20250015

References:
#1: Solid Tumor Rules. Non-Malignant CNS, 2025 Update
#2: WHO Class CNS Tumors, 301-305. Solitary fibrous tumor

Question:
Solid Tumor Rules/Behavior--Brain and CNS: Why was the Behavior of solitary fibrous tumor (SFT)/hemangiopericytoma, WHO Grade 1 changed from /0 to /1 in the 2025 Solid Tumor Rules (STR) updates? See Discussion.

Discussion:
In previous STR versions and the ICD-O-3.2, SFT/hemangiopericytoma, WHO G1 is 8815/0 and only SFT/hemangiopericytoma, WHO G2 was 8815/1. However, Table 6 (Non-Malignant CNS, Specific Histologies, NOS, and Subtypes/Variants) was changed in the 2025 updates to indicate both G1 and G2 SFT/hemangiopericytoma are 8815/1.

No date range was provided for this change in the STR and the behavior of this tumor was not updated by the standard setters in other references (i.e., ICD-O-3.2). The behavior of G1 SFT/hemangiopericytoma was not updated in the 2025 ICD-O-3.2 updates. If the ICD-O-3.2 was the source of this change, should this have been documented in the 2025 NAACCR Implementation Guidelines? However, the 2025 NAACCR Implementation Guidelines indicates, "There are no ICD-O-3 changes for 2025." Is this behavior change in 2025 Solid Tumor Rules updates an error? Should the behavior of SFT/hemangiopericytoma, WHO G1 remain /0?

Answer:
For cases diagnosed 2025 and later: Assign behavior /1 for solitary fibrous tumor unless stated to be malignant.

A review by the Cancer PathCHART expert neuropathologists found behavior code /0 is incorrect and both solitary fibrous tumor grade 1 and grade 2 are coded as 8815/1. WHO Classification of Central Nervous System Tumors, 5th edition, assigns behavior as /1 and no longer recommends terms solitary fibrous tumor/hemagiopericytoma and hemagiopericytoma. The STR table is correct. Future updates to ICD-O should reflect this behavior.

WHO Classification of Tumours, Central Nervous System Tumours, 5th ed. was reviewed by the CPC expert pathologists for implementation for cases diagnosed January 1, 2025.

Reminder: Comparing the CPC Validity Status included in the 2024 CPC*Search to that included in the 2025 SMVL (that table that drives the edits) is incorrect. CNS Tumors were

not reviewed for 2024 implementation, they were reviewed for 2025 implementation. There will be a 2025 CPC*Search and a /1 will be designated as a Valid.

Date Last Modified:
04/25/2025

20250014

References:
#1: 2025 SEER Manual, 80-86; 88-90. Race data items; Spanish Surname or Origin

#2: 2025 SEER Manual. Appendix D. Race and Nationality Descriptions

Question:
Race/Spanish Surname or Origin: How are Race 1 and Spanish Surname or Origin coded for the following race/ethnicity statements: "INDIGENOUS-LATINO/A OR INDIGENOUS-LATINX" and "FIRST NATIONS"? See Discussion.

Discussion:
One of the largest hospital systems in our area includes "INDIGENOUS-LATINO/A OR INDIGENOUS-LATINX" and "FIRST NATIONS" as dropdown items for patients to self-select for race/ethnicity. This hospital system serves 51 hospitals and 1,000 clinics across Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington. If "INDIGENOUS-LATINO/A OR INDIGENOUS-LATINX" is the only item selected with no additional text info available, how should Race 1 and Spanish Surname or Origin be coded? If "FIRST NATIONS" is the only item selected without additional text info available, should Race 1 be coded as 03?

Answer:
Assign code 01 (White) for Race 1 when described as Indigenous-Latino/a or Indigenous-Latinx. Indigenous-Latinx is an umbrella term for Indigenous migrants to the United States from Latin America including South and Central America, the Caribbean, and Mexico (for example, Maya, Mixteco, Purépecha, Taino, Zapotec, etc.). Latin America is listed in Appendix D of the 2025 SEER Manual as White.

Assign code 6 (Spanish, NOS; Hispanic, NOS; Latino, NOS) for Spanish Surname or Origin for Indigenous-Latino/a or Indigenous-Latinx in the absence of more specific information. Code 6 description includes the statement, There is evidence, other than surname or birth surname (maiden name), that the person is Hispanic, but he/she cannot be assigned to any of the categories 1-5.

Assign code 03 (American Indian or Alaska Native) when described as First Nations. First Nations usually refers to Indigenous peoples for ethnic groups who are the original or earliest known inhabitants of an area. The term ‘First Nations’ can be applied to individuals but technically refers only to those who have Indian status under Canadian law as part of a recognized community. Within Canada, the term First Nations is generally used for Indigenous peoples other than Inuit and Métis. Outside Canada, the term can refer to Indigenous Australians, U.S. tribes within the Pacific Northwest, as well as supporters of the Cascadian independence movement.

FINALIZED SEER SINQ QUESTIONS

January - April 2025

Date Last Modified:

04/25/2025

20250013

References:
#1: WHO Class Urinary and Male Genital Tumors, 244-249; 284-285. 5th edition
#2: Solid Tumor Rules. Other Sites, December 2024 Update

Question:
Solid Tumor Rules/Multiple Primaries--Testis: How many primaries and what M Rule applies when metastatic seminoma is diagnosed greater than 40 years after a left testicular teratoma with yolk sac tumor and embryonal carcinoma? See Discussion.

Discussion:
The patient was diagnosed with a left testis primary in the early 1980s that did not include a seminoma component per the information available. The slides were not available for review. In 2024, the patient was found to have a metastatic seminoma involving multiple pelvic lymph nodes and the prostate. The right testicular ultrasound was negative. The managing physician noted this was both a "relapsed seminoma" and a "Stage IIC seminoma."

Should the new diagnosis of metastatic seminoma be accessioned as a new primary based on the histology differences? Or is this situation similar to SINQ 20160073 in which this is a single primary even though the metastases are a distinctly different histology?

Answer:
Without evidence of a new testicular tumor, record this as a single primary now with metastatic disease (seminoma). The seminoma may not have been identified in the original tumor and treatment was based on the histologies found. This allowed the seminoma to metastasize.

Date Last Modified:
04/25/2025

20250012

References:
#1: WHO Class Thoracic Tumors, online. 5th edition
#2: Solid Tumor Rules. Lung, Dec 2024 Update

Question:
Solid Tumor Rules/Histology--Lung: How is histology coded, and which H Rule applies for a lung adenocarcinoma when the greatest percentage of the adenocarcinoma is stated to be, "solid; complex glands (cribriform and fused glands) (50%)"? See Discussion.

Discussion:
In 01/2023, right lower lobectomy final diagnosis proved a single adenocarcinoma tumor with the histological patterns described as acinar (20%), papillary (30%) and solid; complex glands (cribriform and fused glands) (50%). There is no H Rule applicable to a complex glandular pattern adenocarcinoma. Is this equivalent to a solid predominant adenocarcinoma (8230) per Rule H7? Or is the predominant adenocarcinoma a mixed subtype coded as 8255 per Rule H9?

Answer:
Histology code 8255/3 best identifies this histology. Complex glands in lung tumors are often associated with a poor prognosis and represent a high-grade pattern in lung cancer grading systems. This histology is not currently recognized as a variant by WHO.

Date Last Modified:
04/25/2025

20250011

References:

#1: American College of Radiology LI-RADS Manual. https://www.acr.org/Clinical-Resources/Clinical-Tools-and-Reference/Reporting-and-Data-Systems/LI-RADS

#2: American College of Radiology LI-RADS Manual. https://edge.sitecorecloud.io/americancoldf5f-acrorgf92a-productioncb02-3650/media/ACR/Files/RADS/LI-RADS/LI-RADS-CT-MRI-2018-Core.pdf

Question:

Reportability--Liver: Is a 2023 cholangiocarcinoma case with Liver Imaging Reporting and Data System (LI-RADS) M (LR-M) lesion on imaging reportable?

Discussion:

Answer:

Report LR-M unless there is information to the contrary. The American College of Radiology defines LR-M as "probably or definitely malignant, not necessarily hepatocellular carcinoma (HCC)."

Date Last Modified:

03/11/2025

20250010

References:
#1: 2025 SEER Manual, 229-231. Immunotherapy
#2: 2025 SEER Manual, 249-251. Other Therapy

Question:
Immunotherapy/Other Therapy--Heme & Lymphoid Neoplasms: Is the elimination of immunosuppression treatment coded as other treatment? An example is when a post-transplant patient develops a malignant myeloproliferative neoplasm that subsides when immunosuppression drugs are stopped.

Answer:
Do not code as a treatment. Record the cessation of immunosuppressive drug treatment in text to explain the patient's change in disease status.

Date Last Modified:
03/11/2025

20250009

References:
2025 SEER Manual, 105-107. Sequence Number—Central

Question:
Sequence Number--Central/Reportability--Heme & Lymphoid Neoplasms: Is a hematolymphoid disease included in the sequencing if it was not reportable at the time of diagnosis?

Answer:
Do not include the disease in the sequencing if the original hematolymphoid disease was not reportable at time of diagnosis.

The 2025 SEER Manual *Sequence Number--Central* Coding Instruction 1.a advises: A 'reportable' primary refers to the site/histology/behavior of the tumor and the years when reporting was required. Review of the reportability requirements in effect during the diagnosis year will be needed.

Date Last Modified:
03/11/2025

20250008

References:
#1: Heme & Lymph Manual & DB, 18-21. November 2024, Diagnostic Confirmation
#2: 2025 SEER Manual, 118-120. Diagnostic Confirmation

Question:
Diagnostic Confirmation--Heme & Lymphoid Neoplasms: How is Diagnostic Confirmation coded for hematopoietic and lymphoid neoplasms (heme) when immunophenotyping, genetics, etc. confirm the diagnosis.

Answer:
Assign Code 3 (Positive histology PLUS positive immunophenotyping or genetic testing) for

1. Cases with positive histology for the neoplasm being abstracted (including acceptable ambiguous terminology and provisional diagnosis), AND

- Immunophenotyping, genetic testing, or JAK2 is listed in the Definitive Diagnosis in the Heme Database, AND
- Testing
    - Confirms the neoplasm OR
    - Identifies a more specific histology (not preceded by ambiguous terminology)
    - Peripheral blood smear followed by flow cytometry (most commonly done with CLL/SLL, 9823/3)

2. A not otherwise specified (NOS) histology diagnosed and not a provisional diagnosis, AND genetic/immunophenotyping was performed and positive

Refer to the current version of the Heme Manual for specific notes and examples when coding Diagnostic Confirmation.

Date Last Modified:
03/11/2025

20250007

References:
2025 SEER Manual, 123-125. Behavior Code

Question:
Reportability/Behavior: Our registry collects some borderline (behavior /1) cases that are not reportable to SEER or any other standard setters. Can we assign a behavior code of /2 to these cases?

Answer:
Do not assign a behavior code of /2 to these cases unless you have a way to flag them so that they are not reported to the standard setters as in situ cases. Work with your state central registry to ensure that these cases are not unintentionally included in state case submission.

Date Last Modified:
03/11/2025

20250006

References:
#1: ICD-O-3
#2: 2025 SEER Manual. Appendix E.1 Reportable Examples

Question:
Reportability/Histology--Appendix: Is carcinoid of the appendix reportable? If yes, when did this take effect?

Answer:
Report carcinoid, NOS of the appendix. As of 01/01/2015, the ICD-O-3 behavior code changed from /1 to /3.

Date Last Modified:
03/11/2025

20250005

References:
#1: 2025 SEER Manual, 125. Behavior Code
#2: SEER Manual Appendix E. Reportable Malignant Examples

Question:
Reportability/Behavior--Ovary: Is ovarian mucinous borderline tumor with foci of multifocal intraepithelial carcinoma reportable?

Answer:
Report ovarian mucinous borderline tumor with foci of multifocal intraepithelial carcinoma. The foci of intraepithelial carcinoma makes this reportable. See the list of synonyms for in situ in the SEER Manual, Behavior Code data item.

Date Last Modified:

03/11/2025

20250004

References:
Heme & Lymph Manual & DB. November 2024

Question:
Reportability/Histology--Heme & Lymphoid Neoplasms: Is a diagnosis of myeloid stem cell disorder or myeloid stem cell neoplasm reportable when the differential diagnosis includes only reportable neoplasms? If so, how should histology be coded? See Discussion.

Discussion:
Pathologists are increasingly using the terms "myeloid stem cell disorder" and "myeloid stem cell neoplasm" to describe reportable myeloid neoplasms. If the pathologist uses these terms and indicates the differential diagnosis includes only reportable neoplasms such as myelodysplastic syndrome, myeloproliferative neoplasm, and acute myeloid leukemia (AML), should this be accessioned as a reportable primary?

Example: The 01/2023 peripheral blood shows high grade myeloid stem cell disorder, and the differential diagnosis includes chronic myelomonocytic leukemia (CMML) and AML. The patient refused further work-up and expired several days later. No additional information is available.

Answer:
Report the case when the differential diagnosis includes only reportable neoplasms in the absence of additional information. We are unable to provide general instructions for provisional diagnoses as each situation will need to be reviewed and assessed individually when no further work-up information is available.

Assign myeloid leukemia, NOS (9860/3) to the case described in the example. Assign a generic histology code because a specific histology code cannot be assigned when there are several differential diagnoses. Since the differential diagnoses include a chronic and an acute leukemia, code as myeloid leukemia, NOS since it is not clear if this is chronic or acute.

Date Last Modified:
03/11/2025

20250003

References:
2021 ICD-O-3.2 Update

Question:
Solid Tumor Rules/Histology--Fallopian Tube: How is histology coded for a high-grade serous carcinoma with admixed yolk sac tumor of the right fallopian tube? See Discussion.

Discussion:
There was a single right fallopian tube tumor with two distinct morphologies. The diagnosis comment states, "The combined morphologic and immunohistochemical features are best classified as primary fallopian tube high grade serous carcinoma with a somatically derived yolk sac tumor."

Answer:
Assign high-grade serous carcinoma of the fallopian tube (8461/3). There is currently no code to capture this rare mixed histology. Yolk sac tumors rarely occur in the fallopian tubes of postmenopausal patients and are associated with poor outcome. It is important to document the findings in the appropriate text field.

Date Last Modified:
02/20/2025

20250002

References:
WHO Class Soft Tissue & Bone, online. 5th edition

Question:
Reportability/Histology--Soft Tissue: Is superficial CD34 positive fibroblastic tumor reportable and if so, what histology code should be used? See Discussion.

Discussion:
Patient had a left thigh soft tissue mass excision on 7/24/24 and was diagnosed with superficial CD34 positive fibroblastic tumor. Margins were narrowly free of disease. Tumor size was 5.5 cm x 4.4 cm x 3.9 cm. The diagnosis was confirmed.

Answer:
Do not report superficial CD34-positive fibroblastic tumor (8810/1) of the thigh.

WHO Classification of Soft Tissue and Bone Tumors, 5th ed., defines superficial CD34-positive fibroblastic tumor as a distinctive low-grade neoplasm of the skin and subcutis, most frequently occurring in the lower extremities, especially thigh, followed by arm, buttock, shoulder, and rarely, vulva.

Date Last Modified:
02/20/2025

20250001

References:
#1: WHO Class Female Genital Tumors, online. 5th edition
#2: Glossary; NCI Definitions of Cancer Terms

Question:
Reportability/Histology--Endometrium: Are the following terms and diagnoses synonymous with endometrioid intraepithelial neoplasia (EIN) and therefore reportable?

1. Atypical glandular epithelium

2. Isthmic-type mucosa with focal severe atypia

3. Simple hyperplasia without atypia

4. EIN/complex atypical hyperplasia (EIN/CAH) or focal EIN/CAH (on biopsy but the resection pathology or operative note states no EIN/CAH/atypical hyperplasia)

Discussion:
We have questions regarding reportability of some terms/diagnoses after a review of EIN cases back to 2021. While some seem synonymous with EIN, others have different terms in the pathology report though the physician is treating as if they have the diagnosis.

1. Atypical glandular epithelium

Scenario: Endometrium biopsy with ablation performed at Facility A on 8/7/2024 showed atypical glandular epithelium. Patient was sent to Facility B where the total abdominal hysterectomy/bilateral salpingo-oophorectomy (TAH/BSO) on 9/20/2024 showed other reactive fibrosis and obliterated architecture compatible with history of ablation. Is atypical glandular epithelium synonymous with and coded as EIN?

2. Isthmic-type mucosa with focal severe atypia

Scenario: Endometrium biopsy showed isthmic-type mucosa with focal severe atypia. Then Facility B did TAH/BSO that showed no evidence of high-grade dysplasia, atypical hyperplasia, or carcinoma.

3. Simple hyperplasia without atypia

Scenario: Endometrial biopsy pathology states simple hyperplasia without atypia and the TAH/BSO is either negative or has the same histology; however, the treating physician is stating EIN.

4. EIN/CAH or focal EIN/CAH

Scenario: Biopsy showed EIN/CAH but the total abdominal hysterectomy/bilateral salpingo-oophorectomy (TAH/BSO) pathology or the Mirena IUD treatment operative note states no EIN/CAH/Atypical hyperplasia. Are these reportable, similar to an in situ when the re-excision lumpectomy or mastectomy is negative or no residual disease?

Answer:
Reportability for EIN became effective in 2021.

1. Do not report atypical glandular epithelium. Atypical glandular epithelium, also referred to as atypical glandular cells (AGC), refers to abnormal looking cells that may be found in the tissue lining the inside of the endometrium or the cervix. While not malignant (in situ or invasive), they can be associated with a range of lesions in the female reproductive system.

2. Do not report isthmic-type mucosa with focal severe atypia. The NCI data dictionary defines atypia as an abnormality in cells in tissue. Report the case when further defined as atypical hyperplasia.

3. Do not report simple hyperplasia without atypia. WHO Classification of Tumors online, Female Genital Tumors (5th ed.), defines endometrial hyperplasia without atypia as a proliferation of endometrial glands of irregular size and shape without significant atypia. There is no ICD-O code for this term. Simple endometrial hyperplasia without atypia is an acceptable related term for endometrial hyperplasia without atypia. Pathology has priority over a physician statement.

4. Report EIN/CAH or focal EIN/CAH (8380/2) based on the biopsy. WHO Classification of Tumors online, Female Genital Tumors (5th ed.), defines EAH/EIN as a simultaneous change of epithelial cytology and an increased number of endometrial glands in a defined region. The preferred term is atypical hyperplasia of the endometrium; terms not recommended include complex atypical endometrial hyperplasia; simple atypical endometrial hyperplasia; endometrial intraepithelial neoplasia.

Date Last Modified:
02/20/2025

20240079

References:
WHO Class Eye Tumors, 31-33. 4th edition

Question:
Reportability/Histology--Conjunctiva: Is low-grade conjunctival melanocytic intraepithelial lesion (LG-CMIL) with focal high-grade features of the conjunctiva (C690) reportable? If reportable, what histology should be assigned?

Discussion:
Additional comments in this pathology report state "The entire case was sent in consultation to an ophthalmic pathologist. [Pathologist] assigns a conjunctival melanocytic intraepithelial neoplasia (C-MIN) score of 2-3 due to the upward pagetoid migration of small, dendritic melanocytes. A C-MIN score of 2-3 is between low-grade conjunctival melanocytic intraepithelial lesion (LG-CMIL; C-MIN 2) and high-grade conjunctival intraepithelial lesion (HG-CMIL; C-MIN 3). The older terminology for this lesion would be primary acquired melanosis (PAM) with mild to focally moderate atypia."

This term does not appear in the SEER Program Coding and Staging Manual (SPCSM), Appendix E1 of the SPCSM, or Solid Tumor Rules (specifically rule H3) .

Answer:
Conjunctival melanocytic intraepithelial neoplasia (C-MIN) is reportable; therefore, low-grade conjunctival melanocytic intraepithelial lesion (LG-CMIL) with focal high-grade features of the conjunctiva (C690) is reportable, 8720/2. We will add this to a future edition of the SEER manual.

Date Last Modified:
01/06/2025

20240078

References:

#1: WHO Class Thoracic Tumors, 55-74. 5th edition
#2: Gardiner N, Jogai S, Wallis A. The revised lung adenocarcinoma classification—an imaging guide. J Thorac Dis 2014;6(S5):S537-S546. doi: 10.3978/j.issn.2072-1439.2014.04.05. https://pubmed.ncbi.nlm.nih.gov/31200873/

Question:

Reportability/Histology--Lung: Are adenocarcinoma spectrum lesions on lung imaging reportable when no further information is available? See Discussion.

Discussion:

For example, a chest computed tomography showed multiple subsolid and ground glass pulmonary nodules measuring up to 6 mm; findings favored reflect adenocarcinoma spectrum lesions. A literature search seems to indicate that adenocarcinoma spectrum lesions include atypical adenomatous hyperplasia through invasive adenocarcinomas.

Answer:

Do not report this case of "adenocarcinoma spectrum lesions" based on the information provided in the absence of a more specific diagnosis. Do not report until/unless a definitive diagnosis of malignancy is made. "Adenocarcinoma spectrum lesion" covers a continuum of lung neoplasms from preinvasive lesions (atypical adenomatous hyperplasia and adenocarcinoma in situ) to invasive lesions (minimally invasive adenocarcinoma and invasive adenocarcinoma).

Should additional information become available, report the case and assign the histology code if a more specific histology is confirmed later. Use text fields to record the details.

Date Last Modified:

01/06/2025

20240077

References:
2024 SEER Manual, 102-103. Example 4

Question:
2024 SEER Manual/Primary Site--Retroperitoneum: What is the primary site code for a final diagnosis of endometrioid adenocarcinoma from a biopsy of a right retroperitoneal mass? See Discussion.

Discussion:
An 80-year-old post-menopausal female (status post hysterectomy for benign reasons) presents with a retroperitoneal mass on imaging. The pre-operative imaging shows the cervix and uterus are absent. Patient undergoes a robotic left salpingo-oophorectomy with biopsy of the retroperitoneal mass.

Answer:
Code Primary Site to C480 (retroperitoneum).

Endometrial tissue may "break away" from the uterus and implant throughout the pelvic and abdominal cavities. This can occur in patients who suffer from endometriosis. This tissue remains behind when surgical removal of the uterus is done. Common sites of implantation are colon, peritoneum, retroperitoneum, and bladder. These cells may become malignant. When the uterus is no longer present (patient had surgical removal), code the site where the carcinoma was identified.

The site-morphology combination of C480 and 8380/3 was designated as an unlikely site-morphology combination by the Cancer PathCHART expert pathologist review, as this is a rare type of tumor. Assign a value of 1 in the Over-ride Site/Type [2030] data item in order to pass the Primary Site, Morphology-Type, Beh ICDO3, 2024 (SEER) edit.

Date Last Modified:
01/06/2025

20240076

References:
2024 SEER Manual, 13-14. Reportability section

Question:
SEER Manual/Reportability--Vulva: Is vulvar intraepithelial neoplasia (VIN II) alone reportable? An example is a final diagnosis from a pathology report that states only 'VIN II' with no additional details/wording.

Answer:
Report VIN II. The 2024 SEER Manual lists this as a separate diagnosis in the Reportability section under Malignant Histologies 1.a.x.

Date Last Modified:
01/06/2025

20230018

References:
2023 SEER Manual, 203-208. Chemotherapy

Question:
SEER Manual/First Course Treatment--Chemotherapy: Does the First Course of Treatment end when subcategories change for treatments such as hormone therapy or immunotherapy or is that instruction specific to chemotherapy? See Discussion.

Discussion:
Treatment for estrogen receptor positive (ER+) breast cancer started with tamoxifen (non-steroidal estrogen subcategory) and switched to letrozole (non-steroidal aromatase inhibitor subcategory). Patient being treated with immunotherapy, Avastin (cytostatic agent-antiangiogenesis agent subcategory), and then changed to Atezolizumab (monoclonal antibody subcategory).

Is Atezolizumab a new course of therapy because it is a different subcategory?

Answer:
Answer updated April 2025

A change in the subcategory for a hormone drug does not indicate the end of First Course of Treatment because different hormone therapies generally achieve the same result. For example, some forms of breast cancer are estrogen-dependent and the various subcategories of hormone drugs used to treat them, such as gonadotropin-releasing factor agonists, aromatase inhibitors and estrogen antagonists, all achieve the same result - to block estradiol effects in these tumors.

Similarly, a change in immunotherapy is not a new course of treatment.

However, if a change to hormone therapy or immunotherapy is due to a change in the patient's ER, PR, or Her2 status, this could signify a new course of treatment.

The instruction in the SEER Manual is specific to chemotherapy. Chemotherapy is the only systemic treatment for which a change in the subcategory of a drug indicates the end of First Course of Treatment, due to the fact that different chemical agents damage cancer cells in different ways and at different phases in the cell cycle.

Date Last Modified:
04/04/2025

20230012

References:
Solid Tumor Rules. Other Sites, 2023 Update

Question:
Solid Tumor Rules/Multiple Primaries--Prostate: How many primaries are accessioned when a 06/2022 diagnosis of prostate adenocarcinoma is followed less than one year later by a 01/2023 diagnosis of small cell carcinoma (SmCC)? See Discussion.

Discussion:
Rule M4 was added to the Other Sites M Rules to address diagnoses of small cell carcinoma following prostate adenocarcinoma, but Rule M4 states the diagnoses must be greater than one year apart.

In this situation, the diagnoses were less than one year apart, and one must continue through the M Rules. The next M Rule that applies Rule M19: "Abstract multiple primaries when separate/non-contiguous tumors are on multiple rows in Table 2-21 in the Equivalent Terms and Definitions. Timing is irrelevant." If one were to STOP at the first rule that applies, one would stop at Rule M19 which confirms the prostatic adenocarcinoma and small cell carcinoma are separate primaries, regardless of timing. If these are not to be accessioned as multiple primaries, does an Exception need to be added to M19?

Answer:
Assuming the small cell is a separate tumor, accession two primaries, adenocarcinoma (8140/3) of the prostate and SmCC (8041/3) of the prostate using Rule M19 of the current Other Sites Solid Tumor Rules. As these two tumors are less than a year apart, Rule M4 does not apply; however, Rule 19 does apply as these are two distinct histology types. It takes time for an acinar tumor to transform into a small cell and it is usually triggered by hormone and/or radiation treatment.

Date Last Modified:
01/21/2025

20200045

References:
Heme & Lymph Manual & DB. Effective with cases diagnosed 1/1/2010 and forward

Question:
Diagnostic confirmation--Heme & Lymphoid Neoplasms: Is Diagnostic Confirmation coded to 5 or 8 based on a patient diagnosed as multiple myeloma by a physician based on a bone marrow biopsy stating plasma cell neoplasm? See Discussion.

Discussion:
Bone marrow, right iliac crest (aspirate smear, touch preparation, clot section and core biopsy): Hypercellular marrow (40-50%) with plasma cell neoplasm (see Comment): " No evidence of metastatic carcinoma. " Adequate iron storage.

Comment: CBC data shows normocytic anemia. Flow cytometric analysis of bone marrow detects a kappa restricted plasma cell population that expresses CD138 and CD38. CD56 is positive. CD19 and CD20 are negative. T lymphocytes are immunophenotypically unremarkable. Polyclonal B lymphocytes are detected. Blast gate is not significantly increased. Immunohistochemical stains are performed on the biopsy core and clot section for greater sensitivity and further architectural assessment with adequate controls. CD138 positive plasma cells comprise > 70% of the total cellularity. AE1/AE3 is negative. Taken together, the morphologic and immunophenotypic findings are consistent with a diagnosis of plasma cell neoplasm. Trilineage hematopoietic activity as are seen.

Answer:
This would be a Diagnostic Confirmation of 8 based on the physician's diagnosis.

The Pathology report mentions plasma cell neoplasm only. By itself, plasma cell neoplasm is not reportable because it includes a variety of diseases, some that are not reportable, and some that are (See Hematopoietic Database under Plasma Cell Neoplasm.)

The physician probably has other information, including imaging, which may show lytic lesions. He/she is probably using clinical findings, plus findings from the bone marrow, and diagnosing this patient with multiple myeloma.

Date Last Modified:
03/07/2025

20190002

References:
#1: WHO Class CNS Tumors
#2: Solid Tumor Rules. Non-malignant CNS rules

Question:
Histology/Behavior--Brain and CNS: How should Histology and Behavior be coded for a polymorphous low-grade neuroepithelial tumor of the young (PLNTY) arising in the brain?

Answer:
Updated answer

Assign code 9413/0.

History:
Previous answer

Assign code 9505/1 for ganglioglioma. Per our expert neuropathologist, according to the paper that has done the most work on PLNTY cases, it appears most closely related to the ganglioglioma. It is surely a neoplasm as it has recurrent mutations and fusions seen in other tumors, again, most like gangliogliomas.

Date Last Modified:
04/11/2025

20180109

References:
#1: 2018 SEER Manual. See final version of the manual when posted
#2: 2022 SEER Manual, 10, 84

Question:
Date of diagnosis/Ambiguous terminology--Cervix Uteri: Is the date of diagnosis of a cervical pap smear done in December 2017, that states high-grade squamous intraepithelial lesion with features suspicious for invasion, followed by a cervical biopsy in 2018 positive for squamous cell carcinoma, in 2017? Is the ambiguous term used in the cytology in 2017 (suspicious for invasion) to determine diagnosis as the SEER manual states to use the ambiguous cytology as the date of diagnosis if confirmed later.

Answer:
Updated for cases diagnosed 2022 or later

For cases diagnosed in 2022 or later, see the instructions in the SEER manual under Reportability and Date of Diagnosis for ambiguous cytology.

History:
For cases diagnosed prior to 2022

Based on the information provided, this is a 2018 diagnosis. SEER has been asked to postpone implementing the instruction about using the date of the ambiguous cytology until 2019 or later. We will be removing that instruction from the draft 2018 SEER manual when it is finalized.

Date Last Modified:
04/04/2025

20120015

References:
Heme & Lymph Manual & DB

Question:
Diagnostic confirmation--Heme & Lymphoid Neoplasms: How does one determine and code a clinical diagnosis for the diagnostic confirmation in patient diagnosed with essential thrombocythemia? See Discussion.

Discussion:
The Heme DB originally stated the Definitive Diagnostic Method is coded to 8 [clinical diagnosis only] while an updated version stated it can be coded as a clinical diagnosis, or it can be based on the results of a bone marrow biopsy or a genetic test. The Abstractor Note section specifies this is a diagnosis of exclusion. According to a recent Web-based training seminar, the JAK-2 diagnosis would be coded 5 [positive laboratory test/marker study]. Doesn't the Definitive Diagnostic Method of a clinical diagnosis/diagnosis of exclusion mean that the diagnostic confirmation of essential thrombocythemia will always be coded as 8 [clinical diagnosis only]? Many people use code 3 for positive bone marrow biopsy and genetics (JAK-2), but the bone marrow is usually reported as only borderline or is stated to be abnormal for a person's age.

Answer:
For cases diagnosed 2010 and forward, access the Hematopoietic Database at http://seer.cancer.gov/seertools/hemelymph.

Code the diagnostic confirmation to 8 [clinical diagnosis only] in this case.

Per the Heme DB, JAK-2 is only positive in about 50% of essential thrombocythemia (ET) patients. In addition, a positive JAK-2 test does not identify the type of myeloproliferative disease (MPN) the patient has, only the presence or absence of the JAK-2 mutation.

The WHO guidelines for diagnosing ET are: elevated platelet count over months and the elimination of other causes for an elevated platelet count (such as polycythemia vera (PV), chronic myelogenous leukemia (CML), idiopathic myelofibrosis, or myelodysplastic syndrome (MDS)); the absence of Philadelphia chromosome, BCR/ABL fusion gene; and del(5q), t(3;3)(q21;26),inv(3)(q21q26)).

Subsequently, the physician rules out any underlying causes of thrombocytosis such as an inflammation or infection, other neoplasms, and prior splenectomy.

Ultimately, there is a diagnosis of exclusion. In other words, all other causes for the elevated platelet count have been excluded. The physician assembles the information from the blood

counts, bone marrow and JAK-2 testing along with the information that excludes all other diseases and makes a clinical diagnosis of ET.

SEER*Educate provides training on how to use the Heme Manual and DB. If you are unsure how to arrive at the answer in this SINQ question, refer to SEER*Educate to practice coding hematopoietic and lymphoid neoplasms. Review the step-by-step instructions provided for each case scenario to learn how to use the application and manual to arrive at the answer provided. https://educate.fhcrc.org/LandingPage.aspx.

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References:
2024 SEER Manual

Question:
Surgery of Primary Site--Breast: How is this field coded when a patient has a reduction mammoplasty (for macromastia) and within the pathology specimen there is an incidental finding of carcinoma?

Answer:
Code this reduction mammoplasty to the code which best fits the amount of tissue removed. Read the operative report carefully. Code as a partial mastectomy, skin- nipple-areola-sparing mastectomy, or total (simple) mastectomy. Use text fields to record the details.

History:
Code this reduction mammoplasty to 20, 21 or 30, depending on whether or not there was a nipple resection. According to our surgical consultant, a reduction mammoplasty is more like a partial mastectomy than a lumpectomy or other breast surgery.

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