20180016

Question
Primary site--Pancreas: Is the uncinate process of the pancreas coded to C259, C250, or C257?

Answer
Assign C250 to the uncinate process of the pancreas. The uncinate process is part of the head of the pancreas.

Date Finalized
05/01/2018

20180015

References
Source 1: **WHO Class Female Reproductive Organs**
Notes: **4th edition**

Question
Histology--Ovary: What is the correct ICD-O-3 histology code for sertoliform endometrioid carcinoma of the ovary?

Answer
Assign 8380/3. Sertoliform endometrioid carcinoma is a variant of endometrioid carcinoma according to the WHO Classification of Tumors of Female Reproductive Organs, 4th edition. There is no specific ICD-O-3 code for this variant.

Date Finalized
05/01/2018

20180014

References
Source 1: **WHO Class CNS Tumors**
Notes: **4th edition**

Question

Reportability/Histology--Brain and CNS: Is multinodular and vacuolating neuronal tumor of the cerebrum reportable, and if so, is the histology coded as 9492/0? See Discussion.

Discussion
Patient diagnosed with multinodular and vacuolating neuronal tumor of the cerebrum. My research shows: Multinodular and vacuolating neuronal tumor of the cerebrum is a recently reported benign, mixed glial neuronal lesion that is included in the 2016 updated World Health Organization classification of brain neoplasms as a unique cytoarchitectural pattern of gangliocytoma. There is no code in ICD-O-3 for it, so do I report it and use 9492/0 or not?

Answer
Do not report multinodular and vacuolating neuronal tumor of the cerebrum. At this time, WHO is undecided about whether this is a neoplastic or a hamartomatous/malformative process. If WHO makes a determination that this is a neoplastic process, we will update reportability instructions and ICD-O-3 guidelines for registrars.

Date Finalized
05/01/2018

20180013

References
Source 1: **2016 SEER Manual**
pgs: **5-7**
Notes: **Reportability Section**

Question
Reportability--Brain and CNS: Are tuberous sclerosis cancers found in the brain reportable? See Discussion.

Discussion
I have searched ICD-O-3 for a histology listing but could not locate. I also searched the SEER Inquiry database for possible answers, but none were found. The patient underwent a pediatric MRI of the brain of which final impression was: 1) Subependymoma nodules, cortical tubers, and SEGAs are seen bilaterally consistent with tuberous sclerosis.

Answer
SEGA (Subependymal giant cell astrocytoma) is reportable if diagnosed in 2004 or later. Tuberous sclerosis complex (TSC) is not a neoplasm and is not reportable. SEGA is a neoplasm that commonly occurs in TSC patients. Refer to the reportability instructions on pages 5-7 in the SEER manual,
https://seer.cancer.gov/manuals/2016/SPCSM_2016_maindoc.pdf

Date Finalized
05/01/2018

20180012

References
Source 1: **2016 SEER Coding Manual**
pgs: **160**

Question
First course of treatment: What is the correct code to use for allogenic stem cell transplant?

Answer
Code an allogenic stem cell transplant as 20 (Stem cell harvest (stem cell transplant) and infusion) in Hematologic Transplant and Endocrine Procedures in the 2016 SEER Manual.

Date Finalized
05/01/2018

20180010

References
Source 1: **Heme & Lymph Manual & DB**

Question
Diagnostic confirmation--Heme & Lymphoid Neoplasms: Is Diagnostic Confirmation coded as 5 (positive laboratory test/ marker study) or code 8 (clinical diagnosis only) for a case that has a positive JAK2 mutation, and based on the results of the JAK2, the physician diagnosed the patient with polycythemia vera? There were no blood smears or bone marrow biopsies done.

Answer
Assign diagnostic confirmation code 8 for a clinical diagnosis only. Code 5 is not correct in this case because JAK2 is not definitive for any specific hematopoietic neoplasm. The physician uses JAK2 info combined with all of the other facts for the case to make the diagnosis.

Date Finalized
03/29/2018

20180009

References
Source 1: **ICD-O-3**

Question
Reportability--Head & Neck: Is dentinoameloblastoma reportable, and if so, what is the correct histology code? See Discussion.

Discussion
Mixed odontogenic tumor consistent with dentinoameloblastoma, 9.5 cm, See Note: Tumor involves maxillary bone including hard palate, alveolar ridges, nasal cavities and maxillary sinuses bilaterally and buccal soft tissue. Lymphovascular invasion not identified. Perineural invasion not identified. Margins: Tumor involves right posterior bone (alveolar) margin. All other margins negative. Note: This is a rare hybrid tumor showing features of ameloblastoma producing pre-dentin/osteodentin matrix. Submucosal tumor is seen in the nasal cavities and palate. A congo red stain shows that the acellular dentin-like matrix fluoresces similar to collagen after polarization. Immunohistochemistry shows that the tumor cells are diffusely and strongly positive for p63, focally positive for CK19, and negative for CK5/6, SOX10, S100 and calretinin.

Answer
Dentinoameloblastoma is not reportable. It is a variant of ameloblastoma which produces dentin and/or osteoid. It is benign. It can extend locally in a rather aggressive fashion, but is not given a malignant designation unless it metastasizes.

Date Finalized
03/27/2018

20180008

References
Source 1: **2007 MP/H Rules**
Notes: **Other; table 2**
Source 2: **WHO Class Endocrine Tumors**
pgs: **84**
Notes: **4th edition**

Question
MP/H Rules/Multiple primaries--Thyroid: Is medullary carcinoma of the right lobe of the thyroid, with foci of papillary microcarcinoma in both lobes, one primary with mixed histology (8347/3) or two separate primaries?

Answer
For cases diagnosed prior to 2018:
Abstract two primaries, Medullary (8510/3) and papillary microcarcinoma (8260/3). Other sites rule M17 applies.

Date Finalized
03/27/2018

20180007

References
Source 1: **Heme & Lymph Manual & DB**

Question
Multiple primaries/Primary site--Heme & Lymphoid Neoplasms: Are plasmacytomas in thyroid and laryngeal masses one primary based on rule M2, abstract a single primary when there is a single histology? If so, what is the primary site? See Discussion.

Discussion
Patient presented with hoarseness and palpable neck mass. No palpable adenopathy (per hospital abstract).

02/19/16 Thyroid Ultrasound: Right thyroid lobe with mass, 63X35X44XMM (per hospital abstract).

06/01/16 Right thyroid lobectomy, radical resection right laryngeal tumor (per hospital abstract).

06/01/16 Operative Procedure: Tumor was invading laryngeal soft tissue and cartilage anteriorly and to the right. There may be a small amount of residual tumor invading cartilage although this was not clear (per hospital abstract).

GROSS DESCRIPTION: 1. The specimen is received fresh for intraoperative consultation, labeled with the patient's name and "right thyroid mass." It consists of a 3.0 x 2.2 x 2.0 cm irregular, ragged fragment of tan-red, firm, rubbery soft tissue. The specimen is serially sectioned to reveal a tan-red, gritty cut surface with focal fleshy areas. A touch prep is performed. A representative section is submitted for frozen section analysis in 1FSA. A portion of tissue is submitted for flow cytometry with the accession number MSO-16-1786. The remaining specimen is entirely submitted in 4 additional cassettes (1B-1E). 2. The specimen is received in formalin and is labeled "right thyroid lobe." It consists of a thyroid lobe measuring 4.3 x 4.0 x 1.3 cm and weighing 10.0 g. The external surface is covered by a thin fibrous capsule with a focal area of roughening on the posterior surface. The lobe is inked black posterior, blue anterior and orange isthmus margin. Serial sectioning reveals a red-brown and beefy parenchyma. A definitive nodule is not grossly identified. The entire specimen is serially submitted from superior to inferior in 9 cassettes. 3. The specimen is received in formalin, labeled with the patient's name and "right neck/laryngeal mass." It consists of an irregular, focally nodular red-tan mass measuring 7.0 x 5.5 x 4.0 cm and

weighing 54 g. The convex portion of the specimen is mostly encapsulated with focal adherent red-brown striated skeletal muscle. The concave portion of the specimen is focally ragged and disrupted. The convex portion of the specimen is inked black and the concave portion is inked blue. The specimen is serially sectioned to reveal a white-grey to red, granular, gritty cut surface with focal fleshy areas. Representative sections are submitted in 12 cassettes.

Final DX DIAGNOSIS: 1. Right thyroid mass excision Plasma cell tumor /plasmacytoma 3 cm. Tumor cells are positive for kappa and negative for lambda immunostains. Recommend correlation with flow cytometry MSO-16-1786, monoclonal plasma cell population with cytoplasmic kappa positivity. Ki-67 stains 7 percent of cells. Focal stromal hyalinization. Congo red stain for amyloid negative. No thyroidal tissue identified. 2. Right thyroid lobe excision Benign thyroid tissue with focal solid cell nest negative for malignancy. One out of two 1/2 perithyroidal lymph nodes positive for plasma cell tumor. 3. Laryngeal mass excision Plasma cell tumor /plasmacytoma 7 cm involving soft tissue and skeletal muscle. Tumor cells are positive for kappa and negative for lambda immunostains. Ki-67 stains 7 percent of cells. Focal stromal hyalinization and calcification. Congo red stain for amyloid negative

Answer
Abstract this case as a single primary. Hematopoietic Multiple Primary Rule M2 applies.

Code to unknown primary, C809, based on rule PH27. There is no indication in the information provided of the site of origin; therefore, PH2 cannot be used. We recommend a thorough review of the case to determine if the site of origin is identified in the medical record.

Date Finalized
03/27/2018

20180006

References
Source 1: **ICD-O-3**
Source 2: **WHO Class Breast Tumors**
pgs: **106-107**
Notes: **2012**

Question
MP/H Rules/Histology--Breast: Should encapsulated papillary carcinoma of the breast with a separate focus of ductal carcinoma in situ be coded as 8050/2 (papillary carcinoma) and staged as in situ? See Discussion.

Discussion
Pathology--Right breast, lumpectomy with needle localization: Encapsulated papillary carcinoma of the breast. A separate focus of ductal carcinoma in situ is present. Sentinel lymph node, right breast, biopsy: One lymph node, negative for malignancy. No metastatic carcinoma is seen on slides stained with immunostain for cytokeratin (AE1/AE3). Specimen laterality: Right. Tumor size: 1.2 cm. Histologic type: Encapsulated papillary carcinoma. Nuclear grade: Grade 1 (low). Mitotic rate: Score 1. Ductal carcinoma in situ (DCIS): DCIS is present. Estimated size (extent) of DCIS: 3 mm. Architectural patterns: Cribriform and papillary. Nuclear grade: grade 1 (low). Necrosis: Not identified. Margins: Margins uninvolved by encapsulated papillary carcinoma. Distance from closest margin: 8 mm, superior Margins uninvolved by DCIS. Distance from closest margin: 11 mm, superior Lymph nodes: Total number of lymph nodes examined (sentinel and nonsentinel): 1. Number of sentinel lymph nodes examined: 1. Number of lymph nodes with tumor cells: 0. Pathologic staging: Primary tumor: See comment. Regional lymph nodes: pN0(i-). Comment: In the WHO Classification of Tumours of the Breast (2012), it is stated that "there is no universal agreement on how to stage encapsulated papillary carcinomas. In the absence of conventional invasive carcinoma, the consensus of the WHO Working Group was that such lesions should be staged and managed as Tis disease."

Answer
For cases diagnosed prior to 2018: Code as encapsulated papillary carcinoma, 8504/3; this is a synonym for intracystic carcinoma (WHO Classification of Tumors of the Breast). Stage this case as invasive.

Date Finalized
03/07/2018

20180004

References
Source 1: **2007 MP/H Rules**
Notes: **Other sites**

Question
Reportability/MP/H Rules/Multiple primaries: Is a ganglioneuroblastoma (9490/3) following a melanoma (8720/3) a new primary if the diagnosing pathologist states: 'Given the clinical context and patient age, then I believe that this may represent transdifferentiation of metastatic melanoma'? If this is a new primary, what MP/H rule would apply? See Discussion.

Discussion
March 2017 lung biopsy showing metastatic melanoma. Subsequent workup shows imaging with additional metastatic involvement of multiple bone sites but no primary tumor is identified. Chemotherapy is started in May 2017.

July 2017 biopsy of right lower quadrant mass has a final diagnosis of ganglioneuroblastoma and pathologist's comment states I believe that this may represent transdifferentiation of metastatic melanoma. Later, partial colectomy of transverse colon Gross Description indicates this was centered in the mesentery.

Answer
Abstract two primaries: 1. unknown primary site and 2. peripheral nerves and autonomic nervous system of abdomen, based on Multiple Primaries/Histology for Other Sites Rule M11 (topography codes that differ at the second or third character). While it is possible in rare cases that one tumor transforms into the other, transformations do not factor into the current MP/H rules.

Date Finalized
02/08/2018

20180003

References

Source 1: **Heme & Lymph Manual & DB**

Question
Histology/Diagnostic confirmation--Heme & Lymphoid Neoplams: Would you code the NOS term when follicular lymphoma is favored? What would diagnostic confirmation be coded if a positive fine needle aspirate (FNA) is followed by a positive flow cytometry (ambiguous term)? See Discussion.

Discussion
Pathology reads: 1. FNA left groin lymph node tissue (smears and cell block): B-cell lymphoma, low grade. The concurrent flow cytometry (3-FC-16-288) identifies a monoclonal B cell population with immunophenotype of CD10++, CD5-, CD23-, CD20++ and unusual CD19-. Overall findings favor follicular lymphoma. FNA Specimen Adequacy: Evaluation for specimen adequacy: Immediate cytology smear review for specimen adequacy was performed at the time of the FNA procedure by pathologist. Smears reviewed from 2 passes in one reading. The specimen was adequate cytological evaluation. Surg Path Final Report Special Studies Immunohistochemistry (CD45, MCK, CD20, CD3, CD10, Bcl6, MUM1 \T\ Ki67) was performed on block 1A to confirm the diagnosis. All controls show appropriate reaction. Lymphoma cells are positive for CD45, CD20, CD10 and weakly positive for bcl6(+) and MUM1(+/-), and negative for MCK. CD3 highlights few T lymphocytes. Ki67 labeling index is low, less than 10%. The immunoprofile supports above diagnosis. Chromosomal study for t(14;18) translocation will be performed, and an addendum report will follow. Flow Final Report Comment: The lymphoma appears to be derived from germinal centre B cells. Together with the findings from the lymph node biopsy (3-FN16-416), follicular lymphoma is favored. However, negative CD19 and CD22 are unusual.

Answer
Code histology as follicular lymphoma, NOS (9690/3). The clinician rendered the diagnosis after review of all information available, including histology, cytology, and immunophenotyping markers.

Assign diagnostic confirmation code 1 based on histology. Diagnostic confirmation code 3 cannot be assigned in this case because the diagnosis included ambiguous terminology and the immunophenotyping is not unique to follicular lymphoma, NOS.

FINALIZED SEER SINQ QUESTIONS

January – April, 2018

Date Finalized
03/07/2018

20180002

References
Source 1: **2007 MP/H Rules**
Notes: **Urinary**
Source 2: **Beyond the Basics MP/H training**
Notes: **Slide 6, General Instructions**

Question
MP/H Rules/Multiple primaries--Urinary: Is a renal pelvis diagnosed 5/2016 a separate primary when the first invasive bladder was 12/2011? Per rule M7, the 5/2016 renal pelvis is more than 3 years later. Does Multiple Primary/Histology (MP/H) rule M7 refer to the original diagnosis date or to the last occurrence? See Discussion.

Discussion
12/30/11 Bladder Biopsy: Diffuse carcinoma in situ of bladder, urothelial cancer at trigone (Stage T1)

1/30/2012 Transurethral resection of the bladder was non-papillary, urothelial carcinoma, focal invasion of lamina propria, staged T1

11/10/14, 9/28/15, 9/26/16, 10/19/17 all had positive bladder cytology of urothelial carcinoma

5/16/16 Left renal pelvis aspirate: positive for malignant cells, urothelial carcinoma

9/26/16 Left renal pelvis aspirate: positive for malignant cells, urothelial carcinoma

10/18/16-11/7/16 Bacillus Calmette-Guerin (BCG) x3 administered into the renal collecting system via ureteral catheter

Answer
For cases diagnosed prior to 2018: This case is a single primary. This patient has not had a disease-free interval as demonstrated by the positive cytologies from 2014 through 2017. The MP/H rules cannot be applied in this case.

To answer your question about the timing of rule M7, please see slide 6 in the Beyond the Basics MP/H advanced training, General Instructions, https://seer.cancer.gov/tools/mphrules/training_adv/SEER_MPH_Gen_Instruc_06152007.pdf

FINALIZED SEER SINQ QUESTIONS

January – April, 2018

Date Finalized
02/15/2018

20180001

References
Source 1: **2016 SEER Manual**

Question
Reportability/Date of diagnosis--Small intestine: Is this case reportable? Widely metastatic gastrointestinal stomal tumor (GIST) was diagnosed at an out-of-state facility in 2017 and referred back to a hospital in our state for chemotherapy where there is a history of a small bowel resection of GIST of uncertain malignant potential (8936/1) done at the hospital in 2003. If so, is the diagnosis date 2003 or 2017? See Discussion.

Discussion
The hospital registrar reports that the case was identified at the hospital because of the referral for chemotherapy for the metastatic GIST. The records from the out-of-state hospital mentioned a history of a small bowel resection in 2003 for a borderline tumor. The registrar went back through the hospital's old records and found the surgery was done for GIST of low malignant potential at her facility. The question is whether to report the case or not, and if reported, is 2003 the diagnosis date.

The rules say to change the behavior and backdate the diagnosis when a tumor is presumed benign and is later diagnosed as malignant. Another problem for this case is that the out-of-state hospital did not review the slides from the 2003 surgery.

Answer
Report the case with a diagnosis date of 2017. The 2003 diagnosis was not reviewed, and there are no physician statements that cancer was present in 2003, or that the metastases are attributable to the 2003 diagnosis. Document the details of the case in text fields.

History
This answer was revised on 3/21/18. The current answer is shown above in the "Answer" field.
Previous answer: Report the case with diagnosis date of 2003. Unless there was another primary in the meantime, the 2017 GIST metastases prove that the 2003 tumor was malignant and reportable. Be sure to document the details of this case in text fields.

Date Finalized
03/21/2018

20170081

References
Source 1: **ICD-O-3**

Question
Grade/Neuroblastoma: What grade is to be used when pathology states only differentiating retroperitoneal neuroblastoma?

Answer
For cases diagnosed prior to 2018:

Assign grade code 2 for "differentiating" retroperitoneal neuroblastoma. The rationale of our expert pathologist advisor is that "it leaves the grade 1 category open (since a "well differentiated neuroblastoma" is actually called ganglioneuroblastoma), and it also avoids putting "differentiating" into what is usually a well differentiated category."
Additionally, assign grade code 3 to a poorly differentiated retroperitoneal neuroblastoma and grade code 4 to an undifferentiated retroperitoneal neuroblastoma.

For cases diagnosed 2018 and later:

Follow the instructions for coding grade in SEER*RSA

Date Finalized
01/26/2018

20170080

References
Source 1: **2016 SEER Manual**
pgs: **5**

Question
Reportability/Breast: Is lobular carcinoma in situ (LCIS) reportable? The eighth edition, American Joint Commission on Cancer (AJCC) Cancer Staging Manual does not stage LCIS.

Answer
Yes, LCIS is reportable. Staging does not determine reportability. Follow the reportability requirements of your state and national standard setter. SEER reportability requirements are found in the SEER manual starting on page 5, https://seer.cancer.gov/manuals/2016/SPCSM_2016_maindoc.pdf

Date Finalized
01/26/2018

20170079

References
Source 1: **2016 SEER Manual**
Notes: **Appendix C: Surgery Coding Guidelines: Corpus uteri**
Source 2: **SEER Glossary for Registrars**

Question
Surgery of Primary Site--Corpus Uteri: Is surgery for a uterine corpus primary described as total abdominal hysterectomy-bilateral salpingo-oophorectomy (TAH-BSO) with specimens including uterine corpus, cervix, bilateral ovaries and fallopian tubes, and bilateral parametria coded as a modified radical hysterectomy? It would be very helpful if an explanation of the difference between a total hysterectomy, modified radical hysterectomy, and radical hysterectomy can be included. See Discussion.

Discussion
Surgery text indicates TAH-BSO with bilateral pelvic and paraaortic lymph node dissection. The pathology report indicates the specimen includes: Uterine corpus, cervix, bilateral ovaries and fallopian tubes, bilateral parametria. The Gross Description also indicates: Representative sections submitted in 16 cassettes as follows: A1: Anterior cervix A2: Posterior cervix A3: Full thickness anterior lower uterine segment A4: Full thickness posterior lower uterine segment A5: Tumor A6-A7: Full thickness anterior endomyometrium to include tumor A8-A10: Full thickness posterior endomyometrium with tumor A11: Representative sections of right fallopian tube and fimbria A12: Representative sections of right ovary A13: Representative sections of left fallopian tube and fimbria A14: Representative sections of left ovary A15: Right parametrial tissue A16: Left parametrial tissue A17-23: Remainder of cervix.

Answer
Assign code 50: total hysterectomy with removal of tube(s) and/or ovary(ies). Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff. Both the radical and modified radical hysterectomy (code 60) include removal of part of the vagina, not mentioned in the pathology or surgery text.

The SEER Glossary for Registrars defines the procedures as follows.

Total hysterectomy: Surgery to remove the entire uterus, including the cervix

Radical hysterectomy: Surgery to remove the uterus, cervix and part of the vagina. The ovaries, fallopian tubes and nearby lymph nodes may also be removed.

Modified radical hysterectomy: Surgery to remove the uterus, cervix, upper part of the vagina, and nearby ligaments and tissues. Nearby lymph nodes may also be removed. In this type of surgery, not as many tissues and/or organs are removed as in a radical hysterectomy.

https://seer.cancer.gov/seertools/glossary/

Date Finalized
01/25/2018

20170078

References
Source 1: **2016 SEER Manual**

Question
Scope of Regional Lymph Node Surgery--Lung: How do you code Regional Nodes Positive, Regional Nodes Examined, and Scope of Regional Lymph Node Surgery when a fine needle aspirate (FNA) or biopsy of supraclavicular lymph nodes is positive for a lung cancer primary? Supraclavicular lymph nodes are distant in SEER Summary Stage and regional by AJCC. See Discussion.

Discussion
There is a discrepancy in regional lymph nodes for lung between SEER and AJCC. Supraclavicular lymph nodes/cervical lymph nodes are distant for SEER but regional for AJCC. For SEER states, when there is an FNA or biopsy of a supraclavicular lymph node performed and it is positive for a lung primary and no other lymph nodes are examined, do you code 95 in Regional Nodes Positive/Regional Nodes Examined and code "1" for Scope of Regional Lymph Node Surgery or do you not count the FNA/biopsy of the supraclavicular lymph node since it is distant?

Answer
For cases diagnosed through 2017, use the Collaborative Staging (CS) system to determine regional versus distant lymph nodes. Supraclavicular lymph nodes are regional for lung in CS.

Please note that Summary Stage is not the same as EOD, CS, or AJCC staging. Registrars should not use Summary Stage definitions for anything other than directly assigning the Summary Stage field.

Date Finalized
01/25/2018

20170077

References
Source 1: **2016 SEER Manual**
Notes: **First Course of Therapy section**

Question
First Course Treatment: Should the definition in the 2016 SEER Coding Manual be revised for first course of treatment following disease progression for patients who complete the initial first course treatment plan without alteration but had one or more treatment modalities given after disease progression was identified? See Discussion.

Discussion
The FORDS Manual (pg. 22) states: The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. The instructions in the FORDS Manual and clarification from multiple CAnswer Forum posts indicates the planned first course treatment stops following disease progression, even when the first course treatment plan is not altered or changed.

SEER, on the other hand, instructs registrars to do the opposite. The SEER Manual instructs registrars to code all completed treatment given as part of the initial first course treatment plan, even after disease progression, provided the treatment plan is not changed or altered. (See 2016 SEER Manual, Section VII First Course of Therapy, Treatment Timing, Rule 1 and Example 1.)

For consistency in data collection, shouldn't the standard setters use the same guidelines to define first course treatment? Given that the majority of cases are reported to SEER by registrars in CoC facilities, who may not be abstracting treatment modalities that occur after progression, the SEER expectation is likely not able to be performed consistently. Wont this difference in standard setter data collection expectations negatively impact the treatment data reflected on our files?

Answer

The example cited above will not be included in the 2018 edition of the SEER manual. Removing this example will improve the consistency in recording first course of treatment for cases diagnosed 2018 and later.

Date Finalized
01/10/2018

20170076

References
Source 1: **WHO Class CNS Tumors**
pgs: **241-242**
Notes: **4th edition, 2016**
Source 2: **2007 MP/H Rules**
Notes: **Benign Brain**

Question
MP/H Rules/Histology--Brain and CNS: Is meningioma with atypical features coded as meningioma (9530/0) or atypical meningioma (9539/1)? See Discussion.

Discussion
Pathology report microscopic description: The tumor is a meningothelial neoplasm (EMA+; BCL-2 and CD34 negative) with prominent collagen deposition. Necrosis and prominent nucleoli are present; no other atypical features are seen. Mitoses are present, up to 2 per 10 high-powered fields. Final Diagnosis: Dura, bicoronal craniotomy (specimen A): Meningioma with atypical features.

There is no rule in benign brain and CNS section of Multiple Primary/Histology (MP/H) Rules stating to code the most specific histologic term when the diagnosis is (something less specific, i.e., adenocarcinoma). This rule is in other site chapters of MP/H but appears missing in the benign brain and CNS section.

Answer
Code as meningioma, NOS (9530/0). This lesion has some of the features of an atypical meningioma (necrosis and prominent nucleoli), but it does not fit the definition of atypical meningioma in WHO Classification of Tumors of the Central Nervous System. Use text fields to document the details.

Date Finalized
01/10/2018

20170075

References
Source 1: **2016 SEER Manual**
Source 2: **SINQ 20110111**

Question
MP/H Rules/Behavior--Breast: How many primaries are to be abstracted for a patient with a history of left breast ductal carcinoma in situ (DCIS) diagnosed in 2014 and bone lesions showing metastatic carcinoma consistent with a breast primary in 2017? See Discussion.

Discussion
Patient was diagnosed with DCIS of the left breast in June 2014. The patient had a simple mastectomy with 2 axillary lymph nodes removed. The final diagnosis was intermediate to high grade ductal carcinoma in situ, predominantly micropapillary type, forming a 1.4 cm mass. No invasive carcinoma identified. Margins negative. In April 2017, the patient was found to have parietoccipital bone lesions, which were resected. The resulting diagnosis was metastatic carcinoma, morphologically consistent with breast primary – See Comment: The previous breast lesion is not available for review at the time of signout. However, the tumor is morphologically compatible with a breast primary.

SINQ 20110111 would not make this is new primary. However, it seems that rule M8 might apply. An invasive tumor following an in situ tumor more than 60 days after diagnosis is a multiple primary. See Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Answer
Assuming there were no other breast or any other tumors for this patient, change the behavior code to /3 on the original abstract for the 2014 breast primary.

Similar to SINQ 20110111, there was likely a focus of invasion present in the original tumor that was not identified by the pathologist. The behavior code on the original abstract must be changed from a /2 to a /3 and the stage must be changed from in situ to localized.

The MP/H rules do not apply to metastases. Therefore, rule M8 cannot be used.

Date Finalized
01/10/2018

20170074

References
Source 1: **WHO Class Urinary Tumors**
pgs: **22**

Question
Reportability--Kidney: Is a renal cell neoplasm stated to be multilocular clear cell renal cell neoplasm of low malignant potential a reportable tumor if the physician refers to the tumor as renal cell carcinoma in a follow-up note after surgery? If reportable, how is histology coded? See Discussion.

Discussion
The partial nephrectomy final diagnosis is renal cell neoplasm. The College of American Pathologists (CAP) Summary lists histology as: multilocular clear cell neoplasm of low malignant potential. The diagnosis comment adds: This neoplasm currently termed multilocular clear cell renal cell neoplasm of low malignant potential (WHO 2016), was previously termed cystic renal cell carcinoma.

Answer
For now, report the case and code to 8310/3.

In the 3rd Ed WHO Tumors of the Urinary System, multilocular clear cell RCC is coded as 8310/3, however the recent 4th Ed WHO Tumors of Urinary System notes this term is obsolete and a synonym for multilocular cystic renal neoplasm of low malignant potential (8316/1) which would be non-reportable. Per WHO 3rd Ed these tumors never recur or metastasize which may be why the behavior code is shown as /1. The standard setters must review this terminology change in relation to reporting the case as it may impact incidence rates.

Date Finalized
01/10/2018

20170073

References
Source 1: **WHO Class CNS Tumors**
pgs: **177**
Notes: **4th edition**
Source 2: **ICD-O-3**

Question
Histology/Behavior--Brain and CNS: How are histology and behavior coded for a diagnosis of pineal anlage tumor in an infant? See Discussion.

Discussion
Patient is an 11 month old with brain biopsy showing final diagnosis of pineal anlage tumor. How are behavior and histology coded for this rare tumor?

Answer
Assign 9362/3 for pineal anlage tumors. According to the WHO Classification of Tumors of the Central Nervous System, 4th edition, pineal anlage tumors, while extremely rare, share features with pineoblastoma. Although they have a distinct morphology, there is no other ICD-O-3 code for pineal anlage tumors.

Date Finalized
01/10/2018

20170072

References
Source 1: **Heme & Lymph Manual & DB**

Question
Reportability--Heme & Lymphoid Neoplasms: Is the diagnosis of large granular lymphocyte syndrome or large granular lymphocyte disorder a reportable synonym for T-cell large granular lymphocytic leukemia? See Discussion.

Discussion
The physician consult in this case further specifies that the large granular lymphocyte disorder represents an autoimmune disease of autoimmune T-cell mediated mechanism. Is this a reportable diagnosis?

Answer
Report large granular lymphocyte disorder (9831/3). Alternate names for T-cell large granular lymphocytic leukemia (9831/3) listed in the Hematopoietic and Lymphoid Neoplasms Database include but are not limited to Chronic large granular lymphocyte lymphoproliferative disorder, large granular lymphocytosis, NOS, and T-cell large granular lymphocytosis.

Date Finalized
01/10/2018

20170071

References
Source 1: **http://radsource.us/incidentaloma**

Question
Reportability/Brain and CNS: Is incidentaloma reportable from brain and central nervous system (CNS) imaging? See Discussion.

Discussion
We are seeing the term "incidentaloma" on magnetic resonance imaging (MR) reports of head and also with physician statements. For example, this MR of the head: Impression--Suboptimal study due to motion degradation. Heterogeneously enhancing pituitary gland without evidence of acute abnormality. A 3 mm focus of relative hypoenhancement in the left gland is favored to represent an incidentaloma. Advise correlation with clinical findings.

Also, there are cases where the scans show meningioma and then at a later date it is stated to be an incidentaloma in physician notes.

Is the term "incidentaloma" alone reportable, if the term "tumor" for CNS cases is never stated? When I googled the term, it is stated to mean "tumor."

Answer
The term "incidentaloma" alone is not reportable. Look for a reportable term elsewhere or in later information. When the term "incidentaloma" is used on a magnetic resonance imaging (MR) report, it refers to "a disease or physical condition found as a secondary by-product of capturing the necessary volume of tissue within the field of view of the MR examination" (http://radsource.us/incidentaloma). It is not necessarily neoplastic.

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01/10/2018

20170070

References
Source 1: **Subject matter expert**

Question
Primary Site/Histology--Urinary: Is a urethral lesion showing intraductal carcinoma of the prostate reportable? What is the primary site and histology code? See discussion.

Discussion
Pathology report diagnosis: Urethral lesion: Intraductal carcinoma of the prostate, see microscopic. Clinical Information: Urethral Lesion/Hematura. Microscopic Description: The biopsy shows dilated ductal structures filled with anaplastic epithelium showing areas of comedo-type necrosis. The tumor cells have enlarged nuclei prominent nucleoli and mitoses are identified. Surrounding benign prostatic tissue is also present. Immunostains show that the tumor cells stain for PSA, PSAP, P504s but are negative for GATA-3. The other components of the PIN 4 stain CK5/14 and P63 stain the basal cells surrounding the tumor confirming the intraductal nature of the process. Intraductal carcinoma should not be confused with high grade PIN as the former is usually associated with high grade invasive tumor. Is this C619 and 8500/2?

Answer
The primary site is prostate, C619, and the histology is intraductal carcinoma, 8500/2. Further workup on this case is likely. If more information is received, review this case and update if needed.

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References
Source 1: **ICD-O-3**
Source 2: **2007 MP/H Rules**

Question
MP/H Rules/Histology--Lung: What is the histology of a lung tumor described as solid predominant with mucin production, 8230/3 (Multiple Primaries/Histology (MP/H) Rule 5) or 8255/3 (MP/H Rule 6)? See Discussion.

Discussion
Pathology report: Left lower lobe lung, Tumor Size: Greatest dimension: 3.0 cm Additional dimensions: 2.5 x 2.0 cm; Tumor Focality: Unifocal; Histologic Type: Invasive adenocarcinoma Solid predominant with mucin production; Histologic Grade: G3: Poorly differentiated. Is the correct histology for this case 8230/3 (rule H5) or 8255/3 (rule H6)?

Answer
Code histology as 8230/3, solid adenocarcinoma with mucin formation, using MP/H Rule H3 as one histologic type is identified. All of the histologic terms (solid, mucin production) are covered by 8230/3. Therefore, rule H3 applies. Use the first rule that applies, and stop.

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References
Source 1: **2016 SEER Manual**
Notes: **Appendix D**

Question
Race, ethnicity: How do you code race for someone from New Zealand?

Discussion
I recently did a presentation on coding the data item Race. In my presentation I discussed understanding geography help code race in some circumstances. One of the slides demonstrates how large Polynesia is and what Pacific islands are found in Polynesia, such as, Tahiti, Samoa, and even Hawaii, all of which have their own codes. Someone in the audience asked "How do you code New Zealand? Upon some research, New Zealand is not listed in Appendix D of the SEER coding manual. We could code them 01-White. But research shows there is a very large indigenous population. Technically, New Zealand is located within the boundaries of Polynesia - Code 25 (Polynesian).

Answer
If the only information you have on race is that the person is from New Zealand, code race as white. This is based on the instructions for Australia, the closest neighbor to New Zealand as no other guidance was found.

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