# Corrections and Q&A for AJCC Staging

Thursday, January 12, 2017

Corrections:

* Slide 63 Melanoma “Walk-through” case. In the morning session I had the pN as pN0. It should have been pN1a based on the sentinel node biopsy. Stage group should be 3A.
* Quiz 2 question 2. This was a kidney primary with a histology of spindle cell sarcoma. This site histology cannot be staged based on the Kidney chapter, but it can be assigned a stage based on the Soft Tissue Sarcoma chapter. During the morning session we staged the case with 88’s, when we should have assigned values based on the Soft Tissue Sarcoma chapter.

Questions from the live session

Q1: ­In December 2016 issue of (College of American Pathologists) CAP Today magazine, there was an article on the AJCC 8th Edition changes. In it there was mention that lobular carcinoma in-situ of the breast is no longer considered a cancer diagnosis. What is ­­the guidance by registry standard setters about this diagnosis—to report or not; date of implementation? This statement is on page 18, 3rd column, 2nd paragraph.

A­1: One thing to remember is that CAP, AJCC, etc do not set the reporting requirements for cancer registries. However, this is a topic that the standard setters are aware of and will be discussing. I am not aware of any changes to the reporting requirements for lobular carcinoma at this time. If they do change the reporting standards, they will notify registrars.

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Q2: ­If my patient is thought to gallbladder disease and goes in for surgery. Findings are a tumor-cancer. So is this clinical blank, stage 99 and then we assign path T, N, M and stage? ­

A2­: That is a great example of when the clinical T, N, and M would be blank and stage would be 99 because there was not a diagnosis of cancer prior to removing the primary tumor.

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Q3: ­If a person is diagnosed as having a colon adenocarcinoma on colonoscopic bx, and colonoscopy is all that we have as a clinical workup. Can we assign clinical T as cT1? Although we don't have proper extension mentioned on the colonoscopy? ­

A3­: The Clinical T is based on the depth of invasion of the tumor. If on biopsy you do not have that information you will not be able to assign a cT1. More than likely it will be cTX.

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Q4: ­Can you explain the difference between PSA X and Gleason X vs any PSA and any Gleason’s (Prostate Staging)? ­

A4­: ­Donna Gress­ (­dgress@facs.org­)­ - PSA X and Gleason X was meant for 3rd world countries that do not have the capability to determine these. It provides anatomic only staging­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q5: ­If you have tumor size on breast mammogram or ultra sound prior to diagnostic biopsy, can you use the size for clinical staging? ­

A5­: Yes, you can.

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Q6: ­Aside from the in situ rule, for melanoma of the skin, stage 1A patients do not require pathologic evaluation of LN so that is a case where cN can be used in path N field. (pg. 336 small font below stage group table).­

A6­: You are correct. Patients with a pT1a melanoma can be assigned a pathologic stage without removal of a lymph node. A cN0 is assumed.

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Q7: ­I know in the past we could blend our stage and add clinical values in the pathology fields. Do you know why we can't blend values anymore? I guess Stage group being 99 is not as important to standard setters as assigning each T N M values. ­

A7­: I know what you mean! It’s really frustrating to end up with all of those unknown stages. The standard setters all agreed when they chose to collect AJCC TNM stage rather than CS, that they would follow the rules for clinical and pathologic stage.

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Q8: ­On the esophagus stage table, when it says T1 (i.e. stage IA), does that include the T1a and T1b? If so, does that apply to all of the staging schemas? ­

A8­: Yes. When the stage table does not include the subcategories (as is the case with esophagus, breast, etc), it is safe to assume that stage group includes all of the stage groups. For example a well differentiated adenocarcinoma assigned T1 or T1a or T1b, and N0, and M0 would be assigned stage 1A. Other sites such as prostate do include the subcategories in the stage tables. If the subcategories could potentially change the stage group, they may be required to assign a stage.

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Q9: ­Could you expand on the timing rule and progression with an example where we stop due to progression? When diagnostic workup is negative but a met is found after surgical resection but within path timing, this is cM0 (in cM) & cM1 (in pM) which seems like ­progression.

A9­: Disease progression is tough to differentiate from disease that was present but not identified. I would focus more on what was known to the physician when the treatment decisions were being made. In your example the cM data item would be cM0 since the physician did include distant mets as they developed their initial treatment plan (surgery). After surgery, they found distant mets via clinical means. The physician knew this as they developed their treatment plan for adjuvant treatment.

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Q10: ­How do you address the situation where surgery is done emergently and workup is not done until after surgery? ­

A10­: If they do surgery that meets the criteria for the pathologic stage prior to assigning a clinical stage, then the information collected after the surgery would be used to assign the pathologic stage.

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Q11: ­In the Melanoma presentation, I remember you showing a pT in the clinical staging. Is this still correct? ­

A11­: No. The initial excisional biopsy would be a cT. A pT would be assigned when the wide excision was done.

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Q12: ­If a patient doesn't have adjuvant treatment, how long after surgery does imaging count for pathologic stage? I.e. imaging that finds mets after surgery­

A12­: In most cases information can be used up until the time the patient starts adjuvant treatment. If the patient doesn’t get adjuvant treatment, then you would stop with collecting information starting about 4 months after date of diagnosis.

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Q13: ­On your in-situ slide (maybe slide 34) there is a statement on the 2nd bullet which states entire tumor must be removed. However, I think this should read that there is histologic confirmation (i.e. biopsy) is enough to code a pTis. Am I correct in this?

A13­: Good point. What I meant by that statement was the entire tumor must be removed to assign a pTis in the pT data item. A pTis can be entered into the cT data item

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Q14: ­Why wasn't the esophagus example a clinical TX? Only imaging was done. ("downstaging example")­

A14­: The T value is based on depth of invasion and the ultrasound did show depth of invasion into the esophagus wall. Are you concerned that a biopsy was not documented? . In the slide on downstaging I was just giving a very brief example of when the “downstaging” concept would be applied so I left out some of the detail you would expect to have in that situation. However, a clinical stage can be assigned without histologic confirmation for most sites. If for some reason the physician did scope with ultrasound or some other imaging that gave enough detail to assign a value but did not biopsy the tumor, a clinical stage could still be assigned.

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Q15: ­On slide 20, can you give an example of this scenario. Wouldn't we have at least a clinical T or M value in order for the patient to have a diagnosis of cancer? Please explain when all values being blank with stage grouping of 99 would be valid. ­

A15­: I think that graphic would have been clearer if I would have separated the clinical stage and pathologic stage. We wont to apply the “have the rules for classification for T been met” concept to the clinical stage and pathologic stage independent of each other.

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Q16: ­From a central registry perspective can we add that any change to the physician record be noted in the remarks/comments section with justification for registrars decision­

A16­: Great point! We have ignored the importance of text and justifying the codes you enter into the abstract! This is very important at both the hospital registry and the central registry. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q17: ­If you have clinical stage and enter the case without path - then get path later with info for distance mets should we change clinical M? ­

A17­: It all goes back to what the physician making the decisions knew before treatment and what they knew after surgery. If you find out that the physician knew the patient had distant mets as they developed the treatment plan, then you would update the clinical stage. If the physician did not have that information prior to treatment, then you should not update the clinical stage.

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Q18: ­On the lung example of physician staging; looking at the `big picture' and what treatment was given; assists the CTR with assigning stage for LN category.

A18­: Excellent comment. Professional cancer registrars are expected to have a basic understanding of how cancer patients are treated in their facility based on stage of disease. They need this information to make informed decisions in these situations.

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Q19: On pop quiz 4, could we use a cN0 in the pN?

A19: No. We do not have an exception in the rules for classification that allow us to use a cN value in the pN data item.

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Q20: ­On Quiz 4, the last comment about using C-M0 in the path staging. You said the pM and pN can't be blank. Just want to confirm if there was a pM but pN was blank, then you can't use the cM0. Am I thinking correctly? ­

A20­: You are thinking correctly. You cannot use a pM value in the pM data item because there was not histologic confirmation of distant mets. You can use a cM value in the pM data item because we met the rules for classification for the pT. If the rules for classification for pT had not been met, then pT data item would be blank. If pT data item is blank, then we cannot use a cM value in the pM data item.

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Q21: on Quiz 4 I did not mean to say cM, I wanted to confirm if there was a pT but NOT pN then can we use cM?

A21: If we meet the rules for classification for pT, then pN should not be blank. You should **not** run into a situation where the pT has a value (X, 1, 2, etc) and pN is blank. In fact, there will probably be an edit in the near future, that checks pT. If pT data item has something entered (X, 1,2,etc), the pN data item cannot be blank, and the pM data item cannot be blank.

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Q22: ­CT brain said "highly suspicious" for mets. Isn’t it not appropriate to use ambiguous terms for AJCC staging?­

A22: Ambiguous terms cannot be ignored. They have to be part of the decision making process you use to determine what code should be assigned. I did not automatically decide based on the term “highly suspicious” that what they saw on the imaging was brain mets. However, it did push me in that direction. When I combined that with the fact the patient had radiation to the brain, I was able to assign a cM1 with confidence.

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Q23: ­Pop Quiz 7 - Is the cM1a given because it was suspected prior to treatment? I thought we could only have one type of M- can you not bring the pM1 up to the cl staging­

A23­: I think that is a common misconception. One way to think about it is that for distant mets the c or p reflect whether or not the distant mets was pathologically confirmed. A cM means the distant mets was not confirmed pathologically. A pM means the case was confirmed pathologically. What we enter into the cM data item reflects what the physician knew prior to treatment. What we enter in the pM data item reflects what they know after surgery, but before adjuvant treatment.

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Q24: ­Pop Quiz 9 - curative surgery performed followed by liver mets on CT - explain why it is not progression as it was not suspected prior to 1st course treatment. Chemo was not anticipated at time of plan to go to surgery (assuming negative margins and negative ln's.­

A24­: Progression indicates the disease has grown/advanced between the time of diagnosis and the time the stage was assigned. If they had done a CT prior surgery that showed the liver was benign, and then did another CT after surgery that showed liver mets, you might have an argument for disease progression. However, I would tend to think that in that situation they really just missed liver mets on the initial imaging. In our example the patent did not have imaging prior to the definitive surgery. We would assume the liver mets had been there prior to surgery, it just had not been identified.

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Q25: ­On Pop Quiz 9, if the pT or pN had been blank then the liver mets would not be recorded anywhere in the TNM staging? ­

A25­: Correct. If the pT is blank, then we cannot use a cM value in the pM data item. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q26: ­In #9 how did you get the PM value? We have no other information but highly suspicious for mets­

A26­: I based it on the information from the CT. In my professional judgement I felt the physicians thought the patient had distant mets.

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Q27: On quiz 12, shouldn't the clinical staging be blank since a biopsy was not done. It did not meet the criteria for clinical staging.

A27: Unless there is an exception listed in the chapter Rules for Classification, you can assign a clinical stage without histologic confirmation for most sites. A diagnosis of cancer and some sort of staging w-up is all that is required for clinical stage.

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Q28: ­For Quiz 13, can you explain again why the clinical T is pTa if the TURB is clinical­

A28­: Don’t over think this one. It’s the same concept as pTis. cTis and cTa are not valid values. Where we would normally enter a cTis or cTa, enter pTis or pTa.

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Q29: ­In the pop quiz #16, the rule #1 said: Microscopic confirmation: All cases should be confirmed microscopically for classification by TNM page 13 Handbook Manual­

A29­: Notice the word “should”. It is preferred that cases have histologic confirmation, but a stage can still be assigned without histologic confirmation. A researcher would want to analyze those cases separately from cases with histologic confirmation.

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Q30: ­On pop quiz 16. Why would the clinical N not be cN0 instead of cNX?­

A30­: This comes down to professional judgment. Donna Gress noted on a recent lung staging webinar that X-ray is not a good tool for determining lymph node involvement. This is confirmed by information in the TNM Staging atlas. Also, the term lymphadenopathy just means the lymph nodes are enlarged. I didn’t feel there was enough information to assign a cN0.

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Q31: ­As was briefly mentioned kidneys are removed but rarely are nodes removed. There was reference to the general rules for classification. Could you provide more specific direction to correct coding rule? ­

A31­: Statements like that are difficult to translate into a rules for assigning T, N, and M values. AJCC does not interpret that statement has meaning the there is an exception that would allow us to use a cN value in the pN data item. However, if you look at the stage tables, you can see that if the pT is a 3 or 4, we can assign a stage group regardless of the N value (including pNX).

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Q32: ­can you show pop quiz 20 again please­

A32­: Pop quiz 20 is a patient with a primary brain tumor. Even though there is a chapter for central nervous system in the AJCC manual, they have not defined T, N, M or Stage groups for this site. That means enter 88’s into these data items.

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Q33: Jim could you include the answers to these pop questions when you send the info later? Curious minds want to know....­

A33­: Will do!

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Q34: ­would you explain ambiguous terminology a little more and AJCC, please.­

A34­: Sure. My interpretation of what AJCC is saying concerning ambiguous terminology is that we cannot just default the codes we assign based on the ambiguous terminology list we used with collaborative stage. With collaborative stage if we saw an xray with the term suspicious for lymph node metastasis we would automatically code the lymph nodes as involved. If we saw the term possible lymph node metastasis, we would automatically code lymph node metastasis as negative or unknown. I think what AJCC is saying is that we have to take these terms in context. They want registrars to look at the source of the report (x-ray, CT, MRI, etc). They also want the registrar to look at other staging source and to look at how the patient was treated. They want the registrar to look at the big picture and do their best to indicate if the physician thought the patient had metastasis.

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Q35: ­Prostate Case: If you have a T1, N0, M0 but don’t have a PSA or Gleason, can you stage it as stage 1 using T1-T2a, N0, M0 PSA X Gleason X?­

A35­: We got a clarification on this during the webinar from AJCC. The PSA X and Gleason X were put there for physicians in developing countries that don’t have access to these tests. For us, we would need to know the values to assign a stage group since the results of the tests could change which stage group is assigned.

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Q36: ­Where can registrars find written instructions stating items should be left blank rather than having X assigned? The AJCC manual should contain standardized instructions that ALL users must follow in order to obtain standardized results for all reporters.­ All education venues for AJCC staging should cite the exact place anyone can find the authoritative source supporting all coding instructions. Currently, registrars have a hard time finding specific written instructions.­

A36­: The AJCC website has a presentation on Explaining Blanks and X, Ambiguous Terminology and Support for AJCC Staging <http://cancerstaging.org/CSE/Registrar/Pages/Presentations.aspx>. Resources for assigning and entering TNM stage are very disjointed. At this point he burden is on the registrar to stay on top of instructions distributed through AJCC Training materials and the CAnswer forum. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q37: ­Can you show the answers for colon again please. Not sure why TX with a biopsy and exam?­

A37­: They had a diagnosis of colon cancer and they did a work-up, but they didn’t have enough information to assign a T value. Therefore, TX is appropriate.

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Q38: ­In the melanoma example if T2a and T2b fell in the same stage group could we assign a Stage group without knowing whether it was a or b?­

A38­: Yes.

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Q39: ­Slide 63 Melanoma Case - sentinel node biopsy showed micro mets should would the path N = pN1a?­

A39­: Yes…I goofed! pN should be pN1a based on the sentinel node biopsy. The stage group would then be 3A.

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Q40: ­WHAT ABOUT SUBCATAGORIES FOR BREAST CASES?­

A40­: Since subcategories for breast aren’t even listed in the stage group tables, the subcategories are not required to assign the stage group. Every effort should be made to include the subcategories with the T, N, and M categories but if they are not available, a stage group can still be assigned.

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Q41: ­can you show answer to quiz #1 question #1 again? ­

A41: ­cM is cM0 and pM is cM1a. Mets was not identified prior to treatment. Metastasis was found after treatment, but was never pathologically confirmed­.

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Q42: ­Question on Quiz 1 #3, why were pT and pN blank? Pg257 of manual, "if highest T and N categories OR the M1 category of tumor can be confirmed microscopically, criteria for pathologic classification & staging have been satisfied w/o total removal of primary­ cancer" Also table 1.7 M classification rules row #6.­

A42­: The statement you refer to gives us permission to assign a pathologic stage group based on the pathologic confirmation of distant mets. Since the primary tumor was not removed, the rules for pT had not been met. If we don’t meet the rules for classification for the pT, then the pT and pN data item are blank.

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Q43: ­On quiz one question 3 you had pathological M and on page 256 rules of classification it states a thoracentesis is clinical­.

A43­: We confirmed this with AJCC. The malignant cells that were identified from the pleural effusion are enough to classify this as a pM1a.

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Q44: ­I thought in quiz 1 question #3 the pM would have to be blank because pN and pT are blank. Please explain. ­

A44­: When the pT is blank, we cannot use a cM value in the pM data item. We can always use a pM1 or higher in the pM data item if the distant mets was pathologically confirmed. If the pleural effusion had only been seen on imaging and they didn’t do the thoracentesis, then we could not use the cM1a in pM data item. Pathologic stage would have been pT blank, pN blank, pM blank, stage 99.

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Q45: ­Quiz 2, Case 1 for path stage group do you need a Gleason from the prostatectomy? The only Gleason on this example was from the biopsy.­

A45­: Normally, we would expect to see the Gleason from the prostatectomy. However, I am not aware of a rule saying we cannot use the Gleason from the biopsy of the Gleason from the prostatectomy is not available.

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Q46: ­Quiz 2, Case 1 -- Where did you get cN0? ­

A46­: This is tumor that is so small in cannot be felt on the DRE and they are treating it like localized disease. That is enough to say this is a cN0. This is similar to the inaccessible site rule we used in CS.

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Q47: ­On quiz 2 case number 2, I used the sarcoma chapter to stage the case based on page 291 statement that chapter can be used to stage sarcoma of organs.­

A­47: I goofed again!!! You are correct you should be able to use the sarcoma chapter for this example. You cannot assign values based on the Kidney chapter.

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Q48: ­Quiz 2 case 4, path stage - per notes on p99 stage should be assigned independent of previous clinical or biopsy information. Why is pT2a instead of pTa? ­

A48­: See that note below from the CAnswer forum.

<http://cancerbulletin.facs.org/forums/node/6655>

The phrase "independent of" is just a caution that you must use caution in incorporating the clinical stage information, for example you should not use the clinical stage if that information has been disproved. For that example, in the clinical staging statements on page 498 of the AJCC 7th edition manual, it talks about thickening, a mobile mass, a fixed mass and other situations that would suggest T3 and/or T4 disease, but upon resection it may be found that this was due to inflammation or other reaction to the tumor and not actual involvement with cancer, so it may be a T2 for the pathologic stage classification.

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