**Q&A Session**

**Collecting Cancer Data: Ovary**

**December 5, 2013**

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Q: ­If there were multiple invasive tumors, would we code grade based on the higher grade even if it's the smaller tumor of the two? ­

A: ­Yes. Per grade coding instruction #5 for solid tumors, code the highest grade if there is more than 1 grade.­

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Q: ­What about grade for non-invasive papillary urothelial carcinoma? Is there not a special grade system for bladder?

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A: ­The WHO/ISUP grade for bladder is not defined as a special grade system in grade coding instruction #6 for solid tumors and should not be used to code the grade data item.

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Q: ­Do you still take the highest grade even if the highest grade is a lower priority in the rules? Example: Biopsy states poorly differentiated (code 3) and the excision states grade 2 (code 2)­.

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A: ­Instruction #5 says to code the highest grade within the applicable system. In most cases the statement of grade is a higher applicable system than terminology.­

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Q: ­Should brain be on the list for a special grade system rule? We code the WHO grade as a SSF but don't code it in the grade field.­

A: ­No. Brain is not a special grade system in reference to coding the grade data item. Under the table of special grade systems in instruction #6, it is documented that the tables are not used to code grade for WHO CNS tumors, WHO/ISUP for bladder & renal pelvis, or FIGO for female gynecologic sites.­

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Q: ­Is grade still coded differently for non-invasive papillary urothelial carcinoma compared to Invasive papillary urothelial carcinoma?­

A: ­Beginning with cases diagnosed in 2014 the grade coding instructions we reviewed during the webinar will be applicable for all US standard setters. Instructions that differ from that will be deleted from standard setter coding manuals.

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Q: ­What is the grade code if you have a path report for a GE Junction, mucinous adenocarcinoma, histologic differentiation, poorly differentiated, grade 3/4, high grade?

A: ­There is no special grade system for GE junction. That takes you to instruction 7, use 2, 3, or 4 grade system. The statement of grade 3/4 indicates a 4 grade system. 3/4 in4 grade system is grade code 3.­

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Q: ­If you have a well differentiated bronchiolar adenocarcinoma of the lung, would you follow the terminology grade guidance? ­

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A: ­Yes.­

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Q: ­Does the instruction regarding assigning grade prior to neoadjuvant treatment only apply to the grade data item? I was wondering if there was any kind of similar instruction for the data item, lymph vascular invasion.

A: ­The grade coding instructions apply specifically to coding the grade data item.­ Coding instructions for the data item, lymph vascular invasion, are found in Part I of the CS Coding Instructions. Part I in v02.05 does include information on how to code lymph vascular invasion when it is identified in a path specimen after neoadjuvant treatment.

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Q: ­How do you code FIGO Grade; for example, FIGO grade 2? Is this coded in grade or in stage? If grade, is this coded to 2? ­

A: ­FIGO grade is not coded in SSF2 for FIGO stage. This note follows the table in coding instructions for solid tumors #6: “Do not use these tables to code grade for any other groups including WHO (CNS tumors), WHO/ISUP (bladder, renal pelvis), or FIGO (female gynecologic sites) grades.” Following this instruction, FIGO grade should not be used to code the grade data item.

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Q: ­Since the omentum is the part of the peritoneum that covers the mesentery, would mesenteric lymph nodes also be considered regional nodes?­

A: This question was sent to the CS forum in the CAnswer Forum. We have not received an answer yet, but you can follow at this link: <http://cancerbulletin.facs.org/forums/showthread.php?8321-Mesenteric-lymph-nodes>.

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Q: ­Can you give the reference for coding Krukenberg tumor to GI tract? ICD-O-3 indicates C56.9.

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A: ­The ICD-0-3 manual gives a histology code of 8490/6 for Krukenberg tumors. The /6 indicates that it is a metastatic site. As cancer registrars we only use the ICD-O-3 codes for the primary site, not for metastatic sites. Krukenberg tumors generally arise in the GI tract. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q: For stage, if it just states liver (or metastasis to liver or liver involvement), do you code to regional or distant­?

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A: ­If imaging states liver metastasis, consider distant disease and code in CS Mets at DX. If from path, check op report to determine if tissue was from liver surface or parenchyma.­

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Q: ­When the clinical stage is lower than that which is found at resection after neoadjuvant treatment, would the greater extent of disease represent tumor progression? Would that info be used to stage? If progression of disease, would the resection still be first course treatment?­

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A: ­Generally, if surgery after neoadjuvant treatment was part of 1st course treatment plan, then it would not be disease progression and greater extent of disease would be coded.­

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Q: ­Imaging: peritoneal implants. Size: not stated (cT3NOS Ext. 750). Treatment: neoadjuvant therapy, TAHBSO. Pathologist stage: pT3c Ext 720. NO MENTION of response to treatment in chart. Question: Use CS Extension code750 with CS TS/Ext Eval code5?­

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A: ­Yes, I think you have to code the clinical information because the disease was not more extensive after the neoadjuvant treatment. More specificity was identified through surgery but not more extensive disease.­

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Q: ­If it just says FIGO without mention of it being a stage or grade, are we supposed to assume that it is the stage?­

A: ­We cannot make a general statement that you can assume it is FIGO stage. You may be able to determine that through other documentation in the record.­

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Q: ­If the MD stages the case, but doesn't state that its FIGO stage, are we to assume that it is FIGO stage and therefore can use that information when assigning CS extension?­

A: ­I don't believe you can make the assumption that a stated stage is FIGO stage.­

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Q: ­Are all of the abdominal lymph nodes considered regional for ovary? ­

A: ­We are not comfortable making that blanket statement.­

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Q: ­If the T is known, aren't we supposed to derive the FIGO stage based on the T category? Like For T1a, FIGO is IA. So are you saying that unless the clinician states FIGO stage we're not allowed to assign the T category as FIGO stage?

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A: ­FIGO stage is coded in SSF2 based on clinician documentation of FIGO stage. Registrar cannot assign it based on T, N, or M categories.­

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Q: On quiz 2, questions 1 and 2, should the answers be Ext = 750 and Ext Eval = 5 as the implants were not microscopically confirmed?­

A: ­We used 720 and 6 because FIGO IIIC was pathologically confirmed after neoadjuvant treatment and that is more extensive than clinical T3b.­

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Q: On quiz 2, Question 3 would you code the FIGO stage after neoadjuvant chemo? Should the answer for this question be 999?­

A: ­ Coding instructions for SSF2 document to code the FIGO stage as stated in the medical record by the clinician or pathologist. There is no documentation not to use a FIGO stage documented after neoadjuvant treatment. Without that documentation, we feel that the stated FIGO stage should be used even if it is after neoadjuvant treatment.

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Q: ­Please explain how you derived grade 3 in the first case.­

A: The final pathologic diagnosis was papillary serous adenocarcinoma grade 2/3 of right ovary. According to the conversion table for a 3-grade system that is documented in 2013 SEER Program Coding & Staging Manual, grade 2 of 3 is assigned grade code 3.

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Q: The tumor size in case 1 was 6.6 cm per CT. Why did you code CS Tumor Size as 999?

A: The 6.6 cm size per CT was of left adnexal and/or uterine mass. We did not feel it specifically identified the primary tumor.

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Q: ­Why isn't debulking of the pelvic mass considered surgery of other regional site?­

A: Debulking surgery for ovarian cancer is coded as surgical procedure of primary site (in the 60 series of codes). You don’t want to double code the procedure.

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Q: ­Can you please clarify if you can use cM0 in the Pathologic AJCC TNM Stage as per page 11 of the AJCC Manual.­

A: ­YES - YOU SHOULD USE CLINCIAL M0 in the AJCC pathologic stage.....in the way you enter it into the registry database, you cannot put the 0 in the pathologic line since it is marked as pathologic­. (Per Donna Gress from AJCC)

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Q: ­Shouldn’t the code for systemic/surgery sequence in case 2 be 7 instead of 4 because the patient had surgery then chemotherapy then surgery then chemotherapy? ­

A: Looking at the codes, we agree that 7 is the better code.

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Q: ­On case #2 please explain use of code 7 for systemic surgery sequence . The patient had chemo in between and after 2 surgical procedures.­

A: We did originally assign code 4. However, it was pointed out to us that code 4 documents that there must be 2 or more courses of chemotherapy before and after the surgery. We only know that chemo was given before and after surgery. So, we felt that 7 was the better code.

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