**Q&A Session**

**Collecting Cancer Data: Central Nervous System**

**February 07, 2013**

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Q: ­Are intracranial lipomas reportable? ­

A: ­A quick internet search indicates that intracranial lipoma is a congenital malformation, not a tumor. However, we will forward this for clarification to determine if it is reportable or not.­

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Q: ­Do you code "low grade" or "high grade" in the grade field for brain tumors, or is that a reference to the WHO grade?­

A: ­That is most likely a reference to WHO grade. I would not feel comfortable coding histologic grade for CNS tumors based on those terms.­

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Q: ­Shouldn’t the behavior for pilocytic astrocytoma be /3 on the Low Grade Astrocytoma slide instead of /1?­

A: ­Officially in the ICD-O-3 pilocytic astrocytoma is/1, but registrars are instructed to code as /3.­

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Q: Earlier you said juvenile astrocytona was a/3. Now you said pilocytic astrocytoma was the same as juvenile but showed a /1 for the pilocytic astrocytoma. Is pilocytic /3 or 1 and are they the same­?

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A: ­In ICD-O-3 behavior code for pilocytic/juvenile astrocytoma is/1; however, registrars are instructed by standard setters to code as /3.­

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Q: ­I learned that only tumor arising from the intracranial portion of a cranial nerve is reportable. Is this correct?­

A: The cranial nerves are intracranial.

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Q: Where is the reference for midline tumor being different laterality? I looked for it, but only found under melanoma module.­

A: Please see the following from the SEER Inquiry System (SINQ). This answer does say midline is 9, but midline was changed to code 5 in 2010.

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| **Question: 20071009**  |
| **Status**Final **References**Source 1: **2007 SEER Manual**pgs: **10**Notes: **Rule 4**Source 2: pgs: Notes: **Question**MP/H Rules/Multiple Primaries/Laterality--Brain and CNS: How many primaries are to be abstracted and how is laterality to be coded for two meningiomas, one occurring at the midline and the other in the right termporal region? **Discussion**MRI of the brain shows two meningiomas: One is stated to be 'midline' (laterality code 9) and one is stated to be in the 'right' temporal region. The rules state if same site (C700), same histology & laterality is same side or one side unknown, then abstract as single primary. Based on this, the MRI findings would be one primary, but how should laterality be coded? **Answer**For cases diagnosed 2007-2013, abstract two primaries. The lateralities of both meningiomas are known. Right (code 1) and midline (code 9) are different lateralities. **History**For cases diagnosed prior to January 2007:Abstract two primaries. The lateralities of both meningiomas are known. Right (code 1) and midline (code 9) are different lateralities.Reference: 2004 SEER Manual, pg 19, Rule 4 **Last Updated**07/02/2012  |

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Q: ­I'm confused about quiz 1 question 6. If anaplastic is synonymous with undifferentiated, why is the answer not b) anaplastic astrocytoma?­

A: ­You are thinking of histologic grade. Anaplastic is assigned code 4 in the ICD-O-3 grade/differentiation data item. However, anaplastic is not WHO grade 4 and not coded as such in SSF1. Anaplastic astrocytoma is assigned a WHO grade 3. Good question!

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Q: ­Could you describe "drop metastasis".­

A: ­Sometimes glioblastoma multiforme (GBM) metastasizes to the spine. Metastatic cells travel via cerebrospinal fluid to the subarachnoid space and form tumors that are intradural and extramedullary.

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Q: ­Would you please name the histologies that the MGMT test is run on again? Thank you.­

A: ­It is used primarily for anaplastic oligodendroglioma, anaplastic astrocytoma and glioblastoma multiforme, but can also be done for low grade malignant central nervous system tumors.­

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Q: If the Ki-67 percentage is given as a range i.e. 6% - 20% what is the best way to code this?

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A: ­If multiple Ki-67 percentages are recorded, code the highest percentage in the SSF2.­

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Q: ­Is SEER able to use the table in the AJCC staging manual for grade?­

A: ­The CS instructions say to use the table. If SEER does not agree, I am not aware of that.­

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Q: ­What if there are conflicting WHO grades documented in the record? Is there a hierarchy? I.e., med oncologist calls it WHO grade 2, surgeon calls it a WHO grade 3, or is by pathologist only?­

A: ­I am not aware of a hierarchy; however, if different WHO grades are documented I would use the WHO grade documented on the pathology report.

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Q: ­For glioblastoma, do you "automatically" assign/assume Grade/Differentiation as 4?­

A: If a grade or differentiation is not documented for glioblastoma, assign code 9 in the grade data item. If a WHO grade is not documented, refer to Table 56.3 in the AJCC 7th Ed. Staging Manual. It is documented there that glioblastoma is WHO grade IV. You can use that information to code SSF1, WHO grade. Remember that ICD-O-3 grade/differentiation and WHO grade are not the same thing.

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Q: ­Was the Temodor being used as a RT sensitizing agent? If it was, would it be coded as chemotherapy?­

A: Sometimes chemotherapy agents are given in very low doses in order to make the cancer cells more susceptible to the effects of radiation. When this is done we do not code the chemotherapy as treatment. There is nothing in the case scenario 1 to indicate that the temodor was being given as a radiosensitizer.

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Q: ­If a tumor is such as meningioma is only seen on imaging, should SS1 be 010 or 998?­

A: If there was no histologic exam of primary site tissue, assign code 998 to SSF1, WHO Grade.

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Q: ­Op Note "the lateral portion of the temporal lobe was able to be excised...and the path stated left temporal lobe resection justifies surgery code 40.­

A: ­I read that differently. I interpreted the "lobe was able to be excised" as meaning they opened up that portion of the, not that it was removed. I also interpreted the path report reference to the lobes as indicating where the sample was taken from. ­‑

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Q: ­why is the CS Mets at DX code 00 but the CS Met Eval code is 9?

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A: ­For the CNS schemas the eval codes are all not applicable because AJCC stage is not applicable and not derived. The eval codes determine if AJCC stage is pathologic or clinical.­

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Q: ­What's the difference between a daughter tumor and metastasis?­

A: I would consider a daughter tumor an additional tumor while metastasis is the discontinuous spread of the malignancy to another part of the body. However, it is probably worthwhile to find out your physicians definition of a daughter tumor.

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Q: ­In Case 3, where is it documented that the tumor was fully removed?­

A: The path information document tumor resection, and there is no information in the operative report indicating that the entire tumor was not removed.

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Q: ­What morphology would you assign to a clinically diagnosed high grade brain tumor? 8000/3 or 8000/1?­

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A: ­I think it would be 8000/1 but we will get clarified.­

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Q: ­What is the topography for a spinal schwannoma tumor described as intradural and extramedullary? Is this spinal meninges c70.1?­

A: ­I'm going to have to check with SEER on that one.­

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Q: ­WHO grade is not coded unless it is on the path report correct?­

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A: ­For certain histologies the WHO grade can be coded even if not documented on path report if it is documented for specific histology found on Table 56.3 in AJCC 7th Ed.­

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Q: ­Is an acoustic schwannoma reportable?­

A: Yes. The primary site is the acoustic nerve (C72.4).

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Q: What is an example of a malignant tumor of the peripheral nerves?

A: It seems they are mostly of the nerve sheath rather than of the nerve itself; i.e. malignant peripheral nerve sheath tumor.

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A: If a path report states a benign brain cancer without mentioning a WHO grade, can we automatically code WHO grade 1 in Collaborative Staging?

A: If tissue of the brain is histologically examined and a specific benign histology is documented but WHO grade is not mentioned, look the histology up in Table 56.3 in the AJCC Cancer Staging Manual 7th Ed. If the histology is documented in the table, code the listed WHO grade in SSF1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q: Is a cavernous angioma reportable?

A: Cavernous angioma arising in dura or parenchyma of CNS is reportable.

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Q: Please go over why sequence is 02 and not 61 in question 5 in quiz 1.

A: Medulloblastoma is a malignant tumor of the cerebellum. The patient had a benign CNS tumor, meningioma, in 2005 and a malignancy of the prostate in 2007. Four months ago (2012) the patient was diagnosed with medulloblastoma, which is the patient’s second primary malignancy and assigned sequence number 02.

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Q: Can you give a quick explanation of the difference between the MPH Chart 1 and Chart 2? Chart 1 is of Neuroepithelial Malignant tumors and Chart 2 is of Non-neuroepithelial Malignant tumors.  What differentiates neuroepithelial from non-neuroepithelial?

A: Neuroepithelial cells are the "stem cells" of the nervous system, deriving from actual stem cells in several different stages of neural development. These neural stem cells then differentiate further into multiple types of cells, like neurons, astrocytes and other glial cells. Table shows malignancies derived from these neuroepithelial cells. Table 2 shows CNS malignancies that are derived from tissues other than Neuroepithlial cells.