20150011

Question

Surgery Primary Site--Breast: Please clarify how to code both simple mastectomy with tissue expander and AlloDerm reconstruction, and simple mastectomy with tissue expander (NOS). See discussion.

Discussion

There are multiple SEER Notes in the Breast Surgery Codes of Appendix C instructing us to code tissue expanders as reconstruction but none address the type of reconstruction to be coded.

1. Is a tissue expander always equivalent to Implant reconstruction?
2. Is AlloDerm always equivalent to Tissue reconstruction?
3. Is the combination of AlloDerm and tissue expander always equivalent to Combined (tissue and implant) reconstruction?

Answer

Do not code AlloDerm as either a tissue or implant reconstruction, it is a graft material that usually accompanies implant reconstruction. Placement of a tissue expander is an indication of planned reconstruction. Additional information is needed to determine whether the reconstruction involves tissue or implant.

1. A tissue expander is not always equivalent to Implant reconstruction
2. AlloDerm is not equivalent to tissue reconstruction
3. The combination of AlloDerm and tissue expander is not equivalent to combined (tissue and implant) reconstruction

Date Finalized

04/21/2015

20150010

Question

Multiple Primaries/Histology--Colon: What is the correct histology code and MP/H Rule when a colectomy final diagnosis is adenocarcinoma with colloid and signet ring cell features? See discussion.

Discussion

The MP/H Equivalent Terms and Definitions for Colon indicate that type, subtype, predominantly, with features of, major, or with ___ differentiation are all equivalent in terms of coding histology. However, this is not indicated in the General Instructions (e.g., Histologic Type ICD-O-3 or General Instructions Histology Coding Rules). It also is not included as a Note under the Rules where one would expect to use these terms, for example, Rule H7. Is this an oversight or error in the Manual?

In this case, Rule H7 seems to be the first (and most appropriate) rule that applies to this mixed histology tumor. However, the specific histology terms that an invasive tumor may be identified as, are only listed under Rule H13. Can these same terms be used when applying rules for which they are not specifically noted? It would seem logical to use the equivalent histology terms to code a mixed histology tumor identified as a subtype or with features, etc., despite the fact that the specific terms are not listed under Rule H7.

Answer

Rule H7 applies. Assign code 8255. H13 does not apply as mucinous/colloid/signet are not NOS histologies. They are specific histologies. This will be addressed in the upcoming revisions to the rules.

Date Finalized

04/21/2015

20150009

Question

Multiple Primaries/Behavior--Lung: When a patient has an invasive lung primary, should in situ tumors of the lung be considered when determining multiple primaries? See discussion.

Discussion

How many primaries should be reported when a 12/19/14 RUL lung wedge resection shows: 2.0 cm invasive adenocarcinoma (8140/3) and an additional RUL wedge resection during the same procedure shows: multifocal adenocarcinoma in situ (bronchioloalveolar carcinoma), non-mucinous type (8252/2) size: 1 mm - 2 mm; followed by a 2/12/15 left upper lobectomy also showing Adenocarcinoma, invasive at several foci, with a prominent bronchioloalveolar (in situ) component….tumor focality: multifocal (10 cm mass, 6 cm mass and numerous smaller foci)?

Answer

Most often when the invasive tumor and the in situ component are in the same lung and are the same histology, rule M12 (example 3) applies and this is a single primary. If the first wedge resection included part of the tumor and the in situ was not separate from the tumor, it is a single primary. We suspect that the margins were positive on the first wedge specimen which prompted the second wedge resection where the in situ was found. In addition, terminology for lung malignancies is undergoing change: what was called BAC (invasive) is now called adenocarcinoma in situ.

Date Finalized

04/21/2015

20150008

Question

Reportability--Heme & Lymphoid Neoplasms: Is idiopathic hypereosinophilia reportable? Must the diagnosis include the word 'syndrome'?

Answer

Idiopathic hypereosinophilia is not reportable.

Hypereosinophilic syndrome is a different entity and is a synonym for chronic eosinophilic leukemia.

Date Finalized

04/21/2015

20150005

Question

Reportability--Skin: Is this case not reportable if the intranasal polyp is covered with cutaneous epithelium (essentially skin) or, is it reportable as a primary intranasal basal cell carcinoma? I have found one article regarding primary intranasal basal cells, which are described as being "very rare". But, I am not sure whether, in those cases, cutaneous epithelium was found.

FINAL DIAGNOSIS: (A) Nasal cavity, polyp, excision: Sinonasal inflammatory polyp with overlying cutaneous epithelium showing foci of superficial (noninvasive) basal cell carcinoma

Answer

Report this case as a basal cell carcinoma, noninvasive, of the nasal cavity, based on the information provided.

The polyp was removed from the nasal cavity (C300) which is a reportable site for basal cell carcinoma.

Date Finalized

03/24/2015