

The Florida Cancer Data System's Memo

OCTOBER 2021



WHO Histology Codes 8085/8086 and AJCC TNM Chapters 10 & 11 – p16+/p16- Head & Neck Cancers

FCDS continues to receive LOTS of questions from registrars who are confused over when they can and cannot use histology codes 8085/8086 for HPV+ and HPV- squamous cell carcinoma; and, why they cannot assign TNM for some p16+/p16- squamous cell carcinoma cases they feel should be included in the AJCC Cancer Staging Manual Chapters 10 or 11. The standards for histology and staging are in conflict with understanding of HPV and the cancer sites where HPV-related cancers are known to arise.

The main point of order here is that WHO and SEER use one standard for Histology Coding and AJCC uses a different less inclusive standard for AJCC TNM Staging for p16+ and p16- head and neck cancers.

The two standards serve different purposes and for now are at odds with our understanding of HPV as a virus and p16 testing references in the AJCC Staging Manual, in pathology reports or in the medical record for both head and neck and non-head and neck cancers with evidence of cancers of HPV origin.

p16 is described as a surrogate marker for HPV. But it is a specific immunohistochemistry protein test that is primarily used for risk stratification, TNM, and treatment planning in oropharyngeal cancers.

The p16 test is also used for many HPV-associated anogenital squamous cell cancers. And, there is a new SSDI to document p16 for cervical cancers that will be implemented in 2022 to document p16. But, this SSDI will not be used to document p16 for head and neck cancers. Instead, AJCC uses the Schema Discriminators to identify p16+/p16- for TNM Staging of oral cavity/oropharyngeal cancers and will not be using the new p16 SSDI for head and neck cancers...or for any other anogenital cancers.

(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
EDIT's Metafile
V21 Metafile,
posted on 8/26/2021**

**FCDS/NAACCR
WEBINAR SERIES:
NAACCR 2021-2022
Cancer Registry and Surveillance Webi-
nar Series - Uterus 2021 10/7/2021.
*** 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 *****

FCDS Florida Cancer Data System

**Florida Statewide Cancer
Registry**



Florida Cancer Data System Deadlines, Updates, & Reminders

(Continued from page 1)

The only 4 histology codes AJCC ‘allows’ for staging in Chapter 10 (p16+ Oropharynx) are; 8070, 8072, 8083 and 8085. The primary sites allowed to be staged in Chapter 10 are restricted, also. They include; C01.9, C02.4, C05.1, C05.2, C09.0, C09.1, C09.8, C09.9, C10.0, C10.2, C10.3, C10.8, C10.9 and C11.1.

WHO introduced 2 new HPV Histology Codes a few years back for a very different purpose. And, the WHO indications for histology coding and their use in AJCC TNM Schema ID Tables differ. WHO has a much broader and inclusive indication for using histology codes 8085/8086 than does the AJCC. WHO includes other common anatomic sites for HPV cancers include vagina, vulva, uterine cervix, and anus.

AJCC wants registrars to use histology codes 8085/8086 only for specific oral and oropharynx sites. But wants registrars to use code 8070 for other HPV-related squamous cell carcinoma in any other anatomic sites – even if HPV is documented as ‘present’ in the specimen. This instruction by AJCC is contrary to the original purpose behind creating the codes 8085/8086 according to the World Health Organization (WHO).

WHO creates ALL ICD-O Histology Codes and is used worldwide. WHO created the histology codes 8085/8086 to monitor HPV-associated cancers throughout the world for cancer surveillance and cancer control monitoring purposes – not for UICC or AJCC TNM Staging purposes. So, the codes are being used by the AJCC for a very different purpose than the WHO intended them to be used when they created them...a more restricted purpose. WHO recognizes that HPV-positive squamous cell carcinoma may arise in multiple anatomic sites as noted in the current SEER Site/Histology Validation Table.

FCDS contacted SEER for clarification on this topic on 9/9/2021. SEER has historically followed the WHO Standard for using and assigning all histology codes and continues to use WHO as the primary source for site and histology coding. WHO is responsible for creating the histology codes we use everyday. AJCC is responsible for AJCC TNM Staging. SEER plans to follow-up with WHO, CAP, and AJCC regarding the current conflicts over the classification, coding and staging of HPV-related squamous cell carcinoma.

The 5th edition WHO Classification for GYN Tumors was only recently published which brought many of these issues to light. The 5th edition WHO Classification for Neoplasms of the Male Genital System and Neoplasms of the Head and Neck are expected in 2022. SEER will also follow-up with WHO on already published 5th edition Classification of Tumors of GI Tract to verify anal and rectal sites of involvement.

FCDS will allow the use of histology codes 8085 and 8086 in other sites that may not be in the SEER Site/Histology Validation List or in the AJCC TNM Staging Manual for HPV-associated cancers when a pathologist makes reference to HPV status or p16 testing on a pathology report or by a clinician in the medical record. We ask registrars to clearly document any specific references and test results in your text documentation. FCDS will track all anatomic sites where HPV-association is documented in pathology or any other medical record reports. This is what cancer surveillance programs do.

BACKGROUND

HPV infection is the most common sexually transmitted infection in the world with millions of infections occurring every year. Most infections occur among people in their late teens and early 20s. There are many types of HPV infection that cause a variety of clinical diseases from genital warts to cancer. In most cases of HPV, the HPV goes away on its own and does not cause health problems. But when HPV persists and becomes a chronic infection it can cause other health problems – genital warts to cancer. And, in some instances an infected person may not exhibit any symptoms until years after infection.

(Continued on page 3)



Florida Cancer Data System Deadlines, Updates, & Reminders

(Continued from page 2)

HPV DNA is found in many anatomic sites from the oral cavity to the anogenital tract. There are more than 100 known types of HPV found around the world. Some cause neoplasia and malignancy and some do not. That said, several strains or types of HPV have been proven to be active in causing both non-invasive neoplasia and invasive malignancy in numerous anatomic locations in both women and men.

DNA assays that test for high-risk HPV will check for more types of high-risk HPV than just HPV16 and HPV18. Other high-risk HPV Types included in a typical GYN PAP or Non-GYN PAP for HPV DNA include testing for E6/E7 viral messenger RNA (Mrna) from 14 high-risk HPV Types (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68). So, the HPV DNA test is more inclusive of multiple types of HPV than a p16 test.

p16 (INK4a/CDKN2A) is a cell cycle regulatory protein that is overexpressed in anogenital, oral cavity and oropharynx dysplasia and neoplasia related to human papilloma virus (HPV) infection. However, p16 testing is not a direct test of HPV DNA or RNA, nor is it used to test for any specific type of HPV.

But, the expression of p16 is highly correlated with HPV infection (particularly HPV16) of the anogenital region head and neck region for squamous cell carcinoma, pre-malignant lesions and dysplastic lesions.

While p16-positivity is highly-correlated with HPV infection of these anatomic sites, p16-positivity is not just limited to HPV-positive tumors. Therefore, it is 'not a perfect surrogate for HPV infection'.

So, p16 is used as an 'indirect marker of HPV-induced squamous cell carcinoma' of these areas. But the use of p16 testing alone to describe or identify HPV infection is still somewhat controversial.

The prognostic significance of p16-positivity is one area of debate as is the utility of testing. Some studies describe p16 protein detection as a 'useful marker of HPV, particularly HPV Type 16'. Other studies directly state that 'p16 immunohistochemistry testing accurately identifies HPV-positive oropharyngeal squamous cell carcinoma and squamous cell carcinoma of the anogenital region.'

Newer terminology makes the diagnosis even 'fuzzier' as pathologists now may refer to these lesions and neoplasms as HPV-mediated, p16-positive tumors/lesions. This makes it even more difficult for registrars to know whether or not to use histology codes 8085/8086 when p16 is positive or negative or when DNA Testing for HPV is done or not done or HPV testing is not documented in the medical record.

So, there continues to be an argument as to whether p16 is a sufficient surrogate for HPV positivity to consistently identify HPV-positive squamous cell carcinoma of the head and neck and of anogenital sites.

(Continued on page 4)



Florida Cancer Data System Deadlines, Updates, & Reminders

Continued from page 3)

Currently, the SEER Site/Histology Validation Table allows the following site/histology combinations:

SITE RECODE	HISTOLOGY/ BEH	HISTOLOGY/BEHAVIOR DESCRIPTION
C019	8085/3	Squamous cell carcinoma, HPV-positive
C019	8086/3	Squamous cell carcinoma, HPV-negative
C090-C091, C098-C104, C108-C109	8085/3	Squamous cell carcinoma, HPV-positive
C090-C091, C098-C104, C108-C109	8086/3	Squamous cell carcinoma, HPV-negative
C111	8085/3	Squamous cell carcinoma, HPV-positive
C111	8086/3	Squamous cell carcinoma, HPV-negative
C310-C313, C318	8085/3	Squamous cell carcinoma, HPV-positive
C310-C313, C318	8086/3	Squamous cell carcinoma, HPV-negative
C319	8085/3	Squamous cell carcinoma, HPV-positive
C319	8086/3	Squamous cell carcinoma, HPV-negative
C510-C512, C518, C529	8085/3	Squamous cell carcinoma, HPV-positive
C510-C512, C518, C529	8086/3	Squamous cell carcinoma, HPV-negative
C519	8085/3	Squamous cell carcinoma, HPV-positive
C519	8086/3	Squamous cell carcinoma, HPV-negative
C530-C531, C538-C539	8085/3	Squamous cell carcinoma, HPV-positive
C530-C531, C538-C539	8086/3	Squamous cell carcinoma, HPV-negative



Florida Cancer Data System Deadlines, Updates, & Reminders



2019 FCDS Consolidated Follow-Back and Submission of ALL 2020 Cases

FCDS completed the matching of the 2019 In-Patient and Out-Patient Discharges reported by Florida reporting hospitals' and ambulatory surgery centers' Finance-Billing/Medical Records Department to the Agency for Health Care Administration (AHCA). All records with principal or secondary diagnosis of cancer were linked to the FCDS database. A match was also completed of the Florida Vital Statistics Death Certificate files for 2019. All non-matching records have been placed in IDEA for review.

Any case found to meet the FCDS Cancer Case Reporting Requirements outlined in Section I of the FCDS DAM and found to not have been previously reported must be reported to FCDS, immediately.

These are considered missed 2019 cases.

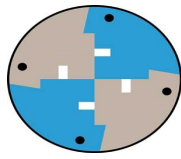
The DEADLINE to complete the review and to submit ALL missed 2019 cases is October 15, 2021.

FCDS recognizes that many vendors are just now getting XML Data Transmissions out to their users.

PLEASE SEND ALL FINAL 2019 & 2020 CASES AS SOON AS YOUR DATA TRANSMISSION IS FUNCTIONAL.

FCDS REMINDS all registrars and managers that you MUST ABSTRACT AND SUBMIT ALL 2020 CASES AND SIGN YOUR CERTIFICATE OF COMPLETENESS FOR 2020 BEFORE YOU SUBMIT ANY 2021 CASES.

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



2021 Virtual FCDS ANNUAL CONFERENCE

RECORDINGS POSTED

All 4 two-hour Sessions of the 2021 Virtual FCDS Annual Conference have been recorded and posted to the FCDS Education and Training Page @ <https://fcds.med.miami.edu/inc/educationtraining.shtml>.

Anybody can view any of the session recordings at your leisure 24/7. Complementary PDF versions of every slide deck are also posted for reference or future use.

There is also an FCDS CEU Certificate of Attendance posted on the website to track your attendance and any earned CEUs from either the 'live' session(s) or the recorded session(s). A total of 7.5 CEUs (4 Category A CEUs) were granted by NCRA. Self-Completion of CEU Attendance Forms are based on the 'Honor System'. Complete your form and save your personal copy just in case you are audited by NCRA.

Below is a copy of the Agenda by Session for easy reference to each session topics for recorded viewing.

Thank you for outstanding attendance at this year's 2021 Virtual FCDS Annual Conference. We had between 275 and 300 viewers for each of the 'live' sessions...and more will attend recorded sessions.

Session	Date/Time	Topic / Speaker – 1 or More Topic/Speaker in each 2-hour block
FCDS Session -1	8/12/2021 1pm-3pm	Introduction to the 2021 Virtual Webinar Series by FCDS
		Explain CEUs for this year – blank certificate that you fill in yourself
		DOH and FCDS Updates – State of the State
		Resumption of Cancer Screenings
		Florida Breast and Cervical Cancer Screening Pilot Project: Update
		FCDS Data Visualization Dashboards
		FCDS DREAMS and Planning Special Data Requests
FCDS Session- 2	8/19/2021 1pm-3pm	2019-2020 Data Acquisition Summary
		2020 FCDS QC Activities
		2021 CDC/NPCR Data Quality Evaluation of FCDS & Florida - Summary
		That Thing You Do (or Don't Do) – Florida Visual Editing by NPCR & FCDS
		2021-2022 FCDS Education and Training Plan
		2021 FCDS Cancer Reporting Requirements
		FCRA/FCDS Task Force Update
		Annual FCDS Jean Byers and Pat Strait Awards
FCDS Session -3	8/26/2021 1pm-3pm	2021 FCDS DAM – A Grand Tour – Where to Find What You Need
		Using the SEER*RSA for Staging/SSDIs and Other SEER Website Features
FCDS Session -4	9/02/2021 1pm-3pm	Manual Updates - ICD-O / Solid Tumor Rules / Grade / SSDIs / SS2018 / etc.
		MORE Resources for Registrars – Interactive Resources Directory Demo



2021-2022 FCDS Annual Educational

Webcast Series

FCDS is once again pleased to announce the 2021-2022 FCDS Annual Educational Webcast Series. Every year FCDS provides a series of timely topics in 2-hour webcast format held the 3rd Wednesday of each month from September through February. This year is no exception. FCDS will build upon topics raised during the 2021 FCDS Annual Conference. This year FCDS will focus on a 'return to standards' to ensure all Florida Registrars are staying up-to-date with abstracting and coding manuals, instructions, websites, references, and other tools required to abstract cases and understand cancers in our ever-changing cancer registry and medical care environment.

2020 and 2021 have been two years filled with many challenges due to the Covid-19 Pandemic. These challenges include overwhelming changes and revisions to many of our abstracting and coding manuals, instructions, reportable lists, case-finding lists, on-line resources and much more. All of these changes have resulted in registrars being overwhelmed with changes. These webcasts are intended to help registrars manage and cope with these changing standards and manuals that now number over 4000 pages if you add them all together. Registrars must understand what each manual is used for, how to use the manuals to find the information you need while abstracting cases, how to find the information without spending countless hours searching documents and websites, and how to apply them to specific cancer sites and histologic types that arise within all anatomic sites and subsites. This is no easy task.

FCDS will continue to reinforce the use of current manuals and instructions and will provide use-case scenarios and general information about major cancer sites including lung, colon, rectum and prostate as sample sites for how to use all of the new manuals and instructions and online tools to abstract cases. This is all part of our best attempt to continue to provide not only quality educational programs, but to allow registrars opportunity to learn to be stronger and more competent abstractors and coders.

Please join us for this 6-part webcast series and continue your education as a registrar and CTR. Each 2-hour webcast has been awarded 2 CEU hours – both Category A CEU hours – by NCRA for every webcast.

Webcast Announcements will be sent to all registrars via blast email beginning one month prior to each webcast. Be sure to register for each webcast and attend either the 'live' session or recorded session in FLccSC. And, remember that all NAACCR Webinar Recordings are also available in FLccSC for CEUs, also.

Date	FCDS Webcast Topic	CEUs	Category A
9/16/2021	FCDS Annual Conference Wrap Up & Review – 2021 Requirements	2	2
10/21/2021	2021 FCDS DAM – A Grand Tour – Where to Find What You Need	2	2
11/18/2021	Using the Grade, SSDI, Solid Tumors, ICD-O, Staging, & Other 2021 Manuals	2	2
12/16/2021	Colon and Rectum – 2021 Updates and How to Use New Resources for Cases	2	2
1/20/2022	Lung – 2021 Updates and How to Use New Resources for Cases	2	2
2/17/2022	Prostate – 2021 Updates and How to Use new Resources for Cases	2	2



FCRA/FCDS Task Force

The FCRA/FCDS Task Force meets monthly to discuss issues related to Florida Cancer Registrars, Cancer Registry Standards and FCDS Operations relevant to registrars and registries across the state of Florida.

The main purpose of the task force is to provide Florida registrars a means for communicating various issues for Cancer Registrars and the State Central Registry and to represent Florida Cancer Registrars relevant to FCDS Operations. The task force tackles problems such as issue resolution, improvement of procedures with the hope of increasing efficiencies, and to assist in identifying areas of educational needs for our Florida Cancer Registry Community. We work together to resolve problems statewide.

The Task Force's focus this year has primarily been on the FCRA Virtual Annual Conference, the FCDS Virtual Annual Meeting and preparations for Florida's transition to NAACCRv21 Standards and 2021 Manuals. We also spend time discussing FCDS Deadlines and FCDS' progress toward meeting national requirements to ensure Florida's cancer data is included in national statistics and national publications.

Future projects include getting our FCRA and FCDS website links working again so registrars can submit questions and concerns directly to the Task Force at the click of a button; and, continuation of problem solving as registries transition to the XML data transmission protocols and working through FCDS EDITS.

Please submit questions and concerns to the Task Force co-chairs; Marcia Hodge, FCDS President, and Steven Peace, FCDS Manager, and we will add your topic to our monthly agenda for discussion.

Co-Chairs: Marcia Hodge (hodgem@shands.ufl.edu) and Steven Peace (speace@med.miami.edu)

Members: Cheryl Taft, Barbara Dearmon, Jennie Jones, Joyce Allan, Mayra Espino, Yolanda Topin



Stereotactic Body Radiation Therapy

SBRT uses standard beam radiation to deliver the radiation to the site. SBRT can be used to treat benign, malignant and metastatic tumors.

For brain tumors they might call this Gamma Knife or Cyberknife – but, these are actually brand names for specific devices and not necessarily the technique which is called SBRT or Stereotactic Body Radiation Therapy.

Cyberknife and Gamma Knife are prominent machines that use the SBRT technique. So, SBRT or Stereotactic Body Radiation Therapy comes in various forms and with use of various terminology and machines. So, often it is the machine that is referred to for the treatment and not the actual technique. Since it is stereotactic radiation it delivers a precise dose to a very specific location(s) and is more exact in delivering radiation. So, they can use it for primary tumors or for metastatic sites if there are problematic sites that radiation will help to reduce symptoms, bleeding, or other problems – brain mets, lung mets, etc.

It is easy to fix a person's head in place using a custom head or face mask so it doesn't move around during the delivery of SBRT. However, there are different problems with SBRT when it is used in sites that move around due to breathing (lung, breast) or when you can't guarantee the patient won't move during TX.

This is why they use fiducials (seeds or coils) that serve as 'tracking devices' in the target site that moves to find and target the radiation in sites that have a tendency to move around – breast, liver, lungs, pancreas, GI.

SBRT requires accurate and custom mapping for each individual patient's anatomy and organ motion so that they can optimally target the tumor and simultaneously spare the surrounding normal tissue from damage.

Radiation Oncologists use all kinds of imaging modalities (PET, MRI, CT or combinations of the 3 typical imaging scans) and other new imaging platforms to localize the tumor in not 3 but 4 dimensions.

This requires highly sophisticated radiation delivery systems not available in most radiation oncology practices. And, it requires clinical expertise and experience of expert Radiation Oncologists to make sound treatment judgments regarding a recommendation for SBRT to make sure it is safe and the best method to deliver radiation to a primary or metastatic tumor site.

SBRT is high energy beam radiation using different techniques to specifically target tumors. SBRT shortens the time for radiation therapy planning and treatment delivery from weeks to days...pretty cool...and still an area where technology is building better, faster machines, software, and delivery devices all the time.

SUMMARY:

SBRT uses advanced tracking technologies, fiducials and sophisticated software to allow imaging machines to track body movements like breathing. SBRT provides a direct target of high-dose radiation in the form of high-energy photons directly to the tumor to treat benign tumors as well as localized tumors in the lung, breast, liver, pancreas, kidney, brain and central nervous system - even as the patient breathes normally. SBRT can also be used to treat small metastatic tumors in the brain, lung or liver. So, it is important to understand the intent of the treatment and the patient's stage of disease at time of treatment.

SBRT is highly effective in delivering high-dose radiation in only a few doses (5 or 6) without damaging surrounding tissues and with fewer risks than conventional beam radiation.

When SBRT is used to treat small localized unresectable non-small cell lung cancers, it is effective 80%-90% of the time. It is the standard of care for localized unresectable NSCLC of the central lung. These patients are being treated for a cancer cure (not palliation). So, at the end of treatment for a localized lung, breast, kidney or pancreatic tumor or a benign tumor of the brain or central nervous system (acoustic neuroma, meningioma, or pituitary adenoma) - the patient's cancer status at the end of treatment should be coded as 'no evidence of cancer'. The patient was treated to cure the unresectable cancer.

When SBRT is used to treat metastatic tumors, this technique is treating patients for palliative purposes. These patients may still have evidence of cancer following SBRT for metastasis.



2021-2022 NAACCR Webinar Series Begins in October (attending ‘live’ sessions or ‘recorded’ sessions in FLccSC)

A new cycle of NAACCR Cancer Surveillance Webinars (monthly NAACCR webinars) begins in October 2021 to carry us through the 2021-2022 NAACCR Webinar Series cycle. The monthly schedule is provided below.

	2021-2022 Webinar Season
Date	Topic
10/7/2021	Uterus
11/4/2021	Bladder
12/2/2021	Treatment
1/6/2022	Lung
2/3/2022	Data Item Relationships
3/3/2022	Boot Camp
4/4/2021	Hematopoietic and Lymphocytic Neoplasms
5/5/2022	Colon
6/2/2022	CNS
7/7/2022	Back to the Future: What year is it and what did I miss?
8/4/2022	Solid Tumor Rules
9/1/2022	Coding Pitfalls

This year in response to the continuation of the pandemic and the varied options available for registrars to work (home or office), NAACCR has provided FCDS with an option to setup a total of 42 ‘live’ attendees for each NAACCR Webinar in the 2021-2022 series. FCDS is working with our 7 host sites to identify 6 registrars from each site-region who used to attend the NAACCR webinars at their host site, and will offer the series to them for ‘live’ attendance on a first-come, first-served basis. The 6 individuals must attend all 12 webinars.

FAC #	NAACCR Host Site - Facility Name	City
2636	Baptist MD Anderson Cancer Center	Jacksonville
6046	Boca Raton Community Hospital	Boca Raton
1300	Gulf Coast Medical Center	Panama City
3932	H. Lee Moffitt Cancer Center	Tampa
5848	Orlando Health Cancer Institute	Orlando
1100	Shands University of Florida	Gainesville
FCDS	FCDS	Miami

(Continued on page 11)

(Continued from page 10)

For registrars who do not make the short list for the host site 'live' group, FCDS still offers every NAACCR Webinar in the series an option to view the 'recorded session' in FLccSC and still earn CEUs once they take and pass the NAACCR CEU Quiz...just like we have for many years. Old webinars can still be viewed – up to 2 years in arrears – and still gain CEU credits for attendance. Please visit FLccSC to view recordings.

Recorded Sessions in FLccSC appear on the site within a week or two following the 'live' session. It takes NAACCR that long to get recordings and exercises and quizzes posted to their website for our viewing. And, sometimes NAACCR has to update exercises or quizzes after the 'live' session, and this takes a little longer.

Florida's FLccSC (Fundamental Learning Collaborative for the Cancer Surveillance Community)

Please remember that FLccSC is always there for you when you miss education & training opportunities from NAACCR or FCDS. We cannot post SEER or NCRA education & training at this time. You must access NCRA or SEER education training portals to have access to these recorded sessions. Only the NAACCR Webinar Series Recordings are available in FLccSC. When NAACCR hosts a special 'public webinar' or 'special topic' webinar that is not part of the monthly series, FCDS does not get the special use webinars...only the monthly series.

Facility Purchase of NAACCR Webinar Series Packages

Another option may be for your facility to purchase a NAACCR Webinar Series package directly from NAACCR. This would provide a large staff one or more 'live' attendance ports for each webinar. Should your facility decide this is something you would like to pursue, please go to the NAACCR website (<http://naaccr.org>). Go to the Education Tab and click on NAACCR Education & Training (NET) for more information on packages available for purchase. Individual webinar packages are also available for purchase from your institution.

If you decide to purchase a package outside the FCDS offerings, please let FCDS know. This way we are aware that your facility has determined the need for additional continuing education for your staff. And, in the future FCDS may be able to incorporate your facility into our FCDS Host Site Group for future webinars.

The pandemic has caused all of us to rethink education & training access for everybody. FCDS continues to make as much as we can available in live sessions. When registrars are unable to attend a 'live' session, we always have FLccSC as a backup LMS where many education & training options are available in recordings. ALL FLccSC sessions are FREE of Charge and available to any Florida Registrars who are registered in FLccSC.

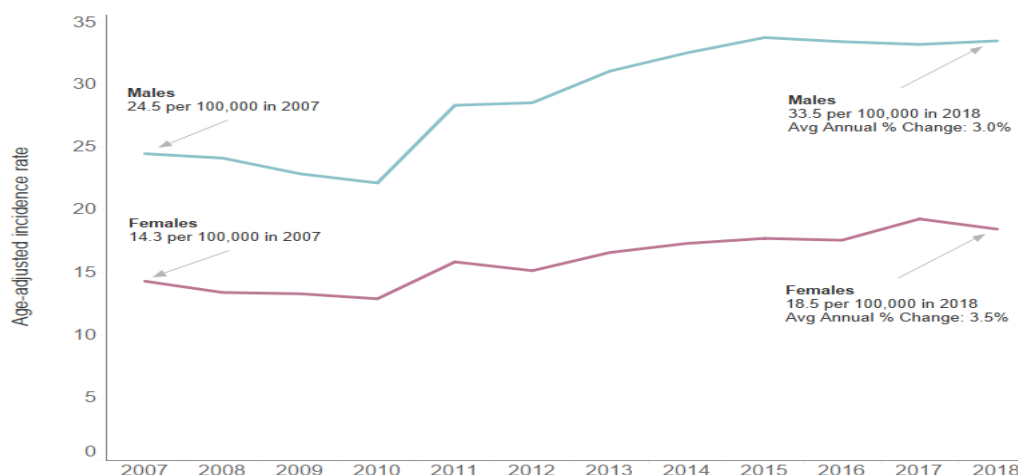
Thank you and we hope to see you at either 'live' or 'recorded' FLccSC Sessions throughout the year. This is an important time for changes to our cancer reporting and abstracting standards. Please continue to pursue your personal continued education to stay current with these changes and use all resources available to you.



FCDS Chart of the Quarter

Bringing you quarterly charts that highlight important cancer trends in Florida.

Melanoma incidence rates in Florida **significantly increased** for both men and women from 2007 to 2018



In Florida, melanoma incidence rates have significantly increased for both males and females since 2007. However, incidence rates are consistently higher among men than women. This could be related to occupational exposures and/or differences in health behaviors related to UV (ultraviolet) sun exposure¹. To find out more about personal risk factors visit https://www.cdc.gov/cancer/skin/basic_info/risk_factors.htm.

Moore KJ, Caban-Martinez AJ, Kirsner RS, et al. Firefighter Skin Cancer and Sun Protection Practices: Evidence From the Florida Firefighter Cancer Initiative. *JAMA Dermatol.* 2018;154(2):219–221. doi:10.1001/jamadermatol.2017.4254

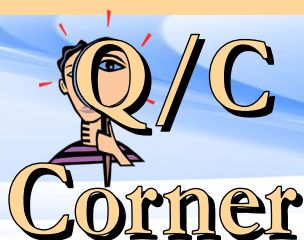
Pancreas - IPMN Reportable Status - Histology Code 8453 with Behavior Code /0, /2, and /3 has recently been clarified by SEER. This clarification revises a key table in the FCDS DAM used to describe the various pancreatic tumors FCDS requires be reported to FCDS. FCDS will include the update in the 2022 FCDS DAM.

According to the SEER Clarification - Intraductal Papillary Mucinous Neoplasm of the Pancreas or IPMN, NOS is NOT REPORTABLE unless there is additional descriptive terminology included on the pathology report. If the additional descriptive terminology noted below is not included – the tumor is a benign condition (N/R).

The IPMN Path Description must include at least one of the clarifying descriptive terms below;

- IPMN, with high grade dysplasia
- IPMN, non-invasive
- IPMN, in-situ
- IPMN, associated with invasive carcinoma
- IPMN, invasive

8453/2	Preferred	Intraductal papillary mucinous neoplasm with high grade dysplasia	(C25.)
8453/2	Related	Intraductal papillary mucinous carcinoma, non-invasive	(C25.)
8453/3	Preferred	Intraductal papillary mucinous neoplasm with an associated invasive carcinoma	(C25.)
8453/3	Related	Intraductal papillary mucinous carcinoma, invasive	(C25.)



QUESTIONS? ANSWERS. and CLARIFICATION

Paget Disease and DCIS with behavior

Question:

Patient dx with Paget disease of the Nipple per biopsy, s/p Left mastectomy c/w DCIS

I coded Histo/Behavior: 8543/2 (Paget disease and IDC. Rule H14). Primary Site: C500 (Nipple

When validate the case ,it shows this errors" Site & Morphology conflict-ICD0-3"

Could you help me with this issue?

Answer:

The reason you are getting this edit is because of the behavior of in-situ (behavior = /2 not /3). The U.S. edits and the site/histo tables are outdated and still want Paget Disease to be /3 (invasive). This is despite the current knowledge that more often than not Paget Disease is associated with DCIS not invasive ductal.

Back 10-30 years ago when screening technology and equipment was not digital and not as sophisticated as today, Paget Disease was almost always associated with an underlying invasive ductal carcinoma not DCIS.

Thanks to screening improvements in equipment, digital imaging replacing plain film mammograms, and many more years of screening experience...plus greater patient awareness - women find and report Paget Disease to their doctors earlier than they used to when the DCIS is still non-invasive...or they find it on screening mammography or MRI earlier than we used to and before invasive cancer can develop.

The huge improvements in patient awareness and the technology used in screening for breast cancers have made the diagnosis of early disease much more common and the tumors either noninvasive or very small.

Back in the 70s and 80s and early 90s before digital imaging – we commonly saw breast tumors 2-5cm. Today we more commonly identify breast tumors <2cm or even before they become invasive cancers.

So, we more often see non-invasive Paget Disease and DCIS today than what we saw historically.

Rectum Tumor Internal Sphincter

Question:

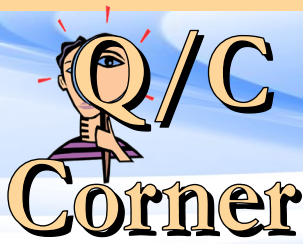
I have a question concerning a low rectal tumor that invades the internal sphincter but does not involve the intersphincter fat.

I cannot find anything in the summary stage regarding the internal sphincter and stage.

MRI says this abuts the prostate and the tumor is all below the ap reflection.

I want to say this is RE since it invades the perirectal fat but the localized info in SEER summary states “invasion of non peritonealized pericolic tissues invaded” which is what this is. I think???

(Continued on page 14)



QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 13)

Answer:

I take it you just have a clinical diagnosis at this time and will treat the person pre-operatively with chemo/radiation then resection. It doesn't sound like you have resection pathology to use to assess extension into or thru the rectal wall...just a clinical observation of tumor extending along the wall from prostate to sphincter.

It is highly likely the tumor extends into/thru the wall into peritonealized fat or greater...but...

Since rectal cancers are staged first by their extension thru the wall...extension to internal structures like the sphincter don't usually affect staging. This tumor extends along the internal wall of the rectal vault to involve a large area from the prostate to the sphincter – but, there does not seem to be any appearance or suggestion or any confirmation of tumor extension into or thru the wall...just along it.

Clinically it sounds like it is still localized...but, you and I both know it is probably at least regional direct ext.

This is a known problem we now have with rectal cancers getting neoadjuvant therapy prior to resection. We never really get a stage at diagnosis that is useful or meaningful...only post-treatment staging if/when they do a resection post-neoadjuvant therapies. It is better treatment...but worse for us – we cannot stage.

Stage at Diagnosis versus yc/yp Stage After Treatment

FCDS always wants 'stage at diagnosis' not 'stage after treatment' – that has always been the case. And, it will not change. The yc/yp stage is a 'stage after treatment' and only records the 'response to therapy'.

In your case there was uterus involvement on MRI prior to neoadjuvant therapy. So, the Summary Stage was in fact 'distant' by MRI at the time of diagnosis. You only have a 'clinical' stage at diagnosis. You have no path stage at diagnosis. You only have 'path stage after treatment' or 'treatment response' stage (yc/yp).

And, it has always been my understanding that for patient care – once a stage IV always a stage IV- despite down-staging accomplished by the pre-surgical therapies. This patient had a great response to treatment. But, the original diagnosis stage was in fact distant...these folks used to not even qualify for neoadjuvant.

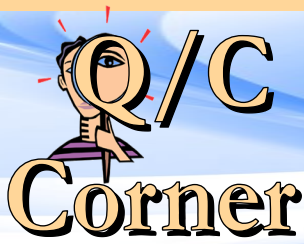
I know that AJCC wants the yc/yp stage to measure response to treatment...but, the fact is that the patient started out with Stage IV disease with uterine involvement. And, that is what you record in Summary Stage.

Vocal Cord Dysplasia to Neoplasia

Question:

Patient has vocal cord biopsy that shows squamous mucosa (squamous papilloma with high grade dysplasia). Biopsy shows both low risk HPV+and high risk HPV+. Is this the same as Laryngeal Intraepithelial Neoplasia (LIN III) and is it reportable?

(Continued on page 15)



QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 14)

Answer:

The terminology and grading systems used to describe dysplasia, metaplasia, and neoplasia are a complex series of nomenclature with overlapping terms that are definitely confusing for registrars.

High grade dysplasia is different than high grade neoplasia. Dysplasia is a step removed from neoplasia.

That said, both dysplasia and neoplasia have varying degrees of abnormality within a diagnosis. So, the terminology becomes very confusing when you look at high grade dysplasia versus high grade neoplasia.

There is an accepted progression of cells changing along a continuum often due to chronic infection in a number of anatomic region. The infection is usually a chronic infection by some type of HPV or human papilloma virus – particularly when mucosal surfaces consisting of squamous cells are the location of the chronic infection. This occurs in the oral cavity, oropharynx, and external genital sites for example. And, there are many types of HPV that can cause chronic infection in any or all of these anatomic locations.

The cells change from normal cells to varying degrees of abnormal cells described as metaplasia, hyperplasia and dysplasia in response to the infection. The longer the infection is present, the worse the abnormality becomes until at some point in time the cells become neoplastic or cancerous.

Each of these degrees of response display varying degrees of abnormality - low grade, high grade, etc. Once abnormal cells become so abnormal and progress beyond dysplasia, they move into the additional classification of neoplasia. So, there is a long continuum of change from normal cells to abnormal cells to dysplastic cells to neoplastic cells. The best example of this continuum is in areas of squamous mucosa.

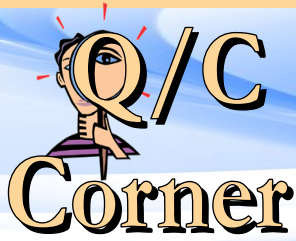
The progression from normal to abnormal cells to dysplastic then neoplastic cells was first described and classified in the cervix and later extrapolated to other squamous mucosal sites (vulva, vagina, oral cavity, etc.). We now know that this progression is due to chronic infection with human papilloma virus (HPV).

There are over 200 types of Human Papilloma Virus or HPV that are known and that can be tested to identify the type of HPV and whether or not the HPV variant is associated with cancers or not. Only a handful are known to be consistently 'high-risk' for cancer. But, all types of HPV can cause disease. The initial infection from HPV can 'go away' with few or no notable symptoms. However, in many cases the virus remains chronically active within the squamous mucosa...causing trouble months or years later.

Below are some definitions that help describe the progression of normal cells to neoplastic cells.

- Normal cells are normal cells. Normal cells can become infected by bacteria, virus or parasitic infection. The immune system mounts a response to the infection and either clears the infection or the infection may become chronic. Chronic infections may not be detected for years after infection.
- Hyperplasia is the occurrence of an increased number of cells in an organ or tissue – often in response to infection. Hyperplastic cells still appear normal under the microscope – there are just more than the usual number of cells. More than the normal number of cells is the only abnormality.
- Once cells begin to change, they start to be described as abnormal cells. Terms such as metaplastic cells (metaplasia) or dysplastic cells (dysplasia) are used to describe varying degrees of abnormality.
- Metaplasia is a change of cells to a form that does not normally occur in the tissue in which it is found. They still look a lot like the normal cells – but, something is characteristically different.

(Continued on page 16)

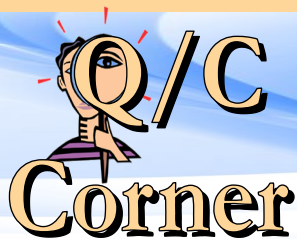


QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 15)

- As abnormal cells begin to take on increasingly abnormal characteristics, they become dysplastic.
- Dysplastic cells are clearly abnormal cells in a tissue or organ. These cells may include hyperplastic cells, metaplastic cells and dysplastic cells – depending on the degree of dysplasia present.
- Dysplasia is not cancer, but it may sometimes become cancer when the cause of the dysplasia is left untreated. Again, these are most often due to a normal immune response to infection of some type.
- Dysplasia can be mild, moderate, or severe, depending on how abnormal the cells look under a microscope and how much of the tissue or organ is affected. Dysplasia is a step removed from neoplasia. Dysplasia is classified as mild, moderate or severe. So the terms start to get confusing.
- Neoplasia is abnormal and uncontrolled cell growth. This is when cells become neoplastic – either precancerous, in-situ, or eventually invasive tumors. Neoplasia is not a reversible process like dysplasia or metaplasia or hyperplasia. Once neoplastic change is noted – the cells have changed so much that the process cannot be reversed and a tumor or area of neoplastic cells must be removed or otherwise treated as a neoplasm. The neoplasm may be benign, borderline, in-situ or malignant.
- And most neoplasia when left unattended or untreated can and will progress to invasive cancer – also along a continuum. More of the same terminology is used to describe yet another continuum.
- Neoplasia is classified as mild, moderate or severe – which is why we have cancer screening for the intraepithelial neoplasia's known to progress to invasive cancers and we report them as LIN III, VIN III, VAIN III, etc. LIN III, VIN III, VAIN III and others are considered in-situ or non-invasive neoplasms.
- Invasive cancer is the last step following pre-invasive and in-situ neoplasia as the neoplasm worsens.
- People do not die of dysplasia, pre-invasive neoplasia, benign or in-situ neoplasms.
- People can and do die from invasive cancers. Invasive cancers also are described along a continuum. This continuum is very familiar to cancer registrars...it is called 'cancer staging' – Stage I, II, III, IV or localized, regional (direct extension and/or regional lymph nodes) and finally distant stage.

We have similar classification in glandular tissues such as tissue found in the pancreas, lower esophagus, colon, stomach as the cellular changes lead to invasive adenocarcinoma in these cases. But, it is not the same as the process identified in squamous mucosa. Also, the causation of cellular changes in glandular tissues is not attributed to HPV. The causes are most often not clearly known. In glandular tissues, the progression moves along a continuum from normal mucosa to abnormal mucosa, then often to polyp phase that might include pre-invasive or in-situ neoplasia, and then to invasive cancer. Sometimes the polyp is not visible, sometimes the polyp is visible on endoscopy. But, the gradation, degree of changes, and the terminology for glandular tissue – and the clear progression from normal to abnormal to dysplastic to neoplastic – is not as clear in glandular tissue as it is in squamous tissue and mucosa. However, the model of progression to neoplasia for squamous mucosal infections are often compared to changes in glandular tissues as 'overlays' and 'models' of response to chronic disease of some type.



QUESTIONS? ANSWERS. and CLARIFICATION

Duodenum or Ampulla of Vater

Question:

What is the histology? If you use histology code 8500/3 you can't TNM Stage the case. Medical Oncology and Surgery just call this 'adenocarcinoma' which of course can be staged. But, that isn't what the pathologist called it. Should this be abstracted as a ductal adenocarcinoma of the duodenum and left unstaged or an adenocarcinoma of duodenum which allows me to stage the case? The tumor was resected. I hate unstaged cases.

Answer

Ductal Adenocarcinoma of the Duodenum: Many adenocarcinomas in many sites are actually ductal adenocarcinoma in that they arise in the ducts of glands; pancreatic ductal, prostate ductal, breast ductal, biliary ductal. But, not all adenocarcinomas arise from within ducts or glands. Some arise from glandular secretory cells in the walls of organs independent of any defined glands or ducts. And, not all ductal adenocarcinoma is coded to 8500 (prostate duct adenocarcinoma for example is coded 8140).

Adenocarcinoma means 'pertaining to a gland'...and all glands have ducts. But, some tissue such as those lining many internal organs such as the GI Tract have glandular cells in the walls. These cells, ducts, glands all make and release substances into the body like mucous, digestive fluids, etc.

But adenocarcinoma does not have to arise from a gland...it can arise from cells within other structures.

The duodenum only has scant glandular cells within the walls of this part of the digestive system. The Upper duodenum is more closely related to other organs of early digestion where the small intestine accepts the digestive fluids from the stomach, pancreas, bile ducts and continues the process of digestion after the bile duct and pancreas dump enzymes into the start of intestine – the duodenum.

So, I would guess that this 'ductal adenocarcinoma' of the duodenum is most likely associated with or arose near the confluence of the pancreato-biliary ducts and the duodenum. The confluence of these ducts is usually referred to as the Ampulla of Vater. But, the pathologist and whomever took the biopsy did not actually call the biopsy site the Ampulla of Vater. They called it adenocarcinoma of the duodenum which makes this more confusing.

Primary adenocarcinoma of the duodenum is actually pretty rare and usually not even primary in the duodenum but rather arises within the pancreato-biliary-duodenum confluence at the Ampulla of Vater.

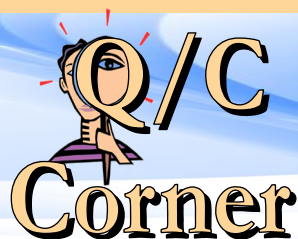
Most primary tumors of the duodenum are lymphoma or leiomyosarcoma or GIST – some carcinoids. True adenocarcinoma of the duodenum is quite rare...it is more likely this is a pancreatio-biliary system ductal adenocarcinoma with extension into the duodenum. But, you have to check the chart to verify.

A primary Ampulla of Vater ductal adenocarcinoma makes more sense.

Tumor Location and Treatment are the Key Factors in Deciding Where this Tumor Started.

- Is there any way you can verify where in the duodenum this specimen was taken?
- Is the patient being treated for pancreatic/biliary cancer or adenocarcinoma of the GI tract?

(Continued on page 18)



QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 17)

- Pancreatic/Biliary/Duodenal Ductal Adenocarcinoma patients often will get a Whipple procedure and will get pre and/or post-operative gemcitabine/FOLFIRINOX/Capecitabine and Oxiplatin.
- GI Tract Adenocarcinoma patients usually receive a different type of resection with node dissection and further treatment is based on how far the adenocarcinoma has gone through the wall of the intestine and whether or not nodes are involved – usually colon – 5FU w/leucovorin or Capecitabine, then FOLFOX, CapeOx

THEN, I got more information from the abstractor. This is how the flow of information often goes...

Here is the path info:

Final Dx: Moderately differentiated adenocarcinoma, 2.5 cm arising from the duodenum. Tumor extends from the ampulla and around the common bile duct into peripancreatic soft tissue (fat)

Tumor Site: Ampulla

Histologic Type: Ductal adenocarcinoma (NOS)

Gross: Tumor site: Bile duct structures involved by tumor

Whipple was performed. Restaging scan prior to adjuvant chemotherapy showed new liver lesions consistent with metastatic disease. Now getting palliative Capecitabine and Oxaliplatin plus Avastin

FINAL RESPONSE:

The pathology report, surgical treatment and drug regimen all point to a primary of the Ampulla of Vater. Per path - the tumor extends from the ampulla (which the pathologist starts out calling the duodenum but clarifies in the report) to involve the common bile duct and peripancreatic tissue. And, it is ductal adenocarcinoma. And, they did a Whipple. The chemo regimen is also geared toward a pancreatic/biliary/duodenal ductal adenocarcinoma rather than a typical GI Tract Adenocarcinoma.

Also, I just checked SEER*RSA – if you use histology code 8163/3 and it will let you stage for duodenum or ampulla of vater. 8163/3 is adenocarcinoma pancreatobiliary type. This is adenocarcinoma pancreatobiliary type – even if called ductal adenocarcinoma. Either code will work for staging.

The College of American Pathologist (CAP) checklist for Ampulla of Vater also has both as valid histology.

Histology code 8163 is valid for staging in the SEER*RSA (registrar staging assistant) which should mimic the AJCC histology requirements for Chapter 27 – Ampulla of Vater. So, adenocarcinoma pancreatobiliary type would be my best recommendation for tumor description and for staging.

The Solid Tumor Rules don't have rules for these increasingly important weight/obesity/diabetes related cancers that are increasing in frequency, cancer incidence and have high mortality. But, this is a great example of the process of reaching a conclusion that is not exactly spelled out in the medical record.

2021-2022 Monthly NAACCR Cancer Surveillance Webinar Series

FCDS is pleased to offer another year of the Monthly NAACCR Cancer Registry and Surveillance Webinar Series - Free of Charge to Florida Registrars in Recorded Sessions.

This year in response to the Covid Pandemic, NAACCR provided FCDS with 42 'live attendance portals' for 42 lucky Florida Registrars to attend the 2021-2022 Webinar Series 'live'.

FCDS worked with our traditional 7 host sites to identify 6 registrars from each site-region who attended the NAACCR webinars routinely at their host site. These registrars were offered the 'live' attendance seats for Florida. Unfortunately, FCDS was unable to purchase 200-250 'live' attendee spots...but, we are fortunate to have acquired 42 slots for the 2021-2022 NAACCR Webinar Series.

For registrars who do not make the short list for the 'live' spots, FCDS offers every NAACCR Webinar as a 'recorded session' in FLccSC.

You can still earn 3 CEUs per webinar in FLccSC...just like we have for many years. Recordings appear in FLccSC within a week or two following the 'live' session.

And, old webinars can still be viewed – up to 2 years in arrears. So, registrars can still gain 3 CEU credits for attendance at any NAACCR Webinar that is up to 2 years old.

The 2021-2022 NAACCR Webinar Series begins on October 7, 2021 and continues through September 1, 2022. The 2021-2022 Webinar Series Schedule is provided below.

Please visit FLccSC to view recordings and earn your CEUs.

DATE	TOPIC
*10/7/21	Uterus
11/4/21	Bladder
12/2/21	Treatment
1/6/22	Lung
2/3/22	Data Item Relationships
3/3/22	Boot Camp
4/4/22	Hematopoietic and Lymphocytic Neoplasms
5/5/22	Colon
6/2/22	CNS
7/7/22	Back to the Future: What year is it and what did I miss?
8/4/22	Solid Tumor Rules
9/1/22	Coding Pitfalls

**CEU information
for the 2020 FCDS
Annual
Conference:**

*CE Hours: 7.25
1.5 Hrs Category A*

*NCRA Recognition
Number: 2020-090*

**CEU information
for the 2021 FCDS
Annual
Conference:**

*CE Hours: 7.5
4 Hrs Category A*

*NCRA Recognition
Number: 2021-124*

Florida Cancer Data System

Cancer Reporting Completeness Report



TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF SEPTEMBER 30, 2021

Total number of *New Cases* added to the FCDS Master file in September, 2021: **6,079**

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
2021	6,452	0	57	5,593	1	Pending	12,103	1,479
2020	141,967	792	115	11,532	5,114	Pending	159,520	3,446
2019	224,243	4,994	545	12,399	24,860	Pending	267,041	1,154
				<u>Actual</u>	<u>Expected</u>			
% Complete for:				2021	5%	25%		
				2020	64%	100%		
				2019	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 FLccSC LMS Site.

The FCDS Webcast recordings are available free of charge and can be viewed any-time/anywhere by anybody. NAACCR Webinars are restricted approved Florida FLccSC Users per FCDS/NAACCR agreement.

FCDS holds all FCDS/NAACCR recordings for 2 years before 'retiring' them due to outdated information.

Registrars must have an active Florida FLccSC Account and must take and pass the CEU Quiz as required to obtain some of the CEUs for certain FCDS Webcasts... always to obtain a Certificate of Attendance.

NAACCR Webinars have their own CEU award mechanism whether viewed live or via a recorded session.

Only Florida registrars with Active/Current FCDS Abstractor Codes can access the NAACCR Webinars.

Please contact FCDS for more information on viewing recorded webinars.

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.

PROJECT DIRECTOR:

David Lee, PhD

DEPUTY PROJECT DIRECTOR:

Gary M. Levin, BA, CTR

EDITORS:

Gary M. Levin, BA, CTR

Steven Peace, BS, CTR

Melissa K. Williams

EDITOR ASSISTANT/ GRAPHICS DESIGNER:

Melissa K. Williams

Danielle Simmons

CONTRIBUTORS:

Steven Peace, BS, CTR

Megsys C. Herna, BA, CTR

FCDS

PO Box 016960 (D4-11)

Miami, FL 33101

Phone: 305-243-4600

800-906-3034

Fax: 305-243-4871

<http://fcds.med.miami.edu>