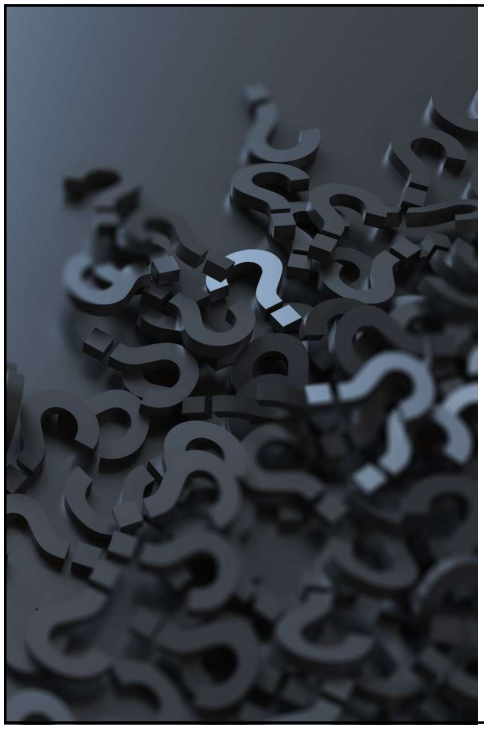
1



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Q&A

Please submit all questions concerning the webinar content through the Q&A panel.

If you have participants watching this webinar at your site, please collect their names and emails.

We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.

2

2

Fabulous Prizes

3

3

Guest Presenters

- Janet Vogel, ODS

4

4

Agenda

- Identify the Most Common Pitfalls by Site
  - Lung
  - Liver & Bile
  - Thyroid
  - CNS

5

Minimum Resources Required to Abstract

- 2024,2023 or previous NAACCR Implementation Guidelines
- Solid Tumor Rules
- Hematopoietic and Lymphoid Neoplasm Database
- Hematopoietic and Lymphoid Neoplasm Coding Manual
- NAACCR Site Specific Data Items and Grade
- SEER*RSA
- EOD 2018
- Summary Stage 2018
- American Joint Committee on Cancer/AJCC
- ICD 0 3.2 Histology Revisions & Annotate Histology List
- NAACCR
- SEER*Rx Interactive Antineoplastic Drugs Database
- STORE Manual
  - Appendix M: Case Studies for Coding Melanoma in STORE
  - Appendix R CTR Guide to Coding Radiation Therapy Treatment in the STORE
- SEER Program Coding and Staging Manual
- Cancer Program News
- Appropriate State Manual
- Cancer PathCHART Search Tool

6

Manuals

- 1/22/22 Patient is found to have a squamous cell carcinoma of the anus that is p16 positive.
- You are abstracting the case in 2024

What version of the following manuals would be used?

V9 for 2023+

Solid Tumor Rules
- 2007 MP/H
- 2022 update
- 2024 update

AJCC Manual
- 8th edition
- V9 Anus protocol

SSDI/Grade Manual
- 2.1 (released 2022)
- 3.0 (released 2023)
- 3.1 (released 2024)

STORE/SEER Manual
- 2021
- 2022
- 2023
- 2024

Summary Stage 2018
- 2.1 (released 2022)
- 3.0 (released 2023)
- 3.1 (released 2024)

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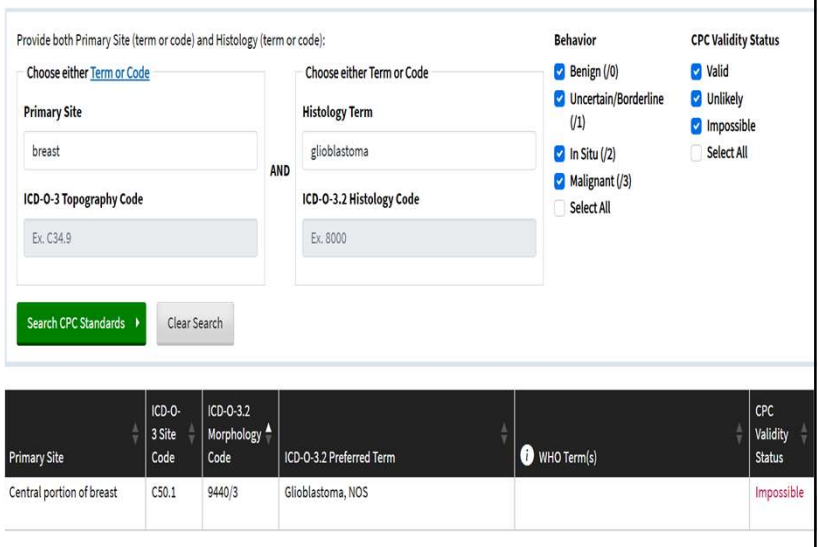
Cancer PathCHART Search Tool



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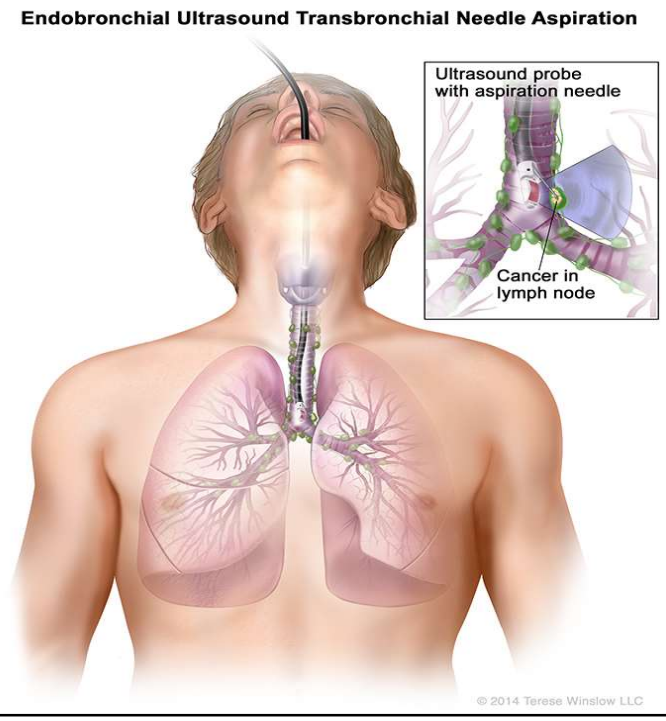
Lung Abstracting Tips



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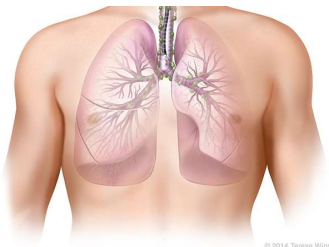
Quiz 1 Match the Scenario to the Primary Site

Scenario

1. 1.6cm mass Right Upper Lobe Bronchus
2. 3cm hilar mass, no mention of lymph node involvement
3. Multiple masses throughout right lung felt to represent intrapulmonary mets. RUL (2.5cm), (2.1cm); RLL (1.5cm) Bx RLL+SCC
4. Patient admitted for right shoulder pain, suspicious for Pancoast tumor

Primary Site

A. C340 Main Bronchus
B. C341 Upper Lobe Lung
C. C349 Lung Nos



10

Resources for Coding Primary Site

- Solid Tumor Rules Lung
  - Terms that are NOT Equivalent or Equal
  - Table 1 Coding Primary Site
- SEER Appendix C: Site Specific Coding Modules
  - Coding Guidelines: Lung
- AJCC 8th Edition Webinars
  - Lung AJCC 8th Edition Staging

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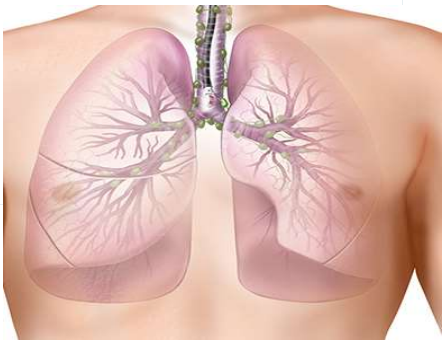
Quiz 1Answer & Rationale



Scenario

B	1. 1.6cm mass Right Upper Lobe Bronchus
A	2. 3cm hilar mass, no mention of lymph node involvement
C	3. Multiple masses throughout right lung felt to represent intrapulmonary mets. RUL (2.5cm), (2.1cm); RLL (1.5cm) Bx RLL+SCC
B	4. Patient admitted for right shoulder pain, suspicious for Pancoast tumor (B)

Primary Site

A. C340 Main Bronchus
B. C341 Upper Lobe Lung
C. C349 Lung Nos

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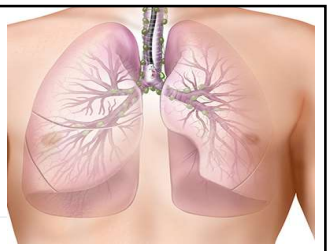
Quiz 2 Coding Negative Results



Scenario- Code Procedure in Red

1. Bx proven RUL adenocarcinoma.
   - FNA Right Hilar Node: Negative
2. Bx proven RUL adenocarcinoma, Scans show enlarged Right axillary lymph nodes.
   - Core Needle Biopsy Right Axillary Lymph Node: Negative
3. Bx proven RUL adenocarcinoma,
   - FNA Supraclavicular Lymph Node: Negative

Procedure

A. Diagnostic & Staging Procedure Code 01 A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site

B. Scope of Regional Lymph Node Surgery Code 1 (Bx or Aspiration of Regional LN)

C. Surgical Procedure/Other Site 3 Non-primary surgical procedure to distant lymph node(s)

D. Do not code the procedure but list it in the text

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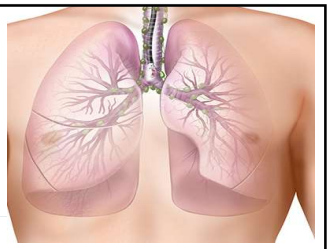
Quiz 2 Answer & Rationale



Scenario- Code Procedure in Red

B 1. Bx proven RUL adenocarcinoma.
   - FNA Right Hilar Node: Negative

D 2. Bx proven RUL adenocarcinoma, Scans show enlarged Right axillary lymph nodes.
   - Core Needle Biopsy Right Axillary Lymph Node: Negative

B 3. Bx proven RUL adenocarcinoma,
   - FNA Supraclavicular Lymph Node: Negative

Procedure

A. Diagnostic & Staging Procedure Code 01 A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site

B. Scope of Regional Lymph Node Surgery Code 1 (Bx or Aspiration of Regional LN)

C. Surgical Procedure/Other Site 3 Non-primary surgical procedure to distant lymph node(s)

D. Do not code the procedure but list it in the text

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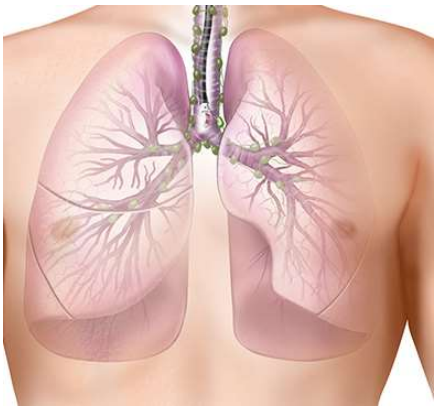
Poll 1
Situations Beyond Standard Descriptors

- **Scenario:**
  - Chest CT & PET Scan states, 3cm RUL Lung mass w/ invasion of the mediastinal fat. Biopsy RUL positive for Adenocarcinoma.

- **Question:** How would you assign the clinical T category?
  - cT1
  - cT4



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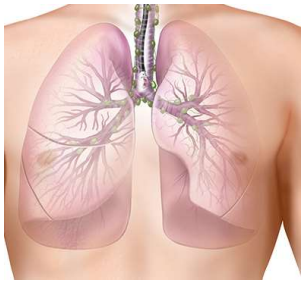
Poll1
Answer & Rationale



- cT4
- Refer to AJCC 8th Edition Chapter 36 Lung
  - **Table 36.12 Guide to uniform classification of situations beyond the standard descriptors.**

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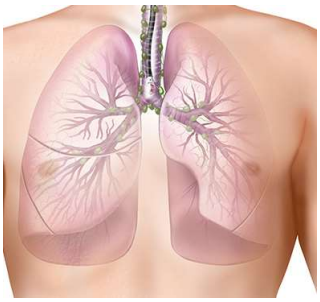
Poll 2
Atelectasis/but No Size



- **Scenario**:
  - CT Brain: right frontal lobe 2.8cm lesion concerning for metastatic disease
  - CT chest: RUL mass highly suspicious for malignancy, compressive atelectasis RLL secondary to pleural effusion, no lymphadenopathy
  - Pleural Effusion-positive for malignancy. Comment: stains favor Lung Primary Adenocarcinoma
  - Medical Oncologist: patient has Stage 4 lung adenocarcinoma
  - Patient decided on hospice care, expired
- **Question**: How would you assign cT category?
  - cTX
  - cT BLANK
  - cT2a

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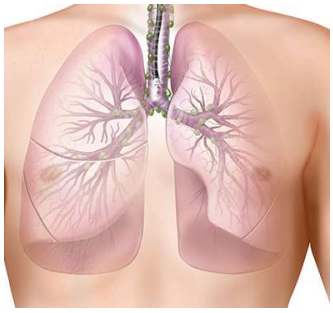
Poll 2
Answer & Rationale



- cT BLANK
  - Our example, there was atelectasis, but it did not state whether it extended to hilar region
  - Registrar does not know the size
    - Can't assign a cT2a without knowing that the size can't be a T3 or T4

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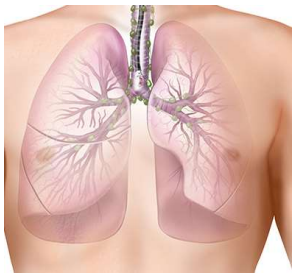
Poll 3
Intrapulmonary/Extrathoracic Mets



- **Scenario:**
  - CT Brain: right frontal lobe 2.8cm lesion concerning for metastatic disease
  - CT chest: RUL mass highly suspicious for malignancy, compressive atelectasis RLL secondary to pleural effusion, no lymphadenopathy
  - Pleural Effusion-positive for malignancy. Comment: stains favor Lung Primary Adenocarcinoma
  - Medical Oncologist: patient has Stage 4 lung adenocarcinoma with brain mets
- **Question:** How would you assign clinical M category?
  - pM1a
  - pM1b
  - pM1c

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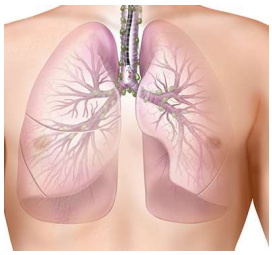
Poll 3
Answer & Rationale



- pM1b
  - Pleural effusion is intrathoracic spread which would fall into M1a category.
  - However , the patient also had a single Brain met which falls into category M1b.
  - That is where we stop, we code the most extensive category.
    - We do not add the categories M1a + M1b and get a M1c… we just stop at the M1b.

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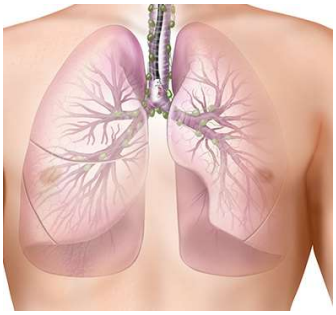
Poll 4
Multiple mets in single organ



- **Scenario:**
  - CT Brain: right frontal lobe 2.8cm lesion, 1cm lesion parietal lobe concerning for metastatic disease
  - CT chest: RUL mass highly suspicious for malignancy, compressive atelectasis RLL secondary to pleural effusion, no lymphadenopathy
  - Pleural Effusion-positive for malignancy. Comment: stains favor Lung Primary Adenocarcinoma
  - Medical Oncologist: patient has Stage 4 lung adenocarcinoma with brain mets
- **Question:** How would you assign clinical M category?
  - pM1a
  - pM1b
  - pM1c

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Poll 4
Answer & Rationale

- pM1c
  - The patient has multiple metastatic lesions in a single organ

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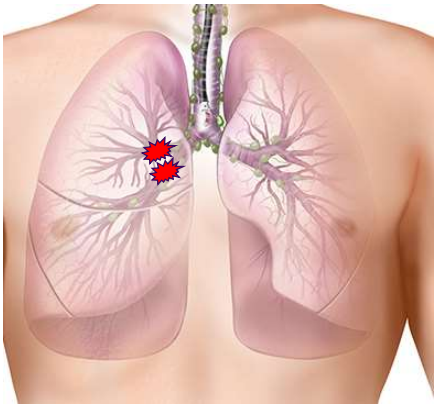
Intrapulmonary vs Synchronous Lung Tumors

- Synchronous tumors
  - Multiple tumors of the same histology occurring in the lung
  - If a single primary, assign the T value based on the tumor that would receive the highest T category.
    - Use the (m) suffix
  - If multiple primaries, stage each primary separately.
    - Do not use the (m) suffix
  - Do not code as multiple synchronous tumors in the SSDI "Separate Tumor Nodules"



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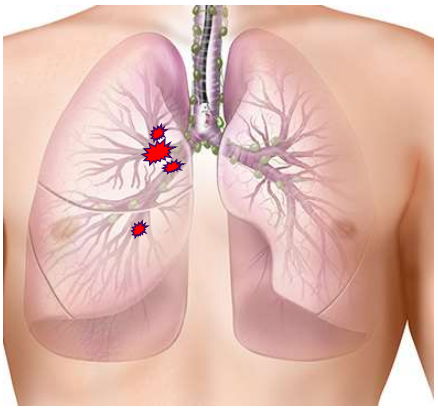
Intrapulmonary vs Synchronous Lung Tumors

- Intrapulmonary metastasis (separate tumor nodules)
  - May present as single tumor with separate lung nodule (s)
  - Assign the T category based on where the tumors are located (same lobe, different lobes, opposite lung).
  - Do not assign the (m) suffix
  - Code intrapulmonary metastasis in the SSDI "Separate Tumor Nodules"



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Pop Quiz

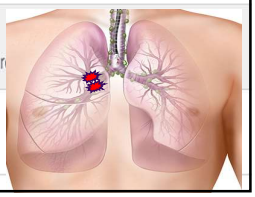
- Patient presents with two lung nodules in the upper lobe of the left lung.
- A biopsy of the larger tumor confirms squamous cell carcinoma.
- The physician refers to these as "synchronous lung tumors" and stag them accordingly.

How would you code SSDI "Separate Tumor Nodules"?

Code	Description
0	No separate tumor nodules; single tumor only Separate tumor nodules of same histologic type not identified/not present Intrapulmonary metastasis not identified/not present Multiple nodules described as multiple foci of adenocarcinoma in situ or minimally invasive adenocarcinoma Non-invasive neoplasm (behavior /2)
1	Separate tumor nodules of same histologic type in ipsilateral lung, same lobe
2	Separate tumor nodules of same histologic type in ipsilateral lung, different lobe
3	Separate tumor nodules of same histologic type in ipsilateral lung, same AND different lobes
4	Separate tumor nodules of same histologic type in ipsilateral lung, unknown if same or different lobe(s)
7	Multiple nodules or foci of tumor present, not classifiable based on Notes 3 and 4
	t applicable: Information not collected for this case s item is required by your standard setter, use of code 8 will r
	nted in medical record Tumor Nodules not assessed or unknown if assessed

Would the (m) suffix be assigned to the AJCC Stage?

Yes!



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AJCC Cancer Registrar Education

AJCC Cancer Registrar Education

Critical Clarifications

- Quick 1 page resource
- In situ neoplasia
- Node Status
- AJCC 8th Edition Melanoma Staging

AJCC Curriculum for Registrars

- Module I Introduction Lesson 1-7
- Module II: Beginning Lesson 8-14
- Module III: Intermediate Lesson 15-21
- Module IV Advanced Lesson 22-28
- Debunking Urban Legends

AJCC 8th Edition Webinars

- Eighth Edition Overview
- Introduction and Descriptors
- Minor Rule Changes
- Major Rule Changes
- CAnswer Forum and Staging Questions
- Head and Neck Staging
- Breast Staging
- Breast AJCC 8th Edition Staging
- Colon and Rectum AJCC 8th Edition Staging
- Lung AJCC 8th Edition Staging
- Melanoma AJCC 8th Edition Staging
- Prostate AJCC 8th Edition Staging

AJCC Version 9 Webinars

- AJCC Cervix Uteri-Version 9 Cancer Staging System

Principles of Cancer Staging

- Blank vs X Definitions and Data Interpretation for AJCC Staging
- Do Not Use Registry Ambiguous Terminology for AJCC Staging
- AJCC yc Stage Classification and How to Use it

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NAACCR Education

- 2023-2024 Webinar Series
  - Lung 2023 Part 1
  - Lung 2023 Part 2
  - Radiation and Radiology

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Questions?

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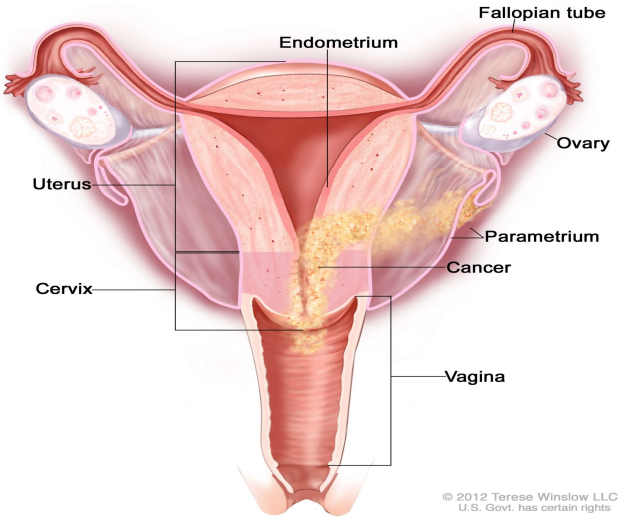
Ovary Abstracting Tips



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Assigning Primary Site

1. Go with physician/surgeon/pathologist statement of primary site
2. Go with SEER rule for assigning primary site
   - See page 105 of the SEER Program and Staging Manual (Note 15) for additional instructions

- Involvement of peritoneal mets (i.e. peritoneal surface of fallopian tubes) is not a factor when assigning primary sites.

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SEER Coding Instruction (pg 105)

- When the choice is between ovary, fallopian tube, or primary peritoneal ***without designation of the site of origin***, any indication of fallopian tube involvement indicates the primary tumor is a tubal primary.
- Fallopian tube primary carcinomas can be confirmed by reviewing the fallopian tube sections as described on the pathology report to document the presence of either serous tubal intraepithelial carcinoma (STIC) and/or tubal mucosal invasive serous carcinoma.
- In the absence of fallopian tube involvement, refer to the histology and look at the treatment plans for the patient.
- If all else fails, assign C579 as a last resort. For additional information, see the CAP GYN protocol, Table 1: Criteria for assignment of primary site in tubo-ovarian serous carcinomas.

Remember…we are looking for a primary tumor, not for mets!

C57.9 will put us in a different Schema. Avoid using if possible!

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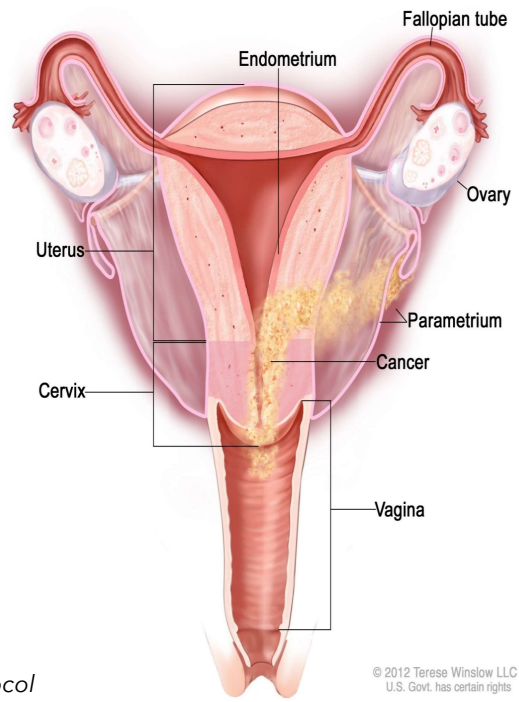
Remember…we are looking for a primary tumor, not for mets!

Fallopian tube primary carcinomas can be confirmed by reviewing the fallopian tube sections as described on the pathology report to document the presence of either serous tubal intraepithelial carcinoma (STIC) and/or tubal mucosal invasive serous carcinoma.



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Review of CAP Protocol

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Primary Site Codes

- Ovary Schema
  - C56.9
- Fallopian Tube
  - C57.0
- Primary Peritoneal Carcinoma
  - C481, C482, C488
- Adnexa Uterine Other
  - C571-C574
- Genital Female Other
  - C55.7 Other specified parts of female genital organs
  - C57.8 Overlapping lesion of genital organs
    - **Tubo-Ovarian**
    - **Utero-Ovarian**
  - C57.9
    - Female genital tract NOS

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Poll 5

Two primaries per rule M10: 9064/3 and 9070/3 are not epithelial histologies so rule M9 does not apply!

- A patient has synchronous ovarian tumors
  - Right ovary has a histology of Germ Cell Tumor (9064)
  - Left ovary has a histology of Embryonal Carcinoma (9070)
- Is this a single primary or multiple primaries?
  - A. Single
  - B. Multiple

What if:
- Right ovary was high grade serous carcinoma (8461)
- Left Ovary was endometrioid carcinoma (8380)

Two primaries…must be same histology or NOS and subtype

What if:
- Right ovary was high grade serous carcinoma (8461)
- Left Ovary was serous carcinoma (8441)

Single primary per rule M9
NOS and subtype

Rule M9 Bilateral epit…
Note 1: Tumors …
Note 2: Same row …
- The s…

Rule M10 Tumors on both si…

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Questions?

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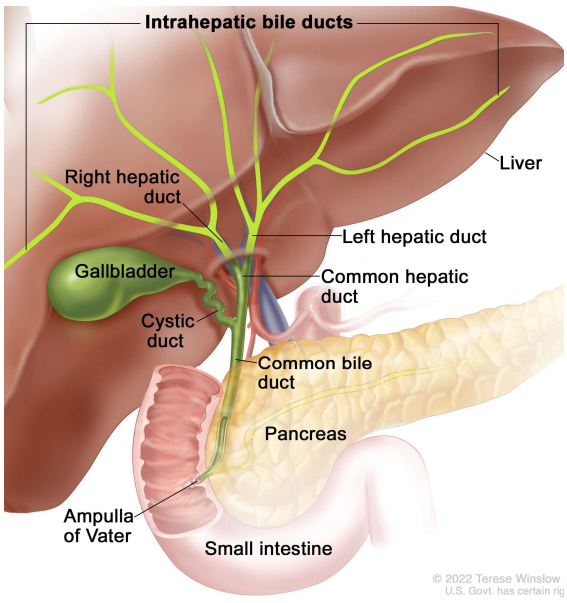
Liver/Bile Duct Abstracting Tips



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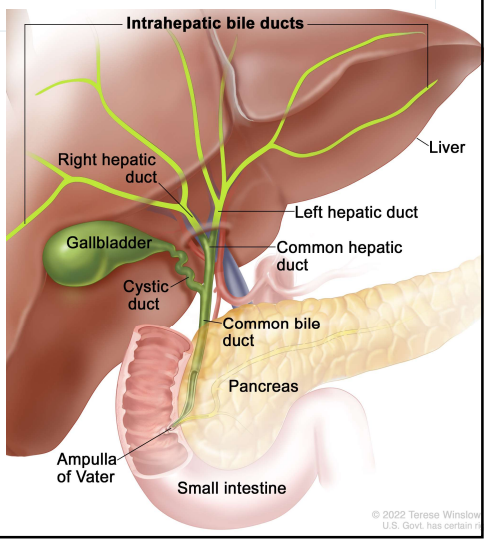
Poll 6 Cholangiocarcinoma

- **Scenario**:
  - 2023 Liver biopsy: Adenocarcinoma
  - Oncologist/GI Multidisciplinary Conference Stage IV (cT2N1M1) intrahepatic cholangiocarcinoma with pulmonary metastases, regional lymphadenopathy, and multifocal hepatic involvement
- **Question**: How should the site/histology be assigned?
  - C220 Liver 8140 Adenocarcinoma
  - C221 Intrahepatic Bile Duct 8160 Cholangiocarcinoma



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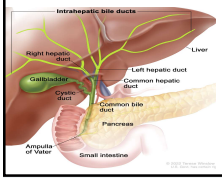
Poll 6 Answer & Rationale

- C221 Intrahepatic Bile Duct 8160 Cholangiocarcinoma
- Solid Tumor Rules Other Sites 2024 Update Table 9a



Site of biopsy or cytology	Pathology or cytology diagnosis	Criteria	Primary Site/ Histology
Liver C220	Adenocarcinoma Adenocarcinoma subtypes/variants	Supporting documentation such as scans, lab tests, or definitive clinical diagnosis of intrahepatic bile duct primary and/or definitive diagnosis of cholangiocarcinoma	**C221** **8160/3**
Liver C220	Adenocarcinoma Adenocarcinoma, subtypes/variants	No documentation supporting the primary site of intrahepatic bile duct is available in the medical record. This includes scans, lab tests or definitive clinical diagnosis. Liver is a common metastatic site for other neoplasms such as breast, lung, and colon. Code unknown primary site C809 when a primary site is not indicated in the pathology report or medical record.	**C809** **8140/3**
Liver C220 or Intrahepatic bile ducts C221	Hepatocellular carcinoma	Cancer PathCHART review has determined hepatocellular carcinoma is valid for liver C220 only. Code C220 regardless of biopsy/cytology site.	**C220** **8170/3**
Liver C220	Combined hepatocellular carcinoma and cholangiocarcinoma	Cancer PathCHART review has determined combined hepatocellular carcinoma and cholangiocarcinoma is valid for intrahepatic bile ducts C221 only. Code C221 regardless of biopsy/cytology site	**C221** **8180/3**

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Poll 7 Liver SSDI-use the highest prior to RX

Scenario:

- 07-13-2024 Liver, core biopsy: Hepatocellular carcinoma, grade 3. Prominent cirrhosis noted
- 08-16-2024 Seen by oncology & palliative care. Family decided for home hospice
- Labs Below

TEST	06-09-2024	07-02-2024	07-13-2024	08-14-2024	08-18-2024
AFP		^214.1 ng/mL		^277.4 ng/mL	^301.4 ng/mL
Bilirubin	1.8 mg/dL	^1.3 mg/dL	^2.2 mg/dL	^2.5 mg/dL	^2.8 mg/dL
Creatinine	1.0 mg/dL	^1.4 mg/dL	0.90 mg/dL	0.70 mg/dL	^1.5 mg/dL
INR	1.1		1.0		1.1

Question: How would you code the SSDI AFP?

- 214.1
- 277.4
- 301.4

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Poll 7 Answer & Rationale

TEST	06-09-2024	07-02-2024	07-13-2024	08-14-2024	08-18-2024
AFP		^214.1 ng/mL		^277.4 ng/mL	^301.4 ng/mL

- 277.4
- SSDI Manual
  - General Instructions Rules for Recording Laboratory Values
    - All laboratory values must be done no earlier than approximately three months before diagnosis
    - Only record test results obtained before any cancer-directed treatment is given (neoadjuvant therapy or surgical), unless instructions for a specific laboratory test state otherwise
    - Record the highest laboratory value if multiple laboratory tests results are available, unless instructions for a specific laboratory test state otherwise
  - Individual Instructions for AFP, Bilirubin, Creatinine, INR also reiterate:
    - Record the highest lab value of the highest test result documented in the medical record prior to treatment.

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Other Fields to Consider

Field	Answer	Document in Text to Substantiate
Date of Diagnosis	07/13/2024	07-13-2024 (XYX Facility) Liver, core biopsy: Hepatocellular carcinoma, grade 3. Prominent cirrhosis noted
Date of First Course Treatment-CoC	08/16/2024	08-16-2024 Seen by oncology & palliative care. Family decided for home hospice
Date Therapy Initiated-SEER	BLANK	SEER Program Coding & Staging Manual- Leave blank a. When no treatment is given during the first course
AFP PreTX Lab Value	277.4	08-14-2023 AFP ^277.4 ng/mL
AFP PreTX Interpretation	1	
Bilirubin PreTX Lab Value	2.5	08-14-2023 Total Bilirubin ^2.5 mg/dL
Bilirubin PreTX Unit	1	
Creatinine PreTX Lab Value	1.4	07-02-2023 Creatinine ^1.4 mg/dL
Creatinine PreTX Unit	1	
INR Prothrombin Time	1.1	06-09-2023 INR 1.1
Fibrosis Score	1	07-13-2023(XYZ Facility) Liver core biopsy: Hepatocellular carcinoma, grade 3. Prominent cirrhosis noted

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Poll 8 Cirrhosis-Fibrosis Score

Scenario:

- Patient presents to facility for biopsy of liver.
- Path shows hepatocellular carcinoma
- Scans reveal changes of hepatic cirrhosis, no further workup done, patient expires.

Question:

How would you code the SSDI Fibrosis Score?

- 0
- 1
- 7
- 8
- 9

Code	Description
0	Any of the following histologically confirmed › No to moderate fibrosis › Ishak fibrosis score 0-4 › METAVIR score F0-F3 › Batt-Ludwig score 0-3
1	Any of the following histologically confirmed › Advanced/severe fibrosis › Developing cirrhosis › Incomplete cirrhosis › Transition to cirrhosis › Cirrhosis, probable or definite › Cirrhosis, NOS › Ishak fibrosis score 5-6 › METAVIR score F4 › Batt-Ludwig score 4
7	Clinical statement of advanced/severe fibrosis or cirrhosis, AND Not histologically confirmed or unknown if histologically confirmed
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.
9	Not documented in medical record Stated in medical record that patient does not have advanced cirrhosis/advanced fibrosi Fibrosis score stated but cannot be assigned to codes 0 or 1 Fibrosis score stated but scoring system not recorded Fibrosis Score not assessed or unknown if assessed

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Poll 8 Answer & Rationale

- 7 Clinical statement of advanced/severe fibrosis or cirrhosis, AND Not histologically confirmed or unknown if histologically confirmed
  - SSDI Fibrosis Score
    - Note 6: Use code 7 if there is a clinical diagnosis (no microscopic confirmation) of severe fibrosis or cirrhosis.

Code	Description
0	Any of the following histologically confirmed › No to moderate fibrosis › Ishak fibrosis score 0-4 › METAVIR score F0-F3 › Batt-Ludwig score 0-3
1	Any of the following histologically confirmed › Advanced/severe fibrosis › Developing cirrhosis › Incomplete cirrhosis › Transition to cirrhosis › Cirrhosis, probable or definite › Cirrhosis, NOS › Ishak fibrosis score 5-6 › METAVIR score F4 › Batt-Ludwig score 4
7	Clinical statement of advanced/severe fibrosis or cirrhosis, AND Not histologically confirmed or unknown if histologically confirmed
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Stated in medical record that patient does not have advanced cirrhosis/advanced fibrosis, r Fibrosis score stated but cannot be assigned to codes 0 or 1 Fibrosis score stated but scoring system not recorded Fibrosis Score not assessed or unknown if assessed

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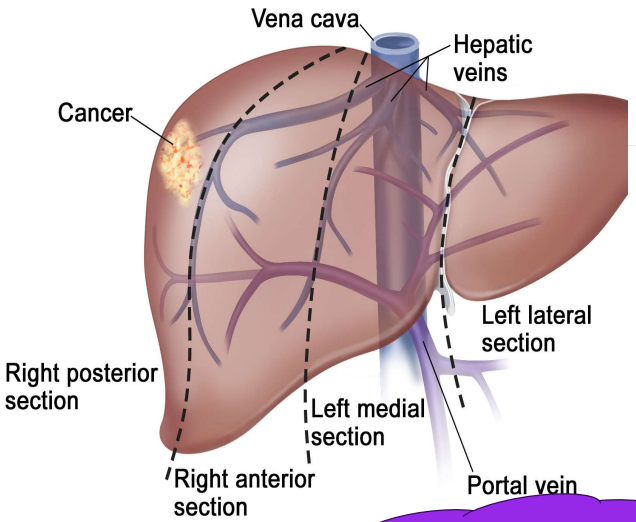
TACE,TARE, RFA

- Transcatheter Arterial Chemoebolization (**TACE**)
  - Code as chemotherapy-single or multiple agents
- Transarterial Radioembolization (**TARE**)
  - Brachytherapy, interstitial, LDR
  - Liver
- Radiofrequency Ablation (**RFA**)
  - Surgery



Bridge Therapy-Therapy done to make/keep patient eligible for transplant.

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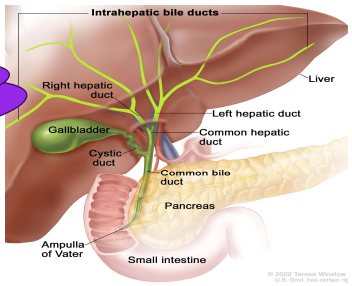
POLL 9

- Patient with a 2.3cm HCC in the liver (cT1b N0 M0) receives TACE with doxorubicin followed months later by liver transplant. The resected liver showed a 1.2cm HCC confined to the liver. No vascular invasion. 23 lymph nodes negative for metastasis.
- What is the correct T category for the liver resection?

A. cT1a
B. cT1b
C. pT1a
D. pT1b
E. ypT1a

even though the tumor was smaller at the time of surgery, we still need to include the clinical information in the pathological stage



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Questions?

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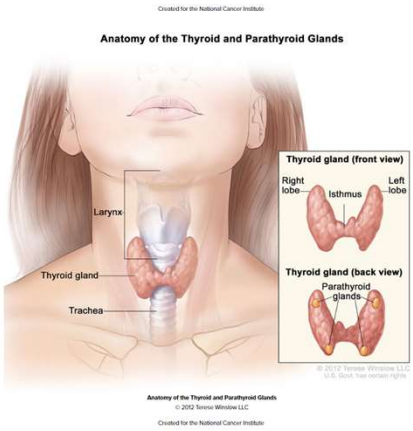
Abstracting Tips Thyroid



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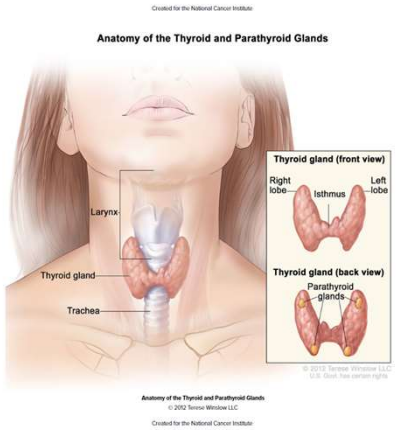
Poll 10 Date of Diagnosis

Scenario:

- 03/15/2024 Patient presented to Staff physician with a nodule in the left thyroid.
- 03/18/2024 US thyroid showed a nodule left thyroid
- 04/06/2024 FNA cytology of the thyroid nodule suspicious for carcinoma
- 05/30/2024 patient presented to the facility for Total Thyroidectomy, pathology reveals papillary carcinoma

Question: What is the Date of Diagnosis?

- 03/15/2024
- 03/18/2024
- 04/06/2024
- 05/30/2024



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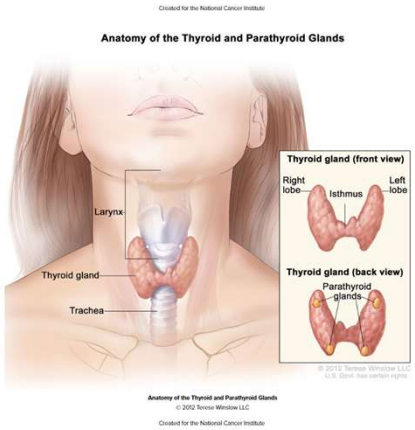
Poll 10 Answer & Rationale

- 04-06-2024 Date of the Suspicious Cytology (that was later confirmed)
  - SEER
    - Use the date of suspicious cytology when the diagnosis is proven by subsequent biopsy, excision, or other means
  - STORE Examples support this as well



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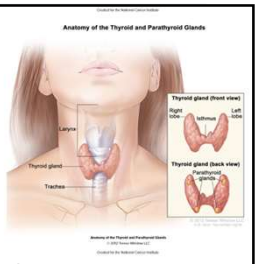
Poll 11 Afirma Test



- **Scenario**:
  - 5-1-2024 FNA Left lobe Thyroid: Follicular Lesion of Undetermined Significance (FLUS); see note:
    - NOTE: Afirma molecular testing was performed on the specimen and was found to be suspicious for malignancy (50% risk of malignancy).
  - 5-17-2024 Physician Consult: Afirma test showed 50% risk of malignancy, refer for surgery
  - 5-22-2024 Left Lobectomy: 2.1cm Papillary Carcinoma, follicular variant
- **Question**: What is the date of diagnosis?
  - 05-1-2024
  - 05-17-2024
  - 05-22-2024

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Poll 11 Answer & Rationale

- 5-22-2024
  - We are not to consider positive or suspicious Afirma tests alone as reportable. The Afirma test provides the risk of developing the disease, but it is not a diagnosis of the disease. The date this patient went on for surgery and received the reportable diagnosis of Papillary carcinoma, Follicular Variant, that is the date of diagnosis.
  - If the Physician had stated in retrospect or had stated the Afirma test diagnosed the cancer, then you could use the earlier date, but that was not the case in this scenario.

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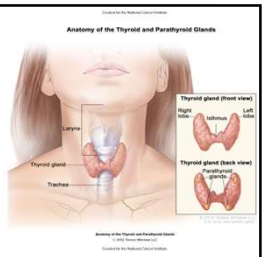
Poll 12 Angioinvasion+/LVI-



Scenario:

- Thyroidectomy
  - Lymphatic Invasion: Not Identified
  - Angioinvasion (Vascular Invasion): Present

Question: How would you code Lymphovascular Invasion?

- 0 Lymphovascular Invasion stated as Not Present
- 2 Lymphatic and small vessel invasion only (L) OR Lymphatic invasion only (thyroid and adrenal only)
- 3 Venous (large vessel) invasion only (V) OR Angioinvasion (thyroid and adrenal only)
- 4 BOTH lymphatic and small vessel AND venous (large vessel) invasion OR BOTH lymphatic AND angioinvasion (thyroid and adrenal only)

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Poll 12 Answer & Rationale

- STORE/ SEER Program Coding and Staging Manual
  - 3 Angioinvasion (thyroid and adrenal only)

Code	Description
0	Lymphovascular Invasion stated as Not Present
1	Lymphovascular Invasion Present/Identified (NOT used for thyroid and adrenal)
2	Lymphatic and small vessel invasion only (L) OR Lymphatic invasion only (thyroid and adrenal only)
3	Venous (large vessel) invasion only (V) OR Angioinvasion (thyroid and adrenal only)
4	BOTH lymphatic and small vessel AND venous (large vessel) invasion OR BOTH lymphatic AND angioinvasion (thyroid and adrenal only)
8	Not applicable
9	Unknown/Indeterminate/not mentioned in path report

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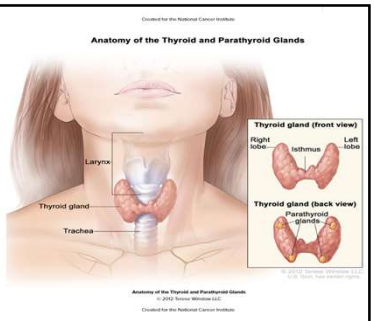
Poll 13 Thyroid Path Stage



- **Scenario**:
  - 65 year old male presents to your facility for resection of a Goiter
  - US shows: 1.5cm nodule right lobe of the thyroid
  - Physical exam reveals 1.5cm thyroid nodule, no apparent adenopathy in neck.
  - Path report from thyroidectomy: 1.5cm papillary carcinoma limited to right lobe of thyroid
- **Question**: What is the pathological stage?
  - pT1b (s) cN0 cM0 Stage I
  - pT1b (s) pNX cM0 Stage 99
  - pT1b (s) pNX cM0 Stage I

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Poll 13 Answer & Rationale

- pT1b (s) ~~cN0~~ cM0 Stage I – only certain situations where you can use cN0 in pN Category-refer to AJCC 8th Edition Staging Critical Clarifications for Registrars Node status document
- pT1b (s) pNX cM0 ~~Stage 99~~ –Refer to Chapter 73 AJCC Prognostic Stage Groups Differentiated Table
- pT1b (s) pNX cM0 Stage I

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AJCC Clin/Path T Suffix

Must be some indication nodules are malignant to use the (m) or (s) suffix. If no indication, leave blank.

Codes:

(m)	Multiple synchronous tumors OR For thyroid differentiated and anaplastic only, Multifocal tumor
(s)	For thyroid differentiated and anaplastic only, Solitary tumor
Blank	No information available; not recorded

Thornton ML, (ed). *Data Standards and Data Dictionary*, Version 25, 26th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2024.

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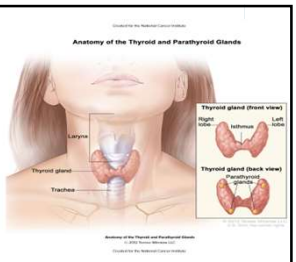
Poll 14 N0a N0b



Scenario:

- A 51-year-old married Hispanic female presents with dysphagia, physical exam shows no lymphadenopathy
- CT Neck: 7cm mass arising from right thyroid, no lymphadenopathy seen
- US Thyroid: 7.5cm mass
- PET/CT: single hypermetabolic mass in right thyroid 4.2cm.
- FNA Thyroid: papillary carcinoma
- Total Thyroidectomy: unifocal papillary carcinoma 6.8cm margins neg, positive angioinvasion & LVI, no extrathyroidal extension 0/4 lymph nodes negative

Question: How would cN be assigned?

- cN0
- cN0a
- cN0b

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Poll 14 Answer & Rationale

- cN0b
- Incidentally the pathology pN would be assigned pN0a

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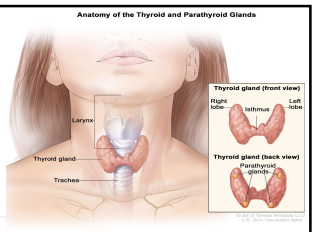
Treatments - Surgery



- Surgery codes are updated for 2024
- Codes are cumulative

  Example:
  - Patient had the left lobe of her thyroid removed in 2021 for a benign tumor.
  - She was found to have a malignant tumor in her right lobe in 2024.
  - The right lobe and isthmus were removed.
  - Assign surgery code B500

- B200 Removal of less than a lobe, NOS
  - B210 Local surgical excision
  - B220 Removal of a partial lobe ONLY
- B250 Lobectomy and/or isthmectomy
  - B251 Lobectomy ONLY (right or left)
  - B252 Isthmectomy ONLY
  - B253 Lobectomy WITH isthmus
- B300 Removal of a lobe and partial removal of the contralateral lobe
- B400 Subtotal or near total thyroidectomy
- B500 Total thyroidectomy
- B800 Thyroidectomy, NOS

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Treatments – RAI Radioiodine (I-131)

CTR Guide to Coding Radiation Therapy Treatment in the STORE	• Version 6.0 – January 2024 • Questions – CAnswer Forum
Volume – 98 (Other)	• This is to maintain historic consistency • Do not use 93 (Whole Body) – for whole body treatment using external beam
XRT Dose Fields – 999998 not prescribed in cGy	
Planning Technique – 88	• No conventional plan – based on risk of residual disease and complications
Date started/ended	• Consider one injection of RAI as both the start and end dates

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Treatments - Systemic

- Hormone Therapy
  - Levothyroxine; L-Thyroxine
  - Liothyronine
  - Liotrix
  - Methimazole (also treats Grave's Disease)

- A patient with a long history of hypothyroidism has been receiving levothyroxine since 2021.
- Patient is diagnosed with papillary carcinoma of the thyroid on 1/12/24.
- Patient has a total thyroidectomy on 2/12/24.
- He resumes levothyroxine on 2/13/24.
- What is the start date for systemic treatment?
- 2/13/24

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Non-invasive Follicular Thyroid Neoplasms

- Encapsulated follicular variant of papillary thyroid carcinoma (EFVPTC) re-classed to non-malignant condition
- non-invasive follicular thyroid neoplasms with papillary-like nuclear features or NIFTP
  - Consensus-based, histopathologic diagnostic criteria to appropriately distinguish NIFTP from malignant thyroid cancer
  - Changed to /1 in 2021.

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Questions?

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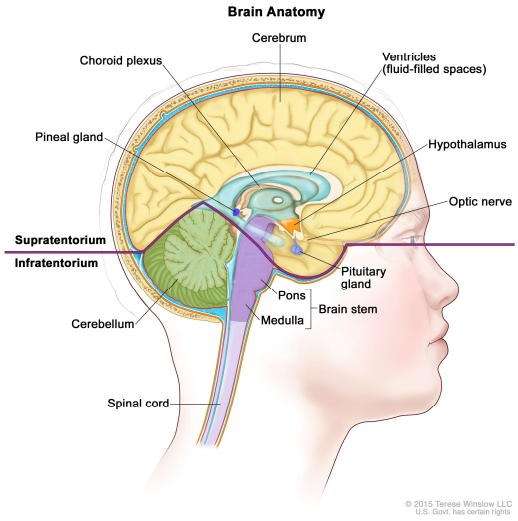
Abstracting Tips CNS



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Glioma, NOS

- The term Glioma, NOS is not a term WHO recommends using. The preferred term is Astrocytoma, NOS.
- Starting with cases diagnosed in 2025, an edit will trigger when the histology 9380/3 is used for a brain primary.
  - The edit can be over-ridden, but the registrar should review the case carefully to see if a more specific histology can be used.

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Low-grade Glioma

- A low-grade glioma is considered a borderline tumor and should be assigned a histology code of 9380/1.
  - This note will be added to the next update of the Solid Tumor Manual.
  - Currently there is a SINQ post confirming this https://seer.cancer.gov/seer-inquiry/inquiry-detail/20230080/
- Do not assume a histology has a behavior of /0 or /1 based on the term "low-grade".

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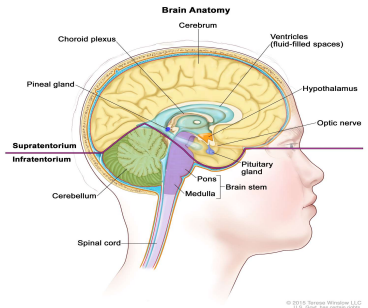
Poll 15

C. 9385/3 Infant-type hemispheric glioma
Disregard "low-grade."

- A patient is diagnosed with a low-grade hemispheric glioma infant-type.
- What histology would be assigned?
  A. 9421/1 Diffuse low-grade glioma
  B. 9380/1 Low grade glioma
  C. 9385/3 Infant-type hemispheric glioma
  D. 9380/3 Glioma, NOS



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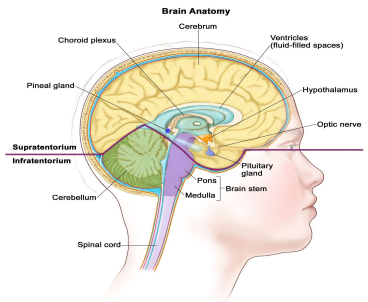
Poll 16 Primary Site Meningioma

- **Scenario**:
  - 04/01/2024 CT Head: There is a tiny 4 mm enhancing lesion that appears to be dural based inferior lateral left frontal lobe most likely a small meningioma. Recommend follow-up perhaps in 12 months.
  - 04/18/2024 Physician recommend Active Surveillance, patient agrees.

- **Question**: What is the primary site?
  - C700 Cerebral Meninges
  - C709 Meninges NOS
  - C701 Spinal Meninges
  - C711 Frontal Lobe Brain



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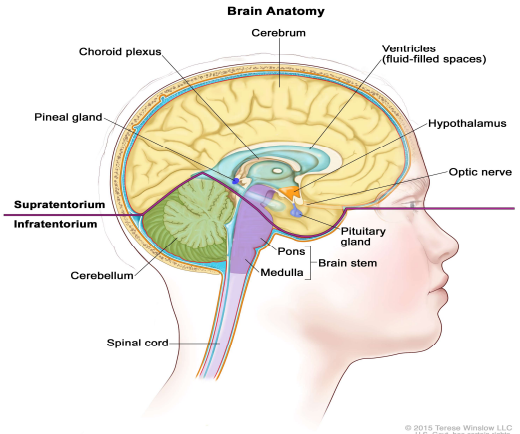
Poll 16 Answer & Rationale

- C700 Cerebral Meninges



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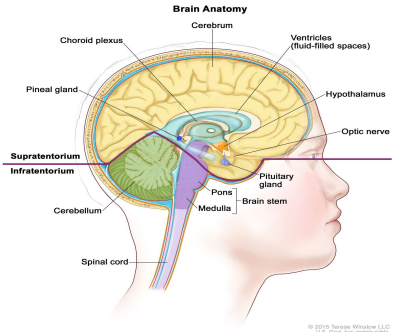
Poll 17 Active Surveillance

Scenario:

- 04/01/2024 CT Head:
  - There is a tiny 4 mm enhancing lesion that appears to be dural based inferior lateral left frontal lobe most likely a small meningioma. Recommend follow-up perhaps in 12 months.
- 04/18/2024
  - Physician recommend Active Surveillance, patient agrees.

Question: What is the Date of First Course Treatment (CoC) & Date Therapy Initiated (SEER)?

- Both BLANK
- Both 04/18/2024
- Date of FCT (Coc) 04-18-2024, Date Therapy Initiated (SEER) BLANK



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Poll 17 Answer & Rationale

- Both 04/18/2024
  - STORE- Date of First Course Treatment
    - Record date patient chose Active Surveillance as Date of First Course Treatment.
  - NEW for 2024 SEER- Date Therapy Initiated
    - Record the date the decision was made for active surveillance even if the patient later changes their mind and opts for additional treatment. Code Treatment Status as 2, Active surveillance/watchful waiting.

Special Note to Registry Software Companies. This is a change in 2024, so be sure when Active Surveillance is chosen the registrar can fill in a date for both of these fields, do not default SEER Date Therapy Initiated to a Blank in this scenario.

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More fields to consider

Field	Answer	Rationale
Laterality	2	Laterality required for site C700
Lymphovascular Invasion	8	Lymphovascular invasion is coded to an 8 For non-malignant brain (intracranial) and CNS tumors
Grade Clinical	1	Grade Clinical For benign tumors ONLY (behavior 0), code 1 can be automatically assigned for all histologies.
Grade Pathological	9	Case was not eligible for pathologic stage/grade- no resection of the primary site

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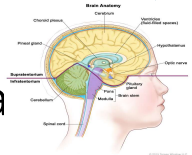
Poll 18 Pituitary Adenoma-Prolactinoma



- **Scenario**:
  - MRI Brain: Approximately 0.7 cm T2 hyperintense, hypo enhancing lesion in the central pituitary gland is suspicious for a pituitary microadenoma.
  - Office Visit: Hyperprolactinemia (prior hx of elevated prolactin), Micro prolactinoma 7 mm. No drugs on board to elevate prolactin. No FHx of pituitary tumors.+ galactorrhea, no headaches, regular cycles, no h/o infertility, not planning any more conception. Plan: Complete pituitary panel, including prolactin. If prolactin high, start dopa agonist treatment (cabergoline 025-0.5 mg weekly).
  - Prolactin 40.90 ng/mL (High)
  - 6-11-2024 Prolactin again mildly elevated, thus would start treatment with Dostinex 0.25 mg weekly
- **Question**: How will you assign diagnostic confirmation?
  - 5 Positive laboratory test/marker study
  - 7 Radiography and other imaging techniques without microscopic confirmation
  - 8 Clinical diagnosis only, other than 5, 6 or 7

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Poll 18 Answer & Rationale

- 7 Radiography and other imaging techniques without microscopic confirmation
  - An elevated prolactin level alone is not diagnostic of a prolactinoma, so we won't use code 5. The MRI was suspicious for a pituitary microadenoma, and a Prolactinoma is the most common type of pituitary tumor (adenoma) that produces a hormone. It makes up about 30% of all pituitary adenomas. We would assign diagnostic confirmation as 7.

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Other Fields to Consider

Field	Answer	Rationale
Primary Site:	C751	Pituitary Gland
Histology/Behavior:	8271/0	Be sure to include in text physician office notes stating physician calling this a prolactinoma & prolactin lab levels
Grade Clinical:	1	**Grade Manual** *For benign tumors ONLY (behavior 0), code 1 can be automatically assigned for all histologies.*
Grade Pathological:	9	Case was not eligible for pathologic stage/grade- no resection of the primary site
Hormone:	01	SEER*Rx Interactive Antineoplastic Drugs Database Cabergoline (Alternate Name Dostinex) Category: Hormones and hormonal mechanisms Primary Site: Pituitary (prolactinoma) Remarks: Pharmacia, Upjohn. Suppresses prolactin secretion by anterior pituitary.

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Poll 19

- A patient is diagnosed with a low-grade glioma (9380/1).
- Histology code 9380 is not included on the list for the SSDI Brain Molecular Markers.
- What code should be assigned?

20	9421/1	Diffuse low-grade glioma, MAPK pathway-altered
21	9430/3	Astroblastoma, MN1-altered
22	9500/3	CNS neuroblastoma, FOXR2-activated
23	9500/3	CNS tumor BCOR internal tandem duplication
85	NA	Not applicable: Histology not 9385/3, 9396/3, 9400/3, 9401/3, 9430/3, 9440/3, 9450/3, 9451/3, 9471/3, 9478/3, 9421/1, 9430/3, 9500/3
86	NA	Benign or borderline tumor Excludes: 9421/1 (codes 19-20)
87	NA	Test ordered, results not in chart
88	NA	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 88 will result in an edit error.)
99	NA	Not documented in medical record No microscopic confirmation Brain molecular markers not assessed or unknown if assessed

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Educational Resources

- AJCC Cancer Registrar Education
- NAACCR Monthly Webinar Series
- NAACCR Implementation Updates
- NCRA Education
  - NCRA Registry Best Practice Mini Learning Series
  - Cancer Registry Events Calendar
- SEER*Educate
- State Associations

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Conclusion

Refer to CAnswer Forum for clarification about what is in these manuals

- AJCC TNM Staging 8th Edition
- Grade
- Site-Specific Data Items
- STORE

Refer to SINQ/Ask a SEER Registrar for clarification about what is in these manuals

- EOD
- Hematopoietic Rules
- ICD-0-3 Updates (for cases diagnosed 2018+)
- SEER*RX
- Solid Tumor Rules (for cases diagnosed 2018+)
- Summary Stage 2018

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Coming Up…

- 10/3/24 Larynx and Base of Tongue
  - Wilson Apollo, ODS
- 11/6/24 and 11/7/24 Bladder
  - Denise Harrison, ODS

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CE Certificate Quiz/Survey

CE Phrase

Link

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