CALIFORNIA CANCER REGISTRY

"Q-Tips"

Quality Tips - Education - Abstracting - Coding

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# Data Collection for Colon Cancer

## *Coding Tips Resulting from 2018 CCR Colon Audits*

The CCR conducted audits to review accuracy for 20 colon data items, which included several CS SSFs and Directly Coded Summary Stage. While CS SSFs will only continue to apply to cases *prior* to 2018, many CS SSFs have been converted to new Site Specific Data Items for 2018. Therefore, patterns in discrepancies identified in a CS SSF could continue in the new SSDI. The most frequently noted coding discrepancy patterns are reviewed below to highlight and clarify areas to watch for, in order to avoid potential miscodes as you complete 2017 cases and segue into 2018 colon cases and their required SSDIs.

- **Circumferential Resection Margin (CRM)**: Coding the status of the CRM was the data field with the highest discrepancy count in the 2018 CCR Colon Audits.
  - The CRM data item captures the exact distance from the deepest invasion of the tumor to the margin of resection 0.1-99 millimeters (the distance of the *negative* surgical CRM margin),
  - *OR,* a positive CRM margin NOS, or the CRM margin is so narrowly negative (described as "less than 1 millimeter"), the pathologist will consider and record the CRM margin as *positive* (coded as 000 through 2017 & coded as 0.0 2018 forward).
  - Synonymous terms for CRM are "radial" margin and "mesenteric" margin.

**The following discrepancy patterns were identified in coding the Circumferential Resection Margin:**

1) **Coding the status of margins OTHER THAN CRM (i.e., proximal, distal, or margins *NOS*)**
COMMENT/REMINDER: **Only specific statements about the CRM should be coded.** Do not code distal, proximal or margins NOS in this data field. "Margins negative" (w/o statement this includes a CRM margin) should be coded to 999 for CS SSF#6 or XX.9 for the new CRM SSDI. As noted above, descriptions of radial or mesenteric margins are equivalent to a CRM, and were occasionally missed in coding the CRM in a number of audit cases.

2) **Coding CRM to 000 (CRM margin IS POSITIVE) when text documentation noted CRM was NEGATIVE.**
COMMENT/REMINDER: The code structure for CRM is different from other data items where codes of 0's (0, 00, 000) are most often used to indicate a negative status. This situation illustrates the importance for registrars to review all codes and their definition to avoid inadvertent coding errors of this type. Do not rely on memory, or presume the definition of a code based on other data items.
**Examples:** Negative CRM margin NOS in CS SSF#6 = code 991
Negative CRM margin NOS in 2018 SSDI for CRM = code XX.1

3) **Incorrectly converting centimeters to millimeters when coding distance of negative CRM.**
COMMENT/REMINDER: SSF #6 was a 3-digit field with an "implied" decimal after the 2nd numeral. The CRM SSDI data item includes the decimal point to aide/improve input of the margin measurement. The margin should be coded in millimeters (mm), and must be converted if documented in centimeters. Examples for conversion using the new 2018 CRM SSDI codes are below.

| CRM Conversion Examples (code in millimeters to nearest tenth) | |
|---|---|
| **CRM recorded in millimeters** | **CRM recorded in centimeters** |
| • If CRM is 2 mm, code 2.0 (mm)<br>• If CRM is 2.78 mm, code is 2.8 (mm) | • If CRM is 0.2cm, multiply 0.2 x 10 and record 2.0 (mm)<br>• If CRM is 3cm, multiply 3.0 x 10 and record 30.0 (mm)<br>• If CRM is 3.2cm, multiply 3.2 x 10 and record 32.0 (mm) |
| Code length for 2018 CRM SSDI is 4 characters including the decimal point: 0.1-99.9 | |

*Colon Coding Tips continued:*

- **KRAS:** Clarification of tissue type, which may be used to assess KRAS:
  - Test results from the primary tumor, nodal or metastatic tissue may be used to determine the presence of KRAS mutations.

- **Microsatellite Instability (MSI):** Clarification on tests, which may be used to code the MSI SSDI for 2018:
  - Testing for MSI is optimally performed via genetic testing and will provide results indicating whether the MSI is high or low.
  - MSI may also be determined by immunologic testing. The most common test used is Mismatch Repair (MMR) Protein.
    - Some laboratories only test for MSI via the immunologic test Mismatch Repair (MMR) Protein. Results from immunology will only provide results with positive or negative results and will not specify whether the MSI is low or high.
  - **Results of Mismatch Repair (MMR) Protein may be used to code the MSI-SSDI for 2018**
    - Record results from Mismatch Repair (MMR) Protein in MSI SSDI codes 0 or 2.

| Code | Description |
|---|---|
| 0 | Microsatellite instability (MSI) stable; microsatellite stable (MSS); negative, NOS ---**AND/OR** **Mismatch repair (MMR) intact, no loss of nuclear expression of MMR proteins** |
| 1 | MSI unstable low (MSI-H) |
| 2 | MSI unstable high (MSI-H) ---**AND/OR** **MMR-D (loss of nuclear expression of one or more MMR proteins, MMR protein deficient)** |

- **Directly Coded Summary Stage:**
  - The most frequent Summary Stage coding discrepancy noted in the colon audit was in coding Summary Stage Localized vs Direction Extension. In the table below, invasion into any of the listed tissues equals a T3 tumor in TNM; however, Summary Stage splits extension to tissue layers noted below into either Localized or Regional Direct Extension. Staging systems are not always in exact alignment. Carefully review involved tissues in making your code selection between Summary Stage code 1 or 2 for colon.

  - In addition, when lymph nodes are also involved, combined with localized disease vs direct extension, these will map to a different overall Summary Stage as well. **Examples: Summary Stage Localized (1) + Regional LNs (3) = SS code 3 vs. Summary Stage Direct Extension (2) + Regional LNs (3) = SS code 4** (Special Registrar Math ☺).
    Summary Stage is used frequently and relied upon by researchers in outcome studies.

| **Extension to any tissues below is T3 in TNM** | |
|---|---|
| **In Summary Stage – Extension is split between two codes** | |
| **Localized (code 1)** | **Regional Direct Extension (code 2)** |
| Extension through wall NOS | Adjacent (connective) tissues, NOS |
| Non-peritonealized pericolic/perirectal tissues invaded | Mesentery (including mesenteric fat, mesocolon |
| Subserosal tissue/(sub) serosal fat invaded | Pericolic/perirectal fat |
| Transmural, NOS | Retroperitoneal |