**Q&A Session for Bladder**

November 7, 2019

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| Question | Answer |
| 1. When synchronous tumors, and its single primary, what topo code do you use? | You should follow the priority order for coding the primary site. If all the tumors are within the bladder, this will most likely be C67.9 unless you know they are all in the same subsite, then code that subsite. |
| 1. Is micropapillary urothelial carcinoma always /3? | It is possible to have a noninvasive micropapillary urothelial carcinoma. |
| 1. For Rule M10, if the patient has a subsequent bladder tumor after a 3 year disease free interval and the new tumor is a squamous cell would this be a new primary? | Yes, assuming that the original bladder tumor was a urothelial carcinoma (8120/3) and there were no recurrences within those 3 years, M10 would apply and you would abstract a second primary. |
| 1. Doesn't the timing clock start over with the 2018 recurrence of IS on Quiz? I'm only questioning your note on the slide, not the answer. | The note was just a note for myself noting it had been more than 3 years between the first and third. You are correct that if we had gotten to rule M10, then the clock would have reset with the 2018 TURB.  The case is correct. We would not apply rule M10 to the 2018 case because it hadn't been 3 years. For the 2019 case rule M9 applies so we don't get to the timing rule. If we had made it to rule M10, it would not apply because (as you noted) the clock would have reset with the 2018 case. |
| 1. For pop quiz 7-2016 invasive followed by 2018 noninvasive followed by 2019 invasive. Agree that 2018 is not a new primary, but confused about 2019 invasive. Would you apply M6-invasive following noninvasive greater than 60 days & abstract a new 2019 primary or disregard the 2018 noninvasive because you already determined it's not a new primary? | We would if we hadn't already had the invasive urothelial carcinoma of bladder in 2016. Since we've already determined that the 2018 tumor wasn’t a second primary, we don't have to take it into consideration when determining if the 2019 case is a new primary. Bottom line is 1 invasive urothelial carcinoma of the bladder per lifetime. |
| 1. Could you comment on what surgical code (diverticulectomy) would be used for Pop Quiz 8? Would code 20 work, local tumor excision NOS? | I guess that depends. If they just did a biopsy, I would code it to dx staging procedure. If they removed the tumor, it would be in the 20 series. Either a 20 or 27. Probably 27. |
| 1. For quiz 9, is the histology 8120, or 8130? | For pop quiz 9, this would be a single primary using rule M7 and, using rule H8, the histology is coded 8130/2 for the noninvasive papillary urothelial carcinoma. We agree it will look odd that your histology does not match the T category (Tis) but it might be a good idea to document the details in text. |
| 1. Some path reports will state "muscle present", how do I assign stage? | You would need to be determine whether this means there is invasion into the muscle or just that the muscle has been sampled and there is no invasion in the muscle. Follow-up with the pathologist may be required. |
| 1. Can Iris review pop quiz #11? CAn post therapy have a stage group? If she used that chart, it would be stage IIIB. | Yes, this should be stage IIIB....another situation of changing the case between versions. |
| 1. Jim for slide with TURB do not forget to mention that almost just as common as a 27 is Code 22 which is used with fulguration to tumor bed. Although the code 22 is lower it is a more specific code and should be used over 27 when tumor bed is fulgurated. A lot of registrars miss this code. | Great tip! If the fulguration is done for hemostasis only though it is 27 only when stated to be fulguration to tumor bed is it coded to 22. |
| 1. How would you stage a micropapillary? OA or IS | Excellent question! We have submitted the question to the CAnswer forum. You can see the question and response at  <http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/education-developed-by-partner-organizations-ab/naaccr-webinars-and-edits-workgroup-aa/97395-micropapillary-carcinoma> |
| 1. Can you clarify path tumor size - where does it state that because of a TURP you can't take the path size? There seems to be conflicting info on whether path should be 999 vs taking the path size when neo therapy done. | I contacted SEER about that one and they said they don’t have a recommendation on how to code that situation. Since tumor size isn’t really used to assign stage, that coding path stage from a cystectomy that was done after a TURB is left to the registrar’s discretion. For sites where tumor size is used to assign the pathological stage, then the path tumor size should be based on how the size used to assign the pathological stage. |
| 1. Is it accurate that you can have a pathological tumor size AFTER neoadjuvant treatment? I was under the impression that if it was altered with chemotherapy before surgical resection that you could not consider that a pathological tumor size. | You are correct. Tumor size based on a surgically resected specimen taken after neoadjuvant treatment should be coded to 999. |
| 1. Case scenario 1 Lymph nodes examined is 32 where is the 29 coming from? | Although the pathology report indicated there were 32 lymph nodes examined, specimen #10 included 3 para-aortic lymph nodes which are distant lymph nodes for bladder. Therefore, only 29 regional lymph nodes were examined. |
| 1. Not sure if SEER would consider TURB in case 1 as surgery due to their rules about coding excision bx with positive margins-if margins macroscopically positive do not code as surgery; code as surgery if only microscopically positive. If margins positive, nos, don't code as surgery. We don't have a statement of margins here, only that lamina propria & muscularis were involved, inferring that there could have been further extent; obviously there was residual tumor or tumor regrowth. | We checked with SEER and they confirmed that a TURB would be considered a surgical procedure even if margins are positive. |
| 1. Path Tumor Size: Code the largest size of the primary tumor measured on the surgical resection specimen when surgery is administered as part of the first definitive treatment Note: This includes pathologic tumor size from surgery when there is neoadjuvant therapy. | Per a statement on the SEER SINQ Path Tumor Size should be 999 if the patient has neoadjuvant chemotherapy.  <https://seer.cancer.gov/seerinquiry/index.php?page=view&id=20190033&type=q> |
| 1. For lymph nodes - is common iliac regional or distant for bladder? | The common iliac nodes are considered the secondary drainage region for bladder BUT are still considered regional lymph nodes in AJCC. They are listed in the EOD Regional Lymph nodes. However, for Summary Stage 2018, a bladder patient with positive common iliac nodes is considered to have a Distant Stage.  Common iliac nodes are counted as regional for Regional Nodes Positive and for Regional Nodes Examined data items. |
| 1. you do not use clinical size for tumor size summary unless there is neoadjuvant therapy. | Registrars would disregard the tumor size for the cystectomy if the patient has neoadjuvant therapy. However, there are other situations where the Clinical Tumor Size would be the same as Tumor Size Summary. For example, if the patient did not have a cystectomy, Clinical Tumor Size would be the same as Tumor Size Summary. |
| 1. Summary Staging Manual has Common Iliac LNs listed as distant LNs. However, the SEER RSA has the common iliac LNs listed as regional nodes. Which manual are we to go with to code the summary stage? | The common iliac are listed under EOD Regional Nodes, but you can see that they derive a distant summary stage. You would code Summary stage as distant if common iliac nodes are involved. |
| 1. If BCG only given (no path sent in), would it be coded as Surg 16 AND in systemic as well? | You would code both! Seems like double coding, but that is the rule and has been the rule for very long time. |
| 1. For case scenario #2 - Can the information from the PET scan be used after surgical tx since it was within 4 months of dx ? | Yes! Since it was in the Pathological time frame and they didn't start adjuvant tx, it can be used. |
| 1. Can we use this in clinical staging ? | Once the surgery was performed, the window for clinical staging closed. All of the info after surgery is part of path stage only. |
| 1. Would the para-aortic nodes in the first case be coded in Surgical procedures of other sites? | Yes! Good catch! |