Q&A Session for Hematopoietic and Lymphocytic Neoplasms

April 14, 2022

#	Question	Answer
1.	Should code 9875/3 (chronic myeloid leukemia, BCR-ABL1-positive) be added to the list of codes/histologies for which the DX confirmation code must always be 3 (Histo PLUS)? You need a positive genetic test to code CML, BCR-ABL1 +, or any of the alternate names for this code.	I will confirm with Jennifer Ruhl. 9875/3 may have been inadvertently omitted from the list in Note 2 under Code 3, and, if so, I will also ask her to take a look at the abstractor notes for this histology to see if they need to be updated. Thank you. Great point!
2.	Diagnostic confirmation: For Multiple Myeloma, if the BM BX final DX is ''Plasma cell neoplasm/dyscrasia'' but Immuno/genetics is done and the treating physician concludes to a DX of MM, what would be the code for DX confirmation, 3 or 7?	Use diagnostic confirmation code of 3, because the physician reviewed the tests, then interpreted the positive tests to establish the diagnosis.
3.	How do you know which information is relevant to pull from the different lab tests and path reports to document in your text for the lab and path text fields for each histology?	Look in the heme database to see which tests are used for that histology and document any of those that were performed. Also, if the physician used a test not listed there to confirm the diagnosis, list that one. Hopefully, that is what you were asking.
4.	Can you confirm that we do not code aspirin for ET?	We collect blood thinners, anticoagulants and/or anti-clotting agents (if which aspirin is included) for essential thrombocythemia 9962/3 ONLY. This is per SEER*Rx “Remarks” and the heme manual page 26. The therapeutic dose of aspirin for essential thrombocythemia is in the range of 70-100 mg/day (this is considered low-dose).
5.	Had a CNS lymphoma (DLBCL) case yesterday (brain psite per rule PH24), imaging show at least 3 tumors in brain, and surgery was done for the largest of the 3 (pt symptomatic). Per op notes "gross total resection" done but since it was only 1 of the 3 known tumors I coded surgery code to 21 (brain code; sub-total resection of mass in brain). Is that correct or should it be code 30 (radical/total/gross resection tumor)?	When it is known tumor is being left behind, we really should not code a gross total resection. THAT tumor was a gross total resection, but there you have the other 2! Be sure to document this in the text to explain the code. We really don’t have a good code for this when there are multiple tumors.

6.	Is Donor leukocyte infusion listed in the SEER*Rx Drug Database?	It's not a drug, so it is not listed in SEER*Rx. They put that information in the Heme Manual to help us with coding DLI. You can find the instructions on page 26 in the Heme Manual.
7.	It would be helpful to learn more about what constitutes "genetic testing" and "immunophenotyping." Some examples and screen shots of various tests would be good; we sometimes get several outside tests relating to the diagnosis, and they aren't easy to read. What should we look for?	There are lists of genetic tests and immunophenotyping test in the heme db. I will pass this on to Jennifer Ruhl as she may be able to put some examples in the heme manual.
8.	Be nice in the Heme Manual if the "exception" notes could somehow be highlighted-different font-something or anything to make them stand out more- to me they kind of get lost in all the notes, etc...	I will pass this on the Jennifer Ruhl, as the exceptions can get easily lost in the rules.
9.	How would you deal with a follicular lymphoma grade 2 transforming into DLBCL per pathologist yet the hematologist prefers to call it a double hit lymphoma?	Double-hit lymphoma (DHL) is an aggressive type of B-cell non-Hodgkin lymphoma (NHL) characterized by rearrangements (parts of genes switch places within chromosomes) in two particular genes. One rearrangement involves the MYC gene, and the other involves the BCL2 gene or, less commonly, the BCL6 gene. According to the heme db, double-hit lymphoma is an alternate name for DLBCL. Follow the MP rules in the heme manual to determine the number of primaries.
10.	For Case Reportability, some of the /0 or /1 behavior code would still be reportable if the primary site is CNS/Brain, correct?	That is correct. Langerhans, NOS is one example of that. If it occurs in the CNS, it would be reportable. Any /0 or /1 behavior with primary site in the CNS/brain/intracranial glands is reportable.
11.	For assigning primary site for lymphomas - PH22 coding the site to C77.9 when nodes and an organ are involved (specifically bone marrow, as in example 2). When can we consider it as part of the primary site for C77.9 and when do we consider it as mets and report stage IV, but not consider it when assigning primary site?	Rule PH22, example 2 applies when there is lymphoma in LNs and bone marrow (**no organs** involved). We would code the primary site to LNs NOS C779 because we don't have clear information about where the lymphoma originated (which LNs are involved). Since we are coding the primary site to LNs NOS (when we don't know which LN chain(s) is/are involved, or to the specific LN region(s), when known, the bone marrow involvement would be recorded in the staging fields.

12.	In the Heme Database, in the Transformations To and Transformations From areas - could the terms "Acute" and "Chronic" be included with the title - like Transformations From could be labeled something like Transformations From (Chronic)- not sure just thinking out loud -be nice to have Chronic and Acute somehow in the titles	I will refer this suggestion to Jennifer Ruhl, as this would be an easy update.
13.	Would you put the website for the annotative ICD-0 list in chat.	https://www.naaccr.org/icdo3/ It's the last link on the page.
14.	Will or has the ICD O 3.2 Coding Table Excel and Annotated Histology List been updated with 2022 histology codes?	The ICD O 3.2 coding table is based on WHO 4th Edition, while the 2022 updates are based on the WHO 5th Edition. They will not be updating that Excel table for that reason. The Annotated histology list has been updated. Annotated Histology List 7/29/21
15.	Re: histology text, I know at least one vendor software with an option to auto-populate psite and histo text based on codes. So registrars may not always update those two text fields. Thank you for the info about up-and-coming NLP/text-data mining.	Correct, but we would want to make sure we have the exact diagnostic term when multiple terms share the same histology code or multiple primary sites share the same topography code.
16.	Would you suggest the different Burkitt lymphoma types be coded in the text-histology title field or in the pathology section?	I would put it in the text-histology section, but either place. It should also go in the pathology section since that is the diagnosis.
17.	For Mets at Dx, if primary site is extranodal (ex. stomach) will 8's still be used?	We think your question is about a lymphoma in the stomach or other extraodal site. For a lymphoma in an extranodal site, code the mets at dx fields to something other than 8. If you have a lymphoma coded to LNs, you would code all mets at dx fields to something other than 8, EXCEPT for the mets at dx – distant LNs field.
18.	Is it okay to say HIV neg based on a rapid test, I don't see any specific instructions that say otherwise? thanks	The instructions do not specifically address the type of test. They say the source documents are a clinical laboratory test or a statement in the medical record. BUT, if a patient has ever had a positive HIV test, this field would be coded to HIV positive.

19.	On page 96 The AML code "pre" 2022 is 9896 and "post" 2022 updates is 9861. Are we to use the 9896 prior to 2022 and the 9861 after 2022?	No. This particular neoplasm (AML w/ recurrent genetic abnormalities NOS) was misclassified with 9896/3. Use the heme DB and manual, which will help you code the histology accordingly. Remember to choose the year you want. For this one, it doesn't matter because even though it was in another histology before, that was an error.
20.	Completely agree about putting in correct histo text. Question regarding tx, sometimes I see re-induction therapy and also tandem stem cell transplants, usually due to sub-optimal or incomplete response first time around. As long as there's no progression it is all first line of therapy?	Yes, because the treatment plan evolves as they wait to see how the patient responds.
21.	I'm a student and cannot remember what the abbreviation EOD means. Can you tell me?	EOD stands for Extent of Disease. If you are interested, you can find the EOD manual at https://staging.seer.cancer.gov/eod_public/manuals/2.1/"
22.	Is it correct that if there is NO RISS stage - for example a "smoldering myeloma" that we do NOT have to do any of the SSDI's?	We assign code 5, which is a new code that was added to those SSDI tables in 2021.
23.	If I understand it correctly, the stages for Plasma Cell Myeloma are not coded under the AJCC fields and the components of the stage are collected in the SSDIs only.	That is correct. We collect the information for the RISS stage in the SSDI and assign the AJCC stage in the AJCC prognostic field.
24.	Pt is diagnosed with t-MN (following a long MTX treatment for psoriasis). After a few months of treatment (Vyxeos), physician states the disease is refractory to vyxeos and proper analysis shows the disease is now leukemic (blasts over 20%). Physician transfers pt for Stem cell transplant. Do we abstract two primaries (t-MN + AML) or just one (t-MN)?	The answer depends on whether the AML is therapy-related. If you have t-AML, this would be the same or a new primary depending on which rule applies of rules M8-M13.
25.	Does it also stand for evidence of disease?	I have not seen EOD used like that, but I can see how we could use EOD for evidence of dz. EOD is not listed as an approved abbreviation for evidence of dz. E/O can be used for evidence of. Also NED stands for no evidence of dz.
26.	What's the passphrase for the quiz?	myeloid
27.	Suggestion for future training. How about showing a demonstration of abstracting a case and showing the different	Excellent. I will pass this on to Jim!

	manuals needed to complete that case? This would be helpful for new registrars as well as students but is also good for others	
28.	Can I ask what version of the manual we are using for this webinar?	The 2021 version. I just clicked the link from the SEER website and it states it was published August 2021. Also, August 2021 publish date is listed when you click the link to the manual from the heme database.
29.	If the immunophenotyping or genetic testing uses ambiguous terminology but the heme oncologist is calling and treating it as that specific histology would I code it specific morphology with a 3-plus histology?	When there is a specific histology described by ambiguous terms plus a NOS histology, we code the NOS. However, to your question, if the physician confirms the more specific histology, we can code the more specific histology.
30.	Can we assign a plus histology diagnostic confirmation 3 when there is histology confirmation but immunophenotyping result on the pathology states the immunophenotyping is consistent with (ambiguous term) states this is a B-cell Non-Hodgkins lymphoma of follicle centre cell derivation?	Sorry. We are a little confused about this question. If the immunophenotyping has an ambiguous term, but the physician states that is the histology, code the histology. If this is not what you are referencing, kindly follow up with us.
31.	Basically, if an ambiguous term is used on the genetic or immunophenotyping diagnosis, can we use the diagnostic confirmation 3 plus histology?	No, we cannot use that in and of itself for diagnostic confirmation code 3. The heme manual (page 19) states “Note 1: Do not use code 3 for positive immunophenotyping or genetic testing identifying a more specific histology when preceded by ambiguous terminology. Note 2: Do not use code 3 for positive immunophenotyping or genetic testing identifying a more specific histology when the test result is preceded by "patchy weak staining." If the physician reviews the immunophenotyping or genetics information and comes up with a diagnosis, even when the tests are described by ambiguous terms or patchy weak staining, we could then use code 3.
32.	Is there a timeline for stem cell transplant for 1st course treatment?	As long as it is part of the planned FCOT, and there has been no progression, the time does not matter.
33.	How do you know when a complete workup is done for a heme neoplasm? Is there an average time?	Good question. In general, when treatment starts, the workup is over. Normally, the workup would be complete in 3 months or less. It just depends on the type of facility and other factors.

34.	I get really hung up on the ambiguous terminology when the pathologist says morphology and immunophenotyping are consistent with _____ so this would just be diagnostic confirmation 1	Unfortunately, if that is all you have, and no physician statement, it has to be code 1. If the physician looks at those tests and decides the patient has the particular diagnosis, you can use code 3. Try to get the physician's office notes if the physician is not in your facility.
35.	Ok different rules regarding ambiguous terminology for histo and dx confirmation. Can only take the heme dr usage of the specific morphology dx with using ambgious terminology on genetic/immuno testing for coding the morphology and not plust histo	If a physician reviews the tests, and confirms the morphology, you would assign code 3.
36.	Is the mets at diagnosis only to be coded for stage 4 lymphomas?	No. There is a mets at dx code in all of the mets at dx fields for no mets. The STORE manual has tables of which primary sites and histologies should be coded to 8 or other than 8.
37.	Are we now required to figure out the RISS stage for Multiple Myelomas? Previously we were not and the DLL only had "88" as a choice. With the V22 DLL Clinical Stage now lists the choices of RISS staging. There is no longer a choice of "88". Are we to figure this out using the high risk cytogenetic SSDI information and the AJCC Prognostic Stage Group table in the AJCC 8th edition on page 985?	That is correct. 88 is no longer a valid value for clinical stage group for multiple myeloma. If the stage is unknown, assign a 99. If the stage is known, assign the stage group.
38.	For cll/sll can we assign primary site as c42.1 if patient has lymph node involvement and peripheral blood has lymphocyosis or do we need a peripheral blood smear or bone marrow confirmation of cll?	Lymphocytosis, without a dx of CLL/SLL is not the same thing as CLL. Lymphocytosis can result from infections, etc. We should not assume peripheral blood involved with lymphocytosis is the same thing as peripheral blood involved with CLL/SLL.
39.	Followup so your 2nd case you gave a AJCC RISS stage of 2 and say that as of 2018+ we need a RISS stage. So do we need to go back to those cases and now provide a RISS stage?	No. Prior to 2022 diagnoses, you are not required to assign RISS stage. You probably already put any RISS stage documentation in your staging text field.
40.	Pathologist's use the term 'Consistent with' all the time when diagnosing heme cases based on morphology combined with immunophenotyping. It doesn't seem right to just say this was diagnosed by histology only.	WE cannot code based on ambiguous terms; however, if the physician documents the dx in their office notes, you could request a copy which would allow you to code dx 3.

41.	In SSDI lab levels, do we always use labs at/after dx and prior to tx or can we use labs prior to dx? In other words, when is cutoff date for lab usage? For example, HIV status is in SSDI, but may have gotten tested a month prior to dx. Can we use?	For the lab values, the timing is normally up to 3 months before diagnoses. For the HIV SSDI, Note 5 says "If patient has a history of HIV, assign code 1 even if HIV is not currently detectable."