**Q&A Session for Collecting Cancer Data: Ovary**

**Thursday, June 6, 2019**

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**Q:** ­If a path report states "Per outside path, bil fallopian tube rcv'd embedded w/in ovarian cystic masses. CAP rec code as fallopian tube origin. Serous tubal intraepithelial ca present, supporting tubal origin." What would primary site be? ­

**A:** ­I would code to fallopian tube, take the CAP protocol. ­

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**Q:** ­Is there any priority order documentation for assigning primary site for these gyn cases? ­

**A:** In the SEER manual there are some site-specific coding guidelines for primary site coding in SEER’s Solid Tumor Guidelines, although Ovary is not listed as having any priority order. For ovary, we recommend that you look at the CAP or talk to the pathologist/oncologist.

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**Q:** ­Just to clarify - although common for ovarian cancer to not have clinical staging, this doesn't affect date of diagnosis (still able to use ambiguous terms, etc.) and would still code clinical tumor size (from exam, imaging, etc.)? ­

**A:** That is correct!

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**Q:** ­Case scenario #1 - would pT suffix be (m) due to bilateral multiple invasive ca? ­

**A:** Correct. Correction will be made on answer sheet

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**Q:** ­For the pathological T, the tumor involves the left ovary and left tube. Would this still be T1c3 or T2? Can you clarify how to stage when both tube and ovary are involved.?

**A: We got this one wrong on the webinar. Extension from the ovary to the fallopian tube or implants on the fallopian tube indicate a T2a.**

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**Q:** ­Question: On case scenario 1 leaving the Clinical TNM blank. On Pg. 10 of the TNM 8th edition all that is required is a Physical Exam by the Physician and imaging studies to come to a cM0. Shouldn't that at least be coded?

**A:** ­Prior to the surgery, they had not confirmed they it was an ovarian primary. Since we didn’t have diagnosis of ovarian cancer, we felt clinical T, N, and M should be blank.

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**Q:** ­Per SSDI released in Sept 2018 for "No Cytoreductive Surgery Performed" its noted as code 98 and not 97. Were there any updates from Sept 2018 published book? ­

**A:** Yes. This change was made in version 1.5 released on 2-22-2019. Code 98 was changed and “No Cytoreductive surgery performed was moved to Code 97. See the Change Log at <https://apps.naaccr.org/ssdi/list/>

Code 98 is only used if the field is not required.

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**Q:** ­Case Scenario 1 because we said we have not met criteria for Clinical Staging, can you code a Clinical Tumor Size?

**A:** We had the same question! We confirmed with SEER that clinical tumor size should be coded in this situation.

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**Q:** ­For case Scenario 1, why the TS was coded to 104 instead of 144? ­

**A:** Originally code 104 was taken as it was the solid component. A question was submitted to Ask a CTR and returned with the answer to take the largest size, so the answer will be updated to 144 for Clinical Tumor size.

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**Q:** ­On Case Scenario 3: Do we code the Omentectomy in Surgical Procedure to Other Site? ­

**A:** No. The omentectomy is part of the surgery code 57. Including it in Surgical Procedure to Other Site would be double coding.

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**Q:** ­Shouldn't the LVI be coded to 8? ­

**A:** In STORE ovary is stated to have a default of 8. However, after STORE was published it was decided by all of the standard setters that if LVI information is available for ovary, it should be coded. Edits will allow any valid code for ovary.

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**Q:** ­Jim where can I find the new update histology codes? Is it in NAACCR or SEER? ­

**A:** ­They are found on the NAACCR webpage under the ICD-0-3 Implementation guidelines. ­It's available at <https://www.naaccr.org/implementation-guidelines/#ICDO3> . They are also found on SEER's webpage - under Resources under Registry Operations tab - 2018 ICD-0-3 Updates­‑

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**Q:** ­If both ovaries are involved the MPH Rules M8 state multiple primaries. When staging the first ovary case how can you have T1b tumor limited to both ovaries? ­

**A:** Per rule M7 Bilateral epithelial tumors (8000-8799) of the ovary within 60 days are a single primary. Rule M8 would not apply.

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**Q:** ­Also, for Breast touch on Allred score. How should it be texted? ­

**A:** Allred score is a summary of ER or PR intensity and percent positive. Those are the values I would be sure to document in the text!

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**Q:** ­How do we add Phase 4 XRT with start and stop dates? ­

**A:** ­That is software dependent. Some software allows you to enter phase 4. Others do not. phase 4 info will not be transmitted to NCDB or your state registry. ­ The field Total Dose (#1533) includes all phases of radiation done for first course treatment, so while you won’t send phase 4 specifics to NCDB or a state registry, the total dose will include all radiation given.

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**Q:** ­What is the name of the procedure where the chemotherapy is given while the patient is on the operating table? They pour chemo into the abdomen and then tip back the table so that it travels throughout the abdominal cavity. ­

**A:** ­it is coded in timing sequence when intraoperative­

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**Q:** ­What is the name of the procedure where the chemotherapy is given while the patient is on the operating table? They pour chemo into the abdomen and then tip back the table so that it travels throughout the abdominal cavity. ­

**A:** Could it be Hyperthermic intraperitoneal chemotherapy (HIPEC) that you are thinking of. It’s where they heat the chemotherapy (cisplatin) and pump throughout the abdominal cavity. In looking up the procedure it appears the sureons physically rock the patient back and forth on the operating table to ensure the drug reaches all the areas of the abdomen. This would be coded depending on the number of chemo agents are used and the systemic sequence would be coded based on timing and if any other adjuvant treatment was done.