Collecting Cancer Data: Pancreas

Thursday, April 5, 2018

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Q: Question for AJCC - when I downloaded the staging forms, the first page said they were last updated in Dec 2017. There has been errata (some critical, involving staging) since then. How often will the staging forms be updated?

A: I don't know! I'll try to get an answer and include it in the Q&A document.

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Q: I saw recently a case that said it was in the confluence. Where this primary would be coded?

A: Without more information, I really can’t way. If they said it was a pancreatic primary in the “confluence”, I would code it to C25.9.

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Q: Has the type of tobacco been looked at? I.e. menthol versus NRML?

A: There have been few studies that look specifically at menthol versus non-menthol cigarettes and pancreatic cancer. One potential reason that has been hypothesized for increased risk of pancreatic cancer among blacks is the higher use of menthol cigarettes by blacks. However, the studies that compare the two cigarette types have either been non-conclusive or showed no increase in risk. This may indicate no difference or it may be a product of how difficult it is to collect the data needed for this type of analysis. There have also been studies comparing the two cigarette types and lung cancer, with no difference in lung cancer risk between the two. However, these studies as well have issues with the data collection and sample size. But the take home: no smoking, menthol or otherwise! ☺

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Q: When you have a genetic risk gene, what are they doing for screening them?

A: Only 10% of pancreatic cancers are considered familial, the majority based on behavioral factors. If 2 or more first degree blood relatives (parents, siblings, children), then an individual is likely at increased genetic risk. Currently, there are a few specific genes under investigation, but the main gene responsible for pancreatic cancer is not yet identified. So any genetic assessments and screening/monitoring/treatment is considered experimental.

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Q: If the gallbladder is removed, what impact does that have on developing pancreatic cancer?

A: Because the gallbladder is also involved in food digestion, specifically fats, it seems intuitive that it may be connected to pancreatic cancer incidence. However, the removal of the gallbladder has no impact on pancreatic cancer risk.

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Q: Can the behavior of insitu/2 be assigned to a case diagnosed by imaging only = Intraductal papillary mucinous neoplasm with high grade dysplasia consistent with IPMN?

A: I sent your question to SEER and they stated that there are mucinous components that play into the diagnosis of IPMN with severe dysplasia. They didn’t think that is something that could be diagnosed via imaging. Remember, IPMN has a behavior code of /0. That is something that could be diagnosed on imaging, but would not be reportable.

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Q: Slide 46 pop quiz, does that mean software and EDITS will allow both options - blank pT and blank pN or cT and cN in the path fields when distant mets are microscopically confirmed?

A: The edits will allow the cT and cN values in the pT and pN fields if there is pathologic confirmation of distant mets prior to any treatment and there was no resection of the primary tumor. Currently the edits will also allow the pT and pN fields to be blank in this scenario. However, if the standard setters want to enforce the pT and pN fields not be blank in this scenario, the edits could change.

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Q: Does the term encasing mean involvement/invading?

A: Based on the third paragraph, page 340, in the AJCC 8th edition, I believe a description encasement or abutment of a vessel on an imaging report would be sufficient to assign a cT4.

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Q: You said 99 for pop quiz are you considering that blank? I would think blank is blank and 99 is 99. Instead of saying blank, I would just say 99 for webinars...it gets confusing.

A: For Pop Quiz 3 pathological stage was left blank because a post therapy stage group was assigned. Pathological stage or post therapy stage must be blank. They cannot both be assigned.

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Q: But the 8th ed offers GX rather than G9

A: GX would be assigned a code of 9.



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Q: When you get to treatment, please provide a clear explanation on the difference between Whipple & ext pancreatdoduodenectomy.

1. I am not exactly sure what the question is here. A Whipple Procedure is a pancreatoduodenectomy. This procedure generally leaves some of the pancreas (and sometimes some of duodenum to reduce symptoms and complications (procedure is known as pylorus-sparing pancreatoduodenectomy). Total pancreotectomy is the same as the Whipple procedure, but the entire pancreas is removed. This is not commonly done—no survival benefit and more symptoms and complications (i.e. patient will be required to take supplemental enzymes and insulin as well as dietary changes).

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Q: Follow up, will EDIT prevent incorrect placement of cT and cN in the path fields when mets are NOT microscopically confirmed?

A: Yes. The edit will check that a pM1 or higher is in the pM data item. If there is a pM1 or higher it will allow the cT and cN.

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Q: In TNM 8th edition page 340 under TNM Categories of Staging by imaging in the 3rd paragraph they address abutment and encasement of vessels by tumor.

A: Thank you! I interpret that to mean those terms indicate involvement.

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Q: Is there a new webinar (being able to add clinical findings in pathologic stage), or is it in the 8th edition about being able to combine c and p codes for all sites now?

A: I just want to make sure you didn't over interpret what i said...If the patient has pathologically confirmed distant mets identified prior to any treatment and didn't meet the rules for classification for pT, then the cT and cN values can be entered into the pT and pN data items. In the past we would have required that those fields are blank. Adding the values does not impact stage group. I do believe that this will be addressed in one of the upcoming webinars.

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Q: The question on in situ on imaging, I think there is currently an EDIT on behavior code (2) and diagnostic confirmation that will be triggered if confirmation is non-histologic/microscopic.

A: I would have to see an actual case of an in situ tumor diagnosed on imaging alone before we could make a decision on whether an in situ case can be diagnosed via imaging. If it is possible, then we would have to change the edit.

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Q: I have seen 2018 presentations that state you still use blank and X as it was in 7th edition so we really need that clarified if this has changed…

A: Will do, but Donna from AJCC was involved with writing the edit.

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Q: Must both mitotic rate & Ki-67 be documented?

A: For neuroendocrine grade codes 1-3, both must be documented.

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Q: Slide 40: If there is no staging for the assigned histology - yet the physician provides a stage. I would suggest putting that information in the staging text.

A: Absolutely. The case would also be eligible for a summary stage.

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Q: So we can assign a clinical stage even though the clinical histology is adenocarcinoma & this histology is not included in either chapter?

A: 8140/3 is a histology eligible for staging in the Exocrine Pancreas chapter. See the Histology and Topography Code Supplement at <https://cancerstaging.org/references-tools/deskreferences/Pages/8EUpdates.aspx> for a complete list of histologies eligible for staging.

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Q: Quiz 2, shouldn't number of phases be 1?

A: Correct. A single phase of radiation was delivered.

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Q: Why wouldn't the draining LN radiation be “88”?

A: I believe one of the clarifications they will be making is that code 88 is to be used only if lymph nodes are the primary volume. So if a patient with lymphoma was receiving radiation to the lymph nodes. The primary treatment volume would be the lymph nodes and draining lymph nodes would be coded to 88.

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Q: when coding, should we use 85003 over 81403 when it is described in the MR as adenoca and it doesn't specifically say ductal?

A: No. if there is no mention of "ductal" then you would not use 8500/3.

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Q: Wouldn't we use MP/H for histology?

A: For 2018 cases you would use the Solid Tumor rules. I am not aware of anything in the MP/H rules or Solid Tumor rules that would have you code 8500 if the diagnosis is adenocarcinoma for a pancreas primary.

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Q: What histology should be assigned to a pancreatic NET (with no functional status description or a description of well differentiated / G1) 8150/1 islet cell tumor or 8150/3 islet cell carcinoma or 8240/3 carcinoid?

A: I checked with the Chair of the ICD O 3 TF and they said 8240/3 would be the appropriate code.

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Q: What is the WHO classification of tumors in the AJCC manual as listed on page 338?

A: It is not accurate. The Histology and Topography Code Supplement should be used to determine if a case is eligible for staging. <https://cancerstaging.org/references-tools/deskreferences/Pages/8EUpdates.aspx>

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Q: Is a stent coded as palliative therapy?

A: I found a couple of interesting posts concerning palliative therapy on the Canswer forum. See below…

<http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/palliative/69252-date-of-first-treatment-and-palliative-care>

<http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/palliative/4452-repair-of-pathologic-fracture-palliative-care>

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Q: Hi we are wondering what API stand for?

A: Application programming interface (API)

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Q: There is an explanation of abutment and encasement on page 340 of 8th ed, 3rd paragraph under TNM Categories of Staging by Imaging.

A: It does state that abutment indicated less than 180 degrees of involvement and encasement is more than 180 degrees of involvement. I take that to mean they both indicate involvement.

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