**Q&A Session for Central Nervous System**

May 7, 2020

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| # | QUESTION | ANSWER |
|  | The best way to code OPTUNE tx on GBM? | Current instructions state to code this to Other Tx code 1 – (doesn’t fit definitions of surgery, radiation, systemic treatment) |
|  | Is OPTUNE also a 1st course TX? | If it is part of the first course of treatment, you would code it as such. With temozolomide, Optune is indicated for newly diagnosed adult patients with histologically confirmed supratentorial GBM following maximal debulking and completion of radiation therapy. Supratentorial = adults It is also used for recurrent GBM, in which case, it would not be FCOT. Looks like it is coded in the Other fields. See SEER Rx. I found a couple of CAnswer forum posts that shows CoC agrees it should be coded as other. https://seer.cancer.gov/seertools/seerrx/rx/53c44af3102c1290262dbe4a/?drug\_direction=UP&regimen\_direction=UP&rx\_type=drug&drug\_field=score&regimen\_field=score&drug\_offset=0&regimen\_offset=0&limit=25&search\_mode=&q=optune&mode= |
|  | What should you code for site when the only description of location of a tumor is "Supratentorial, NOS" or "Infratentorial, NOS"? | First, is the histology known? If it is a brain tumor, in ICDO-3 the supratentorial brain, NOS, is coded to C71.0; infratentorial brain, NOS, is coded to C71.7. If it is a meningioma, it would be coded to cerebral meninges C70.0. |
|  | Where would you code the site if the meningioma is described as a spinal meningioma. Would you still code to meninges? | Yes. Meningiomas arise in the meninges. A spinal meningioma is coded to spinal meninges C70.1 |
|  | Slide 35, table 6 - does a resection/biopsy have to have occurred to prove the transformation? | There is no specific statement that there must be a resection to “prove” the transformation. This table is just showing non-malignant tumors that can transform to malignant tumors. It is not a rule, per se, but more placed there for informational purposes. |
|  | What does FCOT stand for? | First Course of Treatment |
|  | Could you clarify the statement, "Component is only coded when the pathologist specifies the component as a second carcinoma", with an example, pls.? | "I believe they are taking that out of the instructions with the 2021 STR updates because it seems to conflict with the histology coding instructions that state "" Code the most specific histology or subtype/variant, regardless of whether it is described as:1. The majority or predominant part of tumor
2. The minority of tumor
3. A component"" "
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|  | If a patient had a 2015 diagnosis of anaplastic astrocytoma Grade III followed by resection of brain tumor which demonstrated progression in 2018 with path report final diagnosis indicating GBM, WHO grade IV, IDH-1 mutated, does Rule M6 apply to this case as 2018 GBM is to be abstracted a new primary? | If the original tumor was resected, this GBM would be a second primary, since the GBM was diagnosed on/after 1/1/2018.  |
|  | Do we code it because it is higher code minor component was higher code? | No. It is because we want to code as specifically as possible. A subtype/variant is more specific than an NOS term. You will see in the non-malignant rules the ICD-O codes is the same, but the behavior is /1 for the more specific histology. |
|  | Are NF1/NF2 and Schwannamotosis tumors w/in the CNS reportable w/ every occurrence of reportable tumor? Or just for the initial tumor that occurs w/in the Cerebral or Spinal regions? | NF, NF1, NF2, and Schwanomatosis are not reportable, as they are not tumors. They are all genetic syndromes. If you have a reportable tumor and one of these genetic syndromes, we only report the reportable tumor.  |
|  | Optic nerve gliomas associated with NF are pilocytic astrocytomas. I coded pilocytic astrocytoma as 9421/3 per SEER Inquiry question 20081126. Is this still correct or do I change to 9421/1? | That SEER Sinq goes with the 2007 MP/H rules. The 2018 STRs state: “WHO and IARC designate pilocytic astrocytoma as a synonym for optic glioma. When the primary site is optic nerve, the behavior is non-malignant.” |
|  | So are all meningiomas reportable as of 2004? i.e. Benign or malignant with or without histology? | Non-malignant meningiomas are reportable since 1/1/2004. Malignant meningiomas have always been reportable. The diagnosis does not have to be histologically confirmed. Many meningiomas are clinical diagnoses, often by imaging. |
|  | Slide 66, Table 5 for Non-Malig Intracranial Tumors: please repeat the importance of the blue shaded row. How does this apply when North America reports this specific tumor as a /3? | We have a query in about why that row appears with the primary site codes, as pilocytic astrocytoma in those primary sites is coded to /3. WHO and IARC designate pilocytic astrocytoma as a synonym for optic glioma? When the primary site is optic nerve, the behavior is non-malignant. |
|  | Are pituitary gland adenomas reportable? | Yes. They are reportable as pituitary adenomas 8272/0. See table 5 n the non-malignant rules. |
|  | please confirm or refute whether "meningioma with brain invasion" is a /0 whereas atypical meningioma with brain invasion is /3 | "An atypical meningioma is 9539/1 per table 6. If the diagnosis is atypical meningioma, that is what you would use. We code the behavior of a meningioma with brain invasion according to the priority for coding behavior. If it is malignant, we use the malignant rules; it is non-malignant, we use the non-malignant STRs. I am not sure if that answers your question, so kindly follow up with another question to clarify. Answer to brain invasion of meningioma: Please refer to Reportability Criteria: Note 2: Never report a malignant /3 behavior code for a meningioma based on tumor extension to brain, skin of scalp, or other regional organs/tissue. Non-malignant CNS tumors can extend to the regional tissue and bone. Tumor extension is usually equivalent to atypical meningioma 9539/1. Also supporting the idea that brain invasion does not equal /3 when occurring with meningioma: Rules H1 and H5 have same Note: Do not report a malignant /3 meningioma based on:* Invasion of the skull bone
* Tumor extension through the foramina at the base of the skull
* Do not report a malignant /3 meningioma based on tumor extension to brain"
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|  | We have many pediatric patients diagnosed with "low grade glioma" by radiology only (often dx'd by ambiguous terms only) and many are followed for many years without any tx. What histology code should be used for these tumors? | As noted in the Changes from 2007 notes (found in Malignant CNS rules): B. Terms which are not recommended are not included in the tables. When one of these terms are used, refer to the ICD-O and all updates for the correct histology code. For example, glioma NOS is an umbrella term for all gliomas and astrocytomas. " The ICD-O code for glioma, NOS, is 9380/3.  |
|  | If a tumor is extramedullary; outside the medulla oblongata would that not be coded to C701 spinal meninges? See slide 19 | Slide 19 is directly from the STR manual. It is listed as a synonym because C700 (cerebral meninges) is outside the medulla oblongata. The medulla oblongata is not part of the spinal cord. It is a brain site C717 (brain stem). |
|  | Initial bx showed anaplastic astrocytoma and a consecutive bx (5 mos later) showed Glioblastoma; would this be MP? | If the original tumor was resected, this GBM would be a second primary, IF the GBM was diagnosed on/after 1/1/2018. If the original tumor was not treated (still in the workup time for the tumor) and has not been abstracted, the GBM would be a more specific histology. |
|  | We have been coding a stereotactic brain biopsy as surgery code 20 per SEER Surgery Code instructions. Is that correct? | Yes. SEER registries code stereotactic brain biopsies to 20. |
|  | What would the site code be if an MRI stated right frontal meningioma? | Cerebral meninges C700. |
|  | If you are a CoC facility do we use code 20 for stereotactic bx or is it covered under the diagnostic procedure code 02? | CoC facilities code stereotactic biopsy to 20 when it is an excisional biopsy. If it is only a diagnostic procedure, use code 02 in diagnostic and staging procedures. |
|  | Rule M3 in non-malig (and M4 in malig) - any estimate of how this might change incidence stats? Fewer non-malig counts but of what magnitude? | I am not sure at this point in time. As we use the rules for a few years, we will be able to have more information about this. Great question! |
|  | When we change histology to behavior /3 for a prior /1 primary (already abstracted and submitted), do we have to change the sequence from 60 range to malignant range sequence? Would edits be an issue here? Thanks. | Yes. You would need to change the sequence number. It could be 00 if it was the first reportable malignant tumor. Otherwise, you would choose the appropriate malignant sequence number according to date of diagnosis. |
|  | Re: M3 non-malignant CNS becomes malignant do you change the sequence from 60 to 00? | Yes. You would need to change the sequence number. |
|  | If a patient had a 2015 diagnosis of anaplastic astrocytoma Grade III followed by resection of brain tumor which demonstrated progression in 2018 with pathology report final diagnosis indicating GBM WHO grade IV, IDH-1 mutated, does Rule M6 apply to this case so 2018 GBM is to be abstracted as a new primary? | If the original tumor was resected, this GBM would be a second primary, since the GBM was diagnosed on/after 1/1/2018. The 2018 rules would apply to the GBM resection and that should be a new primary according to Rule M6 in the malignant rules. There are several Notes in the Malignant CNS Rules that note a GBM should be documented as a subsequent primary in order to gather data on how often this more aggressive tumor occurs. |
|  | Not sure if this posted; are pituitary gland adenomas 8272/0 reportable? | Yes. They are reportable and are listed in Tables 5 and 6. |
|  | Do we still code the laterality? | Yes. Code the laterality, but don’t use it to determine multiple primaries. |
|  | When a non-malignant CNS tumor originally reported as a Sequence 60 with no surgery, and then has subsequent surgery that is a malignant histology and you change the histology to report to the Central Registry what do you do with the Sequence of the tumor? Change from 60 to 00? Wouldn't you get an edit that you have a Seq 60 with a Malignant Histology if you did not change it? | You would need to change the sequence number. |
|  | Do you think the original tumor that was diagnosed clinically without histology was really malignant all along? Or did it progress and transform to a malignant behavior? | Are you referring Rules M3 (non-malignant rules) and M4 (malignant rules)? |
|  | How can we determine where the blood vessel arises in order to determine reportability for hemangiomas?  | A/V malformations (not tumors) and angiomas (blood vessel tumors) are not reportable because these are not tumors that arise in the brain parenchyma or meninges. Hemangiomas are reportable because they are brain tumors. Hemangiomas typically develop in the cerebellum and may be identified because they cause problems with balance and coordination. |
|  | Reportability--Brain and CNS: Are blood vessel tumors arising in CNS sites reportable?  | Vascular tumors of the CNS are reportable when they arise in the dura or parenchyma of the CNS and should be coded accordingly. Benign and borderline blood vessel tumors are not reportable wherever they arise. The instructions in the CDC book regarding primary site coding are not the most current instructions. SEER assumed responsibility for brain and CNS reporting instructions in 2007. |
|  | Slide 80: 3. Cytology (SF). What does SF stand for? Maybe CSF? |  The tumor in SINQ 20120034 is not reportable because it arises in a blood vessel. The cavernous hemangioma in SINQ 20081113 is reportable because the primary site is the white matter of the cerebral cortex. |
|  | Primary site on. malignant tumor is not C71.8 for overlapping lesion? | No. The primary site is the Left frontal lobe. The tumor is extending to the corpus callosum. The extension information is recorded in the SS2018 and EOD fields. |
|  | What does "Drop" Mets mean? | Remember, the CSF circulates throughout the brain and spinal cord. Any tumor cells can get into the CSF and travel around with the CSF. Because of that, they can establish themselves in areas away from the primary tumor. These occur rarely. |
|  | Where to download the newest manuals?  | Yes. Go to SEER.cancer.gov and you can get most of the manuals there. Select “registry operations” and then scroll down to “Manual reference guide.” This is the direct link to the manual reference guide: https://seer.cancer.gov/registrars/references.html |
|  | Can you accept the grade from MRI scan?  | Yes, per Jennifer Ruhl CAnswer forum 1/10/20: "Except for brain tumors (where grade can be assigned based on imaging), all grades must be histologically confirmed, even during the clinical time frame." (http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/99481-low-gr-on-scan-only) You could not code the grade pathologic or grade post-therapy fields based on imaging because resection of the tumor with a surgery code of at least 30 is required for those two fields. |
|  | When clinical diagnostic procedure does not diagnose meningioma (MRI uses ambiguous terminology that makes it diagnostic), but resection reveals meningioma, do you code clinical grade 1 or 9? | What is the diagnostic terminology? If it says probable (or any of the other ambiguous terms that constitute a diagnosis) meningioma, you could code the grade clinical to 1. If the ambiguous diagnostic terminology does not refer to meningioma (i.e. MRI shows 4cm tumor), the clinical grade would be 9. |
|  | This link does not work on slide 4 https://www.abta.org/primer2.htm. Also, I could not find the primer by searching on the American brain tumor association website. | Thanks for letting us know. Www.abta.org is still findable in internet searches. The primer is now a .pdf called About Brain Tumors: A Primer for Patients and Caregivers. |
|  | When does a brain invasion by meningioma implies a /3 behavior? | Not necessarily. These 2 notes are from the non-malignant STRs. (1) Note 2: Never report a malignant /3 behavior code for a meningioma based on tumor extension to brain, skin of scalp, or other regional organs/tissue. Non-malignant CNS tumors can extend to the regional tissue and bone. Tumor extension is usually equivalent to atypical meningioma 9539/1. (2) Note: Do not report a malignant /3 meningioma based on: • Invasion of the skull bone • Tumor extension through the foramina at the base of the skull • Do not report a malignant /3 meningioma based on tumor extension to brain. If the pathologist states the tumor is malignant, then, yes, the invasion is /3, but just the term "invasion" does not imply /3 behavior.  |
|  | What do you code if you are a CoC facility in a SEER state? | Send it to SEER like they want it and to the CoC like they want it. We are trying to get clarification from the CoC. So far, they have replied that a stereotactic biopsy of the brain is coded to 20 IF it is an excisional biopsy. There are instructions provided when SEER registries handle things differently than the CoC. For example, this is from California Cancer Registry Volume I (California follows SEER Rules): "Note: The CCR follows SEER guidelines and requires coding incisional biopsies without residual at re-excision to be coded as an excisional biopsy only in the Surgery of Primary Site data field. COC Facilities: Please make note in your user defined fields when standards between CoC and CCR differ." |
|  | For GBM what about OPTUNE used for tx? | With temozolomide, Optune is indicated for newly diagnosed adult patients with histologically confirmed supratentorial GBM following maximal debulking and completion of radiation therapy. It is also used for recurrent GBM, in which case, it would not be FCOT. |
|  | CoC/SEER are both responsible for the surgery codes. If facility is both a SEER/COC facility you can't code the same procedure both ways.... We should be coding consistently... Would you like to comment. :) | Send it to SEER like they want it and to the CoC like they want it. We are trying to get clarification from the CoC. So far, they have replied that a stereotactic biopsy of the brain is coded to 20 IF it is an excisional biopsy. There are instructions provided when SEER registries handle things differently than the CoC. For example, this is from California Cancer Registry Volume I (California follows SEER Rules): "Note: The CCR follows SEER guidelines and requires coding incisional biopsies without residual at re-excision to be coded as an excisional biopsy only in the Surgery of Primary Site data field. COC Facilities: Please make note in your user defined fields when standards between CoC and CCR differ." |
|  | Radiation coding would have been a helpful contribution to this presentation. | We just wouldn't have had the time to cover brain radiation coding. If you have specific questions, please see CAnswer Forum under the STORE section. |
|  | How would you code a Gene Modified Cytotoxic Immunotherapy (GMCI) intraoperative for a Glioblastoma? As other?  | Either submit the process and/or drug names to SEER SINQ or Ask-a-SEER Cancer Registrar for guidance. In the meantime, you could use Other code 1 as this process seems to cover multiple choices (cytotoxic/chemo? And immuno) |
|  | How do you handle drugs if they are not in Seer Rx? | Either submit the drug names to SEER SINQ or Ask-a-SEER Cancer Registrar for guidance. |
|  | "https://www.cdc.gov/cancer/npcr/pdf/btr/braintumorguide.pdf. This is an oldie but a goodie resource as well and I believe they instructed to code a 20 a biopsy as well. Code 20 is assigned when the most extensive surgery is a local excision or biopsy of the primary CNS tumor. A specimen is obtained and pathologically examined. For meninges, brain, and other CNS, an incisional biopsy can be coded as the surgical procedure of primary site. Facility Oncology Registry Data Standards (FORDS) changes, corrections, or clarifications in the wording for code 20 are found at the CoC Web" | Per SEER Sinq 20130194, "The instructions in the CDC book regarding primary site coding are not the most current instructions. SEER assumed responsibility for brain and CNS reporting instructions in 2007." We should not be using outdated instructions for coding primary site, histology, surgery, etc. We need to use the current manuals. STORE does not have that verbiage about coding incisional biopsies as surgery. |
|  | Anaplastic Astrocytoma 2017 now with new brain lesion showing Glioblastoma 2020? Is this a new primary? One lesion for both brain tumor? | The 2017 diagnosis of anaplastic astrocytoma fell under the old MPH rules. The 2018 rules would apply to the GBM and that should be a new primary according to Rule M6 in the malignant rules. There are several Notes in the Malignant CNS Rules that note a GBM should be documented as a subsequent primary in order to gather data on how often this more aggressive tumor occurs. Yes. The GBM is a new primary. |
|  | Consecutive bxs were done on the same subsite C710. | It's progression disease. Patient had craniotomy resection in 2015, then in 2018 physician states that the tumor has progressed from anaplastic astrocytoma in 2015. |
|  | STORE Ambiguous Term lists Neoplasm\* and Tumor\* as ambiguous terms for nonmalignant primary intracranial & central nervous system tumors only. If imaging uses either ambiguous term and that is all you have as a diagnosis, wouldn't you be able to use a Clinical Grade of 1 based on the Ambiguous Diagnosis? | Good question. Right now, there is no specific grade rule that allows us to code the grade for any non-malignant tumor to 1. There is a proposed update for 2021 that does allow any non-malignant tumor to be assigned a grade of 1. |
|  | Is a transsphenoidal resection of a pituitary tumor/adenoma coded 30 or 27 (excisional biopsy)? I have always coded 27 because I don't see the surgery documented as hypophysectomy and assumed the surgeon was only removing the tumor and not the pituitary gland or portion of the pituitary gland. | If the surgeon is only removing the tumor, code to 27. The operative note from the neurosurgeon should be helpful in choosing codes 20, 27, 30. It is frequently removed piecemeal and the path report may not be helpful in determining the resection description. |
|  | So how should we code those stereotactic biopsies of the brain??? 02 or 20 [02 makes more sense to me when it's just diagnostic, but the resources don't seem to support that.]  | SEER registries have to use code 20. CoC facilities code stereotactic biopsy to 20 when it is an excisional biopsy. If it is only a diagnostic procedure, use code 02 in diagnostic and staging procedures. |
|  | I work at a central registry and have a question about brain tumors being misdiagnosed as benign. I have seen several brain tumors diagnosed via scan and final diagnosis is stated to be a benign meningioma. Because the tumor looks benign, the patient is told by their physician that they don’t need further treatment. However, the patient is not comfortable with that recommendation and requests to have the tumor resected. The final pathology findings demonstrate that the tumor is actually a malignant lesion. It leaves me to wonder if scans are reliable for brain tumors and should we be resecting all of them instead.  I would like to know if CBTRUS, or any other stakeholder, have conducted any studies to discover how many tumors are being incorrectly classified as benign? | I have not seen studies of misclassification; however, we now have rules that will guide us on whether these should be reported as multiple primaries based on the malignant histology.  That might be a good study for several central registries to conduct. However, I'm not sure how specific the documentation would have to be for a pertinent study to prove a misclassification. |
|  | Should we assign the primary site as c47.5 peripheral nerves of pelvis for a pediatric neuroblastoma diagnosed in the pelvis (not described to be arising from the adrenal gland)? | We are addressing the CNS tumors.  Pediatric neuroblastoma would follow the Other Rules since this is not a CNS tumor. |
|  | Neuroblastoma would not be a malignant peripheral nerve tumor. Correct? | The pediatric neuroblastoma is a tumor of the sympathetic nervous system. If it is found in the pelvis, you would assign C47.5. According to the definitions of neuroblastoma found in the National Cancer Institute dictionary: A type of cancer that forms from immature nerve cells. It usually begins in the adrenal glands but may also begin in the abdomen, chest, or in nerve tissue near the spine. |
|  | Slide 55 lists the criteria for reportability.  Often the non-malignant tumors are not removed or biopsied.  They are only diagnosed on imaging.  Are you saying we no longer report these?? | No. Later in the slides, you will see that some non-malignant tumors can be assumed to be WHO grade I without path (such as probable meningioma on MRI brain, observe until symptoms -- that is reportable.) |
|  | The path report states histology with WHO grade 2, but pathologist does not qualify malignant or non-malignant. No other information is available.  What should one go with--malignant or non-malignant CNS? Two that I've come across are ependymoma and atypical meningioma. | Atypical meningiomas must be stated by the pathologist to be malignant in order to choose the malignant CNS rules. Ependymomas can be anywhere from WHO grade I to III. If the pathologist only uses WHO grade II without indication of malignant or non-malignant, and no other information can be found in the medical record, I would go with the non-malignant rules. |
|  | I would like the clarification on meningioma reportability by imaging as well. Somewhere I remember hearing that if 'architecture only of the tumor is described as a meningioma, that it is not reportable as such? | Is the "architecture" on the path report? Or is it being used by the radiologist to describe a round-ish tumor, dural-tail, whatever words the radiologist would use to indicate (s)he believes this is a meningioma.  Architecture could be the shape of the tumor by the radiologist, or it could be the shape of the cells seen by the pathologist? I would report any tumor where "architecture" is a word used by the radiologist. |
|  | When you are both a SEER & CoC facility, how do you look at rule M3?  Would it be the same way, also, would the stereotactic bx be considered treatment for SEER?? | Both SEER and CoC agree that stereotactic biopsy that is excisional is assigned a code 20. The issue is when the biopsy is just taking a sample of the tumor. This is where SEER and CoC don't seem to agree. We'll contact them and ask what they recommend. |
|  | I believe radiologist. | In that case, "architecture" is a description of the size/shape of the tumor and I would report it. |
|  | If the change for coding benign grade is a proposed change, and not out until v2.0 updates, would this change begin with 2021 cases? | Yes. That is in italics. It has not been confirmed, but it is expected to be added to the grade rules for 2021 implementation. I hope they add it because that will be very helpful, right? |