RESULTS OF CODING & STAGING ASSESSMENT OF IDAHO REGISTRARS

Presented by,
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Acknowledgements:
Florida Cancer Data System (FCDS)
Moodle: A New Learning Management System for FCDS
AJCC Presentations – Donna Gress

Quality Assessment Tool

• Consisted of 25 Questions
  – 15 Multiple Choice
  – 10 True / False
• Registrars – New to Seasoned
• 16 out of 28 took the Assessment
• 3 Questions – All Correct 😊
• Overall Percentage – Correct 64%
Question #1

• A patient has an axillary node biopsy that shows metastatic carcinoma consistent with breast cancer. There is no palpable tumor and no tumor is seen on mammogram, US, or MRI. What is the correct AJCC TNM Clinical Classification and Stage:

• C - cT0 cN1 cM0 Stg 2A

• T0 = No evidence of primary tumor cN1 = The case did not meet the criteria to assign pT and bx of the node was part of staging work-up therefore code in clinical. Stage group page 349.

• Correct - 7 Incorrect - 9
Question #2

- Patient had a CT chest with LLL tumor and mediastinal nodes. Mediastinotomy removed 4 nodes confirming N3 disease; concurrent chemoradiation will be given. What is the correct TNM Pathologic Classification and Stage:

- B - pT_ pN_ pM_ Stg 99


- Correct - 9  Incorrect - 7
AJCC Presentation - Explaining Blanks & X, Ambiguous Terminology

- pT_pN_pM_Stg 99

- This case does not meet the criteria for Pathologic Staging. No resection of the primary tumor, therefore the Pathological values blank.
- The removal of nodes are considered part of staging workup.

Question #3

- Which of the following sources should be used to assist with assigning AJCC TNM Classifications and Stage:
  - C – None      (MPH – FORDS/SEER – ALL)
  - AJCC Presentation - Explaining Blanks and X, Ambiguous Terminology and Support for AJCC Staging Dec 2015. (Guidelines from Other Sources cannot be used for assigning AJCC Stage)

- Correct - 9    Incorrect - 7
**Question #4**

- Height is documented as a 2 digit number and measured in inches. Weight is documented as a 3 digit number in pounds. A patient’s height is recorded as 5'6" and weight is 100kg. Height and Weight would be recorded as:

  - A - 66/220

- CDRI Idaho Cancer Reporting Standards - Page 19 - Coding ID Clinical Trial and Forever & Variables - Height at Diagnosis - Code %’6" = 66 and 100kg = 220 (please document in text)

  - Correct - 16 Incorrect - 0

**Question #5**

- Which location description identifies the area of the body for Mesenteric lymph nodes?

  - C - In the mesentery of small intestine and colon

- SEER Self Instructional Manual - Book Four - Human Anatomy as Related to Tumor Formation

  - Correct - 16 Incorrect - 0
**Question #6**

- Which of the following is correct?

- D - Text documentation is required to justify coded values and to supplement information not transmitted with coded values.

- CDRI Requires text documentation to justify all coded values including dates – **CDRI Theme Song: Text, Text, Text – Document, Document, Document 😊**

- Correct - 15  Incorrect - 1

**Question #7**

- Patient presented with hematuria. Cystoscopy in attending physician office reveals a flat tumor on the lateral wall of the bladder. Patient admitted for TURB. Pathology report states noninvasive flat transitional cell carcinoma of bladder. What is the clinical T code?

- B - pTis


- Correct - 11  Incorrect - 5
Question #8

• Which of the following is correct?

• B - A carcinoid tumor of the appendix is a reportable neoplasm only when diagnosed on or after 1/1/2015

• FORDS Preface 2015 - Reportable Neoplasms - New for 2015 - ICD-O-3 - NAACCR - Guidelines for ICD-O-3 Update

• Correct - 15 Incorrect - 1

Question #9

• Patient presented with hoarseness. Laryngoscopy with multiple biopsies taken from the right and left true vocal cords was performed. Biopsies from both the right and left true vocal cords both showed infiltrating squamous cell carcinoma with areas of keratinizing squamous cell carcinoma in situ. How many abstract(s) should be prepared?

• C - One

• MPH Rules: Head and Neck Multiple Primary Rules - Rule M2 - Single Primary (vocal cord is not a paired site - see Head and Neck Terms and Definitions - Table 1) - so, Rule M3 does not apply. STOP at Rule M2 - Single Primary - one abstract

• Correct - 15 Incorrect - 1
Question #10

- Bone marrow biopsy examination on January 15, 2011 is positive for acute myeloid leukemia (AML); genetic testing revealed AML with inv(16)(p13.1q22). The correct histology would be coded:
  - C - 9871/3
  - Heme Database AML, NOS in Abstractor notes listed as a "More specific myeloid leukemia" also AML inv(16)(p13.1q22) will bring up the correct code 9871/3
  - Correct - 14 Incorrect - 2

Heme Codes
AML with inv(16)(p13.1q22)

- 9871 - Acute myeloid leukemia with inv(16)(p13.1q22) or t(16;16)(p13.1;q22)
- 9861 – Acute myeloid leukemia, NOS
  Abstractor Notes: More specific leukemias include –
  AML with inv(16)(p13.1q22) (9871)
- 9800 - Leukemia, NOS - to generic mainly used for DCO and Path only cases
- 9860 – Myeloid leukemia, NOS
  Abstractor Notes: More specific leukemias include –
  AML with inv(16)(p13.1q22) (9871)
Question #11

- Patient presented with jaundice. CT of the abdomen revealed an 8 cm tumor in the right lobe of the liver with smaller (0.5 cm and 1.0 cm) tumor nodules adjacent to the larger tumor; left lobe negative. A fine needle aspiration biopsy of the liver was performed and revealed hepatocellular carcinoma. The clinical T code is:
  - C - cT3a (multiple tumors more than 5 cm, Any)


- Correct - 13
- Incorrect - 3

Question #12

- A surgical path report states the following: Primary site: Ascending colon. Invasive moderately differentiated adenocarcinoma. The tumor invades through the bowel wall to the pericolic fat. Twelve regional nodes examined, three right colic positive for metastatic adenocarcinoma. Liver biopsy reveals metastatic adenocarcinoma consistent with colon primary. Question: What is the correct clinical M code?
  - B - pM1a


- Correct - 10
- Incorrect – 6
AJCC T, N, and M Category Presentation

- pM1 for clinical stage, biopsy was during workup
- pM1 is both clinical and pathologic stage IV according to AJCC rules –
  - Case with pM1 may be grouped as clinical and pathologic stage IV regardless of c or p status of T and N
- pT and pN are blank since all cT / cN options not available
  - Will be adjusted in 2017 for 8th edition

AJCC 7th Edition – page 11, table 1.7, 6th rule

Question #13

- An excisional biopsy of a breast tumor shows extensive DCIS. Code clinical T as:
  - B - pTis


- Correct - 13
- Incorrect - 3
Question #14

- 54 year old symptomatic patient with heme positive stools. CEA elevated. Colonoscopy reveals 2.5 cm polyp at 35 centimeter location. Polypectomy specimen sent to pathology, reveals infiltrating adenocarcinoma arising in tubulo-villous adenoma, with invasion beyond the lamina propria involving the entire specimen. The base margin is free of tumor. Question: What is the correct pathologic T code?

- C - pT1

- AJCC Cancer Staging Manual, 7th edition, Colon and Rectum Chapter 14 (superficial invasion greater than carcinoma in situ) and 2016 AJCC Category Code Instructions for using "c" and "p" Category Prefix Designator

- Correct - 11  Incorrect - 5

Question #15

- Patient is diagnosed, during the same admission, with papillary transitional cell carcinoma of the bladder and adenocarcinoma of the prostate. The bladder cancer was treated with a TURB. The prostate cancer was treated with radiation to the prostate and pelvis. The pelvic radiation includes the regional lymph nodes for the bladder. Radiation treatment is coded

- C - Both for the prostate cancer and the bladder cancer

- FORDS Page 22 and SEER manual page 108 First Course of Therapy (Example found in the SEER manual, page 110 #5 Code the treatment on each abstract when a patient has multiple primaries and the treatment given for one primary also affects/treats another primary)

- Correct - 7  Incorrect - 9
Question #16

• According to AJCC, the timing rule for Pathological Staging includes: any information through the completion of definitive surgery as part of first course treatment or identified w/in 4 months after the date of diagnosis, whichever is longer, as long as there is no systemic or radiation therapy initiated or the cancer has not clearly progressed during that timeframe.

• True


• Correct - 16 Incorrect – 0

Question #17

• The TNM and Stage from the pathology report is used to assign the Final Stage?

• False

• AJCC and Donna Gress Chapter 1 presentation - Pathology reports are NOT the final stage and are considered only 1/3 of the necessary information. Need to consider other work up involved (clinical work-up, Op report etc….)

• Correct - 15 Incorrect - 1
Question #18

- The use of BLANKs when assigning TNM indicates the registrar could not find information in the chart?
  - True

AJCC Presentation - Explaining Blanks and X, Ambiguous Terminology and Support for AJCC Staging Dec 2015

- Correct - 9  Incorrect - 7

AJCC Presentation - Explaining Blanks & X, Ambiguous Terminology

- Blanks should be used when
  - No information is available in chart
  - Cannot be assigned a valid AJCC category
  - Patient not eligible for clinical and/or pathologic stage
    - Categories are blank
    - Stage group is blank or 99
- Cannot use X for other situations
  - No surgical resection is NOT pTX pNX pM blank
  - Stage 99
Question #19

• If the assigned TNM does not allow a specific Stage to be assigned, you should leave the Stage Blank?

• False

• AJCC Presentation - Explaining Blanks and X, Ambiguous Terminology and Support for AJCC Staging Dec 2015 (CoC mandates non-blank for clinical and pathologic stage group, use 99)

• Correct - 10 Incorrect - 6

Question #20

• AJCC utilizes defined Ambiguous Terms to determine involvement or extension?

• False

• AJCC Presentation - Explaining Blanks and X, Ambiguous Terminology and Support for AJCC Staging Dec 2015.

• Correct - 13 Incorrect - 3
Question #21

• Current cancer reporting software allows registrars to capture Retreatment Classification (rTNM) and Autopsy Classification (aTNM)?

• False

• Retreatment and Autopsy coding is not addressed in FORDS or SEER

• Correct - 14 Incorrect - 2

Question #22

• If two or more malignant neoplasms are diagnosed at the same time, you must abstract both cases using the same accession number with the lower sequence number assigned to the malignancy with the worse prognosis.

• True

• FORDS 2015 Section II Instructions for Coding - Accession Number and Sequence Number

• Correct - 14 Incorrect - 2
Question #23

• Beginning with cases diagnosed 1/1/2016, "c" and "p" classification indicators will be required for assigning TNM?
  
  • True
  
  • All standard setters and CDRI required.
  
  • Correct - 16 Incorrect - 0

Question #24

• A Glioblastoma or Glioblastoma Multiforme following a Glial tumor is a new primary.

• False

• MPH Malignant Brain and CNS Rule M6

• Correct - 14 Incorrect - 2
Question #25

- Patient with pituitary adenoma noted on MRI. The histology and behavior should be coded 8140/0
- False
- ICD-O-3 Histology Code - 8272 Behavior 0 (adenoma, NOS is incorrect)
- Correct - 13 Incorrect – 3

Educational Opportunities

- NAACCR Webinars
  - Available to ALL Idaho Registrars
  - CDRI’s Website
  - Time Commitment - 3 Hours
  - CE’s 3 Recommended webinars
- 2016 Recommended Webinars
  - Sept - Coding Pitfalls – Not available yet
  - Aug – Bladder
  - June - Prostate
  - Mar – Coding Boot Camp
  - My Favorites Coding Boot Camp and Pitfalls
AJCC Presentations

- Web Link - [https://cancerstaging.org/CSE/Registrar/Pages/default.aspx](https://cancerstaging.org/CSE/Registrar/Pages/default.aspx)
- Presentations:
  - Registrar’s Guide to Chapter 1
  - Explaining Blanks & X, Ambiguous Terminology
  - AJCC T, N, and M Category Options for 2016
- Disease Site Webinars: Recording
  - Melanoma – Recording Available
  - Lung – Recording Available
  - Breast – Recording Available
  - Prostate – Scheduled Sept 21\textsuperscript{st}
  - Colorectum – Rescheduled Sept 28\textsuperscript{th}

The End

*Life moves pretty fast. If you don’t stop and look around once in a while, you could miss it.* — Hemingway’s *On the Road*