**Q&A Session for Corpus Uteri**

August 7, 2020

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| # | Question | Answer |
|  | 2018 endometrial primary, surgery path stated as: endometrioid carcinoma with squamous differentiated. Is the 8323 or 8570? | 8570/3 is new code for 2018 per NAACCR implementation guidelines. Even prior to 2018 implementation, we were supposed to code this combination to 8570. SINQ 20110014: For cases diagnosed 2007 or later:  Endometrioid adenocarcinoma with squamous differentiation is coded to 8570 [Adenocarcinoma with squamous metaplasia].  This SINQ post goes on to tell us the table in the Other Sites MP/H rules is missing a row. Yikes. |
|  | AJCC pg 670 pls clarify code. | It is listed, but AJCC should not be used as source for coding histology. The lists in AJCC are to guide us to ensure we are using the correct AJCC chapter – both for site and for histology. First source for coding histology should be the most recent solid tumor rules (STR), second source should be implementation tables https://www.naaccr.org/icdo3/, and third choice should be your ICD O 3 manual. Check the SEER Inquiry system because the question may have been answered already (seer.cancer.gov/seerinquiry) If you don't get the answer there, send the histology to Ask a SEER registrar. |
|  | There is a SINQ question 20110014 for cases dx 2007 that states to code as 8570 instead of 8323. What should we do for those cases(2007-2017)?on the latest ICD-03 Table, correct? | I have note of SEER SINQ 20110014: For cases diagnosed 2007 or later: Endometrioid adenocarcinoma with squamous differentiation is coded to 8570/3 {adenocarcinoma with squamous metaplasia}. SEER indicated that this needed to be added to the next version of the MPH rules (which have not yet been released). |
|  | Where do we go to find that on NAACCR.org? | <https://www.naaccr.org/icdo3/> |
|  | Histology question: Path states: Carcinosarcoma, MMMT of endometrium. Do we code histology 8980/3 or do we use the specific mullerian code 8933/3 even though that is mullerian adenosarcoma on the ICDO3 table? Can we use either term carcinosarcoma and adenosarcoma to mean the same thing for the MMMT histology? | Assign code 8980/3, since both terms are used.  MMMT is a synonym of carcinosarcoma. In carcinosarcomas, **both** components (epithelial and mesenchymal) are **malignant**. In an adenosarcoma, the epithelial component is benign while **only the mesenchymal component is malignan**t.  SINQ post 20180071  “Question: What is the correct histology code for malignant mixed Mullerian tumor (MMMT/Carcinosarcoma)”  Answer: According to the WHO Classification of Tumors of Female Reproductive Organs, 4th edition, MMMT (8950/3) is now a synonym for carcinosarcoma (8980/3) even though it has a separate ICD-O code. The ICD-O code for MMMT is no longer in the WHO book. Per the subject matter experts, when both terms are used in the diagnosis (carcinosarcoma/MMMT), code the histology to 8980/3. If the ONLY term used is MMMT, assign 8950/3.  The information in the 4th edition of the WHO Classification of Tumors of Female Reproductive Organs has not yet been incorporated into the Other Sites Solid Tumor Rules.” |
|  | Slide 15: the FIGO Stages IIIA & IIIB sarcomas are coded higher in Summary Stage than FIGO IIIC? Please confirm. | Summary stage includes extension outside of the pelvis in code 7. Summary stage does not always line up exactly with other staging systems. This is one example of that. Others include the contralateral hilar and mediastinal lymph nodes in lung cancers. Summary Stage puts those in distant, while EOD and AJCC have them as regional lymph nodes. |
|  | If the diagnosis is carcinosarcoma, is the primary site coded to endometrium or corpus uteri, NOS? | Code the primary site according to the documentation in the medical record of where it started. |
|  | Electronic version of ICDO and solid tumors. | [https://apps.who.int/iris/handle/10665/42344](https://apps.who.int/iris/handle/10665/42344%20)  <https://seer.cancer.gov/tools/solidtumor/> |
|  | When would you use the 8933 on the new ICDO table? | Mullerian adenosarcoma is defined as a mixed epithelial and mesenchymal tumor in which the epithelial component is **benign** and the stromal (mesenchymal) component is **malignant** ([IARC: WHO Classification of Tumours of the Female Reproductive Organs, 4th Edition, 2014](https://www.amazon.com/exec/obidos/ASIN/9283224353/pathologyoutl-20)) |
|  | Slide 19: SINQ 20180071 really confuses the issue with MMMT vs. Carcinosarcoma, especially since it is stated that the two terms are synonyms. Synonyms mean the same thing, so codes should be same. I understand this is my opinion and the standard setters have spoken. | Right. Synonyms are supposed to have the same code, but in this particular situation, they don’t. That’s why we wanted to share the SINQ post because this stuff can be very confusing! |
|  | As follow-up, the SINQ post for endometrioid with squamous diff applied even to 2007 rules .... SINQ 20110014 | Yes. That post states “For cases diagnosed 2007 or later: Endometrioid adenocarcinoma with squamous differentiation is coded to 8570 [Adenocarcinoma with squamous metaplasia]. Cases that were diagnosed prior to the SINQ 2011 question are not required to be sought or revised for the histology code used in the past.  The priority for assigning histology should be:  1. Solid Tumor Rules  2. ICD O updates <https://www.naaccr.org/icdo3/>  3. SEER SINQ  4. ICD O 3 manual  5. Ask a SEER registrar |
|  | If FIGO is not listed in EMR can the Ctrl Registry assign FIGO based off of extension? | FIGO must be coded according to the medical record. We cannot assign the SSDI for FIGO stage based on the extension information. |
|  | If the diagnosis is leiomyosarcoma, is the primary site coded to endometrium or corpus uteri, NOS? | (Leio = smooth; myo = muscle) A leiomyosarcoma should be coded to the myometrium. SINQ 20051024 confirms this. |
|  | On the case scenario. They state on the CT the tumor is in the fundus/body of uterus. and post-op dx it says body of uterus, path says uterus and then the gyn says endometrial. What is the priority order for using site? I did not see a specific order for corpus so STR state histo is first and according to that then uterus would be the primary - why did you choose endometrium? | The patient had a curettage of the endometrium which was involved, and the physician stated it was of the endometrium. “Fundus/body” is referring to a region of the uterus, as opposed to the primary site (endometrium) in which the tumor arose. |
|  | Could you please direct me on where to find the information on which sites clinical N can be brought down and used for Pathological N? | Yes. Here is the direct link to download this wonderful resource: [https://cancerstaging.org/CSE/Registrar/Documents/Node Status Not Required Rare Circumstances.pdf](https://cancerstaging.org/CSE/Registrar/Documents/Node%20Status%20Not%20Required%20Rare%20Circumstances.pdf) |
|  | Concerning the case scenario, please explain why the Postop GYN/ONC Office Visit Note statement of "Clinical stage IB" does not appear to apply to assigning the clinical T, according to the answer of cTX given in the presentation. Why is the clinical T not cT1b? | The post-op note did say clinical stage IB; however, the physician was using information from the surgery in that note. If the stage had been assigned prior to the surgery, that would be one thing.To assign clinical T1b, the physician must have the percentage of invasion of the myometrium, which is not available from the D&C path report. The physician was not using the term “clinical” here the way we would use it to assign clinical staging. The physician is using it to communicate that the clinical picture is of a Stage IB tumor and, based on that, further treatment will include RT and femara. |
|  | Can you explain grading for Leiomyosarcoma? | According to the information found in the CAP Protocol notes for primary sarcoma of the uterus, grade for leiomyosarcoma should be described as high grade. Since that is not a definition allowed in Grade Table 13, you may be using “9” for most of your cases. If the pathologist documents the FIGO grade, you may use those definitions seen in the table. |
|  | Occasionally we see path reports that say endometrial adenoca - that would be coded to 8140/3 correct? Not endometrioid 8380/3 since does not say "endometrioid". | Correct. Endometrial just means it is in the endometrium. Endometrioid is a specific histology. |
|  | Is pelvic washing cytology synonymous with peritoneal cytology for coding SSDI peritoneal cytology? | Yes. This is per Note 3 in the SSDI: Note 3: Cytologic examination for malignant cells may be performed on ascites (fluid that has accumulated in the peritoneal cavity in excess amount) or the fluid (saline) that is introduced into the peritoneal cavity or pelvis, and then removed by suction. The introduction of fluid may be termed peritoneal or pelvic washing or peritoneal lavage. |
|  | Please clarify, if the pelv l node is not removed but biopsied, would it count for the item # examined pelv l nodes? | If the pelvic LN is not removed, but is biopsied, we would assign X6 for # examined, X6 for # positive if it was positive, and X9 for # positive if it was negative. |
|  | Are you saying for the Figo Stage SSDI that it explicitly must say "FIGO" - confusing because thought AJCC and FIGO are equivalent? | No. I said if they give a stage, we can assign the FIGO SSDI based on that stage. This is what it says on the slide: “If stage group is stated, but not specified as FIGO, assume it is FIGO” This is the priority for coding FIGO stage per the CAnswer Forum. Note: This priority differs somewhat from the instructions in the SSDI manual which state when there are multiple FIGO stages documented, assign the most extensive.  <http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/83594-figo-corpus-carcinoma-and-carcinosarcoma>  If you have clinical and pathological, record the pathological. If you have clinical and post-therapy, record the higher FIGO stage. This will usually be the clinical FIGO stage.  If you have clinical and pathological, record the pathological. If you have clinical and post-therapy, record the higher FIGO stage. This will usually be the clinical FIGO stage. |
|  | Would this not also apply to the Figo Stage SSDI? | See question 21 explanation |
|  | For a D&C that is pos for inv dz and the pt is not a candidate for surgery, is that code 02 (surg diag and staging procedure)? | STORE Appendix B: For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item  Surgical Diagnostic and Staging Procedure (NAACCR Item #1350).  SEER Appendix C: SEER Note: Do not code dilation and curettage (D&C) as Surgery of Primary Site for invasive cancers.  SINQ 20071070 Assign code 20 for endometrial D&C for in situ cancer of endometrium. |
|  | For cases that have a partial omentectomy along with TAH/BSO - is the omentectomy coded under SORS field? | SINQ 20200009: Continue to record an omentectomy performed with a hysterectomy under Surgery of Primary Site and not as a separate procedure under Surgical Procedure of Other Site.  The guidance In SINQ 2014003 and 20091118 is unchanged.  CoC: Code the omentectomy in surgical procedure of other site  <http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/94083-omentectomy-for-endometrial-primary>  <http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/surgery/67967-endometrial-adenocarcinoma-debulking> |
|  | D&C shows in situ you say code 20, what if patient goes on to have hysterectomy and it shows invasive. Do you still use code 20 or do you use code 02 since proved invasive? | We recommend using 02 once the hysterectomy proved invasive cells. |
|  | What would be the correct Diagnostic Staging Procedure code for a "Hysteroscopy and D&C"? | Hysteroscopy is an endoscopic look inside. It is not a procedure that is coded. It would be documented in the “scopes” text field. The D&C is the surgical diagnostic and staging procedure.  STORE Appendix B: For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item  Surgical Diagnostic and Staging Procedure (NAACCR Item #1350).  SEER Appendix C: SEER Note: Do not code dilation and curettage (D&C) as Surgery of Primary Site for invasive cancers.  SINQ 20071070 Assign code 20 for endometrial D&C for in situ cancer of endometrium. |
|  | To code hormonal tx even though SEERx only lists breast? | When the physician documents that the hormone treatment is given specifically due to the uterine cancer diagnosis, it should be coded along with the text supporting it. SEERRx is an ever-changing document as new data is found. NCCN guidelines recommend letrazole in certain groups of patients with endometrial cancer.  We would need to code it in the “other treatment” field since it has not been FDA approved for the treatment of uterine cancer. This strategy is similar to that used for both Goserelin and Lupron administered to breast cancer patients prior to 2017 when they were FDA approved for the treatment of breast and prostate cancers. Here is a SINQ post from 2015 (prior to the 2017 approval of Lupron for breast cancer treatment) which helps with the rationale: 20150026: “Code Lupron given for breast cancer in the "Other" treatment field using code 6 (other-unproven). Lupron is still not an approved hormone treatment for breast cancer and should not be coded in the hormone field.” (Refer to SINQ for the entire post and discussion.) Confirmation received from Ask a SEER Registrar: Yes, code femara as other treatment. Femara has been in several phase II clinical trials and is still not proven to benefit endometrial carcinoma. |
|  | CoC and SEER have a different set of instructions for coding omenectomy. Presentation states that Omenectomy is coded in Surgical Procedure/Other Site field if it is a separte lesion in the omentum, But SEER has a different set of instructions for those cases(SINQ Question: 20091118). What should registrars do? | SEER registries should follow their rules (SINQ 20200009).  CoC facilities should follow STORE guidelines.  <http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/94083-omentectomy-for-endometrial-primary>  <http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/surgery/67967-endometrial-adenocarcinoma-debulking> |
|  | This is histology related for 2018, endometrium bx shows endometrioid carcinoma with squamous differentiation. Resection TAH/BSO finds endometrioid adenocarcinoma, endometrioid type. No neo-adjuvant treatment. Should this be 8570 based on bx or 8380 based on resection? | If the resection is the most representative specimen, then, yes, you would assign the histology according to the resection. Usually the “most representative specimen” is the most cancer tissue found in the path report specimen size. |
|  | To get clarification, would we code 8980(carcinosarcoma) if path indicates only Malignant mesodermal mixed tumor(carcinosarcoma), heterologous” or should it be coded to 8951/3? | In this example, the path uses both words, MMMT and carcinosarcoma. The SINQ instruction said to code carcinosarcoma when both terms are used. |
|  | Would we need an MRI to code cT? If it is considered localized on CT would we be able to use cT1? just not T1a/1b.... | AJCC says MRI is the preferred modality for local staging of the primary tumor. We would assign the cT based on the chapter definitions. AJCC talks more about this in the section titled “TNM Components of Tumor Staging”. |
|  | For the process for assigning histology that Jim sent out, can it change in the future and is there a reference or source where we can look that up? | Anything can change. ICD-O-3.2 will be implemented for 2021 diagnoses, so that will likely require an adjustment to the current instructions. The reference is in the Solid Tumor Rules:  “Since a release date for either ICD-O-3.2 or ICD-O-5 is unknown, the Solid Tumor Editors recommend coding histology using:  • \_The 2018 Solid Tumor Rules  • \_Updated ICD-O histology codes and terms which can be found at: https://seer.cancer.gov/icd-o-3/  • \_The ICD-O  Check the SEER Inquiry system for histology codes because the question may have been answered already (seer.cancer.gov/seerinquiry) When a histology code cannot be identified using the above recommendations, submit a question to Ask a SEER Registrar.” |
|  | How should we code SLN fields if they remove SLN in uterus. SLN fields are supposed to be coded only for breast and Melanoma or can they be used for other primaries as well? | Currently, we don’t code the SLN fields for any sites other than breast and melanoma as per STORE descriptions. The SLN bx would be documented in scope of RLN procedure, RLNs examined and RLNs positive, and in the AJCC N suffix field. |
|  | The radiation guide coded the vaginal cuff HDR brachy as intracavitary, and I see that w/ vaginal cyinder, tandem & ring and tandem & ovoid techniques. But I had a case where the radonc specifically called it interstitial & it was done in the OR w/ tubes/probes directly inserted into vagina. I forget off hand but there was a specific reason radonc stated why that was done. So I did code interstitial for that case. | Yes, you should definitely code interstitial for that case. |
|  | Can you go over the treatment codes from the scenario we had? | We are posting the answers with this Q&A. |
|  | Is high grade serous carcinoma the same as serous carcinoma, high grade? 8461/3 versus 8441/3? | No, those are not the same entities. Reference: SINQ 20200023 “Code histology for this endometrial primary to serous carcinoma 8441/3. Capture "high grade" in the grade field as instructed in the grade coding manual.  "High grade serous carcinoma" has specific clinical and histopathologic features found in ovarian tumors.” |
|  | For the process for assigning histology that Jim sent out, can it change in the future and is there a reference or source where we can look that up?  Isn’t this the same question as #32? | Anything can change. ICD-O-3.2 will be implemented for 2021 diagnoses, so that will likely require an adjustment to the current instructions. The reference is in the Solid Tumor Rules:  “Since a release date for either ICD-O-3.2 or ICD-O-5 is unknown, the Solid Tumor Editors recommend coding histology using:  • \_The 2018 Solid Tumor Rules  • \_Updated ICD-O histology codes and terms which can be found at: https://seer.cancer.gov/icd-o-3/  • \_The ICD-O  When a histology code cannot be identified using the above recommendations, submit a question to Ask a SEER Registrar.” |