**Q&A Session for Solid Tumor Rules**

**Thursday, August 1, 2019**

Q: ­What would the histology code be for Adenocarcinoma, 30% Acinar, 30% Mucinous, 30% Papillary and 10% Micropapillary? ­

A: 8255 would be the default since there is not a majority of a single type. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q: ­On Table 1 can you explain the laterality column. It is confusing when you have a C34.1 and if it means we use the laterality code of 'bilat' or a 4. Or the note explaining we don't do that. It isn't clear for newer abstractors. ­

A: The laterality column of Table 1 is not intended to direct registrars on coding laterality, but rather to identify on which side (right and/or left) a particular structure resides. For example, Column 2 indicates that a middle lobe presents in the right lung only and that upper lobes present bilaterally.

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Q: ­Please go over non-mucinous adenocarcinoma in histology table. Column 1 has specific codes for types of non-mucinous, but the synonym column has adenocarcinoma, non-mucinous nos, 8140. How do you know when to use 8140 over the other non-mucinous codes? ­

A: Specific (new) codes for non-mucinous adenocarcinoma are limited to tumors that are identified as either microinvasive and minimally invasive (8256/3), or preinvasive and in situ (8250/2). When the tumor is describes simply as non-mucinous without mention of behavior, or as invasive non-mucinous, it is considered synonymous with adenocarcinoma (8140/3).

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Q: ­Was the 2015 diagnosis also RIGHT lung? ­

A: ­Yes! ­

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Q: ­Please confirm that for M4 - does laterality make a difference? ­

A: **I (Jim) answered this incorrectly on the webinar. Laterality does not make a difference in the timing rule for Lung, Breast, Kidney, or any other paired organ unless in there are instructions stating to do otherwise. See the note below from the SEER Solid Tumor Team.**

*If the subsequent tumor is DX’d less than 3 years following a previous tumor, then you continue through the rules (if in a different lung then it would be caught in M11.  If more than 3 years, it’s a new primary regardless of being in a separate or same lung.*

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Q: ­Example 1 of Rule M8 mentions the non-mucinous adenocarcinoma with the code 8250/3.

Should the code be 8140/3 instead? ­

A: Yes. This has been brought to the attention of the STR editors.

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Q: Does the fact that pathologist did the comparison, that we no longer follow the STM? So even if it was different laterality if pathologist compared slides & called it recurrent it would be met from the previous cancer? ­

A: While microscopic comparison to historic slides is relatively rare, and was done to illustrate the exception to the ‘Timing Rule’, if a pathologist microscopically determined that a tumor in the contralateral lung was metastatic from the other lung, it would be considered a single primary.

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Q: Is the term bronchogenic carcinoma the same as bronchoalveolar carcinoma? If not, what code are we going to use for bronchogenic carcinoma?

A: The term Bronchogenic is used to identify site/topography (lung, NOS – C34.9). I would code bronchogenic carcinoma to 8010/3.

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Q: ­If it reads papillary DCIS - would you still only code DCIS or 8507 (papillary insitu)? ­

A: Papillary ductal carcinoma in situ 8503/2. See synonyms for papillary carcinoma in table 3

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Q: ­How would you code primary site when you have a statement of 12-1? C508 vs C504 (left breast) ­

A: If it is a single tumor, go with C50.4. If multiple tumors, go with C50.9.

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Q: ­For lung, how is component coded? The not equivalent terms state that component is not equivalent to type/subtype (page 4) and is only for a second carcinoma. However, the Coding Histology rules on page 33 includes component as acceptable, see Example 3­.

A: The term component is used to describe specific histologies that make up a tumor, and Not to determine the number of primaries. That is why component is not considered equivalent to subtype or variant when looking at Multiple Primary Rules, such as M6, which addresses different subtypes/variants in Column 3 of Table 3. Rather, it is used to assign the histology when there is a component of a specific histology in a tumor, along with a NOS, or to determine the invasive histology when a tumor contains both invasive and in situ components.

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Q: When we will get online access to the ICD manual? ­

A: The ICD O manual is available online. However, you should still go to the solid tumor manual first, the 2018 updates second, and then if you still can’t find a histology code, go to the ICD O manual.

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Q: ­Breast histology question: How would you code Invasive adenocarcinoma, lobular type? Is that one histology and code lobular? Or do you ignore 'type' and code adenocarcinoma? ­

A: We had this clarified by SEER. They feel the most appropriate code would be 8520/3

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Q: ­Quiz 8: Would they not be separate primary's due to different histologies? ­

A: That was my first thought as well. However, if you start with rule M4 and work through the rules, M10 is the first rule that applies and it tells us we have a single primary.

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Q: ­For M10 did you change the original code from lobular to the combination­?

A: For the working histology I made the first tumor 8520 and the second tumor 8500. However, even if I did make the second tumor 8522, rule M10 would still apply.

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Q: ­Pop Quiz 11: Both tumors were medullary and same histology codes for both years-both tumors. I get M18 single primary? ­

A: To get the “working” histology for each tumor we have to apply the 2018 Solid Tumor Rules to each tumor. According to the 2018 Solid Tumor Rules, the first tumor would be 8500 and the second would be 8510. If we run the two working histologies through the solid tumor rules, the first rule that applies is M14. M14 tells us we have two primaries.

***Note: The 8500 we assigned to the first tumor was a “working” histology. We would not go back into the abstract for the first primary and change the original histology that was coded for this case.***

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Q: ­Please clarify the timing rule. So long as patient is disease free after treatment (even if it takes 2 years to complete treatment) we use date of diagnosis and not the date the patient became disease free?

A: Per SEER: ­If you have a statement of NED in the record use that date to start the timing rule. Default to the date of DX if unknown or NS. There are too many possible situations to create rules for. ­

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