20190094

References

Source 1: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3470531/

Question

Reportability/Heme & Lymphoid Neoplasms--Skin: Is elephantiasis nostras verrucosa (ENV) reportable as a lymphoma? See Discussion.

Discussion

The autopsy report indicated a diagnosis of: Skin: Hyperkeratosis and pseudoepitheliomatous hyperplasia as well as reactive angioendotheliomatosis indicating Elephantiasis Nostras Verrucosa.

Answer

Elephantiasis nostras verrucosa (ENV) is not reportable. ENV is a rare form of chronic lymphedema caused by any number of conditions including neoplasms, trauma, radiation treatment, congestive heart failure, obesity, hypothyroidism, chronic venous stasis, and parasitic infection.

Date Finalized

12/27/2019

20190092

References

Source 1: **2018 SEER Manual**
pgs: **171-181**
Notes: **Section VII: First Course of Therapy**

Question

First course Treatment/Lymph Nodes: When a Sentinel Lymph Node (SLN) biopsy ONLY is performed and SLNs are negative, are the SLNs included still counted in Regional Nodes (RNs) Examined and RNs Positive, or are the fields filled in: RLN Examined: 00 (No nodes examined) RLN Positive: 98 (No nodes examined) Date RLN Dissection: 00/00/0000 (No RLN dissection performed) or are the SLN included in the RLN Examined/Positive field but the Date RLN Dissection is 00/00/0000? See Discussion.

Discussion

According to the 2018 SEER Manual, Sentinel Lymph Nodes (SLNs) Examined and SLNs Positive are included in Regional Nodes (RNs) Examined and RNs Positive when both a sentinel node biopsy procedure and a subsequent dissection procedure are performed, or a sentinel node biopsy procedure is performed during the same procedure as the regional node dissection.

Answer

If a SLN biopsy is performed but no RLN dissection is performed, assign as follows.

Date of Regional Lymph Node Dissection: Leave blank as this field records the date non-sentinel regional node dissection was performed.

Date of Regional Lymph Node Dissection Flag: Assign code 11 (Not applicable: No proper value is applicable in this context (for example, no regional lymph node dissection was performed; autopsy only cases).

Regional Nodes Examined: Indicate the number of SLNs examined as this is cumulative from all procedures that remove lymph nodes through the completion of surgeries in the first course of treatment.

Regional Nodes Positive: Indicate the number of SLNs positive as this is cumulative from all procedures that remove lymph nodes through the completion of surgeries in the first course of treatment.

FINALIZED SEER SINQ QUESTIONS

August – December 2019

Date Finalized

12/27/2019

20190090

References
Source 1: **EOD 2018/SEER*RSA**
pgs:
Notes: **v1.7**
Source 2: **Summary Stage 2018**
pgs:
Notes: **v1.7**

Question
Update to current manual/Extent of Disease/Summary Stage 2018--Fallopian Tube: How are behavior, EOD Primary Tumor, and Summary Stage 2018 coded for a diagnosis of serous tubal intraepithelial carcinoma (STIC) of the fallopian tube? See Discussion.

Discussion
The 2018 ICD-O-3 Histology Updates table lists serous tubal intraepithelial carcinoma (C57.0) with a behavior code of 2.

The EOD Primary Tumor schema for Fallopian Tube shows STIC has an extension code of 100. It also maps code 100 to Summary Stage 2018 L (localized).

Summary Stage 2018 for fallopian tube only documents that intraepithelial tumors are summary stage 0 (in situ).

Answer
We are aware of the issue and have been in discussion with standard setters (SEER, NPCR, AJCC, and NAACCR). At this time, we recommend coding:

Histology: 8441/2
Extent of Disease (EOD) Primary Tumor: 000
Summary Stage: 0
AJCC Clin/Path T would be 88, since all in situ lesions are not applicable.

Edits will not allow you to have a 8441/2 with a T1. Also, EOD is not currently set up to derive the correct T value, unless you code 100.

The change to address the issue will take effect in 2021.

FINALIZED SEER SINQ QUESTIONS

August – December 2019

Date Finalized

12/20/2019

20190089

References
Source 1: **Solid Tumor Rules 2018**
pgs: **33, 36**
Notes: **Lung, July 2019 Update**

Question
Solid Tumor Rules (2018)/Histology--Lung: Rule H3 of the Solid Tumor Rules was added to capture non-small cell carcinoma modified by ambiguous terminology when the physician confirms the ambiguous term as the histologic diagnosis, also included in Coding Histology instruction 3.B. If differentiation and features are not included in the histology term, does instruction 2 takes precedence? See Discussion.

Discussion
For example, pathologic diagnosis is non-small cell carcinoma with squamous features. The medical oncologist describes this as squamous cell carcinoma and begins treatment regimen. As I interpret the rules, we would use code 8046, non-small cell carcinoma, because of instruction 2 and the fact that features is not included in the list of ambiguous terminology.

Answer
Code 8046 using Coding Instruction 2 that says to: Code the histology described as **differentiation** or **features/features of ONLY** when there is a specific ICD-O code for the "NOS with ____ features" or "NOS with ____ differentiation."

Note: Do not code differentiation or features when there is no specific ICD-O code.

In the example, no ambiguous terminology is used. If ambiguous terminology is used indicating a more specific term, you would code to the specific histology.

Date Finalized
12/20/2019

20190088

References

Source 1: **2018 SEER Manual**
pgs: **182**
Notes:
Source 2: **2018 SEER Manual**
pgs: **App C**
Notes: **Breast Surgery Codes**

Question
Surgery of Primary Site/Surgical Procedure of Other Site--Breast: When bilateral nipple/skin sparing mastectomies are performed for a single primary confined to one breast, we should code 30 for surgery and 0 for Surgery of Other Site or follow the CAnswer Forum and code 1 in Surgery of Other Site? See Discussion.

Discussion
Registrars are confused because the STORE manual dropped "involved" from the description of contralateral breast removal in the Appendix B surgical codes. In April, 2019, CAnswer Forum instructed registrars to code both the surgery with uninvolved breast to the proper code, plus code Surgery of Other Site to 1. In October, they stepped back and instructed registrars not to code Surgery of Other Site to 1 if a code for uninvolved breast removal is included in the breast surgery code. However, they insist that if the surgery code is 30, subcutaneous mastectomy, and the uninvolved contralateral breast is also removed, then continue to code Surgery of Other Site to 1. This contradicts the specific instructions for Surgery of Other Sites.

Answer
For **single** primaries only, code removal of involved contralateral breast under the data item **Surgical Procedure/Other Site** (NAACCR Item # 1294), this is, code 1, according to the 2018 SEER Manual:

Assign code 1

When the **involved** contralateral breast is removed for a **single** primary breast cancer

This would also apply when Surgery of the Primary Site code is 30 (subcutaneous mastectomy) for breast. If **uninvolved**, assign code 0 to Surgical Procedure of Other Site.

SEER registries should follow the instructions according to the SEER Manual.

Date Finalized

12/20/2019

20190086

References
Source 1: **EOD 2018 Primary Tumor**
pgs:
Notes: **Melanoma Skin in SEER*RSA v1.7**

Question
EOD 2018/Primary tumor--Melanoma: The code and level translations in the Note 4 of Extent of Disease (EOD) Primary Tumor for Melanoma Skin seem incorrect. Please advise.

- Code 000: In situ
- Code 100: Level I (should be level II) (< 0.75 mm Breslow's Depth)
- Code 200: Level II (should be level III) (0.76 mm to 1.50 mm Breslow's Depth)
- Code 300: Level III (should be level IV) (> 1.50 mm Breslow's Depth)

Answer
Please see the corrected levels below for the note. Note 4: If a Breslow's depth is given in the pathology report and there is no other indication of involvement, the following guidelines may be used (Note: If a physician documents a different Clark's Level than provided by these guidelines, go with the physician's Clark Level)

Code 000: Level I (In situ)

Code 100: Level II (< 0.75 mm Breslow's Depth)

Code 200: Level III (0.76 mm to 1.50 mm Breslow's Depth)

Code 300: Level IV (> 1.50 mm Breslow's Depth)

Thank you for bringing this to our attention.

Date Finalized
12/20/2019

20190085

References
Source 1: **NAACCR Guidelines for ICD-O-3 Update Implementation**
pgs:
Notes: **Updated 1/10/18**

Question
Primary site/Histology: Are the 2018 ICD-O Histology Update topography codes intended to specify the most common sites for these new codes and can the histology be coded if they occur in other sites? See Discussion.

Discussion
Example 1: Endometrial biopsy final diagnosis is high-grade serous adenocarcinoma. Should we code this endometrial primary with histology 8441 (serous adenocarcinoma) because C54.X topography code is not listed in the applicable 2018 ICD-O-3 codes Histology Update for the new morphology, or should we apply the new histology code 8461 (high-grade serous carcinoma)?

The NAACCR implementation guideline section 2.3 includes an important reminder that: Many of the new codes, terms, and behaviors listed in this update are site-specific and do not apply to all sites. Applicable C codes will be noted next to the term in bold font.

However, this is followed by the more ambiguous instruction for edits that appear to imply the combination with non-listed sites is possible: These site- and histology-specific combinations will not be added to the Impossible combination edit. However, if a site other than the one listed with the morphology code is assigned, the result will be an edit requiring review. This is Interfield Edit 25.

Answer
The NAACCR Guidelines for ICD-O-3 Histology Code and Behavior Update Implementation, effective January 1, 2018, state: Currently in ICD-O-3, when a topography (C code) is listed in parentheses next to the morphology term, it indicates morphology is most common to that site. It may occur in other sites as well. Many of the new codes, terms, and behaviors listed in this update are site-specific and do not apply to all sites.

Please review the Comments to determine which histology codes are specific to sites. You may use sites not listed as the suggested site; however, it will generate an edit error for review and verification of the appropriate site.

FINALIZED SEER SINQ QUESTIONS

August – December 2019

Date Finalized

12/20/2019

20190084

References
Source 1: **WHO Class Heme and Lymphoid Tissues**
pgs: **30-36**
Notes: **4th edition**
Source 2: **Bauer S, Romvari E. Interpreting molecular monitoring results and international standardization in chronic myeloid leukemia. J Adv Pract Oncol. 2012 May;3(3):151-60. PMID: 25031941; PMCID: PMC4093320.**
pgs:
Notes: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4093320/

Question
Histology/Heme & Lymphoid Neoplasms: Should the histology be coded to chronic myeloid leukemia (CML), *BCR-ABL1*-positive (9875/3) regardless of the quantitative analysis percentage of *BCR-ABL1* that was detected? See Discussion.

Discussion
Example: Bone marrow biopsy diagnosis is chronic myelogenous leukemia, chronic phase, and the RT-PCR test result proved, *BCR-ABL1* p210 (Major Breakpoint) - Detected, 3.3659%.

Even though the p210 fusion transcript was less than 5%, it was detected. The presence of *BCR-ABL1* does define whether or not patients are treated with tyrosine kinase therapies. Therefore, it seems likely that the presence of any *BCR-ABL1* would be captured using the more specific histology code 9875/3, instead of the non-specific CML, NOS histology code 9863/3.

Are there minimum threshold requirements for these quantitative studies in order to code the histology to the more specific type of CML?

Answer
Code chronic myeloid leukemia (CML) *BCR-ABL1*-positive as 9875/3.

According to the WHO Classification of Tumors of Hematopoietic and Lymphoid Tissues, 4th edition, CML BCR-ABL1-positive is characterized by the chromosomal translocation t(9;22) which results in the formation of the Philadelphia (Ph) chromosome containing the BCR-ABL1 fusion gene. The diagnosis requires detection of the Ph chromosome and/or BCR-ABL1. If the mutation is detected, regardless of percentage, it is considered positive. Quantitative levels of *BCR-ABL* are used to monitor response to tyrosine kinase inhibitor therapy.

FINALIZED SEER SINQ QUESTIONS

August – December 2019

Date Finalized

12/20/2019

20190083

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 should be reported when metastatic small cell carcinoma of the prostate is diagnosed at the same time as adenocarcinoma of the prostate? See Discussion.

Discussion
Patient has biopsy of prostate 12/28/2018 showing Gleason 5+5 adenocarcinoma. Liver biopsy on same date is metastatic small cell carcinoma consistent with prostate primary. Oncology consult states that liver biopsy is likely neuroendocrine conversion from prostate carcinoma. Patient also has bone metastasis and receives radiation, Lupron, Casodex, and chemotherapy of Carboplatin and Etopiside.

Per Solid Tumor Rules, we code histology from primary site over a metastatic site. Thus, the small cell carcinoma, which appears to be the focus of the chemotherapy is lost. Is it correct to code this as a single primary with an adenocarcinoma histology?

Both SINQ 20130221 and 20180088 instruct us to abstract multiple primaries when patient develops a metastatic small cell carcinoma of the prostate after being previously diagnosed with adenocarcinoma of the prostate.

Answer
Accession two primaries, adenocarcinoma [8140/3] of the prostate [C619] and small cell neuroendocrine carcinoma [8041/3] of the prostate [C619] per Rule M17 of the Other Sites Solid Tumor Rules 2018, as these are different histologies with different histology codes at the second number.

Adenocarcinoma of prostate often manifests as a small cell carcinoma following treatment or as a progression of disease. It is important to capture these tumors as new primaries.

Date Finalized
12/20/2019

20190082

Source 1: **EOD Data/SEER*RSA**
pgs:
Notes: **v1.7**

Question
Primary site/Histology--Peritoneum: What is the correct primary site code for peritoneal mesothelioma in a female? When I use C482, it seems that the fields are all geared towards primary peritoneal carcinoma with FIGO staging, etc.

Answer
For mesothelioma, NOS (9050) and epithelioid mesothelioma (9052) of the peritoneum for females, assign C481, C482, or C488 as appropriate based on the site of origin in the medical documentation. The Primary Peritoneal Ca schema is assigned, and you will need to complete the SSDIs for FIGO staging, CA-125 PreTx Interpretation, and Residual Tumor Volume Post Cytoreduction.

If the histology is 9051 or 9053 with primary site of C481, C482, or C488 for females, the Retroperitoneum schema is assigned. The only SSDI for this schema is Bone Invasion.

Date Finalized
12/03/2019

20190081

References
Source 1: **Subject matter experts**

Question
Race: How is race coded for a patient who self-reports as white? In the Family History portion of the genetics consult, it states the maternal family is of mixed European and Cherokee descent; the paternal side is of mixed German/mixed European descent. Is race coded as Race 1: 03-American Indian and Race 2: 01-White, or as 01-White according to self-report by the patient?

Answer
Self-reported information is the highest priority for coding race. That is because the race information for the U.S. population comes from census data and that information is self-reported. For national cancer statistics, in order for the numerator (cancer cases) and the denominator (population) to be comparable, use self-reported race information whenever it is available. We will add this clarification to the SEER manual.

Date Finalized
12/03/2019

20190080

References
Source 1: **Standard Setters agreement**

Question
Update to current manual/Surgery of Primary Site/Surgery codes--Melanoma: Can the operative report be used to assess margins if there is no residual melanoma on the wide excision and no margins stated, or if distance is not stated on the pathology report when there is residual melanoma? See Discussion.

Discussion
1) Is the operative report only used for margins when the wide excision states no residual disease and no margins are stated on path report? Or do you use the operative report too for margins when the wide excision has residual melanoma and margins are negative, but distance is not stated on path report? Does it matter if there was residual melanoma on the wide excision or not as far as using the operative report for margins?

2) Do these rules only apply to melanoma cases or do they also apply to Merkel cell?

3) Did CoC and SEER both agree on this? Are they going to send out an update because this is not how I interpret what is in the STORE manual/SEER manual under the surgery codes? It might be good to send out an official update to the surgical coding rules if this is how we are to code now.

Answer
1. You may take margin information from the operative report if it is missing from the pathology report when assigning the surgery codes for skin.

Exception: Do **not** apply this to surgery codes 45-47 where specific instructions about microscopic confirmation are included

2. The rule applies to any skin malignancy for which the skin surgery codes apply.

3. SEER, CoC, NPCR, NCRA, NAACCR, and the Canadian registries participated in this decision. SEER is publishing this SINQ question for reference.

Date Finalized
12/03/2019

20190079

References

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

Question

Reportability/Histology--Pancreas: Is mucinous cystic neoplasm of pancreas reportable?

Answer

Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with low or intermediate grade dysplasia is NOT reportable.

Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high grade dysplasia is reportable. For neoplasms of the pancreas, the term MCN with high grade dysplasia replaces the term mucinous cystadenocarcinoma, non-invasive.

Date Finalized

12/03/2019

20190078

References
Source 1: **Subject matter expert**

Question
Histology/Brain and CNS: What is the histology code for subcortical bubbly T2 hyperintense lesions in the left temporal lobe most consistent with multinodular vacuolating neuronal tumor (MVNT) from a MRI of the brain in 2018. Is the best histology code to use for this tumor 8000/1? See Discussion.

Discussion
This is additional information that I was able to find on the web.

Multinodular and vacuolating neuronal tumor (MVNT) is a newly recognized cytoarchitectural pattern in the recently revised 2016 edition of the WHO classification of CNS tumors… Although currently considered a tumor and a growth pattern of gangliocytomas (WHO grade I), it is possible that MVNTs are closer to developmental abnormalities than true tumors.

Neuronal and mixed neuronal-glial tumors
• WHO grade I
o desmoplastic infantile astrocytoma and ganglioglioma - 9412/1
o dysembryoplastic neuroepithelial tumor (DNET) - 9413/0
o dysplastic gangliocytoma of the cerebellum - (Lhermitte-Duclos) - 9493/0
o gangliocytoma - 9492/0
♣ multinodular and vacuolating neuronal tumors (MVNT) - uncertain class assignment

Answer
Gangliocytoma 9492/0 is the best option.

According to our neuropathology expert: While these tumors look like a malformation to a pathologist, the radiologists insist it grows and has mass effect.

Date Finalized
12/03/2019

20190077

References
Source 1: **Summary Stage 2018 Manual**
pgs:
Notes:
Source 2: **EOD 2018/SEER*RSA**
pgs:
Notes: https://staging.seer.cancer.gov/

Question
Summary Stage 2018/EOD 2018: How should SEER Summary Stage 2018 be coded for a 2018 thymus primary which has mediastinal fat invasion without mediastinal pleural involvement? See Discussion.

Discussion
The Extent of Disease (EOD) manual states that "Confined to thymus WITH mediastinal or pleural involvement" should be coded as regional by direct extension. I have EOD primary tumor coded as 200 and based on SEER*RSA, this is localized.

Answer
Code 200 derives Regional Extension (RE) for Summary Stage; however, based on the information you provided, thymus primary with mediastinal fat invasion without mediastinal pleural involvement, EOD Primary Tumor would be coded to 100: Confined to thymus (encapsulated tumor), which includes extension into the mediastinal fat; No mediastinal or pleura involvement. This derives "Localized" for Summary Stage. Per AJCC T1, extension into the mediastinal fat is separate from involvement of the mediastinal pleura.

For Summary Stage 2018, this would be code 1, Localized only (localized, NOS): Confined to thymus, NOS; No mediastinal or pleura involvement or UNKNOWN if involved.

We will note that "extension into the mediastinal fat" is included in code 100 for the next release (September 2020).

Date Finalized
12/03/2019

20190076

References
Source 1: **ICD-O-3**
pgs: **21**
Notes: **Rule H**

Question
Primary Site/Brain and CNS: How is primary site coded when the ICD-O-3 provides a sub-site-associated morphology code and the only information available to code primary site for a particular diagnosis indicates a non-specific/not otherwise specified (NOS) site code? See Discussion.

Discussion
ICD-O-3 Rule H states to use the topography code provided when a topographic site is not stated in the diagnosis. This topography code should be ignored if the tumor arose in another site. For the following brain and central nervous system (CNS) examples, should the suggested sub-site codes be assigned based on the histology, or should the primary sites be coded as C719 (posterior fossa or suprasellar brain) since the only information available was a tumor in these non-specific sites?

Example 1: Resection of a posterior fossa tumor proved medulloblastoma, WNT-activated. Although medulloblastoma has a site-associated code in the ICD-O-3 (C716, cerebellum), the only information available is that this was a posterior fossa tumor (C719).

Example 2: Resection of a suprasellar brain tumor proved pineoblastoma. The pathologist labeled this as a brain tumor, suprasellar. Although pineoblastoma has a site-associated code in the ICD-O-3 (C753, pineal gland), the only information available is that this was a suprasellar brain tumor (C719).

Answer
If possible, ask the physician(s) about the exact site of origin.

If it is not possible to obtain more information, the information in the medical documentation takes priority over ICD-O-3 Rule H, even when that results in a less specific topography code.

Date Finalized
12/03/2019

20190075

References
Source 1: **2018 SEER Manual**
pgs: **74**
Notes: **Sex**

Question
Sex: How should the sex field be coded for the newly allowable non-binary gender designation Gender X? See Discussion.

Discussion
Washington State added Gender X to birth certificates, which allows people to have their certificates changed to this non-binary gender designation. Gender X is defined as a gender that is not exclusively male or female, including, but not limited to: intersex, agender, amalgagender, androgynous, bigender, demigender, female-to-male, genderfluid, genderqueer, male-to-female, neutrois, nonbinary, pangender, third sex, transgender, transsexual, Two Spirit, and unspecified.

Answer
Code Gender X as 9 when that is the only information available. Use text fields to document the details.

Also refer to coding instruction #7.

When gender is not known

Assign code 1 when the primary site is C600-C639

Assign code 2 when the primary site is C510-C589

Assign code 9 for primary sites not included above

Date Finalized
12/03/2019

20190074

References
Source 1: **2018 SEER Manual**
pgs: **166**
Notes: **Scope of Regional Lymph Node Surgery**

Question
First course treatment/Scope of Reg LN Surgery--Breast: How is Scope of Regional Lymph Node Surgery coded when there is a sentinel lymph node biopsy (SLNBx) and intra-mammary nodes removed for a single primary? See Discussion.

Discussion
Example: Operative report documents a left breast skin sparing mastectomy and sentinel node biopsy procedure. Pathology report lists left axillary sentinel nodes in specimen A) with 0/2 nodes positive, and left breast mastectomy without axilla in specimen B) yielding an additional 0/2 intramammary nodes positive. Would the Scope of Regional Node Surgery be coded as 2 (SLN biopsy) to capture the intent of the sentinel node procedure only, or 6 (code 2 + 4) to capture the actual type and number of nodes removed?

SEER Coding and Staging Manual includes Scope of Regional Lymph Node Surgery instruction 4.b. which mentions assigning code 4 to intra-organ node removal. Similarly, there is instruction for coding SLN biopsy as code 2 and SLN biopsy with axillary dissection at the same time (code 6) or during separate procedures (code 7). However, it is not clear this combination code is how we should also capture an incidental intra-organ node removal.

Answer
Assign code 2, sentinel lymph node biopsy (only) as the additional nodes were discovered incidentally, rather than through a lymph node dissection. See the Note under coding instruction #8 on page 166 of the 2018 SEER manual, https://seer.cancer.gov/manuals/2018/SPCSM_2018_maindoc.pdf

When a sentinel lymph node biopsy is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional non-sentinel nodes may be discovered by the pathologist or selectively removed (or harvested) as part of the SLNBx procedure by the surgeon. Code this as a SLNBx (code **2**). Code 4 is more applicable when no SLNBx is performed.

Date Finalized
12/03/2019

20190073

References

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

Question

Solid Tumor Rules (2018)/Multiple primaries--Lung: How many primaries should be reported for a patient with a March 2018 diagnosis of non-small cell carcinoma with neuroendocrine differentiation on lung biopsy (single left upper lobe tumor only) who also has a prior history of left lung squamous cell carcinoma in 2016 (treated with chemotherapy/radiation)? See Discussion.

Discussion

The Solid Tumor Rules instruct us not to use differentiation for coding histology unless it is specifically listed in the table. The terminology non-small cell carcinoma with neuroendocrine differentiation is not in lung histology Table 2.

However, SINQ 20150033, prior to Solid Tumor rules, indicates this diagnosis should be coded to 8574 (adenocarcinoma/carcinoma with neuroendocrine differentiation).

This presentation appears to represent distinctly different histologies. However, because the 2018 histology diagnosis is not in the table and the prior SINQ appears to disagree with current instruction, it is not clear how to apply the M rules to this case. The outcome of the histology coding will affect the number of primaries reported in this case.

Answer

Abstract separate primaries according to the 2018 Lung Solid Tumor Rules. Lung Table 3 is not an exhaustive list of lung histologies and the H rules instruct you to use the tables, ICD-O and/or ICD-O updates. Per ICD-O-3, carcinoma with neuroendocrine differentiation is coded to 8574/3; whereas, squamous cell carcinoma is coded to 8070/3. These represent distinct histologies on different rows in Table 3.

Date Finalized

12/03/2019

20190072

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Lung, July 2019 Update**
Source 2: **2018 ICD-O-3 New Codes, Behaviors, and Terms-Updated 8/22/18**

Question
Solid Tumor Rules (2018)/Histology--Lung: What is the correct histology code for minimally invasive adenocarcinoma in the lung, 8140/3 or 8256/3? See Discussion.

Discussion
For example, 9/12/18 left lung upper lobe lobectomy: 1.5 cm, 0.8 cm invasive component, lepidic predominant adenocarcinoma with acinar and lepidic patterns, G2, no visceral pleural invasion, no LVI, 0/14 LNS positive. An additional minimally invasive adenocarcinoma, 1 mm, was seen away from the main tumor. The correct coding of the minimally invasive adenocarcinoma will ultimately determine if we have one tumor (using rule M7) versus two primaries (using rule M6).

Answer
Updated answer: Code minimally invasive adenocarcinoma, NOS as 8140/3. This is a new term and code in the 2018 ICD-O-3 New Codes, Behaviors, and Terms-Updated 8/22/18 list. See Solid Tumor Lung Table 3, and Solid Tumor Lung rules H1 and H10.

Date Finalized
12/03/2019

20190071

References

Source 1: **2018 SEER Manual**
pgs:
Notes: **Appendix C, Surgery Codes Rectum**

Question

First course treatment/Surgery of Primary Site--Rectum: Please provide the correct surgery code for a laparoscopic transanal abdominal transanal (TATA) procedure with bilateral salpingo-oophorectomy (BSO) for rectal cancer following neoadjuvant chemotherapy.

Discussion

IMPRESSION/PLAN: Patient is a previously healthy middle-aged woman with a diagnosis of adenocarcinoma of the rectum, clinical stage II (T3N0M0). We will proceed with a neoadjuvant course of radiation and concurrent chemotherapy (5-FU) to maximize local regional control and survival, and hopefully facilitate a sphincter-sparing resection in the future. The primary tumor and the pelvic nodes at risk will receive 4500 cGy delivered over 25 treatments. The primary tumor will subsequently receive an additional 1080 cGy delivered over 5 treatments, for a cumulative dose of 580 cGy.

PATHOLOGY: Adenocarcinoma of the rectum, clinical stage II (T3N0M0). The patient is referred by (Dr) for a neoadjuvant course of chemoradiotherapy.

HPI: Patient presented recently with rectal bleeding and a change in bowel habits. Colonoscopy revealed an ulcerated mass located 4.0 cm above the anal verge. A biopsy was positive for invasive well-differentiated adenocarcinoma that arose from a tubular adenoma. A staging work-up demonstrated no evidence of metastatic disease.

Answer

Code Surgery of Primary Site as 40, Pull through WITH sphincter preservation (colo-anal anastomosis). The TATA procedure is described as transanal abdominal transanal proctosigmoidectomy with coloanal anastomosis.

We are assuming the BSO was not related to treatment of the rectal cancer. Do not code it. You may document it in a text field.

Date Finalized

12/03/2019

20190070

References
Source 1: **WHO Class Heme and Lymphoid Tissues**
pgs: **291**
Notes: **4th edition**
Source 2: **Heme & Lymph Manual & DB**
pgs:
Notes: **Accessed 10/3/2019**

Question
Histology--Heme & Lymphoid Neoplasms: How is the histology coded for a low-grade B-cell lymphoma with plasmacytic differentiation when the pathologist notes the low-grade B-cell lymphoma raises the possibilities of extranodal marginal zone lymphoma of mucosa associated tissue (MALT lymphoma) and lymphoplasmacytic lymphoma (LPL)? See Discussion.

Discussion
Rule PH28 confirms the more specific histologies are ignored if this is truly a low-grade B-cell lymphoma (i.e., non-Hodgkin lymphoma, NOS) since both MALT lymphoma and LPL are more specific types of low-grade B-cell lymphomas. This leaves only a diagnosis of low-grade B-cell lymphoma with plasmacytic differentiation to consider.

SINQ 20130033 states a low-grade B-cell lymphoma with plasmacytic differentiation should be coded as 9680/3 (diffuse large B-cell lymphoma (DLBCL)). However, DLBCL is a high grade B-cell lymphoma, not a low grade B-cell lymphoma.

If the pathologist classifies this as a non-specific low grade B-cell lymphoma, and clarifies that this may represent a more specific type of low grade B-cell lymphoma (MALT lymphoma or LPL), should the histology be coded to a high-grade lymphoma (DLBCL) or non-Hodgkin lymphoma, NOS?

Answer
Code low grade B-cell lymphoma with plasmacytic differentiation as 9591/3 (Non-Hodgkin lymphoma, NOS). Plasmacytic differentiation is commonly seen with B-cell neoplasms. If further information identifies a more specific histology, the abstract can be updated to reflect the more specific histology.

In the latest WHO Classification of Tumors of Hematopoietic and Lymphoid Tissues, 4th ed., there is confirmation that DLBCL is a high-grade B-cell neoplasm. We will update the SINQ question.

FINALIZED SEER SINQ QUESTIONS

August – December 2019

Date Finalized

11/13/2019

20190068

References
Source 1: **2018 SEER Manual**
pgs: **165-168**

Question
First course treatment/Scope of Reg LN Surgery--Breast: How is Scope of Regional Lymph Node Surgery coded when the operative report does not agree with the actual number and type of nodes removed? Are we attempting to capture the intended surgery, or the type and number of nodes removed? See Discussion.

Discussion
Example 1: Operative report states the surgery is a right breast simple mastectomy. There is no lymph node removal documented or attempted; however, a single incidental intramammary node is found in the final pathology results. How should these nodes be captured in the Scope of Regional Lymph Node Surgery field?
CAnswer Forum states to code Scope of Regional Lymph Node Surgery as 0 (No regional lymph nodes removed), see Scope LN surgery, incidental LN found on path, Breast.
However, SEER Program Coding and Staging Manual 2018 instruction states: Code the removal of intra-organ lymph nodes in Scope of Regional Lymph Node Surgery. Example: Local excision of breast cancer. Specimen includes an intra-mammary lymph node. Assign code 4 (1 to 3 regional lymph nodes removed).
The STORE 2018 Manual does not provide instruction for incidental nodes specifically but does appear to be focused on capturing procedural intent.

Example 2: Patient has bilateral breast primaries. Operative report states the surgery is bilateral simple/skin-sparing mastectomies with bilateral sentinel node biopsies and immediate reconstruction. However, pathology shows that the left breast specimens are labeled: (a) Left breast mastectomy, (b) Left sentinel lymph node biopsy, (c) Additional left lymph nodes biopsy, and (d) Left axillary contents biopsy. The total nodes removed for this case are: 2/2 positive SLN, 0/1 positive intramammary nodes, 1/1 positive additional lymph node, and 3/3 positive axillary contents nodes. How should these nodes be captured in the Scope of Regional Lymph Node Surgery field?

Answer
Assign the best code in Scope of Regional Lymph Node Surgery to capture the type and number of nodes removed.

Example 1: Code 4; 1 to 3 regional lymph nodes removed. There is no statement of the procedure being a SLNBx or dissection in the operative report; the pathology report identified one incidental regional lymph node. Coding instruction #4 example says to assign code 4 if there is a local excision of breast cancer and specimen includes an intra-mammary lymph node.

Example 2: Code 6, Sentinel node biopsy and code 3, 4, or 5 at same time or timing not noted. The operative report describes sentinel node biopsies only and does not mention axillary lymph node dissection; however, the pathology report details other lymph nodes in addition to the SLNBx. In addition to the SLNBx and left LN bx, the pathology report describes "Left axillary contents biopsy" and a total of seven lymph nodes removed.

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11/13/2019

20190067

References
Source 1: **2018 SEER Manual**
pgs: **12**
Notes: **#1.b.ii**
Source 2: **2018 Solid Tumor Rules**
pgs: **35**
Notes: **Breast, July 2019 Update**

Question
Reportability/Histology--Breast: Is a breast mastectomy showing mildly atypical cells within the nipple epidermis which are suspicious for early Paget disease of the nipple a reportable malignancy? See Discussion.

Discussion
Example: Left breast total mastectomy final diagnosis is incidental microscopic findings suspicious for early Paget disease of the nipple. The diagnosis comment states: The left breast mastectomy shows mildly atypical cells within the nipple epidermis which are suspicious for early Paget disease of the nipple. Additional sampling of the left breast was performed, and no evidence of atypical hyperplasia, in situ carcinoma, or invasive carcinoma within the left breast tissue was identified.

Would this case be non-reportable using rationale similar to an early/evolving melanoma per SINQ 20180029?

Answer
Code as 8540/3, Paget disease, based on the use of reportable ambiguous terminology (suspicious) listed in the 2018 SEER Coding Manual. In addition, Rule H8 of the 2018 Breast Solid Tumor Rules says to code Paget disease (8540/3) when the diagnosis is exactly Paget disease when a new tumor with no underlying tumor and the pathology documents invasive or unknown behavior.

When two ambiguous terms are used and one is on the reportable list (suspicious) and one is not (early), accept the reportable term and report the case. See #1.b.ii on page 12 in the SEER manual, https://seer.cancer.gov/manuals/2018/SPCSM_2018_maindoc.pdf

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11/13/2019

20190066

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

Question
Solid Tumor Rules (2018)/Histology--Breast: How is the histology coded for a metastatic carcinoma, consistent with primary breast carcinoma, when no other pathology information is available? See Discussion.

Discussion
The 2018 Breast Solid Tumor Rules Equivalent Terms and Definitions - Changes from 2007 Multiple Primaries/Histology Rules states: Mammary carcinoma is a synonym for carcinoma no special type (NST)/duct carcinoma not otherwise specified (NOS) 8500. It will no longer be coded as carcinoma NOS 8010. Should metastatic carcinomas of breast origin be 8500, or is code 8010 (carcinoma NOS) more applicable because histology coding from metastatic sites is not as reliable?

Answer
Code as 8500/3 as it is the only tissue available for this carcinoma associated with a breast primary. Breast carcinoma NST/NOS is now coded as 8500.

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11/13/2019

20190065

References
Source 1:
pgs:

Question
Update to current manual/EOD 2018/Summary Stage 2018--CLL/SLL: Can chronic lymphocytic leukemia (CLL) be staged when diagnosed by peripheral blood and no bone marrow biopsy, and observation is employed? See Discussion.

Discussion
The physicians do not use the Lugano system as we are instructed to stage chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) as lymphomas. I had always been instructed that this qualifies as "bone marrow involvement," or "diffuse disease," and therefore is a Stage IV. Our experts advise that there is not enough information to code it to bone marrow, but do not elaborate as to whether you can actually code Extent of Disease (EOD), SEER Summary Stage, and AJCC Staging?

Answer
For EOD and Summary Stage: Peripheral blood involvement for CLL (or any lymphoma-but most commonly for CLL) can be coded. This is code 800 for 2018 EOD Primary Tumor, and code 7 for Summary Stage 2018. We have recently received confirmation that peripheral blood involvement only is not enough information to assign AJCC stage; assign code 99 for AJCC Stage Group. We will correct in the 2021 release of EOD so that peripheral blood involvement only will have its own code to derive the appropriate AJCC TNM Stage Group (99).

Date Finalized
09/20/2019

20190064

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

Question
Multiple Primaries--Heme & Lymphoid Neoplasms: Patient is diagnosed with myelodysplastic syndrome (MDS) with an early/evolving acute myeloid leukemia (AML) thought to be treatment related. Does rule M11 apply since there are two biopsies within 21 days, and therefore, two primaries, or one primary (9920/3)? See Discussion.

Discussion
Patient has a history of breast cancer and diffuse large B-cell lymphoma (DLBCL), both treated with chemotherapy and radiation.

On 6/26/19, bone marrow biopsy: MDS with excess blasts-2 (18% dysplastic blasts) in a normocellular marrow (overall 40% cellularity) with trilineage dysplasia. Comment: least myelodysplastic syndrome with excess blasts-2. However, an early/evolving AML cannot be completely excluded. The findings likely represent therapy-related myeloid neoplasm.

MD note on 7/15/19: Diagnosis: MDS, high grade borderline AML with complex karyotype secondary disease. Patient has high grade MDS which is bordering on AML transformation with 20% blasts by IHC and areas higher than this. This is likely secondary to the treatment she has received for her other cancers particularly pelvic radiation for her DLBCL. Given her very high IPSS score, it is likely she will eventually develop AML. No treatment given.

On 7/15/19, bone marrow biopsy: Persistent acute leukemia in a marrow with trilineage dyspoiesis and 23% blasts.

Answer
Code as one primary (9920/3). This case does not fit the rules very well, since it is a treatment-related neoplasm and involves a transformation of MDS to AML during the clinical workup. Per the abstractor notes for 9920/3, code 9920/3 when the physician comments that the neoplasm is treatment related. This can be for the MDS or the AML. Use text fields to document that it was first referred to as MDS and then transformed to AML. If you followed the rules strictly and coded this as two primaries (the MDS and AML), you would lose the information that this was treatment related, which is more important.

FINALIZED SEER SINQ QUESTIONS

August – December 2019

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20190063

References
Source 1: **WHO Class Soft Tissue & Bone**
pgs: **236-237**
Notes: **4th Edition**

Question
Solid Tumor Rules (2018)/Histology--Sarcoma: How is histology coded for a CIC gene rearrangement sarcoma? See Discussion.

Discussion
According to the literature, CIC gene rearrangement sarcomas in young patients are soft tissue sarcomas with an aggressive clinical course and may have previously been grouped under the Ewing-like family of tumors or as undifferentiated round cell sarcomas. There is currently no guideline in the solid tumor rules for coding a CIC gene rearrangement sarcoma. However, coding the histology to 8800 (sarcoma, NOS) seems unlikely to capture the more aggressive nature of these tumors. Can a more specific histology be coded?

Answer
Code as undifferentiated round cell sarcoma (8803/3).

The CIC rearrangement exists as a distinct molecular and clinical subset of small round cell tumors, and though similar, is felt to be a distinct entity from Ewing sarcoma. According to WHO Classification of Soft Tissues and Bone, 4th Edition, CID-DUX4 is a recurrent gene fusion associated with pediatric round cell undifferentiated soft tissue sarcoma (USTS). Although the genes involved in the fusion are different from those in Ewing sarcoma, the CIC-DUX4 protein has been shown to upregulate genes of the ETS family of genes thus providing a molecular link between Ewing sarcoma and round cell USTS. In contrast, there are strong arguments to suggest that Ewing-like sarcomas represent a separate and distinct entity.

Date Finalized
09/20/2019

20190062

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Malignant CNS, July 2019 Update**
Source 2: **ICD-O-3**

Question
Solid Tumor Rules (2018)/Histology--Brain: How is histology coded for a left frontal lobe mass when the final diagnosis is malignant neuroglial tumor and the diagnosis comment describes multiple possible histologies? See Discussion.

Discussion
Left frontal mass biopsy diagnosis comment states: Given the synaptophysin and patchy CD34 staining of these cells, the possibility of ganglioglioma and pleomorphic xanthoastrocytoma is raised. Astroblastoma and ependymoma were considered given the perivascular pseudorosettes, however GFAP staining is quite limited against these tumors. Reticulin stain shows limited perivascular reticulin staining however. Nevertheless, the necrosis, mitotic activity and elevated mitotic activity would point to a malignant neoplasm. Given the neural and limited GFAP staining, a generic classification of neuroglial is provided. This is the only available information. Further clarification or discussion with the physician or pathologist is not possible. Therefore, is this diagnosis of neuroglial tumor equivalent to that described in SINQ 20091037?

Answer
Code to 8000/3. Use text fields to record the details.

The WHO Revised 4th Ed CNS Tumors includes a chapter for "Neuronal and mixed neuronal-glial tumors. This chapter lists 13 histologies in this category. Glioneuronal NOS is not listed. Do not assign 9505 because ambiguous terminology was used AND because of the numerous possible histologies discussed for this diagnosis.

Date Finalized
09/04/2019

20190061

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

Question
Solid Tumor Rules (2018)/Multiple primaries--Breast: How many primaries should be reported for a diagnosis of ductal carcinoma in situ (DCIS) on core biopsy of the right breast in 2016 with all treatment refused, followed by a 2019 large right breast mass ulcerating the skin and clinical diagnosis of invasive breast cancer (patient again refused all treatment)? See Discussion.

Discussion
The patient was never treated for the 2016 diagnosis, so the 2019 diagnosis is the same tumor that has progressed. Prior SINQ 20091096 for a similar case type cited multiple primaries per the 2007 Multiple Primaries/Histology Rules, Rule M8, the same rule as the current Solid Tumor rule M17, because this is to be reported as an incidence case. However, it seems like Solid Tumor Rule M3 would apply because a single tumor is a single primary, and behavior of the 2016 primary would then be updated from /2 to /3. It is unclear how one would advance to the Multiple Tumors module and apply M17 because there is really only a single tumor in this case.

Answer
Since the first diagnosis is in situ, and the later diagnosis is invasive, the 2019 diagnosis is a new primary even though it may be the same non-treated tumor.

For cases diagnosed 2018 and later, abstract multiple primaries according to the 2018 Breast Solid Tumor Rules, Rule M17 that states

Abstract multiple primaries **when an invasive tumor occurs more than 60 days after an in situ tumor** in the same breast.

Note 1: The rules are hierarchical. Only use this rule when none of the previous rules apply.

Note 2: Abstract both the invasive and in situ tumors.

Note 3: Abstract as multiple primaries even if physician states the invasive tumor is disease recurrence or progression.

Note 4: This rule is based on long-term epidemiologic studies of recurrence intervals. The specialty medical experts (SMEs) reviewed and approved these rules. Many of the SMEs were also authors, co-authors, or editors of the AJCC Staging Manual.

Date Finalized
09/27/2019

20190059

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Lung, July 2019 update**
Source 2: **WHO Class Lung Tumors**
pgs: **48**
Notes: **4th edition**

Question
Solid Tumor Rules/Histology--Lung: What is the histology code and what H Rule applies for a diagnosis of well differentiated adenocarcinoma in situ (bronchioloalveolar carcinoma)?

Discussion
There is no statement of mucinous or non-mucinous in this case, only adenocarcinoma in situ and an obsolete term bronchioloalveolar carcinoma (BAC) which used to be code 8250. However, 8250 is now lepidic adenocarcinoma, and does not match this diagnosis.

Although the Histology Rules do include a general note indicating that the preferred term for BAC is now mucinous adenocarcinoma 8253, it is not listed as a synonym in Table 3. As a result it is unclear how to apply this statement in accordance with the H rules.

The ICD-O Histology Updates table also includes Bronchioloalveolar carcinoma, non-mucinous which seems to suggest that in order to apply histology code 8252 (non-mucinous) or 8253 (mucinous) one must also have a statement of mucinous or non-mucinous.

Answer
Code adenocarcinoma in situ as 8140/2 using the 2018 Lung Solid Tumor Rules, Rule H4 as this single histology is listed as a synonym for adenocarcinoma (8140) in Table 3. Bronchiolalveolar carcinoma, a synonym for adenocarcinoma in situ, is an obsolete term according to WHO Classification of Tumors of the Lung, Pleura, Thymus and Heart, 4th edition; however, some pathologists add in the no longer preferred term to the diagnosis. When stated as non-mucinous adenocarcinoma in situ, code as 8250/2 for lung only (Rule H2) and mucinous adenocarcinoma in situ as 8253/2 (Rule H1).

Note: WHO published a corrected 4th Ed Lung blue book fixing the 8410 error.

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09/04/2019

20190058

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Other Sites, Updated 9/11/2018**
Source 2: **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3764746/**

Question
Solid Tumor Rules (2018)/Histology--Cervix Uteri: What is the histology code and what H Rule applies for a diagnosis of papillary squamotransitional cell carcinoma of the cervix? See Discussion.

Discussion
It appears that the first Other Sites applicable rule is H16 (and Table 2) instructing the use of histology code 8323 (mixed cell adenocarcinoma). However, this really is not an adenocarcinoma tumor but is a mixed squamous and transitional cell carcinoma. The 2018 ICD-O-3 Histology Update Table provides a new term for a squamotransitional cell carcinoma (C53_) but does not indicate whether that new term would also include a papillary squamotransitional cell carcinoma of the cervix.

Answer
Code papillary squamotransitional cell carcinoma (PSCC) as 8120/3 using the 2018 Other Sites Solid Tumor Rules, Rule H11. PSCC is a distinctive subcategory of squamous cell carcinoma of the uterine cervix. WHO Classification of Tumors of Female Reproductive Organs say that squamotransitional cell tumors show papillary architecture with fibrovascular cores lines by multilayered atypical epithelium.

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20190057

References
Source 1: **WHO Class Male Genital Tumors**
pgs: **277**
Notes: **4th edition**
Source 2: **2018 SEER Manual**
pgs: **E.1.2**
Notes: **Appendix E**

Question
Reportability/Histology--Penis: Are high grade penile intraepithelial lesion and high grade penile intraepithelial neoplasia (PeIN) equivalent to PeIN3 and thus reportable? See Discussion.

Discussion
Appendix E1 of the 2018 SEER manual references a similar diagnosis as being reportable for vulva and vagina only. However, the WHO Classification of Tumors of the Urinary System and Male Genital Organs (4th ed) does include high grade penile intraepithelial neoplasia as a synonym for 8077/2.

Answer
Penile intraepithelial neoplasia, grade III (PeIN III) and squamous cell carcinoma in situ of the penis are reportable. If possible, query the physicians as to whether "high grade penile intraepithelial lesion" or high grade penile intraepithelial neoplasia are synonymous with one of the reportable terms. If no further information can be obtained, report the case as C609 8077/2, and use text fields to document the details.

Date Finalized
09/04/2019

20190056

References
Source 1: **ICD-O-3**
pgs:
Notes:
Source 2: **WHO Class Breast Tumors**
pgs:
Notes: **4th Edition**

Question
Behavior--Breast: What is the behavior of a solid papillary carcinoma when a pathologist does not indicate it in the pathology report and follow-up with the pathologist to obtain clarification regarding the behavior is not possible? See Discussion.

Discussion
Example: Mastectomy specimen final diagnosis shows two foci of invasive ductal carcinoma including: Invasive ductal carcinoma, no special type, in association with solid papillary carcinoma (tumor #1, 1 cm, slices 6 and 7) and invasive ductal carcinoma, no special type (tumor #2, 1.2 cm, slices 9 and 10).

Summary Staging outlines, Tumor #1: Histologic Type: Invasive ductal carcinoma, no special type, in association with solid papillary carcinoma. As well as, Tumor #2: Histologic type: Invasive ductal carcinoma, no special type. Additional findings include ductal carcinoma in situ (DCIS): presently approximately 3.3 cm, spanning slices 10-13.

The behavior of the solid papillary carcinoma component will affect the provisional histology of the first tumor (8523/3) per Rule H17 vs. 8500/3 per Rule H7). Based on the response, we can determine whether this represents a single or multiple primaries (single primary per M13 vs. multiple primaries per M14).

Answer
Review all sections of the pathology report carefully for any mention of invasion, or lack of invasion, pertaining to the solid papillary carcinoma.

Per WHO 4th Ed Breast: If there is uncertainty that there is invasion, these lesions should be regarded as in situ. The distinction between in situ and invasive disease in solid papillary carcinoma is difficult.

FINALIZED SEER SINQ QUESTIONS

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20190054

References
Source 1: **WHO Class CNS Tumors**
pgs:
Notes: **4th ed., Chapter 17**
Source 2: **2018 Solid Tumor Rules**
pgs: **23**
Notes: **Non-malignant CNS, January 2019 Update**

Question
Update to current manual/Solid Tumor Rules (2018)/Histology--Brain and CNS: Table 6 (Non-Malignant CNS Equivalent Terms and Definitions) lists Adenomatous craniopharyngioma 9351/1 as a subtype/variant of craniopharyngioma 9350/1. This is not a valid histology per the ICD-O-3 or the 2018 ICD-O-3 Update Table. Is this actually supposed to read, Adamantinomatous craniopharyngioma 9351/1?

Answer
Adamantinomatous craniopharyngioma (9351/1) is a subtype of craniopharygioma. We will correct the Non-Malignant CNS Solid Tumor Rules in the next update.

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08/29/2019

20190053

References
Source 1: **2018 Solid Tumor Rules**
pgs: **19**
Notes: **Malignant CNS, January 2019 update**
Source 2: **WHO Class CNS Tumors**
pgs: **259-260**
Notes: **4th edition**

Question
Solid Tumor Rules (2018)/Histology--Brain and CNS: What is the histology code for a central nervous system (CNS) Ewing sarcoma family tumor with *CIC* alteration of the right parietal lobe? See Discussion.

Discussion
Table 3 (Specific Histologies, NOS, and Subtypes/Variants) lists Ewing sarcoma as a synonym for Peripheral primitive neuroectodermal tumor 9364. Presumably, this is to be used for the reportable malignant peripheral nerve tumors when diagnosed as pPNET or Ewing sarcoma. However, this patient has a type of central (or CNS) primitive neuroectodermal tumor (histology 9473). Table 3 does not list central primitive neuroectodermal tumor (PNET or CPNET) as a valid histology for CNS tumors.

While Table 3 does not list all the possible histologies for the CNS, it currently is not clear how one would arrive at the histology code for a CNS Ewing sarcoma family tumor with CIC alteration, as this is recognized as a new entity for primitive neuroectodermal tumors of the CNS (i.e., PNET, histology 9473) per multiple journal articles. Ewing sarcoma family tumors include both peripheral PNET and central PNET tumors, but to code this histology as a peripheral PNET (9364) in this case seems incorrect when the primary tumor is stated to be of central nervous system origin, not peripheral nervous system origin.

Answer
Code as 9364/3. WHO Classification of Tumors of the CNS, 4th edition, refers to Ewing sarcoma/peripheral primitive neuroectodermal tumor as a tumor of neuroectodermal origin involving the CNS either as a primary dural neoplasm or by direct extension from contiguous bone or soft tissues (such as skull, vertebra, or paraspinal soft tissue).

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09/04/2019

20190052

References
Source 1: **2018 Solid Tumor Rules**
pgs: **38**
Notes: **Head and Neck, January 2019 update**
Source 2: **WHO Class H & N Tumors**
pgs: **14-17**

Question
Solid Tumor Rules (2018)/Multiple Primaries--Head & Neck: How many primaries are accessioned when a patient is diagnosed with right nasal cavity (C300) invasive nonkeratinizing squamous cell carcinoma (8072/3) in 2015 treated with radiation and excision, followed by a 2019 right nasal cavity (C300) invasive squamous cell carcinoma (NOS, 8070/3)? See Discussion.

Discussion
Head and Neck Multiple Primary Rule M8 appears to be the first rule that applies to this case and instructs the user to abstract multiple primaries when separate/non-contiguous tumors are on different rows in the appropriate site table (Tables 1-9) in the Equivalent Terms and Definitions. Table 1 (tumors of the nasal cavity) shows Non-keratinizing squamous cell carcinoma and squamous cell carcinoma on different rows making the 2019 case a new primary. Is this correct?

Answer
Abstract two primaries using Head and Neck Solid Tumor Rule M8 when separate/non-contiguous tumors are on different rows in the appropriate site table, in this case, Table 1 Nasal Cavity and Paranasal Sinuses.

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20190051

References
Source 1: **2018 Solid Tumor Rules**
pgs: **32**
Notes: **Lung, January 2019 update**
Source 2: **Subject Matter Expert**

Question
Update to current manual/Solid Tumor Rules (2018)/Histology--Lung: What is the histology code and what M Rule applies when there are multiple specific subtypes identified using various equivalent lung terms but only one is stated to be predominant? See Discussion.

Discussion
Example: Lung resection final diagnosis is Lung adenocarcinoma, see Summary Cancer Data, and the Summary Cancer Data (CAP Synoptic Report) states Histologic type: Invasive adenocarcinoma, solid predominant. Other Subtypes Present: 20% acinar and <5% micropapillary components.

Instruction 1B and Note 1 for Coding Multiple Histologies (Lung Histology Rules) indicates type, subtype, component, and predominantly are all terms that may be used to code the most specific histology. In this case, the multiple specific histologies were documented using all of those terms.

Note 2 for instruction 1B states predominantly describes the greatest amount of tumor and when it is used for the listed subtypes of adenocarcinoma, that subtype should be coded. However, Note 2 does not indicate that the other subtypes are ignored when one is identified to be predominant and the others are identified as subtype or component only.

Answer
Code to invasive adenocarcinoma, solid predominant (8230/3), based on the example, using Lung Solid Tumor Rules Coding Multiple Histologies instruction #1 that says to code the specific histology where the most specific histology may be described as component, majority/majority of, or predominantly, in this case, 75%. Apply Rule M2 as this appears to be a single tumor with multiple histologies based on the information provided.

The rules will be updated to add a new H rule and to revise Table 2 when two or more histologies described as predominant are present.

FINALIZED SEER SINQ QUESTIONS

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20190050

References
Source 1: **2018 SEER Manual**
pgs:
Notes: **Appendix C: Melanoma Coding Guidelines**

Question
Reportability/Melanoma: Is evolving melanoma reportable with a Clark's level and Breslow's thickness are cited in the pathology report? See Discussion.

Discussion
We realize evolving melanoma is not reportable. However, how do we interpret the reportability of the following: The histological and immunohistochemical findings are most consistent with an early-evolving malignant melanoma, superficial spreading type, with Clark's level II and maximal Breslow thickness 0.33 mm, arising in association with an atypical nevus. Since a Clark's level and Breslow's thickness are included, is this reportable? Is this really an evolving melanoma?

Answer
Do not report melanoma when described as early or evolving, regardless of dimension, per the Appendix C Melanoma Coding Guidelines in the 2018 SEER Coding Manual that states: As of cases diagnosed January 1, 2018, early or evolving melanoma of any type is not reportable. This includes both invasive and in situ melanomas; early or evolving are not reportable.

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