Questions for the I&R team from June 11 Prostate Webinar

1. We used I&R question #28833 to illustrate an example of when multiplicity counter code for prostate should be '99'. A participant felt that two other I&R answers contradicted this. We stated that the I&R statement in #28833 was more current and the SEER SINQ agrees with #28833. Would it be possible to either revise or delete the older questions? All three of the referenced I&R questions follow.

28833 1/30/2009	SEER Multiple Primary & Histology	/	A needle biopsy of the prostate showed adenocarcinoma, GG 4+3 on the right, left and transitional zone. How many tumors for the Multiplicity Counter?	In the prostate, the tumor may be disseminated throughout the prostate and needle biopsies will find positive tissues in multiple sites. Without clinical documentation of individual nodules, do not assume that biopsies are showing separate lesions. Code Type of Multiple Tumors as 99 (unk if multiple tumors) and Multiplicity Counter as 99. Curator (*I & R Team*)

27189 7/9/2008	SEER Multiple Primary & Histology FORDS	FORDS /	Is the multiplicity counter of more than 01 for prostate cases used if a bx is rt and lt sides pos and patient is treated with radiation or hormones? What if a prostatectomy path only states bilat involvement without mention of tumor(s) size?	Multiple biopsies do not mean there are multiple tumors. If there is no information about whether or not there are multiple tumors, code multiplicity counter to 01. If the tumor is described as multifocal, multicentric, or disseminated, code multiplicity counter to 99. Curator (*I & R Team*)

25950 3/18/2008	SEER Multiple Primary & Histology	FORDS / p99	Patient had twelve cores of prostatic tissue taken by needle biopsies. The path said three cores were positive for adenocarcinoma of the prostate. The patient did not have further surgery. What number is recorded for the Multiplicity counter?	This is one tumor. (*I & R Team*)

I & R response: I&R questions 27189 and 25950 have been deleted from the data base.

2. Should information from a simple prostatectomy, not a radical prostatectomy, be coded in CS SSF3 CS Extension – Pathologic Extension or in CS Extension – Clinical Extension? If it is not coded in CS SSF6 is that because part of the capsule is left intact? What is the code for CS Ext/Eval?

I & R response: Note 2 in the eval code states that "in general a radical prostatectomy" must be performed for pathologic staging. That means that there are cases where a biopsy of the highest T is pathologic, or in rare cases where a simpler procedure can be used if it is clear that all of the tumor has been removed. A simple prostatectomy is not standard treatment for prostate cancer. This would only be coded in SSF3 in rare situations.

3. On needle biopsy, if in 1 core the involved specimen is 90% involved Gleason's score 4 and another core specimen is 40% involved Gleason's score 10, what do you code in CS SSF6? Do we code the higher Gleason's score or the specimen with the most tumor present?

   I & R response: Curators have answered that in the case of needle biopsies where the pathologist does not state the final pattern and score for the cancer, the highest pattern/score should be used.