20140089

Question

Multiple primaries--Heme & Lymphoid Neoplasms: Should the 2014 diagnosis be abstracted as a new primary since it is not mantle cell lymphoma and all of the types listed in the differential diagnosis would be a new primary? See discussion.

Discussion

Mantle cell lymphoma diagnosed in 1997 which was treated with chemotherapy. Now in 2014 a 'relapse' of non-Hodgkin lymphoma. They do a biopsy of the pericardium, which is called low grade B cell non Hodgkin lymphoma. See comment. The comment says histochemical stains are reviewed and findings are consistent with involvement by a CD5 positive low grade B cell lymphoma. Lack of cyclin D1 and SOX-11 positivity as well as negative IGH-CCND1 FISH analysis essentially rule out mantle cell lymphoma. The morphologic and immunophenotypic features of this disorder are not specific for any lymphoma subtype. The differential includes CLL, marginal zone lymphoma, and lymphoplasmacytic lymphoma. If this is coded NHL, NOS (9591) it is the same primary as seq. 1 and would not be abstracted.

Answer

This is the same primary, the mantle cell lymphoma.

Differential diagnoses cannot be used to assign histology. For the 2014 diagnosis, the only histology that can be assigned is 9591/3 for non-Hodgkin lymphoma, NOS. (CLL, mantle cell lymphoma and lymphoplasmacytic lymphoma are all NHL's.)

Compare the 1997 diagnosis of mantle cell lymphoma with the 2014 diagnosis of non-Hodgkin lymphoma. Start with Rule M1. The first rule that applies is Rule M15, which instructs you to use the multiple primaries calculator. Enter 9673/3 and then 9591/3 and then calculate. The result is same primary.

If at a later time one of the differential diagnoses is confirmed, apply the rules again.

Date Finalized
12/18/2014

20140088

Question

Reportability--GIST: The 2014 SEER Program Coding and Staging Manual and the answer to SINQ 20100014 appear to conflict with respect to reporting GIST cases. The manual states (p.5, exception 1) that we are to accession the case if the patient is treated for cancer. However, the patient in Example #7 in the SINQ discussion is receiving chemotherapy, but is deemed not reportable. This is a problematic issue in our area, as pathologists prefer using the NCCN "Risk Stratification of Primary GIST by Mitotic Index, Size and Site" table rather than stating whether the tumor is benign or malignant. Although they tell us that moderate or high risk should receive treatment, they will not characterize them as malignant.

Answer

Determining reportability for GIST is problematic because of the reluctance of pathologists to use the term "malignant" for GIST cases. If you can document the pathologist's terminology and case characteristics (e.g. treatment) that correspond to "malignant" for your registry as part of the registry's policies and procedures, you can report those cases as malignant.

The exception cited above in the SEER manual pertains to a clinical diagnosis with a negative pathology report. Normally, the negative pathology report would override the clinical diagnosis and the case would not be reportable. However, if the patient is treated for a malignancy in spite of the negative pathology, report the case.

Date Finalized

12/18/2014

20140087

Question

MP/H Rules/Multiple primaries--Ampulla of vater: Is this a new primary? Patient has intramucosal adenocarcinoma in a tubulovillous adenoma of the ampula of vater in Sept. of 2011. In May of 2012, patient has another ampullary adenoma with intraepithelial carcinoma (pTis) and an area suspicious for invasion. This is coded 8263/3.

Rule M14, Multiple in situ and/or malignant polyps are a single primary, precedes rule M15, An invasive tumor following an in situ tumor more than 60 days after diagnosis is a multiple primary, per the MP rules for 'Other sites',

Answer

Rule M14 applies. Abstract this case as a single primary.

Date Finalized

12/18/2014

20140086

Question

MP/H Rules/Multiple primaries--Colon: Does rule M7 apply here (A frank malignant or in situ adenocarcinoma and an in situ or malignant tumor in a polyp are a single primary)? Can the frank malignant adenocarcinoma be any specific type of adenocarcinoma for this rule to apply?

A patient has 2 synchronous tumors in the ascending colon. The first is grade 3 adenocarcinoma with signet ring differentiation and focal mucinous features (8255/3). The second is grade 2-3 adenocarcinoma in a tubulovillous adenoma (8263/3).

Answer

M7 applies to this case. The frank adenocarcinoma can be a specific type of adenocarcinoma.

Date Finalized

12/18/2014

20140084

Question

Histology--Heme & Lymphoid Neoplasms: Should the 1995 diagnosis be changed to plasmacytoma? A 1995 case on the central registry database indicates that MRI and bone surveys revealed a pubic ramus lesion that was biopsied. There are no other bone lesions. A bone marrow biopsy was negative. The pathologist's diagnosis at that time was "Plasma Cell Myeloma". In 2013 there was a positive bone marrow biopsy and a diagnosis of Plasma Cell Myeloma. In 2013, a history of "sequential plasmacytomas since 1995" was mentioned. Since the 1995 diagnosis was only a solitary bone lesion with no marrow involvement, it certainly seems to fit a diagnosis of plasmacytoma better than myeloma.

Answer

Do not change the 1995 diagnosis in this case. It is best to code the histology according to information from the time of the diagnosis. Using information obtained many years later is less reliable.

Date Finalized

11/26/2014

20140083

Question

MP/H Rules/Multiple primaries--Thyroid: How many primaries should be reported when a complete thyroidectomy specimen shows two tumors: 1.8 cm papillary carcinoma with tall cell features (8344/3) and a 0.4 cm papillary thyroid carcinoma (8260/3)? See discussion.

Discussion

Is papillary thyroid carcinoma an NOS histology qualifying for rule M16, thus leading to a single primary, or would M17 apply (multiple primaries) because the histology codes are different at the second digit (8260 and 8344)? While rule M16 doesn't include papillary thyroid carcinoma in the listed histologies, it seems like it may be an NOS histology for the thyroid. In addition, code 8260/3 is listed as NOS in the ICD-O-3.

Answer

Apply rule M16 and abstract a single primary. These two thyroid tumors, one papillary carcinoma with tall cell features (8344/3) and one papillary thyroid carcinoma, fit the criteria for rule M16, although not explicitly listed there. We will clarify this in the next version of the rules.

Date Finalized

11/26/2014

20140082

Question

MP/H Rules/Histology--Testis: How should histology be coded for a testicular teratoma with somatic type malignancy (adenocarcinoma)? See discussion.

Discussion

11/8/2013 Rt orchiectomy: teratoma with somatic type malignancy (adenocarcinoma).
5/2/2014 Abdominal mass excision: metastatic teratoma involving matted lymph nodes.
Patient age at diagnosis is 31.

Per web search, a teratoma with somatic type malignancy is a rare type of tumor. Should the histology be coded to 8140/3? This seems to conflict with SINQ 20120085, which indicates a testicular mature teratoma in an adult is malignant, and in this example, it was also the portion of tumor that metastasized.

Answer

Assign code 9084/3, listed in ICDO as teratoma with malignant transformation.

Our expert pathologist consultant states that this is a very rare situation. The non-germ cell components are believed to arise out of the teratoma portions, and are seen in only of few percent of teratomas. They are given the designation "teratoma with somatic type malignancies" (WHO).

Date Finalized

11/13/2014

20140081

Question

Reportability/Histology--Heme & Lymphoid Neoplasms: Is primary erythrocytosis equivalent to primary polycythemia and thus reportable? See discussion.

Discussion

Per the Heme Manual, Appendix F - Non-Reportable list for Heme Diseases, under Polycythemia, the Comment states that polycythemia is also known as erythrocytosis. Because polycythemia is equivalent to erythrocytosis, can we assume that "primary erythrocytosis" is equivalent to "primary polycythemia" and thus reportable as 9950/3 per the Heme DB? Or is the case non-reportable because the exact term of "primary erythrocytosis" is not listed as an alternate name for polycythemia vera, only "primary polycythemia" is listed?

Answer

Primary erythrocytosis is not equivalent to primary polycythemia and is not reportable. This will be clarified in a future revision. Thank you for point it out to us.

Date Finalized

11/13/2014

20140074

Question

Surgery of Primary Site--Brain and CNS: What procedure code would be used for NeuroBlate Laser Interstitial Thermal Therapy? This procedure was used for a Glioblastoma of the brain.

Answer

If a pathologic specimen is not taken during this procedure, code in the surgery field using code 10 (Local tumor destruction, NOS). If specimen is sent to pathology, code 90, surgery, NOS. We will request this procedure be included in future treatment field coding documentation.

Our research notes that this procedure, also known as LITT (Laser Interstitial Thermal Therapy), is a surgical treatment. Lasers transmit heat to coagulate or destroy the brain tumors from the inside out.

Date Finalized

11/26/2014

20140072

Question

Reportability--Head & Neck: Would this be reportable and if so what histology would be coded? Soft tissue mass left cheek excision reveals Carcinoma Ex Pleomorphic Adenoma Non-Invasive with focal vascular invasion. Margins clear.

Answer

Carcinoma ex pleomorphic adenoma (Ca-ex-PA) is reportable. Assign 8941/3. The WHO classification of head and neck tumors defines Ca-ex-PA as an epithelial malignancy arising in a benign pleomorphic adenoma. Most of these originate in the parotid gland but can also arise in other salivary glands.

Date Finalized

11/26/2014

20140071

Question

Reportability--Lung: One of our facilities has a case they are not really sure how to report.

This patient came in for a double lung transplant due to COPD which occurred on 1/27/14. At time of transplant, the team found out the donor hospital had identified a small nodule in the right lower lobe donor lung, which they biopsied and deemed negative. However, the slides were reviewed and felt to represent adenocarcinoma. The team performed a right lower lobe lobectomy of the donor lung before transplanting into the patient.

So, we are not really sure how to handle this case. The adenocarcinoma actually belongs to the donor patient from another hospital, however, they actually didn't identify it at that facility as their pathology was negative for a malignancy.

Answer

This very interesting case is not reportable to either facility. Since the right lower lobe nodule was resected prior to transplantation, the case does not belong to your patient. Ideally, the cancer should be assigned to the donor; however, donor information is confidential.

Date Finalized

11/26/2014

20140070

Question

Reportability--Pancreas: Is this reportable? Is this benign? If reportable, what histology code and behavior code should be used? A final pathology diagnosis reads: "Cystic pancreatic endocrine neoplasm (CPEN)".

Answer

"Cystic pancreatic endocrine neoplasm (CPEN)" is reportable. Assign 8150/3 based on the information provided. We consulted our expert pathologist and he states "Since metastases have been reported in a few, and all the rest of the pancreatic endocrine tumors are now designated malignant, we are safe considering them /3 until proven otherwise. Since most of them are non-functioning, [assign code] 8150/3 unless specified as to G1 (8240/3) or G2 (8249/3)."

Date Finalized

12/10/2014

20140069

Question

MP/H Rules/Histology--Kidney, renal pelvis: How would you code this histology: Renal cell carcinoma, clear and eosinophilic cell type?

Answer

Kidney rule H5 applies, code the more specific histology which is clear cell renal cell carcinoma (8310/3). Per the WHO Tumors of the Urinary System, clear cell renal cell carcinoma contains both clear and eosinophilic cytoplasm. Eosinophilic is not a type or variant of renal cell carcinoma.

Date Finalized

11/26/2014

20140068

Question

Surgery of Primary Site--Corpus uteri: What is the correct surgery code to assign for dilation and curettage (D&C) for an in-situ endometrium (C541) primary? The code to use for the cervix uteri (C530-C539) is specified, but not for the corpus uteri (C540-C549).

Answer

Assign code 20 for endometrial D&C for in situ cancer of endometrium.

Date Finalized

11/26/2014

20140067

Question

MP/H/Histology--Kidney, renal pelvis: What is the histology code for renal cell carcinoma translocation type?

Answer

Code renal cell carcinoma translocation type as renal cell carcinoma, NOS, 8312. While WHO recognizes renal cell carcinomas with associated translocations, there is no specific ICD-O-3 code for this variant of renal cell carcinoma.

Date Finalized

11/26/2014

20140066

Question

First course treatment: When a patient has a Haplo bone marrow transplant, is this coded as an allogenic bone marrow transplant since part of his marrow was used in addition to a donor?

Answer

Use code 12 in the Hematologic Transplant & Endocrine Procedures data field. Per the NCI, this procedure is an allogeneic transplant.

Rather than wiping out a patient's immune system before transplanting donor bone marrow, doctors administer just enough chemotherapy to suppress the immune system, which keeps patients from rejecting the donated marrow without harming their organs. The procedure requires just a half-match, meaning that a patient's parents or children could be suitable donors. AKA: Half-match transplants.

Date Finalized

11/26/2014

20140059

Question

Primary site--Bladder: What is the primary site for bladder tumor biopsy: invasive adenocarcinoma, enteric type favor urachal origin, stage III

Answer

Based on the information provided, code the primary site to urachus (C677). Primary adenocarcinoma of the bladder accounts for less than 1% of all bladder malignancies. Of these, 20–39% are urachal in origin.

Date Finalized

11/26/2014

20140058

Question

Reportability--Pancreas: Is a solid pseudopapillary neoplasm of the pancreas reportable?

Answer

Solid pseudopapillary neoplasm of the pancreas is reportable. According to the WHO classification, it is a "low-grade malignant neoplasm [which] frequently undergoes hemorrhagic-cystic degeneration and occurs predominantly in young women."

Date Finalized

11/26/2014

20140057

Question

MP/H Rules/Histology--Bladder: What is the correct histology code for a diagnosis of urothelial plasmacytoma carcinoma of the bladder per pathology report?

Answer

Assign code 8120/3, urothelial carcinoma, NOS, to urothelial plasmacytoma carcinoma of the bladder. The WHO classification describes plasmacytoid variants of urothelial carcinoma. There is no specific ICD-O-3 code for these variants; however, and 8120/3 must be used.

Date Finalized

11/26/2014

20140056

Question

MP/H--Bladder: Are 8130 and rule H12 correct for this case? Bladder with papillary urothelial carcinoma with squamous cell differentiation.

Answer

Rule H8 applies, code the histology with the numerically higher ICD-O-3 code which is papillary transitional cell carcinoma, 8130.

Based on the information provided, there is a single bladder tumor, papillary urothelial carcinoma with squamous cell differentiation. Urinary sites rule H12 does not apply because this is a single tumor, not multiple tumors. In the single tumor H rules, H3 does not apply as this rule does not include ***papillary*** transitional cell carcinoma. Rule H4 is papillary carcinoma or papillary transitional cell carcinoma and refers you to Table 1. Table 1 does not list papillary urothelial carcinoma with squamous cell differentiation because there is no ICD-O-3 code for this histology. Table 1 does list transitional cell carcinoma with squamous differentiation as code 8120, however, the papillary transitional cell carcinoma is the higher code, 8130. We will review this situation for the next version of the rules.

Date Finalized

11/26/2014

20140055

Question

Reportability--Heme & Lymphoid Neoplasms: Is this a reportable case and if so what codes would be used for the primary site and histology?

Lymph node flow cytometry and bone marrow biopsy revealed involvement by a low-grade B-cell lymphoproliferative disorder. Medical oncologist states monoclonal gammopathy, question marginal zone B cell lymphoma versus lymphoplasmacytic lymphoma/lymphoproliferative disorder.

Answer

Based on the information provided, this case is not reportable. Low grade B-cell lymphoproliferative disorder is not reportable, nor is monoclonal gammopathy. There is no definitive diagnosis for marginal zone or lymphoplasmacytic lymphoma. The terminology used includes "question" and "versus" which are not acceptable ambiguous terms for reportability. If possible, follow up with the physician regarding the definitive diagnosis.

Date Finalized

11/26/2014

20140054

Question

MP/H/Multiple primaries--Stomach: How should I report this case? I reviewed both the MP/H and the Heme Rules and could not determine whether or not this case is multiple primaries in a single site but two histologies and therefore needing two separate abstracts.

Path Diagnosis: Gastric Mass Biopsy: 1) Signet Ring Cell Carcinoma. 2) Extranodal Marginal Zone Lymphoma of Mucosa-Associated Lymphoid Tissue (MALT Lymphoma). 3) Mild Intestinal Metaplasia and Marked Fundic Gland Atrophy, Negative for H Pylori. Comments: Biopsy shows presence of both signet ring carcinoma and MALT Lymphoma.

Answer

Report two primaries: MALT lymphoma and signet ring carcinoma. Use the 2007 MP/H rules and the Heme rules for this case.

This case could be an example of a "collision tumor" - two separate tumors that grow together into one mass. Collision tumors are a rare exception to rule M2 in the MP/H rules.

Date Finalized

11/26/2014

20140053

Question

Multiple primaries--Heme & Lymphoid Neoplasms: Is this abstracted as one primary or two?

5/2/13 Bone Marrow biopsy: myelodysplastic syndrome with approaching to acute myeloid leukemia with del 5q and 7q deletions. FISH: deletion of chromosome 5q and deletion of chromosome 7q detected.

I checked the Heme DB manual and there is no term "With approaching to". I checked the Multiple Primary calculator and it says new primary. My interpretation is that the myelodysplastic syndrome is in the process of transforming to acute myeloid leukemia.

Answer

Abstract a single primary, myelodysplastic syndrome with del 5q and 7q deletions (9986/3). This neoplasm can transform to acute myeloid leukemia (AML); however, "with approaching to" cannot be used to report this AML.

Date Finalized

11/26/2014

20140051

Question

Reportability/Histology: Is this reportable? If so, what is the correct histology?

2012 duodenal nodule biopsy, pathology positive for well differentiated neuroendocrine neoplasm.

Answer

Report this case as 8240/3. In this context, well differentiated neuroendocrine neoplasm seems to be a synonym for neuroendocrine tumor (NET) G1 (carcinoid). According to the WHO classification, "Neuroendocrine neoplasms of the duodenum comprise NETs..."

Date Finalized

11/26/2014

20140050

Question

MP/H Rules/Histology--Sarcoma: What would be the morphology code for a low grade myofibroblastic sarcoma of the left distal forearm? I tried several different combinations but the closest I could come up with is myosarcoma.

Answer

Assign code 8825/3. Apply the ICD-O-3 Matrix Concept, Rule F, page 29 of the hardcover ICD-O-3. The WHO Classification of Soft tissue and Bone, page 85, lists low grade myofibroblastic sarcoma, also called myofibrosarcoma, 8825/3.

Date Finalized

11/26/2014

20140049

Question

Reportability--Brain and CNS: Is Tuberculum sellae meningioma reportable? Is it same as sphenoidale meningioma?

Path: Brain tuberculum tumor resection: Meningioma, WHO grade I.

Answer

Yes, a Tuberculum sella meningioma is reportable if diagnosed 2004 or later. Code the primary site C709, meninges, NOS. It is a meningioma originating from the meninges of the Tuberculum sellae, which is part of the sphenoid bone.

Date Finalized

11/26/2014

20140048

Question

MP/H Rules/Histology--Sarcoma: Is 8811/3 the correct code for myxofibrosarcoma (myxoid malignant fibrous histiocytoma) high-grade (grade 3/3)?

Answer

8811/3 is the correct code for myxofibrosarcoma. See Rule J on page 33 in ICD-O-3. Fibromyxosarcoma is equivalent to myxofibrosarcoma.

Date Finalized

11/26/2014

20140047

Question

MP/H/Multiple primaries--Urinary: In Aug 2008 Patient was diagnosed with Noninvasive Bladder Cancer. In Oct 2013 Patient was diagnosed with Transitional Cell Carcinoma of Right Ureter involving lamina propria, Noninvasive Transitional Cell Carcinoma Left Ureter and Invasive Transitional Cell Carcinoma of Prostatic Urethra. Is this a new primary and what is the primary site?

Answer

Rule M7 applies when comparing the 2008 diagnosis to the 2013 diagnosis: multiple primaries.

Rule M8 applies to the tumors identified in 2013: single primary.

Based on the information provided, code the primary site for 2013 to C689 because there is no indication of the site of origin among the involved sites.

Date Finalized

11/26/2014

20140046

Question

MP/H/Multiple Primaries--Urinary: Is this one primary with a C689 primary code and morphology 8130/3? Or is this 2 primaries: 1. C679 8130/3 and 2.C680 8120/2. See discussion.

Discussion

Urinary: Transitional Cell Carcinoma and open prostatectomy: Path from Bladder: Papillary and solid transitional cell carcinoma of bladder - grade II and III Stage A.

Path from prostatectomy: The prostatic tissue samples shows areas of urothelia carcinoma in situ - related to the tumor present in the bladder.

Conclusion: Prostatectomy showing foci of transitional cell carcinoma in situ of prostatic urethra.

Answer

Abstract a single primary, C679 8130/3. Rules M2 and H4 apply. Transitional cell/urothelial carcinoma in the prostatic urethra is likely an extension from the known bladder TCC in this case, not a separate primary. See prostatic urethra on page 63 in the Urinary Terms and Definitions,http://www.seer.cancer.gov/tools/mphrules/mphrules_definitions.pdf

Date Finalized

11/26/2014

20140032

Question

Histology--Breast: Please confirm the morphology code for a diagnosis of "encapsulated papillary carcinoma" of the breast. Several articles on the internet lead me to believe it is the same as an intracystic carcinoma, code 8504/2 (our case shows no evidence of invasion).

Answer

You are correct in coding 8504/2 for this case. Per the 4th Edition WHO Tumors of the Breast, encapsulated papillary carcinoma (EPC) of the breast is synonymous with intracystic or encysted papillary carcinoma. It is traditionally considered a variant of ductal carcinoma in situ (DCIS).

Date Finalized

11/26/2014

20140031

Question

MP/H Rules: Regarding rules for Renal Pelvis, ureters, bladder & urethra - Please clarify Rule M8. Rule M8 references Table 1, but table 1 is a table of histologies not primary sites, Rule M8 also seems to contradict Table 2 and Rule M10. Does it matter where the first primary is, i.e. bladder then urethra or bladder then renal pelvis?

Answer

Table 2 does not apply to diagnoses in 2007 and later. A watermark over (or near) Table 2 states "Do not use for cases diagnosed on or after 2007." Table 2 lists previous SEER site groupings for cases prior to 2007.

The MP/H rules are in hierarchical order. Use the first rule that applies. When Rule M8 applies, there is no need to check Rule M10. Rule M8 is for the urinary sites listed and derives single primary. Rule M10 is for all sites, except the sites listed in Rule M8, and derives multiple primaries.

It does not matter where the first primary is, i.e. bladder then urethra or bladder then renal pelvis. If there are two or more tumors in two or more of these four sites listed in Rule M8 with histologies listed on Table 1, abstract as a single primary.

Date Finalized

11/26/2014

20140030

Question

MP/H Rules/Multiple primaries--Bladder: Is this a single primary or multiple primaries? Transurethral resection of the bladder identifies two bladder tumors. Pathology states one is high grade papillary carcinoma (8130/3) and the other is lymphoepithelioma-like urothelial carcinoma (8082/3). Lymphoepithelioma-like is listed as an urothelial type in Table 1 but rule M6 does not include it in the list of histologies and we are not told to refer to Table 1. M8 refers to Table 1 but does not include multiple bladder tumors (C67_). Specify which rule would apply and why.

Answer

Rule M9 applies to this case. Abstract two primaries. M6 does not apply to this case because code 8082 is not one of the applicable histology codes for M6. This situation will be reviewed as we prepare the next version of the rules.

Date Finalized

11/26/2014

20140029

Question

MP/H Rules/Histology-Urinary: 1) What is the correct ICD-O-3 morphology code for conventional renal cell carcinoma? Is this clear cell carcinoma or does conventional refer to the general diagnosis?

2) If a patient was diagnosed with invasive papillary urothelial carcinoma of the bladder in May 2011 and returns in February 2013 with invasive urothelial carcinoma of the bladder, what is the correct ICD-O-3 morphology code?

Answer

1) Clear cell renal carcinoma, code 8310, is often called conventional renal cell carcinoma. It is specific compared to renal cell carcinoma, NOS, code 8312, a general morphology term for the majority of kidney cancers. See kidney rules H5 and H12 and Table 1 on page 57 of the Kidney Terms and Definitions, http://www.seer.cancer.gov/tools/mphrules/mphrules_definitions.pdf

2) Do not change the ICD-O-3 code assigned for the 2011 diagnosis. As you know, the 2013 diagnosis is not a new primary per rule M6.

Date Finalized

11/26/2014

20140027

Question

MP/H Rules/Histology--Bladder: What is the correct histology for the following bladder case and how do you determine? See discussion.

Discussion

8/1/10 CYSTOSCOPY -- MULTIPLE BLADDER TUMORS INVOLVING POSTERIOR WALL, DOME & BLADDER NECK AREA. LARGEST WOULD BE MORE THAN 5 CM IN SIZE. 8/17/10 path -- BLADDER TUMORS: PAPILLARY TRANSITIONAL CELL CARCINOMA OF urinary bladder, GRADE III. ONE FRAGMENT OF TISSUE SHOWS NECROTIC CHANGE WITH APPARENT TRANSFORMATION TO A HIGH GRADE SARCOMATOID VARIANT W ITH EXTENSIVE SUBMUCOSAL INVASION & FOCAL AREA SUGGESTIVE OF ANGIOLYMPHATIC INVASION NOTED. MAJORITY OF TUMOR APPEARS CONFINED TO MUCOSAL SURFACE W ITH NO OTHER AREAS OF DEFINITIVE SUBMUCOSAL INVASION FOUND.

Answer

Code 8122/3 (UC/TCC, Sarcomatoid). Rule H5 and Table 1 apply.

This is based on the information provided: Transitional Cell Carcinoma with sarcomatoid variant, and Table 1 in Terms and Definitions for "Ureter/Renal Pelvis/Bladder".

Date Finalized

11/26/2014

20140026

Question

Histology: Are all well differentiated neuroendocrine carcinomas (carcinoid) tumors coded to 8240 or 8246? When do you use code 8246?

Answer

Code 8246 is correct when the mass/lesion is referred to as neuroendocrine "carcinoma" or NEC. Use code 8240 when the mass/lesion is referred to as a neuroendocrine "tumor" or NET G1. The difference is the word tumor versus carcinoma. Carcinoid is most often used interchangeably with neuroendocrine tumor and not with neuroendocrine carcinoma.

Date Finalized

11/26/2014

20140025

Question

Grade--Heme & Lymphoid Neoplasms: Why isn't "T-cell granular lymphocytic leukemia" (9831/3) coded as "5 T-cell" instead of "9" as specified in the Heme database? My path department did not specify any type of grade, but since "T-cell" is part of the name, wouldn't you code it to "5"?

Answer

Assign code 5 when the diagnosis on the pathology report specifies "T-cell granular lymphocytic leukemia." The Heme DB grade instruction states "Code grade specified by pathologist. If no grade specified, code 9." In this case, T-cell was specified - code it. The code for T-cell (5) was not automatically assigned in the Heme DB because of the alternate names for this neoplasm. Some of these include NK-cell. Assign code 8 for alternate names with NK.

The alternate names are: Chronic lymphoproliferative disorder of NK cells, Chronic NK-cell lymphocytosis, Chronic NK-large granular lymphocyte (LGL) lymphoproliferative disorder, CLPD-NK, Indolent large granular NK-cell lymphoproliferative disorder, NK-cell lineage granular lymphocyte proliferative disorder, NK-cell LGL lymphocytosis

Date Finalized

11/26/2014

20140024

Question

MP/H Rules/Histology--Bladder: What is the correct histology code for the following bladder histology? High grade urothelial cancer with extensive neuroendocrine differentiation.

Answer

Code neuroendocrine carcinoma, 8246/3. Note 2 under Rule H7 applies.

We are reviewing mixed histologies for the next version of the rules.

Date Finalized

11/26/2014

20140023

Question

MP/H Rules/Histology--Bladder: What is the correct histology code for this bladder tumor with a "component" of small cell? Component is not included in Note 2 under Rule H7: "The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with ____ differentiation? Would we use Rule H8? See discussion.

Discussion

BLADDER, BIOPSY: INVASIVE HIGH GRADE UROTHELIAL CARCINOMA WITH COMPONENT OF SMALL CELL CARCINOMA (~30%) WITH INVASION INTO MUSCULARIS PROPRIA PRESENT.

Answer

Rule H7 is applicable for this case based on the information provided. This tumor has a mixed histology, urothelial carcinoma with component of small cells. In general, bladder cancers of small cell type show a more aggressive clinical course than urothelial cell type, the more specific histology code 8045/3, combined small cell carcinoma, is preferable for this case, compared to the code 8120/3, urothelial carcinoma, NOS, because the small cell component drives the treatment and survival. This is an exception to the current rules. The next version of the rules will clarify this point.

Date Finalized

11/13/2014

20140022

Question

MP/H Rules/Kidney, renal pelvis--How many primaries are there for this case? Should we stop at rule M8 making this all one primary (C689) even though there were right and left renal pelvis tumors? Rule M3, which contains laterality, does not apply because there is also a bladder tumor. See discussion.

Discussion

Kidney: originally diagnosed 12/21/2011 with right renal pelvis high grade papillary urothelial cancer. Status post right nephrectomy. Then on 01/10/2013 diagnosed with low grade papillary urothelial cancer of the bladder. 01/21/2013 diagnosed with left renal pelvis urothelial carcinoma in situ. Path report stated this may represent a high grade papillary urothelial cancer – unable to confirm due to specimen size. On 01/24/2013 left periaortic lymph node biopsy revealed poorly differentiated carcinoma consistent with prior diagnosed right renal pelvis high grade urothelial cancer. Neither the bladder nor the left renal pelvis tumor was compared to the previous right renal pelvis tumor. Also has bone mets.

Answer

Abstract this case as a single primary.

First, apply the MP/H rules to compare the 2013 bladder tumor to the 2011 renal pelvis tumor. Rule M8 applies, this is a single primary. Next, apply the MP/H rules to compare the 2013 in situ renal pelvis tumor to the 2011 renal pelvis tumor. Rule M8 applies, this is a single primary. As you correctly pointed out, Rule M3 for bilateral renal pelvis tumors, does not apply because there is also a bladder tumor in this case.

Date Finalized

11/13/2014

20140017

Question

Multiple Primaries--Heme & Lymphoid Neoplasms: 2012 path report for removal of an "axillary mass" which consists of 80% diffuse large B-cell lymphoma (DLBCL) and 20% follicular lymphoma. In the original manual, Module 6 instructed us to code as a single primary, DLBCL. However, the multiple primary calculator says each disease is a separate primary. When I looked them up in the data base, I did not get an option to review a current manual. Can you please advise?

Answer

Code as a single primary with histology Diffuse Large B-Cell Lymphoma.

In this case, there are two NHLs in the same location at the same time. Apply Rule M4, this is one primary. Per Note 5 under Rule M4, go to Rules PH11and PH15 to assign primary site and histology.

Rule PH11 states to code to the site of the origin (axillary mass) and to diffuse large b-cell lymphoma (9680/3) when DLBCL and any other non-Hodgkin lymphoma (follicular in this case) are present in the same location at the same time.

Using the multiple primaries calculator in this situation will give you two primaries, which is the wrong answer. Use the rules before using the calculator.

To get to the manual, go to the "Help me code for dx year." section. Choose 2010 or later and the most current manual will appear. We recommend that you save a copy of the PDF on your computer.

Date Finalized

11/13/2014

20140016

Question

Primary site--Heme & Lymphoid Neoplasms: Need help determining primary site for Diffuse Large B-Cell Lymphoma 9680/3 confirmed pathologically in right ovary and soft tissue left adnexa. No lymph nodes examined pathologically. Patient treated outside and no access to notes. See discussion.

Discussion

CT A/P massively enlarged uterus with no distention between the vagina, cervix or proximal to mid uterus identified. Highly concerning for malignancy though distinct etiology not clear. Ovarian not favored though not excluded given lack of clearly defined fat planes between uterus and either ovary. Extensive bilateral iliac chain and periaortic/pericaval lymphadenopathy.

Trying to work through Module 7 in the Hem DB. According to the ovary site, regional lymph nodes include the iliac and the para-aortic lymph nodes. This makes me think I should use Rule PH35 (organ and regional nodes). However, using Appendix C in the Hem DB, the iliac lymph nodes are part of the pelvic C775 while the para-aortic (periaortic) are intra-abdominal C772. This makes me wonder if I should go with rule PH36 present in organ and nodes that are not regional.

Answer

Use Rule PH25 and code primary site to C569.

First determine if the iliac and para-aortic lymph nodes are regional for Ovary. Use AJCC TNM or Collaborative Stage. Per AJCC 7th edition, regional lymph nodes for ovary include iliac and para-aortic (pg. 419). Therefore, this case involves an organ and its regional lymph nodes. Use appendix C to determine how to code a lymph node primary. It should not be used to determine whether lymph nodes are regional for a specific organ.

Date Finalized

11/13/2014

20140010

Question

Primary site--Heme & Lymphoid Neoplasms: Does Rule PH27 apply meaning that primary site is coded to C809 or would it be more appropriate to code to C269 GI Tract NOS since all disease involves the GI tract and this is more specific?

Extranodal lymphoma first diagnosed in the stomach (fundus and antrum) which upon further investigation also involved the small bowel (MALT Lymphoma) in the absence of lymph node findings. MD staged this IIE. Initial thought was Gastric, but PET/CT indicated abnormal uptake involving loop of distended small bowel in the pelvis.

Answer

Assign C269 for Gastrointestinal tract, NOS. Apply Rule PH24, code to the organ when only an organ is involved. This rule can be used for NOS sites such as GI tract, NOS.

Based on the information provided, this lymphoma is confined to the GI tract -- stomach and small bowel.

Date Finalized

11/13/2014

20130194

Question

Reportability--Brain and CNS: Are blood vessel tumors arising in CNS sites reportable? See Discussion.

Discussion

Previous instructions from the CDC (Cancer - Collection and Coding Clarification for CNS Tumors - NPCR) stated that non-malignant blood vessel tumors in CNS sites are reportable and should be coded to the CNS site in which they arose. SINQ 20081113 also states that a blood vessel tumor, cavernoma/cavernous hemangioma, in the brain is reportable. However, SINQ 20120034 contradicts this previous answer stating the site should be coded to C490 [blood vessel] for a blood vessel tumor (venous angioma) in the brain.

If blood vessel tumors arising in a CNS site are no longer reportable, please specify the site/histology codes for these non-reportable tumors and when this change took place.

Answer

Vascular tumors of the CNS are reportable when they arise in the dura or parenchyma of the CNS and should be coded accordingly. Benign and borderline blood vessel tumors are not reportable wherever they arise. The instructions in the CDC book regarding primary site coding are not the most current instructions. SEER assumed responsibility for brain and CNS reporting instructions in 2007.

The tumor in SINQ 20120034 is not reportable because it arises in a blood vessel. The cavernous hemangioma in SINQ 20081113 is reportable because the primary site is the white matter of the cerebral cortex.

Date Finalized

11/04/2014

20130157

Question

Primary Site--Heme & Lymphoid Neoplasms: What primary site code should be assigned and what rule justifies that code?

Scenario: Pleural effusion, underwent thoracentesis. Pleural fluid unexpectedly showed Large B-Cell Lymphoma. Extensive workup including CT & PET was done and all findings were within normal limits. No evidence of lymphoma was seen and no palpable adenopathy was found. The only indication of lymphoma was the malignant pleural effusion.

Answer

Code to pleura, C384.

Per the Hematopoietic database, Diffuse Large B-Cell Lymphoma can originate in the pleural cavity.

Date Finalized

11/13/2014

20130001

Question

Reportability--Brain and CNS: Are hemangioma, NOS (9120/0), cavernous hemangioma (9121/0) or venous hemangioma (9122/0) reportable when they arise in the brain or CNS?

Answer

Hemangioma, NOS (9120/0) and cavernous hemangioma (9121/0) arising in the dura and parenchyma of the brain/CNS are reportable.

Venous angiomas (9122/0) are not reportable wherever they arise. The primary site for venous hemangioma arising in the brain is blood vessel (C490). The combination of 9122/0 and C490 is not reportable. This is a venous abnormality. Previously called venous angiomas, these are currently referred to as a developmental venous anomalies (DVA).

Date Finalized

11/04/2014

20120034

Question

Primary site--Brain and CNS: How is the primary site to be coded if a clinician used an MRI to diagnose a left cerebellar venous angioma? See Discussion.

Discussion

According to the WHO Classification of Brain/CNS Tumors, code 9122/0 (venous angioma) does not appear under tumors of the cerebellum (C716).

Answer

Venous angiomas (9122/0) are not reportable wherever they arise. The primary site for venous angioma arising in the cerebellum is C490. The combination of 9122/0 and C490 is not reportable. Venous angioma is a venous abnormality, currently referred to as a developmental venous anomaly (DVA).

Date Finalized

11/04/2014