LOUISIANA TUMOR REGISTRY

MEMO

PROSTATE CODING ISSUES (CSv2)

CS EXT CODE 150 vs 300:

DO NOT CODE CS Ext to 150 when your *only* information is elevated PSA. This scenario should be coded to 300.

Per CS Ext Note 2A & B: Code 150 is used only for **clinically inapparent** *tumor/ nodule/mass not palpable or visible by imaging* **and** incidentally found microscopic carcinoma (latent, occult) in one or both lobes… by needle biopsy.

Code to 150 ONLY when a clear PHYSICIAN statement of inapparent tumor/nodule/mass is documented.

For example, clear physician statements of INAPPARENT would include: physician statement of normal DRE and/or imaging (TRUS) or physician assignment of cT1. (Clear physician statement of APPARENT tumor/nodule/mass would include physician assignment of cT2—see below CS Ext codes 200-240.)

Code to 300 (which maps to T2 NOS) in the absence of a clear physician statement of inapparent or apparent.

Per CS Ext Note 2D: CODE 300 is used for localized cancer when it is ***unknown if clinically or radiographically apparent***. An example would be when a diagnosis is made prior to admission for a prostatectomy with no details provided on clinical findings prior to admission.

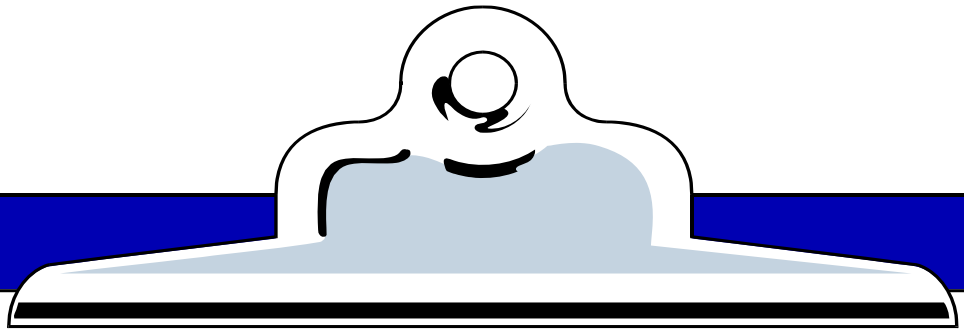
CS EXT CODES 200-240:

DO NOT CODE CS Ext to 200-240 *based on BIOPSY information.*

Per CS Ext Note 2C: CODES 200 to 240 are used only for **clinically or radiographically apparent tumor/nodule/mass**, i.e., *that which is palpable or visible by imaging*. To decide among codes 200-240, **use only physical exam, imaging information and/or a physician assignment of cT2x, and *not biopsy information.***

Use code 240 if the physician assigns cT2 without a subcategory of a, b, or c.

References: 2010 & 2007 Collaborative Staging Manual: ACoS I&R #21989, 27187, 23737, 21989, 23785, 46209 & 46332



PROSTATE CODING ISSUES (CSv2) Cont'd

CS EXT CODE 999:

Code 999 for an "incidental" finding (w/ no prior suspicion) of prostate cancer discovered during cancer surgery for another primary site. **For example, pt with no prior suspicion of prostate cancer prior to surgery is found to have CAP during a cystoprostatectomy for bladder cancer.** *(Also See SSF3 below)*

Reference: ACoS I&R #25877

SSF 1:

Per CS SSF1 Note 1: Record the *highest PSA lab value recorded* in the medical record *prior to diagnostic biopsy of prostate or treatment*. Lab value may be recorded in the lab report, history and physical or clinical statement in the pathology report, etc.

Record the actual lab value with an "implied" decimal point utilizing the standard rounding rules listed below. Determine what your rounding digit is (number immediately adjacent to decimal point) and look to the number to the right of it:

Rule One: If that number is **<5** (4, 3, 2, 1 or 0), simply **drop all digits to the right of the rounding digit.**

For example: PSA 56.3**4** would be recorded as **563 for SSF1**

Rule Two: If that number is **≥5** (5, 6, 7, 8, or 9) **add one to the rounding digit and drop all digits to the right of it.**

For example: PSA 01.6**5** would be recorded as **017 for SSF1**

PSA 00.8**9** would be recorded as **009 for SSF1**

SSF3:

Per CS SSF3 Note 7: *When prostate cancer is an incidental finding during a prostatectomy for other reasons (for example, a cystoprostatectomy for bladder cancer), use the appropriate code for the extent of disease found (for example, one lobe, or both lobes, or more).*

SSF3 & SSF4: (For CASES DXD PRIOR to 2010)

If a Prostatectomy was NOT performed, code SSF3 to 970 & SSF 4 to x50.

The first digit of SSF4 is clinical, reflecting biopsy information only. The second digit of SSF4 is pathological, reflecting surgical excision information.

If surgery was not performed, the second (pathological) digit must be coded to 5. Rationale: Since surgery was *not performed,* you do not know the pathological status of the Apex. Apex status based on bx results has *no bearing* on the second digit of SSF4, which is strictly for surgical specimen results

PROSTATE CODING ISSUES (CSv2) Cont'd

SSF 7 & SSF8:

Code the Gleason's primary/secondary pattern and Gleason Score from *needle core biopsy or TURP ONLY.*

If multiple needle core biopsies performed or needle core biopsy and TURP both performed, *code the highest or most aggressive pattern and score.*

SSF 9 & SSF10:

Code the Gleason's primary/secondary pattern and Gleason Score from *prostatectomy or autopsy ONLY.*

If a tertiary pattern is documented on prostatectomy/autopsy, DO NOT INCLUDE it in either SSF9 or SSF10. *Record the tertiary pattern in Site-Specific Factor 11*. (Disregard any tertiary pattern documented on needle bx/TURP.)

ORCHIECTOMY:

Orchiectomies are CODED ONLY in the data item *"Hematologic Transplant & Endocrine Procedures."*

> **However, if a patient is *also started* on a REGIME OF HORMONE AGENTS after the Orchiectomy (as 1st course treatment), *use the date of the Orchiectomy as the Hormone start date*.** (Reference: FORDS 2009 pp 170 & 277)

TYPE OF MULTIPLE TUMORS REPORTED AS ONE PRIMARY & MULTIPLICITY COUNTER Codes for PROSTATE Cases:

DO NOT AUTOMATICALLY Code "(00) SINGLE TUMOR" for Type of Multiple Tumors Reported as One Primary and "01" for the Multiplicity Counter. (Single tumors *should not be automatically assumed.)*

> **These codes SHOULD BE USED ONLY when a *surgical* pathology report states there is a SINGLE tumor. Often prostate cancers tend to be multifocal rather than solitary tumors. *These codes SHOULD NEVER BE BASED ON BIOPSY FINDINGS. In the absence of such documentation (for example, biopsy only case) CODE both fields to "99."***

Examples:	RRP path: Adenoca, multifocal dz, lgst foci 2cm	Code TMT=40 & MC=99
	RT/LT Lobe Prostate bxs: adenoca	Code TMT=99 & MC=99
	RALP path: Adenoca gl8, dominant nodule lt apex	Code TMT=40 & MC=99
	RRP path: Adenoca bilat, tumor sz 1.3cm & 1cm	Code TMT=40 & MC=02
	RARP path: Adenoca, 9 measured foci, lgst 4.3cm	Code TMT=40 & MC=09
	Prostate Rsxn: single focus (3mm) Adenoca	Code TMT=00 & MC=01

References: SEER SINQ #20071096; ACoS I&R # 25580, 28389, 28988, 28833, 28521 & 26350

PROSTATE CODING ISSUES (CSv2) Cont'd

LEVELS OF PROSTATE CAPSULAR INVASION:

Some pathologists may be documenting *only* the level of capsular invasion on surgical pathology reports without a clear statement of confinement. For example, L3 capsular invasion. The following is a defined list of these levels per UICC & AJCC:

CONFINED (L0-1 SSF3=000 to 030 and L2 SSF3=032)*

Level 0 (L0): tumor confined to prostate stroma within boundary of normal prostatic acini

Level 1 (L1): tumor confined to prostate stroma but outside the boundary of normal prostatic acini

Level 2 (L2): tumor confined to prostate stroma but within a layer more fibrous than muscular (capsule) *Per Dr Ruiz, L2 is true capsular invasion (into, but not through the capsule)**

NOT CONFINED (SSF=041 to 070)

***Level 3 (L3*)*:** tumor invasive into the periprostatic adipose tissue or smooth muscle of bladder neck

***Level 3 focal (L3F*)*:** tumor outside the prostate to a depth of less than one high-power field on no more than two separate sections

Level 3 established (L3E): any amount of extraprostatic tumor more than L3F

According to the staging of the International Union against Cancer (UICC) and the American Joint Commission on Cancer (AJCC), tumors at **levels 0 to 2 are considered pathologically confined (L0-1 SSF3=000 to 030 and L2 SSF3=032)*** and **level 3 is considered pathologically not confined, i.e. there is extraprostatic extension or extension of tumor into periprostatic soft tissue (SSF=041 to 070). *For L3, L3F & L3E capsular invasion, look for addition documentation on the pathology report to determine the full extent of the extracapsular extension.***

References: Vogelzang, Scardino, Shipley, et al. *Comprehensive Textbook of Genitourinary Oncology, Third Edition*. New York: Lippincott Williams & Wilkins, 2005.

*L0-2 Coding guidance per Dr Bernardo Ruiz, LTR pathology consultant