# Q&A Session for Collecting Cancer Data: Bladder2016

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Q1: Your 5 year survival by stage table only adds up to 99% what happened to the 1%? ­

A1­: The percentages are estimates and the not adding up to 99% is due to rounding error.

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Q2: ­Is it known if uranium in water increases risk of bladder cancer?

A2­: From Recinda Sherman - ­Not for bladder cancer--the naturally occurring levels of uranium in water may confer a risk with other cancers though for leukemia, kidney or lung. There may be higher risk for situations like the issue in Japan but I don't believe there has been much research released yet. -

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Q3: ­Is there any risk associated with tap water?

A­3: From Recinda Sherman - If you get your tap water from a well with arsenic, there is a low level risk. However, the vast majority of people in the US and Canada use public water systems so no risk.

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Q4: ­If a patient has multiple/several incidences of bladder cancers over the course of several years, some invasive some in situ, for applying MPH rules do you always refer back to the very first incident? ­

A4: Yes. You always refer back to the first incidence.

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Q5: ­In regards to rule M7, does that apply to the original DX date or their recurrence(s) date? Ex: if patient was DX in 2010, had recurrence in 2011, 2013 and 2015, would the 2015 be another primary or a recurrence? ­

A­5: The original diagnosis date. We had this confirmed by SEER.

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Q6: ­So if your very first diagnosis is noninvasive and you have multiple invasive occurrences more than 60 days after the first dx would each of those invasive diagnoses be multiple primaries?­

A6: The first invasive tumor would be a second primary. If all of the invasive tumors are urothelial and occur in the bladder, rule M6 would apply and you would only have the two primaries. If one of the invasive tumors was outside of the bladder than rule M7 or M8 or a higher rule could apply.

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Q7: ­Quiz 1 Question 5 does not state bladder rates shouldn't the answer be false? ­

A7: Thank you for clarifying that. This question was in regard to bladder rates. So true is the correct answer. Sorry for the confusion.

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Q8: ­Questions 8 and 9 would be improved by stating these where INVASIVE cancers of the bladder. It's important to look if one if invasive and other in non-invasive.­

A8: Thank you for clarifying. Yes the in situ or invasive nature of the tumor is important when determining multiple primaries. The assumption was made that if it was not stated as in situ then it was invasive. Sorry for the confusion. We should have stated if the tumors where in situ or invasive.

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Q9: ­For Quiz 1 question 10, is the histology TCC because the histology already present from the original tumor should be maintained in the database? Would you not apply H4 for this scenario? ­

A9­: You would already use the histology already present from the original tumor in the database. You would not apply rule H4.

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Q10: ­Please ask for Quiz 1, Questions 8-10: Since there was no timing/date for the “pt comes in complaining…” what would the answers be if this presentation was in 2016? ­

A10: Thank you for clarifying. We did assume that this presentation was for 2016. The answers would still be the same. Sorry for the confusion.

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Q11: ­If "muscle" is not mentioned in the path report - do you assume that it is "in situ"?

A11­: No. A tumor that invades the submucosa, the layer before the muscular layer would be defined as invasive.

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Q12: ­Please ask: For your explanation of slide #32, “Labels vs Values”, what is your definition of Labels and your definition of Values? Your explanation was not clear to me.

A12­: Labels are the definitions that you will see in the pull down menu. The values are what will be entered in the data files. For example for the data items sex, you see labels such as “1-Male” or “2-Female”. Those are labels. What actually goes into to data file is simply a “1” or “2”. For TNM the label for the cT might be “cT1”. That is what you would type or select from your pull down. What would actually go into the data file would simply be “c1”. It’s a minor thing and if I had just started using the labels in my examples instead of the values, I doubt if many people would have noticed. I hope I didn’t cause too much confusion!

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Q13: ­ Many of the AJCC chapters are ambiguous in regard to requiring lymph node dissection for pathologic staging. For these chapters is it correct to refer back to the general rules and consider a case unstageable if no path exam of lns?­

A13­: From Donna Gress­ (­dgress@facs.org­)­ - The criteria for pathologic staging does NOT mean you have to have nodes removed....so it qualifies for pathologic staging, but you cannot assign the pN unless a node is removed­

From Jim Hofferkamp: I think it is safe to say that unless the site chapter says you do not need a lymph node removed to assign a pN, then you would

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Q14: ­Can you please briefly explain when Stage group is assigned- 99? Ex- if you have a pT but not eligible for pN or pM can you assign Stage Group? Thanks­

A14­: Stage group 99 is not an official AJCC TNM value. 99 is used as a default code whenever a stage group cannot be calculated based on the T, N, and M values. Stage group can never be left blank (clinical or path). An edit will be triggered if it is left blank.

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Q15: ­Where in the AJCC Manual is the rule that says if you have pT (blank) and pN (blank) you cannot use cM in the abstract? Is this “all or nothing” scenario universally applicable? I understand that either way the Stg Grp can’t be assigned and will be 99.­

A­15: You should start off with the premise that you should only enter clinical values in clinical data items and pathologic values in pathologic data items unless there is an exception in the manual saying you can do otherwise. There is a rule in Table 1.7 row 5 on page 11 that says cases with pT and pN may be grouped as pathologic using cM

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Q16: ­If all you have is a raised tumor and code to Ta - can you then code the histology to 8130 rather than 8120? ­

A16­: This was sent to SEER and we are still awaiting an answer.

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Q17: ­Is invasion of lamina propria equivalent to invasion of sub epithelial tissue for AJCC? ­

A17­: Yes.

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Q18: ­Pathological staging in AJCC book indicates do not include clinical staging. Pop quiz 2 should the pt be pt0­

A18­: From Donna Gress­ (­dgress@facs.org­) ­ – You must include clinical stage when assigning pathologic stage­.

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Q19: ­Can you review the rule when you use the clinical information to supplement the pathologic stage? ­

A19­: First, let’s look at the difference between clinical and pathologic stage. Clinical stage is reflecting what the physician thought the stage was prior to any treatment. Pathologic stage is what the physician thought after the definitive surgery.

Second, let’s look at the rules for classification. These are the rules that tell us the minimum that needs to be done before the physician has enough information to assign a T, N, M and stage group. For clinical stage, the minimum requirement is pretty low. For pathologic stage, it is usually that the entire tumor and at least one lymph node has to be removed before a stage group can be assigned. There are exceptions and Bladder is one of them. For Bladder a TURB excising the entire tumor is part of the clinical work-up. Removal of part or all of the bladder is required for pathologic stage.

So back to your question. The first thing when assigning stage is to make sure the minimum requirements were met to at least assign a pT (cystectomy). Once, we see the requirements were met we then look at the whole picture. The physician would not “forget” what they found from the clinical work-up (TURB). They would supplement what they found during the definitive surgery with what they found during the clinical work-up. For example, if a TURB showed a tumor that was a T1 and then the cystectomy did not show any residual tumor, then the cystectomy is confirming that the TURB did remove all of the tumor and the patient truly had a T1. However, if the cystectomy showed residual tumor invading into the superficial muscle, then we would know the TURB did not get all of the cancer and the patient actually had a T2a.

I know this is a confusing concept but once you get your mind around it, it does make sense.

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Q20: ­Does the information on slide 42 (T2a/T2b cannot be used in cT data item) apply to slide 44 for T3a/T3b? That is, T3a/T3b cannot be used in cT data item? ­

A20­: Yes

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Q21: ­Can "thickening" of bladder wall on imaging be assigned T3 or does the "thickening" have to be on bimanual exam? ­

A21­: From Donna Gress­ (­dgress@facs.org­) ­ - I wouldn't use imaging for bladder thickening UNLESS the physician makes a statement - you are right, you can have thickening for other reasons and a registrar can't say that.... only a physician can ­

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Q22: ­noninvasive papillary low grade=1, high grade=3­

A22­: These were based off of 2012 rules. Instructions for Coding Grade for 2014+ are the rules that we need to use in order to record grade.

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Q23: ­For a cT3 tumor, can you assume cN0? ­

A23­: From ­Donna Gress­ (­dgress@facs.org­)­ – A physician may use their judgement - it does NOT have to be just T1 or T2....i agree that I would worry about T3, let me look at NCCN and see if there are some guidelines, sometimes they say how often nodes are found

­A: From Donna Gress­ (­dgress@facs.org­) ­ - NCCN guidelines show that a cT2, cT3, cT4a SHOULD have CT or MRI to check for nodal involvement......so that tells me there is a risk of positive nodes with T2 or higher.

A: From Jim Hofferkamp-Donna makes an excellent point and I would like to take it a little further. On a different slide we talked about the “inaccessible site rule”. This was a rule in CS, but is really more of a concept with TNM staging. This concept tells us that if a patient has a low clinical T value (usually T1 or T2) and is treated like there are no lymph node mets, then it is ok to give a cN0. You have to be really careful with this concept when it is you as a registrar assigning the cN. For many sites I think you would be pretty safe assigning the cN0 if the patient had a T1 or T2. As Donna points out above, that isn’t necessarily the case for bladder. For bladder if the tumor has invaded into the muscle (T2), the risk of lymph node mets is too high to apply this concept with any confidence. However, if the physician assigned it a cN0, then that is what should be entered into the cN data item.

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Q24: ­Clinically, how do you differentiate between T3 & T4? ­ Stated bladder thickening was T3, but AJCC says T3 &/or T4. How do you differentiate? ­

A24­: Ideally, it would be the physician making the call. If that is not possible, then the AJCC staging atlas gives some help. It says that if during the bimanual exam, the bladder is described as thick, then go with T3. If the tumor is described as “fixed” or “massive”, then T4.

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Q25: Quiz #3: if no lymph nodes were removed can we still use cN0? If not - why?

A25­: Since the path from the cystectomy showed the tumor was invasive, we can no longer apply the "in situ" rule. Therefore, the standard rules for classification apply. In order to enter a valid value in pN, at least one LN must be removed.

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Q26: ­Back to pop quiz 3. Can you explain why under the clinical after a turb it is listed as a pTis and not a cTis for a TURB procedure?

A26: cTis is not a valid value for any site (you will get an edit if you try to use it). If a tumor is in situ, code it as pTis. There is a rule that tells us we can assign a pTis to the cT data item.

Q27: ­For surgical margins of primary site field - if all you have is a TURB - could you code a 7 (when no margins are mentioned) ­

A27­: On FORDS pg. 242 in the Instructions for coding it states Code 9 if the pathology report makes no mention of margins or no tissue was sent to pathology. So if on the pathology report makes no mention of margins you would use code 9.

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Q28: ­When a TURP is performed along with TURB and TCC is found in the TURP specimen, what advice can you provide whether this should be T4a or should be ignored?? Usually no documentation in operative report whether bladder tumor involves prostate.­

A28­: You can follow this question at (you may need to cut and paste the link into your browser).

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/education-developed-by-partner-organizations/naaccr-webinars>

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Q30: ­Case Scenario 1: CT indicated tumor right bladder wall so should topography = C67.2? ­

A30­: See below.

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Q31: ­For scenario 2 - should the primary site be C67.2 for the lateral wall noted in the pathology? ­

A31: The SEER Program Coding and Staging Manual has some Coding Guidelines for Bladder have a priority order for Coding Subsites. It states to use the information from the Operative report (TURB) then the pathology report when the medical record has conflicting information. If we follow this, then we would use the information from the Operative report which stated “mass on the right trigone…” So the primary site would be C670.

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Q32: ­The case mention mass in the trigone, why you code bladder NOS? ­

A­32: You are correct. The primary site should be coded to Trigone C670.

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Q33: I thought you could not use ambiguous terms for AJCC staging- should it be M0??

A33: Ambiguous terms can be used as consideration. However we have to look at the big picture. The CT done after chemo had the liver disease responding to treatment for Case scenario 1.

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Q34: For Scenario #2 - why is the clinical T a cT3 vs a CT2?

A34: The correct answer is cT2.

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Q35: ­C679 for case scenario 2 correct-multiple tumors in different regions of bladder­

A35­: The SEER Program Coding and Staging Manual has some Coding Guidelines for Bladder. For Multifocal tumors it states “If the TURB or pathology proves invasive tumor in one subsite and in situ tumor in all other involved subsites code to the subsite involved with invasive tumor. So we would look for the subsite of the invasive tumor. In Case Scenario 2 we also have conflict on the primary site between the Op Report and Path report. The same document has a priority order for Coding Subsites. It states to use the information from the Operative report (TURB) then the pathology report when the medical record has conflicting information. If we follow this, then we would use the information from the Operative report which stated “mass on the right trigone…” So the primary site would be C670.

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Q36: ­Please clarify MPH rule M7 using the following scenario: PT was dx’d with in situ PTCC in 2004. Returns in 2014 with in situ PTCC. This is still one primary because it is the same histology and the timing (over 3 years apart) would be ignored, correct? ­

A36: ­If the tumors are of the bladder then you would stop at Rule M6. If they are not of the bladder then you would move to rule M7.­

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Q37: ­People are over counting bladder tumors using rule 7 based on the timing rule of 3 years between recurrences. I understood that rule M7 is only used if the bladder tumor is not in the TCC family of tumors.­

A37: I am not aware of any such clarification. It is my understanding that rule M7 applies to all histologies. This would include tumors in the TCC family, those not in the TCC family, or a combination. I don’t see how this would impact incidence rates.

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Q38: ­M7 just says "tumors" diagnosed more than years apart...It does not specify that it means tumors not in the bladder, so that is probably why people are using it to over count bladder tumors.­

A38: ­Good point! Rule 6 applies to urothelial tumors in the bladder. If all of the tumors are in the bladder and are urothelial, then you would never get to rule M7.­

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Q39: ­On slide 53 Jim mentioned that if the CA was not urothelial that we would code 999. Can you clarify? ­

A39: ­I should have said if the grade system was not WHO....997 would be used if not a urothelial tumor.­

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Q40: ­Is okay to mention an "Inaccessible site rule" for AJCC since this is mentioned in CS. It would be easy for registrars to intertwine the two.­

A40: ­That's a good point. For the most part you should not try to apply CS rules to AJCC staging. However, the inaccessible site rule was originally developed by AJCC and then adopted by CS.

However, for AJCC the Inaccessible site rule is really more of a concept than a rule. See the response to Q23.

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Q41: ­Are tumors described as arising in the "bladder base" coded to trigone/floor for topography? ­

A41: ­Yes. See the SEER coding guidelines for Bladder. <http://seer.cancer.gov/manuals/2016/AppendixC/Coding_Guidelines_Bladder_2016.pdf>

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Q42: ­If a TURB showed in situ would it be coded as Tis in both the path and clinical T fields just as the Ta is done?­

A42: ­Yes! Good point! The in situ rule applies to both Tis and Ta.­

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Q43: ­Is a TURB to be considered definitive, or curative treatment for Ta, Tis, and T1 tumors? ­

A43: I’m not sure what you are getting at. If you are asking if they should be coded as a surgical procedure, then yes. If you are asking if they meet the criteria to assign a pT, then the answer is no.

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Q44: ­If a TURBT is done what do you code the tumor status as with evidence, without evidence or unknown? ­

A44: ­Are you referring to Cancer Status?­ ­If so, if the physician is stating that there is cancer then I would code 2 - evidence of this tumor. Instructions for coding state that cancer status is based on info from the patient’s physician or other official source such as a death certificate.

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Q45: ­TURB not count for diagnostic and staging procedure? ­

A45: A transurethral resection of the bladder is considered surgery.

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Q46: How does the use of electrocautery when resecting bladder tumors affect staging?

A46: I am not aware of any impact to staging.