**Q&A Session**

**Collecting Cancer Data: Stomach & Esophagus**

**April 02, 2015**

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Q: ­Is anyone looking at how incidence is affected by some registries reporting high grade dysplasia as cancer in situ and some are not?­

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A: ­Not that I am aware of.­

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Q: ­Don't understand why primary site to 1st pop quiz question wouldn't be C16.0.­

A: ­The picture in the slide moved. The tumor was supposed to be further down in stomach. My point was that even if it is in the body of the stomach (C16.2), we would still use the CS Schema for EGJ and the esophagus chapter in AJCC as long as the tum­or was within 5cm of the cardia.­

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Q: ­On slide 10, the site code for upper thoracic and mid thoracic are both given as C15.1.­

A: ­That is correct. C15.1 is used for both upper and mid thoracic esophagus. They cover about the same area as middle third esophagus which is coded C15.4. Code based on the terminology used by the physician.­

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Q: ­Would you show specifically where the GE junction is in reference to the Z line/Cardia.­

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A: ­In a normal esophagus, the Z line occurs right at the EJG. Reflux can move the Z line distally. Here is a link to a good illustration­: <https://gi.jhsps.org/GDL_Disease.aspx?CurrentUDV=31&GDL_Disease_ID=46159D68-6ED3-4F76-895B-99D8BBBB46EF&GDL_DC_ID=E25BDF77-223D-4B6F-9700-5BE41DBDE28B>

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Q: ­Grade is necessary for staging of esophagus & EGJ tumors but not necessary for staging of stomach tumors, BUT ICD-O-3 lists EGJ as coded to C16.0, stomach cardia. How are EGJ tumors separated from stomach tumors if not by ICD-O-3 code? This seems problematic.­

A: ­That is a really good question! Seems like we will need to have some way of indicating what AJCC chapter was used for tumors coded C16.0-C16.2. My guess is they will use SSF 25 to indicate even though the primary site is C16.0-C16.2, the stage is based on the esophagus chapter of the AJCC Manual. Thank you for bringing this up!­

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Q: ­I don't see a discussion in AJCC esophagus chapter regarding regional vs. distant lymph nodes for sub-sites of the esophagus. Would regional nodes for cervical esophagus be considered regional for distal esophagus? Are we to use the CS designations?­

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A: I ­have not seen any discussion either. I believe the distinction in CS is used to derive the Summary Stage, not AJCC stage.­

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Q: ­What is grade X? Thank you.­

A: The highest histologic grade on biopsy or resection specimen is required for AJCC stage grouping in the esophagus/EGJ chapter of the AJCC 7th Edition. As documented on page 108 of AJCC 7th Edition, grade is recorded as GX if it is not available. It would be recorded in the grade data item as 9.

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Q: ­Are submental and post-auricular nodes considered cervical lymph nodes for SEER staging for esophagus?­

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A: ­I would think no. The cervical lymph nodes listed in the summary stage manual are all along the jugular. Submental and post-auricular nodes are not along the jugular.­

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Q: ­Can you please review again when the esophagus staging is used and when the stomach staging is used when the tumor involves the GE junction.­

A: Use the AJCC 7th Edition esophagus/EGJ chapter to stage if the primary tumor is in the EGJ or proximal 5 cm of the stomach, which includes the fundus of stomach (C16.1) and body of stomach (C16.2) if the epicenter of the tumor is < 5 cm from the EGJ and crossing into the EGJ.

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Q: ­Does the 5cm measurement start at the GE junction? ­

A: Yes.

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Q: Still confused as to why on AJCC pop quiz for stomach, the clinical stage is TX when there is a positive biopsy?­

A: The biopsy confirmed that the mass was malignant, but it did not provide any information about the extension of the primary tumor, which is recorded in the T category. The CT scan did not provide any information about primary tumor extension either. Because there is no information about the extension of the primary tumor clinically, the clinical T category is X.

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Q: ­Isn't perimuscular tissue invaded coded as regional?­

A: ­In summary stage for stomach, perimuscular tissue invasion is local while perigastric fat involvement is regional by direct extension.­

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Q: ­When CS goes away, which list of regional lymph nodes will we use between AJCC & SEER Summary Stage for the coding the fields Regional Nodes Positive and Regional Nodes Examined?

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A: ­Good question. We will forward it to the CS Transition team.­

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Q: ­For direct coding of AJCC and SEER Summary Stage, will ambiguous terminology be taken from the present CS instructions? Lymphadenopathy is not a term by itself that would be considered nodal involvement.­

A: ­Ambiguous terminology is not used in AJCC Cancer Staging. The current definitions for CS are taken from Summary Stage. ­In quiz 2, the adenopathy is not why the clinical N was coded N1 in question 5. The N1 came from the biopsy, but we can use the info from EUS to verify only 1 node.­

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Q: ­Isn't a cervical node, NOS considered distant for intrathoracic primaries in SS? Quiz 2 question 7.­

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A: ­Yes, you are absolutely correct.

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Q: ­Quiz 2 - #8 what information did you use to code the cN0?­

A: The cN0 was based on the abdominal CT scan statement of no lymphadenopathy.

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Q: ­If the patient has had a sleeve gastrectomy for bariatric surgery and now has a tumor in the sleeve, how do we code the primary site?­

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A: ­Good question. I would say if the surgeon says the tumor is in a specific location (cardia, pylorus, etc.) then go with that. Otherwise I think I would code to stomach, NOS.­

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Q: ­For primaries coded as C16.0 (EGJ), what primary site surgery code should be used for entire removal of the esophagus with gastrectomy? Code 50 specifies only a portion of the esophagus may be removed; code 60 excludes any removal of the esophagus.­

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A: ­Good question! I'm not sure. Do you have a case where this actually happened or is this hypothetical?­