

# SEER SINC'S

Finalized February 2011

**Question: 20110048**

**Status**

Final

**Question**

First course treatment--Heme & Lymphoid Neoplasms: Is donor lymphocyte infusion treatment for CLL? If yes, how is it coded?

**Discussion**

**Answer**

Donor lymphocyte infusion (DLI) is coded as immunotherapy. The lymphocytes are donated by the same person who donated the original stem cell transplant. The lymphocyte infusion creates an immune response, the T-cells are activated to attack the cancer cells.

**History**

**Last Updated**

02/18/11

**Question: 20110047**

**Status**

Final

**Question**

Multiple primaries--Heme & Lymphoid Neoplasms: 1. Is there a timing rule for the Hematopoietic Rules? 2. Do we need to compare slides from original time of diagnosis to the current slides as we do with solid malignancies? See discussion.

**Discussion**

Example: Pt diagnosed with NHL, large B-cell lymphoma, in 3/10. Status post 7 rounds of chemo with no evid of disease per PET scan in 10/10. Then in 12/10 - liver biopsy shows "features consistent with recurrence of previously diagnosed non-Hodgkin's lymphoma". Our pathologist didn't compare slides as original diagnosis was elsewhere. He used several immunoperoxidase stains to get his final diagnosis in 12/10.

**Answer**

This is a single primary 9680/3, diffuse large-B-cell lymphoma. There are no timing rules for lymphoma other than rules M7-M12 which deal with chronic and acute diagnoses. The same disease recurred in this case, so it is the same primary regardless of the time interval between the two diagnoses.

**History**

**Last Updated**

02/18/11

# SEER SINC'S

Finalized February 2011

**Question: 20110046**

## Status

Provisional

## 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

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

02/25/11

# SEER SINQ'S

Finalized February 2011

## Question: 20110045

### Status

Final

### Question

Reportability--Ovary: Is immature teratoma of the ovary reportable if a subsequent comment states that "the teratoma shows immature neuroepithelium, but no malignant elements"?

### Discussion

### Answer

There is conflicting information for this case. The final diagnosis conflicts with the comment. Go back and check with the physician to clarify his/her intent. If no further information can be obtained, the final diagnosis is preferred over the comment. This case is reportable based on the final diagnosis: "immature teratoma."

### History

### Last Updated

02/25/11

## Question: 20110043

### Status

Final

### Question

MP/H Rules/Histology--Breast: Which specimen should be used to code histology? See discussion.

### Discussion

Pt had a needle core bx that revealed DCIS, comedo type, cribriform pattern, no tumor size given. Pt then has a partial mastectomy which reveals DCIS, noncomedo type, solid pattern. Largest focus of DCIS 0.2cm. I'm not sure whether to use 8501/2 or 8230/2? The microscopic description on the partial mastectomy says that the previous core needle biopsy site reveals several foci of DCIS. So would I code the 8230/2 from the partial mastectomy?

### Answer

Code the histology from the most representative specimen (the specimen with the most TUMOR tissue). Compare the size of tumor in the two specimens. In the event that you don't have the tumor size from both specimens, default to the histology from the mastectomy specimen when the choice is between needle biopsy and mastectomy.

### History

# SEER SINQ'S

Finalized February 2011

**Last Updated**

02/25/11

**Question: 20110042**

**Status**

Final

**Question**

MP/H Rules/Histology--Testicular: What histology should be assigned to this case? See discussion.

**Discussion**

Per our physician, a large retroperitoneal mass was found on CT and biopsy showed non-seminomatous germ cell tumor. These were done at an outside facility and neither the CT nor biopsy pathology report are available for review at our facility. The patient had neoadjuvant chemotherapy and the retroperitoneal mass decreased to 12 cm. This was followed by a right radical orchiectomy and pathology showed a 3.5 cm mature teratoma (NOS, not stated to be "malignant") of right testicle. The patient then presented to our facility and had resection of the retroperitoneal mass and biopsies. Pathology showed the "excision" specimen contained 6 benign lymph nodes and two of the "biopsy" specimens showed non-seminomatous germ cell neoplasm with IHC findings suggestive of a mix of embryonal carcinoma and a lesser component of yolk sac tumor.

**Answer**

This is reportable case. Even though the pathology from the orchiectomy stated mature teratoma, NOS, the presence of lymph node metastases proves that this tumor is malignant. Code the histology 9065/3 germ cell tumor non-seminomatous.

The majority of germ cell tumors show the presence of multiple histologies. While the original tumor showed only mature teratoma, there were obviously yolk sac cells that were not detected on the sections taken from the primary tumor. Both teratoma and yolk sac are germ cell tumors, which explains why the pathologist gave you the diagnosis of germ cell tumor. The classification of non-seminomatous simply means that there was no seminomas present in the mixture of germ cell histologies.

**History****Last Updated**

02/25/11

**Question: 20110041**

**Status**

Final

**Question**

# SEER SINQ'S

Finalized February 2011

Histology--Heme & Lymphoid Neoplasms: What is the histology code for this Hodgkin lymphoma case? Excision of two cervical nodes. Path report states: Histologic Type based on the 2008 WHO classification: Classical Hodgkin lymphoma, histologic subtype cannot be determined. Comments: Classic Hodgkin lymphoma with features of both lymphocyte rich and nodular sclerosis subtypes.

## Discussion

### Answer

Code classical Hodgkin lymphoma 9650/3. To determine which histology to code:

1. Do a "smart search" by entering "classical" in the Hemato DB. The first histology listed is classical Hodgkin lymphoma 9650/3. Display the information and note that this disease is also called Hodgkin lymphoma, NOS.
2. Display the Abstractor Notes. The notes say 9650/3 is an NOS code and that two of the specific Hodgkin lymphoma types are lymphocyte-rich Hodgkin and nodular sclerosis Hodgkin. That means you have three histologies, one NOS and two specific histologies.
3. Go to the Hematopoietic Manual, PH rules. Only one module deals with multiple histologies, Module 8. Rule PH38 says code the non specific (NOS) histology when the diagnosis is one non-specific (NOS) histology and two or more specific histologies.

## History

### Last Updated

02/17/11

## Question: 20110039

### Status

Final

### Question

Multiple primaries/Primary site--Heme & Lymphoid Neoplasms: How many primaries are there for this case, what are the primary sites, and what are the steps to determine the number of primaries? See discussion.

### Discussion

Follicular lymphoma diagnosed 7/2004, 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 rt 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. Patient had six cycles of CHOP/R with an excellent response. Per clinician's notes on 12/2005, no evidence of recurrence or no sign of active disease and will follow up in 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. Treated with Rituxan. Per clinician's 03/2007 note, no active disease is noted. Patient was regularly followed with no evidence of disease until 10/2010. Patient 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

# SEER SINC'S

Finalized February 2011

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 codes 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 M rules apply, go to the PH rules. Go directly to Module 6 (as directed by the warning pop-up). 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 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.

## History

## Last Updated

02/17/11

## Question: 20110037

### Status

Final

### Question

Multiple primaries/Primary site-Heme & Lymphoid Neoplasms: What is the primary site for a composite lymphoma of cervical node 8 years after diagnosis of follicular lymphoma involving LNs and organs on both sides of diaphragm? See discussion.

### Discussion

Pt had follicular lymphoma since 2002. Follicular lymphoma involved LNs and organs on both sides of diaphragm. 2010 excision biopsy of a left neck LN showed classical Hodgkin lymphoma, nodular sclerosis type (predominant component), Grade 2 assoc with (minor component) low grade follicular lymphoma (composite lymphoma). What site would this be coded to (LNs head, face, neck - or LNs of multiple sites)?

### Answer

This is a second primary. Prepare an abstract and code to composite lymphoma (9596/3). The "new" terminology for this code is "B-cell lymphoma with features indeterminate between diffuse large B-cell lymphoma and classical Hodgkin lymphoma." The synonym "composite lymphoma" will be added to the synonyms in the next revision.

### History

# SEER SINC'S

Finalized February 2011

**Last Updated**

02/15/11

**Question: 20110036****Status**

Final

**Question**

Primary site--Heme & Lymphoid Neoplasms: What is the primary site for a post-transplant lymphoproliferative disorder, histology code 9971/3? See discussion.

**Discussion**

I originally thought it would be lymphoma, C779 (in mult nodes both sides diaphragm and kidney). Then in CS staging it was acting like it was going to hematopoietic and I noticed it's not in the AJCC book. Could you please give insight onto which CS site this should be coded to?

**Answer**

If this is a monomorphic post-transplant lymphoproliferative disorder (PTLD), the PTLD itself is not reportable. You code and abstract only the lymphoma that is co-existing with the PTLD. The histology code would be the lymphoma. For the site code, use PH30 and code to multiple lymph nodes, NOS C778.

If this is a polymorphic PTLD it is coded to 9971/3. The polymorphic PTLD does commonly involve lymph nodes.

We will forward the question regarding which schema should be used for PLTD to the CS team (CAnswer Forum).

**History****Last Updated**

02/10/11

**Question: 20110035****Status**

Final

**Question**

Histology/Primary site--Heme & Lymphoid Neoplasms: This is a 2010 case. What is the histology & primary site for CLL/SLL when both a lymph node biopsy and peripheral blood are positive for CLL/SLL? According to the 2010 instructions, CLL has peripheral blood involvement and SLL does not (PH9 & PH10).

**Discussion****Answer**

Code to CLL/SLL, 9823/3, because this patient is manifesting both leukemia and lymphoma symptoms/involvement. We will modify rule PH9 to say that when there is involvement of only blood and/or bone marrow OR involvement of both bone marrow and/or blood and solid tissue, code to CLL/SLL.

**History**

# SEER SINQ'S

Finalized February 2011

**Last Updated**

02/10/11

**Question: 20110034**

**Status**

Final

**Question**

Multiple primaries--Heme & Lymphoid Neoplasms: Is this a single primary or 2 primaries?

Plasma cell tumor diagnosed 06/01/10 status post laminectomy for epidural mass. A follow up bone marrow bx done 06/21/10 diagnosed a plasma cell myeloma. See discussion.

**Discussion**

If I am reading the new rules correctly, the flow chart ultimately leads me to use the hematopoietic db. Per the db, the plasma cell tumor (9731/3) and the plasma cell myeloma (9732/3) are 2 primaries, but when I look up the plasma cell tumor (9731/3) it states that it can transform to multiple myeloma (9732/3).

**Answer**

Abstract multiple primaries, an osseous plasmacytoma and multiple myeloma.

The first steps (exactly as you did them) would be to look up both osseous plasma cell myeloma and multiple myeloma in the database. The Transformation text tells you that plasma cell myeloma transforms to multiple myeloma. This means that you have a chronic disease (osseous plasma cell myeloma) and an acute disease (multiple myeloma) diagnosed within 21 days.

The bone marrow was done as soon as the patient had sufficiently recovered from the laminectomy. The laminectomy had to be done first because there was obviously impingement on the spinal cord (common for plasmacytomas in the spinal vertebrae).

See the Hematopoietic Manual, Multiple Primary Rules, M8 Abstract as multiple primaries when both the chronic and the acute phase of the neoplasm are diagnosed within 21 days AND \*\*

- There is documentation of two bone marrow examinations, one confirming the chronic neoplasm and another confirming the acute neoplasm

The rule will be clarified to say "documentation of two bone marrows and/or two tissue examinations (pathology)" in the next revision.

**History****Last Updated**

02/08/11

**Question: 20110033**

**Status**

Final

# SEER SING'S

Finalized February 2011

## Question

Multiple primaries--Heme & Lymphoid Neoplasms: Pathology report states "Right Parotid mass - MALT Lymphoma with Transformation to Diffuse Large B cell Lymphoma". There is no history in the H&P of the MALT lymphoma ever being diagnosed. Is this 2 separate primaries, with the same date of diagnosis? Or is this 1 primary (the Diffuse Lrg B cell) with sequence 02?

## Discussion

## Answer

Since you have no information on a previous diagnosis, use rule M7:

Abstract as a single primary when both the chronic and the acute phase of the neoplasm are diagnosed within 21 days AND \*

- There is documentation of one positive bone marrow biopsy

This rule will be clarified in the next revision to read one positive bone marrow OR one positive biopsy.

## History

## Last Updated

02/08/11

## Question: 20110032

## Status

Final

## Question

Primary site--Heme & Lymphoid Neoplasms: We have a patient with LCH [histology 9751/3] limited to the skin. What is the primary site?

## Discussion

## Answer

When in doubt about a primary site code, use the abstractor notes. The abstractor notes give you both common and rare primary sites. According to the abstractor notes for LCH 9751, the solitary form of LCH occurs less commonly in nodes, skin, and lung. This is a solitary form of LCH. Code the primary site to skin.

## History

## Last Updated

02/03/11

## Question: 20110031

## Status

Final

# SEER SINQ'S

Finalized February 2011

## Question

Multiple primaries--Heme & Lymphoid Neoplasms: I know that granulocytic sarcoma is a solid manifestation of AML, but when these diagnoses occur more than 21 days apart, are they coded as separate new primaries? See discussion.

## Discussion

Patient was diagnosed with refractory anemia with excess blasts in 2008. A Bx of vocal cord performed on 06/02/2010 stated "in view of a previous history of myelodysplastic syndrome this is indicative of transformation to acute leukemia" and consistent with granulocytic sarcoma. 07/19/2010 bone marrow biopsy stated compatible with refractory anemia with excess blasts in transformation and by WHO's definition this is acute myeloid leukemia complicating myelodysplasia. What or how to apply rules for this case?

## Answer

Two primaries; refractory anemia with excess blasts 2008, and AML June 2, 2010.

The physician gives a provisional diagnosis of "transformation to acute leukemia" when he sees the solid deposits of myeloid cells on the vocal cord. AML and myeloid (granulocytic) sarcoma appearing simultaneously are a single primary coded to AML. When the patient has AML, solid myeloid deposits (myeloid sarcoma) may appear. This is a manifestation of the AML rather than a new primary. Your physician suspected that when he/she saw the deposit on the vocal cord and gave the provisional diagnosis of transformation to acute leukemia and the July bone marrow confirmed that provisional diagnosis.

## History

## Last Updated

02/03/11

## Question: 20110030

## Status

Final

## Question

Reportability--Heme & Lymphoid Neoplasms: Is LCH a reportable cancer? When is it reportable? See discussion.

## Discussion

From the histiocytosis association of America: "Over the years, cancer treatments have been used in patients with histiocytosis. Consequently, hematologists and oncologists, who treat cancer, also treat children with Langerhans cell histiocytosis. However, the disease is not cancer."

## Answer

LCH is reportable to all agencies starting with cases diagnosed 1/1/2010 and later. See the Hematopoietic Manual, Reportability Instructions, Instruction 6, and Appendix D New Histology Terms and Codes. For cases diagnosed in 2010 and later, use this new code 9751/3 for all of the LCH histologies listed in the ICD-O-3 with a /1 behavior.

## History

## Last Updated

# SEER SING'S

Finalized February 2011

02/15/11

## Question: 20110029

### Status

Final

### Question

DCO/Multiplicity Counter/Type of Multiple Tumors: Are there default values for DCO cases for Multiplicity Counter and Mult Tum Rpt as One Prim? Specifically, if an unknown primary was reported as a DCO, should these fields be coded 88 or 99? See discussion.

### Discussion

In the data item pages for these fields, there is only a reference to see the NAACCR Death Clearance Manual but this manual does not provide an answer. There is guidance to use code 88 for unknown primaries but we noticed that SEER edits skip enforcing this requirement for DCO cases (see SEER IF205 and 206).

### Answer

For a DCO case with an unknown primary, assign 99 for multiplicity counter and for type of multiple tumors.

### History

### Last Updated

02/24/11

## Question: 20110028

### Status

Final

### Question

MP/H Rules/Multiple Primary/Histology--Thyroid: How many primaries and what histology(ies) would be coded for the following thyroid case? See discussion.

### Discussion

Right lobectomy pathology report final diagnosis states: 1.9 cm Hurthle cell carcinoma (see comment). Comment: histologic diagnosis – Hurthle cell carcinoma, probable follicular variant of papillary carcinoma with Hurthle cell features. Subsequent left lobectomy one week later showed a 2 mm microscopic focus of follicular variant of papillary carcinoma, encapsulated.

We are having difficulty because none of the Other Sites rules seems to exactly fit this scenario. Number of primaries in this case depends on the histology coded for each tumor (rule M6 vs. M17: single primary because both are

# SEER SINQ'S

Finalized February 2011

papillary/follicular tumors, or two primaries because one is Hurthle cell, different histology at second digit).

For coding histology of the larger tumor in the right lobe, which would apply: rule H11 (single histology=8290 per path final diagnosis), H15 (tumor has both follicular and papillary carcinoma=8340, per path comment), or H17 because we have Hurthle cell and papillary/follicular (numerically higher code=8340)?

## Answer

This is a single primary. Hurthle cell carcinoma is a synonym for follicular carcinoma according to the WHO. See page 67 of the 2004 WHO Classification of Tumours of Endocrine Organs.

Rule M6 applies. Both lobes of the thyroid contain a follicular variant of papillary carcinoma. Use the comment to code the histology for the right lobectomy. This is one histology best described as a follicular variant of papillary carcinoma. "Probable" is an acceptable ambiguous term to use for histology coding. See page 14 of the general instructions for coding histologic type in the MP/H manual. Apply rule H15, and code 8340 [Papillary carcinoma, follicular variant].

## History

## Last Updated

02/15/11

## Question: 20110027

## Status

Final

## Question

MP/H Rules/Multiple primaries--Thyroid: Case Summary: Left thyroid with 2.2 cm papillary carcinoma and right thyroid with 'multiple microscopic foci of papillary carcinoma (papillary microcarcinoma) ranging from less than 1 mm to 2 mm in greatest dimension.'

Are they using the term 'papillary microcarcinoma' to describe the size of the foci only or are the rt thyroid lesions a totally different histologic type? Does this scenario fall under Rule M6, making it one primary or under Rule M11, making it two primaries?

If this is one primary, when would the code 'papillary microcarcinoma' be used?

## Discussion

## Answer

This is a single primary using M18. For thyroid cancer only, the term micropapillary does not refer to a specific histologic type. It means that the papillary portion of the tumor is minimal or occult. The histology is the same in both the left and right thyroid: papillary carcinoma. Assign code 8260/3 [Papillary adenocarcinoma] according to rule H26.

## History

## Last Updated

02/15/11

## Question: 20110026

# SEER SINQ'S

Finalized February 2011

## Status

Final

## Question

Histology/Primary site--Heme & Lymphoid Neoplasms: What is the histology code for monomorphic post transplant lymphoproliferative disorder consistent with diffuse large B-cell lymphoma diagnosed after 2010? What is the site? The lymphoma was found with a partial resection of small bowel. Other areas of involvement are mesenteric, retroperitoneal, omentum and left inguinal lymphadenopathy.

## Discussion

## Answer

Step 1: Do a "Smart Search" of the Hemato DB by entering the words "monomorphic post-transplant." The DB returns the result "monomorphic B-cell PTD 9971/3."

Step 2: Click on "Display." The monomorphic B-cell PTD is a synonym for polymorphic post-transplant lymphoproliferative disorder.

Step 3: Click on the button "Display Abstractor Notes" to check on common and rare primary sites. The Abstractor Notes say common sites include lymph nodes and GI tract. This case has both involvement of the GI tract (small bowel) and lymph nodes (mesenteric, retroperitoneal, omental, and left inguinal). For lymphomas, lymphadenopathy is equal to involvement.

Step 4: Go to the Manual, MP Rules, Rule 3, a single histology is a single primary.

Step 5: Next the PH rules. Use Module 7 Coding Primary Sites for Lymphomas Only. Always use this module when you are unsure of which site to code for a lymphoma primary. Stop at Rule PH35: Code the primary site to the organ when lymphoma is present in an organ and that organ's regional lymph nodes. Code the primary site as small bowel.

## History

## Last Updated

02/08/11

## Question: 20110025

## Status

Final

## Question

Multiple primaries/Histology--Heme & Lymphoid Neoplasms: Is cutaneous follicular center lymphoma the same as primary cutaneous follicular center lymphoma? What is the histology code and would this be 1 or 2 primaries? Also would primary site be coded to skin. What rules apply? See discussion.

## Discussion

# SEER SINC'S

Finalized February 2011

On 5/27/2008 pt had punch bx of the skin of the left medial shoulder. Final dx after consult: cutaneous follicular center lymphoma. On 3/2/10 pt has excision of skin of the left lower neck and left upper back, final dx: follicular center lymphoma.

## Answer

This is a single primary coded to follicular lymphoma, NOS 9690/3 and the primary site to skin, NOS C449.

To determine multiple primaries, see the Multiple Primary Rules M3 a single histology is a single primary.

See the abstractor notes for primary cutaneous follicle center lymphoma and for follicular lymphoma, NOS. The clinical presentation of follicle center lymphoma does not fit the case you are abstracting. Not only is this a very rare disease, it also manifests as a localized skin lesion and additional skin lesions are not mentioned. In the abstractor notes for follicular lymphoma, NOS, it states that follicular lymphoma can occur in extranodal sites such as skin. Also note the "description" for follicular lymphoma, NOS which says this is a B-cell lymphoma with follicle center cells. This fits the description of the case you are abstracting. Code to follicular lymphoma, NOS 9690/3 and the primary site to skin, NOS C449.

## History

## Last Updated

02/08/11

## Question: 20110024

## Status

Final

## Question

MP/H Rules/Histology--Breast: Which histology code and rule should be used to code a breast primary with a diagnosis of ductal carcinoma in situ with clear cell features? See discussion.

## Discussion

None of the histology rules for in situ breast seem to apply. H3 doesn't seem to apply because clear cell is not a specific intraductal carcinoma. H6 doesn't seem to apply because there is not a combination of intraductal and 2 or more specific types of intraductal. H8 wouldn't apply because one of the types is intraductal.

## Answer

Code 8523/2, intraductal carcinoma mixed with other types of in situ carcinoma. Rule H6 should apply here, but the wording needs to be clarified. This will be done in the next revision of the rules.

## History

## Last Updated

02/15/11

## Question: 20110016

## Status

Final

## Question

Behavior--Brain and CNS: Can hemangioblastomas occurring the in CNS be coded to a /3, malignant, behavior? See

# SEER SINQ'S

Finalized February 2011

discussion.

## Discussion

Hemangioblastomas are borderline (/1) according to ICD-O. The standard matrix rule in ICD-O directs registrars to change the behavior code to malignant when a malignant (/3) behavior is stated by a physician to a morphology code that appears in ICD-O with a non-malignant behavior code. The "malignant" hemangioblastomas we see are not pathologically confirmed; they are radiological or clinical diagnosis confirmed with renal cell carcinoma being one of the malignant differential diagnoses.

## Answer

The behavior code for hemangioblastoma can be coded to /3 when a pathologist indicates that the behavior is malignant. The behavior code should be based on a pathologist's opinion. It is usually not possible for another physician to make this determination.

The histologic appearance of hemangioblastoma may resemble metastatic renal cell carcinoma; therefore, you will often see renal cell carcinoma listed as a possible diagnosis. This does not indicate that the hemangioblastoma is malignant. Do not code the behavior as /3 based on a differential diagnosis of renal cell carcinoma.

## History

## Last Updated

02/08/11

## Question: 20110015

### Status

Provisional

### 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.

# SEER SINQ'S

Finalized February 2011

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 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

02/15/11

## Question: 20110013

### Status

Final

### Question

MP/H Rules/Histology--Testis: Which MP/H rule applies in coding the histology described as a "malignant mixed germ cell tumor with the following features: Histologic type: embryonal carcinoma (97%) and yolk sac tumor (3%)"? See discussion.

### Discussion

Per MP/H Rule H16, code the appropriate combination/mixed code (Table 2) when there are multiple specific histologies or when there is a non-specific histology with multiple specific histologies, but the combination of embryonal carcinoma and yolk sac tumor is not listed in Table 2. Would Rule H17 (Code the histology with the numerically higher ICD-O-3 code) apply instead?

### Answer

Assign 9065/3, Germ cell tumor, nonseminomatous. Our pathologist consultant's comments for this code: Code 9065 is listed by ICDO as germ cell tumor, nonseminomatous. This is a generic code for any germ cell tumor not containing seminoma.

### History

### Last Updated

02/08/11

# SEER SINC'S

Finalized February 2011

**Question: 20100038**

**Status**

Final

**Question**

Surgery of Primary Site--Prostate: Is a prostate saturation biopsy coded under diagnostic biopsy or surgery?

**Discussion**

**Answer**

A prostate saturation biopsy is a transperineal template-guided stereotactic saturation prostate biopsy that typically produces 30 to 80 core biopsies. This is an alternative biopsy technique used for some high-risk patients including men with persistently elevated PSA, those who have atypia on prior prostate biopsies, or men with biopsies showing high-grade prostate intraepithelial neoplasia (PIN). Although this is a different procedure, it is still a diagnostic biopsy. Do not code prostate saturation biopsy under Surgery of Primary Site.

**History**

Sept. 2010 to Feb. 2011 Code prostate saturation biopsy under Surgery of Primary Site. A prostate saturation biopsy is a transperineal template-guided stereotactic saturation prostate biopsy that typically produces 30 to 80 core biopsies. This is an alternative biopsy technique used for some high-risk patients including men with persistently elevated PSA, those who have atypia on prior prostate biopsies, or men with biopsies showing high-grade prostate intraepithelial neoplasia (PIN). Although this is a different procedure, it is still a diagnostic biopsy.

**Last Updated**

02/22/11