	Question	Answer
1.	What if a patient with a previous diagnosis of metastatic melanoma presents years later with metastasis and the metastasis is a different subtype of melanoma than the initial tumor? Is this a new primary?	Great question. I would think since it is a different subtype it would be a different primary. If that actually happens, I would send the question to Ask a SEER registrar before I abstracted the second primary.
2.	With regards to mets, There is a note on page 567 of the AJCC TNM Staging Manual under Metastatic Sites that says, " although most metastases are detected within a few years of diagnosis of the primary tumor, occasionally patients present with distant metastatic disease many decades later.	Good catch! That may be why the multiple primary rules are set up as they are. If a patient presents with metastasis years after the initial diagnosis, the multiple primary rules will not apply. The rules are designed to be used when the patient has a new primary tumor.
3.	If you have mets many years later following an in-situ melanoma is this considered a new or same primary?	We don't have a rule in the Solid Tumor Manual to address this issue. The SEER manual "Changing Information on the Abstract" section (pg. 16), #3, example 3: When better information becomes available: The original diagnosis was in situ. Metastases are diagnosed at a later date. Change the behavior code for the original diagnosis from in situ to invasive when no new primary has been diagnosed in the interim. I'm not sure if CoC would give the same instructions. If this situation arises, you may want to submit the question to your state registry and or CAnswer forum.
4.	If a patient has an insitu tumor in theory can an insitu melanoma metastasize?	In situ indicates it has not metastasized yet. If left alone, it could continue to grow and metastasize. However, in order for us to call a tumor in situ, the entire tumor has to be removed. If the entire in situ tumor is removed before any metastasis has occurred, then there shouldn't be any metastasis. However, if there is metastasis diagnosed at a later date, then see response to question #3.
5.	STR quiz 1: is there confirmation neither of the new lesions are in transit or cutaneous mets?	For the purposes of the quiz, we will assume that the new tumors are not metastasis.
6.	Not 100% sure whether this applies to the question about melanoma in situ then mets	When I sent the question to SEER, that is where they directed me.

	later on: in SEER manual there is a section "Changing info on Abstract", #3 example 3: original dx in situ, mets dx at later date. Change behavior from in situ to invasive when NO new primary has been dx in the interim.	
7.	Tip - don't forget the (m) suffix for the AJCC T category when appropriate - as per the example	Great tip!
8.	We still find it confusing which version of STRs to use...specific for the year we are working on or always the most recent version but being careful to take note of rules within that version that only applied to previous diagnosis years. So is the recommendation to always use the most recent version of STRs?	It is confusing! Yes, use the most recent version of STRs. The SEER website has the historical versions for reference purposes but instructs you to use the current manual. Always start with the most recent version. Notice, for cutaneous melanoma, there is a statement in the header that says, “Rules Apply to Cases Diagnosed 1/1/2021 forward”. That means the most recent version of the STR’s should be used for all cases diagnosed 2021 forward. The 2007 rules would be used for all cases diagnosed prior to 2021. Always use the most up to date version of the STR’s available for all cases diagnosed 2021 forward.
9.	SLN "biopsy" can be confusing to abstractors. They don't take a piece of the LN, the surgeon completely removes those SLN during the procedure, correct?	That is typically the case. The ‘biopsy” is usually the removal of the entre lymph node. It would be highly unusual for them to just take a portion of a lymph node in this procedure.
10.	If there are multiple satellite tumors do you count each one separately or is it just counted as one?	You just indicate whether or not satellite tumors are present. You do not have anywhere to indicate the number of satellites present.
11.	Are the Breslow measurements you just discussed that correspond with Clark level when Clark level not mentioned available in future drop downs or instructions for the SSDI or in the SSDI manual?	They are in Note 4 of the coding instructions for EOD Primary Tumor for Melanoma Skin. Whether Notes are included in a drop-down menu is a software issue.
12.	I'm not an abstractor but was wondering can you stage a melanoma of the eye	Yes. It is far less common that cutaneous melanoma, but they do occur in the eye. see AJCC 8th chapter 66 for conjuctiva melanoma; ch 67 for choroid, ciliary

		body, iris melanoma (in 7th edition they were chapters 50 & 51, respectively)
13.	On AJCC TNM....page 577 there is a column on the Regional LNS for the presence of in transit, satellite and or microsatellite mets. N1c says YES, so that is the difference between N1b and N1c.	Thank you!
14.	I'm sorry if I missed it - for Mohs is clinical margin width defaulted to XX.9 even if MD mentions margins on the Mohs op note?	Yes, that's correct. The data item should only be coded if a wide excision is performed.
15.	Can you use the "p" sentinel LNS in the clinical staging fields also?	No. You want to be able to differentiate what they thought before the SLNBx and after.
16.	What surgical code would you use if the physician does not document what type of biopsy was done and the pathology report notes a shave specimen?	In that case you can use the path report. Code as a shave biopsy.
17.	So most definitive surgery isn't the one that has the most tumor removed? The last one with no residual is the most definitive?	Most definite surgery is the surgical code that is furthest down the list of surgery codes. It's usually, but not always, the surgery code with the highest number.
18.	Comment related to Poll #1 - see https://www.cancerregistryeducation.org/best-practices (melanoma surgery coding video - this was for pre-2023 dx) Although bx is always AJCC clinical staging, per STORE instructions before 2023 dx punch/shave bx could be dx/stg proc OR surgery depending on the margins (grossly positive vs neg/microscopic). It caused a lot of confusion so very glad of the change for 2023+.	Thank you!
19.	Op report states LN dissection but 5 or less LNs removed, do you code date of LN dissection as date of procedure?	I probably would. However, you have to take the statement in context. A lymph node dissection usually entails removal of more than 5 nodes. Usually, a minimum of twice that many nodes are removed. However, there may be a reason so few nodes were removed.
20.	If the SLN Bx fails to map and no dissection was done, do we still use the (sn) suffix for AJCC Staging?	I believe you would.
21.	What is the answer for the clinical margin on Poll Question #7	Clinical Margin Width would be 2.0. Two wide excisions were performed the first one took the largest margin so that is what is coded.

22.	If a subsequent excision has no residual disease and you have a description of the size of the excision margins around the first incision can you use that as your clinical margin width?	Whether or not there is any residual disease is not a factor. If a physician states the margins they used to perform the procedure, that can be used to code clinical margin width.
23.	On poll Q 7, on 1/4/24 the 2 cm margins were taken but margins were positive, so is there a 2cm margin when it's involved?	Whether the margins are involved has no bearing on how we code clinical margin width. We are only interestedinterested in the margins the surgeon was attempting before they performed the wide excision.
24.	Reminder: for skin melanoma in situ & T1 does not require path examination of LN (could use cN in pN)	Great point! It is possible to have a pT1b cN0 cM0 pathologic stage 1A
25.	I think Appendix M STORE scenario #8 addresses the clinical margin when there's no residual on WLE?	Whether or not there is residual tumor does not impact the measurement we use for clinical margin width.
26.	Is a melanoma in situ with regression a melanoma subtype? In the histology table there is only 8723/3 listed and Note 3 states behavior codes are listed when term has only one possible behavior. Thank you	We can assign a /2 for regressing melanoma based on the matrix rule. Regressing melanoma is listed in the STR manual with a /3 because it is only listed on the WHO manuals with a /3. If you run across a regressing melanoma in situ, you can assign a /2. However, be careful, the tumor may have been invasive and “regressed” to be in situ.
27.	Would a 'borderline' melanoma be the same as an early/evolving or would this be non-reportable condition?	We asked SEER. They were not able to find “borderline” listed in any of the WHO histology resources. They felt it would not be reportable.
28.	Do the clinical margins have to be documented on the path report or can they be from the op report in order to do the pathological stage.	The AJCC rules for clinical margin width when assigning pT are the same as the rules we use to assign the data item. Both sets of rules are consist with CoC operative standards. Clinical margin width is measured by the surgeon prior to the procedure and should be documented in the operative report. Residual tumor from the path report does not play a part and should not be used.
29.	Could it be called regional mets if you cannot identify the primary tumor?	If a patient is found to have a lymph node that is positive for metastatic melanoma but no primary tumor is identified, we are instructed to consider the lymph node as regional. I know that seems odd and is different from what we

		do with other sites. However, patients in this situation have been found to have a prognosis more similar to a patient with regional metastasis than a patient with distant metastasis. Therefore, a rule was developed for melanoma that tells us to code them as if they had positive regional nodes. The rules are consistent between AJCC, CoC, and SEER data items.