Q&A Session for Coding Pitfalls 2024

September 4-5, 2024

#	Question	Answer
1.	Can Cancer Path Chart be used for any year of diagnosis?	No. Just for cases diagnosed 2024 and later.
2.	Clinical lung cases that have been deemed to be adenocarcinoma in situ by DI and managing physician and just followed with imaging. Three years later, as the tumor is growing a biopsy is performed and dx adenocarcinoma invasive. SEER tells us to go back and make the original morphology /3. Could you explain why that would be? Would this not be considered progression?	I'm assuming the rules are in place because SEER wants to make sure the incidence is counted as a single malignant tumor.
3.	What page is Table 36.12 on in the AJCC manual?	449
4.	For poll 3...you are saying that the scan is showing metastatic disease in the brain; but, concerning for is not on the list of ambiguous terms that constitute a diagnosis.	When it comes to AJCC words like "concerning" should not be interpreted as a term from the ambiguous terminology list, you must look at the whole picture. The Medical Oncologist also confirmed the patient had Stage 4 lung adenocarcinoma with brain mets. Be sure to review the webinar entitled *Do Not Use Registry Ambiguous Terminology for AJCC Staging* located on the AJCC Cancer Registrar Education Site for further clarification and explanation.
5.	I see this scenario a lot: MULT nodules throughout BIL lungs & 2.5 CM RUL mass & 9 MM RLL mass SUSP for MAL. What is the correct cT value? what about SSDI about tumor in same/different/both lobes?	That is a difficult situation. To assign a stage, you must determine if the patient has intrapulmonary mets or if the patient has synchronous tumors. You then must determine if the nodules are malignant. If you do not have enough information to make these determinations, I would leave the T, N, and M fields blank.
6.	I didn't think we could use the m suffix for Squamous cell carcinoma as per AJCC. I was under the impression that we	The (m) suffix is used for Multiple synchronous tumors. The (m) suffix can also be used for Multifocal Differentiated and

	could only use it for multifocal lung adenocarcinomas with gg lepidic features?	anaplastic thyroid cases. Refer to Chapter 1 AJCC Manual 8th edition instructions on pages 12,15,19, 27,28. Look on page 439 (c.) It tells us to use the m suffix for multifocal lung adenocarcinoma with gg lepidic features as well. Table 36.11 also stated to use (m) for multiple ground-glass or part-solid nodules.
7.	What confuses me is how to figure out if the scenario is Multifocal lung adenocarcinoma w/ ground-glass/lepidic features or Diffuse pneumonic-type adenocarcinoma. Any tips on how to identify those situations?	We would have to see exact scenarios, it's hard to make generalizations that apply across the board, each case is unique.
8.	Quiz 3 is the same situation, but physician refers to these as 2 synchronous primaries and stages accordingly. STR say these are 1 primary. Do we code 1 or 2 primaries?	It's my understanding (Jim) that as registrars, we go by the solid tumor rules.
9.	Since we code Regional LN BX/FNA as surgeries do we notepad regional LN BX/FNA in the surgery text field or just in the path text field?	If it were me, I would note the information in both places to substantiate coding of Scope of regional lymph node surgery and stage of disease.
10.	On Quiz 2 Scenario 2 - Can you re-explain the rationale for not coding procedure?	In this scenario, the right axillary lymph node is considered a distant site according to the current AJCC Staging Manual/EOD. The answer regarding how to code needle biopsy done to a distant site can be found in the STORE Manual under the instructions for Surgical Diagnostic and Staging Procedures, and for this field we are to Only record positive procedures, so since this was negative, it will not be coded, but I would record the procedure & results in your text to help substantiate stage of disease.
11.	Poll 3, what if the doctor hadn't said brain mets? Would we say, "no brain mets?"	You would have to look at the whole picture and try and determine if the patient was being treated as if they had brain mets and if possible, discuss it with your physician. If it is not possible, a BLANK is the option when the registrar is not certain.

12.	For Gail Gautreau's question on AIS then 3 years later invasive. Wouldn't you use rule M13 and be new primary?	M13 is for multiple tumors, you don't have multiple tumors, it's a single tumor, you would never get that far. You would stop at Rule M2 Abstract a single primary when there is a single tumor.
13.	Unfortunately, we often lack those statements by physicians; they don't say anything about synchronous or mets. We just have radiology with multiple tumors in the lung, or lungs.	It can make a huge difference in stage. If you don't have adequate information, you must leave the fields blank.
14.	Using table 36.11, would we not use (m) for ground-glass nodules?	Look on page 439 (c.) It tells us to use the m suffix for multifocal lung adenocarcinoma with gg lepidic features as well. Table 36.11 also stated to use (m) for multiple ground-glass or part-solid nodules
15.	What about single tumor is a single primary so you wouldn't get to M13?	Yes ☺
16.	Lung primary that is found after brain imaging that states susp for mets, or terms neoplasms/ tumors. Would that imaging be date of DX? Or is that only for reportability for brain primaries?	If they use reportable ambiguous terminology to dx the brain mets, that is the date of diagnosis. If the terminology is not reportable, then date of diagnosis would be the date the lung cancer is confirmed.
17.	Physician statement ovarian carcinoma (arising in fallopian tube). Would you code it as ovarian or fallopian tube?	I would code to fallopian tube.
18.	Regarding primary site for gyn sites, the physician will often refer to the primary site as being ovary but the synoptic report in the path report will state that it's fallopian tube. Do we designate fallopian tube as the primary site based on the synoptic report even though the physician keeps calling it "ovarian cancer" in all of their notes?	I would code to fallopian tube based on the synoptic report.
19.	The neurons do not regenerate so what is the function of the stem cells? Can they form a tumor?	I do not know! Great question.
20.	We code brain as a paired organ stating left and right but per the MP rules it's not treated as a paired organ. Why?	At one point laterality impacted the multiple primary rules for benign CNS tumors. That is no longer the case, but there is still interest in knowing which side of the brain the tumor arises.
21.	7 says not histologically confirmed.... does that mean the cirrhosis or just bx of the primary?	The statement is referring to the fibrosis/cirrhosis.
22.	Does it make a difference if the liver transplant was in the initial treatment plan or how long it takes for transplant?	It could. These cases can get complicated.

23.	The path report read: Papillary Thyroid Carcinoma, larger focus w/ follicular & solid growth patterns as well as oncolytic features. Minority is Classical papillary carcinoma. What is the histology?	I would submit the question to Ask A SEER Registrar
24.	Does perineural inv + go in codes 3-7?	No. Just lymphatic and angio invasion.
25.	Are all surgery codes cumulative or it is just thyroid?	All surgery codes are cumulative.
26.	Encapsulated variant of PTC is 8343/3 if it has invasion	Good point!
27.	Does that using Astrocytoma start in 2025 or now?	Registrars should do a thorough review for a more specific histology before assigning glioma, NOS. However, if one cannot be found, glioma can be used. This rule will not change. However, an edit will be triggered if glioma, NOS is used starting with cases diagnosed in 2025. The edit can be overridden, and the histology used, but the registrar will be asked to confirm a more specific code is not available.
28.	If the chart says glioma, we wouldn't code to astrocytoma nos starting 2025, right? We just need to actively look in the chart to see if it is referred to by something other than glioma.	Correct.
29.	SEER Date therapy Initiated is only left blank when pt opts for hospice?	Be careful with this, per SEER manual *Hospice care may include treatment that destroys or modifies cancer tissue. If performed as part of the first course, treatment that destroys or modifies cancer tissue is collected when given in a hospice setting. "Hospice, NOS" is not specific enough to be included as first course treatment.* Always refer to the appropriate SEER Program Coding & Staging Manual for guidance when coding this field because there was a slight change in 2024 regarding instructions when the patient has active surveillance. SEER Program Coding and Staging Manual: *Leave blank* *a. When no treatment is given during the first course* *Note: This includes when a patient dies before treatment is recommended or given*

30.	Isn't there a rule in SEER that if the patient changes their mind within 1 year to have treatment (initially active surveillance) then we code the tx as first course instead of active surveillance? Or is that just if the patient initially refused all treatment?	That is correct. SEER Program Coding & Staging Manual **Code the treatment as first course of therapy if the patient refuses treatment but changes his/her mind and the prescribed treatment is implemented less than one year from the date of diagnosis, AND there is no evidence of disease progression.* **The first course of therapy is no treatment when the patient refuses all treatment. Code all treatment data items to Refused.* *a. Keep the refused codes even if the patient later changes his/her mind and decides to have the prescribed treatment* *i. more than one year after diagnosis, or* *ii. when there is evidence of disease progression before treatment is implemented*
31.	Can you use GR from LN when no primary BX done?	In general, the grade value must be based on tissue from the primary tumor. There are always exceptions, one I can think of, is for Breast Cancer-Note 7: Grade from nodal tissue may be used ONLY when there was never any evidence of primary tumor (T0). To be safe, please refer to Grade Coding Instructions & Tables for specific scenarios.
32.	When your facility DX's CA & no TX given & PT dies at your facility what is COC? 14; when PT is transferred from another facility where CA is DX'ed & no treatment given, PT dies at your facility is COC 22 or 30?	I need more information. Was the decision not to treat made at your facility? Did they die at your facility prior to treatment given? I would need more specifics.
33.	Can you override Impossible? I diagnosis is consistently repeated by a physician?	No. An Impossible site/histology combination cannot be over-ridden.
34.	Why can we not just assign cT2 as the clinical T stage in the absence of tumor size? *Also, I am not able to leave them blank.	You do need to know that it is not a size that would qualify for T3 or T4. That note is just allowing for a small tumor where it cannot be clearly measured. It does not give an option to not have any information on the size. *AJCC has a webinar on Blank vs X Definition & Date Interpretation for AJCC Staging, please review.

		A blank is used by registrar when no info avail in chart, registrar has no access to physician info, patient not eligible, registrar just doesn't know. And an X is only assigned under very certain conditions, they don't like that X now… so be sure to watch that webinar as Donna Gress tries to explain those subtle differences between an X and a BLANK. Your software will absolutely let you leave the TNM fields blank if it's appropriate, contact your vendor and they will tell you how to do it. You will not get any NAACCR/STATE/ or NCDB edits if you leave a TNM category BLANK if it's an appropriate choice. If your facility has instructed you not to leave any of the TNM fields BLANK, they want an X in there or even worse, an invalid value, instead of a BLANK, shame on them. When you are intentionally NOT following the coding rules then you are personally contributing to compromising the data within the NCDB. Donna Gress webinar has laid out the rationale and difference between what a BLANK implicates and what an X implicates, please do not ignore the instructions from the Standard Setter. Review the AJCC Curriculum Lessons 9,10,18,23,24,24,25 for Correct T/N category for uncertain information for Registrars, review the Blank vs X Definition & Date Interpretation for AJCC Staging webinar.
35.	I think colonoscopies are a good example of using TX most of the time.	Yes, that is one of the rare times an X would be appropriate. The colonoscopy does not provide enough information to access how far the tumor extended, please refer to the resources below. AJCC Curriculum for Registrars • Refer to Lesson 23

36.	Why is it not pM1a when it was the only histologically proven metastasis?	We have microscopic proof of the pleural effusion being positive, and Chapter 1 of the AJCC manual states you only need to have microscopic mets of one of the distant sites to assign the higher subcategory, you don't have to biopsy all of them.
37.	I mean the METRIQ system we use won't enable us to leave blank.	That is not true, you absolutely can leave TNM categories BLANK, there is a way. Your software must allow you to code how the Standard Setter requires, and a BLANK is a valid option. Call your vendor, they will tell you how. :)
38.	The software wouldn't allow.	Talk to your vendor, they all allow blanks in the TNM categories, they will tell you how. :)
39.	I would like to know where in the AJCC Book does it stage that cT blank is acceptable?	The AJCC manual is written for physicians, guidelines that apply specifically to the registrar for abstracting purposes are gleaned from other resources. Refer to the Cancer Registrar Education provided by the AJCC. AJCC Curriculum for Registrars lesson 9,10,18, 23, 24,25 Correct T/N category for uncertain information for Registrars Blank Vs X Definitions and Data Interpretation for AJCC Staging webinar Listen to any presentation provided by the AJCC, Donna Gress & Aleisha Williams, they go over the Blank vs X in almost every webinar. Refer to the CAnswer Forum for instruction.
40.	For the TACE poll: Would we still code the chemo tx given at the time of TACE?	Yes.
41.	I don't quite understand why TACE wouldn't affect the pathological stage.	It is a unique situation.
42.	What resource references that TACE is not neoadjuvant?	There is a CAnswer forum post documenting this situation.

43.	Why not code the stage based on Clinical size based on prior to surgery and then the pathological stage based on the final path???	The pathologic stage should reflect all known information after the patient qualifies for pathologic stage.
44.	What if they treat the tumor multiple times (with the intent to treat with ablation) and then finally get to the transplant? Still pathological staging?	These cases get complicated. We would need to see an example from a real case to answer the question.
45.	I've got it stuck in my mind that pathological stage gives a more accurate description of the tumor vs the clinical stage which typically relies on imaging, and therefore less accurate.	Often time that is the case. In this situation, the clinical size better reflects the patient's disease.
46.	SSDI fibrosis score. Can we use physician statement of cirrhosis and code 7?	Yes.
47.	But a physician state no adenopathy - does this not count?	If you are referring to Poll #13, the physician's statement of no adenopathy would count when assigning clinical stage cN category, we could assign cN0, however it has no bearing on assignment of pathologic pN Category in this scenario. There are only certain situations where you can use cN0 in pN Category-refer to the AJCC 8th Edition Node Status Not Required in Rare Circumstances document. Thyroid is not on this list, so if the patient is eligible for pathologic stage and no nodes are removed as in this scenario, the pathologic pN category would be assigned pNX
48.	Not sure if this is something you could address with regard to the "RAD" scores with these sites and when we can use them for a diagnosis date with histologic confirmation. For example, in poll 10, what if the 3/18/2024 thyroid US was noted to be Tirads 4.	As far as I know, no one considers TI-RADS (for thyroid) when coding a date of diagnosis, please refer to your State to confirm. **STORE-** They do not consider PI Rads, BI Rads, LI Rads alone as reportable to CoC. Those cases would have to be confirmed with biopsy or have a physician statement of malignancy to be reportable to CoC. The positive biopsy would be the date of diagnosis. **SEER Appendix E** **Reportable Examples**

		•Liver cases with an LI-RADS category LR-4 or LR-5 {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.} •Prostate cancer cases with an PI-RADS category 4 or 5- unless there is other information to the contrary… this would be the date of dx **Not Reportable** – since these are not reportable alone, the date of diagnosis would be the date they become reportable, i.e., not the date of these scans •Breast cases designated BIRADS 4, 4A, 4B, 4C or BIRADS 5 without any additional information • Lung cases designated "Lung-RADS 4A," 4B, or 4X • Liver cases based only on an LI-RADS category of LR-3 As always, also refer to your State for guidance in these scenarios as well.
49.	Re: hormone tx: Can we assume that pt started it the day after the total thyroidectomy? (but we couldn't find any reference of hrt tx in medical record?)	You would have to ask a standard setter that question.
50.	For how long do we consider levothyroxine as first course treatment? For instance, patient gets treatment elsewhere and then comes to our facility on levothyroxine, do we still abstract the case as patient is still on levothyroxine years later?	I'm not aware of an "end date". The patient will be on the treatment their entire life and the drug will be working a hormone regulator and to prevent further disease.
51.	If levothyroxine is used to compensate for thyroid malfunction, wouldn't this be ancillary, not curative Tx for thyroid after thyroidectomy?	It is also used to prevent thyroid cancer from growing. Refer to SEER*Rx for instructions on how to code. SEER*RX Remarks *Synthroid should be coded as hormonal treatment for thyroid cancer. After thyroid surgery, the thyroid hormone medication levothyroxine (Levothroid, Synthroid, etc) is prescribed often for life. This drug has two benefits: it supplies the missing hormone*

		the thyroid would normally produce, and it suppresses the production of thyroid-simulating hormone (TSH) from the pituitary gland. High TSH levels could conceivably stimulate any remaining cancer cells to grow. *This drug is more commonly used in patients with papillary, follicular carcinomas or one of their variants.*
52.	Text tip for RAI, our software has a text box for Beam Rad Text & a different text box for Other Rad Text - RAI treatment would be texted under the Other Rad Text box because it is not External Beam RT.	Yes, always refer to your state for instructions on how they want text recorded. Some other resources regarding text are below as well. •NACCR Date Standards and Data Dictionary also has instructions, suggestions for text, and general notes that state which Data Item(s) to be verified/validated using the text entered in this field. •NCRA Informational Abstracts (These site-specific abstracts provide an outline to follow when determining what text to include.)
53.	For the infantile glioma...where the heck did you find that code? I looked in the STM and ICD-3	It's included in the Solid Tumor Manual histology table for malignant CNS tumors. Try using the Ctrl+ F function to find it.
54.	When active surveillance is chosen and patient changes their mind to proceed with surgery, systemic or XRT even within a few months, does that become subsequent tx?	It depends on if there is disease progression or not.