# Quiz 1

**Scenario 1**

Patient with history of hemoptysis and chest pain. CT Chest reveals 5 cm nodule in middle lobe of right lung. Regional lymphadenopathy present. Further workup reveals metastasis to brain and carcinomatosis.

1. How would you code Mets at Diagnosis fields?

|  |  |
| --- | --- |
| Mets at Diagnosis Brain |  |
| Mets at Diagnosis Bone |  |
| Mets at Diagnosis Distant Lymph Nodes |  |
| Mets at Diagnosis Liver |  |
| Mets at Diagnosis Lung |  |
| Mets at Diagnosis Other |  |

1. Which is not part of the left lung?
	1. Upper Lobe
	2. Middle Lobe
	3. Lower Lobe
	4. Hilum
2. Where do pleural effusions usually occur?
	1. Visceral pleura
	2. Parietal Pleura
	3. Pleural Cavity
	4. None of the above
3. Which is NOT a common distant metastatic site?
	1. Adrenal gland
	2. Hilar lymph nodes
	3. Bone
	4. Contralateral lung

**Scenario 2**

A patient was diagnosed with adenocarcinoma of the right lung in 2010. In 2016 the patient visited a doctor complaining of chest pain. A CT of chest revealed a nodule in the left main bronchus. A biopsy was done that revealed squamous cell carcinoma.

1. How many primaries are there?
	1. One
	2. Two
2. Which Multiple Primary Rule did you use
	1. M1 - when not possible to determine if single or multiple tumors, opt for single tumor and abstract as a single primary
	2. M2 – A single tumor is always a single primary
	3. M6 - A single tumor in each lung is multiple primaries.
	4. M8 – Tumors diagnosed more than three(3) years apart are multiple primaries

# Quiz 2

**Scenario 1**

A 67 year old white male with a history of smoking presented for a CT due to a persistent non-productive cough.

CT/PET: 2.5 cm mass in the peripheral right upper lung lobe, most likely malignant. No lymphadenopathy or metastasis observed. A core biopsy of the mass confirmed adenocarcinoma. The physician recommended a lobectomy of the right upper lobe.

Pathology from right upper lobectomy: Moderately differentiated adenocarcinoma, 2.5 x 2.3x 1.5, of upper lobe. Tumor is confined within the lung parenchyma with invasion into, but not beyond the visceral pleura (PL1). A microscopic focus of metastasis was found in 1 of 19 ipsilateral hilar nodes.

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| --- | --- |
| Data Item | Value |
| Clinical T |  |
| Clinical N |  |
| Clinical M |  |
| Clinical Stage  |  |
| Pathologic T |  |
| Pathologic N |  |
| Pathologic M |  |
| Stage Group |  |

**Scenario 2**

A patient with SOB and suspected pleurisy presented for a CT of the chest. The CT scan of the chest and abdomen showed a right lung upper lobe mass, measuring less than 4cm, highly suspicious for malignancy. Also noted, was a massive right sided pleural effusion, obstructive pneumonitis, and atelectasis of the entire right lung. No lymphadenopathy or organomegaly. Additional staging work-up was negative. A thoracentesis of the pleural effusion confirmed metastatic adenocarcinoma. The patient was treated with chemotherapy and radiation.

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| --- | --- |
| Data Item | Value |
| Clinical T |  |
| Clinical N |  |
| Clinical M |  |
| Clinical Stage  |  |
| Pathologic T |  |
| Pathologic N |  |
| Pathologic M |  |
| Stage Group |  |