Q&A Session for: Abstracting and Coding Boot Camp 2022

March 3, 2022

#	Question	Answer
1.	I have noticed that some software vendors auto populate the text fields for primary site and histology text fields from codes entered. Just a heads up to make sure you use the scan and pathology text fields when doing QA on codes for these fields.	Registrars need to review the text that is autopopulated. Usually the software populates the “preferred term” associated with a histology code. Many histology codes have multiple terms associated. For example 8140/3 has 14 terms associated! The preferred term is Adenocarcinoma, NOS. However, if you are abstracting a prostate case with acinar adenocarcinoma (8140/3), you want to be sure the term in the text fields is Acinar Adenocarcinoma and not Adenocarcinoma, NOS. Be sure you check to make sure the text in the histology field is correct after you assign the histology code.
2.	Some procedures are both endoscopic & radiologic (ex. EBUS done during bronchoscopy) - do we split up the findings in the 2 text fields or just put it in one of the text fields?	Whatever you prefer, just be sure to document process and be consistent.
3.	Sometimes scope is done as part of surgery (for ex cystoscopy during TURBT) - those would go in op text? I add a note in scopes text to "also see op text".	Smart, good idea.
4.	Maybe you'll cover this but there are times (especially with my imaging text) that I use up the character limit - I've used the NAACCR abbreviation list to help get the characters down, but sometimes I'm missing a whole imaging scan. Are there tips to help with this? Or is there another place I can add overflow text?	Your text needs to back up your codes. Record information that back up your codes. Someone else should be able to abstract your case based on your text. When recording text, ask yourself if the information provided backs up the codes in my abstract.
5.	Clinicians and administrations often want to know what tx was done at facility vs elsewhere so we also document facility info in tx text fields.	Institution referred from, institution referred to, and treatment fields are utilized to document migration patterns as well.

6.	Registry software has trans/endo text field but it is not exported as it is not a NAACCR field. Per the NAACCR dictionary RX Summ--Tranplnt/Endocr (#3250) is validated by RX Text-Chemo, RX Text-BRM, and RX Text--Hormone??? Does this mean we should repeat the trans/endo text in one of those fields?	A transplant plant or endocrine surgery could be documented in the surgery field. Could also be added to the remarks. The main thing is to be consistent on how it is done in your facility.
7.	How to code clinical trials that involve treatment modalities that DOES fit into other modality definitions (e.g. hormone, chemo listed in SEER*RX; RXT)? Would clinical trial only get coded in "other" when it is trial drug not in SEER*RX or modality that is not the other tx categories?	NAACCR Data Dictionary states for RX Text Other Description Text area for manual documentation of information regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown), and blinded clinical trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field.
8.	Where do you document an incisional biopsy if it is not to be documented in the surgery text field?	Standard-setters do not have specific requirements for text. This presentation was based on best practices. Suggest an option for documenting incisional biopsy would DX Procedure OP. It can also go into the Surgery Text field. The important thing is to be consistent!
9.	I've never seen specifics or a guide to what information is needed or pertinent for Hem cases for lab/path. There is so much info on the FISH and other reports for these cases, and I would like a guide or examples-such as CD38, etc; the genetic info, trisomied. there is an overwhelming amount of information, and I doubt it is all pertinent from our standpoint.	I have always been told with text write what covers your coding in the abstract. The idea is that from the text someone else should be able to abstract your case. Text is your verification of the code in your abstract.
10.	Is alternate TX entered only if no other TX given?	We would need a specific example to answer this one. There is an Other treatment field STORE pg 322. There is also a RX TEXT--OTHER field that you could enter that information in.
11.	I am in a Central Registry in Canada and am just wondering what is done with this text abstract. Do you submit it?	The text entered in the NAACCR text fields get transmitted to the central registry. The central registry uses it for Q&A and consolidation. The text does not get transmitted to NPCR or SEER.

12.	FYI there is an exception to the 9421/3 - it is 9421/1 when it is optic glioma/pilocystic astrocytoma of optic nerve (STM2018)	Thanks!
13.	Any tips for case finding for the newly reportable terms for 2022 that are more easily missed such as LAMN, HAMN, and high grade dysplasia of stomach & small intestine?	Yes. Slide 24 refers to your question.
14.	Is there or will there be a table that has all codes, so we don't have to go back & forth between the tables, Solid Tumor Rules, & ICD-O-3 Manual?	There has been quite a bit of discussion about this by the standard setters. There is a project called Cancer Path CHART that will hopefully streamline the procedure, but that won't happen until 2024 at the earliest.
15.	Is the ICD0 3 book going to be updated to a second version?	A .pdf of the ICD O 3.2 is being developed, but i don't know when it will be released. However, I don't believe it will include all the histologies that we are currently using. We'll try to get you some additional info for the Q&A document.
16.	Why is ambiguous terminology c/w Reportable for peripheral blood on B lymphoblastic lymphoma?	live answered
17.	Why is ambiguous terminology c/w Reportable for peripheral blood on B lymphoblastic lymphoma?	In the Heme Manual there is a section on case reportability which list the terms. One of the notes states, “Report the case when a reportable diagnosis appears in any text or report described as a Definitive Diagnostic Method in the Heme DB.” Note: Definitive diagnostic methods differ depending upon the histology. See the Heme DB for details. If you look in the Heme DB for B lymphoblastic lymphoma it says a peripheral blood is a definitive diagnostic method.
18.	Could you provide an explanation on how to treat fee-based physician treatment at your facility and at another facility for class of case?	Class of case would be determined by treatment provided at your facility rather than the physician billing.
19.	For Quiz #2 Question #2 regarding the CIS of the cervix and sequence, would that not be a Class of Case 34 (answer given was 01)?	Question #2 was a sequencing question not a Class of Case question.
20.	Pro tip - for class of case 10, keep case on your incomplete list and check back periodically for additional treatment or referral details, you may be surprised over time that you can capture	Thanks. May cause issues with submission of RCRS cases.

	additional info - not always able to find - but worth to give it a shot -	
21.	What if the patient was diagnosed at your facility and you referred them to a hemonc physician office for treatment options and there is verification they were seen in the hemonc office, but you don't know if treatment was performed. Class 10 or 00?	If it is unknown whether the patient was treated or there was a decision not to treat the patient, the class of case would be 10.
22.	For class of case, if a patient has cytology with an ambiguous term, for example - urine c/w urothelial carcinoma, at an outside facility and comes to your facility for TURBT that confirms that the patient has urothelial carcinoma, would the patient be considered to be diagnosed at the outside facility (because the ambiguous cytology was confirmed by the pathology) and class of case would be 22 (if TURBT was only treatment done)?	With then information you have provided, would be a class of case 14, initial diagnosis and first course treatment at reporting facility.
23.	To verify if we have ER/PR done on bx and surgery and they are different do we use the highest or the pre-tx values?	Please review SSDI notes as there are different instructions dependent upon insitu/invasive tumor, multiple tumors, and post-treatment status.
24.	I was under the assumption that certain SSDI's for breast were not required for 2021 moving forward. Are they re-required for 2022? Such as HER2 IHC SUMMARY, ISH DUAL PROBE COPY RATIO, SINGLE COPY AND HER2 ISH SUMMARY.	That is correct. Here is a link to confirm. Just click on Breast to find the SSDIs https://apps.naaccr.org/ssdi/list/
25.	Q5#3 per SSDI manual "The registrar should not calculate the Allred Score UNLESS both components are available (proportion score and intensity)" - should it be TRUE instead?	The question was revised to read: The registrar should not calculate the Allred score when the ER and PR proportion score and intensity are available. Answer is False.
26.	Q5#10 what are cervical axillary lymph nodes? I thought those are 2 diff regions?	You are right. Cervical lymph nodes are in the neck. Not in the Axillary Lymph node chain. D) Internal mammary & A) cervical would be a correct answer.
27.	Thank you Angela for the clinical trial answer - that's how I abstract in the relevant tx fields w/ note in the other text that it's part of trial but have seen it the other way where clinical	Thank you for your input!

	trial involving RXT/chemo/brm only coded in "other" so wanted to confirm.	
28.	In Quiz 5 was the answer for calculating the Allred score false?? The manual states: x The registrar should not calculate the Allred score unless both components are available (proportion score and intensity), so if both components are available we can calculate the Allred... but she went very quickly through the answers so maybe I heard the wrong thing.....??	Yes, the SSDI Breast Manual states, "The registrar should not calculate the Allred score unless both components are available (proportion score and intensity)."
29.	Q6 - PA/FL, per STORE: "Persons with More than One Residence (summer and winter homes): Use the address the patient specifies if a usual residence is not apparent." Is PA the address because it is the "usual" residence? Is that based on living there more time of the year?	Correct – in our example the pt lives in FL for only the summer vs the rest of the year in PA.
30.	Do you know if a patient is a student in another state and is diagnosed with cancer in that state, should you use the home address or state at school?	Per STORE – for persons with more than one address, code the residence where the patient spends most of their time. In the scenario you've given I would list their address as their home address.
31.	Quiz 6 #1 Suspicious is an ambiguous term. Wouldn't date of dx be 2/15/18?	You are correct. Date of dx should be 2/15/18
32.	I thought the operative text field was more for biopsy, not for findings during surgery?	NAACCR Data Dictionary states suggestions for Text, dates, and descriptions of bxs and surgical procedures where staging info is derived as well as things as LNs removed size of tumor evidence of invasion
33.	Could you please clarify... is it best to put tobacco/alcohol/drug use and history/fhx of cancer in the PE findings or in the remarks section?	Remarks section
34.	Are the ICD-O 3.2 updates incorporated into the current Solid Tumor Rules?	Yes. This is from the Solid Tumor Rules Manual: The North American Association of Central Registries (NAACCR) have released the 2018 Guidelines for ICD-O-3 Histology Code and Behavior Update effective for cases diagnosed 1/1/2018 forward, 2021 Guidelines for ICD-O-3 Histology Code and Behavior Update, effective for cases diagnosed 1/1/2021

		forward, and 2022 Guidelines for ICD-O-3.2 Histology Code and Behavior Update, effective for cases diagnosed 1/1/2022 forward. The updates include: • New ICD-O codes • Changes in behaviors for existing ICD-O codes • New preferred terminology The Solid Tumor Editors recommend coding histology using: • The Solid Tumor Rules • The 2021 Cutaneous Melanoma Solid Tumor Rules • Updated ICD-O histology codes and terms which can be found at: https://seer.cancer.gov/icd-o-3/ • The ICD-O-3.2 When a histology code cannot be identified using the above recommendations, submit a question to Ask a SEER Registrar.
35.	If a PT has diagnostic screening at a OSF and is suspicious of Cancer, but has a bx at our facility to confirm dx of cancer, what would the class of case be at our facility? and what would the date of dx be?	The class of case would also depend on where the patent received treatment. Date of DX in this case would be the date of Bx.
36.	In response to your example: If the facility decides not to treat - why isn't this class of case 14? "Initial dx at the reporting facility and all of 1st course treatment was done at the reporting facility OR a decision not to treat was done at he reporting facility"	live answered
37.	I thought C0C 10 & 20 were rarely used and were further specified by 11, 12, 14 and/or 21 & 22 respectively?	That is my understanding as well. But if you don't have the information code accordingly.
38.	If on the bx the patient is dx with DCIS with a higher ER than later invasive ca - do you still use the invasive ca ER status?	That is correct. You use the ER from the invasive ca. Note 4 in SSDI Breast NAACCR Manual states, "In cases where there are invasive and in situ components and ER is done on both, ignore the in situ results."
39.	If the ER is weak positive, say 5% but the physician refers to the ER as negative, what do we record?	I would refer to the pathologist/bx of ER+ 5%. If possible, contact the physician to confirm.
40.	I remember being told that we could NOT use the information in the pathology report to code treatment response. So that info was incorrect? We CAN use the info in the path report as long as the pathologist states the extent of response?	For the data item Response to Neoadjuvant Therapy (item 3922) the code should be based on a physician statement. Not solely on information from the pathology report. https://cancerbulletin.facs.org/forums/forum/site-specific-

		data-items-grade-2018/121130-response-to-neo-adjuvant-therapy