Q&A

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

If you have participants watching this webinar at your site, please collect their names and emails.

We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.
Fabulous Prizes

Guest Presenter

Iris Chilton, CTR
  Alberta Cancer Registry
Agenda

Anatomy - Iris
Grade - Iris
Solid Tumor Rules & Review of Solid Tumor Rule Cases - Jim

Staging
   ◦ AJCC - Iris
   ◦ Summary Stage - Jim
   ◦ EOD - Jim

Treatment - Jim
Review of Case Scenarios

Anatomy
Bladder

Dome/Apex (C67.1)

Ureter

Peritoneum

Detrusor muscle

Submucosa

Mucosa

Fibrous connective tissue

Internal urethral orifice

External urethral orifice

Rugae

Ureteral opening

Trigone (C67.0)

Neck (C67.5)

Prostate gland


Bladder - Male and Female
Bladder Wall Layers

Perivesical Fat
Muscularis Propria
Lamina Propria
Urothelium

Field Effect

The field effect theory suggests that the urothelium has undergone a widespread change, perhaps in response to a carcinogen, making it more sensitive to malignant transformations. As a result, multiple tumors arise more easily.
Histology

Urothelial (transitional cell) Carcinoma
  ◦ Papillary
  ◦ Flat
  ◦ With squamous metaplasia
  ◦ With glandular metaplasia
  ◦ With squamous and glandular metaplasia

Squamous Cell Carcinoma

Adenocarcinoma

Undifferentiated carcinoma

Grade
# Grade - Table 19

<table>
<thead>
<tr>
<th>Code</th>
<th>Grade Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>G1: Well differentiated</td>
</tr>
<tr>
<td>2</td>
<td>G2: Moderately differentiated</td>
</tr>
<tr>
<td>3</td>
<td>G3: Poorly differentiated <em>(includes undifferentiated and anaplastic)</em></td>
</tr>
<tr>
<td>L</td>
<td>LG: Low-grade</td>
</tr>
<tr>
<td>H</td>
<td>HG: High-grade</td>
</tr>
<tr>
<td>9</td>
<td>Grade cannot be assessed <em>(GX)</em>; Unknown</td>
</tr>
</tbody>
</table>

## Grade Reminders

Grade Clinical must NOT be blank
- Grade on TURB qualifies as clinical grade only

Grade Pathological must NOT be blank
- If Grade Clinical is higher than grade on resection, use it for Grade Pathological
- If Grade Pathological is unknown upon resection OR there is no residual tumor upon resection, use the clinical grade for Grade Pathological

Grade Post Therapy may be blank if no neoadjuvant therapy
Pop Quiz 1

Urine cytology = high grade urothelial carcinoma; TURB = low grade urothelial carcinoma. Which is use for Grade Clinical?

“TURBT should be followed for grading bladder primary. High grade cells floating in urine could be from anywhere in urinary tract (bladder, renal pelvis, ureter, or urethra). Code your clinical grade based on the TURB.”


Solid Tumor Rules
Urinary Sites

Urothelial carcinoma

Originates in urothelial cells
Urothelial cells line the:
◦ Urethra
◦ Bladder
◦ Ureters
◦ Renal pelvis
There are two major subdivisions:
◦ papillary
◦ non-papillary.
Urothelial carcinoma

Papillary carcinoma: (commonly in bladder, ureter, or renal pelvis):
  ◦ A warty growth which projects from the wall on a stalk
Non-papillary urothelial: originates within the mucosa and does not project from the wall

  ◦ **Note:** Both urothelial carcinoma and papillary urothelial carcinoma can be in situ /2 or invasive /3.
  ◦ Code the behavior specified in the pathology report.

---

Terms that are Not Equivalent or Equal
Priority for Coding Primary Site

Primary Site List is in Priority Order

Code overlapping lesion of urinary bladder **C678** when:

- A single tumor of any histology overlaps subsites of the bladder
- A single tumor or discontinuous tumors which are:
  - Urothelial carcinoma in situ 8120/2
  - Involves only bladder and one or both ureters (no other urinary sites involved)

Note: Follow rules in order!

Does not apply to Non-invasive papillary!!
Primary Site List is in Priority Order

2. Code bladder NOS C679 when there are multiple non-contiguous tumors within the bladder AND the subsite/origin is unknown/not documented.

3. Code overlapping lesion of urinary organs C688 when a single tumor overlaps two urinary sites and the origin is unknown/not documented. **Note:** See the following examples of contiguous urinary sites where overlapping tumor could occur:
   i. Renal pelvis and ureter
   ii. Bladder and urethra
   iii. Bladder and ureter
Primary Site List is in Priority Order

4. Code Urinary System NOS C689 when there are **multiple discontinuous tumors** in **multiple organs** within the urinary system.

Table 1

<table>
<thead>
<tr>
<th>Site Term and code</th>
<th>Synonyms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bladder, anterior wall C673</td>
<td>-</td>
</tr>
<tr>
<td>Bladder, dome C671</td>
<td>Roof, Vault</td>
</tr>
<tr>
<td>Bladder, lateral wall C672</td>
<td>Lateral to ureteral orifice, Left wall, Right wall, Sidewall</td>
</tr>
<tr>
<td>Bladder neck C675</td>
<td>Internal urethral orifice, Vesical neck</td>
</tr>
<tr>
<td>Bladder NOS C679</td>
<td>Lateral posterior wall (no hyphen)</td>
</tr>
<tr>
<td>Bladder, overlapping lesion C678</td>
<td>Fundus, Lateral-posterior wall (hyphen)</td>
</tr>
<tr>
<td>Bladder, posterior wall C674</td>
<td>-</td>
</tr>
</tbody>
</table>
Pop Quiz 2

8/2/2019: TURB:
- Trigone of bladder: invasive urothelial carcinoma.
- Second tumor dome of bladder: invasive urothelial carcinoma.

What is the primary site?
- C67.8
- C67.9
- C68.8
- C68.9

Pop Quiz 3

5/9/19 TURB
- Single tumor involving the bladder and right ureter.
- Pathology: Non-invasive papillary urothelial carcinoma

What is the primary site?
- C67.8
- C67.9
- C68.8
- C68.9

What if the histology had been urothelial carcinoma in situ?
- C67.8
- C67.9
- C68.8
- C68.9
Multiple Primary Rules

MULTIPLE TUMORS MODULE

M2 M3 M4

M2- Abstract a single primary when there is a single tumor.

M3- Multiple primaries when
- Separate/non-contiguous tumors in both the right AND left renal pelvis AND
- No other urinary sites are involved with separate/non-contiguous tumors

M4- Multiple primaries when
- Separate/non-contiguous tumors in both the right AND left ureter AND
- No other urinary sites are involved with separate/non-contiguous tumors
M5

Abstract a single primary when synchronous tumors are noninvasive in situ urothelial carcinoma (flat tumor) 8120/2 in the following sites:
- Bladder C67_ AND
- One or both ureter(s) C669

Note 1: No other urinary organs are involved.

Note 2: Use this rule ONLY for noninvasive in situ urothelial carcinoma (may be called noninvasive urothelial carcinoma or noninvasive flat tumor). For other histologies, continue through the rules.

Note 3: Urothelial carcinoma in situ spreads by intramucosal extension and may involve large areas of mucosal surface. The default for these cases is coding a bladder primary.

Pop Quiz 4


How many primaries?

Rationale:

What if the histology had been non-invasive papillary urothelial carcinoma?
M6

Abstract **multiple primaries** when an **invasive** tumor occurs more than **60** days after an **in situ** tumor

**Note 1:** Abstract both the invasive and in situ tumors.

**Note 2:** Abstract as multiple primaries even if physician states the invasive tumor is disease recurrence or progression.

M7

Abstract a **single primary** when the patient has multiple occurrences of /2 urothelial carcinoma in the **bladder**.

Tumors may be any combination of:
- In situ urothelial carcinoma 8120/2 OR
- Papillary urothelial carcinoma noninvasive (does not include micropapillary subtype) 8130/2

**Note 1:** Timing is irrelevant. Tumors may be synchronous or non-synchronous.

**Note 2:** Abstract only one /2 urothelial bladder tumor per the patient's lifetime.

**Note 3:** There are no /2 subtypes for urothelial carcinoma with the exception of papillary urothelial carcinoma.
M7 Cont’d

Example:

On 1/3/2014, the patient had a TURB with a diagnosis of in situ urothelial carcinoma 8120/2. Case has been abstracted and is in your registry.

On 5/8/2019, pathology from TURB is papillary urothelial carcinoma non-invasive 8130/2.

This is a single primary per rule M7
  ◦ The papillary urothelial carcinoma is recorded as a recurrence for those registrars who collect recurrence data.

M8

Abstract multiple primaries when the patient has micropapillary urothelial carcinoma 8131/3 of the bladder AND a urothelial carcinoma 8120/3 (including papillary 8130/3) of the bladder.

  ◦ Note 1: This is a new rule for 2019.
  ◦ Note 2: Micropapillary urothelial cell carcinoma is an extremely aggressive neoplasm.
  ◦ It is important to abstract a new primary to capture the incidence of micropapillary urothelial carcinoma. Micropapillary is excluded from the typical “NOS and subtype/variant” rule (same row in Table 2).
M9

Abstract a **single primary** when the patient has multiple **invasive** urothelial cell carcinomas in the **bladder**.

**All tumors** are either:
- Multiple occurrences of urothelial or urothelial subtypes (with the exception of micropapillary) **OR**
- Multiple occurrences of micropapillary
  - **Note 1:** Timing is irrelevant. Tumors may be synchronous or non-synchronous.
  - **Note 2:** Abstract only one /3 invasive urothelial bladder primary **AND** only one micropapillary urothelial 8131/3 bladder primary per the patient’s lifetime.
  - **Note 3:** An occurrence of micropapillary and an occurrence of urothelial carcinoma would be multiple primaries (see previous rules).

---

**Pop Quiz 5**

- Case is abstracted and in your registry.

5/8/2019 TURB trigone of bladder: invasive papillary urothelial cell carcinoma

**How many primaries?**

**Primary site:**

**M Rule**
M10

Abstract **multiple primaries** when the patient has a subsequent tumor after being **clinically disease-free** for **greater than three years** after the original diagnosis or last recurrence.

- **Note 1:** This rule **does not apply** to urothelial carcinoma of the bladder.
- **Note 2:** Clinically disease-free means that there was **no evidence** of recurrence on follow-up.
- **Note 3:** When there is a recurrence within three years of diagnosis, the “clock” starts over. The time interval is calculated from the **date of last recurrence**.
- **Note 4:** When it is **unknown/not documented** whether the patient had a recurrence, default to **date of diagnosis** to compute the time interval.
- **Note 5:** The physician may state this is a **recurrence**, meaning the patient had a previous urinary site tumor and now has another urinary site tumor. **Follow the rules;** do not attempt to interpret the physician’s statement.

M11

Abstract a **single primary** when there are **urothelial carcinomas** in multiple urinary organs.

- **Note 1:** This rule is **ONLY** for urothelial carcinoma 8120 and all subtypes/variants of urothelial carcinoma. This rule does not apply to any other carcinomas or sarcomas.
- **Note 2:** The behavior is irrelevant.
- **Note 3:** This rule applies to multifocal/multicentric carcinoma which involves two or more of the following urinary sites:
  - Renal pelvis
  - Ureter
  - Bladder
  - Urethra
Pop Quiz 6

  ◦ Pathology: urothelial carcinoma in situ 8120/2.


7/12/2019 RT nephroureterectomy: carcinoma in situ in renal pelvis and ureter

Number of primaries/rule?

M12

Abstract multiple primaries when separate/non-contiguous tumors are two or more different subtypes/variants in Column 3 of Table 2 in the Equivalent Terms and Definitions. Timing is irrelevant.
  ◦ Note: The tumors may be subtypes/variants of the same or different NOS histologies.
Abstract multiple primaries when separate/non-contiguous tumors are on different rows in Table 2 in the Equivalent Terms and Definitions. Timing is irrelevant.

Note: Each row in the table is a distinctly different histology.

Table 2

<table>
<thead>
<tr>
<th>Specific and NOS Histology and Codes</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenocarcinoma NOS 8140</td>
<td>Mixed adenocarcinoma</td>
<td>Clear cell carcinoma 8310</td>
</tr>
<tr>
<td></td>
<td>Urachal adenocarcinoma/carcinoma</td>
<td>Endometrioid carcinoma 8380</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enteric adenocarcinoma 8144</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mucinous adenocarcinoma 8480</td>
</tr>
<tr>
<td>Small cell neuroendocrine carcinoma 8041</td>
<td>Neuroendocrine carcinoma SmCC</td>
<td>Large cell neuroendocrine tumor 8013</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Well-differentiated neuroendocrine tumor 8240</td>
</tr>
</tbody>
</table>
### Table 2-Urothelial Row

<table>
<thead>
<tr>
<th>Specific and NOS Histology Codes</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urothelial carcinoma 8120</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Note 1: Previously called</td>
<td>Infiltrating urothelial carcinoma</td>
<td>Papillary urothelial (transitional cell) carcinoma</td>
</tr>
<tr>
<td>transitional cell carcinoma, a</td>
<td>8120/3</td>
<td>in situ 8130/2</td>
</tr>
<tr>
<td>term that is no longer</td>
<td>Infiltrating urothelial carcinoma</td>
<td>invasive 8130/3</td>
</tr>
<tr>
<td>recommended.</td>
<td>with divergent differentiation</td>
<td>Micropapillary urothelial carcinoma 8131/3</td>
</tr>
<tr>
<td>• Note 2: Micropapillary 8131 is</td>
<td>Infiltrating urothelial carcinoma</td>
<td>Poorly differentiated carcinoma 8020/3</td>
</tr>
<tr>
<td>a subtype/variant of papillary</td>
<td>with glandular differentiation</td>
<td>Sarcomatoid urothelial carcinoma 8122/3</td>
</tr>
<tr>
<td>urothelial carcinoma 8130. It is</td>
<td>8120/3</td>
<td></td>
</tr>
<tr>
<td>an invasive /3 neoplasm with</td>
<td>Infiltrating urothelial carcinoma</td>
<td></td>
</tr>
<tr>
<td>aggressive behavior.</td>
<td>with squamous differentiation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8120/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urothelial carcinoma in situ</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8120/2</td>
<td></td>
</tr>
<tr>
<td>Papillary urothelial (transitional cell) carcinoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>in situ 8130/2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>invasive 8130/3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Micropapillary urothelial carcinoma 8131/3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorly differentiated carcinoma 8020/3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sarcomatoid urothelial carcinoma 8122/3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### M14

Abstract **multiple primaries** when the ICD-O **site** code differs at the **second** (CXxx) and/or **third** (CXXx) character.
**M15**

Abstract a **single primary** when synchronous, separate/non-contiguous tumors are on the **same row** in Table 2 in the Equivalent Terms and Definitions.

- Note 1: The same row means the tumors are:
  - The same histology (same four-digit ICD-O code) **OR**
  - One is the preferred term (column 1) and the other is a synonym for the preferred term (column 2) **OR**
  - A NOS (column 1/column 2) and the other is a subtype/variant of that NOS (column 3)

**M15**

<table>
<thead>
<tr>
<th>Specific and NOS Histology Codes</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenocarcinoma NOS 8140</td>
<td>Mixed adenocarcinoma Urachal adenocarcinoma/carcinoma</td>
<td>Clear cell carcinoma 8310 Endometrioid carcinoma 8380 Enteric adenocarcinoma 8144 Mucinous adenocarcinoma 8480</td>
</tr>
</tbody>
</table>
M16

Abstract a **single primary** (the invasive) when an **in situ** tumor is diagnosed **after** an **invasive** tumor **AND** tumors occur in the **same** urinary site

- **Note 2**: The tumors may be a NOS and a subtype/variant of that NOS. See Table 2 in the Equivalent Terms and Definitions for listings of NOS and subtype/variants.
- **Note 3**: Once the patient has an invasive tumor, the subsequent **in situ** is recorded as a **recurrence** for those registrars who collect recurrence data.

M17

Abstract a **single primary** (the invasive) when an invasive tumor is diagnosed **less than or equal to 60 days** **after** an **in situ** tumor **AND** tumors occur in the **same** urinary site

- **Note 2**: The tumors may be an NOS and a subtype/variant of that NOS.
M17 Cont’d

**Note 3:** When the case has been abstracted, change behavior code on original abstract from /2 to /3. Do not change date of diagnosis.

**Note 4:** If the case has already been submitted to the central registry, report all changes.

**Note 5:** The physician may stage both tumors because staging and determining multiple primaries are done for different reasons. Staging determines which treatment would be most effective. Determining multiple primaries is done to stabilize the data for the study of epidemiology (long-term studies done on incidence, mortality, and causation of a disease with the goal of reducing or eliminating that disease).

M18

Abstract a **single primary** when tumors do not meet any of the above criteria.

**Note:** Use this rule as a last resort. Please confirm that you have not overlooked an applicable rule.
Histology Rules

Priority for Using Documentation to Code Histology
Important Notes

   
   **Note 1:** Histology changes do occur following immunotherapy, chemotherapy and radiation therapy.
   
   **Note 2:** Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.

2. Code the histology using the following priority list and the Histology Rules. Do not change histology in order to make the case applicable for staging.

Priority List Documents – Single Primaries

Use documentation in the following priority order to identify the histology type(s):

Code the most specific pathology/tissue from either resection or biopsy.

**Note 1:** The term “most specific” usually refers to a subtype/variant.

**Note 2:** The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor.

**Note 3:** When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).
Histology Rules Single Tumor

Code the histology when only one histology is present

Note 1: Use Table 2 to code histology. New codes, terms, and synonyms are included in Table 2 and coding errors may occur if the table is not used.

Note 2: When the histology is not listed in Table 2, use the ICD-O and all updates.

Note 3: Submit a question to Ask a SEER Registrar when the histology code is not found in Table 2, ICD-O or all updates.

Note 4: Only code squamous cell carcinoma (8070) when there are no other histologies present (pure squamous cell carcinoma).

Note 5: Only code adenocarcinoma (8140) when there are no other histologies present (pure adenocarcinoma).
H2

Code the invasive histology when in situ and invasive histologies are present in the same tumor.

H3

Code the subtype/variant when there is a NOS and a single subtype/variant of that NOS such as the following:
- Adenocarcinoma 8140 and a subtype/variant of adenocarcinoma
- Papillary urothelial carcinoma 8130 and a subtype/variant of papillary urothelial carcinoma
- Rhabdomyosarcoma 8900 and a subtype/variant of rhabdomyosarcoma
- Sarcoma 8800 and a subtype/variant of sarcoma
- Small cell neuroendocrine carcinoma 8041 and a subtype/variant of small cell neuroendocrine carcinoma
- Squamous cell carcinoma 8070 and a subtype/variant of squamous cell carcinoma
- Urothelial carcinoma 8120 and a subtype/variant of urothelial carcinoma

Note: Use Table 2 to identify NOS histologies and subtypes/variant
<table>
<thead>
<tr>
<th>Specific and NOS Histology Codes</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urothelial carcinoma 8120</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Note 1: Previously called</td>
<td></td>
<td>Papillary urothelial (transitional cell) carcinoma</td>
</tr>
<tr>
<td>transitional cell carcinoma, a</td>
<td></td>
<td>in situ 8130/2</td>
</tr>
<tr>
<td>term that is no longer</td>
<td></td>
<td>invasive 8130/3</td>
</tr>
<tr>
<td>recommended.</td>
<td></td>
<td>Micropapillary urothelial carcinoma 8131/3</td>
</tr>
<tr>
<td>• Note 2: Micropapillary 8131 is</td>
<td></td>
<td>Poorly differentiated carcinoma</td>
</tr>
<tr>
<td>a subtype/variant of papillary</td>
<td></td>
<td>8020/3</td>
</tr>
<tr>
<td>urothelial carcinoma 8130. It is</td>
<td></td>
<td>Sarcomatoid urothelial carcinoma</td>
</tr>
<tr>
<td>an invasive /3 neoplasm with</td>
<td></td>
<td>8122/3</td>
</tr>
<tr>
<td>aggressive behavior.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infiltrating urothelial</td>
<td>Infiltrating urothelial carcinoma</td>
<td></td>
</tr>
<tr>
<td>carcinoma 8120/3</td>
<td>8120/3</td>
<td>in situ 8130/2</td>
</tr>
<tr>
<td>Infiltrating urothelial</td>
<td>Infiltrating urothelial carcinoma</td>
<td></td>
</tr>
<tr>
<td>carcinoma with divergent</td>
<td>8120/3</td>
<td>invasive 8130/3</td>
</tr>
<tr>
<td>differentiation 8120/3</td>
<td>Infiltrating urothelial carcinoma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8120/3</td>
<td>Micropapillary urothelial</td>
</tr>
<tr>
<td></td>
<td>Infiltrating urothelial carcinoma</td>
<td></td>
</tr>
<tr>
<td>with glandular differentiation</td>
<td>8120/3</td>
<td>carcinoma 8131/3</td>
</tr>
<tr>
<td>8120/3</td>
<td>Infiltrating urothelial carcinoma</td>
<td></td>
</tr>
<tr>
<td>with squamous differentiation</td>
<td>8120/3</td>
<td>Poorly differentiated carcinoma</td>
</tr>
<tr>
<td>8120/3</td>
<td>Urothelial carcinoma in situ</td>
<td></td>
</tr>
<tr>
<td>8120/2</td>
<td></td>
<td>8120/2</td>
</tr>
</tbody>
</table>

### Table 2-Urothelial Row

<table>
<thead>
<tr>
<th>Specific and NOS Histology Codes</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urothelial carcinoma 8120</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Note 1: Previously called</td>
<td></td>
<td>Papillary urothelial (transitional cell) carcinoma</td>
</tr>
<tr>
<td>transitional cell carcinoma, a</td>
<td></td>
<td>in situ 8130/2</td>
</tr>
<tr>
<td>term that is no longer</td>
<td></td>
<td>invasive 8130/3</td>
</tr>
<tr>
<td>recommended.</td>
<td></td>
<td>Micropapillary urothelial</td>
</tr>
<tr>
<td>• Note 2: Micropapillary 8131 is</td>
<td></td>
<td>carcinoma 8131/3</td>
</tr>
<tr>
<td>a subtype/variant of papillary</td>
<td></td>
<td>Poorly differentiated carcinoma</td>
</tr>
<tr>
<td>urothelial carcinoma 8130. It is</td>
<td></td>
<td>8020/3</td>
</tr>
<tr>
<td>an invasive /3 neoplasm with</td>
<td></td>
<td>Sarcomatoid urothelial carcinoma</td>
</tr>
<tr>
<td>aggressive behavior.</td>
<td></td>
<td>8122/3</td>
</tr>
<tr>
<td>Infiltrating urothelial</td>
<td>Infiltrating urothelial carcinoma</td>
<td></td>
</tr>
<tr>
<td>carcinoma 8120/3</td>
<td>8120/3</td>
<td>in situ 8130/2</td>
</tr>
<tr>
<td>Infiltrating urothelial</td>
<td>Infiltrating urothelial carcinoma</td>
<td></td>
</tr>
<tr>
<td>carcinoma with divergent</td>
<td>8120/3</td>
<td>invasive 8130/3</td>
</tr>
<tr>
<td>differentiation 8120/3</td>
<td>Infiltrating urothelial carcinoma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8120/3</td>
<td>Micropapillary urothelial</td>
</tr>
<tr>
<td></td>
<td>Infiltrating urothelial carcinoma</td>
<td></td>
</tr>
<tr>
<td>with glandular differentiation</td>
<td>8120/3</td>
<td>carcinoma 8131/3</td>
</tr>
<tr>
<td>8120/3</td>
<td>Infiltrating urothelial carcinoma</td>
<td></td>
</tr>
<tr>
<td>with squamous differentiation</td>
<td>8120/3</td>
<td>Poorly differentiated carcinoma</td>
</tr>
<tr>
<td>8120/3</td>
<td>Urothelial carcinoma in situ</td>
<td></td>
</tr>
<tr>
<td>8120/2</td>
<td></td>
<td>8120/2</td>
</tr>
</tbody>
</table>
**H4**

Code mixed small cell carcinoma **8045** when the final diagnosis is any of the following:
- Small cell neuroendocrine mixed with any other type of **carcinoma** (does not apply to sarcoma)
- Subtype/variant of small cell neuroendocrine mixed with any other **carcinoma** (does not apply to sarcoma)
- Two or more subtypes/variants of small cell neuroendocrine carcinoma

*Example:* Diagnosis from TURB is urothelial carcinoma and small cell neuroendocrine carcinoma. Code mixed small cell carcinoma 8045.

**H5**

Code mixed urothelial carcinoma as follows:
- Code 8120 when urothelial is mixed with:
- Code 8130 when papillary urothelial is mixed with:
- Code 8131/3 when micropapillary urothelial carcinoma is mixed with:
  - Adenocarcinoma or adenocarcinoma subtypes
  - Squamous cell carcinoma or squamous cell carcinoma subtypes
Pop Quiz 7

While performing casefining a pathology report from a TURB was identified
• 8/3/19: Pathology: Invasive papillary urothelial carcinoma, anterior wall of bladder

Further investigation identified two previous TURB’s performed at a different facility.
• 2/15/18: Pathology non-invasive papillary urothelial carcinoma, bladder trigone.
• 4/29/16: Invasive papillary urothelial carcinoma, multiple tumors in bladder.
  • Left lateral wall, right lateral wall, roof of bladder.

Pop Quiz 7 (cont.)

Jim’s Tips
1. Assign a preliminary/working site histology for each tumor.
2. Start with the first diagnosis and then work through the cases chronologically
   a. 2016 case-use the 2007 MPH rules to determine histology and multiple primaries.
   b. 2018 case-compare the 2016 case to the 2018 case.
      i. Use the 2018 Solid Tumor rules for the comparison
      ii. Make sure the 2016 case would be coded the same using the 2018 Solid Tumor Rules (it would).
   c. Compare the 2019 case to the 2018 and 2016 case using the solid tumor rules.
      i. Use the 2018 Solid Tumor rules for the comparison
      ii. Make sure the 2016 case would be coded the same using the 2018 Solid Tumor Rules (it would).

2016-8130/3 and C67.2, C67.2, C67.1
2018-C67.0 8130/2
2019- C67.3 8130/3
(Note-more than 3 years between 1st and 3rd)
Pop Quiz 7 (cont.)

How many primaries?

Histology 1

Primary Site 1:

Questions?
Staging

AJCC 8TH EDITION: CHAPTER 62
SUMMARY STAGE
EOD

Things to look for when assigning clinical stage

Cystoscopy
Biopsy or transurethral resection of bladder (TURB)
Bimanual exam
  ◦ Was there wall thickening or palpable mobile mass?
  ◦ Was there a fixed mass?
Imaging
Transurethral Resection of Bladder (TURB)

Endoscopic procedure that removes bladder tumor(s)
- Tumor(s) can be resected down to muscle; no further
- May be followed by chemotherapy or BCG
- Patient may return for repeat TURB
- Bimanual examination

Bimanual Examination

Examination under anesthesia (EUA) after a TURB

FOR WOMEN: One hand on lower abdomen and the other palpates the bladder via the anterior vaginal wall

FOR MEN: One hand on lower abdomen and the other palpates the bladder via the rectum
Things to look for when assigning pathological stage

Information from pre-treatment evaluation + surgical resection of the primary tumor
  ◦ partial cystectomy, radical cystectomy, cystoprostatectomy

OR

Pathologic confirmation of extension beyond the bladder AND pathologic confirmation of metastatic common iliac node(s)

OR

Positive microscopic exam of distant metastatic site

Things to look for when assigning post therapy stage

Information after neoadjuvant systemic and/or radiation therapy including:
  ◦ post-treatment physical exam, imaging, biopsies
    AND
  ◦ the operative and pathology reports from a subsequent cystectomy/partial cystectomy

Neoadjuvant cisplatin-based combination chemotherapy or concurrent chemoradiation may be considered for muscle invasive and regionally spread tumors
Pop Quiz 8

Patient had bladder diverticulectomy and removal of bladder stones. Pathology indicated an incidental finding of noninvasive papillary urothelial carcinoma, high grade.

- Since this malignancy was an incidental finding during a surgical procedure for another reason, does this meet pathological stage criteria even though bladder was not removed?

“No, this is actually part of the diagnostic workup for bladder cancer and clinical staging. This surgery does not meet the requirement of surgical treatment for pathological staging.”

Pop Quiz 9

TURBT pathology report indicates noninvasive papillary urothelial carcinoma with adjacent urothelial carcinoma in situ.
- Is this assigned cTa or cTis?

“Tis is actually a higher T category and has a worse prognosis than Ta. Therefore, this would be assigned cTis.”

Muscle Invasion

Clinically, cannot differentiate between superficial and deep muscle invasion

Cystectomy or partial cystectomy is required to pathologically assess if the tumor is limited to the superficial muscle or extended into the deep muscle.
Pop Quiz 10

Pathology from TURB indicated invasion of the muscularis propria. Imaging was negative.
Patient subsequently had a cystectomy and was found to have residual urothelial carcinoma in the lamina propria and 16 nodes were negative for metastatic carcinoma.

<table>
<thead>
<tr>
<th>T</th>
<th>N</th>
<th>M</th>
<th>Stage Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Perivesical Tissue
Clinically, can only assess that the tumor has extended into perivesical tissues macroscopically.
Cystectomy or partial cystectomy is required to pathologically assess if the tumor invades perivesical tissues microscopically or macroscopically.
Beyond the Bladder

Bad
- Prostatic stroma
- Seminal vesicles
- Uterus
- Vagina

Worse
- Abdominal wall
- Pelvic wall

Regional Lymph Nodes

How many nodes are involved?
- One?
- Multiple?

Where are the nodes located?
- True pelvis?
  - Perivesical, Internal/External Iliac, Obturator, Sacral, Pelvic, NOS
  - Common iliac?
**Pop Quiz 11**

TURB pathology indicated muscle invasive urothelial carcinoma. Imaging negative.

Patient completed 4 cycles of neoadjuvant cisplatin/gemcitabine combination chemotherapy.

Subsequent cystectomy indicated high grade urothelial carcinoma that invaded the perivesical adipose tissue microscopically and 2 internal iliac nodes were positive for metastatic urothelial carcinoma.

<table>
<thead>
<tr>
<th>T</th>
<th>N</th>
<th>M</th>
<th>Stage Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Distant Metastasis**

Are there distant metastases?
- any nodes beyond the regional lymph nodes?
- any other distant spread?
Assigning Stage Group

Is the tumor confined to the urothelium?
- Non-invasive papillary tumor?
- Flat/sessile in situ tumor?

Does the tumor only involve the lamina propria?

Is the tumor muscle invasive?

Has the tumor spread regionally?
- Beyond bladder?
  - (excluding pelvic/ abdominal wall)
- Regional node involvement?

Is the malignancy advanced?
- Pelvic/ abdominal wall?
- Distant metastasis?

SSDIs

No SSDIs for Bladder!
EOD & Summary Stage 2018

EOD Primary Tumor
EOD Regional Nodes
EOD Mets

Summary Stage 2018
https://staging.seer.cancer.gov/eod_public/list/1.7/

Treatment
Intravesical Treatment

Chemotherapy (15)
- Immediate: Within 24 hours after TURB
- Induction: Initiated 3-4 weeks after resection
  - Typically 2 inductions without complete response

Immunotherapy (16)
- 3-4 weeks after resection
- Typically 2 inductions without complete response

Transurethral Resection (27)

Papillary appearing Tumor (non-muscle invasive)
- Resection with muscle in specimen
- Intravesicle therapy within 24 hours

Carcinoma In Situ
- Biopsy adjacent to papillary tumor

Sessile or Invasive Appearing Tumor (muscle invasive)
- Perform Examination Under Anesthesia (EUA)
- Repeat TURBT
Pop Quiz 12

Patient has TURBT. Final Diagnosis: Papillary transitional cell carcinoma, tumor infiltrates bladder wall deep muscle tissue. Margins: indeterminate. Patient is given intravesicle BCG within 24 hours of the procedure.

Which surgery codes do we use.
- 16 Bacillus Calmette-Guerin (BCG) or other immunotherapy
- 20 Local tumor excision, NOS
- 27 Excisional biopsy

Neoadjuvant Therapy

Systemic therapy or concurrent chemo/radiation therapy given before partial or radical cystectomy.
- Therapy may occur after TURB
- Standard treatment for muscle invasive tumors
Cystectomy

Segmental (Partial) Cystectomy (30)
- Solitary lesion
- No carcinoma in situ
- Bilateral pelvic lymphadenectomy (common, internal and external iliac and obturator nodes)

Radical Cystectomy (60-64)
- Bilateral pelvic lymphadenectomy (common, internal and external iliac and obturator nodes)

Questions?
Fabulous Prizes

Coming Up…

Base of Tongue/Head and Neck
Guest Presenter: Wilson Apollo, CTR Radiation Therapist
  ◦ 12/5/2019

Prostate
  Guest Presenter: Bobbi Jo Matt, BS, RHIT, CTR
  ◦ Manager of Editing/Quality Control
  ◦ State Health Registry of Iowa
  ◦ 1/9/2020
CE Certificate Quiz/Survey

Phrase

Link

Thank You!!!