Collaborative Stage Training:

Difficulties found in completing CS Data Items

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Overview

- Introduction and Background on Training plans in Canada
- Breast- Tumor Size
- Colorectal- Extension
- Lung-Extension
- Ambiguous Terminology
- Timing rules and Progression
- Discrepancies in documentation and doctor’s staging
- Summary

Introduction

- Canada began conducting Collaborative Stage training sessions in February 2006
- Three sessions have been completed
  - Breast, Colorectal, Lung
- Difficulties have been found in completing certain data items

CANADIAN STAGING TRAINING PLAN

- Module Development meetings
  - One meeting per anatomic site
- Case Development and Preparation by trainers
- In person Training
- Follow up Sessions as required

CANADIAN STAGING TRAINING PLAN

- Review of many materials related to the anatomic site
  - Powerpoint presentations from April Fritz of the SEER Program
  - Powerpoint presentations from other provinces or organizations
  - Inquiry and Response questions related to the anatomic site from the Commission on Cancer
  - Review of CS Manual related to anatomic site
  - Consultation with CS Steering Committee
  - Review of CS Reliability Study questions and answers
  - Review of textbooks, websites
  - Consultation with clinicians

FORMAT OF TRAINING SESSION

- Background reading assigned to participants
  - General Rules and Instructions section of CS Manual
  - Section related to site specific training
    - Example: Breast schema
- Pre-test Cases completed prior to attending session
  - 10 cases sent by email to registered participants with at least 2 weeks to complete and return
    - Cases discussed during the session and preferred answers provided
- Questions submitted to trainers prior to training session

FORMAT OF TRAINING SESSION

- Three day sessions consisting of:
  - Powerpoint presentation specific to the anatomical site including overview and general instructions
  - Anatomical specific physician presentation
  - Site specific exercises and group discussion
    - Approximately 30 cases are staged during the session and discussed as a group
    - Preferred answers and rationale provided
  - Evaluations
    - Completed by each participant

RESULTS

- Training for Collaborative Stage for the first three major sites (breast, colorectal, lung) has been conducted for participants from 7 provinces to date
  - Manitoba, Saskatchewan, Newfoundland and Labrador, Nova Scotia, Prince Edward Island, Several hospital based registries in Quebec and the Princess Margaret Hospital Cancer Registry in Ontario

  PLUS

  - New Brunswick (for two sites-colorectal and lung)

FUTURE CANADIAN STAGING TRAINING PLANS

4th Training Session

-Prostate- September 19-20, 2006

-Quebec City in conjunction with annual workshop

5th Training Session-tentative

-Anatomic site not confirmed-tentatively scheduled in January 2007

DIFFICULTIES

TUMOR SIZE
EXTENSION
LYMPH NODES
OTHER ISSUES

Breast- Tumor Size

- Description of Tumor Size based on CS Manual, page 25
  - "Records the largest dimension or diameter of the **primary tumor**, and is always recorded in millimeters."

Breast- Tumor Size

- Problem
  - Code 000-No mass/tumor found
    - Confusing on when this should be used
  - Code 998- Diffuse
    - Confusing and unclear on when to use this
    - See CS Manual, page 27 under CS Tumor Size, rule 5c:
      - “The descriptions in code 998 take precedence over any mention of size. “

Breast- Tumor Size

- Solution
  - Code 000:
    - Used infrequently;
    - Use this code when the case is entered as an unknown primary, but treated as breast
  - Code 998:
    - ¾ or more of breast involved;
    - extensive involvement of breast without measurable size, not just the word “diffuse”

Breast- Tumor Size

- Problem
  - Mixing and matching
    - **Example**: if CS Tumor Size is larger after treatment, but CS Extension is not, difficult to determine which CS TS/Ext Eval code to use

Breast- Tumor Size

- Solution
  - CS Manual, page 26-rule 3e:
    - “In the infrequent event that the tumor does not respond to neoadjuvant treatment and is, in fact more extensive after preoperative treatment as determined by the operative of pathology report, code the farthest extension and code CS Tumor Size/Ext Eval as 6, based on pathology/operative report after treatment”

Breast- Tumor Size

- Problem
  - Non exact sizes-how to choose the appropriate option
    - **Example**: “greater than 2 cm” or “greater than 5cm”
      - No clear code choice for these
    - **Example**: “about 6 cm”

Breast- Tumor Size

- Solution
  - Greater than 2 cm would be Code 993, “Described as less than 3 cm”
  - Greater than 3 cm would be 994
  - Greater than 4 cm would be 995
  - Greater than 5 cm
    - Sent to Inquiry and Response System and is currently being worked on by the CS Steering Committee for next release

Breast- Tumor Size

- Problem
  - Tumors described as "**less than**__cm"
    - Page 457 of CS Manual

    or "**between** __ and __ cm"
    - page 62 of CS Manual

Breast- Tumor Size

- Solution
  - Use the upper size limit
  - Educate registrars that codes
    - 992 can mean:
      - Less than 2 cm OR Between 1 and 2 cm
    - 993 can mean:
      - Less than 3 cm OR Between 2 and 3 cm
    - 994 can mean:
      - Less than 4 cm OR Between 3 and 4 cm
    - 995 can mean
      - less than 5 cm OR Between 4 and 5 cm

Breast- Tumor Size

- Problem
  - Information from imaging/radiographic techniques
    - Difficulty with using an x-ray over a CT scan, since a CT may provide more detail
    - Should there be a priority order for these reports?

Breast- Tumor Size

- Solution
  - Follow rules in the CS Manual, pg. 26
    - Rule 3c:
      - "Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report…"
    - Rule 3d:
      - "If there is a difference in reported tumour size among imaging and radiographic techniques, record the largest size of tumor reported in the record."

Breast- Tumor Size

- Problem
  - Determining the tumor size from an excisional biopsy versus incisional needle biopsy (core biopsy)

Breast- Tumor Size

- Solution
  - Rule 4i and 4j-Page 26-27 of CS Manual
    - Excisional-code the size of the residual tumor at resection if found to be larger at resection than at biopsy
    - Incisional-code the size of the tumor from an incisional biopsy only when **no** residual tumor round at resection. Do not code as 999 automatically

Breast- Extension

- Problem
  - Skeletal muscle-where to list this
    - “Invasive duct carcinoma, grade 3/3, 2.5 cm maximum dimension, invading skeletal muscle, 0.1 cm from deep margin, 0.8 cm from anterior margin”

Breast- Extension

- Solution
  - Skeletal muscle is considered to be pectoral muscle in surgery, therefore Extension code 30 is the correct choice
    - “invasion of (or fixation to) pectoral fascia or muscle”
  - If no other information is listed, and a mastectomy specimen is available, then skeletal muscle, NOS would be Code 30

Colorectal- Extension

- Definition of CS Extension according to the CS Manual, page 28:
  - "Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs…"
  - For colon, see Note 3, page 272:
    - "…Discontinuous involvement is coded in CS Mets at DX."

Colorectal- Extension

- Problem
  - Difficult to determine the appropriate Extension code, when different terminology is used
    - Example: Haggitt level 0-4 versus “head of the polyp” or “stalk of the polyp”

Colorectal- Extension

- **Solution**
  - If the tumor is described as only in the **head of the polyp**, assign extension code 13.
  - If the tumor is described as being in or confined to the **stalk of the polyp** (it could also be in the head of the polyp) assign extension code 14; It is not beyond the stalk
  - Haggitt Level compared to Extension codes:
    - Level 0= 10
    - Level 1=13
    - Level 2=15
    - Level 3=14
    - Level 4=16

Colorectal- Extension

- Problem
  - Extension 60- extension to adjacent organs
  - Depending on whether the schema is colon or rectum, this can determine whether this is extension or discontinuous mets

Colorectal- Extension

- **Solution**
  - Example: For Transverse colon –One should not assume Extension 60 if liver involved.
    - Usually liver is a discontinuous mets for this site and should be coded in Mets at DX
    - Reminder to only code direct extension (contiguous) to Code 60, which is Note 3 of page 272 of the CS Manual
    - Reminder to refer to page 19 of the CS Manual for the description of adjacent organs and structures

Lung- Extension

- Definition of CS Extension according to the CS Manual, page 28:
  - "Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs…"

Lung- Extension

- Problem-When to use Extension 11
  - “Superficial tumor of any size limited to bronchial wall WITH or WITHOUT proximal extension to the main stem bronchus”

Lung- Extension

- Solution
  - This is a rare occurrence
    - In one province, out of 1500 lung cases, there was not one case
  - It is an early stage cancer
  - Biopsy of the bronchial wall is not enough to use code 11

Lung- Extension

- Problem
  - How do you determine when to use code 20 versus code 21
    - Code 20: involving main bronchus greater than or equal to 2 cm from carina
    - Code 21: involving main bronchus, NOS, distance from carina not stated and no surgery as above

Lung- Extension

- Solution
  - Code 20
    - Use when the tumor **goes into** the main stem bronchus from somewhere else
  - Code 21
    - Use when the tumor **starts in** the main stem bronchus
      - Less frequent than code 20

Lung Extension

- Pleural Effusion: Code 72
  - When do you count the pleural effusion?
    - May be related to other conditions
      - Example: Congestive Heart Failure
    - May be multiple reports stating differing results
    - Trace vs. small vs. large-what is the difference?

Lung Extension

- Pleural Effusion: Code 72
  - If in doubt, consult clinician on what is meant by the reports
  - If not possible to consult clinician:
    - Follow Notes 6A and 6B in CS Manual, on page 404 (CS Extension for lung)
      - Ignore if negative for tumor
      - Assume negative if resection performed
      - Ignore if clinical judgement says effusion is not related to tumor
      - Multiple (2 or more) negative cytopathologic exams of pleural fluid excludes pleural effusion as a staging element

Lung –Lymph Nodes

- If a lymph node is greater than 1.5 cm on a radiology report, is this considered involvement?
  - Surgeons and Radiation Oncologists in Canada recommend that if measured on a CT scan, this could be considered involvement

Lung –Lymph Nodes

- Code 10 and 20
  - Where do the Lymph node stations fit into these codes?
  - Recommend to write the station numbers beside the applicable codes in CS Manual
    - Example:
    - Code 10=LN Stations 10-14
    - Code 20= LN stations 1-9

Lung –Lymph Nodes

- Code 80-Lymph nodes, NOS
  - When should one use this code?
- When you don't know if the lymph nodes involved are regional or distant
  - As per downstaging rule, page 8 of CS Manual:
    - "If there is doubt concerning the T, N, or M classification to which a particular case should be assigned, then the lower (less advanced) category should be assigned."

Ambiguous Terminology

- Reference-page 20 of the CS Manual
  - "….if individual clinicians use these terms differently, the clinician's definitions and choice of therapy should be recognized. If a term used in a diagnostic statement is not listed…consult the clinician to determine the intent of the statement."

Ambiguous Terminology

- Examples of other terms that are not listed, but may be considered involvement, based on clinician:
  - Stricture
  - Thickening
  - Approximates
  - Adjacent

Timing Rule

- **Timing Rule** in CS Manual
  - Page 2:”use all information gathered through completion of surgery(ies) in first course of treatment, or all information available within four months of the date of diagnosis in the absence of disease progression, whichever is *longer*.”

Progression

- Page 13-Rule 13:”Metastasis known to have developed after the initial extent of disease was established should be excluded when determining the farthest extent of disease at the time of diagnosis.”
- Page 2: “Information about tumor extension, lymph node involvement, or distant metastasis obtained after disease progression is documented should be excluded from the CS fields.”

Progression

- What progression is not:
  - More precise extension or tumor size discovered within the limit of the timing rules through further tests
- What progression is:
  - Asymptomatic patient prior to treatment, then develops metastases during treatment
    - Treatment decision was made when no mets, therefore the mets are progression

Progression

1. If the clinician states progression
   - Use the first size or extension stated prior to statement
2. If the clinician does not state progression

   AND

   No treatment given

   AND

   Within 4 months of diagnosis

   AND

   Larger size or extension documented
   - USE larger size or more extensive information documented

Documentation and Discrepancies

- Definitions and descriptions
  - Refer to page 13, rule 15:
    - "If a discrepancy between documentation and physician assignment-documentation in the medical record takes precedence"
  - Page 29, rule 5:
    - "If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, the extent of disease may be inferred from the T category stated by the physician."

Evaluation Codes in Autopsy

- Question: Autopsy cases
  - If a tumor is suspected prior to autopsy, but not suspected in the lymph nodes or mets, which Eval code should be used?
    - Page 18 of CS Manual:
      - "If a patient with a suspected diagnosis of cancer dies and an autopsy is performed, extent of disease information obtained from the autopsy may be included along with other clinical and pathologic information, if it meets the timing rules for inclusion."

Evaluation Codes in Autopsy

- Solution:
- Use the same eval fields for all
  - Example:
    - TS/Ext Eval=2
    - Reg Nodes Eval=2
    - Mets Eval=2

Mets Eval

- Move of rule 7, CS Manual page 46 to rule 1 on page 45
  - "Any positive biopsy or resection of distant metastasis meets the requirement for pathologic staging basis and should be coded to CS Mets Eval code 3."
  - This is the most important information, above the farthest involvement
    - "pathology trumps all"

Summary

- Difficulties with assigning Tumor Size for breast, Extension for colorectal and Lung have been identified
- Difficulties with vague descriptions, discrepancies and terms have been identified
- Canada has made some decisions in consultation with the CS Steering Committee and with local clinicians

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