

Q&A Session for Pancreas 2024

January 31 & February 1, 2024

#	Question	Answer
1.	The most frequent histology question that I see, is how to distinguish adenocarcinoma of the pancreatic ducts, vs. ductal carcinoma. The questions usually are when to code 8140/3 and when to use 8500/3.	I would code it based on how it is documented on the pathology report. I would code adenocarcinoma of the pancreatic ducts as 8140/3. I would code ductal adenocarcinoma as 8500.
2.	How can PanIN be a synonym for Glandular intraepithelial neoplasm high grade and not be reportable?	PanIN is a synonym for Glandular intraepithelial neoplasia of the pancreas. It does not imply a grade. PanIN grade 3 is reportable as is glandular intraepithelial neoplasia grade 3 of the pancreas is reportable.
3.	On imaging, if a tumor is described as IPMN, it would not be reportable, correct. Need path to confirm tumor?	It has to be documented as a high grade or grade 3 IPMN to be reportable. A pathologist should be the one to assign the grade of the IPMN. An IPMN identified on imaging alone would not be reportable.
4.	Please explain again coding Grade for NET, when it is a part of histology and when it is the grade.	For NET - well-diff, mod-diff, etc. are part of the histology term - the "grade" is based on the Ki-67 and mitotic rate, so you need the grade given or these two items in order to assign a grade - very confusing I know.
5.	Per SEER 2024 reportable examples PanIN III is reportable as 8148/2	Does it say anything about PanIN nos? Only PanIN III is on the list.
6.	In regard to IPMN what about FCDS memo from 10/2021.	They updated that (I believe it was 2022) that you need the additional terminology now for it to be reportable. See page 7 of the FCDS (Florida only) DAM Manual.
7.	FCDS DAM, Section 1: Guidelines for Cancer Data Reporting - (IPMN/IOPN/ITPN/CPEN) seen on endoscopic ultrasound without biopsy is not reportable unless clinically malignant due to metastasis. Note: some of these patients still get a Whipple Procedure as if they had malignancy. So, treatment is not the	Just below that - The IPMN Path Description must include at least one of the clarifying descriptive terms below; • IPMN, with high grade dysplasia • IPMN, non-invasive • IPMN, in-situ • IPMN, associated with invasive carcinoma • IPMN, invasive An IPMN alone is not reportable.

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	defining characteristic of a malignancy in this case. Please take care when reviewing these cases. So, is it or is it not reportable?	
8.	Are we to code stent placement as palliative treatment?	Great Question - Per the STORE manual this would be coded as a 7 - if the stent is being done because of the cancer (cancer-directed treatment). If the stent is being placed for another reason (and the patient just happens to have cancer) then it would not be coded necessarily
9.	For clarification in the STR they should add a qualifier of "high grade" after all of the listed synonyms for "glandular intraepithelial neoplasia high grade"?	Do you see PanIN, NOS very often? What is worrisome is they can identify what they think is PanIN and IPMN on radiology. However, only a relatively small percentage of those are grade 3.
10.	the code 8272/3 gh producing neuroendocrine tumor that you mentioned, this is a new term for pancreas in 2024+? currently listed in ICDO 3.2 for pituitary carcinoma nos	You are correct. That term has not yet been approved for use with pancreatic primaries.
11.	For TNM of NET of pancreas, Jim mentioned tumors that invade outside the pancreas (into surrounding fat) but not into adjacent organs. What would be the pT for this type of case?	Per the AJCC manual, invasion into the surrounding peripancreatic adipose tissue is not a factor for assigning the T value. We just disregard the information. There is a post on the forum answered by AJCC that once the tumor has invaded other structures, it would be a T4 Pancreas & Retroperitoneal soft tissue - CAnswer Forum (facs.org)
12.	I am still confused about abuts and encases. For AJCC, abuts and encases does not necessarily mean the major blood vessel is involved? or does it? For SS2018, per note 4: "The terms "abutment," "abut(s)," "encases," or "encasement" of the major blood vessels can be interpreted as involvement of these structures. So, can you clarify if abuts and encases means involvement?	Encasement or abutment of the celiac axis, superior mesenteric artery, and/or the hepatic artery qualifies as a T4. Encasement or abutment of other blood vessels is not a factor when assigning a T value.
13.	Is this just for pancreas primary? I've always thought it had to state encasement for involvement.	This is really pancreas - it is not the same for other primary sites.
14.	What if the site is conflicting between Ampulla of Vater (C24.1) and the pancreas (C25). Do we use C25.9 or C26.8, C26.9?	I would look very carefully to identify information that would allow me to assign the case to either Ampulla of the Vater or Pancreas. Assigning a case to C26.8 or C26.9 means the case is

		assigned to a different schema. We would not be able to assign an AJCC stage. You have to take everything into consideration and look at the histology, scans, physician statement, treatment, etc. and make your best choice.
15.	Would this be considered an LND or lns just removed w/ the surgery of the primary site, for this case 1?	I would consider it a lymph node dissection.
16.	I really like your analogy of 'putting all the pieces together' when guidelines/definitions are suboptimal. Very helpful! Thank you.	Thank you!
17.	I just want to make sure I understand this. If prednisone or dexamethasone are given during a regimen, even though SEER rx says that we cannot use it except for lymph leuk; then we can use it as it is in a regimen? does that make sense?	Per the STORE manual: Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone). SEER RX states: <i>Prednisone is used in regimens to treat multiple sites and histologies Code Prednisone when it is part of a drug regimen.</i>
18.	What if the known agent is not approved for the primary site you are working on?	Per the response below, there is a question on SINQ 20220048 that states you would not code under the modality if it is not approved for that site. I also posted a question to the forum and they confirmed. Clinical Trial - agent not approved for the primary site - CANSWER Forum (facs.org)
19.	If a patient is treated on a double-blind study, when the study is "unblinded" would you change the codes for the agents used or leave them under Other Treatment?	Yes, we are supposed to code in the modality if the study is unblinded and we know the agents.
20.	Per the image the body of the pancreas is the "smallest" tumor site compared to the tail and head?	There are not exact lines of distinction, but the body is a little smaller than the head and tail and based on the boundary lines Jim described.
21.	Per SINQ 20220048: "When a drug is administered as part of a clinical trial and it is not yet approved as treatment for the	Thank you, we will check that and let you know. I did post the question on the forum and they confirmed – code under “other” therapy if the agent is not included for that primary

	cancer site for which it is being administered, code in Other Therapy." I could not find any related inquiries after 2022.	site: Clinical Trial - agent not approved for the primary site - CANSWER Forum (facs.org)
22.	When Jim mentioned that T4 includes tumors that are so close to vessels that they're unsafe to resect, does that apply to the Exocrine Pancreas chapter only? Or both exocrine and neuroendocrine chapters of AJCC?	I assume the same concept applies to NET Pancreas, but I recommend sending the question to the CANSWER forum if you have a case of a NET pancreas primary encasing the celiac axis or the superior mesenteric artery.
23.	Are "retroperitoneal NOS" lymph nodes considered regional for pancreas?	SS2018 describes retroperitoneal NOS nodes as regional for all sites of the pancreas. However, that is a very broad term. If you run into a case with positive retroperitoneal nodes, I would send the question to the CANSWER forum. Per the existing questions on the forum, I would say you cannot consider them to be regional without further information: Regional Lymph Nodes Clarification - Answer Forum (facs.org)
24.	Why is Neuroendocrine Carcinoma not a neuroendocrine tumor? I'm still a bit confused with the differences	That is a question for a pathologist! They both develop in the endocrine system, but the carcinomas are usually more aggressive
25.	SS2018 describes retroperitoneal NOS nodes as regional for all sites of the pancreas. We collect AJCC TNM Staging and Donna has told us not to use Summary Staging/EOD to determine AJCC staging. Are you able to comment from a TNM-only perspective?	I think that especially applies to non-specific terms like "retroperitoneal lymph nodes". You are correct that you should follow the AJCC rules for assigning AJCC values.
26.	If the mass is originally labelled by the pathology as IPMN, but a later pathology shows it to be a specific, reportable histology, would the second pathology be the diagnosis date?	If it was a high grade IPMN, that would be the date of dx. IPMN, NOS is not reportable and would not be used as date of dx. In re-reading this question – you would use the date the specimen was taken. So if a later pathologist was reviewing the original specimen, then I would use the date the specimen was obtained as the date of diagnosis (not the date the pathologist read it). From the STORE: If the physician states that in retrospect the patient had cancer at an earlier date, use the earlier date as the date of diagnosis.

27.	I know the lack of high-grade dysplasia is indicative of a non-reportable tumor, but what about the margin involvement? Would that not make it invasive?	I believe the histology is what makes it not reportable, if it was invasive, the pathologist would have labeled it as such.
28.	Is that stent placement coded as palliative or not at all?	Per the STORE examples, it would be coded as a 7, but you would need to consider why the procedure was done, etc.
29.	Palliative stent placement is coded to palliative code 7. If palliative chemotherapy is also given what should the palliative treatment code be since 7 is not listed in the combination code.	Great question, I checked the forum, and it is ambiguous. We can get back to you on this. Here is the question on the forum (that said to code as a 7): Palliative chemo and stent - CAnswer Forum (facs.org)
30.	Is "encases" a term that AJCC recognizes as involvement?	Yes. It is defined within the AJCC Exocrine Pancreas chapter.
31.	Case #1 - Would you consider this patient NED after surgical procedure?	If the surgeon stated he/she believes they removed all of the tumor and the pathologist states all the margins are clear and the treating physicians are not recommending any further treatment, then it makes sense the patient is NED. However, per the STORE manual “ <i>Cancer Status</i> is based on information from the patient’s physician or other official source such as a death certificate.” The forum supports this and technically we should not code as NED without a statement from the treating physician: Cancer Status RLL lobectomy with LN Dissection - CAnswer Forum (facs.org)
32.	Why would we code spleen removal in surgery of other site when there was no indication of involvement by tumor. My understanding (based on information in the SEER Program Manual) is that we do not code incidental removal of an organ when it is NOT involved by cancer.	The splenectomy was planned as part of the "cancer-directed" surgery - it was not an incidental removal. Even though the spleen was not involved, the surgeon planned to remove it as part of the cancer-directed surgery, so I would code it.
33.	Case 2 - I missed the TNM stage assigned; did I see T2? I assigned T4 due to abutment of the main portal vein (per AJCC pg. 340, "Venous involvement of the SMV/portal vein is defined as tumor abutment..." I realize portal vein is not specifically listed in T4, so this might be a confusing point for me?	I see where it says that in the manual, but portal vein is not included as criteria for a T4. I’m not sure why T4 only includes those 3 vessels. Involvement of other vessels can also make the case inoperable. However, AJCC is very clear about what makes a case a T4.