## Q&A for Collecting Cancer Data: Colon

## Date: Thursday, February 2, 2017

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Q1: ­If you have an adenocarcinoma with mucinous features what is the histology code? ­

A1­: By going through the Multiple Primary and Histology rules you would end up at rule H6. You don’t know the percentage of the tumor is mucinous so you would code 8140.

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Q2: ­SEER\*Rx lists Zaltrap as a chemo drug approved for use with Folfiri regimen­

A2: Yes it is. It’s subcategory in SEER\*Rx is an angiogenesis inhibitor. So it will inhibit VEGF (vascular endothelial growth factor) from working.

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Q3: ­Can you please ask the question regarding coding xeloda/capecitabine as a radiosensitizer as chemo. We need some clarification on whether or not to code as chemo. There's been some controversy on this subject.­

A3­: In the FORDS pg 288 it states if chemotherapy was provided as a radiosensitizer or radioprotectant DO NOT code as chemotherapy treatment. When chemotherapy is given for radiosensitization or radioprotection it is given in low does that do not affect the cancer. There is a post on the CAnswer forum specifically related to Xeloda.

<http://cancerbulletin.facs.org/forums/Node/67458>

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Q4: ­Can you repeat the definition of a LAR versus an APR? ­

A4­: A Low Anterior Resection procedure for cancers near the upper part of the rectum. A permanent colostomy is not necessary with this procedure. There are two types of APR. The first, Anterior/Posterior resection sis for cancers of the middle and upper rectum and Rectosigmoid. A temporary colostomy may be needed but not a permanent one. The other APR is an abdominoperineal resection. This is for tumors that are within 5 cm of the anal verge. This is an extensive procedure in which they remove the anus, sphincter muscle and rectum and then the sigmoid is used to create a permanent colostomy.

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Q5: ­I'm a little confused on whether or not a segmental resection is considered a surgical procedure or exploratory surgery. If no positive margins is this not a surgery? ­

A5: If a patient has an exploratory surgery and segmental resection that means the physician opened the abdomen and looked (“explored”) for signs of metastasis. If the surgeon chooses not to proceed with the segmental resection, then the exploratory surgery would be coded as diagnostic staging procedure codes 03-05. If the surgeon decides to proceed with the segmental resection, then we disregard the surgical exploration and code the segmental resection. A segmental resection is a surgical procedure. Code 30 in the FORDS for Colon, Rectosigmoid and Rectum primaries.

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Q6: ­Physicians seem to call the surgery either hemicolectomy or colectomy. What determines what we use for Transverse colon?­

A6: ­In the FORDS on page 389 subtotal colectomy/hemicolectomy includes total right or left colon and a portion of transverse colon. I would code based on what the surgeon called the procedure on the operative report.

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Q7: ­What is the determining factor in surgical code? Surgeons seem to lump everything in to hemicolectomy or colectomy.­

A7: ­Ideally, you would go with what is listed on the operative report. But sometimes that is not available, does not fit the surgery codes, or is obviously incorrect. In that situation you mmay want to look at the op report to see what segments of the colon were removed if they specify them. Or the path report to see if they state them. The CAP protocol should specific which sites are in the specimen under review. Based on the information that is available to you, use the surgery code that best fits what was done.

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Q8: ­Quiz 1 questions 6-7, Multiple Primary General rules p.13 state to code histology from most representative specimen so shouldn't histology for this scenario just be carcinoid tumor? I wouldn't think any of the choices in question 7 would apply. ­

A8­: Correct the histology would be carcinoid tumor and the histology rule we would use would be rule H11. We received clarification from SEER on this.

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Q9: ­Is "localized" Wall, NOS the same as "Regional Direct" serosa? ­

A9­: Localized (1) would include mucosa, submucosa, muscularis, and Subserosa. Invasion into the serosa is regional by direct extension (2). “Wall, NOS” is considered localized.

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Q10: ­If colonoscopy path results state adenocarcinoma with at least submucosal invasion can you assign a clinical T value of T1 or is it still TX?

­A10­: No. We know the tumor has extended at least into the submucosa, but we don’t know that it is confined to the submucosa. With this limited information it would have to be assigned a TX.

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Q11: ­Could please discuss/explain a case in which a polypectomy was done and then a resection with no residual. All we know is the cancer was confined to the polyp. What would be the TNM and stage group for a case such as this? ­

A11­: This question is similar to one I sent to the CAnswer forum. With polypectomies it is difficult to determine if the procedure should be considered clinical or pathologic.

http://cancerbulletin.facs.org/forums/node/69606The pathologic T would reflect what was found in the polypectomy and what found in the segmental resection. The tricky part is the clinical T. Should the colonoscopy/polypectomy be considered part of the clinical work up or was it definitive surgery? I’m hoping the post to the CAnswer forum can help clarify.

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Q12: ­Can you clinically code N if only colonoscopy done? ­

A12­: If a colonoscopy is done, then you have met the rules for classification for cT. Therefore, the cN will not be blank. If absolutely no work-up for lymph nodes was done, the code cNX. If imaging was done and there was no mention of lymph nodes, I would code as cN0.

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Q13: ­Referring back to question regarding assigning clinical N if only scope done. Wouldn't it be N blank?­

A13­: A scope is enough to meet the rules for classification for cT. Therefore, the cN would not be blank. A cNX would be appropriate.

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Q14: ­Polypectomy first, then a Tamis performed w/residual. cT blank cN blank cM blank in this case????? Help! ­

A14­: Transanal Minimally Invasive Surgery (TAMIS) and Trans Endoscopic Microsurgery are procedure to remove early stage rectal tumors. I am not aware of any special rules for classification for colon or rectum that say more than the primary tumor must be removed. I will assume that both procedures meet the rules for classification to assign the pT. The tricky part is what we do with the polypectomy. Can the polypectomy be used to assign the cT? We’ve sent this question to the CAnswer forum and they are awaiting clarification by their expert physicians. You can follow this post at <http://cancerbulletin.facs.org/forums/node/69606>

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Q15: If the patient had a resection and a biopsy is done a few days after the surgery will the biopsy be considered clinical or pathological?

A15: Once the resection of the primary tumors has been done (I’m going to assume the entire tumor was removed), the window for clinical stage has closed. We can no longer update the clinical T, N, M and stage group data items with information that was found after the resections was done. However, the window for pathologic stage is open until the patient receives adjuvant treatment or if they don’t get adjuvant treatment until four months has passed since the time of diagnosis.

So if the biopsy is done within the pathologic window, then that information can be used to supplement the pathologic T, N, M and stage group data items.

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Q16: ­On the clinical NX for unknown number of lymph nodes. Why wouldn’t we just down code to a clinical N1, if we know lymph nodes are clinically involved?­

A16­: The “downstage” concept can only be used when the physician is looking at information and can’t make a definitive statement. So if the radiologist looked at the imaging and stated there are 3 or maybe 4 malignant lymph nodes, we could “downstage” and code as a cN1b. That is different from a statement saying malignant lymph nodes are present, but there is not statement on the number of lymph nodes. In that case information is not present. The “downstage” concept does not apply in that situation.

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Q17: ­Why is invasion of pericolic fat considered direct extension in Summary Stage? If the invasion is non-peritonealized percolic invasion, the extension is considered localized in collaborative stage. ­

A17­: In CS code 400 would derive a localized summary stage. Under code 400 Non-peritonealized pericolic tissues is listed. Code 450 would derive a RE and pericolic fat is listed for all colon sites. I’m not sure what the difference is between Non-peritonealized pericolic tissue and pericolic fat. I’ll see if I can find out.

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Q18: ­Can you please tell us the changes in T3 and T4a again?­

A18­: There is an errata that updates figure 14.3 in your AJCC manual. In the original and incorrect image the tumor on the right is marked as T4b. This is a tumor arising in the non-peritonealized portion of the colon. The tumor is extending beyond the circumferential resection margin, but it is not invading any surrounding structures (i.e. pelvic wall) or organs (i.e. small intestine). Since the tumor has not invaded any surrounding structures or organs, it cannot be a T4b. A T4a is a tumor that has invaded the visceral peritoneum (serosa). Since there is no visceral peritoneum on this portion of the colon, the tumor cannot be assigned T4a. The tumor has invaded through muscularis propria into the pericolic tissue. Therefore, the correct T value is T3. The image in the errata has a T3 next to the tumor on the right. The tumor on the lift is correctly assigned T4a since the tumor has invaded the visceral peritoneum, but has not invaded any surrounding structures or organs.

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Q19: ­Are you path staging after neoadjuvant treatment?­

A19­: If the rules for classification are met after neoadjuvant treatment has been completed, a pathologic stage can be assigned. It is important to indicate that the patient had neoadjuvant treatment prior to surgery by using code 4 in the data item Path Stage Indicators.

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Q20: ­In regard to Quiz 2, how do you know satellite nodule mean nodes and not tumor nodules or tumor deposit?­

A20­: “Satellite nodules” and “tumor deposits” are synonymous when it comes to staging colon cases. If the pathologist sees any kind of lymphatic tissue within the nodule, then they would be coded as a positive lymph node. If there is not mention of lymphatic tissue in the nodule, code as a tumor deposit.

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Q21: ­Can you please re-state the type o-s for Quiz 2?­

A21­: In the original handout I had the procedure listed as a left hemicolectomy and the tumor site as descending colon. It should be hemicolectomy and the tumor site as ascending colon.

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Q22: ­Case scenario 1 what is the Path M?­

A22­: The pathologic M is cM0. Remember, pM0 is not a valid value. Even if they do a biopsy of suspected metastatic site and it comes back negative, we cannot use a pM0.

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Q23: ­Case Scenario 1, Should the pM be pM0 instead of cM0 since a wedge resection was done­

A23­: pM0 is not a valid value. If you think about it, in order for them to have a pathologic M0 it would mean that they would have to biopsy every tissue in the body to confirm no metastatic disease anywhere.

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Q24: ­For case scenario 1, why wouldn't the scope of lymph node surgery be 5 (4 or more lymph nodes)? There were 6 examined right?­

A24­: Correct for case scenario 1, the scope of regional lymph nodes surgery code should be 5.

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Q25: ­Case Scenario 2 could we use code 98 for Regional modality? Radiation, NOS­

A25­: Yes you could use code 98 for Regional Modality.

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Q26: Case ­Scenario 2 - chemotherapy should be 03 for multiple agents­

A26­: Correct chemotherapy code should be 03 for multiple agents.

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Q27: There is a lot of discussion going on about the mesentery being a new digestive organ? I think

A27: Yes there is. Here are a few links.

<http://time.com/4621074/mesentery-organ-human-body/>

<http://www.cnn.com/2017/01/04/health/new-organ-mesentery/>

<http://www.livescience.com/57370-mesentery-new-organ-identified.html>

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Q28: ­For the CTR exam, will the exam accept the current staging form being about to use clinical data items in pathologic data items or will clinical and pathological data items remain separate?­

A28: We have a CTR that just completed the exam and clinical and pathological general rules for classification was on the test. *This response came from one of our participants.*

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Q29: ­AJCC Staging Manual pg. 11 has a table that explains pM1 requires a positive biopsy of metastatic site to assign pM1. See Table 1.7­

A29: ­Yes! You cannot have a pM value unless there is pathologic confirmation of distant mets. Not every site of distant mets has to be biopsied to be included in the assigned pM value.­

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Q30: ­Comment: SSF 6 frequently gets miscoded. If all you have is a statement of negative margins, nos, SSF 6=999. 991 should only be used if there is a specific statement that the CRM is negative, but distance not stated.­

A30: Great point! Note 6 under SSF 6 in the Colon and Rectum schema states *Use code 999 (CRM not mentioned) if the pathology report describes only distal and proximal margins, or margins, NOS. Only specific statements about the CRM are collected in this data item.*

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Q31: Jim, will the edits allow for these types of mixed staging situation between in situ TNM and Localized Summary Stage? If we use behavior code 3, will it fail edits?­

A31­: Yes. This is not a new concept. The Edits WG is aware of this situation.

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Q32: ­When coding Circumferential Resection Margin (CRM) what terms are interchangeable in determining the CRM? Example?­

A32­: The CRM is coded in SSF 6 for the colon schema. According to the CS Note 2: The CRM may also be referred to as the circumferential radial margin or mesenteric margin.

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Q33: ­Our slide labeled Circumferential Resection Margin is different. Will this be changed and provided with the recording?­

A33­: Yes

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Q34: ­Why would you give (on pop quiz 12) a pathologic stage to M when only a biopsy was done? Biopsy is not surgery, it’s not treatment? ­

A34: This is a rule that has been around as long as I have been using AJCC Staging. I think it's because you can't have anything higher than pathologically confirmed distant mets.­

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Q35: Pop quiz 12-if 2nd met lesion (lung) was not pathologically confirmed, why would it not be pM1a?

A35: The bottom line is the physician believe the patient has two sites of distant metastasis. That makes it an M1b. The pM indicates that at least one of the sites has been confirmed pathologically.

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Q36: ­For pop quiz 13: shouldn't we use Y to indicate neoadjuvant therapy was done? For the pT­

A36: ­ypT is not a valid code. Your software probably would not allow it and even if it did the edits would not allow it. The only way we can indicate neoadjuvant treatment is done is using code 4 in the path stage descriptor data item. ­­A physician can assign a ypT, we just can't enter it that way into our software.­

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Q37: ­Pop Quiz 16: Why is answer b. 015 chosen over answer a. 003? How do you distinguish between which radial margin to use? Is it because the 1.5mm is the deepest and doesn’t have anything to do with the serosal vs. mesocolic aspect?­

A37­: This probably wasn’t the greatest example to give and the terminology used in this pop quiz doesn’t really follow the terminology used in the most current CAP protocol.

<http://www.cap.org/ShowProperty?nodePath=/UCMCon/Contribution%20Folders/WebContent/pdf/cp-colon-16protocol-3400.pdf>

However, I do think the pop quiz is correct. What we are really interested in is the distance between the surgical margin in the portion of the colon that is not covered by visceral peritoneum (serosa). The first margin that is given *Radial margin, serosal aspect: 0.3 mm* is measuring the distance between the tumor and the visceral peritoneum. That is .3mm. The second margin Radial margin, mesocolic aspect: 1.5 mm is measuring the distance between the tumor and resection margin in a portion of colon without visceral peritoneum. I would highly suggest reading section J of the CAP protocol discussing margin on page 18 and 19.

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