2026 NCI SEER Symposium
Prostate Cancer Recurrence
-ODS Approach

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Objectives

Discuss the nuances and complexity of assigning the correct codes, to accurately capture prostate cancer recurrence, including interpretation of biochemical recurrence, image findings and physician documentation in various case scenarios.

Highlight areas where registrars struggle abstracting.

Identify various resources available to the cancer registrar and how to apply that knowledge when abstracting.

Address common documentation challenges and terminology pitfalls to improve consistency, accuracy, and confidence in coding prostate cancer recurrence.

Minimum Resources Required to Abstract

- 2026,2025 or previous NAACCR Implementation Guidelines https://www.naaccr.org/implementation-guidelines/
- American Joint Committee on Cancer/AJCC https://www.facs.org/quality-programs/cancer/ajcc
- Hematopoietic and Lymphoid Neoplasm Database https://seer.cancer.gov/seertools/hemelymph/
- Hematopoietic and Lymphoid Neoplasm Coding Manual https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf
- EOD 2018 https://seer.cancer.gov/tools/staging/
- ICD 0 3.2 Histology Revisions & Annotate Histology List https://www.naaccr.org/icdo3/
- NAACCR Site Specific Data Items and Grade https://apps.naaccr.org/ssdi/list/
- NAACCR https://apps.naaccr.org/data-dictionary/?_gl=1*1g26xwm*_ga*NDMxNjA1OTc3LjE1NzIyNzA5MTY.*_ga_V7J8GWYK5P*MTY4OTk0MzQ1NC43Ny4wLjE2ODk5NDM0NTQuNjAuMC4w
- NAACCR Recommended Abbreviations for Abstractors NAACCR Recommended Abbreviations for Abstractors https://apps.naaccr.org/data-dictionary/data-dictionary/version=25/chapter-view/abbreviations-and-acronyms/
- Pediatric Resources https://www.naaccr.org/pediatric-resources/#1733928553777-b2bb2c32-509f
- Solid Tumor Rules https://seer.cancer.gov/tools/solidtumor/
- SEER*RSA https://staging.seer.cancer.gov/eod_public/list/3.3/
- SEER*Rx Interactive Antineoplastic Drugs Database https://seer.cancer.gov/seertools/seerrx/
- SEER Program Coding and Staging Manual https://seer.cancer.gov/tools/codingmanuals/
- STORE Manual https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/
  - Appendix M: Case Studies for Coding Melanoma in STORE
  - Appendix R: CTR Guide to Coding Radiation therapy Treatment
- Summary Stage 2018 https://seer.cancer.gov/tools/staging/
- Cancer Program News https://www.facs.org/quality-programs/cancer/news
- Appropriate State Manual

#1 Scenario- Prostatectomy: Biochemical + Reg Node Recurrence

4-19-2020 PSA 7.1 7-30-2020 Radical Prostatectomy laparoscopic, robotic assisted, bilateral pelvic lymph node dissection margins (-), pT3b, pN0 Gleason 4+3

11-13-2020 PSA 0.02 Doing great. Dry at night. No pain. 1-2 pads during the day. Doing great with undetectable PSA
2-21 & 5-21-2021 PSA <.01
7-25-22 PSA 0.06 Doing great status post prostatectomy. PSA is still extremely low. We discussed some of the criteria & thresholds for biochemical failure. If PSA does reach a 0.2 ng/dL, then we will increase the frequency of PSA to every 3 months and if he reaches 0.4 ng/dL then he will need to be evaluated by Rad Onc. His current level he safe.

7-27-2023 PSA 0.26. We discussed the fact that if he reaches 0.4 then we will order a PET/CT and likely proceed with salvage radiation at that point

1-29-2024 PSA 0.93 Rising PSA status post prostatectomy with negative margins. Order PET/CT and placed a referral to radiation oncology.

2-5-2024 Patient's 2-1-2024 PET CT came back positive for small regional nodal disease within the pelvis. He is status post prostatectomy with rising PSA.

3-7-2024 Started Hormonal Therapy

7-14-2024 Salvage radiation with pelvic nodal radiation completed

1-15-2026 PSA 0.01 Overall doing well. Hold Lupron, has had a good response..0

#1Type of 1st Recurrence

- **Scenario:**
  - 7-25-22 PSA 0.06 Doing great status post prostatectomy. PSA is still extremely low. His current level he safe.
  - 7-27-2023 PSA is up to 0.26. We discussed the fact that if he reaches 0.4 then we will order a PET/CT and likely proceed with salvage radiation at that point
  - 1-29-2024 PSA 0.93 Rising PSA status post prostatectomy with negative margins. Order PET/CT and placed a referral to radiation oncology.
  - 2-1-2024 PET:
    - 1. Three tracer avid pelvic/perirectal lymph nodes compatible with nodal metastases.
    - 2.No abnormal tracer uptake at the prostatectomy bed to suggest local recurrence.
  - 2-5-2024 Rad Onc: Patient's PET CT came back positive for small regional nodal disease within the pelvis.
- **Question:** How will you code Type of 1st Recurrence?
  - 10 Local recurrence and there is insufficient information available to code to 13-17. Recurrence is confined to the remnant of the organ of origin; to the organ of origin; to the anastomosis; or to scar tissue where the organ previously existed
  - 22 Recurrence of an invasive tumor in regional lymph nodes only
  - 30 Both regional recurrence of an invasive tumor in adjacent tissue or organs(s) and/or regional lymph nodes
  - 70 Since diagnosis, patient has never been disease-free
  - 88 Disease has recurred, but the type of recurrence is unknown
  - 99 Unk whether disease has recurred or if ever disease-free

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#1 Answer & Rationale

- TYPE OF FIRST RECURRENCE DEFINITION: indicates the type of first recurrence after a period of documented disease free intermission or remission
  - 22 Recurrence of an invasive tumor in regional lymph nodes only

  - **Points to Ponder**: Was there ever period of documented disease-free intermission or remission?
    - Does your facility adhere to CoC guidance and require a physician to explicitly document that the patient has no evidence of disease (NED)?
    - Does your facility allow registrars to apply professional judgment when interpreting laboratory results, diagnostic imaging, and physician documentation?
    - Does your facility code all cases as status 70 until a physician explicitly states NED?
    - Does your facility code cases as status 99 when a physician does not state whether the patient is NED?

#2 -Biochemical Recurrence

Scenario:

- Feb 2024 Patient presents with elevated PSA 6.19, 3-18-2024 bx + Adenocarcinoma 4+3
- 4/1/24 – 5/16/24 Photon IMRT to whole prostate 7000 cGy, 250 cGy/fractions x 28 fractions
- PSA Results
  - 07/12/2024 2.84
  - 10/10/2024 <.01
  - 10/20/2025 .03
  - 03/04/2026 .06
- 3/18/26 MD visit note: **Rising PSA consistent with biochemical recurrence**. {Scans were negative) Will initiate hormone therapy.
- 3/24/26 Subsequent Lupron started

Question: How will you code Type of 1st Recurrence?

- 10 Local recurrence, NOS
- 20 Regional recurrence, NOS
- 30 Both regional recurrence of an invasive tumor in adjacent tissue or organs(s) and/or regional lymph nodes
- 70 Since diagnosis, patient has never been disease-free
- 88 Disease has recurred, but the type of recurrence is unknown
- 99 Unk whether disease has recurred or if ever disease-free

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#2 Answer & Rationale

- ???
- Discussion:
  - An elevated PSA does not mean prostate cancer, it can be elevated for other reasons, but a continued rise is more indicative (although not diagnostic).
  - Physicians document biochemical recurrence in the medical record. NCCN Guidelines include treatment recommendations for biochemical recurrence.
  - Currently, there are no instructions in the SEER Manual or STORE Manual on how to code biochemical recurrence.
  - Multiple CAnswer Forum postings consistently state that the CoC does not capture biochemical recurrences.
  - In the absence of formal guidelines for documenting biochemical recurrence, facilities have been observed to develop internal policies and procedures (P&P) to identify an agreed-upon code and promote consistent application.

#3 Type of 1st Recurrence -Time of Coding the Abstract

- **Scenario:**
  - 2/2/2022 Bone scan (-), no info about PSA other than elevated, no info about DRE, comes in for Radical Prostatectomy. Adenocarcinoma, Gleason score 4+5=9 (grade group 5). Extra prostatic extension present, seminal vesicle invasion present. Margins clear. Lymphovascular invasion present, perineural invasion present. 1/7 nodes positive. pT3b, pN1, cM0
  - 4/2/2022 Case is abstracted, no other information is available.
- **Question**: How would you assign cancer status, type of 1st recurrence ?
  - Cancer Status 2 Evidence of this Tumor
    Type of 1st Recurrence 70 Since diagnosis, patient has never been disease-free
  - Cancer Status 1 No Evidence of this Tumor
    Type of 1st Recurrence 00 Patient became disease-free after treatment and has not had a recurrence.
  - Cancer Status 9 Unknown
    Type of 1st Recurrence-99 It is unknown whether the disease has recurred or if the patient was ever disease-free

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#3 Answer & Rationale

- Cancer Status 9 Unknown
- Type of 1st Recurrence-99 It is unknown whether the disease has recurred or if the patient was ever disease-free
- **<u>Points to Ponder:</u>**
  - Theoretically the registrar would try to ascertain the cancer status and type of first recurrence through active follow up methods
    - What Actually occurred- Time of abstract cancer status 2 and type of 1st recurrence 70
      - FU date updated by import function every time patient enters the hospital with disease status & recurrence staying the same as entered at time of origination
      - Last time visited hospital 9-2024 syncopal episode at home post dental appointment. In list of previous surgeries, it lists the radical prostatectomy…. That's it.. no further information, patient lost to follow-up

    - How many of you go back and do ACTIVE follow up on ALL of your analytic patients?

Final Thoughts

- Challenges coding recurrence in prostate cancer are:
  - Inadequate or missing physician documentation:
    - Key clinical details needed to accurately determine recurrence are often not clearly documented, incomplete, or absent from the medical record.
  - Limited guidance from standard setting organizations:
    - Standard setters do not consistently provide clear instructions for common recurrence scenarios, resulting in variation in interpretation and coding practices among registrars.
  - Insufficient time for registrars to complete thorough reviews:
    - Heavy workloads and competing responsibilities reduce the time available for registrars to conduct comprehensive chart reviews and validate recurrence information.
  - Reliance on automated follow up processes without human review:
    - Automated systems may flag recurrence without supporting clinical evidence, and lack of manual validation by an abstractor increases the risk of inaccurate coding.

Questions