Quiz 1--Overview

1. An operative report from a colonoscopy described a malignant appearing tumor at 65cm's. If no further information is available the primary site would be coded as ascending colon (C18.2).
    a. True
    b. False
2. Lymphatic invasion should be coded as lymph node involvement.
    a. True
    b. False
3. A pedunculated polyp has a stalk.
    a. True
    b. False
4. A high grade adenocarcinoma of the colon would be assigned a histologic grade code of 3.
    a. True
    b. False
5. The ascending colon receives its blood supply from branches of the superior mesenteric artery.
    a. True
    b. False
6. A patient with colon cancer had his entire colon and rectum removed. This procedure would be coded as a total colectomy (50).
    a. True
    b. False
7. A patient had neoadjuvant chemotherapy for rectal carcinoma. An abdominoperineal resection (APR) showed intramucosal carcinoma in an adenomatous polyp in descending colon which was a second primary The neoadjuvant chemotherapy would be coded for both primaries and reflected in collaborative staging.
    a. True
    b. False
8. A patient with a history of adenocarcinoma of the cecum diagnosed in 2004 presents for a follow-up colonoscopy in 2009. The physician performing the colonoscopy stated there was a recurrent adenocarcinoma located in the proximal ascending colon. Biopsy confirmed adenocarcinoma. This should not be considered a new primary.
    a. True
    b. False
9. A patient was found to have a polypoid mass with adenocarcinoma in the ascending colon. This would be coded as adenocarcinoma in a polyp, NOS (8210).
    a. True
    b. False
10. A patient has two lesions at the same time, both in the cecum, one an adenocarcinoma NOS and the other a mucinous carcinoma. This would be considered a single primary.
    a. True
    b. False

Quiz 2: Collaborative Stage Data Collection System (CSv2) Quiz

Scenario 1

12/3/2010 Final pathologic diagnosis: Poorly differentiated adenocarcinoma of the appendix with infiltration through the muscularis into periappendiceal adipose tissue and with intense acute appendicitis.
Microscopic: Acute appendicitis with periappendicitis is present. However, this specimen contains an adenocarcinoma. This carcinoma does not have the appearance of a carcinoid tumor. Because the tumor was not forming a discrete grossly identifiable mass, the total size of the tumor is not entirely clear. Based upon the number of sections of appendix involved by carcinoma and the total length of the appendix, it is my estimation that the maximum dimension of the carcinoma was around 3.3 cm. There are multiple areas of separation of tumor clusters in adjacent connective tissue. In some foci such areas suggest infiltration of lymphatics. No large vein invasion is identified. While tumor involves mucosa and invades through the muscularis, there is considerable tumor in periappendiceal adipose tissue along with the intense acute inflammation. There is no region where tumor is in a distinct connective tissue margin of the appendix, but because of the inflammation, it is possible that the tumor is in a peripheral margin. The nature of the mucosal margin of the appendix is not clear.

1. What is the code for CS Lymph Nodes?
    a. 000 None
    b. 050 Tumor deposits
    c. 300 Regional nodes NOS
    d. 800 Lymph nodes NOS
2. What is the code for CS SSF4 Tumor Deposits?
    a. 000 None
    b. 001 1 tumor deposit
    c. 081 Greater than 81 tumor deposits
    d. 998 Tumor deposits identified, number unknown

Scenario 2

Lab data
3/26/2010 CEA: Elevated level of 7.6
3/27/2010 Immunohistochemistry: Immunohistochemical staining for MSH-1 shows positive staining in the majority of the tumor cells. There is strong positive staining for MSH-2 in tumor cells.

Procedure
3/27/2010 Right hemicolectomy with en bloc resection of internal oblique extension of colonic tumor. Final pathologic diagnosis:

1. Retroperitoneal fat, biopsy: No malignancy identified.
2. Right colon resection: Invasive moderately differentiated adenocarcinoma of the hepatic flexure. The tumor invades through the wall of the intestine, and focally infiltrates pericolic fat. Radial resection margins are free of involvement by tumor; one is 2 mm from tumor. Mucosal margins of resection are free of involvement by tumor. 22 lymph nodes are present; metastatic adenocarcinoma is found in 1 of these.
3. Mesenteric node: 1 lymph node; no malignancy identified.

Consult
3/30/2010 Assessment/plan: This is a 42-year-old woman with newly diagnosed colon cancer. She is status post en bloc resection of the colon lesion which was adherent to the abdominal wall. She is recovering from her surgery. The final pathology from her surgical excision is not available. I will await final pathology reporting prior to making further recommendations related to chemotherapy, which is likely to be recommended. This was discussed with the patient. She does have a strong family history of colon cancer. Given that she is diagnosed in her 40's, it is reasonable to pursue testing for hereditary cancer syndromes, notably the Lynch syndrome. I have ordered microsatellite instability testing on the tumor as well as staining for non-polyposis gene mutations.

3. What is the code for CS SSF1 Pre-operative CEA?
    a. 000 Test not done
    b. 010 Positive/elevated
    c. 020 Negative/normal
    d. 030 Borderline
4. What is the code for CS SSF3 Pre-operative CEA Lab Value?
    a. 000
    b. 076
    c. 760
    d. 998 Test not done
5. What is the code for CS SSF6 Circumferential Resection Margin?
    a. 000 Circumferential resection margin positive
    b. 020
    c. 991 Margins clear, distance from tumor not stated
    d. 992 Described as "less than 2 mm," or "greater than 1 mm," or "between 1 mm and 2 mm"
6. What is the code for CS SSF7 Microsatellite Instability?
    a. 020 No microsatellite instability
    b. 050 Positive, high
    c. 060 Positive, NOS
    d. 997 Test ordered, results not in chart

Scenario 3

6/10/2010 Operative findings: Large mass involving cecum adherent to peritoneum & retroperitoneum.
Path findings: Adenocarcinoma of cecum invades pericolic soft tissue; margins negative.

7. What is the code for CS Extension?
    a. 300 Localized, NOS
    b. 450 Extension to pericolic fat
    c. 460 Adherent to other organs or structures, but no microscopic tumor found in adhesions
    d. 570 Adherent to other organs or structures, NOS
8. What is the code for CS Mets at DX?
    a. 00 None
    b. 20 Metastasis to a single distant organ
    c. 30 Metastasis to more than one distant organ
    d. 60 Distant metastasis, NOS

Scenario 4

8/4/2010 A colonoscopy showed an apple core lesion, no tissue. MRI of the abdomen documented pericolic lymphadeonpathy and 2cm lesion in liver concerning for metastasis. Patient had a right hemicolectomy with lymph node dissection and a right partial hepatectomy. There was no neoadjuvant therapy. Pathology diagnosis was adenocarcinoma of ascending colon invading pericolonic fat; all 30 lymph nodes negative; right lobe liver tissue negative.

9. What is the code for CS Mets at DX?
    a. 00 None
    b. 15 Metastasis to a single distant lymph node chain other than code 08
    c. 20 Metastasis to a single distant organ
    d. 60 Distant metastasis, NOS
10. What is the code for CS Mets Eval?
    a. 0 Evaluation of distant metastasis based on physical examination, imaging examination, and/or other non-invasive clinical evidence. No microscopic examination of metastatic specimen performed or microscopic examination was negative.
    b. 1 Evaluation of distant metastasis based on endoscopic examination or other invasive technique, including surgical observation without biopsy. No microscopic examination of metastatic specimen performed or microscopic examination was negative.
    c. 3 Specimen from metastatic site microscopically positive WITHOUT pre-surgical systemic treatment or radiation
    d. 9 Unknown