

FINALIZED SEER SINC'S

APRIL 2011

Question: 20110081

Status

Final

Question

MP/H Rules/Histology--Pancreas: What is the correct histology code for pancreatic neoplasia III (PanIN III) for cases diagnosed in 2007 and later?

Discussion

Answer

Code PanIN-III as 8148/2 [Glandular intraepithelial neoplasia, grade III]. See the MP/H histology coding rules for other sites, rule H22.

History

Last Updated

04/20/11

Question: 20110079

Status

Final

Question

MP/H Rules/Histology: Can you please tell me where to find the documentation in the MP/H manual that states that we are not to use the term "focal" in coding histology? (Ex - Neuroendocrine carcinoma with focal squamous differentiation.)

Discussion

Answer

For the purposes of the MP/H rules, the term "focal" is not used to indicate a more specific histology. Terms that may be used to indicate a more specific histology are listed in the relevant histology rules. For example, see Breast histology rule H3. Notice the terms listed in the note for this rule are "type, subtype, predominantly, with features of, major, with ___ differentiation, architecture or pattern." The term "focal" is not included. This concept will be clarified in future revisions to MP/H rules.

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History

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04/13/11

Question: 20110078

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Question

MP/H Rules/Histology--Bladder: I am presuming that the histology for this case would be coded 8082 based on Table 1; however, I cannot find a histology rule that directs me to Table 1 for this scenario. See discussion.

Discussion

Bladder resection path report states high-grade urothelial carcinoma, plasmacytoid variant. Plasmacytoid (8082) is listed in the MP/H manual Urinary Terms and Definitions in Table 1-Urothelial/Transitional Cell Tumors. Please verify the correct histology code and the histology coding rule that applies.

Answer

You are correct, there is no rule that directs you to Table 1 for this combination. We will add the reference to Table 1 in the updates to MP/H Rules. For now, Urinary Rule H7 could help us get to this mix of cell types.

History

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Question: 20110077

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Question

MP/H Rules/Multiple primaries--Breast: A Patient has two separate lesions in the same quadrant with the same histology. This is one primary according to MP/H rules.

Because an Oncotype Dx was done on both tumors, and the DX recurrence was different for both, the med-onc says the patient has two primaries. The pathologist does not say anything about two primaries.

Answer

This is a single primary per breast Rule M13. The only rules we use to determine the number of primaries are the MP/H rules. Do not use other information such as Oncotype Dx for multiple primary determination. Oncotype is used to determine whether the cancer is likely to recur AND whether the cancer would benefit from chemotherapy.

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Question: 20110076

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Question

Multiple primaries/Histology-Heme & Lymphoid Neoplasms: What are the steps I take to abstract this case? I am trying to follow the rules, but I am not sure which rules apply first and when to use the multiple primaries calculator. What rules apply here? See discussion.

Discussion

Diagnosed in 7/2004 with follicular lymphoma, grade 2 per biopsy of the bilateral breasts. Bone marrow biopsy was positive for lymphoma involving 10% of bone marrow. Imaging showed extensive lymphadenopathy mainly in abd/pel with a 8 cm mass in the right pelvis. Smaller lymph nodes were noted in the left periaortic region and also some small precarinal lymph nodes. Therefore this was a stage IVA lymphoma. She had six cycles of CHOP/R with an excellent response. Per clinician's notes on 12/2005, no evidence of recurrence, no sign of active disease, and will follow up @ 6 mos. 08/22/06 imaging shows new disease in the bilateral chest wall. 08/2006 bilateral breast nodule biopsies are positive for grade 1-2 follicular lymphoma. The pt rec'd Rituxan. Per clinician's 03/2007 note, no active disease is noted. Pt was regularly followed with no evidence of disease until 10/2010. Pt had a left arm nodule, biopsy was positive for diffuse large B cell lymphoma(40%) CD pos and grade 3a follicular lymphoma (60%). RICE was recommended due to "transformation" per oncologist.

Answer

The patient has two primaries.

Primary #1 is follicular lymphoma (FL), grade 2 with a primary site of breast (bilateral). FL can start as an extranodal disease and breast is one of the sites in which it originates. It is unlikely that the lymphoma extended from the nodes to the breast, but highly likely that it extended from the breast to the nodes.

Primary #2 DLBCL and a primary site of intrathoracic lymph nodes C771.

Steps used to determine multiple primaries and primary site code are as follows:

Step 1: Hemato DB search: Enter the histology that is in your historic DB 9691/3 (FL, grade 2).

Step 2: Look at the transformation information for FL grade 2; the DB says this neoplasm transforms to diffuse large-B cell lymphoma (DLBCL).

Step 2: Enter DLBCL into the search mechanism to get the histology code. The highlighted DLBCL shows a histology code 9680/3. Click on the display button. The "warning module" says see module 6 PH16, PH19, PH20. KEEP THIS INFORMATION.

Step 4: None of the MP rules apply, go to the PH rules. Go directly to Module 6 (as directed by the warning module). The rules are hierarchical within each module. PH16 directs you to code DLBCL when both DLBCL and FL are present in the same site (nodes, organ, tissue).

Step 5: Go to Module 7 which is a module specifically written to help code primary site for lymphomas. Use PH29, Code

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the primary site to the specific lymph node region when multiple lymph node chains within the same region (as defined by ICD-O-3) are involved. In this case, the intrathoracic lymph nodes.

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Question

Primary site--Heme & Lymphoid Neoplasms, Leukemia Cutis: What is the correct site code for Leukemia cutis? In this particular case, bone marrow exam was negative for marrow involvement with leukemia.

Discussion

Answer

Code the primary site to bone marrow C421. Leukemia cutis is the term for a leukemic infiltration of the epidermis, the dermis or the subcutis. This infiltration is easily identified as cutaneous lesions, but the primary site is still bone marrow. This is a type of "metastasis" or spread of the leukemia cells. The "conventional" definition for leukemia cutis is the infiltration of skin from a bone marrow primary.

Last Updated 4/19/11

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Status

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Question

First course treatment/Date therapy initiated--Breast: We have been seeing several patients that are prescribed 2 wks of "Tamoxifen blunting" to achieve better MRI imaging after biopsy confirmation of an ER/PR pos breast ca. The tamoxifen is then discontinued and they subsequently have definitive surgery followed eventually with start of maintenance tamoxifen. Which date should be recorded for date hormone therapy initiated, the first date or the post surgical date?

Answer

Use the post surgical date for start of hormone therapy. The actual hormone treatment begins after surgery in the case of Tamoxifen blunting. The low dose that is administered prior to surgery does not affect the cancer.

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Question

MP/H Rules/Multiple primaries--Sarcoma: How many primaries are to be accessioned if prior to the resection of the right buttock sarcoma, a left thigh tumor is described on PET scan to be a metastatic deposit? In this case, 18 months subsequent to the right buttock sarcoma diagnosis, the left thigh is removed and is also found to be a sarcoma but it is not referred to by the pathologist as metastasis from the right buttock primary. See discussion.

Discussion

Patient was diagnosed with spindle cell sarcoma in a tumor of the right gluteus musculature on 01/28/2008. At the time of diagnosis, met tumors were found in a vertebral body and in the lung. Chemotherapy was started. PET done to evaluate response to chemo on 04/22/2008 showed increased size of the primary tumor on the right and a mass in left thigh highly suspicious for mets. Left thigh tumor was not accessioned at that time because it was described as a met tumor. The left thigh tumor was eventually resected on 7/03/2009. Path revealed spindle cell sarcoma. In 2009 no mention was made of it representing a met tumor. Does the left thigh tumor represent a new primary based on MP/H rule M12? Or does the previous clinical description of the left thigh tumor representing a met have priority?

Answer

This is a single primary. Rule M1 applies. According to our expert pathologist, "if multiple solid tissue tumors are present (sarcomas), then almost always there is one primary and the rest are metastases. There are infrequent occasions of multifocal liposarcoma or osteosarcoma occurring, but the patient would be treated as a patient with metastatic disease."

Last Updated04/19/11

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Question

Multiplicity Counter/Date Multiple Tumors--Bladder, Urinary Tract: How are these fields coded when a patient presents with multiple tumors at the time of initial diagnosis and a year later an additional tumor is found? See discussion.

Discussion

In November 2007, a nephroureterectomy showed an invasive TCC of the renal pelvis and a separate neoplasm, in situ TCC of ureter. Multiplicity Counter is coded 02 and Date Multiple Tumors is coded to November 2007. In December 2008, patient is found to have an in situ bladder tumor. Would the multiplicity fields be updated to reflect the new bladder tumor?

Answer

Multiplicity counter was initially coded 02. Change the code to 03 because the subsequent, additional tumor was determined to be the same primary. Update multiplicity counter only once. If additional tumors are determined to be the same primary for this case, it is not necessary to update this field again.

Date of multiple tumors was initially coded November 2007. Multiple tumors were present at the time of the initial diagnosis. Do not change the date of multiple tumors. This data item records the earliest date that multiple tumors were present. See example 2 under #3 on page 81 of the 2010 SEER manual.

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Question

MP/H Rules/Histology--Endometrium: How should histology be coded if the histology listed in the CAP formatted histology field in the pathology report is "Clear cell adenocarcinoma, NOS (8310/3)" and the tumor size comment field states: "Carcinoma involves a 1.5 cm endometrial polyp." See discussion.

Discussion

Do we stop at rule H11 and code clear cell adenocarcinoma (8310) because this is the one histologic type identified in the CAP formatted histology field? Or, should we continue to rule H12 and code the clear cell adenocarcinoma arising in a polyp (8210)? Or, should the clear cell and adenocarcinoma arising in a polyp be considered multiple specific histologies to which we would default to rule H17 and code the higher histology code (8310)? For a colon primary, it seems like much importance is placed on whether the tumor arose in a polyp, but is this the case for other sites?

Answer

Rule H11 applies. Code clear cell adenocarcinoma (8310/3).

Last Updated 04/13/11

Question: 20110069

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Question

Reportability--Melanoma: Is "early, evolving melanoma" reportable? See discussion.

Discussion

Per SINQ 20020019 and Melanoma Terms and Definitions, an "evolving" melanoma is not reportable to SEER. Per SINQ 20041034, "early" melanoma diagnosed on January 1, 2007 and later is reportable to SEER. Is a case reportable when these two terms are combined in the final diagnosis? Examples: "early, evolving melanoma," "early/evolving melanoma".

Answer

"Early, evolving melanoma" and "early/evolving melanoma" are not reportable terms. See also SINQ 20110040.

Please note: SINQ 20041034 states that "early" is NOT a reportable term for diagnoses prior to 1/1/2007.

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04/13/11

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