Question: 20140011

Status Final

Question

MP/H Rules/Multiple primaries--Breast: Is the diagnosis of Paget disease two years after a diagnosis of infiltrating duct carcinoma of the same breast a new primary? See discussion.

Discussion

A patient was diagnosed and treated in 2010 for infiltrating duct carcinoma of the left breast. There was no mention of Paget disease. Then in 2012, the same patient was diagnosed with Paget disease of the nipple of the left breast. Rule M9 seems to apply; so this is the same primary, correct? And the information about the Paget disease is simply never captured, correct?

Answer

Yes, Rule M9 makes this a single primary. You could revise the original histology code to 8541/3 on the assumption that Paget was present at the original diagnosis, but not yet identified.

Date Finalized 02/28/2014

Question: 20140007

Status Final

Question
Surgery of Primary Site--Lung: How is surgery coded when a patient undergoes a mediastinoscopy with mediastinal lymph node sampling and then a later upper lobectomy? See discussion.

Discussion
The mediastinal nodes were submitted as a separate specimen. The patient also had several peribronchial nodes identified within the lobectomy specimen.

Does code 33 (Lobectomy with mediastinal lymph node dissection) require a complete mediastinal lymph node dissection (i.e. the removal of all lymph nodes in mediastinal chain(s) as opposed to a selective sampling/dissection of lymph nodes from multiple mediastinal chains)?

Answer

Assign code 33 in this situation. Code 33 can include mediastinal lymph node sampling.

Date Finalized 02/05/2014

Question: 20140006

Status Final

Question
Date Therapy Initiated--Corpus Uteri: How should this field be coded for an endometrial primary when the patient undergoes a hysteroscopic polypectomy on 01/08/2014 (Surgery code 25), followed by a TAH/BSO on 02/07/2014 (Surgery code 50)? See discussion.

Discussion
The hysteroscopic polypectomy showed multiple tissue fragments with invasive endometrioid adenocarcinoma. The hysterectomy and BSO removed an 8.2cm endometrioid carcinoma with no extra-uterine involvement.

Answer

Record 01/08/2014 for date therapy initiated assuming there was no therapy prior to this date. A polypectomy is a surgical procedure for purposes of coding date therapy initiated.

Date Finalized 02/05/2014

Question: 20140005

Status Final

Question

Primary site--Testis: In the absence of a specific statement that the patient's testicle(s) are descended, should the primary site for a testicular tumor be coded as C621 (Descended Testis) when the mass is palpable on physical exam or demonstrated on scrotal ultrasound? See discussion.

Discussion

It seems the non-specific Testis, NOS (C629) code is being over used. Many testis cases have no documentation of the patient's testicular descention. However, testicular tumors in adults are frequently detected by palpation or scrotal ultrasound. An undescended testis (a testis absent from the normal scrotal position) would be non-palpable or not amenable to imaging via a scrotal ultrasound.

Answer

Unless the testicle is stated to be undescended, it is reasonable to code C621 for primary site. Reserve C629 for cases with minimal or conflicting information.

Date Finalized 02/05/2014

Question: 20140004

Status Final

Question

Grade--Liver: How should grade be coded for a liver lesion treated with radio frequency ablation (RFA) followed by a transplant showing moderately differentiated hepatocellular carcinoma? See discussion.

Discussion

The SEER Manual emphasizes the importance of coding grade only prior to neoadjuvant treatment as systemic treatment and radiation can alter a tumor's grade. This patient did not have neoadjuvant chemotherapy or radiation, but did undergo a prior surgical procedure (RFA) in an attempt to destroy tumor tissue. The subsequent transplant showed residual moderately differentiated HCC.

Answer

For this case, record the grade specified even though it is after RFA. RFA is not systemic or radiation treatment and should not alter the grade.

Date Finalized 02/05/2014

Question: 20140003

Status Final

Question

Surgery of Primary Site/Surgical Procedure of Other Sites--Endometrium: How are these fields coded for an endometrial primary when the patient undergoes a radical tumor cytoreduction including modified radical hysterectomy, BSO, omentectomy, resection of intra-abdominal and intrapelvic implants, and partial cystectomy? See discussion.

Discussion

When other regional sites (besides the omentum) are removed with the primary site, how is Surgical Procedure of Other Site coded? There is no cytoreduction surgery code for endometrial primaries, and this patient does not appear to qualify for any of the specific pelvic exenteration codes.

Per SINQ 20091118, an omentectomy is not coded in the Surgical Procedure of Other Site field when it is performed with a hysterectomy.

Answer

In general, record surgery of sites/organs not covered in the surgery of primary site codes under surgery of other site. For this case, code the partial cystectomy under surgery of other site. As you point out, the omentectomy is not recorded under surgery of other site when performed with a hysterectomy for an endometrial primary.

Date Finalized 02/13/2014

Question: 20140002

Status Final

Question
Reportability--Appendix: Is a pathologic final diagnosis of an appendix with "well-differentiated neuroendocrine tumor (carcinoid)" reportable? See discussion.

Discussion
SINQ 20130027 states that "well-differentiated neuroendocrine tumor" of the appendix is reportable (8240/3) while "carcinoid" tumors of the appendix are not reportable (8240/1). Please explain the difference between "well-differentiated neuroendocrine tumor" of the appendix and a "carcinoid" of the appendix.

Answer

Well-differentiated neuroendocrine tumor of the appendix is reportable. The difference is terminology. "Carcinoid" is listed in ICD-O-3 as a /1 for appendix making it non-reportable.

When both terms are used, ask for clarification from the pathologist. Failing that, accept the reportable terminology and report the case.

Date Finalized 02/05/2014

Question: 20140001

Status Final

Question

Grade--Brain and CNS: How should grade be coded for a pineal parenchymal tumor of "intermediate differentiation"? See discussion.

Discussion

Per a web search, the term "pineal parenchymal tumor of intermediate differentiation" refers to a pineal tumor with the histology/behavior that falls somewhere between the category of pineocytoma (9361/1) and pineoblastoma (9362/3). In other words, it is a malignant tumor that is a WHO grade II/III neoplasm because it's histologic features and behavior are not quite equivalent to a pineoblastoma (WHO grade IV). Thus, it appears the expression "intermediate differentiation" is actually referring to a type of WHO classification system rather than the grade field.

Should the type of documentation provided in pathology report be used to imply the grade field is being referenced and thus be coded to 2 for "intermediate differentiation" or should grade be coded to 9 based on the information found during the web search?

Answer

Code the grade as 2 based on instruction #8 in the revised grade instructions for 2014.

Do not use WHO grade to code the grade field for CNS tumors.

Date Finalized 02/05/2014

Question: 20130222

Status Final

Question

MP/H Rules/Histology--Bladder: What code should be assigned to this tumor? A single bladder tumor removed via TURB. Final Dx: Invasive urothelial carcinoma with extensive divergent differentiation including small cell carcinoma, micropapillary carcinoma, and squamous cell carcinoma features.

MP/H rules seem to lead to H8 - code the numerically higher ICD-O-3 code. Out of this diagnosis, it appears that 8131, micropapillary urothelial carcinoma would be the code. That would ignore the small cell carcinoma, which seems prognostically more significant.

Answer

Code this combination to mixed small cell (8045) -- a combination of small cell with other types of carcinoma. There is currently no rule in the urinary site rules for this combination of histologies. This will be included in the revised MP/H rules.

Date Finalized 02/05/2014

Question: 20130221

Status Final

Question
MP/H Rules/Multiple Primaries--Prostate: Is a metastatic small cell (neuroendocrine) carcinoma following a prostate adenocarcinoma a new primary when the physician states "patient has Stage 4 small cell carcinoma of the prostate" or "metastatic small cell carcinoma, likely prostate origin"? See discussion.

Discussion
Would a second prostate primary with histology 8041 be reported or is this metastasis from the previous prostate adenocarcinoma diagnosis, despite the different histologies?

Examples –
1. Prostate adenocarcinoma diagnosed in 2001, no treatment given. Metastatic small cell neuroendocrine carcinoma diagnosed 03/2012 on liver biopsy with physician's statement in 4/2012 that prostate is the likely the cause of the metastasis to the liver.
2. Prostate adenocarcinoma diagnosed in 2006, treated with TURP. Bone Marrow biopsy in 05/2012 shows involvement by metastatic small cell carcinoma with morphologic and immunophenotypic features that argue against prostatic adenocarcinoma. Oncologist assessment states "the patient has Stage 4 small cell carcinoma of the prostate and the bone marrow biopsy path shows metastatic small cell carcinoma (likely prostate in origin)".

Answer

Rule M10 applies to the case examples you provide. In each case, the second histology (since it is not adenocarcinoma) is a new prostate primary. Small cell carcinoma and small cell neuroendocrine carcinoma are not adenocarcinomas and are not covered by Rule M3.

Date Finalized 02/05/2014

Question: 2013220

Status Final

Question

Date of diagnosis/Ambiguous terminology--Breast: I have 3 scenarios for which we disagree on whether this is the date of diagnosis or not. Mammogram - nothing in body of mammogram for any suspicion or malignancy. See discussion.

Discussion

First

ASSESSMENT: BIRADS CATEGORY 4-SUSPICIOUS. FINDING ARE CONSIDERED SUSPICIOUS/INDETERMINATE FOR MALIGNANCY

Second

ASSESSMENT: BIRADS 5- HIGHLY SUSPICIOUS. FINDING ARE HIGHLY SUGGESTIVE OF MALIGNANCY.

Third

ASSESSMENT: BIRADS 4- SUSPICIOUS ABNORMALITY CONSIDER BIOPSY

I say these are not the date of diagnosis. Others say we should not use BIRADS number but we could the BIRADS WORD OF SUSP. Please advise.

Answer

Neither BIRADS category 4 nor category 5 should be interpreted as "malignancy" for cancer registry purposes.

Date Finalized 02/28/2014

Question: 20130205

Status Final

Question
MP/H Rules/Multiple primaries--Breast: For a case of infiltrating duct and lobular carcinoma of the breast (8522) and Paget disease of the same breast, is this one primary or two? If it is just one primary, what is the histology code?

Answer

Abstract as two primaries according to rule M12. We interpret this as one tumor with infiltrating duct and lobular carcinoma (8522) and a second tumor with Paget disease (8540).

Date Finalized 02/05/2014

Question: 20130204

Status Final

Question
MP/H Rules/Histology--Kidney, renal Pelvis: What histology code applies to a "tubulocystic renal cell carcinoma" ? See discussion.

Discussion
Per the resected specimen final diagnosis COMMENT in the pathology report: Tubulocystic renal cell carcinoma is a relatively new renal epithelial neoplasm that has been added to an updated WHO classification of renal tumors, The International Society of Urologic Pathology Vancouver Classification of Renal Neoplasia (Srigley et al. The International Society of Urologic Pathology Vancouver Classification of Renal Neoplasia Am J Surg Pathol. 2013;37:1469-1489). The majority of tubulocystic renal cell carcinomas reported in the literature (greater than 90%) have behaved in an indolent manner.

Answer

Code to renal cell carcinoma, NOS (8312/3) per kidney rule H3. The term "tubulocystic" is not a specific renal cell histology according to our kidney pathologist expert.

Date Finalized 02/05/2014

Question: 20130203

Status Final

Question
MP/H Rules/Multiple Primaries--Brain and CNS: How many primaries are reported for a patient diagnosed with cerebral cavernous malformation disorder (CCM1) and MRI evidence of dozens of cavernous angiomas/malformations throughout the supra and infratentorium? See discussion.

Discussion
9/9/11 IMP: Presymptomatic cerebral cavernous malformation disorder (CCM1).

9/9/11 Brain MRI: FINDINGS: Total of 14 foci. 2 largest in rt frontal lobe. In rt frontal lobe, total of 4 foci. Of remaining 10 small foci, 4 are in cerebellum, 1 in rightward pons, 1 in lt temporal lobe, 1 in lt occipital lobe, 1 in rt occipital lobe, 1 in posterior rt temporal lobe, & 1 in lt frontal lobe. Lesions in bilateral occipital lobes & lt temporal lobe are associated w/weighted signal suggestive of hemosiderin & are most c/w additional cavernous malformations. IMPRESSION: Just over a dozen scattered foci of gradient susceptibility throughout supra & infratentorium.

9/13/13 Brain MRI. Clinical diagnosis: Cerebral cavernous angiomas. FINDINGS: Approximately a dozen scattered foci. 2 largest in rt frontal lobe. Remaining small foci identified w/in cerebellum, rightward pons, rt occipital lobe, rt temporal lobe, & lt frontal lobe. Many are less conspicuous than in 2011 & a few that were present on prior study are not evident on current exam. This is likely due to differences in technique. IMPRESSION: Redemonstration of numerous scattered foci c/w cavernous malformations.

Answer

Vascular tumors of the CNS are reportable when they arise in the dura or parenchyma of the CNS. When they arise in blood vessels or bone, they are not reportable. First determine the primary site. For those arising in reportable sites, apply the M rules to determine the number of primaries to report. Do not report vascular tumors when there is not enough information to determine whether they arise in the dura or parenchyma or elsewhere. Malformations are not neoplastic and therefore, not reportable.

Date Finalized 02/05/2014

Question: 20130199

Status Final

Question
MP/H Rules/Multiple primaries--Breast: Does breast Rule M10: 'Tumors that are lobular (8520) and intraductal or duct are a single primary' apply if you have twp tumors in the same breast, one ductal and the other tubulolobular (8524)? If not, then rule M12 makes these separate primaries, correct?

Answer

Yes, apply Rule M10 to this case. Tubulolobular is now classified as a variant of lobular. Code to lobular, NOS (8520) because Tubulolobular does not have a specific ICD-O-3 code.

Date Finalized 02/05/2014

Question: 20130198

Status Final

Question
MP/H Rules/Multiple primaries--Other sites: A patient has a total colectomy showing neuroendocrine carcinoma of the rectosigmoid junction, as well as a separate adenocarcinoma arising in a villous adenoma, also arising in the rectosigmoid junction. Is this a single primary per rule M17 (a frank adenocarcinoma and an adenocarcinoma in a a polyp) or per rule M16 (adenocarcinoma and a more specific adenocarcinoma) or is this 2 primaries?

Answer

Abstract two primaries per Rule M17. Neuroendocrine carcinoma is 8246 and adenoca arising in a villous adenoma is 8261. Rule M13 does not apply to neuroendocrine carcinoma. M16 does not apply to this case.

Date Finalized 02/05/2014

Question: 20130197

Status Final

Question

MP/H Rules/Histology--Urinary system: Is code 8130 is the only valid code for papillary carcinoma cases dx 2007 forward? If this is correct, then should we have any 2007 cases forward coded to 8050 in our database?

The MP/H rules for ureter, renal pelvis, and bladder H4 states to code papillary carcinoma to 8130, yet code 8050 is also listed in M6 for papillary carcinoma.

The IARC publication Pathology and Genetics of Tumours of the Urinary System and Male Genital Organs uses code 8130 only for papillary carcinoma.

Answer

8050 should not be used for papillary carcinoma of the urinary system diagnosed starting in 2007. Rule M6 was written to take pre-2007 cases into consideration.

Date Finalized 02/05/2014

Question: 20130194

Status Final

Question
Reportability--Brain and CNS: Are blood vessel tumors arising in CNS sites reportable? See discussion.

Discussion
Previous instructions from the CDC (Cancer - Collection and Coding Clarification for CNS Tumors - NPCR) stated that non-malignant blood vessel tumors in CNS sites are reportable and should be coded to the CNS site in which they arose. SINQ 20081113 also states that a blood vessel tumor, cavernoma/cavernous hemangioma in the brain is reportable. However, SINQ 20120034 contradicts this previous info stating site should be coded to C490, blood vessel for a blood vessel tumor (venous angioma) in the brain.

If blood vessel tumors arising in a CNS site are no longer reportable, please specify the site/histology codes for these non-reportable tumors and when this change took place.

Answer The instructions in the CDC book regarding primary site coding are not the most current instructions. Vascular tumors of the CNS are reportable when they arise in the dura or parenchyma of the CNS and should be coded accordingly. The tumor in SINQ 20120034 is not reportable because it arises in a blood vessel. The cavernous hemangioma in SINQ 20081113 is reportable because the primary site is the white matter of the cerebral cortex.

Date Finalized 02/05/2014

Question: 20130193

Status Final

Question
Sex: How is sex coded for the following?

Primary site is testes. The Physical Exam states patient is male. The remarks states patient is transsexual. There is no indication that the orchiectomy was part of gender reassignment surgery.

Answer Code the sex as male in this case. When the natal sex is known, prefer that over transsexual.

Date Finalized 02/28/2014

Question: 20130192

Status Final

Question
MP/H Rules/Histology--Pleura: How is histology coded when a Final Diagnosis is "malignant neoplasm, compatible with malignant mesothelioma" if the COMMENT section of the pathology report indicates the tumor has a mixed epithelial and sarcomatoid pattern? See discussion.

Discussion
This case was discussed with a pathologist, who feels the correct histology should be biphasic mesothelioma (9053/3) because there are both epithelial and sarcomatoid components to this tumor. However, when you apply the current MP/H Rules, the histology is coded to 9050/3 (mesothelioma, NOS) because the term "pattern" cannot be used to code a more specific histologic type for invasive tumors. If this really is a biphasic mesothelioma, that data is lost for researchers, because the current MP/H Rules fail to allow us to capture this information. Should the term pattern be used to code the more specific histology in this case?

Answer

Apply the MP/H rules as written until they are revised. The word "pattern" and other terms will be reconsidered for the next iteration of the rules.

Date Finalized 02/05/2014

Question: 20130191

Status Final

Question

Systemic/Surgery Sequence--Bladder: How is the systemic treatment/surgery sequence field coded for a 2013 case if the patient has a TURBT followed by multi-agent chemotherapy, and then a cystoprostatectomy followed by post-operative multi-agent chemotherapy?

Discussion

For cases diagnosed in 2012 and later, code 7 (surgery both before and after systemic therapy) seems like the most appropriate answer. However, previous SINQ entries 20091055 and 20071102 have conflicting answers regarding surgery before and after systemic therapy. Do these SINQ entries apply to a 2013 diagnosis? Would the systemic treatment/surgery sequence be coded 7 because this patient had surgery then chemotherapy followed by more surgery? Should the post-operative systemic treatment be ignored in coding the sequence in this case?

Answer

Assign code 7 for the case you describe. The answers to SINQ 20091055 and 20071102 do not apply to a case diagnosed in 2013. They were posted prior to code 7 becoming effective in 2012.

Date Finalized 02/05/2014

Question: 20130190

Status Final

Question
Reportability--Is a thymoma, B3 type malignant? Recent information received from a registrar/pathologist states that the WHO classifies well-differentiated thymic carcinoma (8585/3) as a synonym for Type B3 thymoma.

Answer

Type B3 thymoma (8585/1) is not reportable. Well-differentiated thymic carcinoma (8585/3) is reportable.

WHO lists well-differentiated thymic carcinoma as a synonym for type B3 thymoma, but shows two different ICD-O-3 codes as indicated above.

Date Finalized 02/05/2014

Question: 20130189

Status Final

Question
Reportability--Brain and CNS: Do the terms 'mass' and 'lesion' constitute reportability for brain and CNS diagnostic findings? The SEER Manual mentions 'tumor' and 'neoplasm' but not mass and lesion. The SEER MP/H Manual calls tumor, mass, lesion, and neoplasm equivalent terms for determining multiple primaries, but does this apply to reportability? If not, what is the distinction?

Answer

Reportable terms for benign/borderline brain and CNS are "tumor" and "neoplasm." These terms appear in ICD-O-3. Lesion and mass do not appear in ICD-O-3. Page 2 of the SEER manual is the correct source for reportability instructions.

Date Finalized 02/05/2014

Question: 20130187

Status
Final

Question
Reportability: Is this case reportable?

A thymoma is described by the medical oncologist at initial diagnosis as a malignant thymoma, Stage III. The patient has neoadjuvant chemotherapy with CAP beginning that day, followed by resection. At resection, the pathologist gives a diagnosis of spindle cell thymoma.

Answer Yes, this case is reportable based on the information provided. A reportable diagnosis (malignant thymoma) was made by a physician and the patient was treated for this diagnosis. Since there is no mention of amending the initial diagnosis based on the pathology report, we must assume the initial diagnosis is still valid.
Date Finalized 02/05/2014

Question: 20130186

Status Final

Question
Grade: Can the FIGO grade be used for coding the morphology grade? FIGO Grade is coded in CS SSF 7 in the Corpus Uteri schema. The SEER Program Coding and Staging manual does not address using FIGO grade for coding grade in morphology.

Answer
Do not use FIGO grade to code the grade field. See #9 on page 79 of the SEER manual, http://www.seer.cancer.gov/manuals/2013/SPCSM_2013_maindoc.pdf

Date Finalized 02/05/2014

Question: 20130185

Status Final

Question
Reportability/Behavior: Is HGSIL (high grade squamous intraepithelial lesion) of the vulva or vagina reportable? Is this a synonym for 8077/2 -- Squamous intraepithelial neoplasia, grade III?

Answer

HGSIL of the vulva or vagina is not reportable. HGSIL is not a synonym for squamous intraepithelial neoplasia, grade III.

Date Finalized 02/05/2014

Question: 20130184

Status Final

Question
Reportability--Appendix: Are low-grade appendiceal mucinous neoplasms reportable?

Answer

Low-grade appendiceal mucinous neoplasm (LAMN) is not reportable. The WHO classification designates LAMN as /1 with uncertain malignant potential.

Date Finalized 02/28/2014

Question: 20130182

Status Final

Question
Primary site--Head and Neck: Should the primary site be coded to floor of mouth because site of invasive disease? Or is primary site C148 because invasion doesn't translate into determining primary site?

Patient with overlapping lesion of tongue and floor of mouth. Initial biopsy of floor of mouth reveals microinvasive squamous cell cancer. Definitive resection reveals in situ squamous cell cancer. Path report states unifocal tumor, tumor site on path documented as tongue and floor of mouth.

Answer

Code to C068, overlapping lesion of other and unspecified parts of the mouth. Based on the information provided, this sounds like a "book-leaf" lesion – a lesion that overlaps the floor of the mouth and the underside of the tongue.

Date Finalized 02/28/2014

Question: 20130180

Status Final

Question
Histology--Pancreas: Please explain the difference in coding of pancreatic endocrine neoplasm, PanNETs 8240/3 (SEER Inquiry 20120035) and the new ICD-O-3 pancreatic endocrine tumor, benign or malignant 8150/0 or 3

Answer

The difference is that 8150 is for islet cell tumors. The preferred name was changed by WHO/IARC to reflect the current language used by pathologists to describe these islet cell tumors. 8240 added the neuroendocrine tumor, grade 1, low or well diff terms to the carcinoid ICD-O name. Islet cell tumors are more agressive than the pancreatic NET tumors and treatment and prognosis are determined by the histologic type. 8150 is not a new code, the histology name has been updated.

Date Finalized 02/28/2014

Question: 20130177

Status Final

Question
MP/H Rules/Histology--Bladder: What rule and histology code should we use? 6 cm tumor arising in posterior-lateral bladder extends to prostate, obliterates seminal vesicle, and invades pelvic wall. TURB Final DX: Small Cell Neuroendocrine Carcinoma. 10% of tumor is high grade Urothelial Carcinoma. The single tumor rules appear to lead us to H8, the numerically higher code of 8120. This does not seem like a true representation of the tumor.

Answer

Urinary Sites Rule H8 applies: code the urothelial carcinoma 8120/3. The revised 2015 MP/H rules will clarify when to code neuroendocrine histologies.

Date Finalized 02/28/2014

Question: 20130176

Status Final

Question
Reportability--Ovary: Is an adult granulosa cell tumor of the right adnexa reportable if the left adnexa, diaphragm and paratubal tissue are reported to be consistent with metastasis? See discussion.

Discussion
Per the pathology report: Right adnexa: adult granulosa cell tumor. Left adnexa: Foci of metastatic granulosa cell tumor in paratubal tissue. Diaphragm smears: consistent with metastatic granulosa cell tumor. Comment: The morphology and immunoprofile of the cellular aggregates in the paratubal soft tissue are consistent with metastatic granulosa cell tumor.

Answer

Based on the information provided, this case would not be reportable. The "metastases" ("metastatic granulosa cell tumor") are not malignant in this case, they are of low malignant potential, the same behavior as the primary tumor. For this case to be reportable, the metastases would have to be described as malignant. The mets are specifically stated to be granulosa cell tumor, so we know they are not malignant for this case.
Date Finalized 02/05/2014

Question: 20130174

Status Final

Question

Histology--Breast: How should invasive pleomorphic lobular carcinoma be coded? As it is "a very rare and distinct morphological variant of invasive lobular carcinoma," (ncbi.nim.nih.gov) Should it be coded pleomorphic carcinoma (8022/3) or lobular carcinoma (8520/3)? The MP/H rules do not seem to recognize specific lobular carcinomas.

Answer

Code as invasive lobular carcinoma, 8520/3.

The 4th Edition WHO Classification of Tumors of the Breast now describes five variants of invasive lobular carcinoma. These variants are solid type, alveolar, pleomorphic, tubulolobular, and mixed-type. WHO has not proposed that new ICD-O codes be assigned to these variants. The upcoming solid tumor (MP/H) revisions will include instructions on coding these variants.

Date Finalized 02/28/2014

Question: 20130170

Status Final

Question
MP/H Rules/Histology--Breast: What is the histology code for invasive carcinoma of the breast, no special type? See discussion.

Discussion
We have recently started noticing that our pathology reports for breast primaries are no longer listing invasive ductal carcinoma as the histology on many cases where the treating doctors are calling the cancer an invasive ductal carcinoma (the pathology - final and synoptic - are listing invasive carcinoma, no special type).

Upon inquiry to the pathology department we received the following response, "In 2012, the WHO got rid of ductal carcinoma as a specific type. So what would have been called Invasive ductal carcinoma, Not otherwise specified (NOS), is now being called Invasive carcinoma, No Special Type (NST). In the new WHO classification, lobular, tubular, cribriform, mucinous, etc… are the special types. But ductal is gone."

Is this just a change in terminology? Are we supposed to code these cases to 8500/3, or are we supposed to code this to 8010/3, carcinoma, NOS?

Answer

Continue coding the histology to 8500/3. Do not code "invasive carcinoma, no special type" to carcinoma, NOS (8010/3).

The 4th Edition of the WHO Classification of Tumors of the Breast refers to invasive ductal carcinoma as invasive carcinoma, no special type. The ICD-O-3 code remains the same as invasive duct carcinoma (8500/3). The next revision to the MPH/Solid Tumor Rules will clarify this.

Date Finalized 02/06/2014

Question: 20130165

Status Final

Question

MP/H Rules/Multiple primaries--Thyroid: Is this one primary or two primaries of the thyroid? Here is the path report from a complete thyroidectomy: Tumor Focality: Multifocal (bilateral) Dominant Tumor: Tumor Laterality: Right lobe Tumor Size: Greatest dimension: 9 cm Histologic Type: Papillary carcinoma Variant, specify: Classical Architecture: Follicular Cytomorphology: Classical SECOND TUMOR: Tumor laterality: Left lobe Tumor Size: Greatest dimension: 6 cm Histologic Type: Papillary carcinoma, columnar cell variant Architecture: Solid, follicular, and papillary Cytomorphology: Columnar cell The answer seems to hinge on whether or not the two tumors differ at the third digit of histology. Can we code based on the terms listed for variant or architecture?

Answer

This is a single thyroid primary. The tumors are both papillary carcinoma with follicular architecture for the most part. Apply rule M6 and abstract a single primary.

Date Finalized 02/05/2014

Question: 20130152

Status Final

Question

Primary site/Histology--Brain and CNS: How would you code the site/morphology for this situation? Patient has a dermoid cyst of the 3rd ventricle of the brain, diagnosed in 1998. In 2013, the patient has the cyst removed and it is diagnosed as squamous cell carcinoma. In an internet search, we found a journal article in the Journal of Neurooncology that says, "Although rare, malignant transformation of intracranial epithelial cysts has a poor prognosis ...". The combination of C715 and 8070/3 fails SEER Edit IF 38_3: Primary site and Morphology Impossible.

Answer

According to the literature, intracranial squamous cell carcinoma is very rare with most cases arising from a preexisting benign epidermoid cyst. The combination of C71_ and 8070/3 should be allowed. We will work to have the edit revised.

Date Finalized 02/05/2014

Question: 20130150

Status Final

Question
MP/H Rules/Histology--Bladder: How is histology coded for a bladder TUR that demonstrates mixed invasive urothelial and small cell carcinoma? See discussion.

Discussion
SINQ 20041104 (prior to 2007 MP/H rules) states to code histology to 8045. The MP/H rules do not address this combination of urothelial and small cell carcinoma. The current MP/H rule we would apply is H8 – Code the higher histology (8120/3). However, if we code the histology as such, the fact that small cell carcinoma exists will be lost. If the small cell carcinoma drives the treatment plan/prognosis, shouldn't this situation be reflected in the rules for coding histology?

Answer

Code the histology to mixed small cell carcinoma (8045/3). The presence of small cell in the histology drives the treatment decisions for this case.

Date Finalized 02/05/2014

Question: 20130149

Status Final

Question

MP/H Rules/Histology--Testis: How is histology coded for a right orchiectomy specimen with embryonal carcinoma (70%), yolk sac tumor (30%) and a focus of seminoma (<1%)? If there were also retroperitoneal lymph nodes with teratoma (NOS), would that change the Histology code? See discussion.

Discussion

The MP/H Rules for the Other Sites Table 2 (Mixed and Combination Codes) does not include the combination above. A previous SINQ note 20110013 does state that the combination of embryonal carcinoma and yolk sac tumor should be coded to 9065. The question in this case is whether the focus <1% of seminoma should be included when coding histology? If the seminoma is included, Table 2 still does not address that combination (embryonal, yolk sac and seminoma).

Answer

Assign code 9085/3 to this mixed testicular histology.

According to the WHO Classification of Tumors of the Male Genital Organs, tumors of more than one histologic type (mixed forms) can occur in any combination of various germ cell histologies including embryonal, yolk sac, teratoma, and choriocarcinoma. Mixed teratoma and seminoma is included under 9085/3 in ICD-O-3. The revised MP/H rules will expand on these mixed testicular histologies.

Histology from the primary site is preferred over histology from a metastatic site.

Date Finalized 02/05/2014

Question: 20130148

Status Final

Question
Reportability--Brain and CNS: Are “spinal” schwannomas described as extradural or vertebral nerve sheath or of specific vertebrae considered reportable?

Discussion
Are any of the three following cases reportable?

Example 1: Clinical Diagnosis: Extradural spinal cord tumor compatible with schwannoma. What assumptions should be made about reportability if the tumor is described as being extradural? Per a web search, the extradural spinal cord includes epidural fat surrounding the thecal sac and exiting nerve roots. Does this mean there are or are not nerve roots in the extradural spinal cord?

Example 2: Final Pathologic Diagnosis: Designated "C3-4 nerve sheath tumor” excision: Morphologic and immunohistochemical findings consistent with cellular schwannoma. When stated to be a “nerve sheath tumor” does that mean peripheral nerve (C47_) involvement or nerve root (C72_) involvement?

Example 3: Final Pathologic Diagnosis: T-8 vertebral tumor resection: Schwannoma with degenerative changes (calcification, cyst formation) - ganglion and nerve are identified. There is no mention clinically or pathologically as to whether this tumor is “intradural” or “of the nerve root.” In the absence of information about whether the location of the tumor is intradural or involving the nerve root, do we assume that it does involve this part of the spinal cord when a specific vertebrae is removed or should we assume it does not?

Answer

Extradural schwannomas are not reportable. Neither verbebral nerve sheath nor location of/on a specific vertebrae confirm either extradural or intradural. Do not report the schwannoma if it cannot be determined to be "intradural" or "of the nerve root."

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Question

MP/H Rules/Multiple Primaries--Lung: How many primaries are accessioned and which M rule applies if an adenoca with prominent clear cell features (8310/3) is diagnosed on 8/5/10 in the LUL lung and staged T1 N0 M0 is subsequently diagnosed on 10/9/12 with a non-small cell carcinoma with glandular and squamous features (8560/3) stage IV lung primary without pulmonary nodules identified on a scan? See discussion.

Discussion

Should the 2012 disease process in the case below be a new primary because the histology is different from the one diagnosed in 2010? Or should the 2010 and 2012 disease processes be one primary because there appears to be only metastatic disease in 2012 because no new primary lung tumor identified? The choice of one primary seems supported by the fact that the 2012 tumor showed glandular and squamous features and the prior 2010 tumor also showed glandular and clear cell (NOS) features, in which the clear cell could have been a clear cell SCC and the original tumor was not reexamined.

8/5/2010 diagnosis of LUL lung adenoca with prominent clear cell features (8310/3), treated with lobectomy only, stage T1 N0 M0.

10/9/2012 iliac bone biopsy with non-small cell carcinoma with glandular and squamous features (8560/3). Clinically, the physician is calling this stage IV adenosquamous carcinoma of lung origin involving lymph nodes, spleen and bones. There were no FDG avid pulmonary nodules found. There was no pathologic comparison to the prior lung tumor.

Answer

This is a single primary. The MP/H rules do not apply to the diagnosis in 2012 because it is metastatic from the lung primary diagnosed in 2010.

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