20140080

**Question**

Behavior--Breast: Is behavior for encapsulated papillary carcinoma (EPC) of the breast coded as noninvasive or invasive?

**Answer**

The pathologist has the final say on behavior. Code behavior based on the pathologist's final diagnosis. See Rule F in ICD-O-3.

According the WHO Classification of Breast Tumors, encapsulated papillary carcinoma of the breast is in situ, /2. Encapsulated papillary carcinoma with invasion is assigned /3. WHO describes "frank invasive carcinoma" for this histology as "neoplastic epithelial elements infiltrate beyond the fibrous capsule of encapsulated papillary carcinomas." WHO cautions that true infiltration should be "differentiated from entrapment of neoplastic epithelial cells in the fibrous capsule and from epithelial displacement into the biopsy site, which is frequently encountered following needle-core procedures of papillary lesions."

**Date Finalized**

10/27/2014

20140079

**Question**

Laterality: Why is a code 5 for laterality midline only allowed for certain sites of brain and skin? I have a nasal cavity tumor and the path report specifically says "Tumor laterality: midline". What is the correct laterality code here?

**Answer**

Assign laterality code 9 for midline nasal cavity tumor. We will investigate this issue further.

**Date Finalized**

10/27/2014

20140078

**Question**

Surgery of Primary Site--Bladder: Is any mention of cautery in the gross description of pathology for a TURBT specimen sufficient to code 22 (excisional biopsy with electrocautery), or does there need to be a statement in the operative report that electrocautery was performed? See discussion.

**Discussion**

Often, pathology for TURBT with non-invasive papillary TCC includes a gross description with a variety of cautery descriptions. For example, "received are three cautery roughened gray-pale pink tissue fragments." However, the operative report is documented as a "TURBT" with no further description of the procedure.

**Answer**

Assign code 22 when cautery is mentioned in the gross description of pathology for a TURBT specimen.

**Date Finalized**

10/27/2014

20140077

## Question

MP/H Rules/Histology/Multiple primaries--GE junction: How is histology coded for a goblet cell carcinoma in the GE junction? See discussion.

## Discussion

The patient was diagnosed with GE junction signet ring adenocarcinoma (8490/3) in 5/2012, treated with radiation. GE junction biopsy on 9/20/2012 showed residual signet ring carcinoma. Subsequent biopsies on 7/8/2013 showed GE junction biopsy of invasive adenocarcinoma, signet ring cell type along with “Esophagus, distal and GE junction biopsies” (site not further clarified in available documentation) with Goblet cell carcinoma. The histology code for the goblet cell carcinoma is needed to determine the number of primaries.

## Answer

According to our expert pathologist consultant, goblet cell is a descriptive term and not a specific histology in this context. There is no ICD-O-3 code for it. The "goblet cell carcinoma" in this case is not a new primary.

Goblet cell is used to describe some cells containing mucin. In addition to individual tumor cells containing mucin which compresses the nucleus to give the appearance of signet rings, the mucin is present in columnar cells with the nuclei at one end -- this latter is a pattern often seen when glandular structures are formed by the tumor cells. It is also often intermixed with the signet ring cells in the surrounding stroma.

## Date Finalized

10/27/2014

20140065

**Question**

Summary Stage 2000--Melanoma: How should Summary Stage 2000 be coded for 2014+ diagnosed melanoma cases with satellite nodules or in transit metastases? See discussion.

**Discussion**

The SEER SS (SSS) 2000 Manual indicates satellite nodules (NOS or less than/equal to 2cm from primary tumor) are regional by direct extension (code 2) and in-transit metastasis (satellite nodules greater than 2 cm from primary tumor) are coded as involvement of regional lymph nodes (code 3). However, CSv0205 indicates mapping for satellite nodules/in transit metastasis (coded in CS LN) was changed to Regional, NOS (code 5). There are no definitions listed for code 5 in the SSS 2000 Manual.

Our staff independently code SSS 2000. Should we code the existence of satellite nodules and in transit metastases according to the current definitions in the SSS 2000 Manual or using the mapping information from CSv0205?

**Answer**

Code the existence of satellite nodules and in transit metastases according to the current definitions in the SSS 2000 Manual. Do not use the mapping information from CS to code SSS.

**Date Finalized**

10/27/2014

20140064

**Question**

Reportability--Testis: Is a mature teratoma of the testis reportable? See discussion.

**Discussion**

Mature teratoma is listed as a benign neoplasm (9080/0) in the ICD-O-3. SINQ 20120085 references a NAACCR Webinar that indicated pure mature teratomas of the testis in adults are reportable. We are not aware of any further documentation of this change in reportability. When did mature teratomas of the testis for adults become reportable? What is the defined age range for "adult"? The original SINQ question above lists the 2012 SEER Manual as a Reference, however, no clarification or mention of this change in reportability was found in that manual.

**Answer**

For testis, mature teratoma in an adult (post-puberty) is reportable because it is malignant (9080/3); however, mature teratoma in a child is benign (9080/0). The 2011 NAACCR webinar introduced this concept and it was documented in the 2012 SINQ question. You may use 2011 or 2012 as the date of this change. The next edition of the SEER manual will include reportability examples.

**Date Finalized**

10/27/2014

20140063

## Question

MP/H Rules--Histology: How is histology coded when a metastatic site is biopsy positive for adenocarcinoma, but the physician clinically states this is cholangiocarcinoma? See discussion.

## Discussion

The patient underwent a PTA biopsy of a lytic mass showing metastatic adenocarcinoma. Imaging revealed a large hepatic mass consistent with cholangiocarcinoma. The physician's impression on a physical exam note was the PTA biopsy was most consistent with intrahepatic cholangiocarcinoma. However, the PTA pathology report was reviewed at this facility and the final diagnosis was not stated to be cholangiocarcinoma, only adenocarcinoma, NOS.

The priority order for coding histology rules in the MP/H Manual indicates pathology has priority over documentation in the medical record. Following the rules in the MP/H Manual, the histology would be coded as 8140 [Adenocarcinoma, NOS]. While this may be technically correct, it seems that intrahepatic cholangiocarcinoma is often diagnosed as adenocarcinoma on biopsy, but further stated to be cholangiocarcinoma by the physician once other primary sites have been excluded. By applying the rules in the MP/H Manual, cases that seem better characterized as cholangiocarcinomas are being collected as adenocarcinoma, NOS. Should the histology be adenocarcinoma [8140/3] or cholangiocarcinoma [8160/3] for these cases?

## Answer

When the physician has reviewed all of the pertinent information, and the physician's opinion is documented stating that the histology is cholangiocarcinoma, code cholangiocarcinoma.

A pathology report from a primary site has the highest priority for coding histology; however, there is no such pathology report in this case. We will review the histology coding instructions and add clarification in the next version.

## Date Finalized

10/27/2014

20140062

## Question

MP/H Rules/Multiple Primaries--Lung: Does lung MP/H Rule M6 apply to synchronous tumors only, metachronous tumors only, or both? See discussion.

## Discussion

How many primaries should be reported when a patient has a history of RLL adenocarcinoma diagnosed on 10/8/2009 followed by diagnoses of LUL adenocarcinoma on 10/5/2012 and a RUL adenocarcinoma on 3/26/2014?

We applied Rule M6 to the 10/5/2012 diagnosis of LUL adenocarcinoma and reported an additional primary. However, we are unsure how to apply the MP/H rules for the 3/26/2014 RUL adenocarcinoma.

Should we apply Rule M8 because the RUL adenocarcinoma was diagnosed more than 3 years after the original RLL adenocarcinoma and then apply M6 because the RUL and LUL indicate a single tumor in each lung (resulting in a third primary); or does Rule M12 apply because there has been more than a single tumor in each lung (no new primary)?

## Answer

Assuming each of the three diagnoses is a single tumor and there are no other tumors in either lung, abstract two primaries: 1 in the RLL diagnosed on 10/8/2009 and 1 in the LUL diagnosed on 10/5/2012. Do not abstract the 3/26/2014 diagnosis as a new primary.

Rule M6 applies to the 2009 and 2012 diagnoses. Rule M12 applies to the 2012 and 2014 diagnoses. Do not compare the 2014 diagnosis to the 2009 diagnosis. Always compare the latest diagnosis to the most recent previous diagnosis in cases like this.

## Date Finalized

10/27/2014

20140061

## Question

Primary Site/In Situ: How is primary site coded for an in situ carcinoma arising in a mucinous cystadenoma with ovarian stroma (focal) located in the right lobe of the liver? See discussion.

## Discussion

The SEER Coding and Staging Manual instructs one to code the primary site to the location where the tumor originated, in this case the liver. However, there is no CS Extension code for in situ tumors found in the CS Manual Liver Schema.

## Answer

Based on the information provided, the primary site is liver. Submit the CS question to the CoC CAnswer Forum, http://cancerbulletin.facs.org/forums/content.php

## Date Finalized

10/27/2014

20140060

**Question**

MP/H Rules/Histology--Lung: What is the correct histology code for this lung tumor? FINAL PATHOLOGIC DIAGNOSIS: CT-guided Rotex and Franseen needle biopsies: Positive for malignancy, consistent with adenocarcinoma. Comment: the adenocarcinoma present also shows rare CD56 staining which indicates a neuroendocrine component.

Is this a mixed histology? 8045/3? 8244/3?

**Answer**

Assign histology code 8140/3, adenocarcinoma, based on the final diagnosis. The neuroendocrine component in this case is not another histology, nor is it a more specific adenocarcinoma. "Component" is not one of the words that we use to indicate a more specific histology.

**Date Finalized**

10/27/2014

20140060

## Question

Reportability/Primary Site--Lip: Is a right lower lip (NOS) squamous cell carcinoma reportable when the microscopic description states the tumor arises from the epidermis and extends through the dermis? See discussion.

## Discussion

We are having difficulty determining whether the primary site is lip, NOS (C009) or skin of lip (C440). Usually we look for a statement of “skin” or “mucosa” in the microscopic description if the specimen label is only lip, NOS as instructed by the previous SINQ 20051049. Is a statement of "epidermis" or "dermis" in the microscopic description enough to indicate carcinoma is arising in the skin of the lip (C440) and thus not reportable?

## Answer

This case is interpreted as skin of lip and not reportable. According to our expert pathologist consultant, the pathologist in this case "is specifically saying "epidermis" and "dermis" and I would have to think it is skin, and thus not reportable."

## Date Finalized

10/27/2014

20140039

**Question**

Reportability--Heme & Lymphoid Neoplasms: Is a statement of "JAK-2 positive polycythemia" reportable? See discussion.

**Discussion**

Polycythemia, NOS is not reportable. However, there is a statement in the Heme Manual Glossary for JAK2 that states, "When JAK2 is positive, the MPN is definitely reportable." Does a positive JAK 2 always mean there is a reportable myeloproliferative disorder or must there also be an associated statement of a reportable neoplasm (e.g., myeloproliferative disorder, polycythemia vera, or essential thrombocythemia)?

**Answer**

A positive JAK 2 does not always mean there is a reportable myeloproliferative disorder. There must also be an associated statement of a reportable neoplasm (e.g., myeloproliferative disorder, polycythemia vera, or essential thrombocythemia). The glossary entry will be clarified.

**Date Finalized**

10/27/2014

20140038

**Question**

MP/H Rules/Multiple Primaries--Urinary: How many primaries are there and which MP rules apply in this scenario? See discussion.

**Discussion**

Patient has 2 tumors in the left ureter; one is transitional cell (8120) and one is papillary transitional cell (8130). Rule M6 says BLADDER tumors with any combination of the following histologies ... are a single primary. But this is not a bladder case. Rule M8 says urothelial tumors in 2 or more of the following sites are a single primary... but this is not in 2 or more sites. Rule M9 then says histologies different at the 1st, 2nd, or 3rd digit are separate primaries. That makes this 2 primaries, but I do not think this should be 2 primaries.

**Answer**

Rule M9 applies. Abstract 2 primaries.

We will evaluate this scenario for the next version of the multiple primary rules.

**Date Finalized**

10/27/2014

20140037

## Question

Grade--Prostate: How is Grade coded if hormone therapy is given prior to a prostate biopsy that confirms Gleason score 9 (4+5) adenocarcinoma? See Discussion.

## Discussion

Based on the clinical findings and elevated PSA, the physician diagnosed the patient with prostate cancer and started him on Casodex on 2/01/14, to be followed in 2-3 weeks by a prostate biopsy. The prostate biopsy was performed on 02/26/2014. Can the Gleason score from the prostate biopsy be used to code the Grade field in spite of the fact that the patient was given hormonal treatment prior to the biopsy? Or is 25 days of hormone therapy enough to affect the tumor grade?

Of note, a question regarding coding CS fields SSF7 & SSF8 (Gleason pattern and Gleason score) for this case was submitted to the CAnswer Forum. The response received from AJCC physician Expert Panel Members stated the Gleason Pattern/Score could be coded from the biopsy following hormone therapy because there is no "neoadjuvant therapy" for prostate primaries. (http://cancerbulletin.facs.org/forums/showthread.php?9117-Neoadjuvant-treatment-and-Gleason-s-Pattern-Score&highlight=Gleason)

While the CS ruling cannot be used to code a SEER field, there is confusion as to whether the SEER Grade field should also be coded as 3 (Gleason score 9) based on the biopsy, or coded to 9 (unknown) because Casodex was given prior to the biopsy.

## Answer

Assign grade code 9. Grade coding instruction #1 states "Systemic treatment and radiation can alter a tumor's grade. Therefore, it is important to code grade based on information prior to neoadjuvant therapy even if grade is unknown." Hormone therapy administered prior to a biopsy is systemic treatment. http://www.seer.cancer.gov/tools/grade/

## Date Finalized

10/27/2014

20140036

**Question**

MP/H Rules/Multiple primaries--Prostate: Is duct carcinoma of the prostate the same as an adeno/acinar carcinoma of the prostate? Specifically, does rule M3 apply when there is an adenocarcinoma of the prostate followed by a duct carcinoma of the prostate or a duct carcinoma followed by adenocarcinoma?

**Answer**

Rule M3 does not apply to adenocarcinoma followed by duct carcinoma of the prostate or vice versa. Rule M3 pertains to cases of adenocarcinoma and acinar carcinoma. These two terms, adenocarcinoma and acinar carcinoma, are equivalent for the purpose of applying the MP/H rules to prostate cases. See page 77 of the Other Sites Terms and Definitions, http://www.seer.cancer.gov/tools/mphrules/mphrules_definitions.pdf

**Date Finalized**

10/27/2014

20140035

## Question

Reportability/MP/H Rules/Histology: Is this kidney tumor diagnosis reportable? If so, what is the correct histology? See discussion.

## Discussion

Left radical nephrectomy: Tumor histologic type: Renal angiomyoadenomatous tumor (see Note). Note: A clear cell papillary renal cell tumor and a renal angiomyoadenomatous tumor (""RAT"") (renal cell carcinoma with angioleiomyoma-like stroma). Although some authors consider RAT tumors to represent a pattern of clear cell papillary RCC we believe that this represents a distinct entity. The combined findings ...confirm the diagnosis of renal angiomyoadenomatous (RAT) tumor. These tumors are also known as renal cell carcinoma within angioleiomyoma-like stroma. To date none of these tumors have developed metastases. Given the small number of reported cases we would consider these to have at worst a low malignant potential.

## Answer

According to our expert pathologist adviser, renal angiomyoadenomatous tumor ("RAT") is not reportable. He states "I would be reluctant to consider the entity malignant. The authors of the papers describing it do not seem ready to call it malignant either. I agree with calling it LMP, or in this case uncertain malignant potential."

## Date Finalized

10/27/2014

20140034

**Question**

Reportability--Ovary: Can you clarify when widely metastatic borderline histologies of the ovary and various other sites are reportable? See discussion.

**Discussion**

SINQ 20130176 states that an adult granulosa cell tumor of the ovary with metastases is malignant. However, SINQ 20091087 states that a borderline tumor of the appendix with metastasis is not reportable.

The first statement of 20130176 “though granulosa cell tumor is coded 8620/1, the presence of peritoneal or lymph node metastases indicate the tumor is malignant and coded as /3” does not coincide with the second statement of “the behavior of borderline/LMP ovarian epithelial tumors is determined by the ovarian primary, even though there may be peritoneal implants or metastatic disease in the lymph nodes”. If the ovarian metastases do make this a reportable malignancy, can this line of thinking be used to determine reportability for borderline histologies for other sites such as the appendix?

**Answer**

The case in 20130176 is **adult granulosa cell tumor**. The answer points out an important difference in the way "metastases" from this histology should be interpreted versus low malignant potential ovarian **epithelial** tumors. Metastases from adult granulosa cell tumor of the ovary indicates a malignant primary. So-called metastases from a LMP epithelial tumor do not indicate a malignant primary when the metastatic deposits are also LMP/borderline in behavior.

Do not apply instructions for ovarian cases to other primary sites including appendix.

**Date Finalized**

10/27/2014

20140033

## Question

Reportability/Ambiguous Terminology--Prostate: Can you clarify why a prostate biopsy diagnosis of “highly suspicious for, but not diagnostic of adenocarcinoma, suggest another biopsy” is not reportable while a biopsy diagnosis of “atypical glands suspicious for adenocarcinoma with insufficient atypia to establish a definitive diagnosis of malignancy” is reportable? See discussion.

## Discussion

SINQ 20091103 states that prostate biopsies showing “highly suspicious for, but not diagnostic of adenocarcinoma, suggest another biopsy” are NOT reportable. However, SINQ 20071056 states that “atypical glands suspicious for adenocarcinoma with insufficient atypia to establish a definitive diagnosis of malignancy” is reportable. This appears to be an issue of semantics with no clearly outlined method to determine reportability of such cases.

We have two recent cases with similar semantic issues and want to know whether they are reportable.

1) Prostate biopsy with “atypical small acinar proliferation, highly suspicious for adenocarcinoma, with quality/quantity insufficient for outright diagnosis of cancer.”

2) Prostate biopsy with “atypical small acinar proliferation highly suspicious for adenocarcinoma but due to the small size of focus, findings are not definitively diagnostic.”

## Answer

Both case examples provided are reportable using instructions for ambiguous terminology. The diagnoses are qualified by the words "highly suspicious" because neither diagnosis is definitive ("insufficient for outright diagnosis of cancer" and "not definitively diagnostic."). However, we follow our instructions for interpreting ambiguous terminology and report these cases.

SINQ 20091103 differs slightly. The final diagnosis in 20091103 declares unequivocally "not diagnostic of adenocarcinoma." That phrase in the final diagnosis negates the ambiguous terminology. The situation in 20071056 is similar to the two examples above – the ambiguous terminology instructions apply.

## Date Finalized

10/27/2014