QA Tumor Talk: Testicular Cancer
Presented 10-26-2022 & 12-09-2022

Question	Response
Is this Webinar not approved for a AHIMA CEU?/ Will we be able to obtain an AAPC CEU certificate for this presentation? Will CEU approved for AHIMA or AAPC?	This program is approved for 1 CE hours of which 1 hours meet the Category A requirements from NCRA If you are not a CTR, please check with your accrediting agency to determine if they accept CE hours from NCRA.
If it is stated as "around", how would you code?	If you get a scenario when that happens, submit it to the CAnswer Forum for guidance. If it is a common occurrence, it might be something they address in future instructions.
So, the statement of test was stated to be elevated so only be used when a physician state is made and there is not test value given?	Yes, actual test values are more specific & should be used over the Generic statement of elevated range/score not given.
Is note 6 supposed to say code 9?	Slide 30 Testis Serum Markers (S) Pathological (post-orchiectomy). No Note 6 is not supposed to state code 9. it states a 5. The definition for code 5 is Post orchiectomy serum tumor markers unknown or not done but pre orchiectomy serum tumor markers were normal
So was the answer S3 or SX for path	Slide 31 SSDI Manual-S Category Pathological S2
If you have LNS involved, how can it be a in situ tumor?	The pT would be pTis due to in situ neoplasia, but the final AJCC/Summary stage would not be In situ due to the clinical lymph node involvement seen on the CT.
Patient had Orchiectomy & BX, RT testes - GC in situ; Left = Seminoma. Can clinical be staged?	I can not tell from the information you have given me the timeframe of when the biopsy happened. If the biopsy was performed prior to the orchiectomy then the information from that biopsy could be used for clinical staging. In general however, there is no biopsy done prior to surgery for these cases. Were there biomarkers done AFP,HcG, LDH? Were there any scans done? I don't have enough information.
Patient had orchiectomy, pathology showed pt1a. Then, 4 months later, patient underwent RPLN dissection - ALL Negative. Should the staging be pt0 pn0 cm0? Per surgeon, after RPLN dissection, patient is now pT0.	The pT would not be pT0. A pT0 means there was no evidences of a primary tumor ever, but you did have evidence of a primary tumor it was a pT1a. Pathological stage includes information from clinical staging through surgical resection. Refer to AJCC 8th Edition Chapter 1 page 11 General Staging Rules Time Frame/Staging window for determine pathological stage for further instruction. Information including clinical staging data and information from surgical resection and examination of the resected specimens—if surgery is performed before the initiation of radiation and/or systemic therapy—from the date of diagnosis: • within 4months after diagnosis • to the date of cancer progression if the cancer progresses before the end of the 4-month window; data on the extent of the cancer is included only before the date of observed progression • and includes any information obtained about the extent of cancer up through completion of definitive surgery as part of primary treatment if that surgery occurs later than 4months after diagnosis and the cancer has not clearly progressed during the time window Note: Patients who receive radiation and/or systemic therapy (neoadjuvant therapy) before surgical resection are not assigned a pathological category or stage, and instead are staged according to post neoadjuvant therapy criteria.
NAACCR will have a free webinar on 2023 updates on Jan 11	I put it on my calendar. Here is the link to register. https://naaccr.zoom.us/webinar/register/WN_-frIMGW0SJ-v5o8l1--Crw
What is SSDI?	Site Specific Data Item
What is the timing of the POST orchiectomy lab values? I know we take the lowest, but I have seen labs monitored for several weeks to months as the values decrease..	I referred the CAnswer Forum for clarification. https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/134556-testes-ssdi-timing-of-post-therapy-lab-values#post134568 Per the SSDI manual, the note describes which value to take: Note 3: If the initial post-orchiectomy AFP remains elevated, review subsequent tests and record the lowest AFP value (normalization or plateau) prior to adjuvant therapy or before the value rises again. Note 3 is the same for all of these post-orchiectomy lab values and ranges
where is code 5?	This question is pertaining to the instructions for SSDI Manual S Category Pathological Note 6: When all the serum tumor markers are normal pre-orchiectomy and they are not repeated post-orchiectomy, code 5. 5 = Post orchiectomy serum tumor markers unknown or not done but pre orchiectomy serum tumor markers were normal
Janet, this is usually all we get during clinical time frame. Never usually do a bx. So are all clinical T's an X when no chest scan, etc. done?	Yes, that's usually all we will be able to do with clinical stage for Testes cTX cNX
scenario #1 Pt presented with testicular pain and swelling. Would the physician not have done a Physical so he would Know the node status so cN0?	Great question! This is one of those sites when the AJCC manual spells out that a physical exam is not enough to determine N & M you have to have the scans. Per Chapter 59 AJCC Manual Rule for Clinical Classification *"Radiographic assessment are required for clinical staging. Radiographic assessment of chest, abdomen, and pelvis is necessary to determine the N and M status of disease."*
For path staging, if the LND was done BEFORE the adjuvant chemo then would it be pN0?	Yes if the LND was done prior to adjuvant chemo, prior to disease progression, and within the 4 month staging window.

Why would you not use the In Situ General Rule and code the pathologic stage pTis cN0 cM0 in pathologic stage.	There are always the exceptions aren't there. :) There were clinically positive nodes on Scans which the physicians all felt were positive. Refer to AJCC 8th Edition Chapter 1 page 26 *Tis N1–3 In rare situations, whenever the pathology fails to reveal invasive cancer and shows Tis only with nodal involvement, the stage group may be assigned by the managing physician based on the N category as available for patient care. The cancer registry should document Tis with the appropriate N category and no stage group*.
Can you clarify the staging of the case where the medical oncologist stage cN3 and treated based on this where as you document the case should be pNX?	The physician is treating the patient and utilize the information for patient care. We are collecting the data for cancer research and must code according to registry rules.
On the last question, I believe we should use cN0 because in situ, Tis, you can automatically use cN0 for path staging if the tumor is in situ. This is per chapter one of the AJCC manual	There are always the exceptions aren't there. :) There were clinically positive nodes on Scans which the physicians all felt were positive. Refer to AJCC 8th Edition Chapter 1 page 26 Tis N1–3 In rare situations, whenever the pathology fails to reveal invasive cancer and shows Tis only with nodal involvement, the stage group may be assigned by the managing physician based on the N category as available for patient care. The cancer registry should document Tis with the appropriate N category and no stage group.
Please clarify the yp staging again?	yp Staging is used after completion of neoadjuvant therapy followed by surgery. The example in this webinar the patient did not have neoadjuvant therapy, the patient had adjuvant therapy, the patient had surgery then chemo, so yp Stage is not applicable. It's tricky. Refer to page 11 of the AJCC 8th Edition Chapter 1 and review the Time frame/staging window for staging post neoadjuvant therapy or post therapy.
The cN3 would be included in the Summary Stage although pNX for AJCC right?	Yes. Summary stage would include the Regional Lymph Node mets and AJCC will be pNX
Thank you so much for confirming we cannot use cN in the path stage. There's a presentation on AJCC's website and in case 1 they use cN. I emailed the presenter 3 months ago asking for a resource to explain this and never received a response. https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/staging-education/physician/	The link you provided was for physician education, they can use the information to treat the patient. However, we are registrars and the information we use is for clinical research, we don't want to incorrectly categorize a patient because it could either falsely elevate or negatively impact survival stats based on stage.
For the case w/o post therapy staging the LND would still be recorded in scope of LN surg & reg LN examined/positive, etc.?	It's coded regardless in Scope of Regional Lymph Node Dissection & Regional Nodes Examined and Positive
Can you explain why you are using the TX instead of blank?	I'm going to refer you to this Cancer Forum post Aleisha does a wonderful job of explaining. CAnswer Forum Post https://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/male-genital-organs-chapters-57-59/testis-chapter-59/128136-ctx-or-ct-blank-do-i-use-info-from-ajcc-curriculum-or-canswer-forum-posts#post128175
Will a person be able to view this webinar later and still receive the C.E. for it?	Yes
Why 3 as summary stage if the Para-aortic LND was neg?	Prior to adjuvant therapy the patient was felt to have mets to lymph nodes on CT
Often our new CTRs are confused if the chemo are considered Multiagent or single agent, any hints on how to determine this	Refer to SEER*Rx Interactive Antineoplastic Drugs Database https://seer.cancer.gov/seertools/seerrx/ You can look up drugs/regimens and it will tell you each drug and how it is categorized.
Not really a question but I had a Testes case today. The patient had chemo, then progression in which they then had Stem cell transplant! I was so confused. I had to google this! I thought the md had made a mistake with his notes.	Wow, I had not heard of that either, but the Stem Cell Transplant would not be coded in first course treatment since it happened after progression.
Would be great to have a CTR Hotline to call for real-time abstracting questions.	Yes it would! I am so fortunate to have curated my own CTR Hotline over the years. have a wonderful team of co-workers and we always bounce questions off each other. I also have a highly skilled CTR friend group that I have met through the years and reach out to them as well. I encourage you to join NCRA and your State Association and volunteer! You will meet so many fine CTR's to support you throughout your career. I couldn't do what I do without them!!
I shadowed a CTR when I was in my teens so I wanted to see what it was all about. THANKS	Spread the word!! This field is always evolving and we need new folks!! It has been one of the best decisions of my life to become a CTR!