Q1: why can’t we use pos pleural effusion to stage t value?

A: Pleural effusion in Pleural Mesothelioma does not impact stage as it does in staging of Lung carcinoma. There is no T, N or M category in the TNM staging of the Pleura which captures the presence of pleural effusion. However, Collaborative Stage does collect this information in SSF 1.

Q2: You mentioned that women can contract mesothelioma from their spouse. By which method is this disease able to be spread?

A: The disease mesothelioma cannot be spread person to person. However, individuals coming into contact with the clothing and hair of someone who has been working with materials which contain asbestos can be exposed to asbestos as well.
In the past, before exposure to asbestos was known to be hazardous, men did not wear special clothing or protective jumpsuits over hair and clothing while working. The same clothing men worked in all day and contaminated with asbestos fibers, was worn home. Wives or other family members who did the laundry could then be exposed to the asbestos fibers clinging to clothing and handling of the laundry could release asbestos into the air which could then be inhaled or ingested.

Q3: Could peritoneal mesothelioma be associated with talc exposure? Sometimes true "talc" contains traces of asbestos. Are the "ovarian" cancers said to be caused by talc exposure mesothelioma cell types?

A: Medicinal talc used in medical applications is asbestos-free. Also, all talcum powder products used in homes in the United States have been asbestos-free since the 1970s. Per the American Cancer Society website  "Many studies in women have looked at the possible link between talcum powder and cancer of the ovary. Findings have been mixed, with some studies reporting a slightly increased risk and some reporting no increase. Many case-control studies have found a small increase in risk. But these types of studies can be biased because they often rely on a person's memory of talc use many years earlier. Two prospective cohort studies, which would not have the same type of potential bias, have not found an increased risk".  http://www.cancer.org/cancer/cancercauses/othercarcinogens/athome/talcum-powder-and-cancer

Q4: Can you describe how the pleural plaques develop? Are they caused by the asbestosis or by the mesothelioma, if mesothelioma creates the plaques are they then malignant?

A: When we inhale asbestos fibers, they can become embedded in the pleura. These imbedded fibers can trigger an inflammatory response that causes the progressive buildup of fibrous scar tissue and plaques. Pleural plaques are almost exclusively caused by exposure to asbestos, but having the condition
does not necessarily mean that one will develop mesothelioma. However, mesothelioma develops within the pleura in these areas of pleural thickening and plaque.

Q5: For pleural mesothelioma, lung is a distant site as is contralateral pleura. Is this true for lung regardless of the lung laterality related to the laterality of primary site of mesothelioma since contralateral pleura is also a distant site?
Example: primary site is right sided pleura and right lung is involved. Distant mets?

A: We sent this to the Canswer forum. You can follow at http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/education-developed-by-partner-organizations/naacr-webinars/59543-definition-of-m1-in-chapter-26-pleura

Q6: In mesothelioma is talc pleurodesis always considered palliative care?

A: A “talc” pleurodesis procedure is done to alleviate symptoms, to inhibit further development of pleural effusion. It works by closing the space between the parietal pleura and the visceral pleura with talc or an antibiotic. The talc or antibiotic, whichever the doctor decides to use, will effectively irritate the pleura, causing them to stick together and close the gap- the pleural space. Without the gap, there is nowhere for fluid to collect. The “talc” pleurodesis does not treat the malignancy; it is not a cancer treatment.

Q7: How is Melanoma of the sinuses normally found?

A: They are not easy to find early in the disease process. It often times isn’t until the patient becomes symptomatic that the disease is identified.

Q8: For practice case 2 please clarify when you would not use ambiguous terms to assign clinical stage

A: You can still use the terms to help form your opinion of involvement vs non-involvement. The terms just have to be used in context of the bigger picture. In my professional opinion in case 2 the physician felt there was lung mets. So for TNM stage I would count the lung nodules as distant mets.

I don’t have the same flexibility with Summary Stage and CS. When assigning a stage for those systems I would use the list of ambiguous terms. Since “concerning” is a non-involvement term, I would not count the lung nodules ad distant mets.

Q9: If we are not supposed to use ambiguous terms for TNM staging, how can we assign a Clinical stage for this case?

A: you can still use the terms, you just don’t have a list saying “this term always indicates involvement and then this term always indicates non involvement. You need to take the terms in context and make a determination on involvement.-
Q10: Are mucosal melanomas related to sun exposure?
A: No

Q11: Mesothelioma-AJCC p.272 "..most frequent sites of metastatic disease are the peritoneum, contralateral pleura, and lung." I think the comma after "pleura" shouldn't be there and the meaning of the sentence is contralateral pleura and lung.
A: Could be. However, I would think that discontinuous mets in either lung would be considered distant mets. We sent the question to the CAnswer forum. You can follow at http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/education-developed-by-partner-organizations/naaccr-webinars/59543-definition-of-m1-in-chapter-26-pleura

Q12: Jim, just FYI, AJCC never uses the word "schema" we have chapters...Donna Gress AJCC.
A: Thank you Donna!

Q13: The questions 9 is not the letter b?
A: You are correct! The answer to quiz 1 question 9 is A. We use chapter 9 Mucosal Melanoma of the Head and Neck to assign stage for mucosal melanomas. However, chapter 9 tell us to refer back to the chapter that covers the specific site for the rules for classification. In the example, the mucosal melanoma arose in the ethmoid sinus. We use the rules in chapter 9 to assign the T,N, M and stage, but the rules for classification are based on chapter 6 Nasal Cavity and Paranasal Sinuses.

Q14: Please remind abstractors that wide excision codes for Merkel cell ca may be used only when the distance to nearest margin is > 1 cm as confirmed on microscopic path exam.

Q15: P.S. to wide excision tip - this statement is per FORDS Appendix B. The point is, these surgery codes don't apply only to melanoma.

RE: Q14 &15: Yes, that is correct; the pathology report should state the negative margin microscopically is greater than 1cm, in order to use surgery code 45...
OR  >1cm and <2 for code 45
OR  >2cm for code 47

Q16: Please review slide 76 tumor (diameter) 9.3mm vs 5mm
A: I did a poor job with that slide. What I was trying to get at was the tumor size category. Tumor size category is based on table 51.1 of chapter 51 in the AJCC manual. I meant to say it was 9.3 in thickness
and 15.5 in basal diameter. That would make it a category 3 and a T3b. I apologize for the confusion. The correct slide is in the handouts.

Q17: A patient with a subsequent diagnosis of retinoblastoma that is more advanced than the initial primary, and several months or years separate the diagnosis, is the original primary restaged?

A: At this point it is not. You would not count the subsequent diagnosis as a new primary and you would not update the stage or treatment of the original primary. I would update my text and follow-up with this info.

Q18: Reason for no stage group - there isn’t enough data for the stage groups to reflect prognosis....stage groups must ALWAYS provide information that match survival curves. Maybe someday there will be enough info collected to create stage groups... Donna Gress AJCC

A: Excellent point!

Q19: No path T1a for retinoblastoma in the AJCC manual, how did you come up with that? Thank you.

A: Good point! I was looking at the wrong column. It should be T1.

Q20: On practice case 6, it states pt had a previously dx retinoblastoma. Since MPH rules states these are one primary, does it matter when the previous tumor was diagnosed?

A: What I meant by that is the patient was diagnosed at another facility. The patient is presenting to our facility for staging and first course treatment.

Q21: What is the DD in the Reese-Elisworth staging system for retinoblastoma?

A: DD is Optic Disc diameter. It’s a method of measuring the tumors. It’s used in AJCC staging as well.

Q22: In case scenario 2 "concerning for mets" wouldn’t indicate mets in CS, but would for AJCC staging

A: Great point!

Q23: On the QA letter explain why you did not bring over the clinical mets?

A: In case scenario 2 the imaging report read that the patient had lung nodules concerning for metastasis. For CS and Summary Stage we would look at the ambiguous terminology list. “Concerning” is a non-involvement term so we have to code as no mets. For AJCC we have more discretion. For example, we can evaluate the treatment given which in this case is an aggressive multi-agent
chemotherapy regimen usually given for high risk patients and those with metastatic disease. Based on that information we decided to assign cM1.

Q24: In the case scenario #1 the histology epithelial mesothelioma is equal epithelioid 9052 vs 9050

A: 9050/3 would be used for Malignant Mesothelioma NOS, without a statement of specific subtype. 9052/3 is the specific code for Epithelioid Mesothelioma.