## Q&A Session

## Collecting Cancer Data: Bladder and Renal Pelvis

Thursday, May 02, 2013

Q: ­Re MPH Rule M5: For registries that collect /1 cases, should we apply this rule when the patient has a /1 tumour followed by a /2 or /3 tumour60 days or more from diagnosis?­

A: Do not apply the MP/H rules to bladder histologies with a behavior of /1.

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Q: With rule M6 when looking at the 2 histologies, the behavior has to be the same, correct? ­

A: No. If you have an invasive urothelial carcinoma of the bladder first followed by a noninvasive urothelial carcinoma of the bladder, rule M6 would apply. ­Rule M5 would have already applied if the non-invasive tumor came first.

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Q: ­For M7 when you have a 3rd recurrence, would you not use the 2nd recurrence date in terms with the 3 year rule? ­

A: No, we just verified with SEER that the three years begins with the diagnosis, not the recurrence.

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Q: If you have a non-invasive tumor 1st (Seq 01) then an invasive after 60 days (Seq 02) THEN later you have a 3rd tumor which is non-invasive is the 3rd tumor a recurrence of Seq 01 only OR do you consider it a recurrence of both Seq 01 and 02?

A: We’ve sent this question to SEER for clarification.

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Q: For rule M7 to apply (the 3 year rule), does the patient have to have a 3 year Disease Free interval between urothelial tumors?

A: We just asked SEER that question yesterday. They said that the clock starts at the time of dx. The clock does not restart if there is a recurrence.

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Q: If a patient has synchronous tumors (diagnosis within several weeks of each other) that are considered the same primary (per rule M8), do you always code to C68.9? Or if one was non-invasive and one was invasive, would you code to the site of the invasive tumor?

A: I have not seen anything to address that question for urinary primaries. I know for breast SEER says to go with the location of the invasive tumor. We may have to send this for clarification.

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Q: If one tumor has both non-invasive papillary and carcinoma insitu - you said to code this to the higher extension - 060. The Histology according to MPH H7 is 8130 papillary. The histology code does not match the Extension code.

Q: We sent this to SEER for clarification.

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Q: ­Can you please discuss intravesicular treatment with mitomycin c (regarding how to code when given at the same time as surgery).­

A: ­Only use codes 15 or 16 if intravesical therapy or BCG were given and a surgical procedure that would be assigned a code 20 or higher was NOT done. In that situation (rare) you would also code the BCG or intravesical chemo in BRM or Chemo.­ ­If the BCG or intravesical chemo was given on a different day than the surgery code 20 or higher, the BCG or Intravesical therapy would still only be coded in Chemo or BRM. Code 15 and 16 would not be coded as a second procedure.­

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Q: ­What is the correct code for status of surgical margins for TURBT? ­

A: This question has been submitted to the CAnswer forum. You can track it at <http://cancerbulletin.facs.org/forums/showthread.php?7193-Surgical-Margins-TURBT&p=18012#post18012>

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Q: ­Site coding: When there are multiple urothelial tumours in two or more of the urinary sites, what is the current guideline for coding the site? Where is the guideline documented?

A: ­Per SINQ question 20110119, assign code C68.9. I have not found this documented elsewhere.­

­<http://seer.cancer.gov/seerinquiry/index.php?page=view&id=20110119&type=q>

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Q: ­For case #1, the op note says the resection site was cauterized, wouldn't the surgery code be 22? ­

A: No, the electrocautery was done to stop the bleeding not to treat the tumor. Therefore, 27 would be the appropriate code.

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Q: ­In Quiz 2, for the second case scenario, why would the TS be 036, rather than 004? Doesn't the path size override the clinical size?­

A: ­I used the clinical size because tumor had been removed from TURBT and the 0.4 cm tumor size on cystectomy was residual tumor. The clinical information better describes original tumor size.­

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