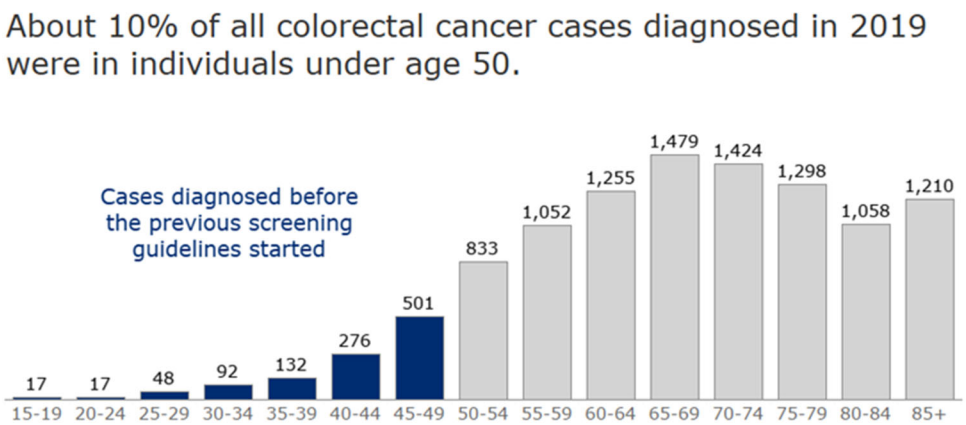
APRIL 2022

Current Trends in Florida Colorectal Cancer Diagnoses

In May 2021, the U.S. Preventive Services Task Force lowered the age at which colorectal cancer (CRC) screening should begin from 50 to 45. Using FCDS data, we explored how this change may impact people in Florida.

1) In 2019, **over 500 cases of colorectal cancer were diagnosed in Florida residents between the ages of 45 and 49.** Another 1,800 cases were diagnosed in those aged 50-59. Since CRC screening can PREVENT cancer by removing pre-cancerous polyps, earlier screening could decrease both incidence and mortality rates in those under age 60.



2) In the chart below, you can see how dramatically rates of CRC in Florida have decreased for older age groups. **However, over the past 30 years, CRC incidence rates have INCREASED in the 45-49 age group by 8%, from 29 to 37 per 100k people.**

(Continued from 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
V21 Metafile,
posted on 11/10/2021

FCDS/NAACCR WEBINAR SERIES:
NAACCR 2021-2022 Cancer Registry and Surveillance Webinar Series - Colon, 2022. ***** In person attendance cancelled until further notice. Please Login to FCDS IDEA->Education->FLccSC Learning Management 2 weeks after webinar to watch recordings and get CEUs *****

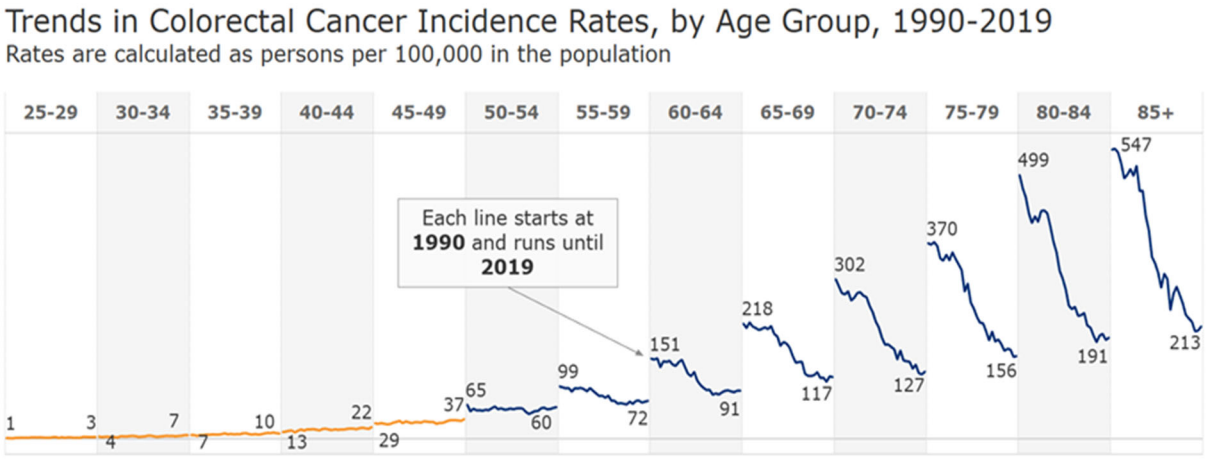
requires registration.

FCDS Florida Cancer Data System

Florida Statewide Cancer Registry

Florida Cancer Data System Deadlines, Updates, & Reminders

(Continued from page 1)



https://fcds.med.miami.edu/inc/statistics_CRC_trends.shtml

Much work remains to decrease unnecessary colorectal cancer diagnoses and deaths. The charts above illustrate how starting screening at an earlier age can reduce rates for younger age groups in the ways older age groups have seen over the past 30 years. To learn more about colorectal cancer in Florida, see our interactive screening visualization at https://fcds.med.miami.edu/inc/statistics_CRC_Screening.shtml.

Colorectal Cancer: 'Tumor Budding' or 'Tumor Sprouting' on Path Report

Regarding the use of the term 'tumor budding' or 'tumor sprouting'…per NCI

- "Tumor budding is an important additional prognostic factor for patients with colorectal cancer.
- Defined as the presence of single tumor cells or small clusters of up to 5 cells in the tumor stroma, tumor budding has been likened to an epithelial-mesenchymal transition.
    1. In malignant polyps, detection of tumor buds is a risk factor for lymph node metastasis indicating the need for colorectal surgery;
    2. Tumor budding in stage II colorectal cancer is a highly adverse prognostic indicator and may aid patient selection for adjuvant therapy;
    3. In the preoperative setting, presence of tumor budding in biopsy material may help to identify high-risk rectal cancer patients for neoadjuvant therapy.
- However, a lack of consensus guidelines for standardized assessment still limits reporting in daily diagnostic practice."

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Florida Cancer Data System Deadlines, Updates, & Reminders

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- In more plain English, "The term tumor budding denotes that at the invasion front of colorectal adenocarcinomas tumor cells, singly or in small aggregates, become detached from the neoplastic glands."

- So, the 'tumor budding' is the leading edge or 'front line' of tumor invasion. It indicates the area of the tumor with the most rapid tumor growth rate. You can find tumor budding or sprouting in one or more than one area just outside of edges of the tumor, 'peritumoral tumor budding,' and you can also find tumor budding within the tumor itself, 'intratumoral tumor budding'.

- The presence of 'intratumor tumor budding' is associated with a lack of response to therapy (adjuvant/neoadjuvant) as well as increased chance of recurrence, metastasis, and decreased survival.

- 'Tumor budding' is an independent adverse prognostic factor in colorectal carcinoma…and is shown to be a risk factor for lymph node involvement, lympho-vascular invasion and higher tumor grade.

- But, 'tumor budding' and 'tumor grade' are not the same thing…and 'tumor budding' is not coded as 'lymph node metastasis' or 'tumor deposit'.

- Unfortunately, there are no standard guidelines in pathology or in cancer registry nomenclature or in any of our staging references for how to assess, measure, or code 'tumor budding'. They actually even hosted an International Tumor Budding Consensus Conference in 2018 to try to establish a methodology for uniform reporting – they met 9 times. But, they could not reach consensus on the criteria.

- So, at this time the documentation and coding of 'tumor budding' or 'tumor sprouting' is only a 'recommendation' from CAP, is not included in AJCC TNM Cancer Staging or Summary Stage, and is not included in any NCCN Guidelines for colorectal cancers. So, they just don't know how or when to incorporate 'tumor budding' into staging, disease classification, or treatment recommendations…yet.

- When you run across this when reviewing pathology reports or abstracting cases, please document the observation from pathology – check for wider excision if present in a polyp and tumor resection – and check for recommendation for adjuvant/neoadjuvant chemotherapy and/or radiation therapy before and/or after resection of the primary tumor due to higher likelihood of lymph node metastasis and micro-metastasis since the risk of nodal metastasis and distant metastasis is increased and the prognosis is poorer than cases of similar stage of disease when 'budding' is present in the resected specimen.

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Florida Cancer Data System Deadlines, Updates, & Reminders

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The 2018 International Tumor Budding Consensus Conference did come up with 10 consensus statements on 'Tumor Budding'

1. Tumor budding is defined as a single tumor cell or a cell cluster of up to 4 tumor cells.
2. Tumor budding is an independent predictor of lymph node metastasis in pT1 colorectal cancer.
3. Tumor budding is an independent predictor of survival in stage II colorectal cancer.
4. Tumor budding should be taken into account along with other clinicopathologic factors in a multidisciplinary setting.
5. Tumor budding is counted on hematoxylin-eosin (H&E).
6. Intratumoral tumor budding in colorectal cancer has been shown to be related to lymph node metastasis.
7. Tumor budding is assessed in 1 hotspot (in a field measuring 0.785 mm2) at the invasive front.
8. For tumor budding assessment in colorectal cancer, the hotspot method is recommended.
9. A 3-tier system should be used along with the budding count to facilitate risk stratification in colorectal cancer.
10. Tumor budding should be included in guidelines/protocols for colorectal cancer reporting.
11. Tumor budding and tumor grade are not the same.

References:

- Tumor budding in colorectal cancer--ready for diagnostic practice?; Viktor H Koelzer, Inti Zlobec, Alessandro Lugli; PMID: 26476568 DOI: 10.1016/j.humpath.2015.08.007
- Tumor Budding in Colorectal Carcinoma: Translating a Morphologic Score Into Clinically Meaningful Results ; Soo-Jin Cho, MD, PhD; Sanjay Kakar, MD; Arch Pathol Lab Med (2018) 142 (8): 952–957.
- Recommendations for reporting tumor budding in colorectal cancer based on the International Tumor Budding Consensus Conference (ITBCC) 2016; Alessandro Lugli, Richard Kirsch, et.al. PMID: 28548122 DOI: 10.1038/modpathol.2017.46

2022 FCDS Annual Meeting & 2022 FCRA Annual Conference
Two Key Florida Cancer Registry Virtual Events

FCDS and FCRA have been working together to bring you a series of 'essential topic' webinars starting in August 2022 and concluding in early September 2022. Both the FCRA and FCDS 2022 Virtual Annual Conference Sessions will be like those hosted the last two years. FCRA will host the FCRA Annual Conference over 2 half days. FCDS will host 4 two-hour sessions over a 4-week period.

Conference Announcements and Agendas for both events are being finalized and will be circulated soon.

FCDS encourages ALL Florida Registrars including Hospital CTR and non-CTR Staff and Managers, Florida Interim Staffing Company Employees and Individual Contractors to attend ALL Sessions if you are able.

Both Events will offer different sets of educational information. All sessions will be relevant and timely.

Please mark your calendars for both key Florida Cancer Registry Virtual Events.

The 2022 FCRA Annual Conference will be on 8/1/2022–8/2/2022 (two half day sessions)

The 2022 FCDS Annual Meeting will be 8/11/2022–9/1/2022 (four 2-hour sessions Thursday 1pm-3pm)

We had to make decisions about hosting in-person -vs- virtual events back in December 2021 when we were unsure what the status of the Covid-19 Pandemic would be or if we might be in a new variant surge – projecting to August 2022. It was a difficult decision to make with so much time between and knowing that registrars like to attend in person. However, we could not ensure everybody in our audience would be protected from conference-acquired Covid-19 infection not knowing what variant(s) might be circulating or how dense the infection rates might be so far out from hotel reservation dates.

NEW FLORIDA CTRs - Winter 2022

Susan Borcherding, *Hudson*

Renilde Campos, *Port Saint Lucie*

Dawn Coons, *Ormond Beach*

Danielle DeVries, *Ruskin*

Remita Gabriel, *Maitland*

Liz Martinez Valenzuela, *Miami*

Rosa Miranda, *Riverview*

Aamra Siddiqui, *Orlando*

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 data information specialists that capture a complete history, diagnosis, treatment, and health status of every cancer patient in the United States; and

WHEREAS, the data guides the work of oncologists, researchers, and public health officials to better monitor and advance cancer prevention and treatments, conduct research, improve cancer preventions and screening programs, and determine 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 opportunity to recognize the essential role that cancer registrar professionals 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 4-8, 2022, 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 4th day of April, in the year two thousand twenty-two.

Governor

CONCURRENT ABSTRACTING WHEN TO SEND CASE TO FCDS

FCDS is starting to see CoC-Accredited Facilities abstracting concurrently again. This is fine for COC reporting; however incomplete cases do not meet the state reporting requirements.

Registrars are sending incomplete cases to the FCDS. Abstractors must wait until the First Course of Therapy is complete before sending cases to the FCDS. This includes incomplete RCRS/RQRS Cases. Meeting NCDB reporting criteria does not meet the state requirements of including treatment and ensuring the cases is complete before submitting.

FCDS does not accept update or modified abstracts. Hence it is important that when you submit an abstract it is complete with all the information available including all treatment. This is the rationale as to the 6 months given to finish cases after the end of every year and the June 30th deadline.

You must wait for the planned first course of therapy to finish (even if neoadjuvant) and the definitive surgery to be performed [even if post-neoadjuvant therapy(s)] Or, you need to have confirmation that the neoadjuvant therapy (or whatever therapy was given first course) resulted in a complete response and no surgery will be performed or that the treatment is ongoing. Otherwise, FCDS does not get the treatment performed after you send the case. FCDS does not accept follow-up cases/update/modify.

In other words, you must wait long enough for a patient to get their screening, have a biopsy to confirm a diagnosis, get their cancer workup and finish the treatment before sending the case to the FCDS.

- Do not send incomplete cases.
- Keep cases in your Pending Files as Incomplete until you get all the information.
- Once complete than submit the case to the FCDS.

The NCDB RCRS/RQRS reporting requirements are different than state requirements. We know that the NCDB has rapid reporting for some cancers. Concurrent Abstracting has a purpose in some registries to get patients onto research protocols and to support adherence to treatment guidelines. It has no purpose sending incomplete cases to the state unless that state has the capacity and staff to process records multiples of times and resolve inconsistencies over time as registrars change and update abstracts in follow-up.

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

Over the year's registrars have grown more and more confused about the use of 'ambiguous terminology' on imaging and pathology reports. Training has focused more on clarifying when to use or not use 'ambiguous terminology' rather than reinforcing the use of 'definitive terminology' over 'ambiguous terminology' in diagnostic imaging reports. The result has been a grand misunderstanding of the preferred and priority use of 'definitive terminology' over 'ambiguous terminology' when determining when a case becomes reportable, the date of initial diagnosis, the primary site, histologic type, and the presence or absence of disease based on the terminology reflected in these reports.

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

Instruction and training has emphasized how to interpret 'ambiguous' terms to the detriment of how and when to apply 'definitive' terms as the preferred/priority terminology in decision-making. Unfortunately, many registrars look for the 'ambiguous' terms to confirm a diagnosis and often will ignore 'definitive' terms…or they expect the radiologist or pathologist who provides a 'definitive' statement to restate an abnormality as 'suspicious for cancer' when definitive terminology already says the abnormality is a cancer until or unless proven not to be a cancer – this is definitive terminology.

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

- Registrars should always apply 'definitive terminology' over 'ambiguous terminology.' Reports do not have to restate 'suspicious for cancer' or 'likely mucinous adenocarcinoma' when a definitive assessment or terminology is used in the first confirmation of cancer or the to use the date of that report as the initial date of diagnosis or confirmed histology when a 'definitive term' is present.

- When a physician uses definitive terminology, they are stating that a mass, tumor, neoplasm or a specified histology is what they say it is unless or until it is otherwise proven not to be what they say it is based on some other test or if a subsequent test clarifies a more specific diagnosis.

- For example; when an imaging report states, 'mass in left lung,' or they state measurements for a tumor or nodes or metastasis – the physician is telling you that they already think the abnormality is cancer until or unless it is later proven not to be a cancer or some other more definitive testing method rules out cancer. The use of a 'definitive term' is a statement made with confidence that it is what they say it is. Again, there is no need to restate 'suspicious for cancer' because the physician already thinks it is cancer – they are not even suspicious – it is cancer until/unless proven not to be.

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

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

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- The 'ambiguous terminology' list of words and phrases for presence or absence of disease are applied only when 'definitive terminology' is NOT used to describe the presence or absence of tumor or a specific histologic type/subtype.

- There are some abnormalities that cannot be further described using a definitive term because they are too small or cannot be further characterized sufficient to state it is cancer such as 'lung nodule'. Lung nodules are just too small to know if they are tumor nodules or nodules that are reactive such as reaction to an infectious process in the lungs. They cannot be characterized as tumor or mass.

- You use the 'ambiguous terminology' lists of words and phrases when only 'ambiguous terminology' is used and there is no 'definitive terminology' in the report. Not the other way around…

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

- But, when a report states 'suspicious for mucinous adenocarcinoma' or 'suggests mucinous adenocarcinoma,' only then do you apply the 'ambiguous terminology' guidelines to determine whether or not you code the histology as 'mucinous adenocarcinoma' or 'adenocarcinoma, NOS.'

- You only use the 'ambiguous terminology' guidelines when 'definitive terminology' is NOT present.

- 'Ambiguous terminology' does not have to be used on imaging to confirm the presence or absence of neoplasm, and, is never used instead of in place of 'definitive terminology'.

- Unfortunately, there is not and never has been a list of 'definitive terminology' – you must use your practical sense and the physician's statement to decide if a term is 'definitive' not 'ambiguous'.

Registrars are looking for the terminology 'suspicious for cancer' particularly on imaging to confirm a cancer diagnosis when the 'definitive terminology' has already confirmed the presence or absence of cancer, date of initial diagnosis or histology type. The radiologist will not and does not need to restate that the tumor mass s/he has described is 'suspicious for cancer' because the definitive terminology that s/he has used already tells you it is a cancer or a specific type of cancer until/unless proven otherwise.

QC Issue: NOS Coding of Anatomic Subsite

Unusual Uptake of NOS coding for the Colon Segments, Breast Quadrants and Skin Anatomy Where Tumor Location is of the Utmost Importance

The FCDS has identified a new and growing problem with registrars not identifying the segment of the colon where a cancer is growing, the quadrant of the breast where the primary tumor is located, which lobe of the lung is involved with cancer, or what part of the body's largest organ, the skin, has the primary malignant melanoma abstracted. This is poor abstracting practice, especially for analytic cases when your facility does the initial biopsy and surgery. It has become a major issue and must be improved.

Coding the correct anatomic site is the basics of identifying and coding Topography. Nothing has changed in this regard. Registrars are just not coding the subsite. They document the subsite in the text, but then they code the NOS topography. Topography means something and must be coded

In addition to colon segments, we are finding the same issue with breast subsite where the breast quadrants are not being coded. As well as the lung where lobes must be coded. The most egregious is when malignant melanoma cases are being reported as skin, NOS (C44.9). Time and effort must be taken to ensure the identity of the skin anatomy involved from where they took the biopsy and/or resection. Skin is not just one site. Coding all these sites to NOS when the text is available and in the medical chart must be remediated immediately.

It is important that registrars take the time necessary to ensure the data being sent to the state is of the highest quality. Your institution, the state of Florida and national sources (CDC, NAACCR, COC) depend on high quality and complete data for many decisions and research projects. Please take the time to code abstracts completely and accurately. The data you provide needs to be the best that we can provide to ensure we are providing clean, clear and complete data to all.

Recently the FCDS has joined two national childhood cancer registries. All our pediatric data comes into question when we find these kinds of coding issues in our data quality.

FCDS has never seen so many NOS sites in our 40 years of cancer reporting as are being reported today.

Please take this information back with you to your staff and discuss this problem.

The FCDS will continue to monitor NOS topography coding. If we do not see any improvement, we will consider focused QC efforts which would include requesting confirmation of cases to ensure the abstracts meets the Florida Data Quality Standards.

Prostate Cancer and Corrections to Clinical/Pathological Grade You Must Also Correct the Gleason SSDIs to Match Grade Changes

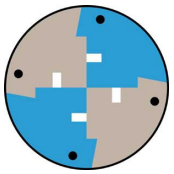
FCDS wants to remind everybody that when you get a case returned asking you to revise/correct/change the Clinical Grade and/or Pathological Grade for a Prostate Cancer – you MUST also revise/correct or change the associated Clinical and Pathological Gleason Pattern/Score SSDIs to match the change to the Clinical Grade and/or Pathological Grade. It is not just a matter of changing the Grade Data Item(s).

First a clarification: Patient MUST have a radical prostatectomy to assign Pathological Grade…period. A path report does not constitute a pathological grade…if there is just a biopsy or TURP – you only have Clinical Grade data. A biopsy or TURP or even simple prostatectomy is not sufficient to code path grade.

For example; you coded pathological grade 2 but there was no prostatectomy performed – so the pathological grade must be changed to = 9. You must also check what you entered in BOTH the Clinical Gleason Pattern/Score and the Pathological Pattern/Score – because you cannot have a Pathological Gleason Pattern or Score unless the patient has a radical prostatectomy – yes, it must match the grade.

Second clarification: You will not find a Tertiary Pattern except when patient has radical prostatectomy.

We have found that registrars are happy to respond to QC Review to correct the Clinical Grade and/or Pathological Grade data item. But they don't yet recognize the Gleason SSDI fields must also match the grade item. Please remember that the grade fields and the Gleason SSDIs go hand-in-hand…always.



New Instructions for Coding Lymph-Vascular Invasion (LVI)

The 2021 STORE Manual added a new set of tables and updated the instructions for Lymph-Vascular Invasion (LVI). Please reference the 2021 STORE for the full set of instructions and restrictions on the codes allowable for this data item. FCDS will add the tables and instructions to the 2022 FCDS DAM. The tables are not in the 2021 FCDS DAM because there was no formal notice of the new instruction and tables, nor the associated changes to the LVI EDITS already in place to enforce the new instructions.

PLEASE NOTE: The expected values are Schema ID driven. So, they are subject to change.

- LVI = 0 for ALL In-Situ Neoplasms
- LVI = 0, 1, 2, 3, 4 or 9 for most Schema IDs
- LVI = 8 for ALL Schema IDs included in the below table.

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Schema ID	Schema Name
00060	Cervical Lymph Nodes, Occult Head and Neck
00118	Pharynx Other
00119	Middle Ear
00128	Sinus Other
00140	Melanoma Head and Neck
00150	Cutaneous Carcinoma Head and Neck
00278	Biliary Other
00288	Digestive Other
00358	Trachea
00370	Pleural Mesothelioma
00378	Respiratory Other
00458	Kaposi Sarcoma
00478	Skin Other
00551	Ovary
00552	Primary Peritoneal Carcinoma
00553	Fallopian Tube
00558	Adnexa Uterine Other
00559	Genital Female Other
00598	Genital Male Other
00638	Urinary Other
00650	Conjunctiva
00680	Retinoblastoma
00690	Lacrimal Gland
00698	Lacrimal Sac
00710	Lymphoma Ocular Adnexa
00718	Eye Other
00721	Brain
00722	CNS Other
00723	Intracranial Gland
00770	NET Adrenal Gland
00778	Endocrine Other
00790	Lymphoma
00795	Lymphoma (CLL/SLL)
00811	Mycosis Fungoides
00812	Primary Cutaneous Lymphoma non MF
00821	Plasma Cell Myeloma
00822	Plasma Cell Disorders
00830	Heme/Retic
99999	Ill-Defined Other

FCDS WILL NO LONGER ACCEPT CODE '99' IN TREATMENT FIELDS

FCDS TREATMENT EDIT FL3038 WILL NO LONGER ALLOW 99 CODE IN ANY TREATMENT FIELD

with a few minor 9-required items such as 9 for Scope for lymphoma/leukemia.

There have been codes available to register '99' – Unknown if *xyz* Treatment was given for many years. Many Cancer Registrars would often use these codes for non-analytic cases. And, FCDS would even 'default' treatment codes for 'minimal case/historical case/default case' assembled cases to indicate FCDS had no information on treatment rather than entering 00 to indicate 'no treatment given'. More recently, Cancer Registrars have been using these codes in any and every treatment field available as a 'default' rather than entering '00' to indicate a treatment was not given – or not gathering all the information from later admissions to complete the First Course of Treatment – only to finish the case, quickly (and incomplete). There was even a time when the CoC instructed and expected Cancer Registrars to look-up and use code '99' for treatment that according to NCCN or other published Treatment Guidelines '*should'* have been given or at least recommended (according to the guidelines). Unfortunately, this made it look like the Cancer Registrars were making Treatment Planning Decisions.

These methods have proven disastrous for data analysis when every treatment code '99' should actually have always been coded '00' until or unless the treatment was later identified and added to the abstract – or found during record linkage to another report source and the treatment was given as part of a Planned First Course of Treatment. We have always asked Cancer Registrars to document the Planned First Course of Treatment – but, many registrars either do not have access to this documented planned course or do not bother to write it in their text to document the expected treatment course.

When the Cancer Registrar registered a '99' unknown or a 'treatment recommended' code without any indication the treatment was ever recommended by the physician team or any individual physician – and often was never even discussed as an option with the patient – FCDS Consolidated Records became 'clogged' with unreliable treatment data where it looked as if treatment should have been or might have been given – but, that FCDS and nobody else ever followed up on the case to see if the treatment the registrar expected to find or 'should' have been given was ever even recommended. This left a huge hole in the data with discrepancy between what was and should have been advised for these patients.

FCDS is now trying to 'clean up' this mess. Part of this 'clean up' is to inform our Florida Abstractors, Cancer Registrars and CTRs to NEVER USE CODE 99 FOR ANY TYPE OF TREATMENT – PERIOD.

Another action that FCDS has taken is to create a new FCDS EDIT FL3038 that checks cases for use of code '99' in the treatment fields. There are a few exceptions to use of code '99' that must be allowed.

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The short and sweet of this is that 'treatment' was either given, not given, recommended but not given or refused.

Treatment should NEVER be coded as 'unknown' – for any treatment type – and not even for non-analytic cases.

You should only code what you know of the case from the medical record – not what you think *should* have been done because it was published in a treatment guideline so you think it should have been at least been recommended.

You can discern past treatment by history and physical, consults, physical exam for scars, etc. You will see this article and edit repeated over and over until we all 'get it'. Please stop using code '99' for treatment of any kind. TX is either known that it was given, it was not given or there is no evidence treatment was given, recommended but not given, or refused for some reason.

And, please always document the reason the treatment was not given if it is stated in the medical record – death, comorbidity, refused, etc.

TREATMENT WAS EITHER:

1) Given (with or without details available to you)
2) Not Given and Not Recommended/Refused (it was not part of any treatment plan stated in the medical record)
3) Recommended (and stated to be recommended in the medical record by a physician)
4) Refused (as documented in the medical record in nurses notes, physician notes, or elsewhere)

Thank you for your cooperation with this enormous 'cleanup effort' – we appreciate all you do. FCDS strives to keep Florida Cancer Data among best curated cancer data in the country.

REMINDER: Code Treatment Recommended and/or Refused
A follow-up to the Do Not Code 99 for Any Treatment Article

Treated is either done, not done, recommended or refused. If you have no information that any treatment was performed, recommended, or refused – then it was not done…do not code '99' unknown if treatment was done. Treatment was either done, not done, recommended or refused.

Do not code treatment '99' unknown when NCCN or other Treatment Guidelines recommend that a treatment is recommended for a specific cancer, histology, stage of disease or other circumstance. It is not your call that a treatment should be recommended based on treatment guidelines…it is the doctors.

- No Treatment is Not Treatment Recommended/Refused
- Active Surveillance is Not Treatment Recommended/Refused

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- Watch and Wait is Not Treatment Recommended/Refused

Treatment Recommended/Refused Requires Documentation from the Medical Record

Treatment Recommended/Refused Requires Documentation in the Abstract

Fields to Code Recommended/Refused Include:**

- Reason for No Surgery
- Reason for No Radiation
- RX Summ – Chemotherapy
- RX Summ – Hormone Therapy
- RX Summ – BRM/Immunotherapy
- RX Summ – Transplant/Endocrine Therapy

**** Please Refer to FCDS DAM for Definitions for TX Recommended/Refused Codes**

REMINDER TO CODE SCOPE OF REGIONAL LYMPH NODE SUGERY FIELD

This is just a reminder to please code the Scope of Regional Lymph Node Surgery Field – even though we no longer require the date of the lymph node surgery when an FNA of a Sentinel Node is Performed.

Registrars seem to forget to code this item, frequently. Please remember to Code Scope Reg LN = 1.

Additionally, when an FNA is the only procedure performed on a regional lymph node, you should document this in the surgery text as well as code Regional Lymph Nodes Examined = 95.

- You should code Regional Lymph Nodes Examined = 95 for all FNA of regional lymph node cases.
- You should code Regional Lymph Nodes Positive = 95 when the FNA is positive.
- You should code Regional Lymph Nodes Positive = 00 when the FNA is negative.

TREATMENT – 99 or 00 – MAJOR Points Bulleted for Emphasis

Treatment was either performed, not performed, recommended or refused. You may not know recommended/refused. You code only First Course Treatment. You document Subsequent Treatment(s). If you do not know if a treatment was recommended, refused, performed or not performed – then you assign treatment code = 00 not done. In other words - Code any treatment performed, recommended and refused – regardless of where it was done or how complete your information is. Below is a bulleted list that should help anybody when coding treatment of any type.

- First Course Treatment Must Be Coded
- Subsequent Treatment Must Be Documented
- Treatment '99' is not a placeholder for treatment that ***might*** *have been* done, recommended or refused
- Do not guess if treatment was done, recommended or refused.
- Do not code treatment recommended based on registrar's interpretation of treatment guidelines – registrar does not recommend treatment.
- Treatment performed, recommended or refused must be stated in the medical record by a physician or by evidence of treatment in the record.
- You should both document and code any treatment given/recommended/refused – and where it was done if you know.
- There are NOS codes for any type of treatment performed – but, you must have statement that treatment was actually performed.
- If a treatment was performed – per history at another facility or at your facility – you code it – even if you have to code *xyz* treatment, NOS.
- There are treatment recommended codes for all types of treatment…albeit in different fields in some cases such as Surgery and Radiation.
- There are treatment refused codes for all types of treatment…same as above – in different fields in some cases such as Surgery and Radiation.
- There are also date flags when treatment was recommended/refused – but, these will go away in 2023…completely.

(Continued on page 17)

(Continued from page 16)

- If you do not know if a treatment was performed, recommended or refused – code 00 (no treatment)

Scenario: 4/99/2021 IMRT RUL at outside facility, unknown dose or fractions, ended 6/15/2021.

- ABSOLUTELY CODE THIS TREATMENT – IT WAS PERFORMED – no matter where it was performed as long as it was first course tx - you code it
- Radiation Modality = 01 Beam, NOS because IMRT usually includes a combination of photons and protons for IMRT
- Include documentation just as written under Radiation Text

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 arears. 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 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 MARCH 31,2022

Total number of *New Cases* added to the FCDS Master file in March, 2022 **30,706**

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	92,627	354	294	11,263	179	**Pending**	104,717	**21,558**
2020	198,165	3,044	180	11,918	17,770	**Pending**	231,077	**8.206**
2019	233,693	6,043	1,946	12,567	25,190	**2,465**	281,904	**942**

		Actual	Expected
% Complete for:	**2021**	**42%**	**75%**
	2020	92%	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 anytime/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.

FCDS Florida Cancer Data System

The Florida Cancer Data System (FCDS) is Florida's statewide, population-based cancer registry and has been collecting incidence data since 1981 when it was contracted by the State of Florida Department of Health in 1978 to design and implement the registry. The University of Miami Miller School of Medicine has been maintaining FCDS (http://fcds.med.miami.edu) since that time.

The FCDS is wholly supported by the State of Florida Department of Health, the National Program of Cancer Registries (NPCR) of the Centers for Disease Control and Prevention (CDC) and the Sylvester Comprehensive Cancer Center at the University of Miami Miller School of Medicine.

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