# Q&A

# Multiple Primary and Histology Rules

# Thursday, May 4, 2017

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Q: If a patient has a single tumor in each lung and you abstract as 2 different primaries, but the only did a biopsy of the one what is the histology for the 2nd primary?

A: Code the histology from the path of the one you biopsied and code the 2nd based on the radiography (scan or x-ray) diagnosis. If the scan or x-ray is not available, base the code on the description of the tumor by the physician. If they called it a malignant tumor, the histology would be 8000/3

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Q: Can you please review the Pop Quiz regarding the two tumors in the lung. There is no mention of non-small cell ca so how did you decide to use non-small cell ca? Is M12 is a better rule to follow.

A: Check Equivalent Terms and Definitions Chart 1. After the non-descript terms malignant neoplasm and cancer NOS, there are only two branches, small cell and non-small cell carcinoma. If you follow the “tree” you will see that adenocarcinoma NOS is a subtype or variant of non-small cell carcinoma.

All of the histologies under the “non-small cell” branch are non-small cell carcinomas. It is a generic term that includes all cancers other than small cell.

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Q: For number 1 you said two primaries per rule M7. M7 states "Are there multiple tumors in Both lungs with ICD-0-3 histology codes that are different at the first, second, or third number." Question one doesn't state that the tumors are in both lungs.

A: You are correct! it is M11 that tells us this is 2 primaries.

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Q: Lung Quiz. What Histology Rules did you use for question 2 and 4?

A: H3 code the histologic type when only one histologic type is identified.

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Q: Lung Quiz #1 our quiz states a tumor in the left lung and a second tumor also in the left lung. Why is this M7?

A: It should have been M11!

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Q: If time permits during the webinar if you could suggest any queries to run on our database to manually review multiple primary scenarios that would be helpful. I think NPCR will be performing audits on multiple primaries in the future.

A: Queries would have to be site-specific because the rules are not the same for all sites. The methodology is to select the top four sites, lung, breast, prostate, and colon. The rationale is that these sites comprise the majority of your database, so spending time auditing them will have a positive effect on the majority of cases.

The second rule of quality improvement is:” do not bite off more than you can chew,” meaning that you simply cannot audit 5 years of data for each site. It is more practical to do one year. After you see the results, you will know which issues you are finding in each site. If one of the sites has few issues, it probably is not worth your time to go back over more years. For those sites with issues/errors, you now know what you are looking for and can go back over a period of years without monopolizing major registrar time.

THE EXAMPLE THAT FOLLOWS IS FOR BREAST. THE PRINCIPLES ARE THE SAME FOR ALL SITES, THE SUBFILES WOULD BE DIFFERENT BASED ON THE MULTIPLE PRIMARY RULES FOR THOSE SITES.

1. Create a file by searching for the topography code(s) for breast C500-C509.
   1. Next, create a subfile (search within the file created in instruction 1) for multiple primaries. By searching for sequence numbers >00 (more than one primary per lifetime)
   2. You now have a subfile of breast cases with multiple primaries.
   3. The next step is to determine whether the other primary(ie) are also breast. If the previous or subsequent primary(ies) are a site other than breast, eliminate the case from the analysis file
      1. e
   4. Search the analysis file (described in #1c) for an first primary (sequence # 01) that has invasive (behavior code /3) and a subsequent primary (Sequence # 02) with an in situ (behavior code /2) that is the same histology code as primary 1
      1. These cases are errors unless the in situ tumor is in the contralateral breast.
      2. Search this subfile (described in #5 for laterality. If laterality for the two cases are different (laterality 1 and 2) these are errors
   5. Search the analysis file described in #1a for cases with a sequence number of 00 (only one primary) and a laterality of 4 (bilateral involvement
      1. Eliminate cases with inflammatory breast cancer (search by histology code)
      2. The remainder of cases must be reviewed (there is a rule that bilateral breast cancer is multiple primaries)
   6. Search the analysis file for multiple primaries in the same breast with the same histology and diagnosis years are < 3 years apart
      1. These cases will require a manual review

For all QI projects, write a QI overview, issues noted, and steps taken to correct the cause of the issues

1. QI overview/proposal must include
   1. Rationale for audit which should include passing the upcoming CDC audit which assures continued funding as well as improving the quality of data for your facility
   2. Site(s) to be audited
   3. Years to be audited, for example diagnosis year 2016
   4. Date audit will begin
   5. Date audit will be finished
   6. Date results of audit will be compiled into a report for the Cancer Committee
   7. Audit methodology
      1. Number of personnel involved
      2. FTE/number of hours projected to complete project
      3. How audit will be performed, i.e. will you set aside 2 hours every Friday for audit only
      4. Preparation of analysis files (subsets that will be analyzed and rules that are being “tested in the analysis”)
      5. How audit results will be recorded (more to follow)
      6. Report that will be generated (more to follow)
   8. Analyzing the data (audit results)
      1. Do a spreadsheet with a column for each of the rules being audited
      2. Add a column that identifies the person who abstracted the case (this is not putative and should never be portrayed in that manner. It is simply needed to do the quality improvement part of the study) More will follow
      3. Total all of the errors (total errors divided by number of cases gives percentage of cases with errors.
      4. Total of errors for each rule (allows you to identify issues)
      5. Once you have identified issues (which rules are problematic) it is time to find out why this rule is an issue in your registry
         * Talk to the staff who made the errors to see whether the error was in misunderstanding the rule; the rule was not clearly stated; or the registrar was not using the MPH Manual
         * Once you have identified what is causing the issues, you can plan an improvement program that will help staff to code consistently
   9. Writing the report
      1. The report must contain the following information (remember, this is different from the audit proposal
         * Site being audited
         * Year(s) of diagnosis being audited
         * Total number of “new diagnosis” for the year(s) being audited (the denominator)
         * Never identify which registrars made errors in any report distributed to registry staff, Cancer Committee, administration, or physician consultants. That information is for the registry manager only.
         * Total number of errors found and % of cases in which errors were found (remember, this is NOT bad PR, your Cancer Committee saw and approved the audit proposal which said the intent was to pass the CDC audit and improve in-house data)
         * Errors broken down, for example, Rule M5 Tumors diagnosed more than 5 years apart are multiple primaries: number of errors; percentage of total breast cases (number of these errors divided by total number of “new diagnosis” for year(s) being audited)
         * Plan for quality improvement
           + If registrars are not using MPH Manual, the plan can be as simple as educating staff on the need for using the Manual and monitoring its usage
           + If registrars did follow hierarchy, again, education on following hierarchy and monitoring
           + If registrars do not understand rule, education and monitoring
           + If rule is ambiguous, write to SEER to ask that the rule be clarified in the 2018 updates
           + Remember, if only one staff member is having a problem with one of the rules, take the time to work one-on-one with that staff member. It is counterproductive to use time to educate all staff if only one is having an issue.
         * The plan for quality improvement is written based on the results of the study. For example, the plan may say for Rule M3, we will do one hour in-house training followed by monitoring.

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Q: Will the new ICD-O be called ICD-O-4, but that won’t be for several years?

A: Yes

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Q: Is SEER revising the general recurrence rule? It seems Physicians and the registry world has different interpretations regarding this.

A: From what i understand it is fairly unusual for a pathologist to compare new specimens to previous specimens. I would assume it was not done if not stated. The rules were written with this in mind. The site subject matter experts (SME) as well as the CoC site-specific teams reviewed the rules, in particular discussed the use of the word “recurrence.” All of the physicians, SMEs and CoC, agreed that the word recurrence should not be used to determine whether or not the case was a new primary.

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Q: I understand we don't use a physician's statement and I am clear on the comparison w/the original tumor. What if the pathologist/path report states recurrence or new primary but does not mention if it was compared to the original?

A: There must be documentation that the original slides were compared. This issue is still being discussed for the 2018 rules.

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Q: Microscopic focus - Kidney primary – final path states renal cell carcinoma with separate focus of small cell carcinoma. Would the small cell carcinoma, presumably more aggressive, be ignored?

A: We ignore a microscopic focus when it is the same histology as the other tumor. In the case you cite, the tumor and the focus are NOT the same histology. This would be two primaries, one renal cell and the other small cell carcinoma.

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Q: If a patient has breast cancer diagnosed in 2008 went into remission. pt presents in 2016 with a t-4 lesion and it determined to be c/w a mets breast primary...do we use the multiple primary rules? or is this considered a single primary?

A: The multiple primary rules state that metastatic lesions are not used to determine multiple primaries. This would be a distant recurrence of the original breast cancer.

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Q: Slide M7: in order to use this rule, must the tumors be biopsied? This was stated in the Dec 2/09 Lung Webinar.

A: Yes, they must be biopsied or resected. If no biopsy/resection it is not possible to determine whether the histologies differ.

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Q: When does the timing rule start? At dx or at NED?

A: The original intent was to start timing at NED date. Example: Vaginal tumors, mucosal based, recur frequently unless there is total surgical removal. If the tumor recurs 3 times during a year, and the fourth time the lesion recurs is after 1 year, it really not a new primary.

However, I did not write those rules clearly and there have been various interpretations of the rules because of the ambiguity. It is advisable to continue counting primaries as you have been doing until the 2018 rules are implemented.

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Q: Why are there 2 criteria for multiple primaries…AJCC and MP/H?

A: Because AJCC and MPH are used for different reasons.

* AJCC stages tumors in order to determine the best treatment for the patient
  + It a sign of good clinical practice when the physician stages a recurrent tumor OR stages each of multiple tumors. The information is needed to make treatment decisions
* The Multiple Primary rules keep the data consistent over years so
  + The incidence is stable
  + The data can be analyzed by clinicians and epidemiologists

There is actually no “discrepancy,” rather different reasons and methodologies for collecting data. The AJCC authors and consultants on the committee are also data users (publish lots of articles). They were very adamant that we continue collecting multiple primaries as we have done and realize that they will stage/determine multiple primaries based on AJCC. They had no issues with the differences.

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Q: How do you handle a situation where the >3-year rule for a new primary is within days of the 3-year mark? EX: 1st tumor dx 4/3/12; 2nd tumor dx 3/31/15. Must the time elapsed be at least 3 full years?

A: Use the time as documented in the rules. There will also be tumors that occur one or two days after the time period. Everything is “evened out” when the data are analyzed.

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Q: For Lung M10 rule, do we need to have one of the tumors with histology of 8046, one is the subtype of non-small cell? If two specific non-small cell carcinomas are present, does the rule M10 still apply?

A: Please let me clarify. There are many histologies under the non-small cell branch. To use M10, one of the tumors must be a non-small cell (for example, adenocarcinoma) and the other directly descending from that non-small cell NOS (a subtype or variant of adenocarcinoma.

A rule for NOS and subtype will be added to the 2018 rules.

However, you must be aware that there are also very generic non-small cell terms such as pleomorphic and large cell carcinoma. The NOS and subtype/variant will not be adequate for those histologies. You must still use Chart 1. For example, if a biopsy came back as large cell carcinoma and the resection as Squamous cell carcinoma, these are all on the same branch, so pleomorphic is the non-small cell (or NOS) and squamous cell the subtype/variants.

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Q: You need to talk about Rule M1 when you have a patient with two or more tumors in one lung and one or more tumors in the other lung, and only one tumor is biopsied. This is a single primary.

A: Rule M1 is only used when you cannot determine whether there is a single or multiple tumors. It would never be used when a patient had >2 tumors in one lung and >1 tumor in the other lung.

Commonly, only one tumor is biopsied and treatment is based on the tumor histology from that biopsy. It is not feasible to surgically resect both tumors other than rare cases where both can be removed with a limited wedge resection and the patient’s pulmonary system can accommodate the loss of lung tissue. Abstract two primaries, one for the right lung, another for the left lung. Code the pathologic diagnosis for the lung biopsied. For the unbiopsied lung code the radiographic diagnosis or physician’s documentation of histology.

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Q: What does "NED" stand for?

A: No Evidence of Disease

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Q: For Lung Rule M4, must at least one tumor be exactly 8046 in order to apply this rule or can the histology be ANY non-small cell carcinoma?

A: Histology can be any of the histologies listed under non-small cell carcinoma NOS in Chart 1

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Q: For number 1, the tumors are in the same lung, would M7 be correct?

A: No. M7 is specifically for multiple tumors in both lungs

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Q : Histology code mucinous adenocarcinoma, does a percentage of mucinous component need to be stated to use the mucinous histology?

A: Yes. The world of pathology has had a standard for many years that at least 50% of the tumor must be mucinous. If, however, the pathologic diagnosis is mucinous adenocarcinoma, that is what you code. Do not mistake adenocarcinoma with mucinous differentiation or mucinous features as being mucinous adenocarcinoma.

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Q: Is this one primary or two? Patient had resected RML lung 5 mm invasive adenocarcinoma on 10/13/16 and had resected LUL lung 1.8 cm adenocarcinoma in situ on 11/16/16. Imaging shows multiple tumors: another in right apex and another in LUL not biopsied.

A: These tumors were diagnosed just a few days over a month apart. So, you have RML invasive adenocarcinoma, multiple tumors in right apex. In the left lung, there is a 1.8 cm adenocarcinoma in situ and another tumor in the LUL. You have multiple tumors in both lungs. You cannot, however, use M7 because the tumors do not have a different histology code (both are adenocarcinoma 8140).

For this case, you would abstract multiple primaries, one for the right lung and another for the left. This is one of the less common situations that occur and there is no rule to cite, it would have to be sent to SEER. I will try to clarify in the 2018 rules.

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Q: Why is Apocrine listed on Table 1 or 2 (specific duct) and also on Table 3 (non ductal)?

A: That is an error. Apocrine is a ductal subtype/variant. This will be corrected in the 2018 rules.

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Q: Would ductal with mucinous features be 8523 or 8500? Does it need to state ductal AND mucinous?

A: In order to code as mucinous, there must be a statement that at least 50% of the tumor is mucinous. Duct with mucinous features is not a diagnosis that can be coded as mucinous. Duct and mucinous cannot be coded as mucinous unless there is a statement that at least 50% of the tumor is mucinous

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Q: On rule M7, if patient has in situ on a biopsy, but doesn't have surgery for treatment until day 61 and they find invasive on the specimen, is this still 2 primaries

A: Yes. The incidence tends to “even out” because there are so many who do have surgery within 60 days.

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Q: Can you clarify that "comedonecrosis" is not the same as "comedocarcinoma".

A: Comedonecrosis is not the same as comedocarcinoma. Comedonecrosis is necrosis/inflammation that occurs within glands (frequently mammary glands).

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Q: In the case of the triple neg tumor and the ER-PR+ tumor of the same histology in the same breast, you said count them as one. but you've also said the whole point of MPH rules are for epidemiology's sake. Won’t that adversely affect triple neg ca studies?

A: What we are concerned about is showing trends over time. Changing how we count multiple primaries based on how the disease is treated would lead to serious fluctuation cancer trends over time that would not reflect the true cancer burden. It would be an artificial inflation of incidence rates.

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Q: Our group is confused about ductal with mucinous features. There is no statement in the MPH rules about the 50% requirement like there is in colon. Please clarify.

A: Yes for colon primaries. Pathology has had a standard for many years that at least 50% of the tumor must be mucinous in order to be coded as mucinous. If, however, the final pathologic diagnosis is mucinous adenocarcinoma, that is what you code. Do not mistake adenocarcinoma with mucinous differentiation or mucinous features as being mucinous adenocarcinoma. It is important to note that the rules for coding mucinous adenocarcinoma differ by site so do not apply the colon rules for mucinous and or signet to all other sites.

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Q: Related to question of histo code for a breast tumor dx of ductal carcinoma (8500) with mucinous features, the answer Carol gave was code to 8500 since there is no mention that mucinous is at least 50%. Please explain is rationale given the statement in No.

A: You are correct, instructions for mucinous are missing from the 2007 rules. Do remember that your first priority for coding histology is the pathology report. The diagnosis is not mucinous carcinoma, it is duct with mucinous features. Mucinous features do not mean the tumor is at least 50% mucinous. As a background for the answer, pathologists have long defined mucinous breast cancer as a tumor that is at least 50% mucinous. I am appreciative that you are bringing these issues to my attention so more specific instructions will be added to the 2018 rules.

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Q: Can you please address how to assign grade for and in situ breast?

A: In the past pathologists seldom assigned grade to in situ breast tumors. With the advent of the new WHO, the statement is that the histologic type is much less important than the grade, so you will be seeing more grading for in situ breast cancer and it is important to record that grade. In situ breast cancer is usually described as

* High grade synonym for nuclear grade 3 and for high mitotic rate
* Intermediate grade synonym for nuclear grade 2 or intermediate mitotic rate
* Low grade synonym for nuclear grade 1 or low mitotic rate

As you can see, this is a three-grade system

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Q: Could you repeat what the 2 theories are for recurrent in situ tumors?

A: I assume you mean for urinary tract primaries. The two theories and their explanations are:

* Field effect: The urothelium (mucosa of urinary tract) is changed or transformed into a site that spawns multiple tumors. These tumors can be in discontinuous organs, such as renal pelvis and bladder, because the urothelium runs throughout the entire tract.
* Drop effect: The theory that malignant cells are carried in the urine and implant in another organ, for example, cells from a renal pelvis primary may implant in the bladder. The bladder stores urine which makes it more susceptible to implantation.

Of the two theories, there are more proponents for the field effect.

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Q: For urinary histology does the "papillary" have to come from the path report or can we take it from the op report or staging form?

A: Papillary is an “appearance” or tumor shape rather than a histology. Yes, you can take papillary from a pathology report or operative report. Papillary urothelial cell and urothelial cell tumors are grouped in analysis.

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Q: Patient had a urothelial bladder cancer diagnosed and 1 year later a ureter urothelial cancer was diagnosed. Is this the same primary or a new primary?

A: If there is no recurrent bladder cancer, you still would bypass M7 (tumors diagnosed >3 years apart) and use M8 urothelial tumors diagnosed in two or more of the following sites are a single primary. The only time limit on this rule is given in M7. That means that you code a single primary for all tumors diagnosed in different sites less than 3 years apart.

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Q: Please address in Q&A. Lung M6 problematic in our central registry & tends to be under reported as some maintain that both tumors have to be supported by reportable terms to count as mult primaries. SINQ disagrees. Please discuss

A: Use the rules to determine multiple primaries. M6 says if there is a single tumor in the right lung and a single tumor in the left lung, abstract two primaries. There is no statement that this must be supported by physician documentation.

When you say “both tumors have to be supported by reportable terms” I am not too sure of what you mean. However, the most common scenario is that one lung is biopsied and you have a pathology diagnosis. The other lung is simply scanned and the diagnosis may be generic such as cancer or malignant lesion, but those are reportable diagnoses.

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Q: Please address in Q&A. MPH rules state ignore focus when determining multiple tumors but your kidney scenario with focus of small cell carc was stated as mult prim.

A: You ignore a microscopic focus or microscopic foci when the tumors are the same histology. In this case, there was a urothelial cell carcinoma and a focus of small cell carcinoma. The tumors are not the same histology, so they are

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Q: Take Home Quiz, Case 6. Did you say morphology is 8570/3 or 8560/3?

A: The code is adenocarcinoma 8140 when the diagnosis is adenocarcinoma with mucinous features. You do not code mucinous, colloid, or signet ring unless the diagnosis is EXACTLY mucinous adenocarcinoma, colloid adenocarcinoma, signet ring carcinoma OR you have a statement that at least 50% of the tumor is mucinous, colloid, or signet ring.

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Q: Question on Pop Quiz: the two lung nodules (RLL) have histologies Acinic Cell AdenoCa (85503) and Adeno, NOS (81403). MPH - M10 describes NSC-Ca, NOS (8046/x) and a more specified sub-type. Since the example appears to be (1) more specific subtype than 8046 and (1) EVEN more specific subtype - why wouldn't you move on to M11?

A: Rules are hierarchical. Stop at first rule that fits. H10 is any small cell carcinoma with a more specific subtype/variant. However, M11 is a “safety net.” If you just do not think M10 fits, M11 will still have you code a single primary.

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Q: Path diagnosis states: Adenocarcinoma with sarcomatoid features. What histology is assigned?

A: There is no code for adenocarcinoma with Sarcomatoid features. If the pathology report says at least 50% of the tumor is sarcomatoid, code to Sarcomatoid. The 2007 rules do say to code features. The physician consultants were not completely on board with that instruction, but since we had differing opinions, we chose to keep the rules that had been in effect. The new WHO editions do address this issue and there will be changes made in the 2018 rules. For the interim, follow the rules as written in the 2007 manual and code Sarcomatoid carcinoma.

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Q: This question may be too specific for this webinar, no worries if that is the case. From one of the visual editors in Los Angeles: "Have standard setters come to a consensus regarding the terminology change of “Encapsulated Follicular Variant of Papillary Thyroid Carcinoma” to “Non-invasive follicular thyroid neoplasm with papillary-like nuclear features?” If so, will this change be reflected in the new Solid Tumor Rules?”

A: This issue is being addressed in several committees including the ICD-O committee. It is our hope that the code and term will be implemented so it can be used in the 2018 rules. Currently, we are still waiting for the final word.

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Q: In the MP on lung, it does state "Frequently a patient may have 2 or more tumors in lung and may have 1 or more tumors in contralateral lung. The physician may bx only 1 of those tumors. Code the case as a single primary (See Rule M1, note 2) unless 1 of tumors is proven to be different histology.

A: That rule takes into consideration that multiple tumors in both lungs or a single tumor in one lung with multiple tumors in the contralateral lung are a classic presentation of metastatic carcinoma. The rule was written to standardize coding for these presentations and to code a single primary because it is most likely metastases

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Q: Explain why rule M10 would not apply to Denise's question Re: lobular and duct tumors 2 yrs apart; same breast

A: You don't get to the same place w/ M10 and M12 for Breast; 10 is single primary; 12 is multiple.

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Q: Last scenario on Breast Quiz, pleomorphic and comedo... I'm not sure comedocarcinoma trumps when tumor is invasive, rules do not say so. Only for in situ. So, higher code, comedoca still trumps, but due to rule H15 I think.

A: Better stated, if 2 or more ductal subtypes, in situ rules, comedo trumps due to rule H4. Same scenario, only invasive, then use rule H15. Comedo only trumps in this scenario if it is the higher code.

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Q: Second scenario, how do you treat the ureter tumor of 6/16/16? Not a 3rd primary since over 3 years since diagnosis of the original bladder primary?

A: Question pertains only to the finding in the ureter...Add'l info, 6/16 was RIGHT ureter (previous finding was in L ureter)

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Q: We see recurrence at anastomotic site often. Common sense says this is from the original primary. Are we over counting colon tumors because of our rules?

A: Yes, we are overcounting. Keep using the 2007 rules until the 2018 rules are implemented. There will be a major change in rules for tumors at the anastomotic site.

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Q:” Features" is a majority term, use code 8480/3. EEEK, is this not the case???

Note 2: The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with \_\_\_\_differentiation.

A: As mentioned in a previous question, the physician consultants for the 2007 manual were split in their opinions of using the term “features” as equivalent to the majority of tumor. Use the 2007 rules as written until the 2018 rules are implemented. There will be specific instructions about coding terms such as features based on the new WHO editions.

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A: For lung MP rules, there is no rule that says, 'Abstract as one primary when one tumor is adenocarcinoma, NOS and another tumor in the same lung is a more specific type of adenocarcinoma.'  Therefore, a right lung adenocarcinoma, NOS (8140) and a right lung papillary adenocarcinoma (8260) would be 2 primaries, according to rule M11.  Why does this rule apply in most other sites, but not in lung?

Q: We will be adding and NOS and a subtype/variant of that NOS rule to the 2018 rules.

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Q: For MP/H rules and upcoming revision, will there be a site code recommended for urothelial carcinomas in multiple urinary sites occurring at the same time?  Something better than c68.9, which is not stageable?

A:Unfortunately, no. The urinary physicians agreed that a Ta or Tis of the bladder with ureter involvement (single or bilateral) should be coded to a bladder primary site. Other than that concession, we were not able to get any other default codes (specific site codes) for multifocal tumors in multiple sites.

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Q: Will there be any change to the timing rules for VIN, VAIN, and AIN?  Numerous patients have multiple primaries of this type because they occur more than a year apart.

A: All of the timing rules will specify that:

* The time starts with DX date of original primary WHEN patient NED
* If recurrence, time restarts with date of recurrence
* If unknown if recurrence, default to date of original DX

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Q: Could you comment on the comment below concerning rules H8 and H19 in the breast chapter of our MP/H manual?

Added 10/14/13

Lobular and ductal in combination with another histologic type.  Per Peggy Adamo of SEER, she reviewed their tracking system and found that they have most often advised the use of rule H19 or H8 and the use of histology code 8255 for these situations.  Based on this advice, even though rule H19 (or H8) appears to mean 8255 is only used when there are multiple histologies and none of them are duct or lobular, a better way to read this is, “Are there multiple histologies present and are any of them something other than duct or lobular”, code 8522 does not adequately describe tumors that include histologies other than invasive ductal and lobular alone, and therefore code 8255 is a better representation of the nature of the tumor (adenocarcinoma with mixed subtypes).

A: This is a rare situation. As mentioned in the webinar, use the rules as well as the answers given by SEER until 2018 rules are implemented.