rather than the connective tissue of the chest which is really what the primary should be if you consider the type of tumor. This was so the tumors would not get lost that they arose in the breast and not the front or back of the connective tissue of the trunk – it was too broad a category and the fact that it was a breast tumor was at that time felt to be more important to identify tumor location than the generic 'connective tissue of trunk'.

Pancreatic Neoplasm Case

Question:

SURGICAL SPECIMEN - HISTOLOGY: S-03596-19 Lee Memorial

Pancreas, Whipple procedure:

Intraductal papillary mucinous neoplasm (IPMN) with intermediate grade dysplasia.

Lesion size: 2.5 cm.

No invasive carcinoma identified.

Background pancreas, no significant histopathologic abnormality identified.

Margins: Negative for high-grade dysplasia or malignancy (pancreatic, uncinate, proximal, and distal margins).

Pancreatic intraepithelial neoplasia-I identified at pancreatic parenchymal margin.

Sixteen benign regional lymph nodes (0/16).

My first inclination was to ignore the "with intermediate grade dysplasia" and proceed with the histology of 8453/2. I taped the sheet FCDS distributed clarifying reporting of /2 and /3 pancreatic neoplasms in my AJCC 8 pancreas chapter. However, in looking at the ICD-0 3 2nd revision, there is an Intraductal papillary mucinous neoplasm with *moderate* dysplasia 8453/0 which would not be reportable.

Answer:

Since printing the 2018 FCDS DAM we have had clarification from WHO on these neoplasms.

WHO considers IPMN an in-situ tumor /2 only when there is associated high grade dysplasia.

IPMN with low grade or intermediate grade dysplasia are considered benign…though they may be precursor lesions to malignancy if not treated.

They specifically now have the code for IPMN with intermediate grade dysplasia listed with /0 behavior - therefore not reportable.

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To make matters even more confusing – they performed a Whipple on this person as if they had malignant pancreatic cancer – but, the path report does specifically state 'no invasive carcinoma identified'. So, we have to go by the WHO Classification that this is a 2.5cm benign tumor in pancreas.

FCDS has requested that the NAACCR ICD-O Work Group provide a more clear set of guidelines along with NCI SEER and the Solid Tumor Rules that would provide greater clarification for new classification and use of terminology for thyroid papillary and follicular neoplasms as well as the numerous pancreatic neoplasms for which we are seeing treatment without histologic confirmation and histology terms based on visualization only.

ICDO 3.2	Histology	Behavior	Level	Term	Code reference
8453/0	8453	0	Preferred	Intraductal Papillary mucinous adenoma	(C25._)
8453/0	8453	0	Related	Intraductal Papillary mucinous tumor with intermediate dysplasia	(C25._)
8453/0	8453	0	Related	Intraductal Papillary mucinous tumor with low grade dysplasia	(C25._)
8453/0	8453	0	Synonym	Intraductal Papillary mucinous neoplasm with low grade dysplasia	(C25._)
8453/0	8453	0	Related	Intraductal Papillary mucinous tumor with moderate dysplasia	(C25._)
8453/0	8453	0	Synonym	Intraductal Papillary mucinous neoplasm with moderate dysplasia	(C25._)
8453/2	8453	2	Preferred	Intraductal Papillary mucinous neoplasm with high grade dysplasia	(C25._)
8453/2	8453	2	Related	Intraductal Papillary mucinous carcinoma, non-invasive	(C25._)
8453/3	8453	3	Preferred	Intraductal Papillary mucinous neoplasm with an associated invasive carcinoma	(C25._)
8453/3	8453	3	Related	Intraductal Papillary mucinous carcinoma, invasive	(C25._)

BRAIN HISTOLOGIES

Question:

I have a Brain Tumor DX 2011.

Pt had a brain resection in 2012. note states the histology was Anaplastic Astrocytoma, WHO Grade 3 (9401/3). Patient had a recurrence in 2018 with path that states glioblastoma multiforme, WHO Grade 4 (9440/3).

2018 outside notes state 'Anaplastic Astrocytoma, WHO Grade 3, Progressed to Glioblastoma Multiforme, WHO Grade 4.'

I know the lioblastoma multiforme is a type of astrocytoma. But, I have never heard of one brain tumor histology transforming into another one. How do I manage this case? Is it the same cancer?

What do I do--use the Anaplastic Astrocytoma (9401/3) or the glioblastoma multiforme (9440/3)?

Answer

This is a typical progression of anaplastic astrocytoma, grade 3 to glioblastoma multiforme WHO grade 4. They are in fact two primaries because of the 'progression' which in the solid tumor rules is referred to as 'transformation' which it really is not. Transformations occur only in the myeloid diseases. But, when the solid tumor rules were written it was easier, though somewhat incorrect, to call these 'transformation' of brain tumors as they are indeed 'progression' to a more aggressive glial tumor – progression from anaplastic astrocytoma to glioblastoma multiforme or transformation to myelodyplastic syndrome to acute myeloid leukemia for exam.

(Continued on page 23)

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Rule M6 Abstract **multiple primaries**[ii] when a patient has a glial tumor and is subsequently diagnosed with a **glioblastoma multiforme 9440** (GBM).

Note 1: Definition of a glial tumor: Any tumor arising from the CNS glial cells. The following is simply a list of all tumors which would be classified as glial.

- Astroblastoma **9430**
- Astrocytomas **9400** and all subtypes
  - Anaplastic astrocytoma IDH-mutant/wildtype; anaplastic astrocytoma NOS **9401**
  - Gemistocytic astrocytoma IDH-mutant **9411**
- Diffuse midline glioma H3 K27M Mutant **9385**
- Ependymoma **9391** and all subtypes
  - Anaplastic ependymoma **9392**
  - Ependymoma, RELA fusion-positive **9396**
  - Papillary ependymoma **9393**
- Glioblastoma **9440** and all subtypes **(this is a glial tumor; however do not apply this rule to a GBM followed by a GBM)**
  - Giant cell glioblastoma **9441**
  - Glioblastoma IDH-mutant **9445**
  - Gliosarcoma **9442**
- Oligodendroglioma and all subtypes **9450**
  - Anaplastic oligodendroglioma; IDH-mutant; 1p/19q-codeleted; IDH-mutant and 1p/19q-codeleted **9451**
- Pleomorphic xanthroastrocytoma **9424**

Note 2: This is a change from the 2007 Rules.

Note 3: Abstracting GBM as a new primary will allow analysis of:

- The number of tumors that recur as a more aggressive histology (GBM)
- The time interval between occurrence of the glial or astrocytic tumors and a GBM
- Which histologies are more likely to recur as a GBM

NAACCR Cancer Registry and Surveillance Webinar Series Registration

The Florida Cancer Data System is happy to announce that for another year we will be presenting the NAACCR Cancer Registry and Surveillance Webinar. Seven Florida facilities will host the 2019-2020 webinar series. 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
*10/3/19	Breast 2019
*11/7/19	Bladder and Kidney 2019
*12/5/19	Base of Tongue 2019
*1/09/20	Prostate 2020
* 2/6/20	SSDIs an In-Depth Look
3/5/20	Abstracting and Coding Boot Camp 2020
4/2/20	Melanoma 2020
5/7/20	Central Nervous System 2020
6/11/20	Esophagus 2020
7/9/20	Navigating the 2020 Survey Application Record (SAR)
8/6/20	Corpus Uteri 2020
9/3/20	Coding Pitsfalls 2020

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CEU information for the 2019 FCDS Annual Conference:

CE Hours: 9.5
4.75 Hrs Category A

NCRA Recognition Number: Pending

CEU information for the 2018 FCDS Annual Conference:

CE Hours: 8.25
5.5 Hrs Category A

NCRA Recognition Number: 2018-143

2019-2020 FCDS Webcast Series Schedule

FCDS is pleased to announce the 2019-2020 FCDS Webcast Series schedule and topics.

Date	Time Schedule 3rd Thursday	Presentation Title
11/21/2019	1:00pm – 3:00pm	**Imaging and Radiation Updates**: When to Use an Imaging Date as Date of Diagnosis, Use of Ambiguous Terminology to Establish a Diagnosis, How to Best Estimate a Diagnosis Date with Limited Information, Review of New Imaging Tests & Radiation Therapy Terms.
12/19/2019	1:00pm – 3:00pm	**FCDS Physician Claims Reporting**: Data Sources, Maintain the DX/Procedure Codes for Cancer, Crosswalk Updates, System Functions, and TX Follow-Up Reports for You to Use
1/16/2020	1:00pm – 3:00pm	**FLccSC Updates and Live Demonstration** of Where to Access Key Registry References, Manuals, Coding Tables, Cancer Learning Resources for New Registrar Training and Continuing Education. Includes demonstrations of educational websites including FLccSC
2/20/2020	1:00pm – 3:00pm	**Genetics and Cancer**: Latest Information on Bio-Molecular Markers and Genetic Testing for the Classification and Treatment of Neoplasms – Understanding Reports to Confirm a Diagnosis

+ 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 JANUARY 31, 2020

Total number of *New Cases* added to the FCDS Master file in January 2020: **2,143**

The figures shown below reflect initial patient encounters (admissions) for cancer by year.

Admission Year	Hospital	Radiation	Ambi/ Surg	Dermatology	Physicians Claims	DCO	Total Cases	New Cases
2019	15,706	0	0	8,669	0	**Pending**	24,375	**474**
2018	154,685	3,062	169	12,556	308	**Pending**	170,780	**1,475**
2017	214,645	9,215	1,660	13,210	22,344	**2,078**	263,152	**194**

% Complete for:	Actual	Expected
2019	**10%**	**58%**
2018	68%	100%
2017	100%	100%

Expected % based on 190,000 reported cases per year

Missed an FCDS or NAACCR Webinar?

Did you know that FCDS Webcasts and NAACCR Webinars can be viewed after-the -fact? FCDS Webcasts and NAACCR Webinars are recorded and posted on the FCDS Website (Education Tab). The FCDS Webcast recordings are available free of charge and can be viewed anytime/anywhere by anybody. However, starting in October 2017 the CEU award mechanism is restricted to approved FLccSC Users. Access to the NAACCR recordings is still password protected.

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Recordings of FCDS Webcasts held 10/2017 or later can be viewed either from the FCDS Website or in FLccSC, Florida's new Learning Management System. However, Registrars must have an active FLccSC Account and must take and pass the CEU Quiz to get any CEUs and to obtain a certificate of attendance.
NAACCR Webinars have their own CEU award mechanism whether viewed live or via a recorded session. Again, access to the NAACCR recordings is password protected. Only Florida registrars with Active/Current FCDS Abstractor Codes can access NAACCR Webinars per FCDS/NAACCR agreement.

Please contact FCDS for more information on viewing recorded webinars, or to obtain the password to view individual NAACCR Webcast Recordings.

FCDS Florida Cancer Data System

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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