Q&A Session

Collecting Cancer Data: Kidney

Thursday, June 06, 2013

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Q: ­In the absence of a nuclear grade and only a four grade system is listed (ie: 2/4 or 1/4 for example), how does the four grade system get converted? FORDS is not clear on this­.

A: If the grade for kidney cancer is not Fuhrman nuclear grade and a 4 grade system is used, code the grade as stated in the Grade data item. So, grade 1 of 4 is assigned code 1 in the Grade data item, and grade 2 of 4 is assigned code 2 in the Grade data item.

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Q: ­How should we code surgical approach when a radiofrequency ablation of a kidney tumor is performed?­

A: ­Documentation in FORDS 2013 on page 217 says to code ablation procedures to code 3 in the Approach data item. I believe radiofrequency ablation would be considered an ablation procedure.­

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Q: ­Radiofrequency ablation is performed with a needle/probe. That's how I've seen it described anyway. I code to open or approach unspecified (code 5) because none of the others seemed to apply.­

A: Documentation in FORDS 2013 on page 217 says to code ablation procedures to code 3 in the Approach data item.

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Q: Would you please explain the code for surgical approach when both the descriptions robotic and laparoscopic are being used.

A: Per FORDS 2013 page 217, if both robotic and laporascopic are used, code to robotic (codes 1 or 2).

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Q: Why is it not laparoscopic converted to open (code 4)?

A: If they had not converted, we would have used robotic; therefore I coded as robotic converted to open.

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Q Q: ­Regarding approach-surgical procedure of the primary site: You said this list is presented as a hierarchy, that "1 trumps 3". Please elaborate as it doesn't seem that robotic is more serious procedure than open approach.­

A: That is a good question. I don't know why they put them in the order they are in. There is a note in FORDS 2013 page 217 that if both robotic and laparoscopic are mentioned to code to robotic. I was told when the codes first came out they were in a hierarchy.­

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Q: On slide 28, did you mean cryosurgery versus cytoreduction?­

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A: No. Cytoreduction surgery is a kind of debulking procedure where as much of the malignant tissue as possible is removed.­

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Please clarify that M8 really is for 2 tumors with specific renal cell carcinoma types and that H6 comes into play when two specific types are in the same tumor and one primary. For example; renal cell with clear and sarcomatoid features is one primary. If renal cell is in one tumor and renal cell papillary type is in another tumor, patient has 2 primaries.

A: I think if you had renal cell carcinoma in one tumor and renal cell carcinoma, papillary type, in the other tumor it would be a single primary per rule M9.

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Q: ­I thought cystic was coded the same as clear cell. I think the answer is correct because of the sarcomatoid features driving the code 8255/3­.

A: ­I’ll double check with SEER, but the SINQ question I referred to stated "Use rule H6 and assign code 8255 for cystic renal cell carcinoma, clear cell type". The question was based on a response in the SEER SINQ http://seer.cancer.gov/seerinquiry/index.php?page=view&id=20120087&type=q

*SEER has agreed to review this question. We will update this Q&A with their response once we receive it. We will also send out a notification to everyone that registered for the even once it is updated.*

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Q: ­For question 7 quiz 1, the Quality Improvement Meeting August 2008 states you would code cystic if the only description was renal cell carcinoma. If a specific renal cell carcinoma (clear cell) is identified, code clear cell. So should this just be 1 primary?­

A: ­I"ll double check with SEER, but the SINQ question I referred to stated "Use rule H6 and assign code 8255 for cystic renal cell carcinoma, clear cell type". The question was based on a response in the SEER SINQ http://seer.cancer.gov/seerinquiry/index.php?page=view&id=20120087&type=q ­–

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Q: ­I am having a hard time understanding why sarcomatoid features isn't used in the histology. I thought this was 2 primaries. Or, is it because the sarcomatoid features were in the grade? How do we handle that if the "features" is part of grade?­

A: In quiz 1 tumor 1 histology code would be 8255 whether you include the sarcomatoid features or not. Cystic and clear cell should be coded to 8255. You could make an argument for including sarcomatoid as well.­ ­However, if you look at case scenario 1 the sarcomatoid is described with grade, not histologic type. In that case I would not include sarcomatoid features in my determination of the histologic type.­ ­In case scenario 2, the histologic type is sarcomatoid.­

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Q: ­Will you address "extensive sarcomatoid features" for tumor 1 in quiz 1? Would you or wouldn't you code?­

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A: ­I probably would not use the statement "sarcomatoid features" in the case scenario. The pathologist refers to the sarcomatoid features after describing grade, not when describing the histologic type. However, someone else might interpret that differently.

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Q: ­Please re-explain question 5 on quiz 2.

A: ­Code 030 was assigned because there was both lateral and medial tumor invasion. Tumor 1 invaded out from kidney into adrenal gland (lateral) and tumor 2 invaded medially (into middle) into perisinus fat.­

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Q: ­In case scenario 1, you assigned code 1 (present) to SSF 4. On the path report, it says sarcomatoid features in the Grade section. Isn't this the same situation as the previous question on Sarcomatoid Features? ­

A: Note 2 preceding the codes for SSF4 (Sarcomatoid Features) states: “Record the presence or absence of sarcomatoid features as documented anywhere in the pathology report.” Sarcomatoid features are not coded in the histology because they are not documented as part of the histologic tumor type. However, they are documented as part of histologic tumor grade in the pathology report, and because they are documented in the path report, they are coded in SSF4.

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Q: In ­case scenario 2, Fuhrman grade = 4/4. What is the nuclear grade?­

A: ­Fuhrman grade is a nuclear grade.­

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Q: In reference to ­SSF 8 from quiz 2, why did you use 010 instead of 030? My understanding was that you had to do surgery to identify extranodal extension.­

A: ­Either pathologic information or clinical information can be used to determine if there is ENE; however, pathologic information does take precedence. In the example, a CT scan was available for review and there was no documentation of ENE so code 010 was assigned.­ Note 3 (preceding the codes for SSF8): If nodes are involved but the clinical documentation and/or pathologic assessment does not indicate extranodal extension, assign code 010 (no extranodal extension documented on the available reports).­

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