Q&A Session for 2022 Solid Tumor Rules

August 8, 2022

#	Question	Answer
1.	Breast module- can you discuss issue for instructions in Changes from 2007 MPH Rules, 3A-Subtype/variant, architecture, pattern, features, not coded for dcis; however, the histology table has a subtype/variant code 8230/2-dcis solid type.	***Note 2:*** Subtypes/variant, architecture, pattern, and features **ARE NOT CODED**. One reason the /2 subtypes are listed is because we need them to determine a single versus multiple primaries for M13. Some WHO histology terms may include the word "type" (example: Intraductal carcinoma, solid type). If the diagnosis states Intraductal carcinoma, solid type, assign 8230/2.). While not a common occurrence, WHO does include some terms like variant, for example, in the "Official" histology name. I have confirmed this with Lois.
2.	Please also discuss in breast module rule H5-code 8500/2 when there is a combination of DCIS and any other carcinoma in situ versus the histology table for synonyms for papillary carcinoma-8503/2 table shows synonym as intraductal papillary carcinoma w/DCIS. Is this an exception to the instructions in H5?	Intraductal papilloma with ductal carcinoma in situ 8503/2 is a single histology term. H2 states to code the histology when a single histology is present. This is not an exception to H5 because H2 is the first rule that applies. If you look at the Specific Term (column 1), this histo type is papillary carcinoma; the synonyms (column 2) include DCIS with the papillary.
3.	Could you go over the rule governing the handling of microscopic foci when determining how many primaries there are, pls.? The answer to SEER SINQ 20200033 has confused me. Are we only to ignore the microscopic foci when the foci and tumor have the same histology?	SEER SINQ 20200033 addresses separate foci of DCIS spanning 12 cm. They are not saying these are microscopic foci. They are simply saying there are multiple foci of DCIS spanning an area covering 12 cm. Since the DCIS and invasive mucinous are on different rows, this represents multiple primaries per M14.
4.	Does the timing rule still apply when the patient's primary site no longer exists? For example, woman s/p mastectomy found recurrent at the chest wall after 5 years and not described as metastatic. The assumption was that there was residual breast tissue remaining after clinically complete removal of primary site. Recurrent or new primary?	If the pathology report states the tumor originated in **residual breast tissue,** then this is a new tumor and, therefore, a new primary per rule M5. If the pathology report stated the tumor arose in the **chest wall** and/**or there is no designation of residual breast tissue**, then this is a regional metastasis and not a new primary.

Commented [DL([1]: Correct.

5.	How do you determine if a patient is disease free for the timing rules? The CAnswer Forum seems to indicate that the Cancer Status can only be changed to code 1-No evidence of this tumor if the physician states that the patient is NED.	According to the breast STRs, **Clinically** disease-free means that there was **no evidence** of recurrence on follow-up. • Mammograms are NED • Scans are NED • Physical exams are NED* • Tumor markers are NED (for breast, CA27-29)* *Only MMG and scans are listed in the STRs because they are the most common method of follow up for breast cancer patients. I checked with Lois and she said "Any statement of NED can be used: PE, lab tests, path or cytology from same or other sites, etc. The underlying assumption for the STR's is we assume the patient does not have recurrence until we find something saying there is recurrence. The underlying assumption for Cancer Status is that patient still has disease until we have a physician statement of no disease. Because the underlying assumptions are so different you cannot apply the STR rules to Cancer Status or vice versa.
6.	Slide 29 Synchronous S/N--C Tumors on Same Row...Multiple subtype/variants as a single primary: which histology code is selected...higher? more specific?	The same row does **not** include multiple subtypes/variants. When multiple subtypes/variants are present, stop at lung rule Rule M6. In the lung rules, the same row is defined as: The same histology (same four-digit ICD-O code) **OR** • One is the preferred term (column 1) and the other is a synonym for the preferred term (column 2) **OR** • A NOS (column 1/column 2) and the other is a subtype/variant of that NOS (column 3) Although this next definition of the same row does not apply to the lung rules, in some of the site-specific STRs, the same row also includes: • A NOS histology in column 3 with an indented subtype/variant

7.	For the Most Specific Histology quiz, #1, shouldn't the histology code for Endometrioid be 8380?	Yes. Typo. Sorry.
8.	Two breast tumors, one invasive and one DCIS with Paget. Code invasive or Paget?	There are 2 breast tumors. One is invasive (I am assuming duct /NST) and the other is DCIS with Paget. Abstract 2 primaries: One for duct/NST and the other for DCIS with Paget. This follows rule M14: abstract multiple primaries when separate/non-contiguous tumors are • On **different rows** in **Table 3** in the Equivalent Terms and Definitions • A combination code in **Table 2** and a code from **Table 3** This rule applies whether the DCIS is w/ in situ Paget (8543/2) or the DCIS is with invasive Paget (8543/2).
9.	for the quiz on histology for the renal cell ca w/minority clear cell - following the kidney STR rules - I come up with clear cell as the rules allow for minority per the notes -	I see renal cell compatible with clear cell. It is coded to renal cell because the clear cell does not describe a carcinoma or sarcoma. It just says clear cell. There are clear cells in many renal cell carcinomas. The clear cell (without the carcinoma term) could be describing features or differentiation. If it said renal cell carcinoma with minority clear cell **carcinoma**, we would code the clear cell carcinoma.
10.	Lots of confusion with code 8522. Can you provide some clarification as to when that can and cannot be coded? If final dx is mammary carcinoma w/ ductal and lobular features do you code the mixed code or does it have to specifically state in synoptic "mixed" ductal/lobular.	H3: Code DCIS and LCIS to 8522/2. H15: Code invasive duct and invasive lobular to 8522/3 Note 1: CAP uses the term **Invasive carcinoma with ductal and lobular features** ("mixed type carcinoma") as a synonym for duct carcinoma/carcinoma NST AND invasive lobular carcinoma 8522/3. Mammary w/ duct and lobular features is coded to 8522 per Note 1. Table 2 also has a note 2 stating: ***This is the exception to the instruction that features are not coded***.
11.	Wouldn't, > one segment of colon involved be an overlapping lesion, if a single lesion?	The rules say C189 for > 1 segment of colon involved. See Colon rule M3. Overlapping lesion codes are only used when a SINGLE tumor overlaps boundaries and the subsite cannot be determined.

12.	Could you address Paget's as being /3. We asked our pathologist and they tell us it's in situ.	The STRs state "Paget disease is classified as malignant /3 in the ICD-O. Paget disease is coded as in situ /2 ONLY when the pathology states the Paget disease is in situ." If your pathologists say it is always in situ, you would need to put that in your P&P to allow you to code it to /2 when they don't specifically state the behavior on the path report. And, be sure to back that up in your text documentation.
13.	To keep us on our toes, for 2022, SEER & NPCR states are collecting adenomatous polyp, high grade dysplasia 8210/2 as reportable for stomach and small intestines but CoC is NOT collecting.	Correct. SEER, NPCR, and CCCR are all collecting HGD 8210/2 for stomach and small intestine, but CoC does not want those cases.
14.	On slide 65 - Colon Rules for Anastomotic Recurrence MY-M8: Multiple Tumors Module Note States: *For cases diagnosed prior to 1/1/2021, the time interval is > 24 months (M7), ≤ 24 months (M8). Previous slide stated 1/1/2022. Which is correct?	The updated STRs say 1/1/2022. That's how I learned my lesson about downloading the manual. I sent in a question about the year (because the initial release of the STR manual said 1/1/2021), and they asked if I was using the most current version of the manual! Slide 65 should say 1/1/2022. I am not sure if I understood your question, but hopefully this helps.
15.	I think the Solid Tumor Rules are confusing for picking the behavior code for LAMN and HAMN. My software gives me an edit if I code behavior /2 with a SS2018 stage greater than 0. I had asked Ask SEERCTR about a case that was a SS2018 7-Distant case I had. Physician and Path report never indicated it was "malignant". According to their answer: "Summary Stage is only a 0 when the entire case is in situ (/2-primary tumor in situ, no evidence of lymph nodes or mets)." Which I interpreted as meaning that if the SS2018 is greater than 0, then the behavior would be a /3?	I agree with SEER...bottom line is the behavior cannot be coded to /2 if there is any indication of invasion or metastasis. See note 3. I know it does not specifically mention mets, but mets is indicative of malignant behavior. Note: CTR's are no longer invited to participate in review of the WHO books. The 5th Ed GI editors were informed of the problem with LAMN and HAMN both assigned to 8480/2. I have been told that the 6th Ed GI blue book will assign new codes to these neoplasms.
16.	For LAMN 1/1/22+: Would the behavior be assumed malignant or in-situ when there is not a physician's statement on the behavior in the medical record?	Per H5, Code low grade appendiceal mucinous neoplasm (LAMN) and high grade appendiceal mucinous neoplasm (HAMN) 8480/2 when: Diagnosis date is 1/1/2022 forward AND Behavior is stated to be in situ/non-invasive OR Behavior is not indicated.

17.	Still confused about the note on slide 65 and the date - 01/01/2021. The previous slide stated 01/01/2022. Which date is correct?	1/1/2022 and forward. Sorry. That was my typo. Slide 65 should say 1/1/2022.
18.	What histo code do you use when you don't have a copy of the path report but oncologist states patient has "signet ring cell carcinoma?"	If that is the only histology you have, you would code signet ring cell carcinoma. This is per the hierarchical list of source documents in the lung STR.
19.	For clarification, use the STR Manual as our first resource for picking our histology and only use the ICD 0 3 tables when we have a histology that is not found in the STR Manual?	Yes, use the STR manual first, and only go to the other resources when you don't find the histology in the STR manual.
20.	We also do not change the psite for multiple tumors abstracted as single primary per rule M7? Example: initial dx posterior wall papillary urothelial carcinoma in situ. Recurrence on lateral wall 6 months later also non-invasive papillary urothelial carcinoma. Psite remains posterior wall C67.4?	Yes. The primary site remains C67.4.
21.	We often see the early evolving melanomas with a lot of verbiage prior to the terminology the diagnosis (for example, atypical melanocytic proliferation c/w early evolving melanoma in situ). When we see this, should we still use the ambiguous terms to determine reportability?	It is reportable based on the ambiguous term c/w describing a reportable neoplasm. Since the only histo you have is described by an ambiguous term, report it as early/evolving MIS.
22.	I wish the STR Manual Breast chapter had a statement about "satellite" lesions/nodules.	Lois said she will make a note to consult with their breast expert on how to add this information. I'm not clear if they want info on satellite lesions/nodules in the same breast or in other sites such as chest wall, etc. Please email me at denisecharrisonLLC@gmail.com if this was your question. I can get this back to Lois.
23.	Cutaneous Melanoma Tip---If you have more than 1 cutaneous melanoma AND 1 was diagnosed prior to 2021 AND 1 was diagnosed on or after 2021 - - - remember to use the 2021+ cutaneous melanoma chapter to determine if you have a new primary.	Correct. Great tip. This information can be found in the melanoma general instructions, Introduction section.

Commented [DL([2]: This information is found in the melanoma general instructions, Introduction section

24.	Hi, this is a DCIS with Paget's disease question. Our path report for a mastectomy is extensive multifocal high-grade DCIS, and Paget's disease involving the nipple and areolar skin. For the Paget's disease it doesn't say in situ or invasive, just Paget's. Two questions: can I code invasive behavior? Is Summary Stage regional by direct extension with the skin involvement? Regional LNS were negative.	The STR state "Paget disease is classified as malignant /3 in the ICD-O. Paget disease is coded as in situ /2 ONLY when the pathology states the Paget disease is in situ." Therefore, you would code the Paget to /3. Summary Stage code 1 includes Paget disease with or without underlying tumor.
25.	Totally agree that the tables should be collapsed into one document/structure.	*Per Lois' comments in the 2nd session, this should be happening by 2024.* They (STR editors) are still looking at how to include the solid tumor histology tables in away the lists the NOS, synonyms, and variants. The initial ICD-O database will likely be available to vendors with the registrars version coming later.
26.	I had heard there were some site specific histology tables coming out for the "Other Sites" Rules such as one for GYN sites for example. Do you know when those are coming out?	Lois said the Other Sites rules will have multiple histology tables (sort of like the head and neck rules have) as well as separate combo code tables. That is going to be such a big help. The new STRs with these updates are expected in November.
27.	Are these regional by DE, with paget's in the skin?	SS code 1 includes Paget disease with or without underlying tumor.
28.	Do we interpret the statement "Final Diagnosis/CAP" to be equivalent when the specimen is from a bx only where no CAP is required?	Yes. You can take the histology from the final dx.
29.	CAP protocols are available for review at the CAP website.	Correct. I was trying to make the point that we never get those protocols with the pathology report. We get the summary or synoptic report.
30.	If a breast biopsy states ductal and the mastectomy resection shows lobular what histology would you use. The priority order states to use the tissue first by addendum then final diagnosis/synoptic. Because CAP/Synoptics are only on resections it leads us to believe that we use the resection specimen for the histology and would code lobular. Is this correct?	Since lobular and ductal were both identified, whether it is in 1 tumor or multiple, it is a single primary and coded to 8522. (I confirmed this answer with Lois.)

31.	Laura here - For these new terms that are approved by the IARC/WHO committee * & the terms approved by standard setters that are not listed in WHO or ICD-O ** - when they have a resection will these appear as options for the physicians on the CAP protocol to choose? I worry that we won't get all the information we need to choose these new options if the physicians don't have the same options!	WHO is the primary resource for terminology, however, per Lois Dickie, they always check the CAP protocols for any terms used in the US that are not found in the WHO blue books. CAP protocols are limited to the preferred term only. Lois has pointed out to CAP Cancer Committee members that pathologist rarely use preferred or standard terminology which is an issue they need to address.
32.	In the cutaneous melanoma histology STR Table 2 a superficial spreading is documented with the behavior /3 8743/3. Is this correct or can we assign superficial spreading in situ as 8723/2 or should we assign as melanoma in situ, nos 8720/2?	ICD-O-3.2 lists superficial spreading melanoma as 8743/3. If the pathologist states it is non-invasive, we need to use the matrix principle and code the behavior stated by the pathologist.
33.	I disagree with the answer to RENAL CELL CARCINOMA c/w CLEAR CELL. The physician is talking about the histology so it makes sense that the clear cell is the carcinoma.	Most renal tumors exhibit “clear cells” but that is not an indication clear cell carcinoma is present. In this example, we have an ambiguous term, and we also have clear cell without “carcinoma” associated with this. So, the ambiguous term is not relevant since to use the ambiguous term we would need to have a more specific histology **and** meet the conditions for using the ambiguous term to code a more specific histology. The path report is stating compatible with clear cell, not compatible with clear cell **carcinoma**. If the pathologist signed it out as compatible with clear cell carcinoma, we can only code that more specific histology when the physician confirms the more specific histology, the treatment plan confirms the more specific histology, or the more specific histology is the only histology we have. In this case, we have the NOS. This is in accord with the instructions in the kidney rules. I checked with Lois, and she agrees.

34.	Will there be an update to the Other site rules regarding thyroid cancer? There are so many new follicular/ papillary / encapsulated / subtypes/ variants that we are having a difficult time trying to assign morphology codes. Example encapsulated Papillary carcinoma with follicular oncocytic variant. Would this be a follicular and papillary tumor 8340/3 and ignore the encapsulated and oncocytic variants?	Lois is going to talk about the updates to the STRs at the end. Other Sites is getting some histology tables, so I expect we will see some of these new variants in the table. This would be a good one to send to ASK a SEER CTR.
35.	If a patient has multiple tumors in different quadrants invasive in one and in situ in another, does the invasive tumor site take precedence when coding primary site?	That's what the SEER manual says to do: "Code the subsite with the invasive tumor when the pathology report identifies invasive tumor in one subsite and in situ "tumor in a different subsite or subsites.
36.	Is a regressing melanoma a subtype of melanoma or a prognostic factor? In WHO blue book 4th regressing melanoma is not listed as have a histology code but the STR Melanoma Histology Table 2 and in ICD 0 3.2 there is a morph code 8723/3. We are noticing that regression is documented on our synoptic reports as being present and we have a diagnosis of melanoma with regression but not sure if this is actually a regressing melanoma.	I checked with Lois and their expert dermopathologists say it has to state "regressing melanoma" to be a regressing melanoma. "Regression" is not thought of as a specific histology anymore and it can be seen in subtype/variants of melanoma. It's important to have the presence of regression on the path/synoptic report because it has a better prognosis - it's information for the physician, but not a histologic type.
37.	MP question: Pt was diagnosed in 2014 with C619 adenoca and was treated with watchful waiting. In 2021, Pt had rising psa so biopsy was done of seminal vesicle and prostate gland. The prostate showed Adenoca and the semina vesicle showed small cell ca. Is this a collision tumor? How many primaries? or, is it just a recurrence since small cell can sometimes (although rare) arise in the prostate gland.	This is a great question. The way I am reading your question is there are separate tumors in the prostate and seminal vesicle. The patient has not been treated with RT or chemo, therefore, the small cell is a new primary. If the original prostate adenocarcinoma had been treated with RT or chemo, this would be considered a transformation and it would be a single primary. This is per ASK SEER #32423: "While working on the new revised Other Sites Solid Tumor Rules, we consulted with our GU pathology expert on this issue and asked if a small cell neuroendocrine carcinoma diagnosed after an adenocarcinoma (acinar) is a second primary or transformation. Our expert stated that while unusual, adenocarcinoma of prostate can transform into small cell following chemotherapy and occasionally radiation

		therapy. This is not a new tumor but transformation due to treatment. The only time we would consider it a new primary is if the patient has not received chemo or XRT treatment." This will be included in a new M rule and will be included in the prostate histology table (for 2023).
38.	For Breast STR M7, timing isn't specified. Are we to assume the right and left breast tumors must be synchronous, or does the rule also apply to subsequent breast tumors (i.e. right sided tumor in 2018, left sided tumor in 2020)?	The timing shouldn't matter because regardless of the timing, the rule returns multiple primaries.
39.	On Table 2 Note 3 it says behavior codes are listed when the term has only one possible behavior so i wasn't sure if the matrix rule was still valid. ICD-O-3.2 lists superficial spreading melanoma as 8743/3. If the pathologist states it is non-invasive, we need to use the matrix principle and code the behavior stated by the pathologist.	Yes. The matrix principle still applies. We always code the behavior according to what the pathologist says.
40.	Are cavernomas of the brain reportable?	Per the SINQ post below, they are considered reportable. https://seer.cancer.gov/seer-inquiry/inquiry-detail/20081113/ It depends on the primary site. Vascular tumors of the CNS are reportable when they arise in the dura or parenchyma of the CNS and should be coded accordingly. Cavernoma is synonymous with cavernous hemangioma. I confirmed this answer with Lois.
41.	How would histology be coded for an invasive breast tumor with core biopsy path final diagnosis of ductal carcinoma, then lumpectomy path final dx & CAP summary of lobular carcinoma (no mention of ductal)? Confused about majority guideline vs. 8522/3 combo code.	That majority guidance (see below) does not apply to duct and lobular. Code the histology to 8522/3 because both duct and lobular were present. (I confirmed this with Lois.) Different Histologies A. Code the histology which comprises the majority of tumor. Note 1: This instruction does not apply to: • Invasive carcinoma NST/ductal and lobular carcinoma (use the combination code 8522/3). • Mucinous carcinoma and a different histology (see Histology Rules) • Metaplastic carcinoma, NOS and subtypes/variants and invasive carcinoma, NST (see Histology Rules)

42.	When will the 2023 updates to the STR be published?	Lois says they will most likely be available in November.
43.	RE: prostate w/Adenoca and SCC in SV...what if we do not know if the patient was treated? Path only case.	If you do not know whether the patient's initial prostate adenocarcinoma was treated with chemo and/or radiation, you would need to default to multiple primaries. A new for M rules this has been added to Other Sites with specific criteria.

Commented [DL([3]: A new for M rules this has been added to Other Sites with specific criteria