20210045

References
Source 1: **2021 SEER Manual**
pgs: **227-231**
Notes: **Neoadjuvant Therapy--Clinical Response**

Question
Update to Current Manual/Neoadjuvant Treatment: What codes should be used for Neoadjuvant Therapy--Clinical Response and Neoadjuvant Therapy--Treatment Effect when the neoadjuvant therapy is still in progress at the time the case is initially abstracted as with rapid reporting. There is no code for neoadjuvant therapy still in progress and code 9 generates an edit for Neoadjuvant Therapy--Clinical Response.

Answer
Assign code 8 for Neoadjuvant Therapy--Clinical Response and assign a code 9 for Neoadjuvant Therapy--Treatment Effect when the treatment is still in progress. Revise these codes after the treatment has been completed.

We will update the manual to include these instructions.

Date Finalized
07/26/2021

20210044

References
Source 1: **Heme & Lymphoid Manual and Database**
pgs:
Notes: **September 2020; Effective with Cases Diagnosed 1/1/2010 and Forward**

Question
Diagnostic Confirmation--Heme & Lymphoid Neoplasms--Plasma Cell Myeloma: Can serum protein electrophoresis (SPEP) be used as a definitive diagnostic method in the absence of a bone marrow biopsy? Is it appropriate to assign code 5 (Positive laboratory test/marker study) if there is no histological confirmation? See Discussion.

Discussion
Patient was diagnosed with lambda myeloma based on the M spike found on serum protein electrophoresis. A bone marrow biopsy was performed, but it was an insufficient sample.

SPEP is not listed in the Hematopoietic Database as a lab test that can be used as a definitive diagnostic method. Since the physician did base the diagnosis on the SPEP result, would it be appropriate to assign code 5 (Positive laboratory test/marker study) since there was no histological confirmation?

Under code 5, the Hematopoietic Manual states: Laboratory tests are listed under Definitive Diagnostic Methods in the Hematopoietic Database.

Answer
Assign code 5 in Diagnostic Confirmation. We consulted with an expert hematopathologist who stated that SPEP would qualify for a diagnostic confirmation code of 5. He also stated that normally a SPEP is followed by a bone marrow biopsy.

SPEP has been added to the Definitive Diagnostic Methods for plasma cell myeloma (9732/3).

Date Finalized
07/26/2021

20210041

References
Source 1: **ICD-O-3.2**
pgs:
Notes: **NAACCR, 2021 ICD O 3.2 Coding Table Excel (full list of ICD 3.2 histology codes)-10/01/2020**

Question
Reportability/Behavior--Paraganglia: Is a 2021+ diagnosis of paraganglioma reportable if the grading of adrenal pheochromocytoma and paraganglioma (GAPP) score falls outside the stated requirements for malignancy? See Discussion.

Discussion
Patient was diagnosed with a retroperitoneal paraganglioma on April 2021 mass resection. Final diagnosis included the comment: Based on the modified grading of adrenal pheochromocytoma and paraganglioma (GAPP), the GAPP score is 1. Scores greater than or equal to 3 are malignant.

We are aware that paraganglioma is classified as malignant for cases diagnosed in 2021+, however it is unclear how the pathologist's interpretation of the GAPP score may affect the behavior of this case.

Answer
Report retroperitoneal paraganglioma based on ICD-O-3.2 histology/behavior that lists paraganglioma, NOS as 8680/3 for cases diagnosed 2021 and forward. While GAPP is a predictor of metastatic potential, it does not factor into behavior, thus reportability.

Date Finalized
07/26/2021

20210039

References
Source 1: **Heme & Lymphoid Manual and Database**
pgs:
Notes: **September 2020; Effective with Cases Diagnosed 1/1/2010 and Forward**

Question
Multiple primaries/Heme & Lymphoid Neoplasms--Lymphoma: Is a 2021 right tongue base biopsy showing diffuse large B-cell lymphoma (DLBCL) (9680/3) a new primary following a prior history of hairy cell leukemia-variant (HCL-v) (9591/3) in 2011? See discussion.

Discussion
Patient was diagnosed with low-grade non-Hodgkin lymphoma in 2011, later classified as hairy cell leukemia-variant.

Right cervical node biopsy in 2020 proved HCL-v and a subsequent 2021 right tongue base biopsy showed DLBCL. The tongue base biopsy path includes the comment, patient has history of HCL-v, but the morphology and flow cytology features are different from the patient's previous right cervical node biopsy. This DLBCL likely represents a second de novo lymphoma, but cannot exclude an unusual transformation of the prior HCL-v.

Per Heme Rule M7, abstract a single primary when a more specific histology is diagnosed after an NOS if the Heme DB confirms the same primary. The histology code for HCL-v, 9591/3 is a non-specific code, but it seems like a specific histology. The Heme Calculator does say 9591 and 9680 are the same primary, but we are unsure if that is correct for this case of HCL-v followed by DLBCL.

Answer
Abstract two primaries. This is a transformation from a chronic disease (the Hairy Cell Variant) to an acute disease (DLBCL). Although this rare situation is not clearly covered in the Hematopoietic rules, the fact that this was originally a Hairy Cell Leukemia variant means that the DLBCL is a new primary.

Date Finalized
07/07/2021

20210038

References
Source 1: **2021 SEER Manual**
pgs:
Notes: **Neoadjuvant therapy data items**

Question
Update to current manual/First course treatment--Neoadjuvant treatment: How are the 2021 neoadjuvant therapy fields coded when neoadjuvant therapy and surgery were part of first course plans, but treatment was never completed. See Discussion.

Discussion
Example: Breast case where first course treatment plan is neoadjuvant therapy and surgery after. The patient was hospitalized during neoadjuvant therapy, elected hospice, and later died, so the neoadjuvant therapy was never completed, surgery not done. How are the 2021 neoadjuvant therapy fields coded in this situation as neoadjuvant therapy and surgery were part of first course plans? I coded neoadjuvant therapy to 2 - started but not completed, but there are no codes to properly explain the clinical response and therapy treatment effect as the patient did not complete neoadjuvant therapy. Should I use code 9 for clinical response and treatment effect, or should this be left blank for this particular case?

Answer
Assign code 8 for Neoadjuvant Therapy--Clinical Response in this case. We will update the SEER manual to allow code 2, in addition to code 1, in Neoadjuvant therapy when Clinical Response is coded 8. We will also add instructions covering a case such as this one.

Assign code 7 for Neoadjuvant Therapy--Treatment Effect and use text fields to record the details. We will add instructions to the manual for this scenario.

Date Finalized
07/26/2021

20210037

References
Source 1: **American College of Radiology TI-RADS Reporting System**

Question
Reportability/Date of diagnosis--Thyroid: Is category Thyroid imaging reporting and data system (TI-RADS) 4 (4a/4b) or TI-RADS 5 on imaging diagnostic of thyroid cancer, and if so, can we use the date of the impression on the scan that states either of these categories as the diagnosis date?

Answer
TI-RADS 5 is reportable for thyroid cancer unless disproven by other documentation and the date of the TI-RADS 5 scan may be used as the date of diagnosis if this is the earliest mention of the malignancy. TI-RADS 5 is "probably malignant nodules (>80% malignancy)."
TI-RADS 4 (including 4a and 4b) is not reportable for thyroid cancer. TI-RADS 4 is "suspicious nodules (5-80% malignancy)." TI-RADS 4b is "suspicious (10-80% malignancy)."

Date Finalized
07/26/2021

20210036

References
Source 1: **Subject matter expert**

Question
Update to current manual/Lymphovascular invasion: Are lymphovascular invasion and lymphovascular space invasion on a pathology report the same thing or do they describe different things?

Answer
We confirmed with our expert pathologist consultant that lymphovascular invasion and lymphovascular space invasion are synonymous.

Date Finalized
07/26/2021

20210035

References
Source 1: **Subject matter expert**

Question
Update to current manual/Lymphovascular invasion--Thyroid: Are psammoma bodies only recorded as vascular invasion in papillary thyroid cancer cases? See Discussion.

Discussion
For example, total thyroidectomy specimen shows right lobe papillary thyroid carcinoma, 4.2 cm, unencapsulated, with numerous psammoma bodies in non-tumoral thyroid parenchyma, without angioinvasion; left lobe with papillary thyroid carcinoma, 0.6 cm, encapsulated, with capsular invasion, with intralymphatic psammoma bodies in non-tumoral thyroid parenchyma, without angioinvasion. The synoptic summary documents vascular invasion present (psammoma bodies only).

Answer
If you are collecting lymphovascular invasion (LVI) for thyroid cases, record "vascular invasion present (psammoma bodies only)" as vascular invasion (code 1, Lymphovascular Invasion Present/Identified) in the LVI data item. Use a text field to specify that this is vascular invasion by psammoma bodies.

Date Finalized
07/26/2021

20210033

References
Source 1: **American College of Radiology LI-RADS Manual**
pgs:
Notes: **Chapter 9 - Treatment Response**

Question
Reportability--Liver: Is a diagnosis of Liver Imaging Reporting and Data System (LI-RADS)-Treatment Response (LR-TR) viable nodule seen on imaging and treated with Y-90 radiotherapy reportable? See Discussion.

Discussion
Patient was initially diagnosed in 2017 with LR-5 lesions in segments 3 and 7 of liver and treated with radiofrequency ablation (RFA). Routine scans in 2019 show no evidence of residual or recurrent disease.

Surveillance imaging in 2020 identifies LR-TR viable segment 3 treatment zone with slowly growing arterially enhancing nodule as well as increasing arterial enhancement in the neighboring parenchyma. No new LR-4 or LR-5 observations. Patient is not a surgical candidate but is treated with Y-90 radiotherapy.

Per Rule M10, tumors diagnosed more than 1 year apart are multiple primaries. However, there is no clear clinical statement of malignancy in this case.

Answer
Do not report LR-TR viable as a new primary. LR-TR viable is a component of the Li-RADS Treatment Response algorithm designed to assess response for path-proven or presumed (e.g., LR-4, LR-5, LR-M) malignancy after locoregional treatment for hepatocellular cancer. LR-TR viable indicates it met the criteria as a viable tumor.

Date Finalized
06/10/2021

20210031

References
Source 1: **2021 SEER Manual**
pgs: **7-8**
Notes: **Reportability**

Question
Reportability--Brain and CNS: Are lipomas of the spinal column reportable as a benign tumor of the central nervous system (CNS)? This is seen occasionally at our pediatric facility.

Answer
Spinal cord tumors (including lipomas) are reportable when they arise in the spinal dura or nerve root. The tumor must be of the spinal cord itself or within the spinal cord dura. Spinal cord tumors are reportable when they arise in the intradural space. A reportable intradural tumor can be either intramedullary or extramedullary. Extramedullary intradural spinal tumors are reportable. A spinal tumor originating in the extradural space is not reportable. If it is outside the dura, it is not reportable because it would be outside the CNS. They are not reportable when they arise in the peripheral nerves.

Date Finalized
06/10/2021

20210030

References
Source 1: **2021 SEER Manual**
pgs:
Notes: **Appendix C, Breast Coding Guidelines**

Question
Primary site--Breast: Patient was diagnosed with invasive ductal carcinoma of the left breast. Site of mass is 2:00 to 3:00. What is the correct site code, C504 upper outer quadrant (UOQ) or C50.8 (overlapping)?

Answer
Assign C504, UOQ, for a left breast primary mass at 2:00 to 3:00. See the illustration in the SEER Coding Guidelines for breast, https://seer.cancer.gov/manuals/2021/AppendixC/Coding_Guidelines_Breast_2021.pdf

Date Finalized
06/10/2021

20210029

References
Source 1: **Heme & Lymphoid Manual and Database**
pgs:
Notes: **September 2020; Effective with Cases Diagnosed 1/1/2010 and Forward**

Question
Multiple primaries--Heme and Lymphoid Neoplasms: Is a patient with peripheral blood initially showing chronic myelogenous leukemia (CML), lymph node biopsy showing granulocytic sarcoma (9930/3), and bone marrow biopsy showing acute myeloid leukemia (AML) one or two primaries? See Discussion.

Discussion
1. 12/11/2020 Peripheral blood revealing what was thought to be chronic myelogenous leukemia BCR/ABL1 positive (9875/3). Patient was started on Hydrea while waiting for further tests on 12/12/2020.
2. 12/14/2020 Lymph node biopsy showed granulocytic sarcoma (9930/3), but flow cytometry states it is similar to that seen in the patient's peripheral blood and is consistent with nodal involvement by myeloblasts.
3. 12/15/2020 Bone marrow biopsy reads acute myeloid leukemia (9861/3), likely arising from BCR/ABL1 positive chronic myeloid leukemia. There is a note on this pathology from medical oncologist that says: This will dramatically change the course of his treatment, likely with a TKI.
4. 12/17/2020 Sprycel started. Patient was weaned off Hydrea.

According to Rule M3, abstract a single primary when a sarcoma is diagnosed simultaneously or after a leukemia of the same lineage. It lists 9930/3 when simultaneously (or after) with 9861/3. Technically, it was two days before, but I feel like I should and could count that as simultaneously because of Note 1 that says: These sarcomas are solid manifestations of the associated leukemia. For example, when acute myeloid leukemia and myeloid sarcoma are diagnosed simultaneously, the myeloid sarcoma is the result of myeloid cells migrating from the bone marrow or blood into tissue. It is part of the disease process for the acute leukemia. Also, the providers never mention granulocytic sarcoma

Based on that, I think that #2 & #3 above are the same primary, which would be acute myeloid leukemia (9861/3).

Per the hematopoietic database, 9875/3 transforms to 9861/3. Therefore, Rule M8 is confusing with the "only one" biopsy. Does this rule apply because the 9875/3 was from peripheral blood only? But peripheral blood is coded in Diagnostic Confirmation as histology.

Rule M9 reads: The two diagnoses are likely the result of an ongoing diagnostic work-up. The later diagnosis is usually based on all of the test results and correlated with any clinical information. Because that is truly what I think is happening here though that rule states there is no available documentation. If you do not have any documentation, how would you know you are dealing with a chronic and an acute diagnosis?

M10 does not apply.

According to Rule M11, abstract as multiple primaries when both a chronic and an acute neoplasm are diagnosed simultaneously or within 21 days and there is documentation of two biopsies. The chronic myelogenous leukemia only had peripheral blood and not a bone marrow, lymph node or tissue, but that is counted as positive histology in diagnostic confirmation, but I don't know if that is kept as a separate field/thought. I would not code a peripheral blood smear as with a surgical code or a surgical diagnostic and staging procedure code, so maybe that is what I should be thinking about and therefore would probably say Rule M8 and one primary.

Answer
This is one primary based on Rule M3. Abstract as a single primary site for the granulocytic sarcoma and AML since they are both evaluating the blood/bone marrow, which are counted as one site. To count them twice would result in over counting primaries.

For Rule M9: This would not apply to your situation since you do have information on both the CML and the AML. We had to write in this rule for cases where you do not always have the information available.

In terms of the peripheral blood versus actually biopsy: In this case, do not count the peripheral blood as a separate site. Rule M8 does fit your case, coding this as the AML and having this as one primary.

Date Finalized
06/10/2021

20210028

References
Source 1: **ICD-O Third Edition, Second Revision Morphology**
pgs:
Notes: **2021 ICD O 3.2 Coding Table Excel, 10/01/2020**

Question
Histology/Biliary tract--Ampulla of Vater: What is the histology code for Intra ampullary papillary-tubular neoplasm in association with microinvasion? See discussion.

Discussion
Patient was diagnosed on 01/2020, and primary site on the pathology report is Ampulla of Vater (C241). Synoptic Report states histology as: Intra ampullary papillary-tubular neoplasm in association with microinvasion.

I have reviewed the ICD-O-3 coding table and found histology Intraductal tubulopapillary neoplasm (C25_) code 8503/2. Based on the Matrix principle (Rule F on the ICD-O-3), I will change the behavior to 3 and code as 8503/3. If I look in ICDO-3, Tubulopapillary adenocarcinoma is coded 8263/3.

Answer
Assign code 8163/3. Based on the microinvasion, the correct term for this neoplasm is pancreatobiliary-type carcinoma. Unfortunately, WHO did not provide all synonyms or related terms for some of the new ICD-O codes. Pathologists may continue using non-preferred terminology as well.

Date Finalized
06/10/2021

20210027

References
Source 1: **Heme & Lymphoid Manual and Database**
pgs:
Notes: **September 2020; Effective with Cases Diagnosed 1/1/2010 and Forward**

Question
Reportability--Heme and Lymphoid Neoplasms--Polycythemia vera: Is secondary polycythemia vera reportable? See Discussion.

Discussion
A physician stated the patient likely had secondary polycythemia vera due to cardiac and pulmonary conditions but that a polycythemia vera could not be ruled out. A JAK2 was ordered that was positive for JAK2 V617F mutation. The patient was treated with hydrea. According to SEER SINQ 20120049, secondary polycythemia vera is not reportable. However, in this case, the patient was positive for JAK2 V617F mutation. Therefore, is this reportable? We looked for guidance in the Hematopoietic and Lymphoid Neoplasms Database and found it confusing that secondary polycythemia vera was not mentioned or discussed under polycythemia vera in the database. The only thing we could find was secondary polycythemia NOS that was discussed under polycythemia.

Answer
Abstract as a new primary for polycythemia vera, 9950/3.
JAK2 is commonly used to assess suspected polycythemia vera and in this case, the mutation is positive for V617F.
Based on the JAK2 results, this looks like a true polycythemia vera and not a secondary polycythemia.

Date Finalized
05/05/2021

20210026

References
Source 1: **Heme & Lymphoid Manual and Database**
pgs:
Notes: **September 2020; Effective with Cases Diagnosed 1/1/2010 and Forward**

Question
Multiple primaries--Heme & Lymphoid Neoplasms--Lymphoma: Is a case initially submitted as C772 with histology coded 9591/3 (lymphoma, NOS) with a second case submitted as C162 with histology coded 9699/3 (extranodal marginal zone lymphoma of mucosal-associated lymphoid tissue (MALT lymphoma) a single primary or multiple primaries? See Discussion.

Discussion
The following cases were submitted to the central registry as separate primaries. First case submitted as C772 with histology coded 9591/3 (Lymphoma, NOS). Second case submitted as C162 with histology coded 9699/3 (MALT Lymphoma).

Sequence 01 - 5/2016, Excisional biopsy pancreatic tail lymph node: suspicious for malignant B-cell lymphoma. No treatment recommended or administered.

Sequence 02 - 2/2019, Stomach biopsy: MALT Lymphoma. Unknown if treatment was recommended or administered. Biopsy was only at this facility.

Using the Hematopoietic and Lymphoid Neoplasm Multiple Primaries/Histology rules, Rule M7 makes this a single primary. Note 4 instructs to change the histology of the initial abstract to the more specific histology (9699/3). If this is done, they would be multiple primaries per the exception within Rule M2. Should the histology on sequence 01 be changed to the MALT lymphoma and the cases would be multiple primaries or is this a single primary?

Answer
Abstract two primaries and assign

Primary 1: C772, 9699/3
Primary 2: C162, 9699/3

Per Rule M7, you would change the first case to histology 9699/3 based on Note 4 under Rule M7, Note 4: Change the histology code on the original abstract to the more specific histology when the original diagnosis is in your registry database. Use previous editions of ICD-O (i.e., ICD-O-1, ICD-O-2) or the Hematopoietic Database to assign the code applicable to the year of diagnosis for the more specific histology.

Per Rule M2 this would be the same primary based on both being the same histology; however, there is an exception for MALT lymphomas (9699/3), which states: Abstract multiple primaries when a nodal MALT (C770-779, 9699/3) occurs before or after an extranodal MALT (all other sites, 9699/3).

Date Finalized
05/05/2021

20210025

References
Source 1:
pgs:

Question
Primary site--Ovary: What information takes precedence for coding the primary site in cases with high grade serous carcinoma that are clinically called ovarian but on pathology, the pathologist calls the primary site fallopian tube and the gynecology oncology/managing physician continues to call the cases ovarian. Both the ovary and tube are involved. Sometimes also referred to as "tubo-ovarian."

Answer
When the choice is between ovary, fallopian tube, or primary peritoneal, any indication of fallopian tube involvement indicates the primary tumor is a tubal primary. Fallopian tube primary carcinomas can be confirmed by reviewing the fallopian tube sections as described on the pathology report to document the presence of either serous tubal intraepithelial carcinoma (STIC) and/or tubal mucosal invasive serous carcinoma.
If there is no information about the fallopian tubes, refer to the histology and look at the treatment plans for the patient. If all else fails, you may have to assign C579 as a last resort. Use text fields to document the details.

For additional information, see the CAP GYN protocol, Table 1: Criteria for assignment of primary site in tubo-ovarian serous carcinomas.

Date Finalized
05/05/2021

20210024

References
Source 1: **WHO Class Female Genital Organs**

Question
Primary Site--Vulva: What is the primary site of patient with an excision of a left vulvar cystic mass showing focal mammary-type ductal carcinoma in situ (DCIS) on 11/06/2020? See Discussion.

Discussion
Final Pathologic Diagnosis:

Vulvar cyst, excision: Focal mammary-type ductal carcinoma in situ, intermediate grade, arising within cystically dilated duct (See Comment)

Size of DCIS: 0.7 CM.

Margins: Negative.

Comment
Sections demonstrate a cystically dilated duct. Focally, at the periphery of the duct, there is a neoplastic monomorphic proliferation of ductal cells with intermediate grade nuclei. No associated necrosis is identified. Immunostains for GATA-3 and estrogen receptor are strongly positive within the neoplastic cells, supporting origin from mammary-like epithelium. Immunostain for p63 demonstrates preservation of a basal layer around the dilated duct, including the region involved by DCIS. Immunostain for cytokeratin 5/6 shows loss of expression within the DCIS. No stromal invasion is identified. The cyst appears to be completely excised.

12/01/2020 post op visit with surgeon:
Ductal carcinoma in situ (DCIS) of the left vulva in an excised cystic lesion.
PLAN: I reviewed the pathologic findings from the excision of the left vulvar cyst. This appears to be a cystic lesion in the mammary line with focal DCIS. It was excised completely with negative margins. It would not warrant any additional treatment except expectant management.

Answer
Code the primary site to vulva. Use text fields to record the details.

According to the WHO classification, several types of primary vulvar mammary-like carcinoma have been reported. It is rare and is thought to arise from specialized anogenital mammary-like glands within the vulva. It does not arise from ectopic breast tissue and is does not represent metastatic breast carcinoma.

Date Finalized
05/05/2021

20210023

References
Source 1: **Subject matter experts**

Question
Reportability/Terminology--Head & Neck: Is an "evolving" squamous cell carcinoma of the vermillion border of the left lower lip reportable?

Answer
For solid tumors, ignore the term "evolving" and apply the registry rules for reportability to this case. Squamous cell carcinoma of the vermillion border of the lower lip (C001) is reportable.

Date Finalized
05/05/2021

20210022

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Other Sites; for cases diagnosed 2007-2021**
Source 2: **WHO Class Urinary System and Male Genital Organs**
pgs:
Notes: **4th edition**

Question
Solid Tumor Rules (2018/2021)/Multiple primaries--Prostate: Is basal cell carcinoma with focal squamous differentiation and a small focus of infiltrating prostatic adenocarcinoma one or two primaries and if one, is the histology 8147/3? See Discussion.

Discussion
Scenario: Patient had a transurethral resection of the prostate on 8-29-19, positive for basal cell carcinoma with focal squamous differentiation involving approximately 50% of tissue (determined not to be mets by consult). On 11-14-19, the patient had a prostatectomy positive for residual basal cell carcinoma and a small focus of infiltrating prostatic adenocarcinoma. According to AJCC, 8th edition, page 724, basal cell carcinoma of the prostate is 8147/3 and we ignored the small focus of adenocarcinoma. The above scenario was reported as two primaries (8090/3 and 8140/3), but we are thinking it is one.

Answer
Abstract a single primary and code as 8147/3 using Rule M18 and Rule H17 of the 2018 Other Sites Solid Tumor Rules. This is based on the findings of basal cell carcinoma of the prostate (8147/3) and adenocarcinoma (8140/3). We consulted with the Subject Matter Expert who advises that basal cell carcinoma and basal cell adenocarcinoma can be used interchangeably.

This updates previous consultation regarding this histology. The Other Sites rules will be updated for 2022 and include this information in the prostate histology table.

Date Finalized
05/18/2021

20210021

References
Source 1: **2018 EOD**
Notes: **Breast schema**

Question
EOD 2018/Lymph Nodes-EOD--Breast: Should Extent of Disease (EOD) Regional Nodes be coded as 150 (Clinical assessment only; Positive needle core biopsy/fine needle aspirate [FNA]) when the patient has a biopsy-proven, clinically apparent, movable ipsilateral axillary lymph node, but no evidence of involvement at surgery after neoadjuvant therapy? See Discussion.

Discussion
The Breast EOD Regional Nodes notes contain new clarification regarding the clinical assessment vs. pathological assessment codes, but the new Note 2 does not specifically indicate an exception for neoadjuvant therapy. However, if the pre-treatment lymph node core biopsy proved cN1 disease, and the post-treatment resection proved ypN0 disease, should the clinical assessment code (code 150) have priority over any pathological assessment code (including 200) since the involved lymph node was only clinically positive and not pathologically positive? Should an exception be added to Note 2 to address cases where neoadjuvant therapy is given, but the clinical assessment is greater than the pathological assessment?

Answer
The clinical assessment code takes priority over the pathological assessment code in this case because the clinical assessment was worse than the pathologic assessment. Although there was a pathological assessment, the clinical assessment is greater. According to the general coding guidelines for neoadjuvant therapy, code the worst information, which in this case is the clinical assessment.

The 2018 EOD General Instructions for EOD Regionals Nodes, instruction #4, addresses neoadjuvant therapy as follows. Neoadjuvant (preoperative) therapy: If the patient receives neoadjuvant (preoperative) systemic therapy (chemotherapy, immunotherapy) or radiation therapy, code the clinical information if that is the most extensive lymph node involvement documented.

A new note is being included for the 2022 updates. Exception: If patient has neoadjuvant therapy, and the clinical assessment is greater than the pathological assessment, the clinical assessment code takes priority.

FINALIZED SEER SINQ QUESTIONS

May – July, 2021

Date Finalized
05/14/2021

20210020

References
Source 1: **2021 SEER Manual**
pgs: **101**
Notes: **Behavior Code**

Question
Behavior--Breast: Should the behavior change to /3, invasive, to get a case to clear edits? The histology of this breast case is ductal carcinoma in situ (DCIS), 8500/2. Lymph nodes are positive for micro-mets (0.2 mm-2 mm). SEER Summary Stage: 3, regional lymph nodes positive. This creates an edit for SEER Summary Stage due to the behavior code of /2, in situ.

Answer
Code the behavior to /3, not just to pass edits, but because this is an invasive case based on the positive lymph nodes.

For most cases, behavior is based on the primary tumor, but in situations like this where an invasive component cannot be found and there are positive lymph nodes, the /3 behavior is assigned based on the positive lymph nodes.

Date Finalized
05/14/2021

20210019

References
Source 1: **2021 SEER Manual**
pgs: **6**
Notes: **Reportability**

Question
Reportability/Histology--Cervix: Is a stratified mucin-producing intraepithelial lesion (SMILE) lesion reportable? Is it reportable if it is invasive SMILE? What is the correct histology? See Discussion.

Discussion
Cervix, loop electrosurgical excision procedure: Cervix at transformation zone with stratified mucin-producing intraepithelial lesion (SMILE). SMILE is present at the ectocervical margin. An immunohistochemical stain* for p16 demonstrates strong, diffuse positivity in the lesional epithelium. A mucicarmine stain is also positive in the lesional epithelium, supporting the diagnosis of SMILE.

Answer
Stratified mucin-producing intraepithelial lesion (SMILE) of the cervix is **not** reportable. SMILE is a variant of adenocarcinoma in situ and is coded 8140/2. In situ neoplasms of the cervix are not reportable. According to the WHO Classification of tumors, p16 is positive and there is a high Ki-67 proliferation index.
If SMILE is stated to be invasive, it is reportable, as any other invasive cervical malignancy would be reportable.

Date Finalized
05/14/2021

20210018

References
Source 1: **2021 SEER Manual**
pgs: **7**
Notes: **Reportability**

Question
Reportability/Histology--Head & Neck: Is carcinoma cuniculatum of the hard palate diagnosed in 2017 reportable? Was this rare variant of squamous cell carcinoma (SCC) missed in Casefinding? If reportable, what is the histology code?

Answer
Carcinoma cuniculatum of the hard palate is reportable. Code to SCC, NOS (8070/3). Use text fields to record the details.

While WHO recognizes carcinoma cuniculatum to be a new variant of oral cancer, it has not proposed a new ICD-O code for this neoplasm.

Date Finalized
05/14/2021

20210017

References
Source 1: **2021 SEER Manual**
pgs:
Notes: **Mets at Dx fields**

Question
Update to current manual/Mets at diagnosis fields--Lymphoma: Are distant metastases possible for a lymphoma with a primary site of lymph nodes? The instructions in the SEER manual tell us to assign code 8 in each of the Mets at Dx fields for a lymphoma originating in lymph nodes.

Answer
This is a **correction** to the SEER manual. Lymphomas originating in lymph nodes (C77) could have distant metastases to any site except lymph nodes. The following corrections to the manual apply now and will appear in the next version of the manual.

Remove C770-C779 from the instruction for assigning code 8 on the following pages.

Page 135 Mets at Dx--Bone

Page 137 Mets at Dx--Brain

Page 139 Mets at Dx--Liver

Page 141 Mets at Dx--Lung

Page 145 Mets at Dx--Other

Example

Biopsy of axillary lymph node: Diffuse Large B-Cell lymphoma. Lymph nodes involved above and below the diaphragm, multiple nodules seen in lung, lesions in liver. Bone marrow biopsy positive for DLBLC. Per Hematopoietic manual, primary site would be C778 for multiple lymph node regions involved.

Mets at Dx--Bone-0

Mets at Dx--Brain-0

Mets at Dx--Liver-1

Mets at Dx--Lung-1

Mets at Dx--Distant Lymph Nodes-8

Mets at Dx--Other-1

Date Finalized
05/14/2021

20210016

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Kidney; December 2020 Update**

Question
Solid Tumor Rules (2018, 2021)/Histology--Kidney: What is the correct histology code for a kidney primary described as clear cell papillary renal cell carcinoma"? Should we use H2 and code 8312/3 or H3 and code 8323/3?

Answer
Assign 8323/3, clear cell papillary renal cell carcinoma using the 2018 Kidney Solid Tumor Rules, Rule H1, as this is a single histology, a variant of renal cell carcinoma NOS.

Date Finalized
05/14/2021

20210015

References

Source 1: **2007 Solid Tumor Rules**
pgs:
Notes: **2007 General Instructions; Other Sites-For use with cases 2007-2021**
Source 2: **2021 SEER Manual**
pgs: **6**
Notes: **Reportability**

Question
Solid Tumor Rules (2007/2021)/Multiple Primaries--Anus: Have the disease-free interval criteria been met for the following case scenario. A patient was diagnosed with anal intraepithelial neoplasia (AIN) III in 7/2018 that was treated with local tumor destruction, followed by Pap smears and biopsies that prove AIN I or AIN II through 2020, before being diagnosed with a reportable AIN II or AIN III in 2021. See Discussion.

Discussion
Since AIN I is not reportable and AIN II is not reportable until 2021, we are not sure if we can say the patient was disease free because there was no intervening reportable tumor (AIN III), or was never disease free because there was evidence of related disease (lower grade dysplasia).

Answer
The 2021 AIN III is not a new primary. According to our GI pathology expert, findings of AIN I and/or AIN II following a diagnosis of AIN III indicates the patient was never NED and indicates persistent disease.

Date Finalized
05/14/2021

20210014

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Lung; December 2020 Update**

Question
Solid Tumor Rules (2018, 2021)/Multiple Primaries--Lung: How many primaries should be reported for a 4/2019 diagnosis of left upper lobe (LUL) adenosquamous carcinoma (left lingula mass biopsy: adenosquamous carcinoma; LUL lung biopsy: pulmonary adenocarcinoma, stated to be a collision tumor and single primary per the Tumor Board), treated with radiation followed by an enlarging LUL mass in 7/2020 found to be squamous cell carcinoma? See Discussion.

Discussion
The physician stated the prior LUL adenosquamous carcinoma was PD-L1 negative and the LUL squamous cell carcinoma is PD-L1 positive and is calling it a new primary.

5/22-7/3/19 6000x30 IMRT Photons LUL lung Chemo refused Not a Surg candidate

10/01/2019 CT Chest: IMP: In comparison to CT chest 03/06/2019 and PET/CT 03/21/2019, left lingular mass has mildly decreased in size. Left apical anterior and posterior lung lesions more anterior lesion appears slightly increased in size, the other slight decreased in size, with adjacent areas of atelectasis and scarring.

06/23/2020 CT Chest: MP: In comparison to CT chest 10/1/2019, left lingular mass has increased in size concerning for increasing tumor with adjacent thicker focal pleural thickening involving the chest wall, concerning for possible chest wall invasion. Left apical anterior and posterior lung lesions appears more solid in appearance, representing known adeno CA, given that the appearance has changed, is concerning for residual tumor.

07/06/2020 PET: Hypermetabolic lingular mass and peripheral nodularity has increased in size and FDG avidity on the prior PET/CT. Left apical nodular opacity is difficult to separate from fairly uniform mild left apical pleural hypermetabolism which may be treatment related and/or neoplastic.

Answer
Abstract two primaries: 8560 and 8140 using rule M6. One of the original tumors with adenosquamous now shows only residual SCC following XRT. PD-L-1 is not used to determine multiple primaries. Assuming three tumors (the post-XRT SCC is not a new tumor but residual from one of the adenosquamous tumors) there are two primaries: 8560 and 8140

per M6. For collision tumors, each histology identified in the tumor is used to determine multiple primaries.

Date Finalized
05/14/2021

20210012

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Lung; December 2020 Update**

Question
Solid Tumor Rules (2018, 2021/Multiple Primaries/)--Lung: How many primaries should be reported and what M rule applies when a diagnosis of presumed adenocarcinoma in situ (AIS) of the left lung follows a known diagnosis of progressive multifocal malignant adenocarcinoma in the right lung? See Discussion.

Discussion
Patient was initially diagnosed with a right lower lobe (RLL) lung adenocarcinoma in 2014 followed by subsequent right upper lobe (RUL) lung adenocarcinoma in 2016 (single primary). Both were treated with radiation and the nodules were seen as stable on surveillance. There was subsequent growth in the RUL nodule in 2019 and RLL nodule in 2020 as well as a new right middle lobe (RML) nodule in 2020. All left sided nodules were noted to be stable and/or ground glass opacities.

There was no documented diagnosis of malignancy in the left lung until June 2020 when the physician noted that if there was a response in the left lung to systemic treatment, then this was probably multifocal AIS. However, only one tumor in the left lung responded to treatment.

While it seems somewhat unlikely that only a single AIS in the contralateral lung should be metastasis from the right lung malignancy, it is difficult to apply the multiple tumors rules to this case.

Answer
Abstract a single primary using 2018 Lung Solid Tumor Rule M9.

The 2014 and 2016 R lung tumors were pathologically confirmed; it is not stated if they were resected. Follow up after XRT noted stable disease but no indication of NED. Subsequent right lung tumor is also the same primary. The issue is the assumed left lung adenocarcinoma in situ. It is not clear how long the left lung nodules were present, but they appeared to be stable as well and only diagnosed as a malignancy based on treatment response. At this time M9 applies and the left lung AIS is not a separate primary. We have discussed at length with lung pathology experts the issue of determining multiple primaries. Identifying and diagnosing lung tumors has become easier with new technology and the result is patients are being diagnosed with multiple lung tumors. Some lung experts feel we

are under-reporting lung primaries, but all noted the many issues with creating rules for consistency.

Date Finalized
05/14/2021

20210011

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

Question
Primary site: Is C720 the correct primary site for a diagnosis of a paraspinal neuroblastoma on autopsy in a nine-month-old with Noonan syndrome? See Discussion.

Discussion
Autopsy/Pathology Report (2020) excerpts

External Examination

Nervous System: There is an 8.5 cm mass located in the right thoracic paraspinal area.

Final Anatomic Diagnosis

Clinical History: Paraspinal mass suspicious for neuroblastic tumor (detected by imaging studies)

Nervous System: Right thoracic paraspinal neuroblastoma, poorly differentiated

Answer
Assign primary site code C473 for this case based on the information provided (peripheral nerves and autonomic nervous system of thorax).

From our expert pathologist consultant: The origin of neuroblastomas is generally in the adrenal medulla or one of the sympathetic ganglia on either side of the vertebral column (although they have been reported in many other locations given the migration of the neural crest cells embryologically).

Date Finalized
05/05/2021

20210010

References
Source 1: **2021 SEER Manual**
pgs:
Notes: **Reportability section**
Source 2: **ICD-O-3.2**
pgs:
Notes: **NAACCR Implementation, October 2020**

Question
Reportability--Head & Neck: Is chondrosarcoma, grade 1 reportable for cases diagnosed 01/01/2021 and later? See Discussion.

Discussion
Neither the ICD-O-3.2 Implementation Guidelines nor the ICD-O-3.2 Coding Guidelines (including Tables 1-7) address reportability changes for chondrosarcoma grade 1. In the Solid Tumor Rules Manual, Head and Neck Equivalent Terms and Definitions, Table 7 (Tumors of Odontogenic and Maxillofacial Bone (Mandible, Maxilla)), Chrondrosarcoma grade 2/3 (9220/3) is included as a subtype/variant for sarcomas in these sites, but it does not address Chrondrosarcoma, grade 1.

The ICD-O-3.2 Coding Table lists Chondrosarcoma, grade 1 as morphology code 9222/1. If Chondrosarcoma, grade 1 is no longer a reportable tumor for cases diagnosed 01/01/2021 and later, why wasn't this reportability change included in the ICD-O-3.2 Implementation Guidelines? If the standard setters chose not to include this reportability change, shouldn't Table 7 also indicate that all chondrosarcomas (NOS, grade 1, grade 2 or grade 3) are reportable for cases diagnosed 2018 and later?

How are registrars to make reportability and histology coding decisions for chondrosarcomas when neither source provides clear instructions regarding these tumors?

Answer
Chrondrosarcoma, grade 1 (9222/1) is not reportable according to the Reportability section in the 2021 SEER Manual. The histology (9222/1) is listed in ICD-O-3.2 as a synonym for atypical cartilaginous tumor (preferred term).

In general, the tables do not include non-reportable terms and codes. Registrars should refer to their standard setter (to whom they submit data) for reportable neoplasms. Currently, /0 and /1 neoplasms are reportable for central nervous system sites only. ICD-O-3.2 includes all neoplasms but that does not mean they are reportable. If a facility collects non-malignant neoplasms, use the corresponding ICD-O code in 3.2.

FINALIZED SEER SINQ QUESTIONS

May – July, 2021

Date Finalized
05/05/2021