Q&A Session for Data Item Relationships

February 2, 2023

#	Question	Answer
1.	Noticed in the slides it states AJCC 9th Edition. It is Version 9 to indicate it is not replacing the AJCC 8th edition as a whole. As disease sites get updated to Version 9, the corresponding 8th edition is no longer used, but the rest of the 8th edition disease sites are still valid.	Thank you!
2.	Scenario 1 - also need to look for physician notes, sometimes a managing physician will interpret the SAME imaging w/ terms DIFFERENT than the radiologist. Ex: radiologist read "new tumor in LUL, recommend PET", other specialty MD impression "malignant appearing 1cm LUL nodule by CT XXX date confirmed by PET next month to be hypermetabolic c/w either primary or metastatic malignancy" (this is from a real case)	Great tip!
3.	For benign brain sometimes physicians do retrospective diagnosis saying the meningioma or pituitary adenoma has been present since imaging from earlier year.	That can be frustrating…if that happens, date of diagnosis will change to the previous imaging.
4.	Scenario 2 - THANK YOU for bringing this up, been seeing this more on edits report processing since edit N1119 was updated in v21 (but only for 2021+ cases). Edit N6701 in v23 may be worth a mention.	The rule “Date of First Contact cannot be before Date of Diagnosis” has been around for a long time. We just didn’t have the edit to enforce it in the past.

5.	Scenario 4 - I thought STM-Other went straight from 2007 (applies to 2007-2022) to 2023, except rectum & rectosigmoid which were moved to colon rules in 2018?	That is correct. However, If you did not know that, you could look at the most current version of the Solid Tumor Manual (STM) and it would state which version of the manual should be used.
6.	Does having software upgrade affect our correct use of manuals (since there's been software delays)?	That is a tricky question. I think a good rule of thumb would be to use the most current version of the manual for the year of case you are abstracting. Even if you have updated your software, you can use coding clarifications. Of course, there may be references to codes and code definitions that may not appear in your software until you do your software upgrade.
7.	While there may be some choices, we are unable to select due to software version shouldn't we still use the correct manual & hold/revisit the case after software upgrade?	That would be my choice.
8.	Scenario 6, wouldn't the date of first contact be 1/30/23, date treatment started for class of case 22?	Yes! Missed that one!
9.	Regarding the poll question about which versions of the manuals to use depending on diagnosis-year and/or software version, can the requirements for use be shown more prominently in the manuals? Maybe in bold on the cover or the first page?	For the SSDI Manual, Grade Manual, EOD Manual, Summary Stage Manual: All of these manuals have a statement on the first page that they are applicable for 2018+.
10.	I did research on this topic of date of first contact. After research, the first date of contact should not be the date of re-biopsy at the reporting facility (dx at osh), but the date reporting facility provided treatment should be date of first contact. Am I missing something? Did understand incorrectly?	That sounds correct. Date First Contact would be the date the case became analytic for a CoC facility. In your scenario, that would be the date of treatment. For a non-analytic case, it is the date the case becomes reportable to the reporting facility.

11.	I checked the SSDI manual for an example and I haven't found it yet, can you please share where to find it? I do see it on the first page of STORE.	Very first page right under the heading. Site-Specific Data Item (SSDI) Manual Effective with Cases Diagnosed 1/1/2018 and Forward Published October 2022 Version 3.0
12.	Was there a final clarification from CoC about class of case for LCIS dx 2018+ (EXCEPT pleomorphic LCIS which IS reportable to CoC)? WHEN is class of case change, if any, effective (the not-reportable to CoC since 2018 information didn't come out until STORE 2023)?	I do know that LCIS cases diagnosed 2018 or later are not reportable to NCDB. Since they are not reportable, they should have a non-analytic class of case.
13.	Our Date of first contact is sent to our state registry and NCDB. NCDB would want the date to be when the case became analytic. But the state registry collects non-analytic cases. This creates conflict; for the state, it would be the date the patient came to our facility with evidence of cancer, regardless of class of case.	I can see how that could get confusing! Date of First Contact for a non-analytic class of case is the date it became reportable to the state.
14.	So, if it says version 3, then that's what indicates the software version it corresponds to?	Correct. It's the version of the SEER API, which includes the Schema ID, SSDIs, Grade, EOD, and Summary Stage. Version 3.0 was released October 2022 and incorporates the changes for 2023
15.	Tip for diagnostic confirmation - when I see that the diagnostic confirmation is something like radiology only code 7 - I IMMEDIATELY go to the diagnostic confirmation field and assign it before I do any other sections of the abstract and also do the TEXT immediately corresponding to the place of diagnosis	Great tip!
16.	Please explain coding sentinel nodes when sentinel nodes are removed, followed by a complete axilla node dissection. I have been	That is incorrect! If a sentinel node procedure and axillary node dissection during the same procedure, you have to assign code 6 to scope of regional nodes surgery.

	told you don’t use code 6, you use code 2? I also thought you would add all the lymph nodes together when one surgery is performed? Wouldn’t it be 97/ 21 instead of 97/5?	You only count the number of sentinel nodes removed during the sentinel node procedure in SN Pos/Ex. You count all nodes in Reg Nodes Pos/Ex.
17.	In the presentation, I thought Jim mentioned something about the SSDI manual being both diagnosis-year and software-version dependent. So that's what I was asking about- if that's stated in the manual. For a case diagnosed in 2022, abstracted in 2023- we would use the 2022 manual if we're in v22 but we would use the 2023 manual if we're in v23. Maybe I misunderstood.	If you are abstracting a 2022 case in 2023, you can use Version 3.0 of the SSDI Manual, Grade Manual, EOD and Summary Stage.
18.	For diagnostic confirmation, for me, it's always hard to remember to code 2-Positive cytology and not automatically code 1-Positive histology when there was only cytology.	Those kind of habits are tough to break! Sometimes, those kinds of errors will get picked up by edits, but not all the time.
19.	If the child (teenage age) has a part time job and also goes to school (either high school or college), do we record "Student" or the job they have?	The focus is on what they do **full time**. If they are a student full time and work only part time, then fill it in with the student/type of school. If they work a full time job and are a student only part time, then put in the appropriate information for the full time job.
20.	We have patients that are international - but provide a local address and get emergency Medicaid. They can be here illegal, visiting, students etc... what do we do?	The STORE 2023 states on page 54, “The registry can resolve residency questions by using the Census Bureau’s definition, ‘the place where he or she lives and sleeps most of the time or the place the person considers to be his or her usual home’.” So, if you can find what their “usual/permanent address” is at the time of diagnosis, that’s the address you would put in. If it’s a student, they will likely put down either the address that they use at school or their family home address. Whichever they put down is the one you will enter. Legal status and citizenship are not factors in residency decisions (also on STORE 2023 p54). You can also look at the STORE 2023

		p78 for further instructions on assigning state codes depending on the country, specifically Canadian and US territories residents. The current address will change depending on their current location. Often, these fields are updated when merge files are uploaded from the EMR software to the registry software.
21.	Please repeat what to enter if occupation is not stated?	The breakdown is on slide 7 of the pediatric PPT. If the patient is not between the ages of 0-22, you have options listed there. If they are past age 22 and the occupation is unknown, you just put “unknown” for both fields. You can also refer to page 12 of the NIOSH guide “A Cancer Registrar’s Guide to Collecting Industry and Occupation” for more info.
22.	Disagree with the Pop Quiz - per the STORE manual this would be a 9 - path report doesn't give margin status.	This is a good point. I added this talking point to my notes for the second presentation on 2/2, so I’ll write it here for you now. “Per the STORE manual 2022, pg 57, SURGICAL MARGINS OF THE PRIMARY SITE records the pathologist’s determination of the presence of microscopic or macroscopic involvement of cancer at the margins of resection following the SURGICAL RESECTION described by SURGICAL PROCEDURE OF PRIMARY SITE. It seems cut and dry, right? The code is a 20, counted as a surgical procedure and the path report is what we should rely on for the margin status. But in brain tumor land, this is still a biopsy. A NEEDLE biopsy. And we don’t often, if ever, see a margin status listed for BIOPSIES on any site. Only for resections. So, we have a conundrum. We have to count this as a surgical procedure, but the pathologist won’t be giving us a margin status BECAUSE it’s a biopsy. It’s not an excisional biopsy either. There will absolutely be macroscopic disease left behind, and often this can be determined by reading the op report from the procedure too. So, do we choose 9 for unknown because technically we don’t have margins mentioned on the pathology report OR do we choose 3 because we know it was ONLY a biopsy and all the treatment happening directly afterwards (and the follow up imaging which shows it) is treating the macroscopically remaining tumor? In a world of black and white, I’d tell you to code 9. Technically, that is the most correct answer if we follow the rules to a T. But the world of pediatrics is often a world of gray. And using deductive reasoning based

		on the procedure type and op report AND proof per follow up imaging, I choose to code this to 3 IF IT'S THE ONLY SURGICAL PROCEDURE. Of course, if there is a subtotal or gross total resection done, those are the procedures you'll be basing this field off of." *Jim…note that the STORE manual states a stereotactic biopsy should not be coded as a surgical procedure. It should be coded as a diagnostic staging procedure. The SEER manual recommends a stereotactic biopsy be coded as a surgical procedure (code 20).*
23.	For surgical margins, for our facility, I usually end up coding a stereotactic bx of brain as 9 - Unknown, since there is no mention of the margins in the path report. Is that not correct?	See answer above.
24.	Are surgical margins coded as macroscopic residual for a brain (any site) stereotactic bx like the example for brain stem that was mentioned	See answer above.
25.	In reference to my margin question: Per STORE Manual: "Record the margin status as it appears in the pathology report"	See answer above.
26.	Clarification about occupation/industry. I thought abstracting instructions state it is the work performed during MOST of the patient's working life before tumor dx, not the particular occupation AT diagnosis?	The STORE manual doesn't actually give instruction for these two fields. NIOSH doesn't state which point in time this field represents either (https://www.cdc.gov/niosh/docs/2011-173/pdfs/2011-173.pdf?id=10.26616/NIOSHPUB2011173). There's also no questions available with answers on SINQ. The only instruction given in the registry software is "This is a free text field for the usual occupation." So, I'm really not sure how to answer this because I'm going with what I was taught and I can't find any evidence that I'm doing this incorrectly! The only proof I have that these fields are based on the date of diagnosis is from the fourth edition of "Cancer Registry Management: Principles and Practices for Hospitals and Central Registries", page 289 where it states "Cancer registry data are standardized, collected by trained and certified professionals, and

		the demographic, clinical, first course of treatment, and outcome data are linked to the primary tumor." My interpretation of that is that these fields are linked to their occupation at the time of diagnosis since that's a more relevant piece of information than what their job might be 10 years after a diagnosis.
27.	Is the Staging Calculator a good tool to use on SEER*RSA? Sometimes, I try it out just to see what I get for staging.	The tool can be used to see how EOD derives the EOD T, EOD N, EOD M, EOD Stage Group; however, do not use this tool to do AJCC staging.
28.	We are wondering about the NCDB Survey that came out yesterday, regarding Class of Case consolidation. Do you have any knowledge or input about analytic vs. non-analytic codes?	I do know that CoC is exploring options to simplify/collapse Class of Case codes. At this point they are trying to assess the impact of simplifying these codes. I would strongly recommend responding to the Survey and let them know what you think!
29.	Often, we see neuroblastomas in the abdomen. Would you assign abdomen, nos c76.2 or peripheral nerve of abdomen c47.4? or assume this is arising from the adrenal gland?	In this case, I would probably look extra closely at what the imaging and the main med onc is saying. Usually, if they are in the "abdomen", it could be any of these sites – retroperitoneum, paraspinal mass with extension into the abdomen (to be a C47 code), or in the adrenal gland. A PET/CT or MIBG scan will give you a much better idea of exactly where the site(s) of disease are and then you can code it from there. If the information available in the EMR is ONLY showing abdomen, NOS and you cannot identify a more distinct location, then you can use abdomen, NOS. Although we might assume it's coming from somewhere specifically based on the histology, as registrars, we need tangible proof to substantiate our codes, including primary site.
30.	What references can we use to find the standard work-up and treatments for pediatric cancers? i.e., books, web sites, etc.	Currently there's no complete manual that includes all the different pediatric staging systems or standard work ups. Everything that I presented was based off my own personal research and a variety of different websites and published articles and studies. This will be changing in the next few years, though, as NAACCR's Pediatric SSDI Work Group will be writing a pediatric manual! Until then, you can use these links to get some of your resources: - http://www.iacr.com.fr/index.php?option=com_content&view=article&id=153&Itemid=657 - https://www.facebook.com/groups/PediatricHospitalCTRs (I started this one and there are lots of resources and great questions here WITHOUT PHI)

		- https://www.cancer.gov/types/childhood-cancers
31.	Jennifer: As far as I'm aware, the STRs don't include SEER's priority order for coding primary site when there is conflicting information about where the tumor originated. Can we assume the priority order is the same order listed in the SEER Coding Manual? Any thoughts about including the priority order for coding primary site in future updates?	I believe some of the STR chapters do include a priority order for assigning primary site. If a priority order is not documented, use the priority order from the SEER manual.
32.	Summary stage-clinically N1 and FNA of LN is Neg, do I code node mets in summary stage and in EOD? Site is lung.	This would be negative for EOD and Summary Stage. Clinically they felt they were involved, but when they did a tissue examination, it was noted to be negative.