

Q&A Session for Ovary

May 1 and 2, 2024

#	Question	Answer
1.	How do we resolve a conflict between SEER coding rules that cite any indication of fallopian tube involvement indicates a tubal primary, but the pathologist for that same case calls it an ovarian cancer? Hierarchy? Other source records to reference?	If you look at the SEER rule on page 105 of the 2024 SEER manual, you will see in the first statement it states “...without designation of the site of origin...”. That statement indicates that a designation of primary site by the pathologist or other physician would take precedence over the SEER Rule. The SEER rule is similar to the rules the pathologist should be using to determine primary site.
2.	For case 2, if the synoptic states the site as "posterior lower uterine segment", why wouldn't you use that?	<p>The more I look at the statement, the more confused I am. I have a hard time believing the pathologist was stating the tumor arose from the posterior lower portion of the uterus. The histology is high grade serous carcinoma. I don't think the tumor would have arisen from the exterior portion of the uterus. Typically, that portion of the uterus is not covered by peritoneum, so I don't think it is a primary of the peritoneum.</p> <p>I chose to ignore the statement for this exercise. Had this been a real case I would have attempted to contact the pathologist or other physician to determine primary site. Using C57.9 really should be a last resort.</p>
3.	Total hysterectomy with bilateral oophorectomy, omentectomy, Synoptic on path states bariat tub-ovarian, high grade serous carcinoma, involving ovary and fallopian tube, pT2bN1b. Pathologists were calling the case ovarian cancer and no indication of STIC. Per SEER coding and staging manual, my interpretation is that any case with both ovarian and tubal involvement would be coded as a fallopian tube primary rather than C579. Is this correct? We coded this case to C57.9.	We received a clarification from SEER that a statement from the physician would take precedence over the SEER Statement. Also, implants on the serosa surface of the fallopian tube are mets. They are not to be considered primary tumors.

4.	For Case Scenario #2 - wouldn't we use the CAP protocol guidelines for reference to determine the primary site of origin? Our registry would lean more towards coding as a Fallopian Tube primary as per the CAP table stating when there is fallopian tube involvement.	The problem is the fallopian tube involvement is on the serosal surface. That means it is probably mets. We really need additional clarification from a physician.
5.	I noticed that the site code 57.9 isn't valid with our current SEER validation list for Serous carcinoma?	The combination will produce and edit for cases diagnosed prior to 2024. However, the edit has an over-ride option that will allow the site/histology combination to pass. The site histology combination is not biologically impossible, but registrars should only use C57.9 if a better option is not available.
6.	Why not Fallopian Tube for Case #2? SINQ 20210025 says to see the CAP Protocol Table	They really should have done a better job of defining "involvement". In case 2 the fallopian tube has serosal surface involvement. That indicates the involvement is mets and should not be a factor when assigning primary site.
7.	Difficult Case #2: It helps to also bring in the med onc discussion, how did they treat this? Look over several progress notes if available to get a feel for how it was treated. If the physicians are sitting on the fence, and can't decide, then I often won't make a leap of calling it "what I think it is". They do have the final say related to how the patient is being treated and often help decide. These are tough ones.	Good advice. Also, look for tumor markers. Things like WT-1 can help distinguish an endometrial primary from an adnexal primary.
8.	Some pathologists are documenting "when ovarian and fallopian tubes are involved, primary should be fallopian tube". Are other registries seeing this in their records?	I'm guessing many registries are seeing similar statements!
9.	I guess in case 4, the tumor on the RT is involvement of both ovary and tube. Do you think we should have coded primary site to right ovary?	If we didn't have the note from the pathologist indicated primary site as bilateral ovaries, I would have gone with fallopian tube based on the Rt ovary and tube.
10.	Aren't ovary and FT treated the same?	I think treatment is very similar. They also have very similar Summary Stage and EOD. AJCC stage is the same. However, C57.9 or C57.8 will end up with a different Summary Stage and EOD and are not eligible for AJCC Staging. I suggest doing as much follow-back as possible to avoid using those codes.
11.	And answer to case 5?	2 primaries. ovary and fallopian tube

12.	Are there any genetic tests involved in diagnosing these GYN serous carcinomas?	Wilms tumor gene 1 (WT1) can be used to differentiate endometrial and extrauterine primaries, but i don't know if it can help distinguish between ovary, fallopian tube, and primary peritoneum. PAX8 is a transcription factor that is expressed in about 90% of malignant ovarian cancers, specifically in high grade serous ovarian cancer (HGSC). Loss of functional p53 protein occurs in the majority of epithelial ovarian cancers. The p53 tumor suppressor gene is mutated in over 96% of high-grade serous ovarian cancer (HGSOC), and 60-70% of both early and advanced stage serous ovarian cancers have TP53 mutations.
13.	I just wanted to quote something from a presentation from Lois Dickie at our state association conference last year: "We consulted with our GYN Expert Pathologist on this issue. The CAP Protocol for Female Reproductive Organs now has a table to assist in determining primary site for these neoplasms, specifically STIC and malignant tumors. Per our expert and the CAP table, when STIC occurs in the fallopian tube and there is invasive disease in the ovary or peritoneal disease, code the primary site to fallopian tube. Longstanding rules go against coding the in-situ tumor as primary site when there is also invasive tumor present. In this case, the primary site would be fallopian tube with the invasive histology coded. This incorrectly identifies an invasive fallopian tube primary."	I asked Lois about the presentation and she confirmed the statement you mentioned is what is recommended by the College of American Pathologist (CAP) for pathologist when determining primary site for GYN malignancies. She also confirmed that a statement from a pathologist concerning primary site takes priority over the rules included included in the SEER manual.
14.	So is the posted Lois comment from Amanda saying that Lois doesn't agree with this CAP protocol table? If it's only in situ in the FT and invasive in the ovary we shouldn't be coding primary as FT /3?	I can confirm that we should go with what the pathologist states.
15.	Is cytoreductive surgery typically done before other planned tx?	Usually, it is done prior to chemotherapy. It may be done before a definitive surgery in some circumstances.
16.	Would you please discuss reportability of Borderline tumors? 1)"Bilateral ovaries of serous borderline tumor"; 2) Ovary-16.8 cm mucinous borderline tumor; 3)Stage Ia mucinous borderline tumor of the right ovary; 4) Ovary-	Prior to the release of ICD-O3 in 2001, borderline tumors of the ovary had a behavior code of /3. Beginning in 2001, the behavior was changed to /1 (borderline). Most registries stopped collecting these cases in 2001. However, there is at least 1 state that still requires these

	serous borderline tumor / atypical proliferative serous tumor".	cases to be collected. There may also be hospitals that collect them as "reportable by agreement" cases. The histologies you mentioned are not reportable to NCDB or to most central registries. Just because a tumor is eligible for AJCC staging does not mean it is a reportable case.
17.	My team mate and I were thinking 2 Primaries, since the LT ovary, benign Lt Fallopian Tube. The Right Ovary is benign, and the Rt Fallopian Tube has STIC.	If you are referring to difficult case 5, I agree.
18.	With these difficult cases, do we have clinical information as well? I am assuming all of these cases presented with 1 large tubo-ovarian mass? Doesn't that factor into determining multiple primaries as well? We start out with Rule M2 - Single primary when there is a single tumor.	All I had available is what you see on the screen.
19.	My manager (Mary Jane) made the following observation... "If genetics took priority in 'naming' the cancer, trying to confirm the location in which it arose would cease to matter except for extent of disease"	I'm always leery of such broad statements, but it is an interesting concept. I'm sure this is something that will play into how we abstract cases in the future and probably impacts how analysis is done today. However, at this point, we still need to follow standardized rules for assigning primary site.
20.	Why in this instance would this not be a case where we assume this is FIGO, since it is given by managing physician?	It is the word "FIGO" that has to be noted by the managing physician. It is trivial, we get it. We had this long discussion yesterday.
21.	What was the final answer for pop quiz 2?	The final answer was <i>Not documented in the patient record</i> . Unfortunately, the managing physician only states Stage IIB (does . The word "FIGO" was not mentioned so we can't strictly go off of the pathologist note. In this field they want to the FIGO stage as documented by the managing physician. We do not want the registrar or the pathologist to assign the stage for this field. We also want to be certain we are not conflating the AJCC Stage and FIGO Stage. We collect patient stage information in Summary Stage, EOD, and AJCC fields. We want the managing physician assigned FIGO stage in this field.
22.	This is just an FYI we ran across this week. We had an ovarian cancer with 1 negative omental lymph node. In the synoptic path report the pathologist stated there were no	That is interesting!

	<p>regional nodes, so we started digging before contacting the pathologist. Per the AJCC, omental nodes are most likely the omentum and falls under the T category not the N category. The AJCC did answer this on the forum to help with our confusion.</p> <p>https://cancerbulletin.facs.org/forums/node/130176</p>	
23.	For case scenario 1 where does the doctor say FIGO Stage IB?	Case scenario 1 is based on a real case. After we posted the scenario, I went back and checked the patients record and the managing physician referred to this as a FIGO IB. I mentioned that during the presentation as a side note. However, since the information did not make it into the case scenario, we have to assign a code 99. Sorry for the confusion!
24.	If a biopsy from a Metastatic Site says "Mullerian Origin". What would be the primary site if no other information is given?	In my opinion C57.9 would be the best option. I have not seen a rule specifically addressing this issue.
25.	Does managing physician diagnosis of malignancy without biopsy or any microscopic test during clinical time frame accepted as clinical staging?	A diagnosis of malignancy is not enough to assign clinical stage for these cases. We need to confirm it is a malignancy arising from the ovary, fallopian tube, or a primary of the peritoneum.
26.	Any idea of the timeline regarding the release of the WHO blue book?	I'm not sure, but the soonest we will see any new changes is for cases diagnosed in 2026.
27.	I am wondering about that Endometrial Thickness being normal, when (with plenty of variations) >10mm thickness can be seen as a risk factor for GYN malignancies.	Are you suggesting the thickness of >10mm would prompt as a red flag for physicians? That is interesting!
28.	Case 3 High grade serous carcinoma arises from epithelial cells of the ovaries and can affect both ovaries simultaneously. Can you explain again why these should not be abstracted as 2 separate primaries in the absence of clear evidence noted by the MDs?	Per the solid tumor rules, epithelial tumors in both ovaries is a single primary. Tumor from both of the ovaries was epithelial.
29.	If a debulking surgery/code 60 is done for an ovarian primary, should removal of other organs (such as omentectomy) be coded in Surgery of Other Sites, or are they just considered to be included in the 60 code?	It is unfortunate that we have included codes in the Surgery of Primary Site field, that aren't really reflecting surgery of the primary site. Code 60 (A600) is one of those codes. When assigning codes for Surgery of Other, it is my understanding that we would only include organs or tissue removed that are NOT part of a standard TAHBSO. An

		omentectomy is often included in a TAHBSO so I would not code it in Surgery of Other.
30.	Note 4: For High-grade serous carcinoma (HGSC) or serous tubal intraepithelial carcinoma (STIC) (8441/2), assign the FIGO stage based on the managing physician's documentation of FIGO. (See Note 1) If FIGO stage for HGSC or STIC is not documented by the managing physician, code unknown (code 99) Do not code 97 (in situ) for HGSC or STIC since FIGO does not have a Stage 0 If diagnosis is low grade serous intraepithelial Note 4: For High-grade serous carcinoma (HGSC) or serous tubal intraepithelial carcinoma (STIC) (8441/2), assign the FIGO stage based on the managing physician's documentation of FIGO. (See Note 1) If FIGO stage for HGSC or STIC is not documented by the managing physician, code unknown (code 99) Do not code 97 (in situ) for HGSC or STIC since FIGO does not have a Stage 0 If diagnosis is low grade serous intraepithelial carcinoma (LGSC) (8441/2) or serous intraepithelial carcinoma (no grade stated carcinoma (LGSC) (8441/2) or serous intraepithelial carcinoma (no grade stated) (8441/2), code 97.	<p>We confirmed with the Chair of the SSDI WG. Note 4 only applies to non-invasive primaries (/2). A clarification will be added to the next update of the SSDI Manual. The note is included because FIGO does not have a stage grouping for in situ cases.</p> <p>The note should read “Note 4: For High-grade serous carcinoma in situ (HGSC) or serous tubal intraepithelial carcinoma (STIC) (8441/2), assign the FIGO stage based on the managing physician's</p>
31.	As far as I know the managing physician is a gynecologist oncologist. 99.9% of the time they use Figo stage. Leaving the word Figo out of his statement is Symantec.	If you have confirmed this with your physician, then I suppose it is ok to assign a FIGO Stage value without explicit documentation in the record. However, I would document that in the text of the abstract and also in your operations manual.
32.	Not sure I heard correctly, in order to pick of the FIGO stage from the managing physician this only pertains to histology of High-grade serous carcinomas? Or is this for all GYN histology's	That is not correct. We were discussing note 4 under the FIGO Stage Data Item. An in situ high grade serous carcinoma or a STIC should be assigned a code based on a statement by the managing physician. If a FIGO stage is not documented, assign code 99. A code 97 should not be used for these histologies.
33.	Would palliative care/hospice be coded on case 2 - I wasn't sure the hospice referral would be counted for the ovary cancer?	Yes. We didn't include that field on the worksheet.