**Histology Coding ANSWERS**

1. Biopsy of a right thyroid nodule reveals papillary carcinoma. What is the ICD-O-3 code?
	1. 8050/3 - Papillary carcinoma
	2. **8260/3 - Papillary adenocarcinoma**

Rationale/comment: per MPH Other Sites Histology coding rules, MPH Rule 14 clarifies if the primary site is thyroid and the histology is papillary carcinoma, always code to papillary **adeno**carcinoma. The thyroid is a gland, and adenocarcinoma reflects a carcinoma which arises in glandular tissue.

1. Ductal or Ductular are synonyms for ductal carcinoma.
	1. True
	2. **False**

Rationale/Comment: Ductular ca is a malignancy that is **infrequently** found in the breast. Code 8521 Ductular ca is seldom applied to the breast, although the ICD-O-3 site associated code (C50.\_) which appears after this code can be misleading. See MPH Breast Terms and Definitions. You would more commonly see a Ductular ca in Pancreas, biliary ducts or prostate.

1. What is the histology code for micropapillary carcinoma of the Thyroid?
	1. 8341/3 papillary microcarcinoma
	2. **8260/3 papillary adenocarcinoma**

Rationale/Comment: The term micropapillary does not refer to a specific histologic type. It means the papillary portion of the tumor is minimal or occult (1cm or less in diameter). According to SEER SINQ **20150023** if the primary is thyroid and the pathology states papillary microcarcinoma or micropapillary carcinoma, code to 8260 not 8341. This applies to micropapillary carcinoma’s of the thyroid only.

1. Which of the following is an alternate name for diffuse large B-cell lymphoma (DLBCL). Circle any that apply
	1. Splenic EBV-associated B-cell lymphoproliferative disorder
	2. B-cell lymphoma, unclassifiable, with features intermediate between diffuse large B-cell lymphoma and Burkitt lymphoma
	3. Double hit lymphoma
	4. b & c
	5. **All of the above**

Rationale/Comment: Per Heme Database-All are coded to histology 9680/3

1. What is the correct histology code for Follicular lymphoma grade 1-2?
	1. 9690/3 Follicular Lymphoma NOS
	2. 9695/3 Follicular Lymphoma grade 1
	3. **9691/3 Follicular lymphoma grade 2**

Rationale/Comment: Per SINQ 20130065 when there is a grade such as 1-2 indicated, take the histology associated with the higher grade disease process, even though the lower grade histology code is higher.

1. Patient diagnosed with high grade endometrioid adenocarcinoma with squamous differentiation. What is the correct histology code?
	1. 8560/3-Adenosquamous carcinoma
	2. 8380/3- Endometrioid Adenocarcinoma
	3. **8570/3-Adenocarcinoma with squamous metaplasia**

Rationale/Comment: Endometrioid Adenocarcinoma, combined with squamous metaplasia or squamous differentiation is coded to Adenoca with squamous metaplasia 8570/3. Reference SINQ 20110014.

NOTE: I highly recommend you update the GYN table in your MPH manual (as recommended in the above SINQ) with this “combo”

|  |  |  |  |
| --- | --- | --- | --- |
| Column 1:Required Histology | Column 2:Combined with Histology | Column 3:Combination Term | Column :Code |
| **Endometrioid Adenocarcinoma** | **Squamous metaplasiaSquamous differentiation** | **Adenocarcinoma with squamous metaplasia** | **8570** |

This will be added to the updated MPH manual when released in 2018.

1. Site Corpus Uteri. Histology is papillary serous adenocarcinoma. What is the correct histology code?
	1. 8323/3
	2. 8260/3
	3. **8460/3**

Rationale/Comment: Use MP/H Rule 11 –Code the histology when only ONE histology type is identified. Papillary Serous Adenocarcinoma, while it is a “mixed” histology, it already has it’s own specific ICD-O-3 code. The rule is always code the *specific* mixed ICD-O-3 code *if one is available* BEFORE coding to a combo/mixed histology code found in the MPH GYN Table 2 (MPH Other Sites). Do not code to 8323.

1. Site Corpus Uteri: Histology is Endometrioid and clear cell carcinoma. What is the correct histology code?
	1. **8323/3**
	2. 8380/3
	3. 8310/3

Rationale/Comment: Using MP/H rule H16, these are multiple specific Histologies, therefore using GYN table 2, this is coded to Mixed cell adenocarcinoma, 8323.

**Multiple Primary & Histology**

1. **Lung**

Left upper lung lobectomy reveals two tumor: #1) 1.2cm Adenocarcinoma, poorly differentiated (Grade 3), confined to lung. #2) 0.9cm Adenocarcinoma, well-differentiated (grade 1), confined to lung. Pathology Comment: The two tumors, although both adenocarcinoma, show markedly different histologies and are considered synchronous primaries. Multiple synchronous primaries are staged separately according to the 7th edition AJCC.

How many primaries should be reported? **One**

Which MPH rule is used? **Stop at rule M12.** **The patient has two tumors in the same lung with the same histology.**
COMMENT: Do not use the AJCC Manual to make multiple primary decisions. Use the MP/H Rules to determine the number of primaries to accession. **Reference SEER SINQ:** **20130054**

1. **Bladder**1/5/15 Bladder base tumor identified on cystoscopy; biopsied. Pathology reveals urothelial carcinoma in situ. PE: Abdomen no palpable masses. H&P otherwise WNL. Treatment plan is TURBT on 1/23/15. 1/18/15 Progress Note: Patient canceled scheduled surgery due to her mother’s death. She will be out of state handling the estate and will reschedule upon her return. 3/1/2016 CT Ab/pelvis: Bladder size normal, no evidence of bladder wall thickening or suspicious LAD. 3/8/15 TURBT: All visible tumor removed with bx of M.P. Pathology: High grade urothelial carcinoma within fragments of fibrovascular tissue and smooth muscle with chronic inflammation and fibrosis at the deep margin. MD TNM Clinical stage is cT2 cN0 cM0 Stage II.

How many primaries should be reported. **Two (CORRECTION –ONE TUMOR)**

Which MP/H rule is used? **M2**

Comment: Patient had a biopsy on 1/5/15 confirming malignancy, followed by the TURBT on 3/8/15- this is one tumor.
*IF*, the scenario had indicated on 1/5/15 the patient had a cystoscopy, bx **and TURBT**, revealing urothelial carcinoma in situ, followed by another TURBT on 3/8/15 revealing an invasive tumor- that would be two primaries using M5- an insitu tumor followed by an invasive tumor more than 60 days apart.

1. **Thyroid**
* 1/5/10 Left thyroid lobectomy for follicular carcinoma
* 4/10/10 Right thyroid lobectomy, papillary carcinoma, follicular variant.

 How many primaries should be reported? **Two** Which MP/H rule is used? **M17 Reference SINQ 20091027**

Comment: For Thyroid, using the Other Sites section, these are separate primaries based on their ICD-O-3 histology codes. Follicular ca is 8330 and Papillary Ca follicular variant is 8340. And because the tumors were diagnosed more than 60 days apart, Rule M6 does not apply.

1. **Breast**

Right breast lumpectomy. Pathology: Multifocal breast cancer demonstrating one 0.8 cm infiltrating ductal carcinoma in the right UOQ, moderately differentiated, with a second 0.5 cm infiltrating ductal ca, moderately differentiated, as well as a 1.9 cm area of intraductal carcinoma. Lumpectomy margins including deep margins are clear.

How many primaries should be reported? **One**

Which MP/H rule is used? **M11**

COMMENT: Multiple intraductal and/or duct carcinoma’s are a single primary. And these are all in the same breast quadrant.

1. **Colon**

Sigmoidcolectomy reveals a large colon polyp and 2cm adjacent but separate from the polyp is a 1.8 cm sessile friable tumor. Pathology reveals focal invasive adenocarcinoma in a tubulovillous adenoma, as well as a 2.2cm moderately differentiated adenocarcinoma extending into the musuclaris propria. 0/22 lymph nodes are positive. No perineural invasion. CRM negative by 4cm.

How many primaries should be reported? **One**

Which MP/H rule is used? **M7**

COMMENT: A “frank” (obvious tumor) invasive or in situ carcinoma, AND an in situ or invasive tumor in a polyp, are a single primary when they are within the same segment of the colon. If they were in different segments such as sigmoid and descending, then that would be two primaries.

**Site Specific Factors Quiz**

**LUNG**Patient has 1.2cm RUL Adenocarcinoma, and a 2.2cm RML squamous cell carcinoma of the lung.

1. **How should you code SSF1- Separate tumor nodules-ipsilateral lung**
2. 000 No separate tumor nodules
3. 010 Separate tumor nodules in ipsilateral lobe, same lung
4. 020 separate tumor nodules in ipsilateral lobe, different lobe

Rationale/Comment: These are two separate tumors/primaries based on histology and MPH rules. They are also considered synchronous primaries per AJCC TNM rules and are staged separately. Thus for each abstract the “other” tumor nodule is not considered when coding SSF1 and should be coded 000.

1. If you have a lung cancer with multiple pulmonary nodules in the right lung upper lobe, middle lobe and lower lobe, and biopsy of one of the pulmonary nodules in the Upper lobe is positive for carcinoma, **would you consider all the described pulmonary nodules to be malignant when coding SSF 1?**
	* 1. **Yes**
		2. No

<http://cancerbulletin.facs.org/forums/forum/collaborative-stage/lung-and-other-respiratory/lung/8966-pulmonary-nodules-vs-tumor-nodules>

**ENDOMETRIUM #1**TAH/BSO: HG serous adenoca of endometrium, 12cm, tumor invading 99% of myometrium, +LVI. Lt fallopian tube involved by met serous adenoca on the surface. Cervix neg. 1/5 obturator LNs pos; 2/15 pelvic LNs positive; 0/1 common iliac LN pos. 1/5 para-aortic LNs positive

**3.) What is SSF 2 – Peritoneal Cytology** a. 000
 b. 010
 c. 997
 d. 998
 **e. 999**

Rationale: PER CS V02.05 Part 1; Recording Lab Test and Tumor Markers: Use code 999 when there is no mention of pelvic wash. Without a statement pelvic wash was done, or negative, you cannot presume it was done and/or negative.

<http://cancerbulletin.facs.org/forums/forum/collaborative-stage/female-genital-system/corpus-carcinoma/1513-site-specific-factor-2-peritoneal-cytology> (#4 and #5)

**4.) What is SSF 3- Number of Positive Pelvic LNs: 003**

Rational: **1**/5 obturator LNs, **2**/15 pelvic LNs and 0/1 common iliac LNs.
Note: Obturator & Common iliac LNs are also “pelvic LNs” (so are internal/hypogastric LNs, paracervical, presacral, parametrial, and external iliac).

**5.) What is SSF 4 – Number of Examined Pelvic LNs: 021** Rationale: 1/**5** obturator LNs pos; 2/**15** pelvic LNs positive; 0/**1** common iliac LN pos; all
 at left are “pelvic” LNs.

**6.) What is SSF 5 – Number of Positive Para-Aortic LNs: 001**

Rationale: **1+**/5 para-aortic LNs

**7.) What is SSF 6 – Number of Examined Para-Aortic LNs: 005**

Rationale: **5** para-aortic LNs examined.

**8.) What is number of Regional LNs positive? 04** Rationale: **1**/5 obturator LNs pos; **2**/15 pelvic LNs positive; 0/1 common iliac LN pos, **1**/5
 para-aortic LNs pos. *Para-aortic LNs are also “regional LNs”, and should be included in
 the regional LN positive total count.*

**9.) What is the number Regional LNs examined? 26** Rationale: Para-aortic LNs are also regional nodes and should be included in the total
 count for nodes examined. 1/**5** obturator, 2/**15** pelvis, 0/**1** common iliac, 1/**5** para-aortic
 LNs.

**ENDOMETRIUM #2**TAH/BSO, tumor debulking, omentectomy and lymphadenectomy: 3cm mixed cell adenoca (mostly high-grade serous ca w/minor endometrioid adenoca) in endometrium, invades inner half/47% of myometrium 0.7cm deep; involving parametrium, fundus, body, lower uterine segment, cervical stroma, peritoneum, omentum, ovaries, tubes. LVI neg. 2/32 LNs positive.

**10. What is SSF 3- Number of positive pelvic LNs? 002
 02**/32 LNs pos11**. What is SSF 4- Number of examined pelvic LNs**? **032** 02/**32** LNs pos
 For #10 and #11 Since the LNs were not defined as pelvic vs para-aortic *presume* the LNs
 removed are at least pelvic regional LNs and code under SSF #3 and SSF #4. See
 CAnswer Forum reference below.

12. **What is SSF 5- Number of positive Para-Aortic LNs? 999**13. **What is SSF 6- Number of examined Para-aortic LNs? 999** For #12 and #13,It is unknown if any of the LNs submitted were para-aortic, therefore
 code SSF5 and SSF6 to 999/unknown.

14. **What is the number of Regional LNs positive?**  **02**

15. **What is the number of Regional LNs examined? 32**

For #14 and #15 Regional Nodes Pos/Examined, code the path totals of 02/32 pelvic LNs pos; since both pelvic and para-aortic LNs are “regional” it does not matter that we do not know if any were pelvic vs para-aortic or a combination of both.

<http://cancerbulletin.facs.org/forums/forum/collaborative-stage/female-genital-system/corpus-carcinoma/6432-ssf-3-4-5-6-when-not-stated-if-pelvic-or-para-aortic>

**ENDOMETRIUM #3**

The lymph node involvement for a uterine cancer was documented in pathology as: 0/5 Rt pelvic LNs, 0/2 Rt common iliac and para-aortic LNs pos, 0/3 L pelvic LNs pos, and 0/4 L common and para-aortic LNs pos.

**15.) What is SSF3- Number of positive pelvic LNs?** **000**

Rationale: All the LNs sampled were negative so we can code 000 negative even though
 the pelvic/para-aortic LNs were combined in descriptions and it is not clear how
 many there were of each .
 **16.) What is SSF 4 – Number of examined pelvic LNs?** **097** Rationale: We know pelvic LNS were resected but we don’t know how many since
 references to the common iliac and the para-aortic were combined- code 997.

**17.) What is SSF 5- Number of positive Para-aortic LNs?**  **000**

 Rationale: All the LNs sampled were negative including the references to para-aortic LNs.

**18.) What is SSF 6- Number of examined Para-aortic LNs?** **097**

Rationale: We know para-aortic LNS were resected but we don’t know how many- code
 097.

**19.) What is the number of regional LNs positive?**  **00** Rationale: All the nodes sampled were negative and all are *regional* nodes.

**20.) What is the number of regional LN examined?** **14**

 Rationale: Combined total of all LNs resected =14 pelvic and para-aortic LNs are all
 regional LNs.

<http://cancerbulletin.facs.org/forums/forum/collaborative-stage/female-genital-system/corpus-carcinoma/727-coding-of-ssf-3-4-for-endometrial-cases>

**TESTIS**
Patient diagnosed with testicular cancer. Tumor markers at diagnosis were Alpha-fetoprotein: 2628 ng/ml (normal range 0-15 ng/ml), beta-hCG: 696 IU/ml (normal range 2-5 IU/ml), LDH: 936 U/L (normal range 300-600 U/L). Patient underwent orchiectomy. Three weeks post orchiectomy serum tests AFP and Beta-hCG dropped to within normal range, but the LDH continued to be elevated (920 IU/L norm 300-600). Patient began a chemotherapy regimen of BEP (Bleomycin, Etoposide, and Cisplatin) on 9/28/14. The LDH Serum markers normalized after completion of the 1st round of chemotherapy noted on 11/2/14 with an LDH of 229 IU/L (norm 300-600).

 **21.) What is the SSF13? 000**

Rationale: Post orchiectomy the AFP was noted to be within the “normal range”;
 even without the value we can code to 000 within normal limits.

 **22.) What is SSF 15? 000**

Rationale: Post orchiectomy the hCG was noted to be within the “normal range”;
even without the value we can code to 000 within normal limits.

**23.) What is SSF 16?** 920IU/L = **Code 020** (Range (S2) 1.5 x 10 x N (between 1.5 and
 10 times the upper limit of normal for LDH

Rationale: See Note #2 for CS SSF16 “Record the range of the LDH text as documented in the patient record **after** orchiectomy and ***prior to further treatment***”. The post orchiectomy value was 920 and this was prior to further treatment with chemotherapy. The LDH value of 229 IU/L after completion of chemotherapy should not be used.

**THYROID**55-year old female presents with left neck mass. Exam reveals a 3.0cm mass just lateral to the thyroid, most likely matted lymph nodes. Neck US: 4.4cm soft tissue mass, likely neoplastic; likely representing thyroid malignancy and LN conglomeration. Right thyroid lobe reveals two nodules, one 2.0cm and one 1.4cm. CXR/CT Chest: Negative. Patient undergoes total thyroidectomy with left neck dissection. Pathology reveals papillary carcinoma in the left lobe 2.3 cm with extrathyroidal extension. Right lobe negative; 7+/8 central compartment LNs pos; 1+/3 retropharyngeal LNs. 3+/6 perithyroidal LNs pos.

**24.) What is SSF 1- Solitary vs Multifocal tumor? 010 –Solitary Tumor**

 Rationale: There is a single 2.3 cm tumor in the left lobe on pathologic exam. The nodules
 in the right lobe noted on US should not be interpreted as multiple tumor foci. *Tumor
 multifocality can only be determined based on pathologic exam of the tumor.*

**25.) What is the number of Regional Nodes Positive? 11**

**26.) What is the number of Regional Nodes Examined? 17**

Rationale/Comment for #25 and #26: All the “named” lymph nodes are regional LNs for thyroid. Central compartment LNs are Level VI LNs which is the most common site for LN mets in thyroid. Parathyroid or Perithyroidal LNs are also level VI LNs and are *not* lymph nodes specific to the parathyroid gland- be sure to include them in regional LNs counts.