Collecting Cancer Data: Stomach and Esophagus

Q&A

Thursday, February 1, 2018

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Q: I think you should add under note 2 that is has to be from bx (not just assessed during clinical time frame).

A: Thank you for the suggestion.

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Q: There was wording in the 2014+ rules that stated you could take the grade from a contiguous site in the rare instance that you had a contiguous site. Is that not going to be the case with these rules since it isn't stated?

A: The same rule is in the general instructions for Grade (grade will have its own manual). It was not included in the site specific instructions we distributed for the webinar. Excellent question!

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Q: Will the new grades instructions ultimately be in the STORE manual?

A: I believe CoC will include reporting requirements and a link to the Grade instructions that will be posted on the NAACCR website in the STORE manual. CoC and SEER are making an effort to not duplicate instructions in manuals that are documented elsewhere (AJCC, SSDI’s, Summary Stage, etc).

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Q: If clinical grade is moderate, and after neoadjuvant the surgical grade is poorly diff, then do you change the clinical grade to poorly 2018?

A: No. Clinical grade is based on information available prior to any treatment. Information collect after treatment should not be included in clinical grade.

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Q: Quiz 1 question 5 choices a and b are the same?

A: Yes they are the same. So they are both correct

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Q: Is there a SS 2018 book that can be bought? Or is it all online?

A: A .pdf will be available on the SEER website at no charge. An online database with Summary Stage 2018 information will also be available.

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Q: What if distance is not staged for a C16.0 primary?

A: If no involvement of the EGJ, then assign code 0. If EGJ is involved, assign code 2. If the primary site is coded to C16.0, then the epicenter of the tumor should be within 2cm of the EGJ.

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Q: What if at surgical resection they remove lymph tissue but no nodes are found in the specimen? What should be assigned?

A: From what I understand, there must be lymph nodes to assign a pN value other than pNX.

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Q: For 16.3 is stage group blank or 88 or 99?

A: 16.3 refers to the AJCC ID that is used for histologies eligible for staging, but cannot be assigned a stage group using the table for Squamous Cell Carcinoma or Adenocarcinoma. The spreadsheet we looked at that listed all of the sites/histologies for each chapter are available at <https://cancerstaging.org/references-tools/deskreferences/Pages/8EUpdates.aspx>

The AJCC ID’s (they call them Disease Numbers in the spreadsheet) are what the computer will use to get you correct codes. I wanted to review the spreadsheet so you would understand that if you have a neuroendocrine carcinoma (8246/3) or carcinoma, NOS (8010/3) tumor of the esophagus, your computer would show you the codes for T, N, and M. However, the only stage group showing would be 88.

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Q: Which 8th Edition stage group table do you use if histology is adenosquamous?

A: It would be the squamous stage group table (AJCC ID 16.1). You can use the spreadsheet referenced above to see this.

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Q: Can Jim repeat the importance of the AJCC 8th Edition errata relative to the “AJCC ID” on slide 34.

A: The AJCC ID is a code generated by the computer that is used to tell the computer which AJCC codes to display in your pull down menus. The AJCC ID is based on the 8th edition chapter number. For chapters with multiple stage tables the AJCC ID has been divided into subcategories. For Esophagus (chapter 16 in 8th edition) there are 3 AJCC ID’s.

* AJCC ID 16.1 is assigned to site/histologies that should be staged based on the AJCC Prognostic Stage Groups for Squamous cell carcinoma
* AJCC ID 16.2 is assigned to site/histologies that should be staged based on the AJCC Prognostic Stage Groups for Adenocarcinoma
* AJCC ID 16.3 is assigned to site histologies that are eligible for staging, but cannot be assigned a stage group using the Squamous or Adenocarcinoma tables.
* AJCC ID 17 refers to the stomach chapter. There is only one stage table in the stomach chapter so there is only the one AJCC ID for stomach.

Registrars may never even see this data items on their abstracts. However, I think registrars should be aware of them and have a basic understanding of what they mean. I think it is helpful if registrars know that the first two numbers of the AJCC ID refer to the AJCC chapter number. The AJCC ID is used in some edit messages. If an edit message refers to AJCC ID 17, then the registrars knows they can check the table of contents on page xiii of the 8th edition manual and find that chapter 17 is the stomach chapter.

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Q: See AJCC 8th Edition, p. 26 - If complete pathologic response & ypTNM is ypT0ypN0cM0, no stage group is assigned?

A: That is the general rule. However, if a chapter has a stage table for post-neoadjuvant therapy and that table includes a combination for T0 N0 M0 and a stage group, then we go with what is in the chapter. Rules in the chapter take precedence over general rules.

Notice that the post-neoadjuvant table for esophagus (both adenocarcinoma and squamous cell carcinoma) include T0 N0 M0 Stage 1. The post-neoadjuvant therapy table for stomach does not include a grouping for T0. So a ypT0 ypN0 cM0 is a Stage 1 for esophagus, but a stage 99 for stomach.

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Q: The adenosquamous information can also be found on page 196 of the 8th Edition.

A: You are correct!

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Q: AJCC website have a great timeline chart that helps with knowing what info to include for clin/path/post-therapy staging.

A: I believe you are referring to

<https://cancerstaging.org/CSE/Registrar/Documents/Stage%20Classifications%20c%20p%20yc%20yp.pdf>

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Q: Quiz 2, case scenario 2, can cN be assigned cN0 from the "no lymphadenopathy" during CT?

A: Yes. I originally had cNX, but cN0 would be the appropriate code. Either way it is stage group 99.

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Q: Please explain clinical lymph nodes on quiz 2. Only 2 lymph nodes were sampled. Please explain. \* note below yellow lymph node box on AJCC page 109 \* Why is this not cN1?

A: I feel cN3 was appropriate in this situation. The patient was found to have “enlarged lymph nodes”. Of those, 8 measured greater than 1cm. Even though they only biopsied 2 of the lymph nodes, I felt the physician was saying that they believed at least 8 of the lymph nodes were metastatic. I believe the number sampled and the number examined is for pN.

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Q: When both site descriptors are used for esophagus i.e. cervical esophagus and upper 1/3 which code should be used?

A: Assign the code that would fit the description of the location of the tumor described in the medical record. So for example if EGD was done and impression was tumor located at 17 cms. I would code C15.0 Cervical esophagus. If it stated that tumor was located in the proximal esophagus i would code to code to C15.3.

In the ICD-O-3 on pg 23 it states “The terms cervical, thoracic and abdominal are radiographic and intraoperative descriptors; upper, middle, and lower third are endoscopic and clinical descriptors.”

Another note in Collaborative Stage suggests that we should code the location of the primary tumor according to the terms in the medical with priority given to radiographic and intraoperative descriptors (cervical, thoracic and abdominal) over endocscopic and clinical descriptors (upper, middle and lower third).

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Q: If a patient has a positive biopsy in 2017 and has the staging work-up, and then has surgery in 2018, do we clinically code the biopsy using 2017 AJCC and the surgery using 2018 8th Edition?

A: Which manual you use is based entirely on date of diagnosis. If the case was diagnosed in 2017, stage based on AJCC 7th edition. If it was diagnosed in 2018 use 8th edition. It does not matter when the stage workup was done or when surgery was done. Date of diagnosis is what determines what manuals we use.

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Q: If there is no biopsy of the primary site, and the imaging give a grade of the tumor, can we use the grade from the imaging report?

A: Not for esophagus or stomach.

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Q: On slide 48 pop quiz 6, I thought we only used the highest grade in coding path?

A: For 2018 cases that rule only applies to Clin and Path grade. Post-therapy grade in no way influences the Clin and Path Grade (grade prior to neoadjuvant treatment). For pre 2018 cases, we do not use the grade from tissue collected after neo adjuvant treatment.