Collecting Cancer Data: Thyroid and Adrenal Gland

Thursday, June 7, 2018

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Q: Does Hypo or hyperthyroidism affect the incidence of thyroid cancer? Are persons with these conditions more likely to be diagnosed with thyroid cancers?

A:From Recinda Sherman *“Some types of hypothyroidism is associated with an increased risk for thyroid cancer--Hashimoto's thyroiditis is an autoimmune disease that is a common cause of hypothyroidism and linked with increased cancer risk.*

*Hyperthyroidism is less clear, but patients with hyperthyroidism associated with Graves disease appear to have an increased risk.”*

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Q: As the manuals get updated, can we be assured all of the info in SEER\*RSA is updated at the same time? Is it 'across the board' changes as manuals are updated?

A: This is the response from Jennifer Ruhl at SEER *“We are trying very hard to do this. Currently, SEER\*RSA is Version 1.2, and so are the SSDI manual, Grade manual, SS manual and EOD manual. It is hard to keep everything in sync, but we are certainly making an effort to do so. We do have some changes coming up, so there may be another version released. We will also have a change log so that registrars know what was changed.”*

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Q: Just to be clear for grade pathological - if clinical grade is higher, we code the clinical grade in the grade pathological field?

A: Correct. If the primary tumor is excised and the clinical grade from a bx prior to the excision is higher than the grade from the excised tumor, the clinical grade would be used in the pathological grade.

A: Page 29 in the Grade Manual Note 3: Assign the highest grade from the primary tumor. If the clinical grade is the highest grade identified, use the grade that was identified during the clinical time frame for both the clinical grade and the pathological grade.

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Q: Should the date be 1/1/2018. We are confused with the 1/1/2017. for the ICD -0-3 codes?

A: The rules for EFVPTC and NIFTP went into effect in 2017. It was felt this change should be included in the 2018 update.

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Q: We don't have slide 34, can we get that resent?

A: That was a clarification that wasn't made until after the slides were distributed. We will include the slide when we post them after the webinar.

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Q: For I-131 treatment volume, is that something registries should review after radiation conversion? Or will radiation conversion convert both '33' and '50' to the 2018 code when it is thyroid?

A: I doubt this is something that will be addressed in the conversion, but it would be great if would! Personally, i would not go back an change old cases unless instructed to do so by your cancer committee.

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Q: Would you only code the synthroid as treatment if the histology is follicular/papillary? Should it not be coded for other histologies such as medullary?

A: SEER Appendix C coding guidelines for thyroid- <https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guidelines_Thyroid_2018.pdf>

Do not code replacement therapy as treatment unless the tumor is papillary and/or follicular.

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Q: Hormone for medullary vs papillary/follicular.. should the former be coded per previous discussion?

A: Do not code replacement therapy as treatment unless the tumor is papillary and or follicular. Please refer to previous questions.

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Q: Since thyroid is included in the "other sites" and the general 2018 rules are not applicable for the "other Rules" wouldn't the slide about the ambiguous terms not being used for histology not apply yet (until 2019)?

A: That is correct. The slide about ambiguous terms are a new change for the Solid Tumor Rules but this is the note in the General Instructions regarding the Other Site groups and Melanoma:

The 2007 Multiple Primary & Histology rules will be used for cases diagnosed 1/1/2007 to 12/31/2018 for the following site groups:

* Cutaneous melanoma
  + Cutaneous melanoma site rules will be revised for 2019 implementation to incorporate information from the new WHO 4th Ed Tumors of Skin scheduled to be released in 2018
* Other sites
  + Primary sites excluded are: Rectosigmoid and rectum which are included in 2018 Colon rules; Peripheral nerves which are included in 2018 Malignant Brain rules
  + Other sites rules will be revised for 2019 implementation. The Solid Tumor Task Force has identified the need to expand the rules to include GYN, soft tissue, thyroid as well as other site-specific solid tumors

You will continue to use ambiguous terms for Other Sites and Melanoma groups. These groups are looking to be revised for 2019 Implementation.

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Q: Question 10, wouldn't grade path be D and grade post therapy be 9?

A: Quiz 1 Question 10: There was a CT scan done and biopsy that confirmed Anaplastic Thyroid Carcinoma. The Grade Clinical is Anaplastic or Code D. Surgery was not done so there was no removal of the primary site. Grade Pathological would be 9 “unknown”

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Q: Quiz 1 #14 should it be false since slide on thryoid survival only about 60% for distant stage?

A: Even though only about 60% of patients that present with distant disease survive 5 years, only about 2% present with distant disease. Patients with “non-distant” disease have close to 100% survival. True is the correct answer.

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Q: It's important to stress the difference in the codes for volume in radiation to NOT be confused with modality.

A: Good point. Volume is the area in the body being radiated and the modality is the type of radiation being used. The coding instruction we were trying to clarify was that volume for I 131 treatment should be coded to Thyroid.

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Q: On SEER\*RSA, it may be helpful to show how you can also search by psite & histo (useful when u r not sure of schema name)

A: The trick to using look-up is to format the primary site and histology correctly. Primary site should be entered with an uppercase C followed by three number (i.e. C341). The histology should only include the 4 numbers of the histology (i.e. 8041). Do not include behavior.

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Q: you can also search the histology codes in SEER RSA Histology table by doing Control F and typing the code if you know it.

A: Great tip!

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Q: Just FYI, those histologies are shown in the 3rd edition of AJCC Staging Manual Chapter 77

A: I’m not sure what printing of the AJCC manual you have. I do not all of the histologies for each chapter are listed in the topography and histology code supplement at <https://cancerstaging.org/references-tools/deskreferences/Pages/8EUpdates.aspx>

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Q: The SEER\*RSA search by psite & histo would have answered the question as well about what chapter to use for staging.

A: Correct. It is available at <https://cancerstaging.org/references-tools/deskreferences/Pages/8EUpdates.aspx>

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Q: For a T3 tumor, what are the tissues that can be invaded? Is there anything other than Gerota's facia?

A: For Adrenal Cortical carcinomas a T4 is one that is of any size that invades adjacent organs (kidneys, diaphragm, pancreas, spleen or liver OR large blood vessels (renal vein or vena cava). So any invasion that is not of those listed for T4 would be a T3 tumor.

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Q: On slide 58 histology codes 8690 and 8692 are not listed on page 919 table - should we still use chapter 77 for C755?

A: No. that was incorrect on the slide.

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Q: Pheochromocytoma NOS is a /0 benign behavior so we would need a statement of malignancy in the pathology report to code & abstract the case, correct? If the case is dx'd by radiology, do we assume benign?

A: Assume pheocromocytoma as not reportable unless you find something indicating it is malignant.

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Q: Thyroid histology-AJCC 8th Ed shows papillary as 8050. Are we no longer coding 8260? Is this included in ICD-O-3 updates or is this a typo in AJCC?

A: 8260 is a known errata and is already on the errata spreadsheet

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Q: For AJCC Chapter 77- What would you assign in the M field if you have Mets to the liver and lung, but not bone? m1B?

A: I would assign M1b, distant metastasis to only distant lymph nodes/liver or lung. M1a and M1b require mets to bone to be present.

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Q: On pop quiz 4 would the cN be cN0b because imaging only? There was no radiologic or clinical evidence of loco regional LN mets?

A: Yes! Good catch.

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Q: If a path report says high grade on thyroid cases, do we assume it's anaplastic for TNM AJCC?

A: This has been sent to SEER for clarification.

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Q: Case 1 - Shouldn't pathologic T be T2 (because tumor is not greater than 4 cm) ?

A: For case scenario 1 the largest tumor size is 4 cm in dimension. T3a is Tumor greater than or equal to 4 cm in greatest dimension limited to the thyroid

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Q: How much of this information will be included if any within STORE Manual?

A: The STORE Manual will include information in regards to treatment surgery codes, it will cover reportability for CoC facilities, but it will not include detailed information in regards to AJCC TNM staging, that you will need to refer to the AJCC 8th Edition Manual.

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Q: SINQ says not to use the code for papillary microcarcinoma. Does this still apply for 2018 cases?

A: Yes! What I said on the webinar was incorrect.

Remember we use the Multiple Primary and Histology Rules 2007 for Other Sites for cases diagnosed 1/1/2018. Here is the SINQ link: <https://seer.cancer.gov/seerinquiry/index.php?page=view&id=20110027&type=q>

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Q: When listing the surgery for the thyroid as a total thyroidectomy and they biopsy the regional LNs; is the LN surgery listed separately or in the current surgery? As I understand it in 2018 it is to be listed separately. Can you please clarify.

A: There are some new data items Date of Sentinel Lymph Node Biopsy, Sentinel Lymph Nodes Examined, Sentinel Lymph Nodes Positive that are required for Breast and Melanoma cases only. Otherwise you would use the Scope of Regional Lymph node surgery to code the surgery to the lymph nodes.

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Q: Scenario 2- Why was cT3a in path T on quiz 2?

A: That should be pT3a. Good Catch!

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