Q&A Session for Bladder 2021

November 4, 2021

#	Question	Answer
1.	The STM website says editors recommend to use the Sep 2021 update AFTER 1/1/2022 and continue to use the Dec 2020 version for 2018-2021 diagnoses. Is the case scenario a 2021 or 2022 case?	It's a 2022 case. We didn't use a year in the case scenario, so that is a good question.
2.	Re-reading the STM website again - maybe the editors mean until registrars get 2022 software to continue using the Dec 2020, but once converted to 2022 can start to use the Sep 2021 STM since that manual still says it is for diagnosis 2018 and forward?	In the urinary rules update for 9/2021, there were no changes to the urinary rules. The revision log shows the note about papillary growth does not equal papillary carcinoma; it also shows do not code histo based on configuration or growth pattern description/terms. The September 2021 release of the STRs are to be used starting in January 2022. At that point, they can be used for any cases diagnosed 2018 and forward, although we are not expected to go back to change any previously abstracted cases based on any changes in the STRs.
3.	Where do find those tables on pages 11-14 of the slideshow?	Table 1 (primary site) is on pages 5-6 (317 in the complete manual download) in the December 2020 STR. Table 2 (histologies) is on pages 8-9 (320 in the complete manual download) in the December 2020 STR. And Table 3 (non-reportable) is on page 10 (322 in the complete manual download) of the December 2020 STR. Denise just added shading and/or arrows to help discuss different portions.
4.	Patient with invasive unilateral-sided renal pelvis papillary urothelial carcinoma with subsequent non-invasive bladder papillary urothelial carcinoma within 3 years is a single primary (first rule M11)? Patient later has invasive bladder papillary urothelial ca (<3 yr from the in situ bladder but >3 years from renal pelvis) still single primary (again M11)?	We confirmed with SEER that the "clock" in rule M10 would restart when the in situ bladder tumor was diagnosed. Therefore, rule M11 would apply when the in situ tumor was diagnosed and again when the second invasive tumor was diagnosed. Since the in situ tumor was considered a recurrence, rule M6 would not apply to the second invasive tumor.

5.	Can you please review Note 1 under rule M10? That note is easy to overlook but is very important.	Rule M10: Abstract **multiple primaries** when the patient has a subsequent tumor after being **clinically disease-free** for **greater than three years** after the original diagnosis or last recurrence. ***Note 1:*** This rule **does not apply** when both/all tumors are urothelial carcinoma of the bladder. Note 1 was put in because bladder tumors frequently occur multiple times and they do not want to overcount the occurrence.
6.	Is it common for a patient to have neoadjuvant therapy for bladder cancer? I suppose any chemo before a cystectomy would be considered neoadjuvant therapy.	Patients with Stage 0a, 0is, or stage 1 bladder cancer may have intravesicle BCG or chemotherapy following a TURB. This is not considered neoadjuvant treatment. Patients with muscle invasive bladder cancer (clinical stage 2 or 3A) are likely to receive systemic chemotherapy after their TURB. This systemic chemotherapy given after the TURB, but before their cystectomy is considered neoadjuvant therapy. Neoadjuvant treatment is recommended (category 1 per NCCN) for patients with clinical stage 2-3A bladder cancer. Defining "Neoadjuvant" is a tricky thing and can mean different things depending on how it is used. When it comes to AJCC staging, if a patient has a TURB followed by a full regimen of chemo, followed by partial cystectomy or cystectomy, we have met the criteria for neoadjuvant therapy and the results from the cystectomy would be coded as yp stage. https://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/urinary-tract/urinary-bladder-chapter-62/87705-if-turbt-followed-by-chemo-and-then-cystectomy https://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/urinary-tract/urinary-bladder-chapter-62/117589-yp-staging-bladder-case. However, when coding systemic/surgery sequence, you would count the TURB as surgery. So, you would assign code 7 Surgery both before and after systemic therapy in this scenario.

7.	Where can we find explanation(s) about what "indented" histologies mean - is this is located anywhere in the STR Manual? Thanks.	If you look at the written instructions just under the title for Table 2: Specific Histologies, NOS, and Subtypes/Variants, you will see the following: "Column 3 may contain NOS histologies which are part of a bigger histologic group. For example, sarcoma NOS 8800/3 (column 1) is a generic term which encompasses a number of soft tissue tumors, including rhabdomyosarcoma 8900/3 (column 3). Rhabdomyosarcoma is also a NOS because it has a subtype/variant 8910/3. The subtype/variant is indented under the NOS (rhabdomyosarcoma) in column 3. There is also a note in column 1 which calls attention to the fact that rhabdomyosarcoma has a subtype/variant. When subtypes/variants are indented under a NOS in Column 3, use coding rules for a NOS and a single subtype/variant. For example, rhabdomyosarcoma **8900/3** and embryonal rhabdomyosarcoma **8910/3** are a NOS and a subtype/variant, **NOT** two different subtypes. " Also, reviewing the examples and notes might be helpful. SEER is relying on our historical use of indentation as found in ICD-O manuals to guide us.
8.	So a TURBT is considered surgery in the surgical coding sense, but NOT in the AJCC staging sense. AKA I can't use a TURBT to pathologically stage?	Correct. TURBT is a resection of the bladder tumor, defined under the "Local tumor excision" section in the surgical codes. But because pathological staging in AJCC requires pathological description of how far through the bladder wall the tumor is found, a TURBT cannot be used for pT description because it frequently removes the stalk or flat tumor without attempt to "dig" into the bladder wall and we don't have complete information. AJCC requires a minimum of a partial cystectomy to meet the pathological classification criteria.
9.	On slide 32, please clarify the difference in example 2 and 3. Both have "component" noted.	Example 3 does not use the phrase micropapillary CARCINOMA component, so we can ignore that phrase and code to 8120. The "component" must describe a carcinoma or sarcoma.

		Please see Note 1 under item #1 in the "Coding Histology" section: "***Note 1:*** The terms above (A, B, C) must describe a **carcinoma** or **sarcoma** in order to code a histology described by those terms. ***Example:*** When the diagnosis is adenocarcinoma with a clear cell **carcinoma** component, code clear cell carcinoma 8310. ***Negative Example:*** When the diagnosis is simply adenocarcinoma with a clear cell component, code adenocarcinoma NOS 8140. Do not assume this is a clear cell carcinoma. This could be clear cell differentiation or features."
10.	Question about histology of urethra. Biopsy shows carcinoma with keratinizing and squamous features, invasive and in situ in smooth muscle and skeletal muscle	With the information provided, we would have to assign code 8010/3 (carcinoma NOS) because we are instructed to ignore "features" and having invasive and in situ in a single tumor is a single primary per Rule M2, Note 3.
11.	so we are going to start coding our 2021 cases. Will we be using the 09/21 updated STR and use configuration? Or follow the note on top of STR and continue to use the Dec 2020 version?	In the urology rules, it truly doesn't matter because no rules for M or H were changed. They just added some updated notes per the revision log. You can use the current (December 2020) STRs until January 1, 2022. Once the latest revision of the STRs becomes effective, that revision can be used for all cases diagnosed 2018 and forward.
12.	Just a reminder that it is very important to include in text when coding a more specific histology described by ambiguous terminology due to histology coding 3B (specific histology confirmed by physician or patient receiving treatment based on specific histology described by ambiguous term).	
13.	The use of configuration or not changes the histology code.	Prior to the September 2021 release of the STRs, we did not code based on "configuration" terminology. The STR editors removed "configuration" from the "do not code" list; however, they did not provide any guidance on using that term to assign

		a more specific histology. We have reached out to them for clarification. Their response is as follows: "By removing "configuration" from the list, this indicates that you may code a histology identified as XXX configuration. This primarily applies to papillary urothelial tumors. So a diagnosis of urothelial carcinoma in situ with papillary configuration is coded 8130/2. The change was made at the request of AJCC AND by agreement with the NCI SEER expert GU pathologists. For surveillance purposes, this change in codable terminology applies to cases diagnosis 1/1/2022 forward."
14.	When you get to rule M11 (single primary when multiple urinary organs involved), can you use cystectomy OR ureterectomy for pathological staging? For example, tumor found first in bladder, 1 year later found in ureter/renal pelvis. Only ureterectomy done. Can I use the ureterectomy for pathological staging for this case?	In this example, you cannot use information from a year later for staging. While this would be a single primary, the rules for staging are different. The ureterectomy was not part of the first course of treatment, and does not fall within the timing criteria for pathological staging in AJCC.
15.	Is the patient with an insitu UC considered to have a disease free interval when treatment is only TURBT then has invasive UC 90 days later?	We do not have adequate information to answer this question. If the tumors are the same tumor (i.e. in situ partially resected then another resection of that same tumor 90 days later), they are a single primary per M2. If the tumors are separate tumors, they would be multiple primaries because an invasive tumor more than 60 days after an in situ tumor returns multiple primaries. https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/122117-bladder-turb-code-27-vs-22
16.	So TURBT then full course chemo then cystectomy is AJCC clinical and yp staging, but for the rest of the abstract it is surgery BEFORE and AFTER systemic tx and we code 2 surgeries (TURBT & cystectomy). AJCC separate from the other rules.	Correct.
17.	03/15/19 renal pelvis 8130/2 and 06/23/20	

18.	It is common for invasive bladder cancer to have neo-adjuvant therapy - see NCCN guidelines. Normal TURBT is to rule out invasive tumor. If patient has chemotherapy after TURBT, it is neoadjuvant. Because TURBT is not surgical resection.	Correct. If patient with muscle invasive urothelial bladder cancer has systemic chemotherapy after their TURB but before their cystectomy, it is considered neoadjuvant treatment.
19.	I have had a case where patient had TURBT and had residual tumor. Urologist felt the tumor was deep and patient would need a Cystectomy, but would need chemotherapy first. Chemotherapy was completed. Patient opted not to have a Cystectomy and instead had a TURBT. Would this be considered Neoadjuvant therapy? And would the patient then have a yc stage with the TURBT since they opted not to have the Cystectomy?	This would be yc staging because the TURB following the chemotherapy does not meet the criterial for yp staging. It is not uncommon for a patient to have TURB after neoadjuvant chemotherapy. If the tumor is no longer muscle invasive, the patient may not have to have a cystectomy. In that case a yC stage would be assigned.
20.	Dx 03/15/19 renal pelvis C65.9 with histology 8130/2 and Dx 06/23/20 bladder C67.5 with histology 8130/2 what rule applies?	The first rule that applies is M11: Abstract a single primary when there are multiple urothelial carcinomas in multiple urinary organs.
21.	Timing Rule, case with small bladder tumor, removed on cystoscopy, and v. lg filling the lumen tumor in the ureter. bx'd on ureteroscopy. Both came back. non-invasive papillary urothelial cancer. Patient opts for ureterectomy (decision within 90 days). Surgery is done over 90 days. Ureter tumor returns invasive papillary urothelial cancer. If I take the 90-day rule literally in this case it's two primaries. But does the fact that the BX is from a larger tumor already present and decision to resect within 90 days affect this? There was no muscularis propria in the original bx to allow determination of invasion. Thank you.	I am not familiar with any 90-day rule. The small bladder tumor was removed and the larger ureter tumor was only biopsied. It is the same tumor that was there at diagnosis because it has not been treated yet, but once resected, it is found to be invasive. These two tumors are a single primary per Rule M11 because we have urothelial carcinomas in multiple urinary organs.
22.	Since we can use the CAP protocol for coding histology and can now use configuration, can we use this section on CAP Tumor Configuration for histology?	We can use the CAP protocol to code histology ONLY when the histology is not listed in any addenda/comments, the final diagnosis or synoptic report. The STR editors have confirmed we are allowed to use "configuration" to assign histology.

23.	I'm a post 2018 CTR: transitional cell = urothelial, correct?	Yes. You can confirm this by looking at the equivalent terms and definitions. They list urothelial carcinoma and transitional cell carcinoma as being equal or equivalent terms.
24.	Is there any special code for blue light cystoscopy vs white light? I assume not?	No. There is no code for cystoscopy under special lighting. This is referring to a scoping procedure and we do not have codes for those. We document them in text.
25.	Can we stage AJCC pathological T for Noninvasive urothelial ca based on TURBT only?	No. pT requires a minimum of a partial cystectomy per the pathological classification descriptions in AJCC bladder chapter https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/122117-bladder-turb-code-27-vs-22
26.	For the exception for pM1, assign clinical grade for pathological grade, is that for 2021 or 2022 cases?	That rule was effective for 2021 diagnoses.
27.	My urologist likes to say "resected the tumor and fulgurated the surrounding areas". Is that considered TURB with fulguration 22 or a only a 27 TURB?	We sent this question for clarification https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/122117-bladder-turb-code-27-vs-22
28.	For TURBT it's important to read the op note and understand the types of instruments used for the correct surgery code. For example-bipolar resectoscope-it's an instrument that uses electrical currents for resection and should be coded 22-electrocautery	We have asked CoC for a clarification on surgery codes 22 vs 27. https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/122117-bladder-turb-code-27-vs-22
29.	How do we determine the first course of therapy - I often see TURBT followed by repeat TURBT (usually to make sure they get some muscle to check for muscularis propria invasion)? If they find more they usually do BCG/chemo instillation, that's all first course right?	For non invasive bladder cancer with visually incomplete resection or high volume tumor, the NCCN guidelines recommend repeat TURBT. The patients are stratified into risk groups, and the treatment recommendations depend on which group they fall into. What you describe appears to be first course treatment.
30.	For the bladder case scenario, can you please go over the surg & systemic therapy codes please?	Please see the answer sheet for the case scenario.

31.	Used to call the intravesical "shake and bake"	This refers to use of post-TURB immuno (BCG) where drug is instilled in full bladder and then “rolled” around to ensure drug touches all of inner bladder mucosa.
32.	Invasive following in situ after more than 60 days would only be a new primary if multiple tumors. If it's the same tumor would you go back and change the behavior of the original dx to 3?	Correct. Invasive following in situ by more than 60 days would only be multiple primaries if the tumors were different tumors. If they are the same tumor, the behavior of the original diagnosis would be updated.
33.	Piggy back on the in situ & invasive 60 days later question: if the initial TURBT op notes state majority removed and path says specimen is superficial and repeat TURBT planned but delayed due to insurance/COVID/etc and on repeat TURBT >60 days later invasive cancer found that still 2 primaries (rule M6) or M1/M2 rule would apply first in that case?	This would only be multiple primaries if the tumors were separate, non-contiguous tumors. A single tumor is always a single primary per rule M2.
34.	Sorry about that, what if the 2nd TURBT shows more tumor that was not there so not resected at the 1st TURBT. Is it still 1st course or is it more like a progression of disease?	Remember that not all flat tumor is seen at the first resection. If the 2nd TURB follows NCCN guidelines, we would consider it first course. Be sure to read the op notes, the urologist H&P, to see how the urologist describes the circumstances.
35.	So where DO we draw the line between first course of treatment and subsequent treatment when TURBT after TURBT shows in situ papillary urothelial carcinoma in the same area?	Follow the NCCN guidelines. Read the urologist’s descriptions of why the TURBT was done. In general, the first and second TURB could meet guidelines, but subsequent TURBs for continued “recurrence” would be considered subsequent therapy.
36.	I agree with Jim on the surgery codes. Familiarity of the instruments used is important. If the surgical instrument uses electrical current then the code should be 22.	We still maintain that the reason the electrical current is being used should be documented (dissecting tumor vs cleaning up bleeders). Once we receive confirmation from the CoC, we will post an updated answer. https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/122117-bladder-turb-code-27-vs-22
37.	If the Op Report states transurethral resection would this be coded to 20? Also, what is the difference between a transuretheral resection and a TURB or are they the same?	A TURB (TURBT) is a transurethral resection of a bladder tumor. The codes most frequently used to document this are 27

		(excisional) vs 22 (excisional plus use of electrocautery or laser to remove tumor)
38.	It is my understanding that it can't be determined that the patient is disease free after a TURBT for Insitu cases. Is this correct?	That would be a question for your urologists. It depends on how the tumor was resected and the follow-up TURB.
39.	Can you explain the difference between the "synoptic report required by CAP" and the CAP Protocol?	The General Instruction in the STRs explain the differences between the synoptic report and the CAP Protocol. "**CAP Protocol:** The CAP Cancer Reporting Protocols provide guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care. The protocol is a check list which allows the pathologist to note their observations while reviewing the slides and/or gross specimen. CAP Protocols include all relative data elements including site, surgical procedure, tumor size, histology, grade, margins, lymph node status, and staging along with other site specific elements. The protocols are multiple pages." "**Synoptic Report:** All core and conditionally required data elements outlined on the surgical case summary from the cancer protocol must be displayed in synoptic report format. Synoptic format is defined as: ● _Data element: followed by its answer (response). ● _The data element should be represented in the report as it is listed in the case summary. The response for any data element may be modified from those listed in the case summary, including "Cannot be determined" if appropriate. ● _Each diagnostic parameter pair (Data element: Response) is listed on a separate line or in a tabular format to achieve visual separation. The following exceptions are allowed to be listed on one line: o Anatomic site or specimen, laterality, and procedure

		o Pathologic Stage Classification (pTNM) elements o Negative margins, as long as all negative margins are specifically enumerated where applicable ● _The synoptic portion of the report can appear in the diagnosis section of the pathology report, at the end of the report or in a separate section, but all Data element: Responses must be listed together in one location “
40.	I remember the pM1 exception ever since AJCC 7th edition?	This has been a long-standing rule in AJCC. It was also in the 6th edition.
41.	Can we presume that papillary carcinoma is a TPCC and coded to 8050?	Papillary (adeno)carcinoma/8050 and papillary urothelial 8130 (transitional cell) carcinoma are not the same entity. If the organs where the histology is being described are urinary, it is more probable that it is 8130.
42.	Janet Vogel went over a great example about the CAP/synoptic/final diagnosis histo coding in her lung webinar recently.	Please see previous answer which explains the difference.
43.	Is superficial papillary bladder carcinoma an in situ behavior as well?	In order to identify a bladder tumor as in situ, that statement ("in situ") must be listed in the pathologic diagnosis. A superficial pap uro carcinoma may have an in situ (/2) behavior OR non-invasive behavior (/2) or could be (micro)invasive (/3) -- depends on the path report
44.	Sometimes the bladder tumors are seen on cystoscopy and then fulgurated and the urologist says superficial papillary bladder carcinoma and stages as ' ta' so can we code as 8130/2?	I would hope those kind of statements are from a follow-up TURBT. If they don't get a pathology report specimen, I can't choose 8130/2. So if all tumors are fulgurated without path, I don't know for sure if malignancy was found. The patient could have PUNLMPs (8130/1 on the Non-Reportable List in the STR). If they call it superficial papillary bladder CARCINOMA, and the pathologist assigned Ta, it would be /2. The assignment of Ta requires microscopic confirmation, and if no tissue was sent to pathology, we cannot use that (Ta).

45.	Is there an example of M14?	Breast (C50) and Bladder (C67) are different at the 2nd characters; Kidney (C64) and Bladder (C67) are different at the 3rd characters. A tumor in the bladder C67_ and a tumor in the kidney C64_ are different at the 3nd character, so those are multiple primaries. A tumor in the bladder C67_ and a tumor in the colon C18_ are different at the 2nd character, so those would represent multiple primaries.
46.	Where are the "Important Notes on Histology" located?	Hopefully you found it right before the H (histology) rules started in the STR. When you click on the Histology section of the rules, you will find IMPORTANT NOTES listed in all caps just under the priority order for using documentation to identify histology.
47.	Urothelial carcinoma with foci of micropapillary urothelial carcinoma would be histology 8120/3 because we can't use foci right?	Correct. (pg 31 of the urinary STR)
48.	Comment/reminder: please document in abstract text any physician/tx plan statements that confirm ambiguous histologies. This helps central registries verify correct histology coding.	Good reminder, thanks
49.	Regarding your slide 35 - ambiguous terms - Is "probably" equal to "probable" or are they different terms?	The example for 3A on page 30 uses the term "probably" and gives the answer per slide 35. Even though probable is the term listed on the ambiguous list, these terms must be considered similar or interchangeable based on how SEER provided the example.
50.	But what about the physician's statement instructions that we are taught?	I am having a hard time finding the context for this. I think it has to do with something Louanne said, so if you could refer me to the slide, I will try to address your question. Thanks.
51.	For slide 32, third example, you stated that it should be coded to Urothelial carcinoma (8120) but shouldn't we code regardless if described as majority, minority or a component? So it should be micropapillary urothelial carcinoma?	While the micropapillary was described as a component, that component does not describe a carcinoma or sarcoma. Here is the example from Note 1 under this instruction in the “Coding Histology” section. Note 1: The terms above (A, B, C) must describe a carcinoma or sarcoma in order to code a histology

		described by those terms. The 3rd example fits with the explanation below provided with the “Negative example.” Example: When the diagnosis is adenocarcinoma with a clear cell carcinoma component, code clear cell carcinoma 8310. Negative Example: When the diagnosis is simply adenocarcinoma with a clear cell component, code adenocarcinoma NOS 8140. Do not assume this is a clear cell carcinoma. This could be clear cell differentiation or features.
52.	I had a pathologist put a "p" stage on a TURBT, can I use that for path staging or just document it in my path text?	No. We cannot break the rules in AJCC. Pathologists often use the “p” when they have looked at something under the microscope; however, the rules in the AJCC urinary bladder chapter require at least a partial cystectomy for pT. “Pathological staging is performed on partial cystectomy and radical cystectomy specimens and is based on both gross and microscopic assessment.” Amin, Mahul B.; Hess, Kenneth R.. AJCC Cancer Staging Manual, Eighth Edition (Page 787). American College of Surgeons. Kindle Edition.
53.	If a TURBT is done and they are planning to do instillation of a chemo drug while in the operating room, do they fill the bladder first to make sure there are not leaks before the instillation of the chemo drug?	The bladder should not “leak” after a TURB. That implies the bladder wall was perforated. However, whether the bladder is filled with saline is not necessary to know to code the use of the instillation of chemo.
54.	Are these all the same primary? 6/1/20 – NON-invasive papillary uro ca HG in BLADDER (C67.X) <8130/2> 8/12/20- NON-invasive papillary uro ca HG in LT URETER (C66.9) <8130/2> 9/28/20 – INVASIVE uro ca HG in LT URETER <8120/3> 11/20/20 – INVASIVE papillary uro ca HG in BLADDER <8130/3>	6/1/20 HG PUC 8130/2 in the bladder followed on 8/12/20 by HG PUC 8130/2 in the Lt ureter. These are a single primary per rule M11. 9/28/20 HG UC in Lt ureter. This is a new primary per rule M6. 11/20/20 HG PUC in bladder. This is the same primary as the 9/28/20 tumor per rule M11.