# Melanoma 2020

Q&A

April 2, 2020

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| # | QUESTION | ANSWER |
|  | Does this webinar qualify for any AAPC or AHIMA CEUs? | No, it does not. |
|  | In regard to laterality, C44.4 is not a paired site, but would we consider multiple primaries if melanoma stated as a specified laterality for this site? | Per the Cutaneous melanoma *Definitions* section they state for skin sites, laterality divides the body into a Rt and Lt half as though a line were drawn from mid forehead to mid pelvis and mid skull to mid buttocks. Melanoma of the Rt side of the body (any part) and melanoma of the Lt side of the body (any part) are multiple primaries. In the 2021 melanoma STRs, this will be clearer because they will have a table that shows which areas have to have laterality coded. Skin of scalp and neck are included in the list for which laterality is required. Denise |
|  | Pt has tumor right back and tumor right chest at same time. Would this be considered single or multiple primaries? | Both chest & back are coded to C44.5. These are the same laterality (Rt), so as long as they are the same histology, they are a single primary. See example 1 Rule M8. |
|  | When a pathology report states that there is partial regression, should the histology code 8723/3 Regressing melanoma be used? | We ONLY use 8723/3 regressing melanoma if that is the final dx on the path report. Otherwise, we use melanoma NOS. Current CAP protocols (from 2016 forward) do NOT list regressing melanoma as a histology option. Melanoma with partial regression would indicate the Breslow depth could be inaccurate and CAP puts this description in the Tx option. Louanne |
|  | What anatomic guidelines do we have to determine "shoulder" site? C44.6 (upper limb and shoulder) versus C44.5 (trunk). | If you look at the Topography codes in the numerical list in ICD-O, you will see specific sites listed for skin of trunk and skin of upper arm/shoulder. In the 2021 melanoma STRs, this will be more straightforward because they will have a table that shows which parts go with which codes. From what I remember, the list is more extensive than the list in ICD-O, but I have only seen the draft, and that can vary significantly from the final published version. Denise |
|  | How would be deal with "early" or "evolving" melanoma. Is this considered reportable or non-reportable? | Not reportable. Please refer to the Cutaneous melanoma Definitions, and SEER Sinq #20190050. Denise |
|  | Are these numbers 1-4 on the breslow slide correlated w/ clark's level 1-4? | The 1 – 4 on the left side of the slide shows Clark’s levels, which are described on the previous slide as the depth into the particular layer of the skin (epidermis, dermis, etc.) But they do not correlate to the Breslow measurements. Louanne |
|  | For the table EOD SS2018, EOD"T", is EOD 100 clark level 1 or 2? the same for EOD for 200. Is the one in red the correct one? | Red is the corrected one. EOD 100 is Clark level II. Clark level I is for in situ. We will be posting the updated slides for you. Denise |
|  | Slide 31 she said “unless bidirectional”—does that mean that a contralateral node was found as a sentinel node? | “Bilateral or contralateral nodes are classified as regional nodes for head, neck, and truncal tumors with bidirectional drainage to primary nodal basins, as shown on lymphoscintigraphy. Truncal tumors may also drain to both cephalad and caudal primary nodal basins as shown on lymphoscintigraphy.  Clinical assessment of bilateral/contralateral or cephalad/caudal regional nodal involvement is required for tumors where lymphoscintigraphy is not performed.” Denise |
|  | Would cT0 cN2b cM0 be SS2018 9-unknown or 3-regional to lymph nodes? | It would be a summary stage of Regional to Lymph Nodes. I know it seems odd since you don't know where the primary tumor is, but SEER is following AJCC's lead on this. AJCC found that patients with occult melanomas and positive lymph nodes have prognosis similar to patients with positive regional nodes. Jim |
|  | C44.4 is also primary site code for scalp. Would axillary nodes be regional nodes for a scalp lesion too? | The list in SS2018 and EOD states “Axillary (neck only, C444)” Denise |
|  | Matted? What does it mean? | ﻿Matted nodes are two or more nodes that adhere to one another. |
|  | What ISM stands for? | ﻿**I**n‐transit, **S**atellite, and/or **M**icrosatellite metastases. Denise |
|  | I thought pT1b required a LN biopsy? | That was AJCC 7th edition. Please see the 8th edition note under the pathological prognostic stage group table. If you look at the Cancerstaging.org website, choose Education > Registrar, then scroll down to the section titles AJCC 8th Edition Staging Critical Clarifications for Registrars, you will find a document titled “Node status” created by Donna Gress, who is the ultimate expert in AJCC staging. The document describes the limited number of situations in which node status is not required. I am quoting from that document here: “For melanoma, cN0 may be used to assign a pathological stage group for T1 melanoma.” This is consistent with the chapter guidance in AJCC. Denise |
|  | Patient has spinal lesion that is removed and is diagnosed with a melanocytic schwannoma which is a 9560/1. Patient has genetic's done which shows GNAQ Q209L mutation which per the physician is diagnostic for primary CNS melanoma. Do we code the path 9560/1 or to melanoma 8720/3? Patient goes on to have radiation and no chemo. No additional information. Thank you. | The provisional diagnosis was melanocytic schwannoma, but the physician is treating the patient for primary CNS melanoma. I would assign 8720/3. Denise |
|  | Here is the link to all chapters that you can use cN for path stage. https://cancerstaging.org/CSE/Registrar/Documents/Node%20Status%20Not%20Required%20Rare%20Circumstances%20(1).pdf  The statement Denise just read from her Kindle version has much more detail than what the AJCC 8thEd book has noted (see page 578). However, I can't tell if the more detail affects the overall message that the note is meant to relay. Will you compare and comment, please. Thanks!  "Do not report melanoma when described as early or evolving, regardless of dimension, per the Appendix C Melanoma Coding Guidelines in the 2018 SEER Coding Manual that states: As of cases diagnosed January 1, 2018, early or evolving melanoma of any type is not reportable. This includes both invasive and in situ melanomas; early or evolving are not reportable.  From <https://seer.cancer.gov/seerinquiry/index.php?page=search\_results&records=n&search\_results\_show=first&search\_type=quick\_search&search\_within\_results=0&quicksearch=reportability+melanoma&Question\_1=1&Question\_3=1&search\_display\_format=1#results>" | Thank you. You can use a cN0 for pT1a and pT1b for cases dx'd 2018 forward (8th edition). In 7th edition, you could only do it for pT1a. Jim  If you look at the Cancerstaging.org website, choose Education > Registrar, then scroll down to the section titles AJCC 8th Edition Staging Critical Clarifications for Registrars, you will find a document titled “Node status” created by Donna Gress, who is the ultimate expert in AJCC staging. The document describes the limited number of situations in which node status is not required. I am quoting from that document here: “For melanoma, cN0 may be used to assign a pathological stage group for T1 melanoma.” This is consistent with the chapter guidance in AJCC. Denise |
|  | BTW, my previous note refers to the need for path LN evaluation. |  |
|  | Shouldn't your pathological stage be pT3apN1a(sn) instead of pT3bpN2c(sn)? | Yes. The prognostic stage group is the same. We changed the case after I made the slides, and I missed that particular update! We will be posting the updated slides for you. Denise |
|  | Melanoma Scenario: Wasn't one of the SLN (#4) w/o an identified LN "benign fibro adipose tissue"? Wouldn't the # of SLN examined be 4? | You are correct. #4 was deemed to be not a LN. 04 examined/01 positive. I have corrected the answer on the slide. We will be posting the updated slides for you. Denise |
|  | Since there was no residual invasive melanoma on the wide local excision in the case scenario, couldn’t you code 2.7 breslow instead of A2.7? | The original path noted the “at least 2.7mm, transected at the base” The transected statement implies there could be melanoma cells beyond the 2.7mm. Please note that the dates of the procedures were separated by time – and there could have been regression when the majority of the tumor was removed. That’s why the “A” codes for Breslow were put into the SSDI. Louanne |
|  | To clarify my question from Slide 31: She said “ipsilateral single or multiple” unless bidirectional. I assumed that bidirectional would be proven by Sentinel Node Biopsies which showed that one of the sentinel nodes was contralateral to the tumor. Is that correct? OR can a physician just state that a contralateral node is “regional”? | They do not have to be positive; they just need to demonstrate bidirectional drainage either by clinical assessment or lymphoscintigraphy: “Clinical assessment of bilateral/contralateral or cephalad/caudal regional nodal involvement is required for tumors where lymphoscintigraphy is not performed.” Denise |
|  | Regarding margin status for Code 45, can you use documentation from Op report, or does it have to be from path report? | As of consensus of NPCR, CoC, and SEER in email conversations of 3/30/20, the microscopic margin status should be noted on the path report. Questions regarding surgical codes should be posted in the CAnswer Forum under the STORE topic. Also, please see SEER Sinq 20190080 (12/2019), which is more current than the CoC release of October 2019. In the SEER Sinq post, they mention ALL of the standard setters agree the margins must come from the path report for codes 45. Denise and Louanne |
|  | When SLN and regional LN are excised: Why do we need to code SLN as 97 in breast and code to the exact number of SLN in melanoma. Why can't we code the information as is in both primaries? | You could post to the CAnswer Forum. I had a long discussion with them about this, and the final verdict was to follow the rules in the manual, and for breast, that means 97 when the SLNBx and RLND occur **during the same procedure.** Denise |
|  | so if a physician on the Op Note states 2cm margins but is found to be within 1cm on pathology its a code in the 30s correct? | That is what they are telling us right now (as of 3/30/20). We were told if the distance is not stated on the pathology report, we cannot use 45-47. As of consensus of NPCR, CoC, and SEER in email conversations of 3/30/20, the microscopic margin status should be noted on the path report. Questions regarding surgical codes should be posted in the CAnswer Forum under the STORE topic. Also, please see SEER Sinq 20190080 (12/2019), which is more current than the CoC release of October 2019. In the SEER Sinq post, they mention ALL of the standard setters agree the margins must come from the path report for codes 45. Denise and Louanne |
|  | A lot of times they excise a larger size but tumor is found to be closer to the margin. |  |
|  | I thought regardless of procedure that the 1st surgical code is 27 | That depends on whether the first procedure qualifies as surgery. If there is macroscopic tumor left, it is not a surgical procedure. Denise |
|  | "We have been instructed: Shave biopsy as Code 27 Excisional biopsy when a follow up surgery is performed (i.e. WLE). This was also addressed in an HIMagine webinar. ""Shave biopsies are RARELY coded as a diagnostic and staging procedure | According to the 2018 SEER manual, page 161, “Shave or punch biopsies are most often diagnostic. Code as a surgical procedure only when the entire tumor is removed and margins are clear.”  The CoC (STORE) allows shave/punch biopsies with clear or microscopic margins to be coded as surgical procedures. Otherwise, the procedures are coded as surgical diagnostic and staging procedures. Denise |
|  | 02. Usually the only time you code a shave biopsy as an 02 is if the physician left GROSS VISIBLE tumor. (This is not very common.)""" | According to the 2018 SEER manual, page 161, “Shave or punch biopsies are most often diagnostic. Code as a surgical procedure only when the entire tumor is removed and margins are clear.”  The CoC (STORE) allows shave/punch biopsies with clear or microscopic margins to be coded as surgical procedures. Otherwise, the procedures are coded as surgical diagnostic and staging procedures. Denise  No, it is not very common, however, it does happen, most often when the procedure is done by the PCP, rather than a dermatologist. Denise |
|  | For your melanoma surgery coding exercise - if software allows coding of multiple surgical procedures AND the shave biopsy specimen was examined by pathologist to determine thickness, margins, etc. Then 4/24/19 surgical procedure code 27 and 5/15/19 code 31? | The 4/24/19 procedure had grossly positive margins per the path report. That is coded 02 in surgical diagnostic and staging procedures and the 5/15/19 procedure is coded to 31. Denise |
|  | slide 73, was more than a diagnostic biopsy on 9/1/19, because there was no residual melanoma on 9/15/19 wide excision. | The central registry had **only** the path report for 9/1/19. The margins were not mentioned, which is why it was coded to 02. The central registry then received the abstract from Facility A. At that point, they can update their code, but on 9/1/19, they had to code to 02. Denise |
|  | The CoC sent out an update recently in the Brief that if margins are clear and path doesn’t state margin size, we can use margin size stated on the op report to code 45-47. | As of consensus of NPCR, CoC, and SEER in email conversations of 3/30/20, the microscopic margin status should be noted on the path report. Questions regarding surgical codes should be posted in the CAnswer Forum under the STORE topic.  Also, please see SEER Sinq 20190080 (12/2019), which is more current than the CoC release of October 2019. In the SEER Sinq post, they mention ALL of the standard setters agree the margins must come from the path report for codes 45-47. Denise and Louanne |
|  | The TAG team met & said if margins were negative and not stated on path, we could use the information from the operative report on the margins. It was sent via emails from SINQ questions & it was also published by COC in a Brief I think. | As of consensus of NPCR, CoC, and SEER in email conversations of 3/30/20, the microscopic margin status should be noted on the path report. Questions regarding surgical codes should be posted in the CAnswer Forum under the STORE topic.  Also, please see SEER Sinq 20190080, which is more current than the CoC release of October 2019. In the SEER Sinq post, they mention ALL of the standard setters agree the margins must come from the path report for codes 45-47. Questions regarding surgical codes should be posted in the CAnswer Forum under the STORE topic.  Also, please see SEER Sinq 20190080, which is more current than the CoC release of October 2019. In the SEER Sinq post, they mention ALL of the standard setters agree the margins must come from the path report for codes 45-47. Denise and Louanne |
|  | "From: AskSEERCTR <askseerctr@imsweb.com>  Sent: Wednesday, August 21, 2019 2:23 PM  Subject: RE: Ask SEER CTR #21342  This was discussed last week at a meeting of the Technical Advisory Group (TAG), an ad hoc group with representation from all of the standard setters. The consensus decision is: For assigning melanoma surgery codes, use the path report as the first priority. If info not available on path report, op report may be used when margins are specified. Exception is for code 47 where specific instructions about microscopic confirmation are included. Important: this does not apply to the margins data item, only to surgery codes.  I will add to this: do not compute margins from path or op report. Use margins when stated. If not stated, margins are unknown. | As of consensus of NPCR, CoC, and SEER in email conversations of 3/30/20, the microscopic margin status should be noted on the path report. Questions regarding surgical codes should be posted in the CAnswer Forum under the STORE topic.  Also, please see SEER Sinq 20190080, which is more current than the CoC release of October 2019. In the SEER Sinq post, they mention ALL of the standard setters agree the margins must come from the path report for codes 45-47. Denise and Louanne |
|  | The SEER Data Quality Team"  "03-10-20, 09:38 AM  Please follow the Rules in Appendix B (STORE): Based on the information in the post, the margins are negative. If the excision or re-excision has microscopically confirmed negative margins less than 1 cm OR the margins are 1cm or more but are not microscopically confirmed; use the appropriate code, 20–36  Note: Code the margins from the path report, if it can't be determined from the path report, code from the operative report."  from the canswer forum stating you can use margins on OP Note if not stated on pathology report | As of consensus of NPCR, CoC, and SEER in email conversations of 3/30/20, the microscopic margin status should be noted on the path report. Questions regarding surgical codes should be posted in the CAnswer Forum under the STORE topic.  Also, please see SEER Sinq 20190080, which is more current than the CoC release of October 2019. In the SEER Sinq post, they mention ALL of the standard setters agree the margins must come from the path report for codes 45-47. Denise and Louanne |
|  | Why can't the shave be an excisional biopsy?? I thought as long as no residual GROSS tumor shaves could be coded as 27 then 1st surgery date would be the shave/def surg date would be the 2nd surgery of 30+... | A shave can be an excisional biopsy or a surgical diagnostic and staging procedure - there was gross residual tumor per the pathology report. It is noted in the comment. According to the 2018 SEER manual, page 161, “Shave or punch biopsies are most often diagnostic. Code as a surgical procedure only when the entire tumor is removed and margins are clear.”  The CoC (STORE) allows shave/punch biopsies with clear or microscopic margins to be coded as surgical procedures. Otherwise, the procedures are coded as surgical diagnostic and staging procedures. Denise |
|  | When determining margin status do we use op report or path report? (for purposes of determining surgical codes) | As of consensus of NPCR, CoC, and SEER in email conversations of 3/30/20, the microscopic margin status should be noted on the path report. Questions regarding surgical codes should be posted in the CAnswer Forum under the STORE topic.  Also, please see SEER Sinq 20190080, which is more current than the CoC release of October 2019. In the SEER Sinq post, they mention ALL of the standard setters agree the margins must come from the path report for codes 45-47. Denise and Louanne |
|  | "This was what I got from SEER This was discussed last week at a meeting of the Technical Advisory Group (TAG), an ad hoc group with representation from all of the standard setters. The consensus decision is: For assigning melanoma surgery codes, use the path report as the priority. If info not available on path report, op report may be used when margins are specified. Exception is for code 47 where specific instructions about microscopic confirmation are included. Important: this does not apply to the margins data item, only to surgery codes. | As of consensus of NPCR, CoC, and SEER in email conversations of 3/30/20, the microscopic margin status should be noted on the path report. Questions regarding surgical codes should be posted in the CAnswer Forum under the STORE topic.  Also, please see SEER Sinq 20190080, which is more current than the CoC release of October 2019. In the SEER Sinq post, they mention ALL of the standard setters agree the margins must come from the path report for codes 45-47. Denise and Louanne |
|  | I will add to this: do not compute margins from path or op report. Use margins when stated. If not stated, margins are unknown. | As of consensus of NPCR, CoC, and SEER in email conversations of 3/30/20, the microscopic margin status should be noted on the path report. Questions regarding surgical codes should be posted in the CAnswer Forum under the STORE topic.  Also, please see SEER Sinq 20190080, which is more current than the CoC release of October 2019. In the SEER Sinq post, they mention ALL of the standard setters agree the margins must come from the path report for codes 45-47. Denise and Louanne |
|  | Please also reconcile guidance on melanoma surgery for op note statement of margin and no measurement noted on path report/just stated negative from the 2019 Coding Pitfalls presentation with Janet Vogel.Per her guidance, the surgical code for your 2.2 cm circumferential margin per op note with no margin distance stated on path report would be 47 wide excision w/ margins greater than 2.2 cm. | As of consensus of NPCR, CoC, and SEER in email conversations of 3/30/20, the microscopic margin status should be noted on the path report. Questions regarding surgical codes should be posted in the CAnswer Forum under the STORE topic.  Also, please see SEER Sinq 20190080, which is more current than the CoC release of October 2019. In the SEER Sinq post, they mention ALL of the standard setters agree the margins must come from the path report for codes 45-47. Denise and Louanne |
|  | Exercise Melanoma Surgery-I thought the new rule per Canswer forum and Sinq was to use the path report margins and if no path report margins then use operative margins | As of consensus of NPCR, CoC, and SEER in email conversations of 3/30/20, the microscopic margin status should be noted on the path report. Questions regarding surgical codes should be posted in the CAnswer Forum under the STORE topic.  Also, please see SEER Sinq 20190080, which is more current than the CoC release of October 2019. In the SEER Sinq post, they mention ALL of the standard setters agree the margins must come from the path report for codes 45-47. Denise and Louanne |
|  | Previous webinars said regardless of technique (shave, punch) to code first procedure a 27 because they want to remove as much as possible. does this not remain true? a 02 would be done if the lesion was so large and they wanted to confirm melanoma. | According to the 2018 SEER manual, page 161, “Shave or punch biopsies are most often diagnostic. Code as a surgical procedure only when the entire tumor is removed and margins are clear.”  The CoC (STORE) allows shave/punch biopsies with clear or microscopic margins to be coded as surgical procedures. Otherwise, the procedures are coded as surgical diagnostic and staging procedures. Denise |
|  | The use of 02 surgery code contradicts previous trainings. Are we to assume that all punch and shave biopsies should be coded as 02, even when followed by an excisional biopsy that shows no residual? | According to the 2018 SEER manual, page 161, “Shave or punch biopsies are most often diagnostic. Code as a surgical procedure only when the entire tumor is removed and margins are clear.”  The CoC (STORE) allows shave/punch biopsies with clear or microscopic margins to be coded as surgical procedures. Otherwise, the procedures are coded as surgical diagnostic and staging procedures. Denise |
|  | http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/96098-wide-excision-surgery-codes | Correct. Per this CAnswer forum post, All codes 45-47 must include microscopic confirmation. Please reach out to SEER ask a registrar who wrote this summary for verification. The consensus was on the use of operative margins can be used when not stated in the pathology report.  As of consensus of NPCR, CoC, and SEER in email conversations of 3/30/20, the microscopic margin status should be noted on the path report. Questions regarding surgical codes should be posted in the CAnswer Forum under the STORE topic.  Also, please see SEER Sinq 20190080, which is more current than the CoC release of October 2019. In the SEER Sinq post, they mention ALL of the standard setters agree the margins must come from the path report for codes 45-47.  Denise and Louanne |
|  | I humbly disagree - I would not go back to change things, but rather proceed from wherever you are with the updated information. Just as we have done from the start with 2018 cases, we changed as clarifications were made. | Every registry needs to decide how they cope with these types of situations. We know there is no one-size-fits-all when it comes to registries. Denise |
|  | What about codes 27 for shave bx? | According to the 2018 SEER manual, page 161, “Shave or punch biopsies are most often diagnostic. Code as a surgical procedure only when the entire tumor is removed and margins are clear.”  The CoC (STORE) allows shave/punch biopsies with clear or microscopic margins to be coded as surgical procedures. Otherwise, the procedures are coded as surgical diagnostic and staging procedures. Denise |
|  | Remind us please the background and credentials of the presenters | Both are CTRs, and were associates with AFritz and Associates. They are both co-authors of the Cancer Registry Casebooks and are nationally-recognized experts and do a lot of education and training for cancer registrars. Louanne has been a hospital registrar (CoC) for more than 30 years. Denise has been a hospital registrar since 2005, and directed the Cancer Information Management program at Santa Barbara City College for 9 years. Denise and Louanne |
|  | If you code surgical procedure based on a margin being unknown, then the margin coding issue would never be an issue. | According to the 2018 SEER manual, page 161, “Shave or punch biopsies are most often diagnostic. Code as a surgical procedure only when the entire tumor is removed and margins are clear.”  The CoC (STORE) allows shave/punch biopsies with clear or microscopic margins to be coded as surgical procedures. Otherwise, the procedures are coded as surgical diagnostic and staging procedures. Denise |
|  | Can you reiterate the association between the source of margins being the path report to be able to assign codes 45-47 and the surgical resection required for pathologic staging? Seems like as a result, many cases will not be pathologic staged?? | Staging rules and surgical codes are separate. To be eligible for pathological staging in AJCC, a wide excision or re-excision has to be performed. Denise |
|  | STORE indicates a neg or microscopic + margins should be coded as a surg procedure, not a diagnostic staging procedure, so even if we have + margins on path report, it should still be coded as a 27 shouldn’t it? | There was gross residual tumor per the pathology report. It is noted in the comment. According to the 2018 SEER manual, page 161, “Shave or punch biopsies are most often diagnostic. Code as a surgical procedure only when the entire tumor is removed and margins are clear.”  The CoC (STORE) allows shave/punch biopsies with clear or microscopic margins to be coded as surgical procedures. Otherwise, the procedures are coded as surgical diagnostic and staging procedures. Denise |
|  | If we are saying for the example case code 02 for surgical and diagnostic procedure - then how can we have a clinical T assigned because clinical requires complete removal? | AJCC rules and surgery coding rules are not the same. We had a Breslow’s measurement (micro-staging occurred), so we could assign cT. Denise |
|  | If software allows for entry of multiple procedures, how is a diagnostic 02, followed by a code 32 for example, coded if done at separate facilities? Is it not important to code where each procedure was performed at? | Yes. Unless you are working on Class of Case 00 and/or non-analytic cases, we are supposed to code all treatment, regardless of where it was performed. Louanne |
|  | Yes, its all about the intent of the procedure if they see gross residual its 02 if they think they are removing it all its a 27. | Correct. |
|  | The surgery codes listed in appendix B of the STORES manual for skin, actually states right under code 45 "If the excision or reexcision has microscopically confirmed negative margins less than 1cm OR the margins are 1cm or more but not microscopically confirmed; use the appropriate code 20-36. | That is correct, and that is why we are saying we cannot use the operative report to code margins for 45-47. Denise |
|  | Can you provide a slide with specifics to better explain Clinically Occult, Microscopic, and Macroscopic detected regional lymph nodes? | Those are AJCC definitions. Please refer to the AJCC Cancer Staging Manual, 8th edition. Basically, clinically occult LNs are what AJCC 7th edition referred to as “microscopic disease.” That means there was no evidence of LN involvement clinically or via imaging. “Microscopically” involved or clinically occult LNs are the LNs identified by SLNB. Clinically detected LNs are what AJCC used to refer to as “macroscopic disease.” Those are LNs identified clinically or on imaging. Denise |
|  | The bigger question to the standard setters is why do we bother with this 45 -47 range if pathologists do not record it? I understand there are margin guidelines in NCCN, but?? Worth considering for 2021 updates. | Agreed. Actually, the margin status is a required element on the CAP protocol, but the DISTANCE from the margin is not required. Denise |
|  | Is cryosurgery the same as cryoablation? | Yes. They freeze it. Denise |
|  | The key to the discussion about margin measurements is related to the statement "Margins MUST be microscopically confirmed negative...", even in the face of the previously published newsletters, webinars, etc. I agree, there should be a joint statement correcting the misinformation/interpretation. Just my opinion. | As of consensus of NPCR, CoC, and SEER in email conversations of 3/30/20, the microscopic margin status should be noted on the path report. Questions regarding surgical codes should be posted in the CAnswer Forum under the STORE topic.  Also, please see SEER Sinq 20190080, which is more current than the CoC release of October 2019. In the SEER Sinq post, they mention ALL of the standard setters agree the margins must come from the path report for codes 45-47. |
|  | Why are melanomas that occur on the scalp so aggressive? | This would be a great question to ask in the CAnswer Forum in the “Ask the Pathologist” section. Denise and Louanne |
|  | If you need to doc where the corrected info for EOD it's per SINQ 20190086 | Thank you! |
|  | Would regional nodes positive be 01 and regional nodes examined 05? | RLNs positive would be 01 and RLNs examined would be 04. The reason for that is the one SLN (#4) was not a LN, it was documented as “benign fibro adipose tissue, no lymph node is identified” Denise |
|  | For surgical codes, what would you code for a biopsy only but with positive margins? I am in a central registry and I receive physician reports where the patient was seen for biopsy only and then sent to a larger facility for wide excision. Margins may be positive on the initial biopsy, and they don't always send me information about the follow-up procedure (that comes later from the larger facility). | According to the 2018 SEER manual, page 161, “Shave or punch biopsies are most often diagnostic. Code as a surgical procedure only when the entire tumor is removed and margins are clear.”  The CoC (STORE) allows shave/punch biopsies with clear or microscopic margins to be coded as surgical procedures. Otherwise, the procedures are coded as surgical diagnostic and staging procedures. Denise |
|  | For the exercise why would the shave bx be coded as an SDSP 02 when the path said the margins extended to the deep and lateral margins? The margins were assessed and were microscopically positive which would be coded as 27 - excisional bx. | The comment on the path report stated “On gross examination of the specimen, the tumor was noted to be transected at the base.” Denise |
|  | 4/24/19 Shave biopsy in dermatologist office, peripheral and deep margins positive. If a surgeon states, during a wide excision, that he is taking 0.5mm margins, wouldn't that be coded to a 45? | As of consensus of NPCR, CoC, and SEER in email conversations of 3/30/20, the microscopic margin status should be noted on the path report. Questions regarding surgical codes should be posted in the CAnswer Forum under the STORE topic.  Also, please see SEER Sinq 20190080, which is more current than the CoC release of October 2019. In the SEER Sinq post, they mention ALL of the standard setters agree the margins must come from the path report for codes 45-47. Denise and Louanne |
|  | Most of our melanomas are biopsied and then resected at a physician. There are usually no margin sizes mentioned. So, my understanding is that we wouldn't "ever" use code 45 for wide excision. correct??? | "Standard treatment for melanoma is an excisional biopsy followed by wide excision with or without sentinel node biopsy. The margin size from the tumor to peripheral tumor is usually documented if the pathologist is following the CAP protocol. However, the margin distance from the previous excision to the peripheral margin of the wide excision isn't always documented on the path report. If they are just doing an excisional biopsy, you wouldn't use code 45." Jim |
| 1. ` | What I meant was, if a 4/24/19 Shave biopsy done in a dermatologist office with positive margins - this is not coded 27? (If not, when would a code 27 be used?) With a 5/15/19 Wide excision that in the op report with margins stated to be 0.5mm, isn't that a code 45? (no margins on the path report) I thought the rules were just changed to allow us to use the 40 codes based on the margins in the operative report. You are saying the codes for these procedures as of today are 02 for the shave biopsy and 31 for the wide excision? | As of consensus of NPCR, CoC, and SEER in email conversations of 3/30/20, the microscopic margin status should be noted on the path report. Questions regarding surgical codes should be posted in the CAnswer Forum under the STORE topic.  Also, please see SEER Sinq 20190080, which is more current than the CoC release of October 2019. In the SEER Sinq post, they mention ALL of the standard setters agree the margins must come from the path report for codes 45-47. Denise and Louanne |
|  | Also, I recently went back and forth with SEER Ask and CAnswer Forum about coding amputation of finger or toe. As you mentioned SEER has a note that amputation of the finger is coded to 47. SEER sticks by this but NCDB staff was clear that codes in the 45 series cannot be used unless they meet the margin criteria of more than 1 cm. | Right. That’s why we put on the slide it was a SEER note. Denise |