**Q&A Session for** **2021 Updates: ICD O 3.2 and Solid Tumor Rules**

December 9, 2020

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| # | Question | Answer |
|  | It was just stated that ICD-O-3.2 changes were adopted in its entirety, but for example "Enterochromaffin-like cell carcinoid 8242/1 to /3" NOT in the NAACCR published ICD-O-3.2 tables? | The tables were developed from documents provided by WHO/IARC ICD-O committee and may differ from other documents. As noted, use 3.2 when the histology is not listed in the 2021 update, solid tumor, or heme rules. |
|  | Deleted codes would still remain in our registry database? or are they converted to new code? | The deleted codes are effective for 2021 diagnoses. They are still valid for pre-2021 diagnoses. They will remain in your database because the codes were valid pre-2021. |
|  | 8323/1 "clear cell papillary renal cell carcinoma C649" is in the WHO table but NOT in tables 1-7. But it IS listed as 8323/3 in STM 2018 (kidney). Does STM 2018 take priority over Tables 1-7 and the WHO table? | This histology remains reportable until otherwise noted in the solid tumor rules. |
|  | If the tables do not identify all the changes what in the full list should we look for to identify the changes not in the tables? |  |
|  | is the excel spreadsheet avail in alpha order by cancer type? | The Excel sheet is in numeric order, starting with 8000. The official ICD O 3.2 spreadsheet is locked by WHO.  |
|  | Table 2 - Dermatofibrocarcoma sarcomatous and fibrosarcomatous dermatofibrosarcoma protuberans both STILL reportable as 8832/3? | Yes. ICD-O-3.2 lists both as 8832/3 (on rows 1460 and 1461). |
|  | Will we have ONE source for ICD-O? In the past we had the purple book only and it was THEE source. Having multiple sources or one source w/multiple errata, it makes for a lot of confusion and errors. | We do expect a .pdf similar to the purple book will be published by WHO. It may be available in early 2021. They will not publish a hard copy of ICD O 3.2. |
|  | Am I understanding 8077/2 grade 2 would include VIN2, VAIN2, AIN2? But NAACCR data dictionary Ch3 table 2 doesn't list them, only the VIN3, VAIN3, and AIN3 list as reportable for standard setters. So VIN/VAIN/AIN2 are NOT reportable? | The table in Chapter 3 of Vol II just states that cases with a /2 and /3 are reportable and says they include VIN 3, VAIN 3, etc. It is not a comprehensive list of neoplasia that have a /2 behavior. We STRONGLY suggest that registrars check with CoC and their State registry and central registries check with their standard setters to determine if they consider these grade 2 neoplasias reportable.Until told otherwise, you should assume they are reportable since they have a /2 behavior. |
|  | Does the SEER Casefinding List for 2021 include and is it in synch with ICD-O-3.2 histology changes so we can find the cases and include all ICD-10-CM codes to go with histo changes - especially those with behavior changes? In other words - Do ICD-10-CM Casefinding Dx Codes match Histo ICD-O-3.2 Updates to behavior and reportable codes so we find all cases? | The SEER Casefinding list has been updated. I don’t know if ICD 10CM has been updated to reflect changes to the ICD O.https://seer.cancer.gov/tools/casefinding/ |
|  | conversely - are the ICD-10-CM codes removed for newly reclassified as not reportable to match changes? | Additional reply for 9 and 10: For specific information concerning ICD-10-CM, submit your question to Ask A SEER Registrar. Be sure to submit under “Other” and indicate your are inquiring about ICD-10-CM.  |
|  | Table 3 - Can you fix the comments when the heme codes have been deleted since 2010 to make it clear or maybe remove them. | The heme database was updated independent of the approval of the changes. For heme/lymphoid neoplasms always check the heme database FIRST.  |
|  | Also 8682/3 parasympathetic paraganglioma (previously 8682/1) and Sympathetic paraganglioma 8681/3 (previously /1)? | Coding instructions for these neoplasms have been added to the H&N Solid tumor rules |
|  | Has anyone considered on online interactive single source for histology codes? We could enter the wording, and the interactive tool could ask relevant questions to lead us to the correct code. This is similar to the heme/lymph data base where we put in the term, year of diagnosis and we get our instructions. Could this be done for ICD-O? | There is a project underway to create a histology database. It is still in the early stages and we are not really sure how it will impact registry operations.We agree that what you suggest would be helpful! |
|  | Can you clarify on date of diagnosis for newly reportable histologies? If the patient diagnosed with GIST in 2020 (non-reportable). Then the patient proceeds with additional work up of the tumor and the diagnosis returns with GIST, is it reportable in 2021 as the term is now reportable? Or is it not reportable at all? What is date of diagnosis? | The behavior would be based on the date of the initial diagnosis. If the GIST, NOS is initially diagnosed 2021 or later, then a behavior of /3 should be assigned. If the GIST, NOS was diagnosed prior to 2021, then a behavior of /1 would be assigned. If the patient returns for work-up or tx after 2021, we would still base the behavior on the date of the original dx. We would only change the behavior if the patient developed metastasis or the physician referred to the disease as malignant. In that case, the dx date would be based on when the disease was determined to be malignant. |
|  | If we have a Thymoma, NOS (C37.9) and no malignancy stated. Do we change to 8580/3? thank you! | If the thymoma NOS is diagnosed on or after 1/1/2021, it is reportable as 8580/3. For thymoma NOS diagnosed prior to 1/1/2021, it would only be /3 if it is multifocal or has LN or other mets. |
|  | 8452 Solid pseudopapillary neoplasm is only behavior /3 for pancreas specifically, right? Ovary would be /1 and not reportable? | Solid pseudopapillary tumor of the ovary is 8452/1. Solid pseudopapillary neoplasm of the pancreas is 8542/3. |
|  | Will these tables update mid 2021 or can we rely on them throughout 2021? | The tables may be updated to make corrections. We will not add any additional changes to codes, terms, etc. |
|  | Do you use Preferred term or Related Term as dx. Example Acinar Adenocarinoma vs adenocarcinoma. both are 8140/3 | Preferred term, related term, or synonym as they are listed in the ICD O 3.2 table or in the ICD O 3 implementation  |
|  | Can you please put an explanation at the beginning of this table, and if needed a hierarchy, when to use this ICD0 table, when to use MPH if they differ | Some of the tables have solid tumors and hematopoietic/lymphoid neoplasms. For solid tumors, use the Solid Tumor Rules first to code the histology. If you cannot find the histology in the Solid Tumor Rules, search the term in ICD-O-3.2. If the case is diagnoses prior to 2021, consult the update tables to confirm reportability and the correct code. For hematopoietic neoplasms, just use the heme database because that will tell you whether the diagnosis is reportable and for which years it is reportable.  |
|  | Would you please explain the true and false wording on the annotated list?  | The annotated histology was developed for use in software. True tells the computer term is the preferred term for each histology code. That really doesn't impact the registrar. The software may display the preferred term next to the histology code. |
|  | Have the edits been updated to handle what is reportable and what is not by diagnosis year? | Yes. We updated them as much as we can. |
|  | So because VIN/VAIN/AIN2 are now behavior /2 they ARE reportable? | They have a reportable behavior. You'll have to contact your state registry or standard setter to determine if they are going to require these cases. |
|  | Can I not make the changes in my old ICD purple book and keep using it with the changes noted and the dates of the changes? | I don’t think that is a good plan, as there are many updates. For the most part, you will be able to code the histology from the Solid Tumor Rules. For heme diseases, you will always use the hematopoietic database and manual. |
|  | Is it a good idea to download tables now? Are they going to change? thanks | I would wait to download the tables because there may be some updates. Or, you could download them, just to practice with them, but make sure you have the most current iteration of the table when 2021 comes around. |
|  | Is Squamous intraepithelial neoplasia, grade II (8077/2) for vulva and vagina reportable? | You will need to check with CoC and your Central registry if you work in a hospital. If you are a central registry, check with your standard setter. |
|  | Can you show example of how you would find the correct histology code... 01-01-2021 Islets of Langerhand bx+islet cell adenoma... What should you do first??? Actually show the process... 1.Solid Tumor Rules, it's not there... so what should we do next?? Check Table 1-5 or go directly to 2021 ICD03.2 Excel Table/ the annotated list?? What's the best process to save time? People get overwhelmed when trying to determine what to do do when??? | 1. Use the Solid tumor Rules (In this case, use the Other Sites rules, and Rule H11 to code the histology.)
2. Search ICD-O-3.2 for islet cell adenoma. It is on row 332 and has a code of 8150/3.
3. Assign the histology: 8150/3
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|  | Follow up to answer - I'm sorry I cannot find info on 8682 and 8681 in H&N STM: https://seer.cancer.gov/tools/solidtumor/Head\_Neck\_STM.pdf. Do you mean that there will be a pending UPDATE to the STM H&N? | They will be updated for 2021, and that should be coming out soon.  |
|  | Where are these tables listed at? | https://www.naaccr.org/icdo3/ |
|  | GIST and Thymoma they are reportable regardless of Multiple tumors or Mets from 2021? However, in the STORE manual update webinar few weeks ago they had mentioned that there is no changes for GIST and Thymoma reportability. | Yes. GIST and Thymoma are reportable as /3 regardless of multiple tumors or mets, effective with 2021 diagnoses. There are two thymomas that are still /1 in 2021, so just check the histology in ICD-O-3.2 to ensure reportability. (STORE will be issuing an update about GIST and Thymoma. We got confirmation of this the morning of December 9, 2020.) |
|  | Do we no longer need to use any of the 2018 and/or 2014 ICD-0-3 histology tables from those implementation periods? | That is correct. YAY! Just use the STRs with ICD-O3.2 for 2021 diagnoses. The same goes for pre-2021 diagnoses, but for those, we need to check the update tables to ensure we have the correct histology code and behavior. For heme cases, just use the heme database for any year. |
|  | When Jim is searching in the 3.2 table, is that the annotated table? | That was the official ICD O 3.2 table. |
|  | can you go back to case 4 niftp, I saw a note and it went by too fast. was this reportable in 2018--19? | Sorry. This term was previously coded to 8343/2 and was reportable. This term has changed both ICD-O and behavior codes and is no longer reportable for cases diagnosed 1/1/2021 forward. |
|  | Oat Cell CA listed as 'obs' obsolete on table. Should we use this code for 2021? | If that is the only term the pathologist or physician is using, then you can use that term to assign the histology. The "obsolete" is more for the pathologist or physician. It indicates there is probably a better term they should be using. |
|  | can we please go over practice cases 4 and 5 again? i thought NIFTP'S WERE REPORTABLE AND IN CASE 5 OAT CELL WASN'T USED ANY LONGER? | You are correct. NIFTP's are no longer reportable effective with 2021 diagnoses. That is what we ultimately found. Oat cell carcinoma is not a term a pathologist should be using anymore, but if that is all we have we can use it to assign a histology. |
|  | What does the obs mean in the row? | The [obs] descriptor is intended to discourage the use of such a term for a new diagnosis when better diagnostic terms are available. If a term marked [obs] is diagnosed, it may certainly be coded, although it is likely that a more current term is available. If the [obs] term is a reportable malignancy (typically /2 and /3 behavior codes), DO it must be included in the registry even though the terminology is out of date. Furthermore, [obs] serves as a reference when such a diagnosis is noted during research using historical data. Some terms are older names for neoplasms that have been more specifically described, for example argentaffinoma [obs] which is now described as carcinoid tumor or grade 1 neuroendocrine tumor with additional codes for several variants. Others are truly archaic, such as lymphosarcoma (first described in the 1890s, although the term is still used in veterinary medicine). In many cases, obsolete terms that had specific codes in ICD-O-2 have been moved to the ‘Not Otherwise Specified’  |
|  | Can you sort alphabetically, then search by term, like "aggressive"?  | The official ICD O 3.2 excel spreadsheet does not allow you to sort. |
|  | What I am asking about ICD-10-CM is - will medical coders know there have been changes to classification/behavior to correctly assign the ICD-10-CM code as now malignant or now borderline with 2021 changes. Or are there any new/deleted ICD-10-CM DX Codes that are specific to any of the ICD-O-3.2 changes...including granularity in ICD-10-CM individual codes rather than just ranges - every code needed for case finding to find them all...maybe this is not an issue?? | I don't know. I certainly hope so. I would guess they had implemented these changes well before the registry community. |
|  | Is pituitary considered CNS or endocrine? | It is an intracranial gland, so it is included with the primary sites that we have to report /0 and /1 behaviors. See STORE and SEER Coding Manual. |
|  | Response from Lois to my question was “see ICD-O-3.1, page 10, section 3.11 for definition of obsolete in ICD-O”. Can you provide an easy access link to ICD-O 3.1? | I copied the text from ICD-O-3.1 into the answer box for question 35. If you would like to download a copy of ICD-O-3.1, you can get it from this link: [ICD-O 3 (1st rev)](https://apps.who.int/iris/handle/10665/96612) https://apps.who.int/iris/handle/10665/96612 |
|  | Do you have the link for what you were typing in your histo on the practice cases? What I am looking at isn’t the same. | The histology will show up on the final copy of the presentation which will be posted with this Q&A document. We didn’t want to include the answers before the presentation. |
|  | Do solid tumor rules make it clear what to do if the pathology report states early/evolving melanoma, but does not specify insitu or invasive? | No. You will need to review the pathology report (gross and micro) OR follow back with the pathologist.  |
|  | Not in the melanoma 2021 STM but for psite, pre-auricular is cheek (C443) and post-auricular is neck (C444)? | The site tables are based on ICD-O-3.2 and input from out dermatopathologist. The table may not include all anatomical terms and corresponding C codes. Per-auricular is directly in front of the ear and not the cheek. Post-auricular is directly behind the ear. |
|  | Our case finding is semi-automated and in real time (i.e. we case find on current path reports and discharge messages), so we are updating our case finding terms THIS MONTH in preparation for Jan 2021. Any tips on key updates so we minimize amount of missed cases? For example, we will add "thymoma". | Would suggest adding the NOS terms that are now reportable.  |
|  | WOULD you please go over that slide with the melanoma on the front of the person and on the back of the person. You said this was one primary. Is That correct? | Yes. The melanomas are synchronous, have the same laterality and the same site code, so they are a single primary per rule M6. See Example 1 under Rule M6.  |
|  | Does note 3 for rule M4 apply retrospectively on PRE-2021 cases? For example, in situ melanoma of right AND left scalp w/in 60 days would be single primary? | No.  |
|  | Does Rule M7: Multiple Melanomas include in situ Melanoma that occurs more than 60 days apart after an invasive melanoma is a multiple primary? | Yes. The neoplasms may be both invasive or in-situ or a combination.  |
|  | During this time of pandemic, would you still apply a 2nd primary if the patient was diagnosed with in-situ, but the surgery was delayed by 90 days due to COVID? | We suggest you check with the appropriate standard setter (who you submit data to). To our knowledge, determining multiple primaries based on timing has not been changes due to Covid-19.  |
|  | The 2021 cutaneous melanoma Solid Tumor Rules says that C444 needs a laterality it says (new) besides it. However, C444 is not in the laterality table in the 2021 SEER manual. Will the laterality table be updated to reflect the change? Or laterality code other than 0 is still not required for C444? | The Laterality section of the SEER manual states: Laterality may be coded for sites other than those required in the table. For example: Code 2 may be assigned for a tumor originating in the left lobe of thyroid. We expect the manual will be updated for 2022.  |
|  | What about procedures done to the same primary over 60 days that we know are of the same primary. Ex. Shave bx and gross resection done on day 70 after the shave bx. With same behavior? and with the ones that have different behavior? | A single melanoma is always a single primary. If the initial DX is in situ but resection indicated invasion, then keep the original DX date and update the behavior to /3. See the 2021 SEER Program Manual, page 15, “Changing Information on the Abstract” |
|  | Pls correlate M7 Note 1 and M8 Note 2 in Multiple Melanoma Rules. | These are long-standing rules for cancer surveillance. In practice. Hopefully you will seldom use M8 |
|  | H8 wouldn't apply if there's a different histology from biopsy versus wide excision, correct? Because the "more representative specimen" takes precedence? | Correct. If you get to M8, go back through the rules again. M8 is a default rule. |
|  | Often times in cutaneous melanoma the biopsy takes more of the specimen than the wide excision in terms of material. How to determine "most representative specimen"? Do we go by sizes in the gross description of the path report or something else? | Use the specimen that provides the most **tumor** for exam.  |
|  | If there is time, can you go back and explain a little more about no longer using ambiguous terminology? If not, can you clarify in a Q&A document the specific change in the use of ambiguous terminology. | At the request of our pathology experts and other pathology organizations, we revised the rules to disallow the use of ambiguous terminology to assign histology. WHO and CAP have specific criteria that must be met to determine histologic type and pathologists are “strongly” encouraged to provide definitive diagnosis. The current Solid tumor rules no longer allow ambiguous terminology unless the case mets criteria noted in each set of rules.  |
|  | What would you assign for High-grade urothelial carcinoma with focal areas of high-grade neuroendocrine carcinoma in Bladder? | See Urinary **Rule H4:** Code mixed small cell carcinoma **8045** when the final diagnosis is any of the following: • Small cell neuroendocrine mixed with any other type of **carcinoma** (does not apply to sarcoma) • Two or more subtypes/variants of small cell neuroendocrine carcinoma • Subtype/variant of small cell neuroendocrine mixed with any other **carcinoma** (does not apply to sarcoma)  |
|  | Do we pay attention to "focal" foci"? | No. Per all of the solid tumor H rules, ignore focal, foci, and focus.  |
|  | Do you think that the time needed to use the manuals has decreased, increased or stayed the same? | Addressing the Solid Tumor rules: Historically, there were only a few rules (developed by WHO) that were used to code complex histologies and determine multiple primaries. As the science of identifying new histologic types, biomarkers, and genetics grew, correctly capture these neoplasms needed to keep up. This resulted in the 2007 MPH rules. Science didn’t stop and the next step was expanding MPH to Solid Tumor rules. Cancer surveillance has become more complex. Registrars now must satisfy both the cancer surveillance and treatment/care communities. For the foreseeable future, the time needed to understand and apply the manuals will likely increase.  |
|  | Where may we download the excel spreadsheet for the 3.2 changes?  | https://www.naaccr.org/icdo3/ |
|  | Just to be clear, the 2018 STM changes/updates that Lois is going over currently are applicable for 2018+ but registrars are NOT to go back and change cases? |  Correct. The changes are clarifications. If a new histology was added to a table, instructions have been provided on how to code pre 2021 cases.  |
|  | The MPH Solid Tumor Rules were initially stated to have been developed back in 2007 with goal of automation in software for central registries who use MP rules and H rules for matching and consolidation - but, they still are developed for abstracting and QC but not for automation in a central registry to manage lots of abstracts from multiple facilities to apply these rules - any chance this will ever been done with central registry/non-manual abstracting to support automation with defined logic rules?? | The editors of the Solid Tumor rules are not responsible for developing automation software. Our obligation is to ensure multiple primaries are reported correctly, incidence data is stable, and histologic types identified for research purposes. |
|  | Have all these changes to the MP documentation discussed other than melanoma been posted? Is there a change log that describes all these changes, or do we have to depend on Lois's presentation? | The updated manual was posted December 9, 2020, after this webinar. The change log is available on the page where you download the rules. |
|  | Where did you say that the melanoma solid tumor rules for 2020 are, now that the 2021 ones are there? | https://seer.cancer.gov/tools/solidtumor/ |
|  | When are software vendors going to have the new/updated histologies? | Vendors were provided documentation to update their software in mid-summer 2020.  |
|  | Note 2: Why would we use the 2021 rules when the diagnosis date is 2020? Shouldn't the same rule set be used for all cases diagnosed in the same year for data analysis purposes? | Here's what Melanoma, Note 2 says: The original tumor diagnosed before 1/1/2021 and a subsequent tumor diagnosed 1/1/2021 or later in the same primary site: Use the 2021 Solid Tumor Rules. |
|  | Will updates to ICD 0 3 be made in the existing tables so it will be ICD0 3.2.1, then 3.2.2 and we don't have to use two documents? | Not at this time.  |
|  | Will the flowchart version of the MP ever come back? For those that are automating or attempting to automate MP what is given is very difficult to work with. | Funding for development, labor, and maintenance of multiple formats has not been approved in budget requests. We do not anticipate providing flowchart or matrix formats any time soon.  |
|  | For coding histology cases diagnosed 2018 + would we ever need to use anything other than ICD-O-3.2 and the 2021 update tables and the Solid Tumor Rules (together)? | There may be some rare cases that you might need to submit to Ask a SEER CTR. |
|  | just making sure...have the solid tumor rules have all the new codes and behaviors starting jan 1 | Where applicable, new codes/terms have been added to the tables. Please note, not all new synonyms and related terms have been added. The majority of changes apply to sites included in “Other”. |
|  | The first statement of Note 2 says: Note 2: 2007 MPH Rules and 2021 Cutaneous Melanoma Solid Tumor Rules are used based on date of diagnosis. It conflicts with the third bullet point that is my second comment, which is what my question (first comment) is about. | The third bullet applies when there are two melanomas, one you know was diagnosed prior to 2021 and one 2021 forward. The rules you use are based on date or dates of diagnosis. Follow the instructions for which rules to use.  |