**Collecting Cancer Data: Central Nervous System**

**Thursday, August 3, 2017**

**Q1****:** Does M5 (benign CNS rules) apply to meningiomas?

**A1:** Rule M4 for benign has an errata so the correction is that the difference must be in 2nd, 3rd, or 4th character?

Yes there is an issue with M4. The problem is that it refers to the “Paired Site” table. The instructions for the paired site table do not explain that the cranial meninges and brain are not a paired site. They are sites for which a laterality MAY be entered if that data would be useful for your registry. Those instructions will be changed in the 2018 rules. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q2:** How is the cranial meninges different from the spinal meninges? Is it d/t location?

**A2:** Yes the difference is location and also ICD-O site/topography codes. The cranial meninges is located within the skull and coded to C700 The spinal meninges is located around the spine and is coded C701 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q3:** What diagnosis date is used when resection done that proves to be malignant when tumor first diagnosed as non-malignant by scan?

**A3:** Date of dx of the non-malignant tumor. One way to think of it is the day that tumor became reportable.

Date of diagnosis is always the date a medical practitioner first diagnosed a malignancy. It does not matter that the benign diagnosis was later pathologically proven to be malignant. The Solid Tumor Rules for nonmalignant CNS tumors will instruct that date of diagnosis will remain the same (will not be changed). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q4:** For the scenario Jim just described, 3 years later, the resection is considered part of first course of treatment? It is an analytic case?

**A4:** Those are good questions!! We'll see how the standard setters want to handle these cases.

The SEER Manual and FORDS determine the parameters for first course treatment and class of case. I have forwarded these issues to SEER asking them to update the manual and to notify CoC of the changes needed. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q5:** For the second change - if the tumor has gotten larger (progressed), is all tx now considered subsequent?

**A5:** The SEER Manual and FORDS determine the parameters for first course treatment and subsequent treatment I have forwarded these issues to SEER asking them to update the manual and to notify CoC of the changes needed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q6:** In regards to CNS changes, with a proven malignant primary would you change the sequence from 60 to 00?

**A6:** The SEER Manual and FORDS determine the parameters for sequencing. I have forwarded these issues to SEER asking them to update the manual and to notify CoC of the changes needed. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Q7:** Would three years later still be first course?

**A7:** The SEER Manual and FORDS determine the parameters for first course of treatment. I have forwarded these issues to SEER asking them to update the manual and to notify CoC of the changes needed. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Q8:** For a case where a benign tumor becomes malignant do we have to change the diagnosis date or not?

**A8:** We assume the dx date will stay the same. However, there is obviously still some implementation issues that need to be worked out. We should have full instructions ready by the time we implement the rules.

Date of diagnosis is always the date a medical practitioner first diagnosed a malignancy. It does not matter that the benign diagnosis was later pathologically proven to be malignant. The Solid Tumor Rules for nonmalignant CNS tumors will instruct that date of diagnosis will remain the same (will not be changed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q9:** Under General Rules and Information, it states that laterality is NOT used to determine multiple primaries. That seems to contradict what Jim said previously. Please clarify. M5 in Multiple Primary states that tumors on both sides are multiple primaries.

**A9:** There is an issue with M5 The problem is that it refers to the “Paired Site” table. The instructions for the paired site table do not explain that the cranial meninges and brain are not a paired site. They are sites for which a laterality MAY be entered if that data would be useful for your registry. Cranial nerves, for example, are actually paired sites. Those instructions will be changed in the 2018 rules \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q10:** For the multiple primaries question, in ICD-O-3, facial nerve is listed under cranial nerve, NOS (C72.5), does this mean part of the facial nerve is intracranial but part of it is extracranial?

**A10:** The facial nerve is CN VII. Cranial nerve 7, the facial nerve, originates in the pons and passes along the posterior cranial fossa (reportable sites). It exits the cranium through the internal acoustic meatus and enters the temple and runs through the facial canal (not reportable). Cranial nerves exit the cranium. Those portions of nerve which are extracranial (not within the cranium) are not reportable sites. Remember, there are three criteria for reportability, behavior code, histology, and primary site. In this case, the primary site is not reportable because it is not within the cranium. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Q11:** Does M5 (benign CNS rules) apply to meningiomas?

**A11:** No M5 does not apply to meningiomas\_ there is an issue with M5 The problem is that it refers to the “Paired Site” table. The instructions for the paired site table do not explain that the cranial meninges and brain are not a paired site. They are sites for which a laterality MAY be entered if that data would be useful for your registry. Cranial nerves, for example, are actually paired sites. Those instructions will be changed in the 2018 rules \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q12:** Per SEER SINQ 20160068 intraosseous meningiomas are not reportable...sphenoid wing is sometimes intraosseous. Your slide shows that intraosseous meningiomas are reportable. Please clarify. Is this new for 2018?

**A12:** Note: This answer updates previous answers which have been removed from the SEER Inquiry System. Intraosseous meningiomas are not reportable. You are correct, these are rare meningiomas originating in bone. The term "sphenoid wing meningioma" is sometimes used for an intraosseous meningioma of the sphenoid bone. Yes, it's possible to have a meningioma of the sphenoid wing on imaging that arises from the meninges NOT the bone. Read the available information carefully. When the site of origin is described as "along the sphenoid wing" or "overlying the sphenoid wing" report the meningioma. These descriptions indicate that the meningioma originates from the meninges covering bone rather than the bone itself. Meningioma arising in bone is rare enough, that when present, we would expect it to be clearly stated as such. In the absence of a statement indicating origin in bone, the meningioma is most likely arising from meninges covering the bone.

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I do not know why the answers to these reportability questions have been changed. I sent an email to SEER asking about the change affecting reportability. Dr. McLendon, neurologist, Duke University was the primary physician subject matter expert on the original rules and again on the 2018 rules. His response to questions about reportability of sphenoid wing meningiomas were as follows

* Yes, they are reportable
* The most common sphenoid wing meningioma originates in the cranial meninges (reportable) overlying the sphenoid wing (a boney structure. They actually originate in the arachnoid layer of the meninges (not the dura). )
  + Physicians use the term “sphenoid wing” meningioma” to indicate the location of the meningioma
  + Sphenoid wing meningiomas can be very “invasive” (that does not mean malignant). They grow large enough to invade the surrounding dura, cavernous sinus, temporal bone
* Doing research for meningiomas arising in bone itself, I find only intraosseous meningiomas (reportable) which are not arising in the bone itself, rather in the periosteum which is a continuation of the cranial meninges.

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**Q13:** This Pop Quiz is the last one we did before break and relates to what histo code to use: astrocytoma vs. glioblastoma vs. mixed glioma. Glioblastoma was the correct answer given.

**A13:** A grade IV astrocytoma with features consistent with secondary blastoma would be coded as a glioblastoma for two reasons, first because the SEEr and FOrDS manual as well as the MPH rules say to code features. Secondly because an astrocytoma is a glial tumor. When there is a glial tumor mixed with glioblastoma, glioblastoma is the most specific histology. Mixed glioma would not be correct because the two components are an NOS and more specific **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Q14:** Could you please clarify, why we shouldn't consider cerebral meninges laterality. According to SEER cerebral meninges, NOS should be coded with codes 1 through 4 or 9.

**A14:** You are correct that the cerebral meninges is on the paired site table. However, the instructions for that table will be clarified in the 2018 rules. There are some sites such as cranial nerves which are paired sites. There are other sites such as cranial meninges and brain which are not paired sites but SEER allows coding laterality if the data were helpful to the registry. Paired sites are those sites which have two separate, non-contiguous bilateral organs/tissue. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Q15:** Is there an estimated release date for the 2018 MPH rules?

**A15:** I have not received a release date. Unfortunately, there are so any moving components such as the ICD-O Committee and Edits Committee that have to say whether or not all new codes/terms will be implemented, it is not as simple as SEER setting a release date. The rules I have completed have the new codes//terms in the histology rules and tables in the Equivalent Terms and Definitions.

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**Q16:** Benign tumors of the spinal vertebra were stated to be reportable (ex. osteioid osteoma, osteoblastom, etc). Shouldn't they be coded to primary site C41.2 and therefore be NOT reportable?

**A16:**After the webinar I checked with CBTRUS and Dr. McLendon about the reportability of spinal vertebrae primaries. They are not reportable **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Q17:** Does the specimen have to be microscopically examined to assign a WHO grade? Can you assign the grade inferred from histology type if only diagnosed from imaging?

**A17:** To code WHO Grade in the SSF the primary tumor must be histologically confirmed.

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**Q18:** Can registrars code Karnofsky for SSF3 based on info in chart using the scale?

**A18:** No. It should be based on a physicians statement

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**Q19:** Isn't spinal column internal to vertebrae?

**A19:** After the webinar I checked with CBTRUS and Dr. McLendon about the reportability of spinal vertebrae primaries. They are not reportable

**Q20:** For clarification- We can not use the AJCC page 596 to determine the WHO grade. It must come from the path report?

**A20:** You must have a histologic diagnosis (pathology) to assign the WHO Grade in the SSF. If you have histologic confirmation, you can then use AJCC page 596 to look up the WHO grade.

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**Q21:** Carol's statement that vertebrae were "intraspinal" therefore reportable. Is this correct since vertebrae are NOT intraspinal?

**A21:** Not correct. After the webinar I checked with CBTRUS and Dr. McLendon about the reportability of spinal vertebrae primaries. They are not reportable

**Q22:** Is C41.2 vertebra with any benign tumor now reportable?

**A22:** No After the webinar I checked with CBTRUS and Dr. McLendon about the reportability of spinal vertebrae primaries. They are not reportable

**Q23:** Beginning in 2018 tumors arising from genetic conditions like neurofibromatosis will no longer be reportable?

**A23:** The genetic conditions themselves have never been reportable. That rull will also be present in the 2018 rules. The tumors/neoplasms within the CNS system that are a part of the manifestation of the genetic condition have always been reportable and will remain reportable in the 2018 rules **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Q24:** If we haven't been reporting sphenoid wing meningiomas based on earlier historic SINQ question which has now been removed, should we continue not reporting until 2018 or should we report now?

**A24:** I am sure you have started the 2017 cases. It would be better to be consistent and make the change to reporting sphenoid wing meningiomas when the 2018 rules are implemented **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Q25:** For take home case 2, per 2018 rules, if the original cancer 50 yrs ago only had a bx (no resection), and was benign, 50 yrs later the malignant tumor would be considered same primary?

**A25:** Yes that will be one of the changes in the 2018 rules When there is no tumor resection and the same tumor is resected at a later date and found to be malignant it is a single primary. Goes back to the principle that a single tumor is a single primary **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Q26:** Would this be 3 primaries? C72.3 (optic nerve/chiasm) 9380/3; C71.0 (hypothalamus) 9380/3; and intradural neurofibroma 9540/0

**A26:** You are correct it is three primaries Rule M4 says topography codes that differ at the second third or fourth digit are multiple primaries. The case you cite has one primary site of C723 a second primary site \_of C710 and a third primary site that says intradural, which means between the layers of the meninges which I am assuming is the cerebral meninges C700. So three primary sites is the correct answer. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Q27:** For Case 4 if you are following the current Benign Brain rules would you code 3 primaries? C70.0 9530/0; C72.5 right 9560/0; and C72.5 left 9560/0 based on rule M5

**A27:** Case 4 has bilateral optic gliomas. I hope I am answering your question. During the session I said that a phrase had been deleted from the case which was key to determining multiple primaries. That phrase was bilateral optic gliomas “originating in the optic chiasm.” The optic chiasm is where almost al optic gliomas originate and is the point at which the two nerves join. The reason for putting this case into the seminar was teaching the origin of optic gliomas and explaining that when you have a statement that the point of origin is the optic chiasm it is a single primary. It was also done to prepare you for the 2018 rules which will have a specific rule saying bilateral optic gliomas are a single primary

The second issue is that M4 refers to the “Paired Site” table. The instructions for the paired site table do not explain that the cranial meninges and brain are not a paired site. They are sites for which a laterality MAY be entered if that data would be useful for your registry. Those instructions will be changed in the 2018 rules.

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**Q29:** Aren't bilateral schwannoma’s 2 primaries? That is in reference to case 4.

**A29:** Case 4 has bilateral optic gliomas. I hope I am answering your question. During the session I said that a phrase had been deleted from the case which was key to determining multiple primaries. That phrase was bilateral optic gliomas “originating in the optic chiasm.” The optic chiasm is where almost al optic gliomas originate and is the point at which the two nerves join. The reason for putting this case into the seminar was teaching the origin of optic gliomas and explaining that when you have a statement that the point of origin is the optic chiasm it is a single primary. It was also done to prepare you for the 2018 rules which will have a specific rule saying bilateral optic gliomas are a single primary

**Q30:** On slide 45 you have anaplastic astrocytoma-Grade III, but on slide 47 it says anaplatic is always Grade IV. Is this a typo on slide 45?

**A30:** Yes it is a typo I apologize **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Q31:** How much of an increase in a central registry annual caseload would be expected due to non-malignant CNS tumors? Can we use this number as a basis to evaluate our completeness for these tumors?

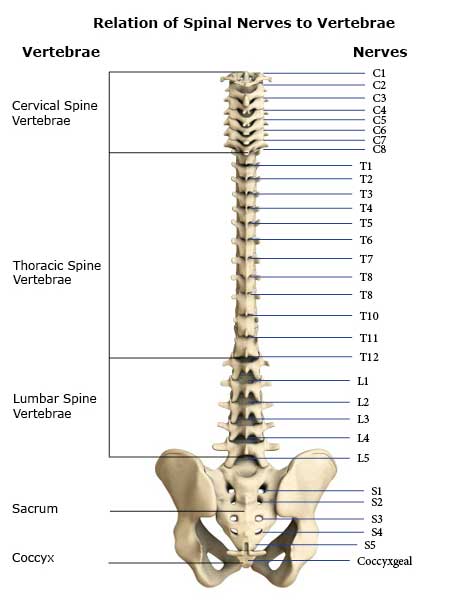
**A31:** From Recinda: We would expect about about 67% of your CNS cases to be non-malig

I think it is possible to use that estimate for assessing completeness. Both the ratio as well as the increase in counts. About 67% of the cases are estimated to be non-malignant..

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**Q32:** What is the topography code for nerve root meningioma and nerve root schwannoma?

**A32:** Topography code for nerve root meningioma is the spinal meninges C701 Schwannomas are coded to the nerve in which they arose. Although all of the “cranial nerves” are named as though they originate in the brain, some of them do originate in the cervical spine Those neoplasms are coded to the cranial nerve in which they arose. The other nerves roots are from peripheral nerves. Although the peripheral nerves are not reportable, the nerve roots are If you find a description of the peripheral nerve, code to that nerve. When the nerve is not identified, code to nervous system NOS C729 If you code to a peripheral nerve you will have edit problems

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**Q33:** On the pop quiz re: epidermoid tumor that is a reportable histology in ICD -O. Is it the site that makes it non-reportable?

**A33:** It is not reportable because there is no ICD-O histology/morphology code for epidermoid tumor. The codes in ICD-O are for epidermoid carcinoma /2 and /3 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Q34:** Nerve root schwannoma would be spinal nerve ? c47 ( which is peripheral nerve ) or should we use c72.9? We have used spinal cord in the past.

**A34:** Schwannomas are coded to the nerve in which they arose. Although all of the “cranial nerves” are named as though they originate in the brain, some of them do originate in the cervical spine Those neoplasms are coded to the cranial nerve in which they arose. The other nerves roots are from peripheral nerves. Although the peripheral nerves are not reportable, the nerve roots are If you find a description of the peripheral nerve, code to that nerve. When the nerve is not identified, code to nervous system NOS C729 If you code to a peripheral nerve you will have edit problems. Please see the graphic in question 37.

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**Q35:** Several SINQ questions (20091127, 20081126) say to report neurofibromatosis as its own primary 9540/1 when it occurs with reportable CNS tumors. Is this another thing we should "keep doing how we've been doing" until new rules come out?

**A35:** It is better to make a change with the 2019 rule. Neurofibromatosis is a genetic disorder not a neoplasm. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Q36:** What is site on sphenoid wing for # 2?

**A36:** Cranial meninges C700 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Q37:** What were the histologies for Case #2?

**A37:** The previous neoplasm was a “complex” meningioma of the right sphenoid wing. There is no ICD-O-3 code for a complex meningioma so the default would be meningioma NOS 9530/0. The subsequent neoplasm was an anaplastic meningioma coded 9530/3 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**