20150067

Question
MP/H Rules/Histology--Kidney: What is the correct histology for this diagnosis? See discussion.

Discussion
Procedure: Nephrectomy

Laterality: Left

Tumor type: SOLID VARIANT RENAL CELL CARCINOMA
Nuclear grade: High grade (3/4)
Histologic grade: Poorly differentiated
Pattern of growth: Solid
Tumor size: 5x4.5x4cm
Local invasion: Present
Renal vein invasion: None
Surgical margins: Negative
Non-neoplastic kidney: Unremarkable
Adrenal gland: Not submitted
Lymph nodes: Not present
Pathologic stage: T1b

There are solid sheets of tumor cells without papillary structure. The tumor stains positive for Pax-2, negative for Ecadherin, P63 and CK7, consistent with renal cell carcinoma, solid variant.

Answer
Assign histology code 8312, renal cell ca, NOS. There is no specific code for the solid variant of renal cell carcinoma.

Date Finalized
12/29/2015

20150066

Question
Grade--Breast: Do you take grade from the most representative specimen along with the histology? What is the correct histology/grade combination? See discussion.

Discussion

Breast biopsy (from hospital A): DCIS, solid, cribriform, comedo type, high nuclear grade

Breast Lumpectomy (from hospital B): DCIS, cribriform type, nuclear grade 1, tumor 2.5cm

Answer
Assign 8201/2 for this case.

MP/H rules are to code histology based on the specimen with the most tumor tissue. That would be the lumpectomy in this case. The histology is DCIS, cribriform type.

Reference: http://seer.cancer.gov/tools/mphrules/mphrules_instructions.pdf

The general rule for grade is to code the highest grade specified within the applicable grading system. For the case information provided, follow instruction #5, nuclear grade: use Coding for Solid Tumors #7: 2-, 3-, or 4- grade system. High nuclear grade (grade code 3 for breast) is higher than nuclear grade 1 (grade code 1).

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

Date Finalized
12/24/2015

20150065

Question

First course treatment/Chemotherapy/Drug category: Instructions in SEER*Rx state that Ibrance should be coded as chemotherapy. They also state that it is an endocrine-based therapy. Local physicians refer to Ibrance as hormone therapy. Please clarify.

Answer

For cancer registry data collection, follow the instructions in SEER*Rx. It is important for all data collection to be consistent for reporting of cancer information.

Per the FDA: Ibrance is a chemotheraputic agent which was approved for use WITH Letrozole. Letrozole is a hormonal drug which may be why the physicians are stating the patient is receiving hormones. Ibrance should not be given alone to treat breast cancer. This drug will not be changing categories in SEER*Rx.

Date Finalized

12/03/2015

20150064

Question

Primary site--Head & Neck: When there is invasive in one subsite and in situ in another, do you code the subsite with the invasive only? Would the correct site be C320, C328, or C329? See discussion.

Discussion

Laryngoscopy - endolaryngeal exam was grossly unremarkable except that she appears to have a T1a squamous cell carcinoma of the right true vocal fold. It extends from almost the anterior commissure all the way back to the vocal process and is exophytic in nature. It does not extend into the ventricle or onto the false vocal fold. No subglottic extension is seen. A right posterior false vocal cord fold, biopsy: squamous cell carcinoma in situ. B. right posterior true vocal cord fold, biopsy: squamous cell carcinoma, suspicious for invasion. C. right mid true vocal cord, biopsy: squamous cell carcinoma, suspicious for invasion. D. right anterior true vocal fold, biopsy: invasive and in situ squamous cell carcinoma, moderately differentiated.

Answer

See the Head & Neck Terms and Definitions for guidance on coding the primary site, pages 17-18, http://seer.cancer.gov/tools/mphrules/mphrules_definitions.pdf

Based on the information provided, use the statement from the endoscopy report and assign primary site to right true vocal fold [cord], C320.

Date Finalized

12/03/2015

20150063

Question

Histology--Heme & Lymphoid Neoplasms: What is the correct histology for a case in which the pathology or clinician states only follicular lymphoma, low grade? See discussion.

Discussion

Follicular lymphoma, low grade is listed as an Alternative Name for follicular lymphoma, grade 2 (9691/3) in the Hematopoietic and Lymphoid Neoplasm Database. It is not listed as an Alternative Name for follicular lymphoma, NOS (9690/3). However, in SINQ 20130137 the instruction states to code follicular lymphoma, low grade as follicular lymphoma, NOS (9690/3) because low grade can mean grade 1 or grade 2.

Answer

Code the histology to 9690/3 [follicular lymphoma, NOS].
Low grade for follicular lymphoma was removed from the Heme DB. Because low grade can mean grade 1 or grade 2, default to follicular lymphoma, NOS [9690/3].

The heme database will be revised to remove follicular lymphoma, low grade, from alternate names for follicular lymphoma grade 2.

Date Finalized

12/03/2015

20150062

Question
Grade--Bladder: How is Grade coded for the following cases diagnosed 1/1/2014 and later? See Discussion.

1) Low grade urothelial carcinoma, invasive carcinoma not identified (8120/2)

2) Papillary urothelial carcinoma, high grade, no evidence of invasion (8130/2)

Discussion
The rules for coding Bladder Grade appear to have changed over time. SPCM 2013 Appendix C instructions state that Grade should be coded to 9 for urothelial carcinoma in situ (8120/2) and to 1 or 3 for non-invasive papillary urothelial carcinoma (8130/2).

When the grade instructions were removed from Appendix C in 2014, these site specific instructions for in situ bladder cases were no longer included. Thus the two grade system, found in SPCSM 2014+ Grade/Differentiation Coding Instructions for Solid Tumors, is being used to code grade for both the in situ and invasive urothelial malignancies stated to be "low grade" (code 2) or "high grade" (code 4). See also, SINQ 20150022. Please clarify the current grade instructions for in situ and invasive urothelial carcinomas of the bladder.

Answer
Follow the instructions in the 2014+ Grade Coding Instructions to code grade for cases diagnosed 2014 and later, http://seer.cancer.gov/tools/grade/ Instruction #4.a. states to code grade for in situ tumors when grade is specified. This instruction applies to bladder cases, as well as other in situ tumors.

1. Assign grade code 2

2. Assign grade code 4

See the note below the table in instruction #7.

Date Finalized
12/03/2015

20150061

Question

Reportability--Vulva: Is this reportable? We have begun to see the following diagnosis on biopsies of the vulva with the statement below. The diagnosis is being given as simply VULVAR INTRAEPITHELIAL NEOPLASIA, no grade is noted. See discussion.

Discussion

The note explains: The International Society for the Study of Vulvovaginal Disease (ISSVD) in 2004 revised its classification of VIN by eliminating VIN 1 and combining VIN 2 and VIN 3 into a single category (see table below). Classification of VIN (usual type) ISSVD [International Society for the Study of Vulvovaginal Disease] 1986 classification 2004 classification VIN 1 VIN2 VIN3 VIN Note: VIN 2 and VIN 3 combined into single [non-graded] category, VIN Reference: Scurry J and Wilkinson EJ. Review of terminology of precursors of vulvar squamous cell carcinoma. Journal of lower genital tract disease, 2006; 10(3): 161-169

Answer

Vulvar intraepithelial neoplasia with no grade specified is not reportable. Reportability instructions have not changed. See page 11 in the SEER manual, http://seer.cancer.gov/manuals/2015/SPCSM_2015_maindoc.pdf

Date Finalized

12/03/2015

20150060

Question

Reportability/MP/H Rules: Where can I find documentation on how to accession malignant tumors in transplanted organs? See discussion.

Discussion

A patient was diagnosed with hepatocellular cancer (HCC) in 2010, and underwent a hepatectomy, and then received a donor liver. In 2014, HCC was discovered in the liver once again. This likely is a new primary, but there are no specific rules to cover this. There are many odd situations involving transplanted organs, many of which pose reportability and multiple primary problems.

Answer

Accession the new tumor in the transplanted organ as you would any other new/second primary. As transplants have become more common especially for liver, lung, and kidney, we are seeing more of these types of cases. We are adding instructions to the revised MP/H rules on coding subsequent primaries when they occur in a transplanted organ. We are also looking at adding a data field that will identify cancers/tumors which arose in a transplanted organ. We feel this is important to track for analysis. Until the revised MP/H rules are implemented, we will look at adding general coding instructions to the SEER Program Manual for transplants.

Date Finalized

12/02/2015

20150059

Question

Primary Site--Liver: What is the topography code for combined hepatocellular carcinoma/cholangiocarcinoma (M-8180/3) especially when there is no documentation that intrahepatic bile duct is the tumor site? Reports usually just indicate a liver mass(es) but since the intrahepatic ducts are within the liver, is the code C221 due to the cholangiocarcinoma component, thus making the case stageable?

Answer

If there is no further information about where the cancer originated, assign C220. Use ICD-O-3 as the source for coding topography. The topography code associated with combined hepatocellular and cholangiocarcinoma (8180/3) is C220 when there is no other information available, according to ICD-O-3.

Date Finalized

12/02/2015

20150058

Question

MP/H Rules/Multiple Primaries: Is this counted as one or two primaries?

Patient is diagnosed with SCC esophageal cancer. Work-up reveals a lung nodule. Lung FNA (cytology) is read by the pathologist as SCC, favor metastatic esophageal SCC. However, the managing physicians are treating the patient as two separate primaries.

Answer

If the patient is being managed and treated as a case of primary lung cancer, report the lung diagnosis as a separate primary.

Date Finalized

11/23/2015

20150057

Question

Reportability--Brain and CNS: Is this diagnosis reportable? If this neoplasm originated in the spinal cord, it is reportable, correct?

Specimen is described as a 'spinal cord mass.' The final diagnosis is 'fragments of adipose tissue demonstrating vascular proliferations consistent with angiolipoma. No histologic evidence of malignancy.' The microscopic description says: Sections of the spinal mass reveal bone, cartilage, fibrous tissue and adipose tissue. The adipose tissue demonstrates increased vascularity with thin walled blood vessels seen with islands of delicate fibrous stroma. The histologic findings are compatible with fragments of angiolipoma.

Answer

The neoplasm is reportable if it originated in the spinal cord or is intradural (within the spinal dura; spinal nerve roots are intradural). If there is not enough information to determine the exact site of origin, do not report the case.

Date Finalized

11/23/2015

20150055

Question

Multiple primaries--Heme & Lymphoid Neoplasms: Is this 2 primaries? In 2011, a patient had a spinal mass biopsied positive for DLBCL and follicular lymphoma. The heme rules make this one primary coded as DLBCL. Patient had 2 rounds of chemo, but in 2014, he had a recurrent tumor in the same location. The 2014 biopsy was follicular lymphoma. Is this a new primary -- conversion of acute to chronic after treatment? Or is it the same, since FL was diagnosed in the original specimen?

Answer

Rule M13 applies, abstract as two primaries. Since both DLBCL and FL were present in 2011, rule M2 does not fit -- not a single histology. Rule M13 reflects the situation in this case much better: an acute neoplasm which was treated and a chronic neoplasm diagnosed later.

Date Finalized

10/27/2015

20150054

Question

Primary Site--Skin: Should cutaneous leiomyosarcoma be coded to primary skin of site (C44_) or soft tissue (C49_)?

Answer

Code cutanteous leiomyosarcoma to skin. Leiomyosarcoma can originate in the smooth muscle of the dermis. The WHO classification designates this as cutaneous leiomyosarcoma. The major portion of the tumor is in the dermis, although subcutaneous extension is present in some cases.

Date Finalized

12/02/2015

20150052

Question

Primary Site--Sarcoma: What is the best primary site code for an undifferentiated sarcoma of the pulmonary artery? See discussion.

Discussion

Consolidation of the case: The operating hospital stated: SOFT TISSUE: Resection: Procedure: Radical resection Other: Pneumonectomy Tumor Site: Right pulmonary artery - They used code C383 (mediastinum NOS). The consulting hospital stated: Lung, right, pneumonectomy: High grade sarcoma consistent with intimal sarcoma; tumor involves pulmonary artery. They used code C449 (other soft tissue NOS). Would C493 (soft tissue thorax) be correct?

Answer

Code the primary site to pulmonary artery, C493. According to the WHO classification of tumors, intimal sarcomas are malignant mesenchymal tumors arising in large blood vessels. They show mostly intraluminal growth with obstruction of the vessel. They may occur in the pulmonary vessels or, less often, in the aorta.

Date Finalized

12/02/2015

20150051

Question

Reportability--Brain and CNS: Is schwannoma of the extracranial part of a cranial nerve reportable? Some cranial nerves, like facial nerve, have intracranial and extracranial branches.

Answer

An extracranial schwannoma is not reportable. The schwannoma must arise on the intracranial part of the nerve to be reportable.

Date Finalized

12/02/2015

20150050

Question

Reportability: Is penile intraepithelial neoplasia, differentiated type, reportable? See discussion.

Discussion

Foreskin circumcision shows: Penile intraepithelial neoplasia, differentiated type (differentiated PeIN). If reportable, how would the histology and behavior be coded? Is this behavior /2?

Answer

Penile intraepithelial neoplasia, differentiated penile intraepithelial neoplasia (differentiated PeIN), is not reportable.

Date Finalized

12/02/2015

20150049

Question

Reportability--Brain and CNS: Is pseudotumor cerebri reportable?

Answer

Pseudotumor cerebri is not reportable. It is not a neoplasm. The pressure inside the skull is increased and the brain is affected in a way that appears to be a tumor, but it is not a tumor.

Date Finalized

12/02/2015

20150048

Question
Reportability--Skin: Is low grade trichoblastic carcinoma, with a small focus of high grade carcinoma of the scalp reportable? See discussion.

Discussion
Pathology report states: the individual nodules of trichoblastic cells resemble those seen in trichoblastoma, but the lesion is very poorly circumscribed with an infiltrative border that extends into the subcutis. The lesion may behave in a locally aggressive fashion, and should be completely removed. High grade trichoblastic carcinomas can metastasize.

Answer
Trichoblastic carcinoma of the skin is not reportable. The WHO classification lists trichoblastic carcinoma as a synonym for basal cell carcinoma, 8090/3. Basal cell carcinoma of the skin is not reportable. See page 11 in the SEER manual, http://seer.cancer.gov/manuals/2015/SPCSM_2015_maindoc.pdf.

Date Finalized
12/02/2015

20150047

Question

Reportability--Bladder: Is a positive UroVysion test alone diagnostic of bladder cancer? See discussion.

Discussion

The UroVysion website says that standard procedures, e.g., cytology, cystoscopy, take precedence over the UroVysion test. The Quest Diagnostics website says that "A positive result is consistent with a diagnosis of bladder cancer or bladder cancer recurrence, either in the bladder or in another site within the urinary system. A negative result is suggestive of the absence of bladder cancer but does not rule it out." Would we pick up the case if the UroVysion test was positive but the standard procedures were negative or non-diagnostic?

Answer

Do not report the case based on UroVysion test results alone. Report the case if there is a physician statement of malignancy and/or the patient was treated for cancer.

Date Finalized

12/02/2015

20150046

Question

Reportability--Appendix: Is the appendix the primary site for a low grade mucinous appendiceal neoplasm (LAMN) with diffuse peritoneal dissemination? See discussion.

Discussion

Patient had an appendectomy revealing a low grade mucinous appendiceal neoplasm (LAMN) with diffuse peritoneal dissemination. Patient now with cytoreduction and hyperthermic intraperitoneal chemotherapy (HIPEC), which revealed metastatic disease in the abdomen, omentum, pelvic peritoneum, peri-cecal, and gallbladder.

Answer

Low-grade appendiceal mucinous neoplasm (LAMN) is not reportable, even when it spreads within the peritoneal cavity, according to our expert pathologist consultant. Peritoneal spread of this /1 neoplasm does not indicate malignancy. It is still /1 when there is spread of LAMN in the peritoneal cavity.

Date Finalized

11/17/2015

20150045

Question

MP/H/Histology--Thyroid: What is the histology code for primary site of thyroid cancer with the histology of papillary thyroid carcinoma, classical and oncocytic type?

Answer

Code the histology to 8342/3, thyroid oncocytic (oxyphillic) papillary carcinoma.

Date Finalized

12/02/2015

20150044

Question

Reportability--Ovary: Is micropapillary serous carcinoma (MPSC) of the ovary reportable? What are the differences between “noninvasive" and “low malignant potential?" See discussion.

Discussion

Pathology report reads left ovary: noninvasive low grade (micropapillary) serous carcinoma (MPSC), fragmented; right ovarian excrescence and posterior cul-de-sac: noninvasive implants identified; right ovary: noninvasive low grade (micropapillary) serous carcinoma (MPSC), scattered autoimplants (noninvasive); tumor is present on ovarian surface, noninvasive autoimplants

Answer

Noninvasive low grade (micropapillary) serous carcinoma (MPSC) of the ovary is reportable. Assign code 8460/2, applying the ICD-O-3 matrix concept to this noninvasive carcinoma. Noninvasive can be used as a synonym for in situ, ICD-O-3 behavior code /2. See page 66 in the softcover ICD-O-3. Low malignant potential (LMP) means that the neoplasm is not malignant, but has some chance of behaving in a malignant fashion. LMP can be used as a synonym for ICD-O-3 behavior code /1, see page 66.

Date Finalized

12/02/2015

20150043

Question

Sequence no-central--Brain and CNS: How should subsequent tumors be sequenced when the patient has a history of a brain tumor, with no information on the behavior of the brain tumor? According to the sequencing rules, it appears some assumption must be made regarding the behavior of the brain tumor.

Answer

Sequence the brain tumor in the 60-87 series when you do not know the behavior. If you have reason to believe the brain tumor was malignant, sequence it in the 00-59 series.

Date Finalized

10/27/2015

20150042

Question

Surgery of Primary Site--Breast: Is the surgery code 42 or 52? Does it matter that the procedure states no axillary LN, but the pathology found 2 additional LN? See discussion.

Discussion

Procedure stated = Bilateral skin-sparing mastectomies, left axillary sentinel lymph node biopsy. On the pathology report it indicates two additional lymph nodes were removed that were not SLN. The axillary aspect measures 2 x 2 x 1 cm. Two lymph nodes are identified ranging from 0.5 up to 1 cm. The lymph nodes are bisected and entirely submitted. Final Diagnosis Left breast, mastectomy including nipple: no residual carcinoma; FINAL DIAGNOSIS for LN = Lymph nodes, left axillary sentinel #1; excision: Two lymph nodes examined - negative for tumor (0/2); Two lymph nodes - negative for tumor (0/2)

Answer

Assign surgery of primary site code 42. It is possible to obtain lymph nodes in a mastectomy specimen without an axillary dissection. Remember to capture the excised lymph nodes in the scope of lymph node surgery field.

Date Finalized

10/27/2015

20150041

Question
MP/H Rules/Multiple primaries--Breast: Does rule M10 apply in this situation?

L breast biopsy = INVASIVE DUCTAL CARCINOMA

L breast simple mastectomy = 2.0 cm INVASIVE DUCTAL CARCINOMA with an incidental finding of separate 1.0 cm INVASIVE LOBULAR CARCINOMA; pathologist specifically states the tumors are morphologically different. The tumors are both pure Ductal/pure Lobular.

Answer
Yes, Breast rule M10 applies. This case is a single primary.

Follow the MP/H rules even though the "pathologist specifically states the tumors are morphologically different" so that situations like this are reported consistently across cancer registries, regions, and states for consistent national reporting.

Date Finalized
10/07/2015