**Q&A Session for Prostate 2020**

October 1, 2020

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| # | Question | Answer |
|  | Are going to register for each webinar every month or no to receive an email to attend? | You can go back into NAACCR NET (https://education.naaccr.org and register for every webinar now. Once registered you should get an reminder email a day before and an hour before the start of the webinar. |
|  | Will liquid biopsy be considered tissue? | No. Don’t let the name fool you. It is a measurement of the tumor DNA in the blood. At this point it is not used for any standard data items. |
|  | Shouldn't SV be a separate phase and volume selected is Other? That is what is stated in Radiation Therapy coding manual. | That is correct if only the SV are stated as being irradiated, which is rare. in most cases, the SV are irradiated along with the prostate. |
|  | What does LDR stand for? | Low dose radiation (LDR) vs High Dose Radiation (HDR) |
|  | Have you heard about radioisotope lutetium-177 which has not been approved by the FDA just yet for use treating Prostate Cancer? |  |
|  | For phase 1, if volume is prostate-whole, we assume that lymph nodes are included even if patient has no lymph node involvement? |  |
|  | Clinical Scenario 4-Start & end dates encompassed about 2 weeks, but only 5 fractions given? |  |
|  | The primary/mets timeline is that for all cases or starting in a certain year? |  |
|  | Why does prostate cancer always seem to go into the bones first? |  |
|  | On the AP/PA question slide: What scenario would you use to code 02 external photons? | If you are given the planning technique as complex, conformal or 3D, then you can go with 02. |
|  | Please explain coding for Xofigo. i.e. site=? | Generally used for bone mets. code to 13, radioisotopes, NOS |
|  | Is a TRUS bx (transrectal ultrasound) acceptable for clinical grade? | Yes. Tissue from a TRUS should not be used for staging, but may be used to assign grade. Any tissue removed from the primary site (prostate) prior to treatment may be used to assign clinical grade. |
|  | If you take PSA that was 3 days prior to bx, it was lower than PSA the month previous. Why wouldn't you use the higher of the two? | That is the recommendation of the SSDI workgroup. Both AJCC and CAP were present when that decision was made. |
|  | What is the maximum number of cores that can be biopsied? I've usually see 12 but came across a case that 14 cores were biopsied. | I don’t know that there is a maximum number. A saturation biopsy may have 20 or more cores removed. |
|  | What is the standard # of cores? Can they take more than core per anatomic area of prostate? | In the morning session I made the assumption that when the path report stated each area of the path report was negative, that only one biopsy of that area was taken. That is an incorrect assumption. For the number of cores examined/pos, you need to know the number of cores taken. You should not assume that only one core from each biopsy was taken. This was corrected in the afternoon session. |
|  | Case Scenario 3 - Why would cores examined not be unknown since it does not specify how many cores were taken on the negative tissue? | You are correct. If the number of cores is not documented, you cannot assume that only a single core was taken of the same area. In the afternoon session we added the number of negative cores. If the number of negative cores is not documented, X6 (Biopsy cores examined, number unknown) should be coded for Number of Cores Examined. |
|  | Question on Case 3 would also effect the other case. I would not assume that only one was taken. | You are correct. Number of cores examined was added to the scenarios in the afternoon sessin. |
|  | Is there manual documentation that we can assume 1 core per bx as in cases 1 and 2? | No. |
|  | If a patient has BPH, will a physician do a DRE prior to TURP as standard procedure? We have a lot of TURP cases with no mention of DRE. | I would imagine a DRE would be done, but I do not know the standard of care. |
|  | What is entailed with a simple prostatectomy? Does it meet criteria for pathologic stage? | It does not. A simple prostatectomy removes the inner portion of the prostate leaving the outer portion. Per AJCC this does not meet the criteria for pathologic stage. |
|  | If there is no DRE performed or there is no text to validate a DRE was done, does that mean we cannot categorize the cT? Would that make it cTblank or cTX? | It is my understanding that if there is not documentation of a DRE, the cT value should be blank. Any further questions should be directed to AJCC. |
|  | What would the cT be if there is no DRE? | cT would be blank. |
|  | Jim, cT can be based on biopsy if bx proves a T3, correct? | There are posts on the CAnswer forum that indicate a cT3 must be based on DRE. Bx confirmation of extraprostatic extension is not enough. |
|  | If we are supposed to assign clinical T according DRE, but the physician assigns a different clinical T, which do we enter into the database when the STORE manual states to assign according to the managing physician's documentation? | Per AJCC, registrars should follow the AJCC rules when assigning stage values in the registry database. If a physician assigns a stage that differs from the AJCC rules, the registrar should defer to the AJCC rules when entering a stage in the registry database. |
|  | So you don't need elevated PSA to meet criteria for cT1c? | Correct. |
|  | If T is blank when the information of the DRE is not available, can you give an example of when to use TX? | I cannot. |
|  | What is the reasoning for T blank if is unknown if a DRE was performed, rather than TX? | I believe a cT blank indicates the registrar is missing information. cTX indicates the physician did not have enough info to assign the cT value. |
|  | Can we use Gleason score obtained from TRUS bx for Grade- Clinical? Per Grade Manual, only TURP can be used. However, CAnswer forum states we can use TRUS Bx with Gleason score results... please clarify. | TRUS is just how the needle was guided. As long as the bx is of the prostate and was done prior to treatment, the TRUS bx may be used to assign clinical grade. |
|  | Can you confirm that when you have a bx of a prostate and it comes back urothelial carcinoma you would be coding primary site to C680, rather than C619? | A urothelial carcinoma of the prostate would be highly unusual. It is much more likely that the urothelial carcinoma arose in a urinary site. |
|  | Targeted therapies are being used to treat Prostate Cancer i.e. PSMA (prostate-specific membrane antigen) targeted therapies... It’s a molecule that targets PSMA (a protein in prostate cancer cells that fuels the disease), which arises from a very common mutation of a gene called PTEN. | Thank you! |
|  | How can you assume no DRE was done when you have "diagnosed on biopsy"? | I would not assume it was or was not done. |
|  | Donna Gress said we should never use Tx for prostate. | Thank you! |
|  | Tx could possibly be where pt refused dre, from what i understand. | That sounds reasonable |
|  | I think if documentations says DRE was not done, that means the physician doesn't know and therefore it's a cTx. | That makes sense |
|  | If physician knows and registrar does not know, it's Tblank, if physician doesn't know, it's Tx. | That makes sense |
|  | Case Scenario 3 slide 34: Prostate RT apex: small fragment suspicious for prostatic adenocarcinoma. Does this mean that a fragment is not counted as a positive core bx? | I read that as meaning a core biopsy contained a fragment of adenocarcionma suspicious for prostatic adenocarcinoma. |
|  | Even if dr. stages clinically we cannot use it if we don't know T was from DRE? | That is correct. |
|  | It appears that the RT is given from the front of the patient. Do you need to make adjustments to make sure the full thickness of the prostate is treated without over treating the front part? |  |
|  | Can you please explain how you knew to code phase 1 to prostate in scenario 1 instead of to the pelvis? |  |
|  | For the change from primary tx volume coded 86 pelvis vs 64 prostate s/p prostatectomy, will this be effective for cases diagnosed in 2021 or abstracted in 2021? |  |
|  | I have seen cases in which a core noted as suspicious for adenocarcinoma. Other cores negative. Would this be considered reportable? if so, would that be considered a positive core? | A core “suspicious for adenocarcinoma” would make the case reportable. |
|  | The SSDI Manual reads this way, opposite of your slide: Record the last pre-diagnosis PSA lab value prior to diagnostic biopsy of prostate and initiation of treatment in nanograms per milliliter (ng/ml) in the range 0.1 (.1 ng/ml) to 999.9 (999.9 ng/ml). • Note: This is a change from CSv2, where the instructions stated to code the highest PSA value within 3 months prior to diagnostic biopsy. | The manual has been updated to state to code the last PSA value prior to diagnostic biopsy, but within 3 months of diagnosis. |
|  | Would you explain "free-PSA"? Would you use that value if that is all that is given? | You can find a good explanation at <https://www.health.harvard.edu/blog/what-is-the-difference-between-psa-and-free-psa-20091001114> |
|  | If there is a size of the prostate nodule noted on the ultrasound-guided biopsy, can that be used to assign the Clinical Tumor Size? | I have not seen specific instructions addressing this situation, I would think the nodule size could be used for clinical tumor size. |
|  | Do you assume nodules felt on DRE are tumors? And therefore stage in the cT2 category? | I would make that assumption. |