

# SEER SINQ's

Finalized March 2011

**Question: 20110067**

**Status**

Final

**Question**

First course treatment--Heme & Lymphoid Neoplasms: Are the treatment guidelines in the "red book" still valid? See discussion.

**Discussion**

While I realize that the Hematopoietic Database & Manual replaces the "red book" guide for hematopoietic disease, I am finding no direction on coding of treatment in the new database. Can you direct me to where in the new manual I will find the treatment guidelines that were in the "red book". As an example, the previous guidelines told us to code transfusions for myelodysplastic syndrome to other therapy.

**Answer**

We will be adding other treatment to the appropriate diseases in the Heme DB in the next revision. We will also follow through and add it to the SEER Manual and ask CoC to include in the FORDS Manual. Blood transfusions will not be collected. The hematopoietic physician experts stated that transfusions are used for symptoms such as anemia and that there is no way to identify neoplasms for which the collection of information on transfusions would be useful. The treatments that should be recorded are as follows: Record phlebotomy for polycythemia vera ONLY. Record aspirin, heparin, or other "blood thinning" agents for the following diseases:

- Myeloproliferative neoplasm, unclassifiable
- Polycythemia vera
- Essential thrombocythemia
- Primary myelofibrosis
- Myelodysplastic/myeloproliferative neoplasm, unclassifiable
- Chronic myelogenous leukemia BCR-ABL1 positive
- Chronic neutrophilic leukemia
- Systemic mastocytosis
- Mast cell leukemia
- Mast cell sarcoma

**History**

**Last Updated**

03/16/11

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**Question: 20110066**

**Status**

Final

**Question**

Multiple primaries--Heme & Lymphoid Neoplasms: Should the lymphoma be reported as a 2nd primary when a patient has a history of CLL and while undergoing chemotherapy a new liver lesion biopsy shows diffuse large B cell lymphoma and the managing physician states that it is likely Richter transformation? Or is this one primary?

**Discussion**

**Answer**

Abstract a second primary, DLBCL 9680/3. Richter transformation is a term that indicates CLL has transformed to DLBCL. Richter transformation will be added as a synonym for DLBCL in the next revision of the Heme DB.

The steps you would use to determine the number of primaries are:

Step 1: Look up the original neoplasm, CLL, in the Heme DB. Enter "CLL" in the search mechanism. CLL/SLL will be highlighted. Click display.

Step 2: Look at the transformation information. Transformation information says that CLL transforms to DLBCL. That means you have a chronic neoplasm (CLL) and an acute neoplasm (DLBCL). Since you say the patient has a "history of" CLL, I will assume that the diagnosis of the acute neoplasm (DLBCL) occurred more than 21 days after the diagnosis of the chronic neoplasm (CLL).

Step 3: Go to the Multiple Primary Rules in the Heme Manual. Use Rule M10, Abstract as multiple primaries when a neoplasm is originally diagnosed in a chronic (less aggressive) phase AND second diagnosis of a blast or acute phase more than 21 days after the chronic diagnosis.

**History**

**Last Updated**

03/16/11

**Question: 20110065**

**Status**

Final

**Question**

Multiple primaries/Histology--Heme & Lymphoid Neoplasms: Path report states: skin, right thigh, consistent with mycosis fungoides (cutaneous T-cell lymphoma). When I apply the rules it shows that this is two primaries. Is that correct? If so, can you please explain the reasoning?

**Discussion**

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## Answer

This is a single primary. The histology is 9700/3 mycosis fungoides with a primary site of skin. The pathologist wrote in parentheses that this was a cutaneous (i.e. primary site is skin) and that it is a T-cell (mycosis fungoides is a T-cell lineage). So the parenthetical statement was not a separate diagnosis; rather a further classification of the mycosis fungoides.

## History

## Last Updated

03/15/11

## Question: 20110063

## Status

Final

## Question

Reportability--Heme & Lymphoid Neoplasms: The following has been added to the SEER 2011 casefinding list:

289.6 Familial polycythemia

Note: This is a synonym for polycythemia vera

I do not see "Familial polycythemia" listed as an alternative name for PV in the hemato database. Will this be added or can you explain the use of this term?

## Discussion

## Answer

Familial polycythemia is a primary polycythemia due to factors intrinsic to red cell precursors, including primary familial and congenital polycythemia (PFCP), idiopathic erythrocytosis, and polycythemia vera (PV). It is on the casefinding list because it may be caused by PV. It is not, however, a synonym for PV.

Delete the note on code 289.6 on your copy of the expanded list that states "Note: This is a synonym for polycythemia vera". We will remove that annotation from future versions of the casefinding list.

## History

## Last Updated

03/15/11

# SEER SINQ's

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## Question: 20110062

### Status

Final

### Question

Histology--Heme & Lymphoid Neoplasms: Is diffuse large B-cell lymphoma, germinal cell type coded to diffuse large B-cell?

### Discussion

### Answer

Yes, code to DLBCL 96803. Look at the synonyms for DLBCL, one of the synonyms is germinal centre-cell like GCB.

### History

### Last Updated

03/15/11

## Question: 20110061

### Status

Final

### Question

Primary site/Histology--Heme & Lymphoid Neoplasms: Patient was dx with chronic lymphocytic leukemia in a bone marrow biopsy 2005. In 2010, the path report shows small b cell lymphocytic lymphoma and the scans show lymphadenopathy. Do the histology and primary site codes change to 9670 and C779 or do we keep the original code of 9823 and C421?

### Discussion

### Answer

This the same disease (one primary). Do not change the original codes. To explain, see the following from the hematology physician experts:.

Expert 1: The distinction of CLL vs. SLL can not be made on bone marrow biopsy in isolation. Also, important, the pathologist can not make a diagnosis of "SLL" vs "CLL" without having peripheral blood counts available for review. Also, if the patient got treated for CLL in the past, that may alter the peripheral counts seen in 2010 (e.g., lymphocytosis). The distinguishing feature is peripheral lymphocytosis in CLL (not seen in SLL). Otherwise, the disease looks the same and both will often have bone marrow involvement and LN involvement etc. If the patient had true "CLL" in 2005 (we probably can't confirm that now, but have to assume it), then any subsequent LN (or other) biopsy consistent with CLL/SLL remains consistent with the original diagnosis of "CLL". I would not change the original CLL code.

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Expert 2: I agree with the previous response. We have to assume the 2005 diagnosis included a peripheral blood supporting that dx. Otherwise, CLL and SLL look the same in nodes and marrow. The interplay between the two "diseases" is expected, and is why they are considered a single disease.

## History

### Last Updated

03/15/11

**Question: 20110060**

### Status

Final

### Question

Reportability--Heme & Lymphoid Neoplasms: Is a case reportable if it is stated as having a recent diagnosis of "polycythemia" and is now being treated with phlebotomy, with no additional information?

### Discussion

#### Answer

No, this case is not reported. Polycythemia (also known as polycythaemia or erythrocytosis) is a disease state in which the proportion of blood volume that is occupied by red blood cells increases. Blood volume proportions can be measured as hematocrit level. It can be due to an increase in the mass of red blood cells, "absolute polycythemia"; or to a decrease in the volume of plasma, "relative polycythemia".

The phlebotomy is treatment for the excessive blood volume. Unless this is called primary polycythemia or polycythemia vera, it is not reportable.

## History

### Last Updated

03/15/11

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**Question: 20110059**

**Status**

Final

**Question**

MP/H Rules/Histology: What is the histology code for a malignant myopericytoma ?

**Discussion**

**Answer**

According to the WHO Classification of Tumours of Soft Tissue and Bone, the histology code for myopericytoma is 8713/1. Malignant myopericytoma would be coded 8713/3 according to the ICD-O-3 matrix concept. The WHO classification states "Very rare malignant myopericytomias exist."

**History**

**Last Updated**

03/29/11

**Question: 20110058**

**Status**

Final

**Question**

Date of Diagnosis/Flag: In what scenario would a Date of Diagnosis Flag be used if an abstractor follows the coding instructions for Date of Diagnosis and Date of Diagnosis Flag that require at least a known or estimated year of diagnosis? See discussion.

**Discussion**

Per the SEER Program Coding and Staging Manual 2010, page 49, Date of Diagnosis, second paragraph:

...Regardless of the format, at least Year of diagnosis must be known or estimated. Year of diagnosis cannot be blank or unknown.

Or page 50, Coding Instructions:

3. If no information about the date of diagnosis is available
  - a. Use the date of admission as the date of diagnosis
  - b. In the absence of an admission date, code the date of first treatment as the date of diagnosis.

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Or page 51, Coding Instructions:

9. Estimate the date of diagnosis if an exact date is not available. Use all information available to calculate the month and year of diagnosis.

Or page 53, Date of Diagnosis Flag, Coding Instructions:

Always leave blank. Date of Diagnosis will always be a full or partial date recorded.

### Answer

The date of diagnosis flag should always be blank.

### History

### Last Updated

03/29/11

### Question: 20110057

### Status

Final

### Question

MP/H Rules/Behavior--Appendix: How do you code mucinous appendix cancers? How would seer code a "low grade mucinous appendix tumor/neoplasm" (this is often what the path report says-won't even call it a carcinoma) that has spread to the peritoneum? See discussion.

### Discussion

Low grade mucinous neoplasms can spread to the peritoneal cavity and in that sense are metastatic but histologically have bland/benign features (and in the sense that they just may be a benign cystadenoma that ruptured and spread by rupturing) are not a carcinoma. Thus some have termed this group DPAM (disseminated peritoneal adenomucinosis) and not a true carcinoma. Some though state that if you have peritoneal mets it is metastatic and thus a carcinoma.

### Answer

Low-grade mucinous tumors of the appendix are a /1, borderline/uncertain behavior, and not reportable. These tumors do spread to the peritoneal cavity (pseudomyxoma peritonei). This spread, or deposits, or implants are also borderline/uncertain behavior and do not make the appendiceal tumor reportable. By contrast, a high-grade mucinous tumor of the appendix may produce malignant/invasive pseudomyxoma peritonei. When the pseudomyxoma peritonei are diagnosed as invasive or malignant, the mucinous tumor in the appendix is reportable as a /3.

### History

### Last Updated

03/09/11

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**Question: 20110056**

**Status**

Final

**Question**

Primary site--Heme & Lymphoid Neoplasms: Would it be correct to code the primary site of PTLD to brain? See discussion.

**Discussion**

I recently abstracted a case of PTLD (post transplant lymphoproliferative disorder) diagnosed 6/2010. The disease was diagnosed with biopsy from the brain. I understand typically this diagnosis involves lymph nodes, but if not, can it correctly be coded to the brain?

**Answer**

Yes, post transplant lymphoproliferative disorder can be coded to the brain. When in doubt about a primary site code, use the Hemato DB Abstractor Notes. First enter PLTD in the search box. Display the information, then click on Abstractor Notes. The Abstractor Notes say that in solid organ recipients the CNS may be the only site of involvement.

**History**

**Last Updated**

03/09/11

**Question: 20110055**

**Status**

Final

**Question**

Multiple primaries--Heme & Lymphoid Neoplasms: Could you please help me determine the number of primaries and how you derived the answer? Bone marrow aspirate: acute myeloid leukemia (non-M3 type; favor FAB:M1), probably arising in myelodysplastic syndrome. Flow cytometry on the same day states "analysis of bone marrow aspirate reveals significantly increased myeloblast population (54%) consistent with acute myeloid leukemia.

**Discussion**

**Answer**

This is a single primary, AML, Acute myeloid leukemia. FAB M1 is an older term for acute myeloid leukemia without maturation 9873/3. The easiest way to find this classification is to enter fab m1 into the Hematopoietic database.

Ambiguous terminology is NOT used to determine histology for hematopoietic or lymphoid neoplasms, so the comment that the AML is "probably" arising in myelodysplastic syndrome is not used to determine the histology code.

**Updated**03/09/11

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Finalized March 2011

## Question: 20110054

### Status

Final

### Question

First course treatment/Other therapy--Heme & Lymphoid Neoplasms: Is a transfusion for a multiple myeloma coded as first course treatment? Does it matter if the patient is given the transfusion because the anemia is chemotherapy-related? See discussion.

### Discussion

2010 SEER Main manual pdf on pgs 98-100 has instructions for first course treatment for heme disease. At bottom of pg 99, it is noted to continue to code some things in 'other' as in the past.

### Answer

Do not code transfusions. The hematopoietic specialty physicians say that transfusions are given for such a variety of reasons (anemia, etc.) and should not be coded as other treatment.

### History

### Last Updated

03/09/11

## Question: 20110053

### Status

Final

### Question

Multiple primaries--Heme & Lymphoid Neoplasms: Is this one or two primaries? History of refractory anemia with excess blasts (RAEB), several months ago, and unknown if treated. Now comes in for bone marrow aspiration and biopsy which is compatible with acute myeloid leukemia.

### Answer

The AML is a second primary. The steps you use to determine this MP status are as follows.

Step 1: Enter 9983/3 (RAEB) into the Hematopoietic DB. The transformation information tells you that RAEB transforms to AML. Also see the abstractor notes which state "The chance of transforming into AML is 25% for patients with type 1 RAEB and 33% for patients with type 2." This confirms that you have a chronic neoplasm (RAEB) and an acute neoplasm (AML) occurring more than 21 days apart.

Step 2: Go to the Multiple Primary Rules in the Hematopoietic Manual. Use Rule M10, Abstract as multiple primaries when a neoplasm is originally diagnosed in a chronic (less aggressive) phase AND a second diagnosis of a blast or acute phase more than 21 days after the chronic diagnosis.

**Last Updated** 03/02/11

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Finalized March 2011

## Question: 20110052

### Status

Final

### Question

First course treatment--Heme & Lymphoid Neoplasms: Is phlebotomy still abstracted as treatment for polycythemia vera? The previous guide to hematopoietic diseases instructed registrars to code phlebotomy as "other therapy". When reviewing polycythemia vera treatment in the current hematopoietic database, it only lists chemotherapy and directs registrars to SEER\*Rx.

### Discussion

### Answer

Yes, continue with current instructions and abstract phlebotomy as treatment for polycythemia vera.

### History

### Last Updated

03/14/11

## Question: 20110051

### Status

Final

### Question

Multiple primaries--Heme & Lymphoid Neoplasms: How many primaries are there for this case? Lymphoma diagnosed on bilateral breast biopsies - MALT lymphoma; bone marrow negative.

### Discussion

### Answer

Abstract a single primary, histology is MALT lymphoma and primary site is breast. Unless your software has edits that prevent coding laterality for lymphomas, code the laterality as bilateral. Up to half of extranodal, extragastric, MALT lymphomas are multiple, particularly in paired sites (breast is an example).

### History

### Last Updated

03/02/11

# SEER SINQ's

Finalized March 2011

## Question: 20110050

### Status

Final

### Question

MP/H Rules/Multiple primaries: How many primaries does this case scenario represent? In Dec. 2003 a patient was diagnosed with epithelioid sarcoma of the left palm. In Jan. 2004 he had an excision with skin graft and positive margins. Amputation was recommended but the patient chose radiation instead. In May 2006 the patient had a local excision positive for epithelioid sarcoma followed by an amputation of the thumb and index finger with positive margins. Then in April 2010, the patient had an amputation of the remnant of left hand up to the middle third of the forearm. Again there is residual distal invasive tumor positive for epithelioid sarcoma.

### Discussion

### Answer

This is a single primary: epithelioid sarcoma of the left upper limb. The sarcoma progressed over the years and the patient was never free of disease -- positive margins were documented at each surgical event.

### History

### Last Updated

03/14/11

## Question: 20110046

### Status

Final

### Question

Multiple primaries--Stomach: After reviewing the medical record, I have doubts with the multiple primary rules in this case. The patient was diagnosed with gastric carcinoid tumors starting in 12/2003 through 03/2009. As per Program Code Manual: Rule 5: If a tumor with the same histology is identified in the same site at least two months after the initial/original diagnosis (metachronous), this is a separate primary. The physician doesn't state that this is a recurrence. Should I abstract every tumor or this can be a single primary? The pt does not have familial polyposis syndrome. See discussion.

### Discussion

12/2003 - Gastric Polyp Removal - Path: Gastric carcinoid tumor

05/2004 - Stomach body polyp removal - Path: Carcinoid Tumor (endocrine cell tumor)

09/2004 - Single polyp in body removal - Path: Gastric carcinoid

03/2005 - Multiple gastric body polyps removed - Path: Carcinoid tumor

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07/2005 - 3 sm polyps in fundus removal - Path: Carcinoid tumor

02/2007 - Localized nodularity in lesser curvature - Path: Carcinoid (neuroendocrine) tumor

03/2009 - Somach body polypectomy - Path: Carcinoid tumor

## Answer

Code as a single primary. The histology is carcinoid.

Our expert pathology consultant replied as follows: This patient clearly has a condition driving the proliferation of neuroendocrine cells. Possibilities include hypergastrinemia from a gastrinoma or from response of antral gastrin cells due to achlorhydria due to long standing chronic atrophic gastritis, or multiple endocrine neoplasia (MEN1) syndrome (genetically driven). So much for the explanation - but how do we code these, since as far as I know we don't have a way to code the inciting situation. (I suspect the gastroenterologist knows what it is, but we haven't obtained that information.)

As the expert consultant states, we do not have an ICD-O-3 code for the underlying condition, MEN1 or hypergastrinemia. The only choice is to code the resulting tumor, carcinoid.

## History

## Last Updated

03/09/11

**Question: 20110044**

## Status

Final

## Question

MP/H Rules/Histology--Corpus Uteri: How many primaries/what histologies does the following resected specimen contain?

"Adenocarcinoma of endometrium with the following features: Histologic type: Endometrioid with squamous and focal clear cell differentiation. A second focus of endometrial adenocarcinoma is present in the fundus with admixed complex atypical hyperplasia in a polypoid, non-invasive mass. The second tumor is endometrioid with secretory differentiation."

Comment: The tissue in between the two tumors is sampled, and contains foci of endometrial adenocarcinoma that is superficially present within the endometrium, as well as a small focus of clear cell carcinoma measuring 0.2 cm.

See discussion.

## Discussion

Per MP/H rule M17, this is counted as multiple primaries, because the histology codes differ at the third number: 8323/3; 8382/3; 8310/3. The M rules make no reference to the histology tables. There is also no rule to ignore in situ tumor. The histology table for other sites also does not include secretory differentiation of endometrioid carcinoma.

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## Answer

This is a single primary. Rule M16 applies. Assign histology code 8323/3 per H30. Our expert pathologist states "I would regard this as a single endometrial primary with extensive endometrial involvement and several types of differentiation, all of which are seen in endometrial carcinomas."

## History

## Last Updated

03/14/11

## Question: 20110040

## Status

Final

## Question

Reportability--Melanoma: Is the following case reportable? The first path report says, "Early melanoma, Early Evolving Melanoma, Early Melanoma or Melanocytic Nevus", all non reportable terms. The second path reports says, "No residual Melanoma" (first use of reportable terms). See discussion.

## Discussion

In regard to SINQ's 20041034 and 20010155

## Answer

No, this case is not reportable based on the information provided. "No residual melanoma" is not diagnostic of a reportable neoplasm.

Note: We recommend that you try to obtain more information for this case due to the poor documentation. Seek clarification from the pathologist. Check for any additional resection performed.

## History

## Last Updated

03/14/11

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## Question: 20110038

### Status

Final

### Question

Reportability/Behavior: Can someone have a minimally invasive thymoma and not have it be malignant? Is this reportable? Nowhere in the path do I see "malignancy" stated. See discussion.

### Discussion

One example is combined types B2 and B3. Are types A through C malignant, even if the path report does not state "Malignant Thymoma"?

### Answer

According to our expert pathologist consultant:

Go by the terms used in the pathology report. Don't try to second guess the pathologist.

- 1) Thymomas are /1 and not reportable unless the pathologist states "malignant". This includes A, AB, B1, B2, and B3. Any may exhibit invasion but do not code /3 based only on invasion.
- 2) Code thymoma as /3 if specifically designated "malignant" by the pathologist.
- 3) Thymic carcinoma and any of its subtypes are malignant, /3.

### History

### Last Updated

03/02/11

## Question: 20110018

### Status

Final

### Question

Multiple primaries--Heme & Lymphoid Neoplasms: The patient had Follicular Lymphoma Grade 2 and was treated over a period of time. The Oncologist thinks the spleen is congested & removes the spleen. Pathology finds Diffuse Large B-cell Lymphoma in the spleen. Is DLBCL a second primary & why?

### Discussion

### Answer

The diffuse large B-cell lymphoma (DLBCL) is a new primary. To determine the answer, do the following:

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Step 1. Search the DB for follicular lymphoma, grade II 9691/3. Look at the transformation information. The DB says FL transforms to DLBCL, which means you have a chronic neoplasm (FL) that has transformed to an acute neoplasm (DLBCL).

Step 2: Go to the MP Rules, M10: Abstract as multiple primaries when a neoplasm is originally diagnosed in a chronic (less aggressive) phase AND second diagnosis of a blast or acute phase more than 21 days after the chronic diagnosis.

## History

### Last Updated

03/15/11

## Question: 20110015

### Status

Final

### Question

Primary site/Histology: Per the SEER Errata for ICD-O-3 Site/Type Validation List, April 1, 2009, Adenocarcinoma, intestinal type, was removed as a valid site/histology combination for the following primary sites: C150-C155, C158-C159, C170-C173, C178-C179, C180-C189, C199, C209, C210-C212, C218.

Questions:

- 1) Does this mean that these combinations are mutually exclusive? If so, then why is an override allowed for these site/type combinations? Shouldn't these site/type combinations be added to the impossible site/type combinations table?
- 2) SINQ 20081085 states that "8144/3 will be removed from the valid site/histology list for large intestine, small intestine, and rectum." It appears from the Site/Type Validation table that a decision was made to also remove esophagus sites as a valid combination with histology code of 8144. Please explain the rationale.
- 3) Cases that were miscoded to 8144/3 will need to be identified for correction. What date of diagnosis should be the reference point in relation to the posted Errata – cases diagnosed 1/1/2009 forward or should all cases be corrected regardless of date of diagnosis?

### Discussion

### Answer

The site/type edit identifies unlikely combinations of primary site and histologic type.

1. Intestinal type adenocarcinoma occurs in the stomach. It would be rare in another primary site, but not impossible.
2. It was decided that all digestive organ sites, except stomach, would be removed from the list. That is why esophagus

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is not listed as a valid site.

3. The site/type edit is for all years. Cases for all years have to be reviewed for combinations of site and type that are no longer on the list. If it is documented in the medical record that the primary site and histology combination are valid, set the over-ride flag so that the case will not come up for review again.

## History

### Last Updated

03/02/11

**Question: 20100009**

### Status

Final

### Question

MP/H Rules/Multiple primaries--Bladder: A patient has a history of invasive bladder cancer diagnosed several years ago in another state. Now in 2009, he is admitted to your hospital with a positive biopsy for transitional cell carcinoma of the bladder. Is this a new primary (since you do not know the histology of the previous bladder cancer) or can you assume it was urothelial in the past and use rule M6 to consider the 2009 diagnosis as NOT a new primary?

### Discussion

### Answer

Apply rule M6. The 2009 diagnosis is not a new primary. Transitional cell carcinomas account for more than 90% of bladder cancers. If the patient actually had a small cell, squamous cell, or adenocarcinoma in the past, it would be highly unlikely that no mention was made in the medical record that the patient had one of these rare bladder tumors.

### History

### Last Updated

03/11/11