20240075

References:
#1: 2024 SEER Manual, 13-14. Reportability

#2: WHO Class Breast Tumors, online version. 5th edition

Question:
2024 SEER Manual/Reportability--Breast: Is "lobular intraepithelial neoplasia" (LIN) a glandular intraepithelial neoplasia? If so, is lobular neoplasia II (LN II)/LIN II non-reportable, similar to PanIN II - SINQ 20240026? See Discussion.

Discussion:
The Reportable Diagnosis List indicates "Lobular neoplasia grade II (LN II)/lobular intraepithelial neoplasia grade II (LIN II) breast (C500-C509)" is reportable.

The ICD-O-3.2 lists “Glandular intraepithelial neoplasia, grade II” and “Glandular intraepithelial neoplasia, low grade” as histology code 8148 with behavior of /0 (benign).

Answer:
Report LN II and LN III along with LIN II and LIN III and assign code 8520/2.

WHO Classification of Breast Tumors, 5th edition, lists lobular neoplasia as acceptable, related terminology for lobular carcinoma in situ.

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12/30/2024

20240074

References:
#1: Solid Tumor Rules. Head and Neck, 2024 Update

#2: WHO Class H & N Tumors. 5th edition, online version

Question:
Solid Tumor Rules/Histology--Head & Neck: How is histology coded for nasopharyngeal non-keratinizing squamous cell carcinoma, undifferentiated type? See Discussion.

Discussion:
Example: Patient had a 2023 nasopharyngeal mass biopsy showing "Nasopharyngeal non-keratinizing squamous cell carcinoma, undifferentiated type."

The Head and Neck Solid Tumor Rules (STRs) do not include an H Rule that instructs us how to code histology when there are two subtypes/variants present for a head and neck primary, nor does the STR define undifferentiated carcinoma as a subtype/variant for 8072.

The WHO Classification of Head and Neck Tumors states non-keratinizing nasopharyngeal carcinoma (non-keratinizing squamous cell carcinoma (SCC) is the most common subtype for nasopharyngeal ca, but that non-keratinizing can be subdivided into undifferentiated and differentiated subtypes.

Should histology be 8020 (undifferentiated carcinoma) or 8072 (non-keratinizing SCC)?

Answer:
Assign histology as 8072 for non-keratinizing SCC, undifferentiated subtype.

WHO Classification of Head and Neck Tumors, 5th edition assigns 8072/3 to squamous cell carcinoma, non-keratinizing, NOS in the nasopharynx. As the tumor exhibits a variety of architectural patterns and appearances histologically, they can be further classified as undifferentiated or differentiated subtypes. These subtypes do not change the histology code.

Date Finalized:
11/29/2024

20240073

References:
#1: Solid Tumor Rules. Urinary, 2024 Update

#2: 2021 ICD-O-3.2 Update

Question:
Solid Tumor Rules/Multiple Primaries--Bladder: Urinary Sites Solid Tumor Rules (STRs), Rule M6, says to abstract multiple primaries when an invasive tumor occurs more than 60 days after an in situ tumor. Does that 60-day interval apply to the original diagnosis date, or to the latest recurrence? See Discussion.

Discussion:
10/2017 Bladder cancer diagnosed as invasive papillary urothelial bladder carcinoma (8130/3) (submucosal invasion).

12/2017 Surveillance scope and transurethral resection of bladder tumor (TURBT) finds "recurrent" bladder tumor, non-invasive papillary urothelial bladder carcinoma (8130/2) - same primary per 2007 Multiple Primaries/Histology, Rule M6, (both papillary urothelial bladder carcinomas).

4/2018 Radical nephrectomy found focally invasive urothelial carcinoma (8120/3) in the renal pelvis.

Is this a new primary per 2018 and forward STR, Rule M6, because it was more than 60 days since the 12/2017 in situ bladder recurrence? Or would one compare the 2018 diagnosis to the original invasive bladder tumor in 10/2017, and continue on to Rule M11, which says to abstract a single primary for urothelial carcinomas in multiple organs, regardless of behavior?

SINQ #20120080 said to compare to the original diagnosis and disregard intervening recurrences, but that pertained to the 2007 MP/H rules. Does this still apply for 2018 forward? STR, Rule M10, Note 3, states when there is a recurrence within three years of diagnosis, the "clock" starts over. The time interval is calculated from the date of last recurrence. Comparing each recurrence for urothelial carcinomas using Rule M6 could result in over-counting them. Can the instructions on how to calculate the 60-day interval be clarified in Rule M6?

Answer:
Abstract a single primary for this scenario based on Urinary Sites STRs.

10/2017 and 12/2017 bladder diagnoses: Single primary (Rule M15: Abstract a single primary when synchronous, separate/non-contiguous tumors are on the same row in Table 2 in the Equivalent Terms and Definitions). This interval is not indicative of recurrence as there is no clinically disease free period on follow-up.

Use the Multiple Primary Rules as written to determine whether a subsequent tumor is a new primary, or a recurrence as stated in the General Instructions. The only exception is when a pathologist compares slides from the subsequent tumor to the "original" tumor and documents the subsequent tumor is a recurrence of the previous primary. Never code multiple primaries based only on a physician's statement of "recurrence" or "recurrent."

12/2017 (bladder) and 4/2018 diagnoses (renal pelvis): Single primary (Rule M11: Abstract a single primary when there are urothelial carcinomas in multiple urinary organs; behavior is irrelevant.)

Date Finalized:
11/29/2024

20240072

References:
#1: Solid Tumor Rules. Head and Neck, 2024 Update

#2: SSDI Manual. v3.1; Appendix A

Question:
Solid Tumor Rules/Histology--Oropharynx: How is histology coded for a 2024 squamous cell carcinoma of the tonsil when immunohistochemistry (IHC) stains are negative for p16, but in situ hybridization (ISH) testing is positive for human papilloma virus (HPV)? See Discussion.

Discussion:
The Solid Tumor Rules state that for cases diagnosed in 2022 and forward, p16 testing CAN be used to assign histology code 8085 (squamous cell carcinoma, HPV positive). The rules also state that for cases diagnosed prior to 1/1/2022, code 8085 MUST be based on ISH testing and not p16. ISH testing is not specifically addressed for 2022+ cases, but are we correct in assuming it can still be used as the basis for 8085?

Multiple CAnswer Forum posts and the AJCC 8th edition Head and Neck staging webinar indicate that the correct chapter/registry staging schema in this situation is determined ONLY by p16 results - not ISH testing, and therefore the Schema Discriminator 2 SSDI should be coded as 1 – p16 negative, regardless of ISH results.

While we understand that histology codes should not be changed based on staging criteria, there is a SEER/NAACCR edit, "Schema Discriminator 2, Head and Neck, Histology (NAACCR)" tag number N6802, that will not allow coding 8085 if Schema Discriminator 2 is coded as 1 (p16 negative). The edit does seem to be correctly enforcing the AJCC guidelines for choosing the staging schema, based on the sources noted above. Do the Solid Tumor or Site-Specific Data Items (SSDI) guidelines need to be modified for this situation?

Answer:
Assign histology as squamous cell carcinoma, HPV positive (8085) for tonsil, NOS (C099) based on the positive HPV test. Codes 8085 and 8086 are valid for a select group of sites. The histology terms and codes that are valid for head and neck sites are included in the Head and Neck Solid Tumor Rules, Table 5 (oropharynx).

HPV detection tests that are used to identify HPV include DNA polymerase chain reaction (PCR), p16 (IHC), or DNA/RNA in situ hybridization. Assign the appropriate method of detection in the SEER data item, SEER Site-Specific Factor 1.

Schema Discriminator 2 captures additional information needed to generate AJCC ID and Schema ID for some anatomic sites as stated in the SSDI Manual. For oropharyngeal cancer, a schema discriminator is used to discriminate between oropharyngeal tumors that are p16 positive, p16 negative, or p16 status unknown in order to assign the appropriate schema ID. Only the HPV p16 test can be used to assign Schema Discriminator 2. If another HPV test is performed, code 9. Override the edit for Schema Discriminator 2 when p16 is negative. Coding updates will be implemented in 2025.

Date Finalized:
11/29/2024

20240071

References:
#1: Heme & Lymph Manual & DB. Published August 2021

#2: Journal article. https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(23)00555-2/fulltext

Question:
Heme and Lymphoid Neoplasms/Multiple Primaries--Myeloproliferative Neoplasms: Are essential thrombocytosis (ET) in 1998 and primary myelofibrosis in 2022 the same primary or is the 2022 diagnosis a new primary? See Discussion.

Discussion:
Patient was diagnosed with essential thrombocytosis 9962/1 or 3 in 1998 (depending if ET was reportable in 1998), treated with Hydrea.

11-17-2022 Blood smear: CALR + myeloproliferative neoplasm, Most Consistent with Primary Myelofibrosis 9961/3 (Noted CALR and ASXL1 mutations).

The following abstractor note from 9661/3 is confusing: A diagnosis of "post essential thrombocythemia myelofibrosis" is a progression of essential thrombocythemia and would be the same primary.

Answer:
Abstract two separate primaries, ET (9962/3) and primary myelofibrosis (9961/3) using the current Hematopoietic and Lymphoid Neoplasms (Heme) Manual and Database (DB), Rule M15, use the Heme DB Multiple Primaries Calculator. Also refer to the example in Rule M15. In 1998, though the ET was not reportable (9962/1), the patient was treated with chemotherapy as a malignant neoplasm (9962/3). The Calculator instructs us to code separate primaries for these two histologies.

ET may evolve into a secondary myelofibrosis, also known as post-essential thrombocythemia-myelofibrosis (post-ET MF). The diagnosis must be stated as post-ET MF; this would be a single primary.

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11/29/2024

20240070

References:
#1: Cancer PathCHART. https://seer.cancer.gov/cancerpathchart/

#2: 2024 SEER Manual, 13-22. Refer to the most current version of the SEER Manual

Question:
Reportability/Histology: Does Cancer Pathology Coding Histology and Registration Terminology (Cancer PathCHART) determine if the histology is reportable, or do we have to use the Excel ICD-O-3.2 spreadsheet?

Answer:
The CPC ICD-O-3 Site Morphology Validation Lists (SMVLs) designate all tumor site-morphology combinations that are either valid or impossible as determined for the sites reviewed by the Cancer PathCHART initiative. These lists provide information on the *Validity Status* of specific tumor site and morphology combinations, similar to the way the ICD-O-3 SEER Site/Histology Validation List used to. However, the CPC SMVLs do **not** include information on the *reportability* of specific tumor site and morphology combinations. For tumor reportability, you will continue to use the Excel ICD-O-3.2 spreadsheets posted to the NAACCR ICD-O-3 Coding Updates website: https://www.naaccr.org/icdo3/, and the most recent SEER Manual and federal, state, local, and other standard setters' reportability requirements.

Date Finalized:
10/04/2024

20240068

References:
#1: Solid Tumor Rules. Other Sites, 2024 Update

#2: WHO Class Female Genital Tumors, 45-47. 5th edition

Question:
Solid Tumor Rules/Histology--Ovary: How is histology coded for an ovary case with a diagnosis of "high grade papillary serous carcinoma" in 2023? This term is not in the Solid Tumor Rules and ICD-O 3.2 updates. Is "high grade papillary serous carcinoma" equivalent to "high grade serous carcinoma" (8461) or to "papillary serous adenocarcinoma" (8441) with high grade captured only in the Grade fields, or is there another more appropriate code?

Answer:
Assign code 8461/3 for high-grade papillary serous carcinoma.

Date Finalized:
11/29/2024

20240067

References:
2024 SEER Manual, 18-21. Reportability/Ambiguous Terminology

Question:
Reportability/Ambiguous Terminology--Kidney: Is a clinical diagnosis of a right kidney lesion with a "75% chance of malignancy" reportable when no further information is available? See Discussion.

Discussion:
The CT findings identified a right kidney rim-enhancing centrally cystic lesion most suggestive of clear cell renal cell carcinoma measuring 3.2 cm. The radiologist's impression was "concerning for renal cell carcinoma." The subsequent urologist's consult states the right kidney lesion has a 75% chance of malignancy. The urologist discussed active surveillance, surgery, and ablation, and after discussion with the patient the plan was for active surveillance.

No further information is available, and we are unable to follow up with the physician regarding this case.

Should a lesion with a high percentage chance of malignancy (e.g., 75% chance) be considered a lesion "most likely" to be malignant?

Answer:
If you are unable to follow up with the physician, do not report this case until or unless more information becomes available.

Date Finalized:
11/29/2024

20240066

References:
WHO Class Hem & Lymph Tumors. 4th and 5th editions

Question:
Histology--Heme & Lymphoid Neoplasms: How should histology be coded for a pathologic diagnosis of "Follicular lymphoma, diffuse pattern grade 3A of 3, equivalent to diffuse large B cell lymphoma (germinal center cell type)" when later referenced clinically as follicular lymphoma grade 3A? See Discussion.

Discussion:
The WHO Classification of Hematopoietic Tumors (Blue Book), 5th edition states: "Rare cases of classic follicular lymphoma with cytological features of follicular lymphoma (FL) grade 3A can present with a prominent diffuse pattern. In the previous edition, such cases were defined as diffuse large B-cell lymphoma (DLBCL). Currently, it is uncertain whether such cases should be classified as FL or diffuse large B-cell lymphoma; and in such cases, individual treatment choices should be made in multidisciplinary conference settings taking into consideration clinical, laboratory, and imaging parameters. The presence of diffuse areas composed entirely or predominantly of large cells, however, warrants a diagnosis of diffuse large B-cell lymphoma."

Our concern is that the Hematopoietic (Heme) Manual and Database do not provide instruction for coding this scenario. We hesitate to interpret the terms "equivalent to" as ambiguous because one could argue it is unambiguous. Barring this argument, the M and H rules would indicate this is a diagnosis of diffuse large B-cell lymphoma. However, the physician does not seem to agree with the pathologist.

Answer:
Assign histology as DLBCL (9680/3) as supported by the WHO Classification of Hematolymphoid Tumors, 5th edition. It is consistent with how it would have been coded in the 4th edition. The Heme Manual and Database currently are based on the 4th edition. Physicians are using the 5th edition blue book, whereas the cancer registry field is not yet at this time.

Regarding the Heme Manual and Database, this type of scenario is not covered because it is part of the 5th edition WHO Blue Book. The database cannot be updated until the 5th edition is approved for implementation (2026).

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10/04/2024

20240065

References:
#1: WHO Class Female Genital Tumors. 5th edition, Ovary

#2: Solid Tumor Rules. Other Sites, 2024 Update, Table 13

Question:
Solid Tumor Rules/Histology--Ovary: What is the histology code for an ovarian primary with a pathology report final diagnosis of "Small-Cell Carcinoma (Hypercalcemic Type), Large-Cell Variant" diagnosed in 2012 (using the Multiple Primaries H rules) and one diagnosed in 2024 (using the Solid Tumor Rules)? See Discussion.

Discussion:
2012 Total abdominal hysterectomy - bilateral salpingo-oophorectomy

Primary Site – Ovary, Right

Histology - Small-Cell Carcinoma (Hypercalcemic Type), Large-Cell Variant

2024 Total abdominal hysterectomy - bilateral salpingo-oophorectomy

Primary Site – Ovary, Left

Histology - Small-Cell Carcinoma (Hypercalcemic Type), Large-Cell Variant

Answer:
Abstract this case as a single primary. Code as 8044/3 (small cell carcinoma, hypercalcemic type) listed in the Other Sites Solid Tumor Rules, Table 13. Small cell carcinoma, large cell variant, is a subtype of small cell carcinoma, hypercalcemic type. This table does not include all possible histologies.

WHO Classification of Female Genital Tumors, 5th edition, states: Small cell carcinoma of the ovary, hypercalcemic type, is rare, accounting for < 1% of ovarian tumors. Small cell carcinomas, hypercalcemic type, are usually large, with a mean size of 15 cm (range: 6–26 cm). Large cells are present (in varying numbers) in half of these tumors, which are designated "small cell carcinoma, large cell subtype" if the large cells are predominant (which is rare).

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11/29/2024

20240063

References:
#1: Solid Tumor Rules. Urinary, 2024 Update

#2: WHO Class Urinary Tumors, 143-146; 150-151; 159. 5th edition

Question:
Solid Tumor Rules/Multiple Primaries--Bladder: How many primaries and what M Rule applies for a diagnosis of noninvasive micropapillary urothelial carcinoma (8131/2) in 2019, followed by a diagnosis of noninvasive papillary urothelial carcinoma (8130/2) in 2024?

Answer:
Abstract two primaries using Urinary Solid Tumor Rules, Rule M12. The histologies include non-invasive papillary urothelial carcinoma (8130/2) and non-invasive micropapillary urothelial carcinoma (8131/3). The two histology codes are listed as subtypes of Papillary urothelial (transitional cell) carcinoma in column 3 of Table 2.

WHO Classification of Urinary and Male Genital Tumors, 5th edition classifies micropapillary urothelial carcinoma as an aggressive subtype of urothelial carcinoma with carcinoma in situ present in more than half of all micropapillary carcinomas.

Rule 7 Note 3 of the Urinary Solid Tumor Rules states that there are no /2 subtypes for urothelial carcinoma with the exception of papillary urothelial carcinoma and applies to multiple occurrences of /2 urothelial carcinoma of the bladder.

Rule 8 applies to 8131/3 and 8120/3.

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11/29/2024

20240062

References:
2024 SEER Manual, 18-21. Reportability/Ambiguous Terminology

Question:
Reportability--Brain and CNS: Is an MRI finding of "statistically meningioma" reportable? See Discussion.

Discussion:
Example: Patient has a 2023 brain MRI described as having a "new dural based nodule, statistically meningioma, along the left distal tentorial incisura." All subsequent chart information is related to patient's unrelated diagnosis of multiple sclerosis only.

Is the terminology "statistically" reportable ambiguous terminology in this context?

Answer:
If you cannot clarify this with the involved physicians, do not report this case of meningioma based on information provided. There is no indication that the patient was treated or further evaluated for meningioma.

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10/04/2024