Q&A Session for Kidney 2021

June 15, 2021

#	Question	Answer
1.	I am constantly conflicted on p-staging with regards to the terms "must" "should" etc when determining yes or no if we can p-stage a case. Example... Resection including...recommended (slide 42). Our speaker said "must" and also said "recommended" in this case if the resection did not include the elements listed, would you say we code "stage unknown?" And this is across the board with many sites that I see this. Is there a general "catch all" that you can give us for guidance?	The requirements for pathological staging vary by AJCC chapter. In general, the primary tumor must be removed; however, there are chapters that require more extensive resections. For example, for bladder cancers, a minimum of a partial cystectomy must be performed to meet the criteria for pathological staging – that is, at least part of the organ, not just the tumor. The only way to get it right is to check the AJCC chapter that applies to your case for the pathological classification criteria. You can always answer the individual fields for each case with the data that is known (T, N, M) and then review the prognostic stage tables to see if a stage other than "99" (unknown) is possible with the data you have. So the "catch all" would be you must read the chapter classification rules for clinical, pathological, y-clinical and y-pathological definitions.
2.	With imaging, when lymph nodes are mentioned or lymphadenopathy is stated, does this automatically mean there is lymph node involvement?	No it does not. Lymph nodes can be enlarged due to inflammation, infection, as well as cancer. We must read the entire chart to see how the adenopathy is interpreted by the physicians. This could be found in statements such as "probably malignant adenopathy" or in staging statements "N1", etc.
3.	Regarding the path report for the nephrectomy, the left kidney noted that large vessel invasion is identified. What would that be referring to?	That is lymphovascular invasion. We only code named vessels in this SSDI. When you look at the codes for LVI, you will see venous (large vessel) invasion listed as one of the choices. (STORE v21 page 158)
4.	Could you explain the difference between cyro 13 vs 23 surgery code please?	Code 13 is used for cryosurgery alone. Code 23 is used when cryosurgery is used in combination with codes 20 (local tumor excision, NOS), 26 (Polypectomy), or 27 (Excisional biopsy).
5.	If there is a biopsy, would this still be a 13?	If the biopsy is excisional, then this would not be 13. If the biopsy is incisional (for diagnosis only), then 13 for cryosurgery would be appropriate.

6.	If on OR report there is mention of milking a thrombosis out of the IVC but no mention on the pathology of the IVC being involved how do we deal with this for the T category for AJCC staging?	Milking a thrombus is simply the process of working the thrombus out (like milking a cow the old fashioned way). Having a tumor thrombus in the IVC which can be milked or moved is not the same as involvement of the IVC walls. The thrombus is filling the IVC, but not invading the wall. If the walls of the IVC are not invaded, we use tumor size to determine our "T".
7.	So in CS tumor thrombosis this was considered a T3?	CS and AJCC do not always classify extension in the same manner. We no longer follow CS descriptions/fields.
8.	In our registry, we often see kidney cases where the tumor has been resected but no lymph nodes are resected because they were all negative on the clinical workup/imaging. CAnswer Forum has confirmed that using pNX is appropriate when there are no lymph nodes microscopically confirmed for kidney cancers. We end up having a lot of Pathological Stage groups 99 because of this. Do you know if there will be any discussions or changes in the future about perhaps including more pNX options on the Stage Group table, or adding Kidney to the "Node Status Not Required in Rare Circumstances" document so we can use cN0 in the Path N field when lymph nodes are not pathologically assessed?	It would be a dream if kidney could be added to the list of sites in the document titled "Node Status Not Required in Rare Circumstances" but I don't know if there are any plans for that at the current time. Those other chapters include phrases such as "regional lymph node involvement is rare" or "lymph nodes not assessed should be considered cN0, not NX or pNX." There is no similar statement in the kidney chapter.
9.	Can you repeat what code the thrombus belongs in? on page 45	Tumor thrombus in a renal vein, NOS is SS 2018 code 2 and EOD Primary tumor code 200.
10.	In our case scenario the path report indicates that the tumor was confined to the kidney, however there was also mention of large vessel invasion. Are we assuming that the large vessel invasion is within the kidney and not taken into account in the coding?	We are not assuming the large vessel invasion was within the kidney. Large vessel invasion is referring to lymphovascular invasion. If you look at the lymphovascular invasion codes on page 158 in STORE, code 3 is for Venous (large vessel) invasion only (V) and code 4 is for BOTH lymphatic and small vessel AND venous (large vessel) invasion. By definition, LVI is the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels WITHIN THE PRIMARY TUMOR as noted microscopically by the pathologist.
11.	It appears this case was not diagnosed until resection of the left kidney. Wouldn't this make AJCC Clinical Stage cT_cN_cM_, Stage 99 since there was no diagnosis of cancer until the radical nephrectomy?	The is very common in Kidney cancers. Per Donna Gress in the CAnswer Forum "Staging depends on the physician's interpretation. If the physician thought it was cancer it would be assigned a clinical stage. If the physician did not think it was cancer, then it would be

		an incidental finding at the time of surgery and the clinical staging would be blank." This was not an incidental finding of kidney cancer. The patient had a workup for kidney cancer. There is a lot more information about this case in the medical record, and we only put the basics here.
12.	On Page 58 ipsilateral adrenal gland involvement: if the adrenal gland is not removed, is it automatically a code 9? even if tumor is "confined to kidney" because code 9 says adrenal gland not resected.	No. We could use code 9 when the tumor is *not* confined to the kidney and the adrenal gland was not resected/assessed. We are allowed to use code 0 per the notes for coding 0 in the SSDI Manual (page 388): "If surgical resection is done and tumor is "confined to kidney" and staging is based on size, then there is no involvement of the adrenal gland."