# Q&A

# Breast Webinar

Q: ­One of my investigators is interested in knowing when Oncotype DX data collection was implemented. That data is collected in SSFs 22 and 23. I remember that the SSFs for breast were expanded, but I don’t recall when....2007, 2010???­

A: ­The SSF fields were expanded in 2010 with CS version 02.00.00­ and at that time SSF’s 22 and 23 were required. However, starting with 2012 it was requested that any newly identified 2004-2009 cases that were abstracted include these ssf’s.

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Q: ­What do you assign for AJCC stage if the patient has a core needle biopsy and it is in situ, then you don't have anything to report on the resection because the patient never came back or the patient refused surgery?

A­: You could have the clinical stage of pTis cN0 cM0 Stage 0. However, the pathologic stage would be blanks because you do not meet the rules for classification in order to get a pathologic stage.

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Q: ­Can you please address MPH & ICD-O instructions to code Paget’s behavior to /3 vs TNM instruction to code Paget’s behavior to /2? Which instruction should we follow for coding behavior of Paget’s of the breast? ­

* When Paget disease is present and stated to be in situ and the underlying tumor is intraductal carcinoma, code 8543/2 per Rule H24. AJCC T value would be Tis.
* When Paget disease (NOS) is present and the underlying tumor is intraductal, code 8543/3 per rule H25. AJCC T value would be Tis.
* When Paget disease is present and the underlying tumor is invasive ductal, code 8541/3 per rule H26. AJCC T value would be based on the size or extent of the underlying tumor (T1-4).

In the AJCC Manual pg 347 Clarification that only Paget’s disease NOT associated with an underlying noninvasive or invasive breast cancer should be classified as Tis (Paget’s) and that Paget’s disease associated with an underlying cancer be classified according to the underlying cancer (Tis, T1, etc). Remember AJCC Manual includes rules that give us stage not the rules that give us behavior. We would use the rules in the MPH and ICD-0-3 to determine behavior not stage. We need to keep these things separate.

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Q: ­on screen 19, it's stated that the entire tumor must be examined for a value of pTis. On screen 23, a pTis is bases on a needle biopsy and not an examination of the entire tumor. On excision the stage is changed to T1b. How can this be pTis? ­

A­: In most circumstances the entire tumor does have to be removed to assign a pTis. The exception would be if all that was done was a core biopsy and based on that information the physician felt the tumor was in situ. A pTis based on core biopsy can only be entered in the cT data item. The pTis cannot be entered in the cT data item unless there is some kind of pathologic confirmation. It could not be based on imaging. A pTis can only be entered into the pT data item if the entire tumor was removed.

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Q: ­How do you clinically code the N if the nodes are stated to be positive on mammogram/US or other imaging? No biopsy of nodes was done.­

A: You would use the appropriate clinical N code to code those positive nodes. A biopsy is not required to assign a clinical N value.

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Q: ­How would you stage the 2nd pop quiz if the sentinel node biopsy was not done before the excisional biopsy­?

A: If sentinel node biopsy was not done prior to the excisional biopsy but was done during or after the excisional biopsy, it could only be used to assign pStage. The information would not be used to assign clinical stage.

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Q: ­Please explain how you get pN1mi on slide 32 vs pN1? ­

A: ­Micromets are defined as tumor deposits greater than 0.2mm but not greater than 2.0 mm. Cases in which at tumor is found in the node, but the tumor measures less than 2mm, regardless of the number of involved nodes are classified as pN1mi or pN1mi(sn) as appropriate and the number of involved nodes should be noted. Pg 356 in AJCC Manual - I had the same exact question when I was going through it myself! ­

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Q: ­For LNs what is the difference between level and station? ­

A: When I think of lymph node “stations” I think of the Naruke lymph node map which organizes hilar and mediastinal lymph nodes in terms of “stations”. I usually associate this with lung primaries. The axillary lymph nodes are commonly organized into “levels”. Level I, II, and III. These are commonly associated with breast primaries.

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Q: ­In the Neoadjuvant treatment pop quiz scenario for survivorship purposes would treatment be considered curative or palliative? And now that they are free of disease would you consider them eligible from a survivorship standpoint? ­

A: ­I just got this from a participant...For Survivorship Care Plans, mets at diagnosis disqualifies patient from needing a survivorship care plan.

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Q: ­question on clinical nodes - what if they do not state MOVEABLE, do we assume that­ are moveable?

A­: From Donna Gress­ (­dgress@facs.org­) ­ yes, you can usually presume movable, fixed is a big deal and they would always say this­.

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Q: ­If the breast ultrasound shows a 1.8 cm lesion, and the physician states in his PE that the tumor measures 2.5 cm, what clinical T value do you assign-- cT1c or cT2?­

A­: From Donna Gress­ (­dgress@facs.org­) ­ - yes, take the most accurate tumor size, not just the largest, we are going to try and explain this better in the 8th edition­

*Thank you Donna! From the NAACCR Staff.*

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Q: ­On slide 41, why do we code the actual results after neoadjuvant treatment for the T & N but ignore it when coding the M? We would like to understand why we do this? ­

A: ­I think it has to do with prognosis. The rules are clear about this. See the discussion of the Post treatment ypT at the top of page 359.

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Q: ­Can't trauma to the breast be a risk factor? ­

A: ­I asked Recinda this and she trauma to the breast is not a risk factor. It is one of the “myths” associated with breast cancer.­

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Q: ­If the ER PR are both positive on the path report, but the Oncotype DX is coded as triple negative and the physician treats the patient as triple negative - how do you code ER/PR­?

A: ­The rules address this situation. ER and PR should be based on path report so they would be coded as positive. If possible, follow-up with physician or pathologist to see if there was another test done.­

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Q: ­Is there any correlation between a triple negative and certain histologies?

A: Triple negative cancers are a collection of a number of different histologies. The majority are infiltrating ductal, NOS (8500/3).

Medullary and atypical medullary, metaplastic, secretory, myoepithelial, and adenoid cystic are less common breast histologies, but the majority of them are triple-negative (or basal-like, approximated by triple-negative).

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Q: ­Can you explain whether Her2 testing has more to do with genetics or the type of cancer?

A: HER2 is a protein found in some cancers that control the growth and spread of the cancer. While there may be a genetic component that predisposes a person to develop HER2+ or HER2- cancer, the testing is focused on the identifying the type of cancer to inform treatment and prognosis. HER2- cancers are less amenable to chemo therapy and often require combination therapies.

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Q: Follow-up with pop quiz on pg 74 - when would you use code 23 bx followed by an excision/lumpectomy.­

A: Per CoC you would use code 23 when the patient had a lumpectomy and then returned later for a re-excision.­

CoC: <http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/surgery/6499>

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Q: ­1. When the report states HER2/NEU only, is it assumed it is by IHC and coded on SSF 8 and 9? Same for HER2 Herceptin Test. If not, is it coded on SSF 14 as other HER2? ­

A: In the past and for this webinar I always based the method on the format of the score. If you see a 1+, 2+, or 3+, it's probably IHC. If it's a ratio, it's probably FISH or CISH. ­ However, we did have a participant direct us to the clarification below that says to code in SSF 14 unless the method of testing is specified. I would recommend following the instructions in the link.

<http://cancerbulletin.facs.org/forums/forum/collaborative-stage/breast/breast-ab/587-ssf-14-her2-result-of-other-or-unknown-test>

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Q: ­Would skin thickening seen on imaging be considered skin involvement in Summary Stage like it is in

A: ­Note 2 in the SEER Summary Stage Manual states to consider thickening as clinical evidence of extension to skin or subcutaneous tissue, code regional by direct extension (pg 188) ­

The footnote you are referring to that addresses “skin thickening” as regional direct extension is easy to take out of context.  It is not a reference to any skin thickening – but to extensive skin thickening that would fall under “Extensive skin involvement” – the intent is to identify clinical inflammatory characteristics not just any thickening…extensive skin thickening. This will be addressed in the next update of the Summary Stage Manual.

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Q: ­AJCC says pathologic stage includes all observation leading up to surgical resection­

A: The same would apply for Summary Stage. We did not feel that the terms “some skin thickening” and “mild edema” meet the criteria for regional by direct extension or for T4B. Also, there was no indication on the pathology report of dermal involvement. We felt the pathologist would have mentioned this if it had been present. Therefore, the skin thickening may have been caused by something else.

When viewed as a whole we felt the correct summary stage for this case was 1-Localized.

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Q: ­I have a question about the 1st case scenario. In the mammogram, it states 'abnormal mass into pectoral muscle'. Would this be coded/noted anywhere. Would the summary stage be a 4? Also, is the radiation/surgery sequence supposed to be a 3? ­

A: If the tumor had involved the pectoral muscle, we felt it would be mentioned on the pathology report. Since it was not, we didn’t include it as a factor when assigning summary stage. When pathologic and clinical information do not agree, one would usually use the pathologic information.

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Q: ­In reference to slide 17. If there is an attempt to resect breast tumor and there is residual tumor but it is not stated to be microscopic or macroscopic do we assume it was microscopic residual and use pathologic stage? ­

A: I don’t think i would be comfortable making a blanket on how to interpret “residual, nos”. Hopefully, you have some context. If not, I would probably lean toward assuming the residual is macroscopic.

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Q: ­Tip-dermal invasion. Per AJCC Staging Moments skin invasion is defined as full thickness involving including epidermis to qualify for T4­

A: ­Thanks for the tip! ­

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Q: ­Can you please share where the coding tip on skin invasion is found. ­

A: ­It was mentioned it was in the AJCC Staging Moment. Here is the link. It is Case #2 https://cancerstaging.org/CSE/general/Pages/Staging-Moments.aspx­

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Q: ­Pop Quiz 32: Would a core biopsy of the axillary lymph nodes done prior to an excisional biopsy of the primary tumor be included when assigning both clinical and pathologic stage?

A: If a core biopsy is done prior to the excisional biopsy, the result would be used to assign the cN. A core biopsy is not enough to meet the rules for classification for a pN. However, if the rules for classification are met, the information from the core biopsy could be used to assign the pN.

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Q: ­I'm looking at FORDS discontinued data items and CS Tumor Size/Ext Eval and CS Lymph Nodes are listed. What am I missing? ­

A: For cases diagnosed January 1, 2016 CS Tumor Size, Ext, TS/Ext Eval, Lymph Nodes, Nodes Eval, Mets, and Mets Eval will no longer be required to be reported for CoC, NPCR and most SEER facilities. However, there will be some SSFs that we will still be collecting. CCCR facilities will still be collecting CS. With that being said the CS fields will probably remain in the layout for some time.

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Q: ­Can we use Ki-67 or Magee 3 recurrence risk scores be used to code the SSF22 multi gene signature method. Thanks­

A: One of our participants sent this question to the CAnswer Forum. See their response at

<http://cancerbulletin.facs.org/forums/forum/collaborative-stage/breast/breast-ab/60828-breast-ssf-22-ihc4-or-magee-equation>

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Q: ­Please address a date for the slide 82; regarding if you only can code one procedure???­

A: ­Good question! Use the date of the first procedure and code the most definitive procedure.­

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Q: ­Where should text to support the surgery codes be documented? Op findings, path text, or both? ­

A: We don’t have national standards on where to put text for specific procedures. I personally, think this is something that should be standardized at the facility or state level not at the national level. My personal thoughts are to make sure you justify as many of the codes you assigned as possible. I also think you should do this as efficiently as possible.

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Q: ­Why are FNA's/core bx's of lymph nodes coded in Scope of LN surgery? It then "counts" as a treatment field and can affect other codes (Tx Status, syst/surg sequence, etc) when it's not really treating the cancer/nodes.­

A: I understand what you are saying. However, at some point it was decided that any kind of surgical procedure done to a lymph node should be coded only in Scope of Regional Lymph Nodes.

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Q: ­In Case scenario 2 why is the positive FNA of the regional node not coded in pN value?

A: The information we are coding in the pN data item is going to ypN. That means we are coding the status of the lymph nodes after neoadjuvant treatment. We do not include clinical information from prior to neoadjuvant treatment with ypN.

If the patient had not had neoadjuvant treatment and the rules for classification for pN had been met, then we could include the information from the positive FNA in the pN value.

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