Q&A Session for Central Nervous System 2022

June 3, 2021

#	Question	Answer
1.	What is meant by skull-based tumors? Can you list examples please?	I found a really good explanation of “skull-based tumors” at the site below. Essentially, these are CNS tumors located in near the bottom portion of the skull that are especially challenging to treat due to their location. https://www.mdanderson.org/cancer-types/skull-base-tumors.html
2.	Are all Meningiomas a WHO grade 1? If not stated, do you assume a grade 1?	All meningiomas with a behavior of /0 are WHO Grade 1. Meningiomas, such as an atypical meningioma, with a /1 behavior are WHO grade 2. A meningioma with a behavior of /3 would probably have a WHO Grade of 3 or higher.
3.	At our facility, meningiomas are found on imaging but no further workup is done, why are they important to abstract when nothing is done with them?	They still have the potential to grow and cause issues, so yes, they still need to be reported. At my facility, we capture those and state that their first course is "watchful waiting/active surveillance".
4.	FYI Canada has been collecting benign and borderline brain/CNS tumors since 1990.	Thanks!
5.	Are cavernous angioma's reportable?	I found this on SEER SINQ. It looks like a Cavernous Angioma is reportable if it arises in the dura or parenchyma of the brain.
6.	For tumor/neoplasm/mass/lesion terms are you saying it does NOT mean that "mass" and "lesion" are interchangeable with the "tumor" and "neoplasm" ambiguous terms found in STORE, but that if there is a HISTOLOGY code with the term "lesion" or "mass" it would be reportable?	The statement in the solid tumor manual only applies to determing histology and multiple tumors. It should not be used to determine reportability. The STORE is correct in that a “tumor” of the CNS or a “neoplasm” of the CNS is reportable. A “mass” or a “lesion” of the CNS is not reportable.
7.	Can you explain the difference between Non-Malignant CNS Histology Rules, Rule H2 and Rule H7?	They are essentially the same rule. H2 applies when a single tumor. H7 is multiple tumors.

8.	What do we do with NF abstracts done before 2018 due to MP/H rules and SINQ instructing NF to be abstracted as 9540/1? (examples: SINQ20091127, SINQ20081126) What do we do when reviewing suspense case & find pt dx w/ NF before 2018? Is it reportable per the prior rules?	That is a good question! We'll send that in to SEER. I would assume they are reportable if dx'd prior to 2018.
9.	We have surgeons at our facility who do not always use anatomical sites that correspond with our primary sites (for example: primary site is anterior clinoid process). If we use the hierarchical list and there is information that does not correspond to our primary sites, what is the best way to assign primary site (assuming we are not able to discuss with any MDs)?	I would first search the SEER SINQ. https://seer.cancer.gov/seer-inquiry/inquiry-search/ If you don't find the answer there, submit the question to Ask a SEER Registrar. https://seer.cancer.gov/registrars/contact.html Hopefully, these can get added to the STM sometime in the future! This is a real problem. Also, be sure to document the Anterior Clinoid Process in your text!
10.	If NF1 or NF2 were diagnosed prior to 2018, and the patient presents with their first brain tumor after 2018, would you still be required to abstract the NF1 or NF2 in that case?	That is a great question. I would assume so, but it would be worth sending a question to Ask A Seer Registrar if the scenario does occur.
11.	Historical note - FORDS 2016's Summary Stage 2000 entry also has instructions for coding 8 for benign & borderline brain/CNS.	Thanks!
12.	I believe there are changes for pilocytic astrocytomas coding starting for dx 2023+. They are all coded to /1.	I believe you are correct! There will also be some new terms for the code. But like you said, that will not apply until cases diagnosed 2023.
13.	Did I misunderstand something? I do not see "Stereotactic biopsy" listed in the STORE manual brain surgery codes as code 20.	There is a discrepancy between the coding instructions for SEER and STORE. STORE instructs registrars to code a stereotactic biopsy as a diagnostic staging procedure 02. That is assuming there is still residual tumor after the procedure.
14.	Can you quickly verify which CNS sites should be coded to AJCC TNM Edition 08 vs. using code 88?	This is really based on the histology of the tumor. Check the AJCC manual if it's a sarcoma-type tumor to see if one of the sarcoma chapters applies. If it's a true CNS-type tumor, and the date of dx applies to TNM Edition 8, you will use code 08 for the edition.

		Even though a T, N, M, and Stage group is not defined, the software will assign and AJCC ID to the case if TNM edition is coded to 08.
15.	If the initial clinical imaging had only 1 differential of glioblastoma, would we then have clinical grade of 4 per grade manual & AJCC table 72.2?	Yes! a clinical grade can be assigned for CNS tumors even if no bx of primary tumor. This only applies to CNS.
16.	Often, we see the primary site described in different ways in the chart and sometimes says something like "temporo-parietal" in one place and then maybe temporal someplace else. Is there a priority on where to find the most accurate primary site and what to code if they are just saying something like temporo-parietal?	First, I would use the priority list of resources in the Solid Tumor Manual. When there is a question of primary site location, look to the imaging studies and the operative report. If it is stated to have started in one lobe and then spread to an adjacent location, then the initial lobe is the primary site. If it is consistently noted to be a tumor that originated in two different lobes, it will get the C71.8 code for overlapping sites of the brain. Make sure to write out the overlapping sites in the primary site text.
17.	Is the diagnosis date based upon presumption of disease (lymphoma, Glioblastoma) on radiology report only (even if there are no ambiguous terms used from Store Manual) to be used for CNS sites only?	No. Once terms are used that make the case reportable, that is the diagnosis date.
18.	XRT technique is sometimes stated as "static" and also sometimes as "static-IMRT". What XRT technique code should be used in these instances?	I believe static IMRT is opposed to arc IMRT. When coding radiation, we do not differentiate between the two when coding at this time.
19.	Comment: I just had an EPIC upgrade few weeks ago & now I have a "hover for details" option in the attribution settings for notes. For op notes it shows which text are from template (EPIC SmartPhrase) and which parts are edits/additions by the surgeon/resident/scribe. Super useful for sifting through long notes!	Very nice!
20.	The childhood cancers NF1 type, can they be found in older children also such as early adulthood?	For NF1, yes, they can be found at other points in a person's life, but most often they are found early on. They also may have

		been exhibiting symptoms later than usual, but as it's a genetic condition, NF patients are born with it. It manifests in everyone at different times and in different ways. The information presented in the slide was the typical presentation of each type.
21.	We are having the same issues in Cancer PathCHART when dealing with lack of specificity of the ICD-O site codes for the brain. Would it make sense to propose a review of these codes to IARC/WHO for the upcoming ICD-O-4?	Yes, it would!
22.	What if the radiology report states there is a satellite tumor (regarding summary stage)?	It IS possible for a brain tumor to metastasize leptomeningeal or into the spine. In this case, you would want to look for further comment from the physicians on whether or not they believe it's the same histology or a second primary tumor. Look for more info in path reports and also treatment reports indicating whether or not that satellite tumor responded to the treatment as expected. If you can definitively determine it is a met, then the summary stage would be a 2 (regional spread). The SS manual is very descriptive in the Brain section on what constitutes a stage 7, so be sure to check there first.
23.	Love the video on immunotherapy! You read about the different kinds but so nice to have a little visual to go with the readings!	Thank you!
24.	I have often read in the EMR that the patient had a near total resection. What surgical code should we use in those cases?	a near total would get a code of 21 for the brain or 22 for the spine. unless it's stated as "gross total", it's going to be a less-than-total resection and indicates a lower surgical code.
25.	I have often read in the EMR that the patient had a near total resection. What surgical code should we use in those cases?	I would think that is a code 21. Subtotal resection of tumor of the brain.
26.	So, we still code the surgery as GTR event though there is residual evidence of disease on post op imaging?	if there is evidence of disease on post-op imaging, then it would be a subtotal or "near total" resection and get that code (21 for brain, 22 for spine)
27.	So, we still code the surgery as GTR event though there is residual evidence of disease on post op imaging?	We should get that clarified. It's my understanding that we code the procedure, not the result of the procedure.