**Q&A Session**

**Collecting Cancer Data: Prostate**

**Thursday, November 07, 2013**

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Q: ­If a DRE is not mentioned in History & Physical, do you assume that it is done or not done? ­

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A: ­If there is no documentation about DRE, you cannot assume it was done or not done.

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Q: ­Is TRUS guided Biopsy considered an imaging procedure? ­

A: ­It would be coded as a diagnostic staging procedure (02). Shannon will discuss how the procedure is handled for staging purposes.­

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Q: Do you need the clinical stage to calculate using the Partin table?

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A: ­You can see the tables at <http://urology.jhu.edu/prostate/partintables.php>. ­When you use the tables they ask for clinical stage, but the options are T1c, T2a, and T2b/c.­

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Q: ­Is there going to be a change to Gleason 7, which is now = grade 3? I've heard it will change to grade 2, MOD DIFF­.

A: ­I am not aware of any proposed change. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q: ­Re: Gleason conversion for Histologic Grade. In Canada we use a new table based on AJCC 7; the table reference appears to be AJCC 6.

A: The following information was provided by Donna Gress, AJCC technical specialist: “AJCC does NOT tell you how to convert grade; the AJCC listing is the PROGNOSIS for the Gleason­.”

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Q: ­In Canada, we capture histologic grade for prostate per our Standard Setter CCR, who bases this decision on AJCC 7th. The difference is (and in ref. to Marcia Hodge's question) AJCC 7th Gleason of 7 = histology grade of 2. Seems SEER hasn't updated their table.­

A: The table in the slides is the conversion table that should be used to convert Gleason score into a grade for the grade data item. The information provided in the AJCC 7th Edition is to be used by the clinician for prognosis, not by the registrar to convert Gleason score to the grade coded in the grade data item.

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Q: ­Please comment regarding grade notes found in AJCC TNM pages 462/467. This caused a lot of discussion on various forums. (Gleason 7 = mod diff). Thanks.­

A: ­The AJCC manual should not be used to convert a Gleason grade to a histologic grade. These tables were created for a different purpose. The conversion table on the slide reflects how registrars should convert Gleason's score to a histologic grade in the grade data item.

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Q: ­If on DRE, there's 1 cm nodule in the prostate and prostatectomy is done with no mention of tumor size, should we code CS Tumor Size from the size of the nodule on DRE?

A: No. Generally, CS Tumor Size for prostate should be from the surgical specimen (radical prostatectomy), not from findings from DRE, CT/MRI, biopsy, etc. See the following link on CAnswer Forum for a discussion of this issue: <http://cancerbulletin.facs.org/forums/showthread.php?2616-Prostate-CS-Tumor-Size&highlight=tumor+size>.

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Q: So, if the ONLY information available is elevated PSA and abnormal DRE (no statement of nodule, etc.), the CS Extension should be coded 300?­

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A: ­Yes,­ because in that situation you cannot determine if the tumor was inapparent or apparent.

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Q: ­Note 3C preceding the CS Extension codes in the CS manual states that you can use 200-240 if tumor/mass/nodule is radiographically apparent. Can you please clarify why you are stating not to use imaging? ­

A: ­The current quality of imaging for the detection and clinical staging of prostate cancer is not sufficiently uniform to make it part of routine staging. The DRE is considered the gold standard for clinical staging of prostate cancer and determination of a clinically apparent (T2) tumor is dependent upon DRE with a physician statement of “mass”, “tumor”, or “nodule”, or a physician stage of cT2. Only a physician can upstage a patient to a cT2 based on imaging. The cancer registrar should not upstage based on imaging since prostate imaging is not consistently accurate in staging.

CAnswer Forum: <http://cancerbulletin.facs.org/forums/showthread.php?5612-Using-the-MRI-to-determine-the-CS-Clinical-Extent>

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Q: ­Regarding clinically apparent tumor vs. clinically inapparent tumor, one slide states that you will use 300 when it is unknown if clinically apparent or inapparent and then in the CS Extension slide for clinically apparent, it says you can use code 300. ­

A: ­Code 300 is used for localized NOS which includes if you don't know if it is clinically apparent or inapparent. It was on the clinically apparent slide because it does derive a T2NOS.­

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Q: ­Regarding the slide for CS Tumor Size/Ext Eval, please explain when you would use code 0 with a biopsy. This is confusing with the pop quiz example for coding CS Tumor Size/Ext Eval.

A: ­If the patient is assigned CS Extension - Clinical extension code 200-240 (clinically apparent), CS Tumor Size/Ext Eval code 0 is assigned even if there is a biopsy.­

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Q: ­In the pop quiz scenario, the patient opted for surveillance himself and hence the prostatectomy goes in the second course. What if the physician says that the patient should be on surveillance for any reason and prostatectomy is done later just like in this case, would it still go in the second course?

A: ­If surveillance is the planned treatment, additional treatment is considered subsequent, not first course.­

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Q: ­If a Gleason is stated as 3+4=7, do you need to document it as 4+3=7 with the higher pattern first? ­

A: ­No. If it is stated as 3 + 4, then 3 is the predominant pattern and that should be recorded first.­

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Q: ­Can you code number of cores examined/positive from the urologist's dictation? This is where I have been seeing it lately, not on the path report­

A: ­If the urologist documents the number of cores positive and examined in dictation describing the biopsy procedure, I think it would be appropriate to code that information in SSF12 and SSF13 if it is not documented in the pathology report. However, if it is documented both in dictation and the pathology report, the pathology report would be the preferred document.­

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Q: ­If patient has a needle core biopsy and the result is positive for adenocarcinoma, but there is no mention of the number of cores examined or positive; when recording the number of cores positive in SSF 12, can we use 991 assuming that cores were examined? ­

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A: ­I believe it would be appropriate in that situation to record SSF12 as 991 (biopsy cores positive, number unknown) and SSF13 as 991 (biopsy cores examined, number unknown).­

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Q: ­Quiz 2 #10 & 11. Why wouldn't answers to both be 991? You don't know exactly how many cores were positive and examined; particularly since specimen A is not stated as to number of cores. # of cores from specs E-H unknown.­

A: ­A-H indicate core needle biopsy which is inferred to be single core. 8 were counted; 4 were positive. This was from CAnswer forum:

<http://cancerbulletin.facs.org/forums/showthread.php?6644-SSF-12-amp-13-Prostate>

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Q: ­Is brachytherapy always coded as boost treatment even if given before the external beam therapy?­

A: Yes. Boost is given to a smaller area within the volume of the primary target. It doesn’t matter in which order it is given.

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Q: ­Where do they inject the beta emitting radiopharmaceuticals? Or how is it administered?­

A: It is typically injected directly into the blood. Sometimes it is given intracavitary.