Q&A Session Colon 2022

May 5, 2022

#	Question	Answer
1.	I thought intramucosal carcinoma of the colon would have a behavior code of 3, not in situ, and be considered localized for Summary stage and only TIS for purposes of AJCC staging? Per SINQ 20210006	You are correct! *This question was asked prior to our review of the topic.*
2.	To use N1c assuming per AJCC the physician/pathologist needs to tell us where those are located correct?	If there are tumor deposits in the synoptic report of the path report and there are not regional nodes involved, then you can assign N1c. The checklist in the CAP protocol for tumor deposits does not include the location of the tumor deposits so I would assume this is built into the pathologist's assessment of TDs.
3.	CCCR required High Grade Dysplasia 2010+ for all GI sites; stopped for C18._, C19._, and C20._ in 2018 In US - high grade dysplasia reportable for stomach & small intestines only beginning 1/1/2022 (not 2021) https://www.naaccr.org/icdo3/	Thanks!
4.	Even if High Grade Dysplasia is not reportable for Colon in the US, if the physician equates it to in-situ, it should then be reported, correct?	Those used to be the instructions. However, starting in 2021, the standard setters specifically state they are not reportable.
5.	We often get diagnostic imaging that says "several lymph nodes" without a number and then we have no indication from physician notes regarding a specific number or N category. Is this cNX or cN blank?	Per CAnswer forum, this should be cN blank. Here is the post: https://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/lower-gastrointestinal-tract-chapters-19-21/colon-and-rectum-chapter-20/126838-clinical-lymph-nodes
6.	Is removal of the appendix considered a contiguous organ?	This question was submitted to the CAnswer forum https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/127786-appendix-contiguous-organ

7.	Can you confirm how you choose the Topo when it reoccurs at the anastomotic site?	Question was sent to SEER for comment. See below. *There is no easy answer, and the registrar will need to use the previous surgery and site to determine this.* *Example: the first primary was in the sigmoid which was resected. The descending colon was attached to the rectosigmoid. The new primary at the anastomosis could be either in the rectosigmoid or descending colon depending on the measurements—tumor up to 17 cm is rectosigmoid and greater than 17 is descending.*
8.	For Macroscopic Evaluation of Mesorectum, what does it mean in the STORE instructions: "Collect on all cases after implementation date regardless of date of diagnosis" mean? Usually, you start collecting a field based on the date of diagnosis, but does this have to do with date of first contact?	I just checked edits. Cases will pass if field is not blank for cases diagnosed prior to 2022. Edits will not check pre 2022 cases, but values are allowed. Looks like this field can be coded for cases diagnosed prior to 2022.
9.	You had said 98% of colon cancers are adneocarcionma and they usually start where? I missed it.	They start in the epithelium (mucosal) layer.
10.	Concerning N blank vs NX. My understanding was if the clinical classification was met (imaging done) but we cannot choose a specific N # because we don't know the actual amount of LN's involved, then that is NX. But if imaging was not done (clinical classification not met), then that is blank?	According to a recent webinar on AJCC Chapter 1: BLANK if we don't know N AND we don't know if the MD knew more (we have NO IDEA). Only use X If we know for sure the MD did not know or did not assess (i.e. physician states "unknown"). That statement was from a participant but is consistent with what Donna Gress and Aleisha Williams from AJCC stated.
11.	Janine I see it in the first paragraph on pg 149 under the header macroscopic eval of the mesorectum	I just checked edits. Cases will pass if field is not blank for cases diagnosed prior to 2022. Edits will not check pre 2022 cases, but values are allowed.
12.	FYI Donna and Aleisha both answered about N blank and NX in the chat	

13.	Can you point us to the reference for the #3950 Macroscopic Eval of mesorectum. I'm not finding it in SEER*RSA v2.1 in SSDI section in colon rectum schema nor in the SSDI manual v2.1; only in the STORE. My understanding is v2.1 covers 2022 dx. Am I off a year?	SSDI is not considered an "SSDI" at this point. The codes and coding definitions are only in STORE. That may change in 2024, but not before then.
14.	Yesterday I was trying to find the answer to "timing" and looking at CAP protocols. I noticed the protocol for Examination of Resection Specimens From Patients with Primary Carcinoma of the Colon and Rectum, have a protocol posting date of November 2021, and a CAP Lab Accreditation Program Protocol Required Use Date of March 2022. That's one reason I think this STORE item Macroscopic Evaluation of Mesorectum collection will be on 2022 cases. We need the pathology report to code these. Also the Required Status in STORE is 2022+	Thank you, Mary! That makes sense.
15.	What was answer to grade post therapy path	Code 1 for grade post therapy path.
16.	Can you explain why we do not record the path size after neoadjuvant tx anymore. This is a change.	I'm not sure, but I think they wanted the criteria to be consistent with AJCC. Per Donna Gress in the Chat: the neoadjuvant therapy could have changed the tumor size, so you cannot compare that data to cases where nothing was given to affect the tumor size.
17.	Just wanted to verify that this new SSDI Macroscopic Eval of Mesorectum is for COC registries only	Correct. Required for CoC registries. Non CoC registries can collect (there is nothing preventing this in the software)
18.	Does a polypectomy qualify for pathologic staging?	If the intent is definitive treatment, then it qualifies for pathological staging. If the intent is diagnostic, then it qualifies for clinical staging. See related slides/poll in the presentation.
19.	For case scenario #1, can you put 2 phases in for the radiation for the boost? Would it be wrong to? I am guessing the boost must have different radiation fields if it was noted in the summary even though there was no change in target volume, tx fraction size, modality, or tx technique.	As you noted, there was no target volume, fraction size, modality, or technique. We felt it should be considered the same phase.
20.	CRM for /2 tumors. SEER says the values is XX.9 for /2 but /3 is XX.7 if treatment is polypectomy, etc. Are we not losing the fact that for /2	This was recently discussed by the NAACCR SSDI WG. It was felt that XX.7 is the appropriate code for /2 tumors. Updated instructions will be posted.

	tumors are being treated with polypectomy or these other mentioned procedures by assigning XX.9?	
21.	For a transanal excision for a rectal cancer, how do you know which surgical code to use? I think I was always coding these as 27-Excisional Biopsy in the past which may not have been correct for all cases, but the CAnswer Forum, I think, indicates you can code them as a 30 if the excision removes part of the wall. I think it is confusing on what to do with a Transanal Exicision.	I read the Canswer forum post and I think what they are saying is that it depends on the extent of the tumor/primary site that was removed. Think of the "transanal excision" more as the approach and what was actually removed during the procedure as the surgery. You need to look at the operative report and see what was removed to determine what surgery code to use. Most of these will be coded as a 27.
22.	Will you please send the links to the MMR/MSI YouTube videos?	https://www.youtube.com/watch?v=s7Dx3fr0fjM https://www.youtube.com/watch?v=eqbgU1aTFR8
23.	Tip for coding biomarkers. If a multi-gene NGS panel is done, look in the report for the test description with a list of genes tested. Negative (non-mutated, wild-type) results may not be listed individually in the results/findings section, but can still be coded as normal/non-mutated if a positive result is not reported.	thanks!
24.	Hello! we often will have a biopsy done via scope showing invasive disease then will go on to have an MRI/CT scan for staging. Often no information will be available for depth of invasion due to nature of the biopsy/low stage disease. What is more appropriate to assign for the clinical T category? cTx or cTblank?	This question came up during our morning session and Donna Gress from AJCC responded. She said that X should only be used when the physician states its unknown or the physician indicates a value cannot be assigned. If the registrar is assigning the value based on reports such as imaging or pathology, the field should be left blank if another value cannot be assigned.
25.	Do we anticipate there ever being an addition to the CAP protocol to include whether or not it's peritonealized?	I don't know! It would be nice. Pay close attention to the pT value assigned by the physician. That should help.
26.	When a patient has a sigmoid carcinoma with L hemicolectomy resection then a second primary arises in the mucosa at the anastomosis what	See question 7 above. I wouldn't hesitate to send the scenario to ask a seer registrar if you still have questions!

	would the second primary site be? Colon, NOS c18.9, Left colon c18.6 or rectosigmoid c19.9.	

27.	The SEER Program Code Manual 2022 indicates that LVI codes of 0, 2, 3, 4 or 9 should only be coded for Thyroid, Thyroid Medullar & Adrenal Gland (pg 136 #2). Has this changed?	The SEER manual says "Code lymphovascular invasion to 0, 2, 3, 4, or 9" for those sites. **It does not say those are the only sites that can be coded to those codes.** Also, the SEER and STORE manual have different requirements. The STORE manual states Lymphovascular invasion must be coded 0, 1, 2, 3, 4, or 9 for Colon/Rectum schema. So I think it depends on your specific registry as to which requirements apply. In addition, state registries may have their own requirements. I will put a note in the Case Scenario Answers to clarify this.
28.	One of our registrars indicates that there is a CAnswer forum post that indicates an Omentectomy should be coded as a 40. https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/112904-appendix-primary-with-mets-to-other-sites#post120285. Is she correct?	Thank you. The Surgery of Other Site code for Case Scenario #2 has been updated in the Case Scenario Answers document to reflect this and a reference to this Canswer forum post has been included.
29.	Often on our diagnostic scopes if they see a sessile polyp they will remove it, if the margins are clear and there is nothing else suspicious/invasive in the colon they will do imaging to look for mets/LN's but are then put on surveillance, no further surgery. Would this qualify for pathological staging only? Even though it was done during a diagnostic scope?	I think we need to research more on this. But I think "surveillance" implies no definitive treatment and I am inclined to say this would qualify for clinical staging. Perhaps we post a question in Canswer forum?