20170006

References
Source 1: **Heme & Lymph Manual & DB**
pgs: **13-15**
Notes: **published January 2015**
Source 2: **Heme & Lymph Manual & DB**

Question
Heme & Lymphoid Neoplasms/Diagnostic confirmation--Lymphoma: To code "3" in Diagnostic Confirmation, does the genetic testing need to confirm a specific histology or is it enough that is simply rules out others? See Discussion.

Discussion
For example, pathology states: Right axillary lymph node, excision: Diffuse large B-cell lymphoma (DLBCL) (see note). COMMENT: FISH studies were performed that were negative for BCL-6, c-Myc/IgH, CCND1/IgH and IgH/BCl-2 gene rearrangement, ruling out the most common forms of double-hit lymphoma. Flow cytometry studies demonstrated positivity for CD45, CD20, HLA-Dr, CD19, CD11c, CD22, CD30, CD38, CD79b, and FMC7. Low positivity was seen for CD5. No reactivity was seen for CD10, CD23, CD25, CD103 or CD123.

Answer
Both histologic plus immunophenotyping or genetic testing should be positive to assign code 3 for Diagnostic Confirmation. The Hematopoietic and Lymphoid Neoplasm Coding Manual Diagnostic Confirmation instructions state, assign 3 for cases positive for 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 DB AND a.) Confirms the neoplasm OR b.) Identifies a more specific histology (not preceded by ambiguous terminology).

Because the patient was diagnosed with DLBCL by histology, and flow cytometry was positive for CD antigens (immunophenotyping) 20, 22, and 30 for DLBCL, code 3 is appropriate.

Date Finalized
03/06/2017

20170005

References
Source 1: **WHO Classification of Tumors of the Urinary System and Male Genital Organs**
pgs: **223**
Notes: **4th ed.**

Question
Reportability/Histology--Testis: Is neoplasm consistent with carcinoid type of monodermal teratoma reportable as a teratoma, NOS, and if yes, what is the histology code?

Answer
Carcinoid type of monodermal teratoma or well differentiated neuroendocrine tumor (carcinoid), monodermal teratoma of the testis is reportable. Assign 8240/3 according to the WHO classification for this neoplasm.

Date Finalized
03/06/2017

20170004

References
Source 1: **WHO Classification of Tumors of the Urinary System and Male Genital Organs**
pgs: **12, 33**
Notes: **4th ed.**

Question
MP/H Rules Histology--Kidney/renal pelvis: How is MiT family translocation renal cell carcinoma (RCC) with Xp11 translocation coded? See Discussion.

Discussion
Pathology states: Translocation renal cell carcinoma. Comment Tumor morphology and IHC profile consistent with MiT family translocation RCC with Xp11 translocation.

Answer
Assign 8312/3 to MiT family translocation renal cell carcinoma (RCC) with Xp11 translocation.

The recent WHO 4th Ed Tumors of the Urinary System has proposed a new ICD-O-3 code for MiT family translocation RCC, however the implementation of this new code has not yet been approved by the standard setters (SEER, CoC, CDC, NAACCR). Until it is approved, code histology to renal cell carcinoma (8312/3).

Date Finalized
03/06/2017

20170003

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

Question
Reportability/Histology--Brain and CNS: Is epidermoid tumor of the cerebellopontine angle (CPA) and trigeminal vesicle nerve reportable, and if so, what is the correct histology code? See discussion.

Discussion
Patient presented to hospital ED and had brain MRI that revealed 3.2 cm space occupying lesion in region of the left CPA and trigeminal vesicle nerve compatible with epidermoid tumor.

Answer
Epidermoid tumor of the brain is not reportable. There is no ICD-O-3 code for epidermoid tumor or epidermoid cyst. This type of tumor is often referred to as a cyst because it has a thin wall that secretes a soft material into the center.

Date Finalized
03/06/2017

20170002

References
Source 1: **2016 SEER Manual**
pgs: **6**

Question
Reportability--Brain and CNS: Are cavernous sinus meningiomas reportable? See Discussion.

Discussion Per SINQ 20160068, sphenoid wing meningiomas are reportable (unless stated to be intraosseous) because they arise from the meninges overlying or along the sphenoid wing/sphenoid bone. These are intracranial and not intraosseous meningiomas.

Therefore, wouldn't this logic also apply to cavernous sinus meningiomas? These are tumors that arise from the meninges of an intracranial space, not from bone or soft tissue. The cavernous sinus is a "true dural venous sinus" within the skull. While not specifically about meningiomas, SINQ 20071095 states a benign tumor in the cavernous sinus is coded to C490. This SINQ would still seem valid for a benign tumor like a blood vessel tumor, but not for a meningioma that doesn't arise from soft tissue or blood vessels.

Answer
Cavernous sinus meningiomas are reportable, as the meningioma arises in the meninges unless stated otherwise. This is similar to sphenoid wing meningiomas.

Date Finalized
03/06/2017

20170001

References
Source 1: **WHO Classification of Tumors of the Urinary System and Male Genital Organs**
pgs: **35**
Source 2: **2007 MP/H Rules**

Question
MP/H Rules/Histology--Kidney: How is the histology coded and what rule(s) apply to the classification of succinate dehydrogenase-deficient renal cell carcinoma? See Discussion.

Discussion Partial nephrectomy showed carcinoma, histologic type: succinate dehydrogenase-deficient renal cell carcinoma. This is not a term in the ICD-O, and is not a histology covered in the Kidney MPH rules. However, a recent web search indicates this is a specific type of RCC that was added to the 2016 WHO classification of RCC (per abstract: https://www.ncbi.nlm.nih.gov/pubmed/27179267) and makes up 0.05-0.2% of RCC cases (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4229399/).

Answer
Code the histology to renal cell carcinoma, NOS (8312/3). While WHO lists succinate dehydrogenase-deficient renal cell carcinoma in the latest edition, no specific histology code is provided. MP/H Rule H10 applies since only one histology type is provided, though no code is listed.

Date Finalized
03/06/2017

20160079

References

Source 1: **https://www.ncbi.nlm.nih.gov/pubmed/22868084**

Question

First course treatment/Chemotherapy: Is metronomic chemotherapy coded as chemotherapy?

Answer

Code metronomic chemotherapy as chemotherapy. Metronomic chemotherapy, also referred to as low-dose metronomic (LDM) chemotherapy, is an emerging cancer treatment approach which administers relatively low doses of traditional chemotherapy drugs over a long period of time and without 'breaks' in treatment. By using lower doses this method of treatment minimizes the side effects of traditional chemotherapy.

Date Finalized

02/02/2017

20160078

References

Source 1: **http://www.radiologyinfo.org/en/info.cfm?pg=fiducial-marker**

Question

First course treatment/Radiation Therapy--Prostate: How do you code fiducial markers for prostate cases?

Answer

Do not code fiducial markers as a form of radiation treatment; rather, code the radiation therapy in the radiation treatment section. Fiducial markers are small metal spheres, coils, or cylinders that are placed in or near a tumor to help guide the placement of radiation beams during treatment.

Date Finalized

02/02/2017

20160077

References
Source 1: **SEER*Rx**

Question
First course treatment/Immunotherapy--Prostate: Is XGEVA, given for bone mets from prostate cancer, abstracted as immunotherapy, or is it an ancillary drug and not recorded?

Answer
Do not record XGEVA when given for bone mets from prostate cancer. See SEER*Rx for more information.

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02/02/2017