

Q&A Session
NAACCR Webinar Series
Collecting Cancer Data: Pancreas
January 05, 2012

Q: Will sticky notes be transferrable from the previous electronic version of CS to the updated version?

A: It is our understanding that if you added any highlights or sticky notes to your electronic version of CS you will be able to export them from your old version and import them into the new version. Keep in mind that the notes/comments might not be in the exact location because page numbers might have changed in the revised version.

Q: For the ICD-9-CM or ICD-10-CM codes that we must truncate to the first 5 characters in the comorbidity data items, does this include alphanumeric characters?

A: Yes, both alpha and numeric characters are included.

Q: What is the site code for the uncinata area?

A: The uncinata process is the part of the head of the pancreas that curves or hooks around the superior mesenteric vessels. The definition of uncinata is hook-like or hook shaped. The ICD-O-3 topography code for uncinata process of the pancreas is C25.0.

Q: Do you code ductal adenocarcinoma of the pancreas to 8500/3?

A: Yes, ductal adenocarcinoma of the pancreas should be assigned histology code 8500/3 per ICD-O-3 coding rule H: "Use the topography code provided when a topographic site is not stated in the diagnosis. This topography code should be disregarded if the tumor is known to arise at another site."

Q: Would the primary site be Islets of Langerhans for all neuroendocrine carcinomas of the pancreas?

A: We will consult the standard setters with that question.

Q: My question is in reference to the question on the slide about coding "non-secretory pancreatic endocrine tumor" with lymph node metastasis. If the histology did not include the qualifier "non-secretory" would we still assign code 8150/3?

A: Pancreatic endocrine carcinoma, malignant, would be assigned ICD-O-3 code 8150/3.

Q: Glucagonoma, insulinoma and somatostatinoma are identified in the WHO Classification of Tumors of the Digestive System (WHO blue book) as /3 (i.e 8152/3, 8151/3 and 8156/3 respectively). Can we use these accordingly?

A: No. Code as they are listed in the ICD-O-3 manual (/0 or /1).

Q: In the WHO classification of tumors (blue book) a well differentiated neuroendocrine tumor is considered a carcinoid (8240/3). Can we use this?

A: Assign histology code as defined in ICD-O-3.

Q: Are you saying that PAIN III is now a reportable diagnosis for NPCR?

A: On page 22 of Volume II Data Standards and Data Dictionary v12.2, it is stated that behavior code of 2 or 3 in ICD-O-3 is reportable, and the code for pancreatic intraepithelial neoplasia (PanIN III or PAIN III) has a behavior code of 2. It is not listed as an exception to reportable conditions with a behavior code of 2. I don't believe this is new. PanIN III has always been reportable.

Q: Is the PanIn III information current or 2012?

A: This is current information. PanIn III is assigned code 8148/2. Behavior code /2 histologies are reportable unless listed in the exception list. PanIn III is not in any of the standard setter's exception list.

Q: Does the pancreatic intraepithelial neoplasia need to be qualified with III (i.e PAIN III or PanIn III) or can the statement just be PAIN and we assume it is a PAIN III?

A: Yes, it must be qualified with III. PAIN I or PAIN II would not be assigned a behavior of /2 so would not be reportable.

Q: We do not have our MPH, but can you check under other sites H22 and tell us if there is any statement in the manual regarding "reportable by agreement"?

A: There is a note that says 8148/2 can be used for PIN III if it is reportable by agreement.

Q: Is that H21 or H22 about prostate?

A: It is a note with rule H22 from the other sites rules. I think they just added PIN as an example of when 8148 can be used. Rule H22 states: "Code 8148/2 (Glandular intraepithelial neoplasia grade III) for in situ glandular intraepithelial neoplasia grade III in sites such as the pancreas (PAIN III)."

Q: Should fine needle aspiration biopsy be assumed to be cytology unless otherwise specified?

A: No, you cannot make that assumption. A fine needle aspiration biopsy may be of tissue (pathology) or fluid (cytology). See <http://cancerbulletin.facs.org/forums/showthread.php?702-Surgical-Diagnostic-and-Staging-Procedure&highlight=cytology>.

Q: Please discuss the difference between surgery codes 40 and 60. You stated that a total pancreatectomy was similar to a Whipple but entire pancreas is removed. Does code 40 include the removal of the same structures as a Whipple?

A: Code 40 is used if the entire pancreas was removed. Code 60 is used if the total pancreas plus stomach and other organs are removed.

Q: If scans document tumor of the pancreas with encasement of the superior mesenteric artery (SMA) or superior mesenteric vein (SMV), do we assume there is extra-pancreatic extension?

A: The term, encasement, is not an involvement term. However, if a major blood vessel is encased by pancreatic tumor, the primary tumor has extended beyond the pancreas. So, I would assign code 400, extension to peripancreatic tissue, to CS Extension unless there is information verifying that the major blood vessel was involved.

Q: On the pop quiz, if we assign code 800, lymph nodes NOS, to CS lymph nodes due to the fact that we do not have specificity of the mesenteric lymph nodes, then shouldn't CS Mets at DX be assigned code 99, unknown, for that same reason?

A: I believe the best code in this example for CS Mets at DX is 00, none, because there is no distant metastasis to sites other than lymph nodes, and the involvement of the lymph nodes is coded in CS Lymph Nodes.

Q: Can you check if correct: When you have surgery of the primary site and they take lymph nodes, no named nodes, can you not assume that they are regional? Which in the pop quiz, code 110 does say regional NOS?

A: Coding instruction 3e in the CS general instructions for CS Lymph Nodes states: "Any unidentified nodes included with the resected primary site specimen are to be coded as regional lymph nodes, NOS." However, in the pop quiz the lymph nodes are identified as mesenteric. We don't have information to determine if they are mesenteric nodes considered regional or distant, so the best code to assign is 800, lymph nodes NOS, based on coding instruction 1h in the CS general coding instructions for CS Lymph Nodes. "1h) **Use of Code 800.** The CS Lymph Nodes table for nearly every schema contains a code 800, defined as Lymph nodes, NOS. This code is to be used only when it is not possible to determine whether the involved lymph nodes are regional or distant. Each schema also includes a separate code for "Regional lymph nodes, NOS". In general, lymph nodes removed during a resection of the primary site are regional and should be coded as such. Occasionally a distant lymph node will be removed separately from the primary site. In the infrequent situation where the involved lymph node is not identified as either regional or distant, use code 800, which will map to the N category using the TNM down staging rule applied in the CS computer algorithm. "

Q: Would the site-specific factors for mitotic count and serum chromogranin A be found on a path report? What if patient does not have a resection? What do you code?

A: CgA may be from blood serum, which would be documented on a clinical lab report, or from immunohistochemistry stain, which would be documented on a pathology report. Mitotic count is from a tissue specimen and if done is documented on the pathology report.

Q: If mitotic count is only stated to be "low" or "rare", should SSF3 be assigned code 999 (unknown) or 996 (mitotic count described with denominator other than 10 HPF)?

A: I would assign code 999, unknown. Low or rare does not document a denominator other than 10 HPF so I would not use 996.

Q: Shouldn't the primary site code in case scenario 1 be C25.8, overlapping tumor of the pancreas, since the tumor is described as extending to the body of the pancreas?

A: The primary site is assigned code C25.0, head of pancreas, based on the statement in the operative findings that the tumor appears to arise from the head of the pancreas and extends to the body. The code for overlapping tumor is used when the tumor overlaps more than 1 sub-site and the sub-site of origin cannot be determined. In this case scenario, the sub-site of origin is documented as head of pancreas.

Q: So, the statement that it is 'arising' in the head is the important point here? If it just said a tumor that covered both the head and the body of the pancreas, but without the statement about 'arising', would the primary site code be C25.8?

A: Yes, arising is the important point. If it said pancreatic tumor encompasses head and body and there was no information about specific sub-site of origin, I would assign primary site code C25.8.

Q: Would surgery code 36 be more appropriate for case scenario 2 since there was no stomach present in pathology specimen?

A: Surgical procedure of primary site code 37 [local or partial pancreatectomy and duodenectomy WITH partial gastrectomy (Whipple)] was assigned in case scenario 2 based on the statement in the H&P that Whipple procedure was scheduled and the description of the specimen as Whipple procedure specimen. However, the fact that there is no documentation of stomach in the specimen does confuse things. Should we code the surgical procedure based on the surgeon's description of the surgery or the actual specimens listed in the pathology report? This is not defined anywhere.

Q: In case scenario 3 should the sequence number be 00 or 60?

A: The sequence is 00 because PanIN III is in situ, and as far as we know this is the patient's one and only single malignant or in situ primary.

Q: In case scenario 3 the fine needle aspiration biopsy was negative for malignancy. My understanding is that only positive biopsy or fine needle aspiration is coded in surgical diagnostic and staging procedure? And if not, when did it change?

A: You are correct. See the note below from Anna Deleve (CoC). The answer will be corrected on the case scenario posted with the recording. Thank you for bringing this to our attention.

For solid tumors except brain/CNS, the items Surgical Diagnostic and Staging Procedure (NAACCR Item #1350) and Surgical Diagnostic and Staging Procedure (NAACCR Item #740) refer solely to the tissue biopsies positive for malignancy (behavior /2 or /3). The word "positive" will be added into the description in 2012 edition. Many patients of certain primary sites have a long history of a series of benign biopsies of the same site before the one biopsy shows cancer. If we follow the registrar's logic to code negative biopsy, how far should she go if there is more than one negative biopsy? Should she collect all negative biopsies, or just one that preceded the positive one?

Anna Deleve (CoC)
