1. Q: Post auricular - ear or scalp?
   A: Auricle is the visible part of the ear on the outside of the head. Post auricular would indicate behind the ear. I would code to scalp.

2. Q: Will you be discussing later about laterality for C44.4 & MPH rules?
   A: Yes. C444, C448 and C449 are not paired sites. Rule M4 for melanoma only applies to paired sites.

3. Q: Wouldn’t a better example of laterality multiple primary be right & left leg. (Because the third digit is different C44.5 & C44.7)?
   A: That would be a good example to explain Rule M4. The example used would be better if it was right trunk and midline trunk. The point I was trying to drive home was that midline is considered a laterality for melanoma skin sites.

4. Q: Melanoma with features of regression -- is this 8723?
   A: Yes. The example they use in the MPH for rule H6 is this exact example. (MPH pg 297)

5. Q: Please clarify use of "pattern" for invasive histologies. Reference: SINQ 20120032, Kathryn Zaitz
   A: 20120032-How is the histology coded for an invasive melanoma stated to have a superficial spreading growth pattern? Can the term growth pattern be considered a more specific histologic type for invasive melanomas when no other information is available?
   Start at Rule H1. The rules are intended to be reviewed in consecutive order within the applicable Module. Stop at Rule H9. Code the most specific histologic term when the diagnosis is melanoma, NOS [8720] with a single specific type, superficial spreading, in this case. The subtype of this invasive melanoma is superficial spreading.
   NOTE: A change will be made to Rule 9 in next update to indicate growth pattern can be used to describe an invasive histology. Great tips Robin...if anything else comes to mind, let us know!

6. Q: Will you please give an example of rule H5?
   A: Nodular melanoma with features of regression would be coded to Nodular melanoma Code 8721. This is the example used in the MPH rules pg 297.

7. Q: Also will you give an example of rule H7?
   A: nodular lentigo maligna melanoma, you would code to nodular melanoma (8721).

8. Q: Or could this increase be a result of more data coming in from dermatology offices (finally getting them on board reporting)?
A: Increased detection probably is one of the explanations for the increase in rates. However, it is still being under reported.

9. Q: Please ask Angela to repeat her statement about “margins <1cm but not microscopically confirmed”...what codes can/cannot be used. She was explaining this while the extraneous conversation was taking place.
A: if negative margins are confirmed microscopically and they are less than 1 cm or if the margins are more than 1 cm but NOT microscopically confirmed you would use codes 20-36. Here is a link to the note in cancer forum with an example

10. Q: According to the guidelines released from CDC yesterday for bxs: if the tumor was small and the intent was to attempt to remove the entire tumor; consider it an excisional biopsy and code in surgery of primary site; if the tumor was large and the intent was to remove the entire tumor.
A: Thanks! This sound like it is in line with both SEER and CoC.

11. Q: Just for clarification, scenario: shave biopsy, margins microscopically positive, re-excision shows no residual melanoma. Would surgery code be 31 or 27?
A: Excisional biopsies with clear or microscopic margins would be coded in surgical procedure of primary site...FORDS pg 138. If I am understanding things correctly, the shave biopsy would be considered an excisional biopsy in this scenario. I would code it a 27.

12. Q: Are the ACOS rules different for coding biopsy?
A: No. From what we have been able to find CoC, SEER, and NPCR are all in line. If biopsy is done and it removes all visible tumor, it is a surgical procedure. If a biopsy does not remove all visible tumor (only a sample), code it as a diagnostic staging procedure.
See the links below to the CAnswer Forum
CAnswer Forum
- Would a shave biopsy for melanoma insitu with positive margins be coded to surg/or dx surgery?
- CA forum: shave or punch biopsy with negative margins code as excisional biopsy code 27.
- When diagnostic staging procedure vs surgery
• When path reports states surgical margins microscopic residual disease at margin it is a surgical procedure
  

13. Q: Quiz question #7 why is the answer not "c" since there was residual melanoma found on re-excision?
   A: This was a relatively large tumor (2x1cm) and they removed all of the visible tumor. This was not a sample of the tumor to confirm this was melanoma, this was an attempt to remove the entire lesion. All visible tumor was removed. Microscopic tumor was found in the margins of the excised specimen. This is definitely a surgical procedure not a diagnostic procedure.


14. Q: On the AJCC website there is a heading "Critical Clarifications for Registrars" that contains information on melanoma staging. It helps clarify the clinical and pathologic classifications.

15. Q: May want to point out that pT1a doesn't require removal of lymph nodes to stage, See AJCC p. 336 under orange box
   A: Good point!

16. Q: Currently in 2016, the use of cN0 in the pathologic N category is limited to in situ tumors only. Are you aware if this is being expanded for 2017? This would be particularly useful for path stage group IA for melanoma.
   A: My guess would be yes, but I don’t know that for sure. I absolutely agree with you.

17. Q: On a recent AJCC colorectal webinar, Donna indicated that since N is based on number of nodes that we assign cNx if imaging doesn’t indicate # nodes/estimate # nodes involved. I wanted to confirm that this concept applies to melanoma as well for cN since it needs #. - Example: Imaging indicates metastatic nodes (pleural) -- we don't assign "at least cN1" but would assign cNx....correct?
   A: I asked this question to AJCC prior to the webinar. They said the number of nodes is required to assign a cN.
18. Q: For T1 tumors: If we have information only for ulceration but no information about mitosis or info for mitosis but no info about ulceration, will we go with T1 and no subcategory?
A: For T1b the thickness is less than or equal to 1.0 mm with ulceration OR mitoses greater than or equal to 1/mm². So if you have info on ulceration (ie ulceration present) and no info on mitotic rate you should be able to use T1b. To assign T1a you would need info on both ulceration AND mitotic rate. Does this help?

19. Q: A little confused about terminology for involved lymph nodes. On AJCC lung webinar Donna said not to consider "enlarged" or "lymphadenopathy" as involved nodes unless physician confirms. Is this across all sites or just for lung?
A: With SEER summary stage, if we see the terms enlarged or lymphadenopathy, we are to automatically assume the lymph nodes are involved based on the ambiguous terminology rules. I’ve personally never been a big fan of this. It makes our lives as registrars easier, but I don’t know that it always accurate. AJCC doesn’t want you to ignore those terms, but you do need to take them in context of the big picture. If you’re lucky, the physician will tell you if he/she feels lymph nodes are involved. If not, you have to use your best judgement based on the information available to you. If you can determine, based on things like treatment, additional workup, or comments from the physician that the physician feels there is or is not lymph node involvement, then you should code accordingly. If you cannot determine this with a degree of certainty, then code as unknown.

20. Q: How come you cannot assume no ulceration if no mention of ulceration?
A: The absence or presence of ulceration is an important prognostic factor.

21. Q: Am I reading it correctly that Stg III(B) also includes T1-4 (A) if N1b or N2 is b or c
A: T1-4A N2b or N2c would be Stage IIIB

22. Q: Please clarify: if we have no LDH mentioned, do we still use M subcategories?

23. Q: Can you pathologically stage this melanoma? Pt presents from OSF, melanoma, nos, Breslow mentioned, but distance not stated. Res-excision at our facility negative for residual disease.
24. A: You have met the rules for classification for clinical T and pathologic T.

25. Q: Many times we have cases that do not include any statement at all regarding the presence of ulceration. By making this a requirement for assigning the a and b categories, won’t it cause an unintentional increase in Stage 99 cases?
A: Probably.

26. Q: Are you still able to have a Path Stage without Mitotic Activity stated?
A: It depends on the T value. If it is T2 or higher, yes. If it is a T1 with ulceration, yes. If it is a T1 without ulceration, you would need the mitotic activity to end up with a stage (assuming no mets).
27. Q: If ulceration is not mentioned is the T assigned to a T1 or T2 or is it unknown?
A: The T category for melanoma is based on Breslow thickness. Ulceration helps to determine the subcategory a or b. If Breslow is less than or equal to 1 mm it would be T1 if is 1.01 to 2 mm it would be T2.

28. Q: Under M1a, is subcutaneous tissue under the primary site or is it referring to subcutaneous tissue away from the primary site?
A: Direct extension from the primary into the subcutaneous tissue is reflected in the T value. A separate tumor in the subcutaneous tissue would be coded to distant mets.

29. Q: Jim can you please revisit mets in subcutaneous tissue. If the subcutaneous mets are within 2 cm it is considered reginal lymph nodes, if greater than 2 cm the subcutaneous mets are called intransit mets pg. 327) When are subcutaneous mets considered distant?
A: I think you are confusing subcutaneous mets with intralymphatic mets. Satellite mets and in-transit mets are occurring in the lymphatics. Subcutaneous mets would be arising from the subcutaneous tissues. Hopefully, you have the pathologist telling you the difference!

30. Q: Still a little confusing because TNM is stating under regional nodes "cutaneous and/or subcutaneous mets. We’ll have to follow the path.
A: I’m not finding the statement you are referring to.

31. Q: On pop quiz #2 the WLE was negative, why is the clinical T2a used as pT2a also?
A: The wide local excision confirmed that there was no residual tumor. To calculate the pT value we look at the information from wide excision and we supplement that with what we know from the cT. This would give us a pT2a.

32. Q: Quiz 2 - cN - would you explain why you can use the pathology, when the rules for clinical classification say physical exam and imaging only? thanks
A: Great question! We discussed this very question with AJCC prior to the session. See the explanation at http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/skin-chapters-29-31/66169-in-transit-melanoma-edit

33. Q: On pop quiz 4 should ct0 be ctx instead? Since no tumor was found.
A: No. They did a thorough exam looking for the primary tumor and did not find the primary tumor. This is a cT0.
35. Q: Sorry - Still on Quiz 4: T0 means no primary tumor. You have nodal mets so you do have a primary tumor.
   A: We know there is a primary tumor, but they looked and couldn’t find it. That means this is a cT0.

36. Q: Last case negative LDH - why M1c?
   A: Liver mets would be visceral metastasis which is an M1c.

37. Q: Pop quiz #6: Sentinel biopsy does not state micro or macromets. PN2a was assigned. Would pN2 be correct or do you assume it is micromets because of the cN0?
   A: The physical exam and imaging did not reveal anything that would indicate LN mets. The lymph node mets were identified from the sentinel node biopsy. That fits the definition for micromets. There was not enough cancer in the lymph nodes to cause the lymph nodes to be clinically apparent.

38. Q: What would SSSF3 be coded for case 1?
   A: 150 clinically apparent in transit metastasis and clinically apparent nodal metastasis (at least one node)

39. Q: Scope of LN Surgery code should be 6 for Case Scenario 1
   A: You are correct it!

40. Q: For the surgery code the procedure states that the margin was greater than 2cm but the path states the margin was only 2mm. The procedure documentation would be from the surgeon and not the pathologist. or am I mistaken
   A: This was a typo it should have been 2 cm

41. Q: Page 329 of AJCC states that ulceration is based on histopathologic exam so for Case Scenario 1 there is no ulceration as per path report.
   A: See the pathology report 1 bullet 2. The tumor was ulcerated.

42. Q: Should diagnostic staging procedure be 02 based on 11/13/16 biopsy?
   A: No. The operative report referred to this as an excisional biopsy. It is also a relatively large tumor that was entirely excised.

43. Q: Case Scenario 2: There is mention of ulceration. Would be T1b.
   A: See bullet 4 under the 3/7/16 pathology report it states that ulceration was Absent.

44. Q: Case Scenario 2 there is only one LDH so should SSF4 be 999?
   A: The AJCC manual does say there should be two LDH tests to confirm that the first wasn’t a false positive. There were two tests done one on 3/5/16 and 3/20/16
45. Q: Would Case Scenario 2 be 8723/3 because of the regression being present (75%)?
   A: No. They did not use regression to describe the histology. Some level of regression can be found in many melanomas. This does not mean it should be reflected in the histology.

46. Q: Clinically - Pt had mole excised, ulcerated w/Breslow's depth 1.3 mm. No palp LN. Pathologically - Pt had wide excision showed 0.8mm residual disease 0/2 LN. What is the pT?
   A: No. You really don’t know if the residual tumor changes the Breslow’s depth. The residual may be on the peripheral margin which would not change the T value.

47. Q: Is there a scenario where pT0 appropriate?
   A: Not that I can think of.

48. Q: what is the clinical significance of a regressing melanoma? Does it carry a poor prognosis because it indicates a history of a more invasive lesion?
   A: I assume you are correct.

49. Q: When you send the Q & A, please explain satellite (microsatellite) and SSF that works along with them?
   A: In the AJCC manual in-transit mets and satellite (microsatellite mets) are described in the section with the header intralymphatic metastasis. This is not lymph node mets, but they are tumor arising in the lymphatic channels. The only SSF related to intralymphatic metastasis is SSF 3-Clinical Status of Lymph Node Mets. In this SSF we are coding whether or not there was enough metastasis in the lymph nodes that they were able to be identified clinically (micro or macro metastasis). We are also indicating whether or not intralymphatic metastasis was identified prior to definitive surgery. The code you use should be similar to the cN data item.

50. Q: If you code C44.9 and code regional nodes wouldn't you get an error?
   A: No. If a patient is found to have lymph node mets, but not primary tumor the cStage would be cT0 cN1 cM0 cStage III. We would default the primary site code to skin NOS.

   A: Thank you!

52. Q: Isn't the grade/differentiation for melanoma always a "9"?
   A: Yes. I believe it is. I have never seen a grade/differentiation for melanoma.

53. Q: Would you talk about dates … date of 1st course treatment and definitive surgery date. Thank You.
   A: A typical melanoma scenario would be a patient presents for an excisional biopsy followed by a wide excision. In this scenario date of dx would be date of excisional biopsy, date first course treatment would be excisional biopsy, date surgical procedure would be date of excisional biopsy, date of most definitive treatment would be date of wide excision.