Q&A Session for Uterus 2021

October 7, 2021

#	Question	Answer
1.	Just to clarify - for PRE-2021, we still do NOT use the 8085 even if the pathologist calls it that in the final diagnosis and/or the synoptic report based ONLY on the p16 IHC (no RNA done)?	Correct. 8085 or 8086 cannot be used for cervix prior to dx year 2022.
2.	To make sure I understand, with regards to these new HPV related adenocarcinoma, we code 8140 adenocarcinoma for Dx year 2021, until 2022. Is that correct?	Correct.
3.	When I say "pathologist calls it that" I mean I see pathologist using terms HPV-associated SCC & HPV-mediated SCC based on IHC p16+ alone.	I believe those terms have been used widely within the clinical world for some time now. We didn't adopt them in the registry world until 2022.
4.	Poll #2 - pt present on Jan 1 for tx so they would have been diagnosed in 2021 right?	That was an unfortunate choice of dates! For the purposes of the poll, we are going to assume the dx was in 2022.
5.	So we can use the HPV associated squamous cell carcinoma, even though this patient was almost certainly diagnosed in 2021 since our date of contact was 1/1/2022 because "that's all we know"?	That was an unfortunate choice of dates! WE are going to assume the dx date was 1/1/2022.
6.	FYI - check w/ central registry, some States collect CIS, CIN3 (ex: Michigan - https://www.michigan.gov/documents/mdhhs/MCSP_Cancer_Program_Manual_REV_20190225_725273_7.pdf)	Thank you!
7.	For the FIGO Stage SSDI, do we need to know which version of FIGO the physician is using, or just code what the physician says regardless of the version they use? For example, if they are using version 9 for a 2020 case, can we use that FIGO stage for the SSDI?	What I said on the webinar was incorrect. The updated FIGO values should only be used for cases diagnosed 2021 forward. If you know they are using the updated FIGO stage for a case diagnosed prior to 2021, you would code the field unknown. You will get and edit if you try use one of the new FIGO values for a case diagnosed prior to 2021.

8.	Tip- look in the Immunohistochemistry (IHC) section of the path report to find p16 results	Great tip!
9.	Are there plans to update the NAACCR recommended abbreviations? For example RA-TLH BSO (robotic assisted total laparoscopic hysterectomy w/ BSO).	I will forward your suggestion to the group that handles the abbreviations. I do not know if or when the next update is scheduled.
10.	Cone excision, under stage 1 is clinical staging and over T1 is pathological staging?	cone excision can be used for pT for pT1a1. Per NCCN guidelines it can be considered a definitive tx. Anything beyond 1A1 would be clinical.
11.	For 2021 cases, if we have coded the new HPV related adenocarcinoma to a specific histology i.e. 8310, 9110 instead of 8140, do we have to go back and correct our cases?	In my mind, it would not be a high priority.
12.	Case #2: pt was diagnosed w/ invasive SCC on D&C/bx (known cancer during clinical timeframe) - would clin AJCC have at least cM0 per chap 1 cM rules even if registrar doesn't know MD impression of cT and cN from exam & imaging work-up?	You are correct. We should have included the cN and cM values. It has been corrected in the current slides.
13.	Question on FIGO stage SSDI for corpus uteri: If the only recorded FIGO stage (say IIB) is from a partial hysterectomy with macroscopic residual disease and further workup reveals metastatic disease, would this FIGO stage be used for the SSDI item? Or would this be coded 99, not assessed?	That is a great question. I do not know the answer. Is this a real case? If yes, could you send the question to the CAnswer forum SSDI forum?
14.	New code in 2018 8461/3 high grade serous carcinoma, if we have that terminology on a endometrium c54 pathology can we use this code? C54 is not listed in bold after this code but I understand this list is just common sites where this would occur. If we can't use this code would we code to 8441/3	I sent this to SEER and they said to use 8441/3 for endometrium.
15.	I struggle with depth of myometrial invasion for clinical staging in endometrial cancers. Is there a measurement that's considered half? I usually only have a measurement from the path report.	Based on information from other participants, you should simply code this as a cT1. You do not have to code the subcategory.
16.	Pop quiz #3: I have scoured pelvic U/S reports & not seen any myometrium measurements/depth of invasion info. I had been coding cTX but per discussion w/ Donna if clinical w/u include info	Thank you Ruth!

	that tumor is confined to uterus - can assign cT1 (w/o subcategories). https://cancerbulletin.facs.org/forums/node/103257	
17.	Doesn't local Summary Stage become regional when there is positive washings?	Yes! I've added that to the slide.
18.	Follow-up to 8461/3 question. We had asked this same question to SINQ and got a different answer. SINQ emailed back with an answer of "when high or low grade serous carcinoma occurs in the endometrium code 8441/3. 8461/3 was to not be used any sites other than those listed." Please verify the conflicting answers. Thanks.	I think you/SEER are absolutely correct. 8461/3 should only be used in specific situations. It does not look like it would ever be used for endometrium. High grade serous carcinoma of the endometrium would code to 8441/3. Thanks Gail!
19.	"Looking ahead in the slides, clinical case#1 - is there a national resource/std for doses of chemo in terms of whether it is radiosensitizing dose vs cancer-tx dose (or is it pt weight/health dependent)?	Not that we are aware of.
20.	Per STORE we are not to code radiosensitizing chemo but I have rarely seen HemOnc explicitly state whether or not the intent is for radiosensitization, but I do have access to dosing info in EPIC under ""meds""."	In general, when chemo is prescribed for gyn malignancies, it is definitely for curative intent. Please review the NCCN Guidelines on this.
21.	Why is brachytherapy alone not considered for total dose if you know how much cGy is used?	Keep in mind that the vast majority of vaginal cuff brachytherapy is delivered via Ir-192 radioactive seeds. The International unit of activity is the Becquerel (mCi widely used in the USA). Activity is then converted to absorbed dose (cGy). It is because of this conversion that we do not add brachytherapy dose to EBRT dose to get the total dose summary.
22.	Just a comment...Coding XRT can be very confusing for those without a background in Radiation Oncology. As a former Radiation Therapist, Wilson Apollo does an excellent job explaining XRT. Tip - IMRT is ALWAYS photons.	Thanks for the compliment! Glad I can provide you with useful information!
23.	Love that Wilson included examples of how to text appropriately! We always say at our facility that you should be able to complete/code a full abstract based on texting alone.	Glad to see that others value the importance of the information provided in the Notepad.

24.	This question has to do with slides 34 and 35. For case #2, I think you had said the clinical TNM would be blank, with Stage 99, Correct? T would be blank since we don't have enough info to assign it, but because the PET indicated a suspicious 20 mm rt iliac node, would we be able to use that for cN and stage as cN1a? Per Cervix V9, on page 18, for Imaging: "Metabolically active lymph nodes of any size on PET/CT are considered metastatic, unless there is another known cause for metabolic activity."	I have to admit I missed that statement about metabolic activity. I'm not 100% sure that was meant for registrar use. I'm also not sure if "biologic activity" which is what was in our case scenario is equivalent to "metabolic activity". I've sent the question to CAnswer forum. https://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-version-9/education-developed-by-partner-organizations-aa/naaccr-webinars-and-edit-workgroup/121232-pet-ct-biologic-tumor-activity
25.	Wilson's case 2...should total dose of Phase 2 be 002400 instead of 001200? Case 2 "Notepad Text" states 12 Gy x 2 fx = 24 Gy	You are correct! Good catch. I will update.
26.	"For new registrars starting out abstracting how to obtain older version of CTR RXT coding guide for pre-2021 cases?	I will bring this up to the CoC RT working group at our next meeting. Keep an eye on the CoC Answer Forum for possible links to older version of the CTR Guide
27.	For example - do they code ""86 pelvis"" on pre-2021 dx yr cases instead of psite after surg of primary site per the v3 CTR RXT coding guide? Or are version 3 info applicable to 2018+ & not just 2021+?"	As per the 2020 revision of the STORE manual, for 2021 cases, code the irradiate volume to the primary site, even if the primary site has been resected. Only exception is breast cases.
28.	For cases when the external technique is NOT provided and NO clue otherwise what the external technique used was, do we default to code 01 external beam, NOS?	This is where it is critical to have familiarity with the equipment used at the facility (ies) you abstract for. For example, if your facility uses a linear accelerator (as most cancer centers do in the US), they you will know that photon beams are used, which will allow you to code the modality to 02, photons. It is also important to reach out to a radiation therapist or treatment planner at your facility for this type of information.
29.	With Case 6 I'm assuming NCDB only collects 3 phases no matter how many phases you enter within your cancer registry software. Is that correct?	The CoC collects only three phases. This is why it's important to document all additional phases and details in text format.

30.	For Case 5, Radiation case, Phase 3, I thought the volume was supposed to be 72-Vagina for vaginal cuff brachytherapy or is it 71 because it was stated to be to the cervix on slide 19?	You are correct! For vaginal cuff brachytherapy, always code to 72-vagina.
31.	I always enjoy his detailed and informative lectures on radiation, as this coding can be complicated even from a former nuclear medicine tech. pictures help in the scenarios you shared. thank you	You are welcome!
32.	I believe I heard you state that IMRT tells us this is photons. Is 02/photons the only possible modality for corresponding IMRT planning technique?	That's correct.
33.	Did you say electrons are always 3D conformal?	I was referring to the use of electron boost for breast cancer following whole breast or partial breast photon therapy (breast tangents). In this particular scenario, the electron boost is invariably 3D conformal.
34.	Do some CTRs really not text?! I thought text was just as important as coding itself!	I truly believe it is. I wish one of our standard setters would conduct a study to focus on this deficiency in the data collecting process.
35.	"Yes, thank you so much Dr Apollo, your RadOnc-CTR expertise is invaluable to the registry profession.	You are very welcome!
36.	If only we have HEmOnc-CTR and/or SurgOnc-CTR too! :-)"	Ditto that!
37.	Follow-up - previous versions of CTR coding guide not on cancer forum or CoC website, so not sure how registrars will know to use the old versions to code pre-2021 cases	I will bring this up to the CoC RT working group at our next meeting. Keep an eye on the CoC Answer Forum for possible links to older version of the CTR Guide
38.	I've sent your question to SEER for a clarification. We'll include it in the Q&A."	
39.	Does the ''HPV positive'' statement needs to be made by a pathologist (on path report) to code 8085 or a DX of SCC only on path report but HPV+ mentioned by another physician would make it 8085 also?	No. A physician statement is good enough to assign HPV associated or independent histologies.
40.	So if the path report provides the FIGO stage, we can't document on the SSDI?	No! If the FIGO stage is given, assign that stage to the FIGO data item. If it is not given, you cannot calculate the field based on imaging, path, etc. If the FIGO stage is not given, assign it as unknown.

41.	Can you pathologically stage group when no lymph nodes are resected? Taking into account the clinical lymph node info when clinical lns are not susp, can we use stage cN0? pT_ NX M0 Stage 99 or cT_ cN0 M0 Stage _	For endometrium you can use a cN value in the pN data item if there is no removal of lymph nodes, but the primary tumor was removed.