

Q&A Session for Breast 2022 – Part II

November 10, 2022

#	Question	Answer
1.	I was abstracting a breast and came across Goldilocks mastectomy. What is it and how do you code that? Is it a lumpectomy or a mastectomy?	The SEER Manual Appendix C (for both 2022 and 2023) states surgery code 30 (A300 for 2023+) seems to be the best available code for a Goldilocks mastectomy; however, the choice between code 30 (A300) and codes in the 40-49 (A400-A490) range depend on the extent of breast removal and to review the operative report carefully in order to assign the code that best reflects the extent of breast removal.
2.	Do you code reconstruction, flap of Subcutaneous tissue?	If a flap of subcutaneous tissue breast tissue is being used to reconstruct the breast after a lumpectomy or partial mastectomy, it would be a code 300; if the subcutaneous tissue is from tissue adjacent (regional) to the breast use code 500. If the patient had a mastectomy with reconstruction using subcutaneous tissue, use code 600 (i.e., DIEP). If we don't know if a mastectomy was done but they had reconstruction with a flap of subcutaneous, we could use 980 for autologous tissue-based reconstruction, NOS in this scenario.
3.	Are you saying that if we have a case diagnosed prior to 2023 that we use A190? Or can we use the appropriate "A" code even if diagnosed prior to 2023?	The "A" codes can only be used for cases diagnosed 2023 forward.
4.	Can you tell me whether LCIS is no longer required by COC for 2023 or is it not required now? Do you know whether central registries have that exclusion?	CoC stopped collecting LCIS with cases diagnosed 2018. That is the same time AJCC stopped allowing them to be staged. NPCR and SEER both continue to require LCIS to be reported. Therefore, they would be reportable to all state registries. A CoC facility would assign these a non-analytic class of case. Pleomorphic LCIS is still reportable to the CoC per the CAnswer Forum https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/case-eligibility-patient-identification-cancer-identification-stage-of-disease-at-diagnosis-tumor-size-and-mets/132915-lcis-pleomorphic .

Q&A Session for Breast 2022 – Part II
November 14, 2022

5.	For the lumpectomy and partial mastectomy what are we considering small vs. larger amount of breast tissue?	It is referring to how much healthy tissue is involved.
6.	According to the slide 14, would a skin-sparing mastectomy be coded to 30 or A30?	For a skin-sparing mastectomy to be coded to 30 (2003-2022) or A300 (2023), the nipple and areola would need to be left in place with the skin (subcutaneous mastectomy). If the nipple/areola are removed, surgery would be coded to a simple mastectomy, and the surgical code would depend on whether the uninvolved contralateral breast was removed and if reconstruction was performed. Mastectomies remove varying amounts of skin depending on a number of factors like breast size, desire for reconstruction, etc., so just because the procedure is called skin-sparing, we cannot assume this is a subcutaneous mastectomy
7.	For LCIS - can it also be class of case 32 in the right context (not just 34/36) since it goes back to 2018?	If a patient was diagnosed with LCIS prior to 2018 and returned for subsequent treatment or recurrence, code 32 would be appropriate. Assign any analytic LCIS cases which are no longer reportable to the CoC to either 34 or 36.
8.	Reconstruction NOS is used for Tissue Expander with Alloderm Matrix correct if that is all we know at the time of abstraction?	For CoC facilities, unless you are sure the acellular dermal matrix is made entirely of human tissue the NOS code should be used. If you are sure it was made entirely of human tissue, it may be coded as tissue (i.e. surgery code 44). SEER Appendix C (2022 and 2023 versions) states “Assign code 43 for a simple mastectomy with tissue expanders and acellular dermal matrix/AlloDerm. The tissue expander indicates preparation for reconstruction. The acellular dermal matrix/AlloDerm is not coded because, while they often accompany an implant procedure, they are not the principal element of reconstructive procedures. The principal elements would be tissue from the patient and/or prosthetics (e.g., gel implants).]”
9.	For Surgery code 30 Subcutaneous Mastectomy if the other breast was equally removed, do we code the surgical removal of the other breast under Surgery of other regional sites?	This is confusing because there was previously an instruction in STORE and FORDS that said, “for single primaries only, code removal of the contralateral breast under the data item Surgical Procedure/Other Site (NAACCR Item #1294) and or Surgical Procedure/Other Site at this Facility (NAACCR Item #674).” This instruction was removed from

		<p>STORE 2022 early in 2022. They sometimes post updated versions, so if this instruction is in a PDF of the STORE manual that you downloaded, go to the NCDB page and grab a fresh copy. Here is the link to access the manual. https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/</p> <p>Summary: For a subcutaneous mastectomy with removal of the contralateral breast, assign code 30 for surgery of primary site and do not code the uninvolved contralateral breast in surgical procedure other site.</p> <p>https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/119283-breast-surgery-coding</p>
10.	Have the standard setters ever discussed just having ONE manual for the surgery codes?	That would be nice!
11.	on poll on page 24 you said B was correct answer, but the pop-up poll said C (A440). Which is correct?	The codes on your PDF were off by one number. The correct answer is 43 (A430).
12.	For the bilateral simple mastectomy for inflammatory breast cancer (slide 21), has it been suggested that the surgery codes be updated to better reflect the surgery code that they want?	The SEER 2023 manual has removed that instruction. The manual was not yet released when we submitted the slides for this presentation; therefore, we were not aware of the change. However, the instruction in SEER does apply pre-2023. I think they updated this instruction based on feedback from the registry community.
13.	I am confused about slides 21 & 22 about bil simple mastectomy for inflammatory breast carcinoma for both breasts. I am looking at the SEER Instructions and it says: "[SEER Note: Example of single primary with removal of involved contralateral breast--Inflammatory carcinoma involving both breasts. Bilateral simple mastectomies. Code Surgery of Primary Site 2023 (NAACCR #1291) as A760.]" and then it says: "[SEER Note: Assign code A760 for a more extensive bilateral mastectomy. Assign code 0	Page 2 2022 SEER Appendix C Breast Surgery codes: "[SEER Note: Example of single primary with removal of involved contralateral breast--Inflammatory carcinoma involving both breasts. Bilateral simple mastectomies. Code Surgery of Primary Site (NAACCR # 1290) 41 and code Surgical Procedure of Other Site (NAACCR # 1294) 1.] " "76 Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma. [SEER Note: Assign code 76 for a more extensive bilateral mastectomy. Assign code 0 in Surgical

	in Surgical Procedure of Other Site (NAACCR #1294)." So, I am not sure where in the instructions it says to use code A410?	Procedure of Other Site (NAACCR # 1294)." Note: This instruction has been removed with the just-released 2023 SEER Manual.
14.	If, by the time you abstract the case you know that the tissue expander was done preparatory to implants, could we use the implant code?	For the Breast Reconstruction fields (Rx-Hosp Surg Breast and Rx-Summ-Surg Breast, you would only code the tissue expander since that is what occurred on the day of surgery.
15.	Could you backtrack and explain more specifically about why you use involved vs uninvolved breast in some cases and not in others? lumpectomy vs simple mastectomy> Is it that the key?	It is based on the coding table. There are no combination codes for the surgeries that are less than mastectomies.
16.	Are we supposed to go back and capture reconstruction once all of FCOT is complete and we have marked our abstract as complete?	There are conflicting CAnswer Forum posts about this topic. Some say to update the original code and others say to code to what happened on that date. For example, this one says to code the procedures separately (https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/104042-breast-surgery-code-with-reconstruction) and this one says to update the original code (https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/103691-breast-surgery-code) Either way, the correct information gets transmitted to NCDB and your central registry.
17.	If a case is coded reconstruction, NOS for expander placement at the time of breast surgery, is it recommended that the surgery code be updated once the reconstruction with implant vs tissue is complete? Or leave it reconstruction, NOS?	See above
18.	If bilateral breast cancer is diagnosed. You code both surgeries as a single breast removal. You don't have a data field to enter to indicate that both breasts are removed?	When the opposite breast is INVOLVED (each breast is abstracted separately), code surgery of other site to 1 per the SEER manual, Appendix C: "For single primaries only, code removal of involved contralateral breast under the data item Surgical Procedure of Other

		Site (NAACCR Item # 1294). When the opposite breast is uninvolved, it is included in the surgery code.
19.	A Plastic Surgeon I worked with described Alloderm as a "sling" or "hammock-like" material that holds and provides support to the expander. My understanding is that's why we don't code it to tissue reconstruction-it's not using tissue to reconstruct the breast itself. Does that help?	<p>That makes sense to me! Thank you!</p> <p>Yes. We are waiting further clarification from the CoC. SEER says not to code any type of dermal matrix, but in recent communications with us they (CoC) have said code it to tissue when the registrar is certain dermal matrix is derived from human tissue.</p> <p>[SEER Note: Assign code 43 for a simple mastectomy with tissue expanders and acellular dermal matrix/AlloDerm. The tissue expander indicates preparation for reconstruction. The acellular dermal matrix/AlloDerm is not coded because, while they often accompany an implant procedure, they are not the principle element of reconstructive procedures. The principle elements would be tissue from the patient and/or prosthetics (e.g., gel implants).]</p>
20.	Do surgery codes 45 - 46 apply only to tissue expander placement with immediate reconstruction?	<p>No. These codes may be used if reconstruction is done at a different time.</p> <p>There are conflicting CAnswer Forum posts about when to assign these codes. Some say to update the original code and others say to code to what happened on that date. For example, this one says to code the procedures separately (https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/104042-breast-surgery-code-with-reconstruction) and this one says to update the original code (https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/103691-breast-surgery-code)</p> <p>Either way, the correct code will be transmitted to NCDB and your central registry.</p>

21.	Ok, I do see the instructions for the codes prior to 2023, do say: "SEER Note: Example of single primary with removal of involved contralateral breast--Inflammatory carcinoma involving both breasts. Bilateral simple mastectomies. Code Surgery of Primary Site (NAACCR # 1290) 41 and code Surgical Procedure of Other Site (NAACCR # 1294) 1.]" So, it looks like the coding instructions have changed for 2023.	Yes. Prior to the release of the 2023 SEER Manual, the instructions were different. The 2023 iteration of the manual was released after we submitted this presentation.
22.	When a Sentinel node procedure is performed and incidental nodes found during surgery, do you record the SN suffix?	Yes, as long as a RLND is not performed during the same timeframe.
23.	SLN with lumpectomy, then decision for completion mastectomy (NO LND) BUT there's incidental LN in the mastectomy specimen. How to code scope reg LN? Is it 7 even though surgeon did NOT do LND or still 2?	Code as a "2" in scope of regional LN surgery because we are coding procedures . The patient did not have any additional procedures to remove lymph nodes. Those LNs were an incidental finding.
24.	When the SLN procedure is done and fails to map and no SLNS are removed do we still use the (sn) suffix to represent the SLN procedure was attempted?	Remember, the (sn) is only used if they decide against performing an axillary node dissection during the same timeframe as the SLN procedure. If a situation such as you described comes up, you should probably send the case to CANSWER forum for clarification. I could see an argument for and against using the sn suffix in this situation. STORE says if a SLN biopsy is performed, the sn suffix should be used. The sn suffix is based on the procedure that was performed, not on whether the nodes were positive or negative; STORE does not mention anything about what to do when no SLNs are identified.
25.	Oops meant to write regional In not sentinel In bx or fna in 2021. I was entering as a surgery but leaving date empty to clear edits. Now we can fill in date?	The way we assigned the dates for these has changed since 2018. There used to be an edit that came up when a SLN procedure was performed, but no nodes mapped and no SLNs were examined. At that time, putting a date in the date of SLN biopsy field triggered an edit. We confirmed the date of the SLN procedure should be entered with the CoC prior to the webinar materials being posted.
26.	Are you saying that you'd add a 2nd row of surgery; the original "reconstruction NOS" with expander, and a 2nd	There are conflicting CANSWER Forum posts about this topic. Some say to update the original code and others say to code to what happened

	surgery code later to include implant? It would look like the mastectomy was done twice.	<p>on that date. For example, this one says to code the procedures separately (https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/104042-breast-surgery-code-with-reconstruction) and this one says to update the original code (https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/103691-breast-surgery-code)</p> <p>The good news is the correct codes will be transmitted to CoC and your state registry either way.</p>
27.	I thought we had to go back and update the surgical code if reconstruction is done later. Per STORE & SEER 2022: "Reconstruction that is planned as part of first course treatment is coded 43-49 or 75, whether it is done at the time of mastectomy or later."	That is what CoC is recommending. However, when the cases get transmitted, the date of the first procedure and the highest code for any additional treatment will get transmitted. Therefore, I don't think it makes much difference whether you update the surgery code for the first procedure or add a new line.
28.	B codes are not in the STORE 2023? Are only certain registries doing the field study?	See page 221 (.pdf number) in STORE 2023. This is where you'll find the breast B codes. When you look at Appendix A in STORE 2023, the only "B" codes are in the skin surgery codes. All the rest are currently "A" codes, meaning there is not a significant change.
29.	A for reconstruction and B for surgery codes?	For 2022 and 2023 CoC facilities will code surgery of primary site for breast twice. They will code the procedure in the standard Surgery of Primary Site field. They will also code it in two separate fields called Rx Hosp -Surg Breast and Rx Summ-Surg Breast. It just so happens that in 2023 we are also updating our surgery of primary site codes. Starting in 2023 all surgery codes (excluding skin, which will start with a B and end with a 0) are going to start with an A and end with a 0.
30.	What is the difference between A600 and A980 reconstruction codes?	If you know the patient had a mastectomy, you could use A600 for mastectomy reconstruction with autologous tissue, NOS, but if you cannot determine whether the procedure was a mastectomy, you could use A980. Since we are only coding immediate reconstruction, we

		should know what surgery the patient had, but if you are reporting a case in which the patient had their surgery and reconstruction elsewhere, you could be missing information.
31.	What is difference in A600 and A980 code?	See above answer. By definition, A600 requires a mastectomy to be performed.
32.	It is important to remember that reconstruction codes ONLY used in the event of the primary breast is reconstructed - there are times when only the opposite non-cancer side is reconstructed	You are 100% correct! We are only coding reconstruction to the breast with the primary tumor. Reconstruction to the contralateral breast is not coded in this field.
33.	What if the pathologist put a range that spans two different ranges, which do we choose?? the higher range or the lower? IE 36-45%	For v3.0, if the range is stated to be 36-45%, we have a range with steps less than or equal to 10, so we would code to the range that contains the lower point of the range. In this example, that would be R40.
34.	According to the Required Status Table v23 although SEER will stop collecting AllRed in 2023, CoC will continue to collect? This contradicts the STORE 2023 manual which says they will no longer be collected 2023+.	Sometimes, there are errors in those tables. No one wants Allred in 2023.
35.	Who sets the rules for recording lab values when it comes to less than, greater than or ranges?	The SSDI WG. We have reps from CAP, AJCC, SEER, NPCR, etc.
36.	For slide 86, I did not realize this has been updated about invasive and in situ. I don't think it is in the SSDI manual yet? "Note 5: In cases where there are invasive and in situ components in the primary tumor and Ki-67 is done on both, ignore the in situ results. If Ki-67 is done on both the in situ and invasive components in the primary tumor, code the Ki-67 value from the invasive component. If in situ and invasive components present and Ki-67 only done on the in situ component in the primary tumor, code unknown	Note 5 was added with v3.0. In v2.1, there were only 4 notes.
37.	How do we tumor size clinical when there is a biopsy, and it is found at mastectomy there is no tumor left?	You can use the clinical tumor size from physical exam and any imaging (largest documented size from PE, mammography, MRI, image guided tissue biopsy) prior to the mastectomy. For the image guided tissue biopsy, don't use a size from the actual core or needle biopsy, unless

		you are confident that size corresponds to the tumor, rather than the specimen size. Size can also be taken from the PE. For breast tumors, clinical size may be recorded based on the size of a non-mass enhancement (NME). NME is defined as an enhancing abnormality that is not associated with the three-dimensional volume of a mass, shape and outlining, and it is separate from the Background Parenchymal Enhancement (BPE).
38.	The doctors almost never commit themselves to saying, "complete response," much in the way they never make a statement like Cancer Status, no evidence of cancer. Do we just fill in unknowns?	If we don't have a physician statement of response to neoadjuvant treatment that can be coded to 1, 2, 3, or 4, we have to assign code 9. For the Cancer Status items, the CoC states this data item is under review by the clinical group responsible for the development of the data item. https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/cancer-status-ab/131971-physician-interpretation-of-cancer-status
39.	If the pathology report indicates that the involved contralateral breast is metastatic from the other breast tumor (such as with inflammatory breast cancer), would you then code that removal of the contralateral breast in surgery of other site?	If the patient had bilateral mastectomies, and the contralateral breast was involved (abstracted as a single primary), assign code 76 (A760). Prior to the November 2022 release of the 2023 SEER Manual, we were instructed to assign bilateral SIMPLE mastectomies for a single primary involving both breasts to 41 and code the removal of the involved contralateral breast under the data item surgical procedure of other site.
40.	In order to put a date of lymph node dissection, did the patient have to have a full lymph node dissection or can you put a date there if just one or two regional nodes were excised?	It can be difficult to distinguish between a lymph node dissection and lymph node sampling. In a lymph node dissection, they are attempting to remove all of the lymph nodes along LN chain. Usually, this is more than just one or two regional nodes. The date of LN dissection should reflect when they do a full dissection, not just a sampling. There is a good discussion about this in the following CAnswer Forum post: https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/sentinel-and-regional-nodes/102644-lymph-node-dissection-date

41.	If SLN and RLND done at same procedure, we need to leave blank number of SLN examined blank and in positive code 97?	No. Those are two different procedures, and two different fields. You would code the number of nodes removed during the SLN procedure in SLN examined. SLN positive would be 97.
42.	Is there a certain number for there to be a dissection?	There really isn't a definitive number of nodes to help you distinguish between a LN dissection and sampling. We need to go by the operative report. Generally, AxLND removes at least 7-9 nodes. However, it is possible for these procedures to remove or harvest fewer nodes." We have to review the operative report to understand what happened.
43.	If a lumpectomy is done with SLN procedure (surg 22 & SLNS is 2) and then patient has reexcision (Surg 23). My question is what to code for SLNS for reexcision surgery-blank?	If your software allows you to code multiple procedures, the second procedure would be the re-excision. No lymph nodes were removed during that procedure so the Scope of regional lymph node procedure would be 0.
44.	If the LN dissection is not planned but during the surgery the dissection is done do we still enter the date of LN dissection?	That is correct. You would code the date of the LN dissection even if it was not part of the pre-op definition.
45.	Will that unplanned dissection then become the most definitive?	No. The "Date Most Definitive" is used for the most definitive surgery to the primary site. A lymph node dissection would not apply.
46.	Could someone comment on capturing clinical size in situations where an incisional biopsy removes the whole tumor, so its actually an excisional biopsy. SEER manual indicates to use 999 in clinical size and the size of the tumor in the pathological size. This feels incorrect, would that size not affect your clinical staging?	If you think of the tumor size rule in terms of coding surgery, it does feel incorrect. However, if you think of it in terms of AJCC staging, it makes sense. The incisional bx that removed the entire tumor would be coded as a dx staging procedure. When assigning an AJCC stage, you would assign a pT. Your cT would be blank. The tumor size would go into pClinical size. This is one of those situations where the AJCC classification doesn't agree with the surgery code rules.
47.	Breast surgery codes-PT had lumpectomy for atypia, due to pos margins she had re-excision. If Breast surgery is coded to B240 how do we capture that PT first had excisional biopsy for atypia?	At this time, you can only code one surgical procedure using the Surgery Breast fields. You would code the most definitive procedure. Denise and I read your scenario differently. I assumed the patient had a bx that showed atypia, then had a lumpectomy positive for malignancy, and the lumpectomy had margins positive for malignancy. She then came back for a re-excision at a

		<p>different time. In that scenario, you code B240 re-excision. You are correct that the initial excision would not be recorded.</p> <p>Denise read the scenario as the re-excision was done due to atypia. There was malignancy, but margins were positive atypia (not positive for malignancy) In that case we would stick with code B215. We can only use the B240 code when the margins are re-excised for gross or microscopic residual disease of the type that is reportable.</p> <p>Once the new codes become permanent (probably with cases dx'd 2024), you will be able to record multiple procedures.</p>
48.	can you explain why you don't code the reconstruction with the incidental finding?	<p>The reconstruction was planned for the known cancer on the left breast. The cancer in the right breast just happened to be identified during the breast reduction surgery, which was performed for symmetry with the left breast. This breast reduction surgery was not a reconstruction.</p> <p>Since there was no preoperative diagnosis of cancer assign Rx Hosp-Surg Breast to code B210 (excisional biopsy; no pre-operative biopsy proven diagnosis of cancer). Reconstruction was not performed due to breast cancer so assign Rx Hosp-Recon Breast to code A000 (no reconstruction).</p>
49.	If the patient comes in 6 months later and has an implant placement, you are going to go in and change the surgery & reconstruction code to reflect that implant placement, correct?	For the field study reconstruction codes, no. Only code what happened on the same day as the surgery.
50.	Would we not go by the pathology report instead of the Oncologist?	Not in this situation. The tissue was microscopically examined, and assigned a generic grade; however, the oncologist stated the grade to be G1. Because of this, we are allowed to enter a "1" for the grade. There is no priority order in the grade instructions that states the pathology report has priority. This is in line with the general grade

		coding instructions for solid tumors, instruction #2: If there is more than one grade available for an individual grade data item (i.e., within the same time frame) a. Priority goes to the recommended AJCC grade listed in the applicable AJCC chapter. We have more than one grade available. One uses the generic grade (not the recommended AJCC grade), and the other uses the recommended AJCC grade.
51.	Where do I find the table, you are referring to for grade?	The grade manual includes the Grade tables. The grade manual is located at https://apps.naaccr.org/ssdi/list/?_gl=1*1ctb917*_ga*NDMxNjA1OTc3LjE1NzlyNzA5MTY.*_ga_ZGX07SVHJF*MTY2ODExNTQ2OC4yNTQuMS4xNjY4MTE1OTI3LjAuMC4w&_ga=2.82682070.1566578541.1668001410-431605977.1572270916