# Q&A/Comments for Data Item Relationships

February 3, 2022

| # | Question | Answer |
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| **1.** | Recently saw where USPS prefers apt # prior to street address? Any thoughts? | Guidance from USPS is not put APT online below if 2 lines needed for address. As we only have one line, that is not an issue. DO NOT PUT APT# before street address in abstract! |
| **2.** | For Foreign residents, who overstay their visa or are here illegally. Can we use their current address at diagnosis, or do we code it all to the country they are from? | We collect based on who is living here at the time of diagnosis to fully assess the burden of cancer in our communities. Citizenship is not relevant for this purpose. |
| **3.** | With more non-gender specific first names, at the hospital level is it better to do a review by extracting PE text & sex from software & put in Excel - using conditional formatting & filters to expedite visual review? | If they have a temporary, current address (for instance, if they are here just for treatment), then use the home address of their country. But this must be documented clearly. Do not make assumptions. |
| **4.** | Is "cancer status" going to be mentioned? We're finding very vague instructions on this field, which result in many codes=unknown. | No, but we will consider it for future webinars! |
| **5.** | Did she say adenoca isn't a correct histology for liver? | Correct. It is highly unlikely that a tumor arising in the liver would have a histology of adenocarcinoma, nos (8140/3). This would be metastatic carcinoma, or extension from the Bile ducts. |
| **6.** | On the renal pelvis question, would the biopsy surgery code be coded to a biopsy of a site other than the primary site (Code: 01) since the renal pelvis was biopsied and not the kidney? | Based on the CAnswer Forum post in Question #7, yes, you would code biopsy of a site other then the primary site (Code: 01) |
| **7.** | With the question asked about how to code Diagnostic and Staging Procedure for biopsy of renal pelvis when primary tumor is extending from the kidney, I did find a post on the CAnswer forum that may answer that question: https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/other-general-questions/121772-tumor-extension-biopsy-to-primary-or-other | Thank you for providing this example from CAnswer Forum |

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| **8.** | I had heme case, primary was bone marrow, bx of bone (femur) was pos, should I have coded 02 bx of primary site or 01 other site than primary? | The bone (femur) would be coded as 01 for site other than primary. Bone marrow (C421) and bone are not the same thing. |
| **9.** | Re the question about dx staging procedure, didn't find anything in STORE, but regarding grade, the grade manual does state grade from contiguous site is to be used when psite bx not available (see top of page 23 of v 2.01). | Yes, if you have a biopsy done of a tumor that is extending to an adjacent organ (contiguous extension), then the grade from the contiguous site can be used |
| **10.** | On the colon question, the scan might be able to tell you where in the colon the tumor is- ascending, descending, transverse. So you may not have to use C18.9 | This is true. |
| **11.** | What is correct code when imaging suggests malignancy, no conclusive or ambiguous terms used. Then Dr. says comments on imaging and then says SUSP for MAL/ or MAL. Would diagnostic confirmation be 07 imaging, or clinical based on physician's comment? | Yes, code to 08 based on the physician's statement |
| **12.** | Bladder tumor seen at cystoscopy, BX done but unconclusive. MD states it is a stage Ta and treat with BCG. Cannot code 8130/2 or 8000/2 because no path. Dx confirmation is visualization. How to consider this case (morpho, stage, ...)? | That is a tough one! You can't really say it is insitu based on cystoscopy alone. You also wouldn't want to code it as a /3. I really don't know the answer. If this scenario arises, send a question to the CAnswer forum. Please let me know what they decide! |
| **13.** | Poll Q#5 scenario - how would you code grade? If path reports High grade DCIS would you code H or 9 because it is really invasive cancer per the LN involvement? | This is another tough question that we don't have an answer to. If the scenario comes up, please send it to the CAnswer forum. Lets us know what they say. |
| **14.** | Would there not be an edit if Code Tis and behavior /3? | No, there will not be an edit for this. It is biologically possible to have Tis and the presence of lymph nodes metastasis, although this is uncommon. |
| **15.** | Where would I find the information about small cell carcinoma of the lung being undifferentiated? | The SSDI WG has spent a great deal of time discussing histologies that have a default grade value. Small cell carcinoma has been discussed extensively. We even sent the question to the College of American Pathologist. Their expert pathologist confirmed that small cell carcinoma is by |

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| | | default a grade 4 histology. Small cell carcinoma cannot be grade 1,2, or 3.<br><br>We have not yet posted this information to the grade manual, but we will. We did use this information to answer a CAnswer forum post. See below.<br><br>https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/124735-small-cell-carcinoma-grade<br><br>https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/107595-small-cell-carcinoma-histology-specific-grade<br><br>If you have tissue from the primary tumor, it is ok to code small cell carcinoma to grade 4 even if a grade is not specified. However, it is also ok to assign a code 9. You will not get an edit if you use code 9 for small cell carcinoma.<br><br>Remember, if you don't have tissue from the primary tumor, you must assign the grade to 9. Also, if you do not meet the rules for classification, you have to assign a code 9. |
| **16.** | How can the grade for the lung with mets to the liver be a grade of 3 when there is no surgical resection of the primary site? | There are two criteria for path grade: Surgical resection, OR clinical grade from primary site, histologically confirmed, AND histological confirmation of metastatic disease. This rules also applies to pathological classification for AJCC stage<br><br>Per the Grade manual for Path grade in all Schemas (note from the Lung Schema): |

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| | | **Note 6:** Use the grade from the **clinical work up** from the primary tumor in different scenarios based on behavior or surgical resection<br><br>• **3rd Bullet: No Surgical Resection**<br>o Surgical resection of the primary tumor has not been done, but there is positive microscopic confirmation of distant metastases during the clinical time frame<br><br>Remember, the biopsy of the metastatic sites means you can assign a value in the pGrade data item. However, the grade you assign in pGrade has to be from the primary tumor.<br><br>We assigned grade 3 based on the tissue from the primary tumor, not the metastatic site. |
| **17.** | Just to clarify, the small cell = G4 ONLY for lung? I think this is the CAnswer Forum post: https://cancerbulletin.facs.org/forums/node/99228? | No, this applies to all schemas. Small cell Carcinoma has been confirmed by the CAP Cancer Committee to be a high grade and the highest grade for that schema should be coded.<br>For Lung, this would be 4. For Prostate, it would be code 5, for Bladder it would be 3. |
| **18.** | For the small cell lung question #2, I realize they didn't bx the primary tumor, but do we not have a clinical dx of small cell? And if small cell ca is always grade 4 we still can't put clinical grade 4? | You still must meet the criteria for clinical grade, and the first criteria is:<br>**Note 2:** Assign the highest grade from the primary tumor assessed during the clinical time frame. |
| **19.** | I copied this from the Coding Guidelines...Does this contradict the pathologies grade with no resection where there was a bx of a mets site? Note 1: Pathological grade is recorded for cases where a surgical resection has been done | Per the Grade manual for Path grade in all Schemas (note from the Lung Schema):<br>**Note 6:** Use the grade from the **clinical work up** from the primary tumor in different scenarios based on behavior or surgical resection |

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| | | • **3rd Bullet: No Surgical Resection**<br>o Surgical resection of the primary tumor has not been done, but there is positive microscopic confirmation of distant metastases during the clinical time frame |
| **20.** | Is excision of a primary brain tumor considered pathological for grade purposes? | Yes. |
| **21.** | I believe surgery code 20; what if they don't take out the entire tumor? | Based on preliminary discussions, I don't think code 20 applies for pathological grade |
| **22.** | Does RFA meet pathological staging requirements for kidney CA? | No this does not. A surgical resection must be done |
| **23.** | The sites with no TNM schema are difficult for grade: what is clinical and what is pathological? | These sites still follow the same criteria. Clinical based on based, while pathological is based on surgical resection, and/or the presence of metastatic disease (histologically confirmed) prior to surgery or no surgery done. |
| **24.** | So for brain when surgery is coded to 20 due to stereotactic bx per SEER notes & SINQ20100059 but per op notes it was only a bx & not a resection/debulking, it would only qualify for a clinical grade & not a pathological grade? | This is correct |
| **25.** | I remember way back in the day, small cell carcinoma of the lung was commonly documented on the path report as anaplastic small cell carcinoma- it was much easier back then with the term anaplastic. | Agree, but we have found that grade is usually not documented for small cell carcinoma, since pathologists know it's always a high grade (anaplastic) |
| **26.** | Where would I find the information that a TURB is not a resection? | TURB does not meet the criteria for pathologic staging of a bladder tumor. That does not mean it isn't a resection. |
| **27.** | How do you justify using questions off the cancer forum as rules, if it's not in the books? | You can use CAnswer Forum as a reference and code accordingly, or you can wait until it's in a manual. I've heard registrars from both sides of the fence on this. |
| **28.** | Are there other surgical terminologies for simple prostatectomy? | Per the SEER Glossary:<br>Segment prostatectomy<br>Subtotal prostatectomy |

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| | | Suprapubic prostatectomy |
| **29.** | Shouldn't Gleason Patterns Path be X7 on Prostate: Surg & Other Data Items slide? | Yes, this was a typo |
| **30.** | What if the lung primary bx says small cell carcinoma grade 3? Do we change it to 4? | Yes, change it to 4. |
| **31.** | When coding chronic lymphocytic leukemia, primary site as c421, my software will not pass edits - it wants me to put in AJCC stage group of 4. Why is that? | This is a lymphoma, which means you can stage it. If the bone marrow is involved, this is a Stage IV |
| **32.** | Selisaure Kumwenda-Listening to the webinar today they mentioned about grading lung small cell carcinoma as grade 4s. This is only mentioned on CAnswer Forum and not in any of the manuals. I did see a post stating that will be updated with the 2022 changes of the grade manual (an addendum). Should we be starting this change now or wait for the updates to the manuals? | The Small Cell Carcinoma default grade applies to all sites, it's just that Lung is the most common site.<br>This clarification can be applied for 2018 forward. We did not get it in the manual for 2022, but are working on it for 2023 |
| **33.** | For colorectal - when polypectomy is definitive surgery for certain cases & qualify for AJCC path staging, I understand about the SSDIs but path grade would follow AJCC rules & be eligible for path grade? | If the case is eligible for AJCC path, then it would be applicable for Grade Path |
| **34.** | So we'd look for a complete excision for pathological grade? | A surgical resection is needed |
| **35.** | Should we be going back on these cases? | You do not have to go back and change grade codes for small cell carcinoma cases. |
| **36.** | Could you clarify your answer for pq6 #2 small cell? Did you said that we need to review the criteria for clinical grade and that you must have a bx of primary tumor? So since there was no bx of primary we can't use grade 4 even though dx is small cell ca of lung. If there are default grades for morphologies would we not use them? ie glioblastoma multiforme is a grade 4 no bx required in pq8 | Even with default grades, you must meet the criteria for clinical and pathological grade. The first criteria for clinical grade is histological confirmation from the primary tumor. Brain cases are different, as I pointed out. |
| **37.** | If primary site is one that we don't collect the sentinel lymph node info in the staging data items, if it is stated in the op note that a SLN bx is done would we code that as a SLN procedure in scope of | Yes! a sentinel node procedure is always coded in scope of regional node surgery. It is only collected in SLN pos/Ex for breast and melanoma. |

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| | regional nodes? Seeing SLN procedures done in uterine/endometrial primaries. | |
| **38.** | Where do we find the updates to the mets at dx? When I hit f1 it must be the old rules that state code 77.0-9 are coded to 8. | SEER manual/STORE manual |
| **39.** | What is the relation between the PSA Lab Value SSDI and the stage group for prostate cancer? A PSA is needed to assign stage group, but the rules/guidelines from AJCC (and the information from the CAnswer Forum) differs from the rules in the SSDI manual. The SSDI Manual says to use the PSA (or any lab value) done no earlier than three months before the diagnosis, whereas the AJCC/CAnswer forum says to use the PSA Lab Value related to the investigation/diagnosis no matter how early it was done. If we use the respective rules for each field, we face situations where we have "XXX.9" in the SSDI Field, but a valid stage group in our stage fields. Are these two data related or are they unrelated even though they refer to the same element (PSA lab value)? | These data items are related and the rules developed were based on AJCC. There are times though where we cannot record the PSA lab value due on the date; however, the physician will use it to stage. So, therefore, you are going to have situations where you code PSA lab value as unknown, yet you have a known stage group. |
| **40.** | Why would we put mets in the mets field for lymphoma when grade 4 is extra lymphatic organ involvement? | This question does not make sense. Grade is not coded anymore for lymphomas.<br><br>Stage 4 does indicated extralymphatic organ involvement, but does not indicate where. If a patient has stage 4 lymphoma based on lung involvement, that information can be coded in mets at DX Lung. That is assuming the lymphoma has a primary site of C77. |
| **41.** | Quick f/u comment to Robin's question about SLN - we can also use the (sn) suffix for AJCC for sites other than breast & melanoma. | You are correct! We are seeing more and more sites where SLN is performed routinely. |
| **42.** | If the Intensity Score is given as a range (i.e. 2+ to 3+) should the Allred Score be coded as 9? | We posted this to the CAnswer forum… https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/124736-intensity-score-given-as-a-range |

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| **43.** | Do you code Apt # or trailer # under address or under supplemental address? | Code Apt# etc at end of street address not supplemental address. |
| **44.** | So if all you have is a PO Box and no other info, do you put that PO Box under supplemental address? | Yes. The address at diagnosis would then be unknown. |
| **45.** | In my State we abstract non-analytic cases. It is difficult to know the address at diagnosis in these cases. Is the address information in non-analytic cases routinely used in analysis? | A non-analytic case (not reportable to CoC) is often reportable to your state registry. Generally, these are patients that had a history of a reportable disease diagnosed and treated elsewhere and are seen at the reporting facility for treatment of a recurrence. It may be difficult for the reporting facility to determine if the patients current address is the same as the address at diagnosis.<br><br>If a registrar has access to systems like CLEAR or LexisNexis, they can review for an address based on the date of diagnosis. If a registrar does not have access to these systems but has a reason to believe the address at diagnosis is different than the current address, they should code address unknown. If there is no reason to suspect the address at diagnosis is different than the current address, the registrar can code current address as address at diagnosis.<br><br>Hopefully, the state registry will have a record from the facility that originally diagnosed/treated the patient that will include the true address at diagnosis and this is the address that will be included in the research files. However, it is not unusual for the report from the facility reporting the case due to the recurrence to be the only incidence record for this patient. In that case, the address you include in the address at diagnosis field is what will be included in research files. Researchers often use class of case for inclusion |

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| | | criteria, but our surveillance statistics use all incident cases reported for the catchment area.<br><br>Note: non-analytic cases at the central registry level are also important. Many central registries have access to administrative databases to supplement address (DMV, voter records, LexisNexis). Finding the address at diagnosis is vital to support appropriate inter-registry data exchange and full, population-based completeness. |
| **46.** | What happens when you only have city and state for place of Diagnosis? What do you put for address, so you won't get an edit.? | UNKNOWN or BLANK will pass edits for the street address. |
| **47.** | Do 9-digit zip codes (extension past the first 5) help at all or is just the 5-digit zip code good enough? | 5-digit zip is good enough. But we have a placeholder for 9-digit zipcode, so it is always better to enter all the information you have. |
| **48.** | Should 01 be coded in Race 2, if the patient is noted as being "Hawaiian" only? | If text states single race, use single race. However, if the face sheet is documented as patient supplied information and they indicate both white and Hawai'ian, then 01 should be in second field. |
| **49.** | Pop Quiz #3 -- Race 1 would be 03 but would Race 2 be 01 since Spanish/Hispanic Origin = 6? | We do not have any information to add 01 to Race 2. Adding assumed race information often misclassifies cases. There are many non-white Hispanics, so a 6 for Spanish/Hispanic Origin of 6 is not enough information to determine. But this example is a common case for how AIAN are misclassified. So, again, don't assume white. If race is unknown, it is unknown. Adding assumed information makes it impossible to identify an issue that may be corrected with linkages or other QC operations. |
| **50.** | If you have both PO Box and street address - should both be coded? If zip codes are different, how do you code zip code? Can you use "PO BOX 234 - 99999"? | PO Box information belongs in the Supplemental Field. There is enough room for the full PO BOX, City, & state. Only the zip code associated with the street address should be documented in the address at diagnosis, zip code field. |

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| **51.** | I see a lot of breast cases with the wrong laterality coded. It is critical that the laterality be correct to avoid erroneous multiple primaries at the central registry. | Agree, very good point |
| **52.** | Per STORE Coding instructions: Non-paired sites may be coded right or left, if appropriate. Otherwise, code non-paired sites 0. When can non-paired site be coded appropriately? | Personally, I would not code a site not listed on the paired site list as paired. I don't see the benefit and it could cause problems. |
| **53.** | I had a patient with situs inversus (internal organs were reversed). the patient had carcinoma of the LEFT MIDDLE LOBE. How should the site be coded? Would not pass edits with right middle lobe. | This questions was sent to SEER and they suggested using primary site C34.9. |
| **54.** | If something is stated in an unusual way, or if the coding depends on the exact terms used, I was taught to put quotation marks around that text to show that this was exactly how it was documented in the medical record. It's also helpful to document any rules/manuals/SINQs/etc referenced on difficult cases where someone might question how, for example, a certain histology code was determined. | Thank you. This sounds like a very good idea. |
| **55.** | Where can I find the table that says which SSDI's are based on histologic confirmation? | Just looked it up, it's further down than I thought. See page 27 of the SSDI manual https://apps.naaccr.org/ssdi/list/ |
| **56.** | Can endometrium EIN be AJCC staged? | According to SEER*RSA, which matches the AJCC DLL, the software will allow you to assign a stage. Any further questions on how to stage should be directed to the AJCC forum. |
| **57.** | Can we take grade from a bx of another site that was deemed primary tumor extn? Such as a pancreatic tumor invading directly into liver and they bx liver - would that be used as clinical grade since it's technically from the primary tumor? | Yes. See the note below from page 23 of the Grade manual. Do NOT code grade based on metastatic tumor or recurrence. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site. |
| **58.** | Did Jennifer say that small cell lung cancer is always a Grade 4? Where is that found in the coding manual? | This coding recommendation is not currently in the grade manual. It will be in the next update.<br><br>The SSDI WG confirmed with pathologist from the CAP and AJCC that small cell carcinoma is, by definition, anaplastic. |

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| | | The WG recommended that if tissue from the primary tumor shows small cell carcinoma, no grade information was available, and the rules for classification have been met, a grade of 4 can be assigned.<br><br>The recommendation was made based on a question in the CAnswer forum.<br><br>Registrars are not required to assign a grade of 4 for small cell carcinoma if no grade information is stated on the pathology report, but it is recommended.<br><br>The recommendation is for cases diagnosed 2018 forward. However, registrars are not being asked to go back and change grade for cases that have already been abstracted. |
| **59.** | Can we assume histologic confirmation based on treatment such as AIs for breast cancer? | It is highly unlikely a patient would be treated with aromatase inhibitors without first having a histologic confirmation of the cancer. However, I don't feel comfortable saying you can code the case based on an assumption of diagnostic confirmation. If you run across such a case, please send the question into the CAnswer forum and let us know what they say! |
| **60.** | Can you perhaps put in an edit that addresses the small cell lung ca grade? | We discussed this extensively! While small cell lung cancer is by default anaplastic, tissue from the primary tumor (not mets) is required to assign a grade. Also, the rules for classification (clin, path, yc, yp) have to be met. With all of these exceptions to the rule an edit enforcing the coding would be very difficult. We try to avoid edits to enforce coding recommendations that have so many exceptions. |

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| **61.** | Why is a simple prostatectomy given a surgery code ( 30) if it's not a classed as a surgery and have a path result coded | It is a surgery; it just doesn't meet the criteria for pathological staging or pathological grade. This is not uncommon. |
| **62.** | Per some States or per some facility specific guidelines, may be asked to enter county as 998 (out of state) for out of state residents. | True. County code 998 is required for out of state residence for most state registries. |

## Take Away Tips

**Foreign Residents**

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| **63.** | For Foreign Residents, STORE states: pg 52 residency rules: Normally a residence is the home named by the patient. Legal status and citizenship are not factors in residency decisions. Rules of residency are identical to or comparable with the rules of the Census Bureau whenever possible. The registry can resolve residency questions by using the Census Bureau's definition, "the place where he or she lives and sleeps most of the time or the place the person considers to be his or her usual home." For city: Identifies the name of the city or town in which the patient resides at the time the tumor is diagnosed and treated. If the patient is a foreign resident, then code either XX or YY depending on the circumstance for state. Country code: This item corresponds to the other Addr at DX items (state, postal code). Use Appendix C to look up appropriate country code. County at dx: If the patient is a non-U.S. resident, use code 999. |
| **64.** | When we have foreign residents, who are in our country for treatment - we are supposed to code City at Diagnosis as Unknown. I received a high number of errors on the CQIP for my foreign residents and I am not sure what else I should document in City at Diagnosis. |
| **65.** | When we (DC) identify out of country residents, we use unknown for city of dx and the foreign country for state. Patients tend to use family addresses to get tx in DC and we have asked the registrars to look for out of country pathology reports or other identifying info to verify their international address. |

**Address**

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| **66.** | I Google the county based on the zip code. Is there a better way to get the correct county?<br><br>Yes! You can geocode it (Google returns are not always precise for towns that are located in multiple zip codes).<br>Central Registry abstractors can use the NAACCR Geocoder: https://geo.naaccr.org/Default.aspx ; log in with your MyNAACCR Account and choose Non-Parsed Postal Address Geocoding (under Services, Geocoding)<br>Hospital abstractors can use the TAMU Version: https://geoservices.tamu.edu/Services/Geocode/ use Interactive Geocoding Option |
| **67.** | Please stress the importance of finding an actual street address. PO Boxes as great but can skew the Geocode data.<br>I would chime in and say, PO BOXES are only good for sending bills, they are not good for cancer surveillance. |

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| **68.** | For county codes we use USPS website to look up the address and it will tell you the correct county code.<br>Historically at least, this is not always true. Both Google and the USPS website often return the county with the greatest population, not addressed based county. Please use the geocoder resources above in this situation. |
| **69.** | Another one: https://www.zipinfo.com/search/zipcode.htm Some registry software auto-populate county code upon completion of zip code |
| **70.** | In SC Central Registry we have access to CLEAR. When l need a street address or correct county because a city is in 2 counties this helps me find this information in order to correct the PO Box and to have the correct county |
| **71.** | I always tell abstractors to look up the actual county in GOOGLE if the city name is different on the website. In Maine, we have towns that share zip codes but are in different counties.<br><br>*Both Google and the USPS website often return the county with the greatest population, not addressed based county. Please use the geocoder resources above in this situation.* |
| **72.** | At OH Central Registry we also have CLEAR - though mainly use to look for correct SSN, DOB when conflicting info comes in from facilities. Addresses w/ tricky county usually handled by geocoding & targeted QC. |
| **Text/Race/Age** | |
| **73.** | I type all text into a word document and then copy and paste into the software as I code. |
| **74.** | For male breast cases, include in the demo text and in the physical exam text this is a male breast cancer-when doing QA can easily look at the text. Very good comment, this is another reason why text is so important. |
| **75.** | Please do NOT assume that all melanoma cases are white.<br>*Thank you! If you don't have information (after looking in all the places), then it really is unknown. Unknown data may be supplemented later. But if you make an assumption about race or other variable, it no longer can be reviewed as it looks like complete and correct data—leading to potentially biased results.* |
| **76.** | Check for identification on patient will help code correct race. |
| **77.** | Tip for typos in text: I use WORD for my text, any typos are obvious (red "squiggly" line!); I make any corrections, then "copy & paste" into the software text fields. (Just don't forget to do the last step!) |
| **78.** | With an uncommon site and histology combo that is correct, it is helpful to put "histology confirmed" in path text. |
| **79.** | Another audit we do is looking at patients who have the same date of birth and date of diagnosis. We will see miscoded dates of birth. |
| **80.** | Along with gender and race the patient's age should be in the text. |
| **81.** | Another age conflict is when diagnosed in utero |

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| **82.** | With cases where a person has a name that is different for their sex (i.e. a male named Delores) I enter a note in the chart that says for example:  Yes, Delores is a male. |

| | Miscellaneous |
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| **83.** | Depending on the path lab - often times they would put in the comments that they did staining to determine psite, especially in light of patient's clinical history. So comments may say "consistent with colorectal primary" or they may compare to previous cancer path slides if available. |
| **84.** | Please consider if ill-defined/overlapping/NOS psite applies before using C809 unknown primary code when specific psite cannot be pinpointed. |
| **85.** | Jim, you should share the tip you gave a few years ago about making the cards for each chapter with things like what's required for pathological staging for example-Those cards are awesome! that's where I found my simple prostatectomy answer.<br>I just wrote those criteria in my manual, but cards are a great idea! We still encourage our CTR Prep participants to do this. |
| **86.** | Reading the NCCN guidelines (patient and/or physician versions) can help give a leg up on learning about standard treatment more quickly. Reading the initial consult notes from various MDs (SurgOnc/HemOnc/RadOnc) w/ tx planning notes carefully also helps. Of course, don't forget to learn from more experienced registrars =) |