Abstracting and Coding Boot Camp
Thursday, March 1, 2018

Q: I thought that you can only have a pathological grade or a post therapy grade. Shouldn't pathological grade be blank for quiz 2?

A: Pathological grade will never be blank. For the bladder grade if you look in the instructions it states in Note 1: Pathological grade must not be blank.

Q: I've copied and pasted both urls from page 2 of the slides and both return an error 'Page Not Found'. Can you please give us the correct urls?

A: I noticed that when I clicked on the web links from the slides I receive the same error. When I typed in the web link, it took me to the page I needed to go to. You can also get the same pages by going to the NAACCR website (naaccr.org), looking Under Announcements and clicking on ***2018 Implementation*** and ***2018 Implementation Open Forum***.

Q: Does the AJCC clarification for melanoma still apply for 2018? The clarification document stated even an excisional biopsy is part of clinical classification and NOT pathological.

A: Yes, the initial excisional biopsy is used to code cT and clinical grade. That is true pre-2018 and 2018 forward.

Q: For Pop Quiz 6: mycosis fungoides (9700/3) is listed in the Heme Manual as Grade Code 5...will this be updated to correspond with these new Grade Rules

A: Yes! Great question. This will be reflected in the updated manual that will be posted in a couple of weeks.

Q: Can you repeat what manual you are using?

A: For grade we are using the ***2018 Grade Manual***: ***Grade Coding Instructions and Tables***. You can find this on the 2018 Implementation page on the NAACCR website.
https://www.naaccr.org/2018-implementation/

Q: The clarification is in the text in the AJCC 8th edition, question is whether new grade rules follows the AJCC rules for clinical/pathological classification?

A: In most cases (including melanoma) the answer is yes. There are some situations where the clin/path rules for grade are not quite in alignment with AJCC. We will go over that in more detail during the definitive training this spring.

Q: Can you give an example of when we would use code D from the grade 24 table for brain if we are to use the AJCC table 72.2?

A: It is important to capture the WHO grade for these tumors of the Brain. Some tumors have a WHO grade associated with them even if not explicitly stated. The table 72.2 in the AJCC manual, gives a list of those tumors. If you have a tumor that is not listed in that table AND no WHO grade listed then you would use the other grade codes from the ***2018 Grade Manual***: ***Grade Coding Instructions and Tables***.

Q: In question 8, why is the pathological grade 9 when there was no resection done?

A: Pathologic grade can never be blank. If no resection is done, it should be a 9.

Q: Can you explain if you are to take the clinical grade for path if higher - what is the reason behind splitting out the clinical and path grade for 2018?

A: You are trying to show the grade information the physician had to work with prior to any treatment (clinical grade) and what they had to work with after surgical resection, but before adjuvant treatment (pathologic grade). The physician wouldn't "forget" the grade from the initial biopsy so information from the clinical grade can be used to assign the pathological grade value.

Q: Lobular carcinoma in-situ is considered benign with AJCC 8th edition. On quiz 1 questions 7 would we only consider the intraductal carcinoma in-situ when assigning a ICD-O histology code? Or would it be a combined code?

A: If the discussion is about assigning histology, then you would need to refer to the Solid Tumor Rules (MPH) rules for what to code the histology. AJCC is used for staging only, not coding histology or determining reportability. Remember, lobular carcinoma in situ is reportable. You just can't assign an AJCC stage. I would use the combination code for assigning the histology. Whether you can assign an AJCC stage or not, you would still assign a clinical/pathalogical grade.

Q: In a scenario with patients that have a lumpectomy or excisional biopsy, and then go on to have further surgery like a mastectomy, would we code grade from lumpectomy in clinical and then grade from mastectomy in pathological?

A: No. Clinical grade reflects the grade prior to any treatment. It is the information the physician had to work with when they decided their initial treatment plan. Pathological grade would be the highest grade found before the patient had adjuvant treatment. It can be based on all path reports the physician has access to after the first treatment related surgical procedure and before any adjuvant treatment.

Q: Will blank be a choice to code or leave it blank, when software changes are out?

A: Blank will not be an option for clinical or pathological grade when the software comes out. Blank will be a choice for post-therapy grade.

Q: For Quiz 2, question 3, if my path indicates squamous cell ca with p16 positive do I use 8085/3?

A: Yes. That would be appropriate.

Q: It would be worth mentioning the behavior change for inv micro papillary carcinoma. Prior to 2018, the SEER site/histology validation only recognized 8507/2 for breast and we had to use the behavior rule to code 8507/3.

A: Excellent suggestion. I'll make sure we discuss that during our definitive training.

Q: Is lobular in-situ still considered to be benign? Or would we need to include it if it is listed in the histology?

A: AJCC has indicated lobular carcinoma in situ is not eligible for AJCC staging. Lobular carcinoma in situ is still a reportable disease and is eligible for summary stage.

Q: Quiz 2, Question 5, is histology code 8550/3 not coded in 2017 due to primary site as Prostate?

A: Correct, the MP/H rules tell use to code acinar adenocarcinoma of the prostate to 8140/3. Remember the updated ICD-O-3 codes are for cases diagnosed in 2018.

Q: If these sentinel node codes are required for breast & melanoma only, do we leave blank for all other sites?

A: Yes. In fact, you will get an edit if you complete them for any sites other than melanoma of the skin or breast.

Q: Would these new codes for SLN be blank for all other sites except breast and melanoma?

A: Yes.

Q: Are the dates not in YYYYMMDD any more?

A: Technically, yes. However, most vendor software allow registrars to enter them in the standard mm/dd/yyyy format. There also flags associated with these date fields that we are not covering today.

Q: Quiz 11 regional LN positive you said 95 shouldn't this be 00 as on the slide?

A: The core biopsy of the lymph nodes was positive for mets. That makes it 95 even though all nodes removed after the neoadjuvant treatment were negative for mets.

Q: Pop quiz 11 text states nodes were negative, why was it “95?

A: The core biopsy of the lymph node was positive for mets. That makes it 95.

Q: In pop Quiz 11, how do we account for positive LN that was biopsied?

A: See the instructions for coding regional nodes positive and regional nodes examined. Regional nodes positive includes the total number of positive lymph nodes identified both before and after neoadjuvant treatment.

Q: Address this scenario & if it will create edit: "Blue" node removed during a sln bx, but on path it turns out to not be a lymph node, ie fibroadipose tissue. How do you code date of sln bx, LNs+ & LNs exam'd?

A: Good question, I’ll send this to CoC for clarification. I can't remember the term used when a sentinel node procedure is done, but no nodes were examined.

Q: In quiz 3 - 1st one, If you don't know the number of sln bx, should the number examined be 98, rather than 15?

A: I think 15 is correct. The scenario states that 1 node found during the sentinel node procedure was positive (1 sentinel node) and that 2 nodes found during the axillary node dissection (2 axillary nodes). The total pos/removed was 3 (1 sentinel and 2 axillary) of 15. Based on that, I feel it is safe to assume 3/15 includes lymph nodes removed during the sentinel node procedure and during the axillary node procedure.

Q: Quiz 3, first scenario: Could the SLN Examined data item be 01? In the scenario it states “the SLN was positive so surgeon proceeded with ALND”. “malignancy was seen in 1 SLN and 2 ALNs” as a summary of all findings.

A: Based on the terminology the physician used, 1 would probably be ok. I originally had 1 or 98 for the answer.

Q: Will there be edits on the radiation fields that require calculation?

A: Not in the initial metafile release.

Q: Isn't total dose supposed to be a 6 digit number?

A: Yes.

Q: What information differentiates between a code 00 vs code 99 for radiation to draining lymph nodes?

A: Use code 00 if the patient did not have radiation at all or if they had radiation, just not to the primary site. 99 would be used if it is unknown if radiation was given. For example, 99 might be used if radiation was recommended, but you don't know if it was done.

Q: What should volume code be for pelvic sidewall for cervix primary? Cervix or pelvic nodes?

A: Good question! I went with 06. One of the radiation oncologist agreed and another thought it should be coded 71. We’ll try to get this scenario clarified.

Q: Case 2 - should primary treatment volume be 65 since the whole prostate is not being treated?

A: It is my understanding that seed implants radiate the entire prostate.

Q: Isn't MeV electrons?

A: Yes!

Q: For radiation to draining LN data items, based on the coding instructions, it seems code 00 is meant to be used when there is NO radiation treatment AT ALL, and 88 when psite is LNs as you said, but also when there was no RT to draining LN.

A: I do not thing that is the intention. We will get this issue clarified.

Q: On case 3, that 15 MeV also states just before that it was given in a 4 filed technique. Would that be where the Rad Onc was stating it would be coded as a 3D technique which would have been previously coded as 32?

A: I believe that is correct.

Q: How can we grade when there has been neoadjuvant pre surgery?

A: The reason we created a new data item call Post Therapy Grade is so grade can be collected for patient that have surgery after neoadjuvant therapy. You are correct that grade from tissue collected after neoadjuvant treatment should never be used to assign the Clinical or Pathological Grade.

Q: Yesterday we were advised that the only clinical grade had to be coded if there was not a path resection by Jennifer and the path and post neoadjuvant treatment grade would be blank.

A: If the patient had an incisional biopsy of the primary site and no resection of the primary tumor, then Clinical Grade would be assigned. Pathological Grade would be 99 and Post-Therapy Grade would be blank. I was not on the webinar where this was discussed, but I do know that Jennifer Ruhl understands this coding concept.

Q: On number 4 - Grade Post-Therapy she said "9" but screen shows "blank". Is it 9 or blank?

A: She mis-spoke. The screen was correct. There was no neoadjuvant treatment, so PT grade has to be blank.

Q: For grade, if we have an in situ tumor and an invasive tumor, but only the in situ has a grade given, do we use the in situ grade?

A: In the general grade coding instructions for solid tumors it states that if there are both in situ and invasive components, code only the grade for the invasive portion even it its grade is unknown.

Q: It would be helpful if the serous carcinoma, high grade be listed by the histology first then state the grade. Cases may be missed if registrars are not looking by grade term first.

A: We are working on a list that would list it both ways, like the ICD O 3 manual does.

Q: Can you clarify the field Date of Sent. LNode biopsy slide 26 where it states record date of sent ln bx procedure, then it states do not record the date of ln asp, FNA, core bx, needle bx. Seems contraindicated.

A: With this data item you are trying to capture the date a Sentinel Lymph Node biopsy was done. If a lymph node aspiration, core biopsy, or needle biopsy are done and are not part of a sentinel node procedure, then they should not be collected in the Sentinel Lymph Node Biopsy data items.

Q: What is the thinking of requiring only recording date LN examined and Ln nodes positive on melanoma and breast. Wouldn't this information be informative and comprehensive for all cancer cases?

A: In some cases yes and at some point in the future these data items may be collected for additional sites. For now, it should only be collected for these sites.

Q: I notice the order of the SLN fields of Exam/Pos are different than our usual LN fields of pos/exam. Is this how it will be, or just presenter preference?

A: I am not sure how they will be presented in the software and I would guess vendors will be make them consistent.

Q: Are draining lymph nodes any regional lymph nodes?

A: I assume so but we will get clarification on this.

Q: Is there any possibility with all the changes to make it more efficient/streamlines is there any way to enter the total dose first , then the number of fractions and let the software auto-populate the dose per fraction?

A: That would be nice! That is something a vendor might be able to do.