**Q&A Session for Grade Review & Update**

August 26, 2020

| # | Question | Answer |
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|  | how many CEs will this be worth? | 2 CEUs per Jim |
|  | Will this recording be shared later?  | Yes, it will be posted on the NAACCR website |
|  | Why is SEER in Charge of SSDIs not AJCC?  | The NAACCR SSDI work group is in charge of the SSDIs and Grade. The SSDI work group is co-chaired by a SEER person; however, that does not mean SEER is in chargeRepresentatives from all the standard setters, AJCC and CAP are represented on this group and participate in the development and revision of data items, codes and coding instructionsSEER does manage the data in one of their data management systems; however, they are still not in charge of this data. All changes must be approved by the SSDI Work group before they can be implemented |
|  | Do you think the AJCC changes next year will affect this at all? They are moving to "Versions" and will be replacing each chapter and of course at another additional cost for each version! With our budgets in the cancer registry being nill I don't know how we are going to purchase this and it is not right that they are going to charge us again! | AJCC contacted:Instead of purchasing another large book, registrars will be purchasing one chapter at a time as they become available. New versions will be available on an annual basis, going into effect the following January 1st. This will be addressed during the NCRA virtual conference and the virtual SEER workshop.Any further questions regarding this should be directed to AJCC |
|  | How do suggest we present changes to our facilities so that they can take into consideration the learning curve of changes during the abstracting process? I do understand that change in necessary in life. It sometimes takes a little while to learn new rules and it is difficult for individuals who don't have direct contact with abstracting to understand the amount of time it takes to look up or familiarize ourselves with the changes, in order to provide accurate data. | You make an excellent point! We are doing this webinar and distributing the changes in August to give registrars 4 months to absorb the changes before the start of the new year. Some changes may be applied now, but they must be applied once we convert to v21. In terms of Grade, please make sure that they have a copy of this presentation, which is available for free to everyone |
|  | Is it possible to document the preferred grading system for each site, to assist newer registrars? | The preferred grading system always uses numbers (1-4, and for prostate, 5) |
|  | Do we use version 2.0 only w/ dx yr 2021+ or also 2018+ (once we convert to v21 software)?When will v 2.0 go into effect?Does 2.0 start with 1/1/2021 diagnosis date? Until then use 1.7? | Once you convert to the 2021 software, use Version 2.0 for all cases diagnosed 2018+. Note: Grade Post Therapy Clin (yc) will not be available for you to code until you get your software updateUntil you get your software updates, use Version 1.7.Keep in mind that some of the updates discussed on the Grade webinar that are in Version 2.0 may be used now; however, those notes will not be in your registry software-if your registry software includes coding instructions for Grade and the SSDIs |
|  | The new grade notes can be used going forward or do they go into effect Jan 2021? | They can be used going forward, but keep in mind that if you are looking at your software, it won't necessarily be in sync. You can use the updated Grade manual prior to the software release, just use with caution. |
|  | In SEER RSA website EOD Data v2.0 - it would be helpful if there is a note/warning on the banner that this is for 2021 use and forward. | Great suggestion. The notices have been updated on the SEER website to address this |
|  | Will vendors have software distributed to facilities by March 1 2021 so we can start abstracting RQRS January 2021 in April 2021.Will these data items be released in enough time for software vendors to apply the new data items before 1/1/2021? It puts a big burden on Registries that abstracting concurrently. | The software vendors received all the information they needed for their updates in early August. This will give the software vendors ample time to get their updates out to their clients by the end of this year, or early 2021. |
|  | Answers on cancer forum are not answers until they are in manuals, are not referenceable and often change. Please make sure all of the changes show up in the manuals. | Yes, answers on CAnswer Forum are not enforceable until they are in a manualWe do track these answers and implement them in the manual as we go along. We try not to miss anything, but it is possible. If you find something that you think has been missed, please notify us in the CAnswer Forum |
|  | If there are default grades, why aren't there edits/validations for all of the defaults to ensure correct grading nationwide? | That gets complicated. We have explored some different options, but keep running into challenges. One issue is that some histology codes are associated with multiple histologic terms. Sometimes the default grade does not apply to all of the terms. In that case we can not apply an edit. We do have an edit that checks the CNS primaries with a behavior /0 is coded with a WHO grade of 1 and CNS primaries with behavior /1 have a WHO grade of either 1 or 2. |
|  | General question: since we have a place to code clinical and path why wouldn't we code each as recorded by pathologist rather than coding the "highest" grade in path? Often times the clinical is a preliminary grade. The oncologist uses the final grade from surgical specimen regardless if higher or lower than clinical grade to determine treatment/stage. | AJCC contactedThe physician will use the grade that represents the patient’s tumor in order to be able to treat it appropriately. Biopsies are usually performed in the “worst” looking area of the tumor to ensure an adequate sample, and the biopsy may have removed the only part of tumor that was the high grade. When the treatment resection of the tumor is done, there may only be lower grades found in the remaining tumor.If would not be appropriate to treat the patient as if they have only the lower grade tumor. Since grade indicates the aggressiveness of the tumor, that could lead to the patient being under treated.The doctors may refer to the clinical as a preliminary grade knowing that reviewing the entire specimen may show something worse. The oncologist does not use the final grade from the resection specimen, and this has been verified by the many oncologists on the AJCC expert panels. The physician’s use the grade that best represents the patient’s tumor, which is looking at bot the grade from the biopsy and the resection and using the worst, the highest grade.This issue was discussed extensively on the SSDI workgroup. There are pro’s and con’s to each approach. The SSDI WG finally decided that it would be best to go this direction. |
|  | If a grade is given that is not on the table for that site, do you use code 9. For example: sarcoma does not list high or low grade, but sometimes on path this is what is stated. Would this be code 9? | Sarcoma has the generic grades A-D, so you can use the generic grade categories. High grade would be a 4.However, if the generic grades were not used and high or low were not listed, it would probably have to be a code 9. |
|  | If they rt a metastaric site, would you still use the grade if bx of primary?Follow up:The patient has brain mets in imaging and they bx thin before they bx the lung to confirm a lung primary. | In this case, they are not treating the actual primary site, so record the grade from the biopsy of the lung primary |
|  | Core biopsy of breast shows grade 2 however final grade is deferred to surgery. | Clinical grade is coded as 2. Path grade would be coded based on the highest known grade after the surgery. |
|  | Core bx showed preliminary grade 2. final surgical grade shows grade 1. How do we code path grade when rule states to code highest grade? Clinical grade was "preliminary" and deferred to surgical. | AJCC contactedNot sure where this idea of clinical being preliminary comes from. The pathologist might state that knowing that the treatment resection might show a higher grade. But that is not correct thinking. You are the treating the patient, not the specimen. If you treat based only on the second specimen, you are not treating the patient appropriately. If the pathologist feels that they had a bad specimen and they could not accurately assign the grade, that is different. If this is the case, then probably wouldn’t use that grade if the pathologist was unsure it was correct. But that is not the normal situation. |
|  | Why would yc Grade be blank and not 9? | yc work up was not done. In order to code anything in the yc grade field, two things must occur. 1. The patient must have neoadjuvant tx. 2. The patient must have a bx of the primary tumor after neoadjuvant tx. If either of those do not occur, the yc grade must be blank. |
|  | What do we do if we don't have a path report? | Then your grades are unknown unless you have a physician’s statement somewhere in the record of what the grade is |
|  | Then pathologic grade will almost always be coded as "9" when reviewing only the pathology report because the pathology report typically doesn't show what treatment has been provided as the time of report. | If a patient truly had neoadjuvant therapy, then there is probably going to be mention of it on the pathology report, or a ‘yp’ stage will be documentedAll sources of information should be reviewed to determine if patient had neoadjuvant therapy. We recognize there are times when no other information is availableWhen only the pathology report is available and there is no reference to neoadjuvant therapy or a ‘yp’ designation, default to coding the pathological grade |
|  | What is this grade post therapy clinical? I thought clinical stage was BEFORE treatment. How are we having a clinical stage after treatment? | Post therapy grade clinical is when neoadjuvant therapy is done and the physician does a work up prior to the surgery. Based on the findings from this work up, which includes microscopic (histological) examination of the primary site, the patient may not have surgery |
|  | Was there an earlier slide where the patient had a lumpectomy and no biopsy, but it was graded clinical as well as pathologic?  | Yes. There was no clinical grade (9), but there was a pathological grade |
|  | For previous answer to grade when there is no path (answer was code unk) - I thought for brain we use the table in AJCC / STM to code grade even if there is no path (ex. radiographic only - grade clinical)? | Imaging can be used **only** for Brain, but no other site. This would only be applicable to Grade Clinical only. For Grade Pathological in the Brain, you still need a surgical resection. If no surgical resection is done, Grade Pathological is 9 |
|  | If they do a post neoadjuvant bx then do surgery would we code both yc AND yp? | Yes you would. |
|  | Breast biopsy IDC Gr3. Surgery is done but no grade given. Since we want the highest grade, I can use the Clinical grade to pathological grade instead of 9. Correct? | Yes. I like to think of it as the rules for classification were met for pathological Grade (resection of the primary tumor). Therefore, we assign the highest known grade after resection of the primary tumor. In this case the highest known grade is the only known grade. That would be Gr3.Per the updated notes:Use the grade from the clinical work up from the primary tumor in different scenarios based on behavior or surgical resectionSurgical Resection (Bullet 1)* Surgical resection is done of the primary tumor and there is no grade documented from the surgical resection
 |
|  | Same rules for classification for both c & p and yc & yp? Example for bladder, TURBT followed by neoadjuvant tx followed by TURBT would be grade clinical (from 1st TURBT), grade path (9), post-therapy grade clinical (2nd TURBT), post-tx grade path (blank)? | CorrectYes.Grade Clinical: based on first TURBTGrade Pathological: 9 (neoadjuvant therapy done)Grade Post Therapy Clin (yc): second TURBTGrade Post Therapy Path (yp): BLANK (need a cystectomy, and since one wasn’t done, would be blank)Excellent question and when reviewing the Grade manual, it was determined that we did not address this after introducing Grade Clinical Post Therapy Clin (yc)This will be added to Note 1 as a 3rd bullet (currently 3rd bullet will be moved to 4th)Note 1: Leave Grade Post-Therapy Path (yp) blank when* Neoadjuvant therapy is completed, and no surgical resection is done
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|  | If the patient has a biopsy after neoadjuvant therapy and the yc grade is 1, what would the yp grade be if there is no residual tumor found on the resection after neoadjuvant therapy? | Excellent question and when reviewing the Grade manual, it was determined that we did not address this after introducing Grade Clinical Post Therapy Clin (yc)Following the pattern of clinical and pathological, you would assign Grade Post Therapy Path (yp) as 1, based on the yc grade of 1It’s obvious that we are missing a note, which will be added for the 2022 updatesUse the grade from the post therapy clinical work up from the primary tumor when surgical resection is done of the primary tumor and there is no grade documented from the surgical resectionThank you for posting this question |
|  | Continued, if TURBT followed by neoadjuvant tx followed by cystectomy then grade clin (from TURBT), grade path (9), post-tx grade clin (blank), post-tx grade path (from cystectomy)? | Correct |
|  | If there is no resection of tumor done for pathological grade, why is it given a 9 and not blank? If they didn't do a resection, doesn't that mean the rules for classification were not met? | Per Note 1 in every Grade Pathological Table* Grade Pathological must not be blank

There is an additional note (usually last one) that states to code 9 when no resection of the primary site is doneThe rules that are applied to AJCC for not meeting classification and leaving T, N, M blank do not apply to Grade Pathological. It can never be blank. |
|  | If you have a prostate case and Grade clinical is 4 and Grade pathologic is 3, do you use that to code the SSDI an also the AJCC pathologic stage ?GLEASON 3+4 = 7, GG2 ON BX; ON PROSTATECTOMY 4+4=8/10 GG 3, WE CODE BOTH CLINICAL & PATH GR AT 3? | Per Note 8 in the Grade Pathological Grade**Note 8:** The Grade Pathological may differ from Gleason Patterns Pathological [NAACCR #3839] and Gleason Score Pathological [NAACCR #3841] if the Grade Clinical, based on Gleason Patterns Clinical [NAACCR #3838] and Gleason Score Clinical [NAACCR #3840], is higher.* *Example:* Prostate biopsy, Gleason Pattern 4+4 and Gleason Score 8. Prostatectomy, Gleason Pattern 3+ 3 and Gleason Score 6.
	+ Both Grade Clinical and Grade Pathological would be coded 4 based on the Gleason Score Clinical of 8
	+ Gleason Patterns Pathological would be coded 33 and Gleason Score Pathological would be coded 06
 |
|  | GLEASON 3+4 = 7, GG2 ON BX; ON PROSTATECTOMY 4+4=8/10 GG 3, WE CODE BOTH CLINICAL & PATH GR AT 3? | No, you never use the pathological grade for the clinical grade. Clinical grade is always based on information that is obtained prior to any treatment.Your clinical Grade would be 2 based on the biopsyYour pathological Grade would be 3 based on the prostatectomy |
|  | The yc grades come and TURB or TURP? Correct?  | They could come from those procedures, but they could also a biopsy performed prior to the cystectomy. Per Grade Clinical, Note 6* For bladder, a TURB qualifies for a clinical grade only

Per Grade Pathological, Note 7* For bladder, a TURB does not qualify for surgical resection. A cystectomy, or partial cystectomy, must be performed

Per Grade Post Therapy Clin (yc), Note 6* For bladder, a TURB qualifies for a clinical grade only

Per Grade Post Therapy Path (yp)* The note for Grade Pathological would be applicable here. We will get it in for next year’s update
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|  | Patient had biopsies of two breast tumor. Tumor A 1.0 cm Nottingham G1 tumor B 0.2 cm Nottingham G3. Mastectomy revealed tumor A 1.3 cm Nottingham G1 & tumor B 0.1 cm Nottingham G3. The biggest tumor has the lower grade. What grade are we using for this scenario?  | Per the newest note, which appears in every grade table:“If there are multiple tumors with different grades abstracted as one primary, code the highest grade”This instruction applies to all cases for grade, there are no exceptions. * Do not apply this instruction to any of the SSDIs
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|  | Are we supposed to use the Grade crosswalk to not mix the grading systems? | The Grade crosswalk is used when* A-D code choices are the only ones available
* A schema has a preferred grading system (codes 1-4) and there are A-D codes available
* The grade documented in the pathology report is not the preferred grading system

Note: If a schema does not have A-D codes, then you cannot use the Grade crosswalk  |
|  | Breast - i thought Nuclear grade is only used for insitu? | No, it can be used for invasive cases for codes A-D when a pathologist documents a nuclear grade instead of Nottingham |
|  | Sorry, I have another question in regards to Pathologic Grade. Breast Case- Bx positive to highest T value (T4d) & SCV LN BX positive to highest N value (N3c). Per AJCC, this specific case can be pathologically staged without a resection. Can the Grade from the BX of the primary site be used for Pathologic Grade?Follow up question:If registrars can't use the Grade from the BX in the Pathologic Grade, then it would look a little weird assigning a Pathologic Stage Group. I'm looking at page 18 of AJCC Manual. | AJCC contactedCan I ask how often you have this type of case with inflammatory cancer with a supraclavicular node involved and they chose not to perform a resection?If you do have this case, this scenario only applies to registrars who are assigning AJCC staging.  Those coding summary stage or EOD are only using the information to code the disease extent ONCE.Registrars assigning AJCC stage need to follow that rule completely.  That rule states that you use the same stage assigned for the clinical stage for the pathological stage.  That means you record (making up the categories not provided in the scenario):cT4d cN3c cM0 Gr2 HER2- ER+ PR+ clinical stage IIIBcT4d cN3c cM0 Gr2 HER2- ER+ PR+ pathological stage IIIBthere is no need for a special rule, you just take exactly what you recorded for clinical and use it ALSO for pathological.  can't you have an override if the edits won't allow this?  if not, anyone doing data analysis will just have to handle these cases manually, using the clinical grade that is documented.  you can still use the grade to figure out and document the stage groupFurther questions regarding this should be posted to the AJCC forum |
|  | What happens when you have a cytology report (or path report) that doesn't list a grade, but a later MD note refers to that report and states a grade. Do we follow the cyto/path report and assign code 9 or would we use the MD stated grade? | You can go with the MD's statement. |
|  | Pop quiz 12, wouldn't clinical be 9 since you are not sure there is no tumor until mastectomy? | No, the grade from the lymph node tissue can be used (this has been confirmed with AJCC) since there was no evidence of the primary site. The following note can be found in Breast, Clinical Grade in Version 2.0* **Note:** This is only valid for Breast. Do not apply this note to any other primary site/schema

**Note 7:** Grade from nodal tissue may be used **ONLY** when there was **never** any evidence of primary tumor (T0). Grade would be coded using G1, G2, or G3, even if the grading is not strictly Nottingham, which is difficult to perform in nodal tissue. Some of the terminology may include differentiation terms without some of the morphologic features used in Nottingham (e.g., well differentiated (G1), moderately differentiated (G2), or poorly/undifferentiated (G3)).* *Example*: No breast tumor identified, but 2/3 axillary nodes were positive. Determined to be regional node metastasis from breast primary. Nodes were described as poorly differentiated with a high mitotic rate
	+ Code G3 based on the poorly differentiated (which is a high grade) although the terminology used is for nuclear grading
 |
|  | Does the breast note 8 (slide 47) apply when only DCIS but never any invasive cancer is found for a patient with positive LNs? | DCIS is still cancerThe note that has been added states “never any evidence of primary tumor (T0).” It does not exclude DCIS. It also does not require a tissue confirmation of in situ or invasive cancer. The tumor can be palpated by physical exam or on imaging. It’s when they can’t find any evidence of tumor that you use this.  |
|  | Ovary slide does not say to always code high but that is what Jennifer said, is that correct? | I misspoke (Jennifer here). For the histologies listed for Ovary, these are always going to be L (low) or H (high). So for those histologies, you are going to assign either L, H, or 9. From what we’ve seen from CAnswer Forum questions, most of these are going to be high grade, which would be coded as H |
|  | Slide 22 references the WHO grade table in AJCC 8th ed. This would only apply to histologically confirmed cases per Note 1 on page 26 of the clinical grade coding guidelines, correct? Asking since they will sometimes give WHO grade on scans. | Per the Notes for Brain, you can use imaging to assign grade. This ONLY applies to benign, borderline and malignant cancers. |
|  | I see a lot of "high grade" neuroendocrine tumors. How do you code those? Grade 3 or 4?I noticed question above about coding grade for "high grade neuroendocrine tumors." Is there a reference list available of tumors like high grade neuroendocrine carcinoma where "high grade" is considered to be the histology and not coded as grade? | For the Neuroendocrine tumors, that is the actually the histology, not the grade. Grade is based on mitotic count and Ki-67. Several CAnswer Forum questions on thisAt this time, we do not have a reference list, although there are other groups that are working on a histology reference that will include grades. We do not know when this reference will be ready though |
|  | You may have touched on this and I missed it, but, is there any reference that states that we can code Small Cell Carcinoma of the Lung to Grade 4? Every pathologist I have ever spoken to has stated that this will always be Grade 4, yet I have never found this rule stated by any standard setter. I always end up having to include it in my policies. | This question has been referred to our CAP Cancer Committee liaison. This question was also posted in CAnswer Forum. We will respond as soon as we hear back.If there is a default grade, we will post updated instructions for the next release |
|  | Generic Grade Table: would it decrease confusion to remove the Grade (middle) column to prevent temptation to assign grades 1-4? | Good idea. I will take this back to the SSDI work group for discussion |
|  | IF clinical grade is G3, neoadj tx given, resection done and no tumor (CR). What is the grade post therapy? G3 or 9 | For this case, your post therapy path (yp) grade would be 9 since there was complete remissionNever use grade clinical information for post therapy path (yp) grade.  |
|  | I just want to clarify that you are saying we can only use the GENERIC GRADE TABLE if the primary site already has A-D listed as a grade option. If A-D is not listed then we cannot use the generic grade table for that primary site? | You are correct* Can only use the generic grade table if codes A-D are available
* If codes A-D are not available, you cannot use it
 |
|  | Slides 53 and 54. Have the rules for using the generic chart changed since 2018 or will they change? Is the NAACCR grade webinar from 2018 still relevant for this information to go back and review? | The general rules have not changed, but we have added clarifications. I believe that first presentation presented it the same way we are presenting. |
|  | Slide 56, middle grade table: is it accurate that "low grade" is equivalent to B? Why not code to A? | Historically, low grade has always defaulted to B (mod diff). This has been the rule for over 40 years |
|  | Pop Quiz 16 Breast: Can you clarify the reason for grading the pathol grade? I understand there are two different gr systems being used, but isn't "low grade" technically lower than the bx (clinical grade 2)? This seems to contradict the guidance to use clinical grade if higher than path grade after resection. Thank you very much. | No, this is one of the issues that we discussed during the webinar and is addressed in the updated note for Path Grade. You cannot mix the preferred grading system (Nottingham for Breast) and a non-preferred grading system (which would be the nuclear grading system used for this case), even though it looks like the low grade is lower than the Nottingham Grade 2. This does not contradict the instructions to use the clinical grade in the pathological grade if the clinical is higher. Those notes come after Note 2, which addresses this situation and takes priority. If both grades were Nottingham and the clinical was higher (or the pathological not available), that’s when you would use the clinical grade in the pathological grade. **Note 2:** There is a preferred grading system for this schema. If the clinical grade given uses the preferred grading system and the pathological grade does not use the preferred grading system, do not record the Grade Clinical in the Grade Pathological field. Assign Grade Pathological using the applicable generic grade codes (A-D). * *Example*: Breast biopsy, invasive ductal carcinoma, Nottingham grade 2. Lumpectomy, invasive ductal carcinoma, nuclear grade 3
	+ Code Grade Clinical 2 (G2) since Nottingham is the preferred grading system
	+ Code Grade Pathological as C (nuclear Grade 2), per the Coding Guidelines for Generic Grade Categories
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|  | Pop quiz 17 , would we use the path grade for the clinical grade?pop quiz 17. bx is DCIS high grade, but lumpectomy is Invasive Gr2. Would clinical grade be 9 since the H for high grade is DCIS and not Invasive ca?pop quiz 17, lumpectomy grade not SBR is it still 2?Pop quiz 17, the lumpectomy specimen states G2. How do you know if this is SBR or nuclear grade?For Breast cases - if you are given G2 only on the path but they don't specify SBR can you use Grade 2? | No, you never use the path grade in the clinical grade.The biopsy only showed DCIS, so you would code the appropriate in situ grade on that. You code what you know during the clinical time frame. So, for this case, all you knew was that this tumor was in situThe lumpectomy shows an invasive cancer, so at this time you would change your behavior to /3 and code grade as 2 per the pathology report. This does not negate the information collected clinically. You would not go back and change your clinical information.G2 (or G1 or G3) is the way the SBR or Nottingham Grade is recorded. As long as they don’t use nuclear grade terminology (well diff, mod diff, poor diff, undiff, or high/low), you can assume this is SBR/Nottingham |
|  | If the bx was HG DCIS, but I'm using lumpectomy as part of the clinical staging as it was part of diagnosing the cancer, can I use the grade on the lumpectomy? | For this example, the lumpectomy was the pathological staging. If you have an example of this type of situation, please post in CAnswer Forum, but in general, whatever is done during the clinical time frame can be used to code grade |
|  | Pop quiz 18-high grade dcis on bx followed by microinvasive, unknown grade on surgery. Shouldn't clinical grade be 9 instead of H since you don't know the clinical grade of the invasive component? | During the clinical work up, the only information you had was that the breast cancer was in situ. So, you would record the grade as H. Then on surgical pathology, microinvasion was found, which now means the case is a /3. This does not mean that you change the clinical grade based on the pathological information. We have also learned that it is very rare to have a grade on microinvasion, so 9 would be codedFor example, in AJCC, this would have been a Tis clinically, but a T1mic pathologically. You would not go back and change the Clinical Tis based on the pathological findings |
|  | Clinical grade for #21 be 4? | No. Based on revised instructions, a consult always takes priority.Original report stated Clinical Grade Group 4However, the consult stated it was Grade Group 3, so you go with the 3 |
|  | Question on consultant path (my facility does it frequently): when original path had a grade (mod diff, etc) but consultant path only has the histology with NO GRADE info. In those cases can I use the grade from the original path? [w/ text documentation of course] | Yes. We have new instructions that state if a consult is done, that the information from the consult takes priority; however, if the information is not available, code what was on the original pathology report.  |
|  | Follow Up to this exchange: You 01:34 PM Slide 56, middle grade table: is it accurate that "low grade" is equivalent to B? Why not code to A? Jennifer Ruhl 01:35 PM Historically low grade has always defaulted to B (mod diff). That was a decision made a long time ago. Wouldn't it be helpful to somehow note this since not all registrars have been around as long we have :) | The generic grade table is available, and registrars can use that to determine the appropriate gradeNew registrars just need to know where that table is and follow it  |
|  | Can you clarify on which Grade to use if you have ambiguous terminology describing Grade? i.e. A biopsy positive for Mod Diff Adenocarcinoma with areas Suspiciuous for Poorly Diff Adenocarcinoma? Do you still use the highest grade? | Go with the highest grade |
|  | Pop quiz 25 Clinical based on invasive and yp showed in situ. If we can't use clinical in the yp field and we cannot go back to in situ once invasive ca. in identified, how can yp be coded H as shown?Slide 76 - for the Grade Post Therapy Path - you coded H but you are mixing behaviors in the exampleOn that bladder case we just discussed, would you code High Grade for post therapy grade if the cystectomy specimen was in situ?Pop quiz 25 recording the hi grade, even though it’s only in situ left doesn’t matter? How are they to know it’s in situ and not invasive anymore? | You are coding what was found on the post therapy grade, which was in situ. This is the same thing that AJCC does, stating it’s possible to have a ypTis or even a ypT0 after neoadjuvant therapy when the original tumor was invasiveThe issue is when there is **no neoadjuvant therapy** and a patient has a clinical work up with microscopic confirmation followed by a surgical resection. In this situation, if the clinical is invasive and path is in situ, then the path grade would be taken from the clinical. If the clinical is in situ and the path is invasive, then you would code the appropriate grade in grade clinical based on the Insitu and the appropriate grade in pathological grade based on the surgical resection.The instructions for post therapy are different. A case can be invasive during the clinical time frame and in situ during the post therapy time frame, or possibly not even evident anymore. The grade is based solely on the information in the post neoadjuvant therapy time frame |
|  | Where do we find grading instructions on Meninigoma? I've never heard of coding it a 1 ? | In Version 2.0: The updated instructions in Brain Table (Grade 24) includeFor benign tumors ONLY (behavior 0), code 1 can be automatically assigned for all histologies. This was confirmed by the CAP Cancer Committee |
|  | I thought for brain tumors we were supposed to code both clinical and pathological grades for both even if there is no surgery. | This is incorrect. Follow the general rules for all schemasPer the Grade Coding Manual for **all** Pathological Grade Tables:Note 1 (for every schema): Grade Pathological must not be blankUnder “Code 9 (unknown) when”No surgical resection is done |
|  | What if Biopsy Gr is 2 and surgery no grade given. Can we used Gr2 pathological or 9, since Gr2 is not the highest grade, we cannot assumed anything for pathological. | Per updated notes and covered on the webinar:Note (number differs by schema): Use the grade from the clinical work up from the primary in different scenarios based on behavior or surgical resectionUnder Surgical Resection, first bullet:Surgical resection is done of the primary tumor and there is no grade documented from the surgical resection |
|  | Are you able to code grade from a cytology report from the primary site? | In general, cytology cannot be trusted, especially with urinary tumors. We are still exploring and need examples of where cytology reports are used and there is a gradeIn other words, when you get a case like this, please post in CAnswer Forum. We need actual cases to review |
|  | If only the Furhman grade is given by the pathologist, can this grade be used in liue of the WHO grading system? Is it considered generic? Or should it be coded as a 9?I thought you could use the generic grade for Kidney parenchyma because of the chart just before the grade tables in the manual. And because WHO grade is not specified as preferred in AJCC in the renal chapter, we can use the generic. I think I remember that in the grade manual also. | If the only documentation you have is Fuhrman, then you must code 9. Fuhrman cannot be translated to the generic codes. However, if you had “mod diff” or “poor diff” then you could use the generic grade table |
|  | Did I see correctly that Quiz 11 has pathological stage when there was no surgery to the primary site? Why is this? | Yes, this is because of the updated coding instruction found in the Grade Pathological tables:Surgical resection of the primary tumor has not been done, but there is positive microscopic confirmation of distant metastasis during the clinical time frame* Pop quiz #11 had microscopic confirmation of liver mets
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|  | If a core biopsy was performed on lung however it was processed in the lab as a smear and reported on a cytology report as consistent with adenocarcinoma poorly diff of the lung, can you use the grade from the cytology report? | Per request, this question was posted in the CAnswer Forum. It has been sent to our liaison from the CAP Cancer CommitteeThank you to the registrar who posted this |
|  | To be clear, on a breast case, if we do not have a usable grade, we cannot stage w/AJCC?What happens when clinical grade example is given only as moderate differentiated for breast cases? Yes I'll pick the B but it won't let me stage group it. | Per the Notes for Schemas where Grade is part of the stage group (Breast, Prostate, Soft Tissue, Appendix, etc.). These notes were included in the initial release of the Grade Manual.**Note (# depends on which Grade Table you are looking at)**If you are assigning an AJCC 8th edition stage group* Grade is required to assign stage group
* Codes A-D are treated as an unknown grade when assigning AJCC stage group
* An unknown grade may result in an unknown stage group

Follow up from AJCCThere are very few cases where you can assign the stage group with the grade. Due to the structure of the breast staging table, there wasn’t a way to assign “any G” and there are a few cases where it is the same stage group whether it is G1, G2, or G3. In those case, the registrar can assign the stage group.Any questions regarding assigning stage group and grade should be posted in the AJCC forum |
|  | A bronch washing is positive for PD Adenocarcino c/w lung primary. Could not biopsy lung mass due to position. Not a surgical candidate due to comorbs. This is a case I just came across | Per request, this question was posted in the CAnswer Forum. It has been sent to our liaison from the CAP Cancer CommitteeThank you to the registrar who posted this |
|  | Question on yp grade when a second primary is found lets say a right breast dx first and then left breast dx later and neoadj was done for right breast, a double mastectomy was done, and now grade for left breast is it a 9 due the recent therapy for left breast? | AJCC contactedThe AJCC physician experts have stated many times that you only count neoadjuvant for the case it was given for - not for any subsequent primaries.  So in this case, the left breast is a new diagnosis and should be assigned a clinical stage using the grade from the biopsy.  The right breast will be staged using yp after the mastectomy, and the left breast will be staged using p after the mastectomy.  The grades will match with the staging classification used for each breast.  |
|  | Is a positive lymph node positive for duct carcinoma, but no primary found in the breast, would that be considered as diagnosis from a metastatic site? | This would be lymph node metastases, not distant metastasis. You have a breast primary based on lymph node metastases |
|  | When you get a biopsy from a metastatic site, does it have to document what the primary site is? Such as mets from GI primary vs just metastatic carcinoma? | To code grade, you must have information from the primary site. If all you have is information from a metastatic site, you can’t use it |