**Q&A Session for Collecting Cancer Data: Testis**

**Thursday, January 10, 2019**

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**Q:** ­Where does it tell us to use MP/H rules for Testis? The solid tumor rules for other sites only tells us that Rectosigmoid, rectum and peripheral nerves and auto nervous system are not included in "other sites". Testis is in Table 1 of solid tumor rules?­

**A:** ­If there is NOT a special section in the Solid Tumor Rules (such as lung, breast, etc.) then you must use the Other Rules. Testis is not a special section so Other Rules guide us for MP and H rules. See the Solid Tumor Rules General Instructions, page 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q:** ­On this slide it says TS is best TS prior to neoadjuvant just make sure they all that pathologic takes precedence over clinical when available for TS Summary.­

**A:** ­Just reminded Denise who explained more about the rules.

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**Q:** ­Case #2 had a clinical size on the sonogram 8.1cm­.

**A:** ­Will review.­

Correct. We failed to add the 8.1 cm clinical TS on the slide. The clinical TS is 081 for case 2.

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**Q:** ­For case 1 - clinical sonogram stated areas of hypoechoic heterogeneity - so we didn't take the clical 2.5 as it didn't say it was a mass/tumor/lesion? Also #2 had a 8.1 mass - would not that be the TS clinical?­

**A:** ­Will review.

Case 1: The imaging stated there were “Multiple areas of Hypoechoic heterogeneity. Overall diameter up to 2.5cm. Appearance is su suspicious for malignancy.” The best clinical measurement of the area of **malignancy** is 2.5 cm or 025.

Case 2: We failed to add the 8.1 cm clinical TS on the slide. The clinical TS is 081 for case 2.

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**Q:** ­Why would we not use the size from the sonogram in Scenario 2 for clinical size. It was 8.1cm left testicular mass concerning for malignancy?­

**A:** ­Will review.­

Case 2: We failed to add the 8.1 cm clinical TS on the slide. The clinical TS is 081 for case 2.

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**Q:** ­Was case #2 size 999 because "concerning for" is not on either ambiguous term list? So no cancer diagnosis?­

**A:** ­Just because the radiologist used "concerning for" did not mean the urologist didn't suspect cancer. The markers were also elevated. You might also have had access to urology notes. It's hard to put everything into a brief example. We believe the size­ should be 081.

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**Q:** I should have asked why would we use the 2007 MP/H rules for testis instead of the 2018 Solid tumor rules? 2018 lists testis under "other sites".­

**A:** ­If you look at the STR, Other sites is defined as "used for cases dx 1/1/2007" and beyond. They did not revise the Other Rules yet. So whether you call them MP/H or STR, they are the same rules.­ See the Solid Tumor Rules General Instructions, page 3.

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**Q:** ­With EOD Regional Nodes codes, if we had both clinical and pathologic nodes noted with same 2 to 5 cm does pathologic EOD code take precedence?­

**A:** ­Per the EOD manual, pathological findings take precedence over clinical ... so you would use the path EOD code.

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**Q:** ­Can you assign cT4 based on imaging only?­

**A:** ­I think that's a question that would need to be sent into Cancer Answer for AJCC. Per the chapter, radiologic assessment is described for nodes and mets only.

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**Q:** ­Clarification: for case #2 (and 3?), EOD reg node was 000 but AJCC cN is cNX? ­

**A:** ­When we are answering fields, we have to use the rules in the particular field we are trying to answer. EOD has different rules than AJCC.­ For EOD, we used the inaccessible nodes rule. That is not a rule that applies to AJCC.

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**Q:** ­Would you mind explaining again by case #3 is pM1a even though the lung met dissection was after 1st course surgery?­

**A:** ­As I noted, that was a mistake on my slide. It should be cM1a.­

**A:** ­Oops. That should be cM0. Sorry ... this case is messy but real.­

For case 3, the clinical M is cM0 and the pathological M is cM1a based on the CT performed post-op).

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**Q:** ­Just to confirm - case 3 - we understand the reason for the cM0 because it was not found until after surgery - but for EOD and Summ Stage - we can take the post-surgery scans as it was prior to chemo or should that be unknown as well? ­

**A:** ­Each staging system has its own rules for time frames. They may not match each other. EOD and SS!8 are clinicopathologic systems. In AJCC, we can use the post-operative imaging to assign the pathological categories and stage group, as long as the imaging falls within the pathological staging window.

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**Q:** ­Regarding the changes to the SSDI instructions, I came across this in another site (breast) where we had a HER2 copy number of <4.0. We ended up coding it to XX.7 since we didn't have instruction to code it 3.9. Will this be changed in other sites?­

**A:** ­That will have to be sent to SSDI (SEER/NAACCR) to ask. We are only addressing the testicular changes.

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**Q:** ­Please explain last bullet on slide 94 again. Serum Markers needed for Code 1.­

**A:** To calculate ng from IU/mL, divide the value for IU by 0.83.

10 IU/mL: 10/0.83 = 12.04 ng/mL

IU/mL: 5/0.83= 6.02 ng/mL

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**Q:** ­For case #1, Donna Gress said in CAnswer Forum that the normal clinical stage serum tumor markers can be used to assign the path stage markers. <http://cancerbulletin.facs.org/forums/node/83831>­

**A:** ­Is there a question here?

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**Q:** ­Denise just went over the slide with it as XXXXX.9­

**A:** ­Different rules for AJCC staging versus how to document SSDI values.

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**Q:** ­Can you reshow the answers for slide 114-ssdi hcg pre and post orchiectomy fields­?

**A:** Please refer to the updated slide presentation with answers.

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**Q:** ­Case #3 I thought you said correct path M is cM0 (because imaging after surgery)?­

**A:** ­We will totally review our answers and submit them within a week. Sorry for so much confusion.­

For case 3, the clinical M is cM0 and the pathological M is cM1a based on the CT performed post-op).

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**Q:** ­Having trouble with the <2.39 being coded to 2.3 - how is 2.3 less than 2.3? ­

**A:** When you have a number larger than the allotted field size (in the case of the BhCG results to the tenth place), SSDI instructions tell us to round up. So 2.39 would become 2. However, the actual result is BhCG < 2.39. Instructions for inexact numbers tell us to take away one digit. So to be < 2.39, the rounded 2.4 would become 2.3 (which is < 2.39)

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**Q:** ­(if time permits) would you mind showing slide 97 again (path serum maker SSDI)?­

**A:** Please refer to the updated slide presentation with answers.

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**Q:** I thought we could assume cN0 if treated that way?

**A:** The rule for assuming clinical information goes back to collaborative stage rules for inaccessible lymph nodes. AJCC does not have any rule like that. Physicians may be able to assume clinically that lymph nodes are negative. If registrars are documenting the clinical staging, they require workup documentation – in testis that would be a CT abdomen, PET, or something that could show the lymph nodes because they are not in an area of the body where they can be palpated.

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**Q:** So for Case 3, pathological staging, pT2 pNx cM1a; not pM1a, just to clarify once more.

**A:** We cannot use the pM1a because the excision of the mets was after the adjuvant chemo had been done. Think of it this way: when the lab markers did not return to normal, the physician had a decision of what to use for adjuvant treatment. (S)he chose chemotherapy rather than surgery. So there must have been enough information to drive that decision.

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**Q:** Why the clinical TX NX and not BLANKS because the Chapter states Clinical Exam & HISTOLOGIC assessment required for clinical stage. So in clinical timeframe, the classification not met so I thought it should be BLANKS and not X's. I had a discussion with Donna on Forum & she said technically it would all bel eft blank. Most testicular cancers would never have a clinical stage. <http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/genitourinary-sites-chapters-40-47/79984-testis-clinical-stage-without-histologic-assessment>

**A:** The idea of blanks is a new idea for us registrars. There is a note under the clinical staging: “Except for Tis confirmed by biopsy and T4, the extent of the primary tumor is classified by radical orchiectomy. TX may be used for other categories for clinical staging.” It is possible that I could have evidence of metastatic lymph nodes AND/OR distant mets AND/OR elevated markers that would allow me to choose a group stage with the Tx. There is no group stage with a blank T.

You might also read “X vs Blank for Clinical Stage” in the Forum. In that, Donna notes that we can use Tx when workup was done. “…There was a workup to try and assess the tumor, through imaging, scopes, etc, but the primary tumor could not be assessed”

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**Q:** I have another issue I would like guidance on because it happens a lot :( Presents with discomfort right testicle. US concerning for testicular cancer. Undergoes orchiectomy. Ct Pelvis concerning for mets in retroperitoneal lymph nodes. Has chemo, then goes on to have lymph node dissection after the chemo & 1/23 node+. So clinical staging is all BLANK because no biopsy prior to surgery and histologic assessment required for clinical stage. Then we can get a Path T, but the Path N should be an X because the nodes weren’t removed until after chemo? Correct?? Or do we leave path staging blank & just do post therapy staging?? It’s a quandary. We see this a lot at this facility.

**A:** Chapter 59 does not require biopsy prior to clinical staging.cTx is allowed in this chapter along with clinical assessment of lymph nodes, distant mets, and serum markers preoperatively to do clinical staging.

Our job is not to make sure every case has a group stage. Our job is to record the physician’s staging in the medical record (when it is accurate) in the registry database. If the physician makes a mistake, that can be discussed with him/her and corrected. If no physician documents the staging, the registrar can use the pieces of information available and answer any staging field for which there is information. That could mean some fields have no information and may be left blank. And that could mean we will be unable to group stage some cases without all the information. We believe the AJCC 8th edition authors are requesting accuracy over completeness – that is, answer what we can answer accurately and don’t try to force a group stage if it is not possible.

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**Q:** ­On the slide titled Germ Cell Tumors what does CIS stands for?­

**A:** ­Carcinoma in situ.

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**Q:** ­Do you think CoC eventually require EOD? ­

**A:** ­I do not know about CoC, but have heard rumor that NPCR may require it in the future and that it could involve all states.­

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**Q:** ­So 46/50 State registries reports to CDC (NPCR) and eventually be required to collect EOD? Hopefully it can start with 2019 cases.­

**A:** ­Nothing is confirmed stating that is the case. We will have to wait and see.­

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**Q:** ­If Physician states Tumor marker HCG is elevated at 51.48 but no units described how do we code HCG?­

**A:** ­The hCG is usually measured in mIU/ml per WHO biological standardization committee (per internet search). If you're not sure, you can ask on CAncer Answer what to do.­

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**Q:** ­Would we use 4 stated to be elevated by physician?­

**A:** ­If the physician includes the word "high" or "elevated". If there is an unusual measurement scale, 51+ could be within normal limits. So I need the physician interpretation words.­

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**Q:** Can the it take longer then 3 months for them to decide on?

**A:** If you are referring to adjuvant treatment decisions, yes, but we would hope to have documentation of what the physician is looking for. An example could be: preop BhCG was 50,000. Post orchi, it was 30,000. One month later it was down to 20,000. So the doctor may write something like “give the patient two more months for hCG to return to normal range” … that could still be more than 3 months before the decision of chemo or RT.