JANUARY 2021

FCDS Physician Claims Article in Cancer Causes & Control

"Finding incident cancer cases through outpatient oncology clinic claims data and integration into a state cancer registry" Cancer Causes & Control © Springer Nature Switzerland AG 2020, Nov 2020, Cogle, Levin, Lee, Peace, Herna, MacKinnon, Gwede, Philip, et al. https://doi.org/10.1007/s10552-020-01368-z

Abstract

Cancer data from population-based cancer registries under-report cancer cases, especially for cancers primarily diagnosed and treated in outpatient clinical settings, away from hospital-based cancer registrars. Previously, we developed alternative methods of cancer case capture including a claims-based method, which identified a large proportion of cancer cases missed by traditional population-based cancer registries. In this study, we adapted a claims-based method for statewide implementation of cancer surveillance in Florida. Between 2010 and 2017 the claims-based method identified 143,083 cancer abstracts, of which 42% were new and 58% were previously registered. The claims-based method led to the creation of 53,419 new cancer cases in the state cancer registry, which made up 9.3% of all cancer cases registered between 2010 and 2017. The types of cancers identified by the claims-based method were typical of the kinds primarily diagnosed and treated in outpatient oncology clinic settings, such as hematological malignancies, prostate cancer, melanoma, breast cancer, and bladder cancer. These cases were added to the Florida cancer registry and may produce an artefactual increase in cancer incidence, which is believed to be closer to the actual burden of cancer in the state.

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 10/25/2020.

FCDS/NAACCR WEBINAR SERIES:
NAACCR 2020-2021 Cancer Registry and Surveillance Webinar Series - Lymphoma 2021
2/4/2021. ***** 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.

Florida Statewide Cancer Registry

Florida Cancer Data System
Deadlines, Updates, & Reminders

Daily/Monthly/Annual
Pathology Department Reports Casefinding

Did You Know You Are Supposed to Conduct Pathology Report Casefinding Every Year to make sure cancer reporting for your facility(s) is complete and that you have identified all cancers for the year? Many registrars are now relying solely on medical record disease indexes for in-patient and ambulatory patient encounters as the one and only source for casefinding…it is not. Medical Record Disease Index Casefinding NEVER identifies all cancers at a facility. The medical coders often do not have final pathology reports to review when they code the discharge diagnosis or secondary diagnoses during any patient encounter. Pathology is important.

Registrars seem to have forgotten or perhaps were never taught that casefinding is a multi-source process that must be performed each and every year to ensure all cancer cases at your facility have been identified and reported. If you rely solely on Medical Record Disease Index Casefinding automatically imported into your software as the only source for identifying cases, you are missing cases every single year that are later identified on your AHCA Listing – two years after they should have been identified and reported to FCDS.

Casefinding Audits have proven time and again that missed pathology cases will often identify 4-12% missed cases at every facility each year. And, your medical records coders often do not have every pathology report available when they assign diagnosis codes for billing patient encounters - whether in-patient or ambulatory.

Registrars seem to presume that medical record disease index coding is the only source they need to review and that the codes are always correct and complete and includes every positive cancer patient – it does not.

Please remember to review ALL Pathology Reports Every Year to ensure ALL of your cancer cases have been identified…these are histology-proven cancers that are missed every year…and they are your responsibility.

Pathology Review should include ALL Surgical Pathology Reports, FNA, biopsy and Bone Marrow Reports, Autopsy Reports, Special Studies such as Molecular Genetic Testing, Consultation Slides and Addenda, and other path lab sources that may identify cancer patients.

Some registries have their registry software interfaced with e-pathology read at their facility. However, even with automation some reports are overlooked, missed, not part of the inclusion criteria in your software or do not include addenda and consultations or specific testing done either at your facility or sent out for review. Please be sure your e-pathology interface is current with terminology and case identification and includes all types of e-pathology reports as noted above…and review the criteria at least every 2 years.

Florida Cancer Data System Deadlines, Updates, & Reminders

IDEA Abstract Entry or Vendor Software Case

FCDS has been getting complaints about QC Reviews and Field Coordinator Corrections and Inquiries asking registrars to follow-back to medical records and answer inquiries or to make corrections on cases that were abstracted and reported in the FCDS IDEA Abstract Entry Program.

Field Coordinator and Quality Control Reviewers have no idea what software you used to enter your case.

Suggestions to the reviewer 'just make the change and don't tell me because I cannot make any changes to update my case in FCDS IDEA' is not helpful to the Final Reviewers or the QC Process. The First Reviewer does not usually even know you abstracted your case in FCDS IDEA Entry…so, they don't know to 'just make changes' as some may suggest.

Additionally, registrars should use the feedback not as a tool to criticize their work – but rather to learn from their mistakes or to make some items more clear in text…it is about quality improvement, not grading papers.

Please be patient with your Field Coordinator or QC Reviewer and remember that we do not know what software you are using, and often do not even know who the abstractor is when we QC cases.

New CTRs for Florida

Sasha Raju, Tampa FL

Reginald Abadsantos, Fort Myers

Carrie Antonelli, Vero Beach

Brianne Arent, North Port

Kathleen Hammel, St. Augustine

Frank Horvath, Cape Coral

Leticia Montalvan, Deltona

Lucrecia Peters, Miami FL

Joan Rezzolla, Boca Raton

Yvette Squire, Port Saint Lucie

Emily Hays, Palm Coast

New Casefinding Source Practicum Training Available

Initial Release: October 19, 2020

Mary Potts, RHIA, CPA, CTR

Director, SEER*Educate

Fred Hutchinson Cancer Research Center, Cancer Surveillance System

Learn by Doing: Casefinding With Scans

The Casefinding Twofer

Casefinding using scans as sources documents will be released:

October – December 2020

As many of you are aware, there are currently 12 modules on the SEER*Educate training platform, which include 100 exercises each, using pathology reports to train everyone in the application of SEER's reportability rules found in the Solid Tumor Rules, Heme Rules, and ICD-O-3 codes reference materials. Trainers and college professors asked that we consider broadening the scope of casefinding education to include non-pathology sources. The SEER*Educate team is pleased to announce the first of three planned casefinding modules aimed at training students and registrars in the fundamentals of casefinding using scans as the source document. During the final months of 2020, we will release three practicums (50 exercises each) monthly from mid-October to mid-December.

This selection of scans is based on the **types of actual reports** that both trainees and sometimes experienced staff at our registry misclassified as potential new primaries and/or misclassified the primary site. These scans are not intended to be tricky cases but are intended to challenge people. After you declare whether the report is considered reportable, you are prompted to code the primary site, if applicable. These exercises provide many opportunities for students and registry staff to practice primary site coding in addition to learning casefinding fundamentals and how to apply the Solid Tumor Rules and Heme Rules.

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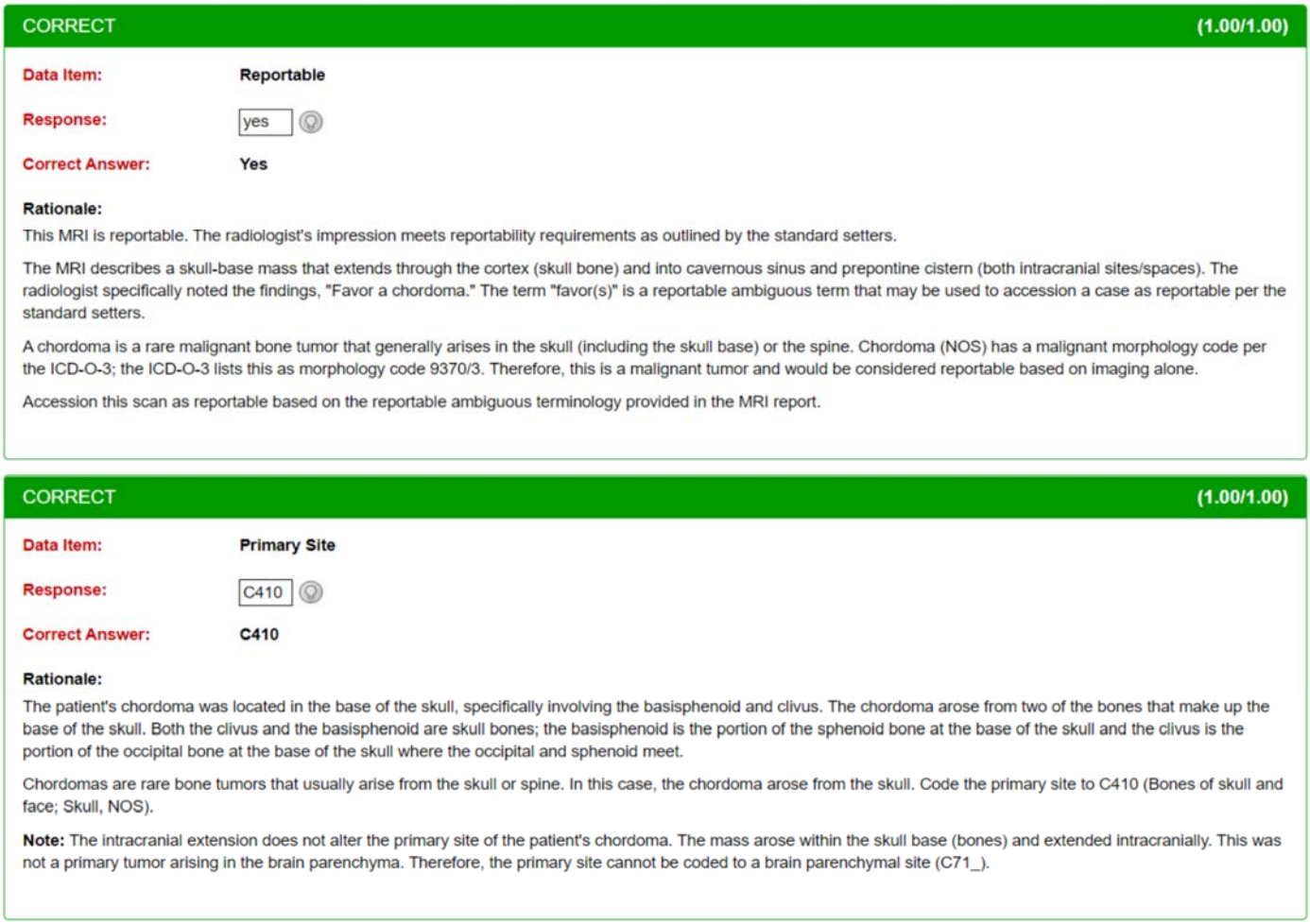
Casefinding is always done in context of a facility's reporting requirements for State reporting, CoC reporting (if the facility is ACoS-approved), and per the facility's own Cancer Committee requests. For this purpose, we created SEER*Educate Memorial Hospital. This hospital registry uses a Casefinding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

We will be submitting a request to the National Cancer Registrars Association (NCRA) to recognize 3 practicum hours for the casefinding requirement for students who complete a set of 50 scan reports accases. Although users can immediately repeat a test to improve one's score, we recommend cycling through all 50 exercises in a set before repeating any tests to improve your actual understanding of the casefinding guidelines, reportability rules and resources, and primary site coding. Immediately repeating exercises to improve performance only tests a person's short-term recall of the answer and rationale you just read.

The goal of both the pathology and scan casefinding modules is to learn how to perform casefinding using different sources. While immediately repeating an exercise will improve your training score, it will not accurately assess your ability to perform casefinding in the future or whether you can accurately recall and apply the casefinding rule(s) described in the rationale.

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

Example Answer/Rationale for a Scan



CORRECT (1.00/1.00)

Data Item: Reportable

Response: yes

Correct Answer: Yes

Rationale:

This MRI is reportable. The radiologist's impression meets reportability requirements as outlined by the standard setters.

The MRI describes a skull-base mass that extends through the cortex (skull bone) and into cavernous sinus and prepontine cistern (both intracranial sites/spaces). The radiologist specifically noted the findings, "Favor a chordoma." The term "favor(s)" is a reportable ambiguous term that may be used to accession a case as reportable per the standard setters.

A chordoma is a rare malignant bone tumor that generally arises in the skull (including the skull base) or the spine. Chordoma (NOS) has a malignant morphology code per the ICD-O-3; the ICD-O-3 lists this as morphology code 9370/3. Therefore, this is a malignant tumor and would be considered reportable based on imaging alone.

Accession this scan as reportable based on the reportable ambiguous terminology provided in the MRI report.

CORRECT (1.00/1.00)

Data Item: Primary Site

Response: C410

Correct Answer: C410

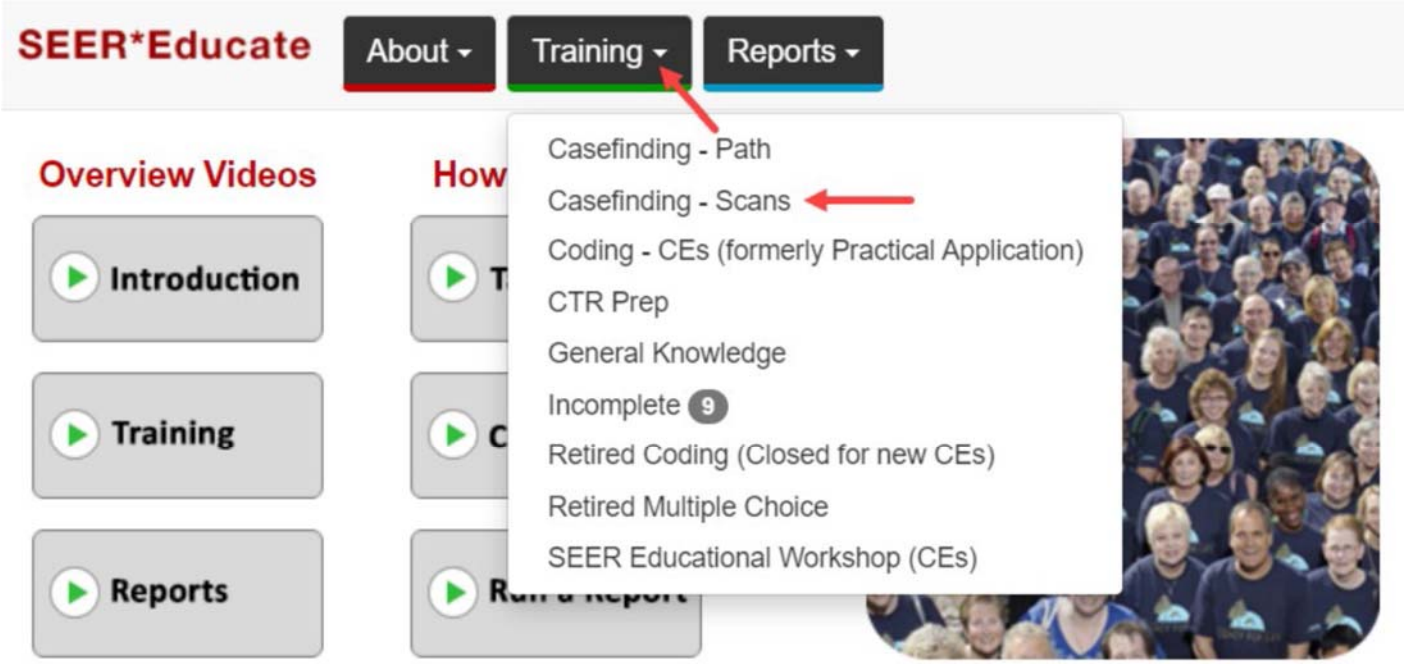
Rationale:

The patient's chordoma was located in the base of the skull, specifically involving the basisphenoid and clivus. The chordoma arose from two of the bones that make up the base of the skull. Both the clivus and the basisphenoid are skull bones; the basisphenoid is the portion of the sphenoid bone at the base of the skull and the clivus is the portion of the occipital bone at the base of the skull where the occipital and sphenoid meet.

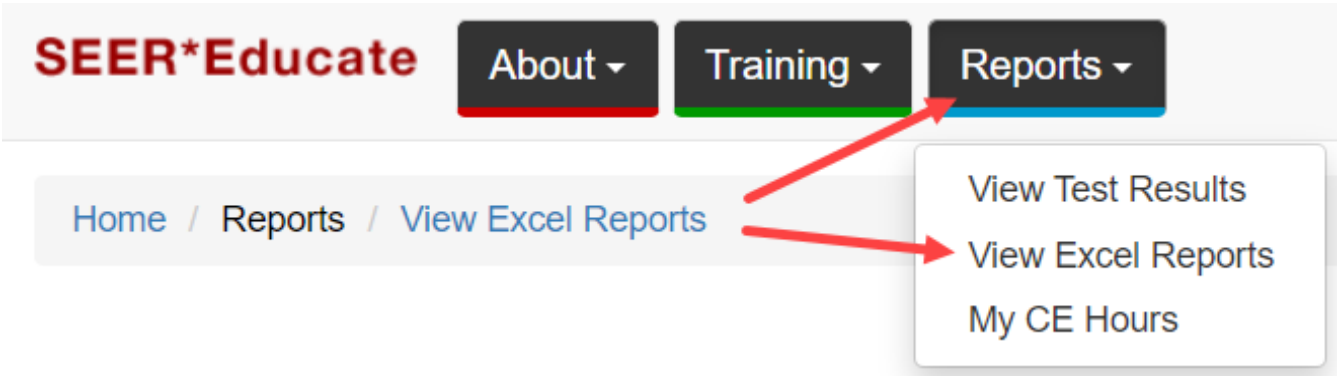
Chordomas are rare bone tumors that usually arise from the skull or spine. In this case, the chordoma arose from the skull. Code the primary site to C410 (Bones of skull and face; Skull, NOS).

Note: The intracranial extension does not alter the primary site of the patient's chordoma. The mass arose within the skull base (bones) and extended intracranially. This was not a primary tumor arising in the brain parenchyma. Therefore, the primary site cannot be coded to a brain parenchymal site (C71_).

Where do I find them? Under Training -> Casefinding - Scans



Is there a report? Under Reports -> View Excel Reports



Are there CEs? No

No CEs are available for the scan practicum exercises; however, going through one set of 50 path reports can be beneficial even for experienced registrars if your schedules permit.

Log in or sign up at **SEER*Educate** today by visiting https://educate.fredhutch.org/ and **Learn by Doing**!

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)

Update on FDA-Approved Plasma-Based Genotyping (liquid biopsy with multi-gene diagnostic testing)

Sources used to write this article include; NCI (www.cancer.gov), FoundationOne CDx and Guiardan360 CDx Websites

The Food and Drug Administration (FDA) has approved two blood tests, known as liquid biopsies, in August 2020 that can help guide treatment decisions for people with cancer. The tests, Guardant360 CDx and FoundationOne Liquid CDx. The tests are made by different companies and were approved separately. Below is some information about each.

Both tests can be used for two different purposes: as a companion diagnostic test and for general tumor profiling. A test is considered a companion diagnostic if it provides key information about the safe and effective use of a corresponding drug. In this case, the tests determine whether a patient's tumor has a genetic change that is targeted by a specific drug.

(NOTE: The tests are not currently used for lymphoma, leukemia, or plasma cell neoplasms…only solid tumors. Hematopoietic neoplasms have many individual genetic markers, specific to blood and lymph – but, they are quite different and more specialized than the solid tumor genetic mutations or combinations.)

(NOTE: Cancer Registries do not yet have a way to report results of these multi-gene panel tests in a standardized manner, yet. We do not yet understand what we should be including in data collection for clinical case reporting (ACOS) or for cancer surveillance reporting (SEER/NPCR/FCDS); nor do we have the capacity to capture all of the results. We are working with physicians and geneticists to better understand our role as cancer registrars and population-based cancer surveillance programs at the state and federal level for capturing this information and what is important for cancer reporting. It may take some time for us to figure this all out. In the meantime, when these tests are used in diagnostic workup and to identify treatment options for patients with solid tumors, registrars should use any physician notes describing testing and results from Summary Reports, Consultations, Lab Results, etc…and specific comments made for each case, as the resource from which tests and results are important for any particular case you are abstracting.)

"Doctors have traditionally based treatment decisions on features like the organ in which the cancer started growing, whether the cancer has spread, and whether the patient has other health conditions. Now they often use another feature to guide treatment: genetic changes in the tumor."

"Certain therapies, called targeted therapies and immunotherapies, work best against tumors that have specific genetic changes. The newly approved tests identify genetic changes, including mutations, by scanning DNA that tumors have shed into the blood.

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Doctors can then use that information to determine if there is a targeted therapy or immunotherapy that is likely to work for the patient. Analyzing genetic changes in a patient's cancer is called tumor profiling, genomic profiling, or tumor sequencing.

Both Guardant360 CDx and FoundationOne Liquid CDx are approved for people with any solid cancer (e.g., lung, prostate), but not for those with blood cancers. While FDA has approved other blood tests that check for the presence a single gene mutation in tumor DNA, these are the first approved blood tests that check for multiple cancer-related genetic changes.

Liquid biopsies can sometimes be an alternative to a traditional biopsy, in which a sample of a tumor is removed with a needle or during surgery. They are less invasive and quicker than a traditional tissue biopsy"

"Even though the tests have been around for a while, we don't know how useful they're really going to be in the clinical setting," said Ben Ho Park, M.D., Ph.D., of Vanderbilt-Ingram Cancer Center. Many details about how the blood tests may be incorporated into everyday care for people with cancer, including who should get them and whether the cost is covered by private insurance companies, are still being ironed out."

FoundationOne CDx - FoundationOne CDx is the first FDA-approved tissue-based broad companion diagnostic (CDx) that has been clinically and analytically validated for all solid tumors. Test results include microsatellite instability (MSI) and tumor mutational burden (TMB) to help inform immunotherapy decisions, and loss of heterozygosity (LOH) for ovarian cancer patients.

You can also order PD-L1 immunohistochemistry (IHC) testing* as an optional add-on test. The FoundationOne CDx test detects substitution, insertion and deletion genetic alterations, and genetic copy number alterations (CNAs) in 324 genes and select gene rearrangements, as well as genomic signatures including microsatellite instability (MSI) and tumor mutational burden (TMB) using DNA isolated from formalin-fixed paraffin embedded (FFPE) tumor tissue specimens.

- FoundationOne CDx (324 DNA genes interrogated from a tissue sample)
- FoundationOne Liquid CDx (324 DNA genes* interrogated from a simple blood draw)
- FoundationOne Heme (406 DNA and 265 RNA genes interrogated from a variety of sample options)

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Current Gene List[2]

Genes with full coding exonic regions included in FoundationOne®CDx for the detection of substitutions, insertion-deletions (indels), and copy-number alterations (CNAs).

ABL1	*ACVR1B*	*AKT1*	*AKT2*	*AKT3*	*ALK*	*ALOX12B*	*AMER1 (FAM123B)*	*APC*
AR	*ARAF*	*ARFRP1*	*ARID1A*	*ASXL1*	*ATM*	*ATR*	*ATRX*	*AURKA*
AURKB	*AXIN1*	*AXL*	*BAP1*	*BARD1*	*BCL2*	*BCL2L1*	*BCL2L2*	*BCL6*
BCOR	*BCORL1*	*BRAF*	*BRCA1*	*BRCA2*	*BRD4*	*BRIP1*	*BTG1*	*BTG2*
BTK	*C11orf30 (EMSY)*	*CALR*	*CARD11*	*CASP8*	*CBFB*	*CBL*	*CCND1*	*CCND2*
CCND3	*CCNE1*	*CD22*	*CD274 (PD-L1)*	*CD70*	*CD79A*	*CD79B*	*CDC73*	*CDH1*
CDK12	*CDK4*	*CDK6*	*CDK8*	*CDKN1A*	*CDKN1B*	*CDKN2A*	*CDKN2B*	*CDKN2C*
CEBPA	*CHEK1*	*CHEK2*	*CIC*	*CREBBP*	*CRKL*	*CSF1R*	*CSF3R*	*CTCF*
CTNNA1	*CTNNB1*	*CUL3*	*CUL4A*	*CXCR4*	*CYP17A1*	*DAXX*	*DDR1*	*DDR2*
DIS3	*DNMT3A*	*DOT1L*	*EED*	*EGFR*	*EP300*	*EPHA3*	*EPHB1*	*EPHB4*
ERBB2	*ERBB3*	*ERBB4*	*ERCC4*	*ERG*	*ERRFI1*	*ESR1*	*EZH2*	*FAM46C*
FANCA	*FANCC*	*FANCG*	*FANCL*	*FAS*	*FBXW7*	*FGF10*	*FGF12*	*FGF14*
FGF19	*FGF23*	*FGF3*	*FGF4*	*FGF6*	*FGFR1*	*FGFR2*	*FGFR3*	*FGFR4*
FH	*FLCN*	*FLT1*	*FLT3*	*FOXL2*	*FUBP1*	*GABRA6*	*GATA3*	*GATA4*
GATA6	*GID4 (C17orf39)*	*GNA11*	*GNA13*	*GNAQ*	*GNAS*	*GRM3*	*GSK3B*	*H3F3A*
HDAC1	*HGF*	*HNF1A*	*HRAS*	*HSD3B1*	*ID3*	*IDH1*	*IDH2*	*IGF1R*
IKBKE	*IKZF1*	*INPP4B*	*IRF2*	*IRF4*	*IRS2*	*JAK1*	*JAK2*	*JAK3*
JUN	*KDM5A*	*KDM5C*	*KDM6A*	*KDR*	*KEAP1*	*KEL*	*KIT*	*KLHL6*
KMT2A (MLL)	*KMT2D (MLL2)*	*KRAS*	*LTK*	*LYN*	*MAF*	*MAP2K1 (MEK1)*	*MAP2K2 (MEK2)*	*MAP2K4*
MAP3K1	*MAP3K13*	*MAPK1*	*MCL1*	*MDM2*	*MDM4*	*MED12*	*MEF2B*	*MEN1*
MERTK	*MET*	*MITF*	*MKNK1*	*MLH1*	*MPL*	*MRE11A*	*MSH2*	*MSH3*
MSH6	*MST1R*	*MTAP*	*MTOR*	*MUTYH*	*MYC*	*MYCL (MYCL1)*	*MYCN*	*MYD88*
NBN	*NF1*	*NF2*	*NFE2L2*	*NFKBIA*	*NKX2-1*	*NOTCH1*	*NOTCH2*	*NOTCH3*
NPM1	*NRAS*	*NT5C2*	*NTRK1*	*NTRK2*	*NTRK3*	*P2RY8*	*PALB2*	*PARK2*
PARP1	*PARP2*	*PARP3*	*PAX5*	*PBRM1*	*PDCD1 (PD-1)*	*PDCD1LG2 (PD-L2)*		*PDGFRA*
PDGFRB	*PDK1*	*PIK3C2B*	*PIK3C2G*	*PIK3CA*	*PIK3CB*	*PIK3R1*	*PIM1*	*PMS2*
POLD1	*POLE*	*PPARG*	*PPP2R1A*	*PPP2R2A*	*PRDM1*	*PRKAR1A*	*PRKCI*	*PTCH1*
PTEN	*PTPN11*	*PTPRO*	*QKI*	*RAC1*	*RAD21*	*RAD51*	*RAD51B*	*RAD51C*
RAD51D	*RAD52*	*RAD54L*	*RAF1*	*RARA*	*RB1*	*RBM10*	*REL*	*RET*
RICTOR	*RNF43*	*ROS1*	*RPTOR*	*SDHA*	*SDHB*	*SDHC*	*SDHD*	*SETD2*
SF3B1	*SGK1*	*SMAD2*	*SMAD4*	*SMARCA4*	*SMARCB1*	*SMO*	*SNCAIP*	*SOCS1*
SOX2	*SOX9*	*SPEN*	*SPOP*	*SRC*	*STAG2*	*STAT3*	*STK11*	*SUFU*
SYK	*TBX3*	*TEK*	*TET2*	*TGFBR2*	*TIPARP*	*TNFAIP3*	*TNFRSF14*	*TP53*
TSC1	*TSC2*	*TYRO3*	*U2AF1*	*VEGFA*	*VHL*	*WHSC1 (MMSET)*	*WHSC1L1*	*WT1*
XPO1	*XRCC2*	*ZNF217*	*ZNF703*					

Select Rearrangements[2,3]

Genes with select intronic regions for the detection of gene rearrangements, one gene with a promoter region and one non-coding RNA gene.

ALK	*BCL2*	*BCR*	*BRAF*	*BRCA1*	*BRCA2*	*CD74*	*EGFR*	*ETV4*
ETV5	*ETV6*	*EWSR1*	*EZR*	*FGFR1*	*FGFR2*	*FGFR3*	*KIT*	*KMT2A (MLL)*
MSH2	*MYB*	*MYC*	*NOTCH2*	*NTRK1*	*NTRK2*	*NUTM1*	*PDGFRA*	*RAF1*
RARA	*RET*	*ROS1*	*RSPO2*	*SDC4*	*SLC34A2*	*TERC**	*TERT (promoter only)***	
TMPRSS2								

**TERC* is non-coding RNA gene.
***TERT* is gene with promoter region.

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Table 1: Companion diagnostic indications

INDICATIONS	BIOMARKER	FDA-APPROVED THERAPY
Non-Small Cell Lung Cancer (NSCLC)	*EGFR* exon 19 deletions and *EGFR* exon 21 L858R alterations	Gilotrif® (afatinib), Iressa® (gefitinib), Tagrisso® (osimertinib) or Tarceva® (erlotinib)
	EGFR exon 20 T790M alterations	Tagrisso® (osimertinib)
	ALK rearrangements	Alecensa®(alectinib), Xalkori® (crizotinib), or Zykadia® (ceritinib)
	BRAF V600E	Tafinlar® (dabrafenib) in combination with Mekinist® (trametinib)
	MET single nucleotide variants (SNVs) and indels that lead to *MET* exon 14 skipping	Tabrecta™ (capmatinib)
Melanoma	*BRAF* V600E	Tafinlar® (dabrafenib) or Zelboraf® (vemurafenib)
	BRAF V600E or V600K	Mekinist® (trametinib) or Cotellic®(cobimetinib), in combination with Zelboraf® (vemurafenib)
Breast Cancer	*ERBB2* (HER2) amplification	Herceptin® (trastuzumab), Kadcyla® (ado-trastuzumab-emtansine), or Perjeta® (pertuzumab)
	PIK3CA alterations	Piqray® (alpelisib)
Colorectal Cancer	*KRAS* wild-type (absence of mutations in codons 12 and 13)	Erbitux® (cetuximab)
	KRAS wild-type (absence of mutations in exons 2, 3 and 4) and *NRAS* wild-type (absence of mutations in exons 2, 3 and 4)	Vectibix® (panitumumab)
Ovarian Cancer	*BRCA1/2* alterations	Lynparza® (olaparib) or Rubraca® (rucaparib)
Cholangiocarcinoma	*FGFR2* fusions and select rearrangements	Pemazyre™ (pemigatinib)
Prostate Cancer	Homologous Recombination Repair *(HRR) gene (BRCA1, BRCA2, ATM, BARD1, BRIP1, CDK12, CHEK1, CHEK2, FANCL, PALB2, RAD51B, RAD51C, RAD51D and RAD54L)* alterations	Lynparza® (olaparib)
Solid tumors	TMB ≥ 10 mutations per megabase	Keytruda® (pembrolizumab)

The test is also used for detection of genomic loss of heterozygosity (LOH) from formalin-fixed, paraffin-embedded (FFPE) ovarian tumor tissue. Positive homologous recombination deficiency (HRD) status (defined as tBRCA-positive and/or LOH high) in ovarian cancer patients is associated with improved progression-free survival (PFS) from Rubraca (rucaparib) maintenance therapy in accordance with the Rubraca product label.

2. **Guardant360 CDx - Guardant360® CDx** is a qualitative next generation sequencing-based in vitro diagnostic test that uses targeted high throughput hybridization-based capture technology for detection of single nucleotide variants (SNVs), insertions and deletions (indels) in 55 genes, copy number amplifications (CNAs) in two (2) genes, and fusions in four (4) genes. Guardant360 CDx utilizes circulating cell-free DNA (cfDNA) from plasma of peripheral whole blood collected in Streck Cell-Free DNA Blood Collection Tubes (BCTs).

Table 3. Genes Containing Alterations Reported by Guardant360 CDx

Alteration Type	Genes
Single Nucleotide Variants (SNVs)	*AKT1, ALK, APC, AR, ARAF, ATM*, BRAF, BRCA1**, BRCA2**, CCND1, CDH1, CDK4, CDK6, CDK12*, CDKN2A, CTNNB1, EGFR, ERBB2, ESR1, FGFR1, FGFR2, FGFR3, GATA3, GNA11, GNAQ, HRAS, IDH1, IDH2, KIT, KRAS, MAP2K1, MAP2K2, MET, MLH1, MTOR, MYC, NF1, NFE2L2, NRAS, NTRK1, NTRK3, PDGFRA, PIK3CA, PTEN, RAF1, RET, RHEB, ROS1, SMAD4, SMO, STK11, TERT, TSC1, VHL*
Indels	*AKT1, ALK, APC, ATM*, BRAF, BRCA1**, BRCA2**, CDH1, CDK12*, CDKN2A, EGFR, ERBB2, ESR1, FGFR2, GATA3, HNF1A, HRAS, KIT, KRAS, MET, MLH1, NF1, PDGFRA, PIK3CA, PTEN, RET, ROS1, STK11, TSC1, VHL*
Copy Number Amplifications (CNAs)	*ERBB2, MET*
Fusions	*ALK, NTRK1, RET, ROS1*

***Reporting is enabled for pathogenic germline alterations only. Somatic alterations will not be reported.**
**** Reporting is enabled for both germline and somatic alterations.**

Guardant360 CDx and FoundationOne Liquid CDx

These are for SOLID TUMORS only. These would constitute lots of new data items to store results of type of test and 360 potential gene mutation results.

The data showed that the results of both tests agreed with results from other tumor profiling tests that have been proven accurate. The tests are also approved for general tumor profiling.

Guardant360 CDx and FoundationOne Liquid CDx are approved for any patient with a solid tumor, there may be specific situations where the tests are best suited.

Guardant360 CDx checks for changes in more than 60 different genes.

FoundationOne Liquid CDx, can identify changes in more than 300 genes, as well as other genetic features that make tumors more susceptible to treatment with certain immunotherapies

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Trend of Emerging Small Specialty Hospitals

FCDS would like to recognize a fairly recent phenomenon we have identified with the latest few years of hospital mergers and acquisitions, particularly large networked hospitals purchasing/acquiring small suburban or even somewhat rural hospitals and turning them into specialty referral hospitals for a certain cancer subspecialty like head and neck cancers or specific types of unique and specialty surgical procedures.

It often takes a couple of years to recognize these changes. However, over 1-3 years an abstractor at a small suburban or semi-rural hospital with only 50 or 100 beds may be converted to a specialty hospital with specialty surgical suites and specialty staffing for certain cancers.

Suddenly, what used to be an ‘easy’ hospital for abstracting basic cases becomes a ‘difficult’ specialty hospital specializing in hard to understand and abstract cancers, advanced cancers, specialty breast or colon cancer hospitals, or hospitals that manage gamma knife and specialty targeted radiation therapy cases, etc.

Hospital networks are doing this to consolidate referrals to one center within their network and to centralize specialty therapy to one institution instead of spreading them all out to every single hospital.

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This saves time, nurses with spcialty in the area, makes referrals easier, often results in specialty surgical suites and shorter wait times for surgical procedures within that specialty, and a better understanding of those cancers and treatment options for those cancers. So, it really does make sense from a corporate point of view.

Again, this is to facilitate consolidation of resources (including physicians and nursing staff) and provide excellent care in one specialty at one facility that is easy to get to by anybody within the city or region.

Please be aware that as these changes occur with mergers and acquisitions, your skills as an abstractor must change along with the new specialty and you must become proficient in abstracting those particular kinds of cancers or specialty treatments now being seen at your hospital…and you must be prepared to abstract more difficult cases and be proficient in the language used, staging, treatment, etc. to keep your contracts.

This is particularly important for single contractors when suddenly your previously straight and steady cases change seemingly overnight and suddenly all you see are difficult lung cancers with surgery and lots of new treatments. It may become evident to you that things have changed…this may be the reason – how and why.

Coding Class of Case

FCDS gets lots of questions asking about how to code Class of Case. Class of Case used to be a very simple field to code. It was 1-digit and told a basic story;

1996-2002 – Class of Case – this item was used to quickly identify which cases your facility participated in original diagnosis and original course of cancer care at your hospital – and what exactly your facility did/not do. When Class of Case originated – the hospital registry only used 4 classes of case when reporting cancers. Central and State Cancer Registries used additional codes – but, they were used only at the central registry.

"Class of Case" divides the data into analytic and nonanalytic categories.

Codes:

0 First diagnosed at the reporting institution since the registry's reference date and all of the first course of therapy elsewhere.

1 First diagnosed and all or part of the first course of therapy at the reporting institution

2 First diagnosed elsewhere and treatment plan developed and documented and/or the first course of therapy given at the reporting institution after the registry's reference date

3 First diagnosed and all of the first course of therapy elsewhere.

4 First diagnosed and first course of therapy at the reporting institution before the reference date of the registry

5 First diagnosed at autopsy

6 Diagnosed and all of the first course of treatment only in a staff physician's office

8 Diagnosis established only by death certificate

9 Unknown

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Type of Reporting Source was always felt to be a related item

- 1 – Hospital inpatient, hospital outpatient, clinic
- 3 – Laboratory Only
- 4 – Physician Office/private medical practitioner
- 5 – Nursing Home, convalescent home, convalescent hospital, hospice
- 6 – Autopsy only
- 7 – Death Certificate Only

The CoC released the first FORDS Manual in 2002 with these codes for Class of Case.

Code	Definition
0	Diagnosis at the reporting facility and all of the first course of treatment was performed elsewhere or the decision not to treat was made at another facility.
1	Diagnosis at the reporting facility, and all or part of the first course of treatment was performed at the reporting facility.
2	Diagnosis elsewhere, and all or part of the first course of treatment was performed at the reporting facility.
3	Diagnosis and all of the first course of treatment was performed elsewhere. Presents at your facility with recurrence or persistent disease.
4	Diagnosis and/or first course of treatment was performed at the reporting facility prior to the reference date of the registry.
5	Diagnosed at autopsy.
6	Diagnosis and all of the first course of treatment was completed by the same staff physician in an office setting. "Staff physician" is any medical staff with admitting privileges at the reporting facility.
7	Pathology report only. Patient does not enter the reporting facility at any time for diagnosis or treatment. This category excludes cases diagnosed at autopsy.
8	Diagnosis was established by death certificate only. Used by central registries only.
9	Unknown. Sufficient detail for determining Class of Case is not stated in patient record. Used by central registries only.

In 2010 the CoC changed ALL OF THE CODES AND DEFINITIONS for Class of Case.
Suddenly, coding Class of Case was a big deal and harder than ever to figure out.
The intent was to provide greater granularity making it easier – the opposite occurred.
Registrars suddenly were hemming and hawing about the difference between codes.

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Codes

Analytic Classes of Case (Required by Coc to be abstracted by accredited programs)	
00	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere.
10	Initial diagnosis at the reporting facility or in a staff physician's office AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS
11	Initial diagnosis in staff physician's office AND part of first course treatment was done at the reporting facility.
12	Initial diagnosis in staff physician's office AND all first course treatment or a decision not to treat was done at the reporting facility.
13	Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility.
14	Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility.
Initial diagnosis elsewhere	
20	Initial diagnosis elsewhere AND all or part first course treatment was done at the reporting facility, NOS
21	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility.
22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility.

Classes of Case not required by Coc to be abstracted (May be required by Cancer Committee, state or regional registry, or other entity)

30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, staging workup after initial diagnosis elsewhere)
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence.
33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only.
34	Type of case not required by Coc to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility.
35	Case diagnosis before program's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility.
36	Type of case not required by Coc to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility.
37	Case diagnosis before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility.
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death.

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Patient appears in person at reporting facility	
40	Diagnosis AND all first course treatment given at the same staff physician's office
41	Diangnosis and all first course treatment given in two or more different staff physician's offices.
42	Nonstaff physician or non-Coc accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)
43	Pathology or other lab specimens only
49	Deaths certificate only
99	Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for

Since 2010 when CoC Changed the Class of Case definitions and coding structure we have had problems with registrars not understanding the codes or how they are different or the same. The original coding structure is still embedded within the new structure 0 became 00.1 became 10-14, 2 became 20-22, 30 became 30-38, and 40 became 40-49…and now a new 99 Class of Case appeared. But, the basics of 0, 1, 2, 3, 4 remained.

"You should always know why a cancer patient is at your facility. Hence you should NEVER use code 99. Please keep it simple if you cannot figure out the second digit…just code 00, 10, 20, or 30.

You should never be using codes 40, 50, 60, 80 or 99 on any of your cases at a facility

So, if you are ever having problems with reporting Class of Case to FCDS – you can always go back to basics and think about 0, 1, 2, 3, 4 or code 00, 10, 20, 30, 40 – we have several state central registries who ONLY require the old coding because the new codes in 2010 were too problematic.

FCDS relies on Proper Coding of Class of Case within the major groups – we don't much care about the 2nd digit subgroup…but, some of the codes that may not be analytic to your facility – may be analytic to the state.

Please take care when coding Class of Case – and when necessary – go back to the basics.

NCRA's 47th Annual Educational Conference

Will be a Virtual Only Event

The National Cancer Registrars Association (NCRA) is holding its 47th Annual Educational Conference as a virtual only event. There will be no in-person conference in 2021.

Like many of you, NCRA is grateful for the progress made on the COVID-19 vaccines, but the timing will not ensure a safe in-person event in June of 2021. With this in mind, the NCRA Board of Directors and staff made the decision to move forward with presenting a virtual-only conference on June 3-5, 2021. NCRA is working with the J.W. Marriott in Indianapolis to reschedule a future NCRA conference in that great city.

NCRA's 2021 Virtual Annual Educational Conference will be hosted on a virtual platform to allow us to continue to offer the high-quality and unique content that is the hallmark of NCRA's conference programming. In addition, the 47th Annual Educational Conference will include a virtual exhibit hall, online basket raffles, roundtable discussions, and other networking opportunities.

Registration information and additional details will be available in mid-January 2021. Updates will be posted to **www.ncra-usa.org/conference**

Did Everybody Forget Importance of Coding Subsite and Other Pet Peeves from QC?

The problems outlined below are growing more common every single year. We visually review over 10,000 abstracts every single year. After your case has passed edits and the case appears correct, we find all kinds of 'minor' errors which add up to a 'major' problem statewide when we review them visually. The intent is to find errors and make inquiries where the case does not make sense or when common coding errors occur. Many new, experienced and contract abstractors are not taking time to learn how to document and code cases properly, whether they document them correctly or not. This occurs frequently in standard data items such as nodes examined and nodes positive counts. Registrars appear to be coding the cases to pass edits as opposed to making sure the case is coded correctly. This may speed up abstracting time but please slow down and make sure the coding is correct. We must remedy this to improve statewide data quality.

Registrars need to stick to what they are taught and know that every data item required in the FCDS data set is **required** and we expect you to look for it before it is coded to 'unknown'. The other option for us is to write new edits that send back every 'unknown' or 'NOS' value coded to research the case for a better code. When you are abstracting an 'analytic' case; there is no reason to have an NOS solid tumor site, or unknown stage, or unknown first course of therapy. NOS coding would only apply when it is a historical cancer with no information.

'Unknown' does not mean 'I don't have time to look up the data item to code it correctly' or 'I will just use my drop down selection and it will be correct' or 'I will document it in my text and FCDS will find it and correct it if it is wrong'. Registrars need to document and code correctly the first time around. We are getting more 'unknown' and 'NOS' codes in critical fields than we have seen in decades just in the past two to five years.

Please pay attention and code all data items to their fullest granularity or level of precision available in the medical record. Do not speed through your abstracts. Take the extra time and focus on quality. Look for SSDIs and other items that many registrars just pass over for whatever reason. After checking with many registrars, we have learned that many items are not even looked up. This is not an excuse for poor abstracting.

And finally, vendor defaults are no help to you. You have to try to code the data item and not just default your way thru the abstract to save time on information you feel is not important for all required items.

1) Code Sub Sites – do not just include the sub site description in the text – be sure to code it, too

2) Try not to code NOS for anything – try to be more precise unless that is all the information you have

3) When coding that that patient has no nodes examined the proper coding is NOT 99/99 for regional lymph nodes examined/regional lymph nodes positive. The correct code is 00 nodes examined, 98 is a default code that goes with the 00 nodes examined and means no nodes were examined to know if any were positive. 99/99 might default with your software – but it is only correct for lymphoma, leukemia, myeloma, and brain tumors. The remainder of all solid tumors should be 00 nodes examined and 98 nodes positive.

4) Do not code Scope of Regional Lymph Node Surgery = 9 when you are not sure. Only code what you do know. This goes for all treatments. Do not use treatment = 9 when you do not know.

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5) **Only Code What You Know** from the medical record and physician notes. Do NOT code what you do not know or what you suspect should have been done or might have been done. Don't guess. Only code what you actually know from the record. Do not assume or code 9.

6) We will be discussing more on nodes positive/examined and Scope of Regional Lymph Node Surgery when we discuss the 2021 Updates. We are watching these data items much more closely than ever.

7) **All** cases of leukemia and **all** primary site C42.1 are **distant Summary Stage** regardless if a history or active.

8) Registrars often do not use the Summary Stage Manual deferring to AJCC TNM for cancer program approvals at the detriment of state mandated data. **All** abstractors are required to follow the FCDS requirements. CoC and AJCC are voluntary programs. FCDS is a legislatively mandated program and **all** state requirements must be met.

9) Remember that Cancer Staging is all about **Stage at Diagnosis** not Stage after Treatment. For 50 years cancer registries have coded cancer stage at diagnosis. Only in the past 10 years have we begun to additionally code Stage after Treatment as part of First Course of Therapy. It is post-treatment stage not stage at diagnosis. So, when in doubt, you must cover stage at diagnosis in at least a clinical stage even if your programs also evaluates effect of treatment on stage in post-therapy staging either clinical or pathological. When these get mixed – epidemiologists cannot follow stage trends over time – some stages are coded as 'at time of diagnosis' and some 'after chemo/xrt/brm therapy – to measure response to treatment'. These are incredibly different definitions and uses.

10) Diagnostic Confirmation should **never** = 5 or 9 on ANY Case submitted to the FCDS. There are no cancers that can be diagnosed only on a biochemical test of any kind. None have ever been approved to use this code. And 9 should never be used for obvious reasons, although your software may set it as a default. Please check Dx Confirmation as you abstract cases to avoid these 2 problems.

11) LVI (lymph vascular invasion) always = 0 for in-situ cancers.

12) **IMPORTANT**: Treatment that is all or part of first course of treatment **must** be coded as well as documented if not done at your facility. It may be mentioned in Summary or Consultation but it should always be coded.

13) Registrars are still over coding Surgery to Other Regional or Distant Sites when the procedure actually includes the removal of adjacent organ as routine part of the documented and coded surgery of primary site. Do not over code this item. It should be used when the intent is to rule out metastatic disease not just for incidental removal of an appendix or other parts of GYN during hysterectomy.

When you have questions please send the FCDS an email explaining your problem or phone the FCDS. That is why we are here. **Managers – You should allow your abstractors to contact the FCDS when they need assistance. That is our job. Please remember the FCDS is here to be used as a resource and to support your team. Please use it.**

Unusual Path

Question:

I've got a case that has unusual path, do you feel this is reportable? If so, do you have any suggestions for histology to use? Is there any histology for microinvasion on a cervix primary? It's just an odd path report, not one I've really had come up before.

HIGH-GRADE CERVICAL INTRAEPITHELIA NEOPLASIA (CIN3) WITH GLAND DUCT INVOLEMENT, MICROINVASION IS IDENTIFIED on the cone bx

Surg path: Focal persistent high-grade squamous intraepithelial lesion (HSIL-CIN3) involving endocervical glands but without evidence of invasive carcinoma and with negative margins.

Answer:

We used to see these a lot when we reported CIN III and CIS of cervix…not so much these days as people tend to ignore them when or if they do pathology report casefinding – which everybody should do every year. This is a reportable invasive cervical cancer – microinvasion makes this a behavior /3 not in-situ. The histology is 8076/3 and the site is cervix. There is no treatment since all they did was a cone biopsy which is not a resection when it returns with invasion or microinvasion – it is just a biopsy.

FCDS QC

Question:

We are still grappling with the prostate cases receiving androgen deprivation therapy before the robotic-assisted laparoscopic prostatectomy. Our admin spoke with the nurse practitioner at our major robotic institute and they insisted this is neoadjuvant therapy. We explained the implications of this and how it will affect stage and coding. But then, we get a case kicked back by QC stating something about a clinical trial, even further confusing our team.

The patient's MD stated the patient was receiving neoadjuvant therapy for over a year. Are we to be coding the RALP as subsequent in this particular case?

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Answer:

Patients with high-risk localized (non-metastatic) prostate cancer may benefit from new hormonal agents such as abiraterone, enzalutamide, apalutamide, for neoadjuvant androgen deprivation therapy (ADT). However, the hormone therapy should always include radiation prior to radical prostatectomy.

"Neoadjuvant androgen deprivation therapy before prostatectomy has been shown to provide long□term progression□free survival and to significantly reduce the risk of recurrence. However, it has generally not been shown to extend Overall Survival." But, it still should be coded as neoadjuvant therapy when given.

https://onlinelibrary.wiley.com/doi/10.1111/ajco.13108 - Androgen Deprivation Therapy in Non-metastatic Prostate Cancer Patients: Indications, treatment effects, and new predictive biomarkers – Asia-Pacific Journal of Clinical Oncology – Feb 2019

There are published guidelines that include ADT plus abiraterone without XRT – so, we are seeing all kinds of combinations of ADT with/without XRT and different XRT modalities may be used causing lots of confusion.

High-risk localized disease would be T3a or Gleason Group 4 or 5 or PSA > 20 (doesn't have to be all 3 – but, at least one of the 3 criteria would be considered and treated as high-risk localized disease. Patients with regional or metastatic disease all fall in a different category for treatment guidelines and whether or not the use of pre-surgical ADT plus or minus radiation would be considered neoadjuvant or not…more confusion.

Primary therapy normally consists of radical prostatectomy or radiotherapy. However, patients with a positive margin, extraprostatic extension, lymph node involvement, high prostate□specific antigen (PSA), or high Gleason Score (GS) are at high risk of prostate cancer recurrence following primary therapy. In these patients, androgen deprivation therapy (ADT) can be given as neoadjuvant therapy prior to primary therapy to shrink the tumor and reduce margin positivity. Radiotherapy, ADT, or a combination of the two can also be given as adjuvant treatment following primary therapy to reduce the risk of recurrence.

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Still even in 2020, the results of using neoadjuvant hormone plus or minus radiation and effect on survival are questionable. The therapy may reduce tumor volume and downstage a bit or perhaps allow for cleaner margins. But, according to many experts – even in the most recent 2020 articles; "Deprivation therapy in the neoadjuvant setting is not recommended prior to radical prostatectomy since it did not provide any survival advantage, although reducing tumor volume, surgical margins rate, local and nodal stage." And definitely not advantageous without radiation therapy. But, we are seeing 'neoadjuvant' hormone alone or in combination with radiation therapy more frequently. So, we definitely need to pay attention and understand conditions.

More recent studies have shown that if they don't have radiation combined with these new agents for ADT that ADT plus Surgery failed to consistently demonstrate any survival advantage in high-risk localized prostate ca. Also, if they used traditional ADT agents like Lupron – these have proven ineffective as neoadjuvant therapies. The agents need to be new ADT drugs or used in clinical trial and specified as a neoadjuvant agent.

NOTE: "A recurrence evaluation (or disease progression evaluation) should be considered when PSA has been confirmed to be increasing after radiation even if the increase above nadir is not yet 2 ng/mL, especially in candidates for salvage local therapy who are young and healthy." We have registrars that code treatment after chemically confirmed recurrence (rising PSA) as first course therapy – it is not – it is subsequent therapy – even if first course was 'active surveillance' – it is treated as "progression" according to NCCN Guidelines.

They continue to investigate novel more potent hormonal agents as an opportunity to eliminate the required radiation…but, today neoadjuvant ADT with new or novel hormonal agents with Radical Prostatectomy alone is not sufficient treatment to provide protection from recurrence/progression or to impact survival positively.

https://pubmed.ncbi.nlm.nih.gov/31977379/ - The Cancer Journal – Neoadjuvant Approaches Prior To Radical Prostatectomy - Jan/Feb 2020

https://pubmed.ncbi.nlm.nih.gov/32564752/ - Current Drug Targets - Neoadjuvant Strategies Before Radical

Prostatectomy for High Risk Prostate Cancer in the Era of New Hormonal Agents – 2020

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https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf - NCCN Guidelines Version 2.2020

This all said, many urologists, oncologists and radiation therapists continue to administer neoadjuvant therapies and refer to them as neoadjuvant – so, we should code them as such when stated.

However, there has always been the question about how long the ADT must be given to be considered neoadjuvant and now add to that which agents are used since ADT takes a while to work as systemic therapy or to downstage the primary. These would not be considered neoadjuvant for cases with metastatic disease.

"Neoadjuvant ADT before Radical Prostatectomy has a real, delayed, and persistent effect on disease-free survival, if and only if ADT is prolonged beyond 3 months." Therefore, ADT should be given for at least 3-6 months to qualify as neoadjuvant because it takes at least 3-6 months for systemic hormones to have an effect at shrinking tumor or downstaging in any significant degree.

https://pubmed.ncbi.nlm.nih.gov/11502453/ - Duration of Neoadjuvant Androgen Deprivation Therapy Before Radical Prostatectomy and Disease-Free Survival in Men with Prostate Cancer – Urology 2001

In the case example provided, the patient received ADT for a year prior to radical prostatectomy – however, if there was any sign of disease progression during that time (even chemical progression with rising PSA)…The ADT is not neoadjuvant and the prostatectomy is salvage subsequent surgery and not first course therapy.

There are still many issues with semantics of first course, subsequent coursre, recurrence and progression with prostate cancer – especially when the progression or recurrence is detected by rising PSA. This is a source of angst for many of us – and we don't have a perfect answer…much is still in clinical trials for ADT.

Help with Edit FL3025

Question:

We are having an issue with a case. It is not letting us pass an edit and when we reached out to CNEXT they gave the response below. Can you assist?

Answer:

When you assign primary site to an ill-defined site like Mouth, NOS (C06.9) or Colon, NOS (C18.9) or GYN, NOS (C57.9) – any of the NOS sites listed in the edit – or an unknown primary (C80.9) – you are not allowed to stage the case as localized. You must know the subsite to stage the case localized or the stage must be unknown (or perhaps distant) – those are you only 2 options when you do not know the subsite for these specific NOS (ill-defined) sites listed in the edit…or for all unknown primaries…If you know the stage is localized, you must know the subsite or how do you know it was localized.

The easiest ill-defined site code to explain is colon, NOS. How do you know with a large stretching site like colon with many defined subsites (transverse, ascending, hepatic/splenic flexure, descending, etc… if you code the site as colon, NOS – how do you know the stage would be localized if you don't know the location and the area of nodes that would have been needed to be examined and such. Same with Mouth, GYN, Bone, if you don't know which bone or what site in the GYN – you cannot code in-situ or localized disease.

This edit used to only be applied to unknown primary. However, in 2018 the ill-defined sites were added.

This is why I continue to reinforce the fact that FCDS doesn't want you to code NOS anything if you can help it. The NOS is just too vague to then turn around and be specific about stage or something as important. You need to be more specific in your site coding to be able to stage other than unknown.

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/naaccr_webinar.pl All webinars start at 9am.

Please go to the FCDS website to register online for your location of choice. Registration link is: https://fcds.med.miami.edu/scripts/naaccr_webinar.pl. A separate registration will be required for each webinar. The number of participants allowed to be registered for each webinar will be dependent on space availability. For more information, please contact Steve Peace at 305-243-4601 or speace@med.miami.edu.

DATE	TOPIC
*10/1/20	Prostate 2020
*11/5/20	Lung 2020
*12/3/20	Thyroid 2020
*1/7/21	Treatment 2021
2/4/21	Lymphoma 2021
3/4/21	Abstracting and Coding Boot Camp 2021
4/1/21	Larynx 2021
5/6/21	Pancreas 2021
6/12/21	Kidney 2021
7/8/21	Quality in CoC Accreditation
8/5/21	Breast 2021
9/2/21	Coding Pitsfalls 2021

NAACCR CANCER REGISTRY AND SURVEILLANCE WEBINAR SERIES

Seven Florida facilities will host the 2020-2021 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: 2019-100

CEU information for the 2020 FCDS Annual Conference:

CE Hours: 7.25
1.5 Hrs Category A

NCRA Recognition Number: 2020-090

Florida Cancer Data System
Cancer Reporting Completeness Report

TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF JANUARY 31, 2021

Total number of *New Cases* added to the FCDS Master file in January, 2021: **4,684**

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
2020	33,619	26	2	9,609	37	**Pending**	43,293	**2,620**
2019	202,519	2,136	166	11,622	11,836	**Pending**	228,279	**1,913**
2018	220,133	8,263	1,962	13,418	23,619	**2,364**	269,759	**151**

		Actual	Expected
% Complete for:	**2020**	**17%**	**58%**
	2019	91%	100%
	2018	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.

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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