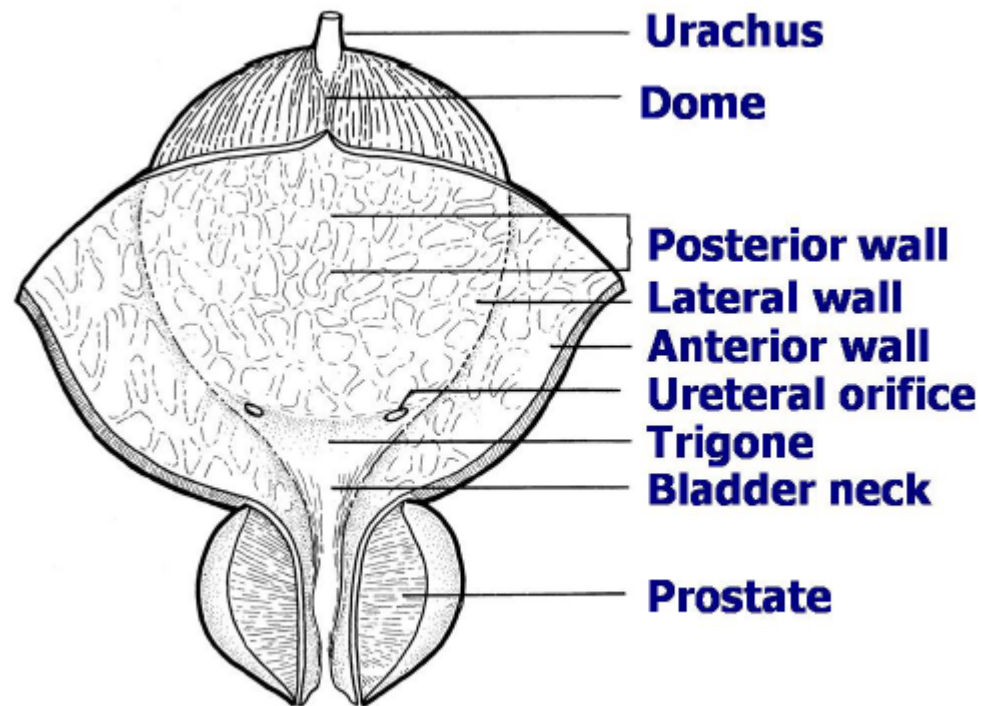
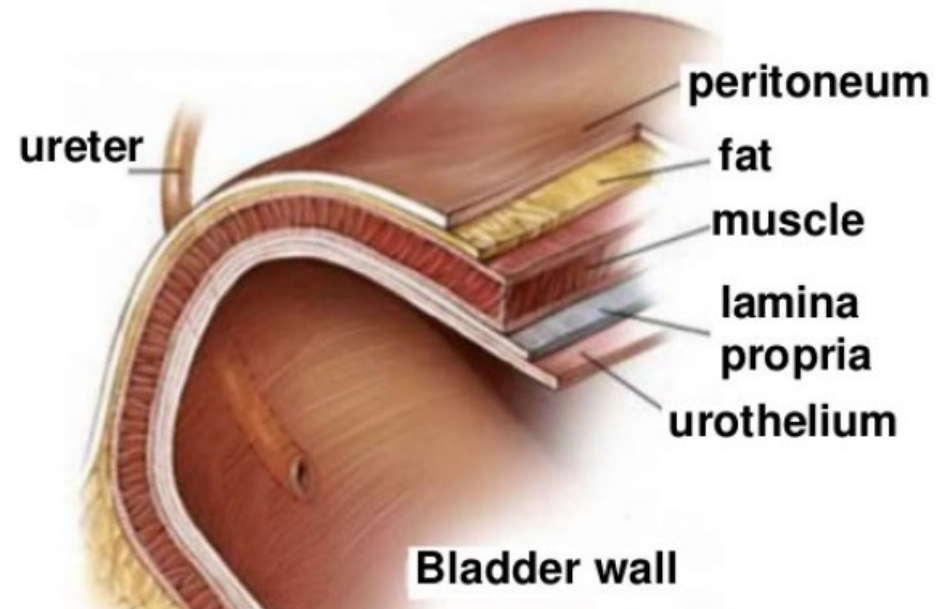


Bladder Abstracting & Pitfalls



Layers of the Bladder Wall



Review

- Solid Tumor Rules
- Extent of Disease and 8th Edition AJCC Staging
- Grade
- Pitfalls with Case Scenarios
- Treatment

Equivalent & Non-Equivalent Terms

Equivalent

These terms can be used interchangeably:

- And; with
Note: "And" and "with" are used as synonyms when describing multiple histologies within a single tumor. Urothelial carcinoma and small cell neuroendocrine carcinoma is equivalent to urothelial carcinoma with small cell neuroendocrine carcinoma.
- Flat transitional cell carcinoma; flat urothelial carcinoma; urothelial carcinoma in situ; noninvasive flat carcinoma; in situ transitional cell carcinoma
- Multifocal; multicentric
- Noninvasive may describe either in situ papillary carcinoma or flat urothelial cell carcinoma
- Papillary transitional cell carcinoma; papillary urothelial carcinoma
- Simultaneous; synchronous; existing at the same time; concurrent; prior to first course treatment
- Topography; site code
- Tumor; mass; tumor mass; lesion; neoplasm
 - The terms tumor, mass, tumor mass, lesion, and neoplasm are **not** used in a standard manner in clinical diagnoses, scans, or consults. **Disregard** the terms **unless** there is a physician's statement that the term is malignant/cancer
 - These terms are used **ONLY** to determine multiple primaries
 - **Do not** use these terms for casefinding or for determining reportability
- Type; subtype; variant
- Urothelial carcinoma; transitional cell carcinoma
- Urothelium; epithelium; transitional epithelium

Non-Equivalent

These terms are **not equivalent**. There are no casefinding implications.

- Carcinoma, NOS (8010) and adenocarcinoma, NOS (8140) are not equivalent
- Phenotype is not equivalent to subtype/type/variant
- Noninvasive, papillary urothelial carcinoma, flat urothelial carcinoma are not equivalent
Note: Noninvasive is **not equivalent** to either **papillary** urothelial or **flat** urothelial carcinoma. Both Ta and Tis tumors are technically noninvasive. Code the histology specified by the pathologist.
- Papillary growth pattern is not equivalent to papillary urothelial carcinoma

Urothelial carcinoma with papillary growth pattern
≠ Papillary urothelial carcinoma. The appropriate code to use for a urothelial carcinoma with papillary growth pattern is 8120 Urothelial Carcinoma.

Topography / Primary Site

Site Term and code	Synonyms
Bladder, anterior wall C673	-
Bladder, dome C671	Roof Vault Vertex
Bladder, lateral wall C672	Lateral to ureteral orifice Left wall Right wall Sidewall
Bladder neck C675	Internal urethral orifice Vesical neck
Bladder NOS C679	Lateral posterior wall (no hyphen)
Bladder, overlapping lesion C678	Fundus Lateral-posterior wall (hyphen)
Bladder, posterior wall C674	-
Bladder, trigone C670	Base of bladder Below interureteric crest Below interureteric field Below interureteric ridge Floor of bladder
Bladder, urachus C677	Mid umbilical ligament Urachal remnant
Bladder, ureteric orifice C676	Just above ureteric orifice

- The following instructions are in **priority order**
 - Code overlapping lesion of the urinary bladder C67.8 when:
 - A single tumor of any histology overlaps subsites of the bladder.
 - A single tumor or non-contiguous tumors are:
 - Urothelial Carcinoma In Situ (8120/2) AND
 - Involves only bladder and one or both ureters (no other sites involved).
 - Code to Bladder NOS C67.9 when there are multiple non-contiguous tumors within the bladder AND the origin is unknown or not documented.

Solid Tumor Rules, Multiple Primary Rules

- M2 Abstract a single primary when there is a single tumor.
- M6 Abstract multiple primaries when an invasive tumor occurs more than 60 days after an in-situ tumor.
 - On 4/1/23, patient is diagnosed with 8120/2 non-invasive urothelial carcinoma s/p TURBT.
 - On 2/5/24, patient returned for repeat TURBT and was diagnosed with invasive urothelial carcinoma 8120/3.
- M7 Abstract a single primary when the patient has multiple occurrences of /2 urothelial carcinoma in situ of the bladder (tumors may be any combination of urothelial 8120/2 OR non-invasive papillary carcinoma 8130/2). *This does NOT include micropapillary subtype)
 - On 8/2/20, patient is diagnosed with 8120/2 non-invasive urothelial carcinoma s/p TURBT. A repeat TURBT on 3/2/24 was positive for papillary urothelial carcinoma non-invasive. Enter recurrence in follow up field for 3/2/24 and text details.
- M8 Abstract multiple primaries when the patient has micropapillary urothelial carcinoma 8131/3 of the bladder and a urothelial carcinoma 8120/3 (including papillary 8130/3) of the bladder.
 - On 7/4/18, patient was diagnosed with invasive urothelial carcinoma 8120/3 via TURBT. On 8/15/23 repeat TURBT proved invasive micropapillary carcinoma (8131/3). Abstract new primary.
- M9 Abstract a single primary when the patient has multiple invasive urothelial carcinomas in the bladder.
 - Multiple occurrences of urothelial carcinoma or subtypes (not including micropapillary)
 - Or
 - Multiple occurrences of micropapillary
 - Timing is irrelevant. Abstract only one /3 invasive urothelial bladder primary OR one /3 micropapillary bladder primary per the patient's lifetime.

Solid Tumor Rules, Multiple Primary Rules

- M15 Abstract a single primary when synchronous, separate/non-contiguous tumors are on the same row in Table 2 in the Equivalent Terms and Definitions
 - TURBT shows invasive papillary urothelial carcinoma (8130/3) and invasive clear cell (glycogen-rich) urothelial carcinoma (8120/3). Abstract a single primary. Papillary urothelial carcinoma and clear cell (glycogen-rich) urothelial carcinoma are on the same row in Table 2.

ROW

Specific and NOS Histology Codes	Synonyms	Subtypes/Variants
Squamous cell carcinoma 8070	Pure squamous cell carcinoma SCC Pure squamous carcinoma of urothelial tract	Verrucous carcinoma 8051
Urothelial carcinoma 8120 <i>Note 1:</i> Previously called transitional cell carcinoma , a term that is no longer recommended. <i>Note 2:</i> Micropapillary 8131 is a subtype/variant of papillary urothelial carcinoma 8130. It is an invasive /3 neoplasm with aggressive behavior. <i>Note 3:</i> The histology term is exactly Plasmacytoid/signet ring cell/diffuse variant. All three terms are used together to indicate a specific variant (coded 8082/3).	Clear cell (glycogen-rich) urothelial carcinoma 8120/3 Conventional urothelial carcinoma 8120/3 Infiltrating urothelial carcinoma 8120/3 Infiltrating urothelial carcinoma with divergent differentiation 8120/3 Infiltrating urothelial carcinoma with endodermal sinus lines 8120/3 Infiltrating urothelial carcinoma with glandular differentiation 8120/3 Infiltrating urothelial carcinoma with squamous differentiation 8120/3 Infiltrating urothelial carcinoma with trophoblastic differentiation 8120/3 Large nested urothelial carcinoma 8120/3	Giant cell urothelial carcinoma 8031/3 Lymphoepithelioma-like urothelial carcinoma 8082/3 Plasmacytoid/signet ring cell/diffuse variant (see Note 3) Papillary urothelial (transitional cell) carcinoma in situ 8130/2 invasive 8130/3 low-grade papillary urothelial carcinoma with inverted growth pattern 8130/2 non-invasive papillary urothelial carcinoma, high-grade 8130/2 non-invasive papillary urothelial carcinoma, low-grade 8130/2 Micropapillary urothelial carcinoma 8131/3 Plasmacytoid urothelial carcinoma/ sarcomatoid urothelial carcinoma 8122/3 Poorly differentiated carcinoma/poorly differentiated urachal carcinoma 8020/3

Solid Tumor Rules, Multiple Primary Rules

- M16 Abstract a single primary (the INVASIVE) when an in situ tumor is diagnosed after an invasive tumor AND tumors occur in the same urinary site.
 - Patient diagnosed with a 2017 invasive urothelial carcinoma of bladder. A repeat TURBT on 4/1/24 proves non-invasive urothelial carcinoma. Enter recurrence and document in text.
- M17 Abstract a single primary (the INVASIVE) when an invasive tumor is diagnosed ≤ 60 days after an in situ tumor AND tumor occurs in the same urinary site.
 - Patient diagnosed on 2/2/24 with non-invasive urothelial carcinoma on TURBT. Patient returns for repeat TURBT on 3/15/24 with path revealing invasive urothelial carcinoma. Abstract one primary and code histology to invasive.

Coding Histology Instructions

Code the histology

- Prior to neoadjuvant therapy
 - EXCEPTION: Initial diagnosed based on FNA, smears, cytology or from regional or metastatic disease and neoadjuvant treatment is given and followed by a resection of the primary site which identifies a different or specific histology. Code the histology from the primary site post-resection.
 - Example: Urine cytology is positive for invasive urothelial carcinoma (8120/3) and MRI notes invasion of detrusor muscle. Patient is treated with neoadjuvant cisplatin/gemcitabine followed by a radical cystectomy with ileal conduit. Path reveals residual invasive papillary urothelial carcinoma. Code histology to 8130/3.
- Using priority list and H rules
- Do not change histology to make the case applicable for 8th Edition Staging.
- Code the most specific histology from either resection or biopsy.
 - Code the invasive when both in situ and invasive tumors are present.
 - If there is a discrepancy between biopsy and resection, code from the most representative specimen (largest amount of tumor).

Solid Tumor Rules, Histology Rules: Single Tumor

Rule H1 Code the histology when only **one histology** is present.

Note 1: Use [Table 2](#) to code histology. New codes, terms, and synonyms are included in **Table 2** and coding errors may occur if the table is not used.

Note 2: When the histology is **not listed** in **Table 2**, use the **ICD-O** and all **updates**.

Note 3: Submit a question to [Ask a SEER Registrar](#) when the histology code is not found in Table 2, ICD-O or all updates.

Note 4: Only code squamous cell carcinoma (8070) when there are no other histologies present (pure squamous cell carcinoma).

Note 5: Only code adenocarcinoma (8140) when there are no other histologies present (pure adenocarcinoma).

Rule H2 Code the **invasive** histology **when in situ** and **invasive** histologies are present in the **same tumor**.

Rule H3 Code the **subtype/variant** when there is a **NOS** and a **single subtype/variant** of that NOS such as the following:

- Adenocarcinoma **8140** and a subtype/variant of adenocarcinoma
- Papillary urothelial carcinoma **8130** and a subtype/variant of papillary urothelial carcinoma
- Rhabdomyosarcoma **8900** and a subtype/variant of rhabdomyosarcoma
- Sarcoma **8800** and a subtype/variant of sarcoma
- Small cell neuroendocrine carcinoma **8041** and a subtype/variant of small cell neuroendocrine carcinoma
- Squamous cell carcinoma **8070** and a subtype/variant of squamous cell carcinoma
- Urothelial carcinoma **8120** and a subtype/variant of urothelial carcinoma

Note: Use [Table 2](#) to identify NOS histologies and subtypes/variants.

Solid Tumor Rules, Histology Rules: Single Tumor, continued

Rule H4 Code mixed small cell carcinoma **8045** when the final diagnosis is any of the following:

- Small cell neuroendocrine mixed with any other type of **carcinoma** (does not apply to sarcoma)
- Two or more subtypes/variants of small cell neuroendocrine carcinoma
- Subtype/variant of small cell neuroendocrine mixed with any other **carcinoma** (does not apply to sarcoma)

Example: Diagnosis from TURB is urothelial carcinoma **and** small cell neuroendocrine carcinoma. Code mixed small cell carcinoma 8045.

Rule H5 Code mixed urothelial carcinoma as follows:

- Code **8120** when urothelial is mixed with:
 - o Adenocarcinoma or adenocarcinoma subtypes
 - o Squamous cell carcinoma or squamous cell carcinoma subtypes
- Code **8130** when papillary urothelial is mixed with:
 - o Adenocarcinoma or adenocarcinoma subtypes
 - o Squamous cell carcinoma or squamous cell carcinoma subtypes
- Code **8131/3** when micropapillary urothelial is mixed with:
 - o Adenocarcinoma or adenocarcinoma subtypes
 - o Squamous cell carcinoma or squamous cell carcinoma subtypes

Note: Adenocarcinoma and subtypes/variants as well as squamous cell carcinoma and subtypes/variants are coded **ONLY** when pure (not mixed with any other histology).

Example: Pathology says majority of tumor is squamous cell carcinoma 8070/3 with a minority composed of papillary urothelial cell carcinoma 8130/3. Code the papillary urothelial cell carcinoma 8130/3. The squamous cell carcinoma is not pure and cannot be coded.

This is the end of instructions for Single Tumor.

Solid Tumor Rules, Histology Rules: Multiple Tumors abstracted as a Single Primary

Rule H6 Code the histology when only **one** histology is present in **all** tumors.

Note 1: Use [Table 2](#) to code histology. New codes, terms, and synonyms are included in **Table 2** and coding errors may occur if the table is not used.

Note 2: When the histology is **not listed** in **Table 2**, use the **ICD-O** and all **updates**.

Note 3: Submit a question to [Ask a SEER Registrar](#) when the histology code is not found in Table 2, ICD-O or all updates.

Note 4: Only code squamous cell carcinoma (8070) when there are no other histologies present (pure squamous cell carcinoma).

Note 5: Only code adenocarcinoma (8140) when there are no other histologies present (pure adenocarcinoma).

Rule H7 Code the **invasive** histology when there are invasive and in situ histologies:

- Mixed in each of the tumors **OR**
- In separate tumors (one or more invasive and one or more in situ)

Solid Tumor Rules, Histology Rules: Multiple Tumors abstracted as a Single Primary, continued

Rule H8 Code the **subtype/variant** when **all multifocal/multicentric** tumors are a **NOS** and a **single subtype/variant** of that NOS such as the following:

- Adenocarcinoma **8140** and a subtype/variant of adenocarcinoma
- Papillary urothelial carcinoma **8130** and a subtype/variant of papillary urothelial carcinoma
- Rhabdomyosarcoma **8900** and a subtype/variant of rhabdomyosarcoma
- Sarcoma **8800** and a subtype/variant of sarcoma
- Small cell neuroendocrine carcinoma **8041** and a subtype/variant of small cell neuroendocrine carcinoma
- Squamous cell carcinoma **8070** and a subtype/variant of squamous cell carcinoma
- Urothelial carcinoma **8120** and a subtype/variant of urothelial carcinoma

Note 1: Use [Table 2](#) to identify NOS histologies and subtypes/variants.

Note 2: All tumors may be mixed histologies (NOS and a subtype/variant of that NOS) **OR** one tumor may be a NOS histology and the other tumor a subtype/variant of that NOS.

Rule H9 Code mixed small cell carcinoma **8045** when the final diagnosis **for all tumors** is any of the following:

- Small cell neuroendocrine mixed with any other type of **carcinoma** (does not apply to sarcoma)
- Two or more subtypes/variants of small cell neuroendocrine carcinoma
- Subtype/variant of small cell neuroendocrine mixed with any other carcinoma (does not apply to sarcoma)

Example: Diagnosis from TURB is urothelial carcinoma **and** small cell neuroendocrine carcinoma. Code mixed small cell carcinoma 8045.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.

Extent of Disease
and
8th Edition AJCC Staging

AJCC Rules for Classification

Clinical

- TURBT
- CT, MRI, PET for extravesical extension, lymph nodes, and metastatic disease

Post-Therapy Clinical (yc)

- After the **completion** of NAC &/or XRT without subsequent surgical resection
- or
- After neoadjuvant and before planned surgical resection.

Pathologic

- Radical cystectomy or partial cystectomy (both gross and microscopic assessment)
- Lymph nodes removed/excision
- Biopsy or FNA of distant metastatic site

Post-Therapy Pathologic (yp)

- Partial or radical cystectomy after NAC &/or XRT.
 - Neoadjuvant therapy must meet National guidelines or standards, and not have been given for variable or unconventional reasons as noted in the AJCC manual, page 23.

Definite Statement vs Inferred Descriptions of noninvasive papillary transitional carcinoma

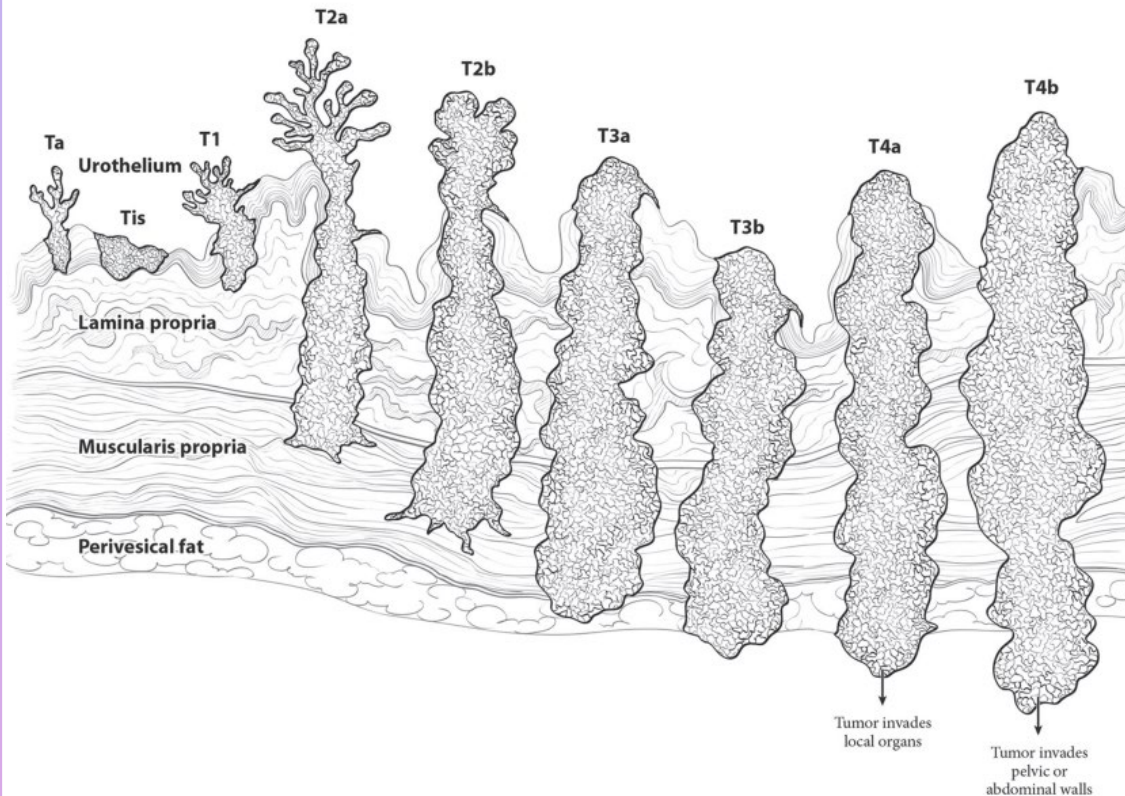
Definite statements of non-invasion for papillary transitional cell carcinomas (Ta)

- Noninfiltrating
- Noninvasive
- No evidence of invasion
- No extension into lamina propria
- No stromal invasion
- No extension into underlying supporting tissue
- Negative lamina propria and superficial muscle
- Negative muscle and (subepithelial) connective tissue
- No infiltrative behavior/component

Inferred descriptions of non-invasion for papillary transitional cell carcinomas

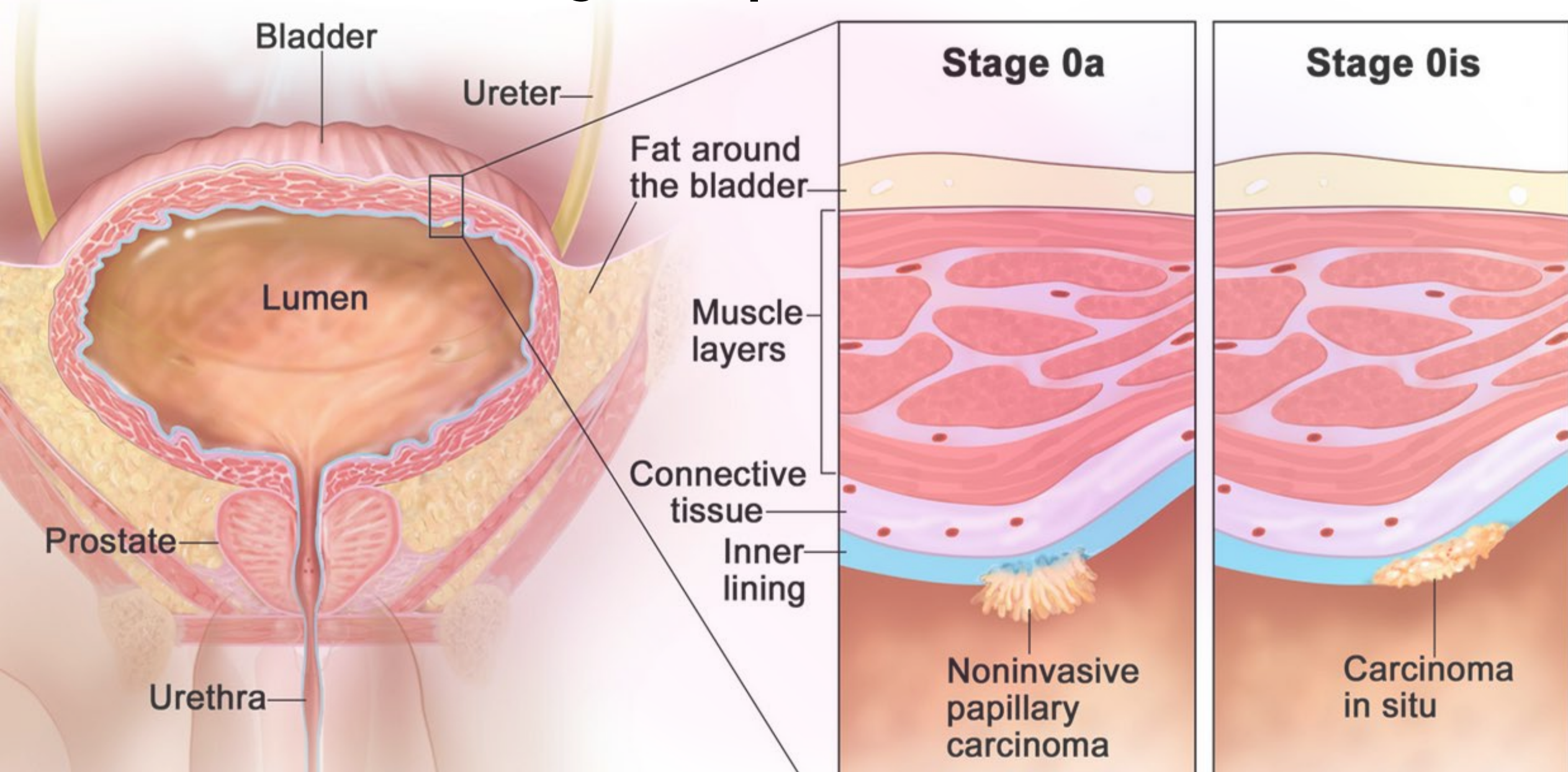
- No involvement of muscularis propria and no mention of subepithelium/submucosa
- No statement of invasion (microscopic description present)
- (Underlying) Tissue insufficient to judge depth of invasion
- No invasion of bladder wall
- No involvement of muscularis propria
- Benign deeper tissue
- Microscopic description problematic (non-invasion versus superficial invasion)
- Frond surfaced by transitional cell
- No mural infiltration
- No evidence of invasion (no sampled stroma)
- Confined to mucosa

AJCC T and EOD primary tumor is based on depth of invasion of the primary tumor



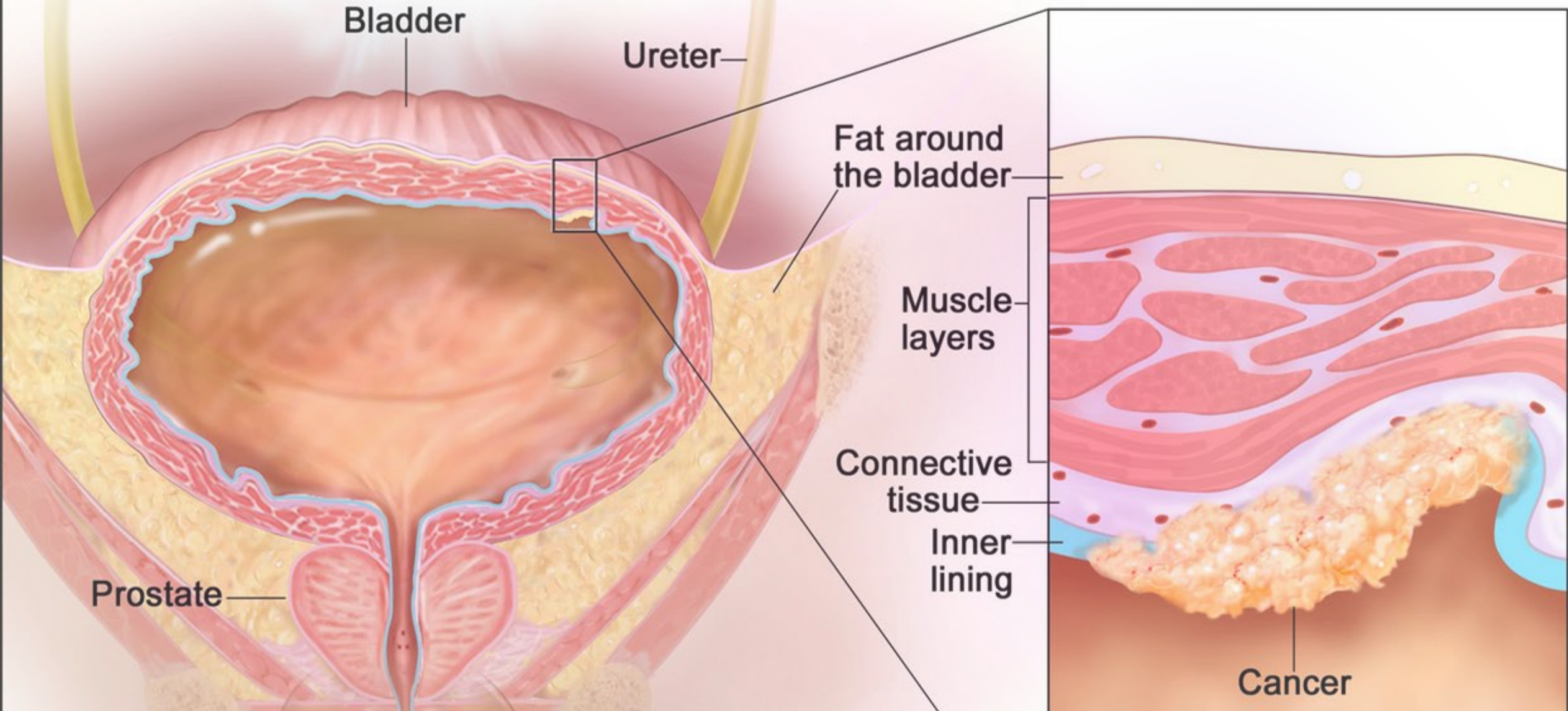
370	Muscle (muscularis propria) invaded, NOS of bladder only
400	Extension to distal ureter > Muscle (muscularis propria) invaded, NOS of bladder and/or distal ureter
450	Extension to perivesical fat/tissues (MICROSCOPIC) including > Adventitia > Distal periureteral tissue > Periprostic tissue > Peritoneum > Serosa (mesothelium) (to/through) > Tunica serosa (to/through)
500	Extravesical mass (Clinically or grossly apparent extravesical mass) Extension to perivesical fat/tissues (MACROSCOPIC) including > Adventitia > Distal periureteral tissue > Periprostic tissue > Peritoneum > Serosa (mesothelium) (to/through) > Tunica serosa (to/through)
550	Extension to perivesical fat/tissues, NOS (UNKNOWN if MICROSCOPIC or MACROSCOPIC), including > Adventitia > Distal periureteral tissue > Periprostic tissue > Peritoneum > Serosa (mesothelium) (to/through) > Tunica serosa (to/through)

Stage Group 0a / 0is



Cancer cells are found in tissue lining the inside of the bladder but have not invaded into the bladder wall.

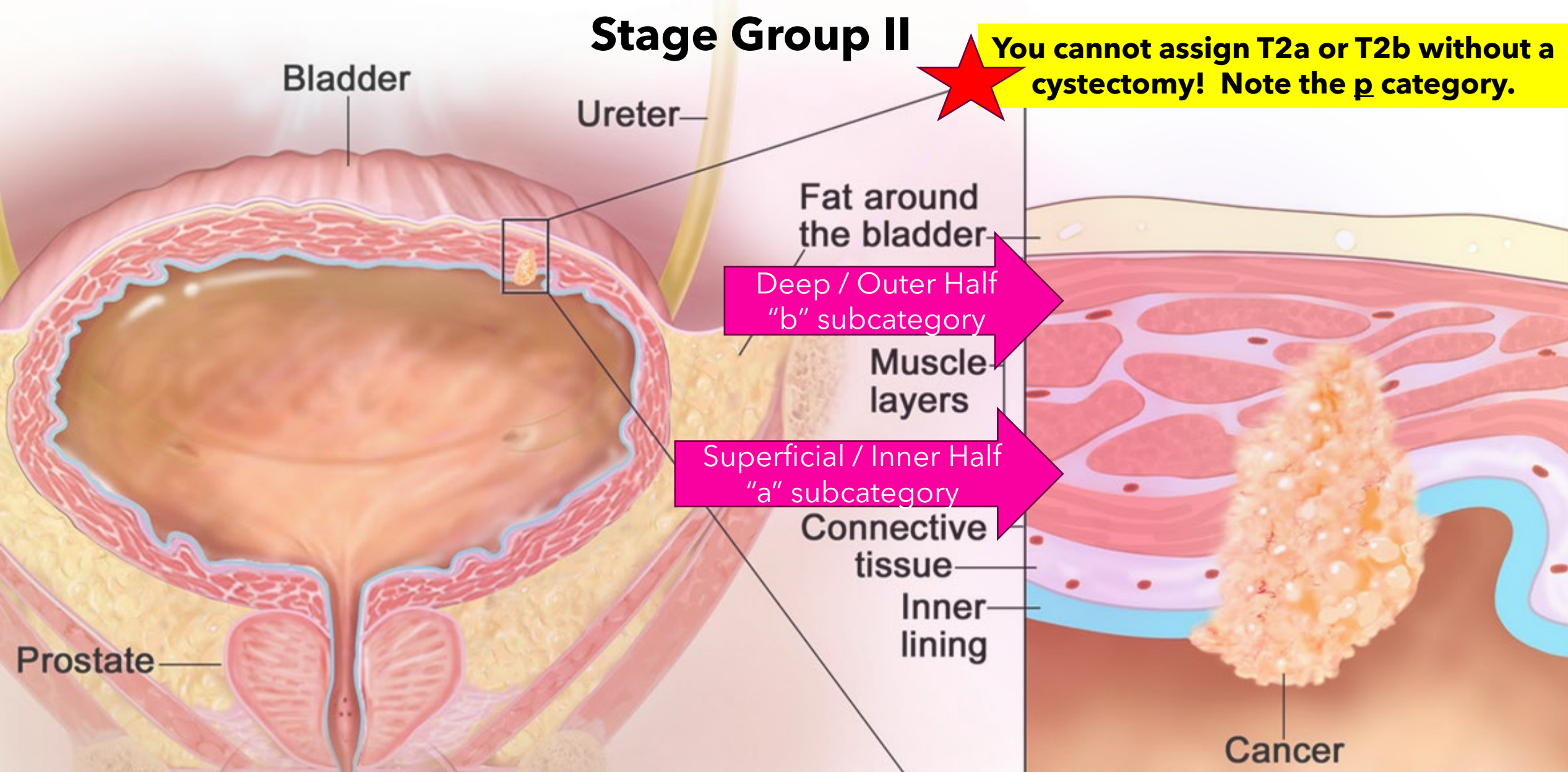
Stage Group I



Stage I bladder cancer (non-muscle-invasive bladder cancer). Cancer has spread into the connective tissue but has not reached the muscle layers of the bladder. T1 N0 M0 (I).

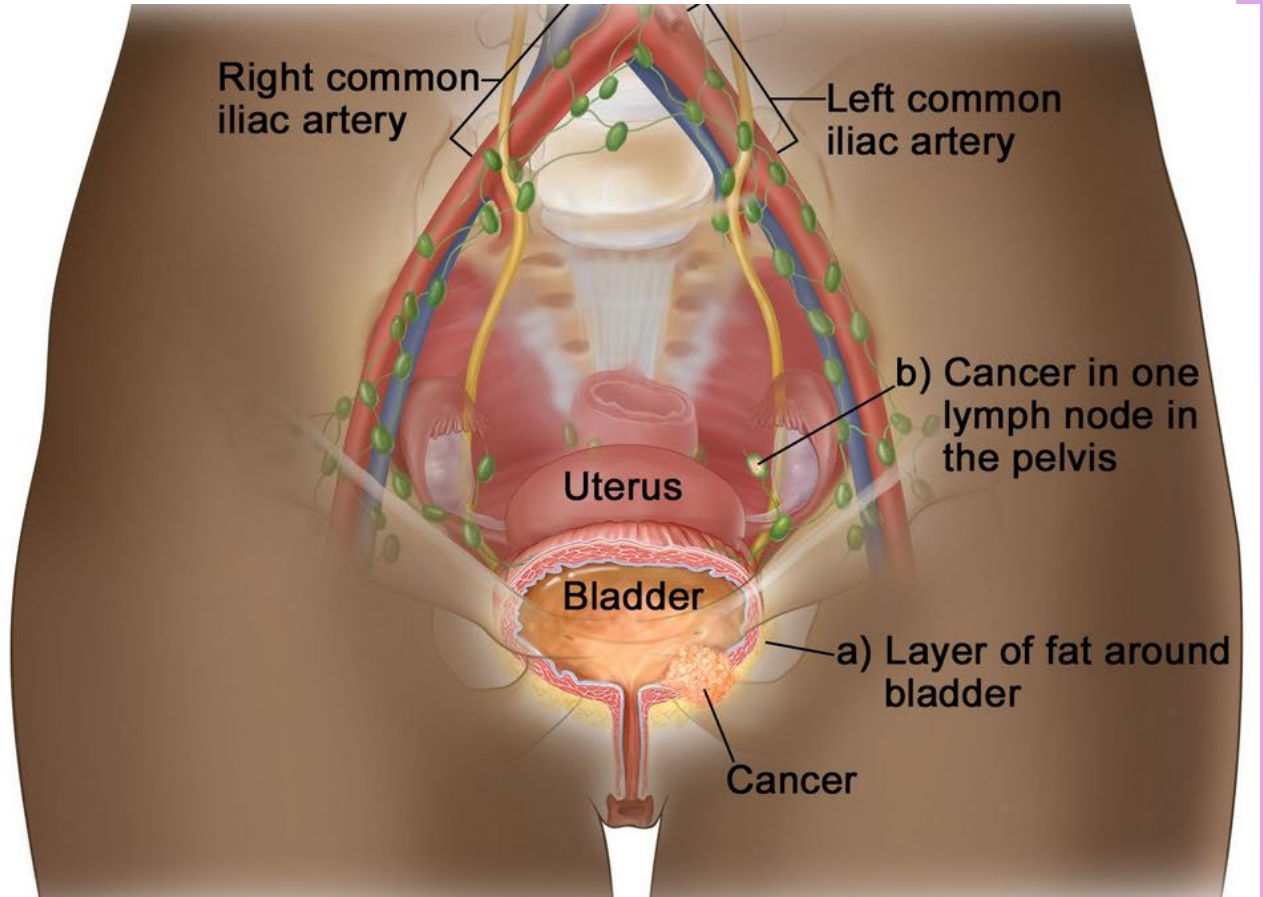
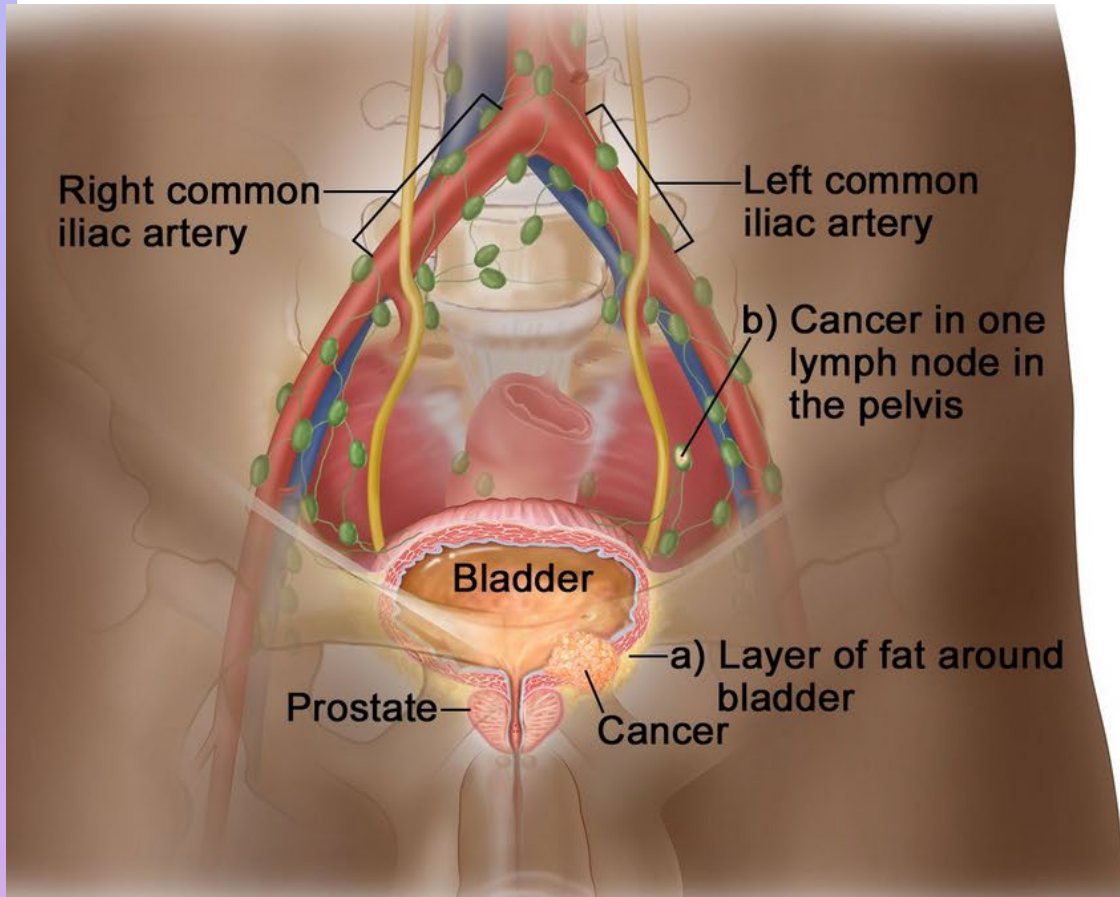
Stage Group II

You cannot assign T2a or T2b without a cystectomy! Note the p category.



Stage II bladder cancer (muscle-invasive bladder cancer). Cancer has spread through the connective tissue into the muscle layers of the bladder. T2/pT2a/pT2b N0 M0 (II)

Stage Group IIIA



Cancer has grown all the way through the bladder muscles and bladder wall into the layer of fat surrounding the bladder and may have spread to the reproductive organs (prostate, seminal vesicles, uterus, or vagina) but has not spread to lymph nodes. T3a/T3b/T4a N0 M0 (IIIA)

or

Cancer has spread to **one** primary drainage lymph node (excluding common iliac). T1-T4a N1 M0 (IIIA)

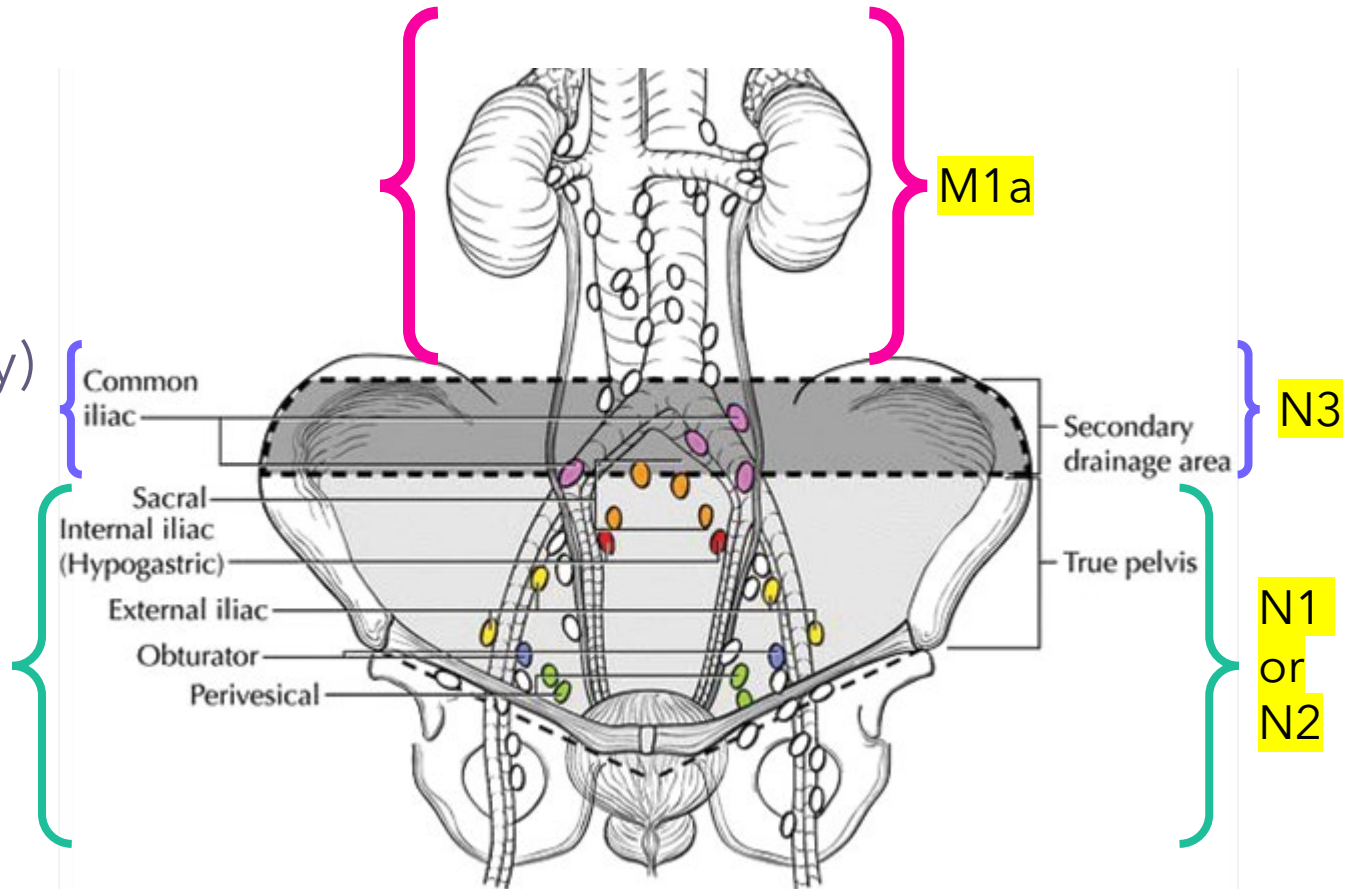
Regional Lymph Nodes

■ **Primary drainage**

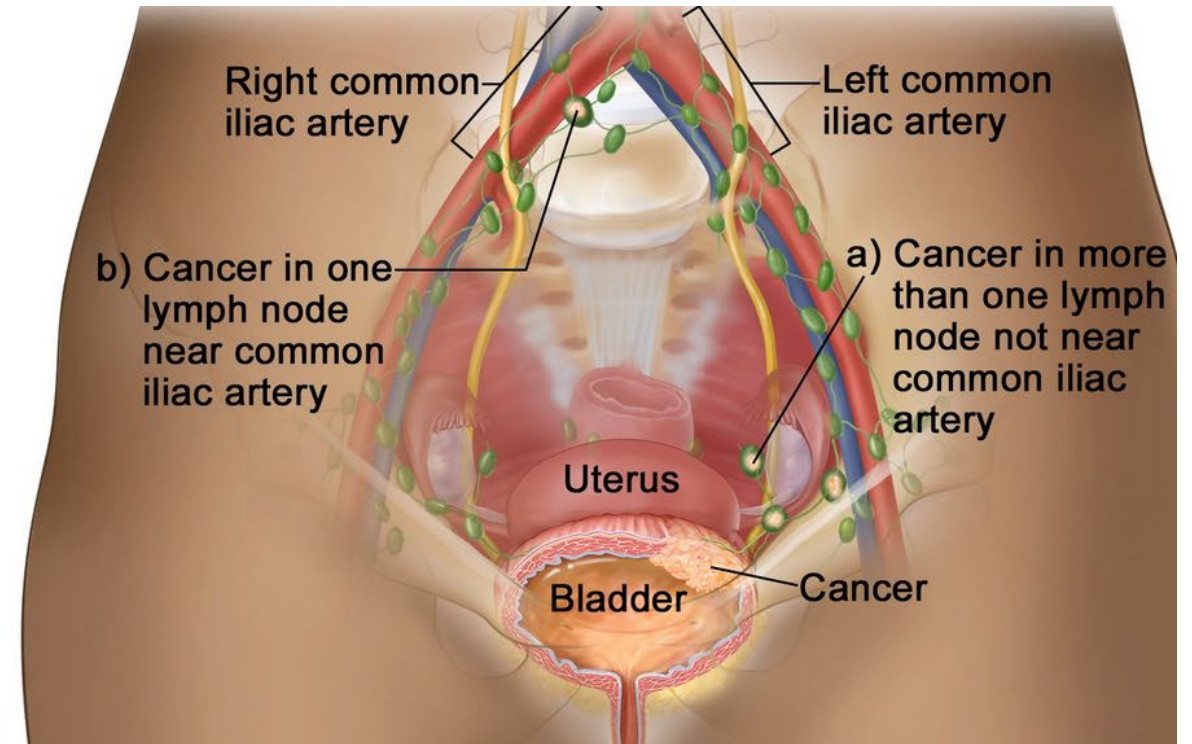
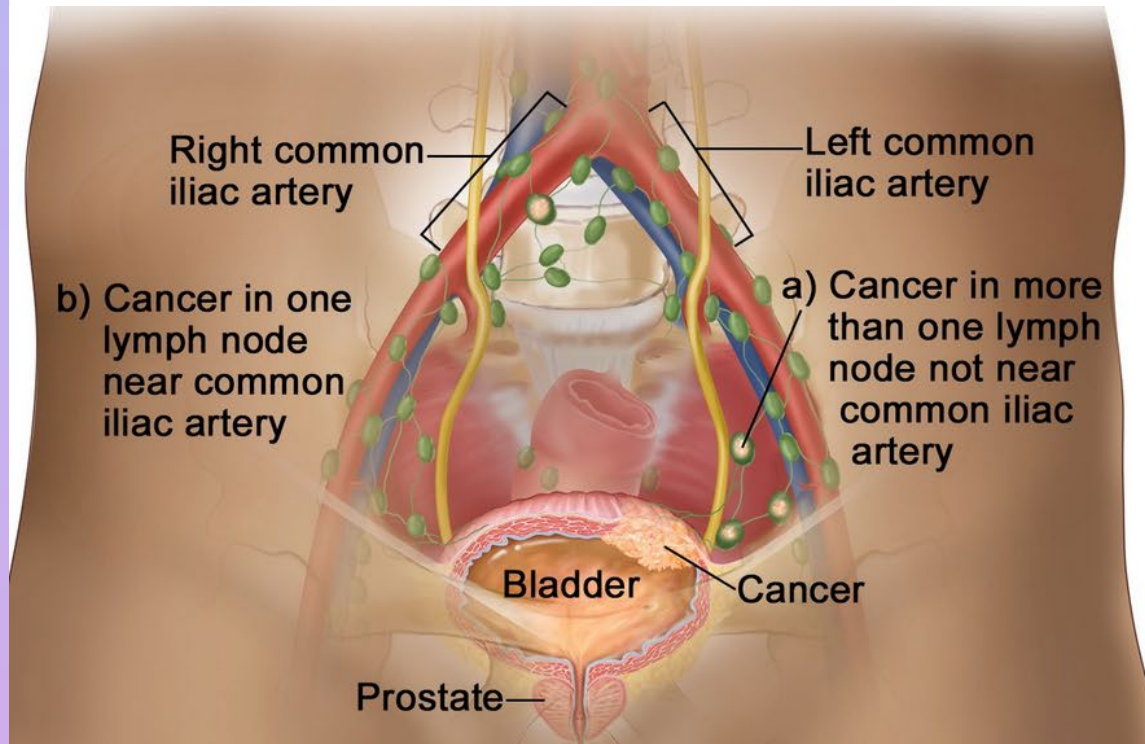
- Perivesical pelvic NOS
- Iliac (internal, external)
- Sacral (lateral, sacral promontory)
- Obturator
 - Single (N1), EOD N = 300
 - Multiple (N2), EOD N = 400

■ **Secondary drainage**

- Common iliac (N3), EOD N = 700



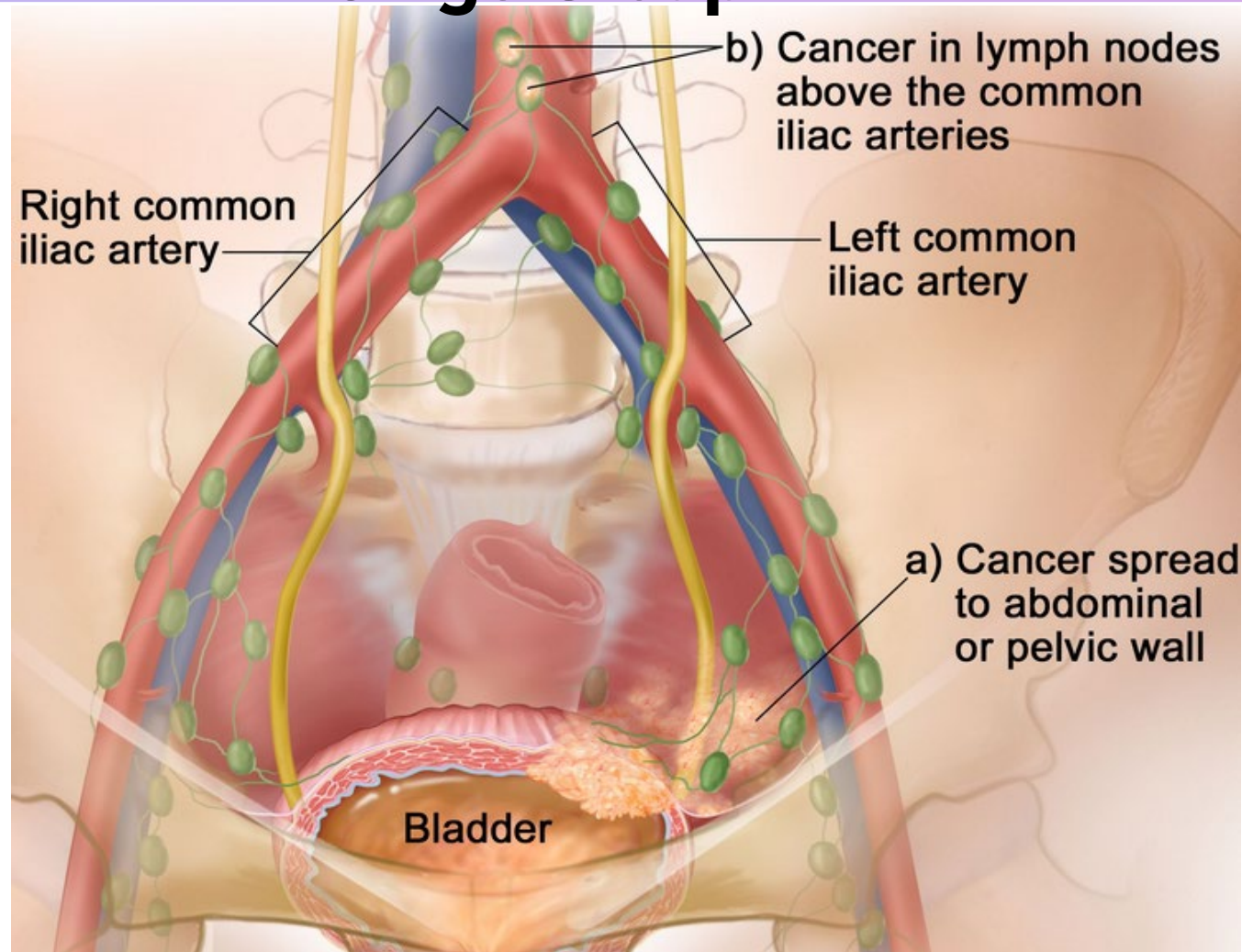
Stage Group IIIB



Cancer has spread to more than one lymph node in the pelvis excluding common iliac T1-T4 N2 M0 (IIIB)

Cancer has spread to the common iliac. T1-T4 N3 M0 (IIIB)

Stage Group IVA



Cancer has spread to the abdominal wall or pelvic wall T4b N(any) M0 (IVA)
or

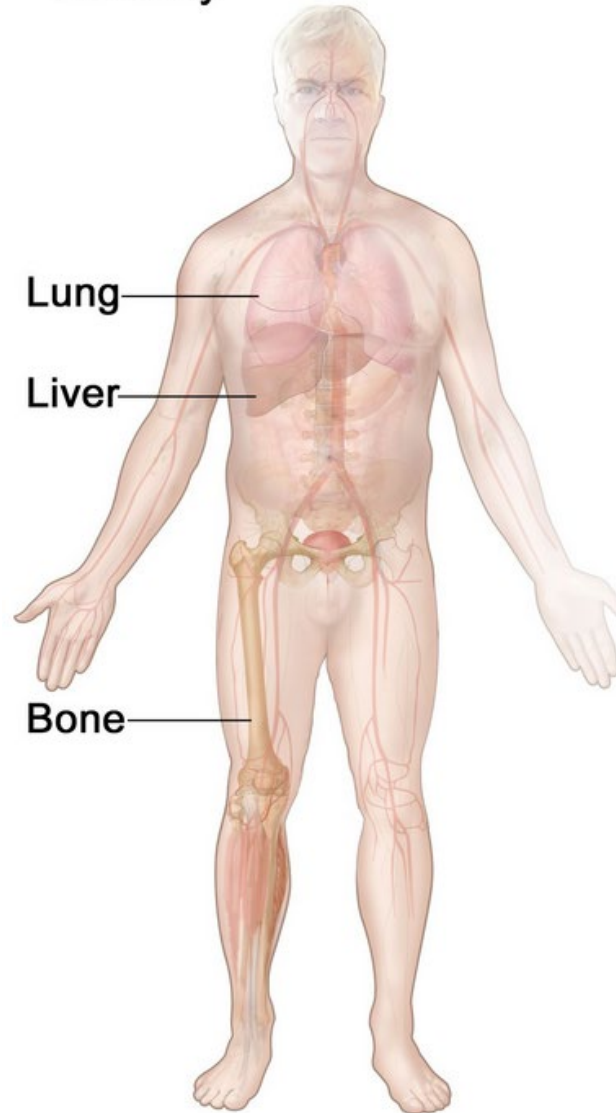
Cancer has spread to distant lymph nodes (nodes beyond the common iliac) or T(any) N(any) M1a (IVA)

Stage Group IVB

c) Spread to other parts of the body

Distant spread is most *common* to lung, bone and liver but can spread to other distant organs.

T(any) N(any) M1b (IVB)



2024 Resource

Bladder EOD v3.1 and 8th Edition AJCC Crosswalk 2024

EOD Primary Tumor	AJCC Primary Tumor	Description
000	Ta	Non invasive papillary carcinoma
050	Tis	Urothelial carcinoma in situ / CIS
100	T1	Confined to mucosa NOS
130	T1	Lamina propria Stroma Subepithelial connective tissue Submucosa Subserosa Tunica propria
150	T1	Localized, NOS
170	T1	Extension to distal ureter (Subepithelial connective tissue of bladder and/or distal ureter)
200	pT2a	PATHOLOGICAL assessment only (requires a cystectomy) Muscle (muscularis propria) of bladder only Superficial muscle - inner half

8th Edition AJCC

Definition of Primary Tumor (T)

T Category	T Criteria
TX	Primary tumor cannot be assessed
T0	No evidence of primary tumor
Ta	Non-invasive papillary carcinoma
Tis	Urothelial carcinoma <i>in situ</i> : “flat tumor”
T1	Tumor invades lamina propria (subepithelial connective tissue)
T2	Tumor invades muscularis propria
pT2a	Tumor invades superficial muscularis propria (inner half)
pT2b	Tumor invades deep muscularis propria (outer half)
T3	Tumor invades perivesical soft tissue
pT3a	Microscopically
pT3b	Macroscopically (extravesical mass)
T4	Extravesical tumor directly invades any of the following: prostatic stroma, seminal vesicles, uterus, vagina, pelvic wall, abdominal wall
T4a	Extravesical tumor invades directly into prostatic stroma, seminal vesicles, uterus, vagina
T4b	Extravesical tumor invades pelvic wall, abdominal wall

Definition of Regional Lymph Node (N)

N Category	N Criteria
NX	Lymph nodes cannot be assessed
N0	No lymph node metastasis
N1	Single regional lymph node metastasis in the true pelvis (perivesical, obturator, internal and external iliac, or sacral lymph node)
N2	Multiple regional lymph node metastasis in the true pelvis (perivesical, obturator, internal and external iliac, or sacral lymph node metastasis)
N3	Lymph node metastasis to the common iliac lymph nodes

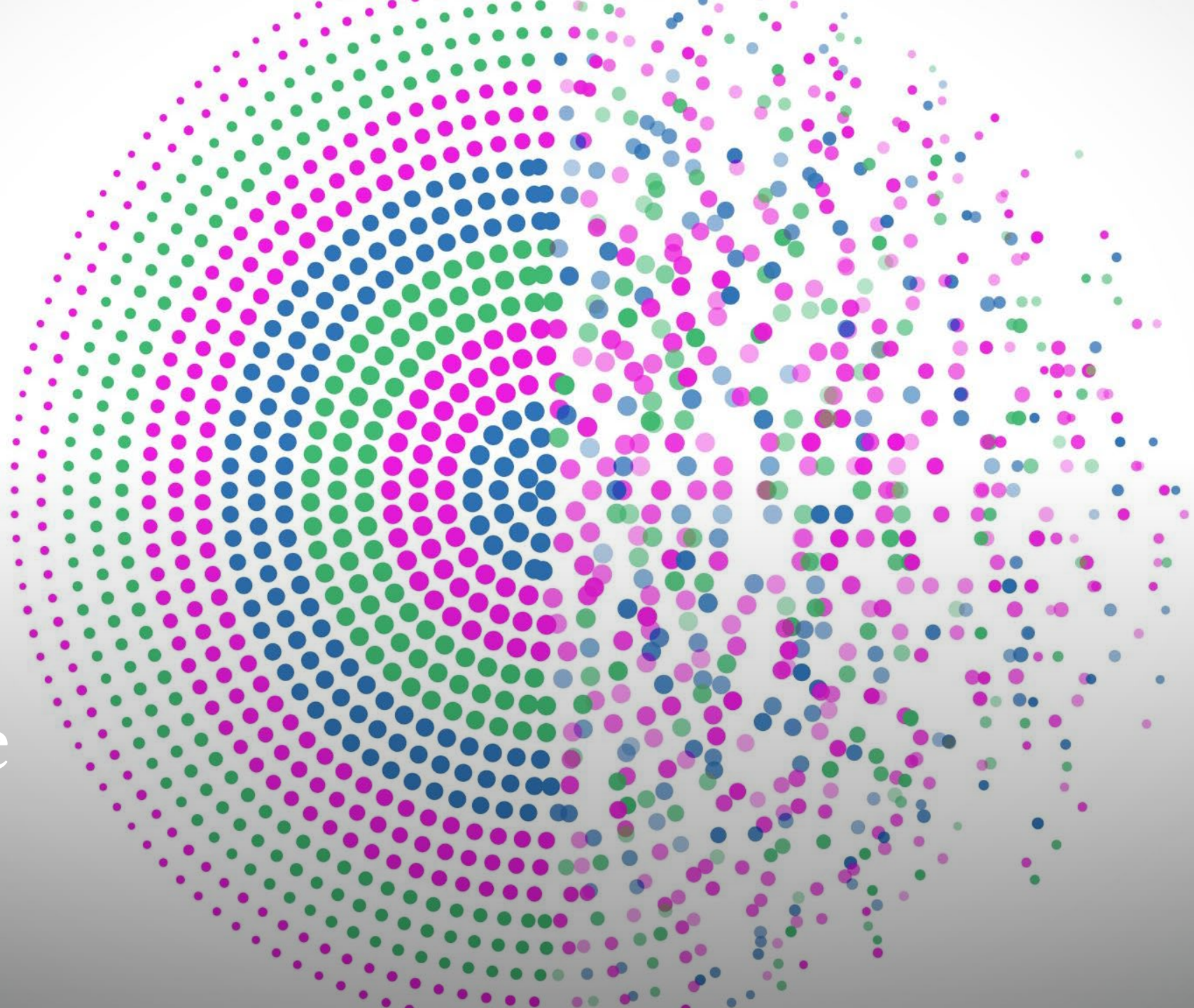
Definition of Distant Metastasis (M)

M Category	M Criteria
M0	No distant metastasis
M1	Distant metastasis
M1a	Distant metastasis limited to lymph nodes beyond the common iliacs
M1b	Non-lymph-node distant metastases

AJCC PROGNOSTIC STAGE GROUPS

When T is...	And N is...	And M is...	Then the stage group is...
Ta	N0	M0	0a
Tis	N0	M0	0is
T1	N0	M0	I
T2a	N0	M0	II
T2b	N0	M0	II
T3a, T3b, T4a	N0	M0	IIIA
T1-T4a	N1	M0	IIIA
T1-T4a	N2, N3	M0	IIIB
T4b	Any N	M0	IVA
Any T	Any N	M1a	IVA
Any T	Any N	M1b	IVB

Grade



Classifications for Grade

- **Clinical**

- Record the grade of a solid primary tumor before any treatment.
 - TURBT or Biopsy

- **Post-Therapy Clinical (yc)**

- Record the grade of a solid primary tumor that has been microscopically sampled following neoadjuvant therapy or primary systemic/radiation therapy. (Cases >1/1/21)
- This may include the grade from the post-therapy clinical workup (yc), as all information from the completion of neoadjuvant therapy (post-therapy clinical (yc)) through the surgical resection is used for post-therapy grade (yp).

- **Pathologic**

- Record the grade of a solid primary tumor that has been surgically resected and for which no neoadjuvant therapy was administered.
 - Cystectomy without NAC

- **Post-Therapy Pathologic (yp)**

- Record the grade of a solid primary tumor that has been resected following neoadjuvant therapy. Neoadjuvant therapy must meet National guidelines or standards, and not have been given for variable or unconventional reasons as noted on page 23 in the AJCC manual.
- Cystectomy after NAC



Answer Forum quick note on CLINICAL TRIALS and post-therapy pathologic staging (yp)....



pjs14

Grade Post Therapy Clin and Clinical Trials

02-18-22, 07:29 AM

Can/should neoadjuvant drug therapies be considered when assigning Grade Post Therapy Clin, if the drug administered is still in trials and has not yet been approved by the FDA?



Ruhlj
Member



02-14-23, 10:21 AM

First of all, many apologies for missing this question when it was first posted. 🙄

For neoadjuvant therapy, we follow the guidelines provided by AJCC on what is determined to be neoadjuvant therapy. I contacted AJCC regarding your question.

If they got the treatment for the length of time it should have been given, then you can record the grade information from the post-therapy clinical findings (Grade Post-Therapy Clin)) and the post-therapy surgical specimen (Grade Post-Therapy Path).

General Grade Coding Instructions for Solid Tumors

Listed below are general guidelines for coding all four new grade data items.

1. Code the grade from the primary tumor only
 - a. Do NOT code grade based on metastatic tumor or recurrence. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site
 - b. If primary site is unknown, code grade to 9.
2. If there is more than one grade available for an individual grade data item (i.e. within the same time frame)
 - a. Priority goes to the recommended AJCC grade listed in the applicable AJCC system
 - i. If none of the specified grades are from the recommended AJCC grade system, record the highest grade per applicable alternate grade categories for that site.
 - b. If there is no recommended AJCC grade for a particular site, code the highest grade per the applicable grade categories for that site.
3. In situ and/or combined in situ/invasive components:
 - a. If a grade is given for an in situ tumor, code it. Do NOT code grade for dysplasia such as high-grade dysplasia.
 - b. If there are both in situ and invasive components, code only the grade for the invasive portion even if its grade is unknown.
4. Priority for grade
 - a. Synoptic report (including CAP protocol)
 - b. Pathology report: final diagnosis
 - c. Physician statement
5. Systemic treatment and radiation can alter a tumor's grade. Therefore, it is important to code clinical grade based on information prior to neoadjuvant therapy even if grade is unknown during the clinical timeframe. Grade can now be collected in grade post therapy clinical (yc) when grade is available after neoadjuvant therapy and prior to surgical resection and grade post therapy pathological (yp) cases when grade is available from post neoadjuvant surgery.
6. If a case is sent out for consult and the grade results are different than the original case, record the results from the consult
 - a. *Example 1:* Patient had biopsy done at a facility which showed a moderately differentiated tumor. Slides were sent out for consult and their review showed a well differentiated tumor.
 - i. Record the well differentiated grade based on the consult

Per the Grade Manual, the preferred grading system for bladder cancers is based on histology of the primary site.

- **Urothelial Carcinomas**

- L – Low Grade
- H – High Grade
- 9 – Grade cannot be assessed or Unknown

- **Adenocarcinomas and Squamous Cell Carcinomas**

- 1 – Grade 1, Well Differentiated
- 2 – Grade 2, Moderately Differentiated
- 3 – Grade 3, Poorly Differentiated
- 9 – Grade cannot be assessed or Unknown

Pitfalls!

Case Scenarios

**YOU SPENT YOUR WHOLE
LIFE TRYING TO AVOID PITFALLS**



**YOU DIDN'T SEE THE
POTHOLE RIGHT IN FRONT OF YOU**

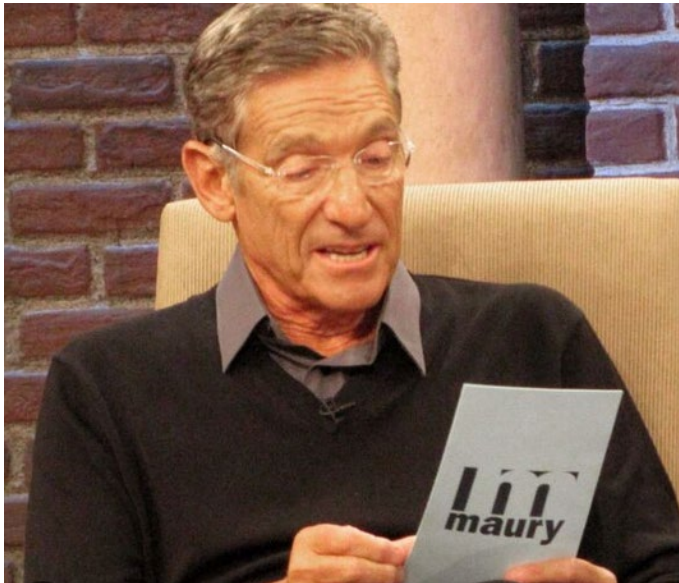
Case 1

64-year-old married, white, non-Hispanic, male current 2 ppd smoker, presents to Dr. Maury Povich's office (Urologist) for c/o gross hematuria. In office cystoscopy notes a 4 cm bladder tumor located on the left lateral wall. Dr. Maury Povich takes patient to Facility A to perform a TURBT which diagnoses patient with bladder cancer.

4/2/24 (Facility A) Transurethral resection of a 3 cm bladder tumor on the left lateral wall per Dr. Maury Povich.

S24-1234 (Facility A) 4/2/24 Bladder, Lateral Wall, TURBT: Invasive Urothelial Carcinoma, Micropapillary, Grade 1.

4/20/24 Dr. Maury Povich's follow up note: Patient returns in follow up with low grade micropapillary urothelial carcinoma. Discussed implications and treatment options. Given the low tumor burden, we will repeat cystoscopy every 3 months with TURBTs if warranted.



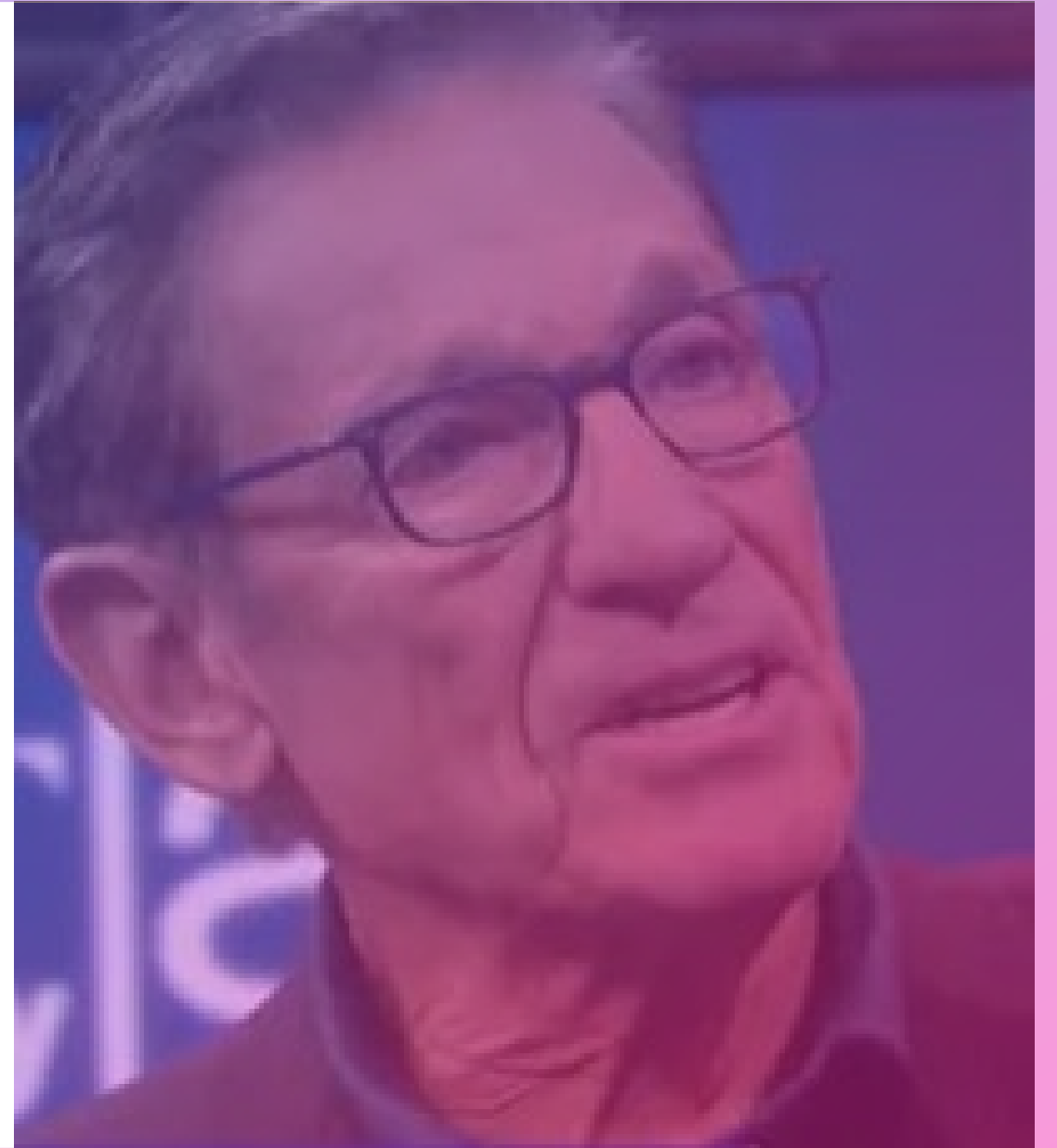
Questions:

1. What is the Histology Code?
2. What is the Clinical Grade?
3. What is the Pathologic Grade?

Answers:

1. Histology Code: 8131/3, Micropapillary Urothelial Carcinoma per path report and STR H1 (Table 2).
2. Clinical Grade: L, Low Grade per MD on 4/20/24 follow up note and grade manual.
3. Pathologic Grade: 9, not applicable.

Why is the clinical
grade coded to L
(low grade)?



Per the grade manual, the preferred grading system for bladder cancers is based on histology of the primary site.

- Urothelial Carcinomas
 - L – Low Grade
 - H – High Grade
 - 9 – Grade cannot be assessed or Unknown
- Adenocarcinomas and Squamous Cell Carcinomas
 - 1 – Grade 1, Well Differentiated
 - 2 – Grade 2, Moderately Differentiated
 - 3 – Grade 3, Poorly Differentiated
 - 9 – Grade cannot be assessed or Unknown

Using the Solid Tumor Rules, Table 2, the histology ‘Micropapillary Urothelial Carcinoma’ is a subtype “Urothelial Carcinoma”. Therefore, the preferred grading system is Urothelial Carcinomas

Specific and NOS Histology Codes	Synonyms	Subtypes/Variants
Squamous cell carcinoma 8070	Pure squamous cell carcinoma SCC Pure squamous carcinoma of urothelial tract	Verrucous carcinoma 8051
Urothelial carcinoma 8120 <i>Note 1:</i> Previously called transitional cell carcinoma, a term that is no longer recommended. <i>Note 2:</i> Micropapillary 8131 is a subtype/variant of papillary urothelial carcinoma 8130. It is an invasive /3 neoplasm with aggressive behavior. <i>Note 3:</i> The histology term is exactly Plasmacytoid/signet ring cell/diffuse variant. All three terms are used together to indicate a specific variant (coded 8082/3).	Clear cell (glycogen-rich) urothelial carcinoma 8120/3 Conventional urothelial carcinoma 8120/3 Infiltrating urothelial carcinoma 8120/3 Infiltrating urothelial carcinoma with divergent differentiation 8120/3 Infiltrating urothelial carcinoma with endodermal sinus lines 8120/3 Infiltrating urothelial carcinoma with glandular differentiation 8120/3 Infiltrating urothelial carcinoma with squamous differentiation 8120/3 Infiltrating urothelial carcinoma with trophoblastic differentiation 8120/3 Large nested urothelial carcinoma 8120/3	Giant cell urothelial carcinoma 8031/3 Lymphoepithelioma-like urothelial carcinoma 8082/3 Plasmacytoid/signet ring cell/diffuse variant (see Note 3) Papillary urothelial (transitional cell) carcinoma in situ 8130/2 invasive 8130/3 low-grade papillary urothelial carcinoma with inverted growth pattern 8130/2 non-invasive papillary urothelial carcinoma, high-grade 8130/2 non-invasive papillary urothelial carcinoma, low-grade 8130/2 Micropapillary urothelial carcinoma 8131/3 Plasmacytoid urothelial carcinoma/ sarcomatoid urothelial carcinoma 8122/3 Poorly differentiated carcinoma/poorly differentiated urachal carcinoma 8020/3

- Urothelial Carcinomas
 - L – Low Grade
 - H – High Grade
 - 9 – Grade cannot be assessed or Unknown

- Per Path S24-1234 (Facility A) 4/2/24 Bladder, Lateral Wall, TURBT: Invasive Urothelial Carcinoma, Micropapillary, **Grade 1**. Grade 1 is not a preferred grading system for Urothelial Carcinomas.
- HOWEVER, on 4/20/24 Dr. Maury Povich’s follow up note: Patient returns in follow up with **low grade** micropapillary urothelial carcinoma. Discussed implications and treatment options. Given the low tumor burden, we will repeat cystoscopy every 3 months with TURBTs if warranted.
- Per page 21 of the Grade Coding Instructions, General Grade Coding Instructions for Solid Tumors, note 2 states:
 - If there is more than one grade available for an individual grade data item (within the same time frame)
 - Priority goes to the recommended AJCC grade listed in the applicable AJCC system.
- Therefore, we can code the **CLINICAL GRADE** to L, low grade as stated by the treating physician.

HISTOLOGIC GRADE (G)

Urothelial Histologies

For urothelial histologies, a low- and high-grade designation is used to match the current WHO/ISUP recommended grading system.

G	G Definition
LG	Low-grade
HG	High-grade

Squamous Cell Carcinoma and Adenocarcinoma

For squamous cell carcinoma and adenocarcinoma, the following grading schema is recommended:

G	G Definition
GX	Grade cannot be assessed
G1	Well differentiated
G2	Moderately differentiated
G3	Poorly differentiated

CAnswer Forum

- Generic grade used on biopsy, preferred grade used in physician note after - CAnswer Forum (facs.org)
 - <https://cancerbulletin.facs.org/forums/node/139743>

Generic grade used on biopsy, preferred grade used in physician note after

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bharris1377
Member
Join Date: Mar 2022
Posts: 62

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Generic grade used on biopsy, preferred grade used in physician note after
04-28-23, 01:11 PM
#1

Hi,

Clinical grade question.

Patient had breast bx reporting IDC well differentiated. Physician note following up after biopsy states pt has IDC grade 1.

In the grade manual under the general grade coding instructions for solid tumors, Number 2 states "if there is more than one grade available for an individual grade data item (within the same time frame) priority goes to the recommended AJCC grade listed in the applicable AJCC system."


and Number 4 states "priority for grade:
a) synoptic report
b) pathology report: final diagnosis
c) physician statement"

So my question is, do I prioritize (according to rule 4) well differentiated because it comes from the path report and that is prioritized over physician statement OR do I prioritize (according to rule 2) grade 1 because that is the preferred grade system?

Thank you!

Tags: None

99 Quote 0 Like



Ruhlj

05-01-23, 05:08 AM
#2

Rule 2 applies so you stop there. Code G1 based on the physician statement.

CAnswer Forum

[Pathology uses generic grade term, managing physician uses preferred grade term - CAnswer Forum \(facs.org\)](https://cancerbulletin.facs.org/forums/node/130112)

<https://cancerbulletin.facs.org/forums/node/130112>

Pathology uses generic grade term, managing physician uses preferred grade term

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keriagrier
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Pathology uses generic grade term, managing physician uses preferred grade term

07-27-22, 08:35 AM

Can we take the clinical grade from a physician statement when it differs from the path report? A generic grade term is used on the biopsy pathology report but the managing physician uses a preferred term.


04/22/2022 Breast core biopsy: Well differentiated to moderately differentiated invasive mammary carcinoma.
05/01/2022 Oncology consult: "Patient has a grade 1 invasive ductal carcinoma."
05/09/2022 Breast lumpectomy: Grade 1 invasive ductal carcinoma.

In the clinical grade we have coded B for moderately differentiated.
In the pathological grade we have coded 1.

Question: Can we code the clinical grade to 1 based on the managing MD statement or must the grade come from the path report?

Tags: None

Quote Like 0



Ruhlj
Member

07-28-22, 04:40 AM

Yes, you can use the physician's documentation and code to Clinical Grade 1.

Remember to read the General Grading Coding Instructions for Solid Tumors on Page 21 of Grade Manual v3.1

General Grade Coding Instructions for Solid Tumors

Listed below are general guidelines for coding all four new grade data items.

1. Code the grade from the primary tumor only
 - a. Do NOT code grade based on metastatic tumor or recurrence. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site
 - b. If primary site is unknown, code grade to 9
 - c. If a range is given for a grade (e.g., 1-2 or 2-3), code the higher grade
2. If there is more than one grade available for an individual grade data item (i.e., within the same time frame)
 - a. Priority goes to the recommended AJCC grade listed in the applicable AJCC system
 - i. If none of the specified grades are from the recommended AJCC grade system, record the highest grade per applicable alternate grade categories for that site.
 - b. If there is no recommended AJCC grade for a particular site, code the highest grade per the applicable grade categories for that site.

Why is the pathologic grade coded to 9 (grade cannot be assessed / unknown)?

To *pathologically grade* a bladder cancer, the patient must have a cystectomy (either partial, simple/total/complete, or pelvic exenteration) without neoadjuvant treatment.

Transurethral resection of a bladder tumor (TURBT) does not qualify as surgical resection.

TURBT/TURBs will only provide you clinical grade. See page 157 of grade manual or SEER*RSA.



74-year-old divorced, white, Hispanic, female presents to Dr. Julia Roberts with c/o pain with urination. In office cystoscopy noted a bladder tumor.

6/8/24 (Facility B) In-Office cystoscopy: Large bladder tumor present. TURBT recommended.

6/10/24 (Facility B) Transurethral Resection of Bladder Tumors per Dr. Julia Roberts: An ulcerated, 2.5 cm sessile mass was noted in the right lateral wall. Mass was friable. Using the resectoscope I widely resected this area. Total resection was about 3 cm.

6/20/24 (Facility B) CT Abdomen/ Pelvis: Negative.

S24-4321 (Facility B) 6/10/24 Final Diagnosis

1. Right Lateral Wall Bladder tumor, TURBT:

- A. Focally ulcerated invasive high-grade urothelial carcinoma.
- B. Carcinoma invades muscularis propria.
- C. No lymphovascular space invasion identified.

SPECIMEN

Procedure: Transurethral resection of bladder (TURBT)

TUMOR

Tumor Site: Right lateral wall

Histologic Type: Urothelial carcinoma, invasive

Histologic Grade: High-grade

Tumor Extent: Invades muscularis propria

Lymphovascular Invasion: Not identified

Tumor Configuration: Flat, Ulcerated

Question:

1. What is the EOD primary tumor?
2. What is the AJCC Clinical Stage?

EOD Primary Tumor:

Per the pathology report, the tumor invades the muscularis propria, but we do not know if it invades the superficial muscle (inner half) or the deep muscle (outer half).

Note 5: Invasion of the muscularis propria

- › Coding of the involvement of the muscularis propria is divided into superficial muscle (inner half) and deep muscle (outer half). This distinction can only be made when a cystectomy is done
 - › If only a TURB is done and states "invasion of the muscularis propria," code to 370
 - › If there is "invasion of the muscularis propria" and the distal ureter is involved, code to 400
 - › If there is a TURB only and the pathologist/physician documents superficial muscle or deep muscle, code to 370 or 400 as appropriate.
- › Codes 200, 250, 300, 350 should only be used when a cystectomy has been done

Even if the treating physician or pathologist state "superficial" or "deep" invasion is present on the TURBT, we are instructed to code either 370 or 400 as appropriate.

8th Edition AJCC Clinical T Category:

Definition of Primary Tumor (T)

T Category	T Criteria
TX	Primary tumor cannot be assessed
T0	No evidence of primary tumor
Ta	Non-invasive papillary carcinoma
Tis	Urothelial carcinoma <i>in situ</i> : “flat tumor”
T1	Tumor invades lamina propria (subepithelial connective tissue)
T2	Tumor invades muscularis propria
pT2a	Tumor invades superficial muscularis propria (inner half)
pT2b	Tumor invades deep muscularis propria (outer half)
T3	Tumor invades perivesical soft tissue
pT3a	Microscopically
pT3b	Macroscopically (extravesical mass)
T4	Extravesical tumor directly invades any of the following: prostatic stroma, seminal vesicles, uterus, vagina, pelvic wall, abdominal wall
T4a	Extravesical tumor invades directly into prostatic stroma, seminal vesicles, uterus, vagina
T4b	Extravesical tumor invades pelvic wall, abdominal wall

Definition of Regional Lymph Node (N)

N Category	N Criteria
NX	Lymph nodes cannot be assessed
N0	No lymph node metastasis
N1	Single regional lymph node metastasis in the true pelvis (perivesical, obturator, internal and external iliac, or sacral lymph node)
N2	Multiple regional lymph node metastasis in the true pelvis (perivesical, obturator, internal and external iliac, or sacral lymph node metastasis)
N3	Lymph node metastasis to the common iliac lymph nodes

Definition of Distant Metastasis (M)

M Category	M Criteria
M0	No distant metastasis
M1	Distant metastasis
M1a	Distant metastasis limited to lymph nodes beyond the common iliacs
M1b	Non-lymph-node distant metastases

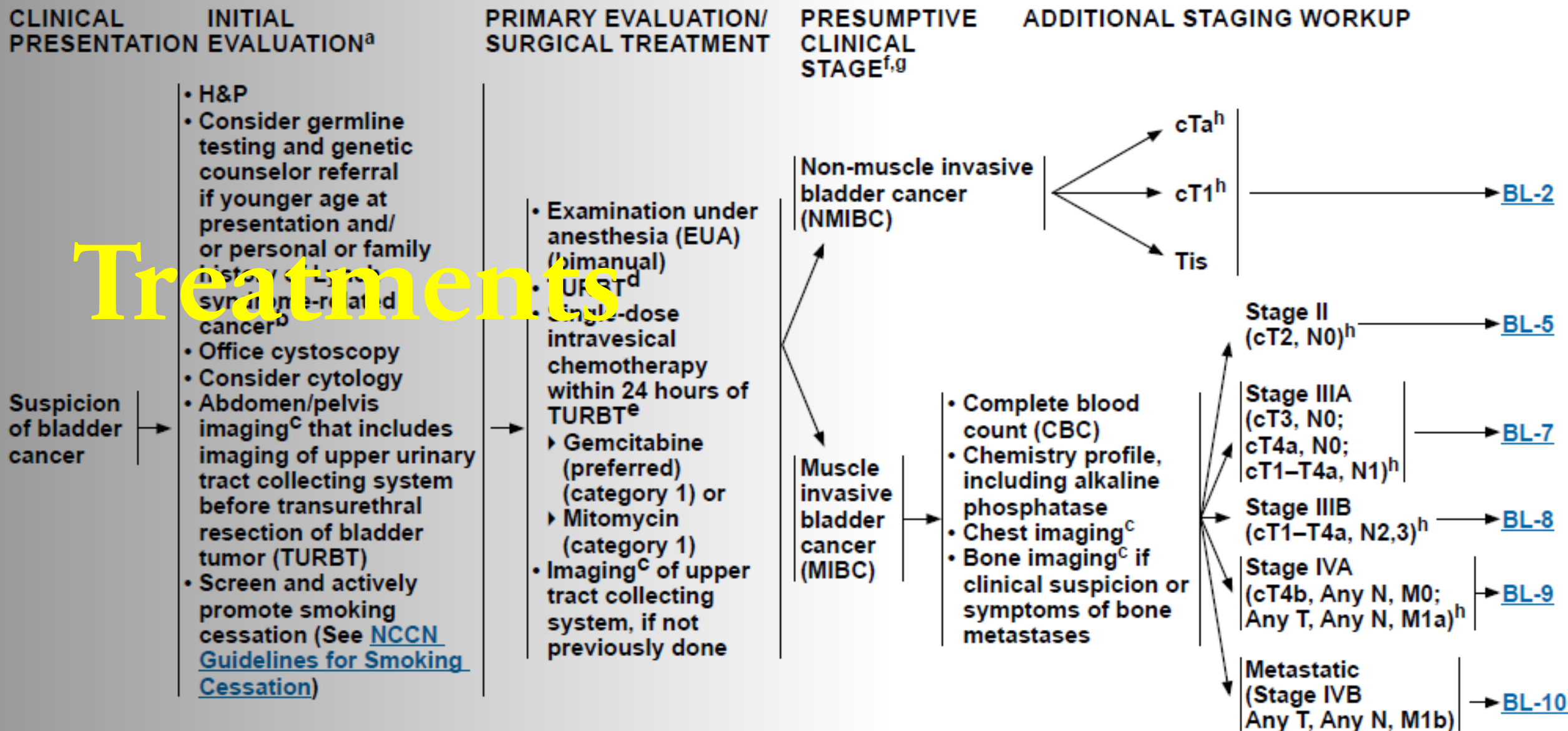
AJCC PROGNOSTIC STAGE GROUPS

When T is...	And N is...	And M is...	Then the stage group is...
Ta	N0	M0	0a
Tis	N0	M0	0is
T1	N0	M0	I
T2a	N0	M0	II
T2b	N0	M0	II
T3a, T3b, T4a	N0	M0	IIIA
T1-T4a	N1	M0	IIIA
T1-T4a	N2, N3	M0	IIIB
T4b	Any N	M0	IVA
Any T	Any N	M1a	IVA
Any T	Any N	M1b	IVB

8th Edition AJCC Clinical Stage: T2 N0 M0 (II)



Treatments



- **Watchful Waiting/Active Surveillance with repeat cystoscopies and TURBTs if warranted**
- **BCG (tumor destruction and immunotherapy)**
- **Mitomycin (single-agent chemotherapy)**
- **Cystectomy (total or partial*)**
- **Cisplatin-based chemotherapy regimen [DDMVAC (dose-dense methotrexate, vinblastine, doxorubicin, and cisplatin) with growth factor support for 3-6 cycles OR Gemcitabine and cisplatin for 4 cycles]**
- **Nivolumab or Pembrolizumab**
- **Radiation Therapy with concurrent chemotherapy**

*Partial cystectomies are only for highly selected cases and pelvic lymphadenectomy should be performed.

Pitfall!

Bacillus Calmette-Guerin (BCG) coding

Case Therapy Edit Form (Surgery - STORE 2024)

987-65-4321, KING KONG

[Type of Therapy](#)
[Course](#)

S
F

[Date Therapy Started](#)

04/02/2024

[Therapy Facility](#)

FACILITY A

[Therapy Local Hospital Id](#)

90201 TRAINING DATABASE

[Surgery Primary Site \(STORE 2024\)](#)

A160 Bacillus Calmette-Guerin (BCG) or other immunotherapy

[Scope Regional LN \(STORE 2024\)](#)

0 None

[Surgery Other Site \(STORE 2024\)](#)

0 None

[Surgical Margins \(STORE 2024\)](#)

9 Unknown or not applicable

[Surgical Approach 2010](#)

3 Endoscopic or laparoscopic

[Treatment Notes](#)

BCG treatment per Maury Povich MD on 4/2/24 at Facility A. [TS 4/5/24]

[Type of Therapy](#)
[Course](#)

I
F

[Date Therapy Started](#)

04/02/2024

[Therapy Facility](#)

FACILITY A

[Therapy Local Hospital Id](#)

90201 TRAINING DATABASE

[Immunotherapy Code](#)

1 Immunotherapy agents, NOS

[Treatment Notes](#)

BCG treatment at Facility A per Maury Povich MD on 4/2/24. [TS 4/5/24]

[Therapy Clinical Trial Number](#)

0 None or unknown

A100 Local tumor destruction, NOS

A111 Photodynamic therapy (PDT)

A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

A130 Cryosurgery

A140 Laser

A150 Intravesical therapy

A160 Bacillus Calmette-Guerin (BCG) or other immunotherapy

Also code the introduction of immunotherapy in the immunotherapy items. If immunotherapy is followed by surgery of the type coded A200-A800 code that surgery instead and code the immunotherapy only as immunotherapy.



PRINCIPLES OF SURGICAL MANAGEMENT

Transurethral Resection of the Prostate (TURP)

- Primary treatment option for urothelial carcinoma of the prostate with ductal/acini or prostatic urethral pathology.
- Postsurgical intravesical BCG is recommended ([see Principles of Instillation Therapy \[BL-F\]](#)).

TUR of the Urethral Tumor

- Primary treatment of Tis, Ta, T1 primary carcinoma of the urethra.
- Patients with a prior radical cystectomy and a cutaneous diversion should consider a total urethrectomy.
- Consider postsurgical intraurethral therapy ([see Principles of Instillation Therapy \[BL-F\]](#)).

Partial Cystectomy

- May be used for cT2 muscle invasive disease with solitary lesion in location amenable to segmental resection with adequate margins, in appropriately selected patients. May also be appropriate in other select situations including cancer in a bladder diverticulum.
- No CIS as determined by random biopsies.
- Bilateral pelvic lymphadenectomy should be performed.

Radical Cystectomy/Cystoprostatectomy

- In non-muscle invasive disease, radical cystectomy is generally reserved for residual high-grade cT1, subtype histology, lymphovascular invasion, concomitant CIS, and BCG-unresponsive disease.
- Cystectomy should be done within 3 months of diagnosis if no therapy is given.
- Primary treatment option for cT2, cT3, and cT4a disease. Highly select patients with cT4b disease that responds to primary treatment may be eligible for cystectomy.
- Bilateral pelvic lymphadenectomy should be performed.
- In appropriately selected patients, approaches that preserve the uterus, vagina, and/or ovaries should be employed when feasible.

Radical Nephroureterectomy with Cuff of Bladder

- Primary treatment option for non-metastatic high-grade upper GU tract tumors.

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

Conclusion

- TURBTs will only provide clinical information.
- Assign EOD primary tumor codes 370 and 400 muscularis propria invasion for TURBTs even if you have a statement from treating physician or pathologist indicating superficial or deep invasion.
- Use Table 2 of the solid tumor rules for coding the correct histology code.
- BCG treatments are coded as a surgery AND immunotherapy.

■ Questions?

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