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# **Solid Tumor Case Scenarios**

**Use 2018 Solid Tumor Coding Manual, 2018 ICD-O updates, and ICD-O-3 Manual**

## Case I

Patient has a history of right breast nass consistent with invasive ductal carcinoma with comedo features diagnosed and treated in 2015.

The patient returned three years later after a mammogram showed a new nodule in the right breast. Patient then had a sterotactic core biopsy of the superior inner quadrant of the right breast mass.

4/5/2018 Biopsy:

Consistent with invasive mammary carcinoma, NST, 3-5 mitotic division per high power field, mild pleomorphism, positive for estrogen and progesterone receptors. Negative for HER2/Neu 1+.

1. How many Primaries are present and what rule did you use to determine this?

**One primary.**

**M11 Abstract a single primary when separate/non-contiguous tumors are in the same row in Table 3 in the Equivalent Terms and Definitions. Timing is irrelevant.**

**Note 1: Tumors must be same behavior**

**Note 2: Same row means tumors are**

* **Same histology OR**
* **One is preferred term and the other is a synonym for the preferred term (Column 2) OR**
* **A NOS (column 1/column 2) and the other is a subtype/variant of that NOS (column 3)**
1. Assign a topography and histology code.

**If we abstract this as a new case the diagnosis date will be 2015, primary site will be C509, and histology will be 8500/3. If this case had previously been abstracted, we would NOT make any changes to primary site and histology.**

**When determining whether the patient had one or two primaries we first assigned a “working” site/histology to each tumor.**

**Tumor 1: C509; 8500/3**

**Tumor 2: C502 (Table 1 Primary Site Codes); 8500/3**

## Case 2

Patient had a bronchoscopy with biopsy done after CT revealed poorly defined 7×7×8-cm superior right upper lobe mass. The pathology report showed anaplastic small cell carcinoma. The patient was treated but came back three years later for a chest X-ray which showed a new round opacity in the left superior sulcus of the left lung. A biopsy was done and the pathology showed poorly differentiated adenocarcinoma.

1. How many Primaries are present and what rule did you use to determine this?

**Because this says “three years later,” you do not know if it is greater than 3 years (rule M4) or exactly 3 years. We would not apply rule M4.**

**M5 Abstract multiple primaries when there is at least one tumor that is small cell carcinoma 8041 or any small cell subtypes/variants and another tumor that is non-small cell carcinoma 8046 OR ANY NON-SMALL CELL SUBTYPES/VARIANTS**

**Note 1: SCC and non-SCC are the two major classifications/divisions for lung cancer**

* **See Table 3 for terms and codes for small cell carcinoma and all subtypes/variants**
* **With the exception of small cell/neuroendocrine carcinoma, all other histologies listed in Table 3 are non-small cell**
1. Assign a topography and histology code.

**Tumor 1: C341 (Table 1) 8041/3 (Table 3)**

**Tumor 2: C341 (superior sulcus is equivalent to apex; usually called a Pancoast tumor); (Table 1); 8140/3 (Table 3)**

## Case 3

Patient had a left sided colonoscopy and found a single 3 cm constricting circumferential neoplastic mass at 60 cm in the sigmoid, likely a carcinoma. Biopsies of each were obtained and revealed adenocarcinoma

**7/9/18 Pathology**

* Biopsy of lesion in the sigmoid colon: polyp with adenocarcinoma.

**7/10/18 Surgery**

* Exploratory laparotomy; left hemicolectomy with transverse sigmoidectomy; wedge resection, left lobe liver.
	+ Exploration of abdominal cavity revealed a normal stomach with no palpable abnormalities. Liver diffusely multinodular, possible metastatic lesions. There was a 4 cm mass in the sigmoid colon consistent with a carcinoma, with no gross evidence of extension through the bowel wall. No gross evidence of metastatic disease within the abdominal cavity.

**7/10/18 Pathology**

* Liver, wedge resection: Macronodular cirrhosis with mild inflammatory activity.
* Descending colon: no lesions.
* Sigmoid colon resection:
	+ Histology: Invasive, moderately to poorly differentiated adenocarcinoma with mucinous and signet ring cell subtypes.
	+ Extension: Tumor penetrates through the submucosa into the muscularis propria, but transmural extension is not identified.
* 0/6 regional lymph nodes are positive.
1. How many Primaries are present and what rule did you use to determine this?

**One primary M2 single tumor; single primary**

1. Assign a topography and histology code.

**C187**

**8140/3 H5 % of mucinous/signet ring cell must be more than 50% of tumor. If either mucinous or signet cell is NOT DOCUMENTED to be more than 50% code adenoca, NOS.**

## Case 4

April 2012 Cystoscopy/TUR of bladder mass right trigone medium sized and random biopsies of the posterior wall of the bladder to look for findings of chronic interstitial cystitis. Pathology revealedUrothelial carcinoma, high-grade, invasive into smooth muscle of the Right Lateral Wall of the bladder.

March 2018 patient came in for a CT Chest/Abdomen/Pelvis: Large transitional cell carcinoma in the left side of the urinary bladder involving the trigone and possibly extending into the distal left ureter.

TUR of large bladder tumor revealed High grade carcinoma with features of poorly differentiated neuroendocrine carcinoma and adenocarcinoma.

1. How many Primaries are present and what rule did you use to determine this?

**Single primary M6 Abstract a single primary when separate/non-contiguous tumors are on the same row in Table 2 in the Equivalent Terms and Definitions. Timing is irrelevant**

**The term “transitional cell” is now called urothelial cell carcinoma. There is no “large” urothelial carcinoma, so the default would be urothelial carcinoma, NOS 8120. Ignore “features off…”**

**M14 reinforces M6 Abstract a single primary when the patient has multiple recurrences of invasive urothelial carcinoma of the bladder**

1. Assign a topography and histology code.

**If abstracting as a new case diagnosis date would be 2012 primary site C672 Original tumor site (Table 1); 8120 H7 Code the histology when one histology present in all tumors. If the case had previously been abstracted, no changes would be made to primary site or histology.**

***Working* site/histology: Tumor 1 C672 8120/3; Tumor 2 C670 8120/3**