Q&A Session for Esophagus

December 1, 2022

#	Question	Answer
1.	If we have two descriptions of primary site, for instance the record says lower third, but elsewhere in the record says abdominal esophagus, which subsite is better, C15.5 or C15.2?	I found almost the same post on SEER SINQ. Their response wasn't much help. https://seer.cancer.gov/seer-inquiry/inquiry-detail/20000450/ I can't find any additional coding instructions to assist. If the situation comes up, you should probably send a detailed questions to SEER SINQ.
2.	Can you please share the website where you found the Barrett's Esophagus stage?	https://www.endoscopy-campus.com/en/classifications/prague-classification-barrett-esophagus/
3.	For radiation coding of regional LN - are all esophageal regional LN "thoracic LN"? I see cases of distal esophagus / EGJ primaries with regional LN RXT that involves abd LN (per definition in STORE)	It depends on the location of the tumor within the esophagus. Please note I have revised this data item codes for each scenario, after further review. There may be instances when multiple LN chains are targeted, in which case the best choice for RT to draining LNs is 08-Lymph Node Region, NOS.
4.	How often does carcinoma invade the diaphragm?	I can't say.
5.	I was under the impression that an EMR [endoscopic mucosal resection] of small tumors is still considered clinical staging...like TURBT...but Jim mentioned that you code it as pathological??	See AJCC 8th (3rd printing) bottom of chapter 16 pages 193-194. It talks about endoscopic resection that is complete (neg margins) is designed as pT (pathologic). If it is a pathological T, then it is pathological staging. If the EMR completely removes the tumor it is definitive treatment which is the criteria for pathological staging

6.	So, for the Schema Discriminator 1, we should mainly be going by how the physician is staging it to determine Esophagus or Stomach? What if there are discrepancies between physicians?	The AJCC Protocol being used would be given priority. If there is a discrepancy between physicians, you would probably go with the managing physician. However, it would probably be a good idea to check with the physician.
7.	For primary site, if you have a tumor that is mainly in the distal esophagus that goes up to the GE Junction or slightly over it and the physician is calling it a distal esophageal cancer, is the primary site C15.5 or C16.0?	I would go with C15.5 in that scenario.
8.	Does Mets a Dx - distant LN follow AJCC or SEER Summary definitions of regional vs distant LN?	SEER and AJCC agree the Mets at Dx fields follow the AJCC definitions of regional and distant.
9.	The difference between AJCC & Summary Stage - AJCC staging is based on prognosis. So, if those nodes have the same survival as regional nodes, AJCC would include them in the N category. Summary Stage is based on anatomical location.	Thank you, Donna Gress!
10.	If you don't know the number of nodes positive, wouldn't you use NX instead of blank?	I believe that is based on the source of information (or lack of information). If the physician assigns an NX, you can go with it. If you as a registrar just don't have the information, go with the blank.
11.	Is the HER2 used for only adenocarcinomas or is it used for SCCs too?	HER2 may be coded for primary squamous cell carcinoma or adenocarcinoma if the information is available. It is most clinically relevant for adenocarcinoma. If you are abstracting a primary squamous cell carcinoma, don't be surprised if a HER2 test is not ordered.
12.	If path stage GR 2-3 do we go w/3?	Yes. Use the standard rules for assigning grade and go with the higher of the two. Same applies to the grade used to assign AJCC Stage.
13.	Is there a difference between EG junct and GE junct or are they the same thing?	For our purposes they are the same. There are several acronyms to describe where the esophagus meets the stomach. Three that I can think of off the top of my head are EG, EJG, GE jct.

14.	Does the type and density of the organs that protons/photons pass through also have an effect on how much dose is delivered throughout the radiation path?	These factors are indeed considered in the treatment planning process. There are correction factors applied when the beam goes through air, for example.
15.	All of the RXT case scenarios have thoracic LN as "Rad to Draining LNs" but one of the 1st slides talk about the regional LN of distal esophagus including gastrohepatic LNs which is abd LN per STORE (peri-gastric, peri-hepatic) - so do we code to thoracic LN regardless of if abd LN are being irradiated?	Please refer to question #3, above.
16.	Do we have separate phases when thoracic and abd LN are included in treatment plan? Or do we code as "LN nos"?	The inclusion of multiple LN regions does not necessarily translate to multiple phases. In general, you are most likely to see multiple LN regions included in the CTV, in which case I would code to 08.
17.	If abdominal and thoracic LNs are being radiated, then do we code Draining LNs as 02-Thoracic or 08-Lymph node region, NOS?	I would code it to 08-Lymph node region, NOS
18.	The AJCC stage groups are based on survival curves. If all N categories have the same survival, do they get the same stage group?	That is a question for the authors of the AJCC chapters!
19.	Remember this is for the patient. The patient deserves to have an accurate prognosis and know how long they will survive. So the data must be right to give the right survival, and then patients know their prognosis	Thank you, Donna Gress! The question was in response to the requirement that the number of lymph nodes be documented to assign an N value.
20.	For case 2, since histology is carcinoma, can we have a stage group?	Yes. I had the same question. Carcinoma, NOS (8010) is eligible for AJCC staging. It falls into the Adenocarcinoma schema.
21.	For esophagus cancer we have seen EMR (endoscopic mucosal resection) treatment for lower stage cancers. When the patient has another recurrence > 1 year this is considered a second primary according to the other sites rules. Does EMR or ablative therapy really mean the patient is disease free or does an esophagectomy need to be performed?	When determining multiple primaries, the timing rule would start after the patient was diagnosed. It would be up to the physician to determine if the patient was disease free when coding Cancer Status.
22.	Just a heads up for the participants regarding morphology, I have seen a MiNen (Mixed neuroendocrine non-	I checked with SEER and they agree.

	neuroendocrine neoplasm) arising in the esophagus. The morph would be 8154/3 and not 8244/3 or 8045/3 right? Jim please confirm.	
23.	When Wilson mentioned RT to esophagus, I thought I heard him say that if esophagus is irradiated you always code LNS as treated also. Is this correct? or is it just a subsite of the esophagus that this applies to?	In most cases I have worked on, LNs are included in the irradiated field, as esophageal cancer has a tendency to involve regional lymphatics. Having said that, it is still up to the abstractor to confirm with rad onc/treatment planner, before coding.
24.	Wilson was saying that if drs use the term "abdominal" lymph nodes that the drs still interpret it as regional LN's. Are we to code RT to thoracic or abdominal LN's in this case?	Code to abdominal LNs.