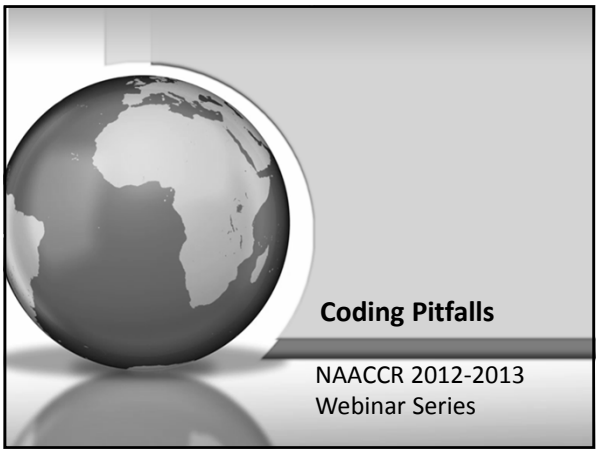

Q&A

- 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

2013 Resource List

- Collaborative Stage Data Collection System (CS)
  - V02.04 effective for cases diagnosed 1/1/2012 thru 12/31/2013
  - http://cancerstaging.org/cstage/index.html
- Multiple Primary and Histology (MP/H) Coding Rules
  - Revised 8/24/12
  - http://seer.cancer.gov/tools/mphrules/download.html

2013 Resource List

- Hematopoietic & Lymphoid Database (Heme DB) and the Hematopoietic Coding Manual
  - Revised 2/25/13
  - http://seer.cancer.gov/tools/heme/
- SEER*Rx Interactive Antineoplastic Drugs Database (SEER*Rx)
  - Updated 8/6/13
  - http://seer.cancer.gov/seertools/seerrx/

2013 Resource list

- FORDS 2013
  - http://www.facs.org/cancer/coc/fords/fords-manual-2013.pdf
- CoC Cancer Program Standards 2012: Ensuring Patient-Centered Care
  - http://www.facs.org/cancer/coc/programstandards2012.pdf

2013 Resource list

- SEER Program & Coding Staging Manual 2013
  - http://seer.cancer.gov/tools/codingmanuals/
- NAACCR Version 13 Data Standards & Data Dictionary
  - http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx#
- State Reporting Manuals

2013 Resource list

- ICD-O-3
  - September 2011 revisions have NOT yet been implemented in the US and Canada
  - New terms, synonyms, and related terms for existing ICD-O-3 codes to be implemented in 2014
  - New codes and behavior code change for carcinoid NOS of appendix to be implemented in 2015
  - Implementation of ICD-O-3 Updates
    - http://newsmanager.commpartners.com/naaccr/issues/2013-07-24/2.html

Where to Send Questions

- CAnswer Forum
  - AJCC TNM Staging
  - Collaborative Stage
  - FORDS
  - http://cancerbulletin.facs.org/forums/forum.php
- Ask a SEER Registrar
  - Multiple Primary and Histology Coding Rules
  - Hematopoietic & Lymphoid Database & Coding Manual
  - SEER*Rx Interactive Antineoplastic Drugs Database
  - ICD-O-3, ICD-10-CM, ICD-9-CM
  - SEER Coding & Staging Manuals
  - http://seer.cancer.gov/registrars/contact.html

NAACCR Data Item #440

GRADE

Coding Grade Data Item

- Grade coding rules are being updated with consensus from all standard setters
  - Planned to be applicable for cases diagnosed 1/1/2014 and after

Coding Grade Data Item

- In situ lesions
  - Are not always graded
  - Code grade if it is specified
  - Code grade from invasive component of tumor if tumor is invasive and in situ
  - Facility Oncology Registry Standards Revised for 2013 (FORDS 2013) p. 123
  - Surveillance Epidemiology and End Results (SEER) Program Coding & Staging Manual (PCSM) 2013 p. 80

Coding Grade Data Item

- Converting terminology to grade code
  - Terminology conversion table
    - FORDS 2013 p. 12-13
    - SEER PCSM 2013 p. 80
- Multiple grades for same primary
  - Code the highest grade even if only a focus
    - FORDS 2013 p. 123
    - ICD-O-3 Rule G p. 21
    - SEER PCSM 2013 p. 79

Coding Grade Data Item

- Coding grade when patient had neoadjuvant treatment
  - Code grade from pathology report prior to neoadjuvant treatment
  - FORDS 2013 p. 123
  - SEER PCSM 2013 p. 79

FEMALE REPRODUCTIVE SYSTEM

Histology Coding: Question

- A physician at my facility has asked for information on all serous carcinomas of the ovary. I ran a list of ovarian cancer patients from my registry database and noticed that some papillary serous adenocarcinomas are coded papillary serous cystadenocarcinoma (8460/3) and that some are coded mixed cell adenocarcinoma (8323/3), the latter due to instructions from the MP/H manual. How should ovarian papillary serous adenocarcinoma be coded?

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Coding Histology
Papillary Serous Adenocarcinoma

- ICD-O-3 Alphabetic Index
  - Adenocarcinoma
    - Papillary
      - Serous
        - » 8460/3
- ICD-O-3 Numeric Index
  - 8460/3
    - **Papillary serous cystadenocarcinoma (C56.9)**
      - Papillary serous adenocarcinoma (C56.9)
    - Micropapillary serous carcinoma (C56.9)

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Other Sites Histology Coding Rules

- Single Tumor: Invasive Only
  - H11: Code the histology when only one histologic type is identified.
  - H16: Code the appropriate combination/mixed code (Table 2) when there are multiple specific histologies or when there is a non-specific histology with multiple specific histologies.

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Table 2

1: Required Histology	2: Combined with Histology	3. Combination Term	4: Code
Gyn malignancies w/ 2 or more of histologies in column 2	Clear cell Endometrioid Mucinous Papillary Serous Squamous Transitional	Mixed cell adenocarcinoma	8323

Histology Coding: Answer

- Stop at H11 and assign code 8460/3 for papillary serous adenocarcinoma of ovary

Staging Question

- In the AJCC Cancer Staging Manual 7th Ed. (page 396), it is documented that for cervix CT, PET, and MRI results can't be used for clinical TNM staging. There is no such documentation in Collaborative (CS) so we are using imaging for clinical CS. Because of that MD stage is I or II while derived is Stage III because of nodes identified on imaging. Are we correct to use imaging for clinical Collaborative Stage?

Staging Answer

- Yes, we are supposed to ignore imaging findings in assigning cervical cancer stage. However, the staging rules allow X-ray and intravenous pyelography (IVP) which are investigations expected to be available to women even in rural areas of developing countries. So, if either of these two imaging findings show a cancer related finding, e.g., cannon ball opacities in the chest (X-ray) or hydronephrosis on IVP, the findings are allowed to be used in stage assignment. All others (CT, PET, MRI) are not allowed and their findings must be ignored for staging purposes. One investigation that is unclear to me is ultrasound; this is now available everywhere, but the staging rule is silent on it.

AJCC Expert Panel Member

NAACCR

Treatment Coding Scenario

- Patient with cervix primary with parametrial extension underwent bilateral salpingo-oophorectomy (BSO) only. Patient's uterus, including cervix, was left in place for planned brachytherapy. Pathology showed no malignancy in ovaries or tubes.

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Treatment Coding Question & Answer

1. What is the code for Surgical Procedure of Primary Site?
   a. 00: No surgery of primary site
   b. 62: Hysterectomy, NOS, with removal of tubes and ovaries
2. What is the code for Surgical Procedure/Other Site?
   a. 0: None
   b. 2: Non primary surgical procedure to other regional sites

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HEAD AND NECK

Primary Site Coding

- What is the primary site code for glossotonsillar sulcus?
- Occasionally we see cancer arising in ectopic thyroid tissue found in the oropharynx. Should the primary site be the thyroid or the orophyarnx?

Primary Site Coding

- Patient diagnosed with squamous cell carcinoma in a lymph node. Primary site is determined to be head and neck, but the specific site was not determined. What is the code for primary site?
  a. C14.8: Overlapping lesion of lip, oral cavity, and pharynx
  b. C76.0: Ill-defined site; head, face, or neck
  c. C80.9: Unknown primary site

Primary Site Coding

- Patient has a single primary lesion that involves both the laryngeal aspect of the aryepiglottic fold (C32.1) and the pharyngeal aspect of the aryepiglottic fold (C13.1).
- What is the primary site?
  a. C13.1
  b. C14.8
  c. C32.1
  d. C76.0

Histology Coding: Thyroid

- Micropapillary (for thyroid only)
  – Means papillary portion of tumor is minimal or occult
  – Micropapillary carcinoma does not refer to a specific histologic type

CS SSF1 Size of Lymph Node

Head and Neck

- Patient had oropharyngeal primary. Physician staged lymph node involvement as N3, but the only description is 7 cm lymph node mass, probably multiple nodes. What is the code for SSF1?

BONE & SOFT TISSUE

CS Tumor Size/Ext Eval: Soft Tissue

- Soft tissue primary tumor is completely resected, but there is no tumor size mentioned on the path report. A radiology report gives a primary tumor size of 4.4 cm.
- What is the code for CS Tumor Size/Ext Eval?
  - 0: Evaluation based on non-invasive clinical evidence?
  - 3: Pathologic exam of resected specimen

CS SSF3 Bone: Percent Necrosis Post Neoadjuvant Chemotherapy

- Patient diagnosed with Ewing's Sarcoma treated with neoadjuvant chemotherapy. Path report for the below knee amputation (BKA) post neoadjuvant chemotherapy reads “necrotic tissue and fibrosis in marrow cavity, negative for residual sarcoma.”
- What is the correct code for SSF3?
  - 000: No tumor necrosis
  - 100: 100% tumor necrosis
  - 990: Tumor necrosis present, percent not stated
  - 999: Unknown

STOMACH & ESOPHAGUS

Coding Involved Lymph Nodes for Esophagus

- EUS with biopsy: Middle Esophageal (28cm) squamous cell carcinoma invading the adventitia (T3); small lymph node near celiac axis with malignant adenopathy. Is celiac node involvement coded in CS Lymph Nodes or in CS Mets at DX? The notes preceding the codes are conflicting.

CS Lymph Nodes: Esophagus GE Junction

- Patient referred to facility for treatment of esophagus GE junction cancer. Lymph node involvement described as cN1 with no other information available.
- What is the code for CS Lymph Nodes?
  - 500: Regional nodes NOS
  - 610: Stated as pathologic N1 with no other info on regional nodes
  - 800: Lymph nodes NOS

CENTRAL NERVOUS SYSTEM

Question-Reportability

- Are any of these conditions reportable when they are found in the primary brain or CNS site?9120/0 Hemangioma, NOS
  - 9121/0 Cavernous hemangioma
  - 9122/0 Venous hemangioma
  - 9122/0 Venous hemangioma

Answer

- 9120/0 Hemangioma, NOS and 9121/0 Cavernous hemangioma are **reportable** when they arise in the dura or parenchyma of the CNS.
- 9122/0 Venous hemangioma is **not reportable.**

SEER SINQ 20130001
http://seer.cancer.gov/seerinquiry/index.php?page=view&id=20130001&type=q

Question-Multiple Primaries

- I am faced with a case of a person being diagnosed with a mixed glioma 9382/3 in 2005 now being diagnosed with what the physicians are calling a recurrent anaplastic astrocytoma (9401/3).
  - Is this a new primary?

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Multiple Tumors

- Rule M6
  - A glioblastoma or glioblastoma multiforme (9440) following a glial tumor is a single primary (See Chart 1).
  - Glioblastoma:
    - A malignant rapidly growing Astrocytoma of the central nervous system. These neoplasms grow rapidly, invade extensively, and occur most frequently in the cerebrum of adults. Any glial tumor can recur as a glioblastoma or a glioblastoma multiforme

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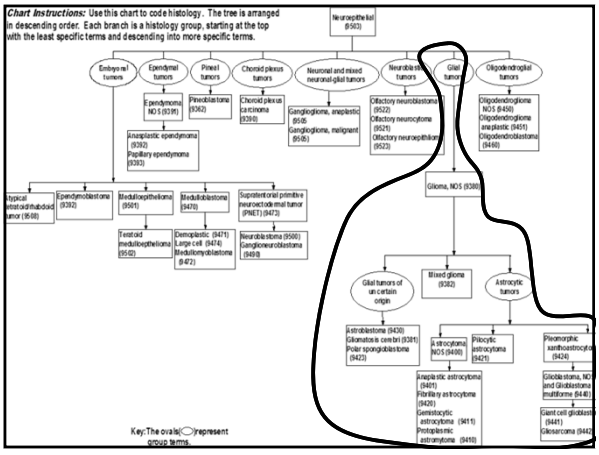
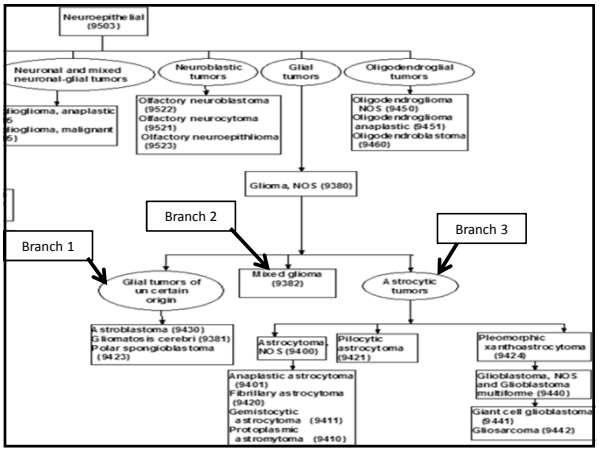
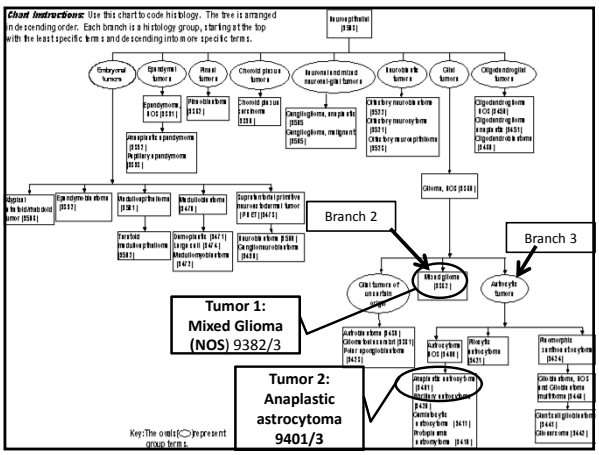


Multiple Tumors

- Rule M7
  - Tumors with ICD-O-3 histology codes on the same branch in Chart 1 or Chart 2 are a single primary.
- Rule M8
  - Tumors with ICD-O-3 histology codes on different branches in Chart 1 or Chart 2 are multiple primaries.





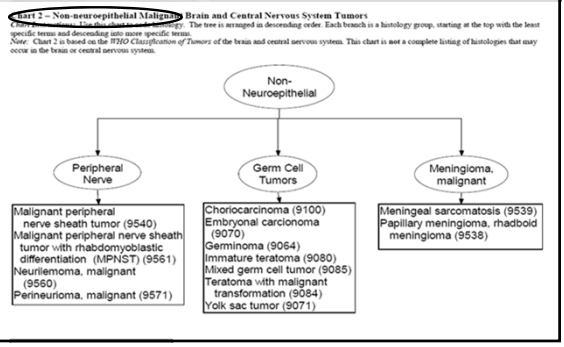
Answer

- One primary per rule M8

Question-Multiple Primaries

- Can you give a quick explanation of the difference between the MPH Chart 1 and Chart 2?
  - Chart 1 is of Neuroepithelial Malignant tumors and Chart 2 is of Non-neuroepithelial Malignant tumors.
- What differentiates neuroepithelial from non-neuroepithelial?

Answer



Question-Sequence Number

- Please review the sequence number rules for benign brain tumors

Sequence Number

- Records sequence of malignant and nonmalignant neoplasms over patient's lifetime
  - 00-59 and 99 for malignant and in situ behavior
    - 00 = solitary malignant neoplasm
    - 01 = first of multiple malignant neoplasms
  - 60-88 for non-malignant behavior
    - 60 = solitary non-malignant neoplasm
    - 61 = first of multiple non-malignant neoplasms

Question-Reportability

- Please clarify the reportability of a "sphenoid wing meningioma"

Answer

- The term "sphenoid wing meningioma" has been interpreted as an *intraosseous* meningioma of the sphenoid bone.
- The term “Sphenoid meningioma" has been interpreted as a meningioma of the sphenoid sinus.
  - Neither are reportable at this time.

SEER SINQ 20130025
http://seer.cancer.gov/seerinquiry/index.php?page=view&id=20130025&type=q

Question-Reportability

- Are all “spinal” schwannomas reportable or only those stated to be “intradural”?

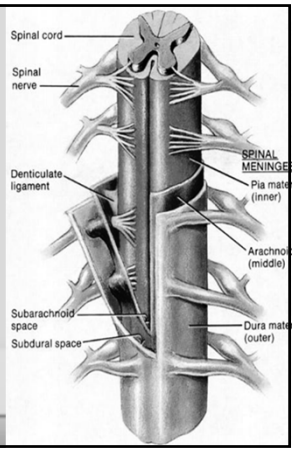
Answer

- …report these spinal tumors when they arise within the spinal dura or spinal nerve roots, or when they are stated to be "intradural" or "of the nerve root."
- Do not report these tumors when they arise in the peripheral nerves.
  - See #2 under Reportability in the Data Collection Answers from the CoC, NPCR, SEER Technical Workgroup http://www.seer.cancer.gov/registrars/data-collection.html#reportability

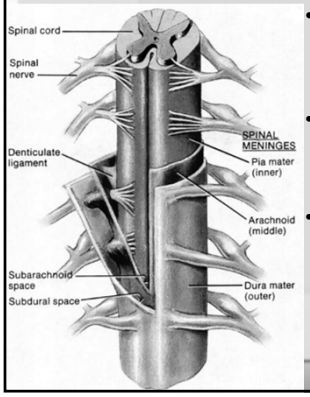
SEER SINQ 20130023
http://seer.cancer.gov/seerinquiry/index.php?page=view&id=20130023&type=q

Primary Spinal Cord Tumors

- Extradural
  - Usually mets
- Intradural-extramedullary
  - Usually meningiomas
- Intradural-intramedullary
  - Usually astrocytomas in children
  - Usually ependymomas in adults



Spinal Nerve Tumors



- Neoplasms arising from the dura covering the spinal cord roots are meningiomas.
- Neoplasms arising in the spinal nerve roots are primarily Schwannomas and neurofibromas.
- The peripheral nerves are the portion of nerve extending beyond the spinal dura.
  - Benign /0 or borderline /1 neoplasms of the peripheral nerves are not reportable.

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Question-Grade

- WHO grade is not coded unless it is on the path report…correct?

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Answer

- For certain histologies the WHO grade can be coded even if not documented on path report if it is documented for specific histology found on Table 56.3 in AJCC 7th Ed.

WHO Grade

- Table 56.3 in AJCC 7th Ed (pg 596)
- Use to code WHO grade not histologic grade

Astrocytic Tumors	I	II	III	IV
Subependymal giant cell astrocytoma	X			
Pilocytic astrocytoma	X			
Pilomyxoid astrocytoma		X		
Diffuse astrocytoma		X		
Anaplastic astrocytoma			X	
Glioblastoma				X

BREAST

Question-Histology

- How is histology coded for a breast primary with a final diagnosis of "infiltrating duct carcinoma with apocrine features"?

Answer

- Apocrine (8401/3) is a type of duct carcinoma.
  - 8401/3 should have been included in rule H12
  - 8401/3 should have been included in Table 2
  - 8401/3 should have been removed from Table 3
- For now you may continue coding these cases as you have in the past.
  - This issue will be clarified with the updated rules planned for 2015 cases.

Table 2 – Duct (8500/3) and Specific Duct Carcinomas

***Note*:** These are the most common specific duct carcinomas**.** This is not intended to be a complete list of all possible duct types. If a histology appears only on table 2, it does not mean that it is impossible for that histology to occur with an in situ behavior (/2).

Code	Type
8022	Pleomorphic carcinoma
8035	Carcinoma with osteoclast-like giant cells
8401	**Apocrine adenocarcinoma***
8500	Duct, NOS
8501	Comedocarcinoma
8502	Secretory carcinoma of breast
8503	Intraductal papillary adenocarcinoma with invasion
8508	Cystic hypersecretory carcinoma

Table 3 – Combination Codes for Breast Cancers

Required Histology	Combined With	Combined Term	Code
Infiltrating duct and **one or more** of the histologies in Column 2	Tubular	Infiltrating duct mixed with other types of carcinoma	8523/3
	~~Apocrine~~		
	Mucinous		
	Secretory carcinoma		
	Intraductal papillary adenocarcinoma with invasion		
	Intracystic carcinoma, nos		
	Medullary		

Question-Histology

- 11/6/12 Ultrasound guided core biopsy of the left breast & left axilla and right breast & right axilla.
  - Pathology was positive for *invasive ductal carcinoma* in both breasts.
- The patient underwent 6 months of chemotherapy.
- May 2013 patient underwent bilateral mastectomies.
  - Left mastectomy specimen showed invasive lobular cancer, pleomorphic type with 11 axillary LNs negative.
  - Right mastectomy no residual malignancy & 11 LNs negative.

Question-Histology (cont)

- What histology code do I use for the left breast?

Answer

- Code duct and lobular carcinoma 8522/3
  - A biopsy produces a small amount of tissue and, in this case, found the invasive duct, but not the lobular carcinoma.
    - The lobular carcinoma was present prior to the chemotherapy.
  - After neoadjuvant chemotherapy, only the lobular was left.
    - The chemotherapy was more effective in shrinking or eliminating the duct carcinoma

SEER SINQ 20130089
http://seer.cancer.gov/seerinquiry/index.php?page=view&id=20130089&type=q

Question-Primary Site

- If you have a tumor at 3:00 and one at 1:00 both same histology, what is the primary site coded to?

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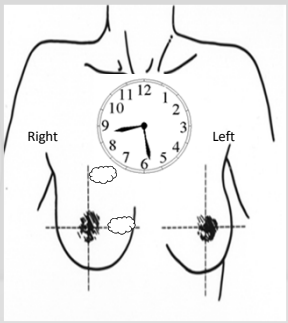
Answer

- If both tumors are invasive, code primary site to C50.9.
- If 1 is invasive and 1 is in situ, code primary site to sub-site with invasive tumor.



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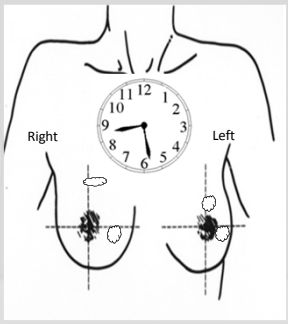
Question-Primary Site

- What is the primary site code for tumors described as being at 1:30, 3:30 etc?

Answer

- Code to the quadrant where the whole number is located.
  - Left breast 1:30 would be upper outer quadrant
  - Right breast 1:30 upper inner quadrant.
  - Left breast 3:30 would be lower outer quadrant
  - Right breast 3:30 would be lower inner quadrant



Question-Primary Site

- Q: Would you define the central portion of the breast?

Answer

- Code C50.1 should be used if the tumor is described as:
  - Central portion of breast (subareolar) area extending 1 cm around areolar complex
  - Retroareolar
  - Infraareolar
  - Next to areola, NOS
  - Behind, beneath, under, underneath, next to, above, cephalad to, or below nipple
  - Paget disease with underlying tumor
  - Lower central

SEER Coding Guidelines for breast
http://seer.cancer.gov/manuals/2013/AppendixC/breast/coding_guidelines.pdf

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Question-Lymph Nodes

- Q: What level are internal mammary lymph nodes?

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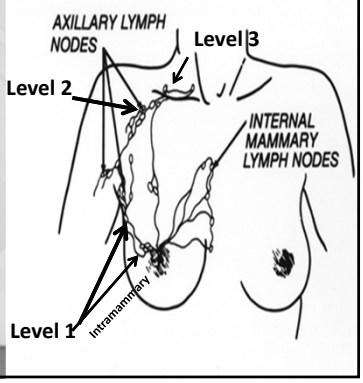
Answer

- Internal mammary lymph nodes are not considered axillary lymph nodes so aren't given a Level.
- Intramammary nodes are considered level 1 axillary nodes.



Question-Collaborative Stage

- Patient has incidental finding of 9mm DCIS in left breast during bilateral mastectomies done after neoadjuvant chemo for inflammatory carcinoma in right breast.
  - What is the TS/Ext Eval Code for the DCIS? This case was designed as a scenario for a breast training in our office. We debated whether the code should be 3 or 6.

Answer

- "We checked with an AJCC breast surgeon and he said this needs to be staged as a yP, so your eval code would be 6 for the DCIS in the left breast. He commented that the neoadjuvant therapy did affect the left breast."

http://cancerbulletin.facs.org/forums/showthread.php?6311-TS-EXT-Eval-Code-for-new-primary-contralat-breast-after-neoadj-treatment&highlight=breast

Question-999 vs. 998

- My question is regarding the SSF's for Her2.
  - If, for instance, IHC is 1+ (negative) and you code those fields accordingly, should the other Her2 fields (FISH, etc.) be coded as 999 or 998?
    - If I read the manual correctly, in order to code 998 there must be a statement in the medical record that these were not done and/or a policy and procedure that these are never done in that facility.

Answer

- Without a proper procedure and policy written up, with no documentation available, registrars should code the rest of the HER2 neu fields as 999.
- If there is something in writing, the registrar could go with 998.
- Those are the current guidelines.

Question-Surgery

- Q: if a simple mastectomy is performed with sentinel lymph node biopsy and the sentinel lymph node is positive and axillary lymph node dissection is then performed, is the surgery code in the 40 range or 50 range?

Answer

- If a patient has an axillary node dissection and a simple mastectomy, the surgery code should be in the 50 series.
  - This is a cumulative code. So even if the axillary node dissection and simple mastectomy were done at different times, the surgery code would be in the 50 series.

Canwer Forum
http://cancerbulletin.facs.org/forums/showthread.php?7018-Surgery-code-simple-mastectomy-for-patient-with-second-primary-in-same-breast

Example

- Axillary node dissection was done on 1/1/13. Simple mastectomy (one breast, no reconstruction) done on 1/15/13.
- The surgery code for the 1/15/13 procedure would be **51**
  - 51-Modified radical mastectomy without removal of contralateral breast.

Question-Sentinel Lymph Node Biopsy (SLNB)

- Could you explain again when we would expect to see a SLNB?

Answer

- If the clinical work-up for lymph node metastasis is **negative** (cN0), a SLNB may be indicated.
- If the clinical work-up for lymph node metastasis is positive (cN1-3), a SLNB would **not** be indicated.
  - *Scope it Out: A Change in Sentinel Lymph Node Surgery Coding Practice*, Jerri Linn Phillips, MA, CTR; Andrew Stewart, MA. Journal of Registry Management 2012 Volume 39 Number 1

Question-Multigene Signature Method

- Please explain how genomic testing will predict how likely radiation will be of benefit.

Multigene Signature Method

- Oncotype DX
  - Assesses the risk of local recurrence based on genomic testing of 21 genes
  - May be used for breast cancer patients that are…
    - Are early stage (AJCC TNM stage 0, I, or II)
    - Lymph node negative
    - Estrogen receptor positive
  - May influence treatment decisions

Things to look for…

- If a patient has **breast conserving surgery**, they should have **radiation**.
- If a patient has a tumor that is **ER/PR-**, they should have **chemotherapy** within four months of diagnosis.
  - Applies to women under 70 with stage II or III disease.
- If a patient has **stage II or III** disease and is **under 70**, and is **ER/PR +** then Tamoxifen or a third generation aromatase inhibitor should be administered.

URINARY SYSTEM

Question-Primary Site

- A patient was diagnosed with at least three non-invasive papillary urothelial carcinomas of the bladder in 11/09.
- The patient subsequently underwent a complete nephroureterectomy in 12/09 showing a single non-invasive papillary urothelial carcinoma of the renal pelvis.
- Per the MPH Rule M8, this is a single primary. Is the primary site to be coded C65.9 (renal pelvis) or C68.9 (urinary system, NOS)?

Answer

- Because the lesions were synchronous, the primary site is coded urinary system, NOS C68.9.

SEER SINQ 20110119
http://seer.cancer.gov/seerinquiry/index.php?page=view&id=20110119&type=q

  - For the purpose of applying the MP/H rules, the term "synchronous" means that the two diagnoses occurred at the same time or less than or equal to 60 days apart.

SEER SINQ 20120048
http://seer.cancer.gov/seerinquiry/index.php?page=view&id=20120048&type=q

Question-Multiple Primary Rules

- If a patient has papillary transitional cell carcinoma of the bladder and ureter in 2010 (C68.9) and then has a diagnosis of transitional cell carcinoma of the renal pelvis (C65.9) in 2012 which Multiple Primary Rule applies?

Question-Multiple Primaries

- Rule M8
  - Urothelial tumors in two or more of the following sites are a single primary* (See Table 1) Renal pelvis (C659) Ureter(C669) Bladder (C670-C679) Urethra /prostatic urethra (C680)
- Rule M9
  - Tumors with ICD-O-3 histology codes that are different at the 1st, 2nd, or 3rd number are multiple primaries.
- Rule M10
  - Tumors in sites with ICD-O-3 topography codes with different second (Cxxx) and/or third characters (Cxxx) are multiple primaries

Answer

- When C68.9 is assigned because tumors of the bladder and tumors of the ureter were determined to be a single primary and the site of origin is not known apply rule M8 when a subsequent tumor is diagnosed in one of the listed sites.
  - However, if C68.9 is assigned for other unknown primary site situations, rule M8 should not be used.

SEER SINQ 20130012
http://seer.cancer.gov/seerinquiry/index.php?page=view&id=20130012&type=q

Question-Multiple Primary Rules

- With rule M6 when looking at the 2 histologies, the behavior has to be the same, correct?
  - Rule M6
    - Bladder tumors with any combination of the following histologies: papillary carcinoma (8050), transitional cell carcinoma (8120-8124), or papillary transitional cell carcinoma (8130-8131), are a single primary.

NAACCR

Answer

- No.
  - If the invasive urothelial carcinoma of the bladder occurred before a noninvasive urothelial carcinoma of the bladder, rule M6 would apply.
    - Rule M5 would have already applied if the non-invasive tumor came first.

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Question-Multiple Primary Rules

- For rule M7 to apply (the 3 year rule), does the patient have to have a 3 year disease free interval between urothelial tumors?
  - Rule M7
    - Tumors diagnosed more than three (3) years apart are multiple primaries

NAACCR

Answer

- No, we just verified with SEER that the three years begins with the date of diagnosis. The time period does not restart if there is a recurrence.
  - This applies to all sites with timing rules, not just urinary.

Question-Mitomycin

- TURBT followed by mitomycin C instillation under the same anesthesia.
  - How would the surgery of primary site and/or chemotherapy be recorded?
  - Would this be coded as two surgical procedures?

Answer

- 10 Local tumor destruction, NOS
  - 11 Photodynamic therapy (PDT)
  - 12 Electrocautery; fulguration 13 Cryosurgery
  - 14 Laser
  - **15 Intravesical therapy**
  - 16 Bacillus Calmette-Guerin (BCG) or other immunotherapy
- 20 Local tumor excision, NOS
  - 26 Polypectomy
  - **27 Excisional biopsy**
  - Combination of 20 or 26–27 WITH
  - 21 Photodynamic therapy (PDT)
  - 22 Electrocautery
  - 23 Cryosurgery
  - 24 Laser ablation

Answer

- Mytomycin is coded as chemotherapy and surgical destruction if **no** other surgical procedures to primary site performed.
  - Surgery code 15
- If TURBT and mytomycin are done during the same surgical event, code TURBT in the surgery field and mytomycin in the chemotherapy field.
  - Surgery code 27 and chemotherapy code 2

Question-Surgical Margins

- What is the correct code for status of surgical margins for TURBT?

Answer

- FORDS instructs to code from the pathology report *for every surgical procedure that expects the margins to be assessed*.
  - If it is not that type of procedure (and the TURB does not have the margin item in the check list in the CAP), code 9. unknown.

http://cancerbulletin.facs.org/forums/showthread.php?7193-Surgical-Margins-TURBT&p=18012#post18012

Question-CS Stage

- If a single tumor has both non-invasive papillary and carcinoma in situ, you said to code to the higher CS extension, code 060.
  - The Histology according to MPH H7 is 8130 papillary.
  - In the CS Extension table, code 060 says for non papillary carcinoma only.
- Which CS Extension code would I use?

Answer

- When a tumor contains both non-invasive papillary carcinoma (Ta and stage 0a) and carcinoma insitu/flat tumor (Tis and stage 0is) it is critical to assign Tis.
  - The Tis is a more aggressive cancer. Therefore you want to stage and treat the more aggressive part of the tumor.

CAnswer Forum
http://cancerbulletin.facs.org/forums/showthread.php?7602-CS-Extension-for-non-invasive-and-in-situ-in-one-tumor

KIDNEY

Question-Surgery

- A patient with a clinical pre-operative diagnosis of renal cell carcinoma was taken to surgery. The surgeon performed a needle biopsy which was positive for carcinoma on frozen section. The surgeon then performed a cryoablation.
  - Final path: right kidney, mass, needle biopsy: renal cell carcinoma, clear cell type.
- What should this surgical event be coded to?

Question-Surgery

- 10 Local tumor destruction, NOS
  - 11 Photodynamic therapy (PDT)
  - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
  - 13 Cryosurgery
  - 14 Laser
  - 15 Thermal ablation

No specimen sent to pathology from this surgical event 10–15.

Answer

- Code both.
  - The biopsy of the kidney should be coded to *Surgical Diagnostic Staging Procedure* code 02
  - The cryoablation procedure should be coded to Surgery Primary Site code 13.

CAnswer Forum
http://cancerbulletin.facs.org/forums/showthread.php?7771-Kidney-Biopsy-and-Cryoblation-same-surgical-event&highlight=kidney

Question-Collaborative Stage

- When would code 998 (no surgical resection of primary site) be used in SSF3 for kidney (Ipsilateral Adrenal Gland Involvement)?

Answer

- Per CSv2 Manual Part 1 Section 2, Version 02.04, you would use code 998 when there is no histologic examination of tissue from the adrenal gland to prove or disprove involvement.

Coming up!

- **Certificate phrase:**
- http://www.surveygizmo.com/s3/1350332/Coding-Pitfalls-copy-August-30-2013

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