

# FINALIZED SEER SINQ'S

MARCH 2012

## Question: 20120033

### Status

Final

### Question

Multiple primaries--Heme & Lymphoid Neoplasms: Is this a single primary (Essential thrombocythemia)?

The patient was originally diagnosed in 2007 with essential thrombocythemia and treated with Hydrea. On 12/4/09 the patient had a bone marrow biopsy showing primary myelofibrosis which the physician states is a transition from the essential thrombocythemia. I could not find reference to this in the rules, and the database calls this 2 primaries? Please advise.

### Answer

Code primary myelofibrosis (9961/3) as a second primary. Essential thrombocythemia can transform to primary myelofibrosis.

Reference: Heme DB - Search on essential. When 9962 essential thrombocythemia appears, display the information. See the transformations box. Myelofibrosis is one of the diseases listed as a transformation. In the revised Heme DB the term will be changed to primary myelofibrosis.

### Last Updated

03/02/12

## Question: 20120032

### Status

Final

### Question

MP/H Rules/Histology--Melanoma: How is the histology coded for an invasive melanoma stated to have a "superficial spreading growth pattern"? See discussion.

### Discussion

Some facilities in our reporting region submit pathology reports that document invasive melanoma cases with a subtype stated to be a "growth pattern." The MP/H rules state that we are not to use the term "pattern" to code the histology of invasive tumors. However, applying this rule means the more specific histology will not be recorded for any of these cases. Can the term "growth pattern" be considered a more specific histologic type for invasive melanomas when no other information is available?

### Answer

Code the histology as superficial spreading melanoma. As you said, the subtype of this invasive melanoma is "superficial spreading." Code the subtype, per rule H9.

**Last Updated**03/12/12

**Question: 20120031**

**Status**

Final

**Question**

Grade--Bladder: How is grade coded for an invasive urothelial carcinoma of the bladder that is stated to be "histologic grade (WHO/ISUP): high grade"? See discussion.

**Discussion**

For invasive urothelial tumors, can a WHO grade be used to code the differentiation?

Per the Bladder Coding Guidelines in Appendix C and SINC 20091067, the grade for a non-invasive bladder tumor that is "high grade" will be coded as 9 [unknown] with the explanation that "WHO grades are applied to urothelial tumors ranging from dysplasia to non-invasive urothelial carcinoma."

**Answer**

Assign code 4, Grade IV. For invasive bladder cases, use the conversion table in the Bladder Coding Guidelines in Appendix C of the 2011 SEER manual to convert the term "High grade" to a SEER grade code. WHO grade is a grade for urothelial tumors, and when those tumors are non-invasive, the WHO grade designates severity of dysplasia.

The answer to SINC 20091067 has been clarified to read "WHO grades are applied to **non-invasive** urothelial tumors ranging from dysplasia to non-invasive urothelial carcinoma."

**Last Updated**

03/12/12

**Question: 20120030**

**Status**

Final

**Question**

MP/H Rules/Histology--Melanoma: What is the correct histology code for a case in which the final diagnosis for an excisional biopsy specimen is reported as "malignant melanoma, superficial spreading type" and in the CAP protocol layout within the same report indicates that the "cell type: epithelioid"? See discussion.

**Discussion**

The MP/H rules do not address the concept of "cell type" for melanomas when the pathologist uses the CAP protocol to report findings. How is the histology to be coded when the final diagnosis of melanoma is reported as being a specific histologic type and there is a different specific cell type reported for the same case? Should the cell type be considered another specific histologic type in this case? Pre-2007 SINC entries indicate the cell type should be coded. Do the MP/H rules still take the cell type into account?

**Answer**

Code the histology to malignant melanoma, superficial spreading type, based on the final diagnosis.

The final diagnosis takes precedence over the CAP protocol. The CAP protocol may be used when it provides additional information, but that does not apply in this case.

**Last Updated**

03/12/12

**Question: 20120027**

**Status**

Final

**Question**

MP/H Rules/Histology--Colon: How is histology coded when a patient has two frank invasive adenocarcinomas in one segment of the colon and multiple tubular adenomas and hyperplastic polyps throughout the entire colon without a diagnosis of familial polyposis [FAP]? See discussion.

**Discussion**

Does rule H19 apply which indicates the histology is coded to 8221 [adenocarcinoma in multiple adenomatous polyps] because there are multiple polyps (number not specified) throughout the colon? Does tumor have to arise in at least one of the adenomas in order to apply rule H19?

Or, does rule H22 apply which indicated the histology is coded to 8140 [adenocarcinoma, NOS] because the adenocarcinomas are both frank invasive adenocarcinomas and not adenocarcinoma arising in an adenoma?

**Answer**

Apply rule H22.

Rules H17 through H21 do not apply in this case because there is no malignancy arising in any of the adenomas or polyps.

**Last Updated**

03/12/12

**Question: 20120025**

**Status**

Final

**Question**

MP/H Rules/Histology--Brain & CNS: Do I put this in as a new primary?

Diagnosis from a brain biopsy: metastatic malignant melanoma, 2003, and meningeal melanomatosis.

Meningeal melanomatosis has a separate ICD code, but is also a very rare form of melanoma.

**Answer**

There is only one primary, the original melanoma. The brain and the meninges are both metastatic sites.

This case was sent to the melanoma physician specialists. The physician stated that, in this case, the meningeal involvement is secondary to the brain involvement (metastatic spread). Whenever brain metastases are diagnosed, the meningeal spread is metastatic.

**Last Updated**

03/02/12

**Question: 20120020****Status**

Final

**Question**

MP/H Rules/Multiple primaries--Breast: How many primaries are to be accessioned when a lumpectomy shows a single 6 mm "infiltrating mammary adenocarcinoma, histologic type: ductal (tubular)" tumor, and "peritumoral microscopic foci of solid type ductal carcinoma in situ?" See discussion.

**Discussion**

Per SINQ 20091117, tubular (ductal) carcinoma would be coded to 8211/3 [tubular], but in that case the tubular/ductal carcinoma is composed of a single tumor. In this case, the foci of DCIS were specifically stated to be peritumoral, and not a part of the infiltrating tubular carcinoma.

Are these microscopic foci of DCIS considered a separate primary per rule M12 and SINQ 20110092 [two primaries are accessioned when one tumor is invasive and another is in situ, and histology codes differ at 1st, 2nd or 3rd numbers]? Does the size of the DCIS matter when there are two distinct histologies? Abstracting a second primary for these microscopic foci seems like over-reporting.

**Answer**

It depends on what this pathologist means by "ductal (tubular)." According to the WHO classification, tubular is not a duct subtype. Check with the pathologist if possible.

If the pathologist means tubular carcinoma, rule M12 applies and this case is two primaries.

If the pathologist means duct, this is a single primary.

**Last Updated**

03/12/12

**Question: 20120019****Status**

Final

**Question**

Surgery of Primary Site/Scope Regional LN Surgery--Breast: How are these fields to be coded for breast cases diagnosed 2011 and later when the patient has a simple mastectomy with removal of seven sentinel lymph nodes? See discussion.

**Discussion**

Per SINQ 20091076, the correct codes would be 41 [simple mastectomy] and 2 [sentinel lymph node biopsy only] when the patient has any number of sentinel nodes removed, as long as they are designated as sentinel nodes. Under the mastectomy codes in the 2011 SEER Manual, Appendix C, Breast Surgery Codes, the SEER Note states that code 41 [simple mastectomy] includes removal of one to three axillary lymph nodes. A simple mastectomy with four or more axillary lymph nodes would be coded as 51. Does this count include both sentinel and axillary lymph nodes? Or strictly axillary lymph nodes, separate from the sentinel lymph node(s) biopsied?

**Answer**

First, make sure that the seven lymph nodes removed were actually sentinel nodes and not a combination of sentinel nodes and other regional nodes. Code sentinel nodes only when designated as sentinel nodes or when the surgical procedure includes the injection of dye to identify sentinel nodes.

If they are all sentinel nodes, follow the instructions in SINQ 20091076 and assign codes 41 [simple mastectomy] and 2

[sentinel lymph node biopsy only].

The SEER Note does not pertain to nodes designated as sentinel nodes.

**Last Updated**

03/12/12

**Question: 20120017**

**Status**

Final

**Question**

Reportability: Is a low-grade neuroendocrine neoplasm with gastrin expression found in a periportal lymph node reportable if the clinical impression is compatible with a gastrinoma? See discussion.

**Discussion**

SINQ 20110095 states that "low-grade neuroendocrine neoplasm/carcinoid tumor with expression of gastrin" is reportable, but in this case "carcinoid tumor" is not mentioned. Is this still reportable without the inclusion of "carcinoid tumor" in the diagnosis? Also, does the fact that the gastrinoma was found in a lymph node affect reportability?

**Answer**

Report this as a gastrinoma. Gastrinomas are usually malignant. This one is apparently present in a metastatic site (periportal lymph node) which confirms malignancy.

**Last Updated**

03/09/12

**Question: 20110155**

**Status**

Final

**Question**

Multiple primaries--Heme & Lymphoid Neoplasms: How many hematopoietic primaries should we abstract, based on this Hematology/Oncology consult report, which is the only information we have? See discussion.

**Discussion**

Patient is 83 year old male diagnosed with thrombocytosis and probably polycythemia about 18 years ago. He has been on hydroxyurea since then. It looks like there is progression of his polycythemia probably to myelofibrosis. Possibility of an MDS will have to be considered. Problem list: Polycythemia probably progression to myelofibrosis or MDS. Then, Bone marrow biopsy 2 weeks later shows some progression of dysmegakaryocytopoiesis. He does have evidence of MDS, as well along with essential thrombocytosis and JAK2 mutation positive polycythemia vera. Six weeks later, on follow up visit, still managing patient with hydroxyurea. Six months later, they are still calling this polycythemia with thrombocytosis.

**Answer**

There are two primaries: essential thrombocytosis (ET) and polycythemia vera (PV). Do not abstract myelofibrosis or MDS because there was no definitive diagnosis of either.

The consult report describes a definitive diagnosis of ET and PV. The JAK2 mutation further confirms the PV.

**Last Updated** 03/09/12

**Question: 20110137**

**Status**

Final

**Question**

MP/H Rules/Histology--Skin: What is the histology code for a malignant baso-melanocytic tumor skin right shoulder?

**Discussion**

**Answer**

This is a malignant skin tumor with both melanoma and basal cell carcinoma histologies. There is no ICD-O-3 code for this entity.

Since melanoma is reportable, and basal cell is not reportable to SEER, code this 8720/3 and document in a text field.

**Last Updated**

03/09/12

**Question: 20091067**

**Status**

Final

**Question**

Grade--Bladder: Are the terms low grade, high grade, Grade II, Grade III, etc. used to code Grade for papillary urothelial cancers of the bladder?

**Discussion**

The reference Anderson's Pathology indicates that these terms (low grade, high grade, Grade II, Grade III, etc) describe WHO levels of hyperplasia. For example. "Noninvasive papillary transitional cell carcinoma, Grade II. SEER states that we not use the WHO Grade to code the sixth digit for ICD-0-3 coding. The term "WHO Grade" is generally not stated as such in the record.

**Answer**

For NON-invasive bladder tumors, assign code 9 [unknown] to the Grade field. WHO grades are applied to non-invasive urothelial tumors ranging from dysplasia to non-invasive urothelial carcinoma. For invasive urothelial carcinoma, if terms such as low grade, high grade, Grade II, Grade III are used, assign the appropriate code in the grade field. See the 2007 SEER Manual instructions on page C-844 for converting a three-grade value to a SEER grade code.

**Last Updated**

03/12/12