

Q&A Session for Breast 2022 – Part I

October 6, 2022

#	Question	Answer
1.	I thought item #1290 is being replaced in 2023 (& renamed) so only required for diagnosis years 2003-2022?	I thought item #1290 is being replaced in 2023 (& renamed) so only required for diagnosis years 2003-2022?
2.	With these new surgery codes will we have to go back and change them? We're abstracting concurrently.	No!
3.	What is the point of the letter in front of the surgery code?	Versioning. If there is another change to the breast surgery codes in the future, they codes will all start with the letter C.
4.	For some of these breast surg codes that require there to be bx proven cancer does the NCDB edits check that dx stg procedure is O2?	I'm not sure! That is something you will have to check on that with NCDB. I would suggest sending an actual case scenario.
5.	Do we code A400 if a patient is at our facility for a breast reduction and cancer is an incidental finding on the pathology review? Cancer not suspected prior to surgery.	I haven't seen this addressed in the CAnswer forum yet. If it comes up, please submit. I can see an argument either way. On the one hand, the patient did have a breast reduction. On the other hand, the breast reduction was not planned for this primary. If you get an answer, please share!
6.	For the reconstruction coding, it is only for breast that has cancer? - for example if the opposite-noncancerous breast had reduction and no reconstruction to the cancerous breast - you would code reconstruction to A000 correct?	That is correct. You only code reconstruction that was done at the same as the definitive surgery and you only code reconstruction to the ipsilateral (cancerous) breast.
7.	do standard setters realize how changed a field from numeric to alpha numeric is going to make data pulls from year to year for comparison much more difficult?	I know it is not ideal!
8.	How will vendors differentiate which codes to use based on type of reporting source? More importantly, how will this data item be reported to the central registries? Will software accept either alpha numeric or just numeric codes? Will edits allow for either?	At this point, the Surg Breast and Surg Breast Recon fields are only collected by CoC facilities. NPCR and SEER are not requiring these fields for 2022 or 2023. Eventually, the Surg Breast fields will be added to Surg Primary Site and replace the current Breast Surgery codes (probably in 2024). However, you will only use the new codes for cases diagnosed 2024 forward. The

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		software vendors and edits WG have been involved in these updates and are prepared to react to them. I don't see a software or edits problem related to the format of the new surgery codes.
9.	Could you clarify about coding of uninvolved breast removal when its bilateral nipple sparing? NCDB telling us to code to surgical procedure/other site as recently as last month. See: https://cancerbulletin.facs.org/forums/node/131467	<p>I did not know that. We'll have to discuss with standard setters and get this resolved.</p> <p>I have to admit that what CoC posted is how I was taught, but a couple of years ago SEER and CoC decided not to collect the contralateral breast in surg other site. When you do that, you are double coding the removal of the contralateral breast. You capture it once in the surg primary site field and again in the surg other field. I would keep an eye on that post. It may be updated.</p>
10.	What would be the surgical code for bilateral mastectomies for bilateral synchronous cancers?	That would be two primaries and two abstracts. each would be coded independently. For example, you might assign a surgery code for single mastectomy without removal of uninvolved contralateral breast. Do not code each primary with a "removal of uninvolved contralateral breast" code. First of all, the contralateral breast does have cancer. Second, if you code them both that way, it looks like 4 breasts were removed!
11.	At the beginning of the webinar, did you say the new codes will be used for 2022 cases or 2023 cases?	The new data items Surg-Breast and Surg Breast Reconstruction will be completed by CoC facilities for 2022 and 2023 breast cases. Everyone will continue to collect the current surgery fields for 2022.
12.	Sorry, I was unclear in my original question. We have no cancer in either breast, but patient comes for breast reduction. Do we code the recon to A400 if the breast reduction was done and cancer was incidentally found? No previous diagnosis of breast cancer in either breast.	That's a tough one. I could make an argument either way. I think you should send the scenario to CoC if it comes up. They are the definitive source.

13.	If the treatment summary does not tell us the kind of treatment planning technique is used but we know it was photons, can we assume planning technique is 3D conformal?	Without any other bits of information, we cannot assume it was 3D.
14.	Here's a similar scenario to your question but the incidental finding is LCIS so NCDB replied case not reportable to CoC. Not sure what their answer would be if it was DCIS that was found. https://cancerbulletin.facs.org/forums/node/130242	Thanks!
15.	When will be the recording be posted?	Hopefully by next Thursday. It will depend on how quickly we can get the Q&A completed. We may need to send some questions to standard setters for clarification.
16.	Regardless of tumor grade, if a patient has an aggressive tumor biology, such as triple negative, do those parameters apply for who receives radiation?	The triple negative status will more directly determine the role of adjuvant or neoadjuvant chemotherapy than that of EBRT. In the high-risk population, EBRT will depend on the effect of adjuvant or neoadjuvant therapy. For example, if pt undergoes neoadjuvant chemo followed by a mastectomy and pt presents w/ positive lymph nodes, then it's very likely that EBRT will be prescribed for this pt.
17.	For your example with the "en face" boost - what is the correct code for the planning technique?	For breast boost using en face (electron), vast majority will be 3D-conformal. A custom-made electron cut-out that conforms to the planned irradiate volume will be used.
18.	What technique do you use for VMAT?	Volumetric Modulated Arc Therapy= Rotational Therapy= in most cases, IMRT(05). However, it can also be 06, SBRT (very unlikely for breast cases, though).
19.	Do you know if they are going to be looking at redoing/updating surgical codes for other sites like they have been doing with breast?	Yes. They did a major update to skin that we will start collecting with 2023 cases. There are other sites getting updates, but most of them are relatively minor changes. Breast and skin are major updates.
20.	You had said the plan is for the Rx Hosp-Surg Breast & Rx Summ-Surg Breast fields to be incorporated into coding surgery in 2024. I think I had heard that the Rx Hosp-Recon Breast & Rx Summ-Recon Breast fields would be a future SSDI field?	I believe that is correct. Also, the addition of the Breast Surg values being added to Surg Primary site in 2024 has not been officially approved. However, i think it is highly likely.

21.	In situ carcinomas, could there be the LVI positive? as they are in situ?	Per the SEER manual coding instructions LVI should be coded 0 for in situ cases. I am not aware of any exceptions.
22.	Patient has positive lymphadenopathy during clinical workup which makes her ineligible for a sentinel lymph node biopsy only procedure. She has an axillary lymph node dissection. Lymph node summary states that sentinel and non-sentinel lymph nodes are removed. Would you still code the cumulative total in the sentinel lymph nodes examined/positive fields? Also, if a sentinel lymph node was removed along with non-sentinel lymph nodes, 3 out of 10 lymph nodes were positive. Summary does not specific if the sentinel lymph node was positive. Would you code sentinel lymph nodes positive to 99?	I'm assuming you have done what follow-back you can do and still cannot determine what resource is correct. If you really aren't sure if a Sentinel node procedure was done, code 99 for both SN Pos and Ex. For your second question, if both SN procedure and LN dissection were done and you cannot distinguish between nodes removed during the SN procedure and nodes removed during LN dissection, use code 98 for SN EX and 97 for SN Pos.
23.	Thank you for the information of electrons vs photons. What about protons?	I did not focus on proton therapy on this webinar as the vast majority of breast cancer patients who are prescribed radiation therapy receive it via photon therapy with photon or electron boost. The proton therapy topic may be for a future webinar.
24.	For case two if phase 2 for the boost was 6 MV would it still be coded the same or how would that be coded?	If the boost is delivered via photon vs. electron, the modality code will change to 04, electrons. Planning technique will remain 04, 3D-conformal.
25.	For scenario 3 - please clarify the surgery of primary site code. You said earlier that NIPPLE-sparing should be coded to a simple mastectomy and that only SKIN-sparing should be coded to subcutaneous. In this scenario you are saying they DID spare the nipple, but it should be coded to 30?	I must have mis spoke...Nipple Sparing is coded 30. Per the CANSWER forum, Skin Sparing is coded 40 or higher.
26.	FOR CASE #3 is the tamoxifen taken into account for the systemic surg sequence - I see in the STORE 2023 it has been changed to At least two courses of systemic therapy were given before and at least two more after a surgical procedure of primary site - in the past it was stated as at least 1 after a surgical procedure.	I was not aware of that change. I see is included with code 4. You are correct. We will assume multiple courses were given before and after for case 3.
27.	For Scenario 3 - Surgery code 30 doesn't account for tissue expander placement?	That is correct. In the current surgery codes (Surg prim site) we would not bump this up to a higher surgery just because some

		reconstruction was done. Nice thing about the new fields is they separate surgery and reconstruction.
28.	If pt got RT to primary site and months later gets prophylactic RT to whole brain. Do you code it to subsequent or 2nd phase?	I would code it as 1 st course treatment, unless it has been determined that the WBRT is due to disease progression.
29.	Why did the surgery codes change?	As ACoS physicians were developing synoptic operative reports for use in the clinical setting they also took a look at the surgery codes registries use. They realized the registry surgery codes were in need of updating!
30.	If they decide to do a surgery e.g., excisional bx but while in the OP decide to do a lumpectomy. How is that coded?	In the current Surg Prim Site codes, they are both a 22. In the Surg Breast it would depend on whether the tumor had been biopsies and cancer had been confirmed. If it was bx confirmed malignancy, then code B200. If not, code B210 or possibly B215.
31.	What's the difference between A600 and A980 when it comes to reconstruction? When would you use each code?	I don't know. The A900 codes are defined <i>as Code A900 when reconstruction is done, but the type of reconstruction is not known.</i> I would only use code A980 if one of the A600 codes does not apply. I can't think of a situation where A980 would be used.
32.	Since we only record sentinel nodes for breast and melanoma, does the same rule apply for both sites when coding the AJCC N (sn)?	From what I understand the definition of N Suffix (sn) applies to any site where a sentinel node procedure is done. Even though we don't collect info in the Sentinel nodes pos/ex for any sites other than breast and melanoma, that doesn't mean the AJCC rules only apply to those sites.
33.	Does a sentinel node biopsy have to have the blue dye done to qualify? or is this more of an indicator?	Remember, in the fields Sentinel nodes pos and examined, we are coding the number of nodes removed during the procedure. We are not just removing the true sentinel nodes (those with the blue dye).

		So, the answer is No. The LN does not have to have the blue dye to be included in the count of sentinel nodes pos and examined.
34.	In general, do you code what is actually done during surgery or what was planned?	That is a tricky question. In general, it is what was done.
35.	Would Partial Breast Radiation ever be coded as SRT - SRS or SBRT?	I have yet to have encountered such cases. This does not mean that it may not be practiced at some facilities.
36.	Has there been any discussion about the impact of an increase in Neoadjuvant Therapy for Breast Cancer and the resulting inability to assign a 'post-Therapy' stage group in AJCC TNM8?	I am not aware of any discussions at AJCC concerning the development of a “post-therapy” stage group for breast. However, I am not privy to those types of conversations! I do know the authors of the breast chapter felt using the clin or path stage group for post therapy patients was not appropriate. Patients staged after neoadjuvant therapy do not have the same prognosis as those staged during the clin or path time frame. Using the clin or path stage grouping would be misleading. Their plan was (and I assume still is) to collect the yp and yc T, N, and M and use that date to create a post therapy stage group that does reflect the patient’s prognosis.
37.	Thank you, Jim, for answering my question about post-Therapy staging...my concern... for sharing with AJCC is the fact that these cases will disappear from Path Stage Group Stats and potentially alter the overall stage group distribution. I appreciate your outreach on my (our :) behalf.	You are welcome!
38.	I thought item #1290 is being replaced in 2023 (& renamed) so only required for diagnosis years 2003-2022?	Once we convert to v23, patients diagnosed prior to 2023 will be assigned a Surg Primary site field (1290) using the same codes we’ve been using. Patients diagnosed 2023 forward Surgery of Primary Site will be coded in a new data item. It will look very similar to the current surgery field (1290), but the codes will be in a different format. Most of the codes will be the same, they will just have an A the beginning and 0 at the end.

		<p>However, the Surg Breast codes we looked at will not be included in the initial release of the new surgery data item. They probably won't get added until 2024.</p> <p>I know it sounds confusing, but the software should tell you what needs coded for each year!</p>
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