Q&A Session for 2018 Directly Coded Stage

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Q: What if physicians do not put clinical staging in the medical record, should cancer registrar assign the clinical staging? or just leave it blank?

A: If a physician stage is not available but the registrar has the information necessary to assign a stage, they should do so.

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Q: Is there any change in the staging timeline for 8th edition or is it the same?

A: It is the same as with 7th edition.

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Q: Are lymphomas C77.0-C77.8 NHL path staged after Ln biopsy + & BM biopsy +. no staging surgery?

A: I believe you will only have the option of assigning a clinical stage.

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Q: When is the ebook coming out?

A: I have not seen any information on when the e-book version of the AJCC manual will be available. You might want to check the AJCC site periodically <https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx>

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Q: For 2018 cases, do you have to code the path T & N with clinical values if you have pathologic confirmation of the M or can you leave them blank? Referencing Pop quiz 8.

A: At this time we do not have an edit to enforce they not be blank, but it would be good practice to fill them when the rule applies.

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Q: Slide 103 -- for 7th edition, wasn't this only allowed in registry software fields for in situ tumors? Edits seem not to allow cN0 in Path N data item for invasive tumors until 2018.

A: In 7th edition registrars were asked to leave the field blank when a cN value could be used in a pN data item.

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Q: With the last quiz #3 what does the clinical 1A3 mean?

A: 1A3 is the stage clinical stage group for quiz 3. See the stage table on page 448.

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Q: Are we still only to report GIST if only stated as malignant?

A: Yes.

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Q: Where is palatine tonsil?

A: <https://en.wikipedia.org/wiki/Palatine_tonsil>

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Q: Just to clarify, concerning when post-therapy stage is greater than clinical info, that is with ABSENCE of disease progression, correct?

A: <http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/education-developed-by-partner-organizations-ab/naaccr-webinars-and-edits-workgroup-aa>

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Q: Stage 2 Lymphoma's were coded to code 5 Regional, NOS. What will they be coded to if the 5 code no longer exists?

A: Summary Stage would be assigned a 2.

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Q: So we can use TNM by MD to drive us to the correct Summary Stage code? Or, do we try to Summary stage independent of TNM?

A: Use all information available in the record!

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Q: Question on slide 46 - lymphadenopathy. If nodes are interpreted as positive without path confirmation, do we treat as positive and code 3?

A: Yes.

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Q: Can you go over the FORDS ambiguous terms?

A: The FORDS ambiguous terms are listed on page 3 in the FORDS manual. You must remember that the terms there are not to be used when doing Summary Stage.

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Q: I have a moral dilemma… We have a client in a SEER state & she sometimes instructs our registrars to code things that go against the standards. For example, for 2018 cases she has instructed Suspected H&N primary with cervical lymph node mets to be coded C14.8 (Overlapping Lesion of lip, oral cavity and pharynx). She tells them not to code to C76.0.

This scenario has been addressed in 2018 & we are instructed to code primary site to C760. I have forwarded the information to her from the manuals, yet she is insistent that is how she wants it coded in their registry. Unfortunately, she is boss & signs the checks, what do you suggest they do?

A: You might tell her that the software won't allow her assign stage or the SSDI's if she instructs folks to code incorrectly.

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Q: For SS In situ w/nodal mets, how would you code behavior to avoid edits?

A: If the patient has nodal metastasis, then behavior must be 3. Summary stage would be regional to lymph nodes. That should not cause any edit problems.

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Q: Regarding using C76.0: For re-coding audits, does this go into effect in 2018 or should we change cases from previous years?

A: The rule applies to cases diagnosed 2018 and forward. Good question.

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Q: For the 8210 to 8140 change for colon you mentioned, will there be an EDIT for 2018 colon cases that doesn't allow 8210?

A: At this point no, but 8210 is not eligible for AJCC staging.

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Q: Does the AJCC ID take into account CoC site type overrides? Example: serous of fallopian tube. Or will we no longer be able to stage these?

A: See the histology/topography spreadsheet at <https://cancerstaging.org/references-tools/deskreferences/Pages/8EUpdates.aspx>

All site histology combination eligible for staging are listed.

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Q: If a breast cancer patient has cT3 and receives neoadjuvant chemo, at surgery there is no tumor left in Breast what is the pT?

A: The post therapy T value would be ypT0.

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Q: Can you clarify again if/when an autopsy can be used for AJCC stage. I thought an incidental finding of ca. at autopsy can't be collected in registries as that is "a" TNM which we don't have a way to indicate "a"?

A: A clinical stage can be assigned to patients diagnosed at autopsy.

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Q: Based on your statement relating to coding AJCC correctly in the software, the statement in Ch 1, pg. 4 of AJCC (only the managing physician can assign stage), does not apply to registrars?

A: I believe that statement is referring to a physician assigning a stage that is documented in the medical record. Registrars can assign a stage that can be entered into the cancer registry database. They cannot assign a stage that would be included in a legal document such as a medical record.

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Q: If a cancer is known, surgery is performed and then autopsy is done within 4 months of diagnosis, could this be used for pTNM?

A: If the patient met the criteria for assigning a pathological stage prior to expiring, then a pathological stage can be assigned.

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Q: If there is no evidence of LNs clinical couldn't we use cN0 for the pN category on the lung example, or other sites also?

A: No. Lymph nodes must be examined pathologically in order to assign a value in the pN data items. The exception would be if the primary tumor was in situ or if the patient had pathologic confirmation of distant mets and the primary tumor was not removed.

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Q: On the missing / unknown info. Here at central state registry we get abstracts from facilities that treat the patient but did not do the work-up and doesn't have that information in the charts, we often see X instead of blank.

A: See the AJCC training on blanks vs X’s.

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Q: In those case would they be able to complete cT blank cN blank cM0? cM0 due to general rules that cM0 assumed unless cM1 known? Would this help distinguish between unknown info vs incidental finding on surgery treatment?

A: In the example the prostate cancer was an incidental finding during a cystoprostatectomy for bladder cancer. In this case the clinical T, N, and M would be blank and stage group would be 99. I am not aware of an exception that would allow us to assign a cM0 in this situation.

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Q: Question for ovarian cancer: pT3c pNX cM0 - Can I still assign a stage 3C since pT3c pN0 cM0 = 3C and pT3c pN1 cM0 = 3C. Regardless of the node status, if pT3c, pNX or pN1, cM0 ovarian will be a stage 3C.

A: pT3c pNX cM0 stage 3C is correct.

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Q: For pop quiz 8, if the clinical T and N were "x's", would we still enter in the path stage as cTX cNX pM1a stage 4A?

A: Yes.

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Q: If patient only receives 1 treatment (single dose) of neo-adjuvant therapy and then goes on to have surgical resection does this case qualify to be staged as post-therapy stage? Or is this pathological stage because a single dose would not have any affect?

A: This has been sent to AJCC

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/education-developed-by-partner-organizations-ab/naaccr-webinars-and-edits-workgroup-aa>

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Q: Is it allowed to leave pT & pN blank if you have pM?

A: Not if information is available that would allow the registrar to assign a pT and pN.

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Q: Can you please make sure that if it is a colon etc you cannot use cN0 in pN value if surgery was done. You will confuse people.

A: If a patient has pathological confirmation of distant mets. The pM data item should be pM1 or higher. If surgery was done to the primary site, then a pT and pN value should be entered in the pT and pN data items. If surgery of the primary site was not done, then the values from the cT and cN can be added to the pT and pN data items.

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Q: The slide right before pop quiz 9. For melanoma, even if the entire tumor removed on initial biopsy, it is still cTIS and not pTIS because excisional biopsy not considered definitive treatment in the case of melanoma?

A: That is correct.

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Q: In your last two quizzes, wouldn't the SLN biopsy be part of the clinical workup and thus cN(sn)? Or is this a coding procedure change?

A: No.

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Q: Pop Quiz 11- I understand that the pTNM fields would be blank due to the neoadjuvant treatment but should the Stage group be 99, I thought that the Groups could never be left blank for clinical or pathological?

A: If a yp Stage is assigned, the pStage must be blank. If ypStage is blank, the pStage must not be blank.

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Q: It was my understanding from previous trainings that clinical & pathologic stage could never be blank and that only post therapy stage could be blank. In your scenario where neoadjuvant treatment was given followed by surgery you said to leave pathologic stage blank?

A: This is a change for 2018.

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Q: If a patient has a met discovered clinically, then undergoes neoadjuvant treatment and the met is no longer present, would we use a clinical M0 for the neoadjuvant M value?

A: In that scenario the Post-therapy M would be cM1 or higher.

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**Q:** In light of abstracts we have seen at the central registry where workup was done, but treating hospital does not have that information or unable to get it from the diagnosing facility, as you explained in the webinar and Donna in the CAnswer forum, those should be blanks instead of Xs.

I ask this because we expect to see more of this in 2018, when non CoC facilities are *not required* to do TNM, and we lack the clinical TNM from the diagnosing facility to consolidate with IF the treating facility is not able to find the workup information (or only have a narrative w/o details to complete clinical TNM) ***In these cases*** - can the registrar at least complete a cT blank cN blank cM0 to help distinguish the case (ca dx prior to treatment and workup done but info unknown to registrar) from looking exactly like incidental finding cases where cTNM are all blank?  [cM0 due to general rule that it is assumed unless cM1 is known]

A: See <http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/principles-of-ca-staging-and-general-info-chapters-1-4/principles-of-cancer-staging-chapter-1/79448-x-vs-blank-for-clinical-stage>