2019-0049

References
Source 1: **SINQ 20091101**

Question
Lymph nodes/Melanoma: Is a single axillary lymph node regional or distant for a patient diagnosed in 2018 with metastatic melanoma to the brain found via imaging. The staging procedure was a single axillary lymph node excision that was positive for metastatic melanoma. The exact site of the primary was never determined; the primary site is coded to C449. See Discussion.

Discussion
The patient was diagnosed in 2018 with met melanoma to the brain found via imaging. The staging procedure was a single axillary lymph node excision which was positive for metastatic melanoma. The exact site of the primary was never determined, and the site code is C449. Is the axillary lymph node regional or distant? This affects how I code regional lymph nodes positive, regional lymph nodes examined, and scope of regional lymph node surgery or surgical procedure other site. Similar question was asked in the past (question # 20091101) but I have not found this question restated since the 2018 changes and just want to verify this is still what we are to do.

Answer
Lymph node mets from a melanoma of unknown primary site are presumed to be regional if the lymph node mets are confined to one area, as they are in this case. We are assuming there are no previous melanoma diagnoses for this patient. The workup should include examination of the skin areas that drain to the axillary area.

Date Finalized
07/19/2019

20190048

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

Question
Reportability/Histology--Skin: Is malignant hidroacanthoma simplex of the scalp reportable? If so, what is the histology?

Answer
Malignant hidroacanthoma simplex of the scalp is reportable. Malignant hidroacanthoma simplex is a synonym for porocarcinoma, 8409/3.

Date Finalized
07/19/2019

20190047

References
Source 1: **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5322844/**

Question
Reportability/Liver: If on imaging, there is no statement of the Liver Imaging Reporting and Data System (LI-RADS) score but there is reference that a lesion is in the Organ Procurement and Transplantation Network (OPTN) 5 category, is hepatocellular carcinoma (HCC) reportable based on the OPTN 5 classification? See Discussion.

Discussion
SINQ 20160008 discusses the reportabilty and diagnosis date for liver primaries where imaging references the LI-RADS category as LR-5 or LR-5V. The 2018 SEER Coding and Staging Manual, Appendix E Reportable Example #16, demonstrates this concept. According to the LI-RADS categories a value of 5 is “definitely HCC" and is concordant with OPTN 5. Often, we see only the OPTN categorization.

Answer
Report HCC based on the OPTN class of 5. OPTN class 5 indicates that a nodule meets radiologic criteria for HCC. Be sure to document in text fields.

Date Finalized
07/19/2019

20190046

References
Source 1: **2018 SEER Manual**
pgs: **107-109**
Notes: **Tumor Size--Clinical**

Question
Tumor Size/Bladder: The 2018 SEER Coding and Staging Manual says to use imaging over physical exam as priority for determining tumor size. If a bladder tumor is 4 cm visualized on cystoscopy, and is 2.8 cm on CT scan, which should be used as the clinical size? Is cystoscopy (endoscopy) a clinical exam or imaging?

Answer
For the case described here, use the size from the CT scan. Physical exam includes what can be seen by a clinician either directly or through a scope. A tumor size obtained visually via cystoscopy is part of a physical exam. Therefore, the imaging (CT) tumor size is preferred. Use text fields to describe the details.

Date Finalized
07/19/2019

20190045

References
Source 1: **2018 Solid Tumor Rules**
pgs: **13**
Notes: **Head and Neck, January 2019 Update**

Question
Solid Tumor Rules (2018)/Multiple Primaries--Head & Neck: How many primaries are accessioned and what M Rule applies when a patient is diagnosed with a right lateral tongue (C023) tumor in 2016 that was verrucous carcinoma (8051), followed by a new left tongue border (C021) tumor in 2019 that was squamous cell carcinoma, NOS (8070)? See Discussion.

Discussion
According to the Multiple Primaries/Histology Rules in place at the time of the 2016 diagnosis, verrucous carcinoma was listed as a specific type of squamous carcinoma (Chart 1). However, in the current Solid Tumor Rules, verrucous carcinoma is not listed in Table 4 (Tumors of Oral Cavity and Mobile Tongue) either as a specific histology or as a specific subtype/variant of squamous carcinoma. The only subtype/variant listed for these sites is acantholytic squamous cell carcinoma (8075).

Verrucous carcinoma is not listed in Table 4, making it unclear if it should be a different histology for these specified sites. However, verrucous carcinoma is listed as a specific subtype/variant of squamous carcinoma for other sites (e.g., Table 3).

Answer
Accession a single primary based on the 2018 Head and Neck Solid Tumor Rule M13 as none of the other rules apply to the situation.

Not all histology codes are contained in the tables in the Solid Tumor Rules as they list the more common histologies. Verrucous carcinoma is a subtype of squamous cell carcinoma according to Table 3 of the Rules.

Solid Tumor rule tables are based on 4th Ed WHO Blue Books. Verrucous SCC is not included in oral cavity/mobile tongue chapter.

Date Finalized
07/19/2019

20190044

References
Source 1: **2018 Solid Tumor Rules**
pgs: **27**
Notes: **Colon, January 2019 Update**
Source 2: **SINQ 20170058**

Question
Solid Tumor Rules (2018)/Histology--Colon: Is the term phenotype equivalent to type, subtype, variant for the purpose of coding histology? See Discussion.

Discussion
In our region, pathologists often describe histology using the term phenotype. However, the use of the term phenotype is not discussed in the Solid Tumor Manual.

Example: Final Diagnosis of a colon tumor is invasive adenocarcinoma with a mixed phenotype, and the Diagnosis Comment states: The majority of the disease is poorly differentiated/signet ring cell phenotype.

Would the histology be coded to 8490 (signet ring cell carcinoma), if the majority of the tumor is a more specific histology described by the term phenotype?

Answer
While variant, type, and subtype can be used interchangeably according to the Solid Tumor Rules, SINQ 20170058 states that the Multiple Primaries/Histology (now Solid Tumor) Rules do not include coding phenotype. Code as invasive adenocarcinoma NOS (8140).

Date Finalized
07/19/2019

20190043

References

Question
Diagnostic Confirmation: How is Diagnostic Confirmation coded for malignancies diagnosed by a FoundationOne Liquid biopsy/assay involving circulating tumor DNA in blood only? See Discussion.

Discussion
Example: FoundationAct assay of circulating tumor DNA in blood sample results: Tumor type = non-small cell lung carcinoma, NOS, with 3 genomic alterations identified: NRAS Q61H, IDH2 R140Q and TP53 V172F. The tumor was identified on imaging and the imaging findings were not clearly what one would expect to see with a SCLC.

Answer
Code Diagnostic Confirmation as 7, Radiology and other imaging techniques without microscopic confirmation for this case. Results of a FoundationOne Liquid biopsy/assay are not specific enough to diagnose this lung malignancy.

Date Finalized
07/19/2019

20190042

References
Source 1: **2018 Solid Tumor Rules**
pgs: **7, 24, 34**
Notes: **Breast; April 2019 Update**

Question
Solid Tumor Rules (2018)/Multiple Primaries--Breast: Is a breast resection showing invasive mucinous carcinoma in a single tumor with associated ductal carcinoma in situ and additional findings of a background of lobular carcinoma in situ single or multiple primaries and which M rule applies? See Discussion

Discussion
Example: Right breast core biopsy found ductal carcinoma in situ in the upper outer quadrant. Subsequent resection has a final diagnosis of invasive mucinous carcinoma, grade 1, measuring approximately 7 mm, with close margins. See staging summary. Gross description mentions only the primary tumor with associated marker clip from previous biopsy.

Breast Cancer Staging Summary lists (testing and margins removed for brevity):
Procedure type: Lumpectomy.
Specimen laterality: Right.
Tumor size: 7mm.
Histologic type: Invasive mucinous carcinoma.
Histologic grade (Nottingham histologic score): Grade 1, (score 5/9).
Tumor focality: Single focus.
Lymph-vascular invasion: Not identified.
Treatment effect: No known therapy.
Ductal carcinoma in situ (DCIS): Present.
Architectural pattern: Cribriform.
Nuclear grade: Grade 1.
Necrosis: Not identified.
Calcifications: Not identified.
Estimated size/extent of DCIS: Spanning an area measuring 15mm.
Pathologic stage: pT1b, pNx. (AJCC 8th ed).
Distant metastasis: Not applicable.
Additional findings: Background lobular carcinoma in situ (LCIS), flat epithelial atypia (FEA), and atypical ductal hyperplasia (ADH).

Answer

Apply Breast Solid Tumor Rule M3, abstract a single tumor when there is a single tumor, as there is reference to the primary, single 7 mm tumor. Apply Rule H7 and code the invasive histology only, mucinous carcinoma, when both invasive and in situ components are present. The rules state: Do not use Table 2 Histology Combination Codes for tumors with both invasive and in situ behavior.

Date Finalized

07/19/2019

20190041

References
Source 1: **2018 SEER Manual**
pgs: **7, 90**
Notes:
Source 2: **2018 Solid Tumor Rules**
pgs: **1**
Notes: **Colon, January 2019 Update**

Question
Reportability/Primary Site--Gastrointestinal (GI) Tract: Is a gastrointestinal stromal tumor (GIST) with a single nodule in the small intestine (C17_) and a nodule in the stomach (C16_) reportable per the 2018 SEER Coding Manual reporting instructions for GIST due to the multiple foci or do the multiple foci need to be in the same organ to be reportable? See Discussion.

Discussion
Example: Small intestine wedge resection with GIST, 1.8 cm in mid small intestine, single nodule. Stomach nodule biopsy: GIST, 0.3 cm. Pathology report comment section indicates the gastric GIST is not staged due to the small size and incidental nature.

Answer
Report the GIST in the small intestine. The 2018 SEER Manual says to report GIST when there are multiple foci and to code the primary site to the site where the malignancy originated. Use text fields to record the details, including the stomach nodule.

Date Finalized
07/19/2019

20190040

References
Source 1: **Heme & Lymph Manual & DB**
pgs:
Notes:
Source 2: **WHO Class Hem & Lymph Tumors**

Question
Reportability--Heme & Lymphoid Neoplasms: Is peripheral blood with a diagnosis of monoclonal B-cell lymphocytosis (MBL) with chronic lymphocytic leukemia (CLL) phenotype reportable for any year? See Discussion.

Discussion
SINQ 20180050 and 20130041 appear to have conflicting answers regarding the reportability of MBL with CLL (immuno)phenotype.

While the question content of SINQ 20180050 does not reference the CLL phenotype, it is included in the Discussion as part of the oncologist's assessment. The answer does not address the clinical diagnosis of MBL with CLL-phenotype and simply states that monoclonal B-cell lymphocytosis is not reportable.

SINQ 20130041 does include the CLL phenotype information in the primary question and it is expanded on in the discussion as present in peripheral blood. Based on that information, the answer is that it should be reportable and coded as CLL (9823/3).

Answer
The description in the question is for 9823/1 per WHO blue book 2016. This description and code are not reportable. We will review the other SINQ questions and revise if necessary.

Date Finalized
07/19/2019

20190039

References
Source 1: **2018 Solid Tumor Rules**
pgs: **32**
Notes: **January 2019 Update**

Question
Solid Tumor Rules (2018)/Histology--Lung: What is the histology code of invasive moderately differentiated adenocarcinoma, predominantly papillary subtype, with minor acinar and lepidic subtypes? See Discussion.

Discussion
11/01/2018, lung, left upper lobe, wedge resection: Invasive moderately differentiated adenocarcinoma, predominantly papillary subtype, with minor acinar and lepidic subtypes. Would this be 8260/3 since the acinar and lepidic subtypes are described as minor or would this be 8255/3 because there is papillary plus two other subtypes/variants described as subtypes?

Answer
Code as adenocarcinoma, papillary predominant (8260/3) according to the Lung Solid Tumor Rules, Coding Multiple Histologies, which says to code the specific histology. The most specific histology may be described as component, majority/majority of, or predominantly, where predominantly describes the greater amount of tumor.

Date Finalized
07/19/2019

20190038

References
Source 1: **2018 Solid Tumor Rules**
pgs: **36**
Notes: **April 2019 Update**

Question
Solid Tumor Rules (2018)/Histology--Breast: How is the histology coded and which H Rule applies for a single tumor with final diagnosis of invasive mammary carcinoma and College of American Pathologists (CAP) synoptic report states, Histologic type: Invasive cribriform carcinoma with no mention of a tumor percentage? See Discussion.

Discussion
In the April 2019 Breast Solid Tumor Rules update, the Priority Order for Using Documentation to Identify Histology was changed, giving equal priority to the Final diagnosis / synoptic report as required by CAP (item 2B).

There are technically two histologies documented for the case above; a Not Otherwise Stated (NOS)/No Special Type (NST) (invasive mammary carcinoma, per final diagnosis text) and subtype/variant (invasive cribriform carcinoma, per CAP report). If we do not use the synoptic report with priority over the final diagnosis, Rule H14 indicates the histology would be the NOS histology (invasive mammary carcinoma) because the percentage of tumor is not given for the subtype. However, SINQ 20180045 states, In the CAP protocol, the term Histologic Type is a label where the histology that corresponds to the largest carcinoma is collected. According to the CAP protocol for invasive breast cancer, the histologic type corresponds to the largest carcinoma.

If the pathologist summarizes the findings in a synoptic report, should the specific Histologic Type identified have priority?

Answer
Based on the synoptic report findings, code cribriform carcinoma using Breast Solid Tumor Rule H12 which says to code the histology when only one histology is present. The histologic type describes one histology and does not describe the components of an NOS/NST with a subtype, in which case a different rule would apply.

The priority order for using documentation to identify histology gives equal weight to final diagnosis and synoptic report, secondary to addendum or comments. Use the more specific

histology if either the final diagnosis or synoptic provides the additional information on the histology.

Date Finalized
07/19/2019

20190037

References
Source 1: **2018 Solid Tumor Rules**
pgs: **27**
Notes: **April 2019 Update**

Question
Solid Tumor Rules/Multiple Primaries--Breast: How many primaries should be abstracted for simultaneously diagnosed non-contiguous invasive duct carcinoma and mucinous carcinoma? Does rule M12 apply since the two histologies are on different rows of Table 3 of the Breast Solid Tumor Rules? See Discussion.

Discussion
Core biopsy of left breast at 2:00: Invasive ductal carcinoma, Nottingham score 6/9.

Core biopsy of left breast at 4:00: Invasive mucinous carcinoma (variant of ductal carcinoma), Nottingham score 5/9.

Post neo-adjuvant mastectomy: Main (largest tumor): Invasive ductal carcinoma, upper outer quadrant grade 2. Secondary tumor: mucinous carcinoma, grade 1 at 4:00.

Answer
Abstract multiple primaries when separate, non-contiguous tumors are on different rows in Table 3 of the Breast Solid Tumor Rules. Use Rule M14 as each row in the table reflects a distinctly different histology, in this case, invasive ductal carcinoma (8500) and mucinous carcinoma (8480).

Date Finalized
07/19/2019

20190036

References
Source 1: **2018 SEER Manual**
pgs: **150**
Notes: **First course of therapy**

Question
First Course of Treatment/Hormone Therapy--Breast: Is hormone therapy (HT) prescribed for invasive ductal carcinoma of the right breast coded as treatment for lobular carcinoma in situ (LCIS) of the left breast even though the treatment plan for the LCIS was documented as surveillance? See Discussion.

Discussion
Patient is diagnosed with invasive ductal carcinoma (IDC), right breast, receives HT, radiation therapy, and surgery. The same patient is diagnosed with LCIS, left breast one month later--recommend surveillance only (no surgery). Is the HT for the left breast coded at all? I think for COC/NCCN, we do not, but for SEER what would I do? Treatment in the SEER Manual 2018 states, "Code the treatment on each abstract when a patient has multiple primaries and the treatment given for one primary also affects/treats another primary." The example includes bladder/prostate and ovarian/cervix. It also states, "Code the treatments only for the site that is affected when a patient has multiple primaries and the treatment affects only one of the primaries." The example includes colon/tonsil. Breast LCIS treatment appears complicated. Per NCCN guidelines, this condition no longer has recommendations, however it appears as though they still state that if a core biopsy is done and is LCIS, follow up should be ultrasound or surgical excision. Nowhere does it state hormone is recommended.

Answer
Do not code the hormone treatment for the LCIS since it was clearly documented that the hormone treatment was given for the IDC and the treatment for the LCIS was documented as "surveillance." Use text fields to record the details on both abstracts.

Date Finalized
07/19/2019

20190035

References
Source 1: **2018 ICD-O-3 Implementation Guidelines**
pgs:
Notes: **Coding Tables**

Question

Reportability/Histology--Vulva/Penis: Are differentiated penile intraepithelial neoplasia (C60._) and differentiated vulvar intraepithelial neoplasia (C51._) reportable for cases diagnosed 2018+? See Discussion.

Discussion
We previously downloaded the 8/22/2018 ICD-O-3 histology update tables which included the note, not reportable for 2018, for both of these terms (with an updated histology 8071/2). SINQ 20180020 confirms differentiated penile and vulvar intraepithelial neoplasia are NOT reportable for 2018 (as does 20160069). However, when looking at the 8/22/2018 ICD-O-3 histology update table today, the not reportable for 2018 comment has been removed and it appears these two terms are reportable. Which is correct?

Answer
Report differentiated vulvar intraepithelial neoplasia and differentiated penile intraepithelial neoplasia (8071/2). The 2018 ICD-O-3 Coding Table errata dated 8/22/2018, lists the summary of changes of 7/20/2018, stating that these were erroneously flagged as not reportable and the flag was changed from not reportable to reportable (N to Y).

We will update SINQ 20180020.

Date Finalized
06/05/2019

20190034

References
Source 1: **WHO Class Male Genital Tumors**
pgs: **277**
Notes: **4th edition**

Question
Reportability/Histology--Penis: Is a diagnosis of undifferentiated penile intraepithelial neoplasia (PeIN) reportable for cases diagnosed in any year? See Discussion.

Discussion
Example: An October 2017 glans penis biopsy final diagnosis was reported as: Undifferentiated (Warty-Basaloid) penile intraepithelial neoplasia.

In January 2018, an additional penile glans biopsy final diagnosis was reported as: At least squamous cell carcinoma (SCC) in situ (HGPIN). Foreskin circumcision on the same pathology report shows SCC in situ.

It is unclear whether the term undifferentiated is synonymous with high-grade for the purposes of determining penile intraepithelial neoplasia (PIN/PEIN) reportability and diagnosis date.

Answer
Report undifferentiated penile intraepithelial neoplasia (PeIN) (8077/2). WHO Classification of Tumors of the Urinary System and Male Genital Organs, 4th edition, lists basaloid (undifferentiated) penile intraepithelial neoplasia and warty (Bowenoid) penile intraepithelial neoplasia as a variant of PeIN.

Date Finalized
06/05/2019

20190033

References
Source 1: **2018 SEER Manual**
pgs: **110-113**
Notes: **Tumor Size—Pathologic**

Question
Neoadjuvant therapy/Pathologic tumor size--Breast: When a patient with invasive breast cancer is started on neoadjuvant therapy and at surgery is found to have only residual in-situ disease, do we record the size of the in-situ tumor for Pathologic Tumor Size? See Discussion.

Discussion
I understand that we are to record the Clinical Tumor Size in Tumor Size Summary because of the neoadjuvant therapy, but the SEER manual does not address what to record in the Pathologic Tumor Size after neoadjuvant therapy. Would we record 999 or the size of the in-situ tumor in the Pathologic Tumor Size field? Will there ever be a new data item added or changes to this current data item? By recording the Pathologic Tumor Size this way, there currently will not be any way to compare tumor size clinically versus after neoadjuvant therapy and assessing the response.

Answer
Assign 999 in Pathologic Tumor Size when neoadjuvant therapy has been administered. We can explore the possibility of another data item in the future.

Date Finalized
06/05/2019

20190032

References
Source 1: **2018 Summary Stage**
pgs:
Notes: **Respiratory Tract and Thorax section, Lung chapter, v1.1**

Question
Summary Stage 2018--Lung: Are ground-glass lung nodules coded as distant for Summary Stage? See Discussion.

Discussion
Chest x-ray: Multifocal pneumonia in left lung; possibility of masses in left lung not excluded.
Chest CT: 4 large ground-glass masses in LUL (largest 46mm); beginning of Tree-In-Bud appearance in LUL; 2 small ground-glass nodules in right lung.
Lung LUL biopsy: Adenocarcinoma, Solid Predominant. No further information as patient did not want to discuss treatment options.

Per the AJCC book and CAnswer Forum, multifocal classification should be applied equally whether the lesions are in the same lobe OR in different ipsilateral lobes OR contralateral lobes, cT2b(m), cN0, cM0.

Answer
Do not assume that ground glass presentation is consistent with a neoplasm. There are numerous causes of a ground glass lung condition such as sarcoidosis or pulmonary fibrosis. A ground glass lung opacity may also be observed in conditions such as alveolar proteinosis, desquamative pneumonitis, hypersensitive pneumonitis, and drug-induced or radiation-induced lung disease. If an area of ground glass opacity persists in the lung, it is usually classified as an adenocarcinoma, a classification that ranges from premalignant lesions to invasive disease. This is in line with AJCC that states to stage based on the largest tumor determined to be positive for cancer.

To Summary Stage the case example provided, ignore the lesions in the contralateral lung (do not assume that they are malignant). There are multiple lesions in the left lung, but once again, do not assume that those not biopsied are malignant. This leaves us with the lesion confirmed to be malignant, making this a Localized (code 1) tumor.

Date Finalized
06/05/2019

20190031

References
Source 1: **SSDI Manual, Volume 1.5**
pgs: **40**
Notes: **Schema Discriminator 1**

Question
Primary site--Head & Neck: Are cases with positive cervical lymph nodes that are EBV positive (EBV+) coded to the nasopharynx, and cases with positive cervical lymph nodes that are p16 positive (p16+) coded to the oropharynx, when no primary site is identified?

Discussion
This question involves positive cervical lymph nodes with an unknown primary site. The SEER Manual says under the coding instructions for Primary Site:

14. b. Use the NOS category for the organ system or the Ill-Defined Sites (C760-C768) if the physician advisor cannot identify a primary site.

Note: Assign C760 for Occult Head and Neck primaries with positive cervical lymph nodes.

Schema Discriminator 1: Occult Head and Neck Lymph Nodes is used to discriminate between these cases and other uses of C760. Does SEER agree with AJCC that cases with positive cervical lymph nodes that are EBV+ should be coded to the nasopharynx and cases with positive cervical lymph nodes that are p16+ should be coded to the oropharynx, if no primary site is identified?

Answer
Assign primary site C119 (nasopharynx) for occult head and neck tumors with cervical metastasis in Levels I-VII, and other group lymph nodes that are positive for Epstein–Barr virus (EBV+) (regardless of p16 status) encoded small RNAs (EBER) identified by in situ hybridization.

Assign primary site C109 (oropharynx) for occult head and neck tumors with cervical metastasis in Levels I-VII, and other group lymph nodes, p16 positive with histology consistent with HPV-mediated oropharyngeal carcinoma (OPC).

Date Finalized
06/05/2019

20190030

References
Source 1: **2018 Summary Stage**
pgs:
Notes: **Male Genital System Prostate chapter, v1.1**

Question
Summary Stage 2018/Extension--Prostate: Can imaging be used to code SEER Summary Stage 2018? MRI shows tumor involved the seminal vesicles and the patient did not have surgery. AJCC does not use imaging to clinically TNM stage a prostate case.

Answer
Per Note 5 of the 2018 SEER Summary Stage Prostate chapter: Imaging is not used to determine the clinical extension unless the physician clearly incorporates imaging findings into their evaluation. This note was added to be in line with how AJCC stages; therefore, AJCC and Summary Stage agree. Do not use the MRI findings when that is all you have, and the physician does not document agreement with the MRI.

Date Finalized
06/05/2019

20190029

References
Source 1: **WHO Class Male Genital Tumors**
pgs: **217**
Notes: **4th ed.**

Question
Reportability--Testis: Is demarcated scar tissue with atrophic seminiferous tubules and cortical bone consistent with burnt-out germ cell tumor and no evidence of germ cell neoplasia in situ (GCNIS) reportable? See Discussion.

Discussion
The patient is a 34-year-old who presented with testicular pain radiating into the abdomen approximately 1 month before orchiectomy in 2018. CT abdomen/pelvis: Multiple focal sclerotic bone lesions. Given the lack of change from July 2014, these are likely benign bone islands. No adenopathy mentioned. He has no prior history of germ cell tumor nor any surgery for any tumor/cancer before this. Pathology: Testis, left, radical orchiectomy: - Demarcated scar tissue (1.3 cm), with atrophic seminiferous tubules and cortical bone consistent with burnt-out germ cell tumor. No evidence of germ cell neoplasia in situ (GCNIS). - Margins are unremarkable.

Answer
Burnt-out germ cell tumor (9080/1) is not reportable. According to WHO Classification of Urinary System and Male Genital Organ, regressed germ cell tumors are germ cell tumors that have undergone partial or complete regression leaving a generally well-delineated nodular focus of scar or fibrosis in the testis.

Date Finalized
05/29/2019

20190027

References
Source 1: **2018 EOD Manual**
pgs:
Notes: **General Coding Instructions, March 2018**

Question
Extent of Disease 2018/Primary tumor/Neoadjuvant treatment: If there is no clinical information available and all that is available is the post-neoadjuvant information, is it better to code EOD unknown (999) or use the post-neoadjuvant information to code EOD? See Discussion.

Discussion
The Extent of Disease (EOD) Manual states: Neoadjuvant (preoperative) therapy: If the patient receives neoadjuvant (preoperative) systemic therapy (chemotherapy, immunotherapy) or radiation therapy, code the clinical information if that is the farthest extension documented. If the post-neoadjuvant surgery shows more extensive disease, code the extension based on the post-neoadjuvant information.

Answer
Code EOD Primary Tumor using the post neoadjuvant information for this case. Since the only information you have is the post neoadjuvant, code that. EOD combines clinical and pathological information.

Date Finalized
05/08/2019

20190026

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Urinary; April 2019 update**

Question
Solid Tumor Rules (2018)/Multiple primaries--Bladder: Does Rule M11 in the 04/2019 Solid Tumor Rules Urinary update apply to synchronous/simultaneous tumors only or to multiple tumors with any timing? See Discussion.

Discussion
Rule M11 states: Abstract a single primary when there are urothelial carcinomas in multiple urinary organs, but neither the Rule nor the Notes describe the timing of these multiple urinary organ carcinomas. Timing requirements for other rules are clearly stated.

Does Rule M11 have a timing requirement or is it intended to apply to all urothelial carcinoma tumors regardless of timing (and not already qualifying for application of a previous M rule)?

Answer
The revised Urinary Solid Tumor Rules 2018 Rule M11, updated April 2019, removed the requirement of synchronous. This applies to urothelial carcinoma (8120) and its corresponding subtypes, regardless of behavior, that occur in more than one urinary site in a patient's lifetime. See change log for the April 2019 update to urinary rules.This is the same M/PH rule for multiple sites. Timing does not factor in to this rule.

Date Finalized
05/08/2019

20190025

References
Source 1: **WHO Class Digest System Tumors**

Question
2018 Solid Tumor Rules/Histology--Colon: What is the histology code of a diagnosis of well differentiated neuroendocrine tumor (NET), grade 2 of the appendix? See Discussion.

Discussion
SINQ 20160023 and the Solid Tumor Rules indicate NET G1 (or well differentiated NET) is coded as 8240 and NET G2 is coded as 8249.
Clarification regarding grade coding in the CAnswer Forum indicates well differentiated neuroendocrine tumor refers to the histologic type, and not the grade. Therefore, the term well differentiated is ignored for the purpose of grade coding.
Neither of these sources clarifies how to code histology for a tumor diagnosed as well differentiated neuroendocrine tumor, grade 2.

Answer
Assign histology code 8249 for histology described as well differentiated NET G2. A synonym for NET of the appendix includes well-differentiated endocrine tumor/carcinoma according to WHO Classification of Tumors of the Digestive System, 4th edition. "Well differentiated" could apply to either NET G1 or NET G2.

Date Finalized
05/02/2019

20190023

Question

First course of treatment/Radiation therapy--Kidney: Patient has a CT-guided biopsy of a right renal mass with procedure details under the Interventional Radiology Procedure Note stating "Gelfoam tract embolization." Is this particular embolization treatment?

Answer

Gelfoam tract embolization for a CT-guided renal biopsy is not treatment. It is a method to plug the biopsy track to reduce the risk of hemorrhage.

Date Finalized

04/16/2019

20190022

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Lung, updated January 2019**

Question
Solid Tumor Rules (2018)/Histology--Lung: Is histology code or the number of primaries assigned differently in SINQ 20180093 if the word 'pattern' was omitted? See Discussion.

Discussion
Regarding the answer to SINQ 20180093: This is a single primary; coded 8140/3 adenocarcinoma. In the biopsy and the two tumors found on lobectomy, the specific adenocarcinoma histologies are described as acinar predominant pattern, solid growth pattern and lepidic predominant pattern. You do not code a pattern, so rule M7 above applies and this is a single primary.

My question is based on Note 2 in Coding Multiple Histologies for lung cancers that says: Predominantly describes the greater amount of tumor. Predominant and majority are synonyms. Per the CAP protocol, the term predominant is acceptable for the following specific subtypes of adenocarcinoma. For these subtypes only, the word predominant is used to describe both the subtype and the grade of the tumor.

Answer
If the word 'pattern' was omitted, you would abstract multiple primaries per the Lung Solid Tumor Rule M6 and code histology to adenocarcinoma, acinar predominant (8551/3) and adenocarcinoma, lepidic predominant (8250/3) per Rule H4 as the word 'pattern' is not included in each histology.

Date Finalized
04/16/2019

20190021

References
Source 1: **2018 SEER Manual**
pgs:
Notes: **final version, p. 87**

Question
Sequence Number Central--Brain and CNS: How is Sequence Number--Central coded for current/recent benign brain/CNS tumors when the patient has a history of an additional non-malignant CNS tumor diagnosed prior to 2004 (when these tumors became reportable to SEER)? See Discussion.

Discussion
We are confused by the SEER Program Coding and Staging Manual 2018 instruction that states: This sequence number counts all tumors that were reportable in the year they were diagnosed even if the tumors occurred before the registry existed or before the registry participated in the SEER Program. Does this rule apply to benign and borderline CNS tumors?

Does this mean that any non-malignant CNS tumor diagnosed prior to 2004 should NOT be included in the sequencing (in the 60s range) if we were collecting non-malignant CNS per our State Registry reporting requirements prior to 2004?

Example: Patient has a March 2017 diagnosis of right sided vestibular schwannoma (C724-1, 9560/0) and a prior history of left sided acoustic neuroma (c724-2, 9560/0) diagnosed in 1991. How should sequence be coded for each primary in our file?

Answer
For your example, code the Sequence Number--Central as 61 for the 1991 diagnosis if this was a state registry requirement in 1991 and code 62 for the 2017 diagnosis.

Date Finalized
04/16/2019

20190020

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Head and Neck, January 2019**
Source 2: **WHO Classification of Tumors, 4th editions: Skin Tumors, Head and Neck Tumors**

Question
Solid Tumor Rules (2018)/Histology--Head & Neck: What table in the Head and Neck Solid Tumor Rules applies to tumors of the lip (C000-C009)? The rules apply to all tumors in sites C000-C148, C300-C339, C410, C411, C442 and C479, but none of the histology tables include the lip. See Discussion.

Discussion
Example: Patient has a secretory carcinoma of minor salivary gland tissue (mammary analogue secretory carcinoma [MASC]) of the mucosal lower lip; it is unclear which table to use and how to arrive at the correct histology using the H Rules.

Rule H1 (code the histology when only one histology is present) states, Note 1: Use Tables 1-9 to code histology. There is no table that includes the lip. The correct histology should be 8502 which is listed in Table 6 (Tumors of Salivary Glands) however this does not correspond to minor salivary glands of the mucosal lip (site C003 per ICD-O-3 coding instruction).

The 2018 ICD-O-3 Update table does not include this histology, however Table 6 indicates code 8502 (secretory carcinoma) is a new code that was approved by IARC/WHO.

The ICD-O-3 only includes this histology as secretory carcinoma of breast. Therefore, in order to arrive at the correct histology, one must be aware of previous SINQ entries 20160036 and 20130003 that indicate secretory carcinoma (or MASC) is histology 8502. However, these are related to MP/H Rules, so registrars may be hesitant to apply this guideline to cases coded using Solid Tumor Rules.

Answer
Assign 8502/3 using Table 6 of 2018 Solid Tumor Rules for Head and Neck. Table 4 notes that there is no ICD-O site code for minor salivary glands. Many minor salivary glands are located in the lips, inner cheek (buccal mucosa), and there are extensive minor salivary glands in the linings of the mouth and throat. Code to the site in which the salivary gland is located.

Mammary analog secretory carcinoma (MASC), also called secretory carcinoma, is a rare, generally low-grade salivary gland carcinoma characterized by morphological resemblance to mammary secretory carcinoma and *ETV6-NTRK3* gene fusion. Common sites are of the parotid gland, oral cavity, submandibular gland, and the axilla with rare sites being the face including the lips, trunk, and limbs according to WHO Classification of Head and Neck Tumors, 4th edition and WHO Classification of Skin Tumors, 4th edition.

This histology is usually associated with primary site of breast and you may get an edit that you can override.

Date Finalized
04/25/2019

20190019

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Non-malignant CNS, January 2019**
Source 2: **Subject matter expert**

Question
Solid Tumor Rules 2018/Histology--Brain and CNS: How is histology coded for a single meningioma tumor when the histology is a meningioma comprised of multiple specific subtypes/variants? See Discussion.

Discussion
Example: Patient has a left cerebral meningioma that is meningothelial meningioma (9531) and two right-sided cerebral meningiomas: one that is transitional meningioma (9537) and the other that is meningioma, transitional and angiomatous, WHO Grade I. If the histology for the mixed tumor is 9534 (angiomatous meningioma), then there are three primaries. If the histology is 9537 (transitional meningioma), then there are two primaries.

Per Table 6, angiomatous meningioma is 9534/0 and transitional meningioma is 9537/0. There is no mixed histology coding rule, or mixed histology meningioma code. There is also no default rule that would instruct registrars to code the numerically higher ICD-O code or to default to a meningioma (NOS) histology code.

Answer
Code the histology for the meningioma, transitional and angiomatous, WHO Grade I to Meningioma, NOS (9530/0). Since a mixed meningioma ICD-O code has not been proposed by WHO, we consulted with our expert neuropathologist.

The other option is to follow back with the pathologist and code what they feel is the predominant type. A new histology rule for coding mixed meningiomas will be added in a future update of CNS rules.

Date Finalized
04/12/2019

20190018

References
Source 1: **WHO Class Endocrine Tumors**
pgs:
Notes: **4th ed.**

Question
Histology--Thyroid: Should any mention of encapsulated be included in the histology coding (8343/3 vs. 8260/3) for papillary thyroid carcinoma cases? See Discussion.

Discussion
Example: Left thyroid lobectomy with final diagnosis Carcinoma, with the following features: Histologic type: Papillary thyroid carcinoma Tumor characteristics; Focality: Unifocal Tumor capsule: Encapsulated, Tumor extension: Tumor capsule: Minimally invaded, Extrathyroidal extension: Not identified

When the only mention of encapsulation is included in the tumor characteristics of the College of American Pathologists (CAP) summary, not the pathologist's choice of histologic type, what is the preferred histology?

Answer
Assign 8343/3 for encapsulated variant of papillary thyroid carcinoma. If the pathology report is not available, use the histologic type in addition to other information in the CAP Protocol.

Date Finalized
04/25/2019

20190017

References
Source 1: **WHO Class Hem & Lymph Tumors**
pgs: **62-69**
Notes: **4th ed.**

Question
Reportability--Heme & Lymphoid Neoplasms: The term indolent systemic mastocytosis is listed in the 2018 ICD-O-3 Histology Update table with borderline behavior (9741/1). However, smoldering systemic mastocytosis is listed in the Hematopoietic and Lymphoid Database (Heme DB) as an alternate name for histology 9741/3. Are smoldering systemic mastocytosis and indolent systemic mastocytosis synonymous? If so, should smoldering systemic mastocytosis also be removed from the Heme DB alternate names listing? See Discussion.

Discussion
In addition to the issue mentioned above, there is a SINQ answer that conflicts with the 2018 ICD-O-3 Histology Update table. SINQ 20130134 indicates indolent systemic mastocytosis is reportable for cases diagnosed 2010 and forward. There is no date restriction indicating the SINQ note applies only for cases diagnosed 2010-2017. Since indolent systemic mastocytosis was changed to borderline (9741/1) for diagnosis year 2018+, should the diagnosis year range be updated for this SINQ answer?

Answer
Smoldering systemic mastocytosis is reportable, 9741/3. Indolent systemic mastocytosis is not reportable as of cases diagnosed 2018, 9741/1.

Smoldering systemic mastocytosis and indolent systemic mastocytosis are not synonymous. Smoldering differs from indolent based on diagnostic criteria and burden of disease; indolent is low whereas smoldering is high burden of disease that can progress to aggressive systemic mastocytosis or mast cell leukemia.

We will update SINQ 20130134.

Date Finalized
04/12/2019

20190016

References
Source 1: **2018 Summary Stage**
Notes: **Breast**
Source 2: **2018 EOD Manual**
Notes: **Breast**

Question
SS2018/Lymph nodes--Breast: Should Code 3 of the Summary Stage 2018 (SS2018) for Breast designate the intramammary and infraclavicular lymph nodes as being ipsilateral? Similarly, should Code 7 designate infraclavicular lymph nodes as contralateral/bilateral? Laterality (ipsilateral, contralateral/bilateral) is included for axillary and internal mammary nodes in the respective codes.

Answer
Based on your question, a review of the AJCC manual was done to clarify how these nodes would be coded. A review of Extent of Disease (EOD) Regional Nodes and EOD Mets was also done. That information is correct and in line with AJCC 8th edition. We apologize that SS2018 was not updated accordingly and thank you for bringing this issue to our attention.

Per AJCC, infraclavicular and intramammary nodes are ipsilateral for the N category. Contralateral or bilateral involvement are included in the M category.

The following will be applied to the planned 2020 update of the SS2018 manual.

Code 3
Ipsilateral will be added to Infraclavicular and Intramammary
Infraclavicular (subclavicular) (ipsilateral)
Intramammary (ipsilateral)

Code 7
The following will be added under Distant lymph nodes
Infraclavicular (subclavicular) (contralateral or bilateral)
Intramammary (contralateral or bilateral)

Date Finalized
04/12/2019

20180088

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Other Sites, updated 9/11/2018**

Question
Solid Tumor Rules (2018)/Multiple primaries--Prostate: How many primaries are abstracted and what M Rule applies when a patient is diagnosed with prostate adenocarcinoma in 2014, followed by liver mass biopsy showing neuroendocrine carcinoma, small cell type of the prostate in 2018? See Discussion.

Discussion
The patient has a history of prostate adenocarcinoma with lymph node metastases, status post prostatectomy and treatment by Lupron in 2014. The most recent prostate serum antigen measurement (April 2018) was normal. CT scan of the abdomen and pelvis revealed new hypodense liver lesions, a slightly enlarging lung right lower lobe nodule, and enlarging lobular mass in the prostatectomy bed. The core liver biopsy contains areas of metastatic tumor with a differential diagnosis on pathology of high-grade neuroendocrine carcinoma of the prostate (small cell type), which may have been seen in association with prostate adenocarcinoma, or metastatic small cell carcinoma of a different site.

Clinically, the physician impression is that this represents metastatic castration-resistant prostate cancer. The Solid Tumor Rules note that the Multiple Primary Rules are not used for tumor(s) described as metastases. However, SINQ 20130221 indicates that, at least historically, these would have been accessioned as multiple primaries (histology 8140 & 8041 per Rule M10). Does the previous SINQ note still apply to these types of cases, and if so, how would one know to move beyond the initial note indicating metastases are not new primaries?

Answer
The guidance provided in SINQ 20130221 still applies. Accession two primaries, adenocarcinoma [8140/3] of the prostate [C619], followed by small cell (neuroendocrine) carcinoma [8041/3] of the prostate [C619] for each of the examples given per Rule M10 of the 2018 Solid Tumor Rules, Prostate. In each case, the second histology (because it is not adenocarcinoma) is a new prostate primary. Small cell carcinoma and small cell neuroendocrine carcinoma are not adenocarcinomas. As a result, they are not covered by Rule M3.

For the case described in this SINQ submission, based on the findings of a lobular mass in the prostate bed, this is a second primary (there is residual prostatic tissue).

This is unchanged from the 2007 Multiple Primaries Rules for Other Sites.

Date Finalized
05/08/2019

20180087

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Malignant CNS, 10/12/2018**

Question
Solid Tumor Rules (2018)/Multiple Primaries--Brain: How many primaries are there and what M Rule applies when two tumors identified in the brain are pathologically proven to be glioblastoma, IDH-wild type and anaplastic astrocytoma per the pathology report final diagnosis, but the diagnosis comment and tumor board indicates multifocal glioblastoma is favored? See Discussion.

Discussion
The patient has one tumor each in the left parietal and left medial temporal lobe. The tumors were excised. The final diagnosis for the left parietal tumor is glioblastoma, IDH-wild type. he final diagnosis of the left medial temporal tumor is, at least anaplastic astrocytoma, WHO grade III; see comment. The comment states: There is a single focus of vascular hyperplasia, separate from neoplastic cells. No necrosis is identified. These findings on their own would warrant a diagnosis of anaplastic astrocytoma, WHO grade III. However, in the context of the patient's glioblastoma in the left parietal lobe, and imaging showing ring-enhancing lesions of the parietal and temporal lobes, this specimen is favored to be an un-sampled glioblastoma, WHO grade IV. The Solid Tumor Rules indicate we may no longer use terms like favor(s) to code the histology, leaving the final diagnosis as the priority source for coding histology per the Histology coding rules.

The tumor board review confirmed that, despite the anaplastic astrocytoma on pathology, they felt strongly that this is a multifocal glioblastoma and not an anaplastic astrocytoma. Both the pathologist's comment and the tumor board's assessment indicate this patient does not have two primaries. However, the Solid Tumor Rules do not give priority to the tumor board's assessment over the pathology, and registrars are not to use ambiguous terms to code histology thus leaving the two histologies to consider. Per the Solid Tumor Rules, one tumor that is glioblastoma and one tumor that is anaplastic astrocytoma are considered multiple primaries per M11 (Abstract multiple primaries when separate, non-contiguous tumors are on different rows in Table 3 in the Equivalent Terms and Definitions. Timing is irrelevant).

As a central registry, we cannot ask the pathologist or attending physician for clarification as

suggested in Section 3 of the Malignant CNS and Peripheral Nerves Equivalent Terms and Definitions. We can only follow the current Solid Tumor Rules. In doing so, we would have to ignore both the pathologist's and tumor board's assessment that this patient has multifocal glioblastoma. Is there any concern that this will lead to over-reporting?

Answer

Abstract separate primaries based on the two histology codes as these are separate tumors on different rows in Table 3 of the 2018 Solid Tumor Rules for Malignant CNS, Rule M11. The priority order for using documentation to identify histology for Malignant CNS is to use pathology/tissue from the resection over the tumor board.

Date Finalized

05/08/2019

20180083

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Urinary sites, April 2019 Update**

Question
Solid Tumor Rules (2018)/Multiple primaries--Bladder: How many primaries are abstracted, and which M Rule applies when a patient is diagnosed with an invasive urothelial carcinoma tumor of the bladder, followed less than three years later by an invasive urothelial carcinoma and small cell neuroendocrine carcinoma tumor of the bladder? See Discussion.

Discussion
The Solid Tumor Rules indicate bladder tumors that are urothelial carcinoma (8120) and small cell carcinoma (8041) are separate primaries per Rule M13 (Abstract multiple primaries when separate/non-contiguous tumors are on different rows in Table 2). These are distinctly different histologies and, presumably, one would want to capture the small cell carcinoma (or small cell carcinoma component) as this has a worse prognosis.

However, if a subsequent bladder tumor is composed of invasive urothelial carcinoma and small cell neuroendocrine carcinoma, the histology is coded as 8045/3 per Rule H4, but this is not abstracted as a multiple primary. The only M Rule that applies is Rule M18 (Abstract a single primary when tumors do not meet any of the above criteria). The mixed histology code 8045 is not included in Table 2, so none of the histology-based M Rules apply. Is the subsequent mixed invasive urothelial and small cell carcinoma tumor (8045/3) the same primary as a previously diagnosed invasive urothelial carcinoma (8120/3) when these tumors are diagnosed within three years?

Answer
Abstract two separate primaries using Solid Tumor Rules Urinary Sites Rule M13. While not stated in the urinary site's rules, these are separate histology codes in two different rows in Table 2 of the Rules. The initial histology is 8120 and the subsequent tumor is 8045 using Rule H4.

Adding 8045 to Table 2 will cause issues. Small cell neuroendocrine in the bladder is very rare, extremely aggressive, and usually has a component of urothelial carcinoma.

Date Finalized
05/08/2019

20180078

References

Source 1: **2018 Solid Tumor Rules**
Notes: **Breast**

Question
Solid Tumor Rules (2018)/Histology--Breast: How is histology coded and which rule applies for a single in situ tumor that is described as an encapsulated papillary carcinoma (EPC) with conventional ductal carcinoma in situ (DCIS)? See Discussion.

Discussion
Patient had a breast excision that proved a single tumor with no evidence of invasive carcinoma. The final diagnosis stated: Size (extent) of EPC DCIS: Spanning approximately 1.3 cm. The pathologist did not describe separate foci of DCIS; only one tumor comprised of both encapsulated papillary carcinoma and DCIS. The encapsulated papillary carcinoma was not described as invasive. The pathology noted: This case is best classified as EPC conventional DCIS. No conventional stromal invasion is identified. Solid Tumor Rule M2 confirms a single tumor is a single primary.

However, there does not appear to be an H Rule that instructs how to code histology. The Single Tumor: In Situ Only module, has only three H Rules and none of them apply to this case. The patient does not have Paget disease (H1), does not have a single histology (H2, there are multiple histologies present as DCIS and EPC are listed on different rows in Table 3) and does not have DCIS and LCIS (H3). How does one arrive at the correct histology for this case?

Answer
Code histology to 8500/2. Per April 2019 update: Rule H5 applies: Code DCIS 8500/2 when there is a combination of DCIS and any other carcinoma in situ.

The 4th Ed WHO Tumors of the Breast states that tumors with encapsulated papillary carcinoma in situ in the absence of DCIS in the surrounding tissue have a very favorable prognosis. Only tumors without DCIS should be coded to 8504/2. The component of DCIS will determine treatment.

Date Finalized
05/17/2019

20180077

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Head and Neck**
Source 2: **2018 SEER Manual**
pgs: **144**

Question
Solid Tumor Rules (2018)/Histology--Head & Neck: How is histology coded for a p16-positive squamous cell carcinoma of the base of tongue? Is p16-positive squamous cell carcinoma equivalent to a diagnosis of squamous cell carcinoma human papilloma virus (HPV)-positive (8085)? See Discussion.

Discussion
Table 6 (Tumors of the Oropharynx, Base of Tongue, Tonsils, Adenoids) in the Head and Neck Equivalent Terms and Definitions lists both squamous cell carcinoma HPV-positive and squamous cell carcinoma HPV-negative as subtypes/variants of squamous cell carcinoma (the NOS histology, 8070). Squamous cell carcinoma HPV-positive and squamous cell carcinoma HPV-negative are also listed in the 2018 ICD-O-3 update table.

Previous clarification from the standard setters regarding the 2018 ICD-O-3 Update table indicated that histology codes 8085 and 8086 (HPV-positive and HPV-negative squamous cell carcinoma, respectively) included p16+ and p16- squamous cell carcinoma, respectively. Presumably, this clarification was made because p16 is a surrogate marker for HPV and capturing whether a tumor is HPV-related or not has implications for staging for 2018 and later diagnoses. However, this clarification was not added to the 2018 ICD-O-3 Update table via errata, nor do the Head and Neck Equivalent Terms and Definitions or Histology Coding Rules address this.

Is a diagnosis of p16-positive squamous cell carcinoma equivalent to a diagnosis of squamous cell carcinoma HPV-positive (8085)? If so, will this clarification be added to the Head and Neck Solid Tumor Rules?

Answer
HPV-positive is not equivalent to HPV-mediated (p16+). According to the 2018 SEER Manual, HPV-type 16 refers to virus type and is different from p16 overexpression (p16+). HPV status is determined by tests designed to detect viral DNA or RNA. Tests based on ISH, PCR, RT-PCR

technologies detect the viral DNA or RNA; whereas, the test for p16 expression, a surrogate marker for HPV, is IHC. HPV testing must be positive by viral detection tests in order to code histology as 8085.

Date Finalized
05/17/2019

20180076

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Head and Neck**

Question
Solid Tumor Rules (2018)/Histology--Head & Neck: Where does cytology rank on the Priority Order for Using Documentation to Identify Histology for Head and Neck primaries? See Discussion.

Discussion
Cytology is not listed in the Priority Order for Using Documentation to Identify Histology (Histology Coding Rules) in the Head and Neck schema. Other schemas do include cytology in the hierarchy below tissue from a biopsy or resection. Cytology is often less specific than histology, so one would expect cytology to be listed below tissue in this hierarchy. Was this an oversight? Or would cytology be equivalent to histology if it provided the most specific histology for the case?

Answer
Instruction #5 in the Priority Order for Using Documentation to Identify Histology of the Head and Neck Solid Tumor Rules, Item 5.B., refers to cytology in the documentation though cytology is not listed before this. In H&N tumors, cytology is usually performed on lymph nodes and seldom on a primary tumor. Cytology will be added to H&N in the next update.

Date Finalized
05/17/2019

20180074

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Malignant CNS**

Question
Solid Tumor Rules (2018)/Multiple primaries--Brain and CNS: Rule M6 notes a diagnosis of glioblastoma multiforme is a new primary when it follows a diagnosis of a glial or astrocytic tumor. Does this rule apply if the subsequent diagnosis was just, glioblastoma, NOS or one of the subtypes/variants of glioblastoma multiforme? See Discussion.

Discussion
Glioblastoma multiforme is listed as a synonym for the preferred term glioblastoma, NOS (9440) per Table 3 Column 2. Therefore, it seems reasonable to assume that a diagnosis of glioblastoma, NOS would be a new primary if it followed a glial or astrocytic tumor. However, in general, the Solid Tumor Rules use the preferred terminology and/or indicate when a specific rule also includes any tumor diagnosed as a subtype/variant. Rule M6 does not explicitly include a diagnosis of glioblastoma, NOS or any of its subtypes/variants (e.g., glioblastoma IDH-mutant or gliosarcoma). Does Rule M6 apply to any diagnosis of glioblastoma, NOS and any of its synonyms or subtypes/variants?

Answer
Apply Malignant Central Nervous System Solid Tumor Rule M6 that refers to glioblastoma multiforme and abstract multiple primaries. If glioblastoma, NOS, an associated synonym with the same histology (9440/3), follows a glial or astrocytic tumor, Rule M6 applies.

With the identification of new variants of glioblastoma based on genetic profiles, we will likely see fewer diagnosis of GBM. M6 applies to cases where the subsequent/new tumor is specifically stated to be GBM, NOS.

Date Finalized
05/17/2019

20180069

References
Source 1: **2018 Solid Tumor Rules**
Notes: **Non-malignant CNS**

Question
Solid Tumor Rules (2018)/Behavior--Brain and CNS: The Behavior coding instructions in the Non-Malignant Central Nervous System (CNS) Equivalent Terms and Definitions section refer to Table 1 for help coding behavior when the other priority order instructions do not apply; however, the behavior cannot be reasonably determined using Table 1 alone for all WHO Grade I neoplasms. Should an additional default, such as the ICD-O-3 or Tables 5 and 6, be used to determine behavior? See Discussion.

Discussion
Similar to an issue previously submitted SINQ 20180063, Table 1 (WHO Grades of Select CNS Neoplasms) in the Non-Malignant CNS Equivalent Terms and Definitions section states WHO Grade I tumors are always non-malignant. However, this does not mean that the tumors listed in Table 1 as WHO Grade I are always benign (/0). Some tumors listed with a WHO Grade I have a behavior of /1 (borderline) per the ICD-O-3 and/or Tables 5 and 6. The Behavior coding instructions do not currently indicate these are the appropriate sources to use when the pathologist and/or physician do not comment on the behavior of these tumors. In our area, pathologists do not explicitly state the behavior for these tumors; the pathologist only assigns the WHO Grade.

Answer
There is no way for us to know what behavior to assign WHO grade II tumors when the pathologist does not provide that information. Defaulting to either benign or malignant is incorrect. Please follow back with the pathologist to determine behavior. The behavior must be non-malignant, meaning /0 or /1, or the tumor is a WHO Grade 1, to be reportable as non-malignant CNS tumor. Refer to Table Instructions under Table 1, WHO Grades of Select CNS Neoplasms that says to use non-malignant CNS rules for all WHO Grade 1 tumors and to use the appropriate rules for WHO Grade 2 tumors

Use ICD-O and all updates if not listed in Table 6 according to non-malignant CNS Histology Rule H3 (for single tumor) and Rule H8 (for multiple tumors) when only one histology is present.

Date Finalized
05/17/2019

20180066

References
Source 1: **2018 Solid Tumor Rules**
Notes: **malignant and non-malignant CNS**
Source 2: **2018 SEER Manual**
pgs: **95**
Notes: **Laterality**

Question
Solid Tumor Rules (2018)/Laterality--Brain and CNS: How is laterality coded for bilateral non-malignant central nervous system (CNS) or malignant CNS tumors now that laterality is no longer used to identify these tumors as multiple primaries? See Discussion.

Discussion
The Equivalent Terms and Definitions sections in the Solid Tumor Rules for these schemas identify which sites must have laterality coded, but there is no instruction for coding laterality when bilateral tumors are a single primary. The SEER Manual currently only indicates code 4 (bilateral) is seldom used (e.g., bilateral ovarian tumors, Wilms tumors, etc.) but does not indicate laterality code 4 should be used for CNS tumors. Is this note going to be updated or should a non-bilateral code be applied?

Example: MRI demonstrates multiple left-sided dural-based meningiomas including a 4.4 cm left posterior fossa meningioma, a 0.8 cm left frontal-parietal meningioma and a right posterior frontal meningioma. The large left posterior fossa meningioma was resected and proved atypical meningioma. Should the laterality be 4 (bilateral) as the patient had both left and right-sided meningiomas confirmed to be a single primary? Or should the laterality be coded as 2 (left) since only the large left-sided meningioma was proven to be a borderline tumor (atypical meningioma, 9539/1) and the others were benign?

Answer
Determine whether the CNS tumors are single or multiple primaries. Multiple cerebral meningiomas are a single primary according to the non-malignant CNS Solid Tumor Rules. Assign laterality using the 2018 SEER Manual for select invasive, benign, and borderline primary intracranial and CNS tumors using codes 1-9 for all sites listed in the Sites for Which Laterality Codes Must Be Recorded table. In the example, assign code 4, bilateral involvement at time of diagnosis, lateral origin unknown for a single primary.

The solid tumor rules are not a one-stop-shop for all coding. Refer to the appropriate coding manual for laterality. We removed laterality for determining multiple primaries in meningiomas as they were being over-reported according to CBTRUS.

FINALIZED SEER SINQ QUESTIONS

April - July 2019

Date Finalized

05/17/2019

20180054

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Urinary Sites**

Question
Solid Tumor Rules (2018)/Histology--Bladder: Under the Terms that are Not Equivalent or Equal section (Urinary Equivalent Terms and Definitions) it indicates noninvasive is not equivalent to papillary urothelial carcinoma and one should code the histology documented by the pathologist. However, many pathologists use Ta as both the description of the stage and the histology. Should this note be amended? See Discussion.

Discussion
The note in the Urinary Terms and Definition states, Noninvasive is not equivalent to papillary urothelial carcinoma. Both Ta and Tis tumors are technically noninvasive. Code the histology specified by the pathologist. While it is true that both Ta and Tis are technically noninvasive, the AJCC defines Ta specifically for, noninvasive papillary carcinoma. A pathologist's use of Ta does indicate the noninvasive carcinoma did arise from a papillary tumor. However, not all pathologists use terminology that, following the Urinary Solid Tumor Histology Coding Rules, will result in a histology coded to 8130, despite an AJCC-defined Ta (noninvasive papillary carcinoma) tumor having been diagnosed because the tumor projected from the wall on a stalk.

In our region a number of pathologists provide the following types of diagnosis. Urothelial carcinoma of the bladder with the following features:
Histologic type: Noninvasive.
Histologic grade (WHO/ISUP 2016): High-grade.
Tumor configuration: Papillary.

The pathologist and/or physician may then stage this as Ta. How is the histology coded for these cases if the H Rules do not allow one to code the papillary tumor configuration and noninvasive Ta disease as not equivalent to noninvasive papillary carcinoma?

Flat (in situ) urothelial carcinoma has an increased risk of invasive disease compared to the noninvasive papillary urothelial carcinomas. Will there be inconsistencies or a resulting impact to analysis of truly flat/in situ urothelial carcinoma vs. papillary urothelial carcinomas if the papillary tumors are not being coded as such?

Answer

Per the April 2019 update: Noninvasive; papillary urothelial carcinoma; flat urothelial carcinoma Note: Noninvasive is not equivalent to either papillary urothelial or flat urothelial carcinoma. Both Ta and Tis tumors are technically noninvasive. Code the histology specified by the pathologist.

Date Finalized

05/17/2019

20180049

References
Source 1: **2018 Solid Tumor Rules**
Notes: **Lung**

Question
Solid Tumor Rules (2018)/Histology--Lung: What is the difference between Lung Rules H7 and H8 (Single Tumor Module)? When would one use H8 rather than H7? See Discussion.

Discussion
Is Rule H8 a duplicate of Rule H7? Rule H7 instructs one to use Table 2 when there are multiple histologies and the combination is listed in Table 2 (or a combination code was received from Ask a SEER Registrar). Rule H8 states to code adenocarcinoma with mixed subtypes (8255) when there are multiple adenocarcinoma subtypes OR any combination of histologies which are not listed in Table 2. However, both conditions for Rule H8 are already included in Table 2 (the last row). How would one ever move past Rule H7 if all the conditions for both Rules H7 and H8 are covered first under Rule H7?

Example: A resection pathology report proves invasive adenocarcinoma, acinar, solid and papillary types. Rule H7 seems to be the first H Rule that applies as there are multiple histologies (identified using a reportable term: type) AND the combination is listed in Table 2. The last row of Table 2 instructs one to code Adenocarcinoma with mixed subtypes (8255) when there are at least two of the subtypes/variants of adenocarcinoma listed in Column 1 (Required Terms). In this case, there were three subtypes/variants that are listed in Column 1 (acinar, solid and papillary). However, Rule H8 also instructs one to, Code adenocarcinoma with mixed subtypes 8255 for multiple adenocarcinoma subtypes. Which rule applies here, Rule H7 or Rule H8?

Answer
January 2019 update: The differences between H7 and H8 are H8 applies to tumors with multiple subtypes of adenocarcinoma while H7 applies to histology combinations other than adenocarcinoma such as adeno and squamous.

Date Finalized
05/17/2019