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# **Solid Tumor Case Scenarios**

**Please complete prior to the webinar.**

**Use** [**2018 Solid Tumor Coding Manual,**](https://seer.cancer.gov/tools/solidtumor/General_Instructions_STM.pdf)[**2018 ICD-O updates**](https://www.naaccr.org/2018-implementation/#Histology)**, and the ICD-O-3 Manual to complete the case scenarios.**

## Case 1

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?
2. Assign a topography and histology code for each primary.

## 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?
2. Assign a topography and histology code.

## 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?
2. Assign a topography and histology code.

## 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?
2. Assign a topography and histology code.