20200059

Question

Reportability--Kidney: Is Bosniak 4 cystic lesion of right kidney reportable, and would the first CT date be the date of diagnosis? See Discussion.

Discussion

CT a/p read by radiologist shows: "Bosniak 4 cystic lesion of right kidney." Follow-up MRI a month later reads "right kidney cystic lesion with enhancing mural nodule… concerning for cystic renal cell carcinoma (RCC)." Urologist consult used the same wording of "Bosniak 4 cystic lesion" and "concerning for renal cell carcinoma." Treatment discussed but due to patient health status recommended repeat imaging. Repeat CT few months later reads: "cystic right renal lesion with enhancing nodule… similar to most recent prior and suspicious for cystic RCC."

Though "suspicious for cystic RCC" per latest imaging is reportable, Bosniak 4 is "clearly malignancy, ~100% malignant" by definition, so is the case actually reportable with the first CT a/p date as date of diagnosis?

Answer

Bosniak 4 is defined as "clearly malignant; ~100% malignant." The case is reportable as of the first date it is diagnosed as a Bosniak 4 lesion unless further workup (especially biopsy or resection) disproves the CT findings.

Date Finalized

12/14/2020

20200058

References
Source 1: **2018 SEER Manual**
pgs:
Notes: **Appendix C, Pancreas Surgery Codes**

Question
Surgery of Primary Site/Surgery Codes, NOS--Pancreas: What exactly is an extended pancreatoduodenectomy? Must the entire pancreas be resected in order to use code 70? What minimal requirements must be met to use code 70? How should a Whipple with cholecystectomy, partial omentectomy, common hepatic excision, portal vein resection, and lymphadenectomy be coded?

Answer
According to our research, a pancreaticoduodenectomy (PD) includes an en bloc resection of the pancreatic head, the common bile duct, the gallbladder, the duodenum, the upper jejunum, the distal portion of the stomach and the adjacent lymph nodes. The extended PD procedure includes extended lymphadenectomy, extended organ resection, and extended vascular resection and reconstruction.

Code 70 could be assigned without the entire pancreas being resected.

A Whipple procedure removes the head of the pancreas, duodenum, stomach and gallbladder and part the common bile duct. The portal vein resection is probably part of the common bile duct excision. If the omentectomy was performed for treatment of this primary, record it in "Surgical Procedure of Other Site." Record the lymphadenectomy in the lymph node data items.

Date Finalized
12/14/2020

20200057

References

Source 1: **Subject matter experts**

Question
Histology--Lung: Is there a better code for SMARCA4-deficient malignant neoplasms than 8000/3 that could be used especially given its aggressive nature? This term is not included in the Lung Solid Tumor Rules or ICD-O-3.1 and 3.2. See Discussion.

Discussion
Per Mayo consulting pathologist, the final diagnosis on this right lung biopsy is: SMARCA4-deficient malignant neoplasm (see Comment). Comment: Sections show a poorly differentiated malignant neoplasm without any apparent glandular, squamous, or stromal differentiation. The tumor near totally replaces the underlying lung tissue without recognizable underlying alveolar parenchyma. Immunohistochemical stains performed at Mayo Clinic (Oscar keratin, INSM1, NUT, S100, desmin and BRG1 protein encoded by SMARCA4 gene) demonstrate that the malignant cells are positive for Oscar keratin (rare cells only), synaptophysin (weak/patchy) and p63 (focal) while negative for the remaining antibodies tested. Of note, SMARCA4 stain is negative in the tumor cells. Thus, this tumor can be categorized as a SMARCA4-deficient malignant neoplasm, which is known to be an aggressive malignancy, likely represent a SMARCA4-deficient thoracic sarcoma, a recently described entity. SMARCA4-deficient carcinomas in the lung have been reported to be mostly adenocarcinomas or squamous cell carcinomas, which would not fit for this case. Please refer to a paper published by our group (Sauter JL et al. Mod Pathol 2017; 30:1422-32.

Answer
Assign code 8020/3. SMARCA4-deficient malignant neoplasms are newly identified. WHO has not proposed an ICD-O code as of yet. Our pathology experts suggest coding to undifferentiated carcinoma until they are better classified.

Date Finalized
12/14/2020

20200056

References

Source 1: **WHO Class Digestive System Tumors, 5th ed.**

pgs:

Notes: **Tumors of the Gallbladder and extrahepatic bile ducts, on-line version**

Question

Reportability--Gallbladder: Is Intracholecystic papillary neoplasm (ICPN) with low-grade intraepithelial neoplasia reportable? The primary site is gallbladder.

Answer

Intracholecystic papillary neoplasm (ICPN) with low-grade intraepithelial neoplasia is not reportable. The WHO assigns a behavior of "0" to these neoplasms.

Date Finalized

12/14/2020

20200055

References
Source 1: **COVID-19 Abstraction Guidelines**
pgs:
Notes: **Updated August 2020**

Question
Solid Tumor Rules (2018)/Multiple primaries--Melanoma: Should a case with treatment delayed due to COVID-19 be abstracted as one or two primaries? It is uncertain if the invasive tumor would be a new tumor, or deeper extension/disease progression from the original tumor. See Discussion.

Discussion
11/18/2019 Left 1st Digit/Thumb Biopsy: Atypical Melanocytic Proliferation consistent with Early Acral Lentiginous Melanoma in situ. Margins Positive. (Not a reportable diagnosis for 2019.)

12/5/2019 Left 1st Digit Shave Biopsies: Malignant Melanoma in situ. Margins Positive.

1/15/2020 Started Aldara (treatment plan: use for ~3 months then Mohs/excision, but due to COVID could not get resection until 7/2020).

7/29/2020 Left Thumb Excision: Residual Melanoma in situ. Margins Positive. Treatment Plan: re-excision.

8/6/2020 Left Thumb Re-Excision: Atypical Lentiginous Melanocytic Proliferation at the 12-2 margin may represent the advancing edge of melanoma in situ. (8/19/2020 Plan to treat the 12-2 margin as positive with in situ; plan for re-excision).

8/20/2020 Left Thumb Re-Excision & Left Nail Plate Excision: Malignant Acral Lentiginous Melanoma with extensive melanoma in situ. Breslow 1.3mm. Margins Positive. Nail plate & bed epithelium with hemorrhage and a mild increase in melanocyte density likely represent melanoma in situ.

9/4/2020 Left thumb partial amputation & Left axillary Sentinel Lymph Node Excision: Residual Malignant Melanoma in situ. 0/3 sentinel nodes positive.

Answer

Abstract a single primary using the Solid Tumor Rules for melanoma. Report this melanoma as invasive (/3) as documented in the information from 8/20/2020. The treatment delay does not influence the number of primaries to be reported. Registries in SEER regions: Report the COVID-related information as directed in the COVID-19 Abstraction Guidelines, https://seer.cancer.gov/tools/covid-19/.

Date Finalized

12/23/2020

20200054

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Other Sites, Updated 9/11/2018; for cases dx'd 2007 and later**

Question
Solid Tumor Rules (2018)/Multiple primaries--Liver: When does a hepatocellular carcinoma (HCC) recurrence in the same area of the liver get accessioned as a new tumor following TACE/Y90/RFA? If there is a new HCC in the same area as previously treated but it is stated to be recurrent and/or progressive disease, is that evidence of a disease-free interval? If the tumor area is stated to be LR-TR and non-viable, but then a new HCC in that area is diagnosed, does that count as a disease-free interval? See Discussion.

Discussion
Example 1: 5/2013 diagnosis of HCC in segment 4B (single tumor), treated with microwave ablation in 7/2013. CT scan in 11/2017 with new 23mm hypodensity in liver segment 4 suspicious for recurrent disease. Clinical assessment in 1/2018: New enlarging lesion in liver most consistent with progression of HCC. Treated with RFA in 2/2018. Is the 2018 occurrence a new primary as imaging stated this was a new lesion?

Example 2: 7/2017 diagnosis of HCC in right liver; 2.5 cm lesion in segment 5/6 with a couple of satellites and 12mm lesion in segment 6, treated with Y90 radioembolization. Follow-up note in 11/2017: complete response of treated cluster of lesions in segment 5/6 and lesion in segment 6, increase in size of caudate lesion not amenable for treatment (this lesion was stated to be indeterminate on 7/2017 imaging). Caudate lesion finally stated as LI-RADS5 on 3/2018 imaging and was treated with chemoembolization 6/2018. 7/2018 and 10/2018 Follow-up imaging states LR-TR nonviable lesion in caudate lobe. 8/2019 CT shows caudate lobe with arterial enhancement, new compared to prior imaging, LR-TR viable. MD note states patient has small local HCC recurrence in segment 1 (caudate lobe) with plan to repeat TACE. Is this 8/2019 HCC a new primary as the patient was disease free for greater than 1 year, or is it the same tumor and a single primary?

Answer
Both examples are multiple primaries.

Example 1: The 2018 lesion is a new tumor. Abstract multiple primaries based on 2018 Other Sites Solid Tumor Rules, Rule M10, when tumors are diagnosed more than one year apart.

Example 2: 2017 diagnosis showed complete response to treatment. 2019 lesion is a new primary based on timing.

The General Instructions of the Solid Tumor Rules instruct: Do not use a physician's statement to decide whether the patient has a recurrence of a previous cancer or a new primary. Each scenario should be evaluated separately using the rules as a guide.

Date Finalized
12/14/2020

20200053

References
Source 1: **2018 Solid Tumor Rules**
Notes: **Urinary Sites, July 2019 Update**

Question
Solid Tumor Rules (2018)/Multiple primaries--Bladder. Would the metastatic diagnosis indicate a new primary? If the metastatic diagnosis indicates a new primary, would the primary site be C688 and date of diagnosis 11/14/18? See Discussion.

Discussion
7/8/16 Urinary bladder, biopsy: Non-invasive low grade papillary urothelial carcinoma. Muscularis propria (detrusor muscle) is not identified.

9/2/16 Urinary bladder, bladder tumor, transurethral resection: High grade papillary urothelial carcinoma. No definite invasion identified. Muscularis propria (detrusor muscle) is identified and not involved by tumor.

1/7/17 A\S\Bladder: Noninvasive low grade papillary urothelial carcinoma. Granulomatous cystitis, consistent with BCG (Bacillus Calmette-Guerin) treatment. Lamina propria is not involved with tumor. Detrusor muscle is not identified.

4/4/17 Dome: Papillary urothelial carcinoma, low grade. No evidence of invasion. Muscularis propria is not present.

Patient is clearly followed for at least a year but no further information until 19 months later, 11/14/18, when biopsy of lung indicates metastatic disease.

11/14/18 Lung, right lower lobe, mass, biopsy: Metastatic urothelial carcinoma. Immunohistochemical analysis results (CK7 positive, CK20 focally positive, P63 positive, GATA3 positive, TTF1 negative and NAPSIN-A negative) support the diagnosis

Answer
Do not use the solid tumor rules to assess the 2018 diagnosis. See Note 1 on page 20 of the Urinary Sites Solid Tumor Rules, https://seer.cancer.gov/tools/solidtumor/Urinary_STM.pdf

The 2018 diagnosis proves that this patient had invasive bladder cancer. Change the behavior on the abstract to /3 and use text fields to record the details.

Date Finalized
11/17/2020

20200052

References
Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Other Sites; Updated 9/11/2018**

Question
Solid Tumor Rules (2018)/Histology--Prostate: How is the histology coded for a diagnosis of mixed prostatic adenocarcinoma (5%) and small cell neuroendocrine carcinoma (95%) from a transurethral resection of the prostate? See Discussion.

Discussion
Following the existing Solid Tumor Rules Histology Rules, it would seem this is a single primary with histology 8045 (Combined small cell carcinoma) because there is no indication there are multiple prostate tumors and Table 2 states combined adenocarcinoma and small cell carcinoma is Combined small cell carcinoma (8045).

Conversely, while not an exact match to this case, SINQ 20190083 implies small cell carcinoma and adenocarcinoma of the prostate are separate primaries. In that SINQ case, the patient was simultaneously diagnosed with metastatic small cell carcinoma of the prostate on a liver biopsy and prostate adenocarcinoma on a prostate biopsy. There is no indication that patient had separate tumors in the prostate, however the SINQ instructs to code as separate primaries.

Would the previous SINQ logic apply to synchronous diagnoses in the prostate as well? Or does code 8045 apply to this situation?

Answer
Assign histology code 8045 for combined small cell carcinoma as this represents one tumor with mixed histologies using the 2018 Other Sites Solid Tumor Rules, Rule H16.

Date Finalized
11/17/2020

20200051

References

Source 1: **2018 SEER Manual**

pgs: **90**

Notes: **#13**

Question

Primary site/Unknown and ill-defined site--Melanoma: What is the primary site for a case of metastatic melanoma with an unknown primary site? See Discussion.

Discussion

A patient had posterior cervical lymphadenopathy status post biopsy and subsequent lymph node dissection showed metastatic melanoma in 2018. Workup showed no skin lesions or primary site. Final diagnosis is melanoma of unknown primary (unknown if cutaneous or non-cutaneous). Should C760 be used as the primary site for this case since the histology codes of 8700-8790 are included in the Cervical Lymph Nodes and Unknown Primary Tumors of the Head and Neck schema in SEER*RSA?

Answer

Code primary site C449. C449 is the default primary site code for melanoma of unknown primary site. C760 should **not** be assigned for this case. Updates will be made to SEER*RSA to remove the melanoma histology codes from the Cervical Lymph Nodes and Unknown Primary Tumors of the Head and Neck schema.

Date Finalized

11/05/2020

20200050

References

Source 1: **2018 SEER Manual**
Notes: **Appendix C Breast Surgery Codes**
Source 2: **2018 Solid Tumor Rules**
Notes: **Breast; July 2019 Update**

Question

Surgery of Primary Site/Multiple primaries--Breast: Should the Surgery of Primary Site for the 2020 diagnosis be coded 51 (Modified radical mastectomy without removal of uninvolved contralateral breast) when a partial mastectomy and axillary lymph node dissection are performed for a 2011 right breast primary and a subsequent 2020 right breast primary is treated with a total mastectomy only? See Discussion.

Discussion

The patient underwent a partial mastectomy and sentinel lymph node biopsy, followed by an axillary lymph node dissection for the first right breast primary in 2011. The separate 2020 right breast primary was treated with a total mastectomy and removal of one involved axillary lymph node. The operative report only refers to this as a non-sentinel lymph node, with no mention of other axillary findings.

Cumulatively, this patient has undergone a modified radical mastectomy since there were likely no remaining axillary lymph nodes. If the Surgery of Primary Site data item is cumulative, does the order of surgeries matter?

It is unclear whether this question should be directed to SINQ (for coding in a SEER registry) or to CAnswer Forum because both have addressed similar surgery related questions in the past and there is no guidance regarding this specific situation.

Answer

Yes, assign surgery of primary site code 51 for the 2020 diagnosis in this case. Code the cumulative effect of all surgeries to the primary site. This means that for the 2020 primary, code the cumulative effect of the surgery done in 2011 plus the surgery performed in 2020. Use text fields on both abstracts to record the details.

Date Finalized

11/17/2020

20200049

References

Source 1: **2018 Summary Stage Manual**
pgs:
Notes: **Lymphoma Orbital Adenexa**
Source 2: **2018 Extent of Disease**
pgs:
Notes: **Lymphoma Orbital Adenexa**

Question
Summary Stage 2018/EOD 2018--Lymphoma Orbital Adnexa: What is the correct Summary Stage 2018 (SS2018) for the site/histology Orbit, NOS (C696), 9699/3? In SEER*RSA, Extent of Disease (EOD) Primary Tumor references code 7 (Distant), whereas SS2018 assigns code 2 (Regional)? See Discussion.

Discussion
We received an edit error in SEER*DMS on the following site/histology (Orbit, NOS (C696)/9699/3) that involved an incorrect staging code being assigned to SS2018. The staging language is identical in AJCC, EOD and SS2018. SEER*RSA notes that SS2018 should be coded distant, but in the SS2018 manual, this language is noted Regional. Staging language is: Orbital adnexal lymphoma AND extra orbital lymphoma extending beyond the orbit to adjacent structures--Bone, Brain, Maxillofacial sinuses

Answer
To clear this edit of the derived Summary Stage (based on EOD) and the manually assigned Summary Stage (based on Summary Stage 2018), assign the manually assigned Summary Stage to 7.

For this particular case, EOD Primary Tumor 700 (which is correct based on the information received) derives Distant; however, for Summary Stage 2018, this description is under Code 2 for Regional by direct extension. This is an error. For 2022, Summary Stage for Lymphoma Ocular Adnexa description under Code 2 (Regional by direct extension) will be moved to Distant. No changes will be done to EOD.

Date Finalized
11/17/2020

20200048

References

Source 1: **2018 Solid Tumor Rules**
pgs:
Notes: **Lung, July 2019 Update**

Question
Solid Tumor Rules/Multiple Primaries--Lung: How many primaries are accessioned when a patient is diagnosed with right lower lobe invasive acinar adenocarcinoma (8551/3) in 2018 and treated with lobectomy, followed by a 2019 right middle lobe cancer (NOS, 8000/3) diagnosed as new stage 1 primary by cancer conference? See Discussion.

Discussion
Lung Rule M14 appears to be the first rule that applies to this case and instructs the user to abstract a single primary. However, we were hoping for confirmation that a cancer (NOS) or malignancy (NOS) would not be a distinctly different histology that may qualify for Lung Rule M8. Currently, these histologic terms are not included in the Table 3 options or mentioned in the preceding notes.

Answer
Use M14 and code a single primary. Per our SME, carcinoma or cancer, NOS is not an acceptable diagnosis which is why 8000 and 8010 were not included in the tables or rules. We assume there was no tissue diagnosis for the 2019 diagnosis. We recommend searching for more information or better documentation on this case.

Date Finalized
11/17/2020

20200047

References
Source 1: **2018 STORE Manual**
pgs: **152**
Notes: **LVI**
Source 2: **2016 SEER Manual**
pgs: **72**
Notes: **Section V: LVI**

Question
Stage-related Data Item/Lymphovascular Invasion--Ovary: The 2018 SEER Program Coding and Staging Manual states that LVI is coded 8 (Not applicable) for Ovary (Schema 00551). What is the reason for having lymphovascular invasion (LVI) coded "8" for Ovary? See Discussion.

Discussion
This direction is also in SEER*RSA for Ovary. Researching a possible explanation for this, we found that LVI is an independent predictor of progression and survival in patients with primary epithelial ovarian cancer at early stage but not at advanced stage. However, studies also recommend that routine evaluation of LVI in ovarian cancer is highly recommended in daily practice.

Answer
The coding instructions were developed and implemented in concert with the AJCC Cancer Staging Manual, 7th edition, and updated with the 8th edition as per the 2018 STORE Manual and were based on sites where distinguishing between lymphatic/small vessel invasion and venous/large vessel invasion was not medically appropriate.

SEER required LVI for penis and testis cases only beginning in 2016; sites other than penis or testis are coded 8 unless required by state or central registries. The list for use of code 8 has been changed for 2021 and will no longer include Ovary.

Date Finalized
11/05/2020

20200046

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

Question
Reportability--Vulva: Is well differentiated vulvar intraepithelial neoplasm (dVIN) reportable? See Discussion.

Discussion
Is this histologic terminology synonymous with 8071/2 Differentiated-type vulvar intraepithelial neoplasia?

Per the 7/20/2018 updates to the 2018 ICD-O-3 Histology list, the reportability flag was changed from N to Y for Differentiated-type vulvar intraepithelial neoplasia as well as Differentiated penile intraepithelial neoplasia, both 8071/2. It appears that both SINQ 20180020 and the second half of SINQ 20160069 are no longer valid and should be deleted.

Answer
Report well-differentiated vulvar intraepithelial neoplasm (8071/2). Our expert pathologist consultant regards this as reportable. Well-differentiated is synonymous with differentiated in this context.

The older SINQ questions have been removed.

Date Finalized
11/05/2020

20200045

References

Source 1: **Heme and Lymphoid Manual and Database**

Notes: **Effective with cases diagnosed 1/1/2010 and forward**

Question

Diagnostic confirmation--Heme & Lymphoid Neoplasms: Is Diagnostic Confirmation coded to 5 or 8 based on a patient diagnosed as multiple myeloma by a physician based on a bone marrow biopsy stating plasma cell neoplasm? See Discussion.

Discussion

Bone marrow, right iliac crest (aspirate smear, touch preparation, clot section and core biopsy): Hypercellular marrow (40-50%) with plasma cell neoplasm (see Comment): – No evidence of metastatic carcinoma. – Adequate iron storage.

Comment: CBC data shows normocytic anemia. Flow cytometric analysis of bone marrow detects a kappa restricted plasma cell population that expresses CD138 and CD38. CD56 is positive. CD19 and CD20 are negative. T lymphocytes are immunophenotypically unremarkable. Polyclonal B lymphocytes are detected. Blast gate is not significantly increased. Immunohistochemical stains are performed on the biopsy core and clot section for greater sensitivity and further architectural assessment with adequate controls. CD138 positive plasma cells comprise > 70% of the total cellularity. AE1/AE3 is negative. Taken together, the morphologic and immunophenotypic findings are consistent with a diagnosis of plasma cell neoplasm. Trilineage hematopoietic activity as are seen.

Answer

This would be a Diagnostic Confirmation of 8 based on the physician's diagnosis. The Pathology report mentions plasma cell neoplasm only. By itself, plasma cell neoplasm is not reportable because it includes a variety of diseases, some that are not reportable, and some that are (See Hematopoietic Database under Plasma Cell Neoplasm.)

The physician probably has other information, including imaging, which may show lytic lesions. He/she is probably using clinical findings, plus findings from the bone marrow, and diagnosing this patient with multiple myeloma.

Date Finalized

10/30/2020

20200044

References

Source 1: **2018 SEER Manual**
pgs: **6**
Notes: **Reportability**

Question

Reportability/Histology--Eye: Is conjunctival intraepithelial neoplasia, moderate to severe, reportable and if so, what are the histology and behavior codes? See Discussion.

Discussion

Left Eye Conjunctiva, biopsy (01/23/2018): Conjunctival intraepithelial neoplasia moderate to severe. Is intraepithelial neoplasia moderate to severe the same as coding 8077/2?

Answer

Report this case as 8077/2. Our expert pathologist consultant reviewed this and confirmed it is reportable. Here is some of his rationale.

The pathologist's designation as "moderate to severe" indicates there are areas of 2/3 of full thickness epithelial change, so the criteria to report are met.

Date Finalized

10/30/2020

20200043

References
Source 1: **2018 SEER Manual**
Notes: **Appendix C Bladder Coding Guidelines**

Question
Histology/Behavior--Bladder: Is the behavior of a bladder tumor with low-grade papillary urothelial carcinoma /2 or /3? See Discussion.

Discussion
Transurethral resection: Microscopic Diagnosis: Bladder, transurethral resection: Low-grade papillary urothelial carcinoma Gross Description: Received in formalin labeled with the patient's name and bladder tumor is a 3.0 x 2.0 1.0 cm aggregate of friable tan tissue biopsies. The specimen is submitted in toto, cassettes

This is all the information there is on this path report. Extent of Disease (EOD) instructions state inferred description of noninvasive: No statement of invasion (microscopic description present) SEER 2018 Appendix C Bladder Coding Guidelines state code behavior 3 if the only surgery performed is a transurethral resection of the bladder (TURB) documenting that depth of invasion cannot be measured because there is no muscle in the specimen OR the pathology report does not mention whether the submucosa is free of tumor or has been invaded by tumor.

Answer
For cases diagnosed 2021 or later
Code the behavior as in situ (/2) when the diagnosis is low grade urothelial carcinoma and there is no information regarding invasion. The SEER Manual Appendix C Bladder Coding Guidelines revision reflects this change. No changes have been made to EOD at this time. The guidelines have been updated as follows.
Low grade urothelial carcinoma with no other information: Code to /2.
High grade urothelial carcinoma with no other information: Code to /3.

For cases diagnosed prior to 2021
Code the behavior as malignant (/3) for a bladder tumor with low-grade papillary urothelial carcinoma.

Date Finalized
11/05/2020

20200039

References
Source 1: **2018 Extent of Disease**
pgs:
Notes: **General Instructions; GIST Schema**

Question
EOD 2018/Summary Stage 2018--GIST: How should Extent of Disease (EOD) and Summary Stage be coded for a multifocal gastrointestinal stromal tumor (GIST)? See Discussion.

Discussion
Example: Patient is found to have a 9.4 cm GIST in the jejunum and 2 cm GIST in the stomach during resection, neither stated to be outright malignant. Similar to the instruction in SINQ 20190041, this case is coded as a malignant jejunal primary due to multifocal tumor. However, it is unclear how to account for the stomach tumor, or any other multifocal tumor for GIST, when coding EOD and Summary Stage.

Answer
For this case, report each GIST diagnosis separately. This differs from SINQ 20190041 because in that case the stomach GIST was incidental and measured only 0.3 cm. Reporting these separately means that each one is no longer a multifocal tumor. If there is no other indication of malignancy for these, they would not be reportable if diagnosed in 2020 or earlier.

For cases diagnosed 2021 or later, all GIST are reportable. Report this as two primaries. Use the new GIST schema for EOD and assign EOD Primary Tumor 100 for each. There is no mention of extension outside the primary site. Summary Stage is Localized for each.

Date Finalized
10/30/2020