Question 20160060

References
Source 1: **2016 SEER Manual**

Question
Mets at diagnosis fields--Heme & Lymphoid Neoplasms (Lymphoma): How are Mets at Diagnosis -- Bone, Brain, Liver, Lung, Lymph Node, and Other -- to be coded for lymphomas in 2016? Are they always 0 if the TNM Stage is I, II, or III? How is bone marrow involvement coded -- in which Mets at Diagnosis field?

Answer
Code all mets at diagnosis fields to 0 when the Stage is I, II, or III.

When the lymphoma is Stage IV, one of the mets at dx fields (other than Mets at Dx-Distant lymph nodes) needs to be coded to 1. Stage IV indicates that there is multiple extralymphatic organ involvement, diffuse involvement of an organ; liver, brain, lung or bone involvement, or bone marrow involvement.

For bone, brain, liver, and lung, code these as 1 when these sites are involved and they are not the primary site. This is the same instruction for solid tumor neoplasms.

For mets at dx-distant lymph nodes, always code to 0. For lymphomas, lymph node involvement is included in stage and not based on whether they are regional or distant.

For mets at dx-other, code to 1 for bone marrow involvement or if there is multi extralymphatic organ involvement.

Date Finalized

09/29/2016

Question 20160058

References
Source 1: **SEER*Rx**

Question
First course treatment--Heme & Lymphoid Neoplasms: Are blood thinners, e.g., warfarin, coded as treatment in the Other Therapy data item for polycythemia vera and myelodysplastic syndrome? See Discussion.

Discussion
Under the hematopoietic data base, treatment for polycythemia vera shows chemotherapy, immunotherapy, and phlebotomy. Essential thrombocytopenia shows blood thinners, anti-clotting medications, aspirin, chemotherapy, immunotherapy, and other therapy (Anagrelide) (for essential thrombocythemia only) and watchful waiting (for asymptomatic patients). Myelodysplastic syndrome shows bone marrow transplant, chemotherapy, immunotherapy, and stem cell transplant.

SEER*RX under warfarin says: Per the 2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual (page 10), blood thinners and/or anti-clotting agents are to be coded as treatment (Other Therapy) for the following histologies: 9740/4 Mast cell sarcoma 9741/3 Systemic mastocytosis 9742/3 Mast cell leukemia 9875/3 Chronic myelogenous leukemia BCR/ABL 1 positive 9950/3 Polycythemia vera 9961/3 Primary myelofibrosis 9962/3 Essential thrombocythemia 9963/3 Chronic neutrophilic leukemia 9975/3 Myelodysplastic/myeloproliferative neoplasm, unclassifiable.

Answer
Based on information from the National Cancer Institute and the Food and Drug Administration, aspirin and/or other blood thinners are not valid treatment for polycythemia vera and myelodysplastic syndrome. These drugs are often given to relieve symptoms of the disease such as bone pain or side-effects of standard treatments including blood clots. The treatment information found on page 22 (2015 Hematopoietic & Lymphoid Neoplasms coding manual) will be updated and ICD-O-3 codes 9950/3 and 9975/3 will be removed from the list. SEER*RX has been updated to reflect this change.

Date Finalized
07/27/2016

Question 20160055

References
Source 1: **WHO Class Soft Tissue & Bone**

Question
Reportability--Bone: Is an "atypical cartilaginous tumor" reportable? See Discussion.

Discussion
Patient had a core needle biopsy of the right acetabulum. Final diagnosis on the path report is: Atypical cartilaginous tumor (formerly chondrosarcoma, grade 1).

Is this cell type reportable? If so, is it reportable only because the pathologist recorded clarifying text in parentheses? If the text in the parentheses was not available, is the histology "atypical cartilaginous tumor" reportable?

Answer
Atypical cartilaginous tumor of bone is **not** reportable. The WHO terminology is "atypical cartilagenous tumor/chondrosarcoma **grade I.**" WHO classifies this entity as low malignant potential (behavior code /1).

Chondrosarcoma **grade II** or **grade III** is reportable based on the WHO classification of malignant (behavior code /3).

Date Finalized
07/25/2016

Question 20160054

References
Source 1: **2007 MP/H Rules**

Question
MP/H Rules/Multiple primaries--Melanoma: How many melanoma primaries should be abstracted if, during the workup for a metastatic melanoma of an unknown cutaneous site, an in situ melanoma is also discovered? See Discussion.

Discussion
Patient has diagnosis of melanoma with spindle cell features found in a right lower lobectomy specimen. Chart notes indicate this is metastatic from a cutaneous primary of unknown site. Further work up includes a biopsy of the tip of the nose, which is diagnostic for in situ melanoma. Should this be abstracted as two separate primaries, one for an invasive melanoma of unknown primary site and the other for an in situ melanoma of the skin on the tip of the nose? Which MP/H Rule would apply?

Answer
Yes, abstract this as two separate primaries, an invasive melanoma of unknown primary site and an in situ melanoma of the skin on the tip of the nose. Rule M3 applies.

Date Finalized
07/25/2016

Question 20160053

References
Source 1: **2007 MP/H Rules**
Source 2: **WHO Class Digest System Tumors**
pgs: **264, 273**

Question
MP/H Rules/Histology: How is the histology coded for an invasive adenocarcinoma arising in a papilloma with high-grade dysplasia? See Discussion.

Discussion
Patient has a perihilar bile duct primary with a microscopic focus of invasive moderately differentiated adenocarcinoma arising in a large papilloma. The MP/H Rules do not address adenocarcinomas arising in a papilloma, only adenocarcinomas arising in an adenoma (or polyp). Should the histology be coded as 8140 for the invasive adenocarcinoma component? Or should the matrix principle be applied and the histology coded as a malignant glandular papilloma (8260/3)?

Answer
Assign 8503/3 for invasive adenocarcinoma arising in a papilloma with high-grade dysplasia, perihilar bile duct primary. Neither ICD-O-3 nor the WHO classification have a code for this specific histology; however, our expert pathologist consultant states 8503/3 is the best available choice based on pages 264 and 273 in the WHO Digestive system classification.

Date Finalized
07/27/2016

Question 20160051

References
Source 1: **2015 SEER Manual**

Question
Diagnostic confirmation: When a CT guided Fine Needle Aspiration is performed and the pathology report indicates smears and cell block were prepared, if the diagnosis is positive for cancer, can you code diagnostic confirmation as 2 (positive cytology) because of the cell block?

Answer
Yes, assign diagnostic confirmation code 2 for diagnosis based on smears and cell block from CT guided FNA. This reply pertains to solid tumors.

Date Finalized
07/11/2016

Question 20160050

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

Question
Reportability--Appendix: Is a mucinous cystic neoplasm with high grade dysplasia of the appendix reportable? See discussion.

Discussion
The language appears similar to the mucinous cystic neoplasm of the pancreas with high grade dysplasia (8470/2), which was clarified to be reportable in 2014.

Answer
WHO does not list MCN as a histology for the appendix. This case should be clarified with the pathologist.

For pancreas specifically, the term "mucinous cystic neoplasm (MCN) with high grade dysplasia" replaced the term "mucinous cystadenocarcinoma, noninvasive" according to WHO. MCN with high grade dysplasia of the pancreas is reportable because it is used in place of the now obsolete terminology. If we did not make the new terminology reportable, trends over time could be affected.

Date Finalized
07/11/2016

Question 20160049

References
Source 1: **2015 SEER Manual**
pgs: **95**
Notes: **See Grade for Sarcomas**

Question
Grade/Sarcoma--Breast: Is the correct grade for high grade angiosarcoma of the breast a code 3 or 4? The breast usually uses a three grade system but sarcoma is not a typical histologic type of the breast.

Answer
Assign grade code 4 using the sarcoma table. Nottingham or Bloom-Richardson (BR) Score/Grade does not apply to angiosarcomas. This is a good question and points out needed clarification of the grade rules.

Date Finalized
07/25/2016

Question 20160048

References
Source 1: **Subject matter expert**

Question
Reportability--Kidney: Is renal cell neoplasm of oncocytosis reportable based on the pathology from a nephrectomy? See Discussion.

Discussion
The pathology diagnosis reads: Diagnosis Right Kidney, Laparoscopic Nephrectomy:

-Renal Cell Neoplasm of Oncocytosis (pT1a, pNX See Comment and Template).
-Surgical margins free of tumor.
Kidney, right, nephrectomy:
Tumor histologic type: Renal cell neoplasms of oncocytosis (see Note)
Sarcomatoid features (%) Not identified
Tumor size: 4 cm (greatest dimension largest tumor)
Other dimensions: 2.7 x 2.5 cm
Macroscopic extent of tumor: Limited to kidney
Focality: Multifocal
Number of tumors: 11 grossly visible, range 0.2 4 cm
Fuhrman grade: 2 of 4
Microscopic extent of tumor:
Perinephric fat invasion: Not identified
Renal sinus invasion: Not identified
Other: N/A
Renal vein involvement: Not identified
Adrenal gland present: No
Involved by tumor: N/A
Direct invasion or metastasis: N/A
Cancer at resection margin: Not identified
Location(s): N/A
Pathologic findings in nonneoplastic kidney: Multiple collections of oncocytic cells
Hilar lymph nodes present: No
Number of involved/number present: N/A

"Thank you for sending this fascinating case. In reviewing the H&E-stained slides, we recognize that multiple lesions of varying sizes are present within the specimen, some with

features of oncocytoma, some with those of chromophobe RCC, and yet others with features of both. The immunohistochemical studies for CK7 performed at your institution serve to highlight this point with "mass #1" showing focal single cell staining typical of oncocytoma and "mass #2" showing a patchy and confluent staining pattern typical of chromophobe RCC. This second mass was also positive with special stain for Hales colloidal iron. As mentioned, the morphology varies somewhat in each tumor, however, every single mass is comprised of cells with eosinophilic (pink to bright red) cytopolasm. Some tumors show more tightly nested or sheet like growth, others are more tubular or microcystic. Another important feature, present on slides of renal cortex are microscopic tumorlets seemingly emanating from eosinophilic tubules. This finding, along with the presence of numerous oncocytic neoplasms is supportive of the above diagnosis. The absence of clinical features to suggest Birt-Hogg-Dube syndrome is noted. Although these tumors are not recognized in the current classification of renal tumors, we regard these neoplasms as being a distinct entity, unrelated to both oncocytoma and chromophobe renal cell carcinoma, and have applied the designation "renal tumor of oncocytosis" to such lesions (Gobbo S, et al. Renal cell neoplasms of oncocytosis have distinct morphologic, immunohistochemical, and cytogenetic profiles. Am J Surg Patholl 34:620-626, 2010). We concur that the expected behavior in these cases is one of indolence."

Answer

Do not report Renal cell neoplasms of oncocytosis. According to our expert pathologist consultant, these neoplasms do not behave "in a malignant fashion." They are not currently classified as malignant and are not reportable to cancer registries.

Date Finalized

07/25/2016

Question 20160047

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

Question
Reportability--Eye: Is conjunctival intraepithelial neoplasia (CIN III) from an excision of the left eye conjunctiva reportable?

Answer
Conjuctival intraepithelial neoplasia grade III (CIN III) is reportable. Intraepithelial neoplasia, grade III, is listed in ICD-O-3 as /2. It is reportable for sites other than skin.

Date Finalized
07/25/2016

Question 20160043

References
Source 1: **2007 MP/H Rules**

Question
MP/H Rules/Histology--Bladder: Should the term "dedifferentiation" be used to code sarcomatoid transitional cell carcinoma (8122/3)? Or is this typically referring to the grade, and not the histologic subtype? See Discussion.

Discussion
Pathology report Final Diagnosis: TURBT : Urothelial carcinoma, high grade. Type/grade comment: Extensive sarcomatoid dedifferentiation is present (40-50% of tumor volume).

Answer
Assign 8122/3 for urothelial carcinoma, extensive sarcomatoid dedifferentiation. Sarcomatoid dedifferentiation refers to the histologic type. 8122/3 is also correct for the following diagnoses.

Urothelial carcinoma, sarcomatoid carcinoma or sarcomatoid variant 8122/3
Urothelial carcinoma with sarcomatoid features 8122/3

Date Finalized
07/25/2016

Question 20160039

References
Source 1: **2015 SEER Manual**

Question
First course treatment/Surgery of Primary Site: If a procedure stated to be an "excisional biopsy" doesn't grossly remove the tumor, should Surgery of Primary Site be coded as an excisional biopsy? See Discussion for example.

Discussion
Would you code an excisional biopsy as Surgery for the following case?

The patient presented with a large protruding polypoid anal canal mass. The diagnosis of malignancy was made following a procedure referred to by the surgeon as an excisional biopsy. The protruding portion of the anal canal mass was excised, but the deep margin was grossly involved. The PE exam after the "excisional biopsy" found a firm mass, 4 cm in length on DRE. Further work-up with imaging showed gross residual disease extending to adjacent skeletal muscle (external anal sphincter). Although the internal/protruding anal canal portion of the tumor was excised, there was clearly extensive residual tumor. The patient underwent definitive concurrent chemoradiation only; subsequent surgery was not planned or performed.

Answer
Do not record this excisional biopsy as surgery because there was residual macroscopic tumor. See Note 1 under #4 on page 130 in the SEER manual, http://seer.cancer.gov/manuals/2015/SPCSM_2015_maindoc.pdf

Date Finalized
07/06/2016

Question 20160036

References
Source 1: **Subject matter expert**
Source 2: **ICD-O-3**

Question
Reportability/Histology--Head and Neck: Is mammary analogue secretory carcinoma (MASC) of the left submandibular gland reportable and how is it coded? See Discussion.

Discussion
The physician is calling it an indolent tumor, pT3/NX/M0 stage 3 with positive margins. Is the correct code C509, 8502/3?

Answer
Mammary analogue secretory carcinoma (MASC) is reportable. MASC is a recently described tumor that predominantly arises in the parotid gland. In this case, if the primary site is submandibular gland, assign C080. We contacted our expert pathologist and he stated that the best code to use for MASC is 8502/3. Override any edits triggered by the combination of C080 and 8502/3.

Date Finalized
07/25/2016

Question 20160035

References
Source 1: **2015 SEER Manual**
pgs: **14**
Notes: **Reportable example 13**

Question
Reportability/Histology--Pituitary Gland: How are Rathke cleft cyst and Rathke pouch tumor distinguished and are they both reportable?

Answer
Rathke cleft cyst is not reportable. Cysts are not neoplastic. However, Rathke pouch tumor (C751, 9350/1) is a reportable neoplasm for cases diagnosed 2004 and later. The Rathke pouch is coded to the pituitary gland. Benign and borderline pituitary tumors have been reportable since 2004.

Date Finalized
07/25/2016

Question 20160034

References
Source 1: **SINQ 20110048**

Question
First course treatment/Immunotherapy--Heme & Lymphoid Neoplasms: Is donor leukocyte infusion for treatment of hematopoietic neoplasms coded as a bone marrow transplant per the Hematopoetic Manual or as immunotherapy per SEER Inquiry System (SINQ) 20110048? See Discussion.

Discussion
In the Hematopoetic Manual, page 22, it is states: "The use of donor leukocyte infusions for treatment of hematopoietic neoplasms, specifically leukemias, is increasing. Abstract as bone marrow transplant when a reportable hematopoietic neoplasm is treated with donor leukocyte infusion, even if it is not listed in the treatment section of the Heme database for the specific neoplasm." Question 20110048 in the SEER Inquiry, it is stated "Donor lymphocyte infusion (DLI) is coded as immunotherapy." Donor lymphocyte infusion and donor leukocyte infusions are the same procedure. Please clarify discrepancy as coding is needed for a case treated with donor lymphocytic infusion.

Answer
Code donor lymphocyte infusion as immunotherapy. SINQ 20110048 is correct. The Hematopoietic Manual will be corrected during the next update.

Date Finalized
07/25/2016

Question 20160033

References
Source 1: **2015 SEER Manual**
Notes: **Appendix C**

Question
First course treatment/Surgery of Primary Site: Is microwave ablation (using heat not alcohol) coded to a surgery code? See Discussion.

Discussion
As of 2013, radiofrequency ablation is coded to "radiation therapy," chemoembolization is coded to "chemotherapy," and microwave ablation code to "other." Or, is coding microwave ablation (using heat not alcohol) coded to surgical code "16"? The latest documentation year that I could find in the SEER website regarding the above was 2013. I would appreciate clarification/confirmation of correct coding especially for microwave ablation.

Answer
According to a consensus answer of the technical advisory group, a small group of representatives from each standard setter that meets periodically, microwave tumor ablation should be coded as surgery. For liver, assign code 16 (Heat-Radio-Frequency ablation (RFA); for kidney, assign code 15 (Thermal ablation).

Date Finalized
07/25/2016

Question 20160032

References

Source 1: **2015 SEER Manual**

Question

Reportability--Brain: Is benign lymphangioma of the brain (9170/0) reportable? It is not on the list of non-malignant blood vessel tumors in the National Program of Cancer Registries Clarifications for Central Nervous System (CNS) tumors.

Answer

Lymphangioma of the brain or CNS is not reportable. Lymphangioma is a malformation of the lymphatic system. Even though it has an ICD-O-3 code, do not report it.

Date Finalized

07/25/2016

Question 20160031

References
Source 1: **NAACCR Guidelines for ICD-O-3 Implementation**
pgs: **7**
Notes: **Effective January 1, 2014**
Source 2: **2007 MP/H Rules**

Question
MP/H Rules/Histology--Brain and CNS: What is the code for Rosette-forming glioneural tumor from a pathology report of a brain tumor biopsy for a date of diagnosis in 2015? See Discussion.

Discussion
This diagnosis is not listed in the ICD-O-3 though it is listed as code 9509/1 for this specific tumor in the 2007 WHO classification of Tumours of Central Nervous System. (See link: http://link.springer.com/article/10.1007/s00401-007-0243-4/fulltext.html.)

Answer
Assign 9505/1 for Rosette-forming glioneuronal tumor. The new code, 9509/1, has not been implemented in the United States. 9505/1 is to be used until the new code is implemented. See page 7 of the NAACCR Guidelines for ICD-O-D Implementation, effective January 1, 2014, http://www.naaccr.org/LinkClick.aspx?fileticket=u7d3sB71t5w%3d&tabid=126&mid=466.

Date Finalized
07/25/2016

Question 20160030

References
None listed

Question
Reportability--Carcinoid: Is a diagnosis of carcinoid heart disease, based solely on clinical information and no pathology, reportable?

Answer
Carcinoid heart disease is not reportable but this diagnosis indicates that the patient likely has a carcinoid tumor which may be reportable. Obtain further information.

Date Finalized
07/25/2016

Question 20160029

References

Source 1: **https://www.researchgate.net/publication/40441911_Current_status_of_radioactive_seed_localization_of_non_palpable_breast_lesions**

Source 2: **http://www.webmd.com/breast-cancer/news/20000116/radioactive-seeds-may-offer-treatment-option-for-breast-cancer**

Question

Radiation Therapy--Breast: Are iodine 125 (I-125) seed implants for breast cancer coded as brachytherapy or as a localization technique similar to wire localization? See Discussion.

Discussion

We are seeing many I-125 seed implants for breast cancer. Many of my associates are coding them as brachytherapy. I think they are the newest of the localization technique like wire localization but with greater accuracy. Most are done the same day as the surgery so brachytherapy does not make sense. Which is correct?

Answer

I-125 seeds could be used for brachytherapy for breast cancer or as a localization technique for nonpalpable breast tumors. If the seeds were in place a short time and removed as part of a breast surgical procedure, they were likely used for tumor localization. Radioactive seed localization (RSL) is thought to be more precise than the wire implantation technique for localizing lesions.

Date Finalized

07/25/2016

Question 20160028

References
Source 1: **WHO Class Soft Tissue & Bone**
pgs: **306-307**
Notes: **2013**
Source 2: **ICD-O-3**
pgs: **95**

Question
MP/H/Histology--Sarcoma: How should Ewing Sarcoma/primitive neuroectodermal tumor (PNET) be coded for a 2012 case? See Discussion.

Discussion
SEER SINQ 20031051 applies to cases diagnosed before 2007 and advises: Code histology as 9260/3, Ewing sarcoma. Ewing sarcoma is a specific histology on the continuum of primitive neuroectodermal tumors. Code Ewing sarcoma as it is more specific than PNET, NOS.
For tumors diagnosed 2007 or later, refer to the MP/H rules.

Answer
Apply the 2007 MP/H rule M6 and assign the numerically higher ICD-O-3 code that reflects PNET (9364/3).
According to the WHO Tumors of Soft Tissue and Bone, though Ewing sarcoma ICD-O-3 code is 9260/3, Ewing sarcoma with a higher degree of neuroectodermal differentiation present is classically termed peripheral neuroectodermal tumors (PNET). WHO does not offer guidance how to classify tumors stated to be Ewing sarcoma PNET.

Histology code 9364/3 is assigned for a Ewing/PNET that arises outside of the brain/CNS. Peripheral neuroectodermal tumor (PNET) and peripheral primitive neuroectodermal tumor (PPNET) are Ewing family tumors.

Histology code 9473/3 (PNET, primitive neuroectodermal tumor, central primitive neuroectodermal tumor, or supratentorial PNET) is only used for tumors arising inside the brain/CNS.

Date Finalized
07/25/2016

Question 20160026

References
Source 1: **WHO Class Endocrine Tumors**
pgs: **28**
Notes: **2004**
Source 2: **http://www.eje-online.org/content/156/2/203.full.pdf**

Question
MP/H/Histology--Pituitary: Would you code Crooke cell adenoma as 8272/0 pituitary adenoma?

Answer
Yes, code Crooke cell adenoma to 8272/0 pituitary adenoma. According to the WHO classification, it is a variant of adrenocorticotropic hormone (ACTH) producing adenoma (8272/0).

Date Finalized
07/25/2016

Question 20160023

References
Source 1: **2014+ Grade Instructions**

Question
Grade/Histology--Digestive System: What is the grade for neuroendocrine tumor (NET) or neuroendocrine carcinoma (NEC) of gastrointestinal morphologies described as: 1) NET G1 (M8240/3) and NET G2 (M8249/3) or 2) neuroendocrine carcinoma, low grade (M8240/3) and neuroendocrine carcinoma, well differentiation (M8240/3) and neuroendocrine carcinoma, moderate differentiation (M8249/3)? The SEER Instructions for Coding Grade for 2014+, Coding for Solid Tumors section, #3 state: Code the grade shown below (6th digit) for specific histologic terms that imply a grade. NET and NEC are not included in the specific terms.

Answer
You may code grade as follows.

Grade 1 – NET G1 (M8240/3)

Grade 2 – NET G2 (M8249/3)

Grade 1 – neuroendocrine carcinoma, low grade (M8240/3) or neuroendocrine carcinoma, well differentiation (M8240/3)

Grade 2 – neuroendocrine carcinoma, moderate differentiation (M8249/3)

Date Finalized
07/25/2016

Question 20160022

References
Source 1: **2007 MP/H Rules**
Notes: **Breast**

Question
MP/H/Histology--Breast: What MP/H Rule, histology, and behavior code for a breast primary apply to the following?

2 foci DCIS, solid, high grade (Grade 3) w/microca++

Answer
Apply the Multiple Primaries/Histology, Breast Rule H3: DCIS and a more specific in situ are coded to the more specific histology term which in this case is solid. Code the histology to ductal carcinoma in situ, solid type (8230/2). Based on the information provided, there is no invasive component. The term "microca ++" means micro-calcifications are present, not micro carcinoma.

Date Finalized
07/25/2016

Question 20160021

References
Source 1: **2015 SEER Manual**
pgs: **76**
Notes: **#12**
Source 2: **SEER Training Website**
Notes: **http://training.seer.cancer.gov/ugi/anatomy/stomach.html**

Question
Primary Site--Stomach: How do I code the primary site when the operative report and pathology report state that the tumor site is incisura of the stomach?

Answer
Assign C163. Incisura, incisura angularis, gastric angular notch, angular incisura of stomach all refer to the sharp angular depression in the lesser curvature of the stomach at the junction of the body with the pyloric canal. See Gastric angular notch in #12 on page 76 in the SEER manual, http://seer.cancer.gov/manuals/2015/SPCSM_2015_maindoc.pdf. See also the SEER training website, #12 on the illustration corresponds to the angular notch, http://training.seer.cancer.gov/ugi/anatomy/stomach.html. We will correct the key for this illustration.

Date Finalized
07/25/2016

Question 20160020

References
Source 1: **ICD-O-3**
Source 2: **2015 SEER Manual**
pgs: **11**

Question
Reportability--Gallbladder: Is high grade biliary intraepithelial neoplasia of the gallbladder reportable?

Answer
High grade biliary intraepithelial neoplasia of the gallbladder is reportable. Assign code 8148/2. It is also known as biliary intraepithelial neoplasia grade 3, or BilIN-3.

Date Finalized
07/25/2016

Question 20160019

References
Source 1: **WHO Class Lung Tumors**
Source 2: **ICD-O-3**

Question
Reportability--Lung: Is a case of pulmonary metastatic leiomyoma (favored) vs. low grade leiomyosarcoma reportable, and if so, what is the primary site and histology code? See Discussion.

Discussion
Patient presents with an abnormal chest x-ray. PET reveals 4.6 cm left lower lobe mass and several additional bilateral nodules measuring up to 1.6 cm. Biopsy was recommended and is positive for metastatic histologically benign smooth muscle neoplasm. ER/PR are positive. Mayo consult on biopsy agrees with histology. The differential diagnosis includes benign metastasizing leiomyoma and low grade leiomyosarcoma. Comment: If these nodules remain small and do not progressively grow would consider this metastasizing leiomyoma. Physicians state bilateral pulmonary metastatic leiomyoma (favored) vs low grade leiomyosarcoma. Tamoxifen was started. Patient has a history of uterine fibroids. Several months later, imaging reveals stable bilateral multi pulmonary nodules and left lower lobe mass but persistent. Surgery was recommended but cancelled due to insurance.

Answer
This case is not reportable based on the information provided. The histologic diagnosis is "metastatic histologically benign smooth muscle neoplasm." The physicians seem to agree with the histologic diagnosis, benign metastasizing leiomyoma (BML). The WHO classification and ICD-O-3 assign 8898/1 to "metastasizing leiomyoma." WHO states "This resembles a typical leiomyoma but it is found in the lungs of women with a history of typical uterine leiomyomas." A recent article states "Because of the hormone-sensitive characteristics of BML, treatments are based on hormonal manipulation along with either surgical or medical oophorectomy." Tamoxifen treatment is in keeping with the BML diagnosis.

Date Finalized
07/25/2016

Question 20160018

References

Source 1: **Glossary for Registrars**

Question

Reportability--Brain and CNS: Is a colloid cyst at the foramen of Monro reportable?

Answer

Colloid cyst at the foramen of Monro is not reportable. Colloid cysts are endodermal congenital malformations and do not have an ICD-O-3 code. See the Glossary for Registrars, http://seer.cancer.gov/seertools/glossary/view/542eeea1102c1d14697ef8ab/?q=colloid

Date Finalized

07/25/2016

Question 20160002

References
Source 1: **2007 MP/H Rules**

Question
MP/H Rules/Histology--Breast: Which is the correct histology code to use and which MP/H rule applies in the case of a single lumpectomy specimen that demonstrates two separate tumors with the following histologies.
1) Invasive lobular carcinoma
2) Invasive ductal carcinoma with tubular features
See discussion.

Discussion
Does ductal carcinoma with tubular features qualify for Breast MP/H Rule H28? Or, is it more appropriate to strictly follow Table 2 (not a type of ductal tumor) and apply Rule H29, thus losing the lobular component?

Answer
Abstract a single primary using Rule M13. Assign 8523/3 using rule H29. The code for invasive ductal carcinoma with tubular features (8523/3) is higher than the code for invasive lobular carcinoma (8520/3). H28 does not apply because 8523/3 is not included as a type of duct carcinoma on Table 2.

Date Finalized
07/06/2016