20240064

References:
ICD-O-3.2

Question:
Primary Site/Histology--Ovary: We are encountering a primary site, histologic type, and behavior combination edit based on the Cancer PathCHART (CPC) tables. Using the CPC*Search tool, C569 and 8441/3 is a valid combination. The diagnosis date is 01/13/2024. Should an over-ride be applied with this combination?

Answer:
The CPC Validity Status of the site morphology combinations of C569/8441/3 and C569/8441/2 was revised from Valid to Unlikely with the latest release of the Version v24A Edits Metafile. As a result, this site and morphology combination will now require an over-ride flag to be set.

Code as 8461/3 (high-grade serous carcinoma) or 8460/3 (low-grade serous carcinoma) if at all possible. Use 8441/3 (serous carcinoma, NOS) only if it cannot be distinguished as low grade or high grade. The codes for high-grade serous carcinoma and low-grade serous carcinoma are relatively new. High-grade serous carcinoma and low-grade serous carcinoma are very different tumors and pathologists should state whether it is high grade or low grade. Please make every attempt to use the newer codes. If unable to determine high gade versus low grade, assign 8441/3 and override the edit.

The files on the CPC website are currently being updated, and CPC*Search will be updated to reflect the changes sometime this Fall.

Date Finalized:
9/13/2024

20240061

References:
WHO Class Hematolymphoid Tumors. 5th edition

Question:
Heme & Lymphoid Neoplasms/Histology--Myelodysplastic Neoplasm: What is the histology code for myelodysplastic neoplasm with low blasts and SF3B1 mutation with primary site bone marrow (C421) diagnosed in 2023?

Answer:
Assign histology as 9982/3 (myelodysplastic neoplasm with low blasts and SF3B1 mutation). This is a new term for 9982/3. WHO Classification of Hematolymphoid Tumors, 5th edition, defines myelodysplastic neoplasm (MDS) with low blasts and *SF3B1* mutation (MDS-*SF3B1*) as a myeloid neoplasm with cytopenia and dysplasia characterized by *SF3B1* mutation and often ring sideroblasts.

Date Finalized:
9/13/2024

20240060

References:
#1: WHO Class Thoracic Tumors, 133-138. 5th edition

#2: Solid Tumor Rules. Lung, 2024 Update

Question:
Solid Tumor Rules/Histology--Lung: What is the histology code for a lung case with a diagnosis only stated as "high-grade neuroendocrine tumor" in 2022? As the disease was advanced, limited workup was done, and no more specific diagnosis was provided. See Discussion.

Discussion:
SINQ #20170064 states this should be coded as neuroendocrine carcinoma for rectum, but that may not apply for a 2018+ lung case. The Solid Tumor Manual lists "neuroendocrine tumor, grade 3" as 8249 in the Lung module, Table 3, but our pathology report does not specify grade 3 and we are unsure if that would be equivalent to "high grade" in this case. We were unable to find this exact term in the Solid Tumor Manual or the ICD-O-3.2 update documents.

Answer:
Assign 8249/3 for high-grade neuroendocrine tumor of the lung.

WHO Classification of Thoracic Tumors, 5th edition, defines two subtypes of neuroendocrine tumor of the lung, typical carcinoids (8240/3), and atypical carcinoids. WHO assigns typical carcinoid/neuroendocrine tumor grade 1 as 8240/3 and atypical carcinoid/neuroendocrine tumor grade 2 as 8249/3. They are regarded as low-grade and intermediate-grade, respectively. The preferred term for 8249/3 in ICD-O-3.2 is neuroendocrine tumor grade 2, with neuroendocrine tumor grade 3 as a related term. The Lung Solid Tumor Rules assign atypical carcinoid as 8249/3.

Date Finalized:
9/27/2024

20240059

References:
#1: 2024 SEER Manual, 156-157. SEER Site-specific Factor 1

#2: SEER*RSA. SEER*RSA v3.1

Question:
Update to the Current Manual/SEER*RSA--SEER Site-specific Factor 1: The 2024 SEER Manual and SEER*RSA say that Codes 10-51 are hierarchical; use the highest code that applies (10 is highest, 51 is lowest). Should the guidance say that 51 is highest, 10 is lowest since code 10 is a HPV negative p16 test?

Answer:
Assign the highest code with 51 as the highest and 10 the lowest when there is more than one test performed with differing results.

The SEER Manual will be updated in the 2025 release. SEER*RSA will be updated in a future release, version 3.3 in 2026, as version 3.2 has been updated for 2025.

Date Finalized:
8/2/2024

20240058

References:
#1: 2024 SEER Manual, 136. SEER Summary Stage 2018

#2: 2018 Summary Stage. v3.1; Female Genital System-Ovary and Primary Peritoneal Carcinoma

Question:
Summary Stage 2018--Ovary: What is the summary stage for an ovarian primary in 2024, in which the ovary capsule was ruptured with surgical spill? See Discussion.

Discussion:
In this case, the surgeon ruptured the ovarian tumor to drain it prior to removal causing the surgical spill. Regional lymph nodes are negative and there is no metastasis. The capsule was then noted as ruptured on pathology.

Does it matter if the surgeon was the one who ruptured the capsule? Would the stage change if the surgeon intentionally ruptured the capsule to drain the tumor intraoperatively causing some surgical spill? The scenarios of an intentional and not intentional rupture are not specified in SEER Summary Stage 2018.

Answer:
Code SEER Summary Stage 2018 to Localized, Code 1. Per consult with AJCC and noted in the Primary Peritoneal Chapter in AJCC 8th edition, an intraoperative rupture is coded as a surgical spill.

A capsule rupture is when the capsule ruptures prior to the surgery (Summary Stage Regional, Code 2).

Date Finalized:
8/7/2024

20240057

References:
#1: Solid Tumor Rules. Non-Malignant CNS 2024 Update

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

Question:
Solid Tumor Rules/Histology--Brain and CNS: What is the histology code for angiocentric glioma? See Discussion.

Discussion:
We would like to confirm that the correct histology code is 9431/1 per ICD-O-3.2, as the Non-Malignant CNS Solid Tumor Manual lists the histology code as both 9431/1 (pages 301 and 303 of the combined manual), but also shows it as a synonym for 9421/1 – Diffuse astrocytoma, MYB- or MYBL1 altered (page 304).

Answer:
Assign code 9431/1 for angiocentric glioma. This has been corrected in the 2025 update. Angiocentric glioma was removed from the 9421/1 row and remains in its own row.

Date Finalized:
8/2/2024

20240056

References:

Rao AG, Danturty I. Leukemia cutis. Indian J Dermatol. 2012 Nov;57(6):504. doi: 10.4103/0019-5154.103086. PMID: 23248383; PMCID: PMC3519272.

Question:

Reportability/Histology--Heme & Lymphoid Neoplasms: How should this unusual 2023 pathology-only case be reported and coded for leukemia cutis? See Discussion.

Discussion:

10/25/2023: Patient presents to dermatology office with a questionable drug eruption having 3 weeks of papular eruptions of Trunk (Left Chest). Punch biopsies were taken that came back as immature hemopoietic infiltrate with monocytic differentiation. Comment: Myelodysplastic syndrome and leukemia cutis are possibilities. Addendum Report: Additional stains were prepared. ERG is strongly positive. CD1a and S100 do not stain the atypical cells. The controls stain appropriately. CD123 perform with appropriate control is also negative. The pattern is that of so-called "leukemia cutis" which could be seen in the clinical setting of myelodysplasia, chronic myelomonocytic leukemia (CMML) or precursor to acute myelomonocytic leukemia (AMML). Recommend work up. The only available information at present is a diagnosis of leukemia cutis, and that there was no prior history of a hematological malignancy in this patient.

Answer:

Report this case of leukemia cutis and code to bone marrow (C421) and leukemia NOS (9800/3) based on the information provided. Update the abstract if new information becomes available.

Leukemia cutis is the rare infiltration of neoplastic leukocytes into the epidermis, dermis, or subcutis from an existing leukemia that results in clinically identifiable cutaneous lesions. Leukemia cutis may precede, follow, or occur concurrently with the diagnosis of systemic leukemia. It is an advanced phase of the leukemia having a poor prognosis that also strongly correlates with additional sites of extramedullary involvement. This can alter the appropriate treatment regimen for a patient. It is a type of "metastasis" or spread of the leukemia cells. The "conventional" definition for leukemia cutis is the infiltration of skin from a bone marrow primary. It is most often diagnosed via skin biopsy—punch, shave, etc., utilizing IHC/biomarker testing and is commonly associated with CMML and acute myeloid leukemia (AML). As such, it a reportable condition especially when preceding a confirmed systemic leukemia diagnosis. In this situation, the diagnosis date would be the date of the positive leukemia cutis skin bx—punch, shave, etc. The case should be coded to C421; 9800/3 Leukemia NOS until the official systemic leukemia diagnosis is rendered. If possible, follow back should be conducted to determine the specific systemic leukemia histology (CMML; AML) and the treatment received. If the leukemia cutis follows or occurs concurrently with the diagnosis of a systemic leukemia, it is NOT a separate primary but merely an advanced stage of the systemic leukemia diagnosis.

FINALIZED SEER SINQ QUESTIONS

July - September, 2024

Date Finalized:
8/2/2024

20240055

References:
#1: 2024 SEER Manual, 124-128. Tumor Size Summary

#2: 2024 STORE Manual, 150-154. Tumor Size Summary

Question:
Update to the Current Manual/Tumor Size Summary—Neoadjuvant Treatment: Would you clarify instructions in the 2024 SEER Program Coding and Staging Manual (SPCSM) for *Tumor Size Summary* when a patient receives neoadjuvant treatment? There seems to be a conflict with the STORE Manual. See Discussion.

Discussion:
Starting for cases diagnosed in 2024, the SPCSM manual no longer requires the data items for clinical and pathologic tumor size. Instead, it appears to align with the CoC data item of *Tumor Size Summary*. The two manuals contradict each other when it comes to coding tumor size summary for neoadjuvant chemotherapy (NAC) treated cancers.

STORE states: "If neoadjuvant therapy followed by surgery, do not record the size from the pathologic specimen. Code the largest size of the tumor prior to neoadjuvant treatment; if unknown code size as 999."

2024 SPCSM states "If neoadjuvant therapy followed by surgery, do not record the size from the pathologic specimen. Code the largest size of the tumor prior to neoadjuvant treatment; if unknown code size as 999." It continues to state

12. Assign code 000 when…. (a) no residual tumor is found… (i) Neoadjuvant therapy has been administered *and* **the resection shows no residual tumor &**

14. Assign code 999 when...(d) Neoadjuvant therapy has been administered and resection was performed. Do not use a post-neoadjuvant size to code pathologic tumor size; however, you may use the clinical tumor size if available

It seems that we will lose the value of the tumor size summary if we code 000 when NAC is administered and there is no residual disease.

Example: Patient has a 90 mm triple positive breast tumor and is treated with neoadjuvant TCHP (docetaxel/carboplatin/ trastuzumab/pertuzumab). After completing neoadjuvant therapy, the patient has a mastectomy with no residual disease noted on the final pathology report.

Using the 2024 SPCSM instructions, code 000 for *Tumor Size Summary* instead of 090 for the clinical tumor size of 90 mm tumor noted before NAC was administered. This has the potential to affect data analysis, research, and clinical trial accrual.

Answer:
When there is neoadjuvant therapy followed by surgery, do not record the size from the pathologic specimen. Code the largest size of the tumor prior to neoadjuvant treatment; if unknown code size as 999. We will remove Coding Instruction 12.a.i in the next version of the manual.

Date Finalized
8/2/2024

20240054

References:
#1: 2018 EOD Manual. General Instructions; SEER*RSA Breast

#2: AJCC Cancer Staging Manual, 589-628. 8th edition, Breast chapter

Question:
EOD 2018/Primary Tumor--Breast: We are having difficulty deciding when we can or cannot use physician-assigned TNM staging to code EOD data items if the medical record or hospital abstract documentation is unclear. As a central registry, we are unable to query physicians for clarification. Please advise what is a "discrepancy" in the EOD General Instructions to "Use the medical record documentation to assign EOD when there is a discrepancy between the T, N, M information and the documentation in the medical record." See Discussion.

Discussion:
We know that physician TNM staging is not always accurate, and we also know that doctors sometimes use information in assigning their TNM which may not be available to registrars. Is it a discrepancy when the documentation in the chart is unclear or not definitive, yet the physician assigns a TNM that seems to incorporate that documentation? Or is a discrepancy an obvious conflict between chart documentation and the doctor's staging – such as a mis-assignment of TNM category that doesn't at all match with clear and complete medical record documentation, or the physician's use of criteria that should be excluded from the TNM assignment per AJCC guidelines?

A real case example is a patient with breast carcinoma, imaging states 12 cm tumor with thickening of dermis, and thickening of morphologically suspicious internal mammary and level 1-2 axillary lymph nodes. Medical oncologist states locally advanced breast cancer with extensive changes involving skin thickening associated with the mass, at least stage IIIC based on imaging and exam findings, cT4 N3b. Only axillary nodes were sampled and found to be positive. Post-neoadjuvant therapy resection showed only focal DCIS. Per EOD guidelines, would the oncologist's staging be a discrepancy with the chart documentation and therefore ignored, with EOD-Primary Tumor coded 200 for skin thickening, and EOD-Lymph Nodes 200 for involvement of axillary nodes only? Or would the doctor's TNM be a clarification/confirmation of documentation terms that we otherwise would not code, with EOD-PT coded 400 for extensive skin involvement and EOD-LNs 600 for internal mammary + axillary nodes?

Answer:
Use all information available in the medical record. EOD is a combination of the most precise clinical and pathological documentation of the extent of disease as instructed in the EOD 2018 General Instructions, Extent of Disease section.

EOD 2018 General Instructions, General Coding Instructions section advises to use the medical record documentation to assign EOD when there is a discrepancy between the T, N, M information and the documentation in the medical record. When there is doubt that the documentation in the medical

record is complete, code the EOD corresponding to the physician staging. A discrepancy can exist within the medical record when the information in the chart is unclear, incomplete, or conflicting, for example, the TNM staging from pathology differs from the medical oncologist's TNM staging.

In the scenario provided, use the medical oncologist stage information that takes into account imaging and exam findings. Based on the stage cT4 N3b, assign

EOD Primary Tumor: 400

Extensive skin involvement

WITHOUT a stated diagnosis of inflammatory carcinoma

WITH or WITHOUT dermal lymphatic filtration

EOD Regional Nodes: 600

Internal mammary node(s), ipsilateral, clinically apparent

(On imaging or clinical exam)

WITH axillary (level I, II, or III) lymph node(s), ipsilateral including infraclavicular

Date Finalized:
8/2/2024

20240053

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

#2: WHO Class Urinary Tumors. 4th and 5th editions

Question:
Reportability/Behavior--Kidney: Is a 2022 diagnosis of "clear cell renal cell papillary tumor" on nephrectomy reportable? See Discussion.

Discussion:
We are aware that the WHO 4th edition for urinary tumors has changed the behavior of "clear cell papillary renal cell carcinoma" to /1 but registries are to continue collecting as /3.

While the diagnosis in our case is stated as "tumor" it does seem like the pathologist may be using the new WHO terminology of "tumor" rather than "carcinoma," so we are not sure if behavior is /3 or /1.

Answer:
Report clear cell renal cell papillary tumor (CCRCPT), formerly classified as clear cell renal cell papillary carcinoma, and assign code 8323/3 until this new term and code (8323/1) have been adopted by standard setters.

The Kidney Solid Tumor Rules advise to code clear cell papillary renal cell carcinoma as 8323/3. WHO Classification of Tumors of the Urinary System and Male Genital Organs, 4th ed., has reclassified this histology as a /1. This change has not yet been implemented and it remains reportable.

WHO Classification of Urinary and Male Genital Tumors, 5th ed., has since reclassified clear cell papillary renal cell carcinoma as CCRCPT (8323/1). The name change was made because there have been no reports of metastatic events for this indolent tumor. The term clear cell renal cell papillary carcinoma is no longer recommended.

Date Finalized:
7/10/2024

20240052

References:
#1: WHO Class Hem & Lymph Tumors. 4th edition

#2: WHO Class CNS Tumors. 5th edition

Question:
Reportability/Histology--Heme & Lymphoid Neoplasms: Should a non-Langerhans cell histiocytosis involving the hypothalamus and pituitary gland be accessioned as a reportable, behavior /1, CNS neoplasm? See Discussion.

Discussion:
Imaging identified a mass involving the hypothalamus and pituitary gland and excision of the mass proved "histiocytosis." The case was extensively reviewed, and the physician notes this patient has a pituitary tumor that is a "non-Langerhans cell histiocytosis," or a "non-LCH histiocytic neoplasm."

There is no histology for histiocytosis (NOS) or non-Langerhans cell histiocytosis. However, this does appear to be a non-malignant histiocytic neoplasm. If this were a Langerhans cell histiocytic neoplasm in the CNS it would be reportable. Should this non-Langerhans cell histiocytic neoplasm also be accessioned as a reportable CNS neoplasm? If so, how is the histology coded?

Answer:
Report this case as a pituitary tumor (8000/1) based on the information provided. This is the best choice as no specific histology code exists for this generic term "non-Langerhans cell histiocytosis" in ICD-O-3.2, WHO Classification of CNS Tumors, 5th ed., and WHO Classification of Tumors of Hematopoietic and Lymphoid Tissues, 4th ed.

Be sure to double-check the behavior code of the tumor. Histiocytosis can be benign, borderline, or malignant. There was no mention of the behavior, so we defaulted to uncertain behavior for this case.

Date Finalized:
8/2/2024

20240050

References:
#1: WHO Class Female Genital Tumors, 445-446. 5th edition

#2: Solid Tumor Rules. Breast, 2024 Update; Other Sites, 2024 Update

Question:
Solid Tumor Rules/Multiple Primaries--Vulva: Why is there no M Rule in the Other Sites Multiple Primary Rules related to extramammary Paget disease of the vulva? See Discussion.

Discussion:
The only Other Sites H Rule related to extramammary Paget disease is included in the Multiple Tumors Abstracted as a Single Primary module. Rule H28 instructs one to code the histology of the underlying tumor when there is extramammary Paget disease and an underlying tumor of the anus, perianal region, or vulva. Therefore, a vulvar extramammary Paget disease with underlying adenocarcinoma is coded as adenocarcinoma (8140/3), and not extramammary Paget disease (8542/3).

However, there is no M Rule confirming extramammary Paget disease and the underlying adenocarcinoma are a single primary (i.e., multiple tumors abstracted as a single primary) making it difficult for one to use the Multiple Tumors Abstracted as a Single Primary H rules module.

We recognize this is a longstanding histology coding rule, but how are registrars supposed to arrive at Rule H28 when the M Rules must be applied first and do not instruct one to accession a single primary? Moreover, if this is to be a single primary (per rule M2), why is there no H Rule in the Single Tumor module?

Answer:
In sites other than breast (see Breast Solid Tumor Rules M8/M9), Paget disease with underlying invasive disease is a single primary and the underlying histology is coded. Primary Paget disease of the vulva is uncommon, and we cannot create rules for all possible situations in the Other Sites module. A GYN specific module is in development, and we will look into adding a Paget-related rule. It will differ because Paget in breast is a different situation while Paget in the vulva is always adenocarcinoma.

Paget disease of the vulva is an in-situ adenocarcinoma of vulvar skin with or without an underlying adenocarcinoma (WHO Classification of Female Genital Tumors, 5th ed.). When there is a statement of “underlying” adenocarcinoma, it is a single primary as with Breast Solid Tumor Rule M8.

Date Finalized:
8/2/2024

20240049

References:
2024 SEER Manual, 227-231. Neoadjuvant Therapy

Question:
First Course Treatment/Neoadjuvant Therapy--Breast: When are pre-operative therapies given as part of a clinical trial coded as neoadjuvant treatment versus limited systemic exposure in the Neoadjuvant Therapy data item? See Discussion.

Discussion:
The SEER Manual seems to give somewhat conflicting instructions for clinical trial therapies under the Neoadjuvant Therapy data item. One section states that limited systemic therapy may occur in clinical trials to impact the biology of a cancer, but is not a full course of neoadjuvant therapy with the intent to impact extent of surgical resection or other outcomes (organ preservation, function or quality of life); do not code as neoadjuvant therapy for the purposes of this data item. Then another section states for purposes of this data item, the criteria for neoadjuvant therapy include that treatment must follow recommended guidelines for the type and duration of treatment for that particular cancer site and/or histology, and that neoadjuvant therapy may be given as part of a clinical trial.

For example, a patient was diagnosed with invasive ductal carcinoma of the breast, 6 cm in size; treatment planning conference recommended neoadjuvant chemotherapy. The patient elected to participate in a clinical trial and was assigned to a group given the antibody drug conjugate datopotamab deruxtecan (Dato-DXd) plus durvalumab for 12 weeks. There was no physician documentation of intent or expected outcomes, nor yC staging or statement of clinical response. Post-therapy imaging showed no residual mass, and post-therapy mastectomy path report showed only residual ductal carcinoma in situ, stating "Treatment Effect (after neoadjuvant): Residual Cancer Burden - pCR, In the breast - complete response." The medical oncologist stated post-therapy stage was ypTis ypN0 cM0.

The trial drugs this patient were given do not appear to be approved or standard neoadjuvant/pre-operative drugs in SEER*Rx or NCCN guidelines for this type of cancer; however, the duration of treatment was fairly substantial, and although we don't have clear documentation from physicians as recommended in the SEER manual (which is usually not stated, in our experience), it seems like they may be considering it as neoadjuvant therapy. How should the Neoadjuvant Therapy data item be coded for cases like this? What is the best way to differentiate between clinical trial therapies that are "limited systemic exposure" (code 3) versus true neoadjuvant therapy (code 1)?

Answer:
When pre-operative therapies are given as part of a clinical trial, code as neoadjuvant treatment in the Neoadjuvant Therapy data item when the intent is neoadjuvant and/or when surgical resection follows the clinical trial therapies.

In the example, neoadjuvant chemotherapy was recommended in the treatment planning and the patient had the planned resection after neoadjuvant treatment. The treatment effect outcome is based on imaging that reported no mass and as documented by the physician, pathologist in this case as complete response to the neoadjuvant therapy based on the resection.

Use code 3 (limited systemic exposure) when treatment does not meet the definition of neoadjuvant therapy in the data item, Neoadjuvant Therapy. Limited exposure occurs when the patient receives some therapy prior to surgical resection, but the treatment is not enough to qualify for a full course of neoadjuvant therapy with the intent to impact extent of surgical resection or other outcomes. While this type of treatment may given as part of a clinical trial, it mostly refers to short term treatments such as hormone therapy.

When neoadjuvant therapy is given prior to surgical resection that is planned (intended) or performed to improve outcomes, use Code 1 or 2. Because a clinical trial is a type of research study that tests new methods of screening, prevention, diagnosis, or treatment of a disease, the treatment regimens likely will not be incorporated in recommended guidelines until all phases of the trial are completed and approved by the U.S. Food and Drug Administration. ClinicalTrials.gov is available to learn more about clinical studies around the world.

Date Finalized:
7/10/2024

20240048

References:
#1: ICD-O-3.2

#2: Solid Tumor Rules. Breast, 2024 Update

Question:
Solid Tumor Rules/Histology--Breast: What is histology code of a breast tumor with ductal carcinoma, lymphoepithelioma-like carcinoma type? See Discussion.

Discussion:
Example: 12/2023 Breast lumpectomy final diagnosis is Invasive ductal carcinoma, lymphoepithelioma-like carcinoma type. This is a single tumor with no in situ carcinoma present.

Lymphoepithelioma-like carcinoma is not listed as a subtype/variant or synonym for breast carcinoma in the Solid Tumor Rules histology tables.

Answer:
Lymphoepithelial carcinoma is a subtype of SCC usually seen in skin or H&N sites and often associated with EBV. CPC SME review determined 8082/3 invalid for breast but did not recommend a substitute code. There were only 45 cases coded 8082 2001 to 2019. For this case, it's possible the lesion originated in the breast skin and progressed to breast tissue. SCC is a subtype of metaplastic breast carcinoma so one could argue it code be coded either 8575 or 8070. For this case, we recommend assigning 8500/3. Use text fields to record the details.

Date Finalized:
7/10/2024

20240047

References:
#1: ICD-O-3.2

#2: 20210043

Question:
Reportability/Histology--Endometrium: Is "high grade serous intraepithelial neoplasm" of the endometrium reportable? See Discussion.

Discussion:
The patient had a 2023 endometrial polypectomy and curettage with final diagnosis of "at least serous intraepithelial neoplasia arising in association with an endometrial polyp." Diagnosis comment states, "There are multiple tissue fragments with highly atypical glandular lining consistent with a high-grade serous neoplasm. There are focal areas which are suspicious, but not conclusive, for stromal invasion." Subsequent hysterectomy and BSO showed no residual carcinoma.

According to previous SINQ 20210043, serous tubal intraepithelial neoplasm (STIN) is reportable when stated to be high grade. Does the same logic apply to a similar neoplasm in the endometrium and/or endometrial polyp?

Answer:
Report high grade serous intraepithelial neoplasm of the endometrium.

Date Finalized:
7/10/2024

20240046

References:
Cancer PathCHART. CPC Search Tool

Question:
Reportability/Histology--Stomach: According to the AJCC manual, histology codes 8240 and 8249 are excluded from site code C160. Does that mean that I cannot use either of these histology codes with C160 even if the pathologist's diagnosis is neuroendocrine carcinoma?

Answer:
Please understand that **AJCC** sets the standards for **TNM Staging** and the **Cancer PathCHART** (CPC) initiative sets standards for the **validity of site and morphology combinations.** The statement in the AJCC manual "8240 and 8249 are excluded for topography code C160" means that these two histologies are not staged using the AJCC Staging System. As with numerous other reportable entities that are not staged by AJCC, the case is reportable, and a Summary Stage should be assigned. Combinations of C160 with 8240 or 8249 are valid site/histology combinations for registry reporting and should **not** be discouraged from use if they correspond to the pathologist's diagnosis. This goes for any other similar note in the AJCC manual. All CPC standards are enforced via the Primary Site, Morphology-Type, Beh ICDO3, 2024 (SEER) N7040 and Histologic Type ICDO3, Primary Site, Date of Diagnosis (NAACCR) N4911 data quality edits. Registrars can also look up the validity of site and morphology combinations using the CPC*Search tool: https://seer.cancer.gov/cancerpathchart/search/tool/.

It is important to remember the following.

- ALWAYS code the tumor histology stated by the pathologist/physician
- NEVER change the tumor histology to assign TNM
- Not all tumors or histologies can be staged per TNM
- Cases that cannot be assigned TNM are assigned a summary stage

Date Finalized:
7/10/2024

20240045

References:
2024 SEER Manual, 18-21. Reportability

Question:
Reportability/Ambiguous Terminology--Prostate: Should cases be reported and abstracted based on ambiguous terminology, e.g., suspicious for prostate cancer, when the physician is not treating the case as malignant? See Discussion.

Discussion:
Please comment on these specific scenarios.

1. A prostate biopsy is suspicious for adenocarcinoma, but the urologist is not considering this malignant, nor is the urologist treating for malignancy, but **there is no clear statement from the physician that this is not reportable**. Should this case be abstracted?
2. A prostate biopsy is suspicious for adenocarcinoma, and **there is a statement by the physician that this is not yet malignant**. Should this case be abstracted?
3. Prostate MRI with PIRADS 4 or 5; however, the treating urologist **does not call this malignant and is not treating patient for prostate cancer.** [Example: 2024 Prostate MRI - PI-RADS 4. Follow up with Urologist states patient to repeat Prostate MRI in 1 year and continue with yearly PSA levels and there is no mention of prostate cancer other than the PI-RADS score]. Should this case be abstracted?

Answer:
For each of your scenarios, the medical record information indicates that the case is not reportable based on physician opinion. Do not abstract these cases.

Remember that the ambiguous terms list is to be used as a **last resort**. The ideal way to approach abstracting situations when the medical record is not clear is to follow up with the physician. If the physician is not available, the medical record, and any other pertinent reports (e.g., pathology, etc.) should be read closely for the required information. See page 19 in the SEER Manual, https://seer.cancer.gov/manuals/2024/SPCSM_2024_MainDoc.pdf

Date Finalized:
7/10/2024

20240044

References:
2024 SEER Manual, 227-231. Neoadjuvant Therapy

Question:
First Course Treatment/Neoadjuvant Therapy--Esophagus: Should the Neoadjuvant Therapy data item be coded as 1 or 2 when the patient completes all, but one cycle of the planned neoadjuvant therapy and the managing physician notes the patient completed the neoadjuvant therapy? See Discussion.

Discussion:
The patient had neoadjuvant chemotherapy (Carboplatin and Paclitaxel) concurrent with radiation per the managing physician. The physician stated the patient completed the neoadjuvant therapy; however, it was also noted that patient completed five cycles of chemotherapy, but the sixth cycle was held due to neutropenia.

The SEER Manual does not address how to code Neoadjuvant Therapy when the patient completed almost all the planned neoadjuvant therapy. It seems inappropriate to code Neoadjuvant Therapy as 2 (Started but not completed) simply because the patient did not have one cycle of chemotherapy but is otherwise felt to have completed neoadjuvant therapy per the managing physician. Does the managing physician's statement of "completion" impact how this scenario is coded?

Answer:
Assign code 2, Neoadjuvant therapy started, but not completed OR unknown if completed, for the 2024 SEER Manual data item Neoadjuvant Therapy. Assign code 2 when neoadjuvant therapy was begun, and the patient did not complete the full course of neoadjuvant therapy. See Coding Instruction #3 on page 230. The fact that the patient completed five cycles of the planned chemotherapy, but the sixth cycle was held due to neutropenia is important information and should be abstracted correctly and documented via text data items.

Date Finalized:
7/10/2024