Q&A Session for Breast 2021

August 5, 2021

#	Question	Answer
1	If you have one tumor and the one invasive component is described as grade 1 invasive ductal carcinoma, tubular variant, would histology be coded to tubular or do the rules push us to code this to 8500/3 also?	We sent this one to SEER. Looks like the pathologist is using the term “variant” incorrectly. *“Our breast experts don’t know why pathologists insist on throwing duct and tubular together. I would tell the registrar to follow back with the pathologist to determine which it is, duct or tubular, if possible. WHO does not recognize tubular as a variant of duct.Based on the info available, the only rule that applies is H19. Code invasive carcinoma NST/duct mixed with other types of invasive carcinoma* ***8523/3.”***
2	Typically, at our facility "Simple mastectomies" are considered nipple sparing. If this was the case here (nipple sparing) would the Surg Code be (30) even though that would not capture the expanders?	Correct, if it was a nipple sparing procedure, then the surgery code would be 30.
3	Should the pN stage reflect pN0 (i-)?	They changed that for us with the 8th edition. pN0(i-) is not a valid value in the 8th edition.
4	Should n the rule be h12 not h14?	H14 - Rule H14 Code the histology when only one histology is present. Note 1: Use Table 3 to code histology. You might want to make sure you have the newest version of the breast rules.
5	Why is tumor site not C50.9?	It would be C50.9 if the tumors were in different quadrants, but since they were both in the same quadrant, we can code the primary site to that quadrant.
6	Not sure why you are taking the site for the largest tumor?	We used the C50.4 primary site because both tumors were in the same quadrant. When coding primary site, size of the tumor is not a factor.
7	Clinically -- If the larger tumor was (GR1) / and the smaller tumor was (G2) would the Grade Clinical be (GR1) based on the larger tumor?	Per the Grade manual: Note 3: If there are multiple tumors with different grades abstracted as one primary, code the highest grade.

8	Can you discuss the use of code 8523/3, especially why it doesn't relate in case #2? Is it ever used anymore?	In case #2, we have two invasive tumors so we start at rule 20 and work our way through. Rule H26 is the first rule that applies. The rule that takes use to table 2 (combo codes) is rule H27. I'm not sure of the rationale. In practice, i don't think you would end up with a histology code of 8523 very often. Probably more common for single tumor than multiple tumors.
9	In case #2 radiation scenario, it states the 45 Gy in 25 fractions was "6x, 10x, 3D conformal" but there is no such specific description for describing the boost to the lumpectomy bed. You assume the description given for the 45 Gy primary dose also applies to the boost dose? You wouldn't code the modality and technique to external beam, nos?	Great question - you are correct, you should not assume - it just got left out of the scenario. We updated the scenario to confirm that the boost was completed using "6x, 10x, 3D conformal".
1	Would the treatment modality be the same for both phases?	The photons and 3D should have also been listed for the boost (sorry that got left out!)
1	Can you discuss why ycN is a 0 instead of ycN1? Imaging after neoadjuvant chemo still showed the lymph node mass.	Because the 16 nodes they removed were all negative - if we did not have an excision (and were only going from the scans) you would have used ycN1 (if the physician believed it was still involved) Likely the mass was still there, but all the malignant cells were dead.
1	Can't EOD LNs be a pathological code due to the dissection?	We went back and forth on this one! We confirmed with SEER that since the lymph nodes removed after neoadjuvant treatment did not provide a higher EOD LN code, we go with information from prior to neoadjuvant tx. If the EOD LN values from surgical resection after neoadjuvant are the same or lower than the pre-neoadjuvant values, we go with the pre-neoadjuvant values.
1	Are we going to code date of the regional ln dissection?	We did not include that field in the answer sheet, but you would code the date.
1	Can you discuss the difference between IGRT and IMRT and why the technique on case #3 is coded as 3D conformal 04 instead of 05?	It is interesting that when they report 3D at my facility, it is often accompanied as 3D/IGRT - the image guided is not equivalent to IMRT (image modulated) so we code as a 3D (04).
1	This may not be the venue for this question, but ... it is my understanding that any breast malig pt on a clinical trial would be considered a "censored case" and	Great question - I am not sure - I know we participate in RCRS and if a patient is on a clinical trial we can make a notation of some kind but I am

	therefore not RCRS eligible. Am I correct in this understanding?	sorry I am not completely sure about it being a "censored case" as I do not do the RCRS submissions.
	Isn't the tumor size on a scan more accurate than the PE?	Correct, and that is why we use it to report the "clinical tumor size" - Jim was just noting that for Staging purposes, AJCC would use the 4 cm.
	Would there also be a surgical procedure coded in addition to bx, to capture the FNA of the LN on 10/22/20?	Yes, there would be a 01 RLN biopsy coded for 10/22/2020.
	Pathological stage 99, I thought that you could only have a path stage or a ypath stage, not both - shouldn't the path stage be blank?	You are correct. I (Jim) was wrong on that one. Pathological stage group should be blank if there is anything in the yp stage. It also works the other way. If something is on pStage, then yp stage must be blank.
	Can you explain the SSDI Response to Neoadjuvant Therapy? When should we code as 9 versus a 3?	Note 1: Clinician statement of Response to Neoadjuvant Therapy ("treatment effect") must be used to code this data item. If we don't have statement from the physician stating the patient has complete, partial, or no response, we have to assign code 9. We cannot use our judgement to code this field.
	This question is concerning the TS question. So if the PE size of the tumor had to be 5.1 which would be a T3, we would stage as a T3 but use the 2.8 cm as Tumor size??	That is my understanding. I am assuming the difference in tumor size from the time of the MRI (2.8) until PE tumor size assessed (4cm in the case or 5.1 cm in your example) just before the start of treatment was disease progression. The tumor grew that much during that time period. If that is the case, then the tumor size recorded in TS Clin or TS Summary would be based on the information from the MRI. We would not include information after the disease progression. However, when assigning the cT value, we would use the size of the tumor just before treatment started. If that size was 5.1cm, then the physician would probably assign a cT3.
	I am sorry I missed the TS explanation of why you chose the 2.8cm over the 4.0 cm mass in case scenario 4. Can you please clarify?	See explanation above.
	Shouldn't the Other code be 2 or 3?	No. the Virus Therapy would be coded under immunotherapy based on SEER Rx.
	Where did you find the information regarding the Oncotype DX leing below 12 that we can code stage 1A?	See AJCC page 632 – when the patient is T1/T2 N0 with an Oncotype of 11 or less, the HER-2 is negative and the ER is positive, then this would be a path stage of IA.

2	Path tumor size, Seer Manual 2018; pg 111 Code the largest size of the primary tumor measured on the surgical resection specimen when surgery is administered as part of the first definitive treatment Note: This includes pathologic tumor size from surgery when here is neoadjuvant therapy. Maybe there was an update to this in the new manual?	The coding instructions were updated in the SEER 2021 manual. It now states pathologic tumor size should be a 999 if the tumor was resected after neoadjuvant tx.
2	How would you code a physician statement as a near complete response?	I think code 3 would be appropriate. However, next time the situation arises, I would send the question, including the exact terms used, to the CAnswer forum.
2	The reason you need the physician statement is that the registrar probably doesn't have access to all of the information. The PR, CR, etc. is NOT just based on the path report, you need physical exam, imaging, etc.	Thank you Donna Gress!
2	Near complete is unfortunately not complete, depending on what is actually going on. For example you can have DCIS and it is still called a complete response.	Thank you Donna!
2	Surgery Code 30 is a little confusing to me. Would you mind expanding on it?	Surgery code 30 is used often for non-cancer breast procedures (i.e. when a woman no longer wants breast tissue), but is sometimes used as cancer-directed surgery also. A good article about this kind of procedure can be found here: https://www.breastcancer.org/treatment/surgery/mastectomy/nipple-sparing Because the nipple (and most often a good amount of the skin) is left, it gives a very natural cosmetic result and based on the placement and size of the tumor, may be chosen by some women and their physicians.
2	Are tissue expanders ever used before tissue-based or combined (tissue + implant) reconstruction?	Yes, tissue expanders are a placeholder for later implants, so in the case where a patient will have tissue + implant procedures, expanders may also be used. We also just recently had a case where the patient’s reconstruction

		was delayed due to COVID and she had tissue expanders placed while awaiting the tissue reconstruction at a later date.
	Can you go over the mastectomy & tissue expander codes? where can i find more information on this subject?	The SEER Program manual appendix C has a little more explanation than the STORE manual. https://seer.cancer.gov/archive/manuals/2018/AppendixC/Surgery_Codes_Breast_2018.pdf There was also a document from the California Cancer Registry we found on line a few years ago that I think helps to understand the procedures a little more, "Q" – Tips (Quality Tips) August 2017 edition. **Breast Reconstruction Surgery of Primary Site - Part Two** https://www.google.com/search?q=breast+reconstruction+codes+for+cancer+registry&rlz=1I7GUEA_enUS709&gws_rd=ssl#spf=1628617872969
	There are 2 tables, prognostic and anatomic. Can you clarify which one we follow?	Yes, we must always use the prognostic staging tables.
	Which code to use for Technique if RAD ONC notes that IMRT and 3D conformal utilized? 03 or 04?	I found a really good post that may help clarify your situation. https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/radiation-data-items-aa/107789-imrt-with-3d-treatment-planning
	Is it correct to leave T blank when the size/extension is not determined, and only assign TX when the physician documents TX or when there is no assessment of the primary (including physical exam) ?	That is my understanding.
	Question about hormones: A breast cancer patient comes to our facility and still gets hormones (e.g. Tamoxifen) years after diagnosis and treatment elsewhere (because of needing hormones 5 years). If our facility takes over and starts prescribing the hormone, does that still make it first course and analytic to our facility even if she comes to our facility years later?	I found a post that might be helpful. https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/systemic-chemo-hormone-endocrine-bio-modifers-aa/115408-hormones-first-course-class-of-case-recording-treatment