**Corrections and Q&A Session for SSDI’s an In-Depth Look**

February 10, 2020

**Corrections**

During the live session two examples were given that were incorrect.

1. In slide 23 referring to Schema Discriminator 1 an example was given where a patient had a tumor at the EsophagusGEJunction, but the epicenter/midpoint was not given. When the epicenter/midpoint of the tumor is not documented, the correct code for schema discriminator is 9. When code 9 is used for a primary of the EGJ, the case is assigned to the stomach schemas. The same example was used to for the data item Esophagus and EGJ Tumor Epicenter (Esophagus). However, that data item is only used for squamous cell carcinomas of the esophagus. Since the case would be assigned to stomach, we would not be coding Esophagus and EGJ Tumor Epicenter (Esophagus).
2. Quiz question 4. During the session we incorrectly stated the answer would be A. We based our answer on the rule that ER/PR percent positive could be assigned after neoadjuvant therapy. That is correct, but for this scenario there are other rules that take precedence.
   * ER/PR Percent Positive Note 2: *Code this data item using the same report used to record Estrogen Receptor Summary*
   * ER/PR Summary Note 7*: If neoadjuvant therapy is given, record the assay from tumor specimens prior to neoadjuvant therapy.*

In the quiz question we had results we could use for ER/PR summary that were taken prior to neoadjuvant treatment. Since those are the test results we would use to code ER/PR Summary, those are the same test results we have to use to code ER/PR Percent Positive. Since ER/PR percent positive was not included in those results, the most appropriate code is XX7. We would disregard the test results post neoadjuvant therapy. See question 20 for additional info.

**Quiz question 4 (corrected)**

Patient diagnosed with breast cancer. ER and PR positive, but no information on percentage positive. Neoadjuvant therapy done. Post neoadjuvant surgery states ER positive, 95%, PR positive 62%. How are ER and PR percent positive coded?

1. ER 095, PR 062 (original incorrect answer)
2. ER R99, PR R70
3. ER XX7, PR XX7
4. **ER XX9, PR XX9**

Q&A

|  |  |  |
| --- | --- | --- |
| # | Question | Answer |
|  | Is "greater than" equal to "at least"? | For SSDIs, the answer being given so far is that “at least” should be treated the same as “greater than.” In the SEER manual, this is how “at least” is treated for Tumor Size, and was the basis for this answer. As noted by one participant on the webinar, this is not how STORE provides instructions for “at least”  We will put this on the agenda for the SSDI work group to get a final answer on how this should be coded, and then have it implemented in the SSDI manual for the 2021 updates. |
|  | Will you be adding updated instructions on range codes for ER/PR for breast when ranges are stated differently than ranges on the table? | These instructions, which are provided in CAnswer Forum, were intentionally not added to the SSDI manual because we felt it would cause more confusion. These instructions are provided in the CAnswer Forum though.  Once the 2021 updates are finalized, will put this on the SSDI work group agenda to discuss this once again |
|  | It would be really nice to have the Allred tables in the SEER\*RSA. It seems that is one table that you have to remember the page number in SSDI manual to find quickly. Or possibly a link back to that manual/page from SEER\*RSA? | We are not able to have tables and links in SEER\*RSA, which is why these tables and/or links have not been previously added. |
|  | on a related note, would you please give advice for selecting a title for your post to aid in searchability. Specific is better. | That’s an excellent suggestion. We’ll discuss with the standard setters. I’m planning on addressing submission of questions on the Boot Camp Webinar. |
|  | Use caution - I asked in the STORE forum regarding "at least" being synonymous with "greater than" for tumor size summary and was told it is not. For example, CAP protocol specifies that DCIS is recorded by the pathologist as "at least \_\_\_ mm" | We will put this on the agenda for the SSDI work group to get a final answer on how this should be coded, and then have it implemented in the SSDI manual for the 2021 updates. |
|  | When you get clarifications and you know there is going to be an update in the SSDI manual, is there a place you can put them besides just buried in the CAnswer Forum? | We have discussed this before, but have not followed through. We will address this again and see if we can get something in place.  We have confirmed that we cannot “tag” specific issues that may be more important, or have them always at the top. |
|  | Why isn't option XX.6 for ER/PR percent available - for example ER is known to be positive but percent is unknown and range is unknown, therefore we have to code to XX.9 and this results in these cases being non-concordant in RQRS . | These should be coded as XX.7, which is test done, results not in chart.  As for RQRS, that is not a SSDI issue. This was not something that was implemented by us. You would need to contact CoC about this. |
|  | Can you clarify which code to use for the schema discriminator 1 esophagus for the epicenter if unknown? Slide 23 states 2 but I think Jen said to use code 9. | You would use 9. Slide 23 was not for the schema discriminator, but for the Esoph Tumor Epicenter |
|  | In future webinars please consider teaching how to find questions in CAnswer forum using the question number. When you get a pdf of slides you can't click on the link and it is hard to type out that long link. | Great suggestion! I’m adding the topic to next month’s boot camp webinar.  One tip…  If you only have the number, you can use this URL with the word "node" and it will locate the question URL <http://cancerbulletin.facs.org/forums/node/55860> |
|  | What if for stomach/GEJ, the midpoint is determined on the pathology report after neoadjuvant therapy? | If this is the only specific information you have regarding the primary site, then you can use the information from after neoadjuvant therapy |
|  | I see the midpoint listed on the path report. I look for that information pre-treatment on the scopes but do not always find it. | This information should be available on a pathology report, but not necessarily a scope. If the midpoint information is not available, then code to 9-unknown. The case will be assigned to the stomach schema. |
|  | LDH is also found more often under lactate dehydrogenase just as a tip when searching the EMR. | Great tip! The full name (which is included in the SSDI manual) is Lactate Dehydrogenase |
|  | When ER/PR is stated to be a "low positive" but the case is being treated as triple negative, do we continue to code as positive? This is causing additional cases to show as delinquent on RQRS due to these patients not receiving hormone therapy. | We are aware of this problem, especially since implementing the updated instructions for ER, PR and HER2 in July 2019. CoC is aware of this issue. Please contact CoC regarding this issue. The NAACCR SSDI work group does not participate in decisions regarding RQRS |
|  | Comment on clinical grade: I saw a newsletter from a central registry that instructed registrars to use path grade if clinical grade was unknown. | This is incorrect. You never use pathological grade in the clinical grade. If your clinical grade is unknown, or there was no clinical workup, then clinical grade would be unknown, even if there is a pathological grade available.  Please contact whoever sent this newsletter out and let them know this. |
|  | Question about Ipsilateral Adrenal Gland Involvement, Invasion Beyond Capsule and Major Vein Involvement, wouldn't you need a statement that microscopic margins were negative on the path report from the resection to be able to use the information from imaging to assign these data fields as 0? | Margins do not play a role in determining how this SSDI is coded. If the surgical pathology report states “confined to the kidney,” that is enough to code 0. |
|  | Fibrosis score slides: Cirrhosis without score is enough to code 1 but second slide says you must have histological exam to code 0 or 1. Do you have to have histo exam of cirrhosis to code 1 too? | If you have a diagnosis of cirrhosis based on pathological exam, use code 1.  If you have a diagnosis of cirrhosis based on clinical only (imaging), then use code 7. |
|  | If grade is stated as 'grade 3' for invasive breast do we assume its Nottingham and code as 3 or code as C? | Yes, you can use this to assign to code 3 |
|  | Would you please explain again how to determine the grade for undifferentiated pleomorphic sarcoma? Grade is based on the sum of differentiation score, mitotic count score, and necrosis score. When I look at the CAP protocol/my pathology report, I only had a differentiation score of 3. I do not have the other scores. | This question has been referred to SSDI work group, and possibly to the CAP Cancer Committee.  <http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/101225-grade-undifferentiated-pleomorphic-sarcoma> |
|  | Where can the EBV and HPV(p16) table be found? | In the SSDI manual, Head and Neck section |
|  | Question #4, I understand if we had no results prior to treatment but we know the ER/PR is + we just don’t have the values prior to neoadj tx so wouldn’t that make the answer XX9? | XX7 is probably the most appropriate code. This was discussed further after the webinar.   * The specimen used to code ER/PR Summary should be used to code ER/{R % pos. * Results that are available prior to neoadjuvant therapy take priority. * The ER and PR were positive in the specimen acquired prior to neoadjuvant tx, but the percent positive was not available, so they would be coded to XX7 Test done, results not in chart.   Unfortunately, when we were putting together the quiz questions we were looking at the individual data items (ER/PR % pos) rather than looking at all of the related data items as a whole (ER/PR Summary, ER/PR % pos, Allred).  In the quiz question the patient was ER/PR pos prior to neoadjuvant tx, but % pos was not given. ER/PR Summary would be coded based on the specimen acquired prior to neoadjuvant tx. The ER/PR % pos should be based on the same specimens used to code the ER/PR Summary Data Items. Since the ER/PR % pos was not given for those specimens, ER/PR % pos would be coded. We would disregard the specimen from after neoadjuvant tx.  If we had been abstracting a case and had already completed the ER/PR Summary data items, it would have been fairly intuitive that ER/PR percent positive should be coded based on the same specimen as we used for the ER/PR summary. That would have led us to the correct answer. |
|  | Question #4, the note 7 is from ER-PR Summary SSDI. Under the ER and PR % SSDI fields, this note is not there. This question refers to the %, not the summary. So, how would we know to use the post neoadjuvant therapy percentage? | For ER and PR percent positive, there is a note that tells you to use the same results that were used for ER and PR Summary. Note 7 under ER/PR summary tells you speciments acquired prior to neoadjuvant treatment take priority. Since the note is under ER/PR summary and ER/PR % pos is based on the same specimen used for ER/PR summary, there is no need for the same note to be included in ER/PR % pos. |
|  | Which SSDI were you referencing about dropping the last number? | HER ISH data items: Single Probe Copy Number, Double Probe Copy Number, Double Probe Ratio  This is listed in the rounding section and the individual SSDIs |
|  | We have a case where the report says both invasive and insitu, but does not specify which the oncotypedx score applied to. How do we code that in the oncotype dx risk level SSDIs? | Code to unknown since you are not able to determine which specimen it was run on |
|  | Can u please repeat when to use code 9 for esophagus in the Esophagus and EGJ Tumor Epicenter slide? | For Esoph Tumor Epicenter, code 9: Esophagus, NOS Specific location of epicenter not documented in medical record Specific location of epicenter not assessed or unknown if assessed |
|  | Do you code the PSA as 4.9 or as XXX.9 since PDA was > than 3 mos?" | You would code as XXX.0 |
|  | Can you code EOD? 120 - elevated PSA ; 300 Localized; or 999 Unknown | Yes, you can code EOD 120 (elevated PSA, no information on DRE) |
|  | Grade-Brain: Is that clinical grade only if no resection was performed? | If no resection was done, then the updated instructions would apply to clinical only.  You still need to meet the surgical requirements for the pathological grade. If those surgical requirements are met, then you can default the grade for benign tumors |
|  | Shouldn't Question 4 be xxx.7 Test ordered, results not in chart? |  |
|  | Question about grade - for morphologies that have an implied grade, is it appropriate to assign generic A-D grade when the AJCC-preferred grade is not documented? Examples would be 1) undifferentiated pleomorphic sarcoma, 8802/3, when mitotic rate and/or necrosis is not assessed, or 2) poorly differentiated thyroid carcinoma 8337/3, 3) undifferentiated carcinoma 8020/3 …. or are these coded to 9 because the grade is already implied in the histology? | This question has been referred to SSDI work group, and possibly to the CAP Cancer Committee.  <http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/101226-implied-grade> |