Collecting Cancer Data: Breast

NAACCR 2015-2016 Webinar Series

---

Q&A

- Please submit all questions concerning webinar content through the Q&A panel.

- Reminder:
  - If you have participants watching this webinar at your site, please collect their names and emails.
  - We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.
**Fabulous Prizes**

- A ring
- Heart-shaped candies
- A teddy bear
- A bouquet of roses

---

**Agenda**

- Anatomy
- Staging
- Epi Moment
- Site Specific Factors
- Treatment
Where is my primary tumor located?

- Priority order for information
- Code subsite of invasive tumor
- Code specific quadrant for multifocal tumors in one quadrant
- Code C508
  - Single tumor in two or more subsites unknown where originated
  - 12, 3, 6, 9 o’clock positions
- Code C509
  - Multiple tumors (2 or more) in at least two quadrants of breast

**Regional Nodes**

- Axillary
  - Level I (low-axilla)
  - Level II (mid-axilla)
  - Level III (infraclavicular)
- Internal Mammary
- Supraclavicular
- Intramammary

**Distant Metastatic Sites**

- Common Sites
  - Bone
  - Lung
  - Brain
  - Liver
Multiple Primary Rules

- A patient was diagnosed with stage I ductal carcinoma of the upper outer quadrant of the left breast in 2009. The patient was treated with a simple mastectomy and chemotherapy.
- She returned in 2016 with a comedocarcinoma located in the axillary tail of the left breast.
- Is this a new primary?

Staging

Summary Stage
AJCC Staging
SSF’s
Summary Stage

Summary Stage Manual Page 186

- 0 In situ
  - Non invasive
- 1 Localized
  - Confined to breast tissue and fat including nipple and areola
- 2 Regional by direct extension only
- 3 Ipsilateral regional lymph node only
- 4 Regional by both direction ext and regional lymph nodes
- 5 Regional NOS
- 7 Distant sites/lymph nodes

Summary Stage Manual Page 186
TNM Staging

Conversion
Rules for Classification
T, N, M, and Stage Group
Site Specific Factors

AJCC Staging Manual page 349

Conversion to NAACCR Layout v16

• Registrars are currently abstracting all cases in NAACCR Layout v15.
• NAACCR Layout V16 will be released this spring.
  • Once conversion is complete registrars will be able to assign T, N, and M
    values with a “c” or “p” classification descriptor.
    • c1, c2, c3,...
    • p1, p2, p3, ...
    • Will not be used with stage groups
  • Registrars should not use “c” or “p” descriptors until their registry software
    has been converted to v16 unless specifically instructed to do so by the CoC
    or their state registry.
Rules for Classification

- **Clinical**
  - Physical examination with inspection of the skin, mammary gland, and lymph nodes
  - Imaging
  - Pathologic examination sufficient to make a diagnosis

- **Pathologic**
  - Resection of the primary tumor
    - May have microscopic residual, but not macroscopic residual
    - Removal of at least a level I axillary node if the tumor is invasive

In Situ

- Ductal Carcinoma In Situ (DCIS)
- Lobular Carcinoma In Situ (LCIS)
- Paget’s Disease of the Breast
  - T value is based on underlying tumor
  - If no underlying tumor, code as Tis
  - Do not enter DCIS, LCIS, or Paget’s in the T data items.

See page 358 for T values
In Situ

- By definition in situ indicates there is not spread to regional/distant organs or lymph nodes
- In order to call a tumor in situ a pathologist must review the entire tumor under a microscope.
- Results from the pathologic review of the entire tumor is recorded in the pT not cT
  - Cannot have a cTis
- See page 12 of the AJCC manual

In Situ Stage Grouping Exception

- An exception was made that allows us to use the pTis for both the clinical and pathologic stage and to use the cN0 for both the clinical and pathologic stage.
**Example 1- v15**

- A breast cancer patient has lumpectomy and is found to have ductal carcinoma in situ with negative margins. Clinically there is no indication of lymph node involvement or distant mets.

<table>
<thead>
<tr>
<th>Data Items as Coded in Current NAACCR Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
</tr>
<tr>
<td>Clin</td>
</tr>
<tr>
<td>Path</td>
</tr>
</tbody>
</table>

Implied value

\[ pT_{is} + cN0 + cM0 = cStage 0 \]
\[ pT_{is} + cN0 + cM0 = pStage 0 \]

---

**Example 1- v16**

- A breast cancer patient has lumpectomy and is found to have ductal carcinoma in situ with negative margins. Clinically there is no indication of lymph node involvement or distant mets.

<table>
<thead>
<tr>
<th>Data Items as Coded in Current NAACCR Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
</tr>
<tr>
<td>Clin</td>
</tr>
<tr>
<td>Path</td>
</tr>
</tbody>
</table>
• If patient has a breast biopsy that is positive for ductal carcinoma in situ. There is no clinical evidence of regional or distant mets. She then has a segmental mastectomy that reveals a 1 cm invasive ductal ca, how do I record AJCC clinical T, N, M and stage group?

<table>
<thead>
<tr>
<th>Data Items as Coded in Current NAACCR Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
</tr>
<tr>
<td>Clin</td>
</tr>
<tr>
<td>Path</td>
</tr>
</tbody>
</table>

\[ pTis + cN0 + cM0 = cStage 0 \]
\[ pT1c + pNx + cM0 = pStage 99 \]

• If patient has a breast biopsy that is positive for ductal carcinoma in situ. There is no clinical evidence of regional or distant mets. She then has a segmental mastectomy that reveals a 1 cm invasive ductal ca, how do I record AJCC clinical T, N, M and stage group?

<table>
<thead>
<tr>
<th>Data Items as Coded in Current NAACCR Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
</tr>
<tr>
<td>Clin</td>
</tr>
<tr>
<td>Path</td>
</tr>
</tbody>
</table>
Assessing the Primary Tumor

- T values 1-3 are driven by tumor size
  - ≤ 20mm
  - >20mm but ≥ 50mm
  - >50mm
- Record multiple tumors in clin or path stage descriptor

Tumors less than 20mm (T1)

- Micrometastasis (mi)
  - Invasive tumor that is no bigger than 1mm
  - a >1mm but ≤ 5mm
  - b >5mm but ≤ 10mm
  - c >10mm but ≤ 20
**Direct Invasion Beyond the Breast (T4)**

- Extension to the chest wall
  - Ribs, intercostal muscle, serratus anterior muscle
  - Not the pectoral muscles
- Ulceration, edema, peau d’orange of the skin of the breast

**Inflammatory Carcinoma (T4d)**

- Primarily a clinical diagnosis
  - Edema, peau d’orange of more than 1/3 of the skin of the breast
  - Skin changes are due to lymphedema caused by tumor emboli within the dermal lymphatics
  - Usually, an underlying tumor is present
(cN) Macrometastases

- Regional lymph nodes that are clinically positive
  - Movable level I or II axillary nodes
  - Mets in fixed or matted level I or II or internal mammary nodes only
  - Mets in level III nodes or axillary nodes and internal mammary or mets in supraclavicular nodes

(cN) Valid Values

- Do not use the pN values to assign the cN unless an exception has been documented.
  - cN is based on clinically detected lymph nodes or
  - Sentinel lymph node biopsy done in the absence of pT
  - A “c” will be added with v16. Values will not change otherwise

See page 359 AJCC Manual
**Sentinel Lymph Node Biopsy (SLNB)**

- If the clinical work-up for lymph node metastasis is negative (cN0), a SLNB may be indicated.
- If the clinical work-up for lymph node metastasis is positive (cN1-3), a SLNB would **not** be indicated.

*Scope it Out: A Change in Sentinel Lymph Node Surgery Coding Practice*, Jerri Linn Phillips, MA, CTR; Andrew Stewart, MA. Journal of Registry Management 2012 Volume 39 Number 1

---

**Pop Quiz**

- Imaging showed a 1cm malignant appearing tumor in the right breast. No enlarged lymph nodes.
- Sentinel lymph node biopsy and excisional biopsy is done on 1/1/16.
  - Path showed 1.3 cm invasive carcinoma.
  - Sentinel lymph node is positive for micrometastasis.

<table>
<thead>
<tr>
<th>Data Items as Coded in Current NAACCR Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
</tr>
<tr>
<td>Clin</td>
</tr>
<tr>
<td>Path</td>
</tr>
</tbody>
</table>

---
**Pop Quiz**

- Imaging showed a 1cm malignant appearing tumor in the right breast. No enlarged lymph nodes
  - Sentinel lymph node biopsy is done on 1/1/16 and patient is found have micrometastasis.
  - An excisional biopsy was done on 1/15/16 showing 1.3cm invasive carcinoma (no lymph nodes removed).

<table>
<thead>
<tr>
<th>Data Items as Coded in Current NAACCR Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
</tr>
<tr>
<td>Clin</td>
</tr>
<tr>
<td>Path</td>
</tr>
</tbody>
</table>

**Pathologic N Values**

<table>
<thead>
<tr>
<th>Pathologic N Values N</th>
<th>Pathologic N Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>2</td>
</tr>
<tr>
<td>0</td>
<td>2a</td>
</tr>
<tr>
<td>0(i-)</td>
<td>2b</td>
</tr>
<tr>
<td>0(i+)</td>
<td>3</td>
</tr>
<tr>
<td>0(mol-)</td>
<td>3a</td>
</tr>
<tr>
<td>0(mol+)</td>
<td>3b</td>
</tr>
<tr>
<td>1</td>
<td>3c</td>
</tr>
<tr>
<td>1mi</td>
<td></td>
</tr>
<tr>
<td>1a</td>
<td></td>
</tr>
<tr>
<td>1b</td>
<td></td>
</tr>
<tr>
<td>1c</td>
<td></td>
</tr>
</tbody>
</table>
Pathologic Assessment of Lymph Nodes (pN)

- Cannot have a pN without a pT
  - If pT has not been established, pN must be blank.
- Isolated Tumor Cells (ITC) vs Micrometastases (mi)
  - ITC’s are clusters of cells not greater than 0.2mm
    - May be assessed by immunohistochemical (i+ or i-) or
    - May be assessed by molecular (mol+ or mol-)
  - pN0
  - Micrometastases (mi) lymph node metastases are >0.2mm and <2.0mm
    - pN1
  - ITC and mi descriptors are only used with pN

Pathologic Assessment of Lymph Nodes (pN1)

- Micrometastasis pN1mi only
- Metastasis in 1-3 axillary level I or II lymph nodes
- cN negative internal mammary mets
- 1-3 axillary level I or II lymph node mets and cN negative internal mammary node mets
**Pathologic Assessment of Lymph Nodes (pN2)**

- Metastasis in 4-9 axillary level I or II lymph nodes
- cN positive internal mammary mets, but no axillary node metastasis.

**Pathologic Assessment of Lymph Nodes (pN3)**

- Metastasis in 10 or more axillary level I or II lymph nodes or mets in level III axillary nodes (infraclavicular)
- cN positive internal mammary mets and axillary node metastasis
- 3 or more level I or II axillary lymph nodes and cN negative internal mammary nodes with pathologically confirmed mets
- Supraclavicular lymph node metastasis
**Metastasis**

- Unless there is documented evidence of distant metastasis cM0
- Metastasis detected clinically but without pathologic confirmation is cM1
- Metastasis detected pathologically is pM1 regardless of whether metastasis is detected clinically.
- Circulating tumor cells in the blood, bone marrow, or other non-regional tissue is cM0+

**Neoadjuvant Treatment**

- Indicate neoadjuvant treatment in TNM Path Descriptor
  - 4 Y (Classification during or after initial multimodality therapy) pathologic staging only
- Patients with distant mets (M1) diagnosed prior to neoadjuvant treatment, will still have M1 disease after neoadjuvant treatment regardless of their status post neoadjuvant treatment.
- We do not collect yc only yp
Pop Quiz

- A patient presents with a 5cm tumor in her left breast extending to the skin causing ulceration. A needle biopsy confirms ductal carcinoma. Imaging showed malignant appearing level I and II axillary nodes and a metastatic lesion in the liver.
- The patient received neoadjuvant chemotherapy followed by a modified radical mastectomy. Final pathology showed a 1.5cm tumor confined to the breast. 23 lymph nodes were negative. Imaging did not show any metastasis.

<table>
<thead>
<tr>
<th>Data Items as Coded in Current NAACCR Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Clin</td>
</tr>
<tr>
<td>Path</td>
</tr>
<tr>
<td>Path Descriptor</td>
</tr>
</tbody>
</table>

Neoadjuvant Treatment

- How should we handle hormone treatment given prior to surgery?
  - When was the treatment started?
  - Is there documentation that the physician does not consider this hormone treatment?
- If it is not being given as neoadjuvant treatment, then do not code TNM Path Descriptor as “4”
- Code treatment items the same as you would if the treatment was neoadjuvant.
Questions?
Quiz 1

And now a brief pause for...
An Epi Moment
(insert “I Am Woman” here)
Breast cancer

- More common in women than men
  - 2015 incidence estimates 246,660 women (plus 61,000 *in situ*) and 2,350 men
  - 2015 mortality estimates 40,450 women and 440 men
- Risk Factors
  - Age, sex, genetics (BRCA1&2—risk of developing 45-65%; other genetic conditions); dense breast tissue (1.2-2x increased risk; mammograms less effective), hormones (early menarche, birth control, HRT), obesity, chest radiation, DES exposure, drinking alcohol
  - Protective: Physical activity and breast feeding
  - Potential: diet, environmental exposures (second hand smoke), night work
  - Disproven: antiperspirants, bras, abortions, breast implants
- Controversies
  - Mammography benefits, DCIS/LCIC
Breast cancer subtypes

- 4 molecular subtypes of breast cancer are approximated by tumor expression of 3 markers collected by cancer registries
- Nationally required data items:
  - Estrogen Receptor (ER) -- SSF1 ER Assay
  - Progesterone Receptor status (PR) -- SSF2 PR Assay
  - Human Epidermal Growth Factor Receptor 2 (HER2) -- SSF15 HER2 Summary Result
- ER and PR jointly defined as Hormone Receptor status (HR)
  - HR+/HER2- (approximates Luminal A)
  - HR+/HER2+ (approximates Luminal B)
  - HR-/HER2+ (HER2 enriched)
  - HR-/HER2- (Triple Negative)
Incidence Rates of Breast Cancer Molecular Subtypes by Race/Ethnicity, 2011

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>HR+/HER2+</th>
<th>HR+/HER2-</th>
<th>HR-/HER2-</th>
<th>Triple-Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic White</td>
<td>375</td>
<td>375</td>
<td>375</td>
<td>375</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>375</td>
<td>375</td>
<td>375</td>
<td>375</td>
</tr>
<tr>
<td>Non-Hispanic Asian/Pacific Islander</td>
<td>375</td>
<td>375</td>
<td>375</td>
<td>375</td>
</tr>
<tr>
<td>Hispanic</td>
<td>375</td>
<td>375</td>
<td>375</td>
<td>375</td>
</tr>
</tbody>
</table>
Breast cancer stage

Rate Ratio of Local vs Distant, breast cancer
Male Breast Cancer

- Rare
  - <1% all breast cancers
  - 2015 Estimates:
    - New cases: 2,350
    - Deaths: 440

- Compared to women
  - Older age, higher stage, lower grade, more ER+/PR+

- Potential risk factors
  - Radiation
  - Genetic Predisposition
  - High estrogen levels
    - Obesity, Cirrhosis, Klinefelter’s syndrome
Male breast cancer issues with coding

Male breast cancer rates: Using the Sex Edit
Male breast cancer rates

- Miscoding of sex disproportionally affects male breast cancer rates
- Without QC, male breast cancer rates are artificially inflated
- QC projects on male breast cancer alone artificially suppress rates
- Appropriate use of Sex Edit (available through NAACCR) can improve quality of sex

Additional information:

Original Article

Misclassification of Sex in Central Cancer Registries

Recsiesa L. Sherman, MPH, PhD, CTR®; Francis P. Boccon, PhD®; David K. O'Brien, PhD, CISP®; Justin T. George, MPH®, Kevin A. Henry, PhD®, Laura E. Sokolay, PhD®, David J. Lee, PhD®


Selected CINA Publications

- ACS Facts & Figures 2015, Special Section: Breast Carcinoma In Situ Link to publication
Site Specific Factors
1,2,3,4,5,6,7,8,9,11,13,14,15,16,22,23

SSF1: Estrogen Receptor (ER) Assay
SSF2: Progesterone Receptor (PR) Assay

- Record highest value if more than 1 test is given
  - Record as positive if any value is positive
- Record value from specimen prior to neoadjuvant treatment
  - Only record post neoadjuvant treatment value if there is no pre-treatment specimen
- Do not record values from Oncogene test in SSF1 and SSF2
Low ER/PR

- The most recent interpretation guidelines for ER do not allow for a borderline result. Therefore, code 030 will rarely be used. **If 1% or greater cells stain positive, the test results are considered positive. If less than 1% of cells stain positive, the results are considered negative.**
- Registrars are to record the pathologist's interpretation of the test result following the above 1% rule, and are NOT to code a value based on how the patient is treated by the clinician.
  - If there is only a statement of weakly positive, the registrar should code the result as "010" Positive/elevated.
  - It is outside the realm of the registrars’ coding responsibility to interpret the values stated on the pathology report based on how the patient was treated.
  - Further, there is no statement in the CS manual that supports this interpretation, and per the CAP Approved Breast Biomarker Reporting Template, a weakly positive result falls under a positive test result.

SSF3: Number of Positive Ipsilateral Level I-II Axillary Lymph Nodes

- Code the number of positive level I and II and Intramammary lymph nodes based on pathologic information
- Code even if patient had pre-operative systemic or radiation treatment
- Do not code lymph nodes with ITCs as positive nodes
- Use code 098 when no axillary nodes were examined or axillary dissection was performed and no nodes were found

http://cancerbulletin.facs.org/forums/forum/rqrs/performance-rates/6963
http://cancerbulletin.facs.org/forums/forum/collaborative-stage/breast/breast-ab/5528
**SSF4: IHC of Regional Lymph Nodes**

**SSF5: MOL Studies of Regional Lymph Nodes**

- **SSF4:** Immunohistochemistry (IHC)
  - Additional test done on negative lymph nodes
  - Use codes 000-009 if CS Lymph Nodes = 000
  - Use code 987 if CS Lymph Nodes does not = 000
- **SSF5:** Molecular (MOL) methods (Reverse Transcription Polymerase Chain Reaction, RT-PCR)
  - More sensitive test to detect ITCs
  - Use codes 000-002 if CS Lymph Nodes = 000
  - Use code 987 if CS Lymph Nodes does not = 000

---

**SSF6: Size of Tumor-Invasiveness Component**

- Code the description that explains code in CS Tumor Size
  - Examples
    - 7 cm breast tumor, intraductal & infiltrating ductal carcinoma; invasive component 3.2 cm
      - CS Tumor Size = 032; SSF6 = 020
    - 7 cm breast tumor per ultrasound; core biopsy positive for ductal carcinoma; patient received neoadjuvant chemotherapy followed by lumpectomy and ALND; lumpectomy path 2.3 cm tumor, residual infiltrating ductal carcinoma with focal intraductal carcinoma
      - CS Tumor Size = 070; SSF6 = 987
SSF7: Nottingham or Bloom-Richardson (BR) Score/Grade

- Code tumor grade in following order
  - BR score (3-9)
  - BR grade (low-1, intermediate-2, high-3)
- Code highest score if multiple scores listed
- BR score not routinely reported for in situ cancers

HER2

- HER2-Human Epidermal growth factor Receptor 2
  - Overexpression of HER2 indicates tumor may grow aggressively
- Tests to measure HER2
  - Immunohistochemistry (IHC)
  - Fluorescence In Situ Hybridization (FISH)
  - Chromogenic In Situ Hybridization (CISH)
**HER 2**

- Record HER2 lab value and interpretation using same test
- Record highest lab value if more than 1 lab value is available
- Record positive value if positive and negative values are available
- Do NOT code HER2 results from multigene signature test
- Use code 998 if documented that test was not done

**HER2 Data Items**

- SSF8: HER2 IHC Lab Value
- SSF9: HER2 IHC Test Interpretation
- SSF10: HER2 FISH Lab Value
- SSF11: HER2 FISH Test Interpretation
- SSF12: HER2 CISH Lab Value
- SSF13: HER2 CISH Test Interpretation
- SSF14: HER2 Results of Other or Unknown Test
**SSF15: HER2 Summary Result of Testing**

- 1 HER2 test done
  - Record results in SSF15
- More than 1 HER2 test done
  - Record results of gene-amplification test if both IHC and gene-amplification are done
  - If gene-amplification done first and IHC done to clarify results, record results of IHC
  - Use code 997 (test done, results not in chart), if results of 1st test available, but 2nd test is done and results are not available

**SSF16: Combinations of ER, PR, and HER2 Results**

- Used to identify triple negative patients
- Based on information coded in SSF1, SSF2, & SSF15
  - Code as negative (0) or positive (1)
    - ER results in 1st digit
    - PR results in 2nd digit
    - HER2 results in 3rd digit
SSF22: Multigene Signature Method
SSF23: Multigene Signature Results

• Multigene signature tests
  • Assay for specific genes
  • Tailor treatment to cancer characteristics
  • Usually done for node negative patients to predict recurrence and response to specific chemotherapy
  • SSF22: Multigene Signature Method
    • Oncotype DX
    • MammaPrint
    • Mammastrat (other)
  • SSF23
    • Record the score, not the percentage

Treatment

Core vs excision
Scope of Regional Lymph Nodes
Surgery Codes
Core Needle Biopsy vs Excision

• “If a needle biopsy preceded an excisional biopsy or more extensive surgery, even if no tumor remained at the time of surgery, both the needle biopsy (Surgical Diagnostic and Staging Procedure) and the Surgical Procedure of the Primary Site are to be reported. Surgical margins must be examined to determine whether a biopsy intended as incisional is excisional instead, and margins cannot be evaluated for a needle biopsy”

FORDS Revised for 2015 pg 138

Pop Quiz

Patient found to have a small spiculated mass on mammogram. Core needle biopsy was done and the patient is found to have invasive ductal carcinoma. Patient returns for an excisional biopsy and no residual tumor is found on biopsy.

• How do we code diagnostic staging procedure and surgery of primary site?
  • Diagnostic staging procedure
    • 02 – a biopsy (incisional, needle, or aspiration) was done to the primary site, or biopsy or removal of a lymph node to diagnose or stage lymphoma
  • Surgery of primary site is
    • 22 – lumpectomy or excisional biopsy
01/15/15 Operative report: Excisional biopsy and sentinel node biopsy done on right breast. Pathology report: Invasive ductal carcinoma with 3 nodes positive for mets

03/15/15 Operative report: mastectomy with axillary node dissection. Pathology report: invasive ductal carcinoma with 7 lymph nodes positive.

How do we code regional lymph node surgery?

Scope of Regional Lymph Node Surgery

Operative Report
- Sentinel Lymph Node Biopsy vs Axillary Lymph Node Dissection

Pathology Report
- Use to complement information in operative report

DO NOT use number of lymph nodes removed and pathologically examined as sole means of distinguishing between Sentinel LN Bx or Axillary LN Dissection
Scope of Regional Lymph Node Surgery

- If two or more surgical procedures of regional lymph nodes are performed, the codes entered in the registry for each subsequent procedure must include the cumulative effect of all preceding procedures.
  - Sentinel lymph node biopsy followed by a regional lymph node dissection at a later time
  - 7: Sentinel node biopsy and code 3, 4, or 5 at different times

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No regional lymph node surgery</td>
</tr>
<tr>
<td>1</td>
<td>Biopsy or aspiration of regional lymph node(s)</td>
</tr>
<tr>
<td>2</td>
<td>Sentinel Lymph Node Biopsy</td>
</tr>
</tbody>
</table>
## Scope of Regional Lymph Node Surgery

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS</td>
</tr>
<tr>
<td>4</td>
<td>1-3 regional lymph nodes removed</td>
</tr>
<tr>
<td>5</td>
<td>4 or more regional lymph nodes removed</td>
</tr>
</tbody>
</table>

## Scope of Regional Lymph Node Surgery

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Sentinel node biopsy and code 3, 4, or 5 at same time or timing not stated</td>
</tr>
<tr>
<td>7</td>
<td>Sentinel node biopsy and code 3, 4 or 5 at different times</td>
</tr>
<tr>
<td>9</td>
<td>Unknown or not applicable</td>
</tr>
</tbody>
</table>
**Pop Quiz**

- When trying to distinguish if a sentinel lymph node biopsy was done, which source document should be used?
  
  a) Pathology Report  
  b) Discharge summary  
  c) Operative Report  
  d) Physician statement in medical record

---

**Pop Quiz**

01/15/15 Operative report: Excisional biopsy and sentinel node biopsy done on right breast. Pathology report: Invasive ductal carcinoma with 3 nodes positive for mets  
03/15/15 Operative report: mastectomy with axillary node dissection. Pathology report: invasive ductal carcinoma with 7 lymph nodes positive.

- How do we code regional lymph node surgery?
  
  - If you code multiple procedures  
    - 2 SLN bx – 01/15/15  
    - 7 SLN bx and code 3, 4, or 5 at different times – 03/15/15  
  
  - If you code only one procedure  
    - 7 SLN bx and code 3, 4, or 5 at different times
What Surgery Code do I Use?

20 Partial Mastectomy, NOS, less than total mastectomy, NOS
21 Partial Mastectomy WITH nipple resection
22 Lumpectomy or excisional biopsy
23 Reexcision of the biopsy site for gross or microscopic residual disease
24 Segmental mastectomy (wedge resection, quadrantectomy, tylectomy)

- These procedures remove the gross primary tumor and some of the breast tissue (breast conserving or preserving). There may be microscopic residual tumor.

What Surgery Code do I Use?

30 Subcutaneous Mastectomy (nipple sparing mastectomy)

- A subcutaneous mastectomy, (nipple sparing mastectomy) includes the removal of breast tissue without the nipple and areolar complex (NAC) or overlying skin.

### What Surgery Code do I Use?

<table>
<thead>
<tr>
<th></th>
<th>Total (simple) mastectomy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td><strong>Without</strong> removal of uninvolved contralateral breast</td>
<td><strong>41</strong></td>
</tr>
<tr>
<td>43</td>
<td>With reconstruction, NOS</td>
<td><strong>42</strong></td>
</tr>
<tr>
<td>44</td>
<td>Tissue</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>Implant</td>
<td><strong>46</strong></td>
</tr>
<tr>
<td>47</td>
<td>Combined (Tissue and Implant)</td>
<td><strong>48</strong></td>
</tr>
<tr>
<td>49</td>
<td>Tissue</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Implant</td>
<td><strong>51</strong></td>
</tr>
<tr>
<td>53</td>
<td>With reconstruction, NOS</td>
<td><strong>52</strong></td>
</tr>
<tr>
<td>54</td>
<td>Tissue</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>Implant</td>
<td><strong>56</strong></td>
</tr>
<tr>
<td>57</td>
<td>Combined (Tissue and Implant)</td>
<td><strong>58</strong></td>
</tr>
<tr>
<td>59</td>
<td>Tissue</td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>Combined (Tissue and Implant)</td>
<td><strong>65</strong></td>
</tr>
</tbody>
</table>

- A total (simple) mastectomy removes all breast tissue, and the NAC. An axillary dissection is not done but sentinel lymph nodes may be removed.

### What Surgery Code do I Use?

<table>
<thead>
<tr>
<th></th>
<th>Modified radical mastectomy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td><strong>Without</strong> removal of uninvolved contralateral breast</td>
<td><strong>51</strong></td>
</tr>
<tr>
<td>53</td>
<td>Reconstruction, NOS</td>
<td><strong>52</strong></td>
</tr>
<tr>
<td>54</td>
<td>Tissue</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>Implant</td>
<td><strong>56</strong></td>
</tr>
<tr>
<td>57</td>
<td>Combined (Tissue and Implant)</td>
<td><strong>58</strong></td>
</tr>
<tr>
<td>59</td>
<td>Tissue</td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>Combined (Tissue and Implant)</td>
<td><strong>65</strong></td>
</tr>
</tbody>
</table>

- Removal of all breast tissue, the NAC and variable amounts of breast skin in continuity with the axilla. May or may not include a portion of the pectoralis major muscle.
Pop Quiz

Operative report states total mastectomy with axillary lymph node dissection. What is the surgery code?

a) 30
b) 40
c) 50
d) None of the above


What Surgery Code do I Use?

<table>
<thead>
<tr>
<th>60</th>
<th>Radical Mastectomy, NOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>WITHOUT removal of uninvolved contralateral breast</td>
</tr>
<tr>
<td>64</td>
<td>Reconstruction, NOS</td>
</tr>
<tr>
<td>65</td>
<td>Tissue</td>
</tr>
<tr>
<td>66</td>
<td>Implant</td>
</tr>
<tr>
<td>67</td>
<td>Combined (Tissue and Implant)</td>
</tr>
<tr>
<td>62</td>
<td>WITH removal of uninvolved contralateral breast</td>
</tr>
<tr>
<td>68</td>
<td>Reconstruction, NOS</td>
</tr>
<tr>
<td>69</td>
<td>Tissue</td>
</tr>
<tr>
<td>73</td>
<td>Implant</td>
</tr>
<tr>
<td>74</td>
<td>Combined (Tissue and Implant)</td>
</tr>
</tbody>
</table>

- Involves removal of breast tissue, NAC, variable amount of skin, pectoralis minor and/or major as well as en bloc axillary dissection
What Surgery Code do I Use?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td>Extended radical mastectomy</td>
</tr>
<tr>
<td>71</td>
<td>WITHOUT removal of uninvolved contralateral breast</td>
</tr>
<tr>
<td>72</td>
<td>WITH removal of uninvolved contralateral breast</td>
</tr>
</tbody>
</table>

- Involves removal of breast tissue, NAC, variable amounts of skin, pectoralis minor and/or major, internal mammary nodes and en bloc axillary dissection

Since you Asked: Questions from you!

- How do you code Intraoperative Radiation Therapy IORT?

- How do you code new things like SAVI spacer?

- What about AccuBoost?
Questions

Quiz 2
Case Scenarios

Coming up!

- 3/3/16
  - Abstracting and Coding Boot Camp: Cancer Case Scenarios

- 4/7/16
  - Collecting Cancer Data: Ovary
**Fabulous Prize Winners Are…**

![Ring and Heart Images]

**CE Certificate Quiz/Survey**

- Phrase
  - Axillary

- Link
Thank You!

Jim Hofferkamp
217-698-0800 x 5
jhofferkamp@naaccr.org

Angela Martin
217-698-0800 x 9
amartin@naaccr.org