


**Collecting Cancer Data:  
Breast**

April 7, 2011  
NAACCR 2010-2011 Webinar Series



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**Q&A**

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



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**Agenda**

- Overview
  - Primary Site
  - Regional Lymph Nodes
  - Distant Metastasis
  - Prognostic Factors
- CSV2
- Case Scenario



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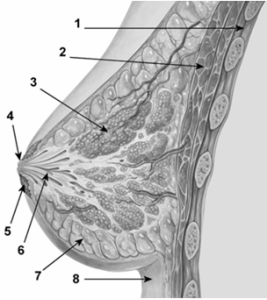
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**Primary Site**

1. Chest Wall
  - Ribs
  - Intercostal muscles
  - Serratus anterior muscle
2. Pectoral Muscle



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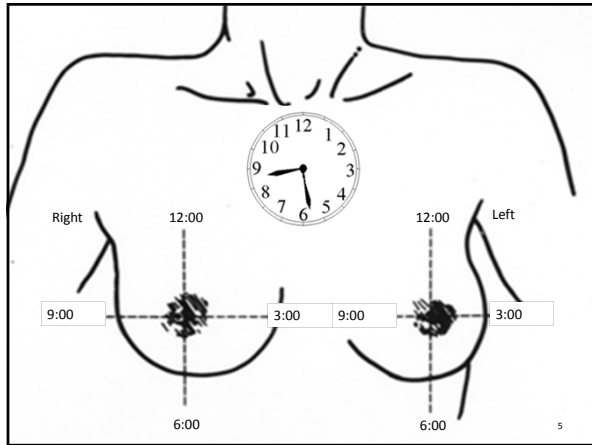
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**Primary Site**

- Coding Primary Site
  - Code the subsite with the invasive tumor when the pathology report identifies invasive tumor in one subsite and in situ tumor in a different subsite or subsites.
  - Code the specific quadrant for multifocal tumors all within one quadrant
    - Do not code C509 (Breast, NOS) in this situation

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**Primary Site**

- Code the primary site to C508 when
  - There is a single tumor in two or more subsites and the subsite in which the tumor originated is unknown
  - There is a single tumor located at the 12, 3, 6, or 9 o'clock position on the breast
- Code the primary site to C509 when there are multiple tumors (two or more) in at least two quadrants of



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**Grade**

- Histologic grade, differentiation, codes
  - 1 = well differentiated
  - 2 = moderately differentiated
  - 3= poorly differentiated
  - 4= undifferentiated



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**Nottingham Combined Histologic Grade**

- Frequency of cell mitosis
- Glandular/Tubule formation
- Nuclear pleomorphism
- Overall Grade
  - Grade 1: scores of 3, 4, or 5
  - Grade 2: scores of 6 or 7
  - Grade 3: scores of 8 or 9



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**Grade**

Code	BR (Nottingham) Score	BR Grade	Nuclear Grade	Terminology	Histologic Grade
1	3-5	Low	1/3 or 1/2	Well Differentiated	I or I/III or 1/3
2	6 or 7	Intermediate	2/3	Moderately Differentiated	II or II/III or 2/3
3	8 or 9	High	2/2 or 3/3	Poorly Differentiated	III or III/III or 3/3
4	--		4/4	Undifferentiated or Anaplastic	IV or IV/IV or 4/4

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**Question**

- Final pathology
  - Infiltrating ductal carcinoma Nottingham score of 7
- How do we code...
  - Grade
  - Grade Path Value
  - Grade Path System

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**Question**

- A biopsy of the breast showed a Nottingham score of 6. The lumpectomy showed a Nottingham score of 4. Do you take the higher score, or the score where the most tissue was resected?

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**Answer**

- The grade plays a role in determining treatment and prognosis, so it is important to have the highest score recorded, even if only a small part of the tumor was more aggressive since this affects survival.
  - CAnswer Forum
- When the pathology report(s) lists more than one grade of tumor, code to the highest grade, even if the highest grade is only a focus.
  - Rule G, ICD-O-3, p. 21



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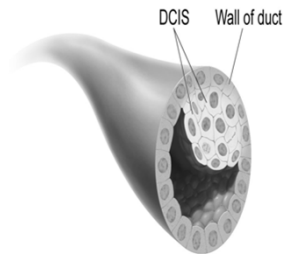
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**Ductal Carcinoma In Situ**

- A malignant carcinoma arising in the lining of the milk ducts.
- Has not yet invaded nearby tissues.



National Cancer Institute

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**Ductal Carcinoma In Situ**

ICD O 3 Code	Type
8201	Cribriform
8230	Solid
8401	Apocrine
8500	Ductal Carcinoma In Situ (Intraductal, NOS)
8501	Comedo
8503	Papillary
8504	Intracystic carcinoma
8507	Micropapillary/Clinging



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**Intraductal mixed with other subtypes**

- Intraductal and two or more of the histologies in below or two or more of the histologies below are coded to 8523/2 (intraductal mixed with other types of carcinoma)
  - Cribriform
  - Solid
  - Apocrine
  - Papillary
  - Micropapillary
  - Clinging



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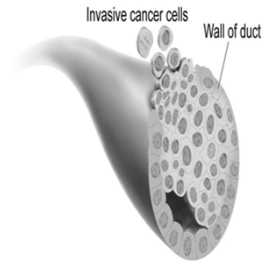
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**Ductal Carcinoma**

- 70-80% of all invasive carcinomas are Ductal in origin.



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**Ductal Carcinoma**

ICD O 3 Code	Type
8022	Pleomorphic carcinoma
8035	Carcinoma with osteoclast-like cells
8500	Ductal carcinoma, NOS
8501	Comedocarcinoma
8502	Secretory carcinoma
8503	Intraductal papillary adenocarcinoma with invasion
8508	Cystic hypersecretory carcinoma



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### Ductal Carcinoma

- A tumor with infiltrating ductal carcinoma and any of the other histologies listed below should be coded to 8523/3 (infiltrating duct mixed with other types of carcinoma)
  - Tubular
  - Apocrine
  - Mucinous
  - Intraductal papillary adenocarcinoma with invasion
  - Secretory carcinoma
  - Intracystic carcinoma, nos
  - Medullary



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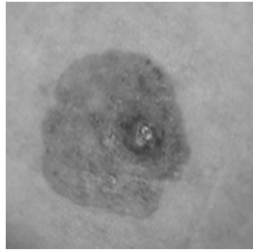
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### Paget Disease

- More than 95 percent of people with Paget disease of the nipple also have underlying breast cancer.
- Symptoms include redness and mild scaling and flaking of the nipple skin



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### Paget Disease

- If Paget disease is present and the underlying tumor is either ductal carcinoma or ductal carcinoma in situ, consider a single primary.
  - Rule M9 MP/H



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**Paget Disease**

- When Paget disease is present and stated to be in situ and the underlying tumor is intraductal carcinoma, code 8543/2
  - Rule H24
- When Paget disease (NOS) is present and the underlying tumor is intraductal, code 8543/3
  - Rule H25
- When Paget disease is present and the underlying tumor is invasive ductal, code 8541/3
  - Rule H26



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**Inflammatory Carcinoma**

- Clinical/pathologic disease
- Characterized by diffuse erythema and edema (peau d'orange) involving more than 1/3 of the breast.
  - Skin changes are due to tumor in the dermal lymphatics
  - An underlying mass is often present
  - A biopsy is done to prove the presence of an invasive malignancy



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**Inflammatory Carcinoma**

- Inflammatory carcinoma in one or both breasts is a single primary
  - Rule M2 if a single underlying tumor is present
  - Rule M6 if multiple underlying tumors are present



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### Inflammatory Carcinoma

- Only use code 8530 (inflammatory carcinoma) when the final diagnosis of the pathology report specifically states inflammatory carcinoma.
  - Rule H13 if a single underlying tumor is present
  - Rule H22 if multiple underlying tumors are present



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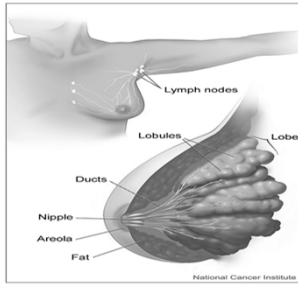
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### Regional Lymph Nodes



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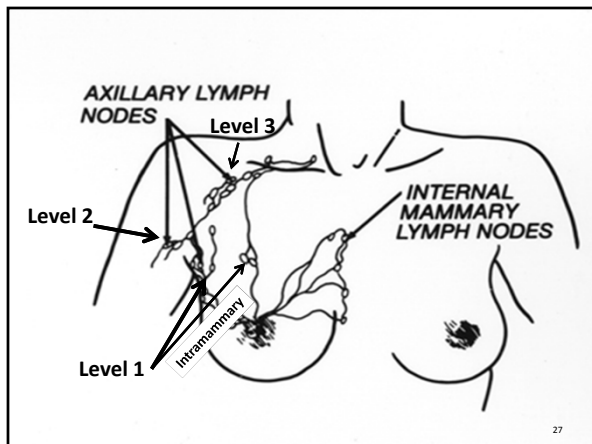
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**Regional Lymph Nodes**

- Axillary lymph nodes level I
  - Low axillary
  - Intramammary
- Axillary lymph nodes level II
  - Mid axillary
  - Interpectoral
  - Rotter's nodes
- Axillary lymph nodes level III
  - High axillary
  - Apical
  - Infraclavicular
- Involvement of Level I or II axillary nodes is assigned AJCC N1 or N2
- Involvement of Level III axillary nodes is assigned an AJCC N3a

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**Sentinel Lymph Node Biopsy**

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**Distant Metastasis**

- The four major sites of metastatic involvement are...
  - Bone
  - Lung
  - Brain
  - Liver
- Disseminated tumor cells (DTCs)
- Circulating tumor cells (CTCs)

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**Clinically Significant Prognostic Factors**

- Paget's disease
- Bloom Scarff Richardson Grade
- Estrogen receptors
- Progesterone receptors
- HER2 status
- Method of node assessment
- Immunohistochemistry(IHC) testing of lymph nodes
- Multigene signature score



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**Questions?**



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**Collaborative Stage Data  
Collection System**

V02.03



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**CS Tumor Size: Breast**

- Assign 'Stated as T\_ ' when no other information on tumor size is available
  - Stated as T1mi; assign code 990
  - Stated as T1a; assign code 005
  - Stated as T1b; assign code 991
  - Stated as T1 (NOS) or T1c; assign code 992
  - Stated as T2; assign code 995
  - Stated as T3; assign code 051



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**CS Tumor Size: Breast**

- When coding pathologic tumor size of breast tumor
  - Code size of invasive portion of tumor if tumor is both invasive and in situ
  - Code size of entire tumor if tumor is both invasive and in situ and size of invasive portion is not given



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**CS Extension: Breast**

- Assign 'Stated as T\_ ' CS Extension code when no other information on extension is available
  - Additional codes available in CS v02.03
  - Some codes changed in v02.03



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**CS Extension: Breast**

- Assign CS Extension codes 512 – 585 for skin involvement as described in the code WITHOUT diagnosis of inflammatory carcinoma
- Assign CS Extension code 600 for diagnosis of inflammatory carcinoma WITH clinical description of specific skin involvement in less than 1/3 of skin of breast
- Assign CS Extension codes 725-750 for diagnosis of inflammatory carcinoma with clinical description of skin involvement as described in the code



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**CS Lymph Nodes: Breast**

- Certain CS Lymph Nodes codes are only used if nodes are evaluated clinically
  - CS Lymph Nodes Eval code = 0, 1, 5, or 9
- Certain CS Lymph Nodes codes are only used if nodes are evaluated pathologically
  - CS Lymph Nodes Eval code = 2, 3, 6, or 8



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**CS Lymph Nodes: Breast**

- Lymph nodes evaluated clinically
  - Code 255
  - Code 257\*
  - Code 510
  - Code 610\*
  - Code 735\*
  - Code 810\*



\*New in v02.03

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**CS Lymph Nodes: Breast**

Lymph Nodes Evaluated Pathologically

- Code 050
- Code 130
- Code 150
- Code 155\*
- Code 250
- Code 258\*
- Code 520
- Code 620\*
- Code 710
- Code 720
- Code 730
- Code 815



\*New in v02.03

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**CS Lymph Nodes: Breast**

- Isolated tumor cells (ITC)
  - Single tumor cells or clusters not greater than 0.2 mm
- Micrometastases
  - Tumor deposits greater than 0.2 mm but not greater than 2.0 mm
- Macrometastases
  - Tumor deposits greater than 2.0 mm



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**CS Mets at DX: Breast**

- Assign code 00 (no distant metastasis) unless there is documented evidence of distant metastasis
- Assign code 05 if there is no clinical or radiographic evidence of metastasis but there are circulating tumor cells (CTC), bone marrow micrometastases, or disseminated tumor cells 0.2 mm or less in size in distant tissue detected molecularly or microscopically



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**SSF1: Estrogen Receptor (ER) Assay**  
**SSF2: Progesterone Receptor (PR) Assay**

- Record highest value for ERA and/or PRA if more than 1 value is reported
- Record pre-treatment ERA and/or PRA if patient is given neoadjuvant therapy unless there are no pre-treatment ERA and/or PRA results
- Do not record ERA and/or PRA results from multigene test in SSF1 or SSF2



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**SSF3: Number of Positive Ipsilateral Level I-II Axillary Lymph Nodes**

- Code number of positive ipsilateral level I and II axillary nodes and intramammary nodes
  - Do not include level III axillary nodes, internal mammary, or supraclavicular nodes that are involved
  - Do not code lymph nodes with only isolated tumor cells (ITC)
  - Assign code 098 if no ipsilateral axillary nodes are removed and pathologically examined
  - Based on pathologic information only



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**SSF4 and SSF5**

- SSF 4: Immunohistochemistry (IHC) of Regional Lymph Nodes
- SSF5: Molecular (MOL) Studies of Regional Lymph Nodes
  - Reverse Transcriptase Polymerase Chain Reaction (RT-PCR)
- Code involvement or non-involvement of regional nodes by ITC
  - ITC are single tumor cells or clusters not greater than 0.2 mm



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**SSF6: Size of Tumor-Invasive Component**

- Indicates how pathological tumor size was coded in CS Tumor Size
- Assign code 987 if clinical tumor size is coded in CS Tumor Size



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**SSF7: Nottingham or Bloom-Richardson (BR) Score/Grade**

- BR score is based on:
  - Degree of tubule formation
  - Mitotic activity
  - Nuclear pleomorphism
- Code in the following priority
  1. BR scores 3-9
  2. BR grade (low, intermediate, high)
- Code highest score if multiple scores are documented



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**HER2 Testing**

- Human Epidermal growth factor Receptor 2
- Four known HER proteins
  - HER1, 2, 3, and 4
- Testing for over expression of HER2



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### HER2 Testing

- Usually only one test will be performed
  - Immunohistochemistry (IHC)
  - Fluorescence In Situ Hybridization (FISH)
  - Chromogenic In Situ Hybridization (CISH)
- May be referred to as:
  - HER2, HER2 neu, c-erbB2, c-neu



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### HER2 Test Lab Values and Interpretations

- SSF8 & SSF9: HER2 IHC Test
  - Lab value is a score
    - 0 or 1+
    - 2+
    - 3+
- SSF10 & SSF11: HER2 FISH Test
  - Lab value is a ratio between the number of copies of Her2/neu gene and number of copies of chromosome 17



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### HER2 Test Lab Values and Interpretations

- SSF12 & SSF13: HER2 CISH Test
  - Lab value is mean number of copies of HER2/neu gene on either 30 or 60 tumor cells
- SSF14: Other or Unknown HER2 Test
  - Silver in-situ hybridization (SISH)
  - Rapid in situ hybridization against mRNA (RISH)



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**HER2 Test  
Lab Values and Interpretations**

- SSF15: Her2 Summary Results
  - If multiple HER2 tests are performed, gene-amplification (in situ hybridization) test takes precedence
  - If IHC is performed to clarify results of a borderline/equivocal gene-amplification test, code IHC results
  - If results of 1 test are available and it is known that a 2<sup>nd</sup> test was performed and results are not available, use code 997 (test ordered, results not in chart)



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**SSF16: Combinations of ER, PR, and HER2 Results**

- Identifies patients who are triple negative
  - ER negative, PR negative, HER2 negative
  - Less likely to respond to hormone therapy or Herceptin
- Code ER results in 1st digit, PR results in 2<sup>nd</sup> digit, HER2 results in 3<sup>rd</sup> digit
- Assign code 999 if 1 or more of tests is not performed



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**SSF17: Circulating Tumor Cells (CTC) and Method of Detection**

- Record whether CTC are present and test used to detect them
- CTC
  - Deposits of molecularly or microscopically detected tumor cells in circulating blood
- Tests
  - Immunomagnetic separation (IMS)
  - Reverse transcription polymerase chain reaction (RT-PCR)



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**SSF17: Circulating Tumor Cells (CTC) and Method of Detection**

- Record whether CTC are present and test used to detect them
- CTC
  - Deposits of molecularly or microscopically detected tumor cells in circulating blood
- Tests
  - Immunomagnetic separation (IMS)
  - Reverse transcription polymerase chain reaction (RT-PCR)



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**SSF18: Disseminated Tumor Cells (DTC) and Method of Detection**

- Record whether DTC are present and test used to detect them
- DTC
  - Deposits of molecularly or microscopically detected tumor cells in bone marrow or other non-regional nodal tissue no larger than 0.2 mm
- Tests
  - Immunohistochemistry (IHC)
  - Reverse transcription polymerase chain reaction (RT-PCR)



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**SSF19: Assessment of Positive Ipsilateral Axillary Lymph Nodes**

- Record information used to determine the number of positive axillary and intramammary lymph nodes coded in SSF3 (Number of Positive Ipsilateral Level I-II Axillary Lymph Nodes)
  - Examples: Clinical only; fine needle aspiration; core biopsy; sentinel lymph node biopsy; lymph node dissection



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**SSF20: Assessment of Positive Distant Metastases**

- Record information used to determine metastases coded in CS Mets at DX, CS Mets at DX - Bone, CS Mets at DX - Brain, CS Mets at DX - Liver, and CS Mets at DX – Lung
- Assign code 000 if CS Mets at DX is assigned code 00
- Use highest code that applies if multiple methods were used



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**SSF21: Response to Neoadjuvant Therapy**

- Code clinician’s statement regarding response to neoadjuvant therapy
  - Do not interpret or infer other documentation into a response



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**SSF22: Multigene Signature Method**  
**SSF23: Multigene Signature Results**

- Multigene signature testing
  - Evaluates multiple genes from the tumor specimen
  - Plans treatment
  - Evaluates prognosis
  - Predicts recurrence
  - Types: Oncotype DX; MammaPrint; IHC- based Multigene Predictors; FISH-based Predictors; RT-PCR-based Multigene Predictors; Genomic Microarray-based Multigene Predictors



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**SSF24: Paget Disease**

- Record absence or presence of Paget disease
  - Record any mention of Paget disease, clinical or pathologic, giving pathologic priority
- Code 020 – New in v02.03
  - Stated as pagetoid involvement of nipple
    - Do not assign code 020 if pagetoid involvement is of ducts or lobules



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**Standard Setters SSF Requirements for Breast**

- Commission on Cancer and NCI/SEER
  - Required
    - SSF1 – SSF14, SSF21 – 23
    - SSF15 beginning with CS v02.03
- CDC/NPCR
  - Required
    - SSF1, SSF2
    - SSF15, SSF16 beginning with CS v02.03
  - Required to calculate AJCC stage; required when available
    - SSF3 – SSF5, SSF8 – SSF14



<http://www.cancerstaging.org/cstage/manuals/coding0203.html> 62

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**Standard Setters SSF Requirements for Breast**

- Canadian Council of Cancer Registries
  - Collected in CSv1
    - SSF1, SSF2, SSF6
  - Essential for TNM
    - SSF3 – SSF5
  - Essential for decision making
    - SSF7 – SSF16
  - Collect if in pathology report
    - SSF17, SSF18, SSF21- SSF24
  - Collect if readily available in chart
    - SSF19, SSF20



<http://www.cancerstaging.org/cstage/manuals/coding0203.html> 63

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**Case Scenarios**



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**Case Scenario 1**

- 1/3/11-A 57 year old white female presents for her annual mammogram and is found to have a suspicious area of calcification, spread out over at least 4 centimeters.
- 1/7/11 Final Pathology from stereotactic biopsy-High grade Ductal carcinoma insitu
  - ER 95% (positive) and PR 90% (positive)
  - HER2/Neu-Negative per IHC
- 1/7/11-MRI of the breast did not show any additional areas of abnormality. She was referred to a surgeon for breast conserving surgery to be followed by radiation.



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**Case Scenario 1**

- 1/27/11 Final pathology from lumpectomy
  - High-grade DCIS, with no invasion. The specimen dimension was 4.6 cm x 3.5 cm x 1.6 cm. Architectural patterns: cribriform, micropapillary, papillary, solid. Necrosis: Present, focal. 9 mm negative margin.
- 2/15/2011 Radiation
  - The patient received IMRT 45 Gy at 1.8 Gy per fraction for 25 fractions.
- 2/30/2011-Tamoxifen
  - Patient started a 5 year course of tamoxifen



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**Case Scenario 1**

- How many primaries are present?
- How would we code the histology?



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**Case Scenario 1**

- |               |         |
|---------------|---------|
| • TS          | • SSF 1 |
| • Ext         | • SSF 2 |
| • TS/Ext Eval | • SSF 3 |
| • LN's        | • SSF 4 |
| • LN Eval     | • SSF 5 |
| • RN Pos      | • SSF 6 |
| • RN Ex       | • SSF 7 |
| • Mets        | • SSF 8 |
| • Mets Eval   | • SSF 9 |



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**Case Scenario 1**

- |          |          |
|----------|----------|
| • SSF 10 | • SSF 18 |
| • SSF 11 | • SSF 19 |
| • SSF 12 | • SSF 20 |
| • SSF 13 | • SSF 21 |
| • SSF 14 | • SSF 22 |
| • SSF 15 | • SSF 23 |
| • SSF 16 | • SSF 24 |
| • SSF 17 | • SSF 25 |



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**Case Scenario 1**

Surgical Codes

- Surgical Procedure of Primary Site
- Scope of Regional Lymph Node Surgery
- Surgical Procedure/Other Site

Systemic Therapy Codes

- Chemotherapy
- Hormone Therapy
- Immunotherapy
- Hematologic Transplant/Endocrine Proc



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**Case Scenario 1**

Radiation

- Radiation Treatment Volume
- Radiation Treatment Modality
- Regional Dose
- Boost Treatment Modality
- Boost Dose
- Number of Treatments to Volume
- Reason no Radiation



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**Case Scenario 2**

- 62 year old female presented with a large palpable mass in the left breast. Mammogram showed a 5.7cm mass highly suspicious for malignancy. Physical exam revealed a single level I movable enlarged axillary lymph node. Additional imaging was negative.



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**Case Scenario 2**

- Core needle biopsy of primary tumor-final report
  - Infiltrating ductal carcinoma with features of comedocarcinoma
  - Estrogen receptor positive
  - Progesterone receptor positive
  - Her 2/Neu 2+ equivocal on IHC
  - Her 2/Neu 2.4 positive on FISH
  - Nottingham score 7
- Core needle biopsy of enlarged axillary lymph node
  - Metastatic ductal carcinoma
- Clinical AJCC Stage
  - T3 N1, M0 Stage IIB



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**Case Scenario 2**

- The patient opted for neoadjuvant treatment followed by breast conserving surgery.
  - Concurrent chemotherapy and hormone therapy for nine weeks.
  - Per the physicians notes she experienced a near total response to the chemotherapy.



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**Case Scenario 2**

- Final pathology report-lumpectomy and axillary node dissection.
  - Largest dimension of invasive tumor: 1.7cm
  - Extension: No skin, nipple or skeletal muscle involvement
  - Histologic type: Invasive ductal carcinoma, comedo type
  - Bloom Scarff Richardson grade: Grade 2
  - Margins: Negative
  - Partial response to presurgical therapy



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**Case Scenario 2**

- Final pathology report-lumpectomy and axillary node dissection
  - 23 axillary lymph nodes negative for metastasis
  - AJCC Stage
    - yP1c N0 Stage Ia
- Adjuvant therapy included continuation of hormone therapy and IMRT radiation therapy
  - 50 Gy in 2Gy fractions to the whole breast and regional nodes over 25 days.
  - 10 Gy Boost in 2Gy fractions over 5 days to the tumor bed.



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**Case Scenario 2**

- How many primaries are present?
- How would we code the histology?



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**Case Scenario 2**

- |               |         |
|---------------|---------|
| • TS          | • SSF 1 |
| • Ext         | • SSF 2 |
| • TS/Ext Eval | • SSF 3 |
| • LN's        | • SSF 4 |
| • LN Eval     | • SSF 5 |
| • RN Pos      | • SSF 6 |
| • RN Ex       | • SSF 7 |
| • Mets        | • SSF 8 |
| • Mets Eval   | • SSF 9 |



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**Case Scenario 2**

- SSF 10
- SSF 11
- SSF 12
- SSF 13
- SSF 14
- SSF 15
- SSF 16
- SSF 17
- SSF 18
- SSF 19
- SSF 20
- SSF 21
- SSF 22
- SSF 23
- SSF 24
- SSF 25

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**Case Scenario 2**

- Surgical Procedure of Primary Site
- Scope of Regional Lymph Node Surgery
- Surgical Procedure/Other Site

Systemic Therapy

- Chemotherapy
- Hormone Therapy
- Immunotherapy
- Hematologic Transplant/Endocrine Proc

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**Case Scenario 2**

Radiation

- Radiation Treatment Volume
- Radiation Treatment Modality
- Regional Dose
- Boost Treatment Modality
- Boost Dose
- Number of Treatments to Volume
- Reason No Radiation

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**Case Scenario 3**

- Physician Office Report 1/3/11
  - A 47 year female presents with changes to her left breast. She was diagnosed with ductal carcinoma of the left breast in February of 2005. At that time she underwent breast conserving surgery with an axillary node dissection showing 3 of 21 positive lymph nodes. She received chemotherapy and radiation.



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**Case Scenario 3**

- She recently presented to my office with concerns that her left breast has become swollen, warm to the touch and that areas of the skin had become thickened and pinkish.
- Physical exam revealed edema and a peau d'orange appearance to the breast. Also noted was a palpable mass in the lower inner portion of her breast.
- A stereotactic needle biopsy was performed and she was found to have invasive ductal carcinoma, ER and PR positive, HER2/neu 3+ (positive) per IHC. She was referred to an oncologist for treatment planning.



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**Scenario 3**

- Oncology Consult/Assessment and Plan 1/12/11
  - A patient with a previous history of ductal carcinoma now presents with inflammatory breast cancer involving a little less than half her breast. A complete staging work-up revealed a 4.8cm tumor in the left breast. No direct involvement of the skin or chest wall. It is noted that the axillary nodes were previously removed. No metastasis is noted. However, IMS testing for circulating tumor cells was positive.
  - It would be my plan to treat her relatively quickly with presurgical chemotherapy. If she responds to the chemotherapy this will be followed by mastectomy and additional chemotherapy.
  - Due to previous radiation she is not a candidate for additional radiation treatment.



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**Scenario 3**

- Progress notes 2/21/11
  - Patient received a nine week preoperative course of anthracycline, taxane, and trastuzumab. She had an excellent partial response to treatment.
  - She has been scheduled for a simple mastectomy with insertion of a tissue expander later this week.



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**Scenario 3**

Simple mastectomy 2/28/11

- Final Report
  - Histologic type: Invasive ductal carcinoma
  - Largest dimension of invasive tumor: 1.3cm
  - Extension: Involvement of the dermal lymphatics by tumor emboli.
  - Nottingham score: 8
  - Definite response to presurgical therapy



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**Scenario 3**

- Oncology Progress Report - 4/1/11
  - She started her final course of anthracycline and taxane last week.
  - She will continue to take her Herceptin until she completes her one year course.
  - She started her five year course of Tamoxifen.



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**Case Scenario 3**

- How many primaries are assigned to this patient
- How would we code the histology?



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**Case Scenario 3**

- |               |         |
|---------------|---------|
| • TS          | • SSF 1 |
| • Ext         | • SSF 2 |
| • TS/Ext Eval | • SSF 3 |
| • LN's        | • SSF 4 |
| • LN Eval     | • SSF 5 |
| • RN Pos      | • SSF 6 |
| • RN Ex       | • SSF 7 |
| • Mets        | • SSF 8 |
| • Mets Eval   | • SSF 9 |



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**Case Scenario 3**

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|----------|----------|
| • SSF 10 | • SSF 18 |
| • SSF 11 | • SSF 19 |
| • SSF 12 | • SSF 20 |
| • SSF 13 | • SSF 21 |
| • SSF 14 | • SSF 22 |
| • SSF 15 | • SSF 23 |
| • SSF 16 | • SSF 24 |
| • SSF 17 | • SSF 25 |



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**Case Scenario 2**

- Surgical Procedure of Primary Site
  - Scope of Regional Lymph Node Surgery
  - Surgical Procedure/Other Site
- Systemic Therapy
- Chemotherapy
  - Hormone Therapy
  - Immunotherapy
  - Hematologic Transplant/Endocrine Proc



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**Case Scenario 3**

- Radiation
- Radiation Treatment Volume
  - Radiation Treatment Modality
  - Regional Dose
  - Boost Treatment Modality
  - Boost Dose
  - Number of Treatments to Volume
  - Reason No Radiation



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**Questions?**



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**Standard Setters SSF Requirements for Breast**

- Commission on Cancer and NCI/SEER
  - Required
    - SSF1 – SSF14, SSF21 – 23
    - SSF15 beginning with CS v02.03
- CDC/NPCR
  - Required
    - SSF1, SSF2
    - SSF15, 16 beginning with CS v02.03
  - Required to calculate AJCC stage; required when available
    - SSF3 – SSF5, SSF8 – SSF14

 <http://www.cancerstaging.org/cstage/manuals/coding0203.html> 94

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**Standard Setters SSF Requirements for Breast**

- Canadian Council of Cancer Registries
  - Collected in CSv1
    - SSF1, SSF2, SSF6
  - Essential for TNM
    - SSF3 – SSF5
  - Essential for decision making
    - SSF7 – SSF16
  - Collect if in pathology report
    - SSF17, SSF18, SSF21- SSF24
  - Collect if reading available in chart
    - SSF19, SSF20

 <http://www.cancerstaging.org/cstage/manuals/coding0203.html> 95

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**Thank You!**

- Collecting Cancer Data: Prostate
  - May 5, 2011

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## MULTIPLE PRIMARY RULES

### UNKNOWN IF SINGLE OR MULTIPLE TUMORS

- Rule M1 When it is not possible to determine if there is a single tumor or multiple tumors, opt for a single tumor and abstract as a single primary.

### SINGLE TUMOR

- Rule M2 Inflammatory carcinoma in one or both breasts is a single primary.
- Rule M3 A single tumor is always a single primary

### MULTIPLE TUMORS

- Rule M4 Tumors in sites with ICD-O-3 topography codes (Cxxx) with different second (Cxxx) and/or third characters (Cxxx) are multiple primaries.
- Rule M5 Tumors diagnosed more than five (5) years apart are multiple primaries
- Rule M6 Inflammatory carcinoma in one or both breasts is a single primary.
- Rule M7 Tumors on both sides (right and left breast) are multiple primaries.
- Rule M8 An invasive tumor following an in situ tumor more than 60 days after diagnosis is a multiple primary.
- Rule M9 Tumors that are intraductal or duct and Paget Disease are a single primary.
- Rule M10 Tumors that are lobular (8520) and intraductal or duct are a single primary.
- Rule M11 Multiple intraductal and/or duct carcinomas are a single primary.
- Rule M12 Tumors with ICD-O-3 histology codes that are different at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries.
- Rule M13 Tumors that do not meet any of the above criteria are abstracted as a single primary.

## HISTOLOGY RULES

### SINGLE TUMOR: IN SITU ONLY

- Rule H1 Code the histology documented by the physician when the pathology/cytology report is not available.
- Rule H2 Code the histology when only one histologic type is identified
- Rule H3 Code the more specific histologic term when the diagnosis is:
  - Carcinoma in situ, NOS (8010) and a specific carcinoma in situ or Adenocarcinoma in situ, NOS (8140) and a specific adenocarcinoma in situ or
  - Intraductal carcinoma, NOS (8500) and a specific intraductal carcinoma (Table 1)
- Rule H4 Code 8501/2 (comedocarcinoma, non-infiltrating) when there is non-infiltrating comedocarcinoma and any other intraductal carcinoma (Table 1).
- Rule H5 Code 8522/2 (intraductal carcinoma and lobular carcinoma in situ) (Table 3) when there is a combination of in situ lobular (8520) and intraductal carcinoma (Table 1).
- Rule H6 Code 8523/2 (intraductal carcinoma mixed with other types of in situ carcinoma) (Table 3) when there is a combination of intraductal carcinoma and two or more specific intraductal types OR there are two or more specific intraductal carcinomas.
- Rule H7 Code 8524/2 (in situ lobular mixed with other types of in situ carcinoma) (Table 3) when there is in situ lobular (8520) and any in situ carcinoma other than intraductal carcinoma (Table 1).
- Rule H8 Code 8255/2 (adenocarcinoma in situ with mixed subtypes) (Table 3) when there is a combination of in situ/non-invasive histologies that does not include either intraductal carcinoma (Table 1) or in situ lobular (8520).

### SINGLE TUMOR: INVASIVE ONLY

- Rule H10 Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.
- Rule H11 Code the histology from a metastatic site when there is no pathology/cytology specimen from the primary site.
- Rule H12 Code the most specific histologic term when the diagnosis is:
  - Carcinoma, NOS (8010) and a more specific carcinoma or
  - Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
  - Duct carcinoma, NOS (8500) and a more specific duct carcinoma (8022, 8035, 8501-8508) or
  - Sarcoma, NOS (8800) and a more specific sarcoma
- Rule H13 Code 8530 (inflammatory carcinoma) only when the final diagnosis of the pathology report specifically states inflammatory carcinoma.
- Rule H14 Code the histology when only one histologic type is identified.
- Rule H15 Code the histology with the numerically higher ICD-O-3 code when there are two or more specific duct carcinomas.

- Rule H16 Code 8522 (duct and lobular) when there is a combination of lobular (8520) and duct carcinoma (Table 3).
- Rule H17 Code 8523 (duct mixed with other types of carcinoma) when there is a combination of duct and any other carcinoma (Table 3).
- Rule H18 Code 8524 (lobular mixed with other types of carcinoma) when the tumor is lobular (8520) and any other carcinoma (Table 3).
- Rule H19 Code 8255 (adenocarcinoma with mixed subtypes) (Table 3) for multiple histologies that do not include duct or lobular (8520).

#### MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

- Rule H20 Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.
- Rule H21 Code the histology from a metastatic site when there is no pathology/cytology specimen from the primary site.
- Rule H22 Code 8530 (inflammatory carcinoma) only when the final diagnosis of the pathology report specifically states inflammatory carcinoma.
- Rule H23 Code the histology when only one histologic type is identified.
- Rule H24 Code 8543/2 (in situ Paget disease and intraductal carcinoma) (Table 3) when the pathology report specifically states that the Paget disease is in situ and the underlying tumor is intraductal carcinoma (Table 1).
- Rule H25 Code 8543/3 (Paget disease and intraductal carcinoma) for Paget disease and intraductal carcinoma (Table 3).
- Rule H26 Code 8541/3 (Paget disease and infiltrating duct carcinoma) for Paget disease and invasive duct carcinoma.(Table 3).
- Rule H27 Code the invasive histology when both invasive and in situ tumors are present.
- Rule H28 Code 8522 (duct and lobular) when there is any combination of lobular (8520) and duct carcinoma. (Table 3).
- Rule H29 Code the histology with the numerically higher ICD-O-3 code.

## BREAST

### C50.0–C50.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

- **Codes**

- 00 None; no surgery of primary site; autopsy ONLY
- 19 Local tumor destruction, NOS

**No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).**

- 20 Partial mastectomy, NOS; less than total mastectomy, NOS
- 21 Partial mastectomy WITH nipple resection
- 22 Lumpectomy or excisional biopsy
- 23 Reexcision of the biopsy site for gross or microscopic residual disease
- 24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

**Procedures coded 20–24 remove the gross primary tumor and some of the breast tissue (breast conserving or preserving). There may be microscopic residual tumor.**

- 30 Subcutaneous mastectomy

**A subcutaneous mastectomy, also called a nipple sparing mastectomy, is the removal of breast tissue without the nipple and areolar complex or overlying skin. It is performed to facilitate immediate breast reconstruction. Cases coded 30 may be considered to have undergone breast reconstruction.**

- 40 Total (simple) mastectomy
- 41 WITHOUT removal of uninvolved contralateral breast
- 43 With reconstruction NOS
- 44 Tissue
- 45 Implant
- 46 Combined (Tissue and Implant)
- 42 WITH removal of uninvolved contralateral breast
- 47 With reconstruction NOS
- 48 Tissue
- 49 Implant
- 75 Combined (Tissue and Implant)

**A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done.**

**For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294) or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #674).**

**If contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.**

**Reconstruction that is planned as part of first course treatment is coded 43-49 or 75, whether it is done at the time of mastectomy or later.**

- 50 Modified radical mastectomy
- 51 WITHOUT removal of uninvolved contralateral breast
- 53 Reconstruction
- 54 Tissue
- 55 Implant
- 56 Combined (Tissue and Implant)

- 52 WITH removal of uninvolved contralateral breast
- 57 Reconstruction, NOS
- 58 Tissue
- 59 Implant
- 63 Combined (Tissue and Implant)
- 60 Radical mastectomy, NOS
- 61 WITHOUT removal of uninvolved contralateral breast
- 64 Reconstruction, NOS
- 65 Tissue
- 66 Implant
- 67 Combined (Tissue and Implant)
- 62 WITH removal of uninvolved contralateral breast
- 68 Reconstruction, NOS
- 69 Tissue
- 73 Implant
- 74 Combined (Tissue and Implant)
- 70 Extended radical mastectomy
- 71 WITHOUT removal of uninvolved contralateral breast
- 72 WITH removal of uninvolved contralateral breast
- 80 Mastectomy, NOS
- Specimen sent to pathology for surgical events coded 20-80.
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

### **Radiation Volume Codes**

- 18 Breast
  - The primary target is the intact breast and no attempt has been made to irradiate the regional lymph nodes. Intact breast includes breast tissue that either was not surgically treated or received a lumpectomy or partial mastectomy (C50.0– C50.9, Surgical Procedure of Primary Site [NAACCR Item #1290] codes 0– 24).
- 19 Breast/lymph nodes
  - A deliberate attempt has been made to include regional lymph nodes in the treatment of an intact breast. See definition of intact breast above.
- 20 Chest wall
  - Treatment encompasses the chest wall (following mastectomy).
- 21 Chest wall/lymph nodes
  - Treatment encompasses the chest wall (following mastectomy) plus fields directed at regional lymph nodes.