

Quiz 1-Reportability

Assume year of diagnosis is 2024 unless stated otherwise.

If participating in the live session, do not use your manual.

1. Which of the following statements describe cases **reportable** to the CoC according to STORE? Select all that apply.
 - a. Lobular Carcinoma In Situ
 - b. Juvenile Pilocytic Astrocytoma with a behavior code of /1 diagnosed in 2023**
 - c. GIST, NOS tumor diagnosed in 2021**
 - d. Carcinoid tumor of the appendix**
Lobular carcinoma in situ is not reportable to NCDB; Juvenile pilocytic astrocytoma became reportable as a /3 prior to 2023 and is reportable with a behavior code of /1 post-2023. The behavior has changed, but reportability has not and it is a specific exception to the reporting rules in STORE; GIST, NOS was /1 and not reportable prior to 2021; Carcinoid of the appendix is reportable.
2. According to the COC, which of the following are examples of **non-reportable** histologies? Select all that apply.
 - a. Intraductal Papillary Mucinous Neoplasm (IPMN) low grade**
 - b. Tectal plate lipoma
 - c. PanIN III
 - d. Squamous cell carcinoma of the canthus**
 - e. Mature teratoma of the testes diagnosed before puberty**
IPMN low grade is not reportable. IPMN must be high grade to be reportable; Tectal plate is part of the brain (AKA the quadrigeminal plate or tectum, it is made up of the superior and inferior colliculi and located in the dorsal midbrain of mammals, or C71.7) . Lipomas of the brain are reportable; PanIN III is not listed as an exception in the STORE manual. Behavior is /2 so case is reportable; canthus is skin (corner of the eye); See Other Rules table 4. Teratoma, mature, prepubertal type 9084/0.
3. Which of the following statements are true of reportable by agreement cases? Select all that apply.
 - a. Hospital registries may be requested to submit cases to their central registry that are not required by the COC from accredited facilities**
 - b. Requests for reportable by agreement cases may come from the state cancer registry or from the cancer committee**
 - c. The requestor determines the extent of information to be abstracted on reportable by agreement cases**
 - d. Reportable by agreement cases are always entered using analytic classes of case
See page 34 of the STORE manual
4. A patient is found to have gastrointestinal stromal tumor (GIST) in their stomach. Pathology confirms the tumor is benign. Further work-up did not show metastasis.
 - a. Reportable
 - b. Not reportable**
 - c. Depends
A GIST that is found to be benign is not reportable

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5. A patient is found to have a GIST in their stomach. Pathology confirms the diagnosis of gastrointestinal tumor. Further work-up did not show metastasis.
- Reportable**
 - Not reportable
 - Depends
- A GIST NOS is considered /3 behavior for cases diagnosed on or after to 1/1/2021. That means that if there is no indication the tumor is benign, we assume it is malignant.*
6. A patient is diagnosed with a lobular neoplasia grade III occurring in her right breast. The physician refers to this as lobular carcinoma in situ.
- Reportable
 - Not reportable
 - Depends**
- LCIS is reportable to state/provincial registries. It is not reportable to NCDB*
7. A patient has a biopsy of a small lesion in his pancreas. Pathology shows pancreatic intraepithelial neoplasia grade 2.
- Reportable
 - Not reportable**
 - Depends
- Grade 2 is not reportable. Grade 3 is reportable. We confirmed this with SEER.*
8. A urine cytology showed malignant cells. Patient refused further work-up.
- Reportable**
 - Not reportable
 - Depends
- A positive cytology is enough to make this reportable*
9. A patient is diagnosed with an adenoma in their adrenal gland
- Reportable
 - Not reportable**
 - Depends
- Adenoma, NOS is 8140/0. Adrenal gland is not in the CNS.*
10. A patient is diagnosed with and adenoma in their pituitary gland.
- Reportable**
 - Not reportable
 - Depends
- Adenoma, NOS is 8140/0. Pituitary gland is located in the CNS area.*

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11. A breast cancer patient had her surgery and radiation treatment completed at Facility A on 1/7/2023. She was started on Letrozole at Facility A on 1/12/23. She transfers her treatment to Facility B on 2/21/2024 and continues her Letrozole at Facility B. Is this case reportable to facility B?

- a. **Reportable**
- b. Not reportable
- c. Depends

Letrozole is a hormone treatment and is part of first course treatment.

12. A patient has a CT of the liver that shows a mass that is assigned a LI-RADS score of 4- Probable hepatocellular carcinoma. A subsequent biopsy of the liver indicated the tumor was benign.

- a. Reportable
- b. **Not reportable**
- c. Depends

The biopsy confirming the mass is benign is the definitive source for determining reportability

Quiz 2-Class of Case

Answer these questions as if you are a registrar at a CoC facility.

We are not asking participants to use the manual for this quiz.

1. A patient had a colonoscopy and with biopsy at your facility. The biopsy was positive for adenocarcinoma. The patient was referred to a different facility for surgery, but it is unknown if any further treatment was done.
 - a. 00 Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
 - b. 10 Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS**
 - c. 14 Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility
 - d. 22 Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility

If it is unknown whether treatment was done, 10 is the appropriate code. A class of case 00 indicates the patient had treatment elsewhere.

2. A breast cancer patient had her surgery and Radiation treatment completed at Facility A on 1/7/2023. She started Letrozole at Facility A on 1/12/23. She transfers her treatment to Facility B on 2/21/2024 and continues her Letrozole as prescribed by the physician at Facility A. What is the class of case for Facility B?
 - a. 11 Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility
 - b. 21 Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.**
 - c. 30 Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup
 - d. 32 Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (active disease)

Letrozole is a medication that limits the amount of estrogen produced and is frequently prescribed to breast cancer patients to stop or reduce the growth of cancer cells. It is a standard part of first course treatment and may be part of their "maintenance" therapy for 5-10 years.

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3. Facility A:

2/10/23 Patient had a shave biopsy at an outside facility due to nonhealing lesion on his nose. Pathology reads melanoma in situ with positive margin.

Facility B:

3/9/23 Patient presented at your facility for wide excision to ensure clear margins. Path returned with no residual tumor. No further treatment. What is the class of case for Facility B?

- a. 00 Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
- b. 12 Initial diagnosis in staff physician's office AND all first course treatment or a decision not to treat was done at the reporting facility
- c. **21 Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.**
- d. 22 Initial diagnoses elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility

In the live presentation, we incorrectly stated the answer was 22. The correct answer is 21. The shave biopsy would be considered both diagnostic and partial treatment for facility A (Class of Case 13) and would be considered partial treatment for facility B.

4. Facility A:

A patient was diagnosed with prostate cancer on 3/2/23. His urologist recommended active surveillance. The patient's PSA and DRE remained stable until 1/4/24 when the PSA returned significantly elevated. Due to the elevation in the PSA and patient anxiety a prostatectomy was recommended.

Facility B:

Robotic Assisted Prostatectomy

What is Class of Case for facility B?

- a. 14 Initial diagnosis at reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility
- b. 21 Initial diagnosis elsewhere AND part of first course treatment or a decision not to treat was done at the reporting facility
- c. 30 Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere)
- d. **32 Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (active disease)**

Active surveillance was the first course of treatment plan for this patient. Once active surveillance starts, any other treatment is considered subsequent treatment.

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5. A patient has a mammogram on 10/4/23 that shows a BI-RADS 4 lesion in her left breast. An ultrasound guided core biopsy showed lobular neoplasia grade III occurring in her left breast. The physician refers to this as lobular carcinoma in situ.

10/28/23 The patient had a lumpectomy of the left breast. Pathology showed lobular neoplasia grade II, but no residual LCIS. The patient did not have any additional treatment.

- a. 00 Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
- b. 21-initial diagnosis elsewhere and part of first course treatment was done at the reporting facility
- c. 30 Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere)
- d. **34 Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility**

Cases are analytic (00-22) if they are reportable to CoC/NCDB. If a case is not reportable to CoC/NCDB but is reportable to a state/provincial registry, class-of-case should be non-analytic.

6. A patient is seen at an outpatient surgery center (not affiliated with your facility) on 2/4/2024 for a biopsy of a left base of tongue lesion. The specimen was sent to your pathology department for review. The pathology report showed the specimen was positive for invasive, poorly differentiated squamous cell carcinoma, basaloid type, nonkeratinizing. No HPV histogenesis. The patient returns to your facility on 2/17/2024 for an excisional biopsy that confirms the diagnosis. The class of case is...

- a. 00 Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
- b. 21-initial diagnosis elsewhere and part of first course treatment was done at the reporting facility
- c. **22-initial diagnosis elsewhere and all of first course treatment was done at the reporting facility**
- d. 30 Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere)
- e. 43 Pathology or other lab specimens only

This was a non-analytic case for your facility until the patient had an excisional biopsy. The reading of the pathology report at your facility is not equivalent to diagnosis at your facility. The facility where the biopsy sample was taken gets the "credit" for diagnosing the patient.

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7. A patient presents at your facility for workup of a skin lesion on 9/20/2023. The shave biopsy is consistent with atypical melanocytic proliferation, and the patient does not return for further evaluation in your dermatology department. On 1/10/2024, the patient is seen in your emergency department for confusion and altered mental status. The patient passes away, and the autopsy reveals several lesions in the frontal lobe, consistent with metastatic melanoma. What is the appropriate class of case?
- 00 Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
 - 30 Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere)
 - 38 Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death**
 - 43 Pathology or other lab specimens only
The patient did not have a diagnosis of melanoma prior to autopsy.
8. A patient presents to his local hospital for evaluation for shortness of breath and general weakness. The emergency room performs a history and physical, which reveals a prior history of meningioma, completely resected in 2019. The patient has been followed with serial imaging since 2020 by the patient's outside neurologist with no known recurrences. A chest x-ray is performed, positive for pneumonia. The patient is prescribed antibiotics and discharged. If this case were reportable by your central registry or facility, what class of case would be assigned?
- 00 Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
 - 21-initial diagnosis elsewhere and part of first course treatment was done at the reporting facility
 - 30 Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere)
 - 33 Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (disease not active)**
Patients not diagnosed or treated at your facility are non-analytic. If your state, province, territory, or facility require you to abstract cases based on a history of disease, assign a non-analytic class of case.

Quiz 3-Ambiguous Terminology/Date of Diagnosis.

We are not asking participants to use their manual.

“Suspicious”, “Consistent” and “consistent with” are considered reportable ambiguous terms. “Encased” is listed as a Not Involved term in the Summary Stage Manual list of ambiguous terms.

1. CT shows a suspicious tumor in the left lung.
 - a. Reportable
 - b. Not reportable**
“Tumor” is not reportable when occurring in the lung.

2. 1/12/23 A CT showed a bile duct dilation consistent with cholangiocarcinoma. On 2/4/23 biopsy showed ductal adenocarcinoma of the head of the pancreas. What is the date of diagnosis?
 - a. 1/12/23**
 - b. 2/4/23
 - c. The case is not reportable.
“consistent with cholangiocarcinoma” is reportable. Even though the bx showed a different histology and primary site for the tumor, reportable terminology was used to describe the tumor on 1/12/23.

3. 4/12/23 A CT of the chest showed a mediastinal mass consistent with lymphoma with a differential diagnosis of metastatic lung cancer or sarcoidosis. A biopsy on 4/25/23 confirmed diffuse large b-cell lymphoma. What is the date of diagnosis?
 - a. 4/12/23
 - b. 4/25/23**
 - c. The case is not reportable.
Sarcoidosis is not a reportable disease. When a differential diagnosis is given and on “one” of the option is not reportable, the statement is not diagnostic.

9/12/23 A CT showed tumor in the head of the pancreas **encasing** the superior mesenteric artery.

4. Would “encasing the superior mesenteric artery” be used to assign Summary Stage?
 - a. Yes**
 - b. No
5. Would “encasing the superior mesenteric artery” be used to assign an AJCC cT value?
 - a. Yes**
 - b. No
 - c. Maybe

“Encasing” is defined as an involvement term in the pancreas section of the Summary Stage Manual and the AJCC Manual. Therefore, “encasing” is not an ambiguous term for pancreas.

10/12/23 A CT showed a tumor in the apex of the left lung **encasing** the superior vena cava.

6. Would “encasing the superior vena cava” be used to assign Summary Stage?
 - a. Yes
 - b. No**
7. Would encasing the superior vena cava be used to assign the AJCC cT value?
 - a. Yes
 - b. No

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c. Maybe

“Encasing” is listed as a Not Involved term in the Summary Stage Manual for lung. The statement is not enough to consider the SVC involved for Summary Stage based on this CT report.

The ambiguous terms list should not be used to assign a cT. The registrar should review the report along with other sources and determine if enough information is available to assigned a cT value. If not, the field should be left blank. If there is enough information, the appropriate cT value should be assigned.

Quiz 4-First Course of Treatment

Please use SEER Rx to answer question related to systemic treatment.

<https://seer.cancer.gov/seertools/seerrx/>

1. Which statement(s) are true about First Course of Treatment (Select all that Apply)?
 - a. **First Course of Treatment is any treatment included in their initial treatment plan, regardless of timing.**
 - b. First Course of Treatment is always administered within 1 year of diagnosis.
 - c. **First Course of Treatment is treatment administered prior to disease progression.**
 - d. **Registrars can use the NCCN guidelines to help determine what First Course of Treatment would be standard of care in the absence of a treatment plan.**
 - e. **Incorrectly determining First Course of Treatment can impact coding Class of Case.**
 - f. The cancer registry definition of First Course of Treatment has not significantly changed since the earliest (DAM) manual.

Planned first course treatment takes precedence over timing rules; first course treatment is not limited to treatment within 1 year. The 1-year rule can be used if a treatment plan is not available; When treatment is altered due to disease progression, subsequent treatment is not first course; The NCCN guidelines may be used to supplement information not included in the treatment plan or when the treatment plan is not available; Coding treatment as first course when it is not could impact class of case.

2. After an ascending colon primary is abstracted, the registrar finds out that the patient has first course of treatment Gemcitabine and Cisplatin. Besides updating Chemotherapy (#1300), what are some of the other fields that the registrar should consider updating as well?
 - a. Chemotherapy at this Facility
 - b. Date Chemotherapy Started
 - c. Date Systemic Therapy Started
 - d. Systemic/Surgery Sequence
 - e. Date of First Course of Treatment
 - f. RX Summary Treatment Status
 - g. RX Text-CHEMO

There may be other data items as well, but at a minimum these should be reviewed

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3. A 35-year-old male presents with abnormal cervical lymph nodes. Bilateral lobes of the thyroid are severely enlarged. The patient was having a slowly increasing upper airway obstruction. Over the last 4 days he was unable to work or sleep. On physical exam, the left thyroid gland is very large going from the angle of the mandible to the base of the neck. The right thyroid gland is mildly enlarged. CT of the neck shows an enlarged thyroid with non-enlarged cervical lymph nodes. A thyroidectomy is performed, revealing a 1.8 cm unifocal follicular carcinoma (encapsulated angioinvasive) of the left lobe. Extrathyroidal extension was not present. Margins were uninvolved. No lymph nodes were submitted.

10/29/2023: Total thyroidectomy with bilateral modified neck dissection. Findings: Massive thyroid enlargement with upper airway obstruction and tracheal compression

11/3/2023: I-131, 171 millicuries

2/21/2024: Thyrogen injection

Which treatment modalities should be coded as part of the patient's First Course of Treatment (Select all that Apply)?

- a. **Surgery**
- b. **Radiation**
- c. Chemotherapy
- d. Immunotherapy
- e. Hormone Therapy
- f. Endocrine/Transplant
- g. Other Therapy

Per note in SEER Rx for Thyrogen-Thyroid stimulating hormone. Probably not cancer directed--verify with attending MD.

https://seer.cancer.gov/seertools/seerrx/rx/53c44b03102c1290262dca50/?drug_direction=UP®imen_direction=UP&rx_type=drug&drug_field=score®imen_field=score&drug_offset=0®imen_offset=0&limit=25&search_mode=&q=thyrogen&mode=

4. A 64-year-old male presents with a positive Cologuard test and a history of colon polyps. PET-CT showed an 8 cm malignant lesion in the caudal portion of the ascending colon and a 5.2 cm metastatic lesion in the anterior aspect of the right hepatic dome, along with an indeterminate lymph node in the portacaval region. The lesion was biopsied on 9/20/2023 and the pathology report demonstrated invasive, moderately differentiated adenocarcinoma. The patient will receive neoadjuvant therapy followed by right hemicolectomy.

10/2/2023: Pembrolizumab x 4 cycles

11/30/2023: MRI Ascending Colon:

- Probable extramural soft tissue haziness along medial aspect of known colonic adenocarcinoma concerning for extramural extension with thickening of the adjacent right anterior fascia.
- Segment 4B hepatic metastasis again present, slightly enlarged from last imaging studies, along with new metastases in segment 6 and segment 8

12/3/2023: Medical oncologist subsequent visit.

- Progression of disease on recent MRI

1/5/2024: Chemotherapy with Fluorouracil, Leucovorin, Oxaliplatin, and Irinotecan (FOLFOXIRI) plus Bevacizumab; poor tolerability

2/1/2024: Right hemicolectomy

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Which treatment modalities should be coded as part of the patient's First Course of Treatment (Select all that Apply)?

- a. Surgery
- b. Radiation
- c. Chemotherapy
- d. Immunotherapy**
- e. Hormone Therapy
- f. Transplant/Endocrine
- g. Other Therapy

On 12/3/2023 the medical oncologist indicated the patient had disease progression and changed the treatment plan. All treatment after the change is considered subsequent treatment.

5. An 87-year-old female presents with petechiae and shortness of breath, and weakness. Her CBC is abnormal, and a bone marrow aspiration and biopsy was performed on 2/16/2023. The pathology is consistent with IPSS-R Very-High Risk Myelodysplastic syndrome with ring sideroblasts and single lineage dysplasia (9982/3). Further genetic testing is being done to determine if mutant IDH1 mutation is present. If present, the patient will begin Ivosidenib.

2/22/2023: Begin Azacitidine, plan for 6 cycles in preparation for stem cell infusion.

3/20/2023: Patient tests Covid positive on PCR after cycle 5 of Azacitidine, cycle 6 put on hold.

4/8/2023: Hematology follow-up visit and repeat CBC.

- Genetic testing shows mIDH1 mutation is present.
- Will start patient on single agent Ivosidenib for further cytoreduction.
- If treatment is successful, will proceed to allogeneic hematopoietic stem cell transplant.

5/1/2023: Patient has achieved <5% blasts with cytoreduction. Stem cell infusion was completed.

5/30/2023: Hematology subsequent visit. Good response 3 weeks post-transplant. Will continue to monitor.

Which treatment modalities should be coded as part of the patient's First Course of Treatment (Select all that Apply)?

- a. Surgery
- b. Radiation
- c. Chemotherapy**
- d. Immunotherapy
- e. Hormone Therapy
- f. Endocrine/Transplant**
- g. Other Therapy

The addition of ivosidenib was part of first course treatment and was conditional on genetic testing. The stem cell infusion was part of first course treatment and was conditional on response to chemotherapy.

Per the NCCN guidelines for MDS p. MS-38 and MDS-7

(efaidnbmnnibpcajpcglclefindmkaj/https://www.nccn.org/professionals/physician_gls/pdf/mds.pdf): "Emerging data are demonstrating effectiveness of ivosidenib and enasidenib for patients with MDS with IDH1 or IDH2 mutations". The standard of care is "Azacitidine (if no response, consider single-agent ivosidenib if mIDH1)"

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6. A 69 year old patient with consistently elevated PSA over the past year (up from 5 ng/mL to 12 ng/mL, reference range 0-4.0 ng/mL), is referred to Facility A Urology department for management on 3/23/2023. The urologist performs a DRE, which is negative, and recommends a prostate MRI. The prostate MRI is completed on 3/30/2023. It demonstrates an “area of interest” in the left apex, and the patient has a prostate biopsy on 4/5/2023, which is positive for a Gleason 6 prostate cancer.

The patient returns to Facility A Urology on 4/10/2023 for treatment discussion. After a conversation between the patient and the urologist, the decision is mutually made to place the patient on active surveillance, with follow-up at 6-month intervals. The patient returns to Facility A Urology on 10/12/2023, and his PSA is essentially unchanged (12.3 ng/mL).

He is next seen on 12/11/2023 at Facility B, where he has transferred services. His urologist there agrees with the plan for Active Surveillance and schedules the patient to follow-up with him in 3 months.

Which facility(ies) participated in First Course of Treatment for this patient?

- a. Facility A Urology only
- b. Facility Urology only
- c. Neither Facility A or Facility B
- d. Both Facility A and Facility B**
- e. The patient did not have any First Course of Treatment

The physicians at Facility B are actively participating in this patient's plan for active surveillance.

Quiz 5-Neoadjuvant Treatment

We are not asking participants to use their manuals for this quiz

A patient is diagnosed with cT3 cN0 cM0 rectal carcinoma on 2/12/23. He received six cycles of chemotherapy followed by a low anterior resection. Pathology showed no residual tumor.

1. Neoadjuvant therapy
 - a. 0 No neoadjuvant therapy, no treatment before surgery, surgical resection not part of first course of treatment plan
 - b. 1 Neoadjuvant therapy completed according to treatment plan and guidelines**
 - c. 2 Neoadjuvant therapy started, but not completed OR unknown if completed
 - d. 3 Limited systemic exposure when the intent was not neoadjuvant; treatment did not meet the definition of neoadjuvant therapy
 - e. 9 Unknown
2. Is this patient eligible for a yp Stage?
 - a. Yes**
 - b. No

A 64-year-old male presents with a positive Cologuard test and a history of colon polyps. PET-CT showed an 8 cm malignant lesion in the caudal portion of the ascending colon and a 5.2 cm metastatic lesion in the anterior aspect of the right hepatic dome, along with an indeterminate lymph node in the portacaval region. The lesion was biopsied on 9/20/2023 and the pathology report demonstrated invasive, moderately differentiated adenocarcinoma. The patient will receive neoadjuvant therapy followed by right hemicolectomy.

10/2/2023: Pembrolizumab x 4 cycles

11/30/2023: MRI Ascending Colon:

- Probable extramural soft tissue haziness along medial aspect of known colonic adenocarcinoma concerning for extramural extension with thickening of the adjacent right anterior fascia.
- Segment 4B hepatic metastasis again present, slightly enlarged from last imaging studies, along with new metastases in segment 6 and segment 8

12/3/2023: Medical oncologist subsequent visit.

- Progression of disease on recent MRI

1/5/2024: Chemotherapy with Fluorouracil, Leucovorin, Oxaliplatin, and Irinotecan (FOLFOXIRI) plus Bevacizumab; poor tolerability

2/1/2024: Right hemicolectomy

3. Neoadjuvant therapy
 - a. 0 No neoadjuvant therapy, no treatment before surgery, surgical resection not part of first course of treatment plan
 - b. 1 Neoadjuvant therapy completed according to treatment plan and guidelines
 - c. 2 Neoadjuvant therapy started, but not completed OR unknown if completed**
 - d. 9 Unknown
4. Is this patient eligible for a yp Stage?
 - a. Yes**
 - b. No

Quiz 6-Grade

We are not asking participants to use their manuals for this quiz

1. According to the general section of the Grade Manual, when can Grade Clinical be coded to unknown (9)?
 - a. There are multiple tumors with different grades abstracted as one primary
 - b. There is only one grade available and it cannot be determined if it is clinical or pathological
 - c. There is no site-specific grade table
 - d. **There is an incidental finding during surgery for another condition that removes the entire tumor.**
 - e. There is a patient on active surveillance
Does not qualify for clinical timing rules
2. Which of the following statements is **true** about Grade? Choose all that apply:
 - a. If there are both in situ and invasive components, code the grade for both the invasive and the in situ component of the tumor.
 - b. A registrar can code grade based on a metastatic deposit.
 - c. The Final Diagnosis in the pathology report takes priority for coding grade over the Synoptic Report.
 - d. Systemic treatment and radiation do not alter a tumor's grade.
 - e. **If the primary site is unknown, code Grade Clinical and Grade Pathological to unknown (9).**
Only code grade from the invasive component "component" when both invasive and in situ are present; grade should come from the primary tumor; use the report that provides the more specific histology (usually synoptic report); they can alter the grade; grade should be from the primary tumor. If the primary tumor is unknown, code 9.
3. 12/14/2023 FNA of Station 7, Station 4L, and hilar lymph nodes: 6 lymph nodes in station 4L positive for non-small cell lung cancer, poorly differentiated. 1/2/2024 Bone Marrow FNA: positive for poorly differentiated adenocarcinoma, suspect lung origin. 2/1/2024: Patient placed on dexamethasone and Keytruda for presumed lung cancer diagnosis. 2/15/2024 Lung, left lower lobe bronchoscopy and biopsy: adenocarcinoma, pulmonary type, undifferentiated.

How should Grade Clinical be coded?

- a. G1: Well Differentiated
- b. G2: Moderately Differentiated
- c. G3: Poorly Differentiated
- d. G4: Undifferentiated
- e. **GX: Unknown**

First biopsy of the primary site came after treatment. Patient does not qualify for clinical grade.

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4. 11/11/2023 MRI Brain: Solitary intra-axial mass centered in the postcentral gyrus on the left. Differential diagnosis includes a primary brain tumor or a solitary metastases.

Addendum: On further evaluation of the images, there is an expansile lesion within the sella without suprasellar extension.

- Measurements of the pituitary mass are 15 mm x 11 mm. This may represent a pituitary adenoma.
- 11/14/2023 MRI Brain: Left postcentral gyrus mass measuring approximately 3.0 x 2.8 x 2.4 cm. Mass is most consistent with a low-grade glial neoplasm, specifically astrocytoma or oligodendroglioma.
- Pituitary mass measuring approximately 1.5 x 1.0 x 1.0 cm is most compatible with pituitary macroadenoma without suprasellar or cavernous sinus extension.

How should Grade Clinical be coded for the suprasellar tumor?

- 1: WHO Grade I**
- 2: WHO Grade II
- 3: WHO Grade III
- 4: WHO Grade IV
- L: Stated as "low grade" NOS
- H: Stated as "high grade" NOS
- A: Well differentiated
- B: Moderately differentiated
- C: Poorly differentiated
- D: Undifferentiated, anaplastic
- 9: Grade cannot be assessed; unknown

Grade may be assigned based on imaging for CNS sites. Pituitary macroadenoma has a behavior of /0. Code 1 is assigned when behavior is /0.

5. 1/29/2024 Lymph node biopsy, left axilla, needle core biopsy: Metastatic neuroendocrine tumor in fibrotic tissue. 2/6/2024: Pancreas, tail, fine-needle aspirate: well-differentiated neuroendocrine tumor in fibrous tissue. 2/12/2024: Distal pancreatectomy: G3 neuroendocrine tumor. KI-67 index 32.59%.

What is the correct Grade Clinical for this tumor?

- 1: G1
- 2: G2
- 3: G3
- A: Well differentiated
- B: Moderately differentiated
- C: Poorly differentiated
- D: Undifferentiated, anaplastic
- 9: Grade cannot be assessed (GX); Unknown**

The FNA of the pancreatic tail did not provide grade information. "well differentiated" is part of the histologic term and cannot be used to assign grade. We confirmed this with SEER.

2024 NAACCR Boot Camp Part 1 Quizzes

6. What is the correct Grade Pathological for the above tumor?
- 1: G1
 - 2: G2
 - 3: G3**
 - A: Well differentiated
 - B: Moderately differentiated
 - C: Poorly differentiated
 - D: Undifferentiated, anaplastic
 - 9: Grade cannot be assessed (GX); Unknown

The entire tumor was removed so the patient does not qualify for a path grade. The "G3" indicates grade. The Ki-67 is greater than 20 which also indicates this is a grade 3.

7. 5/6/2023 Endometrial curettage: Adenocarcinoma, conventional endometrial type, FIGO G2. 6/3/2023 TAH/BSO: Endometrioid adenocarcinoma, FIGO G1, 13 cm. 9% myometrial invasion. No LVI. 1/28 pelvic lymph nodes involved. What is the correct Grade Clinical for this tumor?
- 1: G1; FIGO Grade 1; Well differentiated
 - 2: G2; FIGO Grade 2; Moderately differentiated**
 - 3: G3; FIGO Grade 3; Poorly differentiated or undifferentiated
 - 9: GX; Grade cannot be assessed

The highest known grade from the primary site during the clinical time frame was FIGO G2.

8. What is the correct Grade Pathological for the above tumor?
- 1: G1; FIGO Grade 1; Well differentiated
 - 2: G2; FIGO Grade 2; Moderately differentiated**
 - 3: G3; FIGO Grade 3; Poorly differentiated or undifferentiated
 - 9: GX; Grade cannot be assessed

The highest known grade after definitive surgery of the primary site was from the biopsy (G2). Grade pathological is the highest known grade after resection of the primary tumor. It is not necessarily the grade from the resected primary tumor.