# Kidney Q&A

# 5/5/16

Q1: Can we please get that clarification sent with the presentation and Q&A? Also a start date for that clarification

A1: Yes. See below. I don't think it will have a start date.

Clarification from SEER in regard to coding sarcomatoid features (differentiation, type, etc.):

*We have consulted with several of the physician specialists who contributed to both the CAP protocol for Kidney and also the AJCC 7th Edition chapter on Kidney and they agree that sarcomatoid should not be coded as a specific histology unless the final histology is sarcomatoid RCC (a pure sarcomatoid tumor). Sarcomatoid information should be recorded in the SFF data field. The current MPH rules are not clear in the instruction for coding sarcomatoid and this will be addressed in the 2015 revisions.  We have been instructing registrars to code to RCC, NOS (or unclassified) when the histology include sarcomatoid features or any other terminology listed in Kidney rules H5 or H12.*

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Q2: Does that apply to the sarcomatoid histology only?

A2: Yes. Sarcomatoid features are something pathologist look at in every renal cell histology. Sarcomatoid (or spindle cell) features help determine the patients prognosis.

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Q3: ­When using H6, do we code 8255 if sarcomatoid is in the mix (of the two or more specifics)? ­

A­3: Clarification from SEER:

*Rule H6 does apply and histology coded to 8255/3.  It’s confusing but only pure sarcomatoid tumors should be coded 8318 but if it’s mixed with other types of RCC then the mixed code is correct.  We’ll be clarifying this in the revisions of MPH.*

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Q4: ­In regards to when you have 2 histologies abstracted as 1 - which histology do you use - if you had a renal cell and a clear cell - would you not take the more specific histology even if it's the smaller tumor? ­

A4: Rule H11 *Code the histology of the most invasive tumor* comes before rule H12 which says to code the specific type. Remember, the rules are in order and we have to stop at the first one that applies.

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Q5: ­So if you have renal cell carcinoma w/ clear cell features, then you use the clear cell histology/­

A5 Yes. Per rule H5

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Q6: ­For Stage Scenario 2: Did you say that for the example histology "Sarcomatoid Renal Cell Carcinoma" that the histology we'd code would be the Renal Cell Carcinoma and not the Sarcomatoid RCC?­

A6: ­My understanding of clarification of SEER you would code Sarcomatoid RCC­

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Q7: On quiz 1 what would you use for tumor size 1.7 or 2.5, since 1.7 is more invasive?

A7: In FORDS 2016 pg. 142, Tumor Size Summary states that size needs to be recorded in a specified order. 1) Size measured on surgical resection specimen 2) Largest size of tumor prior to neoadjuvant treatment 3) Largest measurement of tumor from physical exam, imaging or other diagnostic procedures prior to treatment 4) If 1, 2 or 3 do not apply, the largest size from all information available within four months of the date of diagnosis, in absence of disease progression.

When multiple tumors are present, code the size of the largest. Even if the smaller tumor is more invasive.

With this information I would record the tumor size as 2.5.

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Q8: How to code leiomyomatosis-associated RCC, NONCLEAR CELL, NON PAPILLARY, HISTO WOULD BE CODED? WOULD IT BE TO LEIOMYOMATOSIS OR RCC?

A8: From what I have found so far, Leiomyomatosis associated RCC is a hereditary condition. I don't know if there is a specific code for this condition. My best guest would be to code to RCC. I am still researching...

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Q9: Please clarify again the list you gave us for H11, was least to greatest w/tumor size being the last comparison.

A9: In order from least to greatest extension: tumor size, invasion of major veins, adrenal glands perinephric tissues, involvement of gerota's fascia. This is in the MPH manual on page 56

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Q10: ­What is the SS2000 for this example? ­­Please clarify - stage scenario 2 - summary stage should be 2 - regional

A10­: There was direct extension from the kidney into the inferior vena cava (major blood vessel). This would make it a 2-regional by direct extension.

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Q11: ­Most of my nephrectomy surgeries are NOT taking any regional LNs, so for these cases is my CoC path stage assigned as pNx and then the stage group would be 99??­

A11­: Yes the stage group would be 99. From Donna Gress­ (­dgress@facs.org­) ­ - data analysis would be done on the T and N when there cannot be a stage. ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q12: ­Couldn't you have pathologic Stage I? Discussion of pathologic staging in AJCC-don't have to have removal of lns­

A12: ­I think this is when you would refer back to the general rules, which is why you would have pX for the N. ­

A12: From Donna Gress (dgress@facs.org) unless there is a SPECIFIC exception in the chapter, then you must remove a node to assign the pN. There is NOT an exception for kidney.

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Q13: ­For Stage Scenario 2: Why is it pX if no LNs were removed? Shouldn't that be p0 since the LNs were not evaluated?­

A13­: In order to meet the rules for classification for pN at least one lymph node must be removed or there has to be confirmation of the highest N (pN1 for kidney). If that is not done and we have met the rules for the pT, then pN must be pNX.

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Q14: ­Clarification: For Stage Scenario 2: Why is it pX if no LNs were removed? Shouldn't that be pBlank since the LNs were not assessed? ­

A14­: In that case the primary tumor was removed, but lymph nodes were not. We met the rules for classification for pT. If we meet the rules for classification for pT then pN cannot be blank. If we meet the rules for classification for pT, then pN must be pX, p0, or p1. If we had not met the rules for classification pT, then pT would be blank. If pT is blank, then pN must be blank.

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Q15: ­Under rules for classification it only states histologic and confirmation is required, resection is recommended - does that still mean you have to have tumor removed as well as nodes to stage?­

A15­: Yes. There is not specific exception that says we can assign pStage without removal of the primary tumor and/or removal of lymph nodes.

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Q16: ­I have been working in the NCRA workbook that was published for staging help...for case scenario 2: the NCRA work book kidney case 25 states: pathological stage if PT3 then stage group III, because regardless of Lymph node status pt3 = p stage group III­

A16: You are correct.

A16­: From Donna Gress­ (­dgress@facs.org­) ­ ­So if you have pT3, pNX, cM0, and then it is stage III. That is because it doesn't matter if the nodes are positive or not, same stage group­­, that is because stage III is pT3, N0 or N1, M0.

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Q17: ­T3b vs T3c-p.AJCC p. 9- #5 if uncertain classify or stage using lower category. T3 & T3a don't mention extension to vena cava. Shouldn't extension to vena cava, nos be T3b? ­

A17: Downstaging does not apply in this situation.

A17: From Donna Gress (dgress@facs.org) - Jim did the downstaging rule correctly, it is only for when choosing between 2 things, is it invaded or not, it is NOT for use in UNKNOWN info.

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Q18: ­Please clarify Donna's statement of: having NO pathologic info on lymph nodes (ex. pNX)-what pathologic stage groups can go ahead and assign or not assign? Pathologic I, II, III, IV? ­

A18­: From Donna Gress­ (­dgress@facs.org­) ­ ­So if you have pT3, pNX, cM0, and then it is stage III. That is because it doesn't matter if the nodes are positive or not, same stage group­­, that is because stage III is pT3, N0 or N1, M0.

A18- From Jim Hofferkamp - I’d like to add to Donna’s statement…if the patient had a pT1 or pT2, then we could not use a pNX. For example, a pT2 pN0 cM0 would be stage II. A pT2 pN1 cM0 would be stage III. The status of the pN can change the stage group. In Donna’s example the status of the pN does not change the stage group.

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Q19: ­If you have an FNA of a lymph node without resection of tumor would that be considered pathologic N? Since that's the highest N? ­

A19: ­From Donna Gress­ (­dgress@facs.org­) ­ - yes, a FNA of a node can be used to assign pN, but you still can't assign the pathologic stage unless you also have the tumor resected or the highest T­.

A19: From Jim Hofferkamp-I believe Donna has stated in the past that even if you meet the rules for classification for the pN, you still leave pT and pN blank if you have not met the rules for classification for pT.

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Q20: ­If you a have pT and use fna ln for pN-can you use this for any site or just kidney? ­

A20­: You can use information from an FNA to meet the rules for classification for pN if it confirms the highest T. For Kidney pN1 is the highest pN so an FNA of any lymph nodes meets the rule for classification. Other sites, such as Breast or Lung, the highest pN is pN3. An FNA of a pN3 node would meet the rules for classification for pN. An FNA of a pN1 or pN2 node would not meet the rules for classification. An FNA that was negative for malignancy would not meet the rules for classification for pN for any site.

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Q21: ­Regarding a lymph node FNA satisfying the criteria for pN -- did I understand correctly that this would only be for a \*positive\* FNA result? Would a negative FNA satisfy the pN criteria? ­

A: 21 ­A negative FNA would not satisfy the criteria for pN. Remember, the only time we can use an FNA is if it confirms the highest N value. For kidney, that would be pN1. pN0 would never be the highest pN value.

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Q22: ­Will you state the pNX again vs it being a pN [blank]. ­

A22­: It all depends on the pT. If the rules for pT have been met, then pN must be X or a valid value. For Kidney that means if we have met the rules for classification for pT, then pN must be pX, p0, or p1. It cannot be blank. If the rules for pT have not been met, then both pT and pN must be blank. Even if the rules for pN have been met, pN is blank if pT is blank.

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Q23: ­Can you please direct us to where in the general rules we find that you cannot leave N blank if T has a value? ­

A23­: ­See page 11 in AJCC general rules regarding pTs & pNs. It says T is generally necessary to have a pN­. Remember, the AJCC manual was written for physicians to assign stage in a clinical setting, not for registrars to input data into their data base.

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Q24: ­If lymph nodes are not removed pathologically and NCCN guidelines states lymph nodes do not need to be removed, which we see often, then all these cases will be unstaged?­

A24­: Yes the stage group would be 99. From Donna Gress­ (­dgress@facs.org­) ­ - data analysis would be done on the T and N when there cannot be a stage.

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Q25: ­Is the AJCC slides that you reference for X available online? ­

A25: ­Yes. [https://cancerstaging.org/CSE/Registrar/Pages/Presentations.aspx­‑](https://cancerstaging.org/CSE/Registrar/Pages/Presentations.aspx)

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Q26: ­The patient didn't meet qualifications for pathologic stage, so why would you assign a pathologic stage? ­ Stage Scenario 3?

A26: When distant metastasis is confirmed histologically (pM1), the rules for classification have been met for pathologic stage and a stage can be assigned. If there is not histologic confirmation of distant mets, then the pT must be established in order to assign a pathologic stage.

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Q27 ­You can have pathologic stage with endometrium with no lymph nodes removed. See p. 405 in AJCC-last paragraph in discussion of pathologic staging­.

A­27: From Donna Gress (dgress@facs.org) unless there is a SPECIFIC exception in the chapter, then you must remove a node to assign the pN. There is NOT an exception for kidney.

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Q28: ­NOTE: SSF 3 is based only on PATH, correct? so if adrenal not removed then code 998, even if adrenal spread mentioned on scan. (case where pt didn't have nephrectomy)­

A­28: Yes SSF 3 is based on pathologic information. If the adrenal gland is not removed then you would code 998.

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Q29: ­Can you explain which SSF are based on pathologic findings and which are based on clinical findings. Example CT finds vein involvement but surgery does not confirm or if no surgery performed which code should you use.­

A29­: SSF 1, 2, 3, 4: use information as documented in the pathology report. SSF 6: use information as documented in pathology report prior to neoadjuvant treatment. SSF 8: code the status of extranodal extension whether assessed clinically or pathologically, pathology takes priority over clinical assessment

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Q30: ­Where can we find a list of required SSFs? ­

A30­: <http://seer.cancer.gov/csreqstatus/application.html?report=requiredFactors&setter=seer&version=0205&schema=0&years=0>

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Q31: ­Will the SSF's that are required now as stated in all the present CS schemas be the same SSF's that will be continued when no longer using CS?­

A31: No. For SEER and CoC facilities you will be required to report SSF 1, 2, 3, 4, 6, and 8. For NPCR and CCCR facilities they are not requiring any SSF to be reported.

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Q32: ­Can the Fuhrman grade be converted to the histological grade? ­

A32­: Yes, See Instructions for Coding Grade for 2014+ Special Grade System Rules. In the rules it notes that it is important to code grade based on information prior to neoadjuvant therapy even if grade is unknown.

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Q33: ­For Case Scenario 2 should SSF 1, 2, and 3 be 998 as there was no surgical resection of the primary site? If they did not do surgery why wouldn’t you use code 998 instead of 000­?

A33­: Yes SSF 1, 2 and 3 should be 998 because there was no pathologic examination. 000 is used if surgical resection of the primary site is performed, the pathology report is available for review and involvement is not mentioned.

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Q34: ­Could you ask to have the smoking rate of Native Americans clarified regarding kidney cancer? We think here in NM it is much lower than for other races/ethnicities. Thanks.­

A34: ­Recinda said that statement was based on 2014 national data.

2014 national health survey data:

AIAN 29.2%

Non-Hispanic Blacks 17.5%

Non-Hispanic whites 18.2%

Non-Hispanic API 9.5%

NM in general has a higher smoking rates­‑for NM blacks have highest rate of smoking (API still lowest). AIAN have highest rate of smokeless tobacco--but that does not increase risk of kidney cancer (although still not good) ­‑

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Q35: ­Where do we find that large and major mean the same thing, when vessels are not specified? ­

A35­: We discussed this with SEER and they agreed that when used in the context of the case scenario, the major and large vessels meant the same thing. The pathologist was trying to differentiate between the small unnamed vessels in the kidney and the major vessels supplying the kidney. The major vessels are listed in the Summary Stage manual.