20160046

Question
MP/H Rules/Multiple primaries/Histology--Rectum: How many primaries does this person have and what is the correct histology? See discussion.

Discussion
Rectal polyp excised in June, 2012, found to have adenocarcinoma in situ in a tubulovillous adenoma. Additional colorectal biopsies in November; all were negative. Another rectal polyp removed in December 2012 showing a tubulovillous adenoma with focal carcinoma in situ. Then, in February, 2013 another rectal polyp removed. This was diagnosed as mod. diff. adenocarcinoma with mucinous features, infiltrating into submucosa, seen in a background of tubulovillous adenoma. Surgical margins free (mucin %=40%). Finally, in May, 2013, a low anterior resection with no residual adenocarcinoma.

This appears to be adenocarcinoma in multiple adenomatous polyps (8221/3), although the final path from May 2013 described one benign polyp and said, 'no other masses, suspicious lesions or polyps are identified.' Going through the MP/H rules, both M13 and M14 result in this being a single primary, and come before the rule about an invasive tumor following an in situ tumor more than 60 days later is a new primary. The original abstract was coded C209 and 8263/2. If this is a single primary, should it be changed to 8221 with a behavior code of 3? Is this scenario another example of when to change the original diagnosis based on subsequent information?

Answer
Abstract a single primary and code as 8263/3. Other Sites rule M14 applies. The histology code is 8263/3 based on rules H28 and H12. Apply H28 first, make a second pass through the H rules and apply H12. See slide 18 in the "Beyond the Basics" presentation for applicable instructions on a similar situation, http://seer.cancer.gov/tools/mphrules/training_adv/SEER_MPH_Gen_Instruc_06152007.pdf
This case is an example of the need to update the original abstract based on more complete, subsequent, information.

2016044

Question
MP/H Rules/Histology--Sarcoma: What is the appropriate histology code for a final diagnosis of undifferentiated pleomorphic sarcoma and/or pleomorphic sarcoma, undifferentiated? See Discussion.

Discussion
Does the Other Sites MP/H Rule H17 apply in this case, which results in coding the higher histology 8805/3 (undifferentiated sarcoma)? Or does the "undifferentiated" statement only refer to grade, which results in coding histology to 8802/3 (pleomorphic sarcoma)?

Answer
Assign 8802/34 to pleomorphic cell sarcoma/undifferentiated pleomorphic sarcoma. Pleomorphic is more important than undifferentiated when choosing the histology code in this case. Undifferentiated can be captured in the grade code.

2016042

Question
First course treatment/Date 1st surgical procedure--Colon: Should the date of a polypectomy be recorded in the Date of First Surgical Procedure field when the entire tumor is not removed by polypectomy? See Discussion.

Discussion
The patient underwent a polypectomy. The endoscopy report noted the "single piece polypectomy" only partially removed the polyp/mass as the remainder of the mass was more fixed to the wall. The margins were not noted on the pathology report, but were presumably positive given the endoscopy report and the subsequent low anterior resection (LAR) that proved macroscopic residual tumor. Should the date of the polypectomy be recorded in Date of First Surgical Procedure field? Or would the date of the subsequent LAR be recorded since macroscopic residual tumor was present following polypectomy?

Answer
Record the date of the polypectomy as the date of first surgical procedure. Polypectomies are surgery for the purposes of cancer registry data collection regardless of whether or not there is residual tumor after the polypectomy.

2016041

Question
First course treatment/Surgery of Primary Site--Skin: How are Surgery of Primary Site and Surgical Procedure of Other Site coded for an eyelid skin primary diagnosed by punch biopsy and treated with an orbital exenteration? See Discussion.

Discussion
Unlike most other sites, there is no specific code for a radical surgical procedure of a skin primary. In this case, the patient was diagnosed with a sebaceous cell carcinoma of the lower eyelid skin by punch biopsy. The tumor was large and an orbital exenteration was planned. Despite the extensive surgery performed, skin margins were less than 1 cm. Is an orbital exenteration a "major amputation" (code 60) in this case? Given that the margins were not greater than 1 cm, codes 45 - 47 (which includes a minor (local) amputation) don't seem to apply. However, if this procedure cannot be classified as "minor amputation" then doesn't it seem overkill to refer to the procedure as a "major amputation"?

An alternative would be to code Surgery of Primary Site to 32 for the skin resection (punch biopsy followed by a gross excision of the lesion, margins less than 1 cm) and code Surgical Procedure of Other Site to 2 (non-primary surgical procedure to other regional sites) to record the removal of the globe and orbit as part of the orbital exenteration. Which is correct?

Answer
There is a similar question in the FORDS forum of the CoC CAnswer Forum. CoC is the curator for the surgery codes.

Surgical Procedure to Primary Site - Gross excision of the lesion, code in 30s series
Surgical Procedure to Other Site (removal of eye) - code 4

http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/surgery/56355-sebaceous-carcinoma-of-the-eyelid-primary-surgery-code

2016040

Question

Reportability--Thyroid: Is a final diagnosis of "non-invasive follicular thyroid neoplasm with papillary-like nuclear features" reportable when the diagnosis comment states this tumor was historically classified as encapsulated follicular variant of papillary thyroid carcinoma?

Discussion

The term "non-invasive follicular thyroid neoplasm with papillary-like nuclear features" is now being used, instead of the previous classification of an encapsulated malignant thyroid tumor. Recent evidence supports a very minimal risk of aggressive behavior for these tumors, and pathologists in our area are no longer classifying these as malignant in the final diagnosis.

Answer

We are discussing this terminology change with the other standard setters and with the ICD-O-3 Implementation Workgroup. When a consensus decision is made, it will be reflected in the revised MP/H (to be known as Solid Tumor) rules.

For now, you can report noninvasive follicular thyroid neoplasm with papillary-like nuclear features as a synonym for encapsulated follicular variant of papillary thyroid carcinoma and assign 8340/3. Document this in a text field.

2016038

Question
Birthplace/Place of birth, country: For patients originally born in a country that is currently considered as "historic only", where the original birth country now has a one-to-many relationship with the current country, how should the reported original birthplace be coded? (Example: Yugoslavia)

Answer
Assign code for Europe, NOS (ZZE) for Yugoslavia, NOS, without further information.

2016037

Question
Reportability/MP/H Rules/Histology--Ovary: What is the histology code for an ovarian tumor described as a mucinous borderline tumor, intestinal type?

Answer
Mucinous borderline tumor, intestinal type, of the ovary is not reportable. The behavior is /1. There is no applicable histology code for this histology when it occurs in the ovary.

2016025

Question
MP/H Rules/Histology: What is the correct histology code for a NUT midline carcinoma?

Answer
Code histology to 8010/3.

NUT carcinoma is identified by the *NUTM1* gene rearrangement.

NUT midline carcinomas (NMC) are lethal and morphologically indistinguishable from other poorly diff carcinomas. They are epithelial tumors which can range from undifferentiated carcinomas to carcinomas with prominent squamous differentiation.

A new proposed ICD-O-3 code has been suggested for NUT tumors but it is not yet approved for implementation. Do not use the new code until it is approved for use in the United States.

2016024

Question
Reportability--Melanoma: Please explain how a CTR is to interpret the guideline in the MP/H rules (Cutaneous Melanoma): Evolving melanoma (borderline evolving melanoma): Evolving melanoma are tumors of uncertain biologic behavior. Histological changes of borderline evolving melanoma are too subtle for a definitive diagnosis of melanoma in situ. Is this to mean that evolving melanoma in situ is not reportable? Or should we follow the guidelines in SEER Question 20130022 that states the reportability terms for melanoma and melanoma in situ.

Answer
Follow the guidelines in SINQ 20130022 for now. When the MP/H rules are revised, new instructions will be implemented.

See also SINQ 200120078 and 20110069.

2016017

Question
Surgery of Primary Site--Melanoma: Please further explain the SEER Note under Melanoma surgery codes 30-36 for these two examples. Are both examples coded 31?

1. Shave bx: +melanoma in situ, +microscopic margins Wide excision: no residual melanoma in situ

2. Shave bx: melanoma, +microscopic margin Wide excision: Melanoma, margins negative (margin status negative but distance not stated)

Answer
Surgery code 31 is correct for both examples because the margins of excision are not known to be greater than 1 cm. Use code 45 when there is a wide excision AND it is known that the margins of excision are greater than 1 cm

2016016

Question
MP/H Rules/Histology--Bladder: Can the histology for a high grade urothelial carcinoma described as having "extensive sarcomatoid dedifferentiation" be coded to sarcomatoid transitional cell carcinoma (8122/3)?
Example; TURBT, Final Diagnosis - Urothelial carcinoma, high grade. Type/grade comment: Extensive sarcomatoid dedifferentiation is present (40-50% of tumor volume).

Answer
Code high grade urothelial carcinoma described as having "extensive sarcomatoid dedifferentiation" to sarcomatoid transitional cell carcinoma (8122/3).

2016015

Question
Multiple primaries--Heme & Lymphoid Neoplasms: Could you please clarify Note 2 found in Rule M10, which is " 'Transformations to' (acute neoplasms) and 'Transformations from' (chronic neoplasms) are defined for each applicable histology in the database." Do the neoplasms being considered have to contain the words 'chronic' and/or 'acute'?

Answer
Hematopoietic neoplasms that transform generally don't have 'chronic' or 'acute' as part of their preferred name. The 'chronic' and 'acute' designations are determined by the usual course of the neoplasm. Chronic neoplasms are generally slow growing while acute neoplasms grow fast and are more widespread. Not all Hematopoietic neoplasms transform. Each neoplasm that has the ability to transform has the transformations listed under the 'Transformations to' and/or 'Transformation from' sections in the Hematopoietic database.

For example, Diffuse Large B-cell Lymphoma (histology code 9680/3) has no histologies/neoplasms listed under 'transformations to.' This means that this neoplasm does not transform to any other neoplasm. There are multiple histologies/neoplasms listed under 'Transformations from' indicating the neoplasms listed under the Transformations from are the chronic neoplasms, and DLBCL is the acute neoplasm. If DLBCL (9680/3) occurs at the same time, within 21 days, or greater than 21 days of any of the histologies listed under 'Transformations From,' rules M8-M13 apply. If DLBCL (9680/3) occurred at the same time as a neoplasm not listed in the Transformations sections, the acute and chronic rules do not apply.

2016014

Question
Surgery of primary site--Lung: Should microwave ablation be coded as treatment for lung cancer, and if so, how should it be coded?

Answer
Code microwave tumor ablation as surgery. For lung, assign code 15.

This question was discussed by the technical advisory group – a small group of representatives from each standard setter which meets periodically. The group agreed on this consensus answer.

2016013

Question
Reportability--Breast: Is mammary fibromatosis reportable and if so, what histology code is assigned? See discussion.

Discussion
The pathologist completed a CAP protocol using soft tissue. Pathology revealed a 2.5 cm tumor with invasion of skeletal muscle with deep margins positive for tumor.

Answer
Mammary fibromatosis is not reportable. The WHO classification for breast tumors assigns mammary fibromatosis a behavior code of /1. According to WHO, mammary fibromatosis "is a locally infiltrative lesion without metastatic potential…"

2016012

Question
Reportability--Brain and CNS: Is a thalamic amyloidoma reportable if so what histology code is used?

Answer
Thalamic amyloidoma is not reportable. Amyloidoma (tumoral amyloidosis, amyloid tumor) is a tumor-like deposit of amyloid. It is not neoplastic. Amyloid is a protein derived substance deposited in various clinical settings.

2016011

Question
Reportability--Stomach: Are microcarcinoid tumors reportable? See discussion.

Discussion
SINQ 20081076 states carcinoid tumorlets of the lung are not reportable and are defined as being less than 5 mm in diameter and benign. Per the WHO Classification of Digestive Tumours, microcarcinoid tumors are precursor lesions/nodules measuring greater than 0.5 mm, but less than 5 mm (0.5 cm). Is the term microcarcinoid tumor equivalent to carcinoid tumorlet, and therefore not reportable? Or is a microcarcinoid tumor a reportable type of neuroendocrine tumor (NET)?

Answer
Microcarcinoid and carcinoid tumors are reportable. The ICD-O-3 histology code is 8240/3. Microcarcinoid is a designation for neuroendocrine tumors of the stomach when they are less than 0.5 cm. in size. Neuroendocrine tumors of the stomach are designated carcinoid when they are 0.5 cm or larger.

The term microcarcinoid tumor is not equivalent to carcinoid tumorlet.

2016010

Question
Grade--Head & Neck: How should grade be coded for a tonsillar primary (or other solid tumor) with resection pathology final diagnosis of poorly differentiated SCC with histologic grade: G2-3 of 3. See discussion.

Discussion
We are seeing multiple head and neck cases with unclear or multiple grade assignments. Another example is alveolar mucosa SCC with histologic grade stated as: Moderately differentiated (G2 of 3). Grade Coding for Solid Tumor instruction 5.b. is not clear regarding this situation. Does a statement of differentiation take priority? Should we disregard the differentiation statement and code using the 3-grade systems?

Answer
Use the three-grade system table in instruction #7.b to code grade for the situations you describe. Use the Grade Coding Instructions in order. Instruction #7.b (three-grade system) comes before instruction #8 (terminology).

http://seer.cancer.gov/tools/grade/

2016009

Question
MP/H Rules/Histology--Appendix: What is the histology for an appendix resection diagnosis of "Malignant neoplasm of the appendix with the following features: Histologic type: Adenocarcinoma ex goblet cell carcinoid with mucin production (adenocarcinoma arising from goblet cell carcinoid)"? Is this histology best coded to a mixed adenocarcinoma/carcinoid tumor (8244/3)?

Answer
Code histology to combined carcinoid and adenocarcinoma (8244/3). The tumor is a mix of adenocarcinoma and carcinoid.

2016008

Question
Reportability/Date of diagnosis--Liver: Is a statement of LI-RADS 5 or LI-RADS 4 diagnostic of HCC? See discussion.

Discussion
We are seeing more use of LI-RAD categories on scans. The final impression on the scan will be LI-RADS Category 5 or LI-RADS Category 4, with no specific statement of HCC. The scans include a blanket statement with the definitions of the LI-RADS categories as below.

LIRADS (v2014) categories
M - Possible non-HCC malignancy
1 - Definitely Benign
2 - Probably Benign
3 - Intermediate Probability for HCC
4 - Probably HCC
5 - Definitely HCC (concordant with OPTN 5)

A previous SINQ, 20010094, indicates that we cannot use BI-RADS categories for breast cancer diagnosis, but those BI-RADS definitions are slightly different. Most often there will be a subsequent clinical statement of HCC, so the question is also in reference to Diagnosis Date. Can we use the date of the scan's impression, which states LI-RADS category 4 or 5, as the Diagnosis Date?

Answer
Report cases with an LI-RADS category LR-5 or LR-5V based on the 2014 American College of Radiology definitions, http://nrdr.acr.org/lirads/

Do not report cases based only on an LI-RADS category of LR-4.

Use the date of the LR-5 or LR-5V scan as the date of diagnosis when it is the earliest confirmation of the malignancy.

2016007

Question
Surgery of Primary Site--Breast: If the diagnosis is a single primary involving both breasts, do we code 41 Surgery Primary site with 1 in Surgery Other site, or code 76 Surgery Primary site with 0 in Surgery Other site? See discussion.

Discussion
In Appendix C- Breast (SEER Manual 2015) it states under the codes for TOTAL MASTECTOMY (Codes 40-49, 75): For single primaries only, code removal of involved contralateral breast under the data item Surgical Procedure/Other Site (NAACCR Item # 1294). [SEER Note: Example of single primary with removal of involved contralateral breast--Inflammatory carcinoma involving both breasts. Bilateral simple mastectomies. Code Surgery of Primary Site 41 and code Surgical Procedure of Other Site 1.] HOWEVER, underneath that it states code 76 is used for: 76 Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma.

Answer
Assign code 41 with 1 in surgery other site for simple mastectomy. Assign code 76 with 0 in surgery other site for a more extensive mastectomy.

2016006

Question
Diagnostic confirmation--Hem & Lymphoid Neoplasms: Can you please comment on the pathology profile of CALR? Can a + CALR profile be considered + immunophenotyping or genetic testing (similar to the JAK2 confirmation) and be used to code the diagnostic confirmation of Heme diseases?

Answer
Do not code diagnostic confirmation based on + CALR profile at this time. The calreticulin (CALR) gene is associated with cases of JAK2 wild-type essential thrombocythemia (ET) and primary myelofibrosis (PMF). We will investigate this further and if + CALR is diagnostic, we will revise the heme database and manual accordingly.

2016005

Question
Reportability--Skin: Is this a reportable skin cancer? See discussion.

Discussion
Patient had a skin biopsy and this is the interpretation: NASAL SUPRATIP: INVASIVE BASAL CELL CARCINOMA OF SKIN WITH NEUROENDOCRINE DIFFERENTIATION

NOTE: The deep margin is positive for tumor; peripheral margins negative for tumor. The tumor has a basaloid appearance with focal areas appearing slightly squamoid, and it demonstrates myxoid/mucinous retraction from the stroma. It does not demonstrate peripheral palisading of cells within tumor nests and has nuclear chromatin which suggests neuroendocrine differentiation. Mitotic rate is more brisk than typical basal cell carcinoma as well. The differential diagnosis includes basal cell carcinoma with or without neuroendocrine differentiation, basal cell carcinoma with squamous differentiation, basaloid squamous cell carcinoma, Merkel cell carcinoma and metastatic small cell carcinoma. The tumor is further characterized per immunostains x 9 (controls work well). Tumor cells are positive for Ber EP4 and p63; focally positive for Chromagranin; while negative for EMA, CK20, CK7, TTF-1, CD56 and Synaptophysin. Overall, the staining pattern supports basal cell carcinoma with neuroendocrine differentiation.

Answer
Basal cell carcinoma with neuroendocrine differentiation of the skin is not reportable to SEER.

In this case, the pathologist discussed several possible options, and determined that the final diagnosis is basal cell ca with neuroendocrine diff based at least partially on the immunostains.

2016004

Question
First course treatment/Other therapy: How is Sirolimus (Rapamycin) to be coded when given with known chemotherapy agents in a clinical trial? See discussion.

Discussion
The SEER*Rx Database lists Sirolimus as an ancillary agent under the Category section, but as an mTOR inhibitor under the Subcategory. The Remarks section indicates Sirolimus (AKA Rapamycin) is an immunosuppressant, but is also a type of serine/threonine kinase inhibitor. Other types of kinase inhibitors (including Temsirolimus) are types of Chemotherapy. Although the Coding section states this drug should not be coded, Primary Sites (NSCLC and glioblastoma) are listed for this drug.

The SEER*Rx Database page for this drug is confusing. Please address the following.
1) Should Sirolimus not be coded when it is being given as a kinase inhibitor or an immunosuppressant?
2) If Sirolimus is ever considered to be treatment, should it be coded only for the primary sites listed?
3) If Sirolimus is given as part of a non-blind clinical trial for another site other than NSCLC or glioblastoma, should the Other Therapy field be coded to 2 [experimental - other treatment]?

Answer
Sirolimus is used to treat GVHD (graft versus host disease) and is not coded as treatment. Even though the sub-category is mTOR inhibitor it does not automatically mean it is a chemotherapeutic agent. Sirolimus affects cells differently than Temsirolimus. The chemical compounds differ between these drugs. In order to code rapamycin, the drug given must be stated to be either the analog or ester compound. The SEER*RX database has been corrected and NSCLC/glioblastoma are no longer listed for sirolimus.

We researched clinical trials and found several that include sirolimus with other chemotherapy drugs for patients who either have received or will be receiving bone marrow transplants for hematologic diseases. In this case it is not coded. There are a few trials that are looking at sirolimus as a treatment for bladder, prostate, nerve sheath tumors, MDS, and AML. For these cases it would be coded in Other (code 2).

2016003

Question
MP/H Rules/Multiple primaries--Thyroid: How many primaries should be reported for a diagnosis of Hurthle cell carcinoma (2.7 cm) and papillary carcinoma (0.3 cm) in the thyroid? See discussion.

Discussion
SINQ 20110028 includes a note that states "Hurthle cell carcinoma is a synonym for follicular carcinoma according to the WHO." That case is a little different in that the Hurthle cell carcinoma was stated to be a probable follicular variant of papillary carcinoma. The case above does not include that statement.

Is Hurthle cell carcinoma a type of follicular carcinoma? Does rule M6 (follicular and papillary tumors in the thyroid w/in 60 days) apply, report a single primary? Or does rule M17 (tumors with ICD-O-3 histology codes different at the third digit) apply thus leading to multiple primaries (8290 for Hurthle cell and 8260 for papillary thyroid carcinoma)?

Answer
Apply rule M6 and report a single primary.

Hurthle cell carcinoma is a synonym for follicular carcinoma of the thyroid.

2016001

Question
MP/H Rules/Multiple primaries/Histology--Rectum: How many primaries does this person have and what is the correct histology? See discussion.

Discussion
Rectal polyp excised in June, 2012, found to have adenocarcinoma in situ in a tubulovillous adenoma. Additional colorectal biopsies in November; all were negative. Another rectal polyp removed in December 2012 showing a tubulovillous adenoma with focal carcinoma in situ. Then, in February, 2013 another rectal polyp removed. This was diagnosed as mod. diff. adenocarcinoma with mucinous features, infiltrating into submucosa, seen in a background of tubulovillous adenoma. Surgical margins free (mucin %=40%). Finally, in May, 2013, a low anterior resection with no residual adenocarcinoma.

This appears to be adenocarcinoma in multiple adenomatous polyps (8221/3), although the final path from May 2013 described one benign polyp and said, 'no other masses, suspicious lesions or polyps are identified.' Going through the MP/H rules, both M13 and M14 result in this being a single primary, and come before the rule about an invasive tumor following an in situ tumor more than 60 days later is a new primary. The original abstract was coded C209 and 8263/2. If this is a single primary, should it be changed to 8221 with a behavior code of 3? Is this scenario another example of when to change the original diagnosis based on subsequent information?

Answer
Abstract a single primary and code as 8263/3. Other Sites rule M14 applies. The histology code is 8263/3 based on rules H28 and H12. Apply H28 first, make a second pass through the H rules and apply H12. See slide 18 in the "Beyond the Basics" presentation for applicable instructions on a similar situation, http://seer.cancer.gov/tools/mphrules/training_adv/SEER_MPH_Gen_Instruc_06152007.pdf

This case is an example of the need to update the original abstract based on more complete, subsequent, information.