20210009

References

Source 1: **2021 Solid Tumor Rules**

pgs:

Notes: **Cutaneous Melanoma, December 2020 Update**

Question

Solid Tumor Rules (2018, 2021)/Histology--Melanoma: In what situation will Rule H4 be used to code the histology to regressing melanoma? See Discussion.

Discussion

Rule H4 states: Code 8723/3 (malignant melanoma, regressing) when the diagnosis is regressing melanoma. However, if the diagnosis was strictly regressing melanoma or malignant melanoma, regressing, the first rule that applies is Rule H1 because regressing melanoma is a single, specific histologic type and Rule H1 states: Code the histology when only one histologic type is identified. Following the current rules, one would never arrive at Rule H4. Should the H Rules be reordered? Or should an example of when one would use Rule H4 be added to clarify when to use this rule?

Answer

Coding regressing melanoma has been an issue as registrars may not realize it is a reportable histology. Hence, H4 was written to reinforce correct histology. A note will be added to H1 instructing registrars to continue thru rules when the diagnosis is regressing melanoma.

Date Finalized

04/02/2021

20210008

References

Source 1: **2021 Solid Tumor Rules**

pgs:

Notes: **Cutaneous Melanoma, December 2020 Update**

Question

Solid Tumor Rules (2018, 2021)/Histology--Melanoma: In what situation will Rule H6 be used to code the histology to lentigo maligna melanoma? See Discussion.

Discussion

Rule H6 states: Code 8742/3 (Lentigo maligna melanoma) when the diagnosis is lentigo maligna melanoma with no other histologic types. However, if the diagnosis was strictly lentigo maligna or lentigo maligna melanoma, the first rule that applies is Rule H1 because lentigo maligna melanoma is a single, specific histologic type and Rule H1 states, Code the histology when only one histologic type is identified. Following the current rules, one would never arrive at Rule H6. Should the H Rules be reordered? Or should an example of when one would use Rule H6 be added to clarify when to use this rule?

Answer

Solid Tumor rule H6 is the same as MP/H rule H8. We found registrars have problems understanding reportable terminology and the corresponding ICD-O-3 histology code for lentigo maligna melanoma. It is included in H6 to capture cases where the registrar may not stop at H1. We will add another note to H1 instructing users to continue through the rules if the diagnosis is lentigo maligna melanoma.

Date Finalized

04/02/2021

20210007

References
Source 1: **2021 SEER Manual**
pgs: **186**
Notes: **Reason for No Surgery of Primary Site**

Question
First Course Treatment/Reason for No Surgery of Primary Site: How should we be coding Reason For No Surgery of Primary Site for cases where surgery was planned but ultimately cancelled due to progression? See Discussion.

Discussion
There is a discrepancy in the SEER and STORE manual definition of code 2 for Reason for No Surgery of Primary Site. STORE includes progression of tumor prior to planned surgery as part of the definition for code 2, but the SEER Manual does not. The progression statement is included in the SEER Manual (2018 and 2021) for Reason for No Radiation, but not for Reason for No Surgery.

Answer
Assign code 2 for cases where surgery was planned but ultimately cancelled due to progression in the data item Reason For No Surgery of Primary Site. Code 2 description contains examples and is not exhaustive of reasons for no surgery.

We will add the example for consistency in the next version of the SEER manual.

Date Finalized
04/02/2021

20210006

References

Source 1: **Summary Stage 2018 Coding Manual v2.0**
pgs: **147**
Notes: **September 2020**
Source 2: **AJCC Cancer Staging Manual**
pgs:
Notes: **8th edition**

Question

Behavior/Summary Stage 2018--Colon: What is the correct behavior and Summary Stage for a case of intramucosal adenocarcinoma arising in tubular adenoma? AJCC states this is Tis, though SEER Summary Stage states this is Localized (code 1). The histology is 8140/2 (adenocarcinoma in situ), but the SEER Summary Stage is Localized.

Answer

Intramucosal carcinoma of the colon is assigned behavior code of /3. Intramucosal is not the same as in situ in terms of behavior. Behavior and staging are separate concepts, although there is some overlap. Use the instructions for coding behavior to code this field. Do not use stage to determine behavior in this case.

For purposes of Summary Stage, intramucosal carcinoma is a localized lesion; however, for purposes of AJCC staging, assign Tis for the stage.

Date Finalized

04/02/2021

20210005

References
Source 1: **ICD-O-3**
pgs:
Notes:
Source 2: **2021 ICD-O-3.2 UPDATE**
pgs:
Notes: **Table 1.**

Question
Reportability/Histology--Ovary: Is a 2020 ovary case reportable with the positive malignant findings in adnexal cystic fluid and peritoneal washing? See Discussion.

Discussion
11/24/20 Adnexal mass, cyst fluid: Positive for malignant cells. Clusters of inhibin-positive, CK7-negative cells, consistent with adult granulosa cell tumor cells. Groups of inhibin-negative, CK7-positive epithelial cells consistent with serous borderline tumor cells. Peritoneal washing: Positive for malignant cells. Small groups of inhibin-positive, CK7-negative cells, consistent with adult granulosa cell tumor cells.

A. Left ovarian mass: Adult granulosa cell tumor (AGCT) of ovary (see note). pTNM Stage: pT1c3 pNX - Serous borderline tumor (SBT) of ovary (see note). pTNM Stage: pT1a pNX. Fallopian tube; unremarkable.

B. Right ovary: - Serous cystadenofibroma of ovary. Fallopian tube; unremarkable.

C. Left pelvic wall nodule: Fibro-calcified nodule, consistent with necrotic appendix epiploica.

D. Uterus (hysterectomy): Uterine leiomyomas. Endosalpingiosis of uterine serosa and paracervical tissue. Atrophic endometrium.

Note: The left ovarian mass is involved by a combined adult granulosa cell tumor and a serous borderline tumor. The AGCT mainly involves the thick-walled cystic area while the SBT the thin-walled cyst/s. The 2 neoplastic elements do, however, demonstrate areas of intimate and close intermingling. From the current literature, it appears that, based on

FOXL2 mutation, the AGCT component of combined AGCT and ovarian epithelial tumors is either a true neoplastic process or an AGCT- like proliferation morphologically indistinguishable from AGCT. To further evaluate the nature of the AGCT component, a FOXL2 analysis is in progress and an addendum will follow.

Answer

For cases diagnosed prior to 2021, report adult granulosa cell tumor of ovary only when stated to be malignant or when metastases are indicated, as by the positive peritoneal washings for this 2020 case. Beginning in 2021, report all cases of adult granulosa cell tumor of ovary based on ICD-O-3.2.

Date Finalized

04/02/2021

20210004

References
Source 1: **2018 Solid Tumor Rules**
Notes: **Colon; December 2020 Update**

Question
Solid Tumor Rules (2018)/Histology--Colon: What is the histology for a 2020 pathology report final diagnosis showing invasive adenocarcinoma, poorly differentiated with signet ring cell features and signet-ring cell carcinoma in the synoptic report? See Discussion.

Discussion
Since the synoptic report and final diagnosis are equal in priority, and the Solid Tumor Rules tell us to code the more specific histology, would this be coded to signet ring cell adenocarcinoma, 8490/3, even though the pathologist used features in the final diagnosis? There is no histology adenocarcinoma with signet ring cell features on the CAP Protocol, so the pathologist may check off the next closest histology – signet ring cell carcinoma – which would not be truly representative of the actual histology. Final Diagnosis: Proximal colon, segmental resection: Invasive adenocarcinoma, poorly differentiated, with signet ring cell features. Synoptic Report A: Colon and Rectum - Resection Specimen Procedure: Right hemicolectomy, Tumor Site: Right (ascending) colon, Histologic Type: Signet-ring cell carcinoma, Histologic Grade: G3: Poorly differentiated.

Answer
Code histology to 8490/3 per H6.

The December 2020 Solid Tumor Update includes addition of the following instructions to the "Priority Order for Using Documentation to Code Histology" section.

Which document to use when there is conflicting information between the final diagnosis, synoptic report, or CAP protocol: When there are discrepancies between the final diagnosis and synoptic report, use the document that provides the more specific histology. This will likely be found in the synoptic report. The CAP Protocol should be used only when a final diagnosis or synoptic report are not available. Definitions for CAP Protocol, final diagnosis, and synoptic report can be found in the Definitions section.

Date Finalized
04/02/2021

20210002

References

Source 1: **Heme & Lymphoid Manual and Database**
Notes: **September 2020; Effective with Cases Diagnosed 1/1/2010 and Forward**
Source 2: **WHO Class Heme and Lympoid Neoplasms**
Notes: **4th edition, online version**

Question

Multiple Primaries--Heme & Lymphoid Neoplasms: How many primaries are accessioned for a patient diagnosed with therapy-related myelodysplastic syndrome (t-MDS) (9920/3) in 2015 followed by a 2020 diagnosis of myelodysplastic syndrome, NOS (MDS, NOS) (9989/3)?

Discussion

Patient has a history of B-cell lymphoma with multimodality treatment in 2002. Lab work in 2015 showed multilineage dysplasia leading to a diagnosis of therapy-related myelodysplastic syndrome. Patient presents in 2020 for a bone marrow biopsy now showing low-grade MDS. The MDS appears to have the same multilineage dysplasia previously identified.

MDS, NOS is not listed in the Heme DB as a possible transformation of t-MDS, nor is it listed as a Same Primary for t-MDS. Likewise, t-MDS is not listed as a more specific myelodysplastic syndrome, a transformation of MDS NOS, or a Same Primary as MDS, NOS.

The first M rule that applies to this case is M15, and the Multiple Primaries Calculator indicates that the MDS, NOS should be a new primary.

Answer

Abstract separate primaries using Rule M15 of the Hematopoietic and Lymphoid Neoplasms (Heme) Manual. The Heme Database states: Excluded from this category are progression of myeloproliferative neoplasms (MPNs) and evolution of primary MDS or primary MDS/MPN to acute myeloid leukemia (AML); in each of these latter cases evolution to AML is part of the natural history of the primary disease and it may be impossible to distinguish natural progression from therapy-related changes. There is no indication of transformation.

Date Finalized

04/02/2021

20210001

References

Source 1: **NAACCR Version 21 Data Standards**

pgs:

Notes: **Chapter VIII: Required Status Table**

Question

SEER*RSA/Required data items--Melanoma: The site-specific data item, Ulceration, states it is required by "All" in SEER*RSA but in the NAACCR Data Dictionary table it states is it required by SEER, Commission on Cancer (CoC), and Canadian Cancer Registry (CCCR), not the National Program of Cancer Registries (NPCR). Does the definition of "All" in SEER*RSA not include NPCR? Also, please explain the difference between Required by: "All" and "Required by CCCR/Canada, COC, NPCR, SEER" (all listed out).

Answer

Use the NAACCR Data Dictionary Required Status Table or refer to standard setter requirements. Do not use SEER*RSA to determine which data items are required to be collected or transmitted. Though "All" in SEER*RSA generally refers to the standard setters including CoC, NPCR, CCCR, and SEER, some items in SEER*RSA need updating; this is planned for 2022.

Date Finalized

04/02/2021

20200088

References

Source 1: **Heme & Lymphoid Manual and Database**
pgs:
Notes: **September 2020; Effective with Cases Diagnosed 1/1/2010 and Forward**
Source 2: **2021 ICD-O-3.2 Update**

Question

Histology--Heme & Lymphoid Neoplasms: Is there an inconsistency between the histologies listed as deleted in the ICD-O-3.2 Implementation Guidelines and the obsolete histologies in the Hematopoietic and Lymphoid Neoplasms Database (Heme DB)? See Discussion.

Discussion

While we recognize the Heme DB has been the correct source for histology coding for heme and lymphoid neoplasms dating back to 2010, the ICD-O-3.2 Implementation Guidelines appear to provide incorrect coding instructions. Histologies 9670/3, 9728/3, 9729/3 and 9836/3 are listed in Table 3 - Deleted ICD-O codes in ICD-O-3.2.

While we recognize these histologies have been included in this Table because they have now been deleted, it is unclear whether the Comments regarding their use listed in the 4th column of the Table is correct. For each of these histologies, the comment states the histology listed in the 1st column (ICD-O-3/3.1) should be used prior to 2021. For example, for histology 9670/3, the comment states: Cases diagnosed prior to 1/1/2021 use code 9670/3. Cases diagnosed 1/1/2021 forward use code 9823/3. However, each of these histology codes have been obsolete for cases diagnosed 1/1/2010 and later. If registrars were following the Heme DB and Heme Manual instructions (the appropriate coding source for these neoplasms), these histologies would not have been used in a decade.

Should the Comments column in Table 3 be updated? Or should a Note follow the Table indicating registrars should not use these histology codes for cases diagnosed after 1/1/2010, and these histology codes have been deleted for cases diagnosed 1/1/2021? It seems misleading to indicate any of these are valid histology codes for a 2010-2020 diagnosis when the Heme DB confirms these histology codes only apply to cases diagnosed prior to 2010.

Answer

Follow the Heme DB to determine which codes are obsolete as of 2010. These histologies were made obsolete based on the 2010 WHO Hematopoietic book and confirmation with physicians. The official changes from ICD-O-3 were not implemented until ICD-O-3.2 Also, edits will not allow these histologies to be used for cases diagnosed 2010 and later.

The ICD-O tables were based on documentation from IARC ICD-O committee and may differ from practices in North America.

Date Finalized

04/02/2021

20200087

References

Source 1: **2018 Solid Tumor Rules**

Notes: **Other Sites; For use with cases 2007-2021**

Question

Solid Tumor Rules (2018)/Histology--Thyroid: What is the correct histology code for a micropapillary thyroid carcinoma for cases diagnosed 1/1/2021 and later? See Discussion.

Discussion

The 2021 ICD-O-3.2 Update includes papillary microcarcinoma (8341/3) as the preferred term for thyroid primaries (C739). However, there are multiple SINQ entries instructing registrars not to use code 8341/3 for diagnoses of micropapillary carcinoma of the thyroid (including SINQ 20071076, 20081127, 20110027, 20150023, and 20180008).

SINQ 20150023 specifically indicates: Per the WHO Tumors of Endocrine Organs, for thyroid primaries/cancer only, the term micropapillary does not refer to a specific histologic type. It means that the papillary portion of the tumor is minimal or occult (1 cm or less in diameter) and was found incidentally. WHO does not recognize the code 8341 and classifies papillary microcarcinoma of the thyroid as a variant of papillary thyroid carcinoma and codes histology to 8260. If the primary is thyroid and the pathology states papillary microcarcinoma or micropapillary carcinoma, code 8260 is correct.

Does this clarification apply to cases diagnosed 2021 and later? If WHO feels the term micropapillary still does not refer to a specific histologic type for the thyroid, why is 8341/3 listed as a preferred term for this morphology/site combination? For cases 2021 and later, should a diagnosis of Incidental papillary thyroid microcarcinoma (3 mm) in left lower pole, be coded as 8341/3 per the ICD-O-3.2, or as 8260/3 per clarification in multiple SINQ entries?

This question was prompted from preparing SEER*Educate coding exercises. We will use the answer as a reference in the rationales.

Answer

Continue to code micropapillary thyroid carcinoma to 8260/3 until instructed otherwise. This coding instruction is based on input from expert endocrine pathologists. This issue will be revisited based on the 4th Ed WHO Endocrine Tumors and updated if needed.

Date Finalized

04/02/2021

20200085

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Head and Neck; December 2020 Update**
Source 2: **ICD-O-3.2 Update for 2021**
pgs:
Notes: **NAACCR Implementation Guidelines**

Question
Solid Tumor Rules (2018)/Histology--Head and Neck: What is the histology of paraganglioma, NOS arising outside of the adrenal gland (for example, in the bladder) for cases diagnosed 1/1/2021 and later? See Discussion.

Discussion
Should histology be coded as paraganglioma, NOS (8680/3) or as extra-adrenal paraganglioma, NOS (8693/3) for a diagnosis of paraganglioma in the bladder? Does the pathologist have to specifically diagnose the tumor as extra-adrenal paraganglioma, NOS to use histology code 8693/3? Or, does any diagnosis of paraganglioma (NOS) arising outside of the adrenal gland, carotid body, middle ear, or aortic body (the specified sites for other types of paragangliomas) qualify as an extra-adrenal paraganglioma, NOS?

The ICD-O-3.2 Implementation Guidelines (Tables 6 and 7) provide an associated site of C755 for histology 8680/3 (paraganglioma, NOS), but no associated site code is provided for histology 8693/3 (extra-adrenal paraganglioma, NOS). If the preferred site for paraganglioma, NOS is the paraganglia, would a paraganglioma in the bladder be considered an extra-adrenal paraganglioma?

This question was prompted from preparing SEER*Educate coding exercises. We will use the answer as a reference in the rationales.

Answer
Code the histology stated by the pathologist: paraganglioma, NOS 8680/3.

Date Finalized
04/02/2021

20200082

References

Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Other Sites; For use with cases 2007-2021**

Question

Solid Tumor Rules (2018)/Histology--Corpus Uteri: How is histology coded for cases of carcinosarcoma/malignant mixed Mullerian (MMMT) tumor diagnosed 2021 and later? See Discussion.

Discussion

The ICD-O-3.2 Coding Table includes Mullerian mixed tumor as the preferred term for histology code 8950 (previously malignant mixed Mullerian tumor/MMMT). This table also includes carcinosarcoma, NOS as the preferred term for histology code 8980. Neither the ICD-O-3.2 Coding Table nor the Implementation Guidelines address the long-standing issue of coding histology for diagnoses of carcinosarcoma/malignant mixed Mullerian tumor.

These endometrial primaries are frequently diagnosed as both carcinosarcoma and MMMT. The questions regarding histology coding for carcinosarcoma and carcinosarcoma/MMMT of the endometrium date back to before the Multiple Primaries/Histology Rules, with at least three SINQ entries instructing registrars not to use code 8950/3 (MMMT) for diagnoses of MMMT. SINQ has instructed registrars that MMMT is a synonym for carcinosarcoma and these tumors should be coded to 8980 (carcinosarcoma), not to 8950 (MMMT). The most recent SINQ is partly inconsistent with the others, indicating 8950 can be used if the tumor is only described as MMMT. The other SINQ entries state carcinosarcoma should be used as it is the preferred term for MMMT. (See SINQ 20061008, 20100009, 20180071.)

The most recent SINQ (20180071) specifically indicates: According to the WHO Classification of Tumors of Female Reproductive Organs, 4th edition, MMMT (8950/3) is now a synonym for carcinosarcoma (8980/3) even though it has a separate ICD-O code. The ICD-O code for MMMT is no longer in the WHO book. However, MMMT is in the ICD-O-3.2 Coding Table and is not stated to be obsolete or a synonym. Which is correct, the clarification in the SINQ or the 2021 ICD-O-3.2 Coding Table?

For a 2021 diagnosis of carcinosarcoma/malignant mixed Mullerian tumor, how should

registrars code the histology? Follow the previous SINQ entries and Rule H17 to code the histology to 8980 when the diagnosis includes both carcinosarcoma and MMMT? Do these previous SINQ entries still apply to cases diagnosed 2021 and later?

This question was prompted from preparing SEER*Educate coding exercises. We will use the answer as a reference in the rationales.

Answer

According to both the 4th and 5th Ed WHO GYN Tumors, carcinosarcoma (8980) is the preferred term and pathologists are encouraged to no longer use Mixed Mullerian Tumor (8950) in their diagnoses. WHO 4th Ed GYN now lists MMMT as synonym for carcinosarcoma. 8950/3 is no longer included in WHO 4th Ed.

Until the Other Sites Rules can be updated with histology tables to assist in coding, use the following to determine histology.

Carcinosarcoma (8980/3) and MMMT (8950/3)

Path diagnosis often stated as carcinosarcoma (malignant mixed Mullerian tumor)

Per SME, when stated this way code to carcinosarcoma 8980/3.

Per SME, if stated as MMMT only, code 8950/3

Date Finalized

04/02/2021

20200081

References

Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Other Sites; For use with cases 2007-2021**

Question

Solid Tumor Rules (2018)/Histology--Pancreas: How is the histology coded, and what H Rule applies, for a 2021 diagnosis when the pathological diagnosis is neuroendocrine tumor (NET) G1 or NET G2, but clinically, the tumor is stated to be insulinoma? See Discussion.

Discussion

Insulinoma, NOS is reportable for cases diagnosed 2021 and later. However, the diagnosis of insulinoma is most frequently made with clinical correlation of the patient's clinical syndrome and serum hormone levels. Despite a pathological diagnosis of NET, this will clinically be stated as insulinoma based on the functional type of tumor. At the largest facility in our area, all pathology reports with a diagnosis of insulinoma over the last year only provide a pathological Final Diagnosis of NET (either G1 or G2), but elsewhere specify, Functional Type: Pancreatic neuroendocrine tumor, functional. Correlation with Clinical Syndrome and Elevated Serum Levels of Hormone Product: Insulin-producing (Insulinoma).

For 2021 and later, it seems this should be accessioned as insulinoma (8151/3), but one cannot arrive at that histology using the current Other Sites (MP/H) H Rules. Following the existing rules, one would code the histology to NET, G1 or NET, G2 (8240 or 8249) per Rule H6. There are technically two specific histologies to consider: NET (either 8240 or 8249) and insulinoma, NOS (8151). Following the H Rules, Rule H6 instructs one to code the histology with the numerically higher ICD-O-3 code (8240 or 8249).

Coding this histology to NET (8240 or 8249) does not seem to reflect the most accurate classification of this tumor, but applying the current rules, this is the only histology that can be coded. There is no current guideline in the Other Sites schema or the ICD-O-3.2 Implementation Guidelines instructing us to ignore the pathological diagnosis of a NET for these tumors (even though insulinomas are NETs). The only SINQ that currently exists (SINQ 20150019) states the histology can be coded as either a NET or an insulinoma in these cases. How are registrars to consistently code histology for these tumors without a rule clarification?

This question was prompted from preparing SEER*Educate coding exercises. We will use the answer as a reference in the rationales.

Answer

Code the tissue/pathology histology over the clinical diagnosis. Because of implementation timelines, a comprehensive revision to Other Sites rules will not be available 2022. A limited revision is planned, and histology tables will be added for select sites. The General Instructions will also be revised for Other Sites.

Date Finalized

04/02/2021

20200080

References

Source 1: **ICD-O-3.2**

Question

Reportability/Histology--Pancreas: Is a diagnosis of insulin-producing (insulinoma) epithelioid neoplasm reportable if made 2021 and later? If so, is the histology coded as 8151/3 per the ICD-O-3.2 Coding Table? See Discussion.

Discussion

The ICD-O-3.2 Implementation Guidelines and ICD-O-3.2 Coding Table indicate that insulinoma, NOS has changed behavior from /0 to /3 for cases diagnosed 2021 and later. However, the ICD-O-3.2 Implementation Guidelines do not indicate whether this change applies to tumors described as above. Insulinomas are generally neuroendocrine tumors/neoplasms, so it seems any neuroendocrine tumor described as an insulinoma should be collected as 8151/3, but does that apply to an epithelioid tumor/neoplasm also described as insulinoma?

This question was prompted from preparing SEER*Educate coding exercises. We will use the answer as a reference in the rationales.

Answer

If the diagnosis includes insulinoma, it is reportable and coded 8151/3. Insulin-producing epithelioid neoplasm alone, without mention of insulinoma, is not reportable.

Date Finalized

04/02/2021

20200079

References

Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Non-malignant CNS Tumors; December 2020 Update**

Question

Solid Tumor Rules (2018)/Primary Site--Brain and CNS: Should the updated note for optic nerve glioma be included in both the 2018 Solid Tumor Rules for Malignant Central Nervous System (CNS) and Peripheral Nerves, Note 6, and the Non-Malignant CNS Tumors, Note 5? See Discussion.

Discussion

Should the updated Note 5 from the Non-malignant CNS regarding optic nerve glioma also be incorporated into Note 6 for Malignant CNS rules (the pilocytic astrocytoma note)?

This was one of the major issues identified in the SEER*Educate Workshop. Registrars have demonstrated they do not consistently think to look at the Non-malignant CNS schema when they see the term glioma and continue to misclassify optic nerve gliomas as malignant.

This question was prompted from preparing SEER*Educate coding exercises. We will use the answer as a reference in the rationales.

Answer

The 2022 Solid Tumor Update will include a new note in the Terms & Definitions, Introduction section that will state: See the Non-malignant CNS rules when the primary site is optic nerve and the diagnosis is either optic glioma or pilocytic astrocytoma. The behavior is non-malignant and coded 9421/1.

Date Finalized

04/02/2021

20200078

References

Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Malignant CNS; December 2020 Update**

Question

Solid Tumor Rules (2018)/Histology--Brain and CNS: Should the new malignant term pituitary blastoma be added to Table 3 of the 2018 Malignant Central Nervous System (CNS) and Peripheral Nerves Solid Tumor Rules? See Discussion.

Discussion

Pituitary blastoma was not added to Table 3 (Specific Histologies, NOS, and Subtypes/Variants) of the 2018 Malignant CNS and Peripheral Nerves Solid Tumor Rules as part of the December 2020 update. This is a new malignant CNS histology for 2021 and later. Not including this histology in Table 3 results in the registrars being required to check another source to correctly code this histology. If this histology cannot be used for cases diagnosed prior to 2021, should that diagnosis year clarification be included in the STR?

This question was prompted from preparing SEER*Educate coding exercises. We will use the answer as a reference in the rationales.

Answer

The Solid Tumor Malignant CNS tables do not list pituitary specific histologies at this time. Registrars will need to refer to ICD-O and/or updates until the decision to add malignant pituitary neoplasms is made. Pituitary blastoma is a rare tumor which occurs in children.

Date Finalized

04/02/2021

20200077

References

Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Kidney; December 2020 Update**

Question

Solid Tumor Rules (2018)/Histology--Kidney: What is the histology code for succinate dehydrogenase-deficient renal cell carcinoma (SDHD)? See Discussion.

Discussion

Table 1 of the 2018 Kidney Solid Tumor Rules (STR) lists succinate dehydrogenase-deficient renal cell carcinoma as histology code 8312, but in the ICD-O-3.2 Coding Table it is listed as histology code 8311.

No changes were made in the Kidney STR. As a result, the histology change described in the ICD-O-3.2 Coding Table conflicts with Table 1. Succinate dehydrogenase-deficient renal cell carcinoma (SDHD) is listed in Table 1 as a synonym for renal cell carcinoma, NOS (8312). However, the ICD-O-3.2 Coding Table lists this as a related term for histology code 8311/3. This related term was not discussed in the Implementation Guidelines, and no change was noted in the STR.

While it seems we should continue to follow the STR, without clarification as to why this histology change was not implemented in STR, achieving consistency will be problematic if registrars jump straight to the ICD-O-3.2 Coding Table to code histology for cases diagnosed 2021 and later. If this code cannot be used for cases diagnosed prior to 2021, should that clarification be included in the STR?

This question was prompted from preparing SEER*Educate coding exercises. We will use the answer as a reference in the rationales.

Answer

When creating table 1, our GU SME's stated Succinate dehydrogenase-deficient renal cell carcinoma (SDHD) is a rare neoplasm and is coded to RCC, NOS until such time a new code is proposed in the 5th Ed BB. ICD-O-3.2 added this term to 8311 as a related term BUT there is

no documentation that these neoplasms are different and should be on separate lines in table 1 making them separate primaries. Its likely IARC made the decision to group these rare genetic histologies into one code. SEER is waiting for confirmation from GU experts. If it's valid, the RCC row will be updated in columns 2 and 3 with applicable dates each histology is valid.

Date Finalized
04/02/2021

20200074

References

Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Head and Neck; December 2020 Update**

Question

Solid Tumor Rules (2018)/Histology--Head & Neck: What specific table(s) in the 2021 Head and Neck Solid Tumor Rules if any, apply to tumors of the lip? See Discussion.

Discussion

Lip has not been added to any of the site-specific histology tables, nor has any other instruction been provided for coding tumors in this site.

Coding histology for lip primaries is difficult because registrars do not know where to look first. The Solid Tumor Rules indicate one should use the tables first, but then do not inform registrars what table to use for a lip primary (i.e., a specific table, any table, no table).

This question was prompted from preparing SEER*Educate coding exercises. We will use the answer as a reference in the rationales.

Answer

The tables are based on WHO H&N chapters which do not include lip. There are inherent issues in determining reportability for lip primaries based on site and histology. The decision was made prior to release of the 2018 rules to exclude a histology table for lip. We are consulting both our dermatology and H&N pathology experts to explore adding a lip site-specific table to the rules.

Date Finalized

04/02/2021

20200073

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Colon; December 2020 Update**

Question
Solid Tumor Rules (2018)/Histology--Colon: Should the mixed adenoneuroendocrine carcinoma (MANEC) row in Table 1 include the still often used (yet older) terms of adenocarcinoma and carcinoid, adenocarcinoid, etc. for clarity? See Discussion.

Discussion
The Terms and Definitions Introduction discusses how these are older terms, but pathologists may still use them. In our region, pathologists do, in fact, still use these terms. Can these terms be added to Table 1? For registrars who do not reference the Introduction every time they code histology but go directly to Table 1, coding consistency would likely improve if such terms were added in the Table.

This question was prompted from preparing SEER*Educate coding exercises. We will use the answer as a reference in the rationales.

Answer
The next update to the Solid Tumor rules will include adding the following four terms to Colon Table 1 as synonyms for Mixed adenoneuroendocrine carcinoma 8244:

Mixed adenoneuroendocrine carcinoma

Combined carcinoid and adenocarcinoma

Mixed carcinoid and adenocarcinoma

Composite carcinoid

Date Finalized
04/02/2021

20200072

References

Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Breast; December 2020 Update**

Question

Solid Tumor Rules (2018)/Multiple Primaries--Breast: How many primaries are accessioned when there are multiple synchronous/non-contiguous tumors when one tumor is metaplastic carcinoma (with carcinoma No Special Type (NST) or lobular carcinoma) and another tumor is strictly carcinoma, NST? See Discussion.

Discussion

Is an M rule needed to address multiple tumors and Note 2 in Table 3? Does Note 2 in Table 3 apply when multiple tumors exist and one tumor contains only ductal carcinoma?

The M Rules currently confirm that a metaplastic carcinoma (whether it is involved with ductal or lobular) and a separate ductal carcinoma are separate primaries because these histologies are on different rows in Table 3 (separate primaries per M14). There is no specific rule regarding metaplastic carcinomas in the Multiple Tumors (M Rules) module, so presumably, the presence of a separate ductal carcinoma is not lumped into Note 2 in Table 3 for metaplastic carcinoma.

However, the note is confusing when there are multiple tumors involved because it appears to the registrars there are two options for coding the histology. To some registrars, the rules indicate it does not matter if the tumor is predominantly ductal carcinoma as long as some percentage of metaplastic carcinoma is present, code histology to metaplastic carcinoma. For other registrars, the presence of solely a ductal carcinoma in a second tumor is a separate primary from the separate metaplastic carcinoma.

The M rules and Note 2 need to clarify this issue to promote consistency.

This question was prompted from preparing SEER*Educate coding exercises. We will use the answer as a reference in the rationales.

Answer

The term "mixed" implies a single tumor comprised of metaplastic carcinoma or variants of metaplastic and duct or lobular. The metaplastic histology is coded regardless of whether it comprises the majority (greater than 50% of the tumor). M13 is the only rule specific to metaplastic and is in the single tumor module. This implies a single tumor with both histologies. When there are multiple tumors, one with metaplastic or a subtype/variant of metaplastic and another with a histology listed on a different row, continue to the Multiple Tumors module. M13 applies and there are two primaries. We will add "single tumor" to the note in Table 2 in the next update.

Date Finalized

04/02/2021

20200071

References

Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Breast; December 2020 Update**

Question

Solid Tumor Rules (2018)/Histology--Breast: Rule H13 of the 2021 Breast Solid Tumor Rules (a new H Rule added in the December 2020 revision) indicates metaplastic carcinoma is coded when both metaplastic carcinoma and carcinoma No Special Type (NST) are present. Should Rule H13 also address lobular carcinoma so the histology for a single tumor with metaplastic carcinoma and lobular carcinoma is correctly coded to metaplastic carcinoma (8575)? See Discussion.

Discussion

Rule H13 states to code the histology to metaplastic carcinoma when there is metaplastic carcinoma (or a subtype/variant) and invasive carcinoma NST. This rule makes no mention of lobular carcinoma. However, in Table 3, Note 2 for metaplastic carcinoma (8575) states metaplastic carcinoma, NOS and subtypes are almost always mixed with invasive mammary carcinoma, NST and at times lobular carcinoma. These tumors should be coded to metaplastic regardless of percent invasive mammary carcinoma or lobular carcinoma present.

While Table 2 (the mixed histology code table) does include an entry for metaplastic carcinoma AND carcinoma NST OR lobular carcinoma, it is unclear why lobular carcinoma has not been added to Rule H13 as well.

If a single tumor has metaplastic plus lobular carcinoma, Rule H13 does not apply and one has to continue through the rules. Unfortunately, the next rule registrars would be tempted to use is Rule H18: Code the histology that comprises greater than 50% of tumor when two histologies are on different rows in Table 3. This Rule does not state it does NOT apply to metaplastic carcinoma (only mucinous). So, if for some reason the lobular was greater than 50%, the incorrect histology would be coded (unless the registrar happened to remember Note 2 in the metaplastic carcinoma entry in Table 3).

This question was prompted from preparing SEER*Educate coding exercises. We will use the answer as a reference in the rationales.

Answer

Lobular carcinoma was unintentionally excluded from M13. It will be added in the 2022 update. It is important registrars learn to use the tables and read the notes.

Date Finalized

04/02/2021

20200068

References

Source 1: **Summary Stage 2018 Manual v2.0**
pgs:
Notes: **Colon and Rectum, September 2020**

Question

Summary Stage 2018/Extension--Colon: Are colon primaries coded as local or regional (direct extension) on Summary Stage based on invasion into the pericolorectal tissues? For example, is a case with an ascending colon tumor that extends into the pericolorectal tissues, pT3, local or regional by direct extension?

Answer

Code as Localized using the SEER Summary Stage Manual, Colon and Rectum, Note 6. Localized is for subsites that are not peritonealized, including the posterior side of the ascending colon, or when the pathologist does not further describe the "pericolic/perirectal tissues" as either "non-peritonealized pericolic/perirectal tissues" vs "peritonealized pericolic/perirectal tissues" fat and the gross description does not describe the tumor relation to the serosa/peritoneal surface, and it cannot be determined whether the tumor arises in a peritonealized portion of the colon.

Refer to the coding instructions in both EOD and Summary Stage for a list of sites that are nonperitonealized or peritonealized.

Date Finalized
03/29/2021

20200067

References

Source 1: **Summary Stage 2018**
pgs:
Notes: **Colon and Rectum**

Question

Summary Stage 2018/Extension--Colon: What is the Summary Stage for adenocarcinoma of cecum where the tumor extends into the proximal portion of attached vermiform appendix? See Discussion.

Discussion

2020 Diagnosis: Patient had a right hemicolectomy showing adenocarcinoma of cecum, tumor extends into proximal portion of attached vermiform appendix. Tumor invades through muscularis propria into pericolorectal tissues (NOS). Regional lymph nodes: 06/39. Primary Tumor EOD: Where does the appendix involvement come into coding or will this be based on the pericolorectal tissue (NOS) invasion? What is my Summary Stage? I know it is at least 3 due to regional ln involvement, but the appendix involvement is making me question 3 vs 4.

Answer

Assign code 4, Regional by BOTH direct extension AND regional lymph node(s) involved. In this case, the Regional component for Summary Stage 2018 is based on Note 6, under Colon and Rectum where Regional is defined as:

Mesentery

Peritonealized pericolic/perirectal tissues invaded [Ascending Colon/Descending Colon/Hepatic Flexure/Splenic Flexure/Upper third of rectum: anterior and lateral surfaces; Cecum; Sigmoid Colon; Transverse Colon; Rectosigmoid; Rectum: middle third anterior surface]

Pericolic/Perirectal fat

Date Finalized

03/29/2021

20200066

References

Source 1: **ICD-O-3.2**

Question

Reportability--Skin: Effective 2021, a cutaneous leiomyosarcoma is a related term for smooth muscle tumor, NOS (8897/1) in ICD-O-3.2. Currently, we have been capturing these as a C44_ (leiomyosarcoma, 8890/3) but the 2019 SEER inquiry states that atypical intradermal smooth muscle neoplasm (AISMN) was previously termed cutaneous leiomyosarcoma. This is not documented on the 2018 ICD-O-3 updates. Should this 2019 case be considered 8897/1 or 8890/3?

Answer

Cutaneous leiomyosarcoma is reportable for 2019. Code histology to leiomyosarcoma 8890/3.
As of cases diagnosed 1/1/2021, it is no longer reportable based on assignment to 8897/1 in ICD-O-3.2.

Date Finalized

03/29/2021

20200065

References

Source 1: **Subject matter expert**

Question

Tumor Size/Corpus uteri--Endometrium: Is clinical tumor size coded to the endometrial stripe measurement or thickening in the endometrium. See Discussion.

Discussion

Example: Pelvic ultrasound-19 mm thickened endometrium; bilateral ovaries unremarkable. Case was coded to 19 mm for clinical tumor size. I have always been taught NOT to use "endometrial stripe" or "thickening" measurements for clinical size. Can you confirm. Also, is this noted on any of the SEER resources such as SEER training or in the SEER tumor size guidelines? I wanted to point them out to a reference if it is available.

Answer

We consulted with an expert GYN pathologist. He confirmed our thinking that endometrial stripe or thickening does not represent clinical tumor size. We will add this to a future edition of the SEER manual for reference.

Date Finalized

03/29/2021

20200064

References

Source 1: **WHO Class Hem & Lymph Tumors**
pgs:
Notes: **Revised 4th edition**
Source 2: **Heme & Lymphoid Manual and Database**
pgs:
Notes: **September 2020; Effective with Cases Diagnosed 1/1/2010 and Forward**

Question

Primary site--Heme &Lymphoid Neoplasms: What is the primary site of two extraosseous plasmacytomas, with positive pathology of right orbit and left lung. The patient's bone marrow biopsy, flow, and peripheral blood smear were negative. Is this coded as 9732/3, multiple myeloma (Primary Site and Histology Rule PH2) with the primary site as C809 (PH27)? Or is the primary site C421 since code 9732 says primary site is always C421, though bone marrow came back as negative?

Answer

Assign the primary site to C421 since that is the only allowable primary site for plasma cell myeloma, even though the bone marrow was negative. According to the revised criteria from the WHO Blue Book for Hematopoietic and Lymphoid Neoplasms (2017), the presence of multiple plasmacytomas is plasma cell myeloma (9732/3).

Date Finalized

03/29/2021

20200063

References

Source 1: **2021 Solid Tumor Rules**
pgs:
Notes: **Cutaneous Melanoma; December 2020 Update**

Question

Solid Tumor Rules (2021)/Laterality--Melanoma: Will the table called Site for Which Laterality Code Must Be Recorded be updated in the 2021 SEER Program Coding and Staging Manual as C444 is not included? The 2021 Cutaneous Melanoma Solid Tumor Rules say that C444 requires laterality; it says (new) beside it on the new Solid Tumor Rules for 2021.

Answer

The laterality table in the 2021 SEER manual will not be updated. Please follow the 2021 Cutaneous Melanoma Solid Tumor Rules and assign a laterality for C444.

Date Finalized

03/29/2021

20200062

References

Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Lung, December 2020 Update**

Question

Solid Tumor Rules (2018)/Multiple Primaries--Lung: How many primaries should be reported when a patient has a 7/2016 diagnosis of right lower lobe lung mucinous adenocarcinoma, treated with Erlotinib and Avastin? In 4/2020, a liver biopsy finds metastatic high-grade neuroendocrine carcinoma, clinically stated to be metastatic lung cancer, with no evidence of a new primary lung tumor on PET (liver the only site of disease)? See Discussion.

Discussion

We think this should be a single primary because the Solid Tumor rules do not apply to metastases. However, we are not sure whether or not the instructions outlined for prostate (SINQ 20180088, 20130221), that indicate we are to accession a new metastatic tumor only with a small cell neuroendocrine histology after an adenocarcinoma, also applies to lung primaries.

We are aware of a phenomenon in which lung adenocarcinoma cases treated with Erlotinib can transform to small cell, but do not know whether it impacts the number of reportable primaries.

Answer

Accession two primaries, adenocarcinoma [8140/3] and small cell neuroendocrine carcinoma [8041/3] per Rule M8 of the Lung Solid Tumor Rules, as these histology codes are on different rows in Table 3 of the rules. This is consistent with similar prior SINQ questions.

Date Finalized

03/29/2021

20200061

References

Source 1: **WHO Class Tumors of Urinary System**
pgs: **81**

Question

Solid Tumor Rules (2018)/Histology--Bladder: A patient has high-grade papillary urothelial carcinoma with focal glandular and neuroendocrine differentiation followed by carcinosarcoma. Is this one or two primaries? See Discussion.

Discussion

12-19-19 Transurethral resection of bladder tumor pathology revealed high-grade papillary urothelial carcinoma with focal glandular and neuroendocrine features; Pathology Overread: High-grade papillary urothelial carcinoma with focal glandular and neuroendocrine differentiation. Carcinoma invades muscularis propria pT2. Histology 8130

01/20/20 to 07/01/20, completed 6 cycles of gemcitabine/cisplatin.

07/30/20 Robotic radical cystoprostatectomy with bilateral pelvic lymph node dissection, open ileal conduit pathology revealed carcinosarcoma, invading perivesical fat, no lymphovascular invasion, negative margins. ypT3bN0M0 disease; Pathology Overread: Carcinosarcoma arising in association with high-grade papillary urothelial carcinoma.

Histology 8980/3 or is there another histology that should be used?

Answer

The carcinosarcoma is a separate tumor, abstract a new primary per M13. Code this primary to 8980/3.

Based on the information provided, the patient was first diagnosed with papillary urothelial carcinoma and received neo-adjuvant treatment for that specific histologic type. Subsequent resection identified carcinosarcoma arising within the papillary neoplasm. Carcinosarcoma is rare in bladder primaries and is not included in Table 2; however, it is a subtype/variant of sarcoma.

Date Finalized

01/25/2021

20200060

References

Source 1: **2018 SEER Manual**
pgs: **6**
Notes: **Reportability**

Question

First Course Treatment/Reportability: Are there situations for which a case with a class-of-case code in the 30's should be reported to the central registry? We know these are not reportable to the CoC, but should they be reported to the central registry? See Discussion.

Discussion

Example: 3/22/2017 26-year-old white female seen in the emergency room with abdominal pain. Patient was diagnosed about a month ago with breast cancer. Impression: menstrual pain. In this example the patient is newly diagnosed with breast cancer, but the second hospital does not treat or diagnose the patient; pain management for a separate condition is received only. Is this patient reported due to the history of active disease?

Answer

Work with your central registry to determine which cases they require you to report. In general, any case still undergoing first course of treatment, even if not given at your facility, should be reported to the central registry. Many central registries will appreciate knowing that the patient was seen at your facility to update date last seen and other data items.

Date Finalized

01/06/2021