Q&A Session for Boot Camp: Part II

April 4, 2024

#	Question	Answer
1.	In regard to question 13; what about supraclavicular lns? Are they considered low cervical?	I think the question should have been...for which of these sites are cervical lymph nodes NOT distant.
2.	I don't know if you will have time to address this question during webinar but kind of relates to Q#3 Q6. We are seeing extrahepatic bile duct primaries with a diagnosis of "Adenocarcinoma, biliary type (extrahepatic cholangiocarcinoma)" When we look at the CAP protocol this is one of the listed histology types. What morphology should we be capturing? The STR has these listed on 2 different lines in Table 10. Adenocarcinoma 8140 with a synonym of biliary type adenoca; and Bile duct carcinoma 8160 with a synonym of cholangiocarcinoma.	I just got this from SEER: It comes down to terminology: 8140 for biliary-type adenocarcinoma/carcinoma only and 8160 for bile duct carcinoma. When the pathologist indicates a specific histology in parenthesis, code that. This means adenocarcinoma, biliary type (cholangiocarcinoma) is coded 8160/3. The pathologist is just indicating the cells are of the biliary ducts. Coding the histology in parenthesis has been a long time "rule" as it's more specific.
3.	When path says of mullerian origin and isn't more specific, what is the best site code to choose?	One of our participants submitted the statement below. *We use c57.9 Female genital tract, NOS when they don't know a primary site but they say it's a female genital primary.*
4.	When there is an unknown primary, wouldn't the Recurrence Type be 70 [Never Disease Free]?	That is correct!
5.	Quiz 1, Q3 - would a lesion in the brain not be considered mets? and rules cannot be used for mets?	We don't have enough information to determine if this a a recurrence. The point of the question was that when a melanoma is diagnosed via mets and not primary tumor is identified, the primary site is C44.9.
6.	Just thought I would share this SEER Inquiry question for unknown primary as this was something I ran across recently: (https://seer.cancer.gov/seer-inquiry/inquiry-detail/20210068/) "In a situation like this with one area of metastatic involvement and an unknown primary, if there is no further information, we advise that the metastasis are	I knew that was true for melanoma. I did not realize it applied to other sites.

	"regional" until/unless proven otherwise. With this in mind, code the Mets at Diagnosis fields as 0..."	
7.	If you are primarily using the Excel version of ICD-O-3.2 for 2024 will it identify the new terms that you showed in the pdf documents?	No. The ICD 3.2 is not updated with new terms. You can use either ICD O 3.2 Implementation Documents Nancy showed, or you can use the annotated histology. The annotated histology is updated each year.
8.	'Probable' malignant pleural effusion is not reportable?	In the scenario, the diagnosis is made from a cytology sample. Ambiguous terminology may not be used with cytology.
9.	Quiz 5, #9, STORE says Only tumors that would have been reportable at the time of diagnosis for CoC or by agreement with a central registry or the program's cancer committee are required to be counted when assigning sequence numbers.	You are correct! We are assuming the facility is collecting the CIS based on instructions from the program's cancer committee. So the CIS would be sequence 01 once the lung primary is diagnosed.
10.	Adenocarcinoma, biliary type (extrahepatic cholangiocarcinoma) is the option on the CAP protocol for extrahepatic bile ducts which the pathologist is using for their synoptic reporting for extrahepatic bile duct (c24.0). Does choleangiocarcinoma 8160 not refer an intrahepatic bile duct?	This refers back to Gail's question re. cholangiocarcinoma morphology for quiz 3, question 6. CAP protocol for extrahepatic bile duct, note C, says: "By WHO convention, the term cholangiocarcinoma is reserved for carcinomas arising in the intrahepatic bile ducts (see intrahepatic bile ducts protocol)."
11.	I have heard many times over the years the Text Diagnostic Procedure Operative field referred to as "aka the biopsy field". I know that this field is for recording intraoperative findings, but is this also where we record the diagnostic biopsies performed as well? If NOT, then where in your text fields do you record biopsies that are coded in the Surgical Diagnostic & Staging Procedure field?	As we mentioned, there is no national standard for documenting text. The key is consistency- provide specific instructions for what is to be included where.
12.	Are we to code shave BX for melanoma as a Surgical Diagnostic & Staging Procedure AND as treatment?	No. You would not code the procedure twice. For cases diagnosed 2023 and later, code a shave biopsy of a skin primary in surgery of primary site.
13.	I would also recommend that each text box starts with a date. It seems obvious, but it is often missed or dates don't match from procedures and the corresponding path report.	Great suggestion!
14.	For quiz 5, question 11, answer a is also incorrect. Juvenile astrocytoma should be reported with behavior /1 beginning in 2023.	You are correct!

15.	I'm new to this site, so I am confused with Question 10- If the primary site is Bone Marrow, why is it also a Distant Site?	Summary Stage evaluates how far the cancer has spread from the site of origin. Bone marrow cells travel system-wide, and so hematopoietic or lymphoid cancers that involve the bone marrow are spread all over the body. See p. 5 of the section of the Summary Stage manual that covers HP & Lymphoid neoplasms for the definition of code 7 we used for Question 10. The Summary Stage manual has different sections for different types of HP & Lymphoid cancers, so be sure you're using the correct section for the type of HP/Lymphoid cancer you're staging.
16.	I struggle with the concept of transformation. Are they 2nd primaries or not?	It's complicated, which is why so many of the Hematopoietic multiple primary rules (M8-M13) cover transformations. Whether or not the transformation is abstracted as a second primary depends on factors such as the time between diagnoses and the number and type of positive biopsies. Use the Hematopoietic multiple primary rules in order to determine whether you've got a single or multiple primaries and stop at the first rule that applies to your case.
17.	Could you recommend any websites to help us expand our understanding of heme/lymph neoplasms besides SEER heme/lymph manual & database?	I am not familiar with any websites that provide additional training for heme manual and database.
18.	With unk primary do you still fill out mets at DX fields if you know sites aren't primary, summary stage 7 (mets), EOD fields? Or are we supposed to fill in 9's or 999's?	Yes.
19.	Are we assuming we didn't get any more information from a path report? (Question 6 Q2) What if it turned out to be the liver was the primary site?	Then you would change the primary site to liver and code the abstract accordingly.
20.	Specifically, for the 'urine cytology' I'm missing that indicated on those pages. Would we then have to rely on that SEER post in the link Jim shared?	I would hold on to it for reference and always check back to see if it gets updated or if there is an update that comes up. I would even make a note in your Solid Tumor Manual.
21.	What would you code primary site to if on path from bx of pelvic mass reports primary favors bladder or breast. But when pt is admitted to ER, clin notes reports pt has metastatic lung ca primary. Is a non-treating physician statement enough to code	The question is how much weight do you give to the statement in the ER record. That's a tough one. I think you are going to have to make a judgement call. I'm not aware of any coding rules that are going to help with this one.

	to lung primary? Only info on treatment is chemo, nos & xrt to bone mentioned in clin notes.	
22.	Be sure to scour the records before coding to "unknown primary", I often find physicians notes that will use ambiguous terms like "probable" or "most likely" and say a primary site, I was trained to use a primary site if at all possible, versus coding to an unknown primary. For example, initial imaging positive for widespread mets and the record states unknown primary then the patient deceased, and the final discharge summary will say probable lung cancer.	That is an excellent point! Hopefully, we'll have additional information. However, if all you have is a cytology and they are using ambiguous terminology to describe the disease, it would not be reportable.
23.	Should operative text also include dates and location of procedure?	Yes! Including dates and location are definitely a best practices.
	Tips and Suggestions	
24.	I like to include PMH (not a full-blown list, but abbreviations) because I feel it's relevant to the patient's potential outcome.	
25.	Only use NAACCR approved abbreviations, remember the golden rule - you should be able to complete a full abstract only using text.	
26.	I like to occasionally print or print to screen my full abstract including text and see how it looks on the back-end - can often streamline your text - cut out the fat so to speak.	
27.	It is extremely important to text refused and/or contraindicated treatment decisions.	
28.	Text is the only way a central registry can make decisions about MP/H rules. I see it every day where a breast case laterality is coded wrong, and I had no text that stated right or left breast as the primary cancer site. I ended up having to pull the pathology report to find the laterality.	
29.	Some states require autopsy cases are reportable to the central registry.	
30.	Also, NCRA has Informational Abstracts on the web site that have examples of text.	https://www.cancerregistryeducation.org/rr
31.	For class of case 00 it is important to code facility referred to if known, hospital administration wants to know where patients	

	are going. Be sure to use the NPI Registry look-up to find the NPI institution's number.	
32.	I was always taught and always taught, that I should be able to fully abstract (with the exception of course of demographics) from the text I have entered. That is still the way I abstract.	
33.	Not all PV is reportable.	
34.	Only Primary PCV is reportable. If it is related to another disease related to cardiac issues, etc. then it is secondary PCV and is not reportable. There are cases being reported to the central registry that are not Primary PCV incorrectly. When making a decision, I try to look at the patient's other secondary disease codes in their H and P. If they have coronary artery disease or CHF, I will look in the record for a statement from the physician if the PCV is Primary or Secondary.	