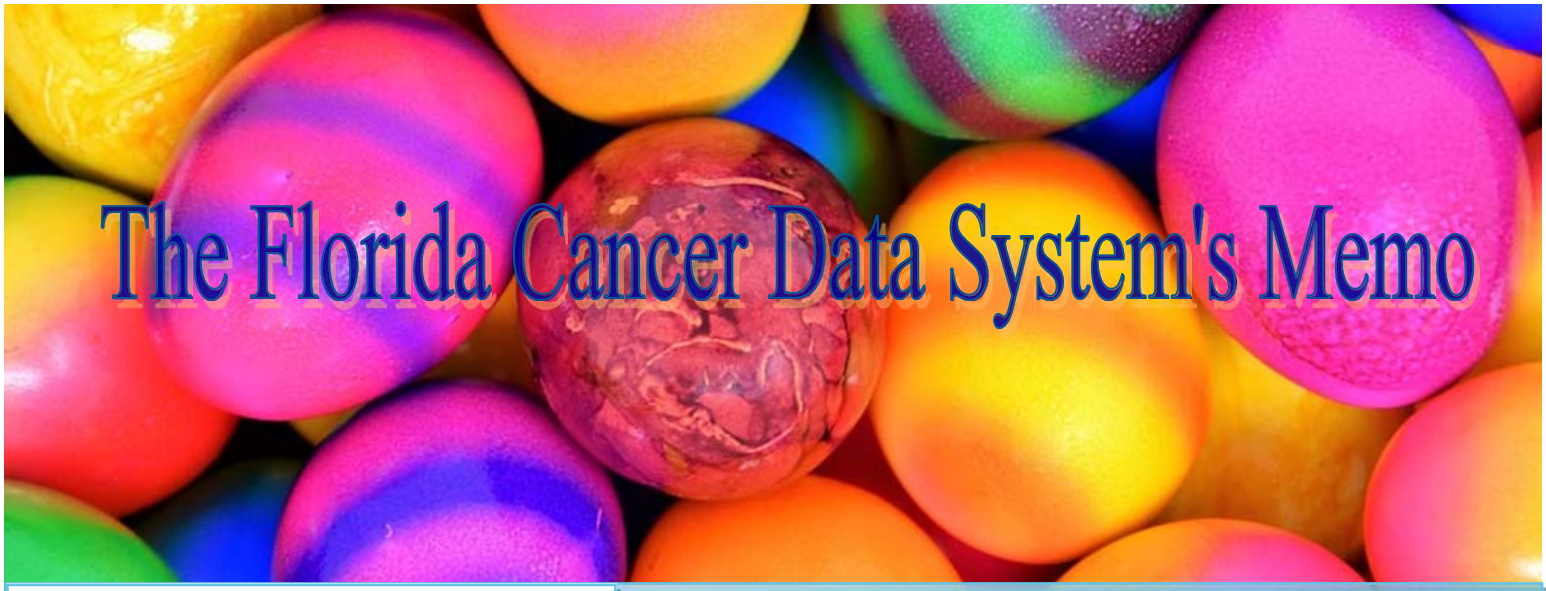


APRIL 2021

The National Cancer Act of 1971 - 50th Anniversary

Credit National Cancer Institute: "Commemorating and Making History: The National Cancer Act 50th Anniversary was originally published by the National Cancer Institute."

In 1971, the National Cancer Act was signed into legislation, changing the face of cancer research and care forever. The National Cancer Institute in coordination with World Cancer Day (February 4th) has been commemorating the 50th Anniversary of the National Cancer Act of 1971 since early February 2021.

The community's theme for this milestone is "Nothing will stop us." This theme is emblematic of the barriers we've overcome and the commitment to overcome those we will undoubtedly face in the future. I believe that it's particularly relevant right now, as we find the most effective and safest ways to continue our work in the midst of the COVID-19 pandemic.

Beginning today and throughout the year, NCI will join with partners across the cancer research and care community to share stories of struggle and discovery, pain and hope, and the challenges and opportunities that have marked the past 50 years. Importantly, we'll also be highlighting what lies ahead: the ongoing research that is offering so much hope for all those with cancer and their loved ones.

(Continued on page 2)

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—Pancreas 2021 5/6/2021.
***** 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

(Continued from page 1)

Updates on these commemoration activities will be posted on NCI's website.

NCI Director, Normal Sharpless, M.D. said; "The President and I stand with you. This is the fight of our lives, and we will never stop working to end this disease. And, together, I know that we're going to go farther than ever before."

National Cancer Act of 1971

Credit: National Cancer Institute

The National Cancer Institute was established in its current form by the National Cancer Act of 1971, signed into law by President Richard Nixon. This legislation was an amendment to the Public Health Service Act of 1944 and represented the US commitment to what President Nixon described as the "war on cancer," which had become the nation's second leading cause of death by 1970.

The act granted broad authority to the director of NCI to plan and develop a National Cancer Program that included NCI, other research institutes, and other federal and nonfederal programs. It established the procedure for submitting NCI's annual budget proposal, called the "professional judgement budget," which is transmitted directly from the NCI director to the President and Congress.

In addition to expanding the authority of the NCI director, the act required the creation of a new National Cancer Advisory Board (NCAB), a presidentially appointed committee of 18 members, to assist NCI in developing its programs. It also established the President's Cancer Panel (PCP), a three-member panel that submits an annual report on a special topic to the President and holds periodic public hearings.

With input from the NCAB, the NCI director may create new cancer centers and researcher and physician training programs, appoint advisory committees, award contracts for research, expand the physical location at NIH and other research facilities, conduct cancer control activities, establish an international cancer research data bank, award research grants, and collaborate with other federal, state, or local public agencies and private industry.

Finally, the act provided additional funding for NCI to establish 15 new cancer research centers, local control programs, and an international cancer research data bank.

Note: This is also when the NCI SEER Program was established to carry out epidemiology of cancer to inform the other new NCI Programs and support cancer research and cancer control efforts through a national sampled data collection effort – The Surveillance Epidemiology and End Results or NCI SEER Program.

(Continued on page 3)

Florida Cancer Data System
Deadlines, Updates, & Reminders

(Continued from page 2)

National Registries Amendment Act of 1992

Credit – Centers for Disease Control and Prevention/National Program of Cancer Registries

The CDC's National Program of Cancer Registries (CDC NPCR) was established in 1992 through a similar act passing congress. This act created the NPCR to collect data on cancer occurrence (including the type, extent, and location of the cancer), the type of initial treatment, and outcomes. FCDS joined the NPCR in 1995 and has been a member ever since.

Today, the CDC's NPCR and the NCI's SEER Program collect data for the entire United States population to include all 50 states, the District of Columbia and 3 United States Territories (Puerto Rico, U.S. Virgin Islands, and the U.S. Pacific Island Jurisdictions. The NPCR cancer registries collect and process more than 1.7 million new cancer cases every single year.

This national coverage enables researchers, clinicians, policy makers, public health professionals, and members of the public to monitor the burden of cancer, evaluate the successes of programs, and identify additional needs for cancer prevention and control efforts at national, state, and local levels.

Also today, the CDC in collaboration with NCI, NAACCR, and the American Society publish the 'Annual Report to the Nation on the Status of Cancer'. Each year highlights a special topic. This report goes to Congress for review every single year.

So, please join with NCI in celebration of the 50th Anniversary of the National Cancer Act of 1971...the act that got our enormous data collection, transmission, processing and publishing operations started and we now actively participate.

Thank you for all your efforts as Cancer Registrars, Cancer Registry Managers, Central Registry Staff and Researchers, and the Florida CCRAB to help us best monitor, manage and improve upon cancer treatment outcomes, cancer screening efforts, and enhanced our ability to address local community concerns of cancer clusters, and make data available to all.

Florida Cancer Data System
Deadlines, Updates, & Reminders

2021 CTR Exam
Deadlines and Testing Dates

March 5 - 27

Application Deadline Has Passed

June 18 - July 10

Application Deadline: June 4

October 15 - November 6

Application Deadline: October 1

RON DESANTIS
GOVERNOR

NATIONAL CANCER REGISTRARS WEEK IN FLORIDA

WHEREAS, Florida is committed to empowering its residents to reach their full potential and lead healthy lives; and

WHEREAS, cancer is one of the leading causes of death in Florida and the nation; and

WHEREAS, cancer registrars are health care professionals and data management experts that capture a complete history, diagnosis, treatment and health status for every cancer patient; and

WHEREAS, the data registrars collect provides essential information for cancer prevention and screening programs, treatment, research, and public health decisions; and

WHEREAS, cancer registrars play an important role in the fight against cancer, and Florida appreciates their hard work and service to our families, friends, and loved ones; and

WHEREAS, National Cancer Registrars Week in Florida is an important opportunity to recognize the significant role that cancer registrars play in our healthcare system.

NOW, THEREFORE, I, Ron DeSantis, Governor of the State of Florida, do hereby extend greetings and best wishes to all observing April 5-9, 2021, as *National Cancer Registrars Week in Florida*.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Florida to be affixed at Tallahassee, the Capital, this 5th day of April, in the year two thousand twenty-one.

Governor

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 717-9249

www.FLGov.com

New QC Review Report Available in IDEA

FCDS is happy to announce the addition of a new QC Report for hospitals. The report can be found under the QC Tab in IDEA. It is called the 'QC Review Report' or 'QC Facility Analysis' and is accessible to users with HOSPADMIN or FAA User Roles. We hope this new report will help to meet CoC Requirement 6.1.

The user can select the time period for the report. And, the report will display every single case that FCDS Visually Edited (QC Review – Every 25th Case) and the Result of that Review (See Below).

This report has been designed specifically to address CoC Cancer Program Requirement 6.1 by giving you a total of cases QC'd by FCDS in any given time period, the accession number and sequence of each case reviewed, and the outcome from each review including the Turnaround Time in Days with totals at the bottom of the report. The report is exportable to Excel or you can print it in PDF format.

You can only run the report for one facility at a time. So, if your program manages multiple facilities, you will need to run a separate report for each facility. We are starting this report one facility at a time.

FCDS has no plans to add the FCDS Abstractor Code to this report - ever. We want to keep this information at the facility level, not the individual abstractor level. Why? The QC Sample is not a large enough sample of any single person's work to be used in a performance evaluation. FCDS highly recommends that nobody tries to incorporate this report into any annual performance reviews. It would not be a fair assessment.

Accession	Receipt	Completed	Turnaround	Corrected	Forced	Deleted	No Changes
[redacted]	04/16/2020	08/10/2020	116	☑	☐	☐	☐
	12/30/2020	01/17/2021	18	☐	☐	☐	☑
	05/04/2020	07/01/2020	58	☐	☐	☐	☑
	01/20/2020	03/02/2020	42	☐	☐	☐	☑
	12/22/2020	01/13/2021	22	☐	☐	☐	☑
	12/14/2020	01/10/2021	27	☐	☐	☐	☑
	07/30/2020	10/02/2020	64	☐	☐	☐	☑
	08/27/2020	10/19/2020	53	☐	☐	☐	☑

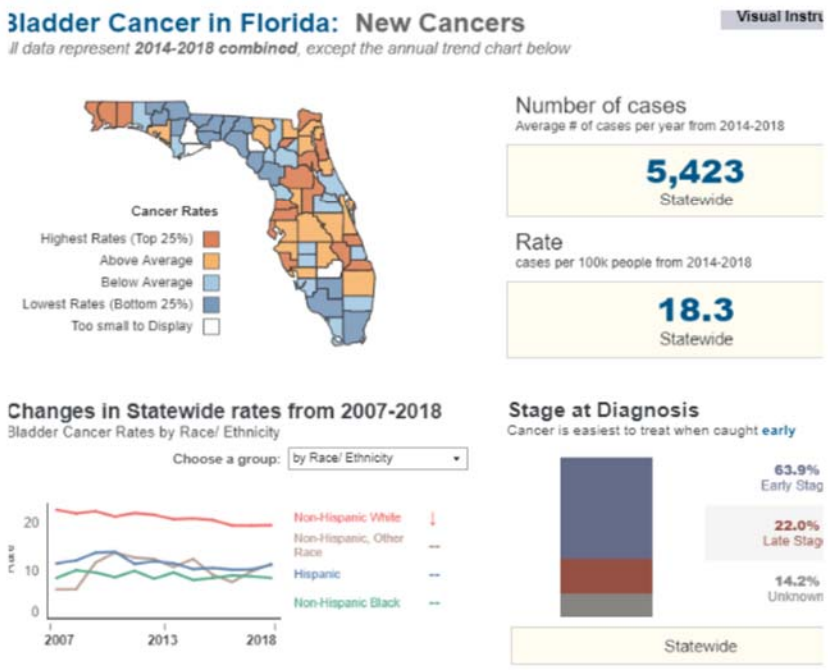
Florida Statewide Cancer Registry

Florida Cancer Data System

DATA VISUALIZATION DASHBOARD UPDATES!

2018 DATA NOW INCLUDED

Check out the latest addition to the dashboard which now includes 2018 cancer data



The Florida Cancer Data System - Statistics (miami.edu)

QC Visual Editing Feedback

Please document Summary Stage Criteria Text as Summary of all Staging done – not just the TNM. We have no official cross-walk to Summary Stage from TNM 7 or TNM 8. When we do visual editing, our editors need to be sure all the elements for SS staging are there to assign the correct SS code.

Dates, Tests, and Results should all be documented in their assigned area (imaging, operative report, pathology) but they should also be 'summarized' in the Staging Text Field. Including TNM helps – but, it is just a shortcut.

Without a direct crosswalk translation from TNM to SS or vice versa, FCDS reviewers need to be assured all elements are included without looking all over the abstract to restage the case…and that the criteria you documented fit into the SS criteria not just the TNM criteria as they are often different.

We still have far too many registrars that do not understand that most the time a T4 in TNM is actually a distant stage in Summary Stage (Distant by Direct Extension into adjacent organ) and most of the time N3 nodes are not regional nodes (Level I or Level II) but rather distant stage nodes sin Summary Stage (Distant by Distant Lymph Nodes) – but not always – and that is why you must check the books…for what SS will classify as direct extension and distant nodes – and not just TNM.

N3 nodes are almost never regional nodes but rather distant 2nd level or 3rd level drainage nodes and this makes them distant not regional. It is a very common error when staging. It is also fairly common for registrars to code these distant N3 nodes as regional nodes examined or regional nodes positive or regional node dissection – but, they are not regional nodes – they are distant nodes.

FCDS depends on all of the correct information and hopes to find this information summarized in the correct text field – and please do not forget this really important text item – FCDS never-ever gets your "text pad" nodes – they don't have a designated field to place them. So, whatever you write in text pad FCDS never even has a chance to see…so, please don't assume we get all that text you enter…we do not.

FCDS relies so heavily on text these days. Our audits are based on them from CDC, from DOH, from FCDS. We rely on the text much more than ever before. So, we are trying to help you to help us get it right. In our latest CDC/NPCR Audit this was one of our biggest errors besides 'unknown' and 'NOS' was 'no text'.

Yes, FCDS has become a bit more strict on text requirements over the years and will continue to do so. It is just the way it works these days. We must have documentation for all primary/key/critical coded data items. And, we must have all documentation for the SSDI data as well…and histology…and dates…all of it.

We appreciate you taking time to attend to these issues – it really should take almost no additional time out of your abstracting time to add these items – but, it saves FCDS hours of back and forth if we get the text the first time you submit your abstract and don't have to ask for it – sometimes repeatedly.

Explanation of T3, T4 - local, regional or distant Summary Stage

FCDS has seen a wide and growing variation in how registrars interpret colon and rectum cancers with invasion of or through the colon/rectal wall. This can be a bit tricky when you look at which parts of the colon have 'peritonealized' surfaces (they are slightly embedded in the peritoneal wall), and which sites do not sit close enough to the peritoneal wall to be treated as a portion of colon with 'peritonealized' surfaces.

This can make a big difference when you translate the 'T' in TNM into 'localized' or 'regional by direct extension' in SEER Summary Stage. The difference between a T3 and a T4 is not just the difference between regional by direct extension and localized disease...but, also the difference between localized and distant disease in rare instances.

The phrases; 'thru the wall,' 'thru the muscularis', 'thru the muscularis propria', and 'into adjacent fat or connective tissue' (which includes pericolic and perirectal fat) can certainly add to that confusion. Some of these neoplasms are T3 lesions and some are T4 lesions...and some are localized, some regional and some distant in SS2018. The degree of extension also makes a difference in treatment options as well as patient outcomes.

T3 Tumors invade through the muscularis propria into pericolorectal tissues but not the pericolic fat. T3 Tumors can be localized or can be regional by direct extension...it is important to distinguish the tumors that just extend thru the muscularis propria from those that extend into pericolorectal tissues such as fat or adventitia. Tumors that invade into the pericolic fat, non-peritonealized tissues invaded are always regional by direct extension but still may be coded as T3 tumors.

T4 Tumors invade beyond the colon's visceral peritoneum and/or invade into adjacent organs or structures. These tumors can be either regional by direct extension or distant by direct extension. Tumors invading only into adjacent tissues and fat completely outside the colon wall are regional by direct extension. But, when the pericolic tissues invaded includes peritonealized surfaces or the peritoneal wall...they have already extended through 2 layers of pleura – the visceral pleural around the colon and the parietal pleura that lines the inside of the peritoneum. So, many T4 lesions are actually staged as distant by direct extension when they extend beyond the fat or the peritonealized pericolic tissue or into adjacent organs.

So, when the peritoneum is involved by direct extension – the neoplasm is not localized. These lesions may not even be regional by direct extension. Some of them are distant stage by direct extension.

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So, you have to review each case you abstract to be sure you are 'translating' the T3 or T4 tumor extension correctly from TNM to SS2021 and do not translate all T3 tumors into 'localized' without taking into account peritonealized segments of the colon. Many of the terms and anatomy sound the same...but, are different when you read closely.

Older crosswalks for TNM to Summary Stage classified nearly all T3 tumors as regional by direct extension because most of these tumors extent into pericolorectal tissues such as fat or adventitia and most of the colon does not have peritonealized surfaces (except at the hepatic and splenic flexures – primarily).

These same older crosswalks find most T4 tumors in the distant by direct extension stage group. However, some of these may be staged regional by direct extension – depending on the level of invasion and the location of the tumor in the colon. Again, this is based on involvement of peritoneal surface or wall or if the tumor has only penetrated the organ (visceral) pleura...or if there is no peritonealized surface to consider.

I hope this helps folks understand the difference between assigning local, regional or distant disease for colon and rectal cancers – especially if you are trying to compare the T value in TNM to come up with your answer. It depends...is the answer. So, please document these cases well...not all T3 are the same, not all T4 are the same...and not everybody easily remembers where the peritonealized parts of the colon are and where they are not.

The Serosal Surface of Colon/Rectum is the same basic anatomical structure and function and is referred to as the Visceral Peritoneum – it is the outermost and final layer of the layers of the colon/rectum wall that holds the colon wall together – usually this is the serosal layer. However, only the upper and lower rectum have a serosa – so, it has no serosal layer equivalent. Tumors poking through the wall at this level of invasion (involves up to and including the serosal layer of the wall with invasion into the subserosal fat and/or the subserosal tissue for all parts of the colon and peritonealized portions of the rectum) – and these are still localized cancers. Cancers that spread beyond this level are regional by direct extension. Both can be assigned T3 by your pathologist...so, this gets very confusing. (Reference: Non-peritonealized pericolic/perirectal tissues invaded [Ascending Colon/Descending Colon/ Hepatic Flexure/Splenic Flexure: Posterior surface; Middle third of rectum: Anterior surface; Lower third of rectum]).

The Peritonealized pericolic/perirectal tissues level of invasion jumps the level of invasion up to at least regional. Peritonealized areas of the colon include;

[Ascending Colon/Descending Colon/Hepatic Flexure/Splenic Flexure: anterior and lateral surfaces; Cecum; Sigmoid Colon; Transverse Colon; Rectosigmoid; Rectum: middle third anterior surface]. So invasion thru the wall into adjacent pericolic/perirectal fat in these areas are coded as regional by direct extension or distant in Summary Stage. Most pathologists only use the T4 category code for TNM when adjacent organs are involved. That is not actually the whole truth. There are other instances of T4 category code that is less invasive.

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Invasion up to and adjacent to other organs and structures are usually localized or regional.

Invasion into adjacent organs and structures is either regional disease or distant disease.

You have to code these and assign the proper summary stage and it can certainly be tricky.

Always reference your AJCC TNM Manual for TNM Questions. And, always reference the latest SEER Summary Stage Manual for SS2021 Questions starting 1/1/2021 or earlier versions of this manual.

Source: SUMMARY STAGE 2018 CODING MANUAL – Colon and Rectum Chapter – Note 6

Note 6: Invasion into "pericolonic/pericolorectal tissue" can be either Localized or Regional, depending on the primary site. Some sites are entirely peritonealized; some sites are only partially peritonealized or have no peritoneum. Localized may not be used for sites that are entirely peritonealized (cecum, transverse colon, sigmoid colon, rectosigmoid colon, upper third of rectum).

- Localized
  - Invasion through muscularis propria or muscularis, NOS
  - Non-peritonealized pericolic/perirectal tissues invaded [Ascending Colon/Descending Colon/Hepatic Flexure/Splenic Flexure/Upper two thirds of rectum: Posterior surface; Lower third of rectum]
  - Subserosal tissue/(sub)serosal fat invaded
- Regional
  - Mesentery
  - Peritonealized pericolic/perirectal tissues invaded [Ascending Colon/Descending Colon/Hepatic Flexure/Splenic Flexure/Upper third of rectum: anterior and lateral surfaces; Cecum; Sigmoid Colon; Transverse Colon; Rectosigmoid; Rectum: middle third anterior surface]
  - Pericolic/Perirectal fat
- If the pathologist does not further describe the "pericolic/perirectal tissues" as either "non-peritonealized pericolic/perirectal tissues" vs "peritonealized pericolic/perirectal tissues" fat and the gross description does not describe the tumor relation to the serosa/peritoneal surface, and it cannot be determined whether the tumor arises in a peritonealized portion of the colon, code Localized.

2020/2021 Treatment Delays Due to Covid-19

FCDS has begun to receive more and more 2020 cases for processing recently. We have noticed new patterns of care related to Covid-19 that we felt the need to share with our registrars abstracting cases. Don't be surprised if you are getting more than the usual edit failures for the 240/365 days between Date of Diagnosis and Date of First Course Therapy coded – there are a variety of reasons, many Covid-19 related.

Specifically relating to Dates of Diagnosis and Dates of Treatment, we are noticing:

1) More cases with advanced disease at first presentation – delays in screening & diagnosis;

2) More cases with delays in treatment between Date of DX in early 2020 and Treatment starting in late 2020 greater than 240 days or greater than 365 days for breast/prostate – some with neoadjuvant XRT, chemo, BRM – but, some with regular planned standard treatments delayed due to Covid-19 stay-at-home or fear of Covid-19 exposure but not always documented; and

3) Treatment interruptions after Covid-19 started and folks interrupted their cancer therapy deciding not to go to the hospital or unable to go to doctor, and to stay home until safer to go to hospital/doctor office for care.

This combination of Covid-19 related treatment issues is creating more cases that we need to carefully review dx date, treatment dates, neoadjuvant tx, standard treatment being delayed, etc. And, not all of these issues are particularly well documented in the abstracts we have been receiving. Registrars are documenting whether or not patients have had Covid-19 testing or Covid-19 illness...but, not delays, etc.

If you have information about screening, diagnosis or treatment delays or interruptions, please document them in your text so we understand why the delay. FCDS will review the case and will be Forcing more cases with treatment going out beyond our 240 day and 365 day treatment edit that is Florida specific.

We expect treatment to extend beyond 240/365 days after diagnosis for cases receiving neoadjuvant treatment like rectum, breast, and other cancers that routinely get pre-surgical XRT, chemo, BRM. But, we now are seeing patterns of delays in standard care during these Covid-19 Months/Years for 2020 and 2021.

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Some of the delays are documented as Covid-19 related. Some of the cases have documented Covid-19 testing. Many cases have negative Covid-19 tests – but, have delays in treatment due to Covid-19 fears, etc.

SO, we need to take special care to review these cases. FCDS will be forcing more cases for the treatment delays based on our standard of 240/365 days from dx date to treatment date...but, these are still first course of planned therapy. And, we need to take care in assessing stage at dx versus stage at treatment because for some cases they may have had disease progression during their treatment delay.

We don't have any direction from standard setters on how to assess these diagnosis, treatment delays and treatment interruptions in terms of what constitutes first course of therapy during the Covid months/years.

FCDS suggests we treat them as first course therapy and take special notice of the neoadjuvant cases.

We just wanted to give you a heads up since we are seeing all of these situations occurring with greater frequency when processing Corrections and QC Reviews...and sometimes the documentation of the delay is in the abstract and sometimes it is not.

So, please exercise caution when assessing first course of treatment starting in early 2020 and continuing to the present day. And, please note that we are still experiencing all of these delay/interruption situations in patient care for everything from cancer to heart disease to strokes and more...people are waiting for cancer screenings...and patients are coming in with more disease than usual...and treatments are a bit goofy.

Surgery Code

Questions:

Bladder case underwent TURBT (pathology specimen) electrocautery per the surgeon was performed for the purpose of hemostasis. He never said it was for tumor destruction/treatment. Surgery was coded to 27. There is debate whether this should be coded as a 22.

Answer:

BLADDER Surgery of Primary Site Codes – Clarification

Any local tumor excision of the bladder is included in the 20-27 Surgery of Primary Site Codes. However, registrars tend to not always know or understand how to used the 21-25 codes as a subset of codes 20, 26, and 27. Surgery codes 21-25 are a subset that includes the method for how they treated the area after the excised the tumor. Did they used photodynamic therapy to treat the tumor bed or was is electrocautery. Did they use cryosurgery or laser ablation to stop the bleeding and treat the tumor bed? This is usually found in the operative report – and registrars often forget to read the actual operative report. Code 25 is a special code that is used to code when the tumor was removed and closed with laser – laser excision.

I hope this helps clear up the difference...all codes are TURP with specimen that goes to pathology. But, the codes 21-25 are more specific than the codes 26 or 27...and the code 20 is the least specific of all of the others. So, if you read the operative report – you should be able to find if they used cautery, laser, or another method to treat the tumor bed. And, the special code 25 is used when only laser was used for both.

No specimen sent to pathology from surgical events 10–16

20 Local tumor excision, NOS
26 Polypectomy
27 Excisional biopsy
[*NOTE:* Code TURB as 27]

Combination of 20 or 26–27 WITH
21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
[*NOTE:* Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation]
25 Laser excision

Specimen sent to pathology from surgical events 20–27.

Thymoma Clarification

Question:

I just wanted clarification on the thymomas.

In FCDS DAM, it states All Thymoma Cases Diagnosed 1/1/2018 and later are Reportable as "malignant thymoma"

I am doing a quality review and wanted to be 100% sure before I send the cases back to the CTR's to fix.

Answer:

Are All Thymoma Cases Reportable to FCDS?

FCDS adopted the full ICD-O-3.2 a little earlier than most states. The 2021 updates are when all thymoma cases are technically designated 'malignant' and 'reportable'...but, we asked for them starting in 2018. If you submit a case diagnosed 2018-2020 and it fails edits...FCDS will override the edit (FORCE the case).

ICDO3.2	Histology	Behavior	Level	Term	Code Reference	obs
8580/3	8580	3	Preferred	Thymoma, NOS	(C37.9)	
8580/3	8580	3	Related	Intrapulmonary thymoma	(C34._)	
8580/3	8580	3	Related	Sclerosing thymoma	(C34._)	
8580/3	8580	3	Related	Metaplastic thymoma	(C37.9)	
8581/3	8581	3	Preferred	Thymoma, type A	(C37.9)	
8581/3	8581	3	Synonym	Thymoma, medullary	(C37.9)	[obs]
8581/3	8581	3	Synonym	Thymoma, spindle cell	(C37.9)	[obs]
8582/3	8582	3	Preferred	Thymoma, type AB	(C37.9)	
8582/3	8582	3	Synonym	Thymoma, mixed type	(C37.9)	

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	8583/3	8583	3	Preferred	Thymoma, type B1	(C37.9)	
	8583/3	8583	3	Synonym	Thymoma, lymphocyte-rich	(C37.9)	[obs]
	8583/3	8583	3	Synonym	Thymoma, lymphocytic	(C37.9)	[obs]
	8583/3	8583	3	Synonym	Thymoma, organoid	(C37.9)	[obs]
	8583/3	8583	3	Synonym	Thymoma, predominantly cortical	(C37.9)	[obs]
	8584/3	8584	3	Preferred	Thymoma, type B2	(C37.9)	
	8584/3	8584	3	Synonym	Thymoma, cortical	(C37.9)	[obs]
	8585/3	8585	3	Preferred	Thymoma, type B3	(C37.9)	
	8585/3	8585	3	Synonym	Thymoma, atypical	(C37.9)	[obs]
	8585/3	8585	3	Synonym	Thymoma, epithelial	(C37.9)	[obs]

Abstracting GYN

Question:

I have an interesting GYN case that I have no idea how I should abstract the case, hoping you can instruct me on what to do.

Female presents with large pelvic mass on imaging and elevated CA125 of 115 at dx

Gyn onc takes patient to surgery Diagnostic laparoscopy removal of the right tube and ovary, infracolic omentectomy, posterior cul-de-sac stripping, posterior cul-de-sac biopsies, pelvic peritoneal biopsies

(Continued on page 17)

(Continued from page 16)

pathology reveals

LEFT OVARY AND TUBE, SALPINGO-OOPHORECTOMY:

OVARY:
• ENDOMETRIOID ADENOCARCINOMA, FIGO GRADE 2.
• CARCINOMA MEASURES 13.5 CM IN GREATEST DIMENSION (GROSSLY).
• NO LYMPHOVASCULAR INVASION IDENTIFIED.
BACKGROUND SEROUS CYSTADENOFIBROMA WITH INVOLVEMENT BY ENDOMETRIOID ADENOCARCINOMA AND ENDOMETRIOSIS.

***all other bxs negative for tumor

Patient goes back to surgery for Exploratory laparotomy, total abdominal hysterectomy, right salpingo-oophorectomy, pelvic peritoneal washings, left internal iliac lymphadenectomy, left obturator node lymphadenectomy, left periaortic lymphadenectomy, right external iliac, obturator, and periaortic lymphadenectomies, left pelvic peritoneal stripping, and removal of small mesenteric nodule

pathology reveals

UTERUS, RIGHT TUBE AND OVARY, HYSTERECTOMY / SALPINGO-OOPHORECTOMY:
• FOCAL ENDOMETRIOID ADENOCARCINOMA OF ENDOMETRIUM, FIGO GRADE 1.
• TUMOR MEASURES 7.0 MM IN GREATEST MICROSCOPIC MEASUREMENT.
• TUMOR CONFINED TO ENDOMETRIUM WITH NO MYOMETRIAL INVASION.
• NO LYMPHOVASCULAR INVASION IDENTIFIED.
• ADENOMYOSIS.
• CHRONIC CYSTIC CERVICITIS.
• HEMORRHAGIC SEROSAL ADHESIONS.
OVARY WITH CORPUS LUTEAL CYST, CYSTIC FOLLICLES, ENDOMETRIOSIS AND HEMORRHAGIC SEROSAL ADHESIONS.
•
• UNREMARKABLE FALLOPIAN TUBE.

***all lymph nodes and all other bxs are negative for tumor

GYN ONC fu note

This is a patient now status post laparotomy for Staging of what was initially thought to be a primary ovarian cancer, but was also present in the endometrium. This is either a stage II ovarian cancer or stage III endometrial cancer versus dual primaries and, regardless will be treated with 6 cycles of carboplatin and Taxol chemotherapy.

(Continued on page 18)

(Continued from page 17)

I think I should do an endometrial primary based on initial path saying BACKGROUND SEROUS CYSTADENOFIBROMA WITH INVOLVEMENT BY ENDOMETRIOID ADENOCARCINOMA AND ENDOMETRIOSIS???

But not sure what to do because the specialist GYN ONC did not make the call.

Because the GYN sites fall into the other solid tumor rules there is not much direction.

What should I abstract this as??

Answer:

We are expecting GYN Solid Tumor Rules later this year...but, we have no idea what will be included or overlooked in the first edition of these rules. But, this case we can figure out okay.

Since the patient has this widespread endometriosis – this is how the endometrial tissue that normally lines the endometrium got outside the uterus to involve the ovaries, fallopian tubes, pelvis, etc. What throws things off is the elevated CA-125. But, the origin of all endometrioid adenocarcinoma is endometrial cells.

That said, primary ovarian endometrioid adenocarcinoma is as common as endometrial endometrioid adenocarcinoma. Since the tumor on the ovary is so large and a higher grade...and the CA-125 is elevated...I would abstract this case as a primary ovarian cancer – but, it is really hard to say with certainty since all of these cancers actually start with endometrial cells that escape the uterus – endometriosis.

CA-125 is often elevated in women with moderate to severe endometriosis...which often involves ovaries.

Endometrioid adenocarcinoma is actually much more aggressive than either serous or clear cell carcinoma – so, it spreads rapidly and is normally treated aggressively – no matter the stage at diagnosis. We have cases with primary in ovary and endometrium – and we used to classify them all as ovarian. So, the understanding of these cancers has changed over time and the way we look at them definitely has changed.

I hope this helps...and makes sense. We can see similar patterns with pancreatic tissue that grows outside the pancreas called ectopic pancreas. In those cases we make them all pancreatic cancers. So, the rules and instructions are lacking and people abstract these cases differently depending on how described or not described by surgeon, pathologist, GYN, and oncologist – there is not agreement on what primary to assign.

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 MARCH 31, 2021

Total number of *New Cases* added to the FCDS Master file in March, 2021: 18,092

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	71,940	311	2	10,932	78	**Pending**	83,263	**13,831**
2019	215,413	3,605	166	11,816	15,061	**Pending**	246,061	**3,368**
2018	221,092	8,861	2,124	13,530	24,125	**2,348**	272,080	**893**

		Actual	Expected
% Complete for:	**2020**	**33%**	**75%**
	2019	98%	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.

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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