20200042

References
Source 1: **2018 Solid Tumor Rules**
pgs: **19**
Notes: **Malignant CNS; July 2019 Update**

Question
Solid Tumor Rules (2018)/Histology--Brain and CNS: How is the histology coded when the diagnosis comment for a posterior fossa tumor resection states: Taken together, these findings are indicative of medulloblastoma with extensive nodularity? See Discussion.

Discussion
Example: Posterior fossa tumor resection final diagnosis was medulloblastoma, WHO Grade IV. The diagnosis comment notes the current tumor resection reveals large irregular reticulin-free nodules with streams of neoplastic cells in a fibrillary background in association with narrow reticulin-rich internodular strands of poorly differentiated neoplastic cells. Taken together, these findings are indicative of medulloblastoma with extensive nodularity. The diagnosis comment provided only one histology.

Per the 2018 Solid Tumor Manual, Malignant CNS, Priority Order for Using Documentation to Identify Histology instructions, an addendum or comment has priority over the final diagnosis. Although indicative is not listed on any ambiguous terminology list, is this an ambiguous diagnosis that must be ignored? Or does the diagnosis comment in this case provide a single, specific diagnosis of medulloblastoma with extensive nodularity?

Answer
Code as medulloblastoma, nodular (9471/3) based on the findings from both the comment and final diagnosis.

Date Finalized
09/11/2020

20200041

References
Source 1: **2018 SEER Manual**
pgs:
Notes: **Appendix E**

Question
Reportability--Brain and CNS: Is an intradural T12/L1 capillary hemangioma reportable? See Discussion.

Discussion
Example: MRI found an intradural, extra-axial mass at T12/L1 with possible intramedullary component. Resection of the intradural intramedullary and extramedullary spinal cord tumor found a capillary hemangioma pathologically. The microscopic description on the path report describes a tumor with extensive vascularity involving the dura.

Should we equate the statement of capillary to mean the tumor is arising in a blood vessel as we do for venous hemangioma (non-reportable per SINQ 20130001)? Or should it be reportable as C700, 9131/0 because it is described as involving the dura (intradural, intramedullary and extramedullary)?

Answer
Reportability of capillary hemangioma depends on the site of origin. If it originates in the dura, it is reportable. If it originates in a blood vessel, it is not reportable. The site of origin is not clear in the information provided. Sites of involvement are mentioned, but not the site of origin. Capillary could refer to the site of origin or to the propensity of this tumor to form tiny blood vessels. If the site of origin cannot be confirmed as dura, do not report this neoplasm.

Date Finalized
09/11/2020

20200040

References
Source 1: **WHO Classification of Skin Tumors**
pgs: **338**
Notes: **4th Edition**

Question
Reportability--Skin: Is pseudomyogenic hemangioendothelioma (PMH) reportable with morphology code 9133/3? See Discussion.

Discussion
According to the literature, PMH is a low-grade malignant vascular neoplasm of different tissue planes including skin and soft tissue. However, the references also state: PMH is a cutaneous tumor that behaves in an indolent fashion. There is no indication that this was a malignant diagnosis.

12/3/18 Foot, left skin lesion, punch biopsy: Superficial squamous epithelium demonstrating hyperkeratosis and fragments of keratin debris, no tumor seen.

Foot, left skin lesion, punch biopsy: Pseudomyogenic (epithelioid sarcoma-like) hemangioendothelioma, see note.

NOTE: The submitted immunohistochemical slides were reviewed. Positive and negative controls reacted appropriately. The tumor cells demonstrate immunoreactivity to CK AE1/AE3 and CK7. The CD31 immunoreactivity described in the report cannot be confirmed as only the positive control is submitted for review. The tumor cells are negative for desmin, CD45, CD68, S-100, CD34, SMA, CD20, and HHV8. The proliferative index via Ki-67 is approximately 10%. The morphology (described below) and immunohistochemistry performed are compatible with a pseudomyogenic hemangioendothelioma.

12/4/18 Final Pathologic Diagnosis: Foot, left bone lesion, biopsy: Pseudomyogenic (epithelioid sarcoma-like) hemangioendothelioma, see note.

Note: The patient's imaging findings were reviewed in conjunction with this case, revealing numerous lytic lesions of the tibia, fibula, talus, tarsal, metatarsal, and phalangeal bones. Additionally, as per the medical record, also reviewed in conjunction with this case, there are lesions of the skin. Thus, an extensive immunohistochemical panel was performed in an attempt to support the morphologic findings in this case, which were morphologically similar to the patient's skin biopsy. The tumor cells demonstrate strong immunoreactivity to

pancytokeratin (CK AE1/AE3) and vimentin with moderate immunoreactivity to Fli-1. The tumor cells demonstrate weak immunoreactivity to epithelial membrane antigen. INI-1 is retained. There is focal immunoreactivity to CD31 although this is limited to the edges of the tissue fragments. The tumor cells are negative for HHV-8, CD34, smooth muscle actin, CK8/18, desmin, CD99, and Bcl-2. The combination of morphologic (see below for microscopic description) and immunohistochemical findings are consistent with pseudomyogenic hemangioendothelioma. Fresh tissue was submitted for karyotype analysis at the time of intraoperative consultation; however, it revealed only a normal appearing male karyotype. Thus, molecular confirmation was sought. The original slides and a paraffin block were submitted for FOSB rearrangement analysis, as pseudomyogenic hemangioendothelioma is known to have recurrent rearrangements with FOSB. Additional immunohistochemistry performed at (FACILITY) demonstrating immunoreactivity for ERG, supporting a vascular origin for this neoplasm. Fluorescence in situ hybridization demonstrated that 13% of the cells examined show FOSB rearrangement. While this FISH probe is for investigational purposes, the above findings support the diagnosis of pseudomyogenic hemangioendothelioma.

Answer

Do not report PMH. The WHO Classification of Skin Tumors lists pseudomyogenic hemangioendothelioma as a borderline malignancy (9138/1). Borderline malignancies of the skin are not reportable.

Date Finalized

09/11/2020

20200038

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

Question
Solid Tumor Rules (2018)/Histology--Lung: Can the stated histology from a biomarker/immunohistochemistry (IHC) report be used for coding histology? See Discussion.

Discussion
Example: Diagnosis is made on liver core biopsy path showing Metastatic carcinoma, poorly-differentiated, consistent with lung primary. Diagnosis Comment notes: Carcinoma cells are positive for CK7 and TTF-1, negative for CK20.

Subsequent immunohistochemistry report for PD-L1 testing states Liver: Metastatic adenocarcinoma consistent with lung primary. Interpretation: no PD-L1 expression.

IHC/Biomarker testing is often performed to determine treatment type, but it seems like some of the biomarkers for treatment planning are also histology specific. The Solid Tumor Rules do not address the use of biomarkers reports in the histology coding instructions.

Answer
Code this case to adenocarcinoma 8140/3. Biomarkers are often reported separately, not as part of the addendum, and can be used to code histology. This applies to cases diagnosed by metastatic site only.

Date Finalized
09/11/2020

20200036

References
Source 1: **WHO Class Skin Tumors**
pgs: **on-line version**
Notes: **4th edition**
Source 2: **2018 SEER Manual**
pgs: **7**
Notes: **1.b.i.**

Question
Reportability--Skin: Is malignant proliferative trichilemmal tumor (PTT) reportable, and if so, do we apply the matrix rule and code it to 8103/3? A literature search reveals these do exist but are extremely rare.

Answer
Malignant PTT (8103/3) of the skin is not reportable. A neoplasm originating in the skin with histology coded to 8103 is not reportable. See 1.b.i. on page 7 in the 2018 SEER manual for a complete list, https://seer.cancer.gov/manuals/2018/SPCSM_2018_maindoc.pdf

Date Finalized
09/11/2020

20200035

References
Source 1: **2018 SEER Manual**
pgs: **10, 79**

Question
Reportability/Ambiguous Terminology--Brain and CNS: Is the expression differential considerations a synonym for differential diagnoses? See Discussion.

Discussion
Example: An MRI Spine showed a large expansile mass arising from the sella turcica and extending into the suprasellar cistern, but the radiologist only noted: The leading differential considerations include pituitary macroadenoma or a large suprasellar base meningioma. The patient was subsequently pathologically diagnosed with a pituitary adenoma. It is unclear if the diagnosis date should be coded to the MRI date.

There are two existing SINQ questions regarding the term consider. SINQ 20061094 confirms a diagnosis that is considered to be is reportable because it is unambiguous, but SINQ 20081033 states the phrase malignancy is highly considered is not a reportable ambiguous term.

How should we interpret differential considerations? If differential considerations is equivalent to a differential diagnosis, then this patient was clinically diagnosed on imaging. However, if differential considerations is not reportable, then there was no diagnosis prior to the resection.

Answer
In an ideal situation, the radiologist should be consulted to determine what he/she meant by "differential considerations." If that is not possible, given the context and usage, "differential considerations" in this case can be interpreted as differential diagnoses. And since the two differential considerations are both reportable, this case is reportable as of the date of the MRI.

Date Finalized
09/02/2020

20200034

References
Source 1: **2018 Solid Tumor Rules**
pgs: **32**
Notes: **Breast; July 2019 Update**

Question
Solid Tumor Rules (2018)/Histology--Breast: How should histology be coded for 2020 breast lumpectomy final diagnosis of invasive ductal carcinoma? Summary Cancer Data and CAP Summary states: Invasive carcinoma with the following features: Histologic type: Tubular adenocarcinoma. See Discussion.

Discussion
Per the 2018 Solid Tumor Rules instructions, Final Diagnosis and Staging Summary (synoptic report) have equal coding priority. However, it is unclear which takes priority, or if this should be a combination of components, when the histologies are two different specific histologic types per Table 3 of the Breast Solid Tumor Rules Manual.

Answer
In this case, the pathologist states two different histologies. Per the H rules, when there are different histologies, code the histology which comprises the majority of tumor. Use H16 and code histology stated to be more than 50% of tumor OR H17, code 8523 when percentage is not stated or unknown.

Date Finalized
09/11/2020

20200033

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Breast; July 2019 Update**

Question
Solid Tumor Rules (2018)/Multiple primaries--Breast: How many primary tumors should be abstracted for a 2018 breast excision with a final diagnosis of invasive mucinous adenocarcinoma (0.7 cm) with ductal carcinoma in situ (DCIS) present as discontinuous foci, spanning 12 cm? See Discussion.

Discussion
If the term discontinuous foci means separate tumors, then rule M14 would apply making these multiple reportable tumors.

Answer
Abstract two primaries, invasive mucinous and DCIS, using 2018 Solid Tumor Rules for Breast, M14, as the discontinuous foci are separate tumors in this example and the histologies are on different rows of Table 3 of the rules.

Date Finalized
09/11/2020

20200032

References
Source 1: **2018 SEER Manual**
pgs: **11; 14**
Notes: **Reportability; Changing Information on the Abstract**

Question
Date of Diagnosis--Brain and CNS: How is the Date of Diagnosis coded when an MRI clinically diagnoses a borderline brain tumor on 4/4/2020, but the subsequent biopsy pathologically diagnoses a malignant brain tumor on 5/20/2020? See Discussion.

Discussion
Clinically, the patient was felt to have a pineocytoma (borderline tumor) on imaging, but the subsequent biopsy proved a pineal germinoma (malignant tumor). The Date of Diagnosis instructions state to code the month, day and year the tumor was first diagnosed, clinically or microscopically, by a recognized medical practitioner, but it does not indicate whether differences in behavior alter the diagnosis date.

For brain and central nervous system tumors, should the diagnosis date be the first date a tumor is SEER reportable? Or should the diagnosis date for those tumors ultimately proven to be malignant, be the date the malignancy was diagnosed?

Answer
This tumor was first diagnosed on 4/4/2020 according to the information provided. The pineocytoma was reportable based on a behavior of /1; it was later confirmed as a pineal germinoma; update both the histology and behavior on the abstract as better information was obtained, retaining the original date of diagnosis.

Date Finalized
09/02/2020

20200030

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Lung; July 2019 Update**

Question
Solid Tumor Rules/Multiple primaries--Lung: How many primaries should be accessioned for the following patient scenario?
1) 09/2014 Left upper lobe (LUL), unifocal, localized acinar adenocarcinoma (8550/3) treated with lobectomy.
2) 04/2016 Right lower lobe (RLL), unifocal, localized acinar adenocarcinoma (8550/3) treated with wedge resection.
3) 04/2019 (within 3 years, but masked full date) Left lower lobe (LLL), unifocal, non-small cell carcinoma (8046/3) with brain metastasis. See Discussion.

Discussion
Rule M4 does not seem to apply because Note 1 defines clinically disease free to mean no evidence of recurrence in the same lung on follow-up. Patient had been disease free in the left lung after 09/2014 diagnosis. The 04/2019 diagnosis was in a different lung than the 4/2016 diagnosis.

The next applicable rule is either M11 or M14 depending on how we should compare the new 2019 tumor: to the most recent prior tumor in 2016 or to both prior tumors.

Answer
Abstract three primary tumors according to the 2018 Solid Tumor Rules as follows:

2014: LUL, single primary using M2

2016: RLL, multiple primary; abstract second primary using M11 (different lung)

2019: LLL, multiple primary after reapplying rules using M4 when comparing to the same lung in 2014. Abstract this tumor as it has been more than three years and it appears the patient had no clinical evidence of disease in the left lung until 2019.

Date Finalized
09/11/2020

20200029

References
Source 1: **2018 SEER Manual**
pgs: **219**
Notes: **Systemic Treatment/Surgery Sequence**

Question
Systemic/Surgery Sequence: The note associated with code 4 in Systemic Treatment/Surgery Sequence in the 2018 SEER Manual says: Code 4 is intended for situations with at least two episodes or courses of systemic therapy. Does this mean two different types of systemic therapy before and after surgery? See Discussion.

Discussion
For example, chemotherapy and immunotherapy administered first, followed by surgery, then immunotherapy and hormone therapy after surgery. Or is code 4 used for two administrations of chemotherapy before surgery and two more courses after surgery?

Answer
Assign code 4 for the example you describe. Code 4 also applies to cases with one course of chemotherapy before surgery and another course after surgery.

Date Finalized
09/11/2020

20200028

References
Source 1: **Extent of Disease (EOD) 2018 General Coding Instructions**
pgs:
Notes: **September 2019**
Source 2: **Extent of Disease 2018, EOD Data V 1.7**
pgs:
Notes: **https://staging.seer.cancer.gov/eod_public/home/1.7/**

Question
2018 EOD Primary Tumor/2018 EOD Mets--Lung: Is EOD Primary Tumor coded to 500 and EOD Mets 10 when there are bilateral lung nodules with nodules in same lobe as the primary tumor? How is EOD Primary Tumor coded when separate tumor nodes are in an ipsilateral lung but there is no documentation as to whether it is in the same or different ipsilateral lobe from the primary tumor?

Answer
Assign 999 to EOD Primary Tumor if this is the only information you have for your case. The mention of nodules does not automatically mean that you have separate tumor nodules. There are many reasons for the appearance of nodules in the lung, some of which are not due to cancer. Unless you have further information on whether the physician has determined that they are related to the lung cancer, then assume that they are not related.

Assign 00 to EOD Mets. Do not code EOD Mets to 10 since you cannot determine whether those nodules are based on the tumor or not. If you are able to obtain more information, then you can update the EOD Primary Tumor and EOD Mets.

Regarding the second question, if separate tumor nodules are noted, you cannot assume that they are due to tumor. Further information, or clarification, is needed on whether the separate tumor nodules are related to the lung cancer. Without further information, code EOD Primary Tumor to 999.

There is also some information in the CAnswer Forum since Separate Tumor Nodules are a Site-Specific Data Item: http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/96061-lung-separate-tumor-nodules

Date Finalized
09/11/2020

20200027

References
Source 1: **2018 SEER Manual**
pgs: **11**
Notes: **Ambiguous Terminology**

Question
Reportability--Ambiguous Terminology: Should either of the terms, strongly characteristic of or most certainly, be used to accession a case as reportable when they are used to describe a malignancy and no other information is available? See Discussion.

Discussion
SINQ 20130140 indicates a histologic diagnosis that is characteristic of a specified malignancy is reportable because this is equivalent to the term, diagnostic of. Does the same logic apply to a clinical diagnosis that is strongly characteristic of a malignancy on imaging?

SINQ 20180104 indicates the term, almost certainly, is not a reportable ambiguous term. If a radiologist notes a mass was most certainly malignant, is this adequate to accession this as reportable? Is a clinically certain diagnosis equivalent to diagnostic of? Or are the modifiers almost and most irrelevant because the terms certainly and certain are not on the ambiguous terminology list?

Answer
Look for more information. What is the plan for each of these patients? Consult with the physician and search for further information to assist with the decision. If no further information can be obtained, accession both of these cases based on the imaging reports. If more information becomes available later, review and revise as applicable.

Date Finalized
09/02/2020

20200026

References
Source 1: **2018 Extent of Disease**

Question
EOD 2018--Lung: How should EOD Primary Tumor be coded when imaging describes a large left upper lobe 9.1 cm mass that traverses the left major fissure. Also noted is no pleural effusion and normal chest wall. See Discussion.

Discussion
It is unclear if code 300 is appropriate, since technically the fissure is comprised of pleura, involvement of the fissure appears to imply a tumor that is no longer localized.

An argument could be made for code 400, since the term traverses could be interpreted as crossing into adjacent lobe, however the lower lobe is not mentioned in this scan.

Answer
Assign code 400 as the term "traverses" indicates involvement with extension to the major fissure and is no longer confined to the left lobe.

Date Finalized
09/11/2020

20200025

Question

Reportability/Ambiguous terminology--Bone: Is a case reportable when the imaging described a left first rib mass as most compatible with a chondroid lesion such as a chondrosarcoma? See Discussion.

Discussion

The radiologist noted the mass was most compatible with a chondroid lesion, which is not reportable on its own, but can the subsequent term such as be used to accession this as reportable if only one malignant etiology is provided by the radiologist? Or does the statement such as imply that this is only one of several possible etiologies?

Answer

Review this case with the involved physicians to determine their opinion on the bone mass. Review the plans for further evaluation and treatment (if any) to determine whether the physicians view this case as a chondroid lesion, chondrosarcoma, or something else.

If it is not possible to obtain further information, do not report the case at this time. If further information becomes available, review the case again for reportability.

Date Finalized

07/30/2020

20200024

References
Source 1: **ICD-O-3; ICD-O-3.2**

Question
Reportability/Histology--Fallopian tube: Is germ cell neoplasia in situ reportable? If so, is the histology and behavior 9064/2? See Discussion.

Discussion
Pathology report dated 10/17/2019: Final Diagnosis: Fallopian tubes and gonads, right and left, excision: Dysgenetic gonadal tissue with nests and tubules of atypical germ cells suspicious for gonadoblastoma and at least germ cell neoplasia in situ; and segments of fallopian tube (pending expert consultation).

Answer
Report germ cell neoplasia in situ as 9064/2. Override the site/type edit.

Date Finalized
07/30/2020

20200023

References

Source 1: **2018 ICD-O-3 New Codes, Behaviors, and Terms-Updated 8/22/18**

Question

Solid Tumor Rules (2018)/Histology--Endometrium: Is the histology for a serous carcinoma, high-grade endometrial primary 8441/3 (serous carcinoma) or 8461/3 (high grade serous carcinoma)? See Discussion.

Discussion

Path report reads: 7/15/2019 A. Endometrium, curettings: Serous carcinoma, high grade. B. Endometrial polyp, curettings: Serous carcinoma, high grade.

If coded to 8461/3, according to AJCC, this would not be an ideal code (since it is outdated). Also, endometrium is not included in the suggested site codes for 8461/3 according to the 8/22/2018 ICD-O-3 update.

Answer

Code histology for this endometrial primary to serous carcinoma 8441/3. Capture "high grade" in the grade field as instructed in the grade coding manual.

"High grade serous carcinoma" has specific clinical and histopathologic features found in ovarian tumors.

Date Finalized

06/26/2020

20200022

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Breast, July 2019 Update**

Question
Solid Tumor Rules (2018)/Multiple primaries--Breast: How many primaries should be reported for a December 2013 diagnosis of lobular carcinoma in situ (8520/2) in the left breast, treated with a lumpectomy, followed by a July 2018 diagnosis of invasive ductal carcinoma (8500/3) also in the left breast? See Discussion.

Discussion
In the April and July 2019 updates to the Solid Tumor Rules, the term simultaneous and Note 1 indicating histologies must be the same behavior were removed from rule M10 (ductal and lobular are a single primary).

We would like to confirm that rule M10 is the correct rule to apply to this case. This case is an invasive diagnosis approximately 4.5 years after an in situ diagnosis, so it seems like M17 should apply (invasive tumor following an in situ tumor more than 60 days later are multiple primaries).

An invasive tumor following an in situ tumor more than 60 days later of the same histology is a new primary. Similarly, it seems like an invasive tumor following an in situ tumor more than 60 days later of different histologies should be a new primary.

Answer
Abstract a single primary using 2018 Breast Solid Tumor Rule M10.

Unless the tumors were diagnosed more than 5 years apart, they are a single primary. The 2021 breast update will include examples and notes plus updating table 2.

Date Finalized
06/26/2020

20200021

References
Source 1: **WHO Class Head and Neck Tumors**
pgs:
Notes: **4th edition**

Question
Solid Tumor Rules/Histology--Head & Neck: What is the histology of human papillomavirus (HPV)--associated multiphenotypic carcinoma? See Discussion.

Discussion
Histologic Type: HPV-associated multiphenotypic carcinoma. Overall, the morphology, immunohistochemistry, and HPV testing results support the diagnosis of an HPV-related multiphenotypic carcinoma. This entity has been described in the sinonasal region, where it behaves more indolently than its other salivary gland carcinoma counterparts (e.g., adenoid cystic carcinoma), with local recurrence but rare metastases.

Answer
Assign code 8072/3 for HPV-associated multiphenotypic carcinoma. WHO Classification of Head and Neck Tumors, 4th edition, lists sinonasal tract HPV-related carcinoma with adenoid cystic-like features as a subtype of non-keratinizing squamous cell carcinoma (NKSCC). Use text fields to record the details.

Date Finalized
06/26/2020

20200020

References

Source 1: **2007 SEER Coding and Staging Manual**
pgs: **2, 3**
Notes: **Updated with 2008 revisions**

Question
Reportability/Brain and CNS--Pituitary: Can a clinical diagnosis of pituitary adenoma be accessioned based on imaging if treatment is not given and subsequent imaging years later shows no evidence of pituitary adenoma? See Discussion.

Discussion
The patient was clinically diagnosed with a pituitary adenoma on MRI in June 2009. The MRI noted an unusual contour involving the superior margin of the pituitary gland and the clinical interpretation was a small pituitary adenoma. The patient did not follow-up with the recommended repeat imaging and never received treatment for the pituitary adenoma.

The patient was eventually seen again in January 2020 and the MRI showed no adenoma in the pituitary gland. Since pituitary adenomas are known to spontaneously regress, should the 2009 diagnosis of pituitary adenoma be accessioned as a SEER reportable benign central nervous system (CNS) tumor?

Answer
Pituitary adenoma is reportable even if it later regresses without treatment. Use text fields to record the details of this case.

Date Finalized
06/26/2020

20200019

References
Source 1: **Hematopoietic and Lymphoid Neoplasms Manual and Database**
pgs:
Notes: **Effective with cases diagnosed 1/1/2010 and forward**

Question
Diagnostic confirmation--Heme and Lymphoid Neoplasms--Lymphoma: Is Diagnostic Confirmation "5" for Hematopoietic Neoplasms appropriate for this case? There appears to be no conclusive histologic diagnosis (Neoplasm, suggestive of lymphoma) and only the IHC/flow cytometry issued a conclusive diagnosis. See Discussion.

Discussion
10/4/2018 Frozen Section Diagnosis: Brain tissue with atypical cells and inflammatory cells, defer to permanents for further evaluation. Note: Tissue for flow cytometry is submitted. Final Diagnosis: Preliminary Diagnosis: Brain Tumor, Biopsy: Neoplasm, suggestive of lymphoma (see comment). Comment: The tumor exhibits nuclear atypia and increased mitosis. The tumor cells are immunologically positive for LCA and with very high ki67 labeling index. GFAP and synaptophysin are not expressed by tumor cells. The above suggests a lympho-proliferative process. This case is forwarded to the hematopathology service of this department for further evaluation. The final diagnosis report will be issued by the hematopathologist as an addendum.

Supp Report Add Addendum Diagnosis: The brain biopsy showed brain tissue large lymphoid cell infiltrate. Additional immunohistochemical stains are performed. The large cells are positive for CD20, BCL2, BCL6 (subset), MUM1, and CD30, negative for CD3, CD5, and CD10. Staining for c-MYC is negative. Ki-67 positive large cells are approximately 18%. EBER is strongly positive by ISH. Diagnosis: Brain lesion, biopsy: EBV+ Diffuse Large B-cell Lymphoma. Addendum Comment: The concurrent flow cytometric study showed monoclonal lambda-positive B-cells without out CD5 and CD10 expression, consistent with B-cell lymphoma.

Answer
Assign Diagnostic Confirmation as code 3, positive histology plus positive immunophenotyping. The biopsy diagnosis demonstrated EBV+ diffuse large B-cell lymphoma, with positive staining as indicated in the Hematopoietic and Lymphoid Neoplasm Database. The information received from the additional studies confirm the more specific diagnosis.

FINALIZED SEER SINQ QUESTIONS

May - September 2020

Date Finalized

05/12/2020

20200018

References
Source 1: **ICD-O-3**
pgs:
Notes:
Source 2: **WHO Class Digest System Tumors**

Question
Reportability: Is ASIN-H (high-grade anal squamous intraepithelial neoplasia) equivalent to anal intraepithelial neoplasia, III (AIN III)?

Answer
High-grade anal squamous intraepithelial neoplasia (ASIN-H) is synonymous with anal intraepithelial neoplasia, grade III (AIN III).

Date Finalized
05/12/2020

20200016

References
Source 1: **WHO Class Female Reproductive Organs**
pgs: **236-237**
Notes: **Chapter 9, Vulva**

Question
Reportability/Histology--Vulva: Is Extramammary Paget neoplasm (intraepithelial glandular neoplasm) reportable? See Discussion.

Discussion
Patient had a vulvar biopsy with final diagnosis of Extramammary Paget neoplasm (intraepithelial glandular neoplasm). No invasion identified. We are unable to contact the pathologist or physician for clarification.

Although this terminology is not listed in the ICD-O-3, web search results refer to this as a possible synonym for Paget disease with associated VIN III, which is reportable.

Answer
According to our subject matter expert, vulvar extramammary Paget neoplasm (intraepithelial glandular neoplasm) represents an in situ malignancy and should be reported.

He states "The traditional terminology should be 'extramammary Paget disease' to describe an in situ adenocarcinoma arising from extramammary glands in vulvar mucosa. I am not so sure about "extramammary Paget NEOPLASM", which may include all three Pagetoid processes: the traditional Paget disease, the Pagetoid spreading of an anal adenocarcinoma and a Pagetoid spreading of an urothelial carcinoma from the urethra. Regardless, all these entities are considered at least in situ carcinomas."

We recommend that you review clinical records and imaging for the clinical scenarios mentioned above.

Date Finalized
05/08/2020