20260015

Question:

SEER Manual/Histology-Ovary: How are *Primary Site* and *Histology* coded for a serous borderline tumor of the

right ovary with malignant cells in the ascitic fluid? See Discussion.

Discussion:

Patient has a CT of the abdomen and pelvis that shows a 11.6 cm mixed cystic-solid right adnexal mass most concerning for malignancy. She then has a right salpingo-oophorectomy with numerous adhesions throughout abdomen/pelvis; mass emanating from right ovary, well encapsulated, filling the entire cul-de sac pelvic cavity; left ovary not found, uterus absent.

Pathology: Right Ovary Integrity: Capsule ruptured; Tumor Site: Right ovary; Tumor Size: Greatest Dimension (Centimeters) - 7 cm; Histologic Type: Serous borderline tumor; Histologic Grade: GB, borderline tumor;

Ovarian Surface Involvement: Not identified; Fallopian Tube Surface Involvement: Not identified; Implants: Not sampled; Other Tissue / Organ Involvement: Not applicable; Peritoneal / Ascitic Fluid Involvement: Malignant

cells present; Chemotherapy Response Score (CRS): No known presurgical therapy; REGIONAL LYMPH NODES Regional Lymph Node Status: Not applicable (no regional lymph nodes submitted or found)

pT Category: pT1c3; pN Category: pN not assigned (no nodes submitted or found); FIGO Stage: IC3

Answer:

Report this ovarian tumor as histology 8442/3. Our subject matter expert, a specialized pathologist who deems

this case reportable, advises if a rupture occurs, the presence of borderline tumor cells in peritoneal fluid is considered true tumor spread and malignant. Both ICD-O-3.2 and ICD-O-4 classify this as behavior /1 (Serous borderline tumor, NOS); however, based on the matrix rule, you should be able to update the behavior to /3. If you cannot override or enter it into your software, please contact your vendor.

Cancer PathCHART guidance for 8442/3 in the ovary recommends using 8460/3 (Low-grade serous carcinoma)

or 8461/3 (High-grade serous carcinoma). Code 8442/3 should be used only when the grade cannot be determined.

Status: Published

Year: 2026

20260013

Question:

Primary Site--Colon: How is primary site assigned when the only documented term is “colorectal cancer?” See Discussion.

Discussion:

Patient is diagnosed with adenocarcinoma documented by the physician as “colorectal cancer.” The medical record does not specify colon, rectosigmoid, rectum, or any specific segment of the large intestine. There is also no imaging, operative, endoscopic, or pathology documentation identifying a more precise site of origin.

Specifically, should the registrar assign:

· C18.9 — Colon NOS - (excludes rectum, NOS C20.9 and rectosigmoid junction C19.9)

· C19.9 — Rectosigmoid junction

· C20.9 — Rectum NOS

· C26.0 — Intestinal tract, NOS

· C26.9 — Gastrointestinal tract, NOS

· or another site

Answer:

Assign primary site as colon, NOS (C18.9) when the only information about the diagnosis you have is "colorectal cancer."

We consulted with a subject matter expert who believes that colon, NOS is closest to being correct and that rectosigmoid is not appropriate.

If further information becomes available through further workup and/or treatment, update the primary site as appropriate.

We will add clarification to the 2027 SEER Manual, Appendix C, Colon Coding Guidelines.

Status: Published

Year: 2026

20260012

Question:

First Course of Therapy/Hormone Therapy--Thyroid: Is Thyrogen (thyrotropin alpha) coded as hormone therapy when a patient is given Thyrogen as part of planned 2-day Thyrogen Stimulated I-131 treatment for a papillary or follicular cancer?

See Discussion.

Discussion:

SEER*Rx categorizes Thyrogen as Hormones and hormonal mechanisms/Thyroid stimulating hormone. Probably not cancer directed–verify with attending MD.

Answer:

Do not code Thyrogen as hormone therapy when given as a stimulating agent in I-131 therapy. The therapeutic agent is I-131.

The Thyrogen/thyroid stimulating hormone (TSH) is sensitizing the gland to absorb more I-131. Thyrogen/TSH is a trophic hormone so it can cause growth of cancer cells. Thyroid hormones are given in follicular and papillary thyroid cancers to suppress TSH. Although Thyrogen can promote cancer growth its use in Thyrogen stimulated I-131 radioactive therapy is justified (benefits exceed the risk), since the use is short (2 days) and the high amount of I-131 would kill cancer cells in addition to majority of thyroid tissue.

We will update the Thyrogen entry in SEER*Rx and clarify in the next release of the SEER manual, Appendix C Coding Guidelines for Thyroid.

Status: Published

Year: 2026

20260011

Question:

Reportability/Histology-Breast 2026: Is lobular neoplasia (atypical lobular hyperplasia) reportable? There is no mention of grade and or conclusive lobular carcinoma in situ (LCIS) statement given.

Discussion: None

Answer:

Do not report a case of atypical lobular hyperplasia of the breast until/unless it is definitively diagnosed as LCIS or another reportable neoplasm. WHO defines this as a non-invasive lobular neoplasia. Atypical lobular hyperplasia does not have an ICD-O code and is not equivalent to in situ.

Status: Published

Year: 2026

20260010

Question:

Reportability/Histology-Breast: Is a spindle cell neoplasm with CLCN6::BRAF fusion reportable? If yes, how is the histology coded?

See Discussion.

Discussion:

A right breast lumpectomy identified a spindle cell neoplasm with CLCN6::BRAF fusion. The diagnosis comment states, "There is limited data on spindle cell neoplasms with this specific fusion, therefore the outcome/malignant potential is unclear. The lesion is well circumscribed with low grade morphology but shows increased cellularity and mitotic activity that reaches 40 mitoses per 10 high power fields, which may be better considered as sarcoma for therapy purposes." The physician clinically calls it a spindle cell sarcoma. Is this a reportable emerging sarcoma histology?

Answer:

Report this case of spindle cell neoplasm with CLCN6::BRAF fusion based on the physician diagnosis of spindle cell sarcoma (8801/3).

CLCN6::BRAF is described as rare kinase fusion identified in a subset of spindle cell sarcomas. It is part of an expanding group of BRAF fusions in spindle cell neoplasms though it not extensively detailed in the literature. Along with other BRAF fusions, CLCN6::BRAF represents a potential oncogenic driver for targeted therapy.

Status: Published

Year: 2026

20260009

Question:

SEER Manual/Reportability/Date of Diagnosis-Prostate: How is the diagnosis date coded when a Prostate Imaging Reporting and Data System (PI-RADS) 4 or 5 lesion is identified on imaging and therefore reportable, but further work-up or biopsy does not follow for 6 months or more?

See Discussion.

Discussion:

2026 SEER Manual Appendix E states PI-RADS (4 and 5) are reportable; they can be used to code the diagnosis date.

The *Date of Diagnosis* Coding Instruction 3 in the SEER Manual states:The first diagnosis of cancer may be **clinical** (i.e., based on clinical findings or physician's documentation) Note: Do **not** change the date of diagnosis when a clinical diagnosis is subsequently confirmed by positive histology or cytology.

2026 STORE Manual states:

PI-RADS, BI-RADS, LI-RADs alone are not reportable for CoC. PI-RADS, BI-RADS, L-RADS confirmed with biopsy or physician statement are reportable to CoC. Date of diagnosis is the date of the positive biopsy or definitive statement from physician.

Example: 01/04/2023 MRI identified both PI-RADS 4 and 5 lesions bilaterally. No work-up immediately followed and there is no chart information to account for the delay. The patient was seen again by urology and a 05/20/2024 biopsy proved adenocarcinoma. The patient underwent a prostatectomy approximately 6 months after biopsy on 01/13/2025. Biopsy diagnosis followed MRI diagnosis more than 16 months later and the plan was for active treatment. When further work-up does not shortly follow the MRI, and no information is available to the central registry to account for the delay, should the date of the biopsy be used to code diagnosis date?

Using the SEER PI-RADS diagnosis in these cases makes it appear as if any first course treatment is often greaterthan 1 year after "diagnosis," when it is really only approximately 6 months after the biopsy.

Which source should be used to code diagnosis date in these cases?

Case 1: 01/04/2023 MRI identified both PI-RADS 4 and 5 lesions bilaterally. No work-up immediately followed and there is no chart information to account for the delay. The patient

was seen again by urology and a 05/20/2024 biopsy proved adenocarcinoma. The patient underwent a prostatectomy approximately 6 months after biopsy on 01/13/2025. Biopsy diagnosis followed MRI diagnosis more than 16 months later and the plan was for active treatment.

Case 2: 02/05/2024 MRI identified a PI-RADS 5 lesion. No work-up immediately followed and there is no chart information to account for the delay. The patient was seen again by urology and a 08/29/2024 biopsy proved adenocarcinoma. After consultation with the urologist, active surveillance was recommended on 01/27/2025. Biopsy diagnosis followed MRI diagnosis more than 6 months later and the plan was for active surveillance.

Answer:

Updated June 2026

Report PI-RADS 4 or 5 PI-RADS only when confirmed with biopsy or when based on a recognized medical practitioner statement. Use the date of diagnosis as the date of the positive biopsy or the definitive statement from the recognized medical practitioner, whichever is earlier.

Use the date of biopsy in the two case scenarios based on the revised guidance.

We will include this update in the next release of the SEER Manual.

Status: Published

Year: 2026

20260008

Question:

Reportability/Ambiguous Terminology--Heme & Lymphoid Neoplasms: Should "consistent with" be included in the ambiguous terminology for reportability list in the updated Heme Manual?

See Discussion.

Discussion:

In the Heme Manual, published October 2025, the ambiguous terminology used to determine reportability for heme and lymphoid neoplasms (Case Reportability Instructions) was updated and "consistent with" was removed.

However, this is an ambiguous term that is used to describe reportability (and not just histology). The term "consistent with" was previously included as a reportable ambiguous term used to report cases prior to this update.

The updated Heme Manual is clear regarding "consistent with" now being a definitive diagnosis for the purpose of coding histology. However, the Note under instruction 4 states, "Do not apply these changes to casefinding, reportability, or staging." Is "consistent with" an exception to this Note? Or should it be re-added to the ambiguous terms related to reportability?

Answer:

The 2027 version of the Hematopoietic Manual (release October 2026) will include the following in the Case Reportability Instructions, pg. 40:

4. “Consistent with” for reportability and casefinding is now a definitive diagnosis and is no longer ambiguous terminology. This is for hematopoietic neoplasms ONLY. a. “Consistent with” has become a very common way for pathologists to document diagnoses for Hematopoietic neoplasms. To ensure that hematopoietic cases are being reported, “consistent with” has now become definitive terminology for casefinding and reportability (see Histology Coding Instructions for assigning histology).

b. Do not apply this instruction to casefinding and reportability for Solid Tumors.

5. Report the case when the diagnosis of a hematopoietic neoplasm is preceded by one or more of the ambiguous terms listed below:

a. This instruction pertains to reportability and case finding only. See the Histology Coding Instructions, #3-5 for instructions on assigning histology with ambiguous terminology (note that “consistent with” has been removed.

See Note #4) .

- Apparently
- Appears
- Comparable with
- Compatible with
- Favor(s)
- Malignant appearing

Status: Published

Year: 2026

20260006

Question:

First Course of Therapy--Heme & Lymphoid Neoplasms: How is first course of treatment coded for hematopoietic and lymphoid neoplasm (heme) cases who are put on surveillance for years while asymptomatic and then start chemotherapy or other treatment years later once they become symptomatic?

See Discussion.

Discussion:

Patient was diagnosed with smoldering myeloma in October 2021 and put on surveillance. In May 2024, the patient became symptomatic and started chemotherapy.

Is the date of diagnosis in 2021, with date of first treatment with chemotherapy in 2024? Or is active surveillance first course and treatment with chemotherapy as second course in 2024?

Answer:

Updated June 2026

Code the first course of treatment as active surveillance. Chemotherapy is second course of treatment based on this scenario due to progression.

We will be adding clarification about this type of scenario to the treatment rules in the 2027 updates, which will be released October 2026.

Status: Published

Year: 2026

20260004

Question:

Solid Tumor Rules/Multiple Primaries-Breast: How many primaries and which Breast Solid Tumor Rules (STR) M Rule applies when a patient has synchronous, separate/non-contiguous breast tumors which are a ductal carcinoma and a separate lobular carcinoma? See Discussion.

Discussion:

Historically, synchronous ductal and lobular tumors have been accessioned as a single primary. These were previously covered under Rule M10, which was removed from the (STR) Manual 2026 Update. While the previous iteration of Rule M10 was problematic, the main issue related to the lack of a timing component within the rule (i.e., indicating it applied to synchronous ductal and lobular tumors). Using the current Breast STR, when there are two (or more) simultaneous tumors which are **not** mixed lobular and ductal within each tumor, the applicable M Rule is Rule M13: Abstract multiple primaries when separate/non-contiguous tumors are on different rows in Table 3. To apply the M Rules, a provisional histology must be assigned to EACH tumor so we cannot code each tumor as 8522 before we start applying the M Rules. These provisional histologies would be 8500 and 8520, and these are on different rows in Table 3.

Answer:

Accession two primaries when a patient has synchronous, separate ductal and lobular tumors using Rule M13, Breast STRs, 2026 Update. Ductal carcinoma (8500/3) and lobular carcinoma (8520/3) are distinct histology terms and codes that are in different rows in Table 3. This is a modification of Rules M10 and H28 from prior versions of the STR Manual.

Status: Published

Year: 2026

20260003

Question:

Solid Tumor Rules/Histology--Thyroid: What is the correct histology for invasive encapsulated follicular variant of papillary thyroid carcinoma (IEFVPTC)? The 2026 Solid Tumor Rules (STR) Manual, Other Sites Table 12, conflicts with the ICD-O-3.2.

See Discussion.

Discussion:

STR Manual, Table 12, Thyroid Histologies, includes "Invasive encapsulated follicular variant of papillary thyroid carcinoma" as histology 8340/3 and is on its own row from other papillary thyroid carcinomas (PTC). A new footnote was added which states, "IEFVPTC and Infiltrative follicular variant of papillary thyroid carcinoma (a PTC subtype) share a histology code, but they are distinctly different histologies. They are on different rows of the table and are different primaries." However, IEFVPTC (and its synonyms) are listed in the ICD-O-3.2 as 8343/3, and 8343/3 was listed as a subtype/variant of papillary thyroid carcinoma in previous versions of the STR Manual.

Answer:

Assign histology as 8340/3 for IEFVPTC using the STR Manual, 2026 Update. Rule M18, Note 2, of the Other Sites STR state: Invasive encapsulated follicular variant of papillary thyroid carcinoma and Infiltrative follicular variant of papillary thyroid carcinoma share a histology code (8340) but are distinctly different entities. They are on separate rows of the table. WHO Classification of Endocrine and Neuroendocrine Tumors, 5th ed., indicates that after classic PTC, the follicular variant of PTC (FVPTC) is the second most common histological subtype of PTC. Two major forms are known, infiltrative FVPTC and invasive encapsulated FVPTC. The majority of follicular PTCs are encapsulated FVPTCs, whereas infiltrative FVPTC is quite rare and clinically behaves like classic PTC.

Status: Published

Year: 2026

20260001

Question:

SEER Manual/Surgery of Primary Site-Ovary: Should "(salpingo)" be removed in the SEER Note under Ovary surgery code A280?

See Discussion.

Discussion:

Code A280 is defined as a total removal of the ovarian tumor or removal of a single ovary (oophorectomy) WITH a hysterectomy. The unilateral removal of both the fallopian tube and ovary [(salpingo-) oophorectomy] is included in surgery codes A350-A370. However, the SEER Note under code A280 states, "Also use code A280 for current unilateral (salpingo-) oophorectomy with previous history of hysterectomy." Should this SEER Note read, "Also use code A280 for current unilateral oophorectomy with previous history of hysterectomy"?

Answer:

Assign code A280 for current unilateral oophorectomy with hysterectomy or with a previous history of hysterectomy. We will remove the text '(salpingo-)' from the Ovary surgery code A280 SEER Note in the next release of SEER Manual.

Status: Published

Year: 2026