

Q&A Session for Liver and Bile Ducts 2024

January 10-11, 2024

#	Question	Answer
1.	If only segment 4a/4b is taken, would that be wedged or segment resection?	Clarification: For SEER, Codes A230-A250 mean 1, 2 or 3 wedges OR segments of the liver were removed.
2.	You said that RFA TARE and TACE are bridge therapy but is still considered sx. After one of these procedures, they are NED for over a year, and then it recurs this would be a new primary as per STR M12 right? Many cases never have a transplant and recur many times over the course of their life and get this type of tx multiple time.	It would depend on whether the tumor is the same tumor or a different tumor. If the patient had RFA, and the tumor > 1 year later arose from residual tumor tissue from the tumor that received the RFA, it would not be a new primary per rule M2. If it is definitely a different tumor, it would be abstracted as a new primary.
3.	Is segment 4a and 4b divided horizontally or vertically?	Basically, 4b is the lower part of segment 4 (although the Japanese use 4a as the lower part of segment 4!). It can be better viewed from the posterior aspect.
4.	It might be helpful if separate site codes could be assigned for the separate ducts especially if we are using separate staging chapters.	Maybe that will happen with the release of ICD-O-4. It would be super-helpful if they had separate ICD-O topography codes.
5.	So if they are NED on DI for a period of year(s) and tumor is in the same place we are to assume that there was residual tumor that it arose from and therefore not disease free and M12 does not apply?	I don't want to make a general statement here, because each case would need to be looked at individually. But, in general, if a patient is stated to be NED, that means the tumor was completely cleared with the treatment. If we don't have a clear indication of NED, I would not consider a tumor growing in the same location as the previously treated tumor to be a new primary. Use the rules in order. M1 – Unknown if single or multiple tumors and M2 – single tumor may apply before going to the timing rule (M12).
6.	I would hope that the degree to which the staging chapters are being subdivided by sub-site (even though the same topography code is assigned) is supported by prognosis, outcome and/or treatment choices. Is there research to	The schema discriminators are not really arbitrary - they are used to get the registry software to pull up the correct tables for AJCC, EOD, Summary Stage, Grade, SSDI, etc.

	support these somewhat arbitrary schema discriminators? Just trying to relate the staging to the anatomy.	
7.	For Poll #4, what if instead of it being 2023 the new tumor was 2022, which rules would be used?	For pre-2023 diagnoses covered under the other sites rules, we would use the 2007 MP/H rules. The other sites STR are only effective for 2023 and forward diagnoses.
8.	I don't see any instructions in the STR that support assuming that if the liver tumor recurs in the same segment, then it is assumed to be the same tumor and not a new primary. This is not the case for lung or other sites treated with radiation, so why would we assume this for liver? If the patient is NED and then there is a new tumor (recurrence or new primary) we are supposed to follow the rules as written and not make assumptions. If there is a statement, they are dz free and then they have another tumor diagnosed more than 1 yr later then I would abstract it as a new primary.	If the tumor recurs in the location that was treated, how do you know if it is the same or a different tumor? A single tumor is a single primary per M2. We should follow the rules as written. If I had a statement, they were disease free, and the tumor occurs more than a year later, then we would have to abstract a new primary. The point is we often don't know they are disease free when they have had one of these bridge treatments.
9.	I agree. At my facility we have clarified with our IR physicians how they determine that HCC patients treated with TACE and/or ablation are considered dz free.	That's awesome you were able to do that! Kudos to you.
10.	Just for clarification, looking in the STR 2024 Update in the Other Sites Introduction, it says "Tumors diagnosed 01/01/2023 and later, use the 2023 Solid Tumor Rules." Is this saying we should open the 2023 STR and use those rules or continue in the 2024 Rules.	It means you use the STR, but you need to use the most current update of the STR, depending on the year in which you are abstracting the case. So, if you are abstracting a 2023 liver case in 2023, use the most recent update of the 2023 other sites rules (May 2023). If you are abstracting a 2023 liver case in 2024, use the 2024 update to the STR.
11.	Can you share how they determine that?	
12.	That is a little confusing because Jim's poll question stated to use the 2024 Update for a case dx in 2023.	That's because he was abstracting the 2023 case in 2024. Let's say you are abstracting a 2023 liver case this month (1/2024). The 2024 update to the STR should be used because it is 2024. If you were abstracting the 2023 liver case in 2023, of course you would use the most recent 2023 update available at the time you are abstracting the case. Or, for example, in 1/2024, you are abstracting a 2018 colon case that you missed that year

		(yikes!). You would use the 2024 update to the STR since it is 2024. It applies to colon cases diagnosed 2018 and forward. There are certain things in the STR that apply only to certain years, but when that is the case, the STR have a note about it (example: LAMN and HAMN, the 24 months versus 36 months timing for the anastomosis rules, etc.).
13.	Use the Multiple Primary Rules as written to determine whether a subsequent tumor is a new primary or a recurrence. The ONLY exception is when a pathologist compares slides from the subsequent tumor to the "original" tumor and documents the subsequent tumor is a recurrence of the previous primary. Never code multiple primaries based only on a physician's statement of "recurrence" or "recurrent".	Yes. Use them as written. We do not use physician statement of recurrence, but if we do not know if the tumor is a different tumor or the same tumor, rule M1 applies.
14.	What is the primary site when the only description is "main bile duct?"	C240
15.	Ok, so that goes back to my original understanding about the STR to use the current rules that are available. If abstracting a case in 2024, use the 2024 Update. Then in the Other Site notes, if the case was dx 2017-2022, open and use the 2007 MPH Rules.	You got it!
16.	Can you talk about the SEER Manual vs STORE with respect to LI-RADS 4 and LI-RADS 5. SEER states that LI-RADS 4 and LI-RADS 5 are reportable based on the American College of Radiology Liver Reporting and Data System. The date of the scans should be used as the date of diagnosis when it is the earliest confirmation of malignancy. This rule is different from how the STORE views LI-RADS 4 and 5.	Yes. That is a problem. For SEER, we use the date of the LR-4 or LR-5 as the date of diagnosis. If all you have is LR-4 or LR-5, the case is not reportable to the CoC and would be reported as a non-analytic case. For STORE, we don't report the case based only on LR-4 or LR-5. Once we have either physician confirmation or confirmation via path. it is reportable to the CoC. If you also report to SEER, you need to make sure you document the dates well so when the central registry links and consolidates the case they will be able to enter the correct date of diagnosis for when they send the case to SEER.
17.	If scan states, liver tumor with "vascular enhancement." is this the same as vascular invasion?	No.

18.	Why is the portal v. thrombosis part of pathological stage, rather than clinical cT4? (Poll 10)	The portal vein thrombosis was not identified in the clinical time frame. It was not found until the time of resection, which is the pathological time frame.
19.	For poll 10 if it said Tumor Thrombosis it would be a t4?	Yes. If they said tumor thrombus/thrombosis it would be T4. We need to know the tumor is at fault for the condition. https://cancerbulletin.facs.org/forums/node/126307
20.	For poll 11 why was the clinical tumor size used for the pathological T?	pT includes all information from definitive surgery as well as the clinical information. We know the tumor size from hepatectomy was smaller than at the time of dx due to the TACE. Therefore, we use the clinical information on tumor size to assign the pT. https://cancerbulletin.facs.org/forums/node/136929
21.	will leaving staging fields blank cause error in edits	Not for the T, N, or M fields, but the clinical stage group would have to be 99, or you will get an edit.
22.	For Thrombosis, there is a CANswer Forum post that says to code T4 for Thrombosis and says: "Tumor thrombus is defined as tumor extending into a vessel, typically a vein." I am guessing that is incorrect? (https://cancerbulletin.facs.org/forums/node/123761)	No. That post is correct. Our case described a thrombosis only, not a tumor thrombus. We have to know the condition is caused by a tumor. https://cancerbulletin.facs.org/forums/node/126307
23.	If the radiology report only states LR-M, would we still consider that as reportable for SEER?	Currently, the SEER Manual Appendix E states the following: Report based on the American College of Radiology Liver Imaging Reporting and Data System (LI-RADS) definitions. "Use the date of the LR-4 (Probably HCC) or LR-5 (Definitely HCC) scan as the date of diagnosis when it is the earliest confirmation of the malignancy. If there is no statement of the LI-RADS score but there is reference that a lesion is in the Organ Procurement and Transplantation Network (OPTN) 5 category, report based on the OPTN class of 5. OPTN class 5 indicates that a nodule meets radiologic criteria for hepatocellular carcinoma."
24.	For perihilar duct cancer if we just can't tell if it is intrahepatic or extrahepatic can we assign c24.8?	For now, code to perihilar C24.0. This could change when AJCC physicians complete their review.

25.	Clarify if path is 2023 to use 2024 STR update?	If path is 2023, but you are abstracting the case in 2024, use the most recent STR for 2024. If you were abstracting a 2023 path in 2023, use the most recent 2023 update to the STR. Make sense?
26.	I'm sorry, but I am still stuck on Poll 6. I'm confused about why it wouldn't be unknown primary with no other information provided	This is a situation that comes up so often. We have little information, but as long as we don't suspect this is Mets, we can code to intrahepatic bile duct and cholangiocarcinoma. We passed this by Lois Dickie.
27.	Ok, I am not sure I always understood that, and I have been doing this a long time. I always thought you abstracted the tumor with the manual that matched the year/dx year	That is true for STORE and SEER. Those manuals go along with date of diagnosis. The STR, Grade, SSDI, EOD, and Summary Stage are used according to the year in which you are completing your abstract. If you had a liver case diagnosed prior to 2023 when the Other Sites STR were updated, you would use the most recent update to the MP/H rules.
28.	I'm pretty sure we get an edit error on the unknown primary abstract if we have a colon primary already in the system (sequence number error). This is in reference to poll #8	You might get an edit, but you should be able to override it. The physician didn't know if it was Mets from the colon cancer or a bile duct primary. If the physician doesn't know the primary site, we need to code it to unknown primary site.
29.	For multiple primary rule M12 we commonly see a patient that has RFA of a malignant liver cancer and >1 year another HCC. We code 2 primaries but struggle with this.	It would depend on whether the tumor is the same tumor or a different tumor. If the patient had RFA, and the tumor > 1 year later arose from residual tumor tissue from the tumor that received the RFA, it would not be a new primary per M2.
30.	I think we got confused because that first line says to go by date of diagnosis	We go by both. For other sites, if the diagnosis date is 2023+, use the most current STR manuals for the year in which you are abstracting. For a pre-2023 diagnosis, we would use the MP/H rules.
31.	Poll 6 Why does intrahepatic mass mean the same as intrahepatic bile duct? Intrahepatic =within liver? It does not mean bile duct in the liver - does it?	No, it does not mean bile duct, but since adenocarcinoma cannot arise from the liver, we know it is from an intrahepatic bile duct.
32.	Yes, if there was residual, it definitely wouldn't be a new primary. We are assuming the patient was disease free when	Yes. I get that. It's not a great situation. If you don't know whether it is the same or a new tumor, Rule M1 applies.

	the second HCC is found in a different lobe, but it becomes difficult to know when there is another primary when arising in the same lobe. Due to rule M12 we have multiple liver cancers coded on our registry when these are just radio ablated at time of each occurrence when they arise > 1 year apart	
33.	on a 2021 pathology the diagnosis is Hepatocellular ca. lymphocyte-rich, should we assign the morphology HCC, NOS 8170/3 or could we assign 8174/3 since the new related term was only available in 2022 in ICD 0 3.2	You would have to use code 8170. You can't use that term to assign a histology unless the case has a dx date of 2022 or later.
34.	Can you explain the rule about the nodules in Poll 9 again?	
35.	Why is TACE not considered treatment?	It is considered treatment per STORE and would be coded as such. However, it is not considered a neoadjuvant treatment when it comes to AJCC staging.
36.	Poll 11 but they have doxorubicin - does this not indicate tx and so the resection would be post systemic therapy = y	The TACE using doxorubicin is not considered neoadjuvant treatment. It would be coded as chemotherapy, but it is not considered neoadjuvant when it comes to AJCC Staging. There are posts on the CANSWER forum confirming this.
37.	OK but now for Poll 16 we do use TACE to determine the SSDI???	Yes. TACE is treatment. It's coded as treatment and is considered treatment for the SSDI. It is not considered neoadjuvant treatment for AJCC staging. It's kind of like hormone treatment prior to definitive surgery for breast or prostate. The hormone tx is coded as treatment, but it is usually not considered neoadjuvant treatment for AJCC staging.
38.	See poll 18 - this (chemo given) does not agree with poll 11, does it?	It does. Remember, not all treatment given prior to surgery is considered neoadjuvant treatment. AJCC has stated that TACE is not considered neoadjuvant.
39.	CBD & HOP. Which abbreviations for abstractors list are being used? I do not see these in the NAACCR abbreviation list. Can you provide the link?	We used those because we could say what they meant when we talked about the slide. You wouldn't want to use them in an abstract, but this is not an abstract – it is a sample case scenario.

40.	Question - if path report states "liver biopsy + MD adenocarcinoma consistent with pancreaticobiliary origin." All MDs say pt diagnosed intrahepatic cholangiocarcinoma. Would this be coded to 8140/3 adenocarcinoma or 8160/3 cholangiocarcinoma?	I would code that to C22.1 8160/3 for 2023+ diagnoses. Prior to 2023, we would code to 8140 since path diagnoses have priority over a physician statement.
41.	Question. For staging in Poll 20, pancreas vs bile duct. If you would have all information w/in the timeframe of 1st course tx and it says the Site is Intrahepatic duct, not Pancreas, why can't you just stage as bile duct?	Because the clinical timeframe has already ended, we cannot go back in time. During the clinical timeframe the patient was being worked up for a head of pancreas primary.
42.	Can you also go back over pathology bx noting adenoca but a clinical dx of cholangioCA and coding histology as cholangioCA?	Let's start with the fact that primary site cannot be liver and histology adenocarcinoma. We have confirmed the combination is histologically not possible. Since the histology is adenocarcinoma, the primary site has to be bile duct or the tumor was metastasis. If there is no indication the patient has metastasis, we can assume the primary is bile duct and the histology is bile duct carcinoma/cholangiocarcinoma 8160/3.
43.	Poll 9 would you assign the (m) suffix to the cT staging?	
44.	Doxorubicin is chemo though?	Doxorubicin is chemotherapy. In this scenario it is part of the TACE procedure. TACE is coded as chemotherapy, but it is not considered neoadjuvant when it comes to AJCC staging.