# Coding Pitfalls

September 1, 2016

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q1: ­Can we get clarification....If an incidental in situ finding on surgery pTis do we have a clinical stage of pTis too or is the clinical T left blank? Edits will not let us leave the clinical TNM blank for incidental insitu cancer found on surgery­

A1­: From Donna Gress­ (­dgress@facs.org­) ­ - if it is an incidental finding at the time of surgery, it should NOT have a clinical stage, even if in situ­.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q2: ­I guess I am confused...On the cancer answer Forum Dated...02/23/16..question-If a patient has an incidental finding of carcinoma in situ, would the clinical stage be blank? Donna Gress replied this would not be given a clinical stage­

A2­: That is correct. If there is no diagnosis prior to excision of the tumor (treatment), then we have not met the rules for classification for a clinical T. Therefore the clinical T, N, and M will be blank.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q3 (*comment from Donna Gress*) ­Clinical staging for breast would be a diagnostic biopsy....not sure why they would be doing a lumpectomy with no known cancer, maybe a prophylactic mastectomy? ­ ­Normally you would NOT remove an entire tumor during the diagnostic workup. All breast guidelines say there SHOULD be a diagnostic biopsy prior to surgical resection.­

Q3: ­Yes that is what we are talking about...breast incidental and we can't leave it blank because of edits. Prophylactic­

A: The edit is TNM T, N, M, In Situ (CoC) and you are correct that it does not allow the cT data item to be blank if pT is pTis. We have modified the edit to allow blanks in cT in this situation, but the modification will not be released until the next edits update v16b. This particular edit is not in any of the standard setters edit sets. I would suggest excluding this edit from any state edit sets at this time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q4: ­If imaging shows microcalcifications consistent with DCIS and the patient goes on to resection without a prior biopsy would cT = pTis or cTx; that is, do we need micro proof of in situ to assign pTis in cT?­

A4: We’ve submitted this question to the CAnswer Forum. You can follow it at <http://cancerbulletin.facs.org/forums/node/66233>

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q5: ­On slide 16, with no removal of LNs, please address pNX vs blank or should we bring down cN1? ­

A5: ­You can only use a clinical value in a pathologic data item when there is a rule giving you permission to do. We do not have such a rule that would apply in this situation.­ If no regional lymph nodes are removed and we have met the rules for classification for pT, then pN would be X. If no regional nodes are removed and we have NOT met the rules for classification for pT and pN will be blank.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q6: ­On slide 18. Previously on your slides you stated if it met classification for the "T" you would assign X's. Your rules did not specifically state pathological classification. Why would you not complete the pTX and pNX for this example??­

A6: To clarify, Clinical Stage and Pathologic stage are two distinct times in staging that come with their own classification rules that are independent of each other. What I mean is that if you don’t meet the rules of classification for clinical stage this doesn’t mean that pathologic stage data fields will be left blank. It would only apply to the clinical stage data fields.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q7: ­Your example on page 14 uses TXNX why are we now leaving them blank when there is only a clinical T and N. This contradicts what was shown on Slide 14 when to use "X" versus blank­

A7: What slide 14 is showing is that if we have meet the rules for classification there must either be a valid value or X? If we do not meet the rules for classification then you would use blanks. Remember clinical staging has classification rules and pathologic staging has classification rules. Rules for classification for cT are there must be a diagnosis of cancer and there must be some kind of work-up. Even a simple physical exam would be enough to meet the rules for classification for cT. It would be unusual to have a blank cT and blank cN. The rules for pT and pN are a little more stringent. They may change by chapter, but usually the primary tumor has to be removed to meet rules for classification. If this is not done, then pT should be blank. If pT is blank, then pN must be blank. If pT and pN are blank, you cannot use the cM in the pM data item.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q8: ­What if the patient had surgery elsewhere do we enter pathology blank slide 18? ­

A8­: If surgery was done elsewhere and you know what was done, then you could be able to complete the pathologic stage. If you know the surgery was done and it met the rules for classification, then you could use X’s or valid values. You wouldn’t leave the T, N, and M values blank. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q9: ­In case 7, should the clinical m: pm1b­

A9­: No, the slide was correct. What we were trying to show with this example was that prior to making any treatment decision, they only had clinical evidence of distant mets, hence the cM1b. They didn’t confirm distant mets until after surgery. Since the cM was cM1, we know the treatment decisions were based on a clinical suspicion of distant mets. The pM1 in the pM data item shows that they pathologically confirmed the distant mets after the decision to do surgery was made.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q10: ­According to slide # 24 it was stated that the M value was pathologic. What type of biopsy would classify this as a pathologic M?

A10: ­Any pathologic confirmation that showed malignant cells would work.­ Even an FNA would qualify for pM1.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q11: ­Question regarding your PSA case that you stated was Stage group 99 due to no subcategory. On page 462 Prostate under Stage IIB there is T1-2 and Gleason. Why couldn't we use this stage group??­It says any PSA, any Gleason­.

A11: The example had PSA was 5.4 and Gleason score was 6. Clinical T was cT2. In order for us to have a Stage group of IIB we would need to have either **T2c**N0M0 with Any PSA, Any Gleason. Our clinical T was only a cT2. The nodule was only in the left lobe. T2c is if the tumor involves both lobes.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q12: ­Could you please explain Case 8 CM1 again and why Clinical Stage is IB?

A12: ­Clinical stage is 1B because the 2a 0 0 equals stage 1B for lung. Prior to treatment, that is what the physician thought the stage was. cM1 in the pM data item means that distant mets was identified using clinically means (not pathologic confirmation). Since cM was cM0 and pM was cM1, we can infer that mets was not diagnosed until after surgery but before adjuvant therapy such as chemo or radiation.­

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q13: ­Case 9 follow-up - if a patient only had a biopsy that showed Tis - no lumpectomy or resection - would you still code Clinical pTis cN0 cM0 - would your path be blank? ­

A13: ­I'm assuming you mean an incisional biopsy. The answer is yes. You can assign a pTis in the cT data item and assign a stage.­ I’m going to send your question concerning pathologic stage to AJCC for clarification.

<http://cancerbulletin.facs.org/forums/node/66234>

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q14: ­Case 10- if SLN biopsy is done after surgery since it was found to be T1a, can we go ahead and change that to pN0 and have stage?­

A14: ­If the SLN is done prior to chemo or radiation and within the 4 month time frame, you could use it in the pathologic stage.­

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q15: ­On slide 26 is mets on imaging found post-surgery not considered progression? ­

A15: ­Not in this situation. Here they didn't do a workup for distant mets until after surgery. It was done before chemo or radiation so it can be counted in path stage.­

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q16: ­For slide 38 it indicates clinical stage group IIA but Jim quickly noted that was an error and should be stage IB. Since cN1mi is not possible, does the note below the stage table (T0/T1 and N1mi is stage IB) only applicable to pathologic stage group??­

A16: It applies to both clinical and pathologic groups. Stage IB would be the correct clinical stage group for clinical stage. See the post at [http://cancerbulletin.facs.org/forums/node /61852](http://cancerbulletin.facs.org/forums/node%20/61852)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q17: ­For lung, does a node need to be removed for pN or can you just biopsy a node to have pN? ­

A17: ­Any pathologic confirmation will do. FNA, core biopsy, etc. will meet the criteria for pN­.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q18: ­If pT & pN blank, but you have microscopically confirmed distant mets can you code pM1? ­

A18: ­Yes.­ The rule is if the pT and pN are blank, you cannot use the cM value in the pM data item. You can use a value of pM1 or higher in the pM data item even if pT and pN are blank.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q19: ­If a patient had a pathological M1a but a clinical M1b, what value would be recorded for clinical M and pathological M if primary was removed? ­

A19: Let’s say a patient has been identified with mets in multiple sites, but only one of these sites was pathologically confirmed. The biopsy of the distant sites means you met the criteria for a pM. You would then use the pathologic information and the clinical information to assign your pM value. So your example would be pM1b­.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q20: I thought you said we could leave those path M blank if 2016 case abstracted before conversion?

A20: You can leave the data item pM blank for cases diagnosed in 2015 and abstracted before the conversion. An edit will be triggered if you leave it blank for cases diagnosed in 2016 and later. If you abstracted a 2016 case prior to conversion, you will have to go back in and add a value after the conversion.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q21: ­Is surgery of primary site considered treatment? If so why would you use pm1 as the clinical M? ­

A21: ­Remember, M is different. The c and p are really just indicating whether the distant mets was confirmed clinically or pathologically. If a pM1 is entered in the cM data item, it means the distant mets was pathologically confirmed prior to treatment.­ A cM1 entered in the cM data item means that prior to any treatment they only had a clinical suspicion of distant mets.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q22: ­You mentioned we should never clinically use cMX? Just cM0 or blank. Correct? Can you explain this further please? ­

A22: ­cMX is not a valid code. M0 and M1 (including subcategories) are the only valid values for cM­. For coding purposes we are to assume no distant mets unless we find something to indicate there is not distant mets when it comes to coding the cM data item.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q23: ­Does the miscellaneous section apply to cases diagnosed 01/01/16 & forward? CS? ­

A23: ­Not necessarily.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q24: ­For pathologic stage prostate-any TN1cM0, would this be pathologic stage IV because of pN1? Prostate question clarified I meant pT any pN1 cM0, path stage IV? ­

A24: ­You still have to meet the rules for classification. If they didn’t meet the rules for classification for pT, then TNM would be blank and stage 99. You could use the lymph node in the clinical stage.­

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q25: ­Pt has liver biopsy positive for met lung ca (pM1). Pt goes then to have chemo. How are clinical and pathologic stages assigned? ­ No surgery done.

A25: ­Clinical stage is T, N, and pM1 Stage 4. Pathologic stage T, N, cM1 stage 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q26: ­For Lymphoma cases, I am assuming we would leave TNM blank and Clinical Stage be filled.­

A26: ­There will be no change in how we enter codes for lymphoma. The T, N, and M will be 88 and the stage will be a valid stage group or 99.­

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q27: ­bladder TURB done cTa, cystectomy done but no residual ca. what is the pT? ­

A27: ­First, cT would be pTa (an edit would be triggered if you used cTa). For the data item pT you met the rules for classification so you combine what you found out from the TURB with what you found from the cystectomy. Cystectomy confirmed there was no invasive tumor.­

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q28: ­Summary Stage 2000 p. 3 "An in situ dx can only be made microscopically, because a pathologist must identify the basement membrane and determine that it has not been penetrated."­

A28: ­For summary stage and for pathologic Stage, the entire tumor would have to be removed and reviewed by a pathologist to assign in situ/stage 0. Clinical stage can be assigned without removal of the entire tumor.­

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q29: ­Does colonoscopy meet criteria for cN? ­

A29: ­No. unless there is an endoscopic ultrasound or some other type of imaging is done, it would be cN­X

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q30: ­With blanks and X's -- If T rules are not met but there are positive lymph nodes the N is still blank? What do you do with coding the positive nodes? ­

A30: ­You are correct. If the pT is blank then the pN is blank...even if you have pathologically confirmed lymph node mets. The lymph nodes that were removed can be used in the clinical stage as long as no treatment (chemo, rad, etc.) was done prior to excision of the lymph nodes.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q31: ­On that last example, can you clarify again the time frame to code pM clinically please? ­

A31: ­The window for pathologic stage goes for 4 months from the time of diagnosis or the start of adjuvant treatment (chemo, radiation, etc.). Once adjuvant treatment starts the pathologic stage window closes. If adjuvant treatment doesn’t start within 4 months of diagnosis, the window closes at 4 months. If mets is diagnosed after surgery but before chemo/radiation, then the information can be included in the path stage. That is assuming chemo/radiation was started within 4 months of diagnosis.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q32: ­What do we do with the case of an in situ breast cancer biopsy only? How do we stage­?

A32: ­Incisional biopsy only? I would be a clinical stage of pTis cN0 cM0 stage 0. Pathologic stage would be blanks and 99.­

<http://cancerbulletin.facs.org/forums/node/66234>

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q33: ­Bad memory here! I remember an email stating that certain agencies (NPCR included) were not going to accept just a T3 is there were subcategories available, i.e. T3a or T3b and it would create errors. Do you recall this new ruling? ­

A33: ­I don’t find any statements saying they would not accept values without the subcategories. However, I can’t say for sure you are incorrect.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q34: ­What if you have, in clinical workup, a pM1. No surgery of site is performed, making PT and PN blank. Would you put in a PM1 for a Pathologic Stage Group of IV??­

A34: ­Yes. That is correct.­

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q35: ­quiz 1, #3 - for clinical T we are wondering if it should either be cT0 - nothing found but indicating it was a lung primary OR because they didn't work up the lung - how can you say they met classification to code - should it not be blank?­

A35: ­I would want to see a thorough exam done excluding a primary tumor in the lung before assigning cT0. Patient had a diagnosis of cancer and at least a minimal workup so rules for classification have been met for clinical Stage­ so we wouldn’t leave it blank.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q36: ­On quiz 1, question 4, why is Clinical N a 0 and not an X? ­

A36: A CT of the abdomen was done. If they had seen mets, I would assume they would have mentioned it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q37: ­quiz 2 #6 why isn’t the answer B? ­

A37: The palatine tonsil if part of the lymphatic system. Code 1 – Extranodal is for sites outside of the lymphatic system.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q38: ­For Quiz 1 question 1, why wouldn't it be pN0 since the scenario stated "no lymph nodes were identified"? ­

A38: It should have read “no lymph nodes identified in the pathologic specimen”. Meaning no lymph nodes were removed (pNX).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q39: ­#5 shouldn't the clinical N be pN1? Because the ax LN was removed? ­

A39: No. The lymph node was removed prior to excision of the primary tumor. Therefore, it is a clinical N1.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q40: ­ON THAT LAST? If IT ONLY SAYS LIKELY, THAT'S NOT A dx TERM WOULDN'T YOU NEED MOST LIKELY? ­

A40­: We have to take at the term in context of everything. I believe they thought metastasis was present and I coded it as such.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q41: ­Regarding the "stage by" field, are there guidelines for the central cancer registry when consolidating abstracts where this field may be different? ­

A41: ­I didn’t cover all the codes in the webinar but there is Code 60 – Staging by Central Registry (FORDS page 163 and 171 and SEER PCSM Section V page 44 and 69). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q42: ­if pathologist puts stage on path report, staged by should be combo code? ­

A42: See CAnswer Forum link:

* <http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/general-questions/61994-cases-diagnosed-01-01-16-and-after-ajcc-pathological-stage>

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q43: ­If registrar codes path stage based on pathologist staging on path report, ex: pT2Nx by pathologist & registrar completes is that a combo code of registrar & physician? ­

A43: ­See CAnswer Forum link:

* <http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/general-questions/61994-cases-diagnosed-01-01-16-and-after-ajcc-pathological-stage>

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q44: ­When a patient has microscopically positive distant mets, but the Dr doesn't state Stage IV, how do we code the pathologic "staged by" field? Can we NOT enter the pM1 unless the Dr clearly documents Stage IV?

A44­: On FORDS page 168 it states in the Instructions for Coding Pathologic M that if the physician has not recorded pathologic M then the registrar will code this item based on the best information available. I think you would then be able to use code 30 – Cancer Registrar and Physician for the Staged By (Pathologic) field.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q45: ­For the Clinical Stage Descriptor, can we assign 3 (multiple) or should we assign 0 (none) if imaging indicates multiple tumors but resection only indicates one tumor is invasive and the others are in situ? ­

A45: ­Code as 0. See the CAnswer Forum link:

* <http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/breast-chapter-32/62884-m-descriptor-for-breast-chapter-further-clarification>

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q46: ­What about the use of 88 for biochemical failure, site unknown.­

A46: Again, according to what I found on CAnswer Forum you cannot record recurrence for biochemical failure alone. There needs to be confirmation of metastatic disease in other tissues or organs. See CAnswer Forum links:

* <http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/treatment-outcomes/cancer-status/6009-prostate-biochemical-failure>
* <http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/treatment-outcomes/cancer-status/2279-prostate-disease-status>

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q47: ­What if physician calls prostate biochemical failure a recurrence & then treats with salvage RT? Can we then code it as a recurrence? ­

A47­: No. I you would need a clinical or histological confirmation of metastatic disease or progression of disease in other tissues or organs in order for it to be considered a recurrence. See CAnswer Forum links:

* <http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/treatment-outcomes/cancer-status/6009-prostate-biochemical-failure>
* <http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/treatment-outcomes/cancer-status/2279-prostate-disease-status>

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q48: ­Due to biochemical failure, salvage radiation is given - wouldn't you code this as recurrence with subsequent treatment...? Our Registry does... and physicians consider a recurrence of disease...­

A48: ­I have also coded things this way, but from what I have found treatment may be initiated but the biochemical failure alone does not count as recurrence. See CAnswer Forum Links:

* <http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/treatment-outcomes/cancer-status/6009-prostate-biochemical-failure>
* <http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/treatment-outcomes/cancer-status/2279-prostate-disease-status>

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q49: ­Is a recurrence noted if patient has surgical treatment for prostate ca, then later because of raising PSA has salvage RT? Is a recurrence coded? ­

A49: ­No. It is recommended to keep an eye on the case until mets in other tissues are detected. This is something that was added to the FORDS Revision Project so hopefully they will clarify this further.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_