Q&A Session for Treatment

April 3, 2025

#	Question	Answer
1.	IF a hospital is collecting the pediatric data should they contact their central registry to let them know they will be sending their data in their submissions?	That would be a good idea.
2.	Is there any exposure risk to the patient undergoing therapy. Are they shielded from the stray beams or is the exposure time during treatment short enough that the risk is negligible?	The objective of radiation therapy is to maximize the dose to the target volume and minimize the dose to healthy tissue and organs at risk. Given the penetrability of photons, we cannot eliminate dose to healthy tissues and OARs, but we can keep it to a safe level.
3.	Is there any way to tell from the isodose curves what the actual targeted area is? Is it always the most internal curve?	When reading isodose curves, we also need to look at the dose associated with each color. The prescribed dose will be one of these colors. Once we identify the isodose curve associated with the prescribed dose, we'll be better able to visualize the dose pattern and coverage. If you review slide 25, left breast isodose curves, the prescribed dose for this plan is 5000 cGy, represented by the yellow isodose lines. We can clearly see that most of the dose is concentrated on this portion of the breast, where the tumor bed is located.
4.	Is there a way to determine if a patient is having IMRT versus other delivery just by looking at the isodose curve schematic?	For the trained eye, definitely yes. IMRT isodose lines/curves more closely "hug" the PTV and minimize dose to healthy tissues.
5.	When you are texting about the radiation modality are you still including the exact photon or electron used like 6X or 9E or just simply texting "photo beam" or "electron beam?" Just curious as I am starting to see treatment summaries that only say photon beam without anything more specific, just wondering if the text needs to be more specific or is just texting "photon beam" or "electron beam" adequate? I hope this makes sense, the specific photon or electron used can usually be found with more digging in the EMR, but if this is not necessary for text requirements then I would like to cut this extra digging out and	Caroline, if you are referring to text in the abstract, it is always good to remember that your text needs to match your code. If someone came and abstracted your case from your text that they would have the same codes. **Wilson**: I would like to add that I typically include the beam energy in my Notepad(Metriq). If treated with photons and I know the beam energy, I type 6MV. If treated with electrons and I know the energy, I type in 9E. Below is an example of my text for RT: 2/20/24-4/3/24 @ XXX Hospital: RT lung, 6X/VMAT, 2 Gy x 30 fx= 60 Gy.

	save some precious time. I guess this could be a facility specific as for text requirements.	
6.	Is there a graph or spread sheet or something that, at a glance, would show us what the usual dose to a primary site is?	The NCCN Guidelines is a good place to start.
7.	When a patient is treated with DART and treatment summary list All sites treated prostate, periprostatic tissue, pelvic nodes followed by seed implant several times to include dose and energies. Is the modality coded to photon, how many phases and what is coded for total dose to primary?	Dynamic Adaptive Radiation Therapy (DART) is typically administered via photons and IMRT planning technique (sometimes referred to as VMAT, dose painting). This portion of the treatment (EBRT) will include the regional lymph nodes (as per the information provided). However, seed implants refers to brachytherapy, most likely the interstitial Low Dose Rate type, which is coded differently than the EBRT component. So we are looking at two phases. As per the dose, we cannot add the EBRT dose to the brachytherapy dose. See case #6 in the CTR Guide to Radiation Therapy found in the STORE Manual
8.	At one time there was talk of Radiation Oncologist moving towards a synoptic template for treatment summaries. Is this still in the works?	Unfortunately, this is still work in progress.
9.	When you speak about the total dosage and with multiple phases for say brachytherapy for cervix and then IMRT for pelvis bones as second dose, both have same total dose given different dose/fraction. Why would we not want to total those two again if that is what is provided in reports on those treatments? Should that now be an understanding that is half for each phase or stick with the documented total dose per phase?	When we treat the primary site as well as a metastatic site, the rule is not to add the dose of each to get the total dose. We can't add the dose from two totally different sites. Doing so will skew the data and provide nothing useful. This is also true if we were treating several metastatic sites in the same time frame. In this scenario, we would only capture the metastatic site that received the highest dose.
10.	For a prostate primary, say they have RT to pelvis, and then a boost. Would the same rationale apply? Would the boost just be to prostate only?	Yes, a boost will be to a smaller volume within the primary site.
11.	Jim...what was the answer for question #5?	Answer to question #5 is No. Bolus does not affect # of phases.
12.	If the treatment intent is "control" but plan/physician does not state curative or palliative, would you still code it as palliative?	Unfortunately, I would need additional information about the particulars of the case. When a patient is prescribed 1st course Rx for early-stage disease, the MD may not necessarily state "curative" in her/his notes.

13.	Pertaining to treatment dates. I try to have our registry team estimate treatment dates and avoid using 99"s. for instance use 4/15/2025 instead of 4/99/25 and just put (Est) in text. So that COC Quality measures can be calculated such as date between surgery and adjuvant chemo initiation. Is this a practice that is universal?	I'm not sure if it is universal or not.
14.	What about first course treatment for leukemia? If there is a progression which requires a change in the drugs or treatment given and the patient eventually reaches remission, is that change in treatment first course or subsequent treatment?	Leukemia is different. A change in drugs does not indicated first course treatment has ended. For leukemia, all treatment provided to achieve the initial remission is considered first course treatment.
15.	After colonoscopy dx with cancer. Followed by EUS for staging to determine reportability. How to code EUS or do we even have to code it?	The EUS is not coded in the scenario you provided. I would be documented in text.
16.	The SEER Program Coding and Staging Manual gives good guidance on when 1st Course Treatment ends, including when there is disease progression, recurrence but also treatment failure, which they define as "The treatment modalities did not destroy or modify the cancer cells. The tumor either became larger or stayed the same after treatment." The STORE Manual doesn't say this, but would the same guidelines be followed in ACOS facilities?	I think STORE chose not to include the definition in order to allow registrars a little more flexibility when determining when "treatment failure" indicates an end of first course treatment.
17.	Would yp stage for scenario 1 be 0is instead of 99?	
18.	For Surgical Diagnostic and Staging Procedure, if a biopsy of primary site and biopsy of metastatic site is done, if your software allows you to code more than one, can you code both?	You may code both if your software allows. Be aware that the code with the higher number will be sent to NCDB or your state registry.
19.	Do you code FNA of breast under surgical and diagnostic staging procedures positive and undergo lumpectomy	An FNA that takes tissue and is positive for malignancy would be coded under surgical diagnostic staging procedure.
20.	Question #4 in Pop Quiz 3…Date first surgical procedure in STORE instructs us to code date of Scope of Reg Lymph Node Surgery (excluding code 1).	Correct.
21.	Does that rule to code 97 for SLNs pos for Breast change when SLN and ALND are done in the same procedure in 2025 and allow you to code the number if it's in the path report?	I misspoke during the webinar! The coding instructions in STORE 2025 allow us to code the number of positive sentinel nodes if they are documented.

22.	If a SLN bx is done and then the patient had a resection of the primary, if there were lymph nodes incidentally removed during the primary site surgery and not as part of the SLN bx, how would the scope of regional lymph node procedure be coded? If this were a breast primary, would those incidental lymph nodes be added to the sentinel lymph nodes pos and examined fields?	Per the STORE 2025 "…, document the total number of positive nodes identified during the sentinel node procedure in this data item. I.e., record the total number of positive nodes from the sentinel node biopsy procedure regardless of whether the nodes contain dye or colloidal material (tracer or radiotracer)."
23.	If a patient chooses hospice - would this date be coded in first course treatment?	If the patient chooses not to be treated and instead receive hospice care, then the date the decision is made would be the date first course treatment.
24.	Are we going to discuss deciding how many phases, and when to combine phases etc.?	This was discussed.
25.	What is the difference in IORT & IOERT?	Both refer to intraoperative radiation therapy. However, IOERT specifies intraoperative RT via electrons.
26.	When we don't code negative biopsies - would we put the info in the comments?	Wilson: I do documents these, especially in breast cases since CoC accredited facilities need to document why a patient may not have gotten a biopsy.
27.	Store 2025 pg 2 1st course of Treatment added note - would this note not have applied to 1st course treatment for your kidney example?	I don't think so. In our example the surgery was never part of the first course treatment plan. They gave chemo to treat the distant mets. The chemo was not given in hopes the patient would be a surgical candidate. I would not count the surgery as first course treatment.
28.	From a Central Registry standpoint - Please make sure to document the date & where the treatment is being given along with the type of treatment being given. This will help us determine if we need to contact another facility to have them report that case.	Thank you!