SEER Advanced Topics for Cancer Registrars

Sunday, April 9, 2017
Gaylord National Resort & Convention Center
Washington, DC
Surgery of Primary Site

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NCI/SEER
Background

- Identified problems with coding surgery data items
- Misunderstanding of coding instructions?
- More education needed?
- Coding instructions need clarification?
Participants asked to code surgery fields on 12 cases:
- Bladder
- Breast
- Colon
- Lung
Background

- Surgery fields coded:
  - Surgery of Primary Site
  - Scope Regional LN Surgery
  - Surgery Other Regional/Distant
  - Surgical Margins
Bladder
### Bladder Frequencies

<table>
<thead>
<tr>
<th>Data Item</th>
<th>Bladder 01</th>
<th>Bladder 02</th>
<th>Bladder 03</th>
<th>Site Ave</th>
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<tbody>
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<td>58%</td>
<td>99%</td>
<td>82%</td>
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</tbody>
</table>
Bladder: Case 1
Surgery Primary Site

Patient had TURBT followed by cystoprostatectomy

Code 71: Radical cystectomy including anterior exenteration
[SEER Note: Use code 71 for cystoprostatectomy.] For males, includes removal of the prostate.

<table>
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Bladder: Case 1
Scope Regional LN Surgery

Path report states 1/13 total lymph nodes positive for metastatic carcinoma. Dissected nodes include Rt. Pelvic nodes, Rt. Common iliac nodes, Lt. common iliac nodes, Lt. pelvic nodes, Lt. obturator nodes, and perivesical node
Bladder: Case 1
Surgery Other Sites

No surgery to other regional or distant sites performed

Code 2: Non-primary surgical procedure to other regional sites (prostate?)
Non-primary surgical procedure to distant lymph node(s)

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<td>1</td>
<td>100</td>
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</table>
Bladder: Case 1

Surgical Margins

Per pathology report: the final margins were uninvolved.

0: No residual tumor
1: Residual tumor, NOS
2: Microscopic residual tumor
3: Macroscopic residual tumor
7: Margins not evaluable
9: Unknown
Bladder: Case 2
Surgery Primary Site

Patient underwent TURBT that also included fulguration.

TURBT is considered excision BX for bladder. Pt also had electrocautery in combination with TURBT. This is a more specific surgical procedure than TURBT, NOS.

Code 22: Combination of excisional biopsy (TURBT) with electrocautery.
Bladder Case:2
Surgery LN
Surgery Other

No LNs removed
No surgery to Other sites

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<tr>
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</table>
Bladder: Case 2
Surgical Margins

A TURBT is a piecemeal excision & margins are often not mentioned on the path report. In this case, the report showed invasive ca with no mention of margins.

SEER/FORDS Manual: data item coded from pathology report. If margins not mentioned, code as 9 (Unk)

Code 7: Margins not evaluable (code ONLY if pathologist did not specifically indicate margins could not be assessed)
Bladder: Case 3
Surgery Primary Site

Pt. had TURBT followed by cystoprostatectomy with ileal conduit

Code 71: SEER note: Use code 71 for cystoprostatectomy

Code 61: Radical cystectomy PLUS ileal conduit

Although PT underwent reconstruction there is no more specific code that includes cystoprostatectomy with reconstruction
Bladder: Case 3
Scope Regional LN Surgery

Pt. had three external iliac (regional) lymph nodes removed with the radical cystectomy specimen

Code 4: 1-3 regional lymph nodes removed
Bladder: Case 3
Surgery Other Sites

An incidental appendectomy was performed at the time of Radical cystoprostatectomy

Code 2: Non-primary surgical procedure to other regional sites

Code 0: None
Bladder: Case 3
Surgical Margins

Pathology report states “final surgical margins were all negative for carcinoma”
Breast
Breast Frequencies

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<tr>
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<tr>
<td>Surgery Other Reg Distant</td>
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<td>96%</td>
<td>98%</td>
<td>94%</td>
</tr>
<tr>
<td>Surgical Margins</td>
<td>92%</td>
<td>97%</td>
<td>95%</td>
<td>95%</td>
</tr>
</tbody>
</table>
Pt. underwent bilateral skin-sparing mastectomies with immediate reconstruction of bilat breasts with silicone implants, an AlloDerm sling, & bilat free-nipple graft

Code 49: Total (simple) mastectomy, NOS with removal of uninvolved contralateral breast with implant

AlloDerm is graft material & free-nipple graft is cosmetic reconstruction
Breast: Case 1
Surgery Primary Site

Code 30: Subcutaneous mastectomy
Note: A subcutaneous mastectomy, also called nipple sparing mastectomy, is the removal of breast tissue w/o the nipple & areolar complex or overlying skin. Is performed to facilitate immediate breast reconstruction. Cases coded 30 may be considered to have undergone breast reconstruction.
Breast: Case 1
Surgery Primary Site

Code 75: Total (simple) mastectomy, NOS with removal of uninvolved contralateral breast; tissue and implant

Free-nipple graft is not considered tissue reconstruction, but is part of the cosmetic reconstruction of the breast
Breast: Case 1
Surgery Primary Site

Code 63: Modified radical mastectomy with removal of uninvolved contralateral breast, combined (tissue & implant)

AlloDerm is graft material & free-nipple graft is cosmetic reconstruction
Breast: Case 1
Scope Regional LN Surgery

Pt. had Lt axillary LN **needle core biopsy** followed at a later date with Lt axillary sentinel LN dissection. 0/6 Lt axillary sentinel nodes positive

Code 2: Sentinel LN biopsy only
Scope Regional LN Surgery: Code 2

**Code 2:** Sentinel lymph node biopsy [only]

a. If a relatively large number of LNs, more than 5, are pathologically examined, review the operative report to confirm procedure was limited to a SLNBx & did not include an axillary lymph node dissection (ALND)

b. Review the operative report to confirm that an axillary incision was made & a node exploration was conducted. Pts. undergoing SLNBx who fail to map will often undergo ALND. Use code 2 if no ALND was performed, or 6 when ALND was performed during the same operative event.
Breast: Case 1  
Scope Regional LN Surgery  

Code 5: 4 or more regional LNs removed  

Code 6: Sentinel node biopsy and code 3, 4, or 5 at same time or timing not noted  

Code 7: Sentinel node biopsy and code 3, 4, or 5 at different times
Breast: Case 1
Surgery Other Sites
Surgical Margins

Code 0: No surgical resection of another regional or distant site was performed

*The removal of the contralateral breast is included under the Surgery of Primary Site field

Code 0: No residual tumor
* Pathology report states surgical margins clear, but posterior margin was close with invasive carcinoma <0.1cm from margin
Pt. had 2 core biopsies followed by Lt. simple mastectomy. Pathology report indicates the specimen was a “modified radical mastectomy”

Code 51: Modified radical mastectomy w/o removal of uninvolved contralateral breast
Code 41: Total (simple) mastectomy w/o removal of uninvolved contralateral breast
Code 50: Mod Rad Mastectomy
Breast: Case 2
Scope Regional LN Surgery

Operative report indicated Pt. underwent Lt. axillary sentinel LND followed by a completion level 1 & 2 axillary node dissection. 2/2 sentinel LNs positive and 6/11 non-sentinel axillary LNs positive

Code 6: Sentinel node biopsy and code 3, 4, or 5 at same time or timing not noted
Code 5: 4 or more regional lymph nodes removed
Breast: Case 2
Surgery Other Sites
Surgical Margins

No surgery to other regional or distant sites done
Code 0: None

Pathology report states surgical margins were clear
Code 0: No residual tumor
Breast: Case 3
Surgery Primary Site

Pt. underwent partial mastectomy of 2 and 4:00 lesions. This was followed by re-excision for a close margin

Code 23: Re-excision of the biopsy site for gross or microscopic residual disease
Code 20: Partial mastectomy, NOS; less than total mastectomy, NOS
Code 22: Lumpectomy or excisional biopsy
Breast: Case 3
Scope Regional LN Surgery

Pt. underwent sentinel LN biopsy (0/4 sentinel nodes positive)

Code 2: Sentinel lymph node biopsy [only]
Breast: Case 3
Surgery Other Sites
Surgical Margins

No surgical procedure of regional or distant site(s) performed

Code 0: None

Re-excision for margins negative for residual carcinoma

Code 0: No residual tumor
Colon
Colon Frequencies

<table>
<thead>
<tr>
<th>Data Item</th>
<th>Colon 01</th>
<th>Colon 02</th>
<th>Colon 03</th>
<th>Site Ave</th>
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<td>57%</td>
<td>83%</td>
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</table>
Pt. underwent a segmental colon resection with partial cystectomy performed with colon resection

Code 32: Partial colectomy plus resection of contiguous organ (partial cystectomy)

Code 41: Subtotal colectomy plus resection of contiguous organ

Code 30: Partial colectomy

Code 51: Total colectomy plus resection contiguous organ
Colon: Case 1
Scope Regional LN Surgery

Pt. had 19 pericolic (regional) lymph nodes removed at time of surgery

Code 5: 4 or more regional lymph nodes removed
Colon: Case 1
Surgery Other Sites

A single terminal ileum mesenteric lymph node removed during sigmoid resection. This node is not considered a regional node for sigmoid colon.

3: Non-primary surgical procedure to distant lymph node(s)
0: None
2: Non-primary surgical procedure to other regional sites
Colon: Case 1
Surgical Margins

Pathology report states proximal and distal mucosal margins were negative for tumor

Code 0: No residual tumor
Colon: Case 2
Surgery Primary Site

Pt. underwent sigmoid colectomy with coloproctostomy and BSO*
*BSO done to prevent metachronous ovarian metastasis.

Code 30: Partial colectomy; segmental resection
Colon: Case 2
Surgery Primary Site

Pt. underwent sigmoid colectomy with coloprostostomy and BSO*

Codes 32, 41, and 70 indicate a primary site resection was performed with resection of contiguous organ(s), NOS

*Although the BSO was not an incidental resection, it was performed to prevent metastatic disease to ovary. Considered a surgical procedure to regional site

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<td><strong>Total</strong></td>
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</table>
Colon: Case 2
Scope Regional LN Surgery

Pt. had 14 mesenteric lymph nodes removed at the time of the resection

Code 5: 4 or more regional lymph nodes removed
Pt. had BSO along with sigmoid colectomy. OP report indicates BSO performed to prevent development of ovarian metastasis as there was extensive tumor in the pelvis. The BSO was not an incidental resection.

Code 2: Non-primary surgical procedure to other regional sites.

Code 0: None

Code 4: Non-primary surgical procedure to distant site
Colon: Case 2
Surgical Margins

Per the pathology report, the margins were clear.

Code 0: No residual tumor
Colon: Case 3  
Surgery Primary Site

Pt. had a Rt. Hemicolecotomy with separate segmental resection of small bowel secondary to mets

Code 41: Subtotal colectomy/hemicolecotomy (total right or left colon & portion of transverse colon) PLUS resection of contiguous organ; example: small bowel, bladder
Colon: Case 3
Surgery Primary Site

Code 40: Subtotal colectomy/hemicolectomy

SEER Manual states:
Specimens from an en bloc resection may be submitted to pathology separately. The separately submitted specimens are still coded as en bloc resections with the primary site.

<table>
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<tbody>
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Colon: Case 3
Scope Regional LN Surgery

Pt. had 14 mesocolic (regional) lymph nodes removed at the time of the hemicolecctomy

Code 5: 4 or more regional lymph nodes removed
Colon: Case 3
Surgery Other Sites

Pt. had Rt. Hemicolecotmy with separate segmental resection of small bowel

The resection of the small bowel is coded in Surgery to Primary Site so the correct code is 0: None
Colon: Case 3
Surgical Margins

Pathology reports states the proximal and distal mucosal margins are uninvolved, but the radial margin was grossly involved.

Code 3: Macroscopic residual tumor (Assign code 3 for involvement of margins grossly (seen by the naked eye))
Code 2: Microscopic
Code 1: Residual tumor, NOS
Code 0: No residual tumor
Lung
## Lung Frequencies

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<tr>
<td>Surgical Margins</td>
<td>45%</td>
<td>100%</td>
<td>97%</td>
<td>81%</td>
</tr>
</tbody>
</table>
Lung: Case 1
Surgery Primary Site

Pt. underwent mediastinal lymph node biopsies (sampling) and a Lt. upper lobectomy with chest wall resection

Code 46: Lobe or bilobectomy WITH chest wall

Code 33: Lobectomy with mediastinal lymph nodes

Code 30: Resection one lobe, bilobectomy but <whole lung (partial pneumonectomy)
Lung: Case 1
Scope Regional LN Surgery

Pathology report states 6 mediastinal lymph nodes and 5 hilar, lobar and peribronchial nodes were taken both separately and with lobectomy specimen. 0/11 total N1, N2, and N3 nodes negative.

Code 5: 4 or more regional lymph nodes removed
Lung: Case 1
Surgery Other Sites

No surgical procedure of another regional or distant site was performed. The chest wall resection is not recorded in this field.

Code 0: None

Code 2: Non-primary surgical procedure to other regional sites
Lung: Case 1
Surgical Margins

The final pathology report indicates the interior bony rib and adjacent soft tissue margin was positive for carcinoma. The pathologist does not state if the margins are microscopic or macroscopic.

Code 1: Residual tumor, NOS
Code 2: microscopic tumor
Code 3: macroscopic tumor
Lung: Case 2
Surgery Primary Site

Pt. underwent a RLL lobectomy and mediastinal lymphadenectomy

Code 30: Resection of [at least one] lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)
Lung: Case 2
Scope Regional LN Surgery

Per pathology report, two peribronchial nodes were removed. 0/2 total regional N1 nodes were positive

Code 4: 1 to 3 regional lymph nodes removed
Lung: Case 2
Surgery Other Sites
Surgical Margins

No surgery of another regional or distant site performed

Code 0: None

Pathology report states the margins were all negative for invasive carcinoma

Code 0: No residual tumor
Lung: Case 3
Surgery Primary Site

Pt. underwent a right pneumonectomy with mediastinal LN dissection

Code 56: Pneumonectomy, NOS WITH mediastinal lymph node dissection (radical pneumonectomy)
The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery (NAACCR Item # 1292).
Lung: Case 3
Scope Regional LN Surgery

LN nodes dissected were not mentioned in OP report

Per pathology report, there were 10 LN nodes in the mediastinal LND, 2 hilar LN nodes, and 8 N1 nodes. 10/20 total regional N1 and N2 nodes were positive

Code 5: 4 or more regional lymph nodes removed
Lung: Case 3
Surgery Other Sites
Surgical Margins

No surgical procedure of another regional or distant site was performed

Code 0: None

Final diagnosis indicates the hilar margin was close, but microscopically clear of carcinoma

Code 0: No residual tumor
Conclusions

- Need to read both operative and pathology reports to determine the surgical procedure(s)
- Do not depend on surgeon’s statement of planned procedure
- Do not depend on final pathologic diagnosis
Conclusions

➢ Surgery codes should be updated to include “new” procedures/terms
➢ Additional notes/clarification for en bloc resections & contiguous organ resection
➢ Examples/clarification when resection of regional/distant sites are coded in surgery versus Other
Conclusions

- Utilize resources to determine regional VS distant lymph nodes
- If margin status not stated in final diagnosis, read microscopic report
Questions