20170066

References
Source 1: **2016 SEER Manual**
pgs: **78**
Notes: **Primary Site**

Question
Primary Site/Corpus uteri: Is the primary site C541 (endometrium) or C543 (uterine fundus) when the histology states endometrial adenocarcinoma, endometrioid type, but tumor site states fundus? See Discussion.

Discussion
Pathology--Final description: Uterus, cervix, bilateral fallopian tubes and ovaries, total hysterectomy and bilateral salpingo-oophorectomy: Endometrial adenocarcinoma, endometrioid type, well differentiated, FIGO 1/3. Myometrial invasion: focal myometrial invasion (30% of myometrium) Tumor size: 2 x2 cm Tumor site: Fundus, exophytic/polypoid lesion Gross description: The 3.0 cm in length by 2.5 cm in diameter triangular endometrium is tan-red and smooth with a 2.0 x 2.0 cm tan-pink, exophytic fundic mass which extends on to both anterior and posterior aspects, 4.1 cm from the os.

Answer
We recommend coding endometrium, C541, as the primary site for this case. While coding to fundus would not be incorrect, according to our expert pathologist consultant, "it is more appropriate in a setting in which the region of the uterus is of importance, e.g. with a myoma or a myosarcoma, or if the endometrioid carcinoma were NOT in the endometrium but arising in a focus of adenomyosis within the fundic myometrium…"

Date Finalized
12/14/2017

2017 0065

References
Source 1: **2007 MP/H Rules**
Notes: **Other Sites**

Question
MP/H Rules/Histology--Thyroid: How should histology be coded for a single tumor with final diagnosis undifferentiated (anaplastic) carcinoma arising in association with papillary thyroid carcinoma and the Summary Cancer Data states Histologic type: Undifferentiated (anaplastic) carcinoma only? See Discussion.

Discussion
The Summary Cancer Data does not seem to describe a more specific histology, but it does describe the tumor histology with the worst outcome and the most extensive tumor. The anaplastic carcinoma grossly extended into skeletal muscle and gave rise to multiple regional lymph node metastases. The more appropriate histology seems to be 8021.

However, current MP/H Rules for a single tumor indicate the histology should be coded to the numerically higher histology code (8260). Coding the histology to 8260 does not account for the more aggressive tumor. Should this histology be 8260 or 8021?

Answer
Code the most specific histologic term, 8260, for papillary carcinoma of the thyroid using Multiple Primary/Histology Rule H13 for Other Sites (single tumor, invasive section). Use text fields to describe the complete histology.

Date Finalized
12/14/2017

20170064

Source 1: **2014+ Grade Instructions**
Source 2: **WHO Class Digest System Tumors**
pgs: **13**
Notes: **2010, 4th ed.**

Question
Grade/Histology--Rectum: How should histology and grade be coded for high grade neuroendocrine tumor (NET) (WHO Grade 3) of the rectum? See Discussion.

Discussion
Rectal mass biopsy final diagnosis: High grade neuroendocrine tumor (WHO Grade 3). Neither SINQ 20170033 nor 20160023 address coding histology or grade for neuroendocrine tumors that are designated as high grade and/or WHO grade 3.

Answer
Assign histology code 8246/3. Assign grade code 4 based on the description "high grade." A **high-grade** neuroendocrine "tumor" is actually a neuroendocrine "carcinoma" (NEC) according to WHO Classification of Tumors of the Digestive System. If possible, verify this interpretation with the diagnosing pathologist. Use text fields to document the details of this case.

Date Finalized
12/14/2017

20170063

References
Source 1: **2016 SEER Manual**

Question
Reportability/Behavior--Ovary: Is adult granulosa cell tumor a reportable malignant tumor if the primary ovarian tumor ruptured intraoperatively, the peritoneum was contaminated, and the patient underwent adjuvant treatment with chemotherapy given the increased risk of recurrence due to intraoperative tumor spill? See Discussion.

Discussion
Per SINQ 20130176 and 20140034, adult granulosa cell tumors of the ovary are reportable malignant tumors when there are peritoneal implants or metastases. The SINQ responses describe how these adult granulosa cell tumors are different from low malignant potential (LMP) epithelial ovarian tumors. Would these SINQ scenarios apply to a case with intraoperative tumor rupture that resulted in peritoneal tumor?

In this case, the pathologist indicated these excised peritoneal specimens were favored to be intraoperative contamination with adult granulosa cell tumor. However, the oncologist went on to treat this patient as high risk with chemotherapy. The oncologist only described one of the pelvic peritoneal implants as possibly contamination due to the rupture. The oncologist never indicated the tumors were definitely peritoneal implants. Should the behavior of this tumor be /1 because the peritoneal tumor appears to be contamination, or /3 because the oncologist treated this patient as high risk?

Answer
If the "implants" were due to intraoperative contamination and were not present prior to surgery, do not interpret them as indicative of malignancy. The behavior of this tumor is /1.

Date Finalized
12/14/2017

20170061

References
Source 1: **2007 MP/H Rules**

Question
MP/H Rules/Histology--Thyroid: What is the correct histology when final diagnosis of a thyroidectomy includes the descriptor "papillary and follicular architecture?" See Discussion.

Discussion
Total thyroidectomy Final Diagnosis: Papillary carcinoma, classical type, with papillary and follicular architecture.

The 2007 MP/H rules state that the term architecture is reserved for coding subtype of in situ primaries only. However, SINQ 20130165 appears to indicate this should be coded for invasive thyroid subtypes as well. Can you confirm the addition of the term architecture for determining an invasive histologic subtype for thyroid?

Answer
Assign code 8260/3, papillary carcinoma per Multiple Primaries/Histology Rule H14.

Architecture is reserved for coding subtype of in situ primaries only. SINQ 20130165 is not intended to indicate this should be coded for invasive thyroid subtypes.

Date Finalized
12/14/2017

20170060

References
Source 1: **2014+ Grade Instructions**

Question
MP/H Rules/Histology/Grade--Unknown & ill-defined sites: What is the correct histology and grade of a liver biopsy with metastatic neuroendocrine carcinoma low to intermediate grade if primary site is unknown? See Discussion.

Discussion
CT-guided liver biopsy, diagnosis: Metastatic neuroendocrine carcinoma. Diagnosis Comment: Cytology of the tumor appears to be low to intermediate grade.

Would this case be coded as an atypical carcinoid tumor (8249/3) based on SINQ 20170033 and the statement of intermediate grade; or should this be 8240/3 (neuroendocrine tumor) per SINQ 20160023 because it is a metastatic site? More clarification is needed on when to code 8249/3 or 8240/3 for a neuroendocrine carcinoma or neoplasm seen in a metastatic specimen only when there is specified grade.

Answer
Assign histology code 8246/3 and assign code 9 for grade.

Since the primary is unknown and the type of NEC is not definitively stated, code neuroendocrine carcinoma, NOS based on the diagnosis.

Code grade from primary tumor only. Assign grade code 9 when the primary site is unknown. See instruction 2.b. in the Grade Coding Instructions for 2014+.

SINQ 20170033 and SINQ 20160023 provide instructions for coding the grade/differentiation field. Using these SINQ questions to code histology could lead to errors.

Date Finalized
12/14/2017

20170058

References
Source 1: **2007 MP/H Rules**

Question
MP/H Rules/Histology--Lung: What is the correct histology code for an initial biopsy of non-small cell carcinoma with neuroendocrine phenotype, possible large cell neuroendocrine carcinoma with a subsequent re-biopsy showing poorly differentiated small cell carcinoma after chemotherapy with no response? See discussion.

Discussion
Patient had a biopsy in April 2014; pathology was reported as non-small cell carcinoma with neuroendocrine phenotype, possible large cell neuroendocrine carcinoma. The patient had five cycles of cisplatin/etoposide with no response. In May 2015, a re-biopsy at a referral institution reports poorly differentiated small cell carcinoma and states "feels that this could have been the histology all along and why patient has failed multi lines of chemo."

Answer
Code to 8041, small cell carcinoma, because the medical opinion confirms that this was the correct histology from the beginning.

"Possible" is not an ambiguous term used to code histology. The MP/H rules do not include coding phenotype. That leaves non-small cell (8046/3) at time of diagnosis. Chemotherapy does not alter cell type so it's likely the tumor was small cell all along only now proven with additional testing.

Page 14 of the SEER Coding Manual gives examples of when to change the abstract's original codes and here is one example: When better information is available later. Example 1: Consults from specialty labs, pathology report addendums or comments or other information have been added to the chart. Reports done during the diagnostic workup and placed on the chart after the registrar abstracted the information may contain valuable information. Whenever these later reports give better information about the histology, grade of tumor, primary site, etc., change the codes to reflect the better information.

Date Finalized
11/24/2017

20170057

References
Source 1: **2014+ Grade Instructions**
Notes: **Solid Tumors**
Source 2: **2016 SEER Manual**
Notes: **data item: Grade, Differentiation, or Cell Indicator**

Question
Grade: If the biopsy site is a higher grade, is the grade of the biopsy used over the grade of the surgical resection? See Discussion.

Discussion
When coding tumor grade, our pathologists have told us to code grade based on the specimen from the most definitive surgery or with the most amount of tissue, and that coding grade from the biopsy would not be appropriate even if it is a higher grade than from the surgical resection. Coding of solid tumors Instruction 5 states: If there is more than one grade, code the highest grade within the applicable system. Code the highest grade even if it is only a focus. Code grade in the following priority order using the first applicable system.

Answer
For cases diagnosed prior to 2018: Use the Grade Coding Instructions to code grade. The instructions are intended to standardize coding of grade across the U.S. and to eliminate differences in opinion between pathologists. Standardized coding ensures that data can be combined and used for statistical analysis.
You may code grade based on the biopsy when following the grade coding instructions.

Date Finalized
11/08/2017

20170056

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

Question
Reportability/Histology--Skin: Is 'skin, left temporal scalp, low grade adnexal carcinoma, probable sweat gland origin' reportable as 8400/3, skin of temple?

Answer
Assign 8390/3 for adnexal carcinoma of skin. 8390/3 is reportable, including 8390/3 of skin.

Date Finalized
11/08/2017

20170055

References
Source 1: **2016 SEER Manual**
Notes: **App. C-Corpus Uteri Surgery Codes**
Source 2: **SEER Glossary; NCI Definitions of Cancer Terms**

Question
First Course of Treatment/Surgery of Primary Site--Corpus uteri: Do you code total hysterectomy or radical hysterectomy when a specimen indicates the uterus, cervix, ovaries, fallopian tubes, and right and left parametrium were resected, but shows no portion of the vagina. See Discussion.

Discussion
AFS1-AFS2-frozen section control, endomyometrium; AFS3-frozen section control, subserosal intramural mass; A4-anterior cervix; A5-posterior cervix; A6-anterior cervical endometrial junction; A7-posterior cervical endometrial junction; A8-A10-anterior endomyometrium, including tumor; A11-A13-posterior endomyometrium, including tumor and adjacent mass; A14-random section subserosal mass; A15-left parametrium at margin of resection; A16-right parametrium at margin of resection; A17-A18-left ovary and fallopian tube; A19-A20-right ovary and fallopian tube. The final diagnosis includes Endometrial adenocarcinoma, favor serous carcinoma, with papillary and solid areas. Tumor involves: Cervix present, Right ovary, Left ovary, Right fallopian tube, Left fallopian tube, Right parametrium, Left parametrium.

Answer
Assign code 50 for total hysterectomy. According to Appendix C Surgery Codes for Corpus Uteri of the 2016 SEER Coding and Staging Manual, total hysterectomy is surgery to remove the entire uterus, including the cervix; whereas, radical hysterectomy includes the vagina.

Date Finalized
11/08/2017

20170054

References
Source 1: **2007 MP/H Rules**
Notes: **Malignant Brain, M rules**

Question

MP/H Rules/Multiple primaries--Brain and CNS: How many primaries should be abstracted for a patient with a 2011 diagnosis of oligodendroglioma followed by biopsy of tumor which demonstrated progression in 2016 with pathology report Final Diagnosis indicating WHO grade III anaplastic astrocytoma? See Discussion.

Discussion
The clinical documentation clearly identifies residual tumor after the 2011 craniotomy. Scans demonstrated slow enlargement of the tumor over the years, which resulted in a repeat craniotomy. The pathologist noted in the diagnosis comment section of the pathology report that since the time of the patient's original diagnosis and the 2016 specimen, new WHO criteria for classifying infiltrating gliomas have been developed. Despite the morphologic features, the absence of 1p, 19q co-deletion precludes the classification of this glioma as an oligodendroglioma using current criteria. The combined histologic, immunophenotypic and molecular findings are consistent with the integrated diagnosis of Anaplastic Astrocytoma, IDH mutant, WHO Grade III.

Is this a single primary per MP/H Rule M3 (A single tumor is always a single primary), or an additional brain malignancy per MP/H Rule M8 (Tumors with ICD-O-3 histology codes on different branches in Chart 1 or Chart 2 are multiple primaries)?

Answer
Based on the information provided, this is a single primary. The 2011 tumor was not completely removed and progressed over the years. MP/H Rule M3 for malignant brain cancer applies. Do not change the original histology code. Use text fields to document the later histologic type of anaplastic astrocytoma, WHO grade III.

Date Finalized
11/08/2017

20170052

References
Source 1: **2007 MP/H Rules**

Question
MP/H Rules/Histology--Bladder: Is urothelial carcinoma, high-grade, predominantly solid type, coded as 8120/3 or 8230/3? See Discussion.

Discussion
Urinary bladder: Invasive urothelial carcinoma, high-grade, 4.5cm, predominantly solid type, arising in background of carcinoma in-situ, carcinoma grossly extends into perivesical adipose tissue; lymph-vascular invasion is seen.

Answer

Assign histology code 8120/3, urothelial carcinoma, NOS. Solid type is not a recognized variant of urothelial tumors and likely represents the appearance of the urothelial cells within the tumor and not a specific histologic type.

Date Finalized
09/20/2017

20170051

References
Source 1: **WHO Class Digest System Tumors**
Source 2: **ICD-O-3**

Question
Reportability--Liver: Is intraductal papillary mucinous neoplasm (IPMN) of the liver a reportable diagnosis? See Discussion.

Discussion
Pathology shows: Right liver lobe, partial hepatectomy – intraductal papillary neoplasm with high grade dysplasia.

Answer
Intraductal papillary mucinous neoplasm (IPMN) of the liver with high grade dysplasia is reportable. While most IPMNs arise from the pancreas, there exists a subset of IPMN of the biliary tract (BT-IPMN). Code as 8453/2.

For more details, see the Reportability section of the SEER manual, https://seer.cancer.gov/manuals/2016/SPCSM_2016_maindoc.pdf

Date Finalized
09/20/2017

20170050

References
Source 1: **SEER*Rx**

Question
First course of treatment/Other therapy--How do you code medical marijuana when given as "treatment?" See Discussion.

Discussion
The patient has gastric cancer and the physician prescribed medical marijuana as treatment. SEER*Rx says marijuana is ancillary as a psychoactive cannabinoid and antiemetic and advises not to code it. The physician specifically wrote "treatment with" in the record. Should it be coded as Other (Code 1) under Other Therapy?

Answer
Do not code as treatment. Enter the information regarding the use of marijuana in a text field. There have been some early clinical trials of cannabinoids in treating cancer in humans and more studies are planned. While the studies so far have shown that cannabinoids can be safe in treating cancer, they do not show that they help control or cure the disease. At this time, marijuana is used to treat side-effects (such as nausea, vomiting, and pain) and to help increase appetite which helps patients tolerate standard therapies.

Date Finalized
08/16/2017

20170049

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

Question
MP/H Rules/Histology--Pancreas: What is the histology code of invasive adenocarcinoma, non-mucinous with intraductal tubulopapillary features, moderately differentiated, from the pathology report final diagnosis of the pancreas? Does 'intraductal" refer to a non-invasive/in-situ component or describe the pattern of growth?

Answer
Assign 8503/3, intraductal papillary adenocarcinoma with invasion, to capture the more specific features of the adenocarcinoma. Histology Rule H13 for Other Sites states to code the most specific histologic term. Examples include Adenocarcinoma and a more specific adenocarcinoma. Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ___ differentiation.

Date Finalized
08/16/2017

20170048

References
Source 1: **2007 MP/H Rules**

Question
MP/H Rules/Multiple primaries--Bladder: Is recurrence of bladder cancer the same primary if the patient has had multiple recurrences each within 3 years of recurrences but 3 years has passed since initial diagnosis date?

Answer
Multiple bladder recurrences each within 3 years of recurrences and more than 3 years since initial diagnosis date would be a single primary. Use the date of the most recent occurrence when applying the bladder M rules. Do not use the initial diagnosis date for timing.

Date Finalized
08/23/2017

20170046

References
Source 1: **2007 MP/H Rules**
Notes: **Benign Brain and CNS Tumors**
Source 2: **ICD-O-3**

Question
MP/H Rules/Histology--Brain and CNS: What is the histology code for a patient with a pathology report Final Diagnosis indicating, mucin-rich neuroepithelial neoplasm, favor low-grade? See Discussion.

Discussion
The pathologist noted this was a challenging brain neoplasm that did not easily fit into a specific WHO diagnostic classification. Multiple differential diagnoses were given including pilomyxoid astrocytoma, ganglioglioma and dysembryoplastic neuroepithelial tumor (DNET), but there were no definitive features characteristic of any of these tumors. In the Comment section following the Final Diagnosis, it further states: "In summary, the tumor appears to be a difficult to classify non-infiltrating glial/glioneuronal neoplasm without definitive high-grade features."

Answer
Code as 9505/1, Ganglioglioma, NOS. The Multiple Primaries/Histology Rules for Benign and Borderline Intracranial and CNS Tumors Chart 1 lists several histology codes for neuronal and mixed neuronal-glial tumors. Ganglioglioma, formerly Glioneuroma that is now obsolete in ICD-O-3, is the most applicable in this situation.

Date Finalized
08/16/2017

20170045

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

Question
Reportability--Brain and CNS: Is meningioangiomatosis reportable as meningiomatosis (9530/1) or angiomatous meningioma (9534/0)? See Discussion.

Discussion
Pathology report: Brain tumor, left side: Gliotic cortex and subcortical white matter with meningioangiomatosis (see Comment). Comment: This specimen represents a meningioangiomatous lesion located in the leptomeninges that projects along the Virchow-Robin spaces into the underlying cortex. The surrounding brain parenchyma demonstrates reactive changes with astrogliosis and microgliosis. An intraparenchymal neoplasm is not seen. Meningioangiomatosis is a rare benign meningovascular hamartomatous condition and usually appears in young patients.

Answer
Meningioangiomatosis is not reportable. It is a cortical lesion which may occur sporadically or in NF2 (neurofibromatosis type 2). It is not listed in ICD-O-3.

Date Finalized
08/16/2017

20170044

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

Question
Histology--Sarcoma: What is the histology code for epithelioid angiosarcoma?

Answer
Assign 9120/3 for epithelioid angiosarcoma.

Date Finalized
08/16/2017

20170043

References
Source 1: **WHO Class Female Reproductive Organs**
Notes: **4th ed.**
Source 2: **Subject matter expert**

Question
Reportability--Ovary: Is ovarian mucinous borderline tumor of intestinal type with microinvasion reportable? If reportable, what is the histology? See Discussion.

Discussion
4/18/17 Right ovary and fallopian tube, salpingo-oophorectomy: mucinous borderline tumor of intestinal type with microinvasion; greatest dimension 24.5 cm. Left fallopian tube and ovary, salpingo-oophorectomy: Benign ovary with multiple benign Mullerian inclusions. Benign fallopian tube with multiple paratubal cysts. Per pathology: pT1a pNx.

Answer
For an ovarian mucinous borderline tumor, the term "microinvasion" is not an indication of malignancy according to the WHO classification of tumors, and our expert pathologist consultant agrees. Therefore, borderline mucinous ovarian tumor with microinvasion is not reportable. Low malignant potential/borderline ovarian tumors are defined by the pathology of the primary tumor in the ovary, and microinvasion there, or invasion in implants does not change that diagnosis. The only exception is when the lymph nodes are positive for malignancy, the case is reportable. If the lymph nodes are positive for mucinous borderline tumor, the case is not reportable.

Date Finalized
08/16/2017

20170042

References
Source 1: **Heme & Lymph Manual & DB**
Notes: **manual published Jan. 2015**

Question
Reportability--Heme & Lymphoid Neoplasms: Is a diagnosis of chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) with large cell transformation equivalent to a diagnosis of diffuse large B-cell lymphoma (DLBCL) without mention of Richter transformation or Richter Syndrome? See Discussion.

Discussion
The patient has a history of CLL/SLL dating back to 2007, but has had progressive disease with development of a new left frontal brain tumor. The brain tumor resection proved CLL/SLL with large cell transformation, but neither the pathologist nor the managing physician called this a Richter transformation, Richter syndrome or provided a diagnosis of DLBCL. However, a large cell transformation of CLL/SLL is a Richter transformation. Can this be accessioned as a new acute neoplasm per Rule M10?

Answer
Accession as multiple primaries according to Hematopoietic and Lymphoid Neoplasm Coding Manual Rule M10. Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) followed by CLL/SLL with large cell transformation is multiple primaries because it is a chronic neoplasm followed by an acute neoplasm, more than 21 days in this case.

Date Finalized
08/22/2017

20170041

References
Source 1: **2007 MP/H Rules**

Question
MP/H Rules/Histology--Thyroid: How should histology be coded for a thyroidectomy final diagnosis of papillary thyroid carcinoma, favor cribriform-morula variant? See Discussion.

Discussion
This specific histology (cribriform-morula variant of papillary thyroid carcinoma) is not found in the ICD-O and is not mentioned in the 2007 MP/H Manual. However, per a web search it appears that this is a distinct type of papillary thyroid carcinoma (http://erc.endocrinology-journals.org/content/24/4/R109.full).

Example: Right lobectomy shows thyroid epithelial neoplasm, pending consultation.

Consultation: Thyroid gland, right lobe: papillary thyroid carcinoma, favor cribriform-morula variant.

Consultation Comment: IHC stains argue against medullary carcinoma. The histologic features of growth patterns and cytologic atypia (with rare grooves and pseudoinclusions) and the immunohistochemical profile support a diagnosis of papillary thyroid carcinoma, favoring the cribriform-morula variant. It is important to note that a significant number of patients with this variant of papillary thyroid carcinoma have been associated with familial adenomatous polyposis syndrome.

Answer
Assign code 8260/3 for papillary carcinoma of thyroid. Cribriform-morula variant is not listed in ICD-O-3 for papillary carcinoma. Multiple Primaries/Histology Rule H14 states to code papillary carcinoma of the thyroid to papillary adenocarcinoma, NOS (8260).

Date Finalized
08/16/2017