## Q&A

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Q1: ­In the SSF12 the info in the path indicate fragments of core, I code 991, you can explain this issue with the fragments of core­

A1­: For Prostate Case Scenario 1 in the path report it stated core fragments. According to the Collaborative Stage rules it does state that the pathologist should count cores, not fragments, chips, pieces, specimens, or lobes positive. It also states to use code 991 if the number of cores positive or cores examined is not documented in the record. If the percentage of tissue involved with cancer is stated but not the number of cores positive, do not calculate the number of positive cores code as 991.

CS Data Collection system Coding Instructions, Part I, Section 2, Version 02.05. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q2: ­For the factor 12, the collaborative said: do not count fragments of core.­

A­2: Correct, do not count a fragment as a positive cores.

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Q3: ­Any efforts to standardize bx core counts??­

A3: Not that I am aware of.

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Q4: ­sometimes on our path reports it will say (ex.) 13 cores taken but within one sample it will say 1 of 2 cores POS... Would you still say 13 total cores taken? ­

A4­: I would go with the 13 total cores taken.

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Q5: ­Is just the statement of abnormal DRE enough to state cT2 nos??­

A5: ­I would say no. I would want to see something indicating they felt a tumor. I would think abnormal DRE could be just an enlarged prostate.­

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Q6: ­What do you do when there is no mention of a DRE? ­

A6: ­You need something to show apparent vs inapparent. You might be able to get this information from imaging, but it is not as consistent for early T values as DRE.­

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Q7: ­Since LVI is not included on CAP protocol - do we assume that it is "9?" Or would it be coded to "0?" ­

A7: ­LVI is not required as part of CAP protocol but it can be indicated. According to the CS rules you would use code 9 when LVI is not mentioned in the pathology report. Code 0 is when the pathology report indicates that there is no lymph vascular invasion. ­­Also, CoC and SEER only require LVI for testis and penis. Not for prostate.­

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Q8: ­Has there been any research that saw palmetto has helped to reduce prostatic swelling? ­

A8: I’m not aware of any of the research related to saw palmetto and its effect on prostate swelling.

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Q9: ­So if PSA is not available, staging cannot be done? ­

A9: ­That depends on if a stage can be assigned based on *Any PSA*.­

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Q10: ­When looking at stage grouping table, does "no" PSA equal "any" PSA? ­

A10­: Yes.

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Q11: ­What is the time table for collecting the PSA value? How far back?

A11­: From Donna Gress­ (­dgress@facs.org­) ­ - ­for AJCC staging - it should be right before the biopsy.....if it was high months ago it was probably due to other reasons - if they thought it was cancer, they would have done a biopsy at that point­.

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Q12: ­The slide on rules for classification for path states removal of lymph node however, in staging case 4 a bx was enough to meet rules for pN. Please explain does it have to be removal or bx? ­

A12: A biopsy is enough to confirm the highest N value. Just remember, that you wouldn't code the information unless you have also confirmed the highest T.­

From Donna Gress­ (­dgress@facs.org­)­ - the rule for AJCC is remove at least 1 node...biopsing the node would allow for a pN­; ­a biopsy is removing a node.

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Q13: ­Please review Case #4. Why is Pathologic stage not assigned? ­

A13: In staging case #4 we did not confirm the highest pT value. Therefore, we cannot assign a pathologic stage.

Donna Gress gives a good explanation of this at [http://cancerbulletin.facs.org/forums/node/64341](http://cancerbulletin.facs.org/forums/node/64341%20%20)

Q14: ­Do i have to have a bx of the (all 3) lymph nodes, seminal vessel and the rectum to do a pathologic T? ­

A14: ­No. You have to confirm the highest T value and the highest N to assign a pT value and pN value in the pT and pN data items.­

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Q15: ­If a rectal bx is done and is negative, there is a positive bx of the seminal vesicle and a positive bx of a regional LN, has the "highest" T value been proven? ­

A15: You have to have a positive biopsy that confirms the highest T in order to meet the rules for classification. A negative biopsy of the rectum, does not meet that criteria.

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Q16: ­The answer for staging case 4 (slide 50) seems to disagree with the info on slide 40 for what meets the rules of pathologic staging (biopsy proving T3A/T3b and removal of regional node) - please explain again. ­

A16: It is a bit confusing. Even though a biopsy confirming p3A or p3B is enough to meet the criteria for assign a pT value, it does not meet the criteria for assigning a pathologic stage. In order to do that you need confirmation of the highest T and the highest N. AJCC has indicated that if you don’t meet the criteria for staging, that you leave the T, N, and M values blank.

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Q17: Jim where does it state in the TNM book you have to have the highest T and N value to assign a pathologic state? ­

A17: See tables 1.5 and 1.6 on page 10 of the manual. These tables indicate if you have pathologic confirmation of the highest value, you have met the criteria for the pT or pN.

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Q18: ­what if a LN biopsy was done and showed NEG, but w/ a cT4? Can you then assign a pT4? ­

A18: If that was the case, then you would not have met the criteria for pN. Therefore, you would leave the T and N blank.

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Q19: ­Under the pathologic staging rules is it saying you can meet the pathologic T by having a prostatectomy OR a biopsy of extraprostatic tissue? (examples are bx of rectum, bx of extraprostatic soft tissue, bx of seminal vesicle extension.)­

A19­: That is correct. However, to meet the rules for assigning the pathologic stage you must either…

1. Have a prostatectomy
2. Have pathologic confirmation of distant mets
3. Have pathologic confirmation of the highest T and the highest N

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Q20: ­On slide 50, if you had removal of the enlarged LN, and bx confirming extension into seminal vesicle, can you get a pathological stage?­

A20­: No. You have to have pathologic confirmation of the highest T.

Donna Gress gives a good explanation of this at

[http://cancerbulletin.facs.org/forums/node/64341](http://cancerbulletin.facs.org/forums/node/64341%20%20)

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Q21: ­Can there ever be a primary ca in the seminal vesical? ­

A21­: From Donna Gress­ (­dgress@facs.org­)­ - from a urology journal article: Primary adenocarcinomas of the seminal vesicle (SVC) are very rare and poorly understood neoplasms with only somewhat more than 50 histologically confirmed cases reported in the literature.­

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Q22: ­Can you clarify clinical staging for the following scenario: pt has elevated PSA goes on to have Bx, then after Bx has a DRE. Physician states T2a. Active surveillance is treatment chosen. Does the DRE have to be done before the Bx? Sometimes the physician doesn't relate the T2a back to the DRE. It seems as if they are referring back to the Bx. Can you provide some direction on this? Would you stage as clinical T2a or T1c? ­

A­22: In that case I would go with what the physician assigned as the cT value. I haven’t seen anything that says the biopsy has to be done after the DRE.

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Q23: ­CAN MRI FINDINGS BE USED FOR CLINICAL STAGING WHEN PERFORMED AS PART OF THE WORKK UP? ­

A23­: Yes. They are especially effective for identifying extraprostatic extension and enlarged lymph nodes.

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Q24: ­Does it make any difference if it's protruding on the capsule but hasn't penetrated, say, the vas deferens.­

A24: If the tumor has invaded into but not through the prostatic capsule, then it is a T2. If it is through the capsule it is a T3 or higher. I believe invasion into the vas deferens would be a T4.

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Q25: ­Coding Grade for Prostate chart on slide 19: Is this based on FORDS or NAACCR standard? ­

A25: This is what was agreed to by all the standard setters. <http://seer.cancer.gov/tools/grade/>

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Q26: On inaccessible site rule- why would the N category = not be cN blank and cM blank? ­

A26: The inaccessible site rule would apply only to cN. If any kind of work-up was done, then the cT and cN would not be blank. If we have a cT1 or cT2, we could apply the inaccessible site rule and give the cN a c0 even if there is not mention of lymph nodes.

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Q27: ­What is required in documentation to be able to code PSA as elevated? Sometime w/ higher valves MD may state "rising". Sometimes only statement is ICD 9 code on biopsy sheet. Does MD have to state "elevated"? ­

A­27: If you don’t have a statement from the physician stating they think the psa is elevated or score with the range, then you would code PSA as 999 in SSF 2.

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Q28: ­can you discuss biochemical recurrence? Example: 1st course- prostatectomy 3 yrs. NED 4th year BIOCHEMICAL RECURRENCE - due to doubling time of PSA 2nd course- RT How do we code the recurrence and what type?­

A28: Biochemical recurrence is a rise in the blood level of prostate-specific antigen after treatment with surgery or radiation. After first course treatment we would expect the PSA to go way down. An increase in the level of PSA could indicated the disease has recurred (biochemical recurrence).

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Q29: ­Can we use “Complete transurethral resection of the prostate” to meet the rules for “prostatectomy” on slide 48? ­

A­29: I am not familiar with the procedure. I would have to say no it does not meet the rules for pathologic staging unless the procedure removes the entire prostate including the prostatic capsule.

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Q30: ­if dre=nodule lt side. bx=lt side benign, rt side+. What T Value would you use??­

A30: ­I would go with the DRE. I would ignore the bx results. Either way is appears to be confined to one lobe.­

Q31: ­It was mentioned earlier in the webinar that prostate cancer is often multi-focal. Would this correlate to a clinical / path descriptor of "m"?­

A31: ­yes.­

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Q32: ­What is the clinical significance of apical involvement? I assumed it was because of the potential invasion of adjacent structures but never got a good answer for that.­

A32 You are correct. Also, the prostatic capsule at the apex of the prostate is very thin so we worry more about regional involvement.

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Q33: ­What if you do not know if the pt has had a first f/u visit but you know there was a change in treatment plan. What do you do? ­

A33: ­Good question! I use to work in a central registry. If I didn't have that information I would default to the change in treatment plan being second course. Not sure if everyone would agree with me on this thought! ­

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Q34: ­Is it documented somewhere that says we should round up PSA? Scenario 2­

A34: See CS Section 1 for recording tumor markers.­

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