Q&A Session for Boot Camp

March 13, 2025

#	Question	Answer
1.	If we are working in a Central Registry, are we answering for what we deem reportable, or is this COC?	Overall reportability. The "maybe" answer might indicate reportability to one standard setter but not another.
2.	SEER RSA colon resection margin SSDI, note 2 states: A surgical resection must be done to evaluate tumor deposits. Do you think Jennifer meant to say, "to evaluate colon resection margin" instead of "tumor deposits"?	Yes!
3.	Jim, if a LAMN is diagnosed on scans only, is it reportable?	No. We confirmed with SEER that imaging alone is not diagnostic of a LAMN. From what I understand, it's not uncommon for a radiologist to indicate they think it is a LAMN, but that is not definitive for our purposes.
4.	I would say 'maybe' for LAMN should count as pass bc it depends on dx date, doesn't it?	You are correct, it does depend on dx date.
5.	STR 2025 RE: Carcinoma in situ of the cervix w/focal invasion - Other Sites histology rules. How to Code Histology Ribbon, right under ambiguous terms states the following "4. Do not code histology when described as: Architecture, Foci; focus; focal and Pattern"	That refers to assigning histology, not reportability. In our example, the "focal" means there is invasion, but the invasive component is very small (focal).
6.	SSDI committee is discussing Gleason scores of 5 not to be considered cancer. So maybe too soon but if the pathology says adenocarcinoma but the Gleason's score is 5 would we still collect it?	If possible, confirm the diagnosis and score with the pathologist. I would also be interested to know the pattern. If you run into a Gleason score of 5 and you confirm with the pathologist that it is adenocarcinoma, please share with SSDI! At this point, if they call it adenocarcinoma, it is reportable (regardless of Gleason).
7.	My facility does not like class of case 10=, if a patient went to another facility, it is no longer analytic.	Understandable.
8.	For question 5, what if the pt chose active surveillance (out of his tx options which included surg) for 6 months and then	I don't really have a timing cut off. What you want to look for are signs of disease progression. Did the patient decide to have

	decided upon surg resect. When is the actual cut off for fcot for this surg procedure? Is it 6 months, 1 year?	the prostatectomy due to signs the cancer is progressing. If yes, then prostatectomy is not a first course treatment.
9.	If the neoadjuvant chemo was completed, then surgery would not be first course treatment?	If the plan is neoadjuvant therapy followed by surgery, then surgery is going to counted as first course treatment. Even if they don't complete all of the planned neoadjuvant therapy or they change drugs. If the surgery is done, it is included as first course treatment.
10.	Could you please revisit #4...why not residence at time of diagnosis?	Residence at time of diagnosis is the residence where the patient resides the majority of time.
11.	Question 4--Why would it be Massachusetts when the diagnosis was when a patient was at her Arizona residence?	Residence at diagnosis is where the patient resides the majority of the time. In this case that is Massachusetts.
12.	What if the length of where the pt spent most of the time is not documented in the text?	Then you have to use your judgement.
13.	So why can't you apply the same logic to recently incarcerated?	I'm not sure, but we have specific rules for incarcerated people.
14.	The FCDS manual says for patients with more than one residence, 'use the street address the patient specifies if a usual residence is not apparent'.	That seems like a practical rule.
15.	Per STORE Persons with More than One Residence (summer and winter homes): Use the address the patient specifies if a usual residence is not apparent.	True. However, a usual residence is defined as where they spend the majority of their time. In this case we know they spend the majority of their time in Massachusetts.
16.	Would active surveillance treatment plan be good to enter into Other Treatment text box?	You can check with your state registry to ask if they have a preference and discuss this at your facility so you are consistent. Wherever you record this, be sure to include the date of the decision for active surveillance and/or no treatment.
17.	PE text - why no actual PE exam text included?	In this particular scenario, we did not have any actual physical exam information to enter; however, when this information is available and pertinent to the case, this information should definitely be included. For example, a breast case should include information on whether the tumor was palpable, where it was located, palpation of the axilla, etc. You might want to refer to the NCRA Informational Abstracts which provide site-specific guidance for what to include: https://www.cancerregistryeducation.org/rr.

18.	I also code the date the pt presented to our facility to help support class of case.	Good idea!
19.	I was concerned that just having active surveillance in PE then the code for treatment given (code 2) would not be readily validated. If we are looking for treatment information in the treatment text boxes when it does not appear anywhere there.	You can check with your state registry to ask if they have a preference and discuss this at your facility so you are consistent. Wherever you record this, be sure to include the date of the decision for active surveillance and/or no treatment.
20.	Would you not include the hx of prostate ca in 2020 to justify the sequence for this primary?	This was included in the "Remarks" text; however, this could also have been included in the PE text. Check with your state registry and/or facility to confirm any specific requirements.
21.	As QA staff at a central registry, we also ask that Path text includes specimen and slide number. That way, reviewers know that abstractors are actually looking at the path report and not a MD document.	Thank you for the tip!
22.	Cover your SSDI'S in the correct text boxes even if not done you should text this.	Another great tip!
23.	I always place Active Surveillance in the Surg text.	You can check with your state registry to ask if they have a preference and discuss this at your facility so you are consistent. Wherever you record this, be sure to include the date of the decision for active surveillance and/or no treatment.
24.	If staff attending the NAACCR webinars work remotely and attend a Live Monthly meet, does this meet the criteria for CEIP?	To qualify for CEIP, they must be viewing the live webinar with at least five other registrars in the same room. There also has to be a facilitator present in the room. At least that is my understanding. NCRA is the authority on this issue!
25.	What if imaging has 2 differential dx 1 reportable 1 not?	It's my understanding that if any of the differential diagnoses are not reportable, then the report is not diagnostic.
26.	What would the Class of case be if Prostate cancer was dx elsewhere and options were discussed, and PT chose radical prostatectomy. No other information is available. Would this be a 22, correct? However, on the Path report - the margins were positive. Would this be still coded 22 based on the info we have, or will it be 21, knowing there is residual cancer, and more treatment may be necessary.	The margins should not impact how you code class of case. If you know they patient has additional treatment elsewhere, code 21. If you are not aware of any additional treatment assign, code 22.

		I'm guessing you are an experienced registrar and recognize that because the patient had positive margins, the patient will probably have additional treatment. Class of Case 20 is also a valid option if you feel you could be missing treatment information. If you choose class 20, be sure to update the Class of Case when more info becomes available.
27.	Why in question 2 is the imaging date not used for diagnosis date?	The imaging was not diagnostic. "Tumor" is not a reportable disease when occurring in the lung.
28.	Could you please confirm that we should be coding FNAs on regional and sentinel nodes even when they are negative? (and that codes would be 95 for nodes examined and 0 for nodes pos?).	That is correct. FNA, core bx, excisional bx, or dissection of regional nodes are coded in scope of regional node surgery regardless of the pathologic (or cytologic) findings.
29.	For #3 - be sure to document that the staging showing no mets was from the oncologist, we at the central registry cannot take the staging unless it is from the physician only. In other words, not from the hospital registrar.	Great tip!
30.	What about high suspicion of mal, probably mal?	Please refer to your standard setter for more information and clarification about these modifiers with ambiguous terms.
31.	Question 8 why not code cervical node as diag staging procedure (01)? staging for dist dz.	An excisional biopsy of a distant node should be coded in Surgical Procedure/Other Site
32.	What about favor(ed) mal?	For reportability, favor(ed) is an ambiguous term that constitutes a diagnosis when stated with a reportable disease.
33.	But w/ #3, if they treat the pt's mets w/RT and the physician stages it wrong, then a registrar would need to correct the staging, right? Doctors do miss things.	You are absolutely correct! The point I was trying to make was that we do have to use our professional judgement. In my scenario, if I feel confident the physician did not think the patient had mets. In your scenario, I would probably asume the physician stage was wrong, and the patient does have mets. At a minimum that would have to be a consideration.
34.	Where would you code FNA of cervical lymph node (distant lymph node). (breast primary)?	That depends. Cytology of a distant lymph node would not be coded. Histology from an FNA/Biopsy of distant lymph node would be coded in diagnostic/staging procedures as an 01. An excisional biopsy of a distant node should be coded in Surgical Procedure/Other Site.

35.	In H&P is the text specific to the reporting facility symptoms or what pt originally presented eveb if elsewhere?	Any presenting symptoms or physical findings applicable to the case should be noted, regardless of where these were identified.
36.	When path says susp for focal LVI can we code LVI POS?	No. We do not apply ambiguous terminology rules to coding LVI. This would be coded as 9.
37.	A patient presenting with cough and weight loss, should the PE include all the information/findings on the patient dx from imaging and treatment recommendation? I thought we would only give reason for admission?	Any presenting symptoms or physical findings applicable to the case should be noted. This is not admission or visit specific but applies to overall workup.
38.	With drug names in text, if the physician uses the brand/alternative name should we switch it to the name listed in SEER*RX or include both in text?	Unless your facility or state registry has a specific requirement related to this, include the drug name(s) as the physician states.