

Q&A Session for Lung 2023 Part I

October 5, 2023

#	Question	Answer
1.	Pop Quiz 1 number 4- supraclavicular Ln is regional for lung but distant for seer summary.	That is correct. However, in most cases SEER defers to AJCC definitions when differentiating between regional and distant for surgery codes. I'll confirm.
2.	Lingula sparing means "Not including lingula", right?	Correct. So, they leave the lingula. We confirm this with physicians from the CoC. They felt segmentectomy was the code for this procedure.
3.	POP quiz 2- #1 why B and not C if B states including lingulectomy and this says lingula sparing?	The description of the procedure says lingula sparing. that means they did not remove the lingula. The lingula is a segment of the lung. since it was not removed, the whole lobe was not removed. Code B is for segmental resection. The statement (including lingulectomy) means removal of just the lingula should be coded as a segmental resection.
4.	What is the correct surgery code when an op report states lobectomy w/mediastinal LN sampling?	We've found conflicting answers from SEER and CoC on this topic. CoC says sampling is not equivalent to mediastinal dissection. SEER says it is equivalent. However, both posts are pretty old. We will follow-up.
5.	Please clarify that excision of a distant lymph node that is benign should be coded as surgery of a distant site.	I know there has been debate for years whether a resection of a distant site has to be positive for cancer to coded in Surgery of Other reg distant sites. It's my understanding that the does not have to be positive for cancer. However, i will get that confirmed.
6.	What is the difference between RAS and KRAS?	Although I generically used the term Ras. Ras has three isoforms- K-,H- and N-Ras. They are all mutated in different cancers. They probably have specific roles as specific isoforms ate mutated in specific types f tumors (or developmental disorders- they are involved in development too). They share downstream effectors and upstream activators. K-Ras

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		<p>mutations predominantly occur in lung adenocarcinomas, hence that is the one we code.</p>
<p>7.</p>	<p>For Gillian...is there an overall summary of the response rates and the length of efficacy for many of these targeted gene therapy agents?</p>	<p>Response and efficacy of targeted therapies. Estimated eligibility for targeted therapies was 5% in 2006 and was up to 27% in 2020 for all cancers. So the option for use of targeted therapies has come a long way. . Response time is around 18 months. However, ongoing research is looking at using multiple targeted therapies against multiple Receptor Tyrosine Kinases may be more effective. A major problem with targeted therapies that the development of resistance can cause resistance to other drugs . EGFR mutation in lung cancer can be treated with EGFR mut specific inhibitors. The third generation irreversible inhibitor osimertinib was developed to be used after resistance developed to the first generation drugs gefitinib and erlotinib. However, osimertinib is now used first line giving OS benefit as resistance to gefitinib and erlotinib crossed over to osimertinib due to mutational activation of a downstream pathway. So there is a lot of research on the best way to use these targeted drugs.</p> <p>I pulled an example of a CARIS report from the CARIS website. The example is breast. Although they list a lot of genes, the most relevant ones for the cancer type are listed at the top. It tells you how the gene was assessed (immunohistochemistry or sequencing data) and whether its present /absent (PDL1) or mutated or fusion protein or none (meaning wildtype).It also list the drugs associated with the gene mutation. Another thing you see on some sites is TMB (tumor mutation burden). It is either High or Low. If high, it is an immunotherapy drug target.</p>

8.	Why wouldn't Immunotherapy be 01 - pt received durvalumab for Case Scenario #1?	It should have been! Good catch.
9.	Case 2 - Surgery included Mediastinal and Hilar LNs should the code be A330 Or A300?	A330- lobectomy and mediastinal dissection is correct. The op report specifically stated a mediastinal node dissection was done. The fact they removed hilar nodes in addition to the mediastinal dissection does not change how the procedure is coded.
10.	For diagnostic confirmation FNA are considered code 1 (tissue specimens from FNA, BX, SX, Autopsy, or D&C) not 2 (examination of cells rather than tissue).	That is the definition in the SEER manual.
11.	Does adaptive radiation treatment ever result in needing to code a new phase (change in volume or dose per fraction)?	<p>It depends on the nature of the change in the revised plan. Case #14 in the CTR Guide illustrates a scenario (more typical) where we do not alter the number of phase(s) if the only change is in the reduction of the planned tumor volume (PTV). However, a repeat assessment of the target volume revealed additional tumor volume reduction resulting in a revised plan that omitted a lymph node chain, creating a new phase due to the different LN coverage in the new plan.</p> <p>Case #10 & 15 also illustrate how we handle the number of phases when there is a reduction in the irradiated volume. Bottom line, if the revised plan simply takes into account a reduction (or an increase) in the irradiated volume, then we code it a single phase.</p>
12.	With the hybrid RT example - would that be coded as 3 separate phases?	This is a question that I (Wilson) will present to the RT working group for discussion so that we can come up with guidelines on how to code this novel approach.
13.	Wilson, would you recommend the book Principles and Practice of Radiation Therapy 3rd Edition as a guide to understanding radiation? Or is it dated?	If you could get a used copy of the 3rd Edition, I would still recommend it. However, there is a 5th Edition now, but it's a bit pricey. Look for a used copy.

14.	If LNs are involved but not specifically mentioned in the tx summary, is it reasonable to assume they were irradiated? My facility does not perform RT so all patients are sent elsewhere for that tx and we cannot always contact them for confirmation.	The scope of the question is rather broad. There are certain malignancies and treatment techniques that, when used together, we can quite accurately discern if the regional lymphatics are included in the irradiated field. Without more specifics on the cases you encounter, it is difficult to provide a useful response. Considering that, I cannot advise making assumptions across the board.
15.	For Wilson, if we don't have the ability to discuss with the MD whether LNS were treated, but we think they probably were due to the staging, can we assume they were treated? Since each case is different it would be very hard to keep asking the doctors.	Please see previous response (question #4). I would first exhaust all other venues to get the information. Do you have access to ARIA or Mosaiq (radiation oncology applications)? How is the information (RT completion summary) described? It takes a great deal of background knowledge on how radiation therapy/oncology is applied with various malignancies to start making accurate educated decisions on lymphatics included/excluded from the planned tumor volume (PTV).
16.	I have seen some XRT end of treatment summaries that include decimal points for the total cgy. Such as 1003. And it does not necessarily balance out to the number of cgy/fx dictated in the treatment planning and summary. Do you have any suggestions on how to handle these?	See the rules on rounding off delivered dose on p. 276 of the STORE manual. Without additional information/example, I cannot provide any guidance here.
17.	I have seen some recent XRT end of treatment summaries that are very specific, such as 1027 cgy total, and they do not balance out to what the dictated cgy/fx in the treatment plan/summary. Can you offer advice how to handle these cases?	See my response to question #6.
18.	For total dose, per the STORE manual: "If phases were delivered to multiple body sites (e.g., simultaneous treatment to multiple metastatic sites), then code the Radiation Course Total Dose as the dose to the body site that received the highest dose." On slide 36, it says "total dose to primary site." So how do you code the Total Dose if a metastatic site is getting a higher dose than the primary site?	Review case #9 of the CTR Guide. There are two different rules here. One rule addresses multiple metastatic sites, excluding the primary site. Rule is clear: total dose is the highest dose delivered to a metastatic site. 2nd scenario addresses cases when metastatic site(s) and primary site are irradiated. I will double check with the RT

		working group to see if they make a distinction between these two scenarios.
19.	Regarding the radiation start/ end date - when a patient gets radiation at different times, how would you enter the dates to reflect both sessions of radiation?	If all RT treatment is part of the 1st course treatment, use the start date of the first phase and end date of the final phase. It is not unusual to see these cases, particularly when a boost is prescribed/delivered, or when EBRT (external beam RT) is used in conjunction with brachytherapy. If EBRT is delivered first, use this as the start date. The completion date will be the date the patient received the last course of brachytherapy.
20.	For Hybrid RT, do you code the Planning Technique as 98-Other if coded as 1 phase?	That is a question I will post to the RT working group. More on that to follow.
21.	I was wondering if you could speak about adenocarcinoma spectrum disease in lungs on our next webinar.	We will ask the presenters.
22.	Where is the instruction to use the AJCC definitions for nodes as regional versus distant to select surgery codes?	I'm looking into that now! Will include it in the Q&A.
23.	Can you please repeat what you said on slide 9 regarding when to use AJCC vs SEER when deciding if a lymph node should be considered regional vs distant?	When determining whether a lymph node is regional or distant for sites other than Summary Stage, go by the AJCC manual. There are some sites where Summary Stage has a LN listed as distant and AJCC includes the LN in the N category. In those cases, go with AJCC (except when assigning Summary Stage).
24.	Is there a code for when a lobectomy w/ mediastinal dissection plus wedge resection is given? I typically just code a 33.	Not that I know of, but that seems to be a common procedure.
25.	Why would an excisional biopsy of cervical lymph node be coded as surgical procedure other site rather than coding as a surgical diagnostic and staging procedure code 01 biopsy was done to a site other than the primary site?	A level 3 cervical node is distant for a lung primary. Code 3 is used for Non-primary surgical procedure to distant lymph node(s) in the data item Surgical Procedure of Other Site.
26.	For Pop Quiz 3, question 3 - Would you not code the excisional biopsy of a distant site if it was negative. Wouldn't it be the same as question 1 when you wouldn't code the biopsy of the regional node that was negative?	It's my understanding that resection procedures coded under Surgery Other Reg/Dist sites does not have to be positive for malignancy. However, that is not specifically mentioned in the STORE or SEER manuals. I know for dx staging procedures we

		do not code procedures that are neg for malignancy. Is that how you understand it?
27.	Scope of Regional Lymph Node Surgery, Code 1 is excluded from recording date in data field first course treatment &/or date of first surgical procedure per STORE. Is the date of reg lns bx/asp captured in another data field?	Not that I am aware of.
28.	Can a specific radiation therapy be delivered by different equipment? For example: Can Grid Therapy only be delivered by Linear Accelerator, or can it be delivered by another type of equipment instead?	At this point, the Grid technique has been tested with the use of a Linac, using photon modality in the Megavoltage range (MV), 02.
29.	I see atelectasis mentioned in a lot of reports. What makes it diagnostic of a T2?	If the atelectasis (collapsed lung) associated with the tumor extends to the hilar region, it would impact the T category.
30.	Tip - always double check your diagnostic confirmation code - especially with lung - very common to see only FNA's with lung cases - which is code 2 for diagnostic confirmation - we are so accustomed to coding 1 for histology - be careful.	Great tip!