# Q&A Session for Boot Camp 2021

## March 4, 2021

| # | Question | Answer |
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| **1.** | What do you do as a date of diagnosis if you pick up a case because of a "suspicious neoplasm in the R occipital lobe" - so based on the benign terms - but the diagnosis ends up being a malignant brain tumor? | The date of diagnosis would not change since the patient had a reportable tumor, regardless of the behavior. Simply change the behavior (and if necessary, the sequence number) |
| **2.** | Please discuss Quiz 1 h) if "most likely" is omitted from the question. | If most likely is omitted the diagnosis becomes an unambiguous diagnosis of Kaposi sarcoma and is reportable. |
| **3.** | If patient comes for port placement for chemo treatment, will it be also class of case 31? | 31 is the code that I would assign. |
| **4.** | What class will it be it patient comes for unrelated issues but patient was recently diagnosed with cancer? will it be 31 or 31? | I don't see a class of case that is a perfect fit for that situation. I think I would probably use 31. Maybe 33. The most important thing is to be consistent. |
| **5.** | Class of Case question. 2 scenario's but I think are different class of case. Dx at your facility you do surgery, refer elsewhere for chemo consult. The chemo consult say you could take chemo or not, patient choice. Patient choses no treatment. Is this Class of Case 14? Next scenario, Dx at your facility, you do surgery, referred elsewhere for chemo consult. Elsewhere says you must have chemo, patient refuses. Is this Class of Case 13? What's class of case for the other facility. | Essentially, you are asking what constitutes a refusal of tx. This is tricky question. I'm not aware of detailed instructions to help distinguish whether a patient is refusing treatment or simply choosing a different treatment option. Patrick and I discussed the scenarios and added our comments to the more detailed descriptions in questions 7 &8 |
| **6.** | Here's the actual example, if it helps.... -Presents to Facility A for Right Hemicolectomy- T3 N0 M0 no high risk features, MSI stable. -Presents to Facility B for Oncology Consult: No high risk features. Discussion regarding Chemotherapy vs Observation. Patient chooses observation. Patient continues close follow-up with Facility B | I think Class of Case for facility A would be 13. Facility B is not as clear. I guess it depends on your definition of Observation. I would lean towards class of case 30 for facility B. However, if the medical oncologist created a structured active surveillance plan and managed the plan, then this could be Class of Case 21. Patrick and I thought it best to submit this one to the CAnswer Forum. |

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| **7.** | Presents to Facility A for Breast Lumpectomy ER+PR+ Her2- Presents to Facility B for Rad Onc Consult: Recommended adjuvant Radiation, patient Refused- Presents to Facility C for Med Onc Consult Recommended adjuvant Hormonal therapy, patient refused Class of Case for A is 13? [Dx here, Some Rx here, but pt refused other treatment elsewhere??] Class of Case for B is 21? [Dx & some treatment elsewhere, but pt refused treatment here??] Class of Case for C is 21? [Dx & some treatment elsewhere, but pt refused treatment here??] | This is a tough one. Patrick and I thought it best to submit this one to the CAnswer forum. |
| **8.** | I think what I finally decided is if treatment is recommended elsewhere and refused elsewhere then it affects Class of Case, but if treatment is an option elsewhere and just not chosen, then it doesn't affect class of case. Does that make sense? It's a fine line?? But we have facilities that go back & forth and it really matters. I think?? | Definitely a fine line! Is it hard to decide if it is an option vs a recommendation? Yet, if your facility only diagnosed the cancer and you know the patient chose not to pursue treatment after seeking a consult elsewhere, I would view that as a decision not to treat, that was made elsewhere and assign a Class of Case 00. |
| **9.** | in Texas cases dx'd prior to 1995 are no longer reportable, if the pt is dx'd with a reportable cancer at your facility, would you include the case dx'd prior to 1995 in your sequence of malignancies? | I would include the earlier diagnosis when assigning Sequence #, as it goes to the patient's overall cancer history. |
| **10.** | I am not sure I am looking at the correct version of STORE. Can you please share that again? | STORE Manual is available at https://www.facs.org/Quality-Programs/Cancer/NCDB/call-for-data/cocmanuals |
| **11.** | This is a little off topic, but can you provide a resource for coding SSDI KRAS? I.E .. If a person has mutated K117N, or 35G>A , PG12D? | Send it to the SSDI page on CAnswer forum. Chances are if you are seeing results like you have documented, others are too. The SSDI page is a great way to share how to code those results. |
| **12.** | This is for Quiz #5- So Peri-ependymoma Germinal Matrix of Undifferentiated Neuro Epithelial Cells would be reportable if it had been a live birth? I couldn't find where Peri-ependymoma Germinal Matrix of | The diagnosis in this situation wasn't the best example. I used that diagnosis as it was part of an actual question, sent to me from a registrar. Rather the question was intended merely to illustrate the point that a diagnosis established in utero is only reportable when the pregnancy results in a live birth. As for the diagnosis, an ependymoma |

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| | Undifferentiated Neuro Epithelial Cells is reportable. Can you show me where I can find this? | would be reportable, however I would discuss it with the clinician, given all of the extraneous information. |
| **13.** | What if your state central registry does not accept partial dates? | If your state doesn't accept partial dates, I would populate the unknown portion of the date field using 9s. This may also be necessary if your software does not allow blanks in the date field. The important thing is Not to estimate the 'Day' of diagnosis and to provide information in the appropriate Text fields regarding any blanks and/or 9s. |
| **14.** | For question #1 on quiz 6, which test would be considered as the one to use for when the cancer was diagnosed? | A reportable diagnosis was provided with the Thoracentesis – "…positive for malignant cells". |
| **15.** | Just for clarification on Quiz 6 question 1, where can we find that the term suspicious "mass" is reportable? I was under the impression it had to say something about malignancy or carcinoma, or does the term suspicious imply that? | A suspicious mass would not be reportable. The case became reportable the day following CXR, based on the diagnosis from the Thoracentesis – "…positive for malignant cells". |
| **16.** | Shouldn't it be date of first contact for abc hosp? | Quiz #6 – Question #4 asked what the date of First Contact would be for XYZ hospital, and that date would be the date the patient was first seen at XYZ Hospital with a reportable diagnosis. That date was the date of the Bronchoscopy (3/27/2020). Having said that the date of diagnosis would be the date the patient's original colon primary was first diagnosed (4/18/2019), since the current tumor was deemed metastatic from the colon. |
| **17.** | You don't have to answer online either, but I have a question about differential diagnosis... Say for example 01-01-2021 scan states differential diagnosis is metastatic carcinoma or primary carcinoma... later bx 01-15-2021 confirms primary disease. Since both dx in differential on 01-01-2021 are reportable is that date of dx or is it 01-15-2021 when confirmed. I thought at some time there was a rule about not using differential diagnosis, but now I'm not sure. | I believe the rule regarding differential diagnoses pertains to assigning the histology, rather than diagnosis date. In the situation you describe, I would 01-01-2021 as the date of diagnosis.<br><br>If one of the differential diagnosis had been for a non-reportable condition, then dx date would have been 01-15-21. |

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| **18.** | Quiz 7, question number 1, your answer suggests that biopsy is regarded as Surgical Diagnostic Staging Procedure? | That is correct. A biopsy of a lesion of a primary tumor of the colon would be considered a code 02 diagnostic staging procedure. |
| **19.** | Hi: How would you code a bone biopsy for a lymphoma case? Pt had a bone biopsy due to pain and was found to have lymphoma. Multiple lymph node regions were involved via imaging. Physician stated that a bone marrow biopsy was not necessary due to the bone biopsy. | That would depend on how you code the primary site. If primary site is lymph nodes, then the bone biopsy would be coded as a diagnostic staging procedure code 01. If the primary site was bone, then diagnostic staging procedure would be code 02. |
| **20.** | I had a breast case for which hormone was NOT bridge therapy. It was done per Patient choice given to shrink tumor (patient had large tumor and wanted lumpectomy). Can this be considered neoadjuvant? | I'm assuming you are asking this in regards to how to code AJCC fields. I don't know the answer to that question! I suggest you send it to the CAnswer forum. Be sure to include detailed information about the case. If you send us the link to the question, I'll add it to the Q&A at a later date. |
| **21.** | For the bridge therapy, it is IMPORTANT to code that treatment so we can assess how it affected the patient's outcome. The ones I really object to is the few days or 1 shot of hormone which is done for other reasons, not as bridge therapy. | Great point Donna! |
| **22.** | Could you explain the changes to LVI? Previous instructions were to code 8 for a list of schemas including Brain and CNS other. Now it is only for GIST and lymphoma/Heme. Also if there is a positive lvi given for a benign or borderline behavior code we would code as positive. | We checked with SEER and code 8 is allowed in the LVI data items for benign and borderline tumors. If LVI is documented as positive for a benign or borderline tumor, it would be coded 8. |
| **23.** | Would "potentially suspiciously for carcinoma" be included as an acceptable reportable ambiguous term? | Suspicious for carcinoma would be reportable. I would not consider potentially suspicious for carcinoma reportable. It seems like we're moving further away from a diagnosis, rather than closer. |
| **24.** | On a), what is the reason why it isn't reportable? | If this is in regard to Quiz 1; **very** likely is not considered ambiguous terminology that represents a reportable diagnosis. If on the other hand it stated **most** likely, that would represent a reportable diagnosis. |

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| **25.** | Would the phrase "with features of malignancy" on imaging be considered reportable? | If that was all of the information I had to work with, I would not consider it reportable. |
| **26.** | What is class of case if diagnosis by radiology at another facility, but biopsy confirmed and then all treatment at the reporting facility? | That would be a Class of Case 22 (Initial diagnosis elsewhere AND all first course treatment…at reporting facility. The biopsy should provide a histology that the imaging cannot, but if they diagnosed a reportable tumor on imaging, then that counts as the diagnosis, which in this case was done elsewhere. |
| **27.** | Is lymphatic space invasion considered a synonym for LVI? | I found a post on the CAnswer forum that indicated the terms are equivalent. http://cancerbulletin.facs.org/forums/forum/collaborative-stage/coding-instructions-part-1/part-1-section-1/3255-lymph-vascular-invasion |
| **28.** | In STORE 2021 the coding instructions, third bullet says to code 8 or n/a for benign borderline brain & cns but SEER 2021 this is not documented. Is this an oversite or if you are a SEER registry capture LVI if documented for /0 /1 brain/cns? I also noticed that for 2021 the malignant brain/cns is no longer n/a, we can now document if LVI is present. Can you explain why in STORE we can capture LVI if documented for the other /1 borderline tumors? | We contacted SEER and they will allow code 8 for a benign/borderline CNS malignancy.<br><br>SEER and STORE will both allow LVI to be coded to a value other than 8 for CNS primaries.<br><br>It's my understanding that LVI only occurs in malignant tumors. I am not aware of any borderline /1 histologies were LVI might be present. |
| **29.** | Isn't an estimated month better than blank? We know it was January or Feb. 2020 alone could mean any month (December) in 2020. | STORE provides instructions for coding a description of "Spring" as April, "Middle of the year" as July, "Fall" as October and "Winter" as either December or January, based on the best information available. In the example provided the best thing to do is leave the month blank and put the information regarding the timing in the Text. |
| **30.** | Mets at dx distant lymph nodes for lymphoma is an 8 now so is this a change for 2021 or a clarification ? | Coding Mets at Dx Distant LN an 8 for a lymphoma with primary site of C77 is consistent with how we have done it in the past. |
| **31.** | If a scan diagnosis a benign tumor but at resection it turns out to be malignant. | This question was submitted to SEER SINQ https://seer.cancer.gov/seerinquiry/index.php?page=view&id=20200032&type=q |