# Q&A Collecting Cancer Data: Solid Tumor Rules

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Q: ­Question on case scenario (asking now as we tend to run out of time). On the colon, pg 26 of STR said code histology when stated / as subtype/type/variant, but NOT when it is feature, etc. pg28 H4 is that the distinction btw bullet pts 1 & 2? Not clear.­

A­:P 28 of colon rules has two main header which are

1. 1 **Code the histology** when
2. second main header 2 **Do not code the histology when**

2 A (Do not code the histology when) The following modifiers are used as a descriptor.

Bullet 2 is Differentiation – Do not code differentiation.

H4

Bullet one is adenocarcinoma with mucinous and signet ring **features**. Ignore the features and code adenocarcinoma 8140.

Bullet two is mucinous **carcinoma** and signet cell ring **carcinoma**.

Bullet one is features – do not code features. Bullet two are two carcinomas.

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Q: ­question continued... 1st bullet H4 says "features" code 8140. 2nd bullet pt would apply when term is documented or described as "subtype/type/variant”? ­

A: Bullet one says ignore/do not code features. Code adenocarcinoma 8140.

Bullet two has **two types of carcinoma** in a single tumor. Carcinoma, not features.

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Q: ­Should we be ready now to mark-up and update our existing MP/H guide right now? As we go? ­

A: Lisa you should have the Solid Tumor Rules, not the MPH rules. You can access them here https://seer.cancer.gov/tools/solidtumor/­‑

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Q: ­I have been unable to figure out how to highlight and make notes within the solid tumor downloads. Can someone tell me how to download so i have those options­

A: ­Send me an email at amartin@naaccr.org. I will send you directions and screen shots to help­. For tips on highlighting and adding comments to an adobe document see [https://helpx.adobe.com/acrobat/using/commenting-pdfs.html­‑](https://helpx.adobe.com/acrobat/using/commenting-pdfs.html)

Also see the General Instructions for navigating the solid Tumor Rules. Most importantly, contact your IT department to

1. Download the latest version of Adobe reader (it is free)
2. Change the settings on your browser so the rules open in Adobe reader, not in the browser. The highlighting, sticky notes, search, etc. only work in the PDF document.

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Q: ­Can you review the Timing instructions for the "disease free interval" when determining multiple primary.­

A: Disease-free simply means that within the specified time period there was no evidence of recurrence or metastases. Each and every time there is a recurrence (a tumor that is not a new primary), the time interval starts over from the date of the **last recurrence**. So if a patient had the original tumor in 2018 and had a recurrence in 2019, the time interval would be calculated starting with the 2019 recurrence, not the date of diagnosis.

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Q: ­Are you saying if it's a site with a 1 yr interval and the Date of Diagnosis is 2010, and the patient recurs in 2011 and there is a second disease free interval and a second recurrence. That the second recurrence would be compared to 2011 in termd of deter­

A: ­correct...the clock resets each time there is a recurrence in the primary site. The one-year interval would be calculated from the 2011 recurrence rather than the date of diagnosis. If you don't know if there has been a recurrence, assume there has not been a recurrence. Remember, this only applies if the new tumor is in the breast tissue. ­Mets doesn't count.­‑

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Q: ­To clarify if you receive a late 2017 case after a 2018 case has already been received we use the 2018 rules?­

A: ­No...it's based on dx date. The 2007 MP/H rules should be used for cases diagnosed 2007-2017. The new 2018 rules apply to 2018+ cases. ­‑

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Q: ­Suggestion: instead of calling it "default" code, "last resort" code is clearer.­

A: Good suggestion. Thank you.

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Q: ­Suggestion: add sentence for Table 2 that is also at the start of Table 3 - "Use only when directed by the Histology Rules." As Carol said, the tables are not stand-alone, only used when instructed to do so by rules.­

A: Can be added in the next revision. Good suggestion. Thank you.

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Q: ­Page 7 of Breast rules Note 1 and Note 2 seem contradictory. Note 1 indicates duct & lobular must have same behavior but Note 2 indicates DCIS/duct carcinoma AND lobular = 8522. Please explain.­

A: The notes are in hierarchical order. The first note says both duct and lobular MUST have the same behavior code If one was invasive and the other in situ, you would only code the invasive, so none of the combination codes would apply.

You have already been told both histologies must be the same behavior (/2 or /3), so Note 2 speaks of the presentation, single tumor or multiple tumors. The DCIS/duct carcinoma/carcinoma NST represents the diagnoses such as DCIS and in situ lobular OR Carcinoma NST and invasive lobular. The reason for note 2 is NOT behavior, it is explaining that the combination code can be used for a single tumor or multiple tumors.

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Q: ­Has the breast Solid Tumor rules been update, as our print off has M11 and M12 backwards? Which is right? ­

A: ­on my copy M12 is Rule M12 Abstract multiple primariesii when separate/non-contiguous tumors are on different rows in Table 3 in the Equivalent Terms and Definitions. Timing is irrelevant.­‑

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Q: ­M13 RULE, INSITU FOLLOWING A INVASIVE, IS THERE A TIME LINE FOR THIS, SAY 10 YRS OUT IS THIS A NEW OR RECURRENCE­

A: If the in situ tumor occurs more than 5 years after the invasive you should have stopped at M8, multiple primaries when clinically disease-free for greater than five years. You should never get to M13.

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Q: ­If possible can we review M10 again.­

A: All of the entries in Column 3 Table 3 are subtypes/variants. Each of the subtypes/variants are histologically different. Separate/non-contiguous tumors which are different subtypes/variants are multiple primaries.

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Q: ­Also our solid tumor rules do not have M16, and M15 states single primary. Are you using a different printing? ­

A: Please check the website to verify that you have the latest version.

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Q: ­Question: If DCIS was diagnosed on 12/23/13 and now on biopsy 7/16/18 patient has Invasive mammary carcinoma, 7/16/18 cancer is 2nd primary? Per Rule M15­

A: That is correct.

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Q: ­Regarding the 90%, is there a priority in the path report where we record this from. Sometimes it is in the CAP and not the final diagnosis or the other way around. ­

A: If the 90% is documented in CAP, use the information. The priority list for documentation is not intended to prevent you from using information from CAP. It is simply giving the priority order in which to use the documents. Look at the path diagnosis, if the information needed is not there, go on to the next priority.

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Q: ­Q: rule M10, is it also only used when the tumor histologies have the SAME BEHAVIOR? ­

A: Two subtypes/variants will always be multiple primaries. It is irrelevant if they are the same behavior or in situ /2 and invasive /3.

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Q: ­Could you please repeat the explanation for pop quiz 1? ­

A: ­Architectural pattern should no longer be used to assign histology. We would ignore the comedo, cribriform, micropapillary, and solid.­‑

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Q: ­What is the histology code for mammary carcinoma with ductal and lobular features? ­

A: See Table 2 Equivalent Terms and Definitions. DCIS/duct carcinoma/carcinoma NST AND lobular carcinoma – column 3 Note 1: CAP uses the term invasive carcinoma with ductal and lobular features. This is a term used only by CAP and is coded 8522/3.

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Q: ­For Lung cancer, most pathologists use the term "predominantly”. If we are not allowed to use this term to code a specific histology, there will be a lot of adenocarcinomas. Are we allowed to use the term "predominant" to code a specific code? ­

A: For lung primaries, you code as you have done in the past, the most specific histology, subtype/variant. It does not matter if it is the predominant/majority of tumor. Predominant does not imply subtype/variant.

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Q: ­I just want to make certain- For H9 you cannot use terms that imply majority of the tumor is cribriform. It must state at least 90% of the tumor is cribriform. In general, you can only use the majority terms if it is specified in the rule, correct? ­

A: Different rules for NOS and subtype/variant (duct and cribriform) and for different histologies.

For **NOS and subtype/variant,** only code subtype/variant when designated to be at least 90% of tumor.

For **two different histologies (different rows in Table 3)** within a **single** tumor, code the histology that is the majority of the tumor.

Researchers are looking for “pure” categories for breast histologies They want a subtype/variant only when it is at least 90% of the tumor.

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Q: ­SEER Seattle has submitted a number of Solid Tumor Rules questions to SINQ. Will these be addressed by anyone while Peggy Adamo is on vacation? Should we submit these anywhere else? ­

A: No. Questions submitted to SINQ will continue to be processed as usual while P. Adamo is out of the office. Expect delays in receiving answers.

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Q: ­In the Coding Multiple Histologies in a Single Tumor section- Is # 2 telling us not to code the histology referred to as subtype, architecture, etc. Code the "other" histology listed, correct? Example: Ductal CA, mucinous subtype would be coded as 8500? ­

Duct carcinoma mucinous subtype is strange because mucinous is not a subtype/variant of duct. If you had these two histologies, duct and mucinous, in a single tumor you would use 1Gi and 1Bii under “Coding Multiple Histologies in a Single Tumor” section. `Bi says to code the majority of tumor. You do not know the majority, so continue to 1Bii which says use a combination code from Table 2. Great job in figuring out where to go!

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Q: ­What is the histology for "ductal carcinoma, mucinous type"? (Breast)­

A: Mucinous carcinoma 8480. Essentially the same as mucinous ductal carcinoma or mucinous mammary carcinoma. See the note under mucinous carcinoma in Table 3 Equivalent Terms and Definitions.

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Q: ­Looking at breast case 1, Please explain one tumor being invasive and one tumor in-situ. Would we look at M14 at all? ­

A: No, you would not look at M14 because it is in the single tumor, invasive module. This patient has two separate tumors, the DCIS and tubulolobular which was documented to be <0.1 cm from the closest inferior margin. The tumors are in close proximity, but are not “merged” or touching according to the pathology report. You would go directly to the multiple tumors module.

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Q: ­case 2 wouldn't the correct rule be H21 instead of H23? ­

A: You are correct. H21 says to code 8522 when duct and lobular are present in multiple tumors. Good catch!

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Q: ­Lung Rules not clear on non-small cell carcinoma (8046) and WHO not using this code but requiring pathologists to commit to squamous or adenocarcinoma - hinted at with Rule H5 - but, is 8046 allowed or not since it is not in AJCC histo for staging? ­

A: Please do not code the histology to “fit” into an AJCC category. Yes, the WHO, IARC, and CAP are all pushing for a diagnosis of either adenocarcinoma or squamous cell carcinoma rather than a diagnosis of non-small cell carcinoma. The rule was “held over” from the 2007 rules because in the real world the diagnosis of non-small cell carcinoma still happens. Two examples: Nursing home patient brought in with respiratory symptoms. Chest X-ray shows large mass in RUL with a diagnosis of non-small cell carcinoma. Because the patient is in the advanced stages of Alzheimer’s and has numerous co-morbidities, the family refuses further work-up or treatment. Second example: Outpatient sputum cytology with diagnosis of non-small cell carcinoma. Patient is lost to follow-up.

The rule is there for those very rare cases in which non-small cell is a diagnosis. It is important to note that when a diagnosis of NSCLC is made on biopsy, the pathologist and physician should pursue further tests to see if a specific type of non-small carcinoma can be identified. This is important for treatment planning. If additional stains and or genetic/molecular test determine a specific histology, update the case.

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Q: ­Suggestion it would be nice to have the histology codes in the required term columns for searching and other purposes on Table 2.­

A: Great suggestion. I agree. That will be done on the next scheduled update.

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Q: ­Sometimes it's confusing when you're going from one page to the next to tell if you're on a new row or not. It's helpful to point out that the the bolded histology in the first column constitutes a new row­

A: Great teaching hint. Thank you.

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Q: ­is there a method that we can use to highlight, add notes to online version of Solid Tumor Manual or most we download the manual? Thank you! ­

A: Yes. Please see the General Instructions for navigation. The first action you have to take is contacting your IT with a request that they do two things:

1. Download the latest version of Adobe Reader (free)
2. Configure your browser so it opens PDF documents in Adobe Reader If this is not done none of the features such as highlighting, sticky notes, page back, etc., will function.

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Q: ­I don't remember, is there an EDIT that inhibits use of laterality code "4 - bilateral" for lung? ­

A There is no edit inhibiting a laterality code 4 for lung primaries.

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Q: ­Under Lung page 29 Lung Solid Tumor Rules 2018, Biomarkers – how do we code DX confirmation, histology/cytology? Do we need to know what they did to obtain the biomarker: tissue, blood, body fluids, hair?

Are we to use Biomarkers over path or cytology? ­

A: Biomarkers are used ONLY when they **definitively identify** the **histologic** type. A biomarker is a rather generic term which means anything from genetic testing, protein analysis, immunohistochemistry, EHR, ER PR, etc.

In most cases biomarkers are done on tissue. The pathology report should mention that tissue was sent for genetic testing, immunohistochemistry, etc.

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Q: ­My facility's path reports often have "See Synoptic" (aka CAP protocol) included in the Final Diagnosis rather than including all the detail there. In this case, does the CAP protocol take precedence over the Final Dx? ­

A: Without seeing a pathology report and a CAP protocol from your facility, this answer will be rather generic.

When the pathology report gives a final diagnosis and refers you to the CAP report for the “details” such as margins, features, etc., use the final diagnosis on the path report. CAP requires that the protocol (the CAP report) must be **summarized** within the medical record. In most facilities, that summarization is the final diagnosis on the pathology report. The pathologist “consolidates” the information on the CAP report.

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Q: ­Case scenario 1, because the comedo in 2015 uses MP/H 2007 rulse, histo is 8501, hense M12 STR rule and so 2 primaries.­

A: **Hospital registries:** Check the text for the 2015 case. If the pathology diagnosis was DCIS with comedo differentiation or DCIS and Comedocarcinoma the 2018 tumor is a recurrence. When text does not confirm/explain histology coding the last resort would be to code multiple primaries.

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Q: ­Solid Tumor Rules 2018 Lung Quiz.. I thought it was 2 primaries due to Rule M9 not M6.. to me 8551 and 8253 are in the same row in Table 3...­

A: The patient had two tumors in the same lung. An invasive mucinous adenocarcinoma 8253/3 in the lower lobe and an invasive acinar adenocarcinoma in the upper lobe. Start with rule M3 since we are dealing with multiple tumors. M3,M4, and M5 do not apply. M6 tells us that tumors that are different subtypes/variants in column 3 of Table 3 are multiple primaries. Both histologies are listed as subtypes/variants of Adenocarcinoma (8140). Therefore they are multiple primaries per rule M6. Rule M9 would give us a single primary. You might want to check and make sure you are working from the final rules and not a draft of the rules.

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Q: Will you please address colon rules M6 & M7; my understanding is that for multiple tumors if rules are hierarchical that you would always stop at either one of these rules before proceeding any further. Confused as to why these rules precede timing rule & anastomotic site rules

A: M6 precedes M7 because if the tumors at the anastomotic site are in different rows on Table 1 they are multiple primaries with no exception.

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Q: The august 29th presentation will be more of a high-level overview. I’m guessing the overview will be more extensive, but they won't have time to go into specifics as we will today for lung and breast. It will only be about an hour and a half. An hour of lecture and will have 30 minutes or so for Q&A.

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Q: The new histologies listed in the new ICD-O table included in the Solid Tumor rules specific site rules?

Yes, the new histologies from the ICD-O update are listed in the Solid Tumor rule tables.

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Q: Just to clarify - breast Solid tumor rules - page 29 - #5 - the list listed for radiography - it's NOT in order by priority - where for the lung rules it is?

The reason the radiography is not listed in priority order for breast is because radiography is not accurate in identifying the histologic type. This is a list of documents used to identify the histology, not the primary site.

The priority order for documents to identify histology in the lung rules precedes the histology rules. This list IS in priority order. The radiography is more effective in identifying histology for lung.

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Q: ­Is there a plan to merge all the separate files into one single manual? ­

A: Yes. Once all of the sites scheduled for revisions in 2018 are finalized, we will consolidate into a single manual.

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Q: ­The new rules are highlighted here, will they be highlighted on the online manual? ­

A: ­no...Lois did that to remind her of things she wanted to discuss. You can do your own highlight to your manual. you can also add comments. See the last two icons on her tool bar.

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Q: ­Pop Quiz 1 - If I know the tumor is in situ and to ignore subtypes, why wouldn't Rule H2 apply?­

A: ­pop quiz 1 for breast? rule h2 is the rule that applies. ­‑

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Q: ­Please define the difference between For Breast: Rule M10 and M12. It seems they both apply and M10 is first so why wouldn't that be the correct rule to use? ­

A: The rules are not the same. M10 refers ONLY to Column 3 (subtypes/variants) in Table 3. If multiple tumors are different subtypes/variants, they are multiple primaries

M12 pplies to Columns 1, 2, and 3 in Table 3. Because 10 eliminated all multiple tumors with **different** subtypes/variants, this rule would be

1. One NOS and **one** subtype variant
2. One NOS and one a synonym of the NOS (biopsy at another facility with a synonym used as diagnosis; resection of adjacent nodule at your facility with the preferred name/NOS used as the diagnosis.
3. Two tumors, both are the same histology **XXXX**

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Q: ­Regarding Case 3 - Colon... The surgery was one day after the biopsy. I would agree with Jim.­

A:

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Q: ­Case #4 what would the histology code be for a pathologic diagnosis of PD Neuroendocrine carcinoma and adenocarcinoma? Is it considered a Urothelial CA? ­

A: Use rule H4 Code mixed small cell carcinoma 8045 when the final diagnosis is

* Small cell neuroendocrine carcinoma mixed with any other type of carcinoma

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