20170040

References
Source 1: **2016 SEER Manual**
pgs: **91**
Source 2: **2007 MP/H Rules**
Notes: **Lung**

Question
MP/H Rules/Histology--Lung: What is the histology code for lung cancer case identified pathologically from a metastatic site that differs from the histology stated by the physician? See Discussion.

Discussion
Bronchial washings were negative. Four lymph nodes were biopsied and found to have metastatic poorly differentiated neuroendocrine carcinoma. The treating oncologist calls it small cell carcinoma, extensive stage, and treats patient with carboplatin and VP-16 (etoposide) The MP/H rule says to take path/cyto from a metastatic site if no pathology/cytology available from the primary site. Is the physician's statement and treatment taken into consideration here?

Answer
Code the histology based on the pathology report from the lymph node biopsy for this case. Pathology has higher priority than a physician's statement for assigning histology code. Use text fields to document the physician's statement.

Date Finalized
07/28/2017

20170039

References

Source 1: **Heme & Lymph Manual & DB**

Question

Histology--Heme & Lymphoid Neoplasms: How should histology be coded for final bone marrow diagnosis of myelodysplastic syndrome with excess blasts? See Discussion.

Discussion

This terminology is not specifically included in either alternate names list for myelodysplastic syndrome, NOS (9989/3) or refractory anemia with excess blasts (9983/3).

Example: Bone Marrow Biopsy, Final Diagnosis: Consistent with involvement by myelodysplastic syndrome with excess blasts-2 (MDS EB-2).

Answer

Assign code 9983/3 refractory anemia with excess blasts. Refractory anemia is a type of myelodyplastic syndrome. We will add this to the Heme & Lymphoid database during the next update.

Date Finalized

07/28/2017

20170037

References

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

Question

Primary site--Other and Unspecified Urinary Organs: What is the topography code for a Skene's gland adenocarcinoma?

Answer

The most appropriate available topography code is C681, paraurethral gland. Skene's gland is also referred to as paraurethral gland.

Date Finalized

06/14/2017

20170036

Question

Grade--Prostate: How are the prostate-related fields completed when documentation in pathology reports only includes one of the new grade groups? See Discussion.

Discussion

Our pathologists have starting to use a new prostate cancer grading system that was adopted by WHO in 2016. The new grading scheme correlates with the prior Gleason grading scheme as follows:

Grade Group 1 = Gleason score 6 or less
Grade Group 2 = Gleason score 3+4=7
Grade Group 3 = Gleason score 4+3 = 7
Grade Group 4 = Gleason score 8
Grade Group 5 = Gleason score 9-10

Our pathologists are no longer dictating the Gleason Primary and Secondary Pattern values nor the Gleason's Score. Reverse correlation from the new grade groups to the required patterns and score are difficult with Grade Groups 2 and 3 needing to be distinguished from one another and Grade Group 5 including two unique scores.

The prostate-related fields include:
Collaborative Site Specific Factor 7: Gleason's Primary Pattern and Secondary Pattern Values on Needle Core Biopsy/TURP
Collaborative Site Specific Factor 8: Gleason's Score On Needle Core Biopsy/TURP
Collaborative Site Specific Factor 9: Gleason's Primary Pattern and Secondary Pattern Values on Prostatectomy/Autopsy
Collaborative Site Specific Factor 10: Gleason's Score on Prostatectomy/Autopsy

Answer

When **all you have** is the **grade group**, you may use the following table to convert the Prostate Grade Groups to the appropriate code for the indicated fields.

Grade Group	Gleason Score	Gleason Pattern	SSF7	SSF8	SSF9	SSF10	Grade/diff
Grade Group 1	6 or less	<=3+3		099	999	099	999	1
Grade Group 2	7	3+4		034	007	034	007	2
Grade Group 3	7	4+3		043	007	043	007	2

Grade Group 4	8	4+4, 3+5, 5+3	999	999	999	999	3
Grade Group 5	9–10	4+5, 5+4, 5+5	099	999	099	999	3

Last Updated

08/10/2017

Date Finalized

06/14/2017

20170035

References

Source 1: **WHO Class Female Reproductive Organs**

pgs:

Notes: **4th ed., 2014**

Question

MP/H Rules/Histology: What is the histology code of serous tubal intraepithelial (in situ) carcinoma (STIC), bilateral fallopian tubes?

Answer

Assign 8441/2. This is based on the WHO classification for female reproductive system tumors.

Date Finalized

06/14/2017

20170034

References
Source 1: **2016 SEER Manual**
Notes: **Appendix C**

Question
Surgery codes, NOS/Reconstruction--Breast: Would you code a unilateral breast simple mastectomy with tissue expanders and AlloDerm or an acellular dermal matrix as Code 45, Reconstruction with Implant, or Code 46, Reconstruction with Combined Tissue and Implant? See Discussion.

Discussion
Since acellular dermal matrix/AlloDerm comes from human tissue donors with cells removed and sterilized to promote regenesis and decrease rejection, is Alloderm coded as 'Tissue' as it also "provides an additional layer of tissue between the skin and the implant?

Answer
Assign code 45 for a simple mastectomy with tissue expanders and acellular dermal matrix/AlloDerm. The tissue expander indicates preparation for an implant. The acellular dermal matrix/AlloDerm is not coded because, while they often accompany an implant procedure, they are not the principle element of reconstructive procedures. The principle elements would be tissue from the patient and/or prosthetics (e.g., gel implants).

Date Finalized
07/28/2017

20170033

References

Source 1: **SINQ 20160023**

Question

Grade--Appendix: What is the code and term to use for the grade/differentiation field for well differentiated, Grade 2 neuroendocrine tumor (NET)? See Discussion.

Discussion

Diagnosis: Fragmented appendix with: Goblet cell carcinoid tumor (typical goblet cell carcinoid): WELL DIFFERENTIATED neuroendocrine tumor; INTERMEDIATE GRADE (GRADE 2 NET). Size 3.5 cm according to surgical pathology report. Tumor infiltrates through appendiceal wall to subserosa. Tumor is present in what appears to be the wall of the appendix near the perforation site or in hemorrhagic tissue on the surface of the appendix. MAXIMUM MITOTIC RATE IS TWO (2) FIGURES PER 10 HIGH POWER fields (2/10hpf). (4/10 hpf according to report).

WD indicates a 3- grade system (code 1 for WD) Intermediate grade indicates a 3- grade system (code grade 3 for intermediate grade), Grade 2 indicates a 2- grade system (code 2 for grade 2). Please advise.

Answer

See SINQ 20160023 for NET grade coding instructions. Coding grade for NETs is slightly different from coding grade for other solid tumors.

Since this diagnosis includes "Well differentiated" and "Grade 2," assign grade code 2, the higher grade. According to our expert pathologist consultant, "intermediate" fits best with grade 2.

Date Finalized

05/30/2017

20170031

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

Question
MP/H Rules/Multiple primaries--Penis: How many primaries should be reported for a diagnosis of invasive squamous cell carcinoma (SCC) of the penis in 6/2011, treated with excision and fulguration followed by 10/2014 penile lesion found to be SCC with basaloid features focally highly suspicious for invasion? Clinically, the 2014 tumor is stated to be in situ and recurrent penile cancer and follow-up in 2/2015 indicates there was no evidence of tumor following treatment. Subsequently, in 3/2016 the patient has another penile lesion biopsy showing SCC in situ suspicious for invasion, clinically stated to be recurrent. See Discussion.

Discussion
At the central registry, we have accessioned this scenario as three primaries per Multiple Primaries/Histology (MP/H) Rule M10 (diagnosed more than 1 year apart), as the patient was stated to be disease free between each occurrence. However, the diagnosing/treating facility is not reporting these cases due to clinical statements of recurrent disease.

This is an example of a case type identified on casefinding audits conducted by our central registry in which we have learned SEER's expectation of MP/H rule application does not match hospital reporting. Can the 2018 version of the MP/H rules more clearly address how this type of clinically recurrent (multiple times) case should be handled?

Answer
Accession three tumors as the tumors were each diagnosed more than one year apart according to the MP/H Rule M10 for Other Sites. And, as you have noted, the patient was free of disease after each diagnosis.

The MP/H rules have very clear instructions regarding the word "recurrence." See page 10, specifically A.7., https://seer.cancer.gov/tools/mphrules/2007_mphrules_manual_08242012.pdf

SEER will evaluate the MP/H rules in the upcoming revision.

Date Finalized
05/30/2017

20170030

References
Source 1: **2016 SEER Manual**
pgs: **1 & 2**
Notes: **Appendix C: Surgical Codes for Melanoma/Skin**

Question
Surgery Primary Site--Melanoma: How should Surgery of Primary Site be coded for a melanoma diagnosed on punch or shave biopsy followed by a wide excision that shows no residual disease and the gross wide excision specimen size showing no residual is greater than 1 cm in all dimensions (length, width and depth)? See Discussion.

Discussion
Example: Shave biopsy with superficial spreading melanoma, Breslow 0.25 mm, Clark level II. Excision with no residual melanoma and gross description of specimen size is 4.0 x 1.6 cm skin ellipse excised to a depth of 1.8 cm.

We have differing opinions in our registry.

Opinion 1: We can assume margins are greater than 1 cm based on the excision specimen size when there is no residual tumor on excision and all dimensions of the excision specimen are more than 1 cm. Surgery would be coded in 40s range.

Opinion 2: We should assume the melanoma defect was in the middle of the excision specimen, so for a skin ellipse that is 4.0 x 1.6 cm, there would be a 2 cm and 0.8 cm margin (respectively) from the middle of the specimen, thus margins are not > 1 cm. Surgery would be coded in 30s range.

Answer
Assign code 30: Biopsy of primary tumor followed by a gross excision of the lesion. The margins are unknown. The registrar should not try to determine the margins when they are not specified. See the SEER Note at the top of page 2 in the Skin Surgery Codes section of Appendix C of the SEER manual "If it is stated to be a **wide excision** or **reexcision**, but the **margins are unknown**, code to 30." https://seer.cancer.gov/manuals/2016/AppendixC/Surgery_Codes_Skin_2016.pdf

Date Finalized
05/30/2017

2017029

References
Source 1: **ICD-O-3**
Source 2: **WHO Class Soft Tissue & Bone**

Question
Reportability--Bone: Are giant cell tumors (GCT) of the bone that metastasize to the lung reportable? See Discussion.

Discussion
Patient had radical resection of pelvic giant cell tumor of bone in August 2012. Final diagnosis clarified that no features to suggest a frankly malignant giant cell tumor were identified.

July 2013 left upper lobe nodules were removed and found to be consistent with multifocal metastatic lung involvement with a previous pelvic giant cell tumor of bone. However, the pathology report comment specifies there are no histological high-grade features to suggest a malignancy:

COMMENT: In a patient with a clinical history of pelvic giant cell tumor of bone, the overall findings are consistent with multifocal metastatic lung involvement. There are no histological high-grade features to suggest a malignancy.

While SINQ 20091087 may apply, these metastases clearly arrived in the lung by hematogenous spread. The previous SINQ note refers to a case where the implants/metastases can seed the surrounding pelvic and abdominal structures by rupture of the tumor or intraoperative tumor spillage. That type of spread is not quite the same as the current case showing tumor cells leaving the primary tumor/site and travelling through the blood to implant in the lungs.

Answer
This case is not reportable. According to the WHO Classification of Bone Tumors, pulmonary metastases from GCTs are "very slow-growing and are thought to represent pulmonary implants that result from embolization of intravascular growths of GCT. Some of these benign pulmonary implants can regress spontaneously. A small number, however, exhibit progressive enlargement and can lead to the death of the patient." The pathologist for this case is very clear that no malignancy was found in the lung or in the bone.

Date Finalized
05/30/2017

20170028

References
Source 1: **2007 MP/H Rules**
Notes: **Kidney**
Source 2: **ICD-O-3**

Question
MP/H Rules/Histology--Kidney: How should histology be coded for a clear cell renal cell carcinoma when the CAP protocol indicates sarcomatoid features are present? See Discussion.

Discussion
Sarcomotoid (8318) is listed as a specific renal cell subtype in the MP/H manual, but it is not listed as a renal cell subtype in the most recent WHO blue book for Urinary Organs. We are wondering if sarcomatoid features, as listed in the CAP protocol format in the following example, should be ignored when coding histology?

Left kidney, radical nephrectomy:
Clear cell renal cell carcinoma, with the following features:

Tumor size: 8.5 X 6 cm.
Tumor focality: Unifocal.
Macroscopic extent of tumor: Tumor limited to kidney.
Sarcomatoid features: Present (<20% of tumor shows sarcomatoid features).
Histologic grade: G4.
Microscopic tumor extension: Tumor limited to kidney.
Margins: All margins negative for invasive carcinoma.
Lymph-vascular invasion: Not identified.

Answer
Code 8255 (adenocarcinoma with mixed subtypes). The Multiple Primaries/Histology Rule H6 applies as there are two or more specific renal cell carcinoma types, clear cell and sarcomatoid (Spindle cell), as listed in Table 1 of the kidney Terms and definitions.

Date Finalized
05/30/2017

20170027

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

Question
MP/H Rules/Multiple primaries--Melanoma: Is a melanoma with an unknown laterality a different laterality for the purposes of applying Multiple Primaries/Histology Rule M4? See Discussion.

Discussion
8/1/2016 Left Abdomen biopsy: Early melanoma in situ (C445-2, 8720/2).
9/2/2016 Upper back: Superficially invasive malignant melanoma (C445-9, 8720/3).
Does rule M4 apply and multiple primaries should be reported or does rule M8 apply and a single primary should be reported?

Answer
Abstract multiple primaries following Multiple Primary Rule M4. Unknown laterality is a different laterality for the purposes of applying the MP/H rules for melanoma.

Date Finalized
05/30/2017

20170026

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

Question
Multiple Primaries/Histology Rules/Multiple primaries--Kidney, renal pelvis: Are tumors diagnosed more than three years apart multiple primaries according to Rule M7 in a case with metastasis? See Discussion.

Discussion
5/27/02 Transurethral resection of bladder tumor (TURBT)--papillary transitional cell carcinoma, +lamina propria, no muscle invasion. All urine cytologies in 2011 and 2012 (only follow up received) show no malignancy. 3/11/15 Lung fine needle aspirate--poorly differentiated carcinoma consistent with urothelial carcinoma. 4/30/15 Renal pelvis biopsy--low grade papillary urothelial carcinoma, no lamina propria invasion, no muscularis propria invasion.

Answer
Rule M7 applies. Abstract the bladder diagnosis and the renal pelvis diagnosis as separate primaries. The lung diagnosis is metastatic. The MP/H rules do not apply to metastatic tumors.

Date Finalized
05/30/2017

20170025

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

Question
MP/H Rules/Multiple primaries--Breast: Is this the same primary per MP/H Rule M10? Ductal carcinoma of the left breast in 2013, treated with a lumpectomy. New tumor with ductal and lobular carcinoma in the same breast in 2016.

Answer
The 2016 diagnosis is the same primary. MP/H Rule M10 for breast cancer applies. Do not change the original histology code. Use text fields to document the later histologic type -- duct and lobular.

Date Finalized
06/15/2017

20170024

References
Source 1: **ICD-O-3**
Source 2: **NAACCR Guidelines for ICD-O-3 Implementation**
pgs: **9**
Notes: **Revised April 2014**

Question
Reportability/Histology--Colon: Is tubular adenoma with high grade dysplasia and focal invasion from a pathology report of a colon biopsy reportable? If so, what is the histology code?

Answer
Tubular adenoma with high grade dysplasia and focal invasion is reportable. Assign the histology code and behavior as 8210/3 (Adenocarcinoma in tubular adenoma).

NAACCR Guidelines for ICD-O-3 Implementation discuss the term high grade dysplasia (without invasion). High grade dysplasia and related terms are under review and study for consideration as a reportable neoplasm. Registries should check with their state reporting legislation to see if included in the reporting requirements.

Date Finalized
05/30/2017

20170023

References
Source 1: **2016 SEER Manual**
pgs: **11-12**

Question
Reportability/Date of Diagnosis--Prostate: Is PI-RADS 5 diagnostic of prostate cancer, and if so, can we use the date of the impression on the scan that states PI-RADS category 5 as the diagnosis date? See Discussion.

Discussion
We are seeing more use of PI-RAD categories on scans. The final impression on the scan will be PI-RADS Category 5, with no specific statement of malignancy. The scans include a blanket statement with the definitions of the PI-RADS categories as below.

PI-RADS (v2) categories:
PI-RADS 1 - Very low (clinically significant cancer is highly unlikely to be present)
PI-RADS 2 - Low (clinically significant cancer is unlikely to be present)
PI-RADS 3 - Intermediate (the presence of clinically significant cancer is equivocal)
PI-RADS 4 - High (clinically significant cancer is likely to be present)
PI-RADS 5 - Very high (clinically significant cancer is highly likely to be present)

A previous SINQ 20010094 indicates that we cannot use BI-RADS categories for breast cancer diagnosis, and SINQ 20160008 indicates we can use LI-RADS for HCC diagnosis, but those definitions are slightly different. Most often there will be a subsequent biopsy diagnosis of carcinoma, so the question is also in reference to Diagnosis Date. Can we use the date of the scans impression, which states PI-RADS category 5, as the Diagnosis Date?

Answer
A workgroup with members from each of the standard setters will discuss this issue in the near future. Instructions will be provided based on the outcome of that discussion.

Date Finalized
05/30/2017

20170022

References
Source 1: **WHO Class CNS Tumors**
pgs: **201, 205**
Notes: **Revised 4th edition**

Question
MP/H Rules/Histology--Brain and CNS: What is the code for an embryonal tumor with multilayered rosettes. WHO shows the code as 9478/3, but this code is not available for use in the United States.

Answer
Assign ICD-O-3 code 9392/3 until code 9478/3 is implemented in 2018. Per our expert neuropathologist, embryonal tumor with multilayered rosettes was previously called ependymoblastoma.

Date Finalized
05/30/2017

20170020

References
Source 1: **2016 SEER Manual**
Notes: **Section V; revised for 2017**

Question
Size of tumor--Breast: Please clarify guideline #7 if the only size you have is from a CORE biopsy specimen and imaging only states nonspecific sizes, like "architectural distortion" or "calcifications" and a core biopsy pathology reports invasive tumor spans 5mm. Do you use the core biopsy size, or use 999 for clinical tumor size? See discussion.

Discussion
SEER Program Coding and Staging Manual 2016 states: Record size in specified order using a. The largest measurement of the primary tumor from physical exam, imaging, or other diagnostic procedures before any form of treatment. See Coding Instructions 7-9 below. b. The largest size from all information available within four months of the date of diagnosis, in the absence of disease progression when no treatment is administered. #7 Priority of imaging/radiographic techniques: Information on size from imaging/radiographic techniques can be used to code clinical size when there is no more specific size information from a biopsy or operative (surgical exploration) report. It should be taken as a lower priority, but over a physical exam.

Answer
Do not code size of tumor based on the size of the core biopsy. If the statement "invasive tumor spans 5mm" from the core biopsy report represents the surgeon's assessment of tumor size, use this information to code tumor size when no other information is available.

Date Finalized
05/30/2017

20170019

References
Source 1: **WHO Class Male Genital Tumors**
pgs: **186**
Notes: **4th Ed.**

Question
MP/H Rules/Histology--Testis: How should histology be coded for a mixed germ cell tumor that also includes choriocarcinoma now that non-seminomatous mixed germ cell tumors (9065) and seminomatous mixed germ cell tumors (9085) are collapsed for analysis? See Discussion.

Discussion
The MP/H Rules (Other Sites Terms and Definitions, Table 2) currently lists a separate mixed germ cell tumor code (9101) for germ cell tumors with choriocarcinoma plus teratoma, seminoma or embryonal carcinoma. Is this separate mixed germ cell tumor code still to be used now that all mixed germ cell tumors (9065 and 9085) have been collapsed into code 9085 for analysis per SINQs 20160056 and 20110013? The current WHO Classification for testis tumors does not list code 9101, but also collapses all seminomatous and nonseminomatous mixed germ cell tumors of more than one histologic type under code 9085.

Answer
While WHO 4th Ed Tumors of Urinary and Male Genital System does not include 9101/3, this code has not been made obsolete. Follow the 2007 MP/H rules and code histology to 9101/3 per Other sites rule H16, Table 2.

Date Finalized
05/30/2017

20170018

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

Question
MPH Rules/Multiple primaries--Melanoma: Does MP/H Rule M7 (diagnosed more than 60 days apart) apply to invasive melanoma cases with margins positive for in situ melanoma, or are these further excision of the original diagnosis and the same primary, even when it appears treatment was complete after the initial excision? See Discussion.

Discussion
A dementia patient has been managed for a persistent right cheek skin lesion that has been slow growing for about 5 years. It was biopsied in 12/23/15 revealing a Breslow 0.12 mm lentigo maligna melanoma by an outside provider. A larger resection of the lesion on 2/3/16 demonstrated a Breslow 0.30 mm lentigo maligna melanoma with melanoma in situ present at the margins per the available pathology report. There was no statement in the record that any additional treatment was planned or necessary.

Patient healed well from the 2/3/16 procedure but developed a recurrent lesion in May that was biopsied on 5/10/16 by the same outside provider which again reveal lentigo maligna melanoma. 7/5/16 Reexcision at the current facility revealed a Breslow 6.1 mm lentigo maligna melanoma, Clarks level V. This was a cutaneous tumor per the path report and not a subcutaneous nodule. Clinically, the MD called this a recurrent lesion, but there was no slide comparison to the previous melanoma.

In auditing files for expected (but not received) abstracts due from facilities, we've observed these types of cases not being consistently reported as multiple primaries.

Answer
Rule M7 pertains to separate tumors. Rule M7 does not apply to invasive melanoma cases with margins positive for in situ melanoma.

Based on the information provided, it is not clear whether or not the 5/10/16 diagnosis is a separate lesion or the same lesion that was diagnosed earlier.

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