# Coding Pitfalls

September 1, 2016

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## Q&A

- Please submit all questions concerning webinar content through the Q&A panel.
- Reminder:
- If you have participants watching this webinar at your site, please collect their names and emails.
  - We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.

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## Fabulous Prizes


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## Agenda

- Updates
- Staging
- Quiz 1
- Epi Moment
- Miscellaneous
- Quiz 2

## Updates

- The following will have a 2018 implementation date
  - Revisions to the MP/H Rule
  - Summary Stage
  - FORDS Revision Project
- ICD O 3 Update

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## Updates

- AJCC 8th Edition
  - Applies to cases diagnosed in 2017 and beyond
  - Scheduled for an October release
  - Additional items will be required to calculate some stage groups
    - CS SSF's
    - Not defined in CS SFF's

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## v15-v16 update

- All CoC facilities and some central registries added a “c” or “p” to all T, N, and M values for cases diagnosed prior to 2016.
  - Did not update fields with implied values
  - Did not change values

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## v15-v16 update

Case diagnosed and abstracted in 2015
Before and after conversion to v16

| | V15 | v16 |
|---|---|---|
| Clinical T | 1a | cT1a |
| Clinical N | 0 | cN0 |
| Clinical M | 0 | cM0 |
| Clinical Stage | 1 | 1 |
| Pathologic T | 2 | pT2 |
| Pathologic N | 0 | pN0 |
| Pathologic M | | |
| Pathologic Stage | 2 | 2 |

Case diagnosed in 2015
and abstracted in v16

| | v16 |
|---|---|
| Clinical T | cT1a |
| Clinical N | cN0 |
| Clinical M | cM0 |
| Clinical Stage | 1 |
| Pathologic T | pT2 |
| Pathologic N | pN0 |
| Pathologic M | cM0 |
| Pathologic Stage | 2 |

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## What if I abstracted 2016 Cases in v15?

- Review each abstract and update fields
  - T, N, and M values will have to be manually updated.
    - Add c's and p's
    - Enter implied values
  - Staged By
  - Tumor Size Summary
  - Values in CS items may need to be removed
- Edits will catch many of these items, but a review should still be done.

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## Edits Issues-v16a

- Most are minor
  - Error message incorrect
  - Edits missing from edit sets
- Three big ones (edit fails even though coding is correct)
  - TNM Path N, SSF 3, 4, 5 Breast (COC)
    - Fails if patient had a lymph node biopsy prior to neoadjuvant treatment and then has lymph nodes removed that are negative after neoadjuvant treatment
      - pN0
      - SSF 3 095
      - SSF 4 987
      - SSF 5 987
  - Primary Site, T 2016 - Ed 7, ICDO3 (COC-NPCR)
    - Does not allow a value in the cT for Testis
    - Does not allow a cT2 or pT2 for Laynx-Glotis
- Will be corrected in v16B

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# Staging

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## Physician Staging

- TNM Stage was meant to be assigned by a physician in an clinical setting.
- Whenever possible, physician stage should be used assign the clinical and pathologic stage data items.
- Ultimately, it is the registrars responsibility to enter the correct codes into the stage data items.

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## "Inaccessible Site/Inaccessible Nodes *Rule*"

- Was a "rule" in CS
  - For certain sites where the nodes were difficult to access, registrars were allowed to code lymph nodes as negative if the patient was treated like they were node negative and the T value was T1 or T2.
- More of a "concept" with AJCC
  - AJCC lets physician judgment be used for assigning the cN category. Based on the case, including extent of the primary tumor and the probability of nodal involvement in that particular disease site (different for different disease sites), physicians are able to use their judgment to assign cN0 instead of cNX. Imaging is not required.

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## Blanks vs X's


| Data Item | Value |
|---|---|
| Clinical T | cT2 |
| Clinical N | cN0 |
| Clinical M | cM0 |
| Clinical Stage | 2 |
| Pathologic T | pTX |
| Pathologic N | pNX |
| Pathologic M | cM0 |
| Pathologic Stage | 99 |

| Data Item | Value |
|---|---|
| Clinical T | |
| Clinical N | |
| Clinical M | |
| Clinical Stage | 99 |
| Pathologic T | |
| Pathologic N | |
| Pathologic M | |
| Pathologic Stage | 99 |

## Pop Quiz 1

- A patient presents for a lung CT and is found to have lung cancer.
- A clinical work-up was done and the physician assigned T2a N1 M0 Stage IIA.
- The patient is treated with chemotherapy and radiation only.
  - Have the rules for classification for clinical T been met?
  - Have the rules for classification for pathologic T been met?

| Data Item | Value |
|---|---|
| Clinical T | cT2a |
| Clinical N | cN1 |
| Clinical M | cM0 |
| Clinical Stage | 2a |
| Pathologic T | |
| Pathologic N | |
| Pathologic M | |
| Pathologic Stage | 99 |

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## Pop Quiz 2

- A patient presents for a lung CT and is found to have lung cancer.
  - Imaging and bronchoscopy are done and the physician assigned a stage of T2a N1 M0 Stage IIA.
  - The patient had a wedge resection and then was treated with radiation and chemotherapy.
  - Pathology confirmed a T2a tumor.
  - No lymph nodes removed.
    - Have the rules for classification for clinical T been met?
    - Have the rules for classification for pathologic T been met?

| Data Item | Value |
|---|---|
| Clinical T | cT2a |
| Clinical N | cN1 |
| Clinical M | cM0 |
| Clinical Stage | 2a |
| Pathologic T | pT2a |
| Pathologic N | pNX |
| Pathologic M | cM0 |
| Pathologic Stage | 99 |

16

## You tell me what happened!

- The stage grouping below represents a patient with lung cancer. You tell me what you think happened with this patient.

Case 1

| Data Item | Value |
|---|---|
| Clinical T | cT1a |
| Clinical N | cN0 |
| Clinical M | cM0 |
| Clinical Stage | 1A |
| Pathologic T | pT1a |
| Pathologic N | pN0 |
| Pathologic M | cM0 |
| Pathologic Stage | 1A |

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## You tell me what happened!

- The stage grouping below represents a patient with lung cancer. You tell me what you think happened with this patient.

Case 2

| Data Item | Value |
|---|---|
| Clinical T | cT1a |
| Clinical N | cN0 |
| Clinical M | cM0 |
| Clinical Stage | 1A |
| Pathologic T | |
| Pathologic N | |
| Pathologic M | |
| Pathologic Stage | 99 |

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## You tell me what happened!

- The stage grouping below represents a patient with lung cancer. You tell me what you think happened with this patient.

Case 3

| Data Item | Value |
|---|---|
| Clinical T | cT1a |
| Clinical N | cN0 |
| Clinical M | cM0 |
| Clinical Stage | 1A |
| Pathologic T | pT1a |
| Pathologic N | pNX |
| Pathologic M | cM0 |
| Pathologic Stage | 99 |

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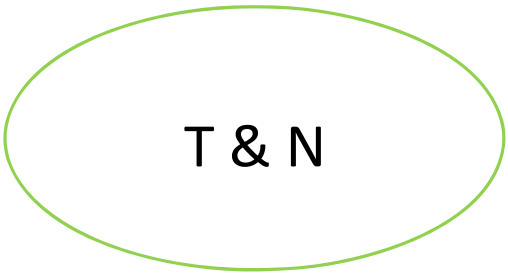
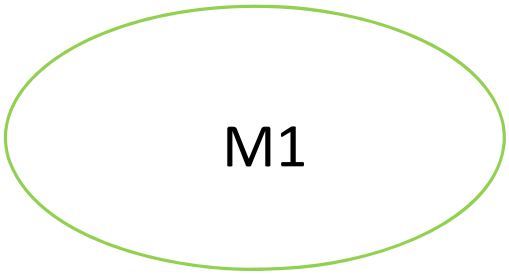
## What about "M"?

- Patients with distant mets




- If no T, then T&N are blank
- If T, then T&N are either X's or valid value

- If patient has distant mets, patient will have a stage regardless of T&N

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## Rules for "M"

- Cases with pathologic T and N may be grouped as pathologic TNM if using the clinical M designator (cM0 or cM1)
  - pT and pN may be "pX" or a valid value.
  - If pT and pN are blank, then pM should be left blank as well
- Cases with pathologic M1 (pM1) may be grouped as clinical and pathologic stage IV regardless of "c" or "p" status of T and N.
  - Pathologic confirmation distant metastasis is more definitive than clinical confirmation alone.
  - This rule allows us to show when distant mets was confirmed prior to treatment.

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## You tell me what happened!

- The stage grouping below represents a patient with lung cancer. You tell me what you think happened with this patient.

Case 4

| Data Item | Value |
|---|---|
| Clinical T | cT2a |
| Clinical N | cN0 |
| Clinical M | cM1b |
| Clinical Stage | 4 |
| Pathologic T | pT2a |
| Pathologic N | pNX |
| Pathologic M | cM1b |
| Pathologic Stage | 4 |

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## You tell me what happened!

- The stage grouping below represents a patient with lung cancer. You tell me what you think happened with this patient.

Case 5

| Data Item | Value |
|---|---|
| Clinical T | cT2a |
| Clinical N | cN0 |
| Clinical M | cM1b |
| Clinical Stage | 4 |
| Pathologic T | |
| Pathologic N | |
| Pathologic M | |
| Pathologic Stage | 99 |

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## You tell me what happened!

- The stage grouping below represents a patient with lung cancer. You tell me what you think happened with this patient.

Case 6

| Data Item | Value |
|---|---|
| Clinical T | cT2a |
| Clinical N | cN0 |
| Clinical M | pM1b |
| Clinical Stage | 4 |
| Pathologic T | pT2a |
| Pathologic N | pNX |
| Pathologic M | pM1b |
| Pathologic Stage | 4 |

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## You tell me what happened!

- The stage grouping below represents a patient with lung cancer. You tell me what you think happened with this patient.

Case 7

| Data Item | Value |
|---|---|
| Clinical T | cT2a |
| Clinical N | cN0 |
| Clinical M | cM1b |
| Clinical Stage | 4 |
| Pathologic T | pT2a |
| Pathologic N | pNX |
| Pathologic M | pM1b |
| Pathologic Stage | 4 |

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## You tell me what happened!

- The stage grouping below represents a patient with lung cancer. You tell me what you think happened with this patient.

Case 8

| Data Item | Value |
|---|---|
| Clinical T | cT2a |
| Clinical N | cN0 |
| Clinical M | cM0 |
| Clinical Stage | 1B |
| Pathologic T | pT2a |
| Pathologic N | pN0 |
| Pathologic M | cM1 |
| Pathologic Stage | 4 |

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## Subcategories and Assigning Stage

- Only assign subcategories if information is available
  - Do not apply the "downstaging" concept if information is missing
  - Value can be entered into data item without subcategory, but this may impact stage
- If subcategories cannot be assigned but subcategories do not change stage, then stage can be assigned
- If subcategories influence stage assignment, stage must be unknown.

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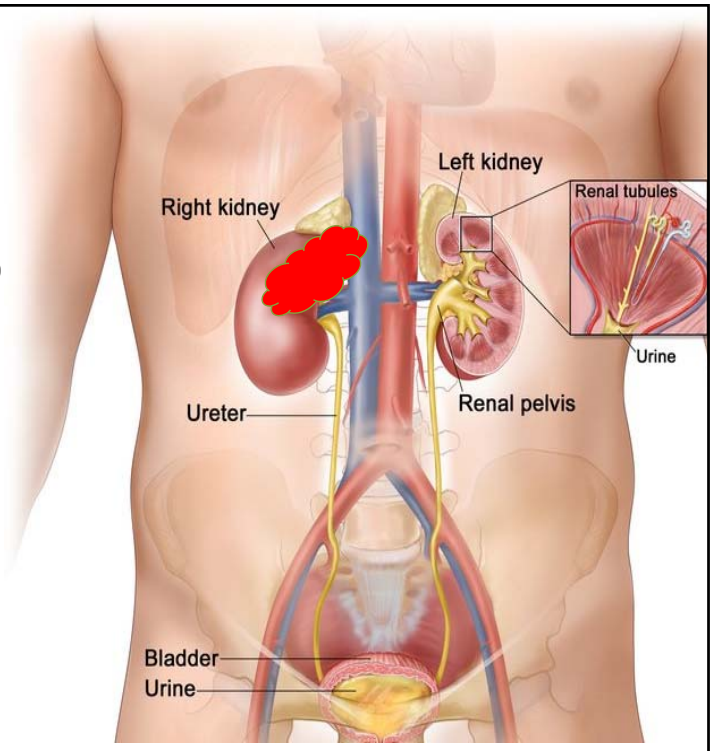
## Kidney

- Tumor extends into the vena cava.
  - No indication if tumor extension to vena cava is confined below the diaphragm or extends above the diaphragm.
  - T3b or T3C?
- Correct answer is T3
- Assuming no mets, what stage would be assigned?

See page 479



## Prostate Stage Grouping - Stage I, IIA, and IIB

- Stage PSA and Gleason score impact stage grouping
- Subcategories may be required
  - If PSA is less than 20 or Gleason is less than 8, subcategories are required for stages I, IIA, and IIB

See page 461

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## Prostate

- A patient had DRE due to an elevated PSA (5.4). The urologist felt a nodule in the left lobe. The urologist did not indicate if it was more or less than half a lobe. Biopsy confirmed adenocarcinoma Gleason 3+3. No indication of any additional disease
  - What is the cT value? cT2
  - What is the clinical stage?

Stage 1

Stage 2A

Stage 2B

Stage 99

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## In situ stage grouping exception

- An exception was made that allows us to use the pTis for both the clinical and pathologic stage and to use the cN0 for both the clinical and pathologic stage.
- However, the criteria for rules for classification have to be met in order to get a pathologic stage.

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## You tell me what happened!

- The stage grouping below represents a patient with **breast** cancer. You tell me what you think happened with this patient.

Case 9

| Data Item | Value |
|---|---|
| Clinical T | pTis |
| Clinical N | cN0 |
| Clinical M | cM0 |
| Clinical Stage | 0 |
| Pathologic T | pTis |
| Pathologic N | cN0 |
| Pathologic M | cM0 |
| Pathologic Stage | 0 |

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## You tell me what happened!

- The stage grouping below represents a patient with **breast** cancer. You tell me what you think happened with this patient.

Case 10

| Data Item | Value |
|---|---|
| Clinical T | pTis |
| Clinical N | cN0 |
| Clinical M | cM0 |
| Clinical Stage | 0 |
| Pathologic T | pT1a |
| Pathologic N | pNX |
| Pathologic M | cM0 |
| Pathologic Stage | 99 |

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## You tell me what happened!

- The stage grouping below represents a patient with **bladder** cancer. You tell me what you think happened with this patient.

Case 11

| Data Item | Value |
|---|---|
| Clinical T | pTa |
| Clinical N | cN0 |
| Clinical M | cM0 |
| Clinical Stage | 0a |
| Pathologic T | |
| Pathologic N | |
| Pathologic M | |
| Pathologic Stage | 99 |

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## Questions?

General Rules

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## Staging by Site

Breast

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## Pop Quiz 3

- Imaging showed a 1cm malignant appearing tumor in the right breast. No enlarged lymph nodes.
- Sentinel lymph node biopsy and excisional biopsy is done on 1/1/16.
  - Path showed 1.3 cm invasive carcinoma.
  - Sentinel lymph node is positive for micrometastasis.

| Data Item | Value |
|---|---|
| Clinical T | cT1b |
| Clinical N | cN0 |
| Clinical M | cM0 |
| Clinical Stage | 1A |
| Pathologic T | pT1c |
| Pathologic N | pN1mi |
| Pathologic M | cM0 |
| Pathologic Stage | 1B |

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## Pop Quiz 4

- Imaging showed a 1cm malignant appearing tumor in the right breast. No enlarged lymph nodes
  - Sentinel lymph node biopsy is done on 1/1/16 and patient is found have micrometastasis.
  - An excisional biopsy was done on 1/15/16 showing 1.3cm invasive carcinoma (no lymph nodes removed).

| Data Item | Value |
|---|---|
| Clinical T | cT1b |
| Clinical N | cN1 |
| Clinical M | cM0 |
| Clinical Stage | 1B |
| Pathologic T | pT1c |
| Pathologic N | pN1mi |
| Pathologic M | cM0 |
| Pathologic Stage | 1B |

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## Pop Quiz 5

- An 86 year old female had a breast abnormality that was biopsied and came back as infiltrating ductal carcinoma.
  - She had needle core biopsy of an enlarged axillary lymph node that returned as negative for malignancy.
- She had a segmental mastectomy but the surgeon did not check lymph nodes at the time of surgery due to the patient's comorbidities.
  - The pathology report included a stage of pT1b, pNX
  - The physician assigned documented "Stage 1, pT1b pN0 (by US-Guided biopsy)".

http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/breast-chapter-32/64618

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## Pop Quiz 5

- Pathologic staging criteria includes the microscopic assessment of a least one node. Whether that node is resected or biopsied, it still meets the criteria.
- In this case, pN0 would be assigned for the pathologic stage.
  - This again highlights why the pathologist cannot assign the pathologic stage, but just provide information on the specimen received to the managing physician.

http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/breast-chapter-32/64618

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## Pop Quiz 5

- An 86 year old female had a breast abnormality (9mm) that was biopsied and came back as infiltrating ductal carcinoma.
- She had needle core biopsy of an enlarged axillary lymph node that returned as negative for malignancy.
- She had a segmental mastectomy but the surgeon did not check lymph nodes at the time of surgery due to the patient's comorbidities.

| Data Item | Value |
|---|---|
| Clinical T | cT1b |
| Clinical N | cN0 |
| Clinical M | cM0 |
| Clinical Stage | 1A |
| Pathologic T | pT1b |
| Pathologic N | pN0 |
| Pathologic M | cM0 |
| Pathologic Stage | 1A |

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## Pop Quiz 6

- A patient presented for a routine mammogram and was found to have a suspicious area in her left breast. A core biopsied was performed. The pathology returned "atypical ductal hyperplasia (ADH).
- A lumpectomy of the area was performed and the patient was found to have a 3mm focus of invasive ductal carcinoma.
- No additional surgery performed

| Data Item | Value |
|---|---|
| Clinical T | |
| Clinical N | |
| Clinical M | |
| Clinical Stage | 99 |
| Pathologic T | pT1a |
| Pathologic N | pNX |
| Pathologic M | cM0 |
| Pathologic Stage | 99 |

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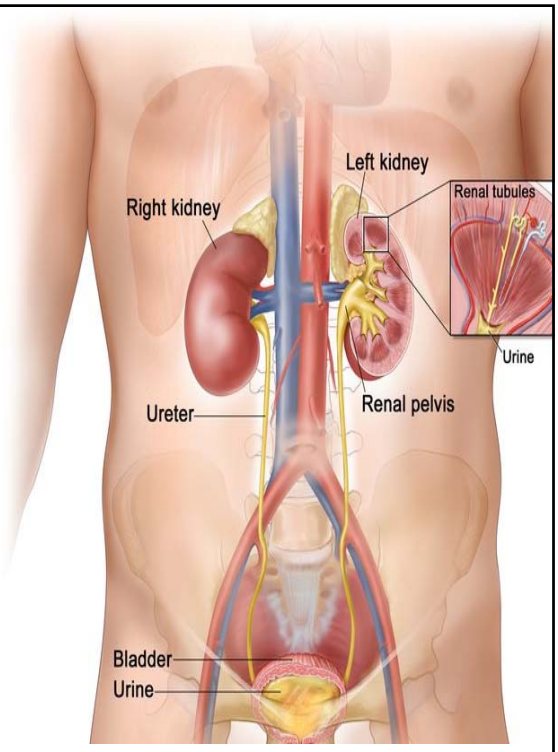
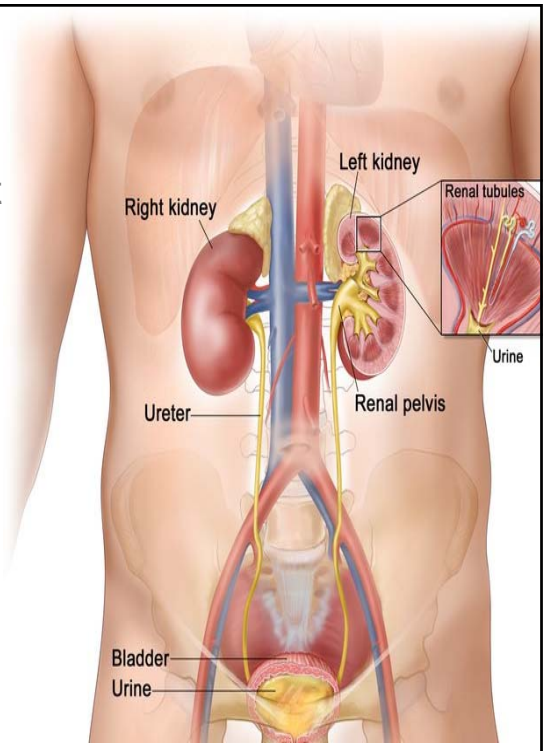
## Question-Kidney

- The pathology from a radical nephrectomy shows a unifocal tumor measuring 6.2 x 5.2 x 5.0 cm and it states that "tumor invades the distal branch of the renal vein".
- The pathologist is staging it a T1b as they are considering the tumor to be limited to the kidney.




## Answer

- The distal branch of the renal vein is not the major vein (renal vein) described in T3.
- T1b would be correct.




http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/genitourinary-sites-chapters-40-47/65765

## Bladder Question

- I have a question on how to assign the T value for this scenario: TURB: Non-invasive urothelial ca, papillary & flat types, high grade. Muscularis propria present & uninvolved.
- Would you assign TA or Tis for this case?

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## Bladder-Answer

- Tis has a worse prognosis than Ta, which is the reason for the order of these T categories.
- If both are present, it is always assigned Tis

http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/genitourinary-sites-chapters-40-47/65694

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## Prostate-Question

- What if the needle biopsy showed a gleason of 7 and the prostatectomy shows a gleason of 6. Which score do we use for the pathologic stage? Do we use the higher gleason or go with the one from the prostatectomy?

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## Ovary-Clinical T

- Q: Is pathologic confirmation of ovarian cancer required to assign a clinical stage? The rules for classification stress the importance of pathologic confirmation to exclude primaries from other sites. I often see on operative reports “pre-op stage-Likely 3c ovarian cancer”. Can we use this to include in the clinical staging?
- *A: If the physician provides the clinical stage, it can be documented in the cancer registry database. There should be microscopic confirmation, but in these cases you don't want to lose that physician documentation.*

http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/education-developed-by-partner-organizations/naaccr-webinars/63400

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## Questions?

Quiz 1

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## And now a brief pause for...

# An Epi Moment

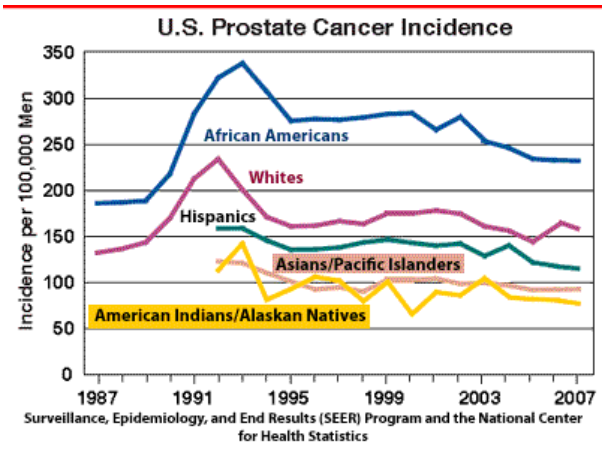
(theme songs from "Here Comes Science" by They Might be Giants

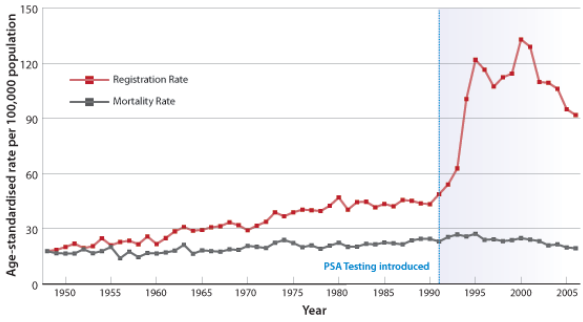
## Prostate Cancer

- #1 cancer diagnosed among man
  - But incidence & mortality ↓
- Average age at dx: 66
- No population based screening
  - USPSTF D grade for PSA (2012)
- Screening impacts incidence rate
- Over-diagnosis


"Doctor says I've got an enlarged procrastinate."

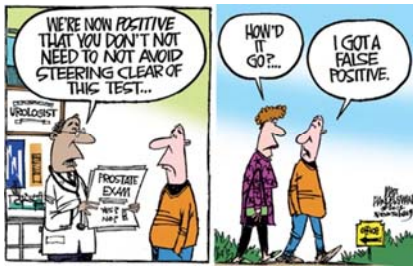
## PSA Cancer Screening and Incidence



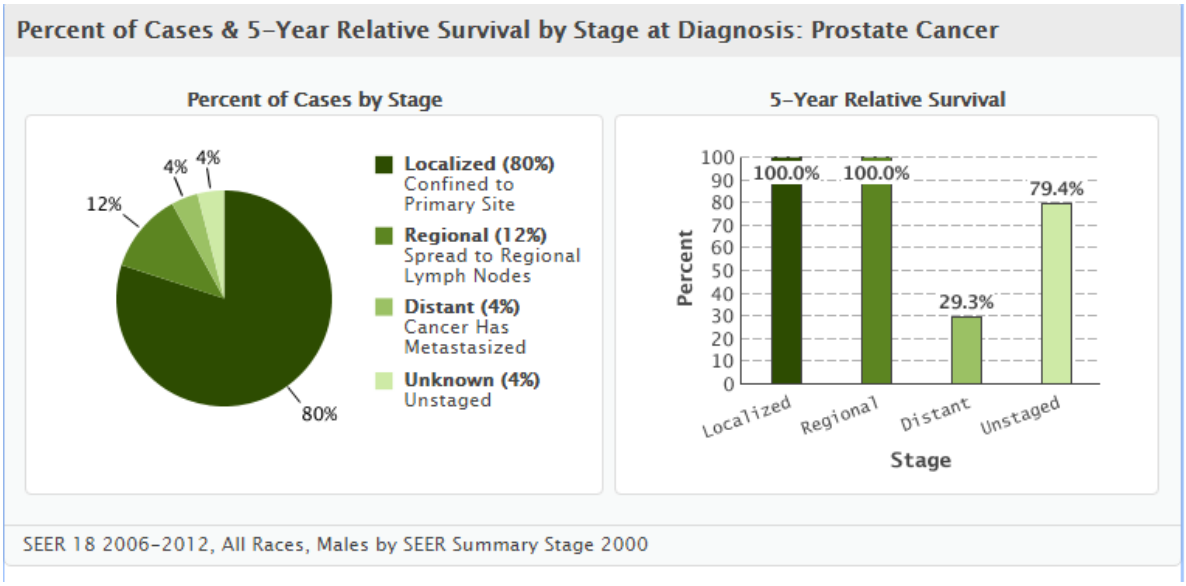



## PSA Cancer Screening and Over-diagnosis

- PSA present in the benign and malignant prostate
- Normal range about 0 – 7 µg/L (age dependent)
- Many men with prostate cancer have normal PSA
- PSA test for screening asymptomatic
  - Not recommended
  - Controversial
  - At age 55, PSA leads to 27% over-diagnosis
  - At age 75, PSA leads to 56% over-diagnosis
  - Cannot distinguish between indolent & aggressive dx




## Prostate Cancer Stage & Survival



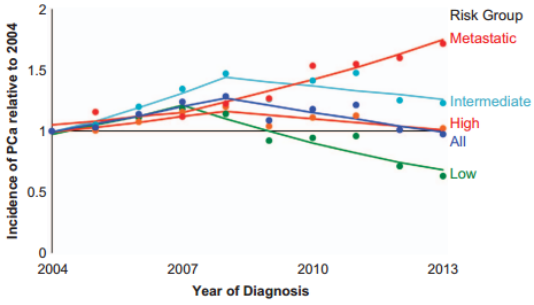
ORIGINAL ARTICLE

# Increasing incidence of metastatic prostate cancer in the United States (2004–2013)

AB Weiner[1], RS Matulewicz[1], SE Eggener[2] and EM Schaeffer[1]

**BACKGROUND:** Changes in prostate cancer screening practices in the United States have led to recent declines in overall incidence, but it is unknown whether relaxed screening has led to changes in the incidence of advanced and metastatic prostate cancer at diagnosis.
**METHODS:** We identified all men diagnosed with prostate cancer in the National Cancer Data Base (2004–2013) at 1089 different health-care facilities in the United States. Joinpoint regressions were used to model annual percentage changes (APCs) in the incidence of prostate cancer based on stage relative to that of 2004.
**RESULTS:** The annual incidence of metastatic prostate cancer increased from 2007 to 2013 (Joinpoint regression: APC: 7.1%, $P < 0.05$) and in 2013 was 72% more than that of 2004. The incidence of low-risk prostate cancer decreased from years 2007 to 2013 (APC: −9.3%, $P < 0.05$) to 37% less than that of 2004. The greatest increase in metastatic prostate cancer was seen in men aged 55–69 years (92% increase from 2004 to 2013).
**CONCLUSIONS:** Beginning in 2007, the incidence of metastatic prostate cancer has increased especially among men in the age group thought most likely to benefit from definitive treatment for prostate cancer. These data highlight the continued need for nationwide refinements in prostate cancer screening and treatment.

*Prostate Cancer and Prostatic Diseases* advance online publication, 19 July 2016; doi:10.1038/pcan.2016.30




| Risk Group | Trend 1 Interval | Trend 1 APC | Trend 1 p | Trend 2 Interval | Trend 2 APC | Trend 2 p |
|---|---|---|---|---|---|---|
| Low | 2004-2007 | 7.5 | 0.3 | 2007-2013 | -9.3 | <0.05 |
| Intermediate | 2004-2008 | 10 | <0.05 | 2008-2013 | -2.7 | 0.3 |
| High | 2004-2008 | 4.1 | 0.1 | 2008-2013 | -2.7 | 0.1 |
| Metastatic | 2004-2007 | 3.3 | 0.4 | 2007-2013 | 7.1 | <0.05 |
| All | 2004-2008 | 6.3 | 0.1 | 2007-2013 | -4.8 | 0.1 |

**Figure 1.** Annual incidence of prostate cancer based on the NCCN risk group relative to 2004 in the United States. Joinpoint regressions were used to model linear trends and determine statistical significance. Trend 1 represents an initial best fit line, whereas trend 2 represents a second linear fit if there is a change in trend from the initial line. The incidence of metastatic prostate cancer has increased recently by 72%, whereas the incidence of low-risk prostate cancer decreased by 37%. APC, annual percentage change; NCCN, National Comprehensive Cancer Network; PCa, prostate cancer.

## Methods:

"The primary outcome was the annual incidence of prostate cancer based on NCCN risk groups relative to that of 2004. That is, the outcome denominator was the incidence in 2004 and the numerator was the incidence for every year after."

## Ways of Measuring Cancer Incidence (Burden)

- Count
  - # of cases
  - Alabama 2013:
    - 2,174 cases white men; 970 cases black men
- Ratio
  - # of cases
  - Alabama 2013:
    - Approximately 2:1 white to black ratio
- Proportion
  - # of subset of cases /# of cases
  - %
  - 69% of prostate cases are white men; 31% are black men

## Ways of Measuring Cancer Incidence (Burden)

- Rate
  - # of cases / population
  - Over time period
  - Age-adjusted incidence rate
  - Alabama 2013:
    - 99.7 per 100,000 white men; 180.7 black men
- Rates represent risk; rates are used to *compare* risk
  - over time, different populations

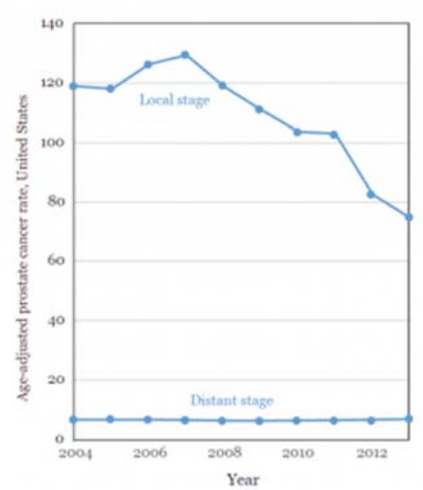
## Is risk of malignant prostate cancer increasing?

| | L Rate | L Count | R Rate | R Count | D Rate | D Count |
|---|---|---|---|---|---|---|
| 2004 | 116.9 | 152,434 | 13.7 | 19,071 | 6.5 | 7,786 |
| 2005 | 116.1 | 146,792 | 13.3 | 17,927 | 6.4 | 7,494 |
| 2006 | 124.5 | 170,787 | 14.2 | 20,735 | 6.5 | 8,204 |
| 2007 | 128.3 | 181,884 | 14.6 | 22,139 | 6.3 | 8,203 |
| 2008 | 117.6 | 172,406 | 14.0 | 21,954 | 6.2 | 8,262 |
| 2009 | 110.0 | 168,725 | 13.8 | 22,665 | 6.2 | 8,598 |
| 2010 | 102.1 | 161,310 | 13.7 | 22,939 | 6.3 | 8,950 |
| 2011 | 101.7 | 165,945 | 13.7 | 23,747 | 6.3 | 9,315 |
| 2012 | 81.5 | 137,852 | 11.8 | 21,053 | 6.5 | 9,863 |
| 2013 | 74.3 | 128,631 | 11.6 | 21,171 | 6.7 | 10,378 |

Rates are per 100,000 and age-adjusted to the 2000 US Std Population (19 age groups - Census P25-1130) standard.

| Total APC | L -4.8* | R -1.7* | D 0.1 |
|---|---|---|---|
| 2004 Rate | 116.9 | 13.7 | 6.5 |
| 2005 Rate | 116.1 | 13.3 | 6.4 |
| 2006 Rate | 124.5 | 14.2 | 6.5 |
| 2007 Rate | 128.3 | 14.6 | 6.3 |
| 2008 Rate | 117.6 | 14.0 | 6.2 |
| 2009 Rate | 110.0 | 13.8 | 6.2 |
| 2010 Rate | 102.1 | 13.7 | 6.3 |
| 2011 Rate | 101.7 | 13.7 | 6.3 |
| 2012 Rate | 81.5 | 11.8 | 6.5 |
| 2013 Rate | 74.3 | 11.6 | 6.7 |

Rates are per 100,000 and age-adjusted to the 2000 US Std Population (19 age groups - Census P25-1130) standard; Confidence intervals are 95% for rates (Tiwari mod) and trends.
Percent changes were calculated using 1 year for each end point; APCs were calculated using weighted least squares method.
*The APC is significantly different from zero (p<0.05).




# cases (distant)
proportion of total cases
population

Risk (rate) stable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**Abortion 'triples breast cancer risk': Fourth study finds terminations linked to disease**

By SIMON CALDWELL
Last updated at 1:55 AM on 24th June 2010

**Seven cups of tea a day 'raises risk of prostate cancer by 50%'**



**TERRIFYING TOLL**

How cancers have increased in England and Wales from 2003 to 2012

| Type of cancer | Cases a year | Increase |
|---|---|---|
| Liver | 2,478 | 66% |
| Malignant melanoma (skin) | 11,281 | 61% |
| Mouth and throat | 6,609 | 48% |
| Kidney | 7,366 | 46% |
| Uterus | 6,946 | 31% |
| Prostate | 37,136 | 28% |
| Breast | 42,489 | 12% |

*"And it was so typically brilliant of you to have invited an epidemiologist."*

## Questions?

61

## Miscellaneous

62

## Tumor Size Summary

- CS vs FORDS
  - If discrepancy about tumor size measurements in various sections of path report code size from synoptic report (CAP protocol)
  - If only a text report is available, use
    - Final Diagnosis
    - Microscopic examination
    - Gross examination

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## Tumor Size Summary

- CS vs FORDS
  - Recording less than/greater than Tumor size
  - If tumor size is reported as less than x mm or x cm, code size 1 mm less
    - Size is < 10 mm
    - Code size as 9mm or 009
  - If tumor size is reported as more than x mm or x cm, code size as 1 mm more
    - Size is > 10 mm
    - Code size as 11mm or 011

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## Tumor Size Summary

- CS vs FORDS
  - Neoadjuvant Therapy followed by surgery
    - Code largest size of tumor PRIOR to neoadjuvant treatment
    - If unknown code size as 999

65

## Tumor Size Summary

- CS vs FORDS
  - Tumor size code 999 is used when size is unknown or not applicable
    - Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms
      - 9590-9992
    - Kaposi Sarcoma
    - Melanoma Choroid, Melanoma Ciliary Body, Melanoma Iris

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## Tumor Size Summary Codes

| Code | Description |
|---|---|
| 002-988 | Exact size in millimeters (2mm to 988 mm) |
| 998 | Site-Specific Codes: Alternate descriptions of tumor size for specific sites |
| | Familial/Multiple polyposis: Rectosigmoid and Rectum; Colon |
| | **If no size is documented:** |
| | Circumferential: Esophagus |
| | Diffuse, widespread: 3/4s or more; linitis plastic: Stomach and Esophagus GE Junction |
| | Diffuse, entire lung or NOS: Lung and main stem bronchus |
| | Diffuse: Breast |

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## Pop Quiz 7

- **Operative Report**:
  - Superior inner quadrant lumpectomy with sentinel lymph node biopsy
- **Pathology Report**
  - Tumor Location: Superior inner quadrant, left breast
  - Histology: invasive ductal carcinoma
  - Tumor Size: 2.0cm x 2.5cm x 3.0cm mass
  - Nottingham Histologic Score: 7
    - Glandular/Tubular Differentiation: 3
    - Nuclear Pleomorphism: 3
    - Mitotic Rate: 1
  - Margins: microscopically positive for invasive carcinoma.
  - Skin involvement: Not identified. No dermal lymphatic involvement.
  - Muscle involvement: Not identified
  - Sentinel Lymph node biopsy
    - 1 of 2 sentinel nodes positive-metastasis measuring 4mm
  - Oncotype DX score of 22

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## Pop Quiz 7

- What is Tumor Size summary?
  - 020
  - 025
  - 030
  - 998

69

## Mets at Diagnosis - BBDLLO

- Mets at Diagnosis – **B**one
- Mets at Diagnosis – **B**rain
- Mets at Diagnosis – **D**istant Lymph Nodes*
- Mets at Diagnosis – **L**iver
- Mets at Diagnosis – **L**ung
- Mets at Diagnosis – **O**ther*

70

## Mets at Diagnosis

- Code 0
  - Indicates that the patient has distant (discontinuous) mets but BBDLLO is not mentioned as an involved site
  - Indicates that there are no mets at all
  - Includes a clinical or pathologic statement no mets
  - Includes imaging reports are negative for mets

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## Mets at Diagnosis

- Code 1
  - If the patient is diagnosed as an unknown primary (C80.9) and bone, brain, distant lymph nodes, liver, lung are mentioned as a metastatic site
  - Do not assign for lung primary with multifocal involvement of the SAME lung only assign if metastasis in the contralateral lung
  - Do not assign for a bone primary with multifocal bone involvement of the SAME bone
  - If patient has distant metastases in any site other than bone, brain, liver or distant lymph nodes

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## Mets at Diagnosis

- Code 8
  - Refer to the tables in FORDS.
  - C770-C779 are not included in the site and histology combinations

| ICD-O-3 Site | ICD-O-3 Histology | |
|---|---|---|
| C000-C809 | 9740-9809, 9840-9992 | Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site |
| C420, C421, C424 | 9811-9818, 9823, 9827, 9837 | Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic |
| C000-C440, C442-C689, C691-C694, C698-C809 | 9820, 9826, 9831-9834 | Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS |
| C000-C440, C442-C689, C691-C694, C698-C809 | 9731, 9732, 9734 | Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS |

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## Pop Quiz 8

- Prostate, right, needle biopsy:
  - Adenocarcinoma, Gleason score 3+4=7, involving 4 of 5 cores and 30% of specimen
  - No perineural or lymphovascular invasion identified
  - No extraprostatic extension identified
  - No seminal vesicle tissue present for evaluation
- 4/19/16 Bone Scan:
  - No scintigraphic findings to suggest skeletal metastases.
- 4/20/16 CT Abd/Pelvis:
  - Impression: There is a lesion in the inferior aspect of the left lobe of the liver suspicious for metastatic disease.

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## Pop Quiz 8

- What would you code Mets at Diagnosis BBDLLO?
  - Mets at Diagnosis – Bone – 0
  - Mets at Diagnosis – Brain - 0
  - Mets at Diagnosis – Distant Lymph Nodes - 0
  - Mets at Diagnosis – Liver – 1
  - Mets at Diagnosis – Lung - 0
  - Mets at Diagnosis – Other - 0

75

## Staged By

- This field identifies the person who recorded the clinical/pathologic AJCC staging data items.
- Code 00
  - clinical stage: tumor was not staged or it is unknown
  - pathologic stage: if criteria is not meet, tumor not staged or stage is unknown
- Code 11-14
  - Assign for the specific physician: Surgeon, Radiation oncologist, Medical oncologist, or pathologist
- Code 15
  - If stage assigned at tumor board
- Code 10
  - Staged assigned by a physician not in codes 11-15

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## Staged By

- Code 20
  - Cancer registrar only
- Code 30
  - Cancer registry and physician
- Code 88
  - Case not eligible for staging

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## Pop Quiz 9

At Tumor Board several cases were presented in which the cancer registrar was currently abstracting but had not staged. During tumor board the physicians clinically staged each case. The patient went on to have surgery but the case was not pathologically staged by the physician. The cancer registrar then completed the pathologic stage.

- What would the code be for Staged By (Clinical Stage)?
  - 15
- What would the code be for Staged By (Pathologic Stage)?
  - 20

78

## Clinical/Pathologic Stage Descriptor

- Record the descriptor as documented by treating physician
- If managing physician not record it, registrars will based on the best available information
- If tumor not staged using AJCC Rules, leave blank

**What is the TNM Descriptor when Stage Group is blank, 88, or 99?**

79

## Clinical/Pathologic* Stage Descriptor

| Code | Label | Description |
|---|---|---|
| 0 | None | There are no prefix or suffix descriptors that would be used for this case |
| 1 | E- Extranodal, lymphomas only | A lymphoma case involving an extranodal site |
| 2 | S- Spleen, lymphomas only | A lymphoma case involving the spleen |
| 3 | M-Multiple primary tumors in a single site | This is one primary with multiple tumors in the organ of origin at the time of diagnosis |
| 4* | Y-Classification after initial multimodality therapy | Neoadjuvant treatment given before staging |
| 5 | E&S- Extranodal and spleen, lymphomas only | A lymphoma case with involvement of both an extranodal site and the spleen |
| 6* | M&Y-Multiple primary tumors and initial multimodality therapy | A case meeting the parameters of both codes 3 & 4 |
| 9 | Unknown, not stated in patient record | A prefix or suffix would describe this stage, but it is not know which would be correct |

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## Clinical/Pathologic Stage Descriptor

- Question:
  - What is the TNM Descriptor when Stage Group is blank, 88 or 99?
- Answer:
  - Stage Group 99 – Code 0
  - Stage Group 88 – Leave Blank

81

## Question – (M) descriptor

- We have a patient that has an infiltrating duct carcinoma with a stated size and a separate DCIS with stated size
- According to the breast chapter the "m" descriptors should only be used for infiltrating carcinoma.
  - Is that correct?
  - Does it apply to all sites?

82

## (M) Descriptor

- General Rules – Chapter 1 (pg. 12)
- Breast Chapter – Chapter 32 (pg. 354)

83

## Answer

- While the rule technically does not state it cannot be used for multiple in situ tumors, that is not the norm.
  - In situ tumors are often multifocal, as that is their nature. Also, the rule was written to indicate tumor burden, and indicate that while cases may seem similar since they are both T2, the fact that one is T2(m) may affect the prognosis.
  - Multiple tumors for in situ doesn't affect the prognosis.
  - The rules will not state this because a physician understands these implications for prognosis
  - The (m) would not be used for non-invasive tumors either.

http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/breast-chapter-32/62884

84

## Prostate – Biochemical Failure

- Question:
  - When patient with prostate cancer experiences biochemical failure, is this considered a recurrence?

85

## Prostate – Biochemical Failure

- What is Recurrence?
  - The reappearance of disease that was though to be cured or inactive.
  - A new occurrence of cancer arising from cells that have nothing to do with the first cancer
- What is Biochemical Failure?
  - Increasing PSA after being treated with prostatectomy or radiation therapy for prostate cancer

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## Prostate – Biochemical Failure

- Question:
  - When patient with prostate cancer experiences biochemical failure, is this considered a recurrence?
- Answer:
  - Elevated PSA may indicate biochemical recurrence/failure and proceeds the starting point of metastatic process but it is not a recurrence in a sense as FORDS describes it.
  - Recommend to keep an eye on the case, update with follow up and cancer status until true mets in other tissue/organs detected.

- 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

87

## GIST

- Question:
  - What is the diagnosis date for a patient with a GIST tumor that when originally diagnosed in 2015 was non-reportable but a year later is diagnosed with metastasis from GIST??

88

## GIST

- Case Eligibility
  - GIST are frequently non-malignant. If noted to have multiple foci, metastasis, or positive lymph nodes abstract and assign /3
- Date of Diagnosis
  - First date of diagnosis – clinically or histologically
  - If physician states in retrospect patient had cancer at earlier date use the earlier date

89

## GIST

- Question:
  - What is the diagnosis date for a patient with a GIST tumor that when originally diagnosed in 2015 was non-reportable but a year later is diagnosed with metastasis from GIST?
- Answer:
  - The date of diagnosis would be the first time that the reportable terminology was used.
  - Exception would be if the physician states that in retrospect that the patients GIST from 2015 was malignant, then abstract using that date as the date of diagnosis.

90

## Refused Palliative Care

- Question:
  - If chemotherapy – palliative was offered and the patient refuses it, should we record the chemotherapy treatment field as “not done” or “recommended, not given, refused”?

91

## Palliative Treatment

- FORD Definition
  - Palliative care is performed to relieve symptoms and may include surgery, radiation therapy, systemic therapy and/or other pain management therapy
- Instructions for Coding
  - Treatment to prolong life, control symptoms, alleviate pain, make comfortable
  - Code as palliative care and first course therapy if removes, modifies either primary or metastatic malignant tissue

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## Palliative Treatment

| Code | Definition |
|---|---|
| 0 | No palliative care provided. Diagnosed at autopsy |
| 1 | Surgery to alleviate symptoms, no attempt to diagnose, stage, treat primary tumor |
| 2 | Radiation therapy to alleviate symptoms, no attempt to diagnose, stage, treat primary tumor |
| 3 | System drugs to alleviate symptoms, no attempt to diagnose, stage, treat primary tumor |
| 4 | Patient received or referred for pain management therapy with no other palliative care |
| 5 | Any combination of codes 1, 2, and/or 3 without code 4 |
| 6 | Any combination of codes 1, 2, and /or 3 with code 4 |
| 7 | Palliative care was performed or refereed but no information on the type is available. Palliative care was provided that does not fit the codes 1-6 |
| 9 | It is unknown if palliative care was performed or referred, not stated in record |

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## Refused Palliative Care

- Question:
  - If chemotherapy – palliative was offered and the patient refuses it, should we record the chemotherapy treatment field as “not done” or “recommended, not given, refused”?
- Answer:
  - We would record the palliative treatment field as 0 and the chemotherapy treatment field as 00.
  - It is advised to make a note in the abstract that palliative treatment was offered and refused by patient.

http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/palliative/31687-refused-palliative-care

http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/palliative/56276-refused-palliative-care-2

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## Palliative Care Example

- Patient had lung nodule that was resected and found to be metastatic kidney cancer. Bone scan also showed metastatic disease. Doctor recommended palliative first-line therapy of Sunitinib, but patient declined any further therapy and he eventually died.
- What do we code palliative treatment field?
  - 0 – No palliative care provided
- What do we code chemotherapy treatment field?
  - 00 – None Chemotherapy was not part of planned first course treatment

95

## Pop Quiz 9 Class of Case

- A patient was diagnosed with liver metastases seen on CT elsewhere and went to facility A for colonoscopy and biopsy of colonic tumor.
- The histology was low grade adenocarcinoma of colonic primary. Additional work up at facility B revealed mesenteric lymphadenopathy and diffuse hepatic metastases.
- The patient was consulted at B for further treatment plan and went to facility C where she received treatment

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## Pop Quiz 9-Class of Case

- What is Class of Case for
  - Facility A
  - Facility B
  - Facility C

The facility A would assign class of case 00
The facility B would assign class of case 30
The facility C would assign class of case 22

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## Pop Quiz 10-Class of Case

- A patient was diagnosed with right breast cancer by positive core needle biopsy of the right breast at facility A.
- The patient then went to facility B for sentinel lymph node biopsy and treatment plan.
- The patient returned to facility A where she underwent recommended treatment.

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## Pop Quiz 10-Class of Case

- What is Class of Case for
  - Facility A
  - Facility B

The class of case at facility A – 14
The class of case at facility B – 30

99

## Pop Quiz 11-Class of Case

- 90 year old patient was diagnosed at facility A with a brain mass suspicious for malignant astrocytoma.
- He was admitted to facility B for consult to determine whether cancer-direct therapy (surgery, hormone, chemotherapy) is an option.
- Based on patient health status the decision not to treat has been made in facility B.

100

## Pop Quiz 11-Class of Case

- What is Class of Case for
  - Facility A
  - Facility B

The class of case at A – 00
the class of case at B – 22.

101

## Questions?

Quiz 2

102

## Coming Up…

- Collecting Cancer Data: Melanoma
  - 10/6/2016
- Collecting Cancer Data: Hematopoietic and Lymphoid Neoplasm
  - 11/3/2016

103

## And The Winners Are…


104

## CE Certificate Quiz/Survey

- Phrase
- Link
  - http://www.surveygizmo.com/s3/3019032/Coding-Pitfalls-2016

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## Thank You!!!!

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