Questions from NAACCR Webinars

Questions from Skin Webinar

Answers from Collaborative Stage Team

1. If there is documentation in the patient's health record of only 1 LDH test and it is abnormal, can that be recorded in SSF4 (LDH) and SSF5 (LDH value), or can the abnormal value only be recorded if 2 tests were performed? If it can only be recorded if there are 2 abnormal values, what code do you assign if there is 1 abnormal value and a 2nd test was not performed?

Answer: Note in the table: Per AJCC, "An elevated serum LDH should be used only when there are 2 or more determinations obtained more than 24 hours apart, because an elevated serum LDH on a single determination can be falsely positive as a result of hemolysis or other factors unrelated to melanoma metastases."

Only record if 2 or more tests are done. If only 1 test and that value is coded, then it skews the data, since they are commonly falsely positive, and you cannot differentiate that data from 1 result from the data of true LDH values which were run at least twice. The LDH is a part of most routine chemistry panels and it is very likely that the panel was ordered for the other tests in the panel, not for the LDH results. If only 1 test performed, code 000, test not done, since it was probably part of a panel and not performed to assess metastasis.

2. If only 1 LDH test is performed and the value is normal, can that information be recorded in SSF4 and SSF5 for melanoma, or can it only be recorded if 2 tests were performed?

***Answer*:** No, same reason as above.

3. Code 000 in SSF8 for melanoma includes the definition, regression not identified. To use that code, must it state in the path report that regression was not identified, or can code 000 be used when there is no mention of regression in the path report?

Answer: Note in the table: Note 2: Record the primary tumor regression as recorded in the pathology report. If the primary tumor regression is "not identified" the registrar should code as absent.

If there is no mention of regression in the pathology report, then code as absent. No mention is the same as the pathologist not identifying it. The AJCC chapter authors specifically provided that guidance to avoid this data field being coded as unknown based on feedback from pathologists on the AJCC taskforce.

4. Code 000 in SSF9 for melanoma includes the definition, vertical growth phase not identified. To use that code, must it state in the path report that vertical growth phase was not identified, or can code 000 be used when there is no mention of vertical growth phase in the path report?

Answer: Note in the table: Note 2: Record the VGP as recorded in the pathology report. When the VGP is "not identified" registrars should code as absent.

Same as answer for #3.

5. If path report for melanoma documents Clark's level II, III etc. but nothing is stated about vertical growth phase, can you assign code 001, vertical growth phase present?

Answer: Note in the table: Note 2: Record the VGP as recorded in the pathology report. When the VGP is "not identified" registrars should code as absent.

Same as answer for #3

6. On page 336 of the AJCC 7th Ed. it is stated: "Histologic grading is not used in the staging of melanoma." A webinar participant stated that based on AJCC 7th Ed., the grade data item should always be assigned code 9, unknown. I believe that the instructions in AJCC 7th Ed. apply only to AJCC staging and CS, not other data items. So, if the path report documents a grade description for a melanoma, that information should be coded in the grade item as something other than 9. Please clarify.

Answer: The AJCC chapter is providing instructions to the physicians on staging, and this is not to be used in coding the FORDS data item of grade. Just because grade is not used in staging, doesn't mean the pathologist won't grade the specimen.

7. The clinical status of regional lymph node metastasis is coded in SSF3 for melanoma and Merkel cell carcinoma of the skin. If the patient has a primary melanoma or Merkel cell carcinoma of the skin and lymphadeonpathy of regional lymph nodes, is the description of lymphadeonpathy enough to be coded as clinical involvement of regional nodes or does it need to be described as malignant lymphadeonpathy? A webinar participant thought the same instructions regarding terminology should be used as are used for CS Lymph Nodes.

Answer: Lymphadeonpathy alone cannot be coded, as this may be due to inflammation, or other type of reactionary process. Malignant lymphadeonpathy is not a term used by physicians. It needs to be clear from the physician that this is related to the melanoma, whether in H&P statements, radiology exams, N stage element, or other documentation. Yes, all of the general guidelines regarding lymph nodes in CSv2 can be used to help new registrars understand the type of terminology used (CSv2 pI-45, #3).

8. Extracapsular extension of regional lymph nodes is coded in SSF17 for Merkel cell carcinoma of the skin. What is used as a guide for determining clinical extracapsular extension? Are the criteria different from criteria used to determine clinical extracapsular extension for head and neck sites? The following is stated in the AJCC 7th Ed. for head and neck sites: "Extracapsular spread (ECS) can be diagnosed clinically by a matted mass of nodes adherent to overlying skin, adjacent soft tissue, or clinical evidence of cranial nerve tissue. Radiologic signs of ECS include amorphous, spiculated margins of a metastatic node and stranding of the perinodal soft tissue in previously untreated patients."

Answer: Note in the table: Note 2: Clinical extracapsular extension is coded when involved regional lymph node(s) are described as "fixed" or "matted".

In Head and Neck sites, radiology imaging is commonly used to assess the primary site and the nodes. This is not true in every site. In Merkel cell, the lesions are obvious, not hidden as they are in the Head and Neck, so imaging is not as common for the primary site, especially if the nodes are in an accessible site which can be palpated, imaging is less likely to be performed. The Head and Neck chapter provides

some terminology used in radiology but it is not an exhaustive list. It is important for the registrar to communicate with the physicians and learn to recognize the terms and other statements such as stage that indicate involvement.

Questions from Kidney Webinar

Answer from Collaborative Stage Team

1. In a recent webinar on kidney, we included an exercise with a mixed histology. The histology included both a subtype of renal cell carcinoma and non renal cell histologies. Following the MP/H rules, the histology code assigned was a non renal cell carcinoma code. The question we have is about coding SSF6, Fuhrman nuclear grade. The path report did include a Fuhrman grade because the histology included a renal cell carcinoma subtype. Should the Fuhrman grade in the path report be coded in SSF6, or should the code be 997, not a renal cell morphology, because the histology code in the histology data item was not a renal cell carcinoma following the MP/H coding rules?

Answer: Report the Fuhrman grade provided by the pathologist based on the mixed histology that included a renal cell type. For studies, this data could be compared to the histology and used appropriately. Need to discuss with MP/H to get their perspective on the histology rules and the reasons.

Answer from SEER QI Team

2. Patient with a right nephrectomy has 3 separate tumors. Histologies are papillary adenocarcinoma, chromophobe renal cell carcinoma, and multicystic renal cell carcinoma. Do we have 2 primaries or 3 primaries?

Answer: See M8: One tumor with a specific renal cell type and another tumor with a different renal cell type are multiple primaries. The papillary, 8260/3, is one primary; the chromophobe, 8317, is second primary; and the third primary is clear cell/multicystic renal cell carcinoma, 8310/3. The multicystic tumor is a subtype of clear cell carcinoma.