

The Florida Cancer Data System's Memo

JULY 2020



CDC/NPCR Registry of Distinction and NAACCR Gold Certification

I am both very proud and happy to announce that the Florida Cancer Data System has been recognized nationally by the Center for Disease Control and Prevention's National Program of Cancer Registries as a "2019 Registry of Distinction". We are one of forty two states to achieve this designation. Due to delays in releasing 2018 requirements by the national standard setters and reporting, the Registry of Distinction was the only award given by the NPCR this year.

Due to the high quality of our data, Florida received the "U.S. Cancer Statistics Registry for Surveillance" designation which represents Florida's inclusion in the CDC/NCI SEER USCS national dataset.

Furthermore, I am both very proud and happy to announce that for the 18th consecutive year the Florida Cancer Data System has been recognized nationally by North American Association of Central Cancer Registries (NAACCR) at the highest level of certification, NAACCR GOLD. We officially received the certification on June 5th, 2020. Gold certification is awarded to central registries that meet the highest levels of completeness, data quality and timeliness in cancer registry surveillance. Additionally our data will be included in the "Cancer in North America (CINA)" datasets and publications.

This does not happen by accident. This is a team effort between the FCDS, University of Miami, DOH and all of our reporters around the state. I want to personally thank each of you for all your hard work and dedication to what we do. Through all your efforts, you have made and continue to make Florida one of the top registries in the country.

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
V18 Metafile,
posted on 9/18/2019.**

**FCDS/NAACCR
WEBINAR SERIES:
NAACCR 2019-2020**
Cancer Registry and Surveillance Webinar Series – Navigating the 2020 Survey Application Record (SAR) 7/9/2020 .
***** In person attendance cancelled until further notice. Please Login to FCDS IDEA->Education->FLccSC Learning Management 2 weeks after webinar to watch recordings and get CEUs *****

[requires registration.](#)

FCDS Florida Cancer Data System

**Florida Statewide Cancer
Registry**



Florida Cancer Data System Deadlines, Updates, & Reminders

CONGRATULATIONS TO KAREN MASON

Incoming NCRA President



The National Cancer Registrars Association held its 2020 election in March.

Please join us in Congratulating Karen Mason MSc, RN, CTR, from Baptist Health Miami in her successful bid for the office of President-Elect/Secretary. Karen is the current Director of the Cancer Data Center for the Miami Cancer Institute at Baptist Health, Miami. She joins a long line of Florida Cancer Registrars who have been elected to this noteworthy position over the years.

Again, congratulations to Karen and Thank You for continuing the tradition of representing Florida Cancer Registry Professionals at the national level and for our leading cancer registry professional organization!



Florida Cancer Data System Deadlines, Updates, & Reminders



ANNOUNCEMENT – FCDS Changing to Zoom Meetings & Webinars on 6/1/2020

FCDS will be transitioning ALL of our FCDS Webinars and Virtual Meetings to Zoom Meetings starting 6/1/2020.

This should be nearly invisible to FCDS webinar attendees and people who participate in virtual meeting with FCDS.

The appearance will be a little bit different than Go To meeting. And, some of the functionality has changed.

However, both platforms accomplish essentially the same tasks and operate very similarly for users.

Please bear with us while we learn this new online virtual meeting and broadcast webinar tool.



Florida Cancer Data System Deadlines, Updates, & Reminders

Certification of Completeness: 2018 Cancer Reporting

The deadline for 2018 cancer reporting to Florida Cancer Data System was March 31, 2020. We are requiring each facility to certify they have completed reporting the 2018 cases. You can find information on how to certify your completeness here:

<https://fcds.med.miami.edu/inc/technicalresources.shtml>

If you believe your 2018 reporting is complete, please log into the IDEA system and certify that you are complete.

The Florida Department of Health and Florida Cancer Data System

2019 Cancer Reporting Deadline

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.

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

Facilities need to certify Completeness of 2019 Reporting on or before 9/30/2020.

At FCDS, we try to balance the requirements of the hospital registries as well as the demands at the state level. Adhering to this September 30th deadline is crucial for FCDS.

If you are experiencing difficulties with data collection at your facility and data reporting to FCDS due to the COVID-19, please inform your FCDS Field Coordinator. Thank you for your support and patience. If you have any questions, please do not hesitate to contact the FCDS.



Florida Cancer Data System Deadlines, Updates, & Reminders

SEVERAL REMINDERS OF GREAT IMPORTANCE – PAY ATTENTION

The Anatomic Stage of a Solid Tumor is a critical indicator for the type(s) of treatment that should be recommended and/or provided as well as a first look at what the patient and family can expect in terms of patient survival when going over the various treatment options. The STAGE at DIAGNOSIS is the most important stage you can provide whether it is a clinical stage based on imaging or other clinical factors or if it is based on a surgical resection of the primary site and accompanying regional lymph nodes to check for lymphatic spread. So, Stage at Diagnosis is Clinical AJCC Stage or Pathological AJCC Stage – NEVER is post-treatment stage equal to the Stage at Diagnosis – it is staging after treatment is given.

FCDS is finding more and more cases where registrars are mixing the pre-treatment/clinical stage with the post-surgical/pathological stage or the post-treatment yc/yp stage. DO NOT MIX THESE STAGES.

While AJCC does provide and support post-therapy staging criteria in ycTNM and ypTNM designations – these are both post-treatment anatomical staging that is meant to measure the effects pre-surgical treatment with radiation, chemotherapy, or immunotherapy has on down-staging the primary tumor and any positive nodes noted at the time of diagnosis. They are not the stage at diagnosis. They are not the stage at diagnosis.

Please do not mix stage at diagnosis with post-treatment staging...they do not go together in any staging system. Stage at Diagnosis is key.

ADDITIONALLY, do not mix the Clinical and Pathological Histologic Grade – this has become one of our biggest new errors since January 2018.

Clinical Grade is biopsy grade...not the grade from a primary tumor resection. Do not code pathological grade from a biopsy just because you have a pathology report – clinical grade is from a biopsy or FNA.

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Florida Cancer Data System Deadlines, Updates, & Reminders

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Pathological Grade is the resection grade...not the grade from the biopsy or from the pathology report from the biopsy...just because you have a pathology report does not mean you can code the pathological grade.

You must have a primary tumor resection to code pathological grade.

TURBT and TURP and D&C are not primary tumor resections – they are glorified biopsies and not actually complete resection of the primary.

Do not code grade from TURBT, TURP or D&C in pathological grade. Code the grade from these procedures as Clinical Grade, only.

Post-therapy grade is reserved for patients who receive neoadjuvant therapy – not just one dose but a course of pre-surgical radiation and/or chemotherapy and/or immunotherapy. Hormone therapy is almost never neoadjuvant therapy. Hormone therapy must be given for at least 6 months with the intent to shrink tumor to be ‘counted’ as neoadjuvant therapy – this is almost never the case...usually there is disease progression during this time – so, when treatment is started after ‘failing’ hormone therapy, alone...then it is no longer first course treatment.





Diffuse Intrinsic Pontine Glioma (DIPG)

Diffuse Intrinsic Pontine Gliomas or DIPG are highly aggressive pediatric brain tumors found in the lower brainstem or pons area of the brain (C71.7). Both children and adolescents may develop DIPG. But, they are most commonly diagnosed in children between the ages of 5 and 9.

The pons/brainstem controls vital body functions such as breathing, blood pressure and heart rate as well as the nerves and muscles that help us see, hear, walk, talk and eat. Histologic diagnosis from a biopsy or treatment with surgical resection is rare and difficult due to both the tumor location and the critical functions of this area of the brain. Even with advanced neuro-surgical techniques, complete surgical resection of these tumors is not considered a valid treatment option as any surgical procedure can easily impair neurologic function critical to sustaining life.

Thus, DIPG is usually diagnosed based on imaging only (CT and/or MRI) with the imaging diagnosis is based on tumor location and patient age.

Radiation is the primary treatment of choice. However, treatment with radiation in most cases produces only a short-lived response of 6-9 months before tumor progression. Tumors tend to progress rapidly and behave much like grade IV Glioblastoma Multiforme. This is the main reason the WHO includes DIPG as a 'Related Term' under Glioblastoma, NOS along with Glioblastoma Multiforme for the histology code 9440/3.

There is a new ICD-O-3 histology code for DIPG with a specific genetic mutation (9385/3 - Diffuse intrinsic pontine glioma, H3 K27M-mutant). However, the patient **MUST** have a biopsy to verify this mutation is present. Otherwise, these cases should be coded to Glioblastoma, NOS (9440/3). The below ICD-O-3.2 Histology Code Table is from the WHO and includes DIPG and Diffuse Midline Glioma, NOS under 9440/3.

ICDO3.2	Histology	Behavior	Level	Term
9440/3	9440	3	Preferred	Glioblastoma, NOS
9440/3	9440	3	Related	Epithelioid glioblastoma
9440/3	9440	3	Related	Glioblastoma, IDH-wildtype
9440/3	9440	3	Related	Glioblastoma, primary, NOS
9440/3	9440	3	Synonym	Glioblastoma multiforme
9440/3	9440	3	Synonym	Spongioblastoma multiforme
9440/3	9440	3	Related	Diffuse midline glioma, NOS
9440/3	9440	3	Related	Diffuse intrinsic pontine glioma

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Diffuse Intrinsic Pontine Glioma (DIPG)

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Assigning the Glioblastoma, NOS code makes it super important to correctly code the primary site, brainstem, for these tumors. Otherwise, we cannot identify these neoplasms correctly for researchers. C71.9 or other brain topography codes make these cases nearly impossible to find. And, incorrectly coding the histology or incorrectly coding both primary site and histology make these cases impossible to find for researchers.

In summary;

- DIPG should always be coded to C71.7 – Brainstem so we can find them.
- Only use the new histology code 9385/3 when there is biopsy-proven H3 K27M mutation identified.
- Otherwise, code histology to 9440/3, Glioblastoma, NOS when the diagnosis is based on imaging-only.

References:

- Dana Farber/Boston Children's Cancer and Blood Disorders Center
- National Cancer Institute
- St. Jude Children's Research Hospital
- Diffuse Intrinsic Pontine Glioma Resource Network
- WHO – ICD-O-3.2



FCDS 2018 Consolidated Follow Back Records are available for review

The Consolidated Follow Back is a combination of AHCA, Ambulatory Surgery Center (AMBI) and Death Clearance follow back annual casefinding process into a single file.

The 2018 In-Patient and Out-Patient Discharges reported by the reporting facilities Finance-Billing Department to the Agency for Health Care Administration (AHCA) with a principal or secondary diagnosis of cancer were linked to the FCDS database. A match was also completed of the Florida Vital Statistics Death Certificate files for 2018.

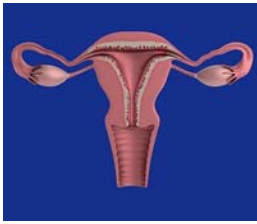
The full list of ICD-10-CM codes used to identify missed cases is included in Appendix O in detail. Reporting facilities must remember that the casefinding lists are always changing nearly every single year and the lists that the IT group has or uses in their facility may not be current. We expect IT personnel at the reporting facilities to update the casefinding lists every single year if necessary.

The Consolidated FB records must be reviewed in IDEA. If the case is found to not be reportable, assign the appropriate disposition code; if the record was previously reported to FCDS assign disposition code 07, accession number, and sequence number, then press the Submit button. In addition, any case found to meet the FCDS Cancer Case Reporting Requirements outlined in Section I of the FCDS DAM and found to not have been previously reported must be reported to FCDS using IDEA. These are considered missed cases. Assign a disposition code of 01, accession number, and sequence number to the reportable cases and press the Submit button.

The missed cases must be electronically reported to FCDS within 30 days of assigning the disposition code, otherwise, after the 30 days, the record(s) will be placed back in the facility queue and marked as incomplete.

The deadline to complete the review and submission of any missed cases is October 15, 2020.

Please keep in mind that all audits conducted by FCDS are dictated and closely monitored by the Florida Department of Health. Facilities failing to meet the reporting requirements will be reported to DOH for non-compliance. Should you have any questions, please contact your Field Coordinator at (305) 243-4600.



Carcinosarcoma/Mixed Mullerian Tumor of Uterus

Uterine carcinosarcoma is a mixed tumor that includes both (adeno)carcinoma elements of various types mixed with sarcomatous elements of various types. These neoplasms historically have been referred to as mixed Mullerian tumors of the uterus. However, there are multiple ICD-O-3 codes available to code the histology (8933/3, 8950/3, 8980/3). This creates a lot of confusion when registrars abstract these important cases.

Mixed tumors of the GYN neoplasms have also gone through multiple reclassifications over time making them even more confusing.

Carcinosarcomatous neoplasms tend to have a poor clinical course even when diagnosed at an early stage and treated aggressively.

(Adeno)carcinoma elements may include adenocarcinoma, serous carcinoma, uterine clear cell carcinoma and other types of (adeno)carcinoma.

Sarcomatous elements may include leiomyosarcoma, endometrial stromal sarcoma and other types of sarcoma.

When these elements are mixed, both elements are frequently high grade. And, the mixed neoplasm may be comprised of a mixed percentage of (adeno)carcinoma and sarcoma. So, registrars are not sure which histology is the best histology for their case...or if they should code the majority percentage of the mixed neoplasm when for example the neoplasm is 89% sarcoma but called carcinosarcoma, , adenosarcoma, mixed Mullerian tumor or even mesodermal mixed tumor in the final diagnosis...yes, very confusing, especially with multiple available histology codes.

Exposure to radiation, tamoxifen, exogenous estrogen and obesity are associated with an increased risk of developing uterine carcinosarcoma.

The incidence of high grade carcinosarcoma has been increasing in women with notable increases over the past 20 years.

Currently, cancer registries have limited instructions or guidelines for abstracting and coding gynecologic malignancies. Therefore, the mixed neoplasms of the uterus/endometrium causes confusion over how to code histology as well as how to assign stage for AJCC TNM, 8th edition.

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Note: The AJCC TNM staging criteria for GYN cancers is adopted directly from the FIGO staging and not actually developed by AJCC. FIGO is the international organization representing obstetricians and gynecologists across the world. The International Federation of Gynecology and Obstetrics is most often referred to as “FIGO”, the acronym of its French name “Fédération Internationale de Gynécologie et d'Obstétrique”.

Pure adenocarcinoma of the endometrium is the most common type of endometrial neoplasm. When diagnosed at an early stage, pure adenocarcinoma has a good outcome. These neoplasms are less frequently diagnosed at a late stage and are more difficult to treat.

Pure sarcoma is very rare, highly aggressive, and carries a poorer prognosis than pure adenocarcinoma or mixed tumors of the endometrium.

Endometrial stromal sarcoma can be low grade or high grade. Low grade tumors can recur even 20 years after initial diagnosis.

Uterine adenosarcoma is a mixed mesenchymal tumor that arises in the lining of the endometrium. Both the adenocarcinoma and sarcomatous elements are usually low grade in adenosarcoma portending a better outcome than a high-grade carcinosarcoma. They sound alike but are not.

Carcinosarcoma is the same thing as mixed Mullerian tumor –and mesodermal mixed tumor. Pathologists may use any of these terms to describe these neoplasms. However, the terms mixed Mullerian tumor and mesodermal mixed tumor are outdated and should not be used in these cases. Most pathologists today refer to these neoplasms as carcinosarcoma. These neoplasms arise in the transitional zone between the lining of the endometrium and the myometrium or muscular layer of the uterus. Code the histology that most closely aligns with the path text.

- Do not code the majority component/element of a mixed tumor in any case.
- Do code the histology that most closely reflects the terminology used by the pathologist in the final diagnosis.
- Pure adenocarcinoma (8140/3) of the uterus/endometrium should be coded to primary site endometrium (C54.1).
- Pure sarcoma of the uterus should be coded to the specific type of sarcoma (i.e. leiomyosarcoma) with primary site of myometrium (C54.3) not Uterus, NOS (C55.9) as they arise in the muscular wall of the uterus not in the lining of the endometrium.

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- Endometrial stromal sarcoma may be low grade (8931/3) or high grade (8930/3) and should be coded to primary site myometrium (C54.3).
- Mixed neoplasms of the endometrium/uterus should always be assigned a mixed tumor histology code.
- Adenosarcoma (8933/3) of the endometrium is usually low grade and should be coded to primary site endometrium (C54.1) as these neoplasms usually have a better prognosis than carcinosarcoma/mixed Mullerian tumor and align more closely with pure adenocarcinoma.
- Carcinosarcoma (8980/3) of the uterus/endometrium is usually high grade and should be coded to primary site myometrium (C54.3).
- Mixed Mullerian Tumor (8950/3) of the uterus/endometrium is usually high grade and should be coded to primary site myometrium (C54.3).
- Mesodermal Mixed Tumor (8951/3) may be low grade or high grade and should be coded to primary site myometrium (C54.3).
- Please note that mixed neoplasms (carcinosarcoma) may also arise in the ovary, fallopian tube, adnexa, or peritoneum.
- So, please be careful when abstracting GYN neoplasms including paying special attention to the primary site and histology coding.

Sources:

- International Federation of Gynecology and Obstetrics
- National Cancer Institute – Genetic and Rare Diseases
- Journal of Cancer Research and Therapeutics
- Archives of Pathology
- Pathology Outlines
- Gynecologic Oncology



New data available: U.S. Cancer Statistics

New [U.S. Cancer Statistics](#) data are available.

Please help us spread the word! You can access the new data through the Data Visualizations tool and public use database –

[Data Visualizations tool](#)

This tool is an easy way to explore the latest U.S. Cancer Statistics data. It includes interactive graphics and text explaining the data. You can create and export presentation-ready trend graphs, maps, and tables by state, county, and demographic characteristics.

[Public use database](#)

The public use database for researchers includes cancer incidence and population data for all 50 states, the District of Columbia, and Puerto Rico. This year, a [rural-urban county variable](#) has been added. With more than 28 million cases in the database and 17 years of data available (2001 to 2017), this is a powerful data source for obtaining new insights and targeting action.

More Information

[U.S. Cancer Statistics](#) are the official federal cancer statistics, providing cancer information on the entire U.S. population. This data resource combines cancer registry data from CDC's National Program of Cancer Registries (NPCR) and the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program.

U.S. Cancer Statistics | www.cdc.gov/uscs

CDC's National Program of Cancer Registries | www.cdc.gov/cancer/npcr

NCI's Surveillance, Epidemiology, and End Results Program | <https://seer.cancer.gov>

Questions? Please contact us at uscsdata@cdc.gov



2019 Pat Strait Award Winners

The Pat Strait Award for Excellence in Cancer Abstracting recognizes those individuals that contributed to a facility winning the Jean Byers Award by presenting a certificate to all its abstractors. The certificate is a way for FCDS to show our appreciation to those individuals that were responsible for helping a facility reach this exceptional quality standard.

We recognize that the facilities that achieve this high quality standard are staffed by exceptional professionals that made it possible for the facility to be awarded the Jean Byers Award.

The 2019 Pat Strait Award Winners are:

Joyce Allan	Jennifer Brown
Lori Allison	Heather Burner
Allissa Anderson	Julianne Campbell
Barbara Anderson	Sandra Carlson
Victor Angles	Kimberly Castaneda
Stacey Applegate	Magda Castro
Prudence Ashley	Kali Cerdan
Marichu Auffenberg	Curry Chapman
Hector Aviles	Kathie Churchill
Deborah Bambrick	Judith Clark
Karishma Banda	Sharon Clevenger
Leigh Bishop	Denise Colburn
Melissa Blakley	Colleen Condron
Lisa Borodemos	Katherine Cook
Krist Bowman	Nurgul Cooper
Bessie Brokenburr Henderson	Jennette Cox
Holly Brown	Charisse Creech
	Edna Cruet

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Maureen Curcio	Alicia Gassert	Jennifer Lewis
Gina Damm	Ashley Giesecke	Barbara Lorentson
Barbara Dearmon	Tammy Goas	Janae Lott
Abelardo Delarua	Carol Hammond	Rosalba Marte
Aymara Delarua Fernandez	Johanna Haneline	Jessica Martin
Anna Deluague	Annette Harnage	Keir Martin
Ismael Diazrodriguez	Vicki Hawhee	Elizabeth Martinez
Claudia Downs	Stuart Herna	Dawn Mason
Deana Duarte	Maggie Herrera	Mary Mason
Neil Dungca	Megan Hoffmann	Celia Mathews
Heather Duque	Carol Hutchison	Nicola Mattis
Elizabeth Elrod	Armand Ignacio	Penny May
Mayra Espino	Brigitte Johnson	Krishna Mcdonald
Elizabeth Exilus	Joshua Johnson	Gladys Mejia
John Fairfield	Jennie Jones	Elizabeth Melendez
Susan Finn	Patricia Jones	Pamela Melton
Diane Forsythlarsen	Joyce Jones Pic	Dinah Merrill
Stephanie Fox	Deborah Jordanreith	Julie Mierzejewski Yousif
Frederick Furner	Jennifer Kassin	Jorge Migoya
Joan Galbicsek	Jacqueline Kenney	Clarissa Moholick
Gerardo Gallardo	Katherine Khin	Maeisidrisis Monte
Jesmarie Garcia	Laura Kindergan	Susana Morales
Tammy Gardner	Lisa Kofron	Karen Moulds
Kellie Garland	Tamara Lehman	Carol Muir

Deborah Mulini	Paula Riccio	Leann Tanaskovic
Sue Neufeld	Marie Romulus	Paulette Thomas
Joyce Newhouser	Erica Santos	Sharon Thomas
Dawn Nguyen	Kathleen Saslow	Ann Thompson
Carmen Nieves	Deborah Schulte	Lisset Todd
Heidi Noell	Melissa Schuster	Nancy Tucker
Jennifer Nolte	Ileeta Scolaro	Roberto Urruchi
Leslie Nye	Adela Seidman	Monica Vasquez Olivas
Mary Oleary	Deylis Sequeira	Jennifer Vazquez
Kari Oliger	Bubblela Simmons	Joyce Wallace
Laura Ortega	Darleen Small	Lucas Wassira
Luz Ortizromero	Shauntel Smith	Judy Webber
Janice Pagano	Tracy Smith	Janette Wienecke
Grace Patrick	Susan Smith-pierce	Jennifer Wiggs
Sandra Pham	Angie Straughn	Jacqueline Williams
Peter Pierce	Tammy Strickland	Wendy Williams
Maritza Polania	Francis Suarez Penas	Nancy Wilson
Martina Price-Austin	Tina Swinney	Janet Wyrick
Albert Reyes	Susan Smith-Pierce	Celia Zapata
		Jessica Zilke





Prostate MRI and Use of PIRADS in Impression for Prostate Workup

Interpreting and Using the xyzRADS Designation on Imaging Reports

We are seeing more and more use of xyzRADS designations in imaging reports. And, not just for cancer. We see these designations for breast (BIRADS), lung (Lung-RADS), thyroid (TI-RADS), prostate (PIRADS), NI-RADS (head and neck), CRADS (colonography), CADRADS (coronary artery disease), HIRADS (Head Injury), LIRADS (liver), ORADS (ovary/adnexal), and more. The designations are begin used in screening, imaging for suspected malignancy, and in early workup to assess primary site. I covered these during the 12/19/2019 FCDS Webcast – Advances in Imaging.

The intent is the same, though the experience using them is not the same for breast, lung, prostate, etc. Furthermore, we all recognize that breast cancer screening and BIRADS designation has led the way from decades of use. Other anatomic site designations are now following suit.

The American College of Radiology has standardized the basic RADS Category Definitions across MRI, CT, Ultrasound, mammography, brain, and other imaging. Although, the criteria are different for each specific type of imaging and for each anatomic site and/or condition being screened whether for artery disease, head injury or cancer), the designations and recommendations from imaging reports are all very similar (see table).

Category	Definition
0	Incomplete
1	Negative
2	Benign (non-cancerous) finding
3	Probably benign finding – Follow-up in a short time frame is suggested
4	Suspicious abnormality – Biopsy should be considered
5	Highly suggestive of malignancy – Appropriate action should be taken
6	Known biopsy – proven malignancy

Computer assisted/aided diagnostics (CAD) and artificial intelligence (AI) are both helping all types of diagnostic imaging to better characterize abnormalities and the evolving use of these designations for multiple anatomic sites and conditions are lending aid to screening and diagnostics.

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Prostate MRI and Use of PIRADS in Impression for Prostate Workup

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CAD/AI 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 CAD databases and uses AI to look for similarities and differences to other tumors or conditions to better establish a diagnosis based on imaging either alone or in combination with clinical factors and support or recommend specific recommendations for follow-up biopsy and/or resection based on the analysis and evaluation from this type of digital imaging.

When cancers are proven on biopsy following a designation of 4 or 5 – you can use these diagnostic imaging exams as date of first diagnosis.

The reason you can use them is that designations indicate a suspicion for cancer or high suspicion for cancer... and the biopsy just confirms what the imaging has suggested is already suspicious for cancer. As CAD and AI improve over time designations are used with increased confidence.

Combining technical advances in equipment, CAD, AI, and related imaging evolution – diagnostic imaging of all types can be used with greater and greater confidence and some neoplasms and other health conditions may be treated based on imaging alone without the need or requirement to biopsy the cancer to type it, unless there are other issues in disease classification that histologic characterization with IHC, molecular genetics or other specific typing may improve treatment decisions for targeting therapy based on histology or other markers.

When AJCC mentions that they do not deal with or does not include ‘ambiguous terminology’; the rationale is that one of the criteria for AJCC TNM staging is that any cancer you assign a TNM/AJCC Stage MUST be histologically confirmed. Registrars often overlook this requirement and try to stage non-confirmed/clinically diagnosed only cancers with TNM Staging when they should not assign a TNM/AJCC Staging without at least a biopsy proving a patient has xyz cancer with diagnostic confirmation = 1. This is often overlooked by registrars when abstracting cases because not very many of our cases are only diagnosed on imaging...most solid tumors get a biopsy or resection – and we take this for granted in staging.



In Case You Missed It - In-Situ LVI always = 0

In Case You Missed It - In-Situ LVI always = 0

Just in case you missed the update to the 2018 STORE Manual – and the write-up in the FCDS DAM;

- LVI is only coded when the biopsy/resection is from the primary site
- LVI = 0 when a case is diagnosed with Stage 0 (in-situ) then the
- LVI = 8 when lymphoma, leukemia, plasma cell neoplasm (see table from STORE below)
- LVI = 9 when not stated in pathology report from primary site biopsy or resection

LVI = 0 when Stage = 0 (in-situ)

LVI = 8 (not applicable) for these Schema IDs:

- 00060 Cervical Lymph Nodes, Occult Head and Neck
- 00118 Pharynx Other
- 00119 Middle Ear
- 00128 Sinus Other
- 00140 Melanoma Head and Neck
- 00150 Cutaneous Carcinoma Head and Neck
- 00278 Biliary Other
- 00288 Digestive Other
- 00358 Trachea
- 00370 Pleural Mesothelioma
- 00378 Respiratory Other
- 00458 Kaposi Sarcoma
- 00478 Skin Other
- 00551 Ovary
- 00552 Primary Peritoneal Carcinoma
- 00553 Fallopian Tube
- 00558 Adnexa Uterine Other

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- 00559 Genital Female Other
- 00598 Genital Male Other
- 00638 Urinary Other
- 00650 Conjunctiva
- 00680 Retinoblastoma
- 00690 Lacrimal Gland
- 00698 Lacrimal Sac
- 00710 Lymphoma Ocular Adnexa
- 00718 Eye Other
- 00721 Brain
- 00722 CNS Other
- 00723 Intracranial Gland
- 00770 NET Adrenal Gland
- 00778 Endocrine Other
- 00790 Lymphoma
- 00795 Lymphoma (CLL/SLL)
- 00811 Mycosis Fungoides
- 00812 Primary Cutaneous Lymphoma non MF
- 00821 Plasma Cell Myeloma
- 00822 Plasma Cell Disorders
- 00830 Heme/Retic
- 99999 Ill-Defined Other

Use code 9 when

- there is no microscopic examination of a primary tissue specimen
- the primary site specimen is cytology only or a fine needle aspiration
- the biopsy is only a very small tissue sample
- it is not possible to determine whether lymphovascular invasion is present
- the pathologist indicates the specimen is insufficient to determine lymphovascular invasion
- lymphovascular invasion is not mentioned in the pathology report
- primary site is unknown



How and When to Apply Definitive Terminology –vs- Ambiguous Terminology

Over the years registrars have grown more and more confused about the use of ‘ambiguous terminology’ on imaging and pathology reports. Training has focused more on clarifying when to use or not use ‘ambiguous terminology’ rather than reinforcing the use of ‘definitive terminology’ over ‘ambiguous terminology’ in these reports. This has resulted in misunderstanding of the preferred or priority use of ‘definitive terminology’ over ‘ambiguous terminology’ when determining date of diagnosis, primary site, histologic type, and the presence or absence of disease based on the terminology used in these reports.

The following rather lengthy and repetitious description is my best attempt to clarify how and when to use ‘definitive’ terminology over ‘ambiguous’ terminology to establish a date of diagnosis, confirm the presence or absence of disease, and to code the histologic type.

Our instructions and training have emphasized how to interpret ‘ambiguous’ terms to the detriment of using ‘definitive’ terms as the preferred/priority terminology. And, many registrars now look for the ‘ambiguous’ terms to confirm a diagnosis and often ignore ‘definitive’ terms or expect a ‘definitive’ description to be restated as ‘suspicious for cancer’ when the definitive terminology already says it is cancer.

- When ‘definitive terminology’ is used on a report, the reviewing physician/radiologist/pathologist is confident that cancer is present or a stated diagnosis is not in question. The physician has high confidence that a stated ‘definitive term’ is what they say it is – they do not have to repeat themselves and say that they are ‘suspicious’ about the presence or absence of disease – they are confident it is what they say it is in the report.

- Registrars should always apply ‘definitive terminology’ over ‘ambiguous terminology.’ Reports do not have to restate ‘suspicious for cancer’ or ‘likely mucinous adenocarcinoma’ when a definitive assessment or terminology is used in the first confirmation of cancer or the to use the date of that report as the initial date of diagnosis or confirmed histology when a ‘definitive term’ is present.
- When a physician uses definitive terminology, they are stating that a mass, tumor, neoplasm or a specified histology is what they say it is unless or until it is otherwise proven not to be what they say it is based on some other test or if a subsequent test clarifies a more specific diagnosis.

For example; when an imaging report states, ‘solid mass in left lung,’ or they state measurements for a tumor or nodes or metastasis – the physician is telling you that they already believe this to be a cancer until or unless it is later proven not to be a cancer on biopsy, a different type of imaging, or some other more definitive testing method. The ‘definitive term’ is a statement of confidence that it is what they say it is.

- The report does not have to restate that the mass is ‘suspicious for cancer’...the definitive terminology has already made that statement and a cancer diagnosis is established at that time. Biopsy or resection may clarify the type of cancer – but the radiologist already believes with a high confidence that the mass is cancer. And, this report is used for the date of initial diagnosis of cancer – not the date of the biopsy or other test.

(Continued on page 22)



How and When to Apply Definitive Terminology –vs- Ambiguous Terminology

(Continued from page 21)

Additionally, when ‘definitive terminology’ is used to describe a primary tumor, presence or absence of regional or distant lymph node(s) or the presence or absence of metastatic disease – the physician is stating with confidence that tumor, nodes or metastasis is present and is cancer unless otherwise proven not to be cancer by some other more definitive method or test.

- The ‘ambiguous terminology’ list of words and phrases for presence or absence of disease are applied only when ‘definitive terminology’ is NOT used to describe the presence or absence of tumor or a specific histologic type/subtype.
- You use the ‘ambiguous terminology’ lists of words and phrases when only ‘ambiguous terminology’ is used and there is no ‘definitive terminology’ in the report.

Another example would be a pathology report that states, ‘mucinous adenocarcinoma.’ This is a definitive diagnosis of ‘mucinous adenocarcinoma’ and you code the histology as ‘mucinous adenocarcinoma.’

- But, when a report states ‘suspicious for mucinous adenocarcinoma’ or ‘suggests mucinous adenocarcinoma,’ only then do you apply the ‘ambiguous terminology’ guidelines to determine whether or not you code the histology as ‘mucinous adenocarcinoma’ or ‘adenocarcinoma, NOS.’
- You only use the ‘ambiguous terminology’ guidelines when ‘definitive terminology’ is NOT present.
- ‘Ambiguous terminology’ does not have to be used on imaging to confirm the presence or absence of neoplasm, and, is never used instead of in place of ‘definitive terminology’.
- And, NO...there is not a list of ‘definitive terminology’ – you must use your practical sense to decide if a term is ‘definitive’ not ‘ambiguous’.

Registrars are looking for the terminology ‘suspicious for cancer’ particularly on imaging to confirm a cancer diagnosis when the ‘definitive terminology’ has already confirmed the presence or absence of cancer, date of initial diagnosis or histology type. It doesn’t have to be restated that the tumor described is ‘suspicious for cancer’ because the definitive terminology already tell you it is cancer or a specific type of cancer.



QUESTIONS? ANSWERS. and CLARIFICATION

SCHWANNOMA QUESTION

Question:

Would the site for a Vestibular Schwannoma be Acoustic Nerve (c724) even though the term nerve isn't mentioned and it only states Internal Auditory Canal (c442) in the MRI?

EXAMPLE - 3mm enhancing nodule within the left internal auditory canal most c/w small Vestibular Schwannoma.

Would that also be the same for a Cochlear Schwannoma?

ASK SEER answer = Schwannomas originating in the internal auditory canal, vestibular system, or the cochlea are not reportable. Schwannoma is reportable when it originates within the cranium or elsewhere in the CNS. The internal auditory canal, vestibular system, and the cochlea are outside the cranium, and not part of the CNS.

I interpreted their answer as them telling me that my example was not reportable but looking at the older FCDS Webinar it states:

- Schwannoma may be called a Neuroma.
- The common sites are Vestibular or Auditory Nerve.
- Acoustic Neuromas AKA Vestibular Schwannoma

So then I think my first example would be reportable but would the site be acoustic nerve?

I also looked back at cases right before I started that were abstracted.

CASES ABSTRACTED

1.MRI=Auditory canal compatible with Vestibular Schwannoma.

a.SITE=Acoustic Nerve

b.HISTO=Schwannoma, NOS.

(Continued on page 24)



QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 23)

2.MRI=Nodule in right Cerebellopontine Angel Cistern and right auditory canal; it doesn't extent into cochlear or vestibule; compatible with Vestribular Schwannoma.

a.SITE=Acoustic Nerve

b.HISTO=Acoustic Neuroma

Cochlear Schwannoma would NOT be reportable, correct?

Answer:

The rules continue to evolve and change for schwannoma as well as meningioma and some other nervous system neoplasms that we used to not report but now we do. We used to restrict reporting of benign/borderline tumors to the brain and the central nervous system. This also included tumors of certain intracranial glands or areas of brain like the pituitary gland, pineal gland, and hypothalamus which is not a gland. Over time, we have added other non-CNS sites, other non-brain/CNS nerves and other types of neoplasms – some of which are really tumors and some that really are not but we still report them as benign tumors even though they are actually vascular malformations.

The main reason we started to include benign and borderline brain tumors (in addition to malignant brain tumors) is because they can cause morbidity (illness and symptoms and disability) and mortality (death) due to the confined space within the cranium and the fact that if they grow very large within the confines of the brain - even while still benign, they can cause a patient morbidity or disease with disabling symptoms and can even cause death because they press against other vital tissue or organs which in turn cause death and/or disability. So, they are not like other benign tumors because they can cause death and disability where most benign tumors can grow very large but don't make a person sick or die.

Sometimes reporting gets out of control when folks like CBTRUS (Central Brain Tumor Registry of the United States) or some researchers or some special brain tumor program wants to expand their definition (and subsequently ours) for what should be included as a reportable 'tumor' when it involves any type of nervous tissue – not just central nervous system tissue or brain tissue but any type of nervous tissue. And, we have nervous tissues everywhere in the body – the peripheral nervous system is expansive and enormously complicated as is the neuroendocrine system which intertwines the nervous system (peripheral and central) with the endocrine glands and structures all over the body – we have nerves everywhere.

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QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 24)

So, when SEER added 'peripheral nerve' tumors in the 2018 Solid Tumor Rules – they started to bend the rules again and even more – we only used to report malignant tumors of the peripheral nerves...now we have to report some selected non-malignant peripheral nerve system tumors – not just central nervous system and not just brain.

So, it is confusing and is more confusing over time. We are including tumors beyond the auditory/acoustic/ vestibular or optic nerves – which is where we used limit the cranial nerves...now we include all cranial nerves and even peripheral nerves that we never would have captured before.

Schwannoma: A schwannoma is a tumor that develops from the Schwann cells in the peripheral nervous system or cranial nerves. They are actually tumors of the protective nerve sheath that covers the nerve fibers called the myelin sheath and not nerve tissue per se. The most common location for schwannoma is within or along the nerve that connects your inner ear to your brain. This type of tumor is usually benign but it can cause permanent hearing loss and major problems with balance and steadiness for walking and such. These can also be bilateral neoplasms which can make balance even worse. Schwannomas are also called neurilemmomas, neurolemomas, or neuro-mas. And often the cranial nerve they effect is used in the description such as vestibular schwannoma, acoustic neuroma, optic neuroma, etc. BUT, schwannoma can develop anywhere in the peripheral nervous system – but, non-cranial nerve schwannoma tumors are not reportable – they are just benign tumors of peripheral nerve.

SEER's answer about cochlear versus vestibular is an absolutely ridiculous distinction that should not be used – especially since intracochlear schwannoma is extremely rare...they should not even mention it because it is so rare. A vestibular schwannoma/acoustic neuroma can occur anywhere along the auditory nerve and can be of any size – so, it might appear to be intracochlear but probably is not – ever. I would ignore that answer and treat any inner ear schwannoma as a vestibular schwannoma/acoustic neuroma unless specified to be something altogether differently. SEER sometimes does this – make things harder than need to be – but, in this case it is over-specific. I have not seen one intracochlear schwannoma in 40 years in this business...so, that is rare since I have seen literally hundreds of thousands of cancers and tumors of brain, etc.

Meningioma: In the 2018 version of Solid Tumor Rules SEER made Meningioma more difficult than it used to be also. We used to only collect meningioma within the cranium even though we know there can be meningioma's arise in sphenoid sinus and other areas where there are meninges. It is just that most of the meningioma's are intracranial and the ones that are not, usually are not causing morbidity or mortality. So, apparently somebody decided since we are capturing meningioma since 2004...we should now be capturing ALL meningioma, even the most rare.

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QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 25)

So, now we capture meningioma in the cranium (most of which are cerebral meninges) and spinal cord (spinal meninges) AND we capture meningioma of the cavernous sinus, sphenoid wing and any intraosseous meningioma regardless of which bone they might involve – ridiculous. Cavernous sinus meningioma was added because when they grow they can cause pressure on as many as 5 nearby cranial nerves including most importantly the optic nerve and optic chiasm and they can even block the carotid artery. So, these meningiomas make sense to report even though they are outside the cranium; because they can cause disability, vision problems, numbing in face and other symptoms and even death.

Meningioma and Schwannoma/Neuroma are usually benign tumors. So, they are not typically treated surgically unless necessary due to location and high possibility of complications because of their proximity to major cranial nerves that could accidentally cause blindness, deafness, etc. if the knife or laser slips even just a little. Often they are just followed for years until/unless they become symptomatic then they are treated often with a single dose of radiation which causes the cells to stop reproducing. Yep, just a single zap and that usually is all they need. So, these tumors are often followed for years and years...and we just report them when they were diagnosed 1/1/2004 or later in most registries.

Question:

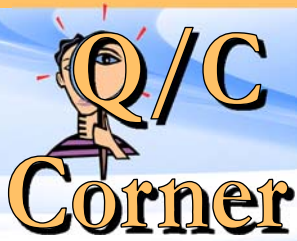
1. I can safely assume that when an MRI states Vestibular Schwannoma the site is coded to Acoustic Nerve (C724) unless it specifically states something else AND the histology would be 9560/0 (Acoustic Neuroma / Schwannoma, NOS)?
2. Cochlear Schwannoma is NOT reportable.
3. MRI=5mm extra-axial nodule arising from medial dural margin of right petrous apex; Right Petrous Apex Meningioma. Would the site be Cerebral Meninges since it states dural margin or would the site be Cranial Meninges b/c google states it is located along anterior extent of the petrous temporal BONE?

Is a Clinoidal Meningioma the same as Sphenoid Wing Meningioma making the site Cranial Meninges?

Answer:

1. Yes - absolutely
2. Correct – if you ever see one in your entire career – I would clarify that it is not a typical vestibular schwannoma/acoustic neuroma – it is more likely that the schwannoma involves the cochlea rather than arises from it.

(Continued on page 27)



QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 26)

3. Petrous Apex is at the skull base near the auditory canal and is cerebral meninges not spinal or meninges, NOS – the tumor most likely extends into the apex and does not arise from the apex – it would arise from the dura as the most likely meninges layer for origin. You may even see schwannoma here since auditory schwannoma/acoustic neuroma can arise here as well. But, the meningioma extends into this space – the schwannoma may arise within the space.
 - a. Meningioma is always of the meninges – cranial, spinal or other.
4. Clinoidal meningioma is same as sphenoid wing meningioma.

Total Neoadjuvant Treatment for Rectal Cancers

Question:

I have had two rectal primary cases that state as treatment “TNT- total neoadjuvant treatment”

Does this mean that the patient will have chemo/rt only and surgery is not part of the planned first course?? And if perchance they have completed TNT, and have residual, the surgery would still be first course??

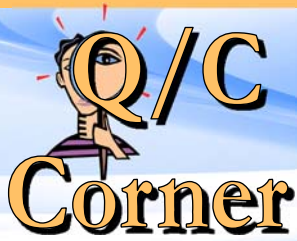
Answer:

Total neoadjuvant therapy involves chemoradiation and chemotherapy before surgery to optimize the delivery of systemic therapy aimed at micrometastases. Memorial Sloan Kettering Cancer Center and other centers have previously published papers on the benefits of TNT some showing a greater than 90% total clinical response to neoadjuvant treatment with no surgery required and patient/physician elected no surgery.

So, if they do surgery – it is post-neoadjuvant surgery – but, the intent is to eliminate the need for surgery altogether for Stage II and III LARC.

Total neoadjuvant therapy is a viable treatment strategy for patients with locally advanced rectal cancer and is associated with improved delivery of planned therapy, increased downstaging, earlier introduction of optimal systemic chemotherapy to address micrometastases, and the potential to sidestep any surgical treatment at all. It also helps patients complete their chemo with fewer dose reductions than post-op or pre+post chemo.

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QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 27)

Following studies at Memorial Sloan Kettering there is a new call for the TNT strategy to be considered the standard of care for clearly node-positive patients with low-lying rectal tumors. This study, along with others, led the NCCN to include TNT as a viable treatment strategy for stage II and stage III LARC in its rectal surgery guidelines.

So, the intent is to eliminate the need for surgery for Stage II and Stage III low anterior rectal cancers...

Treatment Question

Question:

I have a case where the patient is receiving treatment at Ochsner Medical Center with Lutathera. This is not something I've ever seen at my facility and I'm a little unclear on how to code this treatment. SEER says to code it to radiation but I wasn't sure what kind, the subcategory was radiosensitizer. In reading the available notes from that facility they are calling it liver directed (patient has liver mets) therapy. In a description online it said something about radioisotopes but I'm just not sure if that's correct.

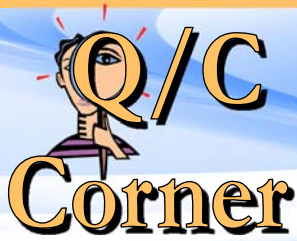
Answer:

Gastroenteropancreatic neuroendocrine tumors (GEP-NETs), also known as carcinoids and islet-cell tumors, are tumors of the neuroendocrine cells that occur in the gastrointestinal (GI) tract. Lutathera is a 2018 FDA Approved treatment for GEP-NETs and it is a radioisotope, Lutetium Lu-177 in a dotate suspension...and is targeted for NETs of pancreas and GI Tract. The dotate allows the isotope to bind to somatostatin receptors on the surface of tumor cells. It is injected in a liquid solution.

Luathera has proven to extend life longer than high-dose octreotide LAR with up to a 75% response in some studies. The general response rate was closer to 15-20% for most patients. One warning is that about 3-5% of patients who take Lutathera will develop myelodysplastic syndrome.

Patients must be somatostatin receptor positive to receive it. It does result in some shrinkage of tumor – and can even result in short-term complete response. But, it will never be a cure as it is only available as a late stage therapy for advanced and recurrent/progressive high grade NETs with widespread usually liver mets. Patients with advanced GEP-NET generally have about a 1 year life expectancy.

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QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 28)

On January 26, 2018, the Food and Drug Administration approved lutetium Lu 177 dotatate (LUTATHERA, Advanced Accelerator Applications USA, Inc.) a radiolabeled somatostatin analog, for the treatment of somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs), including foregut, midgut, and hindgut neuroendocrine tumors in adults. Luthera is not a first line drug for any cancer.

The drug has limited efficacy over the standard of care for advanced metastatic disease, high-dose long-acting octreotide administration.

The major efficacy outcome measure was progression free survival (PFS) determined by a blinded independent radiology committee using RECIST 1.1. The median PFS was not reached for lutetium Lu 177 dotatate and was 8.5 months in the high-dose long-acting octreotide arm.

The recommended dosage of lutetium Lu 177 dotatate is 7.4 GBq (200 mCi) given intravenously every 8 weeks for a total of 4 doses, followed by long-acting octreotide 30 mg administered intramuscularly 4 to 24 hours after each dose of lutetium Lu 177 dotatate. Short-acting octreotide can be used as needed for symptom management. Lutathera should be coded as radioactive isotope, NOS

Lutetium Lu 177 dotatate, a somatostatin analog, is the first radiopharmaceutical and the first PRRT approved by the FDA for the treatment of adults with somatostatin receptor-positive GEP-NETs. Lutetium Lu 177 dotatate, combined with long-acting octreotide, significantly prolonged PFS and OS compared with high-dose long-acting octreotide alone in the randomized, phase 3, NETTER-1 clinical trial.

Extramammary Paget Disease

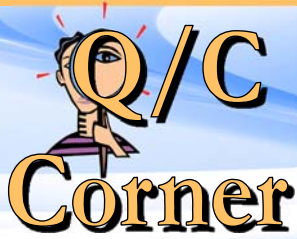
Question:

Is Extramammary Paget Disease Reportable?

Answer:

- Extra-mammary Paget disease of the skin (9542/3) is reportable. But, is not reportable when of bone origin.

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QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 29)

- Most often you will find Paget disease of skin in breast., axilla, or anogenital regions of both men and women – usually vulva or scrotum.
- Occasionally you can find Paget Disease in other locations...prostate, bladder, bone...but, these are pretty rare.
- They can invade locally, to regional nodes and in rare cases can metastasize to distant regions of the body.
- They are often mistaken for exzema or other dermatitis rash – so, unless they have a biopsy it often takes a while to establish the diagnosis.
- But, they are definitely reportable malignancies.
- They are often treated with topical chemotherapy. But sometimes radiation therapy and photodynamic therapies are effective.
- Prognosis is usually good unless the disease has metastasized – then they have relatively poor survival.

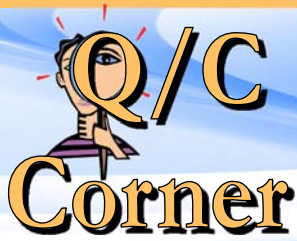
Coding Bladder Histology

Question:

Could you please assist me in determining the histology for this bladder case? I have read the rules, but still unsure. Would it be 8131/3?

- Bladder
- **Invasive high-grade urothelial carcinoma** with micropapillary, sarcomatoid, and plasmacytoid variant morphologies
- Tumor Site
- Histologic Type
- The mass is thickest in bladder dome and left lateral wall, but extends diffusely throughout the bladder involving all six walls, the bladder neck, and abuts the prostatic stroma.
- The mass involves the full thickness of the wall, and invades into the subjacent perivesicular fat.

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QUESTIONS? ANSWERS. and CLARIFICATION

Answer:

The histology code is 8131/3...and I certainly understand why this would be a question with so many variants described. But, only the one has a specific code that is to be used. There are no mixed urothelial or subtype/variant/differentiation among the urothelial histology codes.

You only code sarcoma, squamous cell, etc. when they are 'pure' squamous cell carcinoma or pure sarcoma, pure small cell neuroendocrine, etc. And, these are all pretty rare with the exception of squamous cell carcinoma which is more common for folks who have long-term and recurrent bladder infections, long-term use of urinary catheters, and in other countries where schistosoma (a parasitic blood flatworm or fluke) is endemic.

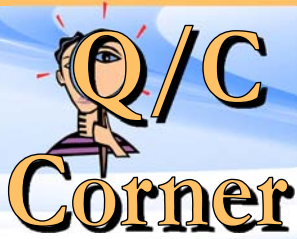
Acute and chronic schistosoma parasitic disease causes chronic inflammation in the bladder when the eggs get trapped from eggs in the urine. In countries where schistosoma is endemic the worms infest waterways and drinking water (Africa, Caribbean, Brazil, Venezuela, Southern and Southeast Asia) where squamous cell carcinoma accounts for up to 75% of bladder cancers...but, only about 6% in the US. Urothelial carcinoma accounts for the vast majority of cases in Western and Developed Countries where drinking water is cleaner and the parasites are not endemic.

Micropapillary got its own code because these tumors are fairly rare and are distinct in histologic features with a particularly aggressive course of disease and often advanced disease at presentation such as you see in this case.

We don't know if WHO will ever assign variant codes under urothelial carcinoma for sarcomatoid, plasmacytoid or other subtypes/variants or types of differentiation such as 'with squamous differentiation' or 'with neuroendocrine features'.

There are actually quite a few variants that are noteworthy that you might find...but only micropapillary (8131/3) and sarcomatoid/spindle cell (8122/3) have their own codes at this time.

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QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 31)

- Infiltrating urothelial carcinoma with squamous differentiation
- Infiltrating urothelial carcinoma with glandular differentiation
- Infiltrating urothelial carcinoma with trophoblastic differentiation
- Nested variant
- Microcystic variant
- Micropapillary variant
- Lymphoepithelioma-like variant
- Lymphoma-like and plasmacytoid variants
- Sarcomatoid/Spindle cell variant
- Giant cell variant
- Undifferentiated



FCDS Annual Data Quality Indicator Report(s) Now Available in IDEA QC Menu

The Florida Cancer Data System (FCDS) is charged with providing the highest quality data available for annual cancer surveillance reporting to the Florida Department of Health and the CDC National Program of Cancer Registries (NPCR). Data must meet rigorous data quality and reporting standards (accuracy, timeliness, completeness) to be included in local, state, and national cancer rates, reports to Congress, and various cancer-related publications.

The facility report examines abstractor use/overuse of ‘unknown’ and ‘ill-defined’ values in key variables. Key variables include: Sex, race, ethnicity, primary payor, tobacco use, marital status, missing social security number, address at diagnosis, % microscopically confirmed cases, ill-defined/unknown primary site, NOS Histology, Unknown Summary Stage, and unknown values in Key SSDIs.

The FCDS Data Quality Indicator Report (DQIR) is an annual QC Report that FCDS examines the frequency of assignment of “unknown” or “ill-defined” values to key analysis variables over the course of the five-year period. Unknown values in key variables is a negative indicator of data quality. The FCDS DQIR also includes a target Goal for many of the data items or groups of data items represented on each line of the report.

The report is a scaled down version of a report the NPCR provides to Florida and each NPCR state as an assessment of our state-wide data called the FCDS Data Evaluation Report(s). The most recent FCDS report reflects “analytic case data” submitted for Diagnosis Years 2014-2018.

The percent of “unknown” and “ill-defined” values is a data quality indicator used to rank Florida’s overall data quality and completeness of the data for each case reported and can be used to compare Florida data to other states for overall data reliability. These data are also indicators of potential problem areas where FCDS and local registries can improve upon cancer reporting as data are available.

This report is now available in the FCDS IDEA QC Menu for folks with HOSPADADMIN Role in IDEA The report can be run for the current period (2014-2018) or for 2 previous reporting periods (2013-2017) and (2012-2016). As variable requirements change over time, the report evolves. Some data items come and some go and others change slightly in meaning and representation.

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The current period report includes 2018 required SSDI variables for the first time. We have set the goals for use of unknowns in these variables at <5% unknown. However, when examining use of unknowns in these fields recognize this goal has likely been set too high, represents the fact that FCDS is not receiving values in data on analytic cases required under SSDIs, or SSDI data do not apply to all analytic cases in the schema.

Please remember that this is a data quality “indicator” report that can be used to identify potential problem areas across your facility’s abstracts. There may not be an actual problem when your facility does not meet each goal for reasons noted above. FCDS will continue to evaluate SSDI completeness over time and will like change the goals for these items as we better understand how and when they are used.

Please use this report and the FCDS Quarterly Submission Summary Report to monitor your data quality.

Questions about the report - contact Steven Peace, CTR at (305)243-4601 or speace@med.miami.edu.

Thank you for your support in providing complete, accurate and timely reporting of high-quality cancer data to FCDS and the state of Florida.



CTR Exam Testing

CTR Exam Testing Schedule in 2020

June 26 – July 25 **EXTENDED!**

APPLICATION DEADLINE: JUNE 25 **EXTENDED!**

September 1 – September 12

APPLICATION DEADLINE: AUGUST 31

NEW!

October 12 – November 14 **EXTENDED!**

APPLICATION DEADLINE: OCTOBER 11 **EXTENDED!**



Dear Florida Registrars:

FCRA and FCDS have been working diligently to provide our registrars with a semblance of continuity in education and training despite COVID-19 restrictions, furloughs, remote working from home, home schooling, or drinking by the pool (no glasses, please). We realize that some organizations have decided to hold indoor conferences while others have ditched their entire conference. Our resilient group decided 'virtual'.

You have already received a joint virtual conferences announcement – here is the REGISTRATION ANNOUNCEMENT.

Please register for whichever webinar(s) you would like to attend on Tuesday and/or Thursday from July 7, 2020 to July 31, 2020. July 31st is an alternate date just in case we have technical problems during one of our scheduled dates. We are now using ZOOM as our webinar provider. So, our understanding of controls and features is not as strong or experienced as our use of the previous webinar provider, Go To Meeting.

Below is a table of the 4 FCRA and 4 FCDS Sessions – the topics are available in a separate PDF on our websites with speaker/topic information.

Please try to join us for one or more or even all of the 8-9 sessions provided. We hope you can find the time.

Recordings will be available on both the FCRA and FCDS websites for 12 months only...then they will be retired.

Thanks much.

The FCDS/FCRA CoChairs Planning Committee

FCDS Virtual Annual Meeting Webinar Will Be Re-Scheduled Later in the Year

(Continued on page 37)



FCRA Sessions 1-4 will be held July 9-July 30 (Thursdays) from 1pm-3pm

FCDS Sessions 1-4 will be Re-Scheduled Beginning in Early August

Session Name	Date/Time	Registration Link
FCDS 2020 Annual Meeting Session 1	To be rescheduled	
FCDS 2020 Annual Meeting Session 2	To be rescheduled	
FCDS 2020 Annual Meeting	To be rescheduled	
FCDS 2020 Annual Meeting Session 4	To be rescheduled	
FCRA 2020 Annual Meeting Session 1	7/9/2020 1-3pm	Registration
FCRA 2020 Annual Meeting Session 2	7/16/2020 1-3pm	Registration
FCRA 2020 Annual Meeting Session 3	7/23/2020 1-3pm	Registration
FCRA 2020 Annual Meeting Session 4	7/30/2020 1-3pm	Registration

(Continued on page 38)



**FCDS Virtual Annual Meeting Webinar Will Be Re-Scheduled Later in the Year and
FCRA – Thursdays from 1pm-3pm**

Session	Date/Time	Time Spot	Topic/Speaker-1 or More Topic/Speaker in each 2-hour block	Speaker(s)
FCDS Session 1	TBA	1pm-1:10pm	Introduction to the 2020 Virtual Webinar Series by FCRA and FCDS	Steven Peace, BS CTR/Barbara Deamon, BS CTR-FCRA/FCDS Joint Virtual Conferences Program Co-Chairs
		1:10pm-1:15pm	Explain CEUs for this year-blank certificate that you fill in yourself	Steven Peace, BS CTR-FCDS
		1:15PM-1:30PM	DOH and FCDS Updates-State of the State	Meredith Hennon, MPH-DOH/Gary Levin, BA CTR
		1:30pm-2:00pm	2020 Florida Cancer Plan Updates	Christopher Cogle, MD-CCRAB
		2:00pm-2:30pm	Florida Firefighters Cancer Linkage Study Update	David Lee, PhD-UM/SCCC
		2:30PM-3:45PM	NPCR Cancer Screening Pilot-Breast & Cervical Cancers	Monique Hernandez, PhD/Gary Levin BA, CTR
		3:45PM-4:00PM	2020 Data Visualization and Trends in Data Use	Monique Hernandez, PhD-FCDS
FCRA Session 1	7/9/2020	1:00pm-1:15pm	Introduction and announcements	Heather Burner, CTR-FCRA President
		1:15pm-2:00pm	Cancer Screening & Early Detection	Daniel Morris, MD– Florida Cancer Specialists
		2:00pm-3:00pm	Survivorship	Smitha Pabbathi, MD– Moffitt Cancer Center
FCDS Session 2	TBA	1:00pm-1:15pm	2018-2019 Data Acquisition Summary	Meg Herna, BA CTR-FCDS
		1:15pm-1:30pm	2019 FCDS QC Activities and 2020 FCDS Data Quality Audit Summary	Steven Peace, BS CTR -FCDS
		1:30pm-2:00pm	Current QC Topics: Class of Case, Grade, Lymph Nodes, Surgery Fields	Steven Peace, BS CTR - FCDS
		2:00pm-2:30pm	NPCR Data Evaluation Report & FCDS Data Quality Indicator Report	Brad Wohler, MS/Steven Peace, CTR –FCDS

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**FCDS Virtual Annual Meeting Webinar Will Be Re-Scheduled Later in the Year and
FCRA – Thursdays from 1pm-3pm**

Session	Date/Time	Time Spot	Topic/Speaker-1 or More Topic/Speaker in each 2-hour block	Speaker(s)
		2:20pm-2:45pm	2020-2021 FCDS Educational and Training Plan	Steven Peace, BS CTR-FCDS
		2:45pm-2:50pm	2021 FCDS Cancer Reporting Requirements	Meg Herna, BA CTR-FCDS
		2:50pm-2:55pm	FCRA/FCDS Task Force Update	Steven Peace, BS CTR/Lindsey Mason, BS CTR
		2:55pm-3:00pm	Annual FCDS Jean Byers and Pat Strait Awards	Meg Herna, CTR-FCDS
FCRA Session 2	7/16/2020	1:00pm-2:00pm	Tumor Talks	Gina McNelliS, CTR, Himagine
		2:00pm-3:00pm	COVID-19 and Its Impact on Cancer Accreditation	Lisa Landvogt, CTR-ACOS/Henry Ford Health
FCDS Session 3	TBA	1:00pm-2:00pm	Viral Infections Associated With Increased Cancer Risk	Steven Peace, BS CTR-FCDS
		2:00pm-3:00pm	COVID 19 Data Collection Guidelines for 2020	Steven Peace, BS CTR-FCDS
FCRA Session 3	7/23/2020	1:00pm-2:00pm	Pancreatic and Upper GI Cancer	Juan Pablo Arnoletti, MD-Advent Health
		2:00pm-3:00pm	Breast Cancer	Christine Laronga, MD-Moffitt

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**FCDS Virtual Annual Meeting Webinar Will Be Re-Scheduled Later in the Year and
FCRA – Thursdays from 1pm-3pm**

Session	Date/Time	Time Spot	Topic/Speaker-1 or More Topic/Speaker in each 2-hour block	Speaker(s)
FCDS Session 4	TBA	1:00pm- 2:00pm	The FCDS Visual Editing Process: A Group Data Quality Exercise	Steven Peace, BS CTR-FCDS
		2:00pm- 3:00pm	2020 Updates in Cancer Diagnostics, Work-Up and Treatment	Steven Peace, BS CTR-FCDS
FCRA Session 4	7/30/2020	1:00pm- 2:00pm	FCRA Business meeting & Installa- tion of officers	Heather Burner, CTR- FCRA President
		2:00pm- 2:15pm	FCRA/FCDS Task Force Update	Lindsey Mason, BS CTR/Steven Peace, CTR
		2:15pm- 3:00pm	Radiation Oncology for the Cancer Register	Jeffrey Brabham, MD,MBA
Session 5	FCDA/FCDS		TBD-Optional	



EDUCATION AND TRAINING

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)

*** In person attendance cancelled until further notice. Please Login to FCDS IDEA->Education->FLccSC Learning Management 2 weeks after webinar to watch recordings and get CEUs ***

Special thanks to the hosting facilities for their participation and support. For a complete description of the webinars, click here: https://fcds.med.miami.edu/scripts/naacccr_webinar.pl 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/naacccr_webinar.pl. A separate registration will be required for each webinar. The number of participants allowed to be registered for each webinar will be dependent on space availability. For more information, please contact Steve Peace at 305-243-4601 or speace@med.miami.edu.

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

NAACCR CANCER REGISTRY AND SURVEILLANCE WEBINAR SERIES

Seven Florida facilities will host the 2019-2020 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 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

Florida Cancer Data System

Cancer Reporting Completeness Report



TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF JUNE 30, 2020

Total number of *New Cases* added to the FCDS Master file in June 2020: **20,557**

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	99,284	685	124	10,870	339	Pending	111,302	17,863
2018	208,014	5,763	169	12,868	21,156	Pending	247,970	2,548
2017	217,211	9,342	2,300	13,341	25,630	2,018	269,842	146
				<u>Actual</u>	<u>Expected</u>			
% Complete for:				2019	45%	100%		
				2018	99%	100%		
				2017	100%	100%		

**Expected % based on 250,000 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.

Recordings of FCDS Webcasts held 2014-2017 can be accessed from the FCDS Website. There are no CEU Quizzes for sessions held 10/2014-9/2017. However, your attendance must be manually logged into the FCDS CEU Tracking System for you to get credit for attending these recorded sessions.

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.

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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