20180082

References

Source 1: **Summary Stage Manual 2018**
pgs: **15**
Notes: **General Coding Instructions, April 2018**

Question

Summary Stage Manual 2018—Lymphoma: SEER Summary Stage 2000 states: For lymphomas, any mention of lymph nodes is indicative of involvement and is used to determine the number and location of lymph node chains involved (see lymphoma scheme). This statement is not in SEER Summary Stage 2018. Does that mean we follow rules #4-7, pages 14-15, under Code 3: Regional Lymph Nodes only, for every site, including lymphoma?

Answer

The following statement "Any mention of the terms including fixed, matted, mass in the hilum, mediastinum, retroperitoneum, and/or mesentery, palpable, enlarged, shotty, lymphadenopathy are all regarded as involvement for lymphomas when determining appropriate code," is included in EOD Primary Tumor and is applicable to Summary Stage 2018.

The statement will be added as note 4 to the Lymphoma Summary Stage chapter. This will be included in the 2019 update (estimated release January 2019).

Date Finalized

12/14/2018

20180081

References
Source 1: **WHO Class Female Reproductive Organs**
pgs: **122**
Notes: **Uterine corpus section**

Question
Reportability--Corpus uteri: Is endometrial atypical complex hyperplasia/borderline endometrial adenocarcinoma (FIGO 1), (mucinous type), (no invasion of myometrium) reportable?

Answer
Do not report this case based on the information provided. The actual diagnosis is somewhere between atypical hyperplasia and carcinoma in situ. Do not report until/unless a more definitively reportable diagnosis is made.

Date Finalized
12/14/2018

20180079

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Breast**

Question

Solid Tumor Rules/Multiple primaries--Breast: How many primaries should be abstracted when papillary carcinoma is identified in two biopsies and a subsequent lumpectomy identified invasive ductal carcinoma with multifocal ductal carcinoma in situ (DCIS)? See Discussion.

Discussion
The right breast ultrasound shows a 1.4 cm mass at 8 o'clock and a separate mass .6 cm at 7 o'clock (site code for both C50.5). Pathology report: Right 8 o'clock core needle biopsy fragments of intracystic noninvasive papillary carcinoma (8504/2), right 7 o'clock core needle biopsy fragments of intracystic noninvasive papillary carcinoma (8504/2). Then, another facility performs a right breast lumpectomy (operative note not available). Outside Facility: Right breast lumpectomy pathology shows invasive ductal carcinoma .6cm (8500/3) multifocal DCIS .5cm greatest dimension tumor site right breast NOS.

Should we use Rule M12-Abstract multiple primaries when separate/non-contiguous tumors are on different rows in Table 3 in the Equivalent Terms and Definitions. Timing is irrelevant. Note: Each row in the table is a distinctly different histology. So would this be two primaries C50.5 (8504/2) and C50.9 (8500/3)?

Answer
Abstract as multiple primaries using Breast Solid Tumor Rule M12 as these are separate, non-contiguous tumors on different rows in Table 3.

Date Finalized
11/15/2018

20180071

References

Source 1: **WHO Class Female Reproductive Organs**
pgs:
Notes: **4th edition**

Question

Solid Tumor Rules (2018)/Histology--Cervix uteri: What is the correct histology code for malignant mixed Mullerian tumor (MMMT/Carcinosarcoma)? See Discussion.

Discussion

An endometrial cancer was diagnosed in 2018. The endometrial biopsy showed malignant mixed mullerian tumor (MMMT/Carcinosarcoma). The total abdominal hysterectomy/bilateral salpingo-oophorectomy showed Endometrial Carcinosarcoma (50% serous carcinoma, 50% high grade sarcoma with rhabdomyoblastic differentiation) with invasion of 100% of the myometrium and involvement of the uterine serosa. I am not finding this in the Solid Tumor Rules or the site-specific ICD-O-3 code lists.

Answer

According to the WHO Classification of Tumors of Female Reproductive Organs, 4th edition, MMMT (8950/3) is now a synonym for carcinosarcoma (8980/3) even though it has a separate ICD-O code. The ICD-O code for MMMT is no longer in the WHO book. Per the subject matter experts, when both terms are used in the diagnosis (carcinosarcoma/MMMT), code the histology to 8980/3. If the ONLY term used is MMMT, assign 8950/3.

The information in the 4th edition of the WHO Classification of Tumors of Female Reproductive Organs has not yet been incorporated into the Other Sites Solid Tumor Rules.

Date Finalized

11/15/2018

20180070

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Lung**

Question
Solid Tumor Rules (2018)/Histology--Lung: The Histology coding guidelines for lung cancer state to code histology when stated as type or subtype but not to code when described as pattern. How should the histology be coded (Adeno, NOS or Adeno, Mixed subtypes) if the College of American Pathologists Protocol of the pathology report lists the following: Histologic type: Adenocarcinoma, papillary (90%), lepidic (8%), and solid (2%) patterns?

Answer
The term/modifier "patterns" is no longer allowed to code a specific histology according to the Lung Solid Tumor H rules. Disregard the papillary, lepidic, and solid patterns and code histology to adenocarcinoma, NOS (8140/3).

Date Finalized
11/15/2018

20180065

References

Source 1: **2018 SEER Manual**
pgs: **149**
Notes:
Source 2: **NAACCR Item #3270**
pgs:
Notes: **RX Summ-Palliative Proc**

Question

Immunotherapy: Is immunotherapy ever palliative treatment according to any oncologists or SEER?

Answer

Any treatment that destroys or modifies cancer tissue should **not** be recorded as palliative. Even if immunotherapy is given for symptoms/palliative treatment, it is likely to kill off tumor cells.

Date Finalized

11/15/2018

20180064

References

Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Breast**

Question

Solid Tumor Rules (2018)/Recurrence--Breast: Does any recurrence within the multiple primaries-stated timeframe count, not those just in the primary site? See Discussion.

Discussion

A patient has a left breast cancer diagnosed in 2011; then has a "recurrence" in her lymph nodes in 2017. In 2018, she has a new left breast mass that is the same histology and behavior as the 2011 cancer. Based on the 2017 "recurrence" in the lymph nodes, this is not a new breast primary, is that correct?

Answer

This is a single primary using 2018 Breast Solid Tumor Rule M11. Rule M8 does not apply because the patient was not clinically disease free for 5 years. We are interpreting the 2017 diagnosis as lymph node metastasis from the 2011 breast cancer diagnosis.

Date Finalized

11/15/2018

20180062

References
Source 1: **Heme & Lymph Manual & DB**
pgs:
Notes: **May 2018**

Question
Histology--Heme & Lymphoid Neoplasms: How is histology coded when a lymph node excisional biopsy shows Nodular lymphocyte predominant Hodgkin lymphoma (NLPHL), predominantly in diffuse T-cell histiocyte rich large B-cell lymphoma-like (THRLBCL) pattern. Comment states: The findings are that of nodular lymphocyte predominant Hodgkin lymphoma with diffuse T-cell rich pattern (T-cell/histiocyte-rich large B-cell lymphoma-like). This variant is regarded as clinically more advanced. See Discussion.

Discussion
It appears an argument could be made for both NLPHL (9659/3) and THRLBCL (9688/3). We favor coding NLPHL (9659/3) because the pathologist did specifically call this a Hodgkin lymphoma, and also specified that it only has a T-cell/histiocyte-rich large B-cell lymphoma-like pattern.

Answer
Assign histology code 9659/3. According to the Hematopoietic database, this histology frequently has T-cells. The other description was not an actual histology but noting that the appearance of the cells was similar to that histology.

Date Finalized
11/13/2018

20180061

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

Question
Primary Site: How should primary site be coded when there is an invasive tumor in one subsite and an in situ tumor in another subsite of the breast? See Discussion.

Discussion
The previous SEER Program Coding and Staging Manual included Appendix C that has Coding Guidelines for some sites. The breast guidelines specifically instructed one to code the subsite with the invasive tumor when the pathology report identifies invasive tumor in one subsite and in situ tumor in a different subsite or subsites. The current Breast Solid Tumor Rules Table 1: Primary Site Codes refers one back to the SEER Manual and COC Manual for a source document priority list but does not make mention of invasive vs. in situ on that final version of the source document.

In addition, the Colon Solid Tumor Rules currently contains no Site Coding Section/Table. However, the Lung Solid Tumor Rules do and also refer one to the SEER/COC Manuals for document priority lists. The Urinary Solid Tumor Rules has both the Primary Site Codes Table and an additional section called Priority for Coding Primary Site, which does not reference a document priority list or other manuals. Unfortunately, there is additional information in Appendix C Bladder Coding Guidelines that may have been used in the past regarding site source priority.
Could the remaining applicable Appendix C information be consolidated into the Solid Tumor Rules consistently among all the sites to lessen the need for additional manual referencing? Also, is there a reason one site includes the Priority Site Coding instructions and others do not?

Answer
Code the subsite with the invasive tumor as the primary site when the pathology report identifies invasive tumor in one subsite and in situ tumor in a different subsite or subsites as stated in Appendix C, Breast Coding Guidelines, 2018 SEER Program Coding and Staging Manual. This statement is unchanged from the previous version; however, the priority list was modified for coding a subsite when there is conflicting information.

The focus of the Solid Tumor Rules is to differentiate between single vs. multiple primaries and to assist with identifying the appropriate histology code. The site tables in the solid

tumor rules are a reference only. The site-specific Coding Guidelines assist with additional considerations when abstracting cases.

Date Finalized
11/13/2018

20180056

References

Source 1: **2018 SEER Manual**

pgs:

Notes: **Changing Information on the Abstract**

Question

Primary Site--Ovary: How should primary site be coded for a previously diagnosed ovarian cancer which is now being reclassified as fallopian tube? See Discussion.

Discussion

There is a group of patients diagnosed within the past few years with ovarian cancers who are now enrolled in a clinical trial and are being screened as potential patients for a particular protocol. The screening for these particular cases is being done by a pathologist who has a particular interest in GYN pathology. As the pathologist is screening the cases, there are some which the pathologist is reclassifying as being fallopian tube primaries rather than ovarian primaries. This is apparently due to newly emerging findings and literature. The problem for me is that these cases have been entered into the registry as ovarian primaries, which was correct as of the time of the initial diagnosis. Should the abstracts remain as they were initially coded, since the diagnosis was ovarian cancer at the time they were diagnosed, or should these cases be updated to reflect the current pathologist's interpretation that these are fallopian tube primaries?

Answer

Do not change the primary site in this situation. Since the review was done for a clinical trial and the change was not officially made in the patient's medical record, the primary site remains ovary for the cancer registry. Add an explanatory note in a text field for future reference.

Date Finalized

11/13/2018

20180050

References
Source 1: **WHO Class Hem & Lymph Tumors**
pgs: **11**
Notes: **Revised 4th ed., 2017**
Source 2: **Heme & Lymph Manual & DB**

Question
Reportability/Heme & Lymphoid Neoplasms: Is monoclonal B-cell lymphocytosis reportable? See Discussion.

Discussion
We noticed this term was added to the most recent version of the Heme Database (DB) as an alternate name for chronic lymphocytic leukemia/small lymphocytic lymphoma; however, we do not recall being notified that this was a new reportable term for code 9823 and the term was not included in the 2018 ICD-O-3 Histology updates. The Definition in the Heme DB for Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) includes information that the term was added in the 2016 WHO revision, thus would be reportable back to 2016, is that correct? In addition, the Definition seems to be describing it as a precursor condition to CLL and may never actually evolve into CLL, so it is unclear if this term should really be reportable.

Example: 09/08/2016 Onc Note: A/P: monoclonal B-cell lymphocytosis of undetermined significance (MBL): I reviewed with him the results of the bone marrow biopsy. Interestingly, there is no evidence of abnormal plasma cell population by flow cytometry and immunohistochemistry. Nevertheless, flow cytometry does demonstrate a very small population of abnormal and monoclonal B-cell lymphocyte population with immunophenotype consistent with CLL/SLL. Given the very low number of the abnormal B cells, this can be categorized as monoclonal B-cell lymphocytosis (MBL). I recommend surveillance visit in one year.

9/12/2017 Onc note: A/P: Monoclonal B-cell lymphocytosis of undetermined significance (MBL) and IgM MGUS. No symptoms concerning for active disease or progression. Explained that MBL is a very indolent process. Patients with CLL-phenotype MBL progress to CLL at a rate of ~1-2 percent per year. Follow-up in 1 year. Is this case reportable?

Answer

Monoclonal B-cell lymphocytosis is not a reportable condition. This term will be removed from 9823/3 since it is a /1 (has its own code). This will become much more clear once we get the new WHO Heme terms into the database.

Date Finalized

11/06/2018

20180048

References

Source 1: **SEER*RSA**

pgs:

Notes: **EOD and other data items**

Question

EOD 2018/Summary Stage 2018--Head & Neck: When the reportable suspicious cytology used to code diagnosis date is a regional lymph node fine needle aspirate (FNA), should this information also be used to code positive Extent of Disease (EOD) Regional Nodes, Regional Nodes Positive, Regional Nodes Examined, and SEER Summary Stage 2018? See Discussion.

Discussion

The 2018 SEER Program Coding and Staging Manual revised instructions for clinical diagnoses say the date of suspicious cytology may be used as the date of diagnosis when followed by a definitive diagnosis. However, it is unclear how this would apply to the subsequent staging of regional nodes for EOD and Summary Stage 2018.

Example: Patient presents with a tongue mass and necrotic node. Left neck node FNA final diagnosis is necrotic atypical cells suspicious for squamous cell carcinoma, see comment. The diagnosis comment clarifies that the sample is less than optimal for evaluation due to low cellularity, necrosis and degenerative changes and an additional biopsy should be considered, if clinically indicated, for a more definitive diagnosis and better assessment for P16. One month later, patient has a base of tongue biopsy showing invasive non-keratinizing squamous cell carcinoma (p16+). Considering the prior regional node cytology will be used as the date of diagnosis and Scope of Regional Lymph Node Surgery will be coded as FNA (code 1) on that same date, how should the corresponding regional lymph node staging fields be coded (EOD Regional Nodes, Regional Nodes Positive/Examined, and Summary Stage 2018)? It seems if the FNA is used for coding diagnosis date, node fields should be incremented to include that FNA too.

Answer

Use information from the suspicious cytology of the lymph node for determination of EOD and Summary Stage when there is a subsequent definitive diagnosis.

Code as follows based on the information provided.

EOD Regional Lymph Nodes: 500

Regional Nodes Examined: 95

Regional Nodes Positive: 95

SS2018: 3 (RN)

If subsequent treatment involves surgery and nodes are removed, code to the status of the surgically resected nodes.

Date Finalized
11/06/2018

20180047

References

Source 1: **WHO Class Urinary Tumors**

pgs: **43**

Notes: **4th ed.**

Source 2: **2018 SEER Manual**

pgs:

Notes: **Reportability section**

Question

Reportability--Kidney: Is a hybrid oncocytic tumor reportable? See Discussion.

Discussion

10/27/2017 partial nephrectomy final path diagnosis: renal oncocytic neoplasm, favor hybrid oncocytic tumor. Comment: Overall, this tumor exhibits mixed features of both oncocytoma and ChRCC (chromophobe renal cell carcinoma) and is best designated as hybrid oncocytic tumor (HOCT). It should be noted that HOCTs in general have very indolent behavior.

Answer

Do not report renal HTOC. According to our expert pathologist consultant, "the genetic studies seem to indicate that the chromosomal changes of chromophobe renal carcinoma are not found in the hybrid tumors."

Date Finalized

11/06/2018

20180040

References
Source 1: **WHO Class Urinary Tumors**
pgs: **56**
Notes: **4th ed.**
Source 2: **2015 SEER Coding Manual**
pgs: **11**

Question
Reportability--Kidney: Is congenital cellular mesoblastic nephroma reportable for a newborn baby? See discussion.

Discussion
2015 Rt kidney nephrectomy pathology states: congenital cellular mesoblastic nephroma, tumor size 5.9cm, tumor limited to kidney, extension into pelvicalyceal system, margin not applicable, LVI negative. Per PubMed.gov: (In newborns) among the low-grade malignant tumors, congenital mesoblastic nephromas can be successfully treated with simple nephrectomy. Per ScienceDirect: ...currently thought that cellular mesoblastic nephroma is actually a renal variant of infantile fibrosarcoma.

Answer
Do not report congenital mesoblastic nephroma (8960/1). Congenital mesoblastic nephromas are low-grade fibroblastic neoplasms of the infantile renal sinus according to WHO Classification of Tumors of the Urinary System and Male Genital Organs. The WHO classification is the standard used to determine behavior and histology for entities not listed in ICD-O-3.

Date Finalized
09/07/2018

20180038

References

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

Question

Multiple Primaries--Heme & Lymphoid Neoplasms: How many primaries should be reported when a 10/10/2017 skin biopsy identified myeloid sarcoma with monocytic differentiation, clinically stated to be leukemia cutis is followed by an 11/2/2017 BM biopsy showing an evolving high-grade myelodysplastic process with atypical monocytes, likely an early evolving acute myeloid leukemia (AML), clinically stated to be a therapy-related AML (9920/3)? See Discussion.

Discussion

Code 9920/3 is not included under rule M3. However, disease process knowledge would indicate that because the patient has an underlying AML subtype, the leukemia cutis is due to the AML cells that have migrated into the skin tissue. This appears to be a single advanced disease process essentially diagnosed simultaneously.

Answer

The leukemia cutis is secondary to leukemia that is already present. This is multiple disease processes going on at the same time. Look for more information on this case. Is there any previous diagnosis of MDS, leukemia, or some other disease that would result in a treatment related AML?

If no further information can be found, abstract one primary with 9920/3.

Date Finalized

11/07/2018

20180037

References
Source 1: **2018 SEER Manual**
pgs: **83**

Question
Date of Diagnosis--Colon: If a patient has a positive Cologuard test, is the date of diagnosis the date of the cologuard test or the date of the biopsy?

Answer
Do not use the date of a positive Cologuard test as the date of diagnosis.

Date Finalized
09/07/2018

20180036

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

Question
Reportability/Behavior--Eye: Is bowenoid actinic keratosis/evolving squamous cell carcinoma in situ in the left eye/lateral conjunctiva reportable for 2017? See Discussion.

Discussion
Pathology final dx: Left eye/lateral conjunctiva -- bowenoid actinic keratosis/evolving squamous cell carcinoma in situ. SINQ 20130075 indicates that "evolving" acute leukemia is reportable but "evolving leukemia" is listed as non-reportable in the Heme Database with a note that states "only evolving myeloma is reportable." SINQ 20130022 indicates that "evolving" in situ melanoma is reportable. Our original feeling was this is NOT reportable, but the posted SINQs brought up questions.

Answer
Do not report **evolving** squamous cell carcinoma in situ of the conjunctiva. "Evolving" is interpreted as "not quite" carcinoma in situ. The case is not reportable at this point.

Date Finalized
09/07/2018

20180035

References

Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Lung**

Question

Solid Tumor Rules (2018)/Multiple Primaries--Lung: How many primaries should be abstracted in this 2018 lung case? See Discussion.

Discussion

CT chest findings: 1. There is a dominant 1 cm. nodule in the left mid lung. 2. In addition, there is a new rather dominant bilobed nodule in the left lung base. 3. Distant metastases are not identified. Four months later, a doctor's note says routine follow-up visit status post Cyber Knife stereotactic body radiation therapy for synchronous early stage non-small cell carcinomas of the left upper and left lower lobes, both Stage IA. He is medically inoperable. This situation is described as a second primary tumor in AJCC8 page 438. However, by the 2018 Lung Solid Tumor rules, this would be a single primary, per rule M7. Is that correct?

Answer

Abstract one primary per Rule M7. Follow the Lung Solid Tumor Rules to determine the number of primaries. The AJCC TNM manual is used for staging. Do not apply AJCC instructions to determine the number of primaries.

Date Finalized

09/07/2018

20180034

References
Source 1: **2018 SEER Manual**
pgs:
Notes: **Appendix E1**
Source 2: **WHO Class Female Reproductive Organs**
pgs: **232**
Notes: **4th ed.**

Question

Reportability--Vulva: Is a biopsy showing high grade squamous intraepithelial lesion (VIN II) in the vulva reportable for cases diagnosed in 2018? See Discussion.

Discussion
In comparison to SINQ 20180022, this case does not mention VIN III anywhere in the final diagnosis. Is any mention of HGSIL in the final diagnosis reportable, even if it is qualified with a non-reportable term in parenthesis or CAP protocol?

Answer
Since this HSIL diagnosis is specified as VIN II, do not report it.

WHO includes both VIN II and VIN III as synonyms for HSIL of the vulva. HSIL is reportable and VIN III is reportable. VIN II is not reportable.

Date Finalized
09/07/2018

20180033

References

Source 1: **WHO Class Female Reproductive Organs**
pgs: **122, 138**
Notes: **4th edition**

Question

Reportability--Corpus uteri: Is smooth muscle tumor with uncertain malignant potential (STUMP) reportable? See Discussion.

Discussion

Spindled cell lesion of smooth muscle origin (desmin and SMA are positive, CD34, S100, pancytokeratin, Pax8, MDM2 and CDK4 are negative). Many of the cells have hyperchromatic, bizarre-shaped nuclei. Mitotic activity is inconspicuous. There are no areas of necrosis. The overall findings in this biopsy is best classified as a "STUMP"; however, a leiomyosarcoma cannot be excluded.

Answer

STUMP (smooth muscle tumor of uncertain malignant potential) is not reportable. According to the WHO classification of uterine corpus tumors, the behavior code for STUMP is /1.

Date Finalized

07/11/2018

20180032

References

Source 1: **2018 ICD-O-3 New Terms, Behaviors, Codes**

pgs: **6**

Notes: **https://20tqtx36s1la18rvn82wcmpn-wpengine.netdna-ssl.com/wp-content/uploads/2018/02/2018-ICD-O-3-Coding-Table-Alpha-order-.pdf**

Question

Reportability--Appendix: Is low grade appendiceal mucinous neoplasm (LAMN) reportable for 2018? It is staged as pTis(LAMN) AJCC 8th ed by pathologist.

Answer

Low grade appendiceal mucinous neoplasm (LAMN) is not reportable in 2018. See page 6, https://20tqtx36s1la18rvn82wcmpn-wpengine.netdna-ssl.com/wp-content/uploads/2018/02/2018-ICD-O-3-Coding-Table-Alpha-order-.pdf. Use cancer registry reportability instructions to determine reportability. Do not use the AJCC TNM manual to determine reportability.

Date Finalized

07/11/2018

20180031

References

Source 1: **SEER*Rx**

Question

First Course of Treatment/Other Therapy: Where do you code Optune TTF therapy? What needs to be included in the text portion to document this treatment?

Answer

Code OPTUNE in the Other Treatment field. See NovaTTF in SEER*Rx (http://seer.cancer.gov/seertools/seerrx/). NovaTTF is the pre-FDA approval name for OPTUNE.

If OPTUNE was administered for recurrence, be sure NOT to record it in the first course of treatment fields. Check with CoC if you have questions about coding treatment for recurrence.

Date Finalized

09/07/2018

20180030

References

Source 1: **2018 SEER Manual**
pgs: **219**

Question

First Course of Treatment/Surgery of Primary Site--Melanoma: How do you code UVB therapy treatment for melanoma?

Answer

Code UVB therapy for melanoma as photodynamic therapy under Surgery of Primary Site for skin. Assign code 11 [Photodynamic therapy (PDT)] if there is no pathology specimen. Assign code 21 [Photodynamic therapy (PDT)] if there is a pathology specimen. Use text fields to document details.

Date Finalized

07/11/2018

20180029

References
Source 1: **2018 Solid Tumor Rules**
pgs: **3**
Notes: **2018**

Question
Reportability--Skin: Is early/evolving lentigo maligna reportable?

Answer
Early/evolving lentigo maligna is not reportable. As of 1/1/2018 diagnoses, none of the early/evolving melanoma types are reportable.

Date Finalized
07/11/2018

20180025

References
Source 1: **2018 SEER Manual**
pgs: **10, 83**

Question
Date of diagnosis: The 2018 SEER Manual confirms the date of a suspicious cytology may be used to code the date of diagnosis when there is a subsequent definitive biopsy. Does this new instruction apply if the definitive biopsy or resection is performed 6 months following the suspicious cytology? See Discussion.

Discussion
The example provided in the 2018 SEER Manual states, Cytology suspicious for malignancy 01/12/2018. Diagnosis of carcinoma per biopsy on 02/06/2018. Record 01/12/2018 as the date of diagnosis. In this example, it is clear that a malignancy was suspected, so a diagnostic procedure was repeated within a few weeks.

Does this new rule apply to the following case? Patient underwent a thyroid fine needle aspirate (FNA) on 11/09/2017 that was suspicious for carcinoma. No further biopsy was done and the patient did not undergo a resection until 05/21/2018 that definitively proved papillary thyroid carcinoma. The clinical indication noted on the resection path was goiter with no mention of malignancy. Should the diagnosis date be 11/09/2017 or 05/21/2018?

Should a time parameter be established for this rule that indicates if the definitive biopsy (or resection) occurs X number of days or months subsequent to the suspicious cytology, to code the date of diagnosis to the date of definitive biopsy rather than the date of the suspicious cytology? If such a guideline is not added, won't there be cases that appear to have a treatment delay when, in fact, there was not really a diagnosis of a reportable disease process until much later?

Answer
Do not use the date of the suspicious cytology as the date of diagnosis for the example you provide.

If the physicians do not act on the suspicious cytology results, do not use the date of the suspicious cytology as the date of diagnosis when there is a later definitive diagnosis. If the physicians recommend further workup, but the patient does not comply, use the date of the suspicious cytology when there is a later definitive diagnosis. We will add examples to the 2018 SEER manual to illustrate these points.

FINALIZED SEER SINQ QUESTIONS

May- December 2018

Date Finalized

07/11/2018

20180024

References

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

Question

Primary site--Colon: What is the correct topography code for appendiceal orifice? See Discussion.

Discussion

From a number of definitions reviewed, it seems unclear if it's part of the appendix or the cecum of the colon. For example: The cecum is usually located in the right iliac fossa. In the pole of the cecum, there is often the appearance of fusion of the three teniae coli around the appendix, giving rise to the tri-radiate fold (Mercedes Benz sign), but the anatomy can be variable. The most reliable landmarks of the cecum are the appendiceal orifice and ileocecal valve. The appendiceal orifice is usually an unimpressive slit, often crescentic in shape. The ileocecal valve is made up of the superior and inferior lips (usually not seen en face) and is the gateway leading into the terminal ileum. It is located on the prominent ileocecal fold encircling the cecum, between 3 and 5 cm distal to the cecal pole. (https://www.sciencedirect.com/science/article/pii/S2212097113701730)

Answer

Assign C180, Cecum, when the neoplasm originates in the appendiceal orifice. The appendiceal orifice is a landmark in the cecum. During colonoscopy, visualization of the appendiceal orifice indicates that the entire colon was examined, from the anus to the cecum.

Date Finalized

07/11/2018

20180023

References
Source 1: **2018 ICD-O-3 New Terms, Behaviors, Codes**
pgs:
Notes: **updated 4/20/2018**

Question
Reportability/Behavior: Is myxoinflammatory fibroblastic sarcoma (MIFS) reportable for 2018? This histology is on the 2018 ICD-O-3 histology update list with a behavior code of /1. See discussion.

Discussion
This will be a tough one for registrars to recognize as non-reportable since the terminology contains sarcoma, so we just want to double check.

Answer
Myxoinflammatory fibroblastic sarcoma (MIFS) (C49._), 8811/1, is not reportable for 2018 based on the 2018 ICD-O-3 New Codes, Behaviors, and Terms list. This is a new histology/behavior not previously listed in ICD-O-3. According to the WHO 4th Ed Tumors of Soft Tissue & Bone, this histology has been given a benign (/1) behavior; however, if the pathologist and/or physician state the tumor is malignant or metastatic, report the case and assign behavior code /3.

Date Finalized
06/25/2018

20180022

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

Question
Reportability/Histology: Is a focal high grade squamous intraepithelial lesion (HSIL/moderate to severe dysplasia/VIN II-III) in the vulva reportable for cases diagnosed in 2018? See discussion.

Discussion
Considering high grade squamous intraepithelial lesion (HGSIL) is reportable for the vulva in 2018 (per SINQ 20130185) but VIN II-III is not reportable, we need to clarify this reporting format seen in our area.

Answer
Report when stated to be high grade squamous intraepithelial lesion of the vulva. The 2018 SEER Manual says to assign 8077/2. HGSIL is a synonym for squamous intraepithelial neoplasia, grade III for vulva and vagina only.

Date Finalized
06/25/2018

20180021

References

Source 1: **WHO Class Female Reproductive Organs**
pgs: **188**
Notes: **4th ed.**

Question

Solid Tumor Rules (2018)/Histology--Corpus uteri: What is the correct histology code for "Mesophrenic-like adenocarcinoma" of the corpus uteri?" See Discussion.

Discussion

The article I read (https://www.ncbi.nlm.nih.gov/pubmed/?term=28984674) makes the distinction between mesophrenic adenocarcinoma and mesophrenic-like adenocarcinoma. The authors propose the term mesonephric-like Mullerian adenocarcinoma. So would this be coded as Mullerian adenocarcinoma?

Answer

Assign code 9110/3, mesonephric adenocarcinoma. These tumors commonly arise in the cervical wall and more commonly involve the lower uterine segment than do other cervical adenocarcinomas.

Date Finalized

07/11/2018

20180020

References
Source 1: **2018 ICD-O-3 New Terms, Behaviors, Codes**

Question
Reportability/Histology: Differentiated penile intraepithelial neoplasia and differentiated-type vulvar intraepithelial neoplasia are on the ICD-O-3 Histology update list for 2018 and they are stated to be Not reportable for 2018. However, SINQ 20160069 states that differentiated-type intraepithelial neoplasia, 8071/2 is reportable. Please clarify reportability for the two terms in the 2018 ICD-O-3 histology update. In addition, is differentiated intraepithelial neoplasia non-reportable for all sites?

Answer
Differentiated penile intraepithelial neoplasia (PeIN) and differentiated vulvar intraepithelial neoplasia (VIN) are not reportable for 2018 according to the 2018 ICD-O-3 New Codes, Behaviors, and Terms list. SINQ 20160069 has been edited.

WHO Classification of Tumors of the Urinary System and Male Genital Organs states that differentiated (simplex) PeIN is most commonly associated with usual and low-grade subtypes of squamous cell carcinoma (non-HPV related variants).

WHO Classification of Tumors of Female Reproductive Organs defines differentiated-type VIN as HPV-negative squamous intraepithelial proliferation with abnormal keratinocyte differentiation and basal cell atypia.

Standard setters are reviewing these histologies to determine if they will become reportable in 2019.

Date Finalized
06/25/2018

20180019

References
Source 1: **2016 SEER Manual**
pgs: **64**
Notes: **Marital Status data item**

Question
Marital Status: Is Marital Status always a self-reported status? See Discussion.

Discussion
The SEER Manual states that Marriage is self-reported for the instruction in code 2, but it does not indicate if all other marital statuses are self-reported.

Examples: How is Marital Status reported for the following situations?
1. Patient with multiple tumors in the database, for the first tumor marital status is reported as married (code 2), for the subsequent tumor, marital status is reported as single (code 1).
2. Patient self- reports as single, but also has children.
3. Patient states they are in common law marriage, but our state is not a common law marriage state.

Answer
Marital Status is self-reported because the information is recorded in the medical record based on information obtained from the patient. Use text fields to document relevant information.

Examples

1. Assign code 2 for the first tumor and assign code 1 for the subsequent tumor unless the available information indicates the patient is divorced at the time of the subsequent tumor diagnosis. Patient may self-report single after a divorce. Assign code 4 in that situation.

The code assigned for marital status reflects the patient's marital status at the time of diagnosis for the tumor being abstracted. It is possible that marital status may be different for each tumor if the patient has multiple tumors.

2. If marital status is stated to be single, assign code 1.

3. If marital status is stated to be common law marriage, assign code 2.

Common Law Marriage is defined as a couple living together for a period of time and declaring themselves as married to friends, family, and the community, having never gone through a formal ceremony or obtained a marriage license.

Date Finalized

06/08/2018

20180018

References

Source 1: **2007 MP/H Rules**
pgs:
Notes: **Benign, borderline CNS**
Source 2: **WHO Class Endocrine Tumors**
pgs: **24**
Notes: **4th ed.**

Question

MP/H Rules/Histology--Brain and CNS: How should histology be coded for the following 2017 cases (pituitary adenoma vs. prolactinoma)? See Discussion.

Discussion

1. (2017) Pituitary mass resection with a path diagnosis of pituitary adenoma immunoreactive for prolactin.

Do we code as prolactinoma when the tumor is immunoreactive for prolactin or must there be a definitive statement of prolactinoma?

2. (2017) Pituitary lesion on imaging, MD diagnosis of pituitary microadenoma is prolactinoma.

Current (2007) MP/H rule H9 states when there are multiple histologies in the same branch in Chart 1, code the more specific histology. These histologies are NOT in Chart 1, but prolactinoma seems to be a more specific type of pituitary adenoma. The next rule, H10 states to code the numerically higher code, 8272/0 (pituitary adenoma)?

3. (2017) Imaging diagnosis of pituitary macroadenoma with clinical diagnosis by MD of macroprolactinoma.

Current rules indicate when there is no path specimen that physician reference to type of tumor has priority over imaging.

Will these answers/histologies change with the upcoming 2018 Solid Tumor rules?

Answer

Code each of these 2017 cases as prolactinoma (8271/0), the more specific histology.

If these cases were diagnosed in 2018, the answer would be the same: code as prolactinoma.

Date Finalized

06/22/2018

20180016

References

None

Question

Primary site--Pancreas: Is the uncinate process of the pancreas coded to C259, C250, or C257?

Answer

Assign C250 to the uncinate process of the pancreas. The uncinate process is part of the head of the pancreas.

Date Finalized

05/01/2018

20180015

References

Source 1: **WHO Class Female Reproductive Organs**

pgs:

Notes: **4th edition**

Question

Histology--Ovary: What is the correct ICD-O-3 histology code for sertoliform endometrioid carcinoma of the ovary?

Answer

Assign 8380/3. Sertoliform endometrioid carcinoma is a variant of endometrioid carcinoma according to the WHO Classification of Tumors of Female Reproductive Organs, 4th edition. There is no specific ICD-O-3 code for this variant.

Date Finalized

05/01/2018

20180014

References

Source 1: **WHO Class CNS Tumors**

pgs:

Notes: **4th edition**

Question

Reportability/Histology--Brain and CNS: Is multinodular and vacuolating neuronal tumor of the cerebrum reportable, and if so, is the histology coded as 9492/0? See Discussion.

Discussion

Patient diagnosed with multinodular and vacuolating neuronal tumor of the cerebrum. My research shows: Multinodular and vacuolating neuronal tumor of the cerebrum is a recently reported benign, mixed glial neuronal lesion that is included in the 2016 updated World Health Organization classification of brain neoplasms as a unique cytoarchitectural pattern of gangliocytoma. There is no code in ICD-O-3 for it, so do I report it and use 9492/0 or not?

Answer

Do not report multinodular and vacuolating neuronal tumor of the cerebrum. At this time, WHO is undecided about whether this is a neoplastic or a hamartomatous/malformative process. If WHO makes a determination that this is a neoplastic process, we will update reportability instructions and ICD-O-3 guidelines for registrars.

Date Finalized

05/01/2018

20180013

References

Source 1: **2016 SEER Manual**

pgs: **5-7**

Notes: **Reportability Section**

Question

Reportability--Brain and CNS: Are tuberous sclerosis cancers found in the brain reportable? See Discussion.

Discussion

I have searched ICD-O-3 for a histology listing but could not locate. I also searched the SEER Inquiry database for possible answers, but none were found. The patient underwent a pediatric MRI of the brain of which final impression was: 1) Subependymoma nodules, cortical tubers, and SEGAs are seen bilaterally consistent with tuberous sclerosis.

Answer

SEGA (Subependymal giant cell astrocytoma) is reportable if diagnosed in 2004 or later. Tuberous sclerosis complex (TSC) is not a neoplasm and is not reportable. SEGA is a neoplasm that commonly occurs in TSC patients.

Refer to the reportability instructions on pages 5-7 in the SEER manual, https://seer.cancer.gov/manuals/2016/SPCSM_2016_maindoc.pdf

Date Finalized

05/01/2018

20180012

References

Source 1: **2016 SEER Manual**

pgs: **160**

Question

First course of treatment: What is the correct code to use for allogenic stem cell transplant?

Answer

Code an allogenic stem cell transplant as 20 (Stem cell harvest (stem cell transplant) and infusion) in Hematologic Transplant and Endocrine Procedures in the 2016 SEER Manual.

Date Finalized

05/01/2018