SHRI VIDEO TRAINING SERIES
2018 DX
Recorded 10/2019

LUNG EOD, SSDI & Grade

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Iowa Cancer Registry
2019

NIH NATIONAL CANCER INSTITUTE
SEER Registrar Staging Assistant

EOD Data v1.5
SEER*RSA

LUNG C340-C349

EOD Primary Tumor
EOD Regional Lymph Nodes
EOD Metastasis

EOD General Instructions

https://seer.cancer.gov/tools/staging/2018-EOD-General-Instructions.pdf

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LUNG EOD Primary Tumor

Note 1: Bronchopneumonia not same as obstructive pneumonitis (see definitions)

Note 2: Code 100 only applies to lepidic pattern

Note 3: Atelectasis (collapse)

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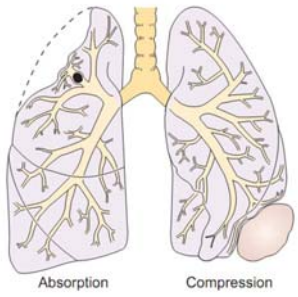
Atelectasis



- Atelectasis caused by airway obstruction and absorption of air from the involved lung area **on the left** and by compression of lung tissue **on the right.**

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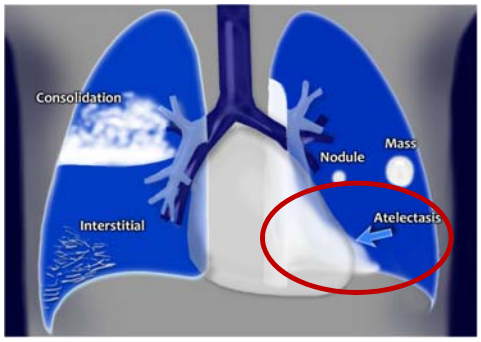
Atelectasis



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EOD PRI Tumor

Note 4: Specific info on visceral pleura codes 450 (PL 1 and PL2) and code 500 (PL3).

Note 5: Visceral pleural invasion

Note 6: Separate tumor nodules in same lung

Note 7: Occult tumors

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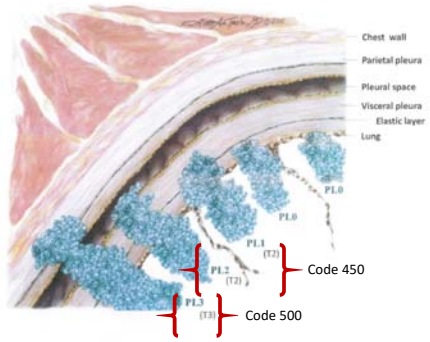
Pleural Invasion



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EOD Pri Tumor

Code	Description
000	In situ, Noninvasive, intraepithelial SCIS = squamous cell carcinoma in situ AIS = adenoca in situ: adenoca w/pure lepidic pattern </=3 cm
100	Minimally invasive adenoca >with predom lepidic pattern meas </= 3 cm >with invasive component meas </= 5 mm
200	Superficial spreading tumor, any size >with invasive component limited to bronchial wall >with or without proximal extension to MSB (uncommon)
300	Any size tumor; confined to lung; localized NOS

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Code	Description
400	Any size tumor >adjacent ipsilateral lobe (direct tumor invasion) >confined to hilus >MSB, NOS (w/o involvement of carina) >including extension from other part of lung
450	Any size tumor >atelectasis/obstructive pneumonitis [see Note 1, Note 3] >pleural NOS >Pulmonary ligament >Visceral pleural (PL1 or PL2) [see Note 4]
500	Any size tumor >Brachial plexus, inferior branches or NOS >Chest wall (thoracic wall) separate lesion – see EOD mets) >Pancoast tumor (superior sulcus syndrome) NOS >Parietal pericardium, Pericardium, NOS >Parietal pleural (PL3) [see Note 4] >>Phrenic nerve Separate tumor nodule(s) in same lobe as the primary [see Note 6]

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Code	Description
600	Tumor limited to the carina
650	Blood vessel(s) (major) >Aorta >Azygos vein >Pulmonary artery or vein >Superior vena cava (SVC syndrome) Carina from lung Compression of esophagus or trachea no specified as direct ext Esophagus Mediastinum, extrapulmonary or NOS Nerve(s) >Cervical sympathetic (Horner's syndrome) >Recurrent laryngeal (vocal cord paralysis) >Vagus Trachea

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Code	Description
675	Any size tumor >Adjacent rib, Rib NOS >Skeletal muscle >Sternum
700	Heart Inferior vena cava Neural foramina Vertebra(e) (vertebral body) Visceral pericardium Separate tumor nodule(s) in different ipsilateral lobe [see Note 6] Further contiguous extension
800	No evidence of primary tumor
980	Tumor proven by presence of malig cells in sputum or bronchial washings but not visualized by imaging or bronch "occult' carcinoma. [see Note 7]
999	Unknown; extension not stated Primary cannot be assessed Not documented in pt record; DCO

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LUNG EOD
Regional LNs

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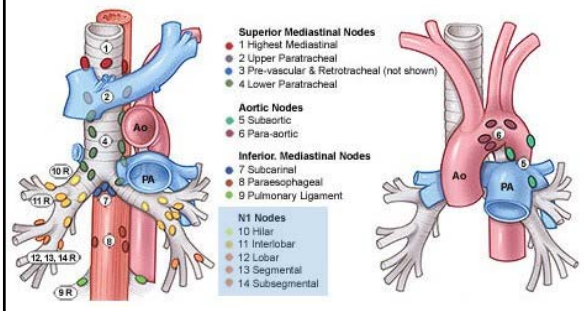

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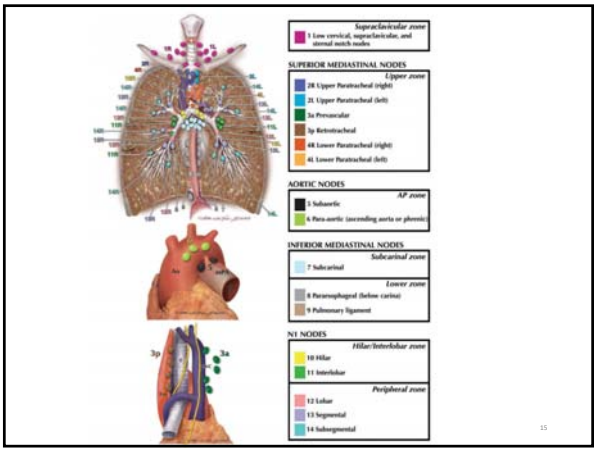

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LUNG EOD Reg LNs

Note 1: Code only regional nodes and nodes, NOS in this field. Distant nodes are coded in EOD mets.

Note 2: Code 400 mediastinal LN involvement:

- "Vocal cord paralysis"
- "Superior vena cava syndrome"
- "compression of trachea or esophagus"

unless there is a statement of involvement by direct extension from pri tumor.

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LUNG EOD Reg LNs

Code	Description
000	No regional LN involvement
300	IPSILATERAL nodes only Bronchial, hilar, intrapulmonary [interlobar, lobar, segmental, subsegmental] Peri/parabronchial
400	IPSILATERAL nodes only Carina (tracheobronchial) (tracheal bifurcation) Mediastinal, ipsilateral or NOS >Numerous mediastinal LNs here… Peritracheal, NOS >Azygos (lower peritracheal) Precarinal Pretracheal, NOS

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Code	Description
600	IPSILATERAL OR CONTRALATERAL Low cervical Proximal root Pulmonary root Scalene (inferior deep cervical) Sternal notch Supraclavicular (transverse cervical)
700	CONTRALATERAL OR BILATERAL Bronchial Hilar Mediastinal >numerous named mediastinal nodes
800	Regional lymph node(s), NOS Lymph node(s), NOS
999	Unknown; regional nodes(s) not stated Regional nodes cannot be assessed Not documented in patient record, DCO

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LUNG EOD Mets

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EOD Mets

Note: Most pleural and pericardial effusions with lung cancer are due to tumor.

In a few patients, however, multiple cytopathological exams negative for tumor, and the fluid is non-bloody and is not an exudate.

Clinical judgment dictate that the effusion is not related to the tumor, the effusion should be excluded as a staging element. Code 00 in the absence of any other metastasis.

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EOD Mets

Code	Description
00	No distant mets; unknown if distant mets
10	Pericardial effusion or pleural effusion (malig) (ipsilateral, contralateral, bilat, NOS); Pericardial nodules Contralat lung/MSB; Contralat MSB Separate tumor nodule(s) in contral lung
20	Single distant LN involved >Cervical; >Distant LN, NOS
30	Single extrathoracic mets in a single organ
50	Multiple extrathoracic mets in a single organ or in multiple organs Abd organs, skin of chest, separate lesion in chest wall or diaphragm. Multiple distant LN(s): Cervical, Distant NOS Carcinomatosis; Distant mets WITH or WITHOUT distant LN(s)
70	Distant mets, NOS
99	DCO

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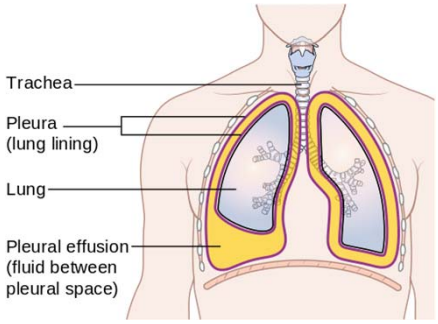
Pleural effusion



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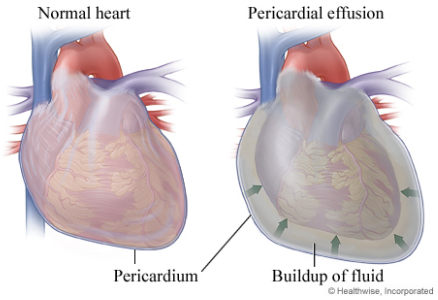
Pericardial Effusion



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Separate Tumor Nodules SSDI #3929

- Refers to a single tumor with intrapulmonary mets in ipsilateral (**same**) lung.
- Collected previously for SSF#1
- Defined as intrapulmonary mets in same lobe or same lung originating from a single lung primary at time to dx.
- **Bx of tumor may or may not be performed**
- **Histology of separate tumors must be the same**
  - **[**If not all tumors are biopsied, ASSUME they are the same histology.]
- Record from imaging reports and path reports

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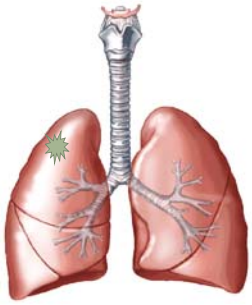
Code 0



- No separate tumor nodules; single tumor only
- Separate tumor nodules of same histo type not identified/not present
- Intrapulmonary mets not present
- Multiple nodules described as multiple foci of adenoca in situ or minimally invasive adenoca.
- Note 4 & 7

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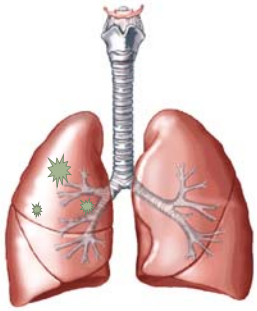
Code 1

Separate tumor nodules:
>same histo type
>same lobe



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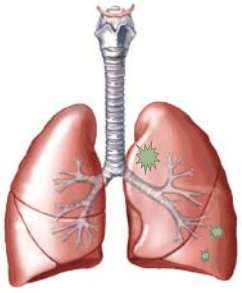
Code 2

Separate tumor nodules:
>same histo type
>same lung
>different lobe



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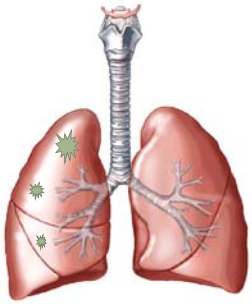
Code 3

Separate tumor nodules:

>same histo type

>same lung

>same AND different lobes



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SSDI #3929 Codes 4-9

Code	Description
4	Separate tumor nodules of same histo type in ipsilat lung, unknown if same or different lobe(s)
7	Multiple nodules or foci of tumor present, not classifiable based on Notes 3 and 4
8	Not applicable: Info not collected
9	Not documented in med record Primary tumor is in situ Separate tumor nodules not assessed or unknown if assessed

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Forum QnA:

- Q: Does there have to be proof that nodules are the same histologic type to be coded 1-4? Or can the assumption be made that they are of the same histologic type unless specified otherwise?
- A: Per note 2, separate tumor nodules can be defined clinically by imaging, so not all separate tumor nodules need to be confirmed microscopically. Unless specified otherwise, you can assume they are all the same histologic type.

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QnA

- Q:If a patient has a cT0 lung tumor, diagnosed due to mets from lung primary, how would separate tumor nodules be coded? A CT chest didn't identify any nodules.
- A: Code to none (0) since the CT of chest didn't show any.

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Separate Tumor Nodules

SSDI #3929	EOD Tumor	SS18
Code 1: Same histo (or assumed), in same lobe as primary	Code 500	2
Code 2: Same histo (or assumed), in same lung, different lobe	Code 700	7
Code 3: Same histo (or assumed), in same lung, same and different lobes	Code 700	7

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Visceral & Parietal Pleural Invasion SSDI # 3937

- Invasion beyond the elastic layer or to the surface of the visceral pleura
- Previously collected as SSF#2
- Elastic stain is not needed in most cases to assess pleural for invasion
- VPI (visceral pleural invasion) relevant for peripheral lung tumors
- Source document: Record VPI as stated on path report

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Visceral & Parietal Pleural Invasion SSDI # 3937

Note 1: Phys statement of visceral and parietal pleural invasion can be used to code this data item when no other info avail.

Note 2: Standardized definition of pleural/elastic layer invasion (PL) in AJCC Lung Chapter.

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Visceral & Parietal Pleural Invasion SSDI # 3937

Four Categories of PL:

- PL0 - Tumor that is surrounded by lung parenchyma or invades superficially into the pleural connective tissue beneath the elastic layer but falls short of completely traversing the elastic layer of the pleura
- PL1 - Tumor that extends through the elastic layer
- PL2 - Tumor that extends to the surface of the visceral pleura
- PL3 - Tumor that extends to the parietal pleura or chest wall

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Visceral & Parietal Pleural Invasion SSDI # 3937

When pathologists have difficulty assessing the relationship of the tumor to the elastic layer on routine hematoxylin and eosin (H and E) stains, they may perform a special elastic stain to make the determination.

Note 3: An FNA is not a histologic specimen and is not adequate to assess pleural layer invasion. If only an FNA is available, code 9

Note 4: Code 9 if there is microscopic confirmation and there is **no mention** of visceral pleural invasion.

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SSDI #3937

Code	Description
0	Stated PL0 ***Must be stated not present; cannot assume No evidence of visceral pleural invasion (PL) Tumor does not completely traverse the elastic layer
1	Stated PL1 Invasion of visceral elastic pleura, but not beyond visceral pleura
2	Stated PL2 Invasion outside surface of visceral pleural Invasion through outer surface of visceral pleura
3	Stated PL3 Tumor invades into or through parietal pleura OR chest wall
4	Invasion of Pleura present, NOS; not stated if PL1 or PL2

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SSDI #3937

Code	Description
6	Tumor extends to pleura, NOS; not stated if visceral or parietal
8	Not applicable
9	Not documented in medical record No surgical resection of primary site performed Visceral pleural invasion not assessed or unknown if assessed or cannot be determined [see Note 3 & 4]

***CHANGE from CS: In CSv2, if pathology report was available and there was no mention of visceral pleural invasion, the registrar could assume that it was negative and code appropriately.

For the SSDI, **this assumption cannot be made**. There must be a statement that visceral pleural invasion is not present to code 0.

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Forum QnA:

- Q: Pathology report of Lung Left lobe Lobectomy on 6/1/18 states a focal area is positive for visceral pleural invasion and is confirmed by elastic stain . No designation if this is PL1 or PL2 on the pathology report. Per the SSDI manual it states source documents are the pathology report. Note 1 states: Physician statement of visceral pleural invasion can be used to code this data item when no other information is available.

  The operating surgeon states: invasion through visceral pleura. What is the correct code?

- ANSWER: Code 4 for "Invasion of visceral pleura present, NOS; not stated if PL1 or PL2."

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QnA

- Q: Lung cancer, received chemo, radiation followed by surgery but resection aborted due to stage IV. Thoracotomy performed. Path reads: Right pleura, bx-acinar adenocarcinoma, two nodules, four and 7 mm, involving the orange inked parietal pleural margin. Right pleural bx (frozen section and touch preparation) -invasive adenocarcinoma in the lung parenchyma **involving the visceral pleura and the orange inked parietal pleural margin**. Lung resection margin is negative.
- A: Code to 3: Tumor invades into or through parietal pleural or chest wall.

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Grade Table 02

Code	Grade Description
1	G1: Well differentiated
2	G2: Moderately differentiated
3	G3: Poorly differentiated
4	G4: Undifferentiated **anaplastic**
9	Grade cannot be assessed (GX); Unknown

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Forum question on grade

Question: Lung biopsy of the LUL shows a high grade spindle cell histology malignant neoplasm. The patient goes onto have a resection/lobectomy and has a anaplastic pleomorphic spindle cell giant cell arising from mod diff adenocarcinoma - acinar, lepidic, micropapillary patterns. No further information than what is listed above from the pathology reports. Treating this as a lung case which does not offer high grade under the clinical grade section. Please advise below.

1) What is the clinical grade?

2) What is the pathologic grade?

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FORUM answer

- Answer: Clinical grade would be 9. "High" grade is not terminology collected for Lung.

Pathological grade would be 4. Per the note 3 in the Lung grade, "Anaplastic" is coded as G4. The pleomorphic (with the anaplastic grade) tumor is arising from the adenocarcinoma tumor (which is mod diff); however, you would still take the higher grade from the pleomorphic spindle cell.

1) What is the clinical grade? 9

2) What is the pathologic grade? 4

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Questions

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