20240043

References:
#1: ICD-O-3.2
#2: Solid Tumor Rules. Other Sites, 2024 Update

Question:
Reportability/Histology--Digestive Sites: Is a diagnosis of "tubulovillous adenoma with high grade dysplasia" in the duodenum equivalent to a diagnosis of "tubulovillous adenoma, high grade" and, therefore, non-reportable, or is this a reportable non-colorectal high-grade dysplasia? See Discussion.

Discussion:
The 2022 ICD-O-3.2 Implementation Guidelines indicate "Tubulovillous adenoma, high grade" is 8263/2 and is not SEER reportable. However, the 2024 SEER Manual and clarification from recent SINQs (20240021 and 20240025) confirm high grade dysplasia in the esophagus, stomach, and small intestine is reportable (8148/2).

Which reportability reference applies to a diagnosis of a tubulovillous adenoma with high grade dysplasia in non-colorectal sites?

Answer:
A diagnosis of "tubulovillous adenoma with high grade dysplasia" in the duodenum is **not** equivalent to a diagnosis of "tubulovillous adenoma, high grade."

Tubulovillous adenoma, high grade (8263/2) is not reportable as of 2022.

High grade dysplasia (glandular intraepithelial neoplasia, grade III) is reportable in the esophagus, stomach, and small intestine (8148/2).

Date Finalized:
06/05/2024

20240042

References:
2018 EOD Manual. SEER*RSA, EOD Primary Tumor, Cervix v9

Question:
EOD 2018/EOD Primary Tumor--Cervix: How is Extent of Disease (EOD) Primary Tumor of the cervix coded when it invades into the bladder on surgery and noted as T4. No further information is provided, and it is not possible to contact the physician for clarification. Would you code 550 (Bladder wall; bladder, NOS excluding mucosa), 750 (Bladder mucosa), or 999 Unknown?

Answer:

Assign code 550 (Bladder, NOS excluding mucosa) to EOD Primary Site based on invasion into the bladder with no mention of mucosa. EOD Primary Tumor for cervix, Note 1, instructions are to use the extension information to code primary tumor in preference to a statement of FIGO stage when both are available. TNM staging is closely related to FIGO stage, and the surgical findings of bladder invasion NOS in this case should be used in preference to the statement of T4.

Date Finalized:
05/29/2024

20240041

References:
#1: Solid Tumor Rules. Non-Malignant CNS 2024 Update
#2: WHO Class Eye Tumors, 139-140. 4th edition

Question:
Reportability--Brain and CNS: Is an optic nerve meningioma reportable if stated to arise in the "intraorbital segment" of the optic nerve meninges? See Discussion.

Discussion:

Patient was diagnosed on imaging with enhancement along the right optic nerve intraorbital segment, displacing the optic nerve, most consistent with optic nerve sheath meningioma.

Extracranial meningiomas are rare, however SINQ 20230052 does contain an exception for reportability in a different head and neck site because it is not an intracranial location.

It is unclear if this portion of the meninges surrounding the intraorbital optic nerve is still "intracranial" and thus reportable.

Answer:

Report optic nerve sheath meningioma arising in the intraorbital segment. The optic nerve contains four segments, of which intraorbital is one. The WHO Classification of Eye Tumors, 4th edition, defines meningioma as a neoplasm originating from the meningothelial cells of the optic nerve leptomeninges. According to Table 3 of the Non-malignant Solid Tumor Rules, all portions of the optic are reportable and meningiomas arising in the dura/meninges of an intracranial nerve are coded to cerebral meninges C700.

Date Finalized
05/29/2024

20240040

References:
2024 SEER Manual, 163-166. First Course of Therapy

Question:
First course treatment--Kidney: How should the different treatment fields be coded if surgery is planned but cancelled due to patient noncompliance, then the tumor is treated with ablation, and eventually surgery is given due to residual disease? See Discussion.

Discussion:
Patient was diagnosed in July 2022 with biopsy confirmed left kidney renal cell carcinoma. Initially, partial nephrectomy was planned for February 2023 but canceled at the last moment due to the patient's "history of narcotic use." The details of that cancellation were otherwise unclear. It appears the treatment plan was changed due to patient non-compliance.

Patient then had cryoablation of the tumor in May of 2023. Subsequent imaging in October found residual tumor, but no disease progression was noted. Again, additional ablation was offered but patient decided on surgical treatment which did not occur until December 2023.

Is the cryoablation second course due to a change of plan if there is no disease progression, recurrence, or treatment failure?

If the cryoablation is first course treatment, then would the partial resection also be first course treatment because it was documented as the treatment plan?

Answer:

The treatment with cryoablation is second course. Once the initial treatment plan is changed, everything after the change is no longer first course of treatment. If the cryoablation was not mentioned as part of the original treatment plan, it is second course.

Date Finalized

05/29/2024

20240039

References:
2024 SEER Manual, 80. Race data items

Question:
Update to Current Manual/Race: For the Example #15 under Race Coding Examples in the 2024 SEER manual, could coding these as 97 result in an under-reporting of Native Hawaiians? See Discussion.

Discussion:
The race category in some hospital electronic medical record systems includes a combined category of “Native Hawaiian/Pacific Islander.” What race code should be used in a situation where the only available information is “Native Hawaiian/Pacific Islander?”

Answer:
Change to current instructions. We will update this example in the next edition of the manual. The new example will instruct registrars to look for other descriptions of the patient’s race. When no other information is available, assign 07, Native Hawaiian, in Race 1 and assign 97, Pacific Islander, NOS in Race 2. Begin following this new instruction now.

Date Finalized
06/07/2024

20240038

References:
#1: Solid Tumor Rules. Malignant CNS, 2024 Update
#2: WHO Class CNS Tumors, 406-414. 5th edition

Question:
Solid Tumor Rules/Multiple Primaries--Brain and CNS: How many primaries are accessioned, and what M Rule applies to a 2023 diagnosis of pituitary macroadenoma followed by a 2024 diagnosis of pituitary neuroendocrine tumor (PitNET) when the patient did not undergo surgery, but did undergo hormone therapy with Cabergoline? See Discussion.

Discussion:
Malignant Central Nervous System (CNS) Rule M5 instructs us to abstract a single primary (as malignant) when a single tumor is originally diagnosed as non-malignant, the "First course treatment was active surveillance (no tumor resection)," and the subsequent resection pathology is malignant.

This patient's first course of treatment was not active surveillance. While the patient did not have first course tumor resection, the tumor was treated with Cabergoline. Should Rule M5 apply because there was no tumor resection? If so, should Rule M5 clearly state no tumor resection is the criteria (not active surveillance)?

SINQ 20230023 does indicate a PitNET diagnosis following a diagnosis of pituitary adenoma does not fall into standard rules, but in the previous SINQ the first course treatment was a partial resection. It is unclear whether other types of treatment could result in a new malignant PitNET, following a previously treated non-malignant pituitary tumor.

Answer:
Abstract a single primary as 8272/3 (pituitary adenoma/PitNET) using the Malignant CNS and Peripheral Nerves Solid Tumor Rules, Rule M2, a single tumor is always a single tumor. Change the histology of the 2023 diagnosis to 8272/3. This scenario does not meet the criteria in the current rules for M5 in that it requires a resection as part of the criteria. Since the patient did not undergo resection for either diagnosis, the 2024 diagnosis may indicate recurrence or progression.

A diagnosis of **pituitary adenoma only** is still coded 8272/0 (this code is still valid). A diagnosis of pituitary adenoma/PitNET, PitNET, or pituitary neuroendorine tumor is coded 8272/3. Cabergoline is used to treat prolactinoma or high levels of prolactin but does not impact the PitNET.

Date Finalized
05/29/2024

20240037

References:
#1: WHO Class Urinary System and Male Genital Organs, 394-396. 5th edition
#2: Solid Tumor Rules. Urinary Sites, 2024 Update

Question:
Solid Tumor Rules/Histology--Bladder: How is histology coded for a bladder tumor when the diagnosis is 95% large cell neuroendocrine carcinoma and 5% high grade urothelial carcinoma of no special type? See Discussion.

Discussion:
In the 2024 Solid Tumor Rules update, the small cell neuroendocrine carcinoma row in Table 2 was changed. The NOS histology became neuroendocrine carcinoma, NOS (8246) and both large cell and small cell neuroendocrine carcinomas (8013 and 8041, respectively) became the subtype/variants. This change impacts Rule H4 but Rule H4 was not updated. Rule H4 still refers to small cell neuroendocrine carcinoma as being the NOS histology.

In the prior STR versions, it was clear the tumor in question would be coded as 8045 per Rule H4 and Table 2. Considering Rule H4 was not updated according to the changes for Table 2, does histology 8045 still apply to this diagnosis?

There is currently no way to arrive at a histology for this case. Does Rule H4, bullet 3 need to be updated to indicate, “subtype/variant of neuroendocrine carcinoma mixed with any other carcinoma (does not apply to sarcoma)”?

Answer:
Assign 8013/3 (combined large cell neuroendocrine carcinoma). There are two histologies present: large cell NEC and urothelial. Literature search found primary large cell NEC of the bladder is extremely rare with less than 20 reported cases. This case does not fall into the site-specific rules and given it's a rarity, a specific rule for this situation was not and will not be added to the Bladder rules. See #1, Example 2, in the general instructions for coding histology.

Date Finalized
06/14/2024

20240036

References:
#1: 2024 SEER Manual, 78. Race data items
#2: 2024 SEER Manual, Appendix D. Race and Nationality Descriptions

Question:
Update to Current Manual/Race: How is Race coded when stated as Hispanic and there is no other information? See Discussion.

Discussion:
There appears to be discrepant information in the 2024 (and prior) SEER manual regarding race coding when the patient is described only as Hispanic/Latina. Page 78 tells us to Code as 01 (White) when: b. There is a statement that the patient is Hispanic or Latino(a) and no further information is available

i. A person of Spanish origin may be any race; however, for coding race when there is no further information other than “Hispanic” or “Latino(a),” assign race as White as a last resort instead of coding unknown.

However, in Appendix D, under "Other Race descriptions", there is a statement that "If no further information is available, code as 99 Unknown." The list includes "Hispanic."

Answer:
Assign code 01 (White) for Hispanic when there is no additional information. It is listed in the 2024 SEER Manual, Race Coding Instruction 6.b.i. and in Appendix D for code 01. We will remove Hispanic from the list in Appendix D under code 99 in the next version of the manual.

Date Finalized
06/05/2024

20240035

References:
Solid Tumor Rules. Urinary, 2024 Update

Question:
Solid Tumor Rules--Urinary: The example used in Rule M15 of the Urinary Solid Tumor Rules refers to the same row in Table 3. Should the example say Table 2 since Table 3 is non-reportable urinary tumors. See Discussion.

Discussion:
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.

Note: The same row means the tumors are

- The same histology (same four-digit ICD-O code) OR
- One is the preferred term (column 1) and the other is a synonym for the preferred term (column 2) OR
- A NOS (column 1/column 2) and the other is a subtype/variant of that NOS (column 3) OR
- A NOS histology in column 3 with an indented subtype/variant

Example: TURBT shows invasive papillary urothelial carcinoma 8130/3 and CIS/in situ urothelial carcinoma 8120/2. Abstract a single primary. Papillary urothelial carcinoma and urothelial carcinoma are on the same row in Table 3.

Answer:
The example used in Rule M15 of the Urinary Solid Tumor Rules should refer to Table 2. We will update this in the next revision of the Rules.

Date Finalized
06/05/2024

20240034

References:
#1: 2024 SEER Manual, 15. Reportability
#2: ICD-O-3.2

Question:
SEER Manual/Reportability--Skin: Is keratoacanthoma (8071/3) of the skin reportable? This code is also for squamous cell carcinoma (SCC), keratinizing. In the 2024 SEER manual, 8071/3 falls under the not reportable section of skin (outside of specific sites).

Answer:
Do not report keratoacanthoma of the skin (8071/3). The preferred term for keratoacanthoma is squamous cell carcinoma (SCC), keratinizing, NOS. According to the 2024 SEER Manual, Reportability section, SCC of skin (8050-8084) is not reportable.

Date Finalized
06/05/2024

20240033

References:
Solid Tumor Rules. Other Sites, 2024 Update

Question:
Solid Tumor Rules/Multiple Primaries--Stomach: Is a carcinoid tumor of the stomach diagnosed on 01/01/2023, on a patient who was followed up by Gastrointestinal (GI) and was found to have another stomach carcinoid on 02/01/2024, one primary or two? See Discussion.

Discussion:
Based on the Solid Tumor Rules, we would make this two since it is over one year. According to a previous SINQ question 20110046, we are to code this as one primary. We see patients come back with multiple carcinoid tumors over the years and would like clarification.

Answer:
Stop at the first rule that applies which is M12. Per note 3: When it is unknown/not documented whether the patient had a recurrence, use date of diagnosis to compute the time interval. This means there are two primaries.

There is a genetic syndrome that causes multiple carcinoid tumors in the GI tract, per our GI expert, and they should be treated as new primaries per M12.

SINQ 20110046 describes a unique situation whereby the subject matter expert felt that the occurrence of multiple tumors was due to an unknown underlying condition driving the proliferation of neuroendocrine cells.

Date Finalized
06/14/2024

20240032

References:
#1: 2007 Solid Tumor Rules. Other Sites, 2024 Update
#2: WHO Class Digest System Tumors, 273-275. 5th edition

Question:
Update to Current Manual/Reportability--Biliary Tract: Is a diagnosis of high-grade dysplasia of the gallbladder reportable? See Discussion.

Discussion:
Patient was diagnosed March 2024 with high grade dysplasia of the gallbladder during excision for clinical history of acute cholecystitis and obstruction.

Per the STR, Table 10 for Gallbladder and Extrahepatic Bile Duct Histologies shows Biliary intraepithelial neoplasia, high grade as code 8148/2. High grade glandular intraepithelial neoplasia of the biliary tract is also code 8148/2.

Recent SINQ 20240021 (GI specific) indicates high grade dysplasia is reportable as high grade glandular intraepithelial neoplasia (8148/2) for stomach, small intestine, and esophagus. Does the same hold true for gallbladder? If so, then it appears there is a conflict between STR and Appendix E2.

However, using the logic of SINQ 20240021 for this site would appear to contradict Appendix E2 which indicates high grade dysplasia in sites other than stomach, intestine, and esophageal sites is not reportable.

If we can code high grade dysplasia of GI sites to 8148/2, should we accession high grade dysplasia of the gallbladder and other biliary sites in a similar manner? If so, then Appendix E needs to be modified.

Answer:
Report biliary intraepithelial neoplasia (dysplasia), high grade. As noted in SINQ 20240021 and the Other Sites Solid Tumor Rules, Rules H4/H26, the listed sites may not include all reportable neoplasms for 8148/2.

We will update the Other Sites Solid Tumor Rules to reflect this code as well as make revisions in the next release of the SEER Manual.

Date Finalized
06/05/2024

20240031

References:
#1: SINQ 20081076; 20160011
#2: Pathology Outlines. Carcinoid tumorlet

Question:
Reportability/Histology: Is a diagnosis of non-lung neuroendocrine tumorlet reportable? See Discussion.

Discussion:
Patient was diagnosed March 2023 with a neuroendocrine tumorlet of the rectum measuring 0.8 mm via excisional biopsy during colonoscopy.

Prior SINQ 20160011 (stomach specific) indicates microcarcinoid and carcinoid tumors are reportable. Microcarcinoid is a designation for neuroendocrine tumors of the stomach when they are less than 0.5 cm. in size.

Is the current rectal tumor a reportable gastrointestinal neuroendocrine tumor if it is less than 5 mm (i.e., is a neuroendocrine tumorlet equivalent to a microcarcinoid)?

Answer:
Do not report neuroendocrine tumorlet of lung and non-lung sites. Microcarcinoid and carcinoid tumors are reportable.

Tumorlet is a tumor of neuroendocrine differentiation, defined by size < 5 mm in diameter, mitotic count < 2 mitoses/2 mm^2, and absence of necrosis. Microcarcinoid is a designation for neuroendocrine tumors when they are less than 0.5 cm. in size. The term "tumorlet" is used in a number of other settings, referring to small tumors (usually < 0.5 cm), and does not necessarily mean carcinoid tumor.

The term microcarcinoid tumor is not equivalent to neuroendocrine tumorlet.

Date Finalized
06/05/2024

20240030

References:
#1: ICD-O-3.2
#2: Subject matter expert

Question:
Reportability/Primary Site--Skin: Is squamous cell carcinoma (SCC) that overlaps skin and the vermillion border reportable when the percent of overlap is unknown? See Discussion.

Discussion:
SINQ 20031110 addresses an overlapping lip lesion between skin and the vermillion border. We were instructed to go with area of greatest involvement. Case would be reportable if >50% of tumor was on the vermillion border and site would be coded to vermillion border (C00._). Often times percentage of involvement is not stated and all that is known is that the lesion overlaps skin and mucosa.

Answer:
Determine whether the lesion is on the mucosa or skin based on the pathology report, history and physical, and operative notes when available. The gross description of the pathology report should include information to help in determining whether the site of origin is epithelium (skin) or mucosa (lip).

Do not report the case when the site of origin cannot be determined between a reportable site and non-reportable site for this histology. This includes situations where the site of origin or the site with the greatest involvement is undetermined. In this case, you cannot confirm reportability.

Date Finalized
05/29/2024

20240029

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

Question:
Solid Tumor Rules/Multiple Primaries--Head and Neck: Is a 11/2023 diagnosis of invasive squamous cell carcinoma (SCC) in lower gum (C031) a new primary and what rules apply for a patient with 09/2017 invasive SCC of lower gum (C031) and 05/2022 invasive SCC of lateral tongue (C023)? See Discussion.

Discussion:
The 11/2023 lower gum tumor is a separate tumor occurring after a disease-free interval, so we know the Head and Neck Multiple Tumors Module applies. However, our staff is having difficulty applying the rules to this particular scenario with consistent results.

Is the 11/2023 SCC a non-reportable recurrence per M12, since M4 is ignored due to patient's prior 2017 C031 (lower gum) primary, and then M6 is ignored due to patient's prior 05/2022 C023 primary?

Or is the 11/2023 SCC a new primary per M4, since the last diagnosis was in a site differing at the third character (C03 vs C02)? If M4 does not apply due to patient's previous C03 primary, then does M6 apply since it has been more than 5 years since the previous C03 primary?

Answer:
Abstract three primaries for the scenario you describe.

1. 09/2017 invasive SCC of lower gum (C031)
2. 05/2022 invasive SCC of lateral tongue (C023): Apply Rule M4, differ at 3rd site code
3. 11/2023 SCC of lower gum (C031): Apply Rule M6, greater than 5 years from the 9/2017 C031

Date Finalized
05/29/2024

20240028

References:
#1: 2024 SEER Manual. Appendix C: Breast Coding Guidelines
#2: Solid Tumor Rules. Breast, 2024 Update

Question:
2024 SEER Manual/Primary Site--Breast: Is Primary Site coded as C504 or C501 based on the Solid Tumor Rules and the SEER Manual Breast Coding Guidelines? The pathology report reads "Right Breast 10:00 1 cm from the nipple."

Codes C502-C505 take priority over code C501. The description for C501 in the Solid Tumor Rules has "Area extending 1 cm around areolar complex."

Answer:
Assign Primary Site code C504 based on the location in the upper outer quadrant of the right breast, 10 o'clock, as opposed to code C501, around the areolar complex. The 2024 SEER Manual Breast Coding Guidelines advise that C502 - C505 are generally preferred over C501 when there is no other way to determine the subsite.

Date Finalized
04/30/2024

20240027

References:
#1: Solid Tumor Rules. Malignant CNS, 2024 Update
#2: WHO Class CNS Tumors, 19-27; 39-55. 5th edition

Question:
Solid Tumor Rules/Multiple Primaries--Brain and CNS: How many primaries are accessioned when a 2005 diagnosis of glioblastoma multiforme is followed by a 2024 diagnosis of astrocytoma, IDH-mutant, WHO grade 4? See Discussion.

Discussion:
The patient underwent a gross total resection of the 2005 glioblastoma multiforme (9440/3). The patient was subsequently diagnosed with a 2024 diagnosis of astrocytoma, IDH-mutant, WHO grade 4 (9445/3).

Should Rule M13 apply to the new 2024 diagnosis and a new primary be accessioned because astrocytoma, IDH-mutant, WHO grade 4 is listed on a different row than glioblastoma? It is unclear whether histology 9445 should be classified as being on a different row because it is also listed as a subtype/variant for glioblastoma in Table 3. Table 3 lists histology 9445 as both “Astrocytoma, IDH-mutant, WHO grade 4” and as “Glioblastoma IDH-mutant.”

Answer:
Abstract two primaries using the 2024 Malignant Central Nervous System (CNS) and Peripheral Nerves Solid Tumor Rules, Rule M13. Glioblastoma, IDH-wild-type (9440/3) and astrocytoma, IDH-mutant, grade 4 (9445/3) are on two separate rows in Table 3 of the Malignant CNS and Peripheral Nerves Solid Tumor Rules.

WHO Classification of Central Nervous System, 5th edition, lists the subtypes of glioblastoma, IDH-wild-type as giant cell glioblastoma; gliosarcoma; and epithelioid glioblastoma. The term glioblastoma multiforme is not recommended for glioblastoma, IDH-wildtype in the 5th edition, and lists astrocytoma, IDH-mutant, grade 4 as a subtype of astrocytoma, IDH-mutant.

Date Finalized
04/30/2024

20240026

References:
#1: WHO Class Digest System Tumors, 307-309. 5th edition
#2: ICD-O-3.2

Question:
Update to Current Manual/Reportability--Pancreas: For cases diagnosed 2024+, is a diagnosis of pancreatic intraepithelial neoplasia II (PanIN II) reportable? If so, how should histology be coded? See Discussion.

Discussion:
SEER Program Coding and Staging Manual: Reportability – Reportable Diagnosis List indicates pancreatic intraepithelial neoplasia (PanIN II) (C250-C259) is reportable.

However, 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:
Do not report PanIN II. WHO Classification of Digestive Tumors, 5th edition, now categorizes PanIN into two categories, low grade (8148/0) and high grade (8148/2). PanIN grade I and PanIN grade II are categorized as PanIN low grade; PanIN grade III is categorized as PanIN high grade.

We will update the Reportability section of the manual.

Date Finalized
04/30/2024

20240025

References:
2024 SEER Manual, 21. Example 4

Question:
Update to the current manual/Reportability--Esophagus: Is high grade dysplasia of the esophagus reportable? The 2024 Seer Program Manual, page 21, has an example that states it is not reportable. See Discussion.

Discussion:
Example 4: Esophageal biopsy with diagnosis of "focal areas suspicious for adenocarcinoma in situ." Diagnosis on partial esophagectomy specimen "with foci of high-grade dysplasia; no invasive carcinoma identified." Do not accession the case. The esophagectomy proved that the suspicious biopsy result was false.

Appendix E2 #32 of the SEER Manual states high grade dysplasia in sites **other than** stomach, small intestines, and esophageal primary sites are not reportable. Does this mean high grade dysplasia is reportable for esophagus primaries?

Answer:
High grade dysplasia of the esophagus is reportable. The example will be corrected in the next edition of the SEER manual.

Date Finalized
04/30/2024

20240024

References:
ICD-O-3.2

Question:
Reportability/Histology: Is angiomyxoma (this includes borderline or behavior code /1 cases) of the soft tissue reportable?

Can you provide us with coding guidelines for angiomyxoma for when it's reportable or not reportable?

Answer:
Do not report angiomyxoma. ICD-O-3.2 assigns 8841/0 to this benign tumor. This includes superficial and deep (aggressive) angiomyxoma.

Date Finalized
04/30/2024

20240023

References:
#1: Solid Tumor Rules. Other Sites, 2024 Update
#2: WHO Class Urinary System and Male Genital Organs, 373-377. 5th edition

Question:
Solid Tumor Rules/Histology--Penis: Why is warty carcinoma listed in Other Sites, Table 23 (Penis and Scrotum Histologies) as 8051 when the ICD-O-3.2 and SINQ 20200003 indicate the correct histology is 8054 for this neoplasm? See Discussion.

Discussion:
The ICD-O-3.2 indicates histology 8051 only applies to diagnoses of condylomatous carcinoma and warty carcinoma made prior to 2018. For penis cases diagnosed 2018 and later, these neoplasms should be coded as 8054. This is consistent with SINQ 20200003.

However, a new Table was added to the Other Sites schema in the 2024 Solid Tumor Rules update. Table 23 lists “Verrucous carcinoma / carcinoma cuniculatum / Warty carcinoma” as histology 8051. While verrucous carcinoma is still listed under histology 8051 in the ICD-O-3.2, warty carcinoma is not.

Does Table 23 need to be updated? Or is this an error in both the ICD-O-3.2 and SINQ 20200003?

Answer:
Assign histology code 8054/3 for warty carcinoma. Assign 8051/3 for verrucous carcinoma and carcinoma cuniculatum.

The WHO Classification of Urinary and Male Genital Tumors, 5th edition (2022) revised the terminology for squamous cell carcinoma groupings from "non-HPV-related" to "HPV-independent" and from "HPV-related to "HPV-associated". Warty carcinoma is defined as a "morphologically distinct ***HPV-associated*** verruciform neoplasm that shares histological features with a giant condyloma but has definitive cytological atypia and a malignant infiltrative architecture." Verrucous carcinoma (including carcinoma cuniculatum) is defined as an ***HPV-independent*** squamous cell carcinoma and is correctly coded to 8051/3.

The 2024 Solid Tumor Rules, Table 23, Penis and Scrotum Histologies will be updated to reflect this revised terminology and coding.

Date Finalized
03/14/2024

20240022

References:
#1: Solid Tumor Rules. multiple sites
#2: WHO Classifcation of Tumors

Question:
Solid Tumor Rules/Histology: When should the designation of "poorly differentiated" be used to further specify histology for carcinoma, NOS (8010) as undifferentiated carcinoma (8020)? See Discussion.

Discussion:
The term "poorly differentiated carcinoma (NOS)" is listed as related to "undifferentiated carcinoma (NOS)" in the ICD-O 3.2. It is also listed in the Solid Tumor Rules for Urinary Table 2 (Urinary subtypes), Other Sites Table 16 (uterine corpus primaries) and Table 19 (vulvar primaries).

Are these the only sites in which one should code "poorly differentiated carcinoma (NOS)" as 8020 (undifferentiated carcinoma)?

How is histology coded if the only microscopic confirmation is from a metastatic site showing "poorly differentiated carcinoma" (NOS) or "invasive carcinoma, poorly differentiated" (NOS)?

Example 1: Primary pancreatic cancer diagnosed on imaging and confirmed with liver mets core biopsy showing "poorly differentiated carcinoma." The immunostaining pattern was non-specific. No further workup or treatment was planned.

Other Sites - Table 11 (Pancreas Histologies) includes undifferentiated carcinoma (8020/3) as a valid histology; however, the synonyms/subtypes/variants do not mention poorly differentiated carcinoma. How should histology be coded for this case?

Example 2: Hemicolectomy with cecal tumor final diagnosis of "invasive carcinoma, poorly differentiated" and synoptic summary listing "Histologic type: Invasive carcinoma. Histologic grade: G3 of 4: poorly differentiated."

Colorectal Table 1 (Specific Histologies and Subtypes/Variants) includes undifferentiated adenocarcinoma/carcinoma 8020 as a subtype of adenocarcinoma NOS. There is no mention of poorly differentiated in this context. How should histology be coded for this case?

Answer:
Assign code 8020/3 when the histologic type specifically includes the term of poorly differentiated, dedifferentiated, undifferentiated, or anaplastic undifferentiated carcinoma

along with carcinoma as terms vary depending on the primary site. When the term poorly differentiated is included in the grade section only of the pathology report or only mentions poorly differentiated carcinoma without further substantiation from a pathology report as in examples 1 and 2, do not use code 8020/3.

The histology code 8020/3 and terms may be used for selected primary sites as included in the Solid Tumor Rules, WHO Classification of Tumors series (latest versions), and the Site/Morphology Validation List including

Nasal cavity

Nasopharynx

Salivary glands

Urinary sites

Colon, rectosigmoid, rectum

Esophagus

Stomach

Gallbladder and extrahepatic bile duct

Pancreas

Thyroid

Ovary

Uterine corpus

Vagina

Uterine cervix (also referred to as unclassifiable in WHO Classification of Female Genital Tumors, 5th ed.)

For sites other than those listed, if the diagnosis is poorly differentiated carcinoma, code 8010/3 and poorly differentiated in the grade field.

Date Finalized
04/30/2024

20240021

References:
#1: Solid Tumor Rules. Other Sites, 2024 Update
#2: WHO Class Digest System Tumors, 32-37, 71-75, 118-120. 5th edition

Question:
Solid Tumor Rules/Reportability/Histology--Digestive Sites: Is a diagnosis of "high grade dysplasia" (not specified to be squamous or glandular) reportable for esophagus, stomach, and small intestine for cases diagnosed beginning in 2024? If so, how should histology be coded? See Discussion.

Discussion:
SEER Program Coding and Staging Manual indicates high grade dysplasia of esophagus, stomach, and small intestine are reportable. The ICD-O-3.2 does not include "high grade dysplasia" as equivalent to "high grade squamous dysplasia."

If reportable, would high grade dysplasia (NOS) that originates in the stomach and small intestine default to 8148/2, while esophageal high-grade dysplasia (NOS) default to 8077/2?

Answer:
Report these high-grade dysplasia of the following organs as stated below.

Stomach: Assign code 8148/2 glandular intraepithelial neoplasia, high-grade using the Other Sites Solid Tumor Rules, Table 6: Stomach Histologies and as described in the WHO Classification of Digestive Tumors, 5th edition.

Small intestine and Esophagus: Assign code 8148/2 glandular intraepithelial neoplasia, high grade, using the Other Sites Solid Tumor Rules, Other Sites Histology Rules, Rule H4/H26. The following note is listed for both of these rules.

> Note: This list may not include all reportable neoplasms for 8148/2. See SEER Program Coding and Staging Manual or STORE manual for reportable neoplasms

The Other Sites Solid Tumor Rules, Table 5: Esophagus Histologies and Table 7: Small Intestine and Ampulla of Vater Histologies will be updated to reflect this code as time permits.

Date Finalized
03/20/2024

20240020

References:
Subject matter expert

Question:
Histology/Behavior: There are currently no codes available on the ICD-10-CM casefinding list for several of the site-specific intraepithelial neoplasias (8077/2). Will there be an update with additional codes for these sites that currently do not have codes to enable casefinding for these? See the table below.

Description		**ICD-10**
Anal intraepithelial neoplasia (AIN)	II or III	R85.613
Biliary intraepithelial neoplasia	High grade	
Endometrioid (endometrial) intraepithelial neoplasia	II or Iii	N85.02
Esophageal intraepithelial neoplasia	High grade	
Glandular intraepithelial neoplasia	High grade	
Laryngeal intraepithelial neoplasia	II or III	
Lobular intraepithelial neoplasia (LIN)	II or III	
Pancreatic intraepithelial neoplasia (PanIN)	II or III	
Penile intraepithelial neoplasia (PeIN)	II or III	
Squamous intraepithelial neoplasia (excluding cervix)	II or III	
Vaginal intraepithelial neoplasia (VAIN)	II or III	N89.3
Vulvar intraepithelial neoplasia (VIN)	II or III	N90.3

Answer:
Many of these terms are not specified in the codes and definitions in ICD-10-CM. This is because ICD-10-CM does not have the same granularity as ICD-O-3.2. There are a few sites where intraepithelial neoplasia II and/or III are mentioned.

Even though ICD-O-3.2 classifies these as /2 (in-situ), for the intraepithelial neoplasia that are listed in ICD-10-CM, Grade II is designated as benign, while Grade III is designated as in-situ. It is not clear if medical coding will change the Grade II to an in-situ code.

All the in-situ codes (except cervix) are included in the casefinding list. Grade III is included with the in-situ codes; however, there is no guarantee that medical coders will code them as in situ. High grades are coded as in-situ in ICD-10-CM.

For those where there is no specific intraepithelial neoplasia code, the benign codes will cover any benign lesion for that site. This would make for a lot of review using the codes for casefinding. Most of the benign codes were removed from the casefinding list a couple of years ago to make it more manageable.

Use the casefinding list as a guide for these neoplasias. It is not the most definitive source due to the lack of specificity of ICD-10-CM. It is not possible to map every single histology to a specific code. It is also not known how medical coders across the U.S. are coding these neoplasias. For that reason, pathology should remain the foremost casefinding resource used.

The casefinding team will need to review the prepared list below and determine what codes to add. Any updates will be incorporated in the FY2025 updates (October 2024.)

Description	**ICD-10-CM Description**	**ICD-10-CM Code**
Anal intraepithelial neoplasia (AIN II)	Anal intraepithelial neoplasia I and II (histologically confirmed)	K62.82
Anal intraepithelial neoplasia (AIN III)	Carcinoma of in situ of anus and anal canal	D01.3
Biliary intraepithelial neoplasia (high grade)	Carcinoma in situ of liver, gallbladder and bile ducts	D01.5
Endometrioid (endometrial) intraepithelial neoplasia II -Not specified in ICD-10-CM as	Endometrial intraepithelial neoplasia (EIN)	N85.02

Endometrioid (endometrial) intraepithelial neoplasia III -Not specified in ICD-10-CM	Carcinoma in situ of endometrium	D07.1
Esophageal intraepithelial neoplasia (high grade) -Not specified in ICD-10-CM	Carcinoma in situ of esophagus	D00.1
Glandular intraepithelial neoplasia (high grade) -Not specified in ICD-10-CM	In situ code No specific site or code-could apply to any site	D00-D09
Laryngeal intraepithelial neoplasia II I -Not specified in ICD-10-CM	Other diseases of larynx	J38.7
Laryngeal intraepithelial neoplasia III -Not specified in ICD-10-CM	Carcinoma in situ of larynx	D02.0
Lobular intraepithelial neoplasia (LIN) II -No specification of II in ICD-10-CM	Other benign mammary dysplasia	N60.8-
Lobular intraepithelial neoplasia (LIN) III -- No specification of III in ICD-10-CM	Carcinoma in situ of breast	D05.--
Pancreatic intraepithelial neoplasm II -Not specified in ICD-10-CM	Benign neoplasm of pancreas	D13.6

Pancreatic intraepithelial neoplasm III -Not specified in ICD-10-CM	Carcinoma in situ of other specified digestive organs (includes pancreas)	D01.7
Penile intraepithelial neoplasia (PeIN) II -Not specified in ICD-10-CM	Benign neoplasm of penis	D29.0
Penile intraepithelial neoplasia (PeIN) III -Not specified in ICD-10-CM	Carcinoma in situ of penis	D07.4
Prostatic intraepithelial neoplasia (PIN), III	Carcinoma in situ of prostate, Prostatic intraepithelial neoplasia [PIN], grade III	D07.5
Squamous intraepithelial neoplasia (excluding cervix) II -Not specified in ICD-10-CM	Benign code -No specific site or code-could apply to any site	D10-D36
Squamous intraepithelial neoplasia (excluding cervix) -Not specified in ICD-10-CM	In situ code No specific site or code-could apply to any site	D00-D09
Vaginal intraepithelial neoplasia (VAIN), II	Moderate vaginal dysplasia -Vaginal intraepithelial neoplasia [VAIN], grade II	N89.1
Vaginal intraepithelial neoplasia (VAIN), III	Carcinoma in situ of vagina -Vaginal intraepithelial neoplasia [VAIN], grade III	D07.2

Vulvar intraepithelial neoplasia (VIN), II	Moderate vulvar dysplasia -Vulvar intraepithelial neoplasia [VIN], grade II	N90.1
Vulvar intraepithelial neoplasia (VIN), III	Carcinoma in situ of vulva -Vulvar intraepithelial neoplasia [VIN], grade III	D07.1

Date Finalized
04/30/2024

20240019

References:
#1: Solid Tumor Rules. Head and Neck, Other Sites, 2024 Update
#2: WHO Class Urinary System and Male Genital Organs. 5th edition

Question:
Solid Tumor Rules/Histology--Head and Neck, Other Sites: Do human papilloma virus (HPV) histologies that occur with subtype/variants of squamous cell carcinoma (SCC) in various sites apply only to sites in Solid Tumor Rules, Head and Neck, Table 5 and Other Sites, Table 23? See Discussion.

Discussion:
The 2024 Solid Tumor Rules, Table 5: Tumors of the Oropharynx, Base of Tongue, Tonsils, Adenoids contain notes that say beginning 1/1/2022, keratinizing or non-keratinizing SCCs, HPV positive or HPV negative, are coded 8085 or 8086, respectively, for sites listed in the Head and Neck Solid Tumor Rules, Table 5 only. Table 5 introductory section also states for cases diagnosed 1/1/2023 forward: "When the diagnosis is a subtype/variant of squamous cell carcinoma and HPV status is also noted, code the subtype/variant." This latter instruction is also included in Other Sites Table 23 (Penis and Scrotum Histologies) as a "Penis Coding Note."

Do these instructions ONLY apply to sites on those tables (and only to Penis or to Scrotum also in Table 23)? How should we code HPV-related keratinizing/non-keratinizing or other subtype/variant SCCs, for sites NOT on those tables, given the fact that only the more common histologies are listed in the Solid Tumor tables? For example, we recently reviewed a case with HPV-positive basaloid squamous cell carcinoma of the anus (C21.0).

Answer:
Code the specific histology as stated by the pathologist according to the site-specific instructions in the Solid Tumor Rules. When the histology provides a subtype/variant in addition to the HPV histology codes, code the subtype/variant as it is important to capture this histology as in the example provided. the instruction to code the subtype/variant over 8085 or 8086 applies to the following sites: oropharynx, cervix, vagina, vulva, anus, and penis. A note will be added indicating this in 2025.

Per 2024 Cancer PathCHART expert pathologist review, morphology codes 8085/3 and/or 8086/3 are valid and applicable to head and neck, oropharynx, cervix, vagina, vulva, fallopian tube, anus, and penis (reference: Cancer PathCHART: Product Downloads and Timelines). Other coding resources will be updated to reflect these changes in 2025.

Date Finalized
04/30/2024

20240018

References:
#1: Solid Tumor Rules. Head and Neck, Other Sites, 2023 and 2024 updates
#2: NAACCR Implementation Guidelines

Question:
Solid Tumor Rules/Histology--Head and Neck, Other Sites: Please provide clarification about effective dates for using p16 testing to assign HPV-related histology codes for various primary sites. See Discussion.

Discussion:
1. The 2022 and 2023 SEER Program Coding Manuals state under Histologic Type ICD-O-3: Beginning with cases diagnosed 01/01/2022 forward, p16 test results can be used to code squamous cell carcinoma, human papilloma virus (HPV) positive (8085) and squamous cell carcinoma, HPV negative (8086).

NAACCR 2023 Implementation Guidelines contain similar instructions on HPV histologies for cervix, vulva and vagina that are applicable back to 2022 (2021 for cervix).

The current Other Sites Solid Tumor Rules state on the Histology tables for anus, cervix, vagina, vulva, and penis and scrotum: "p16 is a valid test to determine HPV status and can be used to code HPV associated and HPV independent histologies." Since Other Sites Solid Tumor Rules apply to cases diagnosed 2023+, can p16 results only be used from 2023 onward, to code HPV-related histologies for primaries that fall under the Other Sites module? Or per the 2022 SEER Manual statement and NAACCR 2023 Implementation Guidelines, could a p16-confirmed HPV histology code also apply to a 2022 Other Sites case and if so, is that only for cervix, vulva, and vagina? Further complicating the matter are the 2024 ICD-O-3.2 update documents indicating these codes are valid 1/1/2024+ for the “Other Sites” penis and scrotum.

2. Is using p16 testing for HPV-related histology codes ONLY allowed for sites in the Solid Tumor tables that contain the statements about p16 (Head & Neck Table 5, and the Other Sites tables noted above for anus, cervix, etc.)? Or could it apply to primary sites outside of those tables; for example, a 2022 pathology report from the ethmoid sinus C311 indicating an HPV-related histology based on p16 testing? The ICD-O-3 Annotated Histology lists include C310-C313 among the common site codes for 8085 and 8086. The Head and Neck Solid Tumor Rules “New for 2022” section and rule H1 Note 4 also mention that p16 can be used to code HPV histologies; these sections would seem to apply to all sites in that module, since only the more common histology codes are listed in the tables and if not, we are instructed to use ICD-O.

Answer:
Per 2024 Cancer PathCHART expert pathologist review, morphology codes 8085/3 and/or 8086/3 are valid and applicable to head and neck, oropharynx, cervix, vagina, vulva, fallopian tube, anus, and penis scrotum (reference: Cancer PathCHART: Product Downloads and Timelines). The Cancer PathCHART SMVL will be updated for C632, Scrotum, with the next release of the NAACCR Edits Metafile, currently scheduled for May 2024.

Assign histology codes 8085 and 8086 for the sites listed in the Solid Tumor Rules histology tables. The codes 8085 and 8086 are applicable for a small group of sites according to the year they became valid for implementation as follows.

Head and Neck

Oropharynx, Base of Tongue, Tonsils, Adenoids (2022+)

Other Sites

Cervix (2021+)

Anus (2023+)

Vagina (2023+)

Vulva (2023+)

Penis (2024+)

Scrotum (2024+)

While ICD-O-3.2 and Cancer PathCHART list additional sites such as Accessory Sinuses, they have not yet been implemented in the U.S.

Date Finalized
04/30/2024

20240017

References:
SEER EOD. SEER*RSA, EOD Prostate Pathologic Extension

Question:
EOD/Prostate Pathologic Extension--Prostate: Is a pathology report from a prostate biopsy/transurethral resection of the prostate that states "with intraductal spread" extraprostatic/extracapsular extension or localized?

Answer:
Code as a localized, intracapsular tumor as ductal carcinoma in situ does not invade. Intraductal spread is describing the neoplasm spreading through the acinar/ductal cells in the prostate specimen. It is an in-situ type of spread and not invasive but almost always presents with an invasive tumor.

Date Finalized
04/30/2024

20240016

References:
ICD-O-3.2

Question:
Histology/Behavior--Head and Neck: What is the histology code for sinonasal glomangiopericytoma in 2023? See Discussion.

Discussion:
6/8/2023 A. Left nasal mass: Sinonasal glomangiopericytoma B. Additional left nasal mass: Sinonasal glomangiopericytoma

Is this a borderline tumor? I am unable to find this in the ICD-O-3 purple book or the Head and Neck Solid Tumor Rules.

Answer:
Assign histology code 8815/3 per ICD-O-3.2. Sinonasal glomangiopericytoma is also referred to as a sinonasal hemangiopericytoma. Prior to 2021, it was coded as 9150/3.

Date Finalized
04/30/2024

20240015

References:
#1: Solid Tumor Rules. Breast, May 2023 Update
#2: ICD-O-3

Question:
Solid Tumor Rules/Histology--Breast: Is ductal carcinoma in situ (DCIS), solid type coded as 8500/2 or 8230/2? See Discussion.

Discussion:
In the NAACCR Coding Pitfalls 2023 webinar, the example of DCIS, solid type is given. The webinar advised us to code 8230/2 (ductal carcinoma in situ, solid type). When going through the beginning of the solid tumor rules in the Changes from 2007 MPH Rules section it states "DCIS/Carcinoma NST in situ has a major classification change. Subtypes/variant, architecture, pattern, and features ARE NOT CODED. The majority of in situ tumors will be coded to DCIS 8500/2." In the equivalent or equal terms section it lists "Type, subtype, variant" can be used interchangeably.

Since the example has it listed as ductal carcinoma in situ, solid "type," would we code 8500/2 or 8230/2?

Answer:
Assign 8230/2 (ductal carcinoma in situ, solid type/intraductal carcinoma, solid type) using Breast Solid Tumor Rules Table 3 as instructed in Rule H2 for in situ tumors. The carcinoma, NST row lists this histology in the subtype/variant column 3.

Coding histology for in situ breast tumor differs from invasive. While the majority of in situ breast primaries will be coded to DCIS 8500/2, there are others that are listed in Table 3 that should be coded according to the specific histology. Some codes have the word subtype or type as part of their histologic term so these can be coded based on the histologic term as listed in the table. We suggest you routinely review the histology tables to see if a term is listed.

Date Finalized
04/30/2024

20240013

References:
#1: Solid Tumor Rules. Other Sites, May 2023 update
#2: WHO Class Urinary System and Male Genital Organs, 281-283. 5th edition

Question:

Solid Tumor Rules/Histology--Testis: Can a definition for "teratoma with somatic-type malignancy" (9084) be added to the Other Sites Solid Tumor Rules? See Discussion.

Discussion:
We included this histology in SEER Workshop Case 12 and the histology coding accuracy was less than 40%. From emails we received, it is clear that registrars are unaware that the "somatic type malignancy" can vary but code 9084 applies when the diagnosis is teratoma WITH any non-germ cell tumor component. It may be helpful to add a definition for "teratoma with somatic-type malignancy" (9084) to the Solid Tumor Manual.

Answer:
We will add the same definition for teratoma with malignant transformation found in the ovary table: 9084/3 Teratoma with malignant transformation when a malignant (/3) histology arises in a benign teratoma.

Teratoma with malignant transformation and teratoma with somatic-type malignancy are synonyms. The term teratoma with somatic-type malignancy is outdated and no longer recommended.

Date Finalized
04/30/2024

20240012

References:
#1: Solid Tumor Rules. Other Sites, May 2023 update
#2: ICD-O-3.2

Question:
Solid Tumor Rules/Histology--Other Sites: Should an additional Note be added to Other Sites Solid Tumor Rules, Rule H12, to indicate that if the diagnosis is an NOS histology in a polyp, continue on through the rules or should Other Sites Rule H13 be moved ahead of Rule H12 to capture this specific histology? See Discussion.

Discussion:
The accuracy rate for SEER Workshop Case 04 (a duodenal invasive adenocarcinoma in an adenomatous polyp) was very low because Rule H13 was either being ignored or users were stopping at Rule H12 to code adenocarcinoma.

If the presence of an NOS histology in a polyp is still clinically relevant for the Other Sites module, this information will be missed due to the order of the H Rules, or the lack of clarification in Rule H12.

If a change is made to Rule H12 (Single Tumor: Invasive Only module), then changes must also be made to the Single Tumor: In Situ Only module and the Multiple Tumors Abstracted as a Single Primary module because both these modules include the same polyp coding H Rule.

Answer:
The rule order is the same as in the previous MP/H rules. Will keep as is for now.

Assign codes adenocarcinoma in adenomatous polyp (8210), adenocarcinoma in villous adenoma (8261), and (adenocarcinoma in tubulovillous adenocarcinoma (8263) using Other Sites Solid Tumor Rule H12 or Rule H27 as these are specific invasive histology codes. Rule H13 applies to histology codes associated with polyps but associated with a histology term/code other than adenocarcinoma.

Date Finalized
04/30/2024

20240011

References:
#1: Solid Tumor Rules. Other Sites, May 2023 update
#2: ICD-O-3.2

Question:
Solid Tumor Rules/Histology--Other Sites: Other Sites Table 2 (Mixed and Combination Codes) requires site designations; can sites be added? See Discussion.

Discussion:
There are multiple possible entries (rows) for a tumor with a neuroendocrine component and non-neuroendocrine component, but these rows do not specify which primary sites are applicable. Row 1 (Combined small cell carcinoma, 8045) seems applicable to a prostate primary, but not to a GI primary since GI primaries are now generally referred to as MiNENs (mixed neuroendocrine non-neuroendocrine tumors), but Table 2 does not provide any instructions regarding how to determine the difference between 8045 and 8154 (or 8244).

For SEER Workshop Case 03 (mixed prostate case), many users selected 8154 or 8244 as the mixed histology code per Table 2, but these histology codes are not listed as applicable in Table 3 (Prostate Histologies). Per the WHO Blue Books, these histologies are not listed as applicable to the prostate.

How are registrars to determine the correct mixed code without site designations, especially if they don't have access to the WHO Blue Book or to a pathologist who may be able to clarify the codes?

Answer:
Sites may be added to certain combinations when indicated by ClinCORE review for Cancer PathCHART. Please note some sites were added in the 2024 update as a result of PathCHART review. A newly formed Solid Tumor Editorial Board and its subgroups are currently working to evaluate the Solid Tumor Manual and make recommendations on ways to improve the structure and formatting of the manual and its content.

Follow the rules and instructions in the Other Sites STRs when assigning combination histology codes.

Histology Coding Rules

Use the Histology Coding Rules when assigning combination codes.

Coding Histology Information

Use this section that includes the mixed histology (Table 2) and site-specific histology tables (Tables 3-23) for one or more histologies within a single tumor. Do not use this section in place of the Histology Coding Rules.

While site-specific histology tables, based on current WHO Classification of Tumors books, have been added to Other Sites STRs, not all site groups have individual histology tables; coding may require the use of ICD-O and updates. The histology tables in Other Sites STRs include additional coding instructions and notes to assign the correct ICD-O code when appropriate.

The tables are not meant to be all-inclusive; rather they are intended to address difficult coding situations to facilitate the assignment of the correct histology code.

Table 2: Mixed and Combination Codes Instructions

Once you have identified the histology terms and have been instructed to use Table 2 by the Histology Coding Rules, compare the terms in the diagnosis to the terms in Column 1. When the terms match, use the combination code listed in Column 2. Use adenocarcinoma mixed subtypes 8255 as a “last resort” code.

Date Finalized
04/30/2024

20240010

References:
#1: Solid Tumor Rules. Other Sites, May 2023 update
#2: WHO Class Male Genital Tumors, 223-224. 5th edition

Question:
Solid Tumor Rules/Histology--Prostate: Other Sites Solid Tumor RulesTable 3 (Prostate Histologies), Note 1 in the Adenocarcinoma with neuroendocrine differentiation (8574/3) row, conflicts with Note 2 and requires further clarification. See Discussion.

Discussion:
Note 1 states that this histology is treatment-related neuroendocrine prostatic carcinoma demonstrating complete neuroendocrine differentiation or partial neuroendocrine differentiation with adenocarcinoma after androgen-deprivation therapy (ADT). Conversely, Note 2 says to code 8574/3 only when there is no history of previous prostate adenocarcinoma or history of androgen-deprivation therapy.

The WHO Blue Book does confirm this is a treatment-related histology, so it seems we would only use this for an adenocarcinoma with neuroendocrine differentiation (or even possibly a mixed histology tumor with adenocarcinoma and small cell carcinoma components) if the patient had previous treatment.

If this histology is treatment-related, why would we use this code for a patient without a history of prostate adenocarcinoma or androgen-deprivation therapy? Should Note 2 be corrected?

Does this histology apply to a post-treatment diagnosis of mixed adenocarcinoma and small cell carcinoma? If yes, should this clarification be added?

Answer:
Assign code 8574/3 only when there is

A history of androgen-deprivation therapy **or**

No history of previous prostate adenocarcinoma

Prostate cancer with neuroendocrine differentiation (PCND) can present as untreated primary pathology (i.e., a new primary) or more commonly as a post ADT and androgen receptor inhibition resistance phenomenon. PCND is either a newly diagnosed prostate cancer or a result of ADT indicated for treatment of other prostate cancers or other non-cancer diagnoses (e.g., benign prostatic hyperplasia) but not for the PCND diagnosis.

We will edit the notes to make them more clear.

Date Finalized
04/30/2024

20230078

References:
SSDI Manual, 430-431; 442. Rai Classification section; Derived Rai Stage

Question:
Primary Site/Heme & Lymphoid Neoplasms--CLL/SLL: Should the primary site be coded C421 (bone marrow) for a diagnosis of chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) when the managing physician provides a Rai stage? See Discussion.

Discussion:
The patient has adenopathy and a lymph node biopsy proved CLL/SLL. The patient underwent a peripheral blood smear, but the final diagnosis only indicated there is an abnormal CLL panel, positive for monoallelic or biallelic deletion of 13q. The pathologist noted a CLL related clone was detected, but there was no definitive diagnosis of CLL on the peripheral blood. No bone marrow biopsy was performed. However, the managing physician noted this was Rai Stage I CLL/SLL with adenopathy in the neck.

The SSDI Manual notes, “Rai stage is only applicable for CLL, in which the bone marrow and/or peripheral blood are involved (primary site C421 for bone marrow, see Hematopoietic Manual, Module 3: PH 5, 6).” Should primary site default to C421 if the physician provides a Rai Stage in the absence of definitive peripheral blood or bone marrow involvement documented in the medical record?

Answer:
Assign primary site C421.

The Site-Specific Data item (SSDI) Manual, Rai Classification section, states: Per confirmation from medical oncologists, Rai stage is only recorded for patients who have bone marrow and/or peripheral blood involvement. Per the Hematopoietic Rules, primary site would be C421 (See Hematopoietic Manual, Module 3: Rules PH 5, 6). A new code has been added to the 5 SSDIs (code 5) to use when the primary site is not C421.

Date Finalized
04/30/2024

20230077

References:
#1: SEER EOD. SEER*RSA v3.0, Lymphoma-CLL/SLL
#2: Heme & Lymph Manual & DB. Published August 2021

Question:
EOD 2018/ Primary Site/Heme & Lymphoid Neoplasms--CLL/SLL: How are Primary Site and Extent of Disease (EOD) Primary Tumor coded when a lymph node biopsy proved chronic lymphocytic leukemia (CLL), and the peripheral blood is involved with an "abnormal CD5-positive B-cell population"? See Discussion.

Discussion:
The patient has adenopathy in multiple lymph node regions above and below the diaphragm and a lymph node biopsy pathology proved CLL/small lymphocytic lymphoma (SLL). Further work-up with peripheral blood proved an abnormal CD5-positive B-cell population comprising only a small percentage of the white blood cells (WBCs). The pathologist noted this neoplastic B-cell population comprises "3.5% of white blood cells and has an immunophenotype characteristic of CLL/SLL and is similar to the recent lymph node biopsy in this patient." The managing physician indicated this was a Lugano Stage III SLL. The registrar coded the peripheral blood involvement in EOD Primary Tumor.

If this small percentage of WBCs with an abnormal B-cell population is included in EOD Primary Tumor as peripheral blood involvement, then this would indicate peripheral blood/bone marrow involvement and primary site would need to be coded to C421 per Rule PH5. Rules PH5 and PH6 confirm primary site must be coded C421 if peripheral blood or bone marrow are involved.

Is there a cutoff value for these abnormal B-cell populations in the peripheral blood? Or should these abnormal B-cell populations be ignored unless the pathologist states the abnormal B-cell population is consistent with CLL/SLL (not just immunophenotypically characteristic of CLL/SLL)?

Answer:
Primary site would be C421 based on Hematopoietic and Lymphoid Neoplasm Manual, Module 3, Rule PH 5.

Assign EOD Primary Tumor to code 800 (peripheral blood involvement WITH other involvement).

Per consultation with an expert hematologist oncologist, this is a Stage IV CLL/SLL since the peripheral blood is involved. There is no cutoff value for the abnormal B-cell populations in the peripheral blood when the cells are consistent with CLL/SLL. If the peripheral blood is

involved, even only slightly, it is a Stage IV CLL/SLL. Our expert stated that the physician's staging was wrong (this is not a Lugano, Stage III).

Date Finalized
04/30/2024

20230076

References:
#1: WHO Class Urinary System and Male Genital Organs, 203-219; 223-224. 5th edition
#2: ICD-O-3.2

Question:
Solid Tumor Rules/Histology--Prostate: How is histology coded and what rule applies to a diagnosis of “prostatic adenocarcinoma with neuroendocrine differentiation” with reference to the Comment: Immunohistochemical findings are consistent with amphicrine carcinoma for a patient with no prior androgen-deprivation therapy. See Discussion.

Discussion:
The case in question represents an adenocarcinoma with neuroendocrine differentiation that arises in the absence of androgen-deprivation therapy. A 2023 journal article states, “We show that amphicrine prostate cancer is a unique entity and differs in clinical and molecular features from high-grade neuroendocrine carcinomas of the prostate. Our study highlights the need to recognize AMPC as a unique molecularly defined subgroup of prostate cancer.”

Should we be coding this with histology 8140 (Adenocarcinoma, NOS) because we have no specific code for an amphicrine carcinoma? Should we code this as 8045 (Mixed small cell carcinoma) because this is possibly the only way to capture both the adenocarcinoma and neuroendocrine components in a patient without previous treatment?

Our concern about using histology code 8574 (Adenocarcinoma with neuroendocrine differentiation) is that, while a valid histology code, this might confound the data if researchers are trying to separate the truly treatment-related tumors from other histologies captured under 8574.

Answer:
Assign 8140/3 (adenocarcinoma, NOS). WHO has not yet recognized the variant amphicrine prostate carcinoma and has not proposed an ICD-O code for this neoplasm. Document information in a related text field.

Date Finalized
04/30/2024

20230075

References:
#1: SEER EOD. SEER*RSA v3.0, Eye
#2: SEER Summary Stage 2000. SEER*RSA v3.0, Eye

Question:
EOD/Summary Stage--Eye: How is stage coded for a patient with extranodal non-Hodgkin lymphoma involving bilateral choroids (single focus, both sites) and no lymph node involvement? Since the eyes are a paired site, are these two separate extranodal sites? If so, there are no Summary Stage or EOD tumor codes that best fit this scenario.

Answer:
Assign as Stage IV as recommended by our expert hematological oncologist. This is a rare occurrence, and this type of presentation does not fit the definition of intraocular extension. Stage IV is probably the best stage for this type of presentation, since there are two extranodal organs involved, even though they involve a bilateral site.

EOD Primary Tumor: 700

SS: 7 (Distant)

Date Finalized
04/30/2024

20230074

References:
SEER EOD. SEER*RSA, v3.0-NET Jejunum and Ileum

Question:
Extent of Disease/EOD Regional Nodes--Small Intestine: For an ileal/jejunal neuroendocrine primary, how should mesenteric soft tissue deposits (less than 2 cm) be collected in Extent of Disease (EOD) Staging? See Discussion.

Discussion:
Example: Patient is diagnosed with grade 1 well-differentiated neuroendocrine tumor of the ileum, confirmed on ileocolic resection in 2023. The final diagnosis is a 2.8 cm ileal mass, with focal lymph-vascular invasion and a single 0.6 cm tumor deposit within mesenteric fat; primary tumor completely resected with widely negative margins and 10 regional nodes negative for malignancy.

According to AJCC, mesenteric masses less than 2 cm should be stated in the pathology report as being present and collected by registrars but do not affect stage. EOD Regional Nodes has a code for large mesenteric masses greater than 2 cm only. How should we record these smaller tumor deposits if they are not supposed to affect stage?

Answer:
Do not code 500 for involvement of the mesentery unless the mesentery is specifically stated to be involved (and we don't have that information). We need more information on this case to assign EOD primary tumor.

EOD Regional Nodes would be 000 per AJCC.

Date Finalized
04/30/2024

20230073

References:
2023 SEER Manual, 208; 236; Appendix C. Appendix C Liver and Intrahepatic Bile Ducts Surgery Codes

Question:
First Course Treatment/Surgery of Primary Site--Liver/Intrahepatic Bile Ducts: For a liver/intrahepatic bile duct primary, is alcohol embolization the same thing as a percutaneous ethanol injection (PEI)? See Discussion.

Discussion:
For C220-C221 primaries, Surgery of Primary Site includes code A150 for Alcohol tumor destruction (percutaneous ethanol injection/intratumoral injection of alcohol/alcohol ablation). The SEER and STORE manuals also indicate that alcohol embolization should be coded as Other Therapy, code 1. We are trying to determine whether alcohol embolization should be coded under Surgery of Primary Site or Other Therapy.

Answer:
Code alcohol ablation under *Surgery of Primary Site 2023*. Code alcohol embolization as *Other Therapy* when tumor embolization is performed using alcohol as the embolizing agent.

Alcohol ablation, also known as an ultrasound-guided percutaneous ethanol injection (PEI); is treatment that involves injecting concentrated alcohol directly into the tumor. Embolization uses special techniques to close off blood flow by introducing special medications or using other techniques designed to block blood vessels. Types of embolization are arterial embolization as with alcohol (ethanol), chemoembolization, and radioembolization. Refer to the current SEER Program Coding and Staging Manual when assigning surgery and embolization procedures.

Date Finalized
04/30/2024

20230072

References:
#1: WHO Class Urinary System and Male Genital Organs, 140-146. 5th edition
#2: Solid Tumor Rules. Urinary Sites, 2023 Update

Question:
Solid Tumor Rules/Multiple Primaries--Bladder: How many primaries and what M Rule applies to a diagnosis of non-invasive urothelial carcinoma of the bladder in 1996, followed by multifocal non-invasive papillary urothelial carcinoma involving bladder, prostatic urethra, and left ureter in 2022? See Discussion.

Discussion:
An argument could be made to apply Rule M10 (timing rule which may result in reporting the case as an additional primary) because the 2022 primary included multiple non-invasive urothelial carcinoma tumors in both the bladder and other urinary sites (coded to site C689, not C679) following a long disease-free interval. While Rule M10 excludes multiple bladder tumors, does that also apply when new, multifocal urothelial tumors arise in both bladder and other urinary sites? Does the presence of any subsequent bladder tumor rule out the use of M10 and one must use M11 that indicates reporting this disease process is a single primary?

Answer:
Abstract as a new primary per rule M10, as the subsequent tumors are not limited to the bladder. Code the primary site to C689, per Instructions for Coding Primary Site, #4: "Code Urinary System NOS C689 when there are multiple non-contiguous tumors in multiple organs within the urinary system" and following Note: "The physician subject matter experts (SME) discussed the issue of coding primary site for multifocal/multicentric urinary tract carcinoma. Although the SMEs understood and acknowledged the importance of coding a specific primary site, there is no literature or criteria for determining the organ of origin for multiple tumors involving multiple urinary sites".

Date Finalized
04/30/2024

20230071

References:
#1: WHO Class Female Genital Tumors, 367-371. 5th edition
#2: Solid Tumor Rules. Other Sites, May 2023 Update

Question:

Solid Tumor Rules/Histology--Cervix: How is histology coded for a 2023 endocervical adenocarcinoma negative for high-risk human papilloma virus (HR-HPV) on Pap smear and strongly positive for p16 on biopsy? See Discussion.

Discussion:
The Solid Tumor Rules indicate p16 is a valid test to determine HPV status and can be used to code HPV-associated/-independent.

In this case, we do not know whether the HR-HPV test was done on cytologically malignant cells, or on benign cervical cells. It may be impossible to tell unless 100% of the cytology specimen is malignant, but we will not have access to that information. Also, HR-HPV testing is routine on Pap smears, so this testing does not mean the tumor cells specifically harbor HPV.

Answer:
Assign histology as adenocarcinoma, HPV-associated (8483/3) as designated in Table 17, Uterine Cervix Histologies, of the Other Sites Solid Tumor Rules. The WHO Classification of Female Genital Tumors, 5th edition, states that p16 immunohistochemistry is an effective (yet flawed) indirect test for HR-HPV infection, in line with the STRs that state p16 is a valid test to determine HPV status and can be used to code HPV-associated and HPV-independent histologies. In this scenario, "negative for high-risk human papilloma virus (HR-HPV) on Pap smear" would be cytology-based and may have missed cytologically malignant cells. A subsequent, more definitive biopsy was performed and was found to be strongly positive for p16, therefore, the tumor should be coded as 8483/3.

Date Finalized
04/30/2024

20230070

References:
Solid Tumor Rules. Breast, 2023 Update; May 2023 Update

Question:
Solid Tumor Rules/Multiple Primaries--Breast: How many primaries should be accessioned for a diagnosis of invasive carcinoma of the left breast (8500/3) in 2020 followed by a 2023 diagnosis of dedifferentiated carcinoma in the left breast (8020/3)? See Discussion.

Discussion:
The WHO Blue Books do not include dedifferentiated carcinoma as a valid histology for the breast. However, there is known to be progression of ductal carcinoma that is essentially dedifferentiation of an estrogen receptor, progesterone receptor, and HER2 breast carcinoma to a triple negative "dedifferentiated" carcinoma which it appears this patient has. Whether we should accession this as a separate 8020/3 primary per M14 is unclear and the Solid Tumor Manual does not address this scenario.

Answer:
Abstract a single primary using Breast Solid Tumor Rules, Rule M18, as none of the previous rules apply.

Undifferentiated carcinoma is a malignant epithelial tumor lacking overt evidence of a specific line of differentiation. **Dedifferentiated** carcinoma is composed of an undifferentiated carcinoma and a differentiated component. Dedifferentiated carcinoma (8020/3) as a morphology is associated with cancer of the endometrium and ovary rather than the breast. Breast cancer shows a broad spectrum of morphology with extensive variation in histological type and grade, related to the complexity of carcinogenesis. This includes initial genetic changes in the cell of origin, subsequent genetic and epigenetic alterations, and reprogramming that occur at various stages of development along with interaction of other factors that influence the process of differentiation. This scenario likely represents the process of phenotypic change of a carcinoma at a later stage, better known as transdifferentiation.

Date Finalized
04/30/2024