Q&A Session for Lung 2022

January 6, 2022

#	Question	Answer
1.	What is the best way to determine if you have lung nodules in bilat lungs if this is a 2nd primary or mets to contralateral lung? This is very confusing to figure out when abstracting. I have been asked to abstract a 2nd primary before for 2nd primary for contralateral lung nodule without bx proven diagnosis? Any help with this would be greatly appreciated.	Janet Vogel mentioned in one of her lung webinars about page 449 Table 36.12 - additional guidance on AJCC categories which is helpful. You also always need to follow the STR – that should be your first stop any time there are multiple tumors. From there you need to also take guidance from the pathologist, radiologist and treating physicians.
2.	When we see collapse of the lung, can we consider this at be atelectasis?	Since the T table for lung specifically states atelectasis or obstructive pneumonitis extending to the hilar region, I don't think I would consider "collapse" alone to be enough to qualify for T2.
3.	T2 says atelectasis/obstructive pneumonitis that extends to the hlar region. Does atelectasis without mention of the hilum be considered T2 also?	Since the T table for lung specifically states atelectasis or obstructive pneumonitis extending to the hilar region, I don't think I would include those cases that do not mention the relationship to the hilum as a T2.
4.	Jim, for the T2 tumor w invasion of visceral pleura. Do you carry all the bullets from the general T2 down into the T2a and T2b for size? Or should all cases that have visceral pleural invasion just be a T2 (without the a or b category)	See page 451 of your AJCC manual. there is a really good explanation. If the tumor is less than or equal to 4cm and involvement of one of the sites listed, then t2A. If greater than both less than equal to 5cm it's a t2B.
5.	Doesn't note 4 for "separate tumor nodules" say not to code in this item for diffuse pneumonic-type adenocarcinoma?	You are correct, this was my mistake – we do not code separate tumor nodules for diffuse pneumonic-type adenocarcinoma per the instructions in the SSDI manual.
6.	For the separate vs intrapulm mets - physician's assessment takes priority over the guidance in AJCC tables 36.7-36.9 then? The tables are there to help the physicians but ultimately the physicians make the call, right?	Correct! They make the call because that is the way they will be treating the patient.

7.	We don't usually have access to the physician. When we see groundglass on diagnostic imaging can we assume (m) if the patient also has other lung disease, such as emphysema?	I try not to assume - but this is a clue - the way the physician is treating the patient is also a clue.
8.	"Another fun thing to remember about T2. You might have associated with atelectasis or obstructive pneumonitis that extends to the hilar region, involving part or all of the lung and want to assign a cTa.. but if you don't know the size of the tumor, you still have to leave the cT BLANK... per Donna Gress "T2a does give you that option of size not determined. But, you do need to know that it is not a size that would qualify for T3 or T4. That note is just allowing for a small tumor where it cannot be clearly measured. It is not giving an option to not have any information on the size. So in order to assign T2a you must know something about the size, it cannot be completely unknown. For the stage group, you cannot assign it with just T2 N0 M0." https://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/education-developed-by-partner-organizations-ab/other-organizations-resources/121114-lung-t2-size-cannot-be-determined#post121164"	That makes sense. Thank you!
9.	I thought you can't do Pl 0 Pl1 Pl2 unless there is surgery and pathologist states this?	That is correct. PL must be based on pathology.
10.	Case 1 would you code Reason No Surgery as 2 contraindicated or 7 Refused? It was kinda both... I think 2 would take priority, but it doesn't really state that anyplace?? Thoughts??	I would use "1-not recommended". The physicians did not recommend because of the emphysema, so would not necessarily code it as refused. You have to base this on all of the information – in this case (based on the whole chart) the physicians were not really recommending surgery and the patient did not really want surgery, but the physicians felt XRT would be the best option.
11.	Is there a priority order for "reason for no surgery of primary site"? For case #1 would it be 2 (contraindicated) or 7 (pt refused)? Or is patient not really offered surgery due to emphysema	I would code it as not recommended because she had the emphysema and the physicians felt that the radiation would be just as effective. I don't believe there is a priority order.

12.	I thought we were supposed to code lymph node biopsies / FNA as a surgical procedure? Are you supposed to code negative biopsies?	An FNA of a regional node is coded in scope of regional ln surgery as code 1. Doesn't matter if the results are pos or neg. We do code negative surgeries.
13.	On slide 15, "MR-gated approach", is that supposed to say "MR-guided approach" instead? I just want to make sure I am understanding it correctly.	I would have to go back and look in the MR but I think it did say gated? Yes the MR said gated.
14.	Ann Hatfield-You just said use code 95 for FNA of the LNs and the nodes were neg. Per STORE it appears we would only use 95 if they are positive??:	For regional nodes examined, I don't see anything in the STORE about only coding this if the LN is positive. RLN examined = 95 (they did an FNA on a RLN). RLN positive = 00
15.	Wouldn't you code as 2 contraindicated?? It wasn't recommended due to emphysema.	See prior explanation.
16.	STORE: Use code 95 when the only procedure for regional LNs is a needle aspiration (cytology) or core bx (tissue). Use code 95 when a positive LN is aspirated and there are no surgically resected LNs. Use code 95 when a positive LN is aspirated and surgically resected LNs are negative	Thank you.
17.	Case #1 - What is the date of diagnosis?	02/01/2021 – Most likely a malignancy.
18.	Could XRT in case 1 be hypofractionated IMRT? hypofractionation would require reimaging to redefine the treatment site but would no be 9 or 10? clarification: egfr mutation is not amplification. Amplification means increased number but still dependent on its igand for activation to stimulate growth. Mutation is a change in the EGFR amino acid sequence (due to change in DNA) that permanently turns on EGFR signaling that is no longer ligand dependent.	I don't know about the radiation – in this case it was MR adaptive because of the daily MRIs being done while the patient was being irradiated.
19.	Without a physician's statement that they are malignant, can "lung nodules", "pulmonary nodules" and "tumor nodules" be used interchangeably?	I believe the 3 terms can be used interchangeably but would not consider any of them to be malignant without guidance from the managing physician.
20.	The Keytruda would also be coded to palliative tx, correct?	It depends on intent. If the Keytruda was given for palliative purposes, it would be coded to palliative.

21.	Case #1 scenario specifically states patient NOT surgical candidate due to her emphysema, and that was why surgery was not recommended. That's not the same as surgery & RXT both being on the table as tx options & RXT was chosen. Per STORE code 2 definition is "Surgery of the primary site was not recommended/performed BECAUSE it was contraindicated due to patient risk factors..." I often see lung surgery being contraindicated due to cardiac issues, poor pulm function tests, etc.	This can be a tough call. I know there is not a lot of information in the case scenario, but Vicki had access to the entire record. She said it was clear that the physician felt the patient had two treatment options and one was not necessarily preferred over the other. Radiation was selected because the patient had emphysema. In our opinion, reason for no surgery would be 1. The patient had two relatively equal treatment options and the physician chose one over the other. If the physician would have preferred surgery over radiation, but could not do surgery because of the emphysema, then code 2 would be appropriate.
22.	Regional nodes examined, 00, positive 98?	Correct
23.	Case 2 rnp and rne s/b 98/00 not 00/98 right?	Correct
24.	Does option 4 state there was a resection?	I am not sure which jeopardy question this goes with?
25.	For number 2. pathologic grade 3. where is the guideline for this answer located...I think that I am overlooking in the grade manual.	Grade manual page 30 (under the description for pathologic grade, note 5)
26.	For #6, we are so conditioned that we can't use TX, because we're supposed to assume that a doctor "really" staged the case. I thought the answer would have been T Blank.	This one is tricky and unique for lung that the malignant cells in the washings and no primary tumor seen is TX.
27.	For case #1, for SRS, could it be code 06? Why is it code 10?	Although the patient was sent to rad/onc to discuss SRS they determined the better treatment was MR guided adaptive, which is how the patient was treated.
28.	For Q9 you coded 8253/3 for option #4. Would you not code 8140/3 according to note under H1 that states to code the mucinous only if it's greater than 50% and this one doesn't state the percentage. 8140/3 for minimally invasive adenoca.	We checked with SEER and confirmed this one. Since there was an NOS and a mucinous – see second bullet under H6.
29.	Question 9, answer 2: Wouldn`t you have codes 8253/3 (as per Note 1 in column1) for mucinous carcinoma and 8257/3 for the minimally invasive, that would make both tumor ''subtypes'' in column 3 and not only one subtype?	In column 3, when you have subtypes indented under another subtype, this makes the “non-indented” subtype an NOS. Denice Harrison did a great job of explaining this during her webinar.
30.	Are Hilum and Hilar interchangeable terms?	Yes, hilum should be the noun (the anatomical site) and hilar is the adjective :)

31.	If you have a statement that says the patient has mediastinal lymph node involvement (with no mention of N stage) but no mention of laterality, will you consider those ipsilateral lymph nodes?	I would. I would consider the mention of lymph mets as ipsilateral unless something states they are contralateral. My assumption is that contralateral involvement would be mentioned if it occurs.
32.	Is there a difference between "tumor nodules" and plain old "pulmonary nodules"? Does the latter term imply a malignancy?	When it comes to AJCC staging you have to use those terms in context. I don't think you can say pulmonary nodules should always be considered malignant or always be considered not malignant. If it is not clear in the documentation, then you should contact the physician. If that is not an option, you may have to stage the case as unknown.
33.	A good way to visualize the elastic layer is to compare it to a spare rib that you get from a bar-b-que restaurant. The outside of the rib meat that you bite into is the elastic layer.	Great tip!
34.	In case scenario 1, the CT scan showed a 1.9 cm mass. I thought the standard baseline for a biopsy was anything 1cm or larger? Why wouldn't they have biopsied her lung when it was at 1.9 cm?	I'm not sure.
35.	When you have a clinical tumor size that grows from 1st time it was noticed to prior to treatment, which size would you use? ie: CT shows 1.5cm tumor. PET done 2 months later the same tumor if 4cm	Use the larger size as long as there was no treatment done between imaging.
36.	Wouldn't that tumor growth be progression?	The tumor is always growing. Per the standard setters we could use the larger size even though the tumor has grown between scans.
37.	If CT was the larger and not the one directly before tx - we would take the CT?	See the statement below from the SEER manual. You would probably go with the larger size. *Use the largest size from available diagnostic imaging procedures in no priority order unless the physician specifies the imaging procedure that is most accurate. Examples include: MRI, ultrasound, mammography, CT, PET, x-ray.*
38.	For #7, how do you arrive at t1b when no size is given?	You are correct, I should have included the size, but it was the only scenario that could have fit the answer.