**Q&A Session for Collecting Cancer Data:**

**Hematopoietic and Lymphoid Neoplasms**

**Thursday, April 4, 2019**

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**Q:** ­Notes: per pg 16 Heme Manual diagnostic confirmation codes 1-4 take priority over 5-8, there is a hierarchy. Also, the use of Code 3 doesn't require the diagnosis of a MORE SPECIFIC histology, per pg 17 it should be used when the diagnosis is "confirmed"­.

As for all cancer cases, microscopic confirmation (codes 1-4) takes priority over non-microscopic confirmation (codes 5-8).

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**Q:** ­For transformation it may be helpful to clarify that the database is kind of the opposite of slide 11. Neoplasms listed UNDER "Transformation FROM" are chronic and those listed under "Transformation TO" are acute ones.

If you have an acute neoplasm, you will see at least one neoplasm under “transformation from”. For example, AML will have the MDS histologies listed under “transformation from.”

If you have a chronic neoplasm, you will see at least one neoplasm under “transformation to.” For example, MDS histologies will have the AML histologies listed under “transformation to.” ­

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**Q:** ­For the primary site modules, can you just go to the correct module without starting at Module 1 each time? Then once in the module, go in order and stop when rule applies?­

**A:** ­Yes, you can go straight to the appropriate module. The Heme DB directs you to Module 6: PH11 and PH15 and Module.

Always check the Heme DB to see if there are specific modules listed under the “Module Rule.” If a specific module is listed, yes, you can go directly to the Module. For some histologies, the DB provides a default primary site, so in those cases, you would not need to go through the Modules for the PH rules. The rule that applies to those default primary sites is PH30.

For the Multiple Primary Rules, always start at the beginning until you are familiar with the rules.

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**Q:** ­Will you please go over at some point in the presentation when we should code the mets fields and how to code them? Where are instructions for this? ­

The following are always coded as 8 for the Mets at Dx fields

Use code 8(Not applicable) for the following

Any case coded to primary site C420, C421, C423, or C424

Plasma Cell Myeloma 00821

Plasma Cell Disorders 00822

HemeRetic 0083

For the lymphomas, the Mets at Dx fields are coded. For the Mets at Dx-Distant Lymph Nodes, if the primary site is C77\_, then it would be 8 (this has been sent to SEER and CoC for correction in the next manual).

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**Q:** ­Why does the Heme database say refer to Module 6 PH 11, 13 and not include Module 7 also? ­

Module 6 PH 11, 13 has some specific rules for certain cases with the DLBCL. Always check these first to make sure that your case doesn’t fall into one of those rules. DLBCL commonly occurs with other histologies (PH11) or is involved with the skin (PH13). If neither one of these situations occurs, then you can go directly to Module 7.

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­For CLL/SLL is it correct to tag the primary site as P77 and topography code to C42.1 when positive blood smear and/or bone marrow bx positive - the C77 directs the software to the lymphoma AJCC schema which we need to assign the clinical AJCC Stage 4 .

Not sure I understand the “P77.” Also, primary site and topography code are the same thing.

Per the Hematopoietic rules for CLL/SLL (9823/3), if the peripheral blood or bone marrow are involved, primary site is C421. Regardless of primary site, you should be directed to the Lymphoma schema in your software. AJCC Stage would be IV (Summary Stage 7)

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**Q:** ­Maybe helpful to remind heme manual has own set of reportability instructions. Although "possible" is not a diagnostic ambiguous terminology, case reportability rule #5 - report case when pt is treated for reportable neoplasm. ­

Yes, always review the allowable ambiguous terminology. Even if a physician reports something with non-allowed ambiguous terminology for the registry, if they are treating the patient as though they have the disease, you would report it.

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**Q:** ­This can be tricky especially with ET - when there's no diagnostic term and pt on surveillance or baby aspirin ("other" tx for ET)­

Baby aspirin is a treatment for ET, so based on that and a diagnosis of ET (even with ambiguous terminology), would make this reportable.

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**Q:** ­About the Mets at Dx, STORE has a table of when code 8 is used (combination of psite & histo). pg 179, 181, 185, 189­

This table is not current and does not cover all the cases. It does cover most of them though.

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**Q:** ­If there is no AJCC staging schema listed (for example multiple myeloma), it seems inappropriate to code Stage 4. ­

If there is no AJCC staging, you assign “88.” Your software should default to 88.

Multiple Myeloma has no AJCC staging system, it would always be 88.

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**Q:** ­For lymphoma and CLL/SLL we have been instructed by the CAnswer Forum to use Lugano for AJCC Clinical Staging only (as the pathologic would require an exploratory laparotomy). EOD and Summary Stage DO typically default C421 to "systemic" but not AJCC. ­

For Lugano staging, if primary site is C42.1, that means the peripheral blood or bone marrow is involved and that is a Stage IV for AJCC. Stage IV is another term for “systemic.”

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**Q:** ­Is there known Edit issues for AJCC for CLL/SLL? Our does not seen to pass edits?

No. I checked and edits will pass with CLL/SLL, primary site C42.1 and AJCC clinical stage group of 4.

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**Q:** ­For case scenario 3; what would the diagnostic confirmation code be? ­

For case 3: The pathology report states “plasmacytoma.” Then additional information stated this may be “multiple myeloma.” Per the new clinical definition, “lytic lesions” are diagnostic of multiple myeloma.

Since the pathology findings do not indicate multiple myeloma and clinical information is used to assign histology, diagnostic confirmation would be 8.

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**Q:** ­Is there documentation of all the changes/clarifications/updates on rules in the manual and histologies added or changed in the Heme manual and database?­

Yes. This can be found on the SEER website.

<https://seer.cancer.gov/tools/heme/update.html>

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**Q:** ­What determines spleen involvement? Does the term splenomegaly constitute involvement­?

­Splenomegaly does not necessarily mean involvement, although it can be involvement. You really need to look for a physician's statement that the spleen is involved­

Per the SSDI manual (under Organomegaly where Splenomegaly is recorded)

**Note 3:** Organomegaly is defined as presence of enlarged liver and/or spleen on physical examination and is part of the staging criteria.

**Note 4:** This data item is determined from physical exam alone. If a physical exam cannot be used to detect organomegaly due to issues related to the patient’s obesity, a physician statement of organomegaly based on a CT scan can be used.

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**Q:** ­Would pleural fluid involvement be stage 4 if not stated to be primary effusion lymphoma? ­

Pleural fluid involvement usually is metastatic, except for when the pleural is the primary site­. Would need to address this on a case by case basis instead of making an overriding rule that pleural fluid involvement is always stage 4.

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**Q:** ­What would be considered a pathologic stage? Is there ever a pathologic stage? ­

­Pathological stage is pretty much never done based on advances in imaging. To qualify for path staging, a staging laparotomy must be done. ALL procedures in the staging laparotomy must be done.

Staging laparotomy includes:

* Splenectomy
* Wedge liver biopsy
* Multiple lymph node biopsies
* Bone marrow biopsy

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**Q:** ­Is a dx of plasma cell dyscrasia or plasma cell neoplasm without any further information considered MGUS?­

**­**Not necessarily, there are multiple conditions that can be grouped under plasma cell dyscrasia or plasma cell neoplasms.

Per the Hematopoietic database, plasma cell dyscrasia is defined as: Plasma cell dyscrasia includes a diverse group of diseases that produce monoclonal immunoglobulin fragment. Reportable diseases include lymphoplasmacytic lymphoma, multiple myeloma, Waldenstrom macroglobulinemia and heavy chain disease. Non-reportable diseases include benign monoclonal gammopathy (MGUS), immunocytic amyloidosis and POEMS (polyneuropathy, organomegaly, endocrinopathy, M protein, and skin changes) syndrome.

<https://seer.cancer.gov/seertools/hemelymph/533189b3e4b0626b19275d05/?q=dyscrasia>

Per the Hematopoietic database, plasma cell neoplasm is defined as: is the umbrella term that includes MGUS, plasma cell myeloma, solitary plasmacytoma of bone, immunoglobulin deposition disease, extraosseous plasmacytoma and osteosclerotic myeloma. Of these, only the plasma cell myeloma, solitary plasmacytoma of bone and extraosseous plasmacytoma are reportable.

<https://seer.cancer.gov/seertools/hemelymph/5331a216e4b0626b192764b4/?q=plasma>

If the only diagnosis you have is “plasma cell dyscrasia” or “plasma cell neoplasm” these would be non-reportable.

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**Q:** ­We can't use the factors on the table on page 985 to code high risk cytogenetics?­

**A:** ­Technically yes, but CAP is saying those are not the correct cytogenetics to use, which is why they are not listed in the SSDI. ­

We have addressed this question with AJCC and CAP. For now, you may use the factors that are listed in the AJCC chapter, which are not consistent with what CAP has. We are still hoping to get the correct high-risk cytogenetics updated soon.

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**Q:** ­If there is no mention of B Symptoms and/or HIV Status in the medical records, are they coded to 0 or 9? ­

For most of the SSDIs, if what you are looking for is not mentioned, code unknown.

There are specific notes addressing this for B symptoms and HIV status.

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**Q:** ­Just to confirm; if you have a physical exam and there is no mention of splenomegaly, can you code organomegaly negative? ­

See Note 5: If there is no mention of organomegaly (present or absent), code 9. ­

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**Q:** ­Case 3 the iliac wing lesion wasn't +, so it should not be coded, correct? ­

The iliac wing did not have to be biopsied. There was clinical evidence that there was lytic lesions, which is all that was needed to collect this plasma cell myeloma/multiple myeloma.

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**Q:** ­Diagnostic Confirmation was an 8 for this case. ­

Case 3 is code 8 based on the clinical evidence of the multiple myeloma.

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**Q:** ­Then would your dx conf be something other than 8­?

If this case had microscopic confirmation of multiple myeloma, then it would be code 1.

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