# Q&A Session for Collecting Cancer Data:

# Central Nervous System

# Thursday, August 6, 2015

1. Q: Kendra mentioned that meningioma are coded to the meninges but if the meningioma is of the sphenoid wing, it is not reportable...correct? See SINQ 20130025.­

A: You are correct. The meninges of the sphenoid wing is not reportable.

1. Q: ­If all we have is a radiology report with a low grade glioma is this consistent with malignant behavior (/3)? ­

A: We sent this off to SEER and they said we should code low grade glioma to glioma, nos (9380/3).

1. Q: ­On slide 13 you mention that histology must be known to be reportable. What about benign CNS tumors diagnosed by radiology? Are we not to collect those when they are only diagnosed on imaging? ­

A: We probably should have said “enough information to assign an ICD O 3 histology code” rather than just histology. A histology code can be assigned based on information from radiology. Histologic confirmation is not required to assign an ICD O 3 histology code or to determine reportability.

1. Q: ­Why is survival rate higher in US vs Europe for non-malignant? ­

A: Good question! We don’t know why. This may reflect a difference in collection and not a true difference in risk. But this disparity has not been conclusively investigated.

1. Q: ­As stated in your slide Benign and Borderline, to be reportable the neoplasm must meet 2 criteria, Histology and the primary site. Is a fibrolipoma of the spinal cord reportable? Is there a list of reportable benign tumors? ­

A: It depends on where the fibrolipoma occurs. From what I have found they often occur in the filum terminale which is within the dura of the spine. This would be reportable. However, if they occur outside of the dura of the spine, they would not be reportable.

I am not aware of a list of benign histologies that are reportable. In order to be reportable the tumor must be located in a reportable CNS site and must have an ICD O 3 histology code with a behavior of /0 or /1. If you don’t find a histology code or if you the tumor is located outside of the meninges of the brain or spinal cord, the case is not reportable.

1. Q: ­FYI in Quiz 1, question 1 the code for cerebral meninges is C70.0, not C70.9.­

A: You are correct. It should be C70.0.

1. Q: ­I learned that Medulloblastoma was always coded to the cerebellum. I believe the American Brain Tumor Assoc has this documented. Please research...I do not think the 4th ventricle is in the cerebellum....I could be coming from an old rule.­

A: medulloblastoma should be assigned to the site from where they arose. Most occur either within the cerebellum or the fourth ventricle. [*http://seer.cancer.gov/seerinquiry/index.php?page=view&id=20140013&type=q*](http://seer.cancer.gov/seerinquiry/index.php?page=view&id=20140013&type=q)

Here is some additional information on the anatomy of the fourth ventricle <http://radiopaedia.org/articles/fourth-ventricle>

1. Q: ­AJCC pg. 596 is a list of WHO grades, we don't not use this for coding the grade field, correct? ­

A: ­ Correct! Do not use the WHO grade to code histologic grade. WHO grade is coded in SSF1.

1. Q: ­When does one use meninges, nos (C70.9)? ­
2. A: ­you mean as opposed to cerebral or spinal meninges? That is a good question. Usually, you would at least know if it occurred in the spine or brain! ­However if a Cancer Registry has decided to place the institutions non-reportable list in the abstracting software, a meninges, nos (C70.9) code can be used to represent a non-reportable patient with documentation in the medical record stating they were diagnosed in 19XX year, at an outside institution with a meningioma. In this situation you do not know the exact location of the meningioma and records for that time/facility may not be obtainable. Placing the patient in the non-reportable list of your abstracting software allows you to indicate to the central registry that your facility is aware of the prior diagnosis but has no other information on it. This also allows the registrar to quickly realize in subsequent casefinding (disease index, etc...) that this patient’s meningioma has already been reviewed and is non-reportable for your facility and thus should not be abstracted. This also serves a great purpose in being supporting documentation to quickly show the non-reportability of this case, if a Registry were to be audited by that states Central Registry.
3. Q: ­Is tissue diagnosis required to code the WHO grade, or can we code based on imaging (i.e. meningioma) as WHO grade I or 998­

A: SSF 1 is where we collect WHO grade. There is coding note that tells us we can only assign WHO grade from a tumor that has been histologically confirmed. <http://web2.facs.org/cstage0205/cnsother/CNSOther_jpo.html>

After the webinar we confirmed this with a member of the TAG team and a member of the mapping team. Below are suggested coding guidelines.

*What I’ve told our registrars here is to code the WHO grade as documented on the pathology report in SSF 1. If there is a pathology report but the WHO grade is not documented, then they should refer to Table 56.3 and use the WHO grade indicated for the histology, if it is listed on the table; otherwise, assign 999. If, however, the case is only clinical, they should assign code 998.*

1. Q: ­For ssf4 is it coded before or after chemo treatment? ­

A: We couldn’t find a rule to address this, but MGMT is used to determine the type of chemotherapy that can be used and in some studies has been used to link specific radiation and chemo combination treatments. MGMT (O6-methylguanine- methyltransferase) is a DNA repair enzyme that shuts down DNA repair. This allows the damage done to DNA by chemotherapy to continue cytotoxicity and apoptosis. MGMT methylation is a molecular test done on tumor tissue and used primarily for anaplastic oligodendroglioma, anaplastic astrocytoma and glioblastoma multiforme. Code in SSF4 the methylation status of the MGMT gene or promoter.

I could not find any data that examined the benefit to collecting this info after chemo was given.

 Visit the College of American Pathology site to review more information about the molecular markers in CNS tumors. The “Archives” of Pathology and laboratory Medicine has a lot of information on this subject and. <http://www.archivesofpathology.org/doi/full/10.1043/2010-0649-RAIR.1> Furthermore, MGMT is used to indicate if a patient will be responsive to the treatment planned. Since we are capturing the first course of treatment initially in our abstracts, it should be uncommon for you to find a patient who has MGMT labs run after chemotherapy has started.

1. Q: ­For surgery does code 20 include a stereotactic bx?

A: We checked with both SEER and CoC and they both agree a biopsy being done for diagnostic purposes only (i.e. an incisional biopsy), would not be coded as surgery, but an excisional biopsy would. In coding a case such as this it is important to remember the significance of reading the surgery/op report to see what amount tissue was removed. Often times, the surgeon will state the intended procedure, but the actual report may show that a more definitive procedure or excision was done.

1. Q: ­Based on your slide regarding coding a 'bx' as a surgical code 20, would you also code a stereotactic needle bx here when there was no attempt at resection or would you code this as a diagnostic/staging procedure?­

A: If it was an incisional biopsy, I would code as a diagnostic staging procedure. SEER and CoC agree on this issue.

1. Q: Pilocytic astrocytoma is coded to behavior code 3 but WHO grade 1 is for benign tumors please explain.­

A: Pilocytic astrocytoma has a behavior code of /1 in the ICD O 3 manual which does correspond with a WHO grade of I. However, we started collecting these cases prior to the time all benign CNS tumors became reportable in 2004. At that time we asked that registrars report these cases with a /3 behavior code. In order to keep the data consistent, we have asked registrars to continue to code these with a /3. This consistency in data collection allows for exact research comparison of these cases over time.

1. Corrections to case scenario number 2.
	1. Tumor size, SSF 5, and SSF 6 should be coded 999. Information necessary to code these data items was available in our first draft of the case scenario, but ended up being edited out.
	2. CS Ext should be coded 100.
		* This is the answer we originally gave during the live session, but after the session I changed the answer. I now realize the original answer was correct.
	3. A corrected version of the Case scenarios are available at <http://www.naaccr.org/LinkClick.aspx?fileticket=gYwLAnniuHE%3d&tabid=161&mid=523> The corrected answers are in red.