Q&A Session Coding Pitfalls 2023
September 7, 2023

#	Question	Answer
1.	How do we handle conflicting site info for sites that don't have a priority order guide? Is there a general priority order we should use (for example op report always highest priority)?	To the best of our knowledge there is not such a list, but we sent the question to SEER to confirm. Below is their response confirming we do not currently have a list for all sites. *Here's what we have in the SEER manual for general instructions, page 92.* *Resources for Coding Primary Site for Solid Tumors, in priority order* *1. ICD-O* *2. SEER Program Manual* *a. Including Coding Guidelines in Appendix C* *3. Solid Tumor Rules* *For breast, we have the following in the Coding Guidelines.* *Coding Subsites Use the information from reports in the following priority order to code a subsite when there is conflicting information:* *1. Operative report* *2. Pathology report* *3. Mammogram, ultrasound (ultrasound becoming more frequently used)* *4. Physical examination* *There's more here:* *https://seer.cancer.gov/manuals/2023/AppendixC/Coding_Guidelines_Breast_2023.pdf* *Does this help?*
2.	For DCIS with solid subtype, can it only be the solid subtype to code that histology or can there be several subtypes including solid to code the 8230/2?	You would have to follow the rules. Our example there was one in situ tumor with one histology present that is listed in Table 3, we stopped at Rule H2. Each scenario is different, use your rules and if you have questions be sure to send them to SEER Ask a Registrar.

3.	The rule change for ductal and lobular carcinoma, is that for cases diagnosed 2023+, since I think that Dec 2022 update was for the 2023 Solid Tumor Rules?	We can't find anything saying it should be implemented for a certain year forward so we would follow the general rule. The general rule is that we apply updates to all cases diagnosed in 2018 forward. You do not have to go back and change histologies for cases already abstracted.
4.	With our breast cases, the pathologist places a clip during us or CT guided bx and that's where the surgeon takes the lumpectomy. So why does the pathology report have higher priority than imaging?	We contacted SEER and they stated we should stick to the list.
5.	Do we leave the n suffix blank in the clinical, when a sentinel node dissection is performed?	You must follow the timing rules for clinical and pathologic time frames. In most situations that is correct. If the sentinel node procedure is done on the same day as the surgery to the primary site, the (sn) is collected in the pN Suffix field. In that case the cN suffix field is left blank. I incorrectly stated we would collect the (sn)I in the cN in this situation during the webinar. Thank you, Donna and Janet, for correcting me! Below is a statement from Donna Gress that helps clarify the situation. *They do the SLN first (before the lumpectomy) so that they have time to get the frozen section results back by the time the breast surgery is over and be ready to make the decision if they are going ahead with a node dissection. Everything that happens during this operative event is part of pathological staging. Just like when they do the assessment of the abd/pelvis before starting a surgical resection for primaries in that area, all of that info is part of pathological staging.*
6.	May 2023 update of STM is effective for different diagnosis years for different sites. For cutaneous melanoma section it is for dx 2021+. For other sites section it is for dx 2023+. For all other sites in the manual, it is for dx 2018+.	Thanks!

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7.	Would this rule also apply for the (f) for other sites, for example lung? FNA, and then resection with regional nodes removed?	Information used to code (f) and (sn) in the Suffix fields is not limited by site. If only an FNA was done use the (f) suffix. If both a FNA & further resection of regional nodes was done, you would leave the suffix blank.
8.	What if they just have mastectomy and axillary dissection (no SLN), is this still code A500? Also, if the Dr says simple mastectomy but does an axillary LN dissection, is this A500?	A500 is a modified radical mastectomy. By definition, a modified radical mastectomy includes removal of the axillary nodes. A sentinel node procedure is not required to code a modified radical mastectomy. A "simple mastectomy" that includes an axillary node dissection should be coded as an A500 modified radical mastectomy.
9.	For poll #7 E would it be cT1a? found the CAnswer Forum post: https://cancerbulletin.facs.org/forums/node/126580	It's our understanding that a T1, T1a, T1b, T1c can only be assigned if a DRE was done, and no tumor was felt. If no tumor was felt on DRE, then we can assign one of the T1 subcategories. If a DRE was not done, then the cT must be blank or X.
10.	If you know for sure that a DRE was not done, wouldn't it be cTX for D on Poll #7?	A registrar has to have a high level of confidence a DRE was not done to assign a cTX. In this scenario we felt a DRE may have been done by a different physician.
11.	Will a statement "DRE-deferred" in a video visit qualify as a CTX?	If you can say for absolute certain that DRE was not at any point in time, then you can assign a cTX, however you must be certain it was done at the time of biopsy or any other time during the workup.
12.	For quiz 5 would we not assume that a DRE was done for the physician to determine the cause of the urinary retention and that it required a TURP?	What was the result of the DRE? It's not enough for a DRE to just be done, we need to know the results of that DRE, was the tumor palpable or not. In this scenario, there was no information about the DRE results, so when in doubt BLANK it out.
13.	Seeing target bx's in addition to 12 random core bx's. The Dr's only say 12 cores but target bx's have multiple cores, do we add all together?	Consulted the CAnswer forum. The gross findings take priority per Note #3 in the SSDI manual. https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/male-genital-schemas/126189-prostate-cores
14.	If you had a PIN3 (we collect this in MB, CAN.) would you choose X6	We submitted this question to the CAnswer forum. They felt the appropriate code wouddl bee X9.

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	(TURP and/or Biopsy done, primary and secondary pattern unknown), or X9 (Not documented...etc.)?	
15.	What if they do the BCG or mitomycin in Dr office. What codes are used? Same?	Same.
16.	Why would you record Extent, Tumor size and Stage in the Op Report when that is then repeated in Path Text?	Please refer to the NAACCR Data Standards and Data Dictionary for the definition of these text fields. https://apps.naaccr.org/data-dictionary/data-dictionary/version=23/chapter-view/ Refer to the Informational Abstracts A Guide to Determining What Text to Include https://www.cancerregistryeducation.org/Files/Org/f3f3d382a7a242549a9999654105a63b/site/Final_Informational_Abstracts_Summer_2022.pdf Refer to your State Manual for Guidance. Finally refer to facility specific policy on text documentation.
17.	If a urologist mentions patient had enlarged prostate, can we assume that pt had a DRE to be able to code cT?	An enlarged prostate is not enough information to code cT. Yes, the enlarged prostate might have been found during the DRE, however did the physician document why the prostate was enlarged? Was it due to tumor, BPH, etc. enlargement alone is not enough to assign a cT.
18.	IF TURB and Mitomycin was given, if TURB not considered definitive surgery, does this have an impact on Systemic Surg Seq?	A TURB is still a surgery, so code accordingly.
19.	Quality text is also great for searching & queries like what Jim said regarding data mining. SQL database founded registry	Excellent point! Text can be such a rich source of information, do not overlook the possibilities of its usefulness.

	software you can search for specific text using the LIKE operator & "%". For example, I can find specific cases by key words in specific text fields.	
20.	With pos path from distant site do we fill out both clinical & path fields?	Depends on the timing. If the positive path was found during the clinical timeframe- refer to AJCC manual Chapter 1 (page 17& 22 of 3rd edition, page 36 Kindle version)
21.	Oops cT1 cN0 pM1, pT blank pM1	For example, if you are talking about a positive biopsy of distant mets found during the clinical timeframe and the clinical stage is assigned as cT1 cN0 pM1…. And there is no further surgery of the primary site, the path stage will also be assigned cT1 cN0 pM1.
22.	What are you discussing about pM1 only applies if there is no surgical treatment resection?	If there was further surgical resection the pT and pN would reflect the information from that surgical resection.
23.	Would a radiation boost be coded to 41?	If the patient had radiation to the full breast in the initial phase and then they came back and did a "boost" to the tumor bed, that would be code 41 for the second phase or "boost". Refer to the examples in the Appendix R: The CTR Guide to Coding Radiation Therapy Treatments in the STORE.
24.	Could you please clarify why the skin sparing mastectomy is not A300? The film you showed detailed the skin sparing mastectomy as a subcutaneous procedure. A400 would remove the skin?	Skin sparing also removes the nipple & areolar complex- so it is bumped up to the A400 codes.
25.	I see the MD note 12 cores examined (6 from each side) in the OP writeup, but then in the bx report there will be multiple cores from one of the 12 sites. How would we code? so e.g., site 3 the	Consulted the CAnswer forum. The gross findings take priority per Note #3 in the SSDI manual. https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/male-genital-schemas/126189-prostate-cores

	MD notes 1 core - but the path report says 3 cores taken from this site.	
26.	Why can't the authors of the Solid Tumor Rules and the SEER Appendix C meet in the middle and give the same information on both sources? Everywhere else always promotes consistency, but not in this case?	The primary site coding rules were added to the STR as a kind of bonus. They are not intended to be the definitive source for primary site. However, they are incredibly useful and I hope they continue to develop them in the manual. If you have concerns be sure to post them to the appropriate forums. The Standard setters might not be aware of the discrepancies. Also, we don't really have a place in the Solid Tumor Rules for rules that apply to all sites. The rules in the STM are typically site specific. I've never seen any rules that with the rules in the SEER manual, but the STM is definitely not as complete.
27.	What would the most definitive surgery date and code be? a TURB or BCG?	Most definitive surgery code & date would be the TURB.
28.	No surgery code for instillation of mitomycin? only for immunotherapy?	Refer to this SEER post. https://seer.cancer.gov/seer-inquiry/inquiry-detail/20041043/ Code the instillation of Mitomycin-C into the bladder for a bladder primary in both the Chemotherapy and Surgery to Primary Site fields. Code the Chemotherapy field to 02 [Single-agent chemotherapy administered as first course therapy]. Mitomycin-C is listed in SEER book 8 as a chemotherapeutic drug, specifically an alkylating agent. Also, code the Surgery of Primary Site field to 15 [intravesical therapy]. Code the surgical procedure as well as the type of drug (chemotherapy in this case).
29.	Can you help me with the Breast Codes where to go to better understand how to code the surgery codes?	If you are talking about the Site-Specific Surgery Codes - Refer to SEER Appendix C for the surgery codes, they have great notes and further explanations. - Refer to the 2022-2023 Webinar Series Breast 2022 Part 1 & Breast 2022 Part 2 webinars, Denise Harrison did a very thorough explanation of the different surgery codes & what is removed during each procedure. - Refer to the SEER Training Website https://training.seer.cancer.gov/ look at the Site-specific modules and review the section on Treatment-Surgery.

		If you are referring to the 4 Field study fields Rx Hosp-Surg Breast, Rx Summ-Surg Breast, Rx Hosp Recon Breast, Rx Summ-Recon breast, you will have to consult the STORE manual.
30.	I am waiting on an AskSEER on a case where I have comedo AND solid type DCIS. Comedo is not mentioned anywhere in the breast STM.	Please reach out & share your case when you receive an answer.
31.	Sometimes when you edit your question/post in CAnswer forum more than once you get flagged as spam.	Yes, it has happened to me before too. Best suggestion is to write it all out and have someone re-read it to see if it makes sense, then post it.
32.	Last poll - the manual has multiple definitions for code 9 including "No surgical resection of primary site is performed" I find SEER*RSA easier to reference/navigate than the PDF version of SSDI & grade manual.	SEER*RSA is fantastic!! You just must remember to also review the General Instructions from those manuals as well.
33.	I did see one scenario where we would assign cTX (when there's no rectal access): https://cancerbulletin.facs.org/forums/node/89527	That is a great example of when a cTX would be appropriate. When there is no rectal access, we can be assured no DRE was done, so a cTX would be appropriate in this scenario.
34.	Come back the next day or 2 and take a fresh look at a difficult case - sometimes just need to walk away and come back to it.	Great tip!
35.	Every once in a while, I go to the print abstract and print to my	This is also a great tip! Sometimes just looking at the information in a different platform, you will catch things you might have missed.

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	screen my whole abstract and do a visual review, it is great to see the abstract the way it is transmitted to the State & NCDB and a great way to view your text and streamline it!	
36.	I was confused by the fact that the scenario stated, "no reconstruction done" and so when I looked at the A400 code that stated that reconstruction would be included in this code I thought I could not choose that code for Skin Sparing Mastectomy, so I defaulted to A200. I had the same confusion about Nipple Sparing Mast because of no reconstruction having been done.	Yes, I should only have included the words no reconstruction for the Simple Mastectomy w/ SLN and Mastectomy w/SLN + Axillary Dissection. I was going down a path, then veered left…. I was trying to keep it simple by just looking at the main category codes, but managed to confuse things a bit, sorry about that.