20150040

Question

Surgery of Primary Site--Pleura: How is this field coded if the patient underwent an exploratory thoracotomy with partial decortication that excised some, but not all, of the pleural mesothelioma tumors? See Discussion.

Discussion

This patient underwent a "partial decortication" per the operative report. While the operative report does not specifically note that this was performed with a partial pleurectomy, it appears the patient had a partial pleurectomy because the largest specimen removed was a "pleural peel" specimen, which included the parietal and visceral pleural surfaces with a small amount of underlying lung tissue. The operative report notes the patient had involvement of both the lung and chest wall. A total resection was not possible due to the extent of the tumor. However, this patient does appear to have undergone at least a partial resection of the pleura/tumor burden. The patient did not simply undergo a pleurodesis to free adhesions. Per the NCI's PDQ, pleurectomy and decortication are performed together. Because the operative report and pathology report only called this procedure a "partial decortication" without specifically mentioning a pleurectomy, would this be coded as a tumor excision (surgery code 20)? Or should we assume the procedure is best coded as a partial pleurectomy and decortication and use code 30 (simple/partial resection)?

Answer

Read the operative report and the pathology report and assign the surgery code that best represents the extent of the surgery. In this case, code 30 seems most appropriate. Do not assign the surgery code based only on the name of the procedure; use all information available to choose the most representative code.

Date Finalized

09/21/2015

20150039

Question

Reportability--Skin: Is this reportable? If so, what is the correct histology code? The pathology report says, " bx of 0.7 x 0.5 cm gray-pink papule on tan-pink skin of left inferior central malar cheek revealed invasive SCC of skin, signet ring cell type, invading papillary dermis; LVI neg; "findings are diagnosis of SCC exhibiting the rare signet ring histologic subtype"; deep margin positive for tumor but peripheral margins clear;".

Answer

SCC of skin, signet ring cell type, is not reportable to SEER. SCC's of skin classifiable to 8050-8084 are not reportable to SEER. See page 11 in the SEER manual, http://seer.cancer.gov/manuals/2015/SPCSM_2015_maindoc.pdf

Signet ring is a rare histological variant of SCC and is coded to 8070/3 according to the WHO classification for skin tumors.

Date Finalized

09/21/2015

20150038

Question
Reportability/MP/H Rules/Histology: Is malignant perivascular epithelioid cell tumor (PEComa) reportable, and if so, what is the histology code?

Answer
Malignant perivascular epithelioid cell tumor (PEComa) is reportable because it is malignant. Assign 8005/3 to malignant PEComa.

We consulted an ICD-O-3 expert who explained that some PEComas such as angiomyolipoma and lymphangiomyomatosis have specific ICD-O codes and their malignant counterparts may be coded to 8860/3 and 9174/3 respectively. There are no separate ICD-O codes for other specific PEComas, e.g., clear cell "sugar" tumor of lung, clear cell myomelanocytic tumor of the falciform ligament and some "unusual" clear cell tumors occurring in other organs—or for PEComa, NOS. These PEComas may therefore be coded to 8005 as clear cell tumors NOS; in other words as clear cell tumors that are not clear cell variants of carcinomas, sarcomas, or other specific tumor type.

Please note, PEComa is non-specific as to behavior. Unless the pathologist states that it is malignant, (as was the case for this question), the default code is 8005/1 (non-reportable).

Date Finalized
09/21/2015

20150037

Question

Reportablility--Breast: Is lobular neoplasia reportable as lobular carcinoma in situ? See Discussion.

Discussion

According to College of American Pathologists (CAP), lobular neoplasia is also known as lobular carcinoma in situ. In a previous SEER question 20041089, it was stated that they were not the same and should not be reported unless it was a Grade 3. I assume this has changed and we are to report lobular neoplasia as lobular carcinoma in situ, is this correct?

Answer

According to the WHO classification of breast tumors, "lobular neoplasia (LN) refers to the entire spectrum of atypical epithelial lesions originating in the terminal-duct lobular unit…" Report the case when lobular carcinoma in situ (LCIS) is stated. When LN or lobular intraepithelial neoplasia (LIN) are described using the three-grade system, report LN/LIN grade 3. Only LN/LIN grade 3 is reportable since those terms are analogous to ductal intraepithelial neoplasia grade 3 (See Intraepithelial neoplasia 3, ductal in ICD-O-3). WHO Classifications of Tumors are the preferred references for questions like this.

Date Finalized

09/21/2015

20150036

Question

Reportability/MP/H--Kidney: "Multilocular clear cell renal cell carcinoma." Would this be coded 8310? See discussion.

Discussion

Multilocular clear cell renal cell carcinoma is a specific histologic type listed in the CAP cancer protocol for kidney, but not in the ICD-O-3 and it is not on the list of specific types of renal cell carcinomas in Table 1 of the kidney equivalent terms and definitions in the MP/H manual. There is a malignant multilocular cystic nephroma 8959 in Table 1, but I can't tell if this the same histology as what is stated in this path report.

Answer

Apply Kidney rule H5 and code the clear cell (8310/3) which is the specific type of renal cell. Multilocular is a variant of clear cell which is a variant of renal cell carcinoma. As of yet, no new ICD-O morphology code has been proposed for this specific histology. It will be addressed in the revised rules.

Date Finalized

09/21/2015

20150035

Question

Primary site--Anus/Anal Canal: What site do you code squamous cell carcinoma of the anal verge?

Answer

Assign C211 for anal verge. Anal verge is defined as the lower (distal) end of the anal canal, junction between the skin of the anal canal and the perianal skin, http://www.seer.cancer.gov/manuals/2015/AppendixC/rectosigmoid/coding_guidelines.pdf

Date Finalized

09/21/2015

20150034

Question
MP/H/Histology/neuroendocrine : How should the following histologies with neuroendocrine differentiation be coded?

1. Bladder - Invasive urothelial carcinoma with neuroendocrine differentiation

2. Nasopharnyx - Undifferentiated nonkeratinizing nasopharyngeal carcinoma with neuroendocrine differentiation

3. Ductal carcinoma in situ (with neuroendocrine features) cribriform and solid patterns

See discussion.

Discussion
We are starting to see more specific histologies with neuroendocrine differentiation. How are we to deal with these histologies and will this be addressed in the revised MP/H rules?

Answer
The term neuroendocrine is often included with other histologies and usually means that neuroendocrine cells are present but not neuroendocrine tumor.

1. If the neuroendocrine cells are stated to be either small cell or large cell, code that histology; however, neuroendocrine, NOS mixed with urothelial does not have an applicable mixed code. Code histology to 8120.

2. Code histology to squamous cell carcinoma, nonkeratinizing, NOS (8072/3). The neuroendocrine component is not specified as either small cell or large cell.

3. Code to 8523/2 per MP/H Rule H6 as intraductal mixed with other types of carcinoma present.

Note that while neuroendocrine differentiation can be identified, it seems to have no prognostic implications. We have consulted with our site specific Subject Matter Experts on how best to capture neuroendocrine, NOS when combined with other histologies. These instructions will be included in the revision of the MP/H rules including the wording of MP/H breast rule H6.

Date Finalized
09/21/2015

20150033

Question

MP/H/Histology--Lung: Would you code a lung primary of "non-small cell carcinoma with neuroendocrine differentiation" to non-small cell carcinoma (8046/3) or carcinoma with neuroendocrine differentiation (8574/3)? See discussion.

Discussion

The pathology report states "Right mediastinal mass: poorly differentiated non-small cell carcinoma with neuroendocrine differentiation." This is the only histologic confirmation of this lung primary that is collected.

Answer

Code carcinoma with neuroendocrine differentiation (8574/3). MP/H rule H7 applies: code the higher ICD-O-3 code. There is non-small cell lung carcinoma (8046/3) and a carcinoma, NOS with neuroendocrine differentiation present (8574/3).

Date Finalized

09/22/2015

20150032

Question

MP/H/Multiple Primaries--Lung: When using the Lung Multiple Primary rules, Rule M6 (single tumor in each lung), are nodules to be interpreted as tumors or are they tumors only if they are stated to be suspicious for malignancy or another term that constitutes a diagnosis? MRI states: "multiple subcentimeter pulmonary nodules."

Answer

Per the Lung Equivalent Terms & Definitions, 'nodule' is not equivalent to tumor, mass, lesion, or neoplasm when determining multiple primaries. Do not assume the nodules are malignant unless stated by the physician(s).

Date Finalized

09/21/2015

20150031

Question

MP/H Rules/Multiple primaries--Colon: This is an unusual case of multifocal colon cancer. The case is staged pT4b,N1b. Per our MP rules, this will be 4 separate primaries. Would this be an exception to the rules; if not now, possibly in future versions of the MP rules for colon cancer? See discussion.

Discussion

The path report reads: COMMENT: There is multifocal involvement throughout both bowel segments which combined represent a subtotal colectomy procedure. There are at least 11 tumors, all of which are histologically similar. Given the unusual gross appearance, a representative portion of the largest mass (hepatic flexure) was forwarded to _____ for flow cytometric evaluation. There is chronic active colitis in the background suggestive of idiopathic inflammatory bowel disease, specifically ulcerative colitis. However, no dysplasia is seen in multiple random sections of grossly benign large bowel. ADDENDUM from expert gastroenterologist: The carcinomas are poorly differentiated without specific histologic features but are consistent with colon primaries. These findings are consistent with an MLH1-deficient carcinoma. Given the background chronic active colitis consistent with ulcerative colitis, this likely represents colitis-associated neoplasia which can be associated with multifocality.

Answer

This unusual case of multifocal colon cancer is not an exception to the MP/H rules currently.

The current WHO classification for colon tumors mentions ulcerative colitis (UC) associated colorectal cancers and states they are often multiple. This will be discussed for the next version of the MP/H rules.

Date Finalized

09/21/2015

20150030

Question

First course treatment--Surgical procedure of other sites: How is this field coded when the patient undergoes a lung wedge resection for a pulmonary nodule that was never definitively or was ambiguously stated to be a metastasis? See Discussion.

Discussion

The patient was diagnosed with a carcinoid tumor of the small intestine. The pre-surgical work-up also identified a lung nodule that showed no octreotide uptake, but was indeterminate on biopsy. The imaging differential diagnosis included carcinoid, hamartoma, or a non-calcified granuloma. The patient underwent a resection of the primary small bowel tumor, and the physician noted the lung nodule was of unclear diagnosis. The physician stated a solitary lung metastasis would be atypical, but that lung metastatic involvement could not be ruled out. The physician recommended resection of the lung nodule to ensure that the patient was disease free. The lung wedge resection proved a pulmonary hamartoma.

The rules for coding Surgical Procedure of Other Site are not entirely clear. The definitions for First Course of Therapy in the SEER Manual do state that treatment includes, "Procedures that destroy or modify primary (primary site) or secondary (metastatic) cancer tissue." This would seem to exclude the lung resection as it did not destroy, modify or remove metastatic cancer tissue. However, the instructions for coding Surgical Procedure of Other Site do not address removal of distant sites that are not incidental. The lung resection was not incidental; the physician recommended it to ensure the lung was not involved, but it also disproved metastatic involvement. Should the Surgical Procedure of Other Site field be coded 0 (none) or 4 (non-primary surgical procedure to distant site) in this case?

Answer

Code 0 for Surgical Procedure of Other Site in this case. The Surgical Procedure of Other Site field is used to capture surgery to destroy or modify cancer tissue that is not captured in other surgery fields.

Date Finalized

08/27/2015

20150029

Question
First course treatment/Hormone Therapy--Lung: How is this field coded when the patient receives Prednisone for a metastatic lung adenocarcinoma? See Discussion.

Discussion
The SEER*Rx Database, Prednisone Primary Site indicates "Prednisone is used to treat multiple sites and histologies." The Remarks information states, "Prednisone may be coded as treatment (hormonal) for all sites and histologies. It is most often used as part of a drug regimen." While it is clear that Prednisone is coded as hormone therapy when administered as part of a drug regimen like CHOP, how is Prednisone coded when given outside of a drug regimen? Also, how is Prednisone coded for cancer-directed treatment of a metastatic lung primary? The NCI's PDQ does not list hormone therapy as cancer-directed treatment for a Stage IV lung adenocarcinoma.

In our specific case, Prednisone was started just after diagnosis, and before the completion of work-up proving distant metastasis. Often, Prednisone (or another hormone agent) is given as an ancillary treatment for the symptoms associated with the malignancy, and not as cancer-directed treatment.

Answer

Do not code Prednisone when it is given for symptoms. In most cases when Prednisone is given by itself, not as part of a drug regimen, it does not affect the cancer and would not be coded as treatment.

Date Finalized
08/27/2015

20150028

Question

MP/H Rules/Histology--Head & Neck: Please clarify rule H3. The first statement is "Do not code terms that do not appear in the histology description". The second statement is "Do not code...unless the words...appear in the final diagnosis"

One of our pathology labs frequently will state "keratinizing squamous cell" in the microscopic description (histologic description), but only state "squamous cell carcinoma" in the final diagnosis. May we code from the histologic description if it's not in the final diagnosis?

Answer

Follow rule H3 and code squamous cell carcinoma for these cases unless you can obtain confirmation that these cases should be coded keratinizing squamous cell carcinoma from the lab and/or pathologist. Document this confirmation in your policies and procedures.

The MP/H rules were written with input from leading pathologists in each specialty area. Based on their expert opinion, we instruct registrars to code histology based on the information in the final diagnosis. The microscopic description may contain other terms, but the pathologist lists only the pertinent terms in the final diagnosis.

Date Finalized

08/18/2015

20150027

Question
Date of diagnosis--Diagnostic confirmation: How are the diagnosis date and diagnostic confirmation coded when the pathology (needle biopsy followed by resection) reports GIST, NOS and the physician subsequently states this is a malignant GIST and treats the patient for a malignancy? See Discussion.

Discussion
Pathologists rarely diagnose a GIST as a malignant tumor. Per the AJCC, GISTs encompass a continuum in terms of biologic potential, with larger more mitotically active tumors landing on the "histologically sarcomatous" or malignant end of the spectrum. Because the pathologists generally do not categorize these tumors as benign or malignant, the judgement is typically made by the clinician in light of all the clinical and pathologic findings. Unless there are obvious distant metastases, the clinician usually decides whether a GIST is malignant and treats the patient as such.

In the case above, the patient underwent a gastric biopsy on 04/10/2014 that showed GIST. The subsequent resection on 04/12/2014 showed a 4.5 cm GIST, spindle cell type with 6 mitoses/5 square mm. The resection pathology report does not indicate the GIST is malignant, but does identify a large tumor with mitotic activity. After reviewing the evidence in this case, the clinician calls this a malignant GIST on 04/29/2014 and starts the patient on Gleevec.

Although neither the biopsy nor the resection call this a malignant tumor, should the date the GIST was first diagnosed (biopsy on 04/10/2014) be used to code the diagnosis date, since this is the date the tumor (ultimately felt to be malignant) was diagnosed? If the diagnosis date is coded as the date malignant GIST was first mentioned (04/29/2014), this would exclude surgery as treatment for this tumor.

Would this be a histologic diagnosis because the tumor was histologically confirmed to be GIST? Or must this be a clinical diagnosis because the diagnosis of malignancy was only made clinically (by the clinician's review of the clinical and pathologic findings)?

Answer
Code the diagnosis date for this case as 04/10/2014. Code the diagnostic confirmation as histologically confirmed. The clinician is using all of the information available to determine the diagnosis, including the biopsy and resection.

Date Finalized
07/27/2015

20150026

Question

First course treatment--Breast: When Lupron is given as cancer-directed treatment for metastatic breast cancer, should it be coded as Hormone Therapy or Other Therapy? See Discussion.

Discussion

Per the SEER*Rx Database, Lupron is coded as Other Therapy for breast cancer until such time that it receives FDA approval. However, SINQ 20021042 states Lupron should be coded as Hormone Therapy when given as cancer-directed therapy. These two sources contradict each other.

Information regarding hormone therapy for breast cancer in both the SEER*Rx Database and the National Cancer Institute's Cancer Topics website (http://www.cancer.gov/types/breast/breast-hormone-therapy-fact-sheet) seem to indicate that the SINQ answer is the correct choice. The NCI Cancer Topics website states that Lupron acts to block ovarian function and is an example of an ovarian suppression drug that has been approved by the FDA. The SEER*Rx Database Remarks section states that a combination of letrozole and leuprolide (Lupron) "is considered standard treatment for metastatic breast cancer and is sometimes used for treatment of early stage breast cancer." But the Remarks go on to state that Lupron should be coded as Other Therapy until it receives FDA approval.

It is unclear how to code Lupron for breast cancers when the NCI website indicates that it is standard treatment while the SEER*Rx Database states both that it is and that it is not standard treatment.

Answer

Code Lupron given for breast cancer in the "Other" treatment field using code 6 (other-unproven). Lupron is still not an approved hormone treatment for breast cancer and should not be coded in the hormone field.

Date Finalized

07/29/2015

20150025

Question

Primary Site--Lung: What are the guidelines for coding primary site when a lung tumor is described as a hilar mass? See discussion.

Discussion

At a recent meeting, one registry stated that they apply the following guidelines.
1) If the tumor is described as a hilar mass and there is no mention of LN involvement, Primary Site is coded to hilum (C340)
2) If there is LN involvement along with the mention of a hilar mass, then Primary Site is coded to C349

Answer

Assign primary site code C340 when a lung tumor is described as a hilar mass.

Date Finalized

07/27/2015

20150024

Question
Surgery of Primary Site--Breast: How should the Surgery of Primary Site field be coded when a patient has a lumpectomy and an additional margin excision during the same procedure? See discussion.

Discussion
Operative report indicates a wire localized lumpectomy was performed. The pathology report includes a final diagnosis for two specimens as follows:

A) LEFT BREAST, EXCISION: INFILTRATING DUCTAL CARCINOMA
B) LEFT BREAST, NEW DEEP MARGIN, EXCISION: BENIGN BREAST TISSUES AND BENIGN FIBROFATTY SOFT TISSUES; NO EVIDENCE OF NEOPLASIA.

The definition for Breast surgery code 23 is "Re-excision of the biopsy site for gross or microscopic residual disease". There is no indication whether the re-excision has to be a separate procedure or can be during the same procedure as the excisional biopsy (lumpectomy). Some hospital registrars in our region believe code 22 is more appropriate.

Answer
Assign code 23 when a patient has a lumpectomy and an additional margin excision during the same procedure.

Date Finalized
07/27/2015

20150023

Question

MP/H Rules/Histology--Thyroid: When is 8341/3, papillary microcarcinoma coded? The code description in ICD-O-3 is followed by (C739), yet there are two SINQ answers that tell us specifically to not use this code for thyroid primaries. Even the first revision of ICD-O-3 still carries the (C739) as part of this code, which goes against SINQ 20110027 and 20081127.

Answer

Per the WHO Tumors of Endocrine Organs, for thyroid primaries/cancer only, the term micropapillary does not refer to a specific histologic type. It means that the papillary portion of the tumor is minimal or occult (1cm or less in diameter) and was found incidentally. WHO does not recognize the code 8341 and classifies papillary microcarcinoma of the thyroid as a variant of papillary thyroid and thereby should be coded to 8260. If the primary is thyroid and the pathology states papillary microcarcinoma or micropapillary carcinoma, code 8260 is correct. This information will be included in the upcoming revisions to the MP/H manual.

Date Finalized

07/27/2015

20150022

Question

Grade--Bladder: Do you use the grade stated on the pathology report for coding the grade/differentiation field for bladder and renal pelvis field? See discussion.

Discussion

Please confirm correct coding for grade for papillary urothelial carcinoma of the bladder/renal pelvis and urothelial carcinoma of the bladder/renal pelvis. SEER Manual 2014 and 2015 state: "Do not use these tables to code grade for any other groups including WHO (CNS tumors), WHO/ISUP (bladder, renal pelvis), or FIGO (female gynecologic sites) grades." They also state "In transitional cell carcinoma for bladder, the terminology high grade TCC and low grade TCC are coded in the two-grade system" in the Grade section. These statements are not included in SEER Manuals prior to 2014.

Answer

Use the grade stated on the pathology report to code grade/differentiation for bladder and renal pelvis field unless the grade is stated to be WHO/ISUP grade.

Date Finalized

07/27/2015

20150021

Question
MP/H Rules/Histology--Skin: How is histology coded for an "endocrine mucin-producing sweat gland carcinoma with transformation to mucinous carcinoma"? See Discussion.

Discussion
Endocrine mucin-producing sweat gland carcinoma (EMPSCG) is a rare type of low-grade sweat gland carcinoma. Some journal articles indicate that most patients with EMPSCG have coexisting mucinous carcinomas, suggesting that EMPSCG is a precursor to invasive mucinous carcinoma of the skin. Sweat gland carcinoma has its own histology code per the ICD-O-3 (8400/3); should an endocrine mucin-producing sweat gland carcinoma also be coded as 8400/3? If so, would the correct histology for the skin case above be mucinous carcinoma (8480/3) per Rule H17? Conversely, if the terms "mucin-producing" are referring to mucin-producing carcinoma, and not referring to the sweat gland carcinoma, would the histology be coded 8481/3 (mucin-producing carcinoma)?

Answer
Assign 8480/3.

There is no mixed ICD-O-3 code for EMPSCG. Both histologies are in the mucinous family: mucinous adenocarcinoma (8480/3) and sweat gland carcinoma (8400/3). Apply “Other” sites rule H17 and code the numerically higher ICD-O-3 code (8480/3).

Endocrine mucin-producing sweat gland carcinoma (EMPSGC) is a rare low-grade sweat gland carcinoma with a strong predilection to the eyelid region. It is histologically analogous to endocrine ductal carcinoma/solid papillary carcinoma of the breast and is characterized by a multinodular solid cystic mucinous tumor with immunoreactivity to neuroendocrine markers. Only 20 cases of this unusual tumor have been reported.

Date Finalized
06/25/2015

20150019

Question

Reportability/Histology--Pancreas: Is well-differentiated neuroendocrine tumor (M8240/3) as stated on a pathology report reportable or can the clinical information be used as an adjunct to the path report, which further states the specific type of neuroendocrine tumor is an Insulinoma, therefore, NOT reportable (M8151/0)? See discussion.

Discussion

The diagnosis date is 2/24/14. The pathology report of the pancreas shows: Well-differentiated neuroendocrine tumor (NET), low grade (WHO G1 of 3). Addendum: Ki-67 confirms low grade of pancreatic endocrine tumor (less than 2% Ki-67/MIB-1 index). Chromogranin confirms the endocrine nature of the tumor. The Pre and Post Op Diagnosis is pancreatic neuroendocrine tumor consistent with insulinoma. AJCC Stage as noted on path report: pT1, pNX, pM.

The physician states: The patient has a well-documented insulinoma. Biochemistries confirmed the disease and it is localized in the tail of the pancreas.

The issue with NETs is that pathology report reflects what is seen or what is quantified under the microscope; often, there is a specimen without the accompanying medical history and clinical signs. Many of these NETs are specified on the basis of the hormone, as usually measured in the blood, which is overproduced, something not seen microscopically. All of the islet cell tumors are NETs. The insulinoma in the example above is a well-differentiated NET that is causing insulin to be over-produced. Thus, the diagnoses are not discordant; insulinoma is a more specific NET.

Answer

When the pathology diagnosis is a neuroendocrine tumor (/3) and the clinical diagnosis is an insulinoma (/0), report the case. Although ICD-O-3 classifies insulinoma as /0, the most recent WHO classification lists it as /3. The pathologist and physicians for this case are likely guided by the WHO classification and as a result, would view both the NET diagnosis and the insulinoma diagnosis as malignant. You could report this case as 8240/3 or 8151/3.

Date Finalized

06/25/2015

20150018

Question

First course of treatment--Immunotherapy: Should Rituxan be coded to immunotherapy? See discussion.

Discussion

Is the instruction under #4.b. on page 114 of the 2014 SEER Program Coding and Staging Manual incorrect? It says to code Rituxan as chemotherapy.

Answer

Rituxan changed categories from chemotherapy to a biologic therapy/Immunotherapy agent effective with cases diagnosed January 1, 2013. See page 150 or page 164 in the 2015 SEER manual. The instruction in the 2014 SEER manual was incorrect regarding Rituxan.

Date Finalized

06/25/2015

20150017

Question

MP/H Rules/Histology--Head and Neck: What is the histology code for salivary duct carcinoma of parotid gland?

Answer

Code salivary duct carcinoma to invasive ductal carcinoma (8500/3). Salivary duct carcinoma is an aggressive adenocarcinoma which resembles high-grade breast ductal carcinoma according to the WHO Classification of Tumors of Head & Neck.

Date Finalized

06/25/2015

20150016

Question

Reportability--Stomach: Is a well-differentiated neuroendocrine tumor of the stomach reportable?

Answer

Well-differentiated neuroendocrine tumor (NET) of the stomach is reportable. The WHO classification of digestive system tumors uses the term NET G1 (grade 1) as a synonym for carcinoid and well-differentiated NET, 8240/3.

Date Finalized

06/25/2015

20150015

Question

Primary Site--Testis: What is the primary site for a 38 y/o male diagnosed with testicular cancer in a formerly undescended testis that was treated with orchiopexy at age 10-11? See discussion.

Discussion

Should it be coded to where the testis was physically at the time of diagnosis (C621), or should it be coded to C620 to reflect the increased risk for developing malignancy in an undescended testis?

Answer

Code the primary site C621 (descended testis). The primary site of this neoplasm is a scrotal (descended) testis. The history of orchiopexy can be noted in a text field, but does not change the primary site in this case.

Date Finalized

06/25/2015

20150014

Question

Reportability--Brain and CNS: Is "Lhermitte-Duclos disease" is reportable? See discussion.

Discussion

The MRI states "Lhermitte-Duclos disease" but does not include "dysplastic gangliocytoma of cerebellum"; is this the same as "Lhermitte-Duclos dysplastic gangliocytoma of cerebellum (C716)"?

Answer

"Lhermitte-Duclos disease" alone can be interpreted as "Lhermitte-Duclos dysplastic gangliocytoma of cerebellum (C716)" and reportable. The WHO classification for CNS tumors lists this entity as "Dysplastic gangliocytoma of the cerebellum (Lhermitte-Duclos disease)" signifying that the terms are used synonymously.

Date Finalized

06/25/2015

20150013

Question

Surgery of Primary Site: What is the most extensive, invasive or definitive surgical procedure when the second surgical procedure performed has a lower surgery code? See discussion.

Discussion

Examples:

8/xx/13 TURBT with path specimen (27): Papillary Urothelial Carcinoma, HG 9/xx/13 Bladder fulguration w/o path specimen (12)

5/xx/14 Segmental Mastectomy(24): Ductal carcinoma with <1mm margin 6/xx/14 Breast Re-excision (23): Residual ductal carcinoma 1.5mm, margin negative.

Answer

The code in Surgical Procedure of Primary Site should correspond to the most **invasive, extensive, or definitive** surgery when the patient has multiple surgical procedures of the primary site even if there is no residual tumor found in the pathologic specimen from the more extensive surgery. The timing of the procedures does not affect the code choice.

Assign code 27 for the first example. Assign code 24 for the second example.

Date Finalized

06/25/2015