20240009

References:
#1: WHO Class CNS Tumors, 4th ed.: pp.10, 16-89; 5th ed.: pp.8-93. 4th and 5th editions
#2: Solid Tumor Rules. Malignant CNS and Peripheral Nerves, March 2023 Update

Question:
Solid Tumor Rules/Histology --Brain and CNS: Why is high grade astrocytoma with piloid features (HGAP) not grouped together with the other astrocytoma histologies as a subtype/variant of astrocytoma? See Discussion.

Discussion:
It appears there was some confusion about finding this new malignant HGAP tumor (2023+) code. If this is not a specific subtype/variant of astrocytoma, can clarification be added to the "New for 2023" entry for HGAP?

Answer:
HGAP is listed as a separate classification and is not a subtype of the diffuse gliomas. WHO Classification of Tumors of the Central Nervous System, 5th edition, has two categories dealing with non-pediatric astrocytic tumors:

Adult-type diffuse gliomas

Circumscribed astrocytic tumors

HGAP falls into the second category as a result of updates to the 4th edition WHO classification in 2016 with advances in the role of molecular diagnostics with the 5th edition. All astrocytic tumors were previously grouped together whereas not all diffuse gliomas (astrocytic or not) are grouped together on the basis of growth pattern and behaviors, and shared *IDH1* and *IDH2* genetic status. The new classification separates astrocytomas that have a more circumscribed growth pattern, lack IDH gene alterations, and sometimes have BRAF mutations (i.e., pilocytic astrocytoma). The impact of molecular advances has driven classification changes as described in the 5th edition.

Review of site/histology combinations for CNS neoplasms is currently being performed by Cancer PathCHART experts. It's possible they will recommend HGAP be moved to a subtype/variant of astrocytoma, NOS.

Date Finalized
02/20/2024

20240008

References:
#1: Solid Tumor Rules, 139-142. Non-Malignant CNS, 2023 Update
#2: WHO Class CNS Tumors. 5th edition

Question:
Solid Tumor Rules/Histology--Brain and CNS: Should the term “diffuse” be added to Note 2 in the Non-Malignant Central Nervous System (CNS) Solid Tumor Rules, Table 6: Specific Histologies, NOS, and Subtypes/Variants, for the papillary glioneuronal tumor 9509/1? See Discussion.

Discussion:
Should Note 2 state, "Beginning with cases diagnosed 1/1/2023 forward, diffuse leptomeningeal glioneuronal tumor is coded 9509/3? See the Malignant CNS rules." Currently the Note only states, "leptomeningeal glioneuronal tumor," but the histology that changed behavior is listed in both Table 6, Column 1 (Non-Malignant CNS) and Table 3 (Malignant CNS) as, "Diffuse leptomeningeal glioneuronal tumor."

Answer:
The correct term is diffuse leptomeningeal glioneuronal tumor listed as a synonym in Column 2.

We will add the term diffuse in Note 2, Column 1 with the 2025 updates. In the meantime, you can add "diffuse" to your pdf version until the update is published.

Date Finalized:
02/20/2024

20240007

References:
#1: ICD-O-3.2
#2: NAACCR Implementation Guidelines. 2024 Guidelines

Question:
Histology--Brain and CNS: Provide clarification about the priority order of histology coding sources and an explanation of why the annotated histology lists are not the same as the WHO IARC ICD-O-3.2 Excel Table (adopted 1/1/2021). See Discussion.

Discussion:
We have had multiple users unable to find the applicable histology in the ICD-O-3.2 (i.e., the site-specific table did not include the histology) because they were using the annotated histology list and could not find the complete list of related terms or synonyms for the histology code.

For example, the ICD-O-3.2 lists Medulloblastoma, SHH-activated, NOS as a related term for 9471/3, but many users were unable to find this valid histology because they were using the annotated histology list, not the ICD-O-3.2.

Answer:
The NAACCR Annotated Histology List (AL) serves as an aid to registry software vendors for implementing annual histology changes. This file has been maintained by the Registry Plus team at CDC's NPCR for several years and reflects modifications to ICD-O-3 implemented by North American cancer registries over time. Although this list is reviewed multiple times prior to posting, there is no guarantee of 100% accuracy.

As such, the AL is not a substitute for referring to various standard-setter documents and implementation guidelines. In this instance, Medulloblastoma Desmoplastic SHH-activated and TP53-wildtype 9471 is across several resources: the Solid Tumor Rules, Malignant CNS and Peripheral Nerves module in Table 3, column 3 as a subtype/variant of Medulloblastoma NOS 9470; in the CNS WHO 5th Edition BB; and in the WHO IARC ICD-O-3.2 posted to ICD O 3 Coding Updates (naaccr.org). Although the exact related term of Medulloblastoma, SHH-activated, NOS is not listed, the NAACCR Implementation Guidelines for 2024 recommend checking the 2024 ICD-O-3 Update Table 1 or 2 to determine if the histology is listed. If the histology is not included in the update, then review ICD-O-3.2 and/or Hematopoietic and Lymphoid Database and/or Solid Tumor Rules (MP/H).

The Cancer PathCHART initiative has been undertaken to address gaps such as this between standard setting resources. Having all the standard histology coding resources included in a single all-inclusive database enables alignment of morphology codes & terms included in the CPC*SMVL (Cancer PathCHART Site-Morphology Validation List), Solid Tumors Rules, ICD-O-3

Annual Updates, NAACCR Annotated Histology List as well as the WHO 5th edition Blue Books. Please see Cancer PathCHART - Tumor Site-Morphology Surveillance Standards Initiative for more information on the Cancer PathCHART initiative, and more specifically, see Transitioning the Annotated Histology List to Cancer PathCHART (naaccr.org).

Date Finalized:
02/20/2024

20240006

References:
#1: WHO Class Hem & Lymph Tumors. 4th edition
#2: Subject matter expert

Question:
Primary Site/Histology--Heme & Lymphoid Neoplasms: What are the correct primary site and histology for patient diagnosed with an oropharyngeal soft tissue mass revealing plasma cell neoplasm with 5-10% of marrow cellularity in 2022? See Discussion.

Discussion:
Patient underwent excision of an oropharyngeal soft tissue mass revealing plasma cell neoplasm with extensive amyloid deposition. During work-up, bone marrow biopsy also revealed involvement by plasma cell neoplasm, with 5-10% of marrow cellularity. No amyloid seen in bone marrow. Patient was referred for radiation of the oropharyngeal mass. Per medical oncology qualifying best for the diagnosis of solitary extramedullary plasmacytoma with minimal marrow involvement. Decision made for observation by medical oncology in view of “minimal” bone marrow involvement. Question: Is rule M11 correct, and I abstract this case as a plasma cell myeloma, 9732/3, C421?

Answer:
Code as an oropharyngeal primary site and histology as solitary plasmacytoma (9734/3) based on consultation with our hematological expert.

The WHO Classification of Hematopoietic and Lymphoid Tissues defines multiple myeloma as "bone marrow plasma cell percentage >60%." There are several other factors, but the bone marrow involvement is the key point for your case. The pathologist also states that the bone marrow is consistent with "plasma cell neoplasm," which by itself is not the same as multiple myeloma.

This case has 5-10% involvement by plasma cell neoplasm. This does not meet the bone marrow qualifications for multiple myeloma and is consistent with the pathologist's statement that there is minimal bone marrow involvement.

We will be updating the Hematopoietic and Lymphoid Neoplasms Database and Manual to clarify this (2025 updates).

Date Finalized:
02/20/2024

20240005

References:
2022 SEER Manual, 140-143. Mets at Diagnosis--Bone, --Brain

Question:
SEER Manual/Mets at Diagnosis--Lung: Would calvarium lesions invading the brain be both brain and bone metastasis or only bone metastasis? See Discussion.

Discussion:
Lung cancer, 2022

12/1/2022 PET/CT showed destructive hypermetabolic bone lesions in right frontal and left posterior calvarium. Left posterior calvarium lesion involves portions of left parietal and temporal bones w/invasion of mastoid air cells.

1/4/2023 MRI Brain showed large destructive mass involving left posterior temporal calvarium that extends into left mastoid region and may invade left distal transverse sinus.

2/8/2023 Radiation Oncology follow-up note: MD states there are extensive calvarium metastasis with the left parietal lesion invading the brain causing edema and MS-like changes.

2/13/23 Radiation Oncology Final Letter- Patient was treated with 1 EBRT fraction aimed at brain/skull before enrolling in hospice.

Answer:
Abstract as bone metastasis for the first two examples. Abstract as both bone and brain metastasis for the third and fourth examples in the respective Mets at Diagnosis fields based on the description provided.

Date Finalized:
02/20/2024

20240004

References:
#1: 2023 SEER Manual, Appendix E.1. see also 2024 SEER Manual
#2: Solid Tumor Rules. Other Sites, May 2023 Update

Question:
Reportability/Histology--Skin: Is a malignant spindle cell neoplasm consistent with atypical fibroxanthoma reportable for cases diagnosed 1/1/2023 and later, after thorough immunohistochemical work-up? See Discussion.

Discussion:
Appendix E1 in both the 2023 and 2024 SEER Program Coding and Staging Manual (SPCSM) lists these malignant spindle cell neoplasms, consistent with atypical fibroxanthoma, as reportable when other tumors have been ruled out with immunohistochemistry. This contradicts both SINQ 20190102 and the Solid Tumor Rules (STRs) general instructions indicating ambiguous terminology (e.g., "consistent with") cannot be used to code the more specific histology when there is a NOS (malignant spindle cell neoplasm, 8004/3) and a more specific (malignant atypical fibroxanthoma, 8830/3) histology.

These tumors are typically diagnosed and treated in dermatology offices, so further chart review or confirmation by a physician is not possible for central registries.

As non-melanoma skin primaries are included in the Other Sites schema, and this schema was updated for cases diagnosed 2023 and later, which instruction applies to 2023+ diagnoses? Should these continue to be collected per Appendix E1 despite the conflict with the STR Manual and SINQ? If these are reportable, should the SINQ and STR Manual be updated to reflect this? Or should these be non-reportable per the STR Manual and SINQ?

Answer:
Report malignant spindle cell neoplasms consistent with atypical fibroxanthoma as directed by Appendix E.1 of the 2023 and 2024 versions of the SEER Manual using 8830/3 (fibroxanthoma, malignant).

We will update the answer in SINQ 20190102. While the Other Sites Solid Tumor Rules address coding an NOS and specific histology sub-type/variant, this situation is not specifically addressed. We will also review the rules.

Date Finalized:
02/20/2024

20240003

References:
ICD-O-3.2

Question:
Solid Tumor Rules/Histology--Head & Neck: How is histology coded for laryngeal intraepithelial neoplasia II-III (LIN II or LIN III)? See Discussion.

Discussion:
Laryngeal intraepithelial neoplasia II-III is not included in the ICD-O-3.2 and, while the SEER Program Coding and Staging Manual (SPCSM) confirms this is reportable, neither the SPCSM nor the Solid Tumor Rules Manual provide the specific histology to use for LIN II or LIN III. Should this be coded as 8077/2 since this is most like a high-grade squamous dysplasia?

Answer:
Assign histology code, 8077/2 (squamous intraepithelial neoplasia, high grade) for LIN III and for LIN II. ICD-O-3.2 lists squamous intraepithelial neoplasia, grade II and grade III as 8077/2 indicating it is reportable. ICD-O-3.2 does not list every site-specific type of intraepithelial neoplasia. Check the SEER manual for reportable and non-reportable examples.

Date Finalized:
02/20/2024

20240002

References:
#1: Heme & Lymph Manual & DB, 25-26. Published August 2021
#2: 2023 SEER Manual, 234-236. Other Therapy

Question:
First Course Treatment--Heme & Lymphoid Neoplasms: How should treatment data items be coded for a diagnosis of myelodysplastic syndrome (MDS) and symptomatic anemia treated with Reblozyl (Luspatercept)? See Discussion.

Discussion:
Example: Patient has a 04/2023 diagnosis of symptomatic anemia not responsive to Retacrit. Further testing includes diagnostic bone marrow biopsy 10/2023 proving MDS with low blasts and SF3B1 mutation, treated with Relozyl (Luspatercept).

There is no SEER*Rx listing for Reblozyl or Luspatercept. Per web search, Luspatercept, sold under the brand name Reblozyl, is a medication used for the treatment of anemia in beta thalassemia and myelodysplastic syndromes.

Is this non-cancer directed treatment since it is given to address the anemia rather than the MDS? If cancer-directed treatment, how should it be coded?

Answer:
Do not code Reblozyl (luspatercept) as treatment. Luspatercept is an ancillary drug approved to treat anemia associated with MDS but not the malignancy.

Date Finalized:
02/20/2024

20230080

References:
Solid Tumor Rules. Non-Malignant CNS, 2023 Update

Question:
Solid Tumor Rules/Histology--Brain and CNS: What is the histology code for low grade glioma? See Discussion.

Discussion:
Patient has a 3 cm tumor in the temporal lobe of the brain. This was noted on MRI 12/2022. The radiologist states this is a low-grade glioma and recommends following with routine scans. No pathology or resection performed or planned. Patient has been followed with imaging every six months with stable disease. Low grade glioma is not currently listed in ICD-O-3.2 or the current Solid Tumor Rules. What histology should be assigned to the case?

Answer:
Assign 9380/1 for low grade glioma diagnosed 1/1/2018 forward and for low grade glioma diagnosed prior to 1/1/2018 assign code 8000/1 on the advice of our expert neuropathologists. The site/type combination of C71 _ and 9380/1 will flag histology/site/behavior edits which should be overridden.

Low grade glioma is an umbrella term or non-specific diagnosis, primarily seen on radiologic reports such as CT scans and MRIs. Often, the patient is actively followed with scans and surgical intervention delayed or not recommended. WHO Classification of Central Nervous System Tumors, 5th edition, does not recognize this term and indicates that tissue diagnosis (including genetic testing) is needed to provide a specific diagnosis. Since biopsy of these “neoplasms” is not routinely done, a definitive diagnosis is not available. Literature searches yielded conflicting information with some stating low grade gliomas are malignant with an indolent clinical course while others felt they were benign. Until such time as WHO proposes a code for this neoplasm, our expert neuropathologists recommend coding glioma, NOS with borderline behavior 9380/1.

Date Finalized:
02/20/2024

20230079

References:
#1: ICD-O-3.2. 2021 Update
#2: Solid Tumor Rules. Cutaneous Melanoma; 2023 Update

Question:
Solid Tumor Rules/Histology--Cutaneous Melanoma: How is histology coded for a 2023 diagnosis of “early lentiginous melanoma in situ” of the skin? See Discussion.

Discussion:
Previous SINQ 20091100 has a similar scenario, and the instruction was to code as lentigo maligna (8742/2); however, it does not appear to be applicable to cases diagnosed after 2020.

The WHO Blue Book does not list melanoma, lentiginous type or lentiginous melanoma in situ as an alternate term for lentigo maligna and neither do the STR or the ICD-O-3.2.

Answer:
Assign code 8742/2 (lentigo maligna) for “early lentiginous melanoma in situ.” ICD-O-3.2 lists the preferred term for 8742/2 as lentigo maligna (C44._).

Date Finalized:
02/20/2024

20230069

References:
#1: 2023 SEER Manual, 214-216. Immunotherapy
#2: SEER*Rx

Question:
First Course Treatment/Immunotherapy--Colon: Is Infliximab cancer directed treatment? See Discussion.

Discussion:
While SEER*Rx does indicate Infliximab should be coded as biological response modifier (BRM)/Immunotherapy, the manufacturer website for this medication indicates it is given for: Crohn's disease, ulcerative colitis, rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, and plaque psoriasis. In addition, SEER*Rx does not indicate which primary sites this treatment may be given for. If it is indeed cancer directed treatment, can the typical primary sites be added for clarity?

Case example: Patient is diagnosed with colorectal cancer and also has an existing diagnosis of Crohn's disease; received surgery and FOLFOX6, as well as Infliximab. There was no statement of what disease the Infliximab was given to treat.

Answer:
Infliximab is not cancer-directed treatment. This drug was last updated by the FDA 2/22/2023 with additional information on its approval to treat non-malignant neoplasms. To date, the FDA has not approved it for use in colon cancer. This drug was initially developed to treat colon cancer; however, found to be ineffective treating cancer.

Date Finalized:
02/14/2024

20230068

References:
#1: WHO Class Endocrine Tumors, 81-91; 100-103. 5th edition
#2: Solid Tumor Rules. Other Sites, May 2023 Update

Question:
Solid Tumor Rules/Histology--Thyroid: What is the histology code for a diagnosis of poorly differentiated thyroid carcinoma arising in a background of solid papillary thyroid carcinoma? See Discussion.

Discussion:
Patient had a hemithyroidectomy with the final diagnosis above. There does not appear to be an Other Sites H rule or table that addresses this combination of histologies for thyroid primaries.

Answer:
Code to poorly differentiated thyroid carcinoma, 8337/3.

In this case the tumor is comprised of two different thyroid histologies: poorly differentiated carcinoma 8337/3 and papillary thyroid carcinoma 8260/3. WHO does not have a code for this combination. Per our endocrine pathology expert, the poorly differentiated carcinoma is the more aggressive histology and will determine treatment and prognosis.

Date Finalized:
02/12/2024

20230067

References:
2023 SEER Manual, 173-176; 178-180. Scope of RLN Surg; Sentinel LNs Examined; Sentinel LNs Positive

Question:
First Course Treatment/Scope of Regional Lymph Node Surgery--Breast: How is Scope of Regional Lymph Node Surgery coded when initially there is a sentinel lymph node biopsy (SLNBx) and an intramammary node removed followed a month later by an axillary dissection for a right breast primary? See Discussion.

Discussion:
Patient has a diagnosis of invasive carcinoma of the right breast from a core biopsy on 04/2023. Subsequent bilateral mastectomy and sentinel node biopsy proves one positive sentinel node and one negative intramammary node. One month later there is a completion axillary node dissection with 15 nodes negative for malignancy.

Per previous SINQ 20190074, the initial mastectomy and sentinel node excision with intramammary node removal should be coded as Scope of Regional Lymph Node Surgery 6. It is unclear how the resulting axillary dissection should be recorded in Scope of Regional Lymph Node Surgery. There is no code for sentinel node biopsy and 3, 4, or 5 at same time (code 6) PLUS an additional subsequent axillary dissection.

Please provide coding instructions for Sentinel Lymph Nodes Positive, Sentinel Lymph Nodes Examined, and Scope of Regional Lymph Node Surgery in this scenario.

Answer:
Scope of Regional Lymph Node Surgery: Assign code 7, Sentinel node biopsy and code 3, 4, or 5 at different times. In this case, the SLNBx (code 2) preceded the regional node dissection (code 5: 4 or more regional lymph nodes removed), i.e., procedures performed in separate surgical events.

Sentinel Lymph Nodes Examined: Assign code 98, Sentinel lymph nodes were biopsied, but the number is unknown. In this case, only the results were provided.

Sentinel Lymph Nodes Positive: Assign code 01, Sentinel nodes are positive (code exact number of nodes positive). In this case, there was one positive sentinel node.

Date Finalized:
02/14/2024

20230066

References:
#1: Solid Tumor Rules. Lung, May 2023 Update
#2: 2021 ICD-O-3.2 Update

Question:
Solid Tumor Rules/Histology--Lung: Table 3 in Lung Solid Tumor Rules, 2023 Update, lists Neuroendocrine Carcinoma, NOS 8246 as a specific subtype/variant for Small Cell Carcinoma 8041/3. Should the table be updated? See Discussion.

Discussion:
Small Cell Carcinoma is a specific type of Neuroendocrine Carcinoma for the lung. However, Table 3 lists Neuroendocrine Carcinoma, NOS as the more specific subtype/variant in Column 3.

Using Lung Solid Tumor Rules, Rule H6, a diagnosis of Poorly Differentiated Neuroendocrine Carcinoma (Small Cell Carcinoma)" would be coded as 8246, instead of 8041, because there are two histologies under consideration (an NOS and a subtype/variant in Table 3), and the rule tells us to code the subtype/variant. However, Small Cell Carcinoma is more specific than the NOS diagnosis (Neuroendocrine Carcinoma, NOS). Should Table 3 be updated to reflect which histology is the NOS and which is the more specific?

Answer:
The Solid Tumor Rules for Lung have been updated for 2024. The row for Small Cell Carcinoma 8041/3 has been deleted and new separate rows have been added for Neuroendocrine carcinoma (NEC) 8246 and Neuroendocrine tumor, NOS (NET) 8240. This change is based on the WHO Classification of Thoracic Tumors, 5th edition, and current concepts. In addition, Table 3 now reflects that Small Cell Carcinoma/Small Cell Neuroendocrine Carcinoma 8041 (located in Column 3) is a subtype/variant of Neuroendocrine Carcinoma, NEC 8246 (Column 1). As a result, application of Rule H6 to a diagnosis of Poorly Differentiated Neuroendocrine Carcinoma (Small Cell Carcinoma)" would be coded as 8041, instead of 8246. **Please note:** the 2024 updates may be used for cases diagnosed prior to 1/1/2024 unless otherwise noted in the rules.

Date Finalized:
02/12/2024

20230065

References:
Solid Tumor Rules. Other Sites, May 2023 update

Question:
Solid Tumor Rules/Histology--Prostate: Is histology coded as 8045 (Combined small cell carcinoma) for a 2023 diagnosis of two-component carcinoma comprised of both acinar adenocarcinoma and small cell neuroendocrine carcinoma of the prostate? See Discussion.

Discussion:
This patient does not have a previous diagnosis of prostate adenocarcinoma nor a previous history of androgen-deprivation therapy.

Does the logic in the Other Sites Solid Tumor Rules (STRs) noted in SINQ 20200052 still apply? This SINQ confirms a diagnosis of mixed prostatic adenocarcinoma and small cell neuroendocrine carcinoma is 8045. This matches the STRs instructions for Rule H21 and Table 2 (Mixed and Combination Codes), row 1. Row 1 indicates a mixed small cell carcinoma and adenocarcinoma is combined small cell carcinoma (8045). For a patient without previous treatment, is this the correct mixed histology code?

Answer:
Code histology as combined small cell carcinoma (8045) based on the Other Sites Solid Tumor Rules, May 2023 Update, Table 2, Mixed and Combination Codes, for this mixed histology prostate carcinoma consisting of adenocarcinoma and small cell neuroendocrine carcinoma regardless of treatment status. This is similar to SINQ 20200052 that applies to one tumor with mixed histologies.

Date Finalized:
02/12/2024

20230064

References:
#1: 2023 SEER Manual, 92-97. Primary Site
#2: ICD-O-3, 45. ICD-O, 3rd edition (purple book)

Question:
Primary Site--Cervix Uteri: When no other information is available regarding the origin of the tumor, can an overlapping cervical adenocarcinoma (C538, 8140/3) be coded to the endocervix (C530) based on the histology? See Discussion.

Discussion:
Adenocarcinoma is a glandular tumor and the endocervix is generally the origin of glandular tissue for the cervix. However, if the only available information is pathology proving a single tumor overlapping the endocervix and exocervix, can we code the site to C530 instead of C538?

Applying the current primary site coding instructions, primary site would be coded as C538 because there is no specific statement of the tumor origin; the primary site coding instructions state the tumor is coded to an overlapping site in the absence of a specific statement of origin and there is no existing SINQ confirming the site can be assumed to be the endocervix based on the histology.

Answer:
Code Primary Site as Overlapping lesion of cervix uteri (C538). The 2023 SEER Program Coding and Staging Manual Primary Site Coding Instructions for Solid Tumors #4 says to code the last digit of the primary site code to '8' when a single tumor overlaps an adjacent subsite(s) of an organ, and the point of origin cannot be determined. This is also supported by the ICD-O-3, 3rd edition, note in the Topography section that states: In categories C00 to C809, neoplasms should be assigned to the subcategory that includes the point of origin of the tumor. A tumor that overlaps the boundaries of two or more subcategories and whose point of origin cannot be determined should be classified to subcategory '8."

Date Finalized:
02/12/2024

20230063

References:
#1: 2018 EOD Manual. General Instructions; SEER*RSA Melanoma Skin
#2: SEER Summary Stage 2000. Skin

Question:
EOD 2018/EOD Regional Nodes--Melanoma: Can central cancer registries code Extent of Disease (EOD) Regional Nodes as 000 based on Breslow's depth and/or Clark's Level (per EOD and/or Summary Stage) from a melanoma pathology only report with a localized tumor and no information on regional lymph nodes or mets. See Discussion.

Discussion:
Based on the EOD General instructions for accessible sites, the following three requirements must be met

a. There is no mention of regional lymph node involvement in the physical examination, pre-treatment diagnostic testing, or surgical exploration;

b. The patient has localized disease;

c. The patient receives what would be the standard treatment to the primary site (treatment appropriate to the stage of disease as determined by the physician), or patient is offered usual treatment but refuses it.

As a central registry, we receive a lot of melanoma path reports but never receive an abstract since the patients are seen at a dermatology office that does not report to the central registry. In these scenarios, we have both the diagnosis and wide excision or Mohs surgery from which we create a consolidated record. It is not often that lymph nodes are removed which indicates there were no palpable nodes.

Since Breslow's and Clark's level allow for summary staging, is it possible to have central registry guidelines that allow for coding lymph nodes other than 999? The path reports meet two of the three criteria. Is there any new literature that supports coding lymph nodes 000 based on a Clark's level or Breslow measure providing the patient has a wide excision?

Answer:
Assign 000 for EOD Regional Nodes when you have a pathology only report with a localized tumor based on Breslow's depth and/or Clark's Level (per EOD and/or Summary Stage) and no information on regional lymph nodes or mets. When the tumor is noted to be regional or distant based on Breslow's Depth and/or Clark's based on the definitions in EOD and/or Summary Stage, do not assume that the nodes are negative and assign 999. Clarification will be added to the EOD manual.

FINALIZED SEER SINQ QUESTIONS

January – February 2024

Date Finalized:
02/12/2024

20230061

References:
2018 EOD Manual. SEER*RSA, EOD Prostate Pathologic Extension

Question:
EOD (2018)/EOD Primary Tumor--Prostate: How is Extent of Disease (EOD) Prostate Pathologic Extension coded when no residual cancer is found? See Discussion.

Discussion:
Patient was diagnosed with a pT1c prostate cancer in 2022. Patient was then treated with radical prostatectomy. No residual disease was found. Would the correct EOD prostate path extension code be 999 based on Note 8 (code 999 when radical prostatectomy is performed, but there is no information on the extension); or, would we use code 300 (confined to prostate) because the data item "…is used to assign pT category for prostate cancer based on radical prostatectomy specimens" and we know it was limited to the prostate because no residual was found?

Answer:
Assign code 300 for EOD Prostate Pathologic Extension.

In this scenario, the patient has a localized cancer confirmed by radical prostatectomy; the needle core biopsies likely removed all the cancer. Unlike prostate, other sites' extension information is collected in EOD Primary Tumor, as seen commonly with breast tumors where the results from the surgical resection are recorded with tumor confined to primary site.

Date Finalized:
02/12/2024

20230060

References:
#1: WHO Class Urinary System and Male Genital Organs, online. 5th edition
#2: Subject matter expert

Question:
Histology--Urinary: How is histology coded for a diagnosis of bladder carcinoma with a mix of different urothelial carcinoma subtypes? See Discussion.

Discussion:
The 10/2023 TURBT final diagnosis is “Urothelial carcinoma with mixed histologic appearances, see synoptic summary below for details.” The synoptic report includes, “Histologic Type Comment: Invasive carcinoma percentages: Micropapillary 60-70%, high grade or poorly differentiated urothelial 20-30%, squamous 10-20%.” The squamous component is stated to be “Urothelial carcinoma with squamous differentiation.”

It appears there are two specific urothelial carcinoma subtypes to consider: Urothelial carcinoma, micropapillary variant (8131/3) and poorly differentiated carcinoma (8020/3). The squamous component would not be considered because there is no specific histology for “squamous differentiation.”

The micropapillary component is the predominant histology (60-70%) in this case, and it does seem like this is important to capture. However, the WHO Blue Book indicates poorly differentiated carcinoma of the bladder has a poor prognosis.

Answer:
Code histology as urothelial carcinoma, NOS (8120/3). Our subject matter expert advises that WHO Classification of Urinary and Male Genital Tumors, 5th edition, does not recognize mixed urinary histologies; therefore, has not assigned an ICD-O code for urothelial mixed with multiple variants. Only pure variants are coded as they have a different prognosis from those that are mixed. According to WHO, invasive urothelial carcinoma is remarkable for its diversity of morphological appearances and a single lesion can display an admixture of conventional urothelial and various well-defined histological subtypes.

Date Finalized:
02/12/2024

20230059

References:
WHO Class Hem & Lymph Tumors. 5th edition, Beta version 2

Question:
Histology--Heme and Lymphoid Neoplasms: How is histology coded for a diagnosis stated as MDS/AML (myelodysplastic syndrome/acute myeloid leukemia) per the international consensus classification (ICC)? See Discussion.

Discussion:
The final diagnosis on bone marrow biopsy was high grade myeloid stem cell neoplasm, 17% blasts by differential count. The pathologist further states that this could be classified as "MDS with increased blasts (MDS-IB2) per the WHO 5th edition classification, or MDS/AML per the international consensus classification (ICC)." FISH and cytogenetics revealed a loss of 7q, but no other AML-related genetic abnormalities. The physician confirms the patient has MDS/AML.

Answer:
Code histology as myelodysplastic neoplasm with increased blasts (9983/3) based on the WHO Classification of Hematolymphoid Tumors, 5th edition, Beta version 2. WHO lists MDS with increased blasts-2 (MDS-IB2) as a subtype of 9983/3.

When differences exist between WHO and ICC, assign the histology based on the WHO Classification.

Date Finalized:
02/12/2024

20230058

References:
Solid Tumor Rules. Breast, 2023 Update, General Instructions

Question:
Solid Tumor Rules/Multiple Primaries--Breast: How many primaries should be accessioned for a patient with known history of right breast carcinoma in 2018 followed by 2022 biopsy proven right and left breast invasive ductal carcinoma if the physician states this is a right breast primary with widespread metastasis including the left breast? See Discussion.

Discussion:
The patient was initially diagnosed with invasive mammary carcinoma of the right breast in 2018, treated with lumpectomy, sentinel node biopsy, radiation, and hormones. Hormones were discontinued early due to dysfunctional uterine bleeding.

Answer:
This is a single primary according to the Solid Tumor Rules.

1. Breast Solid Tumor Rule M18 applies to the occurrence of the second right breast tumor (single primary).
2. Apply the Solid Tumor Rules, General Instructions, that state the rules are NOT used for tumor(s) described as metastases. Tumor in a metastatic site is not counted when applying the Solid Tumor rules. In this case, the physician stated that this is a right breast primary with widespread metastasis to the left breast.

Date Finalized:
02/12/2024

20230057

References:
#1: WHO Class Endocrine Tumors, 81-91. 5th edition
#2: 2018 EOD Manual. EOD Regional Nodes; see SEER*RSA

Question:
EOD (2018)/EOD Regional Nodes--Thyroid: How is Extent of Disease (EOD) Regional Nodes coded for thyroid primary with cervical lymph nodes containing psammomatous calcifications (psammoma bodies) but negative for metastatic tumor cells? See Discussion.

Discussion:
The AJCC 8th edition confirms that the identification of psammomatous calcifications within a cervical lymph node is metastatic disease.

Example: Patient had a thyroid lobectomy and level VI neck node excision in August 2022. The final diagnosis is multifocal papillary carcinoma of the thyroid, as well as rare psammomatous calcifications only in the resected node. The pathologist notes that "psammoma bodies only" in lymph nodes is not well defined, and while indolent, they do indicate capacity for lymphatic spread and are pN1a.

Should thyroid primaries with cervical node psammomatous calcifications get captured in EOD Regional Nodes category as it is in the AJCC pN staging?

Answer:
Assign EOD Regional Nodes code 300 for Psammoma bodies within a cervical lymph node that are microscopically confirmed. A clarifying note for the Thyroid Schema will be included in the 2025 EOD updates.

Date Finalized:
02/12/2024

20230056

References:
WHO Class Hem & Lymph Tumors. 5th edition, Beta version

Question:
Reportability/Histology--Heme and Lymphoid Neoplasms: What is the histology code for nodular lymphocyte predominant B cell lymphoma that is never called Hodgkin lymphoma? Is it acceptable to record the histology code for nodular lymphocyte predominant Hodgkin lymphoma, (9659/3)? See Discussion.

Discussion:
Patient has a history of human immunodeficiency virus and diffuse large B cell lymphoma diagnosed in 2012 and is status/post systemic therapy and in remission since completing first course treatment. In 2022, the patient has imaging suspicious for recurrence. A biopsy of a deep left cervical lymph node showed atypical lymphoid infiltrate with the comment: “This is a challenging case. The constellation of findings is most in keeping with early / focal and subtle involvement by a nodular lymphocyte predominant B-cell lymphoma. We find no evidence of involvement by a diffuse large B-cell lymphoma.” The managing physician later states, “Cervical lymph node biopsy (06/2022) was consistent with nodular lymphocyte predominant B cell lymphoma.”

Answer:
According to the 5th edition WHO Blue Book for Hematopoietic Neoplasms, Beta Version, (not released yet), nodular lymphocyte predominant B-cell lymphoma is an alternate name for 9659/3. We will update the Heme database once the 5th edition is released in print.

Date Finalized:
02/12/2024

20230055

References:
2010 Heme & Lymph Manual & DB, 29. General Instructions for Multiple Primary Rules

Question:
Reportability/Histology--Heme and Lymphoid Neoplasms: Is "the differential diagnoses include, but not limited to, mantle cell lymphoma, atypical chronic lymphocytic leukemia/small lymphocytic lymphoma and a variant of marginal zone lymphoma" reportable? In the Heme manual, they use differential diagnosis that include reportable conditions as reportable. This can be found under Code 1: positive histology in the Diagnostic Confirmation Coding Instruction section page 18. The phrase "include, but not limited to" makes this not clear.

Answer:
This is reportable as 9591/3, B-cell lymphoma, NOS. All diagnoses in the differential are all B-cell lymphomas. The pathologist knows it is a B-cell lymphoma but has not determined the subtype. If at a later time a specific lymphoma is determined, update the histology code accordingly.

Date Finalized:
02/12/2024

20230054

References:
#1: WHO Class Digest System Tumors, 4th ed.: pp. 327-330; 5th ed.: 340-342. 4th and 5th editions
#2: 2015 SEER Manual, 14. See also subsequent manuals.

Question:
Reportability/Histology--Pancreas: According to SINQ 20140058, solid pseudopapillary neoplasm of the pancreas is reportable (as of 2014). However, per ICD-O-3.2, this histology is not reportable until 2021+. Please clarify which is correct and clearly state the timeframe that it was reportable or not reportable.

Answer:
Solid pseudopapillary neoplasm of the pancreas is reportable for cases diagnosed in 2014 and later. Report solid pseudopapillary neoplasm of the pancreas (8452/3) as the guidance in SINQ 20140058 is still in effect.

The 4th and 5th editions of the WHO Classification of Tumors of the digestive system define solid pseudopapillary neoplasm of the pancreas as a low-grade malignant pancreatic tumor.

Date Finalized:
02/12/2024

20230053

References:
#1: ICD-O-3.2
#2: Subject matter expert. SINQ 20220032

Question:
Reportability/Histology--Ovary/Testis: Is serous borderline tumor-micropapillary variant (8460/2) of the ovary or testis reportable? If so, what dates are applicable to the reportability changes? See Discussion.

Discussion:
Serous borderline tumor–micropapillary variant (8460/2, C569) was included in the ICD-O-3 Behavior Code/term updates effective 1/1/2018 but marked as Not Reportable for 2018.

There have been multiple additional updates to the ICD-O but no further clarification as to the reportability of this histology. ICD-O-3.2 currently lists serous borderline tumor, micropapillary variant (C569) as 8460/2 with no mention of reportability and no information provided in Includes/Excludes.

SINQ 20220032 instructs capturing this histology as reportable when diagnosed 1/1/2021 or later and occurring in the testis. The answer indicates this is reportable due to the /2 behavior code in ICD-O-3.2, but it does not specify that it is limited to specific sites.

Is serous borderline tumor, micropapillary variant reportable for ovary? If so, what dates apply? Is serous borderline tumor, micropapillary variant of the testis diagnosed after 1/1/2021 reportable?

Answer:
Do not report serous borderline tumor–micropapillary variant of the ovary (8460/2, C569) as borderline ovarian tumors are not reportable. This applies to cases 2018 and later.

Do report serous borderline tumor–micropapillary variant of the testis as stated in SINQ 20220032. It is reportable for cases diagnosed Jan 1, 2021, and later.

Date Finalized:
02/12/2024

20230052

References:
2023 SEER Manual, 92-97. Primary Site

Question:
Reportability/Primary Site--Brain and CNS: What is the primary site of a meningioma arising from the jugular bulb/petrous aspect of the temporal bone? See Discussion.

Discussion:
July 2022, Brain CT describes a mass appearing to be centered on the petrous aspect of the temporal bone with intracranial and extracranial extension.

July 2022, Brain MRI describes an extra-axial mass centered in the right jugular bulb with intracranial and intraosseous extension as well as extension within the internal jugular vein.

September 2022, Resection operative report surgical findings are of a calcified mass filling middle ear, abutting stapes and appearing to enter the stapes obturator foramen, debulked. Final diagnosis is right middle ear meningioma, WHO grade I of III.

Is this a reportable intraosseous meningioma of the temporal bone/skull base, or a non-reportable meningioma arising in a meningocele within the middle ear?

Answer:
Do not report cases of meningioma originating in the jugular bulb or petrous aspect of temporal bone or middle ear. These are not intracranial locations.

This is a non-reportable meningioma arising in a meningocele within the middle ear. The jugular bulb is the confluence of the lateral venous sinuses situated in the jugular fossa. The precise location of this structure within the temporal bone is variable. The jugular bulb, petrous aspect of temporal bone, and middle ear are not intracranial locations, and therefore meningiomas arising in these areas are not reportable.

Date Finalized:
02/12/2024

20230051

References:
#1: Subject matter expert
#2: 2023 SEER Manual, 172. Surgical Margins of the Primary Site

Question:
First Course Treatment/Surgical Margins of the Primary Site--Melanoma: Is margin status positive or negative when the lesion “approximates” margins? This was noted in the pathology report comment on a malignant melanoma in-situ shave biopsy. Follow-up with physicians is not possible in this situation.

Answer:
Assign margin status as “positive” when stated as approximates margins as recommended by our expert pathologists. Approximating means coming right up to inked margin without the margin transecting the tumor.

Date Finalized:
02/12/2024

20230050

References:
#1: ICD-O-3.2
#2: WHO Class Soft Tissue and Bone, 71-73

Question:
Reportability/Histology--Soft Tissue: Is a diagnosis of Myofibroblastoma with sarcomatous transformation a reportable malignancy? See Discussion.

Discussion:
Patient was diagnosed in September 2022 via excision of a 12 cm pelvic mass with final diagnosis of Myofibroblastoma with sarcomatous transformation.

Diagnosis comment states, “Most of the tumor is composed of conventional features of myofibroblastoma. However, a focal area demonstrates increased cellularity, fascicular growth and increased mitotic activity (up to 11 per 10 hpf), consistent with sarcomatous transformation (morphologically low to intermediate grade).”

Is this sarcomatous transformation describing a malignant transformation from an otherwise benign histology? If so, how should histology be coded in this case?

Answer:
Do not report the case. The histology is 8825/0 based on the example provided and not reportable. Myofibroblastoma with sarcomatous transformation is a rare, benign condition, sometimes referred to as sarcomatous features. A malignant tumor would be referred to as a myofibroblastic sarcoma.

Date Finalized:
02/12/2024

20230049

References:
2023 SEER Manual, 169-171. Surgery of Primary Site 2023; Appendix C Coding Guidelines

Question:
Update to Current Manual/Surgery of Primary Site 2023--Skin: Regarding the 2023 skin surgery codes for punch biopsy NOS (B220) and shave biopsy NOS (B230), how is Date of First Surgical Procedure coded for cutaneous lymphoma and Kaposi sarcoma when the punch or shave biopsy is not excisional? See Discussion.

Discussion:
Now that there are specific surgery codes for shave and punch biopsies, are these biopsies always the Date of First Surgical Procedure (NAACCR Item #1200)? Or should we still be applying the Surgery of Primary Site 2023 instruction in the SEER Manual that states shave or punch biopsies are most often diagnostic; code as a surgical procedure only when the entire tumor is removed and margins are free/gross disease is removed?

We are aware of the instruction for melanoma cases outlined in SINQ 20230034; however, it is unclear if this should also apply to cutaneous lymphomas and Kaposi sarcomas, or if the intent of the procedure is used for these specific types of skin cases that typically present with multifocal involvement.

Example 1: Patient is diagnosed March 2023 with primary cutaneous T-cell lymphoma presenting pink, tan patches on the trunk. Punch biopsy diagnosed CTCL and treatment was given via narrow band UVB phototherapy.

Example 2: Patient is diagnosed February 2023 with Kaposi sarcoma presenting as widespread violaceous macules, papules, plaques on the torso, bilateral extremities, and abdomen. Punch biopsy diagnosed Kaposi sarcoma.

Answer:
Code the Date of First Surgical Procedure (NAACCR Item #1200) as the date the shave, punch, or elliptical biopsy was performed. This instruction applies to cutaneous lymphoma and Kaposi sarcoma as well. Beginning with cases diagnosed 2023 and after, shave, punch, or elliptical biopsies are coded as a surgical procedure regardless of margin status.

The instruction in the 2023 SEER Manual that states "shave or punch biopsies are most often diagnostic; code as a surgical procedure only when the entire tumor is removed, and margins are free/gross disease is removed" has been deleted from the 2024 SEER Manual. Refer also to the Appendix C Coding Guidelines for Kaposi Sarcoma of All Sites and Lymphoma for coding primary site.

FINALIZED SEER SINQ QUESTIONS

January – February 2024

Date Finalized:
02/12/2024

20230048

References:
Solid Tumor Rules. Other Sites, May 2023 update

Question:
Solid Tumor Rules/Histology--Uterine Corpus: How is histology coded for an epithelioid and myxoid leiomyosarcoma of the myometrium? See Discussion.

Discussion:
Patient had a total abdominal hysterectomy-bilateral salpingo-oophorectomy performed in January 2023 with final diagnosis of myxoid and epithelioid leiomyosarcoma.

Diagnosis comment states: The tumor is 15 cm per report. It grows in nests and poorly formed interanastomosing trabeculae and cords that are separated by abundant myxoid background. The cells have an epithelioid morphology with eosinophilic cytoplasm, large nuclei, and very prominent nucleoli. The mitotic activity is overall low ranging from 1 to 3/10 HPFs.

Immunohistochemical stains performed at the outside hospital showed diffuse positivity for SMA, desmin, caldesmon, and PR. They are negative for CD10, claudin-4, calretinin, HBM45, MART1 (rare weakly positive cells), PANCK, and SOX10. This immunohistochemical profile supports a smooth muscle derivation of this neoplasm. As this tumor is extensively myxoid, diagnostic criteria differ from the spindle cell leiomyosarcoma.

Per Solid Tumor Rules Other Sites, Table 16: Uterine Corpus Histologies, Epithelioid Leiomyosarcoma (8891/3) and Myxoid Leiomyosarcoma (8896/3) are both subtypes of Sarcoma, NOS (8800/3). Per Rule H21, use a combination code when there are multiple specific histologies AND the combination is listed in Table 2 OR there are coding instructions for the combination in the applicable histology Tables 3-21 OR you receive a combination code from Ask A SEER Registrar. Since there is no combination listed in Table 2 and there is no instruction for the combination in Table 16, how should the histology be coded for this tumor?

Answers:

Assign code 8891/3 (epithelioid leiomyosarcoma) as cells were described as having an epithelioid morphology, whereas myxoid was used as a descriptive term and not a specific histologic type.

Date Finalized:
02/12/2024

20230047

References:
2023 SEER Manual, p. 107. Behavior Code, In Situ and Invasive section

Question:
Reportability/Histology--Head & Neck: Is a 2023 mandibular biopsy showing “severe squamous dysplasia with microscopic focus suspicious for superficial invasion” reportable? See Discussion.

Discussion:
Patient had a mandibular mucosal lesion resected in June of 2023, with a diagnosis of “atypical squamous proliferation” and case was forwarded to an expert in oral pathology for best classification. Subsequent slide review final diagnosis was “moderate to severe squamous dysplasia.” That slide review diagnosis goes on to state “microscopic focus suspicious for superficial invasion.”

Currently there is no ICD-O code for severe squamous dysplasia, however it is unclear if this terminology is equivalent to high grade squamous dysplasia (histology code 8077/2).

Answer:
Report as squamous cell carcinoma (8070/3) on the basis of “microscopic focus suspicious for superficial invasion.” "Severe dysplasia″ is equivalent to "high grade dysplasia" in the Head and neck. As such, "severe squamous dysplasia" would be coded to 8077/2. However, in combination with the statement of "with microscopic focus suspicious for superficial invasion,” report as squamous cell carcinoma (8070/3) based on “microscopic focus suspicious for superficial invasion.” The 2023 SEER Manual instructs us to code the behavior as malignant (/3) if any portion of the primary tumor is invasive no matter how limited, i.e., microinvasion. Use text fields to record the details.

Date Finalized:
02/12/2024

20230046

References:
#1: 2023 SEER Manual
#2: ICD-O-3.2

Question:
Reportability/Histology--Tongue: Is high grade squamous dysplasia of the tongue reportable; and is it the same as carcinoma in situ (CIS), code 8077/2?

Answer:
High grade squamous dysplasia of the tongue is reportable as of 2021 and later as 8077/2.

Date Finalized:
02/12/2024

20230045

References:
2023 SEER Manual, 11-14. Ambiguous Terminology

Question:
Reportability/Histology--Thyroid: Is a diagnosis of "angioinvasive oncocytic thyroid neoplasm with features worrisome for a poorly differentiated oncocytic carcinoma" reportable if the diagnosis comment states, additional immunostains were performed which demonstrate the carcinoma cells are positive for thyroglobulin and negative for calcitonin? See Discussion.

Discussion:
Patient had a right thyroid lobectomy on 12/2022, with initial diagnosis of "thyroid carcinoma pending expert consultation for definitive classification." The slide review documented in the addendum shows a final diagnosis of "Angioinvasive oncocytic thyroid neoplasm, see comment." The subsequent comment states, "I would classify this lesion as an angioinvasive oncocytic thyroid neoplasm with features worrisome for a poorly differentiated oncocytic carcinoma." The comment goes on to state, "Additional immunostains were performed which demonstrate the carcinoma cells are positive for thyroglobulin and negative for calcitonin. The diagnosis remains unchanged."

Answer:
Do not report angioinvasive oncocytic thyroid neoplasm with features worrisome for a poorly differentiated oncocytic carcinoma based on the final, unchanged diagnosis. Worrisome is not a reportable ambiguous terminology.

Date Finalized:
02/12/2024

20230043

References:
#1: Solid Tumor Rules. Lung, May 2023 Update
#2: ICD-O-3.2

Question:
Solid Tumor Rules/Histology--Lung: What is the histology code for a lung tumor diagnosed as "Minimally invasive adenocarcinoma, mixed mucinous and non-mucinous, grade 1, lepidic-predominant"? See Discussion.

Discussion:
The resection pathology report final diagnosis indicates this is both mixed mucinous and non-mucinous with a lepidic predominant component. The pathologist notes this is "Lepidic: 75%. Acinar: 25%." The percentage of the mucinous component is not documented.

Rule H1, Note 1, states "When mucinous carcinoma is mixed with another histology, such as adenocarcinoma and mucinous carcinoma, code mucinous ONLY when mucinous is documented to be greater than 50% of the tumor." While mixed invasive mucinous and non-mucinous carcinoma is included in Table 2 (Combination/Mixed Histology Codes) without a required percentage, it is unclear whether one should move past Rule H7 and use Rule H8 to code this combination histology code. Rule H7 would instruct one to code the histology to lepidic adenocarcinoma (adenocarcinoma, lepidic predominant) based on the percentage of the lepidic component in the tumor. However, this does not address the mixed mucinous and non-mucinous diagnosis. Which H Rule and histology apply to this case?

Answer:
Assign histology code 8254/3 (mixed invasive mucinous and non-mucinous adenocarcinoma) to this lung tumor using Lung Solid Tumor Rules, Rule H4. This is a new code/term approved by IARC/WHO for ICD-O. Rule H4 instructs one to code the histology when only one histology is present. In this case, the pathologist indicates the tumor is mixed mucinous and non-mucinous histologies. The non-mucinous carcinoma that is seen in this mixed histology may be identified as: Adenocarcinoma in situ, minimally invasive adenocarcinoma, or lepidic predominant adenocarcinoma. In this case it is lepidic predominant adenocarcinoma. Lepidic is a recognized histology in lung. It is not unusual for the pathologist to indicate mixed non-mucinous and mucinous adenocarcinoma AND also list the non-mucinous subytpe. It is important to capture both mucinous and non-mucinous histologies which drives treatment, etc.

Date Finalized:
02/12/2024

20230041

References:
Solid Tumor Rules. Breast, 2023 Update; May 2023 Update

Question:
Solid Tumor Rules/Multiple Primaries--Breast: Is an in-situ tumor followed by an invasive tumor a single or multiple primaries? See Discussion.

Discussion:
In the examples below, are these a single or multiple primaries?

Example 1:

Tumor 1: C509/left breast, 8520/2 (in situ lobular carcinoma), dx date-01/10/2019

Tumor 2: C509/ left breast, 8500/3 (carcinoma NST), dx date-08/19/2021

Example 2:

Tumor 1: C509, right breast, 8520/2, dx date 06/26/2014

Tumor 2: C508, right breast, 8500/3, dx date-05/23/2019

There seems to be some conflicting info on this. In the 2020 Breast Rules there was a note added to the revision history. “M10 Same behavior requirement re-added.” Which is not in the rules now, nor was it noted to the revision changes in the last two change logs.

Inquiry 20200070 would seem to indicate that this is multiple primaries, but that contrasts with 20230010 which would seem to indicate a single primary, and an ASK A SEER Registrar question that we received a response to. I don’t see a scenario where rule M17, an invasive tumor DX more than 60 days after an in-situ tumor would come into play.

If behavior no longer applies to rule M10, at what point did that change get made? Please advise.

Answer:
Abstract a single primary when there are multiple tumors of carcinoma NST/duct and lobular using the current Breast Solid Tumor Rules, Rule M10, May 2023 Update, for cases diagnosed 01/01/2018 and forward in the examples provided. The rule also notes to follow the H rules to determine the correct histology code when a mixture of behaviors is present in carcinoma,

NST and lobular carcinoma. Rule M5 does not apply as the timeframe is less than 5 years in both examples.

The 2023 update for the Breast Solid Tumor Rules (released November 2022) states: The rules for determining single versus multiple primaries in tumors with carcinoma NST/duct and lobular carcinoma have been revised and now align with ICD-O-3.2. Applicable Histology Rules have also been revised to reflect ICD-O-3.2 histology terminology and corresponding ICD-O codes.

Date Finalized:
02/20/2024