20200017

References
Source 1: **ICD-O-3 SEER Site/Histology Validation List**
pgs:
Notes: **June 18, 2019**

Question
Histology--Head & Neck: Why is 8070 not listed as a valid histology for ill-defined sites as squamous cell carcinoma arises in the head and neck sites. See Discussion.

Discussion
Per the site validation list: https://seer.cancer.gov/icd-o-3/sitetype.icdo3.20190618.pdf#search=site%20validation, ill-defined sites (ILL-DEFINED C760-C768) does not include 8070- Squamous cell carcinoma as a valid histology. Therefore, when a Cervical Lymph Node and Unknown Primary Tumor of the Head and Neck is submitted with a C760 and 8070/3, it requires an override be set.

Answer
Histology code 8070 has been added to C760 on the site validation list. It will be updated for 2021. Continue to override this combination for now.

Date Finalized
04/08/2020

20200015

References
Source 1: **2018 SEER Manual**
pgs: **107-109**
Notes: **Tumor Size--Clinical**

Question
Tumor Size--Clinical--Breast: Does information from any type of biopsy take precedence over an imaging report? See Discussion.

Discussion
For example, a patient has a 2.6 cm breast tumor on MRI; a core biopsy measuring 0.7 cm is positive for infiltrating duct carcinoma. Rule #1 states "Use the largest measurement of the primary tumor from physical exam, imaging, or other diagnostic procedures before any form of treatment." However, Rule #9 seems to imply that size from an "incisional biopsy" takes precedence over imaging, even though it is known to be less than the entire tumor in size.

Answer
We do not recommend using the size from a core biopsy for clinical tumor size. A core biopsy does not necessarily obtain enough tissue to know the actual tumor size. Since there is imaging for this patient, it is preferable to record clinical tumor size from the imaging report in this case.

The instructions will be clarified in the next revision of the SEER manual.

Date Finalized
04/08/2020

20200014

References
Source 1: **WHO Class CNS Tumors**
pgs: **266-269**
Notes: **4th ed.**
Source 2: **2018 Solid Tumor Rules**
pgs:
Notes: **Non-Malignant CNS, July 2019 Update**

Question
Solid Tumor Rules (2018)/Histology--Brain and CNS: How are histology and primary site coded when a resection of a spine, designated intramedullary lesion, shows primary intramedullary melanocytoma? See Discussion.

Discussion
Patient has a resection labeled as: Spine, designated intramedullary lesion. The Final Diagnosis is: Melanocytic neoplasm with features most consistent with primary intramedullary melanocytoma. The Diagnosis Comment states: The overall immunophenotypic and morphologic impression is a primary central nervous system melanocytoma.

The ICD-O-3 lists melanocytoma, NOS histology code as 8726/0, but does not provide a site-associated code. If the ICD-O-3 is used, the histology would be 8726/0 and the primary site presumably would be C720 since the tumor was specifically described as being intramedullary (i.e., within the spinal cord medulla).

Table 6 (Solid Tumor Rules, Non-Malignant CNS Equivalent Terms and Definitions) does not list either an intramedullary melanocytoma or melanocytoma (NOS). However, Table 6 does include meningeal melanocytosis 8728/0 and meningeal melanocytoma 8728/1. If Table 6 is used and the histology is coded 8728/1, then the primary site would presumably be C701 per the ICD-O-3 site-associated listing for this histology (C709).

Answer
Code primary site to spinal meninges (C701) and histology to meningeal melanocytoma (8728/1).

According to the WHO Classification of Tumors of the Central Nervous System, 4th ed., primary melanocytic neoplasms of the central nervous system are diffuse or localized

tumors that presumably arise from leptomeningeal melanocytes. Benign or intermediate grade lesions are termed melanocytomas. Meningeal melanocytoma is defined as a well-differentiated, solid, and non-infiltrative melanocytic neoplasm that arises from leptomeningeal melanocytes. Most arise in the extramedullary, intradural compartment at the cervical and thoracic spine though they can be dural-based or associated with nerve roots or spinal foramina.

Date Finalized
04/08/2020

20200013

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Colon, Updated July 2019**

Question
Solid Tumor Rules (2018)/Multiple primaries--Colon: Solid Tumor Rules 2018, Colon Rule M7, bullet 3 indicates that (if neither bullet 1 or 2 apply) a new tumor at the anastomotic site must be stated to arise in the mucosa (confirmed in SINQ 20190096) to qualify as a new primary. However, there is often no clear statement of tumor arising from or involving mucosa (unless the new tumor is limited to the mucosa) noted by pathologists in our region. Do any of the following examples imply a new tumor arising in mucosa per Rule M7, bullet 3? See Discussion.

Discussion
Examples:
1) New tumor at the ileocolic anastomosis, described as a, Circumferential centrally ulcerated mass with raised borders. Tumor extension: Tumor invades through muscularis propria into subserosal adipose tissue, no involvement of the serosal surface identified. The only mention of mucosa on the resection is the uninvolved enteric mucosa or uninvolved colonic mucosa in the otherwise uninvolved portions of the ileum/colon. If neither bullet 1 or 2 apply, is this a new primary per M7 bullet 3?

2) Right colon with anastomosis site. Tumor site: Anastomosis. Tumor extension: Tumor invades through the muscularis propria. Gross description does not describe mucosa, only noting, at the central area of anastomosis is an ill-defined, slightly raised, tan-brown to purple mass measuring 2.2 x 2 cm, which is nearly circumferential, causing obstruction at the site of anastomosis. If neither bullet 1 or 2 apply, is this a new primary per M7 bullet 3?

3) Polyp at ileocolonic anastomosis, polyp biopsy final diagnosis was, Invasive moderately differentiated colonic adenocarcinoma in association with adenoma. No mention of mucosa on the biopsy final diagnosis or gross description. Clinical info indicates, there is an ulcerated 5 cm mass at the ileo-colonic anastomosis that was biopsied. If neither bullet 1 or 2 apply, is this a new primary per M7 bullet 3?

Answer
Following the 2018 Colon Solid Tumor Rules M7 and M8:

Example 1: Assuming the first and second tumors are not different histologies or they occurred less than or equal to 24 months apart (M7 Bullets 1 and 2 do not apply), abstract a single primary as the pathology states uninvolved enteric mucosa or uninvolved colonic mucosa (no involvement noted).

Example 2: Assuming the first and second tumors are not different histologies or they occurred less than or equal to 24 months apart (M7 bullets 1 and 2 do not apply), abstract a single primary as there is no mention of mucosal involvement.

Example 3: Assuming the first and second polyps/tumors are not different histologies or they occurred less than or equal to 24 months apart (M7 bullets 1 and 2 do not apply), abstract a single primary as there is no mention of mucosal involvement. Of note in the case of the polyp, tumors coded as adenocarcinoma in a polyp, should be treated as adenocarcinoma (8140) for cases prior to 2018. Also, if the pathologist states the new tumor/polyp originated in the mucosa, it is a new primary.

The rules which address recurrence or new tumor at the anastomosis were created with the input of several gastrointestinal expert pathologists (CAP, AJCC, and WHO). Pathologists should be following CAP reporting guidelines and include information such as mucosal involvement in the final diagnosis and/or synoptic report. We can revisit this question that all polyps start in the mucosa and if needed, revise the rules to state this.

Date Finalized
04/14/2020

20200012

References
Source 1: **Hemeatopoietic and Lymphoid Neoplasm Coding Manual**
pgs:
Notes: **July 2019; Effective for Cases Diagnosed 1/1/2010 and Forward**

Question
Multiple primaries--Heme & Lymphoid Neoplasms: How many primaries are accessioned for a patient diagnosed with myelodysplastic syndrome (MDS) with ring sideroblasts in 2005, and stated to have progressed to high risk disease/early evolving acute myeloid leukemia (AML) in 09/2019? See Discussion.

Discussion
The bone marrow biopsy proved bone marrow with blasts comprising 15-19%. Neither the pathologist nor the physician specifically diagnosed this as AML, calling this only high-risk disease or early evolving AML prior to starting the patient on Vidaza.

No further information can be obtained from the pathologist or the physician for this case. Should this early evolving AML be accessioned as an additional primary per Rule M10, or should this be considered the same MDS that is now high risk as the blast count is up to 19%, but has not yet reached the threshold of 20% blasts usually required for AML per the Hematopoietic and Lymphoid Neoplasm Database?

Answer
Abstract a single primary as we do not abstract early/evolving AML. This is still one primary until there is a confirmed diagnosis of AML.

Date Finalized
03/13/2020

20200011

References
Source 1: **2018 SEER Manual**
pgs: **61-65**

Question
Race: How should race information from linkages be incorporated into the coding of Race? See Discussion.

Discussion
Race information is provided in the Centers for Medicare and Medicaid Services (CMS) linkage results. Oftentimes it matches what is coded in the database, but other times it does not.

In situations where the CMS (or other) linkage provides a race value that differs from the coded Patient set, are we to ignore the CMS stated race given the SEER Manual instructions indicating self-reported race has priority or should we add the different Race values from linkages as an additional race (ex. Race 02)?

Answer
Use self-reported race as the priority when information on race is available. Use the associated text field to document why a particular race code was chosen when there are discrepancies in race information. Generally, race information is used from linkages when race data is missing or unknown, or to enhance data.

We will add clarification on linkages in the next SEER Manual update.

Date Finalized
03/13/2020

20200010

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Head and Neck, Updated July 2019**

Question
Solid Tumor Rules (2018)/Histology--Head & Neck: How is histology coded for a glossotonsillar sulcus tumor with both squamous cell carcinoma and mucoepidermoid carcinoma? See Discussion.

Discussion
Patient had a radical pharyngectomy showing a glossotonsillar sulcus tumor with high grade squamous cell carcinoma and adjacent high grade mucoepidermoid carcinoma. The pathologist commented, the tumor is composed of high grade mucoepidermoid carcinoma and high grade conventional-type squamous cell carcinoma that are immediately adjacent to one another. Given that the tumors are arising so close together and could represent a single neoplastic process with divergent morphologies, they are staged together.

Employing Solid Tumor Manual Rule M1 (single primary if unable to determine if there is a single or multiple tumors), it was determined that this should be reported as a single tumor because the pathologist referred to the case as both a tumor singular and tumors pleural. However, the Solid Tumor Manual Histology Rules for a Single Tumor do not appear to have an instruction for coding this histology combination.

Answer
Abstract multiple primaries using 2018 Head and Neck Solid Tumor Rule M8 as these are separate tumors described as arising close together and are on different rows in Table 3. Code histology separately as squamous cell carcinoma (8070/3) and mucoepidermoid carcinoma (8430/3).

This appears to be a collision tumor. Collision tumors are counted as two individual tumors for the purpose of determining multiple primaries. Collision tumors were originally two separate tumors that arose in close proximity. As the tumors increased in size, they merged or overlapped each other. While more common in the colon, they can occur in other sites as well.

Date Finalized
03/13/2020

20200009

References
Source 1: **2018 SEER Manual**
pgs:
Notes: **Appendic C, Surgery Codes-Corpus Uteri**

Question
First course treatment/Surgery of Primary Site--Corpus uteri: Is an omentectomy performed with a hysterectomy for an endometrial primary site recorded under Surgery of Other Site? See Discussion.

Discussion
Per SEER 20140003, an omentectomy is not recorded under Surgery of Other Site when performed with a hysterectomy for an endometrial primary. Is this still correct? CoC appears to have different guidelines stating in a forum that an omentectomy is coded in data item Surgical Procedure to Other Site. I would like to confirm SEER guidelines. Is this one of those unique situations that SEER and STORE differ? Our state follows SEER guidelines and would like to communicate the appropriate rules to our facilities.

Answer
Continue to record an omentectomy performed with a hysterectomy under Surgery of Primary Site and not as a separate procedure under Surgical Procedure of Other Site. The guidance In SINQ 2014003 and 20091118 is unchanged.

Date Finalized
03/13/2020

20200008

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Other Sites, Updated 9/11/2018**

Question
Solid Tumor Rules (2018)/Multiple primaries--Corpus uteri: How many primaries are accessioned for patient with a minimally invasive endometrial adenocarcinoma arising in a polyp in 2001, followed by a metastatic poorly differentiated clear cell carcinoma of gynecologic (GYN) origin in 2019? See Discussion.

Discussion
The patient has a history of a minimally invasive endometrial adenocarcinoma that was low grade and confined to an endometrial polyp in 2001. The patient underwent a total abdominal hysterectomy/bilateral salpingo-oophorectomy (TAH/BSO) that entirely removed the tumor at that time.

Almost 18 years later, the patient had a left inguinal mass excision that was, Carcinoma of gynecologic origin, consistent with clear cell carcinoma. No other disease was found, the physician never indicated whether this was felt to be metastatic from the previous, low grade adenocarcinoma or not. It was only noted as, an unusual malignancy of the left lower quadrant and inguinal region of gynecologic origin. No further information was available in the medical record or from the physician on follow-up.

Although neither the Solid Tumor Rules nor the MPH Rules (still in use for the Other Sites schema) apply to metastasis, given the differences in histology and behavior of these two tumors (i.e., minimally invasive, low grade disease diagnosed in 2001 vs. higher grade, more aggressive tumor in 2019) should the current clear cell carcinoma of GYN origin really be considered the same primary as the 2001 endometrial adenocarcinoma?

Answer
Abstract multiple primaries using 2018 Other Sites Solid Tumor Rule M10 as these tumors are more than one year apart. This represents endometrioid adenocarcinoma (8380/3 of C541) and 18 years later, clear cell Carcinoma (8310/3 consistent with GYN (C579) primary).

Date Finalized
03/13/2020

20200007

References
Source 1: **Hematopoietic and Lymphoid Neoplasms Manual and Database**
pgs:
Notes: **Effective with cases diagnosed 1/1/2010 and forward**
Source 2: **WHO Class Hem & Lymph Tumors**
pgs: **69**
Notes: **Revised 4th edition**

Question
Multiple primaries--Heme & Lymphoid Neoplasms: How many primaries are accessioned when a patient is simultaneously diagnosed with systemic mastocytosis and chronic myelomonocytic leukemia (CMML-0) on a single bone marrow biopsy? See Discussion.

Discussion
The Hematopoietic and Lymphoid Neoplasms Database (Heme DB) definition for systemic mastocytosis with an associated hematological neoplasm (SM-AHN, 9741/3) states SM-AHN is a variant of systemic mastocytosis that arises with a myeloid disease of non-mast cell lineage (e.g., MDS, MPN, etc.) and that, The AHN should be abstracted as a second primary.

However, SINQ 20130172 conflicts with the Heme DB stating the systemic mastocytosis and the associated hematological neoplasm are a single primary coded to a single histology (9741/3) per Rule M2.

Answer
Abstract a single primary when the diagnosis is systemic mastocytosis with an associated clonal hematogoical non-mast cell lineage disease (SM-AHNMD) (9741/3). However, if the patient has a previous history of myelodysplastic syndrome, myeloproliferative neoplasm, myelodysplastic/myeloproliferative neoplasm or acute leukemia, abstract the SM-AHNMD as a second primary as stated in the Heme DB.

SINQ 20130172 represents a single primary as there is no mention of a prior history of myelodysplastic syndrome, myeloproliferative neoplasm, myelodysplastic/myeloproliferative neoplasm or acute leukemia.

Date Finalized
02/20/2020

20200006

References
Source 1: **WHO Class Tumors of the Eye**
pgs: **118-120**
Notes: **4th edition**

Question
Reportability--Retina: Is a diagnosis of retinal astrocytoma reportable? See Discussion.

Discussion
There is no specific ICD-O-3 code for a retinal astrocytoma which resulted in abstractors assigning the malignant astrocytoma, NOS code. These lesions were previously called retinal astrocytic hamartomas, but we are seeing the new terminology more frequently.

Answer
Report retinal astrocytoma. The WHO Classification of Tumors of the Eye, 4th edition, lists astrocytoma, NOS as 9400/3 with astrocytic hamartoma of the retina as a synonym. You may receive a site/type edit (IF25) which can be overridden.

The changes in terminology, codes, etc. proposed in WHO 4th Ed Eye book were implemented for cases diagnosed 1/1/2018 forward. Apply this to retina astrocytoma's and do not accession cases diagnosed with this histology prior to 1/1/2018.

Date Finalized
03/18/2020

20200005

References
Source 1: **Hematopoietic and Lymphoid Neoplasms Manual**
pgs:
Notes: **Effective for cases diagnosed 1/1/2010 and forward**
Source 2: **2018 SEER Manual**
pgs: **14**
Notes: **Changing Information on the Abstract**

Question
Multiple Primaries--Heme & Lymphoid Neoplasms: How many primaries are accessioned and what M rule applies when a patient is diagnosed with both plasmablastic lymphoma and at least one plasmacytoma? See Discussion.

Discussion
The patient was diagnosed with an EBV-positive plasmablastic lymphoma involving the left testis on radical orchiectomy in April 2019.

In September 2019, a plasmacytoma was found on a right mandibular mass biopsy. Imaging at that time revealed diffuse disease involving the thoracic spine and sinus involvement. The patient then underwent a resection of the T8 spinal/epidural tumor that also proved plasmacytoma.

Subsequently, the right mandibular mass and testis slides were reviewed (at an outside facility) and both were stated to be, EBV-positive plasmablastic neoplasm, best classified as plasmablastic lymphoma. The T8/epidural tumor pathology was not reviewed, so it is unclear if this is also assumed to be the same disease process as the right mandibular mass or still considered a separate, solitary plasmacytoma.

Additionally, some chart notes indicate the patient has plasmablastic lymphoma with a secondary diagnosis of plasmacytoma, while other chart notes state this is stage IV plasmablastic lymphoma involving all documented sites. Although the plasmablastic lymphoma and at least the plasmacytoma of T8 have different ICD-O-3 histology codes, the physicians do seem to be treating this as a single disease process.

Answer
Abstract multiple primaries using the Heme and Lymphoid Rule M15. The Multiple Primaries Calculator shows that the plasmablastic lymphoma (9735/3) and extraosseus plasmacytoma

(9734/3) are separate primaries. We also checked with our expert pathologist who concurs as the spinal lesion was not reviewed to prove that it is plasmablastic lymphoma, therefore, the diagnosis as per pathology remains plasmacytoma.

Date Finalized
03/13/2020

20200004

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Lung, July 2019 Update**
Source 2: **2018 EOD Manual**
pgs:
Notes: **SEER*RSA, v1.7**

Question
Solid Tumor Rules (2018)/Multiple primaries--Lung: How are Primary Site and EOD Primary Tumor coded when a patient is diagnosed with four invasive tumors in the right lung that represent three separate primaries, but the not otherwise specified (NOS) tumor and one of the specific subtype/variants are in separate lobes? See Discussion.

Discussion
There are four invasive tumors in the right lung:

Large cell undifferentiated carcinoma in the right lower lobe (8012/3, C343);

Adenocarcinoma, acinar-predominant in the right lower lobe (8551/3, C343) that was 0.7 cm in size and limited to the lung;

Mucinous adenocarcinoma in the right upper lobe (8253/3, C341) that was 0.9 cm and limited to the lung;

Adenocarcinoma, NOS also in the right upper lobe (8140/3, C341) that was 1 cm and limited to the lung.

The Lung M Rules confirm the large cell undifferentiated carcinoma is a separate primary from the three adenocarcinoma tumors (Rule M8). The acinar adenocarcinoma and mucinous adenocarcinoma tumors are separate primaries (Rule M6). The adenocarcinoma, NOS tumor is considered the same primary as both the acinar and mucinous are adenocarcinomas (Rule M7).

How is Primary Site coded for both the acinar and mucinous adenocarcinomas if they represent multiple tumors reported as a single primary (when compared to the adenocarcinoma, NOS tumor)?

Should the adenocarcinoma, NOS tumor also be included when coding EOD Primary Tumor for both the right lower lobe acinar adenocarcinoma and right upper lobe mucinous adenocarcinoma primaries? Further follow-up with the physician is not possible.

Answer
Abstract three primaries using 2018 Lung Solid Tumor Rules, Rule M6 and M8 as these are multiple synchronous tumors.

M6 (Subtypes in Column 3 of Table 3):

Adenocarcinoma, acinar predominant:

Primary Site: C343 (RLL)

EOD Primary Tumor: 300

Mucinous adenocarcinoma

Primary Site: C341 (RUL)

EOD Primary Tumor: 300

M8 (Separate rows in Table 3):

Large cell undifferentiated carcinoma:

Primary Site: C343 (RLL)

EOD Primary Tumor: 300

Note: The adenocarcinoma, NOS, along with the other subtypes, is on a different row than the large cell undifferentiated carcinoma and is already accounted for in Rule 6 as multiple synchronous tumors.

Do not include the adenocarcinoma, NOS in EOD Primary Tumor for the reportable primaries.

Date Finalized
02/20/2020

20200003

References
Source 1: **WHO Class Urinary Tumors**
pgs: **268**
Notes:
Source 2: **2018 ICD-O-3 New Terms, Behaviors, Codes**

Question
Histology--Penis: What is the histology code of a glans penis primary with the final diagnosis squamous cell carcinoma, verrucous type? See Discussion.

Discussion
Penile mass excision shows final diagnosis of squamous cell carcinoma, verrucous type. Subsequent partial penectomy has a final diagnosis of squamous cell carcinoma, verrucous type and the summary cancer data lists Histologic Type: Verrucous carcinoma.

Both the final diagnosis and summary cancer data indicate a histology code of 8051/3 (squamous cell carcinoma, verrucous type / verrucous carcinoma). However, this site and histology combination triggers edit IFN4911. Edit documentation indicates that for sites C600-C609 (all penile sites) use histology code 8051 and do not use 8054.

Review of the 2018 ICD-O-3 Histology Updates table does not indicate these terms are synonymous.

Answer
Code squamous cell carcinoma, verrucous type of the penis as verrucous carcinoma (8051/3). In WHO Classification of Tumors of the Male Urinary System and Male Genital Organs, 4th edition, tumors of the penis, verrucous carcinoma is described as an extremely differentiated keratinizing papillomatous and acanthotic neoplasm; it accounts for 2-3% of penile squamous cell carcinomas.

The coding of condylomatous carcinoma and warty carcinoma changed from 8051/3 to 8054/3 in 2018 for penile sites only in the 2018 ICD-O-3 New Codes, Behaviors, and Terms-Updated 8/22/18.

Override the edit until the edit issue is explored.

Date Finalized
02/20/2020

20200002

References
Source 1: **2018 SEER Manual**
pgs: **7, 9-10**
Notes: **Reportability section**

Question
Reportability/In situ--Prostate: Has there been a change in reportability for prostatic intraepithelial neoplasia (PIN III) (C619)? The 2018 SEER Manual notes: Collection stopped effective with cases diagnosed 01/01/2001 and later; however, on the casefinding list effective 10/01/2019, code D07.5, carcinoma in situ of prostate, is listed as reportable.

Answer
PIN III is not reportable in accordance with the 2018 SEER Manual; however, carcinoma in situ of the prostate is reportable as they represent different histology codes. The casefinding list is used to search for reportable cases and is not the same as a reportable list.

Date Finalized
02/20/2020

20190108

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

Question
Primary site--Breast: how is subsite coded for a breast cancer when it is described as central portion between 1-3:00 or central portion at 12:00?

Answer
See the SEER coding guidelines for breast, https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guidelines_Breast_2018.pdf
Generally, codes C502 - C505 are preferred over C501. C501 would be preferred over C508. Apply these general guidelines when there is no other way to determine the subsite using the available medical documentation.

Table 1, Primary Site codes, in the breast solid tumor rules also provide helpful information for coding site.

Date Finalized
01/17/2020

20190107

References
Source 1: None listed

Question
First Course Treatment/Chemotherapy--Colon: Is maintenance therapy coded as part of the first course of treatment or as part of subsequent course of treatment?

Discussion
Patient was diagnosed with Stage IV colon cancer (liver metastasis) and started on Folfox with Avastin. The medical oncologist decided to continue maintenance treatment with Xeloda and Avastin.

Per Colon NCCN Guidelines Version 3.2019, interest in the use of maintenance therapy approach after first-line treatment of unresectable, metastatic colorectal cancer is growing. In general, this approach involves intensive first-line therapy, followed by less intensive therapy until progression in patients with good response to initial treatment.

Colon Therapy

5/1/18 Colonoscopy biopsy: mod diff colon adenoca, MMR proficient, BRAF wild type

5/5/18 Liver biopsy: mets from colon cancer

6/18/18 – 11/20/2018 Med Onc: started 12 cycles Chemo - Folfox (Fluorouracil, leucovorin, Oxaliplatin) with Avastin

11/28/18 CT Pelvis: continued improvement in the liver mets; no residual tumor involving colon; no new mas or adenopathy in the chest, abdomen or pelvis

12/02/18 Med Onc follow up: Pt had tremendous response to chemotherapy and Avastin, cancer is not curable. Is amenable to maintenance therapy with Xeloda and Avastin; also, amenable to descending colectomy in the future

1/7/19 Med Onc: starting maintenance treatment Xeloda + Avastin.

Answer
Code the maintenance therapy as first course when the maintenance therapy includes at least one of the drugs from the original treatment. Use text fields to record the details.

FINALIZED SEER SINQ QUESTIONS

January – April 2020

Date Finalized

01/17/2020

20190106

References
Source 1: **2018 SEER Manual**
pgs: **107-109**

Question
Tumor Size--Esophagus: Can information from the endoscopy procedure that implies a size of 3 cm for Tumor Size--Clinical be used for Esophagus? See Discussion.

Discussion
1-28-2018 CT Scan: 2.4 cm mass

2-15-2018 Endoscopy: Mass was present 22 to 25 cm. Biopsies were taken with cold forceps for histology; biopsy positive.

Answer
For the case you describe, we would record the clinical tumor size stated on the CT report.

The priority order for clinical tumor size is as follows.

1. Biopsy or operative (surgical exploration) report

2. Imaging

3. Physical exam

We do not recommend coding tumor size based on an inferred tumor size from a description such as "Mass was present 22 to 25 cm." Look for an actual measurement of the mass, or a stated tumor size. Use text fields to record details.

Date Finalized
04/24/2020

20190105

References
Source 1: **Subject matter expert**

Question
Histology--Brain and CNS: What morphology code should be assigned to a low-grade glial/glioneuronal neoplasm? See Discussion.

Discussion
Pathology Diagnosis: Left temporal lesion - Low grade glial/glioneuronal neoplasm BRAF mutant. Pathologist Comment: The histopathological appearance of this lesion does not allow for a definitive diagnosis. However, the low-grade appearance, fibrillary nature, immunohistochemical profile, and the presence of a BRAF V600E mutation allow this to be categorized as a low-grade glial or possibly glioneuronal tumor. Despite the lack of exact classification this neoplasm can be expected to behave in a very indolent manner consistent with a WHO grade I classification.

Answer
Assign 9413/0 for glioneuronal neoplasm.

We consulted with our expert neuropathologist about the histology "glioneuronal neoplasm." This term is relatively new and has not yet been recognized by WHO or assigned an ICD-O code. Until such time that WHO determines a code for this neoplasm, our expert instructed us to use 9413/0. Since this is not a recognized neoplasm it is not included in the solid tumor rules.

Date Finalized
01/17/2020

20190104

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

Question
Histology--Corpus uteri: Is 8020/3 used for a predominantly dedifferentiated carcinoma with focal well-differentiated endometrioid adenocarcinoma diagnosed in 2018? See Discussion.

Discussion
After a little research, it appears as though Endometrial Dedifferentiated carcinoma is a relatively new term and is set to be included in ICD-O-3.2:

http://www.iacr.com.fr/index.php?option=com_content&view=category&layout=blog&id=100&Itemid=577

If you look at the link on that page for All Additions, Changes, and Revisions to the ICD-O-3, 1st Revision for ICDO-3.2, there is 8020/3 Dedifferentiated carcinoma. Currently, 8020/3 is Carcinoma, undifferentiated, NOS. For 2018 diagnosis, would you use 8020/3 for a predominantly dedifferentiated carcinoma with focal well-differentiated endometrioid adenocarcinoma as stated in the pathology: Uterus, bilateral ovaries and fallopian tubes; supracervical hysterectomy/BSO: Predominantly dedifferentiated carcinoma with focal well-differentiated endometrioid adenocarcinoma in the endometrium, FIGO grade 1 Portion of omentum, omental/anterior abdominal wall/ round ligament/uterine/small bowel mesenteric tumor nodules all involved by dedifferentiated carcinoma. Synoptic reads as follows: Histological Type: Endometrioid carcinoma, NOS Dedifferentiated carcinoma predominantly Histological Grade: Endometrioid carcinoma, FIGO grade 1.

Answer
Assign code 8380/3 for endometrioid carcinoma, NOS as this is listed as the histological type in the synoptic report.

Date Finalized
01/17/2020

20190103

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

Question
Solid Tumor Rules/Multiple primaries--Brain and CNS: What M rule applies to a clinically diagnosed right-sided parietal meningioma undergoing active surveillance, followed by a left-sided frontal anaplastic oligodendroglioma? See Discussion.

Discussion
The patient has two, separate, non-contiguous tumors. One tumor is a benign meningioma and the other is a malignant oligodendroglioma.

The original plan was not to treat the asymptomatic meningioma. However, after worsening symptoms, imaging and resection proved a separate left frontal lobe malignant tumor.

Rule M5 is the only M Rule in the Malignant CNS Multiple Primary Rules, Multiple Tumors module that addresses separate non-malignant and malignant tumors. This rule provides only two criteria to follow when a malignant tumor follows a non-malignant tumor. The first criteria (for non-malignant tumor followed by malignant tumor) states:

--Patient had a resection of the non-malignant tumor (not the same tumor) OR

--It is unknown/not documented if the patient had a resection.

This patient did not have a resection of the original, separate, non-malignant tumor, but the treatment plan was known to not include a resection. Should Rule M5 also apply to cases where the patient never had treatment planned for the separate non-malignant tumor?

Answer
Apply 2018 Malignant CNS Solid Tumor Rule M5 and abstract multiple primaries when there are multiple CNS tumors, one of which is malignant /3 and the other is non-malignant /0 or /1. According to Note 3, a non-malignant CNS tumor and a malignant CNS tumor are always multiple primaries (timing and primary sites are irrelevant). Prepare two abstracts; one for the non-malignant and another for the malignant tumor.

FINALIZED SEER SINQ QUESTIONS

January – April 2020

Date Finalized

01/17/2020

20190102

References
Source 1: **ICD-O-3**
pgs:
Notes:
Source 2: **2018 SEER Manual**
pgs: **6-7**
Notes: **Reportability section**

Question
Solid Tumor Rules/Histology--Head & Neck: What is the histology code of an external ear lesion when the dermatopathology report is the only available information (follow-up with the physician or pathologist is not possible) and the final diagnosis is malignant spindle cell neoplasm, most consistent with atypical fibroxanthoma? See Discussion.

Discussion
There are two histologies provided in the final diagnosis, malignant spindle cell neoplasm (8004/3) and atypical fibroxanthoma (8830/3). There is a definitive diagnosis of the non-specific histology, but the more specific histology is only described using ambiguous terminology.

The external ear (C442) is included in the Head and Neck schema for diagnosis year 2018 and later. The Head and Neck Histology Rules indicate ambiguous terminology cannot be used to code a more specific histology. So, ignoring the atypical fibroxanthoma, because it is modified by ambiguous terminology, we are left with a non-reportable site and histology combination (C442, 8004/3).

Diagnoses of malignant atypical fibroxanthomas are regularly diagnosed using the syntax above in our area. Follow-up with the physician or pathologist is generally not possible as these cases are received from dermatopathology clinics only. The pathology report is the only information that will be received. If the reportable diagnosis of malignant atypical fibroxanthoma is ignored per the current Solid Tumor Rules, incidence cases will be lost.

Answer
By definition, atypical fibroxanthoma (AFX) is a diagnosis of exclusion. Markers of specific differentiation must be negative. As written in your example, neither histology is reportable for skin. If possible, clarify the behavior of the AFX (8830/1) with the pathologist to determine reportability of the case.

FINALIZED SEER SINQ QUESTIONS

January – April 2020

Date Finalized
04/24/2020

20190098

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

Question
Solid Tumor Rules (2018)/Multiple primaries--Breast: How many primaries are there and how is histology coded for a breast primary showing encapsulated papillary carcinoma and Paget disease of the nipple? See Discussion.

Discussion
Patient has a 1.7 cm encapsulated papillary carcinoma staged as pTis located 2 cm from the nipple and Paget disease of the nipple on mastectomy pathology.

There is no indication in Table 3: Specific Histologies, NOS/NST, and Subtypes/Variants that encapsulated papillary carcinoma is a subtype of ductal carcinoma. Rule M8 notes that if the histology of the underlying tumor is any histology OTHER THAN duct or subtypes of duct, one should continue through the rules. But if M9 applies to this case, then incidence reporting will be increased in comparison to prior years.

Answer
Abstract multiple primaries when there is Paget disease (8540/3) and an underlying tumor that is not duct, in this case, encapsulated papillary carcinoma (8504/2) using Rule M9 of the 2018 Breast Solid Tumor Rules.

Date Finalized
01/02/2020

20190097

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

Question
Solid Tumor Rules (2018)/Multiple primaries--Lung: How many primaries are there and what M rules apply for multiple lung histologies in the left lower lobe (LLL) and right upper lobe (RUL) of the lungs? See Discussion.

Discussion
There is one tumor in the left lung that is acinar adenocarcinoma, 8551/3, and two tumors in the right lung, one of which is 8551/3 and a separate one that is mucinous adenocarcinoma 8253/3.

3/21/18- left robotic video assisted thoracoscopy with left lower lobe lobectomy: 2.5 cm adenocarcinoma, acinar predominant, margins negative

11/3/18- right upper lobe lobectomy: invasive mucinous adenocarcinoma, 1.7 cm, invasive adenocarcinoma, acinar predominant, 0.6 cm, margins negative

If you start by comparing the 8551/3 left lung tumor to the 8253/3 right lung tumor, M6 applies and these would be separate primaries (seq 01 and seq 02). How would we handle the third tumor, 8551/3, in the right lung? Seq 01: 3/21/18- left lung primary 8551/3 Seq 02: 11/3/18- right lung primary 8253/3 Is the right lung tumor 8551/3 a third primary, and if so, which M rule applies? I cannot find a rule that seems to fit completely. Rule M6 may apply if you were comparing the right 8551/3 tumor to the seq 02 8253/3 tumor. But how would you know to use the seq 02 histology code 8253/3 or seq 01 histology code 8551/3 for the comparison? I think M9 was designed for situations where you have multiple tumors involving both lungs, but they didn't biopsy all of them. Is that correct? If so, then we would be able to bypass M9. Would M11 apply since we already took care of two of the tumors with rule M6? If M11 doesn't apply, it seems like you would get to M14.

Answer
Abstract two primaries applying Rules M6 and M9 s follows.

First, assign a histology for each tumor.

--LLL adenocarcinoma, acinar predominant 8551/3

--RUL invasive mucinous adenocarcinoma 8253/3

--RUL invasive adenocarcinoma, acinar predominant 8551/3

For the RUL, this is two primaries according to Rule M6, to subtypes in Column 3 of the histology table.

For the LLL and RUL, this represents the same primary as these are the same histology according to Rule M9.

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01/02/2020

20190096

References
Source 1: **2018 Solid Tumor Rules**
pgs: **21-22**
Notes: **Colon, July 2019 Update**

Question
Solid Tumor Rules (2018)/Multiple primaries--Colon: Is a colorectal anastomotic site recurrence reportable, that is, a second primary, per Rule M7, third bullet, if there is no mention of mucosa but the tumor is seen on colonoscopy? See Discussion.

Discussion
Colon, Rectosigmoid, and Rectum Multiple Primary Rule M7 states, Abstract multiple primaries when a subsequent tumor arises at the anastomotic site AND the subsequent tumor arises in the mucosa.

We identified tumors at the anastomotic site of previous colon primaries with no mention of mucosa in any of the available documentation. Are there any other indicators that would imply a tumor arising in the mucosa, or do we need this specific statement to consider these an additional primary?

Example: Patient has a history of invasive ascending colon adenocarcinoma diagnosed in October 2017 status post hemicolectomy followed by adjuvant chemo. There is no documentation of disease until August 2019 colonoscopy which shows a mass in the ileocolic anastomosis. Biopsy of the anastomotic site is positive for adenocarcinoma consistent with recurrence of the patient's colonic adenocarcinoma. There is no mention of mucosa found on the pathology report.

Answer
Abstract a single primary using 2018 Colon Solid Tumor Rule M8 in the example provided as there is a subsequent tumor occurring less than 24 months in the anastomotic site, with the same histology and no mention of mucosa.

The new tumor would be a new primary when it meets any one of the criteria noted in M7. The tumor does not have to be stated to have arisen in the mucosa. M8 also has three options to determine if a single primary is present.

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01/02/2020

20190095

References
Source 1: **ICD-O-3**
pgs:
Notes:
Source 2: **2018 SEER Manual**
pgs: **7**
Notes: **1.a.vii**

Question
Reportability/Histology--Thymus: Is a thymoma a malignancy if described as having separate tumor nodules within peri-thymic adipose tissue? See Discussion.

Discussion
Patient had a thymectomy including pericardial fat for a mediastinal mass found incidentally during lung screening. Final diagnosis is WHO B3 thymoma. Staging Summary lists transcapsular invasion: "Present, as separate tumor nodules within peri-thymic adipose tissue." Tumor extension is stated to be "Confined to thymus, including peri-thymic adipose tissue." The pathologist staged this resection as pT1a pNX with no mention of mets. Clinically, there are no noted metastatic sites and no further treatment is planned.

Answer
Report this case as a malignant thymoma. Our expert pathologist consultant reviewed this case and, in his opinion, the "separate tumor nodules within peri-thymic adipose tissue" fit registry reporting criteria for separate tumor nodules making this a malignant thymoma.

Date Finalized
01/16/2020

20130123

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

Question
Primary site--Heme & Lymphoid Neoplasms: How is the primary site coded for a diffuse large B-cell lymphoma, immunoblastic variant involving the left maxillary vestibule and entire left maxilla? See Discussion.

Discussion
The clinical history indicates a destructive, quickly growing intra-oral lesion in the left soft tissue vestibule and the entire left maxilla.

Pathology report final diagnosis: Oral cavity, left maxilla, incisional biopsy: Malignant lymphoma, non-Hodgkin, diffuse large B-cell type, immunoblastic variant.

Answer
Code the primary site to C068 [overlapping lesion of the mouth] per Rule PH24. Code the primary site to the organ when lymphoma is present only in an organ.

This lesion overlaps the left soft tissue of the maxilla (the maxillary gingiva) [C030] and the left vestibule of the mouth [C061]. There is no documentation indicating in which specific site the lesion arose. The maxilla is the upper jawbone. The soft tissue that overlies the maxilla is a part of the oral cavity. It is reasonable to interpret the documentation such that the tumor in the maxilla is an extension of the overlapping oral mucosa tumor.

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.

History
Code the primary site to oral cavity/oral mucosa, C069. This lesion arises in the soft tissue of the maxilla. The maxilla is the upper jawbone and the soft tissue that overlies the maxilla is part of the oral cavity. DLBCL does not originate in the bone, so it is reasonable to interpret the documentation such that the tumor in the maxilla is an extension of the oral mucosa tumor.

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