# Q&A Session for Directly Coded Cancer Stage…NOW

Thursday, December 3, 2015

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Q1: ­Will there be an expansion of fields for reporting pre & post treatment AJCC staging.

pre-tx cT2 cN0 pM1, stg IV

post-tx ypT3 ypN0 ycM0, Stg IIA

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A1: No. We will continue to identify patients that had neoadjuvant treatment prior to surgery by using the data item TNM Path Descriptor. We don’t currently have the capability to add the y to the T or N category.

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Q2: ­How would you know if the mets were pathologically confirmed prior to or at surgery?­

A2: If you have a clinical stage group of IV and the cM is blank and the pM is 1 (or higher), then you know that the pM1 is being used to calculate the clinical stage group. The main point is that the physician knew prior to any treatment that the patient distant mets. By leaving the cM blank and entering the 1 in the pM data item we are showing that the physician knew the distant mets was histologically confirmed.

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Q3: ­Are we thinking correctly.....if a radiology states "susp for mets" and then the bx....we are to leave the cM blank? We took the cM blank if the radiology stated "worrisome" and then they biopsy. So my question that needs to be confirmed If a bx of mets is ever done.....we are to always leave cM blank?

A3: First thing to remember is that clinical stage group is based on what we know before surgery and pathologic stage group is based on what we know after surgery. For clinical stage group we want to document the most definitive method used to confirm the distant mets. In the case you described above there was confirmation via imaging and via histologic confirmation. The histologic confirmation was the most definitive method of diagnosis. Therefore a pM1 is going to be used to calculate the clinical stage group. Currently, the only way we can show that the confirmation was based on histologic confirmation rather than imaging or “clinical” means is by leaving the cM data item blank. Leaving it blank and having a stage IV in the stage group implies that the value being used to calculate the stage group included a pM1. We can do this with the M category based on the rule on page 11 Table 1.7 row 6. In the future we will be able to enter a pM1 in the cM data item so this will be much clearer.

Also, there is no ambiguous terminology for AJCC staging. So a statement of suspicious for mets or worrisome for mets does not guide whether or not we assign cM. In the AJCC Staging Manual pg 10 it states “Cases with clinical evidence of metastases by examination, invasive procedures including exploratory surgery, and imaging, but without a tissue biopsy confirming metastases are classified as cM1.” So the answer to your question according to the manual would be yes if you have histologically confirmed metastatic disease then you would leave cM blank.

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Q4: ­In order to assign pM1 mets, does surgery have to be performed or can you use Bx only?­

A4: No surgery does not need to be performed. See AJCC Staging Manual pg 11 “Pathologic staging depends on the proven anatomic extent of disease, whether or not the primary lesion has been completely removed.”

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Q5: ­To confirm lymph node involvement, can you explain the difference between removal and bx/ c vs. p? ­

A5: The difference really has more to do with when the information is available than what procedure was done. For example, if a sentinel node biopsy is done for a breast primary before an excision of the primary tumor, we are still in the Clinical time frame. That information will be used to determine the primary treatment. Therefore we can use the information from the sentinel biopsy to assign the clinical stage (and the pathologic stage…we’ll cover this in detail during our Breast webinar in February). However, if the sentinel biopsy is done during the surgery or after the surgery, the clinical stage should have already been assigned. The information is not going to be used to determine the primary treatment. Therefore, we would include the sentinel lymph node information in the pathologic stage group and not in the clinical stage group.

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Q6: For lung example where supraclavicular node was bx+ ­­Wouldn't N be X? Criteria met, but stage unknown/not staged because no path T­

A6: I believe you are referring to example 3 on slide 34. For lung the rules for pathologic classification require the primary tumor to be removed to assign a stage group. If you look at table 1.6 row 4 on page 10 you can see that if you do not have a pT you cannot have a pN. Therefore, you would leave the T, N, and M blank.

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Q7: ­Question on referring to staging lymph nodes based on Table 1.6 on page 10. For example, a prostate case. The patient has a prostate bx done that is positive. Then the patient goes on to have only a lymph node dissection and no prostate surgery. The ln dissection is positive. Based on my understanding from table 1.6 you cannot assign a pathologic N? ­

A7: The key word is assign. Even though we have met rules for classification for the pN category, we have not met the rules for classification to assign a pathologic T category. According to the rule in Table 1.6 we cannot assign a pN if we don’t have a pT. Therefore, we leave the T, N, and M blank when entering our stage data.

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Q8: ­thanks! On the last colon case, slide 35, couldn't you have the pT1 actually phantom to the cT to get a stage of I instead of both being 99??­

A8: No. Once they did surgery to remove the primary tumor we moved from the pretreatment stage (clinical stage) to the post-surgery stage (pathologic stage). Before they removed the primary tumor they didn’t know this was a T1 so we can’t use that information to assign the clinical stage.

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Q9: ­For that colon example where physician stated T1N0M0 stage I; shouldn’t path stage be T1NXM\_, Stage I instead of stage 99? We had a question to Donna about his a couple weeks ago and I think this is how she handled it­

A9: From what I understand a pN is required to assign a pStage. There may be some exceptions, but I am not aware of any for colon. Let me know if you find something different! Donna Gress from AJCC is the definitive authority so we will go with what she says. I just want to make sure we are all talking about the same thing.

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Q10: ­In rules for classification indicates rules for N have been met, but the rules for T have not... why in example 4 in cT is X and not blank. T and N have been blank with this rule. ­

A10: The colonoscopy was enough to meet the rules for classification. However, the colonoscopy does not give us enough information to assign a T value to the cT category. Therefore, the value we enter is X. An X is used when the rule for classification have been met, but we don’t have enough information to assign a value. Since we met the rules for classification for T we can assign the N. The CT was good enough to make the N and M data items 0’s.

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Q11: ­looking at slide 40, if my facility did the bx only - please explain the staging process­

A11: It could be different based on the rules for classification for the specific site. For breast removal of the primary tumor is all that is required to meet the rules for pathologic stage group. Therefore, we have enough to assign a pathologic stage. If all your facility did was the excisional biopsy, then you would have a pTis cN0 cM0 Stage 0 for both your clinical and pathologic stage.

If the primary site was bladder, you would need either a partial or full removal of the bladder to meet the rules for pathologic classification. If all your facility did was a TURB, then you would assign a pTis cN0 cM0 clinical Stage 0 and pTis pN cM0 pathologic Stage 99.

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Q12a: I thought on one of the AJCC Webinars we were told that the M element was not coded in both c and P, and the P overrode the cM no matter when the M1 was found. Doesn't slide 26 disprove slide 27? How can there be a cM1 coded?

A12a: Several people have said the same thing so I sent it to the Canswer forum.

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/education-developed-by-partner-organizations/naaccr-webinars/60569-coding-distant-mets-found-during-or-after-surgery>

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Q12b: How is the example in Quiz 2 #1 different from slide 27. I really don't think it is and there should not be a cM1 in slide 27.

A 12b: The difference is what was known when. In slide 27 the best information available before the definitive treatment was based on clinical information (imaging, palpation, etc). Therefore, the cM1 would be used. The histologic confirmation didn’t come until after the definitive surgery was performed.

In Quiz 2 question 1 the patient had histologic confirmation before any treatment was done. Therefore, the clinical stage group IV was based on histologically confirmed distant mets.

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Q13: ­Slide 43 pTis stage 99 and CStage 0is leaves us with the issue of how to code staging basis. Our software uses that field to pull the best stage for data analysis, and with all the Stage 99's we will have a lot of data that yields little information. ­

A13: I think that is going to be a very real issue for most cancer registrar. I don’t have an answer at this point. All I can say is that the only way this is going to work is if we are all coding consistently. If we are all coding consistently, I think we will be able to find a way to address these issues. If everyone is going a different direction, it will be very difficult to find a standardized solution.

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Q14: ­Slide 40 - What staging basis should be used? cStage is not correct, but pStage 99 tells us nothing about the pT value.­

A14: Please see my response above. I think we are going to have to rethink how we evaluate this data. However, I think the the only way we will be able to find a solution to this issue is if everyone is following the same rules for assigning stage.

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Q15: ­could you go back to slide 40 and explain the clinical & pathological again? ­

A15: First thing to remember is we can’t have a cTis. Second we have to keep in mind that prior to any treatment the physician thought the tumor was in situ. So we show that the tumor was in situ by leaving the cT blank, but assigning a stage group of 0. The only way we know that the cT data item has an in situ value is because of the stage group. For the pathologic stage, we supplement our information from before the surgery with what we found out from the surgery the surgery. So post-surgery we have a pT1b, pNX. We assign pNX because we met the criteria for pathologic stage, but they didn’t remove any lymph nodes. Since the pN is X and there is not distant mets that leaves us with a stage group of 99.

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Q16: ­ If the entire tumor needs to be examined to determine in situ (slide 38), how can you determine PTis from a needle bx (slide 40).­

A16: ­I know it seems to be contradictory, but you still have to reflect what stage the physician thought it was prior to surgery.­ However, this information can only be used to calculate the clinical stage. A needle biopsy would not meet the rules for classification for pathologic stage.

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Q17: ­I think my question got missed on example 4, slide 35, if the biopsy on colonoscopy had a statement on the pathology report "invades at least the submucosa" would that be enough to assign a clinical T1 and stage I?­

A17: In my judgement that would be enough to assign a cT. I would assign a clinical T1 N0 M0 Clinical Stage I.

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Q18: ­How can a CT BE BLANK IF THE TUMOR IS LATER FOUND TO BE INVASIVE? WE CAN USE THE PHYSICAL EXAM AND SCAN TO ASSIGN THAT CT, CAN WE NOT? ­

A18: *Remember AJCC has told us that cTis is not a valid value.* If this is referring to slide 40 the combination of the blank cT and the Stage group of 0 lets us know that the cT is “filled in” with the phantom value of pTis. If you have more information from physical exam or scan that refers to invasive tumor then you can use that information to assign the cT. For our example the only information we had was an incisional biopsy that was positive for insitu and no other evidence of regional or distant mets. The physician planned and performed surgery thinking the tumor was insitu.

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Q19: ­if you only have confirmed imaging of mets - please explain the staging process­

A19: If you don’t know the primary, you can’t assign a stage. T, N, M and stage group would be 88. Let’s say that you do know the primary site. If the only staging information you have is imaging showing distant mets, then the stage would be something like:

cT cN cM1 clinical stage IV

pT pN pM pathologic stage 99

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Q: ­Perhaps for a future presentation- I would find it helpful to understand the reasons for some of the rules. For instance, why does the rule that states you have to have path assessment of the primary tumor in order to code the pN exist? ­

A: Good point. I don’t know for sure, but I would imagine they feel that unless the rules for pT have been met assigning a pN may be misleading.

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Q20: ­I thought for melanoma that micromets is included as positive LN for clinical? ­

A20: The term “micrometastasis” is used two different ways in this chapter.

1. If you look on page 332 you can see the section titled *Nodes Positive for Defining Nodal Micrometastasis*. In this section they discuss the minimum threshold of metastatic tumor that must be present to assign an N1 or higher value to the pN data item. For melanoma they don’t have a minimum size. Metastasis measuring as small as .1mm would be assigned as N1 or higher in the pN data item.
2. If you look at the section on *Micrometastasis vs. Macrometastases* on page 331, you’ll see that micrometastasis means something different in this section. Here they are essentially dividing lymph nodes with pathologically confirmed lymph node metastasis into two categories. Category A are lymph nodes that were not detected prior to surgical excision. So the lymph nodes were not enlarged enough be detectable by palpation or imaging or some other non-surgical method. Category B are lymph nodes that were enlarged enough to be detectable by palpation, imaging, or some other non-surgical means.

As registrars we have to do our best to understand how the terms are being used.

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Q21: ­Lung example 2, I left pT, pN and pM blank based on the post <http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/education-developed-by-partner-organizations/naaccr-webinars/53467-tnm-edits-wg-biopsy-of-highest-t-category-for-pathologic-staging>­. ­Donna states "If you only have the highest T and no surgical resection with nodes for pN, then you leave ENTIRE path stage blank.­

A21: You are correct. Even though we met the criteria to assign the highest pT we didn’t meet the rules for classification for the stage group. The minimum standard for lung would be removing the primary tumor. This was not done so the T, N, and M should be blank. Stage group 99.

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Q22: ­melanoma-can't you consider no ulceration if not mentioned? ­

A22: No. We sent your question to the Canswer forum for confirmation.

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/education-developed-by-partner-organizations/naaccr-webinars/60565-melanoma-and-no-mention-of-ulceration>

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Q23: ­Scenario 3 Colon-wouldn't you consider the enlarged pericolic nodes involved-cN1? ­

A23: Since the physician didn’t give us much of an indication of whether they thought the enlarged lymph nodes were enlarged due to metastasis, it becomes a judgment call for the registrar. Angela and I didn’t feel there was enough information to assign a cN1. We also didn’t feel it was appropriate to make it a cN0. We felt we didn’t have enough information

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Q24: ­Could you please explain further how a sentinel of LN for melanoma would not be used to assign the cN category? ­

A24: See the response below from the Canswer forum:

*There is a special rule for melanoma that states the clinical stage N category is ONLY physical exam and imaging. Therefore a sentinel node biopsy is not used in the clinical stage. This was discussed with the AJCC Melanoma Expert Panel and they stated that it is not medical practice at this point in time to do a sentinel node procedure as part of the diagnostic workup, that it is done as part of the surgical resection.*

*Since all of the clinical stage information is used as part of the pathologic staging along with the surgical op findings and the surgery pathology report, the sentinel nodes would definitely be part of the pathologic stage, no matter when it was done.*

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/education-developed-by-partner-organizations/naaccr-webinars/60566-melanoma-sentinel-node-biopsy>

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Q25: ­I can never seem to find out where to post a question so I ask you. Do you have some directions to follow on how to post a question? ­

A25: Go to the Canswer forum <http://cancerbulletin.facs.org/forums/> Go to the specific forum where you want to post the question. If it is related to a NAACCR webinar go to AJCC TNM Staging then Education Developed by Partner Organizations then NAACCR Webinars and Edits Workgroup. When you get there click on the +New Topic button. This will create a window where you can submit your question.

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Q26: ­As an FYI-Autopsy stage is only assigned for patients who were not suspected or known to have cancer prior to death.­

A26: Thank you!

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Q27: Are you saying that if you don't have a bx of the metastatic site the pM data item cannot be coded if it was just a clinical mets dx???­

A27: Currently that is correct. For example, let’s say we have a patient that had a CT that showed a colon tumor and a metastatic liver tumor. The patient then had a colonoscopy that confirmed the colon cancer. The patient went on to have a segmental resection with removal of regional lymph nodes. The stage would be

cTX cN0 cM1 cStage IV

pT1 pM0 pM (blank) pStage IV

We would use the cM1 to calculate the pathologic stage.

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Q28: ­Clarification on in situ with clinical tnm. I thought on certain sites you could not code clinical tnm only a pathologic tnm? ­

A28: I can’t think of any sites that fit that scenario right now. However, it shouldn’t change how the information is entered.

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Q29: ­Pt had colon primary but it was incidentally found through an appendectomy making it a stage IV, the mets was removed from entire appendix, what is your pM, all prior treatment was Clinical ­‘

A29: That is an interesting one. I guess it depends on what they did with the colon tumor. If during the same procedure they went in and removed the colon tumor, then the clinical T, N, and M would be blank and the stage group would be 99 and pathologic stage would be based on whatever they found from the surgical resection plus the histologically confirmed mets (stage IV).

If they just removed the metastatic tumor and then closed the patient up, we would assign a pM1a or b which would be used to calculate the clinical stage. At minimum the clinical values would be cT (blank) cN (blank) cM (blank) cStage IVa or b. The clinical stage would be based on the histologic confirmation of the distant mets that was known before treatment was started. The pathologic stage would be based on surgical resection of the primary tumor and resection of the regional nodes. If no surgery was to the primary site was done then we would have a pT (blank) pN (blank) pM1 pStage IV. If surgery was done to the primary site the pT and pN would be based on those results, but the pM would be 1a or b.

This is based on my interpretation of the rules. I think it really comes back to “what did the physicians think prior to treatment of the disease” and “what did they know after surgical resection of the primary site”. I am not aware of any special rules related to incidental findings. If I missed anything, I apologize. As always, please defer to any rules or statements that come from AJCC.

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Q30: The “phantom values” infer using pathological for clinical staging? Where is the rule for this?

A30: This is a very good question. AJCC feels that it is important that people using the staging data know how the stage group was calculated. Using the current values that are available for the T, N, and M data items we cannot indicate if clinical values are being used to calculate a pathologic stage or when pathologic values are being used to calculate the clinical stage. To address this we developed the “phantom values” concept as a kind of work-around. If you have experience entering TNM data into the current data items you know that we show that a cM is being used to calculate the pStage by leaving the pM data item blank. We should have been using this same work-around to indicate that a pTis is being used to calculate clinical stage 0 and cN and cM were being used to calculate the pStage. However, we didn’t have an edit for this and the educational material addressing this issue had not be widely distributed. Now that CS is going away and more attention is being given to TNM more of these inadequacies with our data items are surfacing.

The “phantom values” work around is just temporary and plans are being made that will address this issue in the near future!

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Q31: ­Is the insitu exception only for DCIS (Breast) or any site w/ In situ disease..? ­

A31: It applies to all sites. Remember…cTis is not a valid value.

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Q33: Jim - because the pathological classification criteria for bladder was not met in the In Situ Bladder case, you have to assign a cTis. That comes from the Cancer Case Studies, Case #2 Bladder. This is an exception to the general in situ rule. ­

A33: cTis is not a valid value. I am not aware of any situation when it can be used. In the bladder situation there is an implied or “phantom” pTis being used to calculate the clinical stage group. Even if the cT and pT data items are blank, we would know this because we have a stage group of in situ. The fact that cT is blank and you have a stage group of in situ means that pTis was used to calculate the stage group.

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Q36: ­Pt has a breast or prostate BX followed by surgery with no LN removal. No imaging on file. What is the clinical N? ­

A36: If you meet the rules for classification for cT then I would probably go with cTX cNX cM0 Stage 99. If I had more information about the cT I might change the N value. If I knew the cT was small and localized, I might use the “inaccessible site rule” and assign cN0.

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Q37: ­I am a little confused...if you don't have ANY information on the lymph nodes or mets, are you not supposed to use an "X" for unknown rather than the 0, which to me means "none"?­

A37: That is a complicated question and really depends on lots of different factors. Let’s assume you are talking about clinical stage. For M “X” is not a valid value. The cM or pM data items can only be blank, 0, or a valid value such as 1, 1a, 2. Etc. for a cM we assign a 0 unless distant mets is present. For cN there are lots of factors such as if the rules for classification have been met, the T value, and the M value.

If you can assign a cT value and the physician is treating the case like it is localized, I would assign a cN0 even if no imaging or other clinical information was available concerning the lymph nodes.

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Q38: ­Example 4 can you over-ride pT1 pNx cM0 stage group 1 if the dr. states so instead of stage group 99? ­

A38: It is the registrar’s responsibility to make sure that the information entered into their database and sent to the NCDB or their state registry has been assigned using the correct rules. If the registrar sees that a pStage was assigned, but it did not meet the rules for classification then the registrar should correct it in their registry software.

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Q39: ­Example 2 and 3 if everything in pT, N, and M is blank shouldn’t the stage grouping be blank not 99?

A39: This is where we move from the AJCC rules/logic for assigning stage to the CoC and other standard setter’s rules for entering data. If we were just following the AJCC rules/logic for assigning stage, you are correct the stage group would also be blank. However, for various reasons related to evaluating data the standard setters have all agreed that they do not want the stage group to be blank. If a valid stage group cannot be assigned then the default value should be 99. If the site/histology is not included in the AJCC manual, then the stage group should be 88. CoC has not allowed blanks for the clinical stage for several years. Beginning with 2015 cases neither the cStage or pStage can be blank.

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Q40: In example 7; why use 88 for stage group instead of stick with 99?

A40: 88 means not applicable. Even though CNS has its own chapter in the AJCC manual, the chapter does not include T, N, M or Stage values. Since there are no values that apply, we use code 88.

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Q41: TNM descriptor --- what should it be if the stage group is blank, 88, or 99

A41: I’ll look into this some more and address it on a future webinar. For now I would use code 9 unknown. Good question.

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Q42: ­I don't think we've had this specific example but are the phantom values to keep the c and p stage group the same? This is the case in each example. ­

A42: We use the “phantom values” to show when a clinical value is being used to calculate the pathologic stage or when a pathologic value is being used to calculate the clinical stage. With the limited values we have to work with it was felt this was the best work around currently available. In the near future we should have a more robust selection of values to work and so won’t need to use “phantom values” to show how the stage is being calculated.

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Q43: ­colon example 1: How do we know that it is a clinical M0? The patient went elsewhere for work up and treatment.­

A43: clinical MX is not a valid value. The only evaluation necessary to classify a case as clinically M0 is history and physical examination according to the AJCC staging manual pg 10. The only way we would code M1 is if we know for sure that there are mets. In our example we do not so we default to M0

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Q44: ­Can you give us your perspective on when to us an X VS blank Vs 0­

A44: Below is a stripped down explanation. I would highly suggest reviewing the slides available from AJCC at <https://cancerstaging.org/CSE/Registrar/Pages/Presentations.aspx> for a complete explanation.

X means that we have met the criteria for classification, but we do not have enough information to provide a valid value. Blank means that we did not met the criteria for classification or that one physician may not have the information available to them. 0 means that we have met the criteria for classification and the result is that there were no regional nodes or distant mets found.

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Q46: Can you please add to the Q&A clarification for the positive LN biopsy when there is a pTx.

Can we code it cN1 at least or should it be cNx and pN\_ instead? It feels weird to not record the diagnosis for positive LN anywhere in the staging process. Thank you.­

A46: I’m not exactly sure which example you are referring to. In the example you describe we could use the positive lymph node biopsy in the cN if it was done prior to definitive surgery. If it was done during or after the definitive surgery of the lung, it could only be used in the pN. If the entire tumor was removed, but for some reason we couldn’t assign a valid value the pT would be X. In that situation I believe you could enter a 1 in the pN value. If the rules for classification have not been met and the pT is blank, then the pN must also be blank (see the rule on page 10 table 1.6 row 4 tells us that we cannot have a pN unless we have a pT.)

I agree that is does seem to leave valuable information unrecorded.

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