

FINALIZED SINQ QUESTIONS

FEBRUARY 2012

Question: 20120026

Question

Primary site/Histology--Heme & Lymphoid Neoplasms: What is the primary site of Kaposi sarcoma and Human Herpesviruses 8 with associated primary effusion lymphoma (body cavity based lymphoma)?

1/2/11 Skin biopsy was positive. IMMUNOSTAIN for Human Herpesviruses 8 is positive confirming a diagnosis of Kaposi's sarcoma.

1/4/11 Groin lymph node biopsy was positive: Kaposi's sarcoma. (There are multiple positive nodes on PET) Bone marrow biopsy was negative.

Answer

Code the primary site to lymph node(s) (your information does not specify whether multiple chains are involved or only the groin node). Code the histology 9738/3 Large B-cell lymphoma arising in Human Herpesviruses 8-associated multicentric Castleman disease. See the abstractor notes: Code is effective for cases diagnosed 2010 and later. This is a lymphoma which usually affects lymph nodes and spleen but can spread to other viscera via blood stream.

Last Updated

02/13/12

Question: 20120024

Question

MP/H Rules/Histology--Breast: How many primaries are there and what histology code should be used for two tumors, one with duct and lobular and another with pleomorphic lobular and duct? See discussion.

Discussion

Path report of breast has 2 tumors in upper outer quadrant. One is a ductal and lobular (8522/3), and the other is a "Pleomorphic lobular and ductal".

According to the MP/H rules, "pleomorphic" is a specific type of duct carcinoma (8522/3)(general rules for breast). This does not show up in the tables, and I'm not sure if this should be one primary (with 8523/3, per M10) or two primaries (with 8022/3 and 8522/3, per rule M12).

When I Google pleomorphic lobular, it says it's a recently recognized subtype of lobular cancer. Please advise.

Answer

Use M10 and code a single primary. Use H16 and code 8522/3 duct and lobular.

Pleomorphic is listed on the duct table. It is a word that describes the cellular appearance rather than a specific histology. It is coded when that is the only description/diagnosis (pleomorphic carcinoma/pleomorphic duct carcinoma). However, you have two words, duct and lobular, that describe the actual histologic types. In that case, you ignore the

term "pleomorphic" and code the actual histologic descriptors, ductal and lobular. We will make appropriate changes to the breast rules in the MP/H revisions so this distinction is clear.

Last Updated

02/24/12

Question: 20120023

Question

Histology--Heme & Lymphoid Neoplasms: What is the histology? I cannot find a combination. Is it Burkitt Lymphoma?

Bone Marrow biopsy shows diffuse infiltration by B-Cell Lymphoma/Leukemia, consisting of medium-sized cells with Burkitt Morphology. Flow Cytometry: No evidence of leukemia or lymphoma.

Answer

Code a single primary, histology is diffuse large B-cell lymphoma 9680/3.

The steps to getting this answer are:

Step 1: Look up diffuse B-cell in the Hematopoietic Database. The first matched term is diffuse large B-cell lymphoma 9680/3.

Step 2: Look at the alternate names. One of the alternate names is "B-cell lymphoma, unclassifiable, with features intermediate between diffuse large B-cell lymphoma and Burkitt lymphoma.

Last Updated

02/24/12

Question: 20120022

Question

Reportability/Histology--Heme & Lymphoid Neoplasms: Is the following diagnosis reportable for a bone marrow biopsy dated 10/99/10 and what histology would be used. See discussion.

Discussion

Bone, left posterior iliac crest, biopsy: Small B-cell Non-Hodgkin lymphoproliferative disorder. See comment.

Comment: The differential diagnosis includes atypical small lymphocytic lymphoma/chronic lymphocytic leukemia and marginal zone lymphoma. Mantle cell lymphoma is very unlikely based on B-Cell Lymphoma 1 negativity.

Lymphoplasmacytic lymphoma is also excluded due to absence of a plasma cell component (CD138 negative).

Answer

Yes, report as non-Hodgkin lymphoma, NOS 9591/3. When there is a diagnosis of lymphoproliferative disorder and any lymphoma, code the lymphoma.

The information in the comment is reflective of the difficulty inherent in diagnosing hematopoietic and lymphoid neoplasms. The comment tells you that they ruled out a number of possible specific diagnoses (which explains why the final diagnosis is non-Hodgkin, NOS).

Last Updated 2/24/12

Question: 20120021

Question

Multiple primaries/Heme & Lymphoid Neoplasms: Would very much appreciate clarification of what "chronic" and "acute" mean. See discussion.

Discussion

Diagnosed 7/31/08 with Diffuse Large B-Cell Lymphoma (9680/3) (biopsy left supraclavicular node) but stage IIIB. Treated with chemotherapy. 10/14/10 Biopsy right supraclavicular node shows Follicular Lymphoma Grade 3A of 3 (9698/3).

Do we ignore rule M3? Does rule M12 apply since normally Follicular transforms into Diffuse Large B-Cell Lymphoma. However in our case, the Follicular came AFTER the Diffuse Large B-Cell Lymphoma. (so "acute" reverted to "chronic"?) Or do we just go on to rule M13 and use the HemaDB/calculator.

Do we have two primaries?

By using the Ask SEER site and looking at previous answers, I stumbled onto the fact that apparently you consider "transformations" to be acute phases of the more "chronic" disease. That was NOT apparent to me from the manual or from any of the original training sessions (and I viewed them all.)

Answer

Use rule M12 which tells you to abstract as multiple primaries when a neoplasm is originally diagnosed in a blast phase and reverts to a chronic phase after treatment.

You cannot use M3 because Diffuse Large B-Cell Lymphoma and Follicular Lymphoma weren't present in the same node(s) AT THE SAME TIME (we need to add a clarification to M3).

Last Updated

02/24/12

Question: 20120016

Question

Reportability--Heme & Lymphoid Neoplasms:

Amyloidosis is not Commission on Cancer reportable. My Medical Oncologist states that it is a malignancy. He presented a case at Cancer Conference and stated that the case was a Stage III. Your guidance is appreciated.

Answer

Amyloidosis (AL) is a group name that includes benign conditions (found in pancreas of type II diabetes patients and brain lesions of Alzheimer patients, for example) as well as in malignant diseases (AL found in multiple myeloma and ACal (calcitonin) found in medullary carcinoma of the thyroid). Amyliodosis, NOS is not a term that equates to a malignant diagnosis. Check your medical record to see if this is designated as either AL or ACal. There should be a malignant diagnosis such as multiple myeloma or medullary carcinoma of the thyroid rather than just amyloidosis because you need to code the disease, not the symptoms.

Last Updated

02/24/12

Question: 20120015

Question

Diagnostic confirmation--Heme & Lymphoid Neoplasms:

Could you give me step by step instruction of how to code the diagnostic confirmation for thrombocythemia? Do we use the Hematopoietic Manual Rules? See discussion.

Discussion

The Hematopoietic Manual states that this is a clinical diagnosis and a diagnosis of exclusion, coded 8. The JAK-2 diagnosis must be coded 5, according to a recent webinar, but I think that code 8 is stating thrombocythemia is always a clinical diagnosis or diagnosis of exclusion. Many people use code 3 for positive bone marrow biopsy and genetics (JAK-2), but the bone marrow is usually borderline or not normal for a person's age.

Answer

Code diagnostic confirmation as 8, clinical diagnosis, in this case.

Use the Hematopoietic Manual. JAK-2 is only positive in about 50% of essential thrombocythemia (ET) patients. In addition to that, JAK-2 cannot identify the type of myeloproliferative disease (MPN) the patient has.

The WHO guidelines for diagnosing ET are: elevated platelet count over months and the elimination of other causes for an elevated platelet count (such as polycythemia vera (PV), chronic myelogenous leukemia (CML), idiopathic myelofibrosis, or myelodysplastic syndrome (MDS), the absence of Philadelphia chromosome, BCR/ABL fusion gene and del(5q), t(3;3)(q21;26), inv(3)(q21q26).

Then they rule out any underlying causes of thrombocytosis such as an inflammation or infection, other neoplasms, and prior splenectomy.

Now we have a diagnosis of exclusion (all other causes have been excluded) and the physician puts together the information from the blood counts, bone marrow, JAK-2 with the exclusion of all other diseases and makes a clinical diagnosis of ET.

Last Updated

02/27/12

Question: 20120014

Question

Histology--Heme & Lymphoid Neoplasms: What histology code should we use?

Pathology report states the diagnosis to be "plasma cell dyscrasia, consistent with multiple myeloma". No other information is available if patient is deceased or refuses further investigations.

Answer

Report as multiple myeloma.

All of the standard setters, central registries, and hospital registries have collected/reported cases based on ambiguous terminology since the 70's. It is most definitely confusing when cases are reported based on ambiguous terminology but you are instructed not to code histology based on ambiguous terminology.

The instruction "Do not code histology based on ambiguous terminology" is intended for the NOS and more specific histologies. When the diagnosis is (myeloproliferative disease (MPN), probably polycythemia vera (PV) or essential

thrombocytopenia (ET), for example, the pathologist/laboratory is saying the results are equivocal between the two diseases OR it can mean that the specific markers have not yet been done, so they cannot specify which disease is actually present. In that case, you use PH38 and code the NOS (in this case MPN). When the markers clearly show which disease is present and the diagnosis is MPN, PV, use PH39 and code the specific disease, polycythemia vera. We will clarify those instructions in the next revision.

Last Updated

02/24/12

Question: 20120013

Question

Reportability--Heme & Lymphoid Neoplasms: Is this case is reportable?

Patient had Langerhans cell histiocytosis as a child, back when the disease was not reportable (9751/1). Patient was disease free until it recurred in 2011. The disease is now reportable (Diagnosis date greater than 1/1/2010 - 9751/3). Hemato Manual says it is a single primary, but the code changed from benign to malignant since the initial diagnosis.

Answer

This is a recurrence of the previous Langerhans. Since the original diagnosis was made before the disease was reportable, do not report recurrences. This is disease progression.

Last Updated

02/24/12

Question: 20120012

Question

Histology/CLL/SLL--Heme & Lymphoid Neoplasms:

What histology would you use for a diffuse large B-cell lymphoma (DLBCL) arising in small cell lymphoma-Richter's transformation, also compatible with chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma(SLL) in the body of the pathology report.

See discussion.

Discussion

I have looked this up in the hematopoietic database and nothing came up for this. If you put in Richter's transformation in the hematopoietic database you get 9945/3.

Answer

Use M7 and code a single primary, the acute disease, DLBCL 9680/3.

Your case is explained by defining Richter's transformation. For CLL (and CLL/SLL), Richter's transformation is when the CLL changes into DLBCL. In this case, you are seeing a biopsy with the chronic disease (CLL) transforming (Richter's transformation) into an acute disease DLBCL.

Entering only the word "transformation" in the hematopoietic database will result in the display: chronic myelomonocytic leukemia in transformation. This is not Richter's transformation.

Last Updated02/24/12

Question: 20120011

Question

Histology--Heme & Lymphoid Neoplasms:

1. Based on the abstractor's notes under myelodysplastic syndrome (MDS) in the Hemato Manual and Database it states that "if the characteristics of a specific subtype of MDS develop later in the course of the disease, change the histology code to the more specific diagnosis. So based on this note, should the MDS 9989 code be changed to refractory anemia with excess blasts (RAEB-2) 9983?
2. Is there a time limit (months versus years status post original diagnosis) for applying this abstractor's recoding note?
3. Have I interpreted the pathology reports and Hemato Manual and Database correctly in making this TWO separate primaries?

See discussion.

Discussion

Background:

Facility A: 04/08/10 Bone Marrow biopsy: features most compatible with MDS (no treatment administered); 07/02/10 Peripheral Blood: transforming Myelodysplastic Syndrome (MDS), Comments: clonal abnormality compatible with MDS/acute myeloid leukemia (AML) in all metaphases examined. (still no treatment)

Facility B: 10/06/10 Patient now presents for evaluation and treatment. Patient started on Vidaza. 10/07/10 Bone Marrow biopsy: Refractory anemia with excess blasts (RAEB-2) Note: evolution towards AML with myelodysplasia related changes considered; cytogenetic analysis reveals abnormalities most compatible with MDS and/or AML.

Based on the Hemato Manual and Database, the 04/08/10 diagnosis of MDS, NOS (9989/3) would be the first primary. Then the 07/02/10 diagnosis of transforming MDS to AML (9861/3) would be a new, second primary. But then a biopsy taken on 10/07/10 (1 day status post treatment) reads RAEB-2 (9983/3) with evolution towards AML.

Answer

1. Yes, you used the abstractor notes correctly, change the MDS 9989 to RAEB-2 9983.
2. No, there is no time limit for recoding to the more specific disease. Unlike solid tumors, hematopoietic and lymphoid neoplasms may take a year or more to manifest the specific disease. It is simply a part of the "disease characteristics."
3. You did indeed interpret the Hemato Manual and Database correctly in that the MDS/RAEB and AML would be two separate primaries; however, the terminology used is "consistent with" AML. Ambiguous terminology is used for reportability, not for coding specific histologies (see the following, which explains why we are so careful with ambiguous terms). The patient was not treated until three months later; but literature shows that AML, untreated, is usually fatal within 1-3 months. The treatment given 3 months after the "compatible with diagnosis" was a drug used for MDS, not AML. The other problem is that the bone marrow examination (more reliable than peripheral blood) shows "evolution towards AML." That means that the bone marrow is exhibiting the changes seen in the final stages of MDS prior to progression to AML. Wait for a definitive diagnosis of AML and/or treatment for AML before abstracting the second primary.

Last Updated

02/24/12

Question: 20120010

Question

Multiple primaries/Behavior--Ovary: Is this one or two primaries? If one primary, what is the date of diagnosis and histology?

Patient was diagnosed with an ovarian mucinous borderline tumor in 2003. Now presents with bone metastases. See discussion.

Discussion

2011 PATHOLOGY REPORT:

Spine at L3 biopsy: metastatic adenocarcinoma. Per addendum: prior total abdominal hysterectomy specimen from 2003 was reviewed and showed an ovarian mucinous cystic tumor of borderline malignancy which has a similar morphology to the invasive adenocarcinoma seen on current specimen.

Abdominal tissue and omental biopsy: invasive and non-invasive glandular implants compatible with origin from ovarian mucinous borderline tumor.

Final diagnosis per radiation oncologist MD, "recurrent ovarian cancer."

Answer

Report this as a 2003 case. Code the behavior as invasive, /3.

This is a case where an invasive or microinvasive element was missed in the original pathology. Since the entire tumor is not sectioned and placed on slides, the pathologist uses their expertise when sectioning and selecting tissue to be examined. It is not a matter of poor judgement, just a fact that it is impossible to review the tissue from the entire tumor.

Last Updated

02/24/12

Question: 20120009

Question

Histology--Heme & Lymphoid Neoplasms: What would the correct histology code be for this example?

The morphologic features and immunophenotype of this low-grade B-cell lymphoma are most compatible with lymphoplasmacytic lymphoma or marginal zone lymphoma. CT chest/abdomen/pelvis was unremarkable.

Answer

Always go to the PH rules, Module 8 when you have a diagnosis with multiple histologies. Use rule PH38 code the NOS histology, B-cell lymphoma, NOS.

Rule PH38 was written for these types of cases. The term "compatible with low-grade B-cell lymphoma (LBL) 9671/3 or marginal zone lymphoma (MZL) 9699/3" means that the immunophenotype was not diagnostic of either LPL or MZL. Wait until there is a definitive diagnosis of either LPL or MZL, then change the histology code to the more specific diagnosis.

If you were to choose the higher ICD-O-3 code, for example, you would code MZL 9699. If the case was later determined to be LPL, you would incorrectly record two primaries when there should only be one.

Last Updated 02/24/12

Question: 20120008

Question

Recurrence/MP/H Rules--Ovary:

Patient was diagnosed with ovarian serous carcinoma 4 years ago and currently has sacral and pelvic masses positive for serous carcinoma on biopsy. Is this disease progression (i.e. metastatic disease) or considered recurrent disease? See discussion.

Discussion

The pathologist did not compare the mass biopsies with the original pathology. Is this our only criteria for determining recurrent disease? It seems that this better fits the definition of metastatic disease rather than recurrence, thereby eliminating the need to make this an entirely new primary cancer (per MPH Other Sites Rule M10 for diagnoses more than one year apart).

Answer

This is a single primary.

In this case, the sacral and pelvic masses are distant metastasis. Metastases: When cancer cells appear in other nodes or organs that are not the primary site, they are metastatic cells. Discontinuous (separate from the primary tumor) masses or cells in regional lymph nodes, distant lymph nodes, or distant sites are always metastases. In this case, the sacral and pelvic masses are distant metastasis. The pathologist does not have to compare cells to the original tumor slides; the discontinuous tumor mass/cells in any site other than the primary site are metastases.

Recurrence: For a disease to recur there are several criteria that must be met. First and most important, the patient must have had a disease-free interval (a tumor cannot recur if it has always been present). The other criteria are: the "new tumor" has to occur in the original primary site, it must be the same histology as the original tumor, AND must meet the timing requirements in the MPH rules for that organ/site.

Last Updated

02/24/12

Question: 20120007

Question

Histology--Heme & Lymphoid Neoplasms: Would the histology code be 9895 (AML with prior MDS) or 9920 (treatment related AML) or is there another histology code more appropriate?

Patient was treated with neoadjuvant chemotherapy and radiation for Stage IV rectal cancer in 2004 followed by an abdominoperineal resection, then FOLFOX. Lung metastasis resected March 06. Pelvic recurrence Dec 06, treated with Temodar, capecitabine, Thalidomide for approximately 2 years until remission June 08. Maintained on Thalidomide in 2008; stopped Dec 08 for cytopenia. MDS diagnosed Nov 09. Progressed to acute myeloid leukemia (AML) Jan 10.

Answer

Code the histology 9920/3 therapy-related acute myeloid leukemia alkalinizing agent related. MDS can also be caused by exposure to radiation therapy and/or chemotherapy. This type of MDS is usually more severe and is more difficult to treat. That seems to be the case with your patient - in Dec 08 the Thalidomide was stopped due to cytopenia and MDS was diagnosed in Nov 09. The patient developed AML two months later. This pattern certainly points to therapy-related neoplasms (both the MDS and AML).

Last Updated 02/13/12

Question: 20120006

Question

Histology/Primary Site--Heme & Lymphoid Neoplasms: How would the histology & primary site be coded?

Bone marrow biopsy states lymphoplasmacytic lymphoma. Oncologist "Bone marrow showing 50% marrow involvement with IgM kappa restricted B-cell lymphoma consistent with lymphoplasmacytic lymphoma. Lab revealed normal quantitative immunoglobulin save for slightly elevated IgM and very small IgM kappa serum protein spike. PET revealed no abnormal liver or lymph nodes, asplenic, slight uptake throughout skeleton consistent with marrow involvement but being somewhat nonspecific. Asymptomatic Stage 4A lymphoplasmacytic lymphoma with early incidentally discovered bone marrow involvement."

Answer

It is necessary to evaluate the flow cytometry on the peripheral blood to determine whether the patient has lymphoplasmacytic lymphoma (LPL), Waldenstrom's macroglobulinemia (WM), or gamma heavy chain disease (GHD). The bone marrow in these cases will show LPL.

The difference between LPL and WM is:

LPL is the "NOS" or parent disease of both Waldenstrom's macroglobulinemia and gamma heavy chain disease. These diseases are characterized by an abnormally large production of B-lymphocytes or plasma cells. The B-lymphocytes and plasma cells produce an abnormal amount of immunoglobulin in the peripheral blood. Increased lymphocytes produce an abnormal amount of IgM which is the diagnostic criteria for WM. An abnormal amount of plasma cells produces an abnormal amount of IgG which is the criteria for the diagnosis of GHD. An abnormal production of BOTH IgM and IgG (because of increased B-lymphocytes AND plasma cells) is the criteria for LPL.

Last Updated

02/13/12

Question: 20120005

Question

Histology--Heme & Lymphoid Neoplasms: What is the correct histology for monomorphic post-transplant proliferative disorder, 9680/3 or 9971/3?

The answers to questions 20110026 and 20110036 appear to conflict with each other. Question 20110026 (see discussion) states that monomorphic is an alternate name for polymorphic and should be coded to 9971/3. Question 20110036 states the monomorphic post transplant lymphoproliferative disorder itself is not reportable, code the lymphoma.

See discussion.

Discussion

2010 Diagnosis of diffuse B-cell lymphoma (monomorphic post-transplant lymphoproliferative disorder) with involvement of multiple lymph node regions, bowel, and stomach.

Answer

We will revise the SING answers. Post-transplant lymphoproliferative disorder (PTLD) is classified into two major categories: polymorphic PTLD and monomorphic PTLD. Monomorphic PTLD cases are commonly associated with B-cell non-Hodgkin lymphoma, for example, diffuse large B-cell lymphoma. There are rare cases of association with

plasmacytoma or a T-cell lymphoma.

When PTLN is associated with a lymphoma or plasmacytoma, the lymphoma or plasmacytoma is coded.

Polymorphic PTLN is NOT associated with a lymphoma or plasmacytoma. The diagnosis will be ONLY PTLN. The histology is coded to polymorphic post transplant lymphoproliferative disorder 9971/3.

Last Updated

02/13/12

Question: 20120004

Question

Grade--Heme & Lymphoid Neoplasms: What grade/differentiation would I use for this?

Malignant non-Hodgkin lymphoma, large B-cell type, with features consistent with T-cell rich variant.

Answer

Assign grade code 6, B-cell, according to rule G6 in the Heme/Lymph Grade of Tumor coding rules.

See the Heme DB definition for diffuse large B-cell lymphoma (DLBCL), 9680/3. In the last sentence it says the morphologic variants are: centroblastic, immunoblastic, plasmablastic, T-cell/histiocyte rich, and anaplastic. Code the grade to B-cell. Although this is a variant that is T-cell/histiocyte rich, it is still a B-cell phenotype.

Last Updated

02/13/12

Question: 20120003

Question

Multiple Primaries--Heme & Lymphoid Neoplasms:

Plasma cell leukemia is a variant of multiple myeloma and when these two histologies are found simultaneously in bone marrow, it should be abstracted as multiple myeloma (single primary). Why code the histology to multiple myeloma 9732/3 rather than to plasma cell leukemia 9733/3 which has the higher code, as instructed in Rule PH41? Why does the multiple primaries calculator show these histologies to be multiple primaries?

Answer

Use the 2010 rules which state simultaneous MM and PCL are a single primary. Plasma cell leukemia was determined to be a variant of plasma cell myeloma/multiple myeloma in the 2008 WHO Classifications of Hematopoietic and Lymphoid Neoplasms. The rule to code plasma cell leukemia as multiple myeloma is effective for cases diagnosed 2010 and later.

The pre-2010 instructions to "code to the numerically higher ICD-O code" are not valid for cases diagnosed 2010 and later. Over years, classifications and clinical knowledge change; the codes and their numeric arrangement, however, remain the same. In addition to that problem, there was simply not enough room to insert the new hematopoietic/lymphoid codes in correct sequence - the problem started with ICD-O-2 for a few codes and increased dramatically in ICD-O-3.

In the case of simultaneous multiple myeloma and plasma cell leukemia, the leukemia is a late-stage manifestation of multiple myeloma; the leukemia is not the primary disease.

The MP calculator shows new primary because when a case of plasma cell leukemia was diagnosed prior to 2010, and multiple myeloma diagnosed 2010 and later, you would abstract two primaries. You cannot go back in time and change the rules for the pre-2010 case of plasma cell leukemia.

Last Updated

02/13/12

Question: 20120002

Question

Histology/Diagnostic confirmation--Heme & Lymphoid Neoplasms:

According to Hemato Manual Module 1, PH2, I am supposed to code the histology diagnosed by the definitive diagnostic method, which for lymphoma, NOS (9590/3) is histologic confirmation, but if I use that it will be 8000/3 and will no longer be a lymphoma. If there is no histologic confirmation of lymphoma, would I go to PH3 and code to 9590/3 and use diagnostic confirmation code 7?

See discussion.

Discussion

This patient had CT scans showing extensive bilateral retroperitoneal lymphadenopathy suspicious for lymphoma and left axillary lymphadenopathy. Thin core biopsies were done of the left axillary lymph nodes and immunohistology pathology was read as malignant neoplasm with extensive necrosis. Flow cytometry analysis of the sample shows no definitive or sufficient CD45+ events for informative analysis. Karyotype analysis could not be performed on this specimen due to inadequate sample. FISH analysis using IGH break apart probe showed no evidence of clonal rearrangement in limited number of cells available for analysis. Physician's diagnosis is probable lymphoma, no further workup felt necessary because patient would not tolerate chemotherapy anyway and hospice was felt most appropriate care for patient.

Answer

You are correct, you code 9590/3 as the histology.

Reportability instruction 2 states that the ambiguous term "probable" should be reported and instruction 3 says to report clinical diagnosis.

For the histology, you do bypass PH2 because it does not apply. Go on to PH3.

The diagnostic confirmation is 7 because the scan was "suspicious for lymphoma."

Last Updated

02/13/12

Question: 20120001

Question

Multiple Primaries/Recurrence--Heme & Lymphoid Neoplasms: Is this a second primary?

A patient was diagnosed with diffuse large B-cell NHL in 2001. Patient presents in 2011 with a biopsy of the pharynx showing diffuse large B-cell lymphoma after an interval of being disease free for 8-9 years. The medical oncologist states that this is almost certainly a second malignancy rather than recurrence since recurrence almost always does so within the first 2-3 years.

Answer

This is the same primary using rule M1.

Our hematopoietic physician experts say that the problem with lymphomas is that the patient may be disease-free then recur years later. Even though years have passed, this is still a recurrence or relapse. Currently, there are no molecular markers that are able to distinguish "new primaries" from recurrences. There are also no established criteria for timing rules that could be used to determine a new primary VS. recurrence.

Last Updated

02/13/12

Question: 20110154**Question**

Behavior--Breast:

Does stromal invasion mean invasive, behavior /3?

The breast biopsy shows DCIS with focal and very early stromal invasion and microcalcifications. The following lumpectomy and sentinel node biopsy shows DCIS and no invasive malignancy.

Answer

Yes, stromal invasion means the cancer is invasive. "Stroma" is the supporting connective tissue around and between ducts. It is outside the duct basement membrane, and if the tumor cells extend into it, the proper designation is invasive. Code behavior as a /3.

Last Updated

02/13/12

Question: 20110153**Question**

Reportability/Heme & Lymphoid Neoplasms:

Should macrocytic anemia be collected?

Answer

No, macrocytic anemia is not reportable. Anemia is the condition of having a low count of red blood cells. The term macrocytic refers to the enlarged size of the red blood cells. Macrocytic anemia is usually caused by vitamin deficiencies, alcohol use, medications or thyroid disorders.

Last Updated

02/13/12

Question: 20110151

Question

Reportability/Heme & Lymphoid Neoplasms:

Patient presented to the ER and the medical oncologist stated the diagnosis as "common variable immunodeficiency," also known as acquired hypogammaglobulinemia, code 279.6 on SEER casefinding list, supplemental list. Is this reportable?

Answer

No, this is not a reportable condition. Common variable immunodeficiency is a group of approximately 150 primary immunodeficiencies which have a common set of symptoms but which have different underlying causes, both benign and malignant.

The case is not reportable unless this immunodeficiency diagnosis is accompanied by a diagnosis of a cancer, or by a hematopoietic or lymphoid neoplasm.

Last Updated

02/13/12

Question: 20110150

Question

Ambiguous Terminology/Heme & Lymphoid Neoplasms:

I have a patient that the physician states "patient's clinical picture certainly is most consistent with MDS." He performed several FISH probes on peripheral blood, specifically looking for the 5q minus syndrome as well as other molecular rearrangements to suggest or confirm MDS. These studies came back as normal as well as the initial bone marrow that came back negative. The physician then states, "The suspicion was that this represented a myelodysplastic syndrome despite the normal cytogenetics. Additional studies that we performed on the date of the clinic visit included the FISH for the 5q minus syndrome as well as CD59 to exclude PNH. Both of these were negative.

Therefore, at this juncture, the patient has a macrocytic anemia not yet requiring transfusional support with a normal white count and an elevated platelet and a hypercellular bone marrow. This is certainly consistent with a myelodysplastic syndrome.

Since we do not use ambiguous terminology to code histology, only for reportability, what is the histology code for this case?

Answer

Report as MDS, unclassified 9989/3. The statement that you do not use ambiguous terms to code histology is intended for those NOS histologies with an ambiguous term being used to describe the subtype, such as MDS, NOS, probably refractory thrombocytopenia. In that case, you would record the NOS (MDS) rather than the refractory thrombocytopenia.

As an additional piece of information, in the Heme database you will see "clinical diagnosis" listed as the definitive diagnostic method for MDS. This is often a diagnosis of exclusion, meaning that the tests are not positive for any other neoplasms, so the physician uses his/her expertise to evaluate the clinical presentation as well as the equivocal and negative test results and determines a diagnosis of MDS, NOS.

Last Updated

02/13/12

Question: 20110149

Question

Ambiguous Terminology/Heme & Lymphoid Neoplasms:

When can we use ambiguous terminology and when should we not be using ambiguous terminology? See discussion.

Discussion

Our pathologists often use the diagnosis 'plasma cell dyscrasia' followed by an ambiguous term such as 'consistent with' or 'favors' with a more specific histology such as 'plasma cell myeloma'. What histology code would we use for plasma cell dyscrasia? We cannot use ambiguous terminology to code heme/lymphoid neoplasms (as per the Advanced Quality Abstracting: Hematopoietic and Lymphoid Neoplasms online presentation - slide 18 'First Rule').

If the physician states the diagnosis is 'plasma cell myeloma', for example, in a note following the pathology, would we then use that diagnosis as though it didn't have the ambiguous terminology preceding it?

Also, would we be using this pathology as diagnostic confirmation if we can't use the histology 'plasma cell myeloma' because it is preceded by the ambiguous terminology and plasma cell dyscrasia is not found in the hematopoietic database & manual?

Answer

Report the case. We do use ambiguous terminology for reportability because we have done so for 30+ years and any deviation from using ambiguous terminology for case reportability would cause problems with incidence counts.

We do not, however, use ambiguous terminology to report a more specific diagnosis for the heme/lymph neoplasms. For example, Myeloproliferative Neoplasm, probably Polycythemia Vera would be reported as Myeloproliferative Neoplasm, NOS. That is because the ambiguous terminology tells you that the genetic testing, immunophenotyping, etc., probably are not complete or are not diagnostic of the specific disease. Wait until you have a definite diagnosis to code a specific type.

Last Updated

02/13/12

Question: 20110148

Question

First Course Treatment/Multiple primaries--Heme & Lymphoid Neoplasms: How would you record the treatment on each abstract? The first abstract as subsequent treatment and the second abstract as first course? See discussion.

Discussion

I have a case with an original diagnosis of follicular lymphoma, multiple lymph nodes (9690/3) diagnosed on 12/2/09. The patient had a negative bone marrow and was treated with CHOP as the 1st course treatment. In Oct. 2010, the patient was put on maintenance Rituxan but had progression of disease noted in Nov. 2010. A biopsy of the mesenteric lymph node in Dec. 2010 was diffuse large B-Cell lymphoma (9680/3).

The patient went on to have chemotherapy and autologous bone marrow transplant.

According to the multiple primary calculator, this is a new primary. But the physicians are calling the December diagnosis a transformation from the 12/09 diagnosis.

Answer

Abstract this case as two primaries. For first course of treatment, record CHOP for the follicular lymphoma. Record

chemo and BMT for the DLBCL.

If you look at follicular lymphoma in the Hematopoietic DB, Transformation box, you will see that FL does transform to DLBCL. This "transformation" is actually a new disease.

FL is a disease in which the LN have a prominent follicular pattern; DLBCL is a disease with diffuse proliferation of large lymphoid cells. While it is true that FL will transform to DLBCL, the keyword is transform, i.e., becoming a different entity.

We code the DLBCL as a second primary for several reasons: so that we can get an incidence on how many FL transform to DLBCL; so that the survival time starts with the diagnosis of the more aggressive DLBCL; so that the death will be attributed to the DLBCL (mortality statistics), not the FL. So, the DLBCL is abstracted as a second primary.

Last Updated

02/24/12

Question: 20110147

Question

Multiple Primaries/Heme & Lymphoid Neoplasms:

Peripheral blood results state (differential diagnosis per flow interpretation) "findings consistent with a small mature b-cell neoplasm differential - marginal zone lymphoma, lymphoplasmocytic lymphoma, and atypical CLL." Physician states diagnosis = "SLL." There was no bone marrow exam.

Per MPH rule 9: if diagnosis is B-cell CLL/SLL and peripheral blood is involved (there was no bone marrow biopsy or CT looking for lymphadenopathy), histology should be coded to B-CLL/SLL 9823/3. To confirm, do I code to 9823/3-C421 and despite the physician diagnosis of SLL (coded to 9870/3)?

Answer

Code to CLL/SLL 9823/3 because the peripheral blood is involved. This may appear to contradict the physician's diagnosis, but the 2008 WHO no longer codes CLL and SLL as separate neoplasms, rather one neoplasm, CLL/SLL, which reflects the actual neoplastic process.

Those patients with SLL usually manifest CLL during the neoplastic process and those patients with CLL usually manifest SLL during the neoplastic process. WHO recommends coding to CLL/SLL rather than coding two primaries when the other neoplasm manifests.

Last Updated

02/13/12

Question: 20110146

Question

Multiple Primaries/Heme & Lymphoid Neoplasms:

I have a patient who was diagnosed in 2003 with malignant lymphoma, mixed cell type, follicular. This was in the inguinal nodes.

The patient now has adenopathy in the neck which, on biopsy was follicular lymphoma. The PET scan shows only the adenopathy in the neck and some mediastinal nodes.

Is this one or two primaries?

Answer

This is the same disease using rule M2, a single histology is a single primary.

This case is one in which the terminology for follicular lymphoma has changed over time. In 2003, follicular lymphoma (FL) was classified as small cleaved cell, large cell, or mixed cell (both small cleaved and large cell). Those designations are no longer used, the neoplasm is currently called follicular lymphoma. The change was simply a change in classification/terminology.

Last Updated

02/13/12

Question: 20110145**Question**

MP/H Rules/Recurrence--Skin:

A patient with dermatofibrosarcoma protuberans left upper inner arm diagnosed and treated 8/2008. A "Recurrence" was noted 10/2010 in the scar per another surgeon. Pathologist has not compared histology.

Can we count this as same primary, or since it has been over a year, a new primary?

Answer

The physician specialists for soft tissue and bone replied as follows:

Low-grade sarcomas tend to recur locally. Because this tumor recurred in same area i.e. scar of prior surgery, and recurred in this period of time, this is a local recurrence.

Dermatofibrosarcoma Protuberans is a low grade tumor which can recur many years following tumor excision.

Last Updated

02/13/12

Question: 20110144**Question**

Reportability/Heme & Lymphoid Neoplasms:

Is steroid resistant ITP the same as refractory thrombocytopenia 9992/3?

Discussion**Answer**

Idiopathic thrombocytopenic purpura (ITP) is not a synonym for refractory thrombocytopenia (RT). ITP is not a reportable disease. The statement that the disease is resistant to steroids simply means that the ITP is not responding to treatment (steroids are used to treat ITP).

Last Updated

02/13/12

Question: 20110143

Question

Multiple primaries/Heme & Lymphoid Neoplasms:

Patient had a biopsy of the skin of the clavicle & neck. Both lesions were consistent with mycosis fungoides.

According to Hematopoietic rules (which I am assuming I would use), it is same primary. If I used MP/H rules, it would be considered multiple primaries. Please clarify.

What is the primary site?

Answer

The Hematopoietic rules are used for mycosis fungoides 9700/3. Step 1 Search the Heme DB for "fungoides." Display the information. In the primary site box it tells you the code must always be skin (C440-C449).

Step 2: Use the Heme Coding Manual, multiple primary rules. M2 says abstract as a single primary when there is a single histology. That rule fits this case. Although there are two primary sites (clavicle and neck) there is only ONE histology, mycosis fungoides.

The primary site is skin of trunk (C44.5).

Last Updated

02/13/12

Question: 20110142

Question

Reportability/Heme & Lymphoid Neoplasms

Would you abstract this case?

Path Report: 2/16/11–mesentery biopsy-follicular lymphoma who grade 1-2, findings may represent an "in situ" follicular lymphoma.

Physician Note: 3/7/11-nodularity of the mesentery which upon biopsy may be in situ follicular lymphoma. No treatment is necessary. This is not a proven malignancy. It may evolve into one. Plan 6 month followup and CT scans prior.

See discussion.

Discussion

I checked the ICD-O book and follicular lymphoma grade 1 is 9695/3 and grade 2 is 9691/3. The note from our oncologists, and the phrase "may represent" an in situ lymphoma from our pathologist, has us question whether this should be abstracted or not.

Answer

In situ lymphoma is not reportable for any of the standard setters (CoC, NPCR, or SEER).

Last Updated

02/13/12

Question: 20110141

Question

Multiple primaries/Heme & Lymphoid Neoplasms

A patient has history of cutaneous t-cell lymphoma in the 1980's and a history of DLBCL of bowel (NOS) in 1991. The patient presents in 2010 to our hospital. Stated to have been in remission from the DLBCL, however CT of brain is consistent with Central Nervous System DLBCL. Cerebrospinal fluid cytology is consistent with DLBCL. CT Scan of torso does not show any lymphadenopathy or suspicious findings.

Is this a primary Central Nervous System DLBCL, and therefore a third primary, or is this a recurrence / progression, which some of the documentation I have states.

Pt is referred to a cancer center and receives no further workup or treatment at our hospital

Answer

Use rule M2 and abstract as a single primary when there is a single histology. DLBCL of bowel in 1991 is the same histology as the current neoplasm, DLBCL of the brain.

History

Last Updated

02/13/12

Question: 20110140

Question

Breast: MP/H Rules--Breast

In the final diagnosis of the pathology report the morphology is DCIS & LCIS. But in the microscopic examination of the report it states "focally, between ducts involved by DCIS there are minute tubular structures associated with stromal fibrosis and chronic inflammation. These foci are suspicious for micro invasive carcinoma."

Is this coded to invasive even though this is not listed under the final diagnosis and is found only in the body of the report under microscopic exam?

Is it then coded to 8522/3?

Answer

Do not code to invasive in this case. The pathologist indicated that these findings were "suspicious," not definite. If the pathologist decided that this was truly an invasive tubular element, it would have been included in the final diagnosis.

Last Updated

02/13/12

Question: 20110138

Question

First Course Treatment/Heme/Lymphoid Neoplasms

What would be considered first course of treatment?

A patient is being treated for Diffuse Large B-Cell Lymphoma who was initially treated with involved field radiation and R-CHOP. The patient still had residual disease and treatment was changed to RICE.

There was still residual disease, so there was one more chemotherapy treatment which was unspecified. The patient was transferred to a transplant center for pre-transplant chemotherapy and a bone marrow transplant. Only then did the patient achieve a complete response.

Would only the R-CHOP be considered first course in a case like this or would first course be considered continued through the transplant?

Answer

For hard-to-treat diseases such as DLBCL, the treatment plan may include "the first course of treatment will be radiation and R-CHOP. If the R-CHOP does not achieve remission, we will use RICE." In other words, the first course treatment plan includes a second round of chemotherapy if the patient has not achieved a complete response. If this was part of the first course treatment plan, it would be recorded as first course. If it was not a part of the documented treatment plan, RICE would be second course of treatment.

Last Updated

02/13/12

Question: 20110136

Question

MP/H Rules/Histology--Bladder: What is the correct histology when the final diagnosis is 'Bladder tumor: urothelial carcinoma' and the CAP checklist shows 'Tumor Configuration: Papillary'? The pathologist staged it as pTa. Can we use the information about papillary configuration to code the histology as 8130 rather than 8120?

Answer

Code the histology as 8130. Use information from the CAP checklist when available. See SINC 20081100.

Last Updated

02/27/12

Question: 20110135

Question

MP/H Rules/Histology--Lung: Why is micropapillary adenocarcinoma of the lung coded to 8260? I am just wondering why the correct code is 8260 rather than 8050? See discussion.

Discussion

See SINC 20110115

Answer

The histology codes for lung tumors are based on the World Health Organization Classification of Lung Tumors. See

Chart 1 in the MP/H Lung Equivalent Terms, Definitions, Charts, Tables, and Illustrations document.

Last Updated

02/27/12

Question: 20110134

Question

Multiple primaries--Heme & Lymphoid Neoplasms: What rule is used for the following scenario?

Diagnosed in 1999 with Burkitt, high-grade B cell lymphoma of the thyroid gland and cervical nodes. The patient was treated with a thyroidectomy and chemotherapy. Recent biopsy of the parotid gland is positive for diffuse large B cell lymphoma.

Our pathologist reviewed both paths and stated they are one primary.

Answer

It is not a rule, rather a definition that explains your pathologist's statement that this is a single primary.

When you have a case such as this, search the Hematopoietic DB for the most unique word, Burkitt. There are 10 results in the matched term list, one of which is B-cell lymphoma, unclassifiable with features intermediate between large B-cell lymphoma and Burkitt lymphoma 9680/3. (I realize the full name does not display. That will be fixed in the next revision.)

When you click on this term to display the information, you will see that the "preferred" name for this disease is diffuse large B-cell lymphoma (DLBCL). That means that the first primary in the thyroid should have been coded 9680/3. If it was not, the histology code should be changed.

The second primary is the same histology code 9680/3. The aggressive DLBCL is now the only histology that is apparent, but as your pathologist stated, this is one disease process, thus a single primary.

Last Updated

02/13/12

Question: 20110130

Question

MP/H Rules--Lung: Should a July 2011 subsequent left lower lobe mass with adenocarcinoma be accessioned as an additional primary per rule M7 or as the same primary per rule M12 if it follows a September 2010 right upper lobe/right middle lobe lobectomy with clear cell adenocarcinoma in one nodule and adenocarcinoma in another nodule? See discussion.

Discussion

09/2010: RUL/RML lobectomy: Two separate nodules. One nodule showed clear cell adenocarcinoma, and the other showed adenocarcinoma (NOS). Potential brain metastasis per scan. Patient also received chemotherapy. These are two separate primaries per rule M11.

07/2011: New LLL mass + satellite nodule, biopsy of LLL mass compatible with adenocarcinoma (NOS).

Is the 07/2011 an additional new primary per rule M7? Or is it the same primary as the 09/2010 adenocarcinoma per rule M12?

Answer

The 2011 diagnosis is a separate primary according to rule M7. Since rule M7 does apply to this case, rule M12 cannot

be used because you must use the rules in order.

Last Updated

02/27/12

Question: 20110129

Status

Final

Question

MP/H Rules/Histology--Lung: How many primaries are accessioned if a pathology report for a right upper lobectomy with a chest wall resection describes the disease as 1) two foci of poorly differentiated non-small cell carcinoma, 2) mixed adenocarcinoma and non-mucinous bronchioloalveolar carcinoma, each present as a separate focus? See discussion.

Discussion

We have coded this case as two primaries, 8255/3 (adenocarcinoma, acinar and papillary types) and 8252 (non-mucinous bronchioloalveolar) per rules M5 and M10. If this is indeed just two primaries, what is the stage for each tumor? The non-small cell tumors were the most invasive, but they were not considered a separate primary per the MPH rules.

RUL lobectomy and chest wall resection: Carcinoma of the lung with the following features:

1. Non-small cell carcinoma, poorly differentiated (see comment). Two foci in same lobe: 10 cm and 3 cm (largest dimensions of each tumor). Invades pleura (PL3), main bronchus and chest wall invasion present.
2. Adenocarcinoma and bronchioloalveolar carcinoma (see comment). Histologic subtype: Acinar and papillary (adenocarcinoma); non-mucinous (BAC). Two foci in same lobe: up to 1.0 cm. Pleural invasion absent, chest wall invasion absent.
3. Metastatic carcinoma in 5/7 peribronchial LN's.

Comment: Two histologically distinct neoplasms identified in the lobectomy/chest wall resection specimen: Poorly differentiated non-small cell carcinoma, present as two foci; and adenocarcinoma and non-mucinous bronchioloalveolar carcinoma, each present as a separate focus.

Answer

SEER will answer the question about the number of primaries to accession. Please submit questions about stage to the CoC CAnswer Forum.

This case is two primaries: Mixed adeno, acinar & papillary (8255), and bronchioloalveolar carcinoma, non-mucinous (8252). Rule M10 states that NSCC is not a separate primary in this case. M5 states that mixed adeno and BAC are separate primaries.

Last Updated

02/27/12

Question: 20110126

Question

Multiple primaries--Heme & Lymphoid Neoplasms:

If a person presents with follicular lymphoma in the inguinal and abdominal nodes in 2010, with a history of lymphoma in 2003 and again in 2009, is it still one primary?

What rule helps us make that determination?

Also, what if we do or don't know if the patient has been disease free, does that affect how the rules are used?

See Discussion.

Discussion

History of diffuse large B-cell lymphoma (site C778, BM involved) diagnosed in 2003 and a follicular lymphoma confined to the thyroid and neck nodes diagnosed in 2009 which are the same primary according to the fold-out chart used for cases diagnosed through 2009.

If I get to the rule that tells me to use the DB, which histologies am I comparing? The 3rd to the 2nd or the 3rd to the 1st?

Answer

Reportability is determined by the year of diagnosis. The original DLBCL was diagnosed in 2003 and the FL in 2009. The pre-2010 rules are used for both cases.

When the patient presents with FL in the inguinal and abdominal nodes in 2010 and you have a FL case (thyroid and neck) in your database with a diagnosis date of 2009, you need to ascertain whether the 2009 and 2010 FL are the same primary because you have a new tumor/areas of involvement in 2010. Using rule M2 - a single histology is always a single primary.

You do not compare the DLBCL and FL in 2010 because the determination of a multiple primary was done (as it should have been) using the rules in effect in 2009. That decision is made the first time the patient presents with the two diseases, it is not changed when one of the diseases disseminates.

Last Updated 2/24/12

Question: 20110118

Question: [20110118](#)

Add to Report

Question

Reportability--Colon: Is a polypectomy that is suspicious for invasive adenocarcinoma followed by a partial colectomy with no residual neoplasm considered reportable? See discussion.

Discussion

Original diagnosis: 08/28/09 Cecum, bx: Adenomatous polyp with focal areas suspicious for invasive adenocarcinoma. Is it possible that the polypectomy removed the entire tumor and the suspicious diagnosis should be reported? The related SINC 20071060 doesn't seem to apply because that case refers to only a biopsy followed by negative resection, and this case is a polypectomy (surgical treatment), followed by a second surgical treatment which was negative.

Answer

This case is reportable. It is possible that the polypectomy removed the entire tumor. Invasive carcinoma in a polyp does not mean that it has invaded the stalk. If the stalk is not invaded, all of the cancer would have been removed with a polypectomy.

History

Last Updated
12/19/11