March 2024

Missouri Cancer Registry and Research Center
Show-Me-Tips

Coding...Abstracting...Education…

Ed 24:01
Liver & Bile Ducts

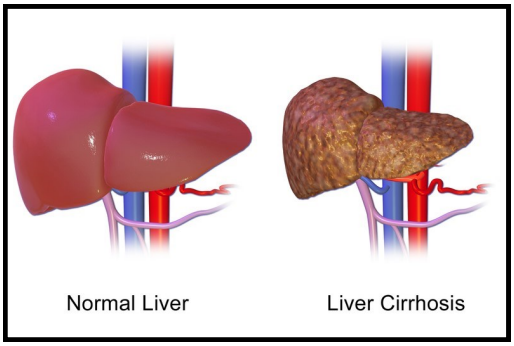
Liver and Bile Ducts

Diagnosing Hepatocellular Carcinoma

Populations at risk are those with liver cirrhosis

May present with non-specific symptoms

- Jaundice
- Anorexia
- Malaise
- Upper abdominal pain
- Hepatomegaly
- Ascites



https://commons.wikimedia.org/wiki/File:Liver_Cirrhosis.png

LI-RADS Ultrasound

- LI-RADS are used for patients who have **cirrhosis** or who are at **high risk of developing Hepatocellular Carcinoma**
- LI-RADS for US range from 1-3; may also have a letter from A-C to represent liver visualization scores

LI-RADS CT/MRI Categories

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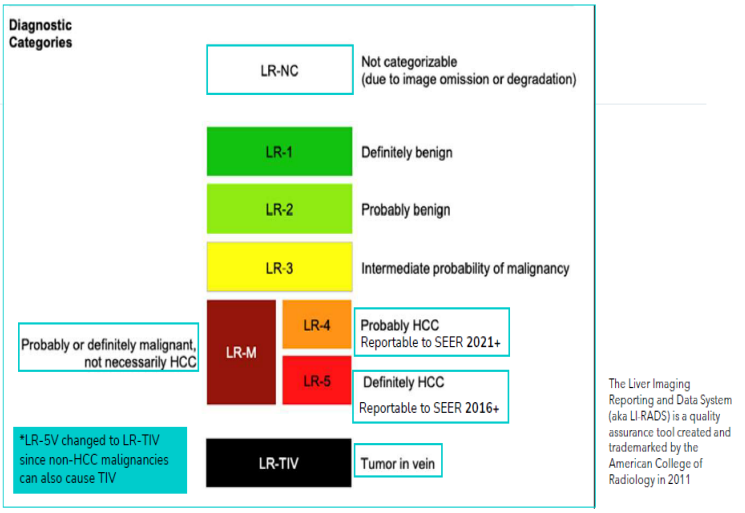

STORE 2023 posted 6/28/23 and STORE 2024

PI Rads, BI Rads, **LI Rads alone** are not reportable for CoC. PI Rads, BI Rads, **LI Rads confirmed** with biopsy **OR** physician statement are reportable to CoC. When confirmed, date of diagnosis is the date of the PI Rads, BI Rads, LI Rads imaging. Date of diagnosis is the date of the positive biopsy.

For SEER, use the date of the LR-4 or LR-5 as the date of diagnosis. If all you have is LR-4 or LR-5, the case is not reportable to the CoC and would be reported as a non-analytic case. For STORE, don't report the case based only on LR-4 or LR-5. Once you have either physician confirmation or confirmation via path. it is reportable to the CoC. If you also report to SEER, you need to make sure you document the dates well so when the central registry links and consolidates the case they will be able to enter the correct date of diagnosis when they send the case to SEER

NAACCR Webinar: Liver and Bile Ducts 2024 presented January 2024 Q & A

Topography Codes/AJCC Chapter

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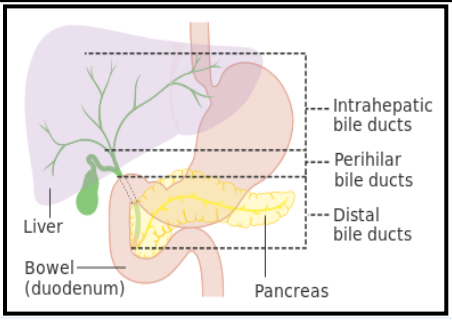
- **C22.0** Liver **(Chapter 22)**
- **C22.1** Intrahepatic Bile Duct **(Chapter 23)**
- **C24.0** Cystic Duct **(Chapter 24)**
- **C24.0** Perihilar Bile Duct **(Chapter 25)**
  - Right and Left Hepatic Duct
  - Junction of Left and Right Duct
  - Common Hepatic Bile Duct
- **C24.0** Distal Bile Duct **(Chapter 26)**

Same topography code, different AJCC Chapter



https://commons.wikimedia.org/wiki/File:Diagram_showing_the_groups_of_bile_ducts_CRUK_302.svg

This project was supported in part by a cooperative agreement between the Centers for Disease Control and Prevention (CDC) and the Missouri Department of Health and Senior Services (DHSS) (NU58DP007130-02) and a Surveillance Contract between DHSS and the University of Missouri.

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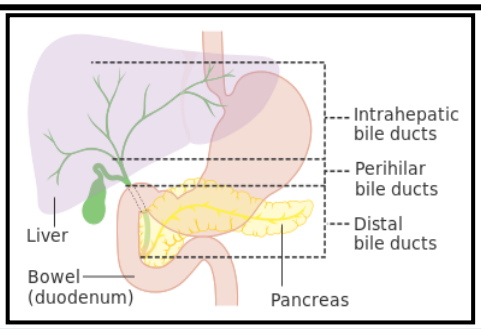
Liver & Bile Ducts

Primary of Right or Left Hepatic Bile Duct is Intrahepatic

- What AJCC Protocol is being used?
- What pathology template is being used?
- What did the physician say?
- If no clinical information, code C24.0 (perihilar)
- If unknown if intrahepatic, code C24.0 (perihilar)

Outside the liver is Perihilar (C24.0)

Note: If primary site is Perihilar C24.0 a schema discriminator is required



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https://commons.wikimedia.org/wiki/File:Diagram_showing_the_groups_of_bile_ducts_CRUK_302.svg

Solid Tumor Rules - Other Sites

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- Set of Rules used is based on **Date** of Diagnosis
- Tumors diagnosed **01/01/2007 through 12/31/2022**: Use 2007 MPH Rules and 2007 General Instructions (See Note 2 in Solid Tumor Rules)
- Tumors diagnosed **01/01/2023 and later**: Use the most current version of the Solid Tumor Rules and Solid Tumor General Instructions

Example: You are abstracting a case on 2/10/24. Patient has a history of cholangiocarcinoma of the intrahepatic bile duct on 3/15/2021. The patient is found to have a new cholangiocarcinoma of the intrahepatic bile duct on 10/4/2023.
Questions - Which manual would be used to determine if this is a new primary? What manual do you use to determine if the patient has a second primary? **Answer** - Solid Tumor Rules 2024 update

New for 2024

Guidelines for assigning primary sites for liver and intrahepatic bile duct neoplasms based on histology and other criteria are included in the newly added Table 9a. The criteria for coding liver (C220) versus intrahepatic bile duct (C221) is based on Cancer PathCHART Specialty Matter Expert review. The experts have determined adenocarcinoma and subtypes of adenocarcinoma cannot be primary to liver and therefore are biologically impossible. The coding instructions in Table 9a may be applied to cases diagnosed 2023 forward.

Table 9a: Guidelines for Assigning Primary Site for Liver and Intrahepatic Bile Duct 2023+ Diagnoses

Site of bx or cytology	Pathology or cytology diagnosis	Criteria	Primary Site/ Histology
Liver C220	Adenocarcinoma Adenocarcinoma subtypes/variants	Supporting documentation such as scans, lab tests, or definitive clinical diagnosis of intrahepatic bile duct primary and/or definitive diagnosis of cholangiocarcinoma	C221 8160/3
Liver C220	Adenocarcinoma Adenocarcinoma, subtypes/variants	No documentation supporting the primary site of intrahepatic bile duct is available in the medical record. This includes scans, lab tests or definitive clinical diagnosis. Liver is a common metastatic site for other neoplasms such as breast, lung, and colon. Code unknown primary site C809 when a primary site is not indicated in the pathology report or medical record	C809 8140/3

Note: Not the complete table

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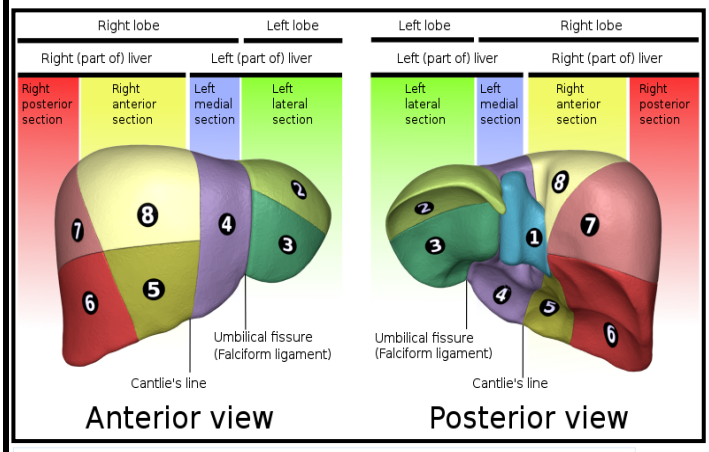
Solid Tumor Rules - Other Sites (cont.)



https://commons.wikimedia.org/wiki/File:Liver_04_Couinaud_classification.svg

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Example: 2/15/24 CT/Abdomen - intrahepatic mass seen in segment 5. No other abnormalities noted.
2/15/24 FNA Liver positive for adenocarcinoma.
Question - What is primary site and what is histology?
Answer - Primary site is C22.1 Intrahepatic bile duct
Histology is 8160/3 Bile duct carcinoma

Example: Patient has history of colon cancer and CT/Abdomen showed an intrahepatic mass in segment 5. No other abnormalities noted.
3/20/23 FNA Liver positive for adenocarcinoma.
Managing physician stated this is either a bile duct primary or metastasis from the colon cancer.
Question - What is primary site and what is histology?
Answer - Primary site is C80.9 Unknown primary
Histology is 8140/3 Adenocarcinoma, NOS

SEER Summary Stage 2018 - Liver

Note 3: The liver is divided into several lobes as defined below. In the absence of other tumor involvement (lymph node involvement or distant metastasis), code the lobe or segment involvement as follows:

- If multiple segments (such as 5 and 6 in the right lobe) in the same lobe are involved, this would be multiple tumors within one lobe, code 1 (Localized)
- If multiple lobes (such as the Caudate lobe and the Left Lobe) are involved, code 2 (Regional)

Lobe	Segment(s)
Caudate lobe	1
Quadrate lobe	4b
Left lobe	2,3,4a
Right lobe	5,6,7,8,

SEER Summary Stage 2018 - Intrahepatic Bile Ducts

Note 3: Intrahepatic vascular invasion (code 1, Localized) includes the following

- Major hepatic vessel invasion
  - First and second-order branches of the portal veins or hepatic arteries
- Hepatic veins (right, middle, or left)
- Microscopic invasion of smaller intraparenchymal vascular structures (identified on histopathological exam)

TACE Coding for Liver Cancer - CAnswer Forum

Transcatheter arterial chemoembolization (TACE) is coded as chemotherapy. Follow STORE rules for coding based on the number of agents administered

https://cancerbulletin.facs.org/forums/node/71746

STORE:
Code chemoembolization as 01, 02, or 03 depending on the number of chemotherapeutic agents involved

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Liver & Bile Ducts

5-year relative survival rates for liver cancers

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Liver cancers

SEER Stage	Survival rate
Localized	37%
Regional	14%
Distant	4%
All SEER stages	22%

https://www.cancer.org/cancer/types/liver-cancer/detection-diagnosis-staging/survival-rates.html

Intrahepatic bile duct cancers (starting within the liver)

SEER Stage	Survival rate
Localized	23%
Regional	9%
Distant	3%
All SEER stages	9%

Extrahepatic bile duct cancers (starting outside the liver)

SEER Stage	Survival rate
Localized	18%
Regional	18%
Distant	2%
All SEER stages	11%

https://www.cancer.org/cancer/types/bile-duct-cancer/detection-diagnosis-staging/survival-by-stage.html

Grade

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Grade - New Autopsy Grading

Autopsy grading follows the grade timeframe rules; if a patient dies and has an autopsy during the initial workup and treatment of their cancer, in the absence of any signs of progression, the autopsy grade can be used in the appropriate timeframe.

- Patient diagnosed at autopsy – do NOT use grade information from the autopsy
- Patient diagnosed and dies w/out any treatment – grade info from autopsy can be coded in grade clinical
- Patient diagnosed, has surgical resection, then dies shortly after – grade pathological can come from the surgery or autopsy (whichever is higher)
- Patient diagnosed, has surgical resection, and completed all FCT prior to death – do NOT use grade info from the autopsy because that procedure was not done during the initial workup or through the FCT

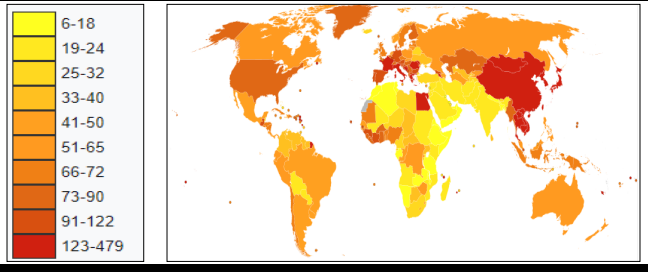
Ranges in Grading

New instruction "c" added to Grade Manual v3.1 under item 1
General Grade Coding Instructions for Solid Tumors

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.
      - Applies to cases diagnosed 1/1/2018 and forward (you don't have to recode cases already abstracted)

Liver cancer - Deaths per million persons

https://commons.wikimedia.org/wiki/File:Liver_cancer_world_map-Deaths_per_million_persons-WHO2012.svg



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