# Q&A for Collecting Cancer Data: Liver and Bile Ducts

Thursday, June 1, 2017

Q1. Could the incidence rate have increased due more accurate reporting? Half the cases are diagnosed via imaging alone so that would make sense.

A1. Absolutely. And this was touched on a bit in the presentation. But unlike some sites, like thyroid or melanoma (where more accurate diagnosis methods and increased reporting efforts are likely driving much of the increase in rates), liver cancer rates are believed to largely be increasing due to increase in risk. The increase in risk is due to the baby boomer cohort (highest infection with Hepatitis C) as well as increased rates of obesity and diabetes. However, as mentioned, younger cohorts have lower prevalence of Hepatitis C—so we expect to see a decrease in rates of liver cancer as the younger cohorts age and the number of baby boomers decline.

­­Q2. On pop quiz 5, can you explain summary stage since both tumors are on the left and not in both lobes? Also, why are we picking up the thrombus when it is on the right and both tumors are on the left?

A2. There was typo...6cm tumor was supposed to be on the right. The illustration was correct.

Q3. Can you clarify the statement: brachytherapy of "surgical" or body cavity is coded as intracavitary. We understand this is true for "natural" body cavity but is it also true for surgically created cavity? ­

A3. It is true for “surgical cavities” as well. There is a good post on the CAnswer forum explaining this

<http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/radiation/3067-accelerated-partial-breast-irradiation-apbi>

Q4. ­Can you explain again regular/minor vascular invasion?­

A4. Vascular invasion as we are defining it for liver primaries includes invasion of blood vessels within the liver. Major vascular invasion includes invasion of the right or left branches of the portal vein or invasion of the left, middle, or right branches of the hepatic vein. Invasion of any of these main branches of the hepatic or portal vein would be at least a T3. Vascular invasion within the liver of any other veins or arteries would be what I referred to “regular” or “minor” invasion. The tumors fall into the T2 category.

Q5. ­Can you explain again how we staged pathologically for Quiz without resection being done?

A5. According to the AJCC manual surgical resection is only needed for pathologic stage for perihilar and distal sites. Liver and intrahepatic do not have to have surgical resection as long as the other criteria have been met.

Q6. Just curious why we cannot use the cN0 in the pathologic area if we are using cM0?

A6. AJCC feels that in order to meet their standards for pathologic stage, lymph nodes need to be removed. I'm not sure how they come up with the standards, but that is what they feel is correct.

­Q7. Always code other when embolization is done with other therapy (or not) with liver cancer?

A7: Just for reference in the SEER Inquiry System, SINQ 20071080 specifically addresses Chemoembolization with no mention of a specific chemo agent and directs in that case to code to Other treatment.

Q8. What is the 7th type of treatment? 1) surveillance, 2) surgery, 3) ablation, 4) chemoemcolization, 5) TARE, 6) EBRT?

A8: Partial hepatectomy and liver transplant were considered two different treatments.

Q9. We see microwave ablation often. How do you code microwave ablation?

A9. ­Microwave Ablation is coded to 16 for heat ablation. Reference SEER SINQ 20160033­.

Q10. Because of your histology for pop quiz 8 would you not use the intrahepatic duct schema?­

A10. ­According to the AJCC Staging manual cholangiocarcinoma can develop anywhere along the biliary tree from proximal peripheral intrahepatic ducts to the distal intraduodenal bile duct. ­

Q11. ­Will you please define for intrahepatic, perihilar and distal if they need surgery for pathologic stage?

A11. ­According to the AJCC manual surgical resection is only needed for pathologic stage for perihilar and distal sites. Liver and intrahepatic do not have to have surgical resection as long as the other criteria have been met.­

Q12. ­Can you reiterate for pop quiz 8 why the biopsy isn't sufficient for pathologic staging please­

A12: ­This is a distal bile duct cancer and according to the AJCC manual those cancers require a surgical resection for pathologic staging.

Q13: Are you saying that embolization to cut off part of the blood supply to large or vascular liver cancers when there is no chemo given, should be coded to Other?

A13: According to SINQ 20071080 that is correct

Q14: Histology question - if you have a statement from a doctor saying cholangiocarcinoma but the path only states adenocarcinoma - which histology would you use - bile duct primary

A14: If you have a path report from the primary site then the priority order from the histology rules state you should use that histology first, so it would be adenocarcinoma.

Q15: Where is it stated that 'thrombus' is considered involved?

A15: Tumor thrombus when it is involved in the liver that is considered as invasion. It has been documented on the Canswer forum.

Q16: For Quiz 2, Case 1: why wouldn’t the Clinical T be 2b since the imaging result states “tumor appears to invade the surface of the adjacent liver”?

A16: Yes; it should be a clinical cT2b