# Abstracting and Coding Boot Camp: Cancer Case Scenarios

# Q&A Session

March 7, 2016

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Q: ­For slide 8, can you explain who requires CS Input Original and Current and why...also, how is this possible without assigning the core CS items (size/ext/nodes/mets, etc.)?­

A: ­My understanding is that CS Input Original and Current are fields that are auto-filled when any of the CS fields are entered. Since all standard setters are collecting SSFs, CS Input Original and Current will populate. ­CS Version Input Original and Current are required or recommended by all the standard setters (NPCR, CoC, CCCR, SEER).

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Q: ­If a patient has a recurrence, can that patient ever be disease free again? It sounded like you said that it couldn't be possible or recorded that way.­

A: ­My understanding is once that once a recurrence occurs you can't change the date of first recurrence or type of first recurrence. ­

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Q: ­is a physician statement of recurrence ok for recurrence or does it need to be confirmed by pathology­

A: I sent this question to Anna Delev at the CoC and she said that it is absolutely a reliable source of information and would be enough to complete the cancer status.

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Q: ­Please explain the way AJCC and SEER Summary Stage looks at extension described as "up to" vs "into".­

A: From Donna Gress - the AJCC chapter usually has "up to" meaning it is not involving, but need to look at the situation some chapters provide clear guidance¬

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Q: ­Couldn't you use imaging for bladder primary to assign clinical N for prostate?-N0?­ Appendix case-why wouldn't Clinical T be X since imaging done?­

A: You have to have a dx of cancer before you can assign a stage. That's kind of easy to forget when you are looking back at a case, but it is something to keep in mind.

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Q: ­So you can't clinically stage unless there's already known cancer?­

A: ­Correct! I confirmed this with AJCC prior to the session and Donna just confirmed it again. This applies to both invasive and in situ cases.­

A: From Donna Gress­ ¬if the cancer was not known prior to surgery, then it does not meet the criteria for clinical classification, it is all blank.....clinical classification means you suspect cancer and are doing a workup

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Q: ­Shouldn't answer for 7d be p2a?­

A: ­It should be. I didn't include the p in front of the 2a value. ­‑

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Q: ­Jim when would you apply note 3 under the general instructions for Summary Stage?­

A: ­ An example of when note 3 would apply would be if distant mets was identified after tx was started. If the physician thinks it was there the whole time but just hadn't been identified, then you would code the mets in summary stage. You would not stage­ ­information from after neoadjuvant tx if extent of disease is less than it was at time of dx. ­

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Q: ­On the breast scenario, can you explain the difference between clinical N for c2 vs. c2a? Question #3.­

A: ­c2a is a subcategory of c2. You would only use c2 if for some reason you couldn't assign c2a or c2b. I can't think of a situation where you wouldn't be able to use one of the subcategories.­‑

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Q: ­Scenario 2: Please explain T4 vs T4a. Does T4 include or not include the pectoralis muscle? We have staff with notes both ways. T4a explain statement of "not including ONLY pectoralis muscle".­

A­:T4a is a subgroup of T4. You should be able to use one of the subgroups rather than just T4. If tumor invades the pectoralis, it is not considered chest wall involvement for AJCC staging. We would base the T value on the size of the tumor.

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Q: ­Scenario 3: Please explain the rationale for using clinical 0 for 10 & 11.­

A: ­We apply the "in situ" rule. We use pis for the cT and pT. We use cN0 and cM0 for both the cN & cM and the pN & pM.­‑

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Q: ­On Quiz 3 question 11: how can it be active surveillance if they didn't have time to watch him? It's within the 4 month window ­

A: It looks like I was wrong on that one. It looks like the rule of thumb is if they don’t change their mind before the first evaluation it’s considered active surveillance. The first follow-up visit is usually 3-6 months after the plan is established. Our patient only waited two months.

<http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/surgery/5832-1st-course-tx-vs-subsequent-prostate-ca-watchful-waiting-followed-by-surgery-or-xrt>

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Q: ­Can you go over question 2, not considered or considered PBS as path confirmation?­

A: For hematologic cases peripheral blood smears are considered pathologic diagnostic confirmation BUT it is not considered to be a surgical procedure and because of this it would not be recorded in the Surgical Diagnostic Staging Procedure data item.

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Q: ­Shouldn't tumor size be 988?­ ­That is according to CS V02.05 988 is a default code for lymphomas.­

A: For cases diagnosed in 2015 yes 988 would be the correct code.

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Q: ­In the new tumor size summary variable, tumor size for lymphoma is 999­

A: For cases diagnosed in 2016 yes 999 would be the correct tumor size for lymphoma according to the new field Tumor Size Summary

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Q: ­With the new Tumor Size fields, I think your answer of 999 for tumor size in the lymphoma case is correct!­

A:­ You are correct! For cases diagnosed in 2016 the Tumor Size would be coded to 999 for lymphoma.

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Q: ­Are you sure we can assume no B symptoms if it's not documented?­

A­: On page 608 in the AJCC Manual 7th Edition it state that Each Stage should be classified as either A or B according to the absence or presence of defined constitutional symptoms.

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Q: ­Did you guys notice that the Mets at Diagnosis category is missing from the Case Scenarios.­

A: Good point! We should have added them. We will in the future.

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Q: if the AJCC PATH Stage group is 99, should the Path Stage Descriptor be 9??­

A: We will look into that. Stage group descriptors will be something we cover in more detail on upcoming webinars.­‑

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Q: ­Questions #3 - shouldn't inter be intra?­

A: ­These are the definitions i found intra- on the inside; within. inter-between or among­‑

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Q: ­In Cancer Status: Can I record pathological evidence as of the date of last contact, as well as clinical? ­

A: I assumed the question was asking can registrars use clinical and or pathological evidence to code cancer status. I sent this on to Anna Delev at CoC and her response was No, The FORDS is very clear that the conclusion about the cancer status should be done by physician. The registrars can use this statement to code the cancer status – negative, positive, or unknown.

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Q: ­Case where pt has Lumpectomy or mastectomy with neg margins and and node dissection with positive lymph nodes: No further surg. Would you code this as NED, having evidence or unknown? Or would you need a doctor's statement?­

A: Sent this to CoC Anna Delev responded: The FORDS, page 307, says: *Cancer Status records the presence or absence of clinical evidence of the patient’s malignant or non-malignant tumor as of the Date of Last Contact or Death*. I would look for MD statement – written or verbal that the disease was eradicated, NED, responded to treatment well, etc”

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Q: ­Quiz 2 Scenario 1 - Since the imaging would be the same for the bladder and prostate region, Why couldn't you assign at least a cNo?­

A: ­It seems like you should be able to when you look at all the information, but you have to remember they didn't even have a diagnosis of cancer prior to surgery. The purpose of the clinical stage is to show what the physician thought the stage was prior to treatment. This is a little bit different way of thinking that how we think of summary stage or CS.­

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Q: ­What is your source document for the colon site determination for case 3 (descending colon.)?

A­: The MPH Terms, Definitions and Illustrations for Colon has an image of the Colonoscopy Measurements.

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