

# FINALIZED SEER SINQ'S

May 2011

## Question: 20110087

### Status

Final

### Question

Multiple primaries--Heme & Lymphoid Neoplasms: Do I abstract this case as 2 primaries since the Hematopoietic database counts as 2? My confusion is in the terms evolving and transition which makes it sound as if it is the same disease process. See discussion.

### Discussion

Patient diagnosed per bone marrow biopsy with the following: myelodysplasia possibly in transition, consistent with a myelodysplasia (refractory anemia with excess blasts in transition), these findings are consistent with an evolving acute myeloid leukemia. The physician is treating patient with the following diagnosis: MDS/AML. The patient had no previous diagnosis of MDS.

### Answer

This is a single primary. Code the histology 9861/3 AML. The steps used to arrive at this decision are as follows:

Step 1: Search the Hemato DB for MDS. Display MDS, unclassifiable 9989/3

Step 2: Look at the transformation information. The Transformations box shows that MDS (chronic neoplasm) transforms to AML (acute neoplasm). This means that a chronic and acute disease were diagnosed simultaneously (at the same time) based on a single bone marrow biopsy.

Step 3: go to the Multiple Primary Rules. Use M7 Abstract a single primary when both the chronic and acute phase of the neoplasm are diagnosed within 21 days and there is documentation of one bone marrow.

### Last Updated

05/13/11

## Question: 20110084

### Status

Final

### Question

Histology--Heme & Lymphoid Neoplasms: Pathology report states, "diffuse large B cell lymphoma, immunoblastic variant." Would you code this histology to 9684/3?

### Discussion

### Answer

Please see the Hematopoietic DB, search on DLBCL (abbreviation for diffuse large B-cell lymphoma). See the definition which says "Morphologic variants: centroblastic, immunoblastic, plasmablastic, T-cell/histiocyte-rich, anaplastic." The correct code for this disease is DLBCL 9680/3.

**Last Updated** 05/13/11

**Question: 20110083**

**Status**

Final

**Question**

Multiple primaries--Heme & Lymphoid Neoplasms: Please confirm if these are two different primaries when both AML and leukemia cutis are present. See discussion.

**Discussion**

A bone marrow biopsy positive for acute myeloid leukemia with minimal differentiation 9872/3. Then develops a skin rash while undergoing treatment within two weeks from the date of diagnosis. A skin punch biopsy was done and showed cutaneous involvement by myeloid sarcoma 9930/3 (Leukemia Cutis).

**Answer**

No, they are the same primary. Leukemia cutis is defined as leukemic infiltration of the skin from a bone marrow primary (leukemia). The leukemia cells form skin lesions (cutis) that are visually apparent. The biopsy, however, will show "leukemia cutis" or as in the case you cite, "leukemia cutis as well as myeloid sarcoma." Myeloid sarcoma is simply a "solid form" of myeloid leukemia. When the AML has been established, a later diagnosis of myeloid sarcoma would not be reportable. It is simply a manifestation of the systemic disease, AML.

In summary, leukemia cutis is an extension/infiltration of the skin by the AML cells. Myeloid sarcoma is reportable when there is no bone marrow involvement (AML). When the bone marrow is involved, only report the AML.

**Last Updated**

05/13/11

**Question: 20110082**

**Status**

Final

**Question**

First course treatment/Other therapy--Skin: How do we code PUVA - [psoralen (P) and long-wave ultraviolet radiation (UVA)] when used for skin primaries such as melanoma and mycosis fungoides?

**Answer**

Code PUVA as "Other treatment" with Code 1 - Other. We do not have a code specifically for ultraviolet radiation.

**Last Updated**

05/13/11

**Question: 20110071**

**Status**

Final

**Question**

Primary site: How is primary site coded for an adenocarcinoma arising in a chronic perianal fistula? See discussion.

**Discussion**

The patient underwent a resection of a perineal mass that, after a review of slides, was stated to be "primary mucinous adenocarcinoma arising in a chronic perianal fistula." The adenocarcinoma was invasive into the dermal connective tissue and skeletal muscle, but there was no extension into the anal canal. The discharge diagnosis from the reporting facility called this adenocarcinoma of "ectopic rectal tissue in perianal area."

Should the primary site be coded to skin based on the dermal involvement and lack of anal or rectal involvement? Or, should the primary site be coded to rectum based on the physician's assessment that this adenocarcinoma arose in ectopic rectal tissue?

**Answer**

Assign code C210 [Anus, NOS]. According to our expert pathologist, "There is no ideal site code [for] this case. I would code to C210. In this

location it can at least be located by anyone who wants to get a look at such lesions. Because of the unusual location of this tumor, I would like to be able to code it to perineum, but it will be totally lost in those site codes as they represent extensive areas beyond perianal (skin of trunk, soft tissue of pelvis, and pelvis, respectively)... I would not code to rectum [because it would be] lost among too many primary rectal carcinomas."

### **History**

### **Last Updated**

05/12/11