Bladder 2024 Q&A

11/6 and 11/7 2024

	Question	Answer
1.	I have confusion as to when to consider a cystectomy as first course vs subsequent tx. Especially when repeat TURBTs are done that are positive and then pt ultimately has a cystectomy	That is a tough call. One suggestion is to follow the NCCN guidelines. If repeat TURB's are given as part of the protocol before a cystectomy, then count the cystectomy as first course treatment. If they continue to get TURB over the course of a year or more before they finally get a cystectomy, I would assume the intent was to manage the case via TURB's. When that didn't work, they did a cystectomy. I would not count the cystectomy as first course in that situation. Because urothelial bladder cancers recur so often and can be managed for a time via TURB, it is difficult to determine when first course treatment ends. The best you can do is try to understand how the disease is managed and use what guidance we've been given in our coding manuals to help distinguish first course from second course. Try to be consistent!
2.	If med onc documents a cT2a or T2b, should we code it as that, or keep it T2?	We need to follow the rules in AJCC. There is no cT2a or cT2b. Clinically, we need to assign cT2. If you look at the table in AJCC, they only allow pT2a and pT2b. I would document what the physician assigned in a text field.
3.	SCENARIO #2 wouldn't the TURB be coded and not dx staging procedure 02? Thanks!	A bx was done as part of the initial workup so code 02 for dx staging is correct. You are correct that a TURB

		is never coded as dx staging procedure.
4.	If a patient has 2 TURBTs and the second surgery has no residual, do you still code both surgeries? Which is the most definitive?	If your software allows you to code multiple surgeries, you would code both procedures regardless of whether the pathology was positive or negative. When assigning surgery codes you should avoid coding based on pathologic results from the path report. Both procedures may have the same surgery code. There is no "re excision" code.
5.	Is chemo given as a radio sensitizing agent coded as chemo therapy?	For cases diagnosed prior to 2025, you code the chemo as systemic treatment unless the physician specifically states it was given and a low dose and is only for radiosensitizing purposes. For cases diagnosed 2025 or later chemo used for radio sensitizing purposes is always coded as systemic treatment.
6.	It's our AJCC manual that reminds us which procedures allow for certain staging?	Exactly!
7.	In Scenario 3, could you yc stage it?	No. The patient did not have neoadjuvant treatment. I know it's counterintuitive, but just because a patient has chemo before something we code as surgery, we shouldn't think of that as neoadjuvant treatment (i.e. TURB, intravesical chemo, TURB). If you look at the NCCN guidelines they define what they consider neoadjuvant and differentiate that from a bladder preservation procedure.
8.	Since discussion is moving to STRs I have a new question. This is really a central registry case consolidation scenario. Post 2018 primary 1 is noninvasive bladder ca. Subsequent primary of invasive bladder ca. Would a TURBT positive for noninvasive ca following the invasive dx	I don't know that there is anything in the STR's that is going to help us determine what is "correct" for this scenario. I would like to hear how other central registries are handling this situation!

	be correclty attached to primary 1 (noninvasive) or pimary 2 (invasive)	
9.	Patient got treatment of TURBTs in 2023, 2024 looks like yearly got treatment for bladder low stage tumors and in some occasions, BCG instillation was done. In some cases, 2022, 2023, 2024 - patients got TURBTs with pT2a	It will still have to be entered as cT2. TURBT is a clinical staging criterion. TURBT does not meet the criteria for pathological stage. It is the responsibility of the registrar to ensure the AJCC stage and TNM categories are entered correctly and follow AJCC guidelines.
10.	In regard to the primary site assignment question for separate tumors in bladder & ureter w/ histology 8120/2-does that also apply to 8130/2?	It only applies to 8120/2 when the tumors are synchronous and the only sites involved are bladder and 1 or both ureters.
11.	Where was it said that we could find the information on low grade = non invasive and high grade = invasive when no other information is provided? Thanks	That information is in SEER Appendix C. https://seer.cancer.gov/manuals/2024/AppendixC/Coding_Guidelines_Bladder_2024.pdf
12.	Would you please repeat your explanation about using the most current rules? If in 2024 I correct edits on cases abstracted in 2015 and 2017 (the tumors are in 2015 and 2017), I should use the MPH valid for this DX year and not the 2024 Solid TR, the most reasent one, correct? Thank you!	The Solid Tumor Rules you use should be based on the date of the new tumor - the one you are trying to decide if it is a new primary. if you have a case originally dx'd in 2015 and then a new tumor is found in 2017, use the 2007 MPH rules. If the original was diagnosed in 2015 and the new tumor in 2018, use the most current version of the Solid Tumor Rules.
13.	Sorry, maybe my question was not clear. I am not deciding if there is a new primary in 2018. I just work on edits on 2015 and 2017 cases in 2024, so I should go by MPH rules?	Correct. You would use the 2007 MPH rules since all of the cases have dx date prior to 2018. The fact you are doing the review in 2024 is not a factor.
14.	I thought that this rule does not apply to urothelial carcinomas for the 3-year rule. That is why I put it as one primary.	Rule M11 applies to UCs in **multiple urinary organs** - Rule M11 comes after rule M10 (3-year timing rule), so since the 6/2022 tumor was more than 3 years after the initial diagnosis date, it is multiple primaries.

		Urothelial carcinomas (not micropapillary) in the **bladder** are always a single primary and micropapillary UCs in the **bladder** are always a single primary. The timing does not matter when they are in the **bladder**.
15.	Can you explain how polls #9 and #10 are different?	Poll 9 was more than 3 years apart. Poll 10 was less than 3 years apart.
16.	What if there is a differential diagnosis between two histologies on the path report and the physician calls it one of the histologies and treats it as that. How do we code the histology?	I would use the physician statement.
17.	So subtypes trumps the others?	Yes. Code the most specific histology regardless of whether it is from a biopsy or resection.
18.	What is the histology if on a cystoscopy or TURBT,, a patient is found with a papillary lesion in the bladder. Pathology states High Grade Urothelial carcinoma. 8120 or 8130?	If you are asking if the description of papillary features from an op report can be used to differentiate 8120 and 8130, the answer is no. I had the same question and submitted it to SEER several years ago.
19.	If a tumor is stated to be papillary on TURBT and the diagnosis on the path report is non-invasive urothelial carcinoma on the path report (no mention of papillary), histology would not be 8120/2 correct? Would it be staged as cTa or cTis?	Histology coding instructions are to code the histology as 8120/2. If you see this situation on an actual path report, please submit to AJCC for guidance on how to assign the cT value.
20.	Can you please repeat what you said about a neobladder?	It is a “new bladder” created from a loop of the small intestine. This is a type of reconstructive surgery. The neobladder functions to hold the urine (since the bladder has been removed) until it can be released from the body.
21.	If a Patient undergoes TURBT and pathology is Ta or Tis followed by BCG x6 treatments. Patient is returned to the	No. The NCCN guidelines do a good job of defining neoadjuvant treatment. The chemo given as part

	facility and patient still has Ta or Tis tumors in the Bladder, do we code the AJCC Pathological stage as neoadj. therapy?	of neoadjuvant is systemic. Intravesical chemo does not qualify as neoadjuvant. Also, TURB does not meet the criteria for surgery following neoadjuvant chemo. To get a ypT, the patient must have a partial or full cystectomy.
22.	If urologist states it's a T2a after TURBT, can we stage as T2a? or do we have to use the T2	When entering information into the AJCC fields, you have to assign a cT2. You can document the physician referred to it as a cT2a in the text.
23.	Question 2: if a patient is diagnosed with Papillary Urothelial Ta or Tis, s/p BCGx6 treatments. Repeat TURBT now has invasive Urothelial CA (non papillary), this part confuses me. Do I now have a recurrence with the histology is changed or do I have a new primary. Urinary bladder cases are frequently returned to the facility for follow up Cystoscopy. This makes it very difficult to know when it's a new primary vs. recurrence. Especially when a decision is made to surgically proceed with Cystectomy.	First, we have to decide if this is a new tumor or if it is the same tumor. If the invasive tumor is found within the site of the previous TURB, we can assume they missed some of the cancer cells during the initial TURB and the repeat TURB has identified an invasive component of the tumor. In that case, we are dealing with a single tumor and abstract a single primary that is invasive. If the repeat TURB shows a new tumor that is invasive, then we go through solid tumor rules to determine if it is a new primary.
24.	If you have a path report that documents the grade as "mixed grade" with 95% high grade and <5% high grade. How do we code the grade for this case	The grade instructions tell us to code the highest grade, so assign H (assuming this is a urothelial carcinoma).
25.	So in Poll#2 you say we use the 2024 rules but I thought you said we use the rules of the year that the cancer was diagnosed. So why 2024 instead of 2019. Should it be the year I am looking at the case not the year that the case was diagnosed?	If the report you are looking at is from 2018 or later, use the most current version of the solid tumor rules available. Denise was trying to make the point that even though the original dx was prior to 2018, the new tumor was diagnosed after 2018. Since the new tumor was dx'd after

		2018 we use the most current version of the STRs.
26.	Do we bypass rule M4 in this case because of the bladder involvement?	Correct. M4 only applies when no other urinary sites are involved.
27.	Would you please clarify your decision making for recording the recurrence. It is our hospital registrars understanding that we cannot take this as a recurrence without the physician stating that the patient is NED or they have a documented time of disease free status. If you don't have that you can code the ancer status but not the type of 1st recurrence. Is the understanding correct?	Cancer status is a separate field with specific instruction. From the scenario, everything was WNL (no tumor present) until the new tumor was found. In fact, the STORE Manual instructions for the *Type of First Recurrence* data item include this instruction: *Check the SEER Multiple Primary and Histology Coding Rules Manual or the 2018 Solid Tumor Rules to determine which subsequent tumors should be coded as recurrences*.
28.	Wasn't there a rule once that if you had an insitu cancer and then an invasive cancer that you had to report both to the State to capture the numbers of insitu cases? Or have I been in this field too long?	There is still a rule about that. If an invasive tumor follows an in situ tumor by more than 60 days, we report both tumors. In the example of M6, there were not 2 tumors. It was the same tumor. You may be referring to the rules documented in the standard setter manuals from prior to 2007 (before the MP/H rules were implemented). There were rules that said if a patient had an in situ case and was later then an invasive tumor, it was multiple primaries.
29.	One of the most confusing issues is deciding one tumor or multiple tumors (per prior M6 example) This hangs up new abstractors (and us oldies) all the time. We have to figure out how many tumors in the path report(s) first, not how many histologies/behaviors are present. It can	I agree and I don't think it is a newbie thing. If they see a suspicious area when doing a repeat TURB, they are going to excise it. Then, you have to decide if the tissue on the path report is part of the "re-excision" or tissue from a different area. And, please remember to use the

	be a smoke-screen sometime. Thanks for the good example.	information from the cystoscopy to help sort out how many tumors are present. We need to use all information available, not simply the pathology report.
30.	Please review poll 7 again. What are the histologies? 8120/3; 8130/3; and ??	1/3/2018: Bladder dome, TURBT - urothelial carcinoma 8120/3 5/8/2019: Bladder lateral wall, TURBT - papillary urothelial carcinoma 8130/3 7/14/2022: Bladder base, TURBT – giant cell urothelial carcinoma 8031/3
31.	Going back to the beginning, if the patient had suspicious imaging and the muscularis propria was not sampled during TURB would we be able to assign clinical T1? The patient passed so there will be no further workup/treatment	Imaging can be used to assign the clinical T values. If the imaging clearly stated the tumor invaded into, but not through the muscularis, you can assign a cT2. However, I would want to make certain the imaging was definitive.