Q&A Session for CNS

August 2024

#	Question	Answer
1.	What would the primary site for an olfactory meningioma be? C722 or C700?	
2.	If radiology indicates "dural based" would that be considered c709 vs c700?	Unless it is in the spine, I would code C700. If you don't know if it is brain or spine, then C70.9
3.	Do the standard setters anticipate adding site codes and more histology codes for CNS in the near future? It seems like it would be extremely helpful for research based on the presentations.	At this point we follow ICD. At some point ICD O will be updated to ICD O 4 and we will have more options for histology. Until then, we will probably have to continue using SSDIs to differentiate. Not an ideal solution!
4.	What is their advice for publishing brain stats over time, re juvenile astrocytoma?"	Great question! Carol had not had a chance to responded at the time the document was posted. We will update the document when she responds. Jennifer had the suggestion below… *A registry would have to take all their 9421/3 from 2004-2022 and convert them to 9421/1, and them combine them with the 9421/1 for 2023 forward. Of course there are several alternate names under 9421/1, so not sure that they could really tease out pilocytic astrocytoma for 2023 forward.*
5.	I am still confused about Brain Molecular Markers. How do you code it if it's a benign tumor and not 9421/1. Do you code it as 85 or 86?	In the SSDI Manual, or SEER*RSA, go to Brain Molecular Markers and you will see Code 86, which is defined for benign/borderline tumors. Updated note for Version 3.2 (coming soon) **3) Code 86** when there is a **benign (/0)** or **borderline (/1)** tumor • **a.** This includes microscopically or non-microscopically confirmed cases

		• **b** *Exception*: 9421/1 (see codes 19-20 when microscopically confirmed) ○ **i.** If codes 19 or 20 don't apply, or not microscopically confirmed, code 99
6.	Is the Pons part of the brain stem or above the brain stem? Site code C71.7?	The pons is part of the brain stem. The topography code is C71.7 (brainstem, nos). Since pons shares a topography code with other brainstem subsites, it is important to complete the data item Brain Primary Tumor Location.
7.	It is interesting that the IDH mutation is most prevalent in the 15-39 age group. I'm curious why do you think that is?	Carol Kruchko will forward this question to one of the physicians she works with at CBTRUS.
8.	Did she say we started collecting benign brain tumors because we didn't have enough malignant to report on?	LoL…NO! She stated that benign brain tumors can cause significant morbidity. They do not metastasize but can get large enough to cause significant problems.
9.	Most of our meningiomas are only seen on imaging, very rarely are they ever treated, always wondered why we collected them.	It does make you wonder! Many of these cases are indolent for the patient's lifetime. However, others do cause significant problems. I've forwarded this to Carol to see if she has any insight as to the research interest.
10.	If satellite lesion is infratentorial and the other lesion is supratentorial is this considered extending to involve or a 500?	Per the table that was shown in the presentation, this a supratentorial site and an infratentorial site involved, which is a Regional tumor (EOD PT 500). The fact that one of them is a satellite lesion does not make a difference.
11.	How would you code EOD Primary Tumor for a single medulloblastoma that involves both infra and supratentorial sites?	Staging for Medulloblastoma is not based on infratentorial versus supratentorial sites, which is why it was not mentioned. The infratentorial and supratentorial terminology applies **only to the Brain schema.** What you are describing here is extension to an adjacent structure, which is not coded in EOD Primary Tumor, but in EOD Mets. EOD PT would be 999. See SEER*RSA, Version 3.1, EOD Primary Tumor, Notes 1 and 2
12.	Would it hurt to code both CoC and SEER stereotactic bx?	We don't have a recommendation on how to handle the discrepancy.

13.	Glioma NOS brain tumors, code 9380/3, the STR don't even list this, but there are many records for which this is the only term. I'm noticing this: suddenly people are coding glioma NOS as 9421/1. I think they should still be using 9380/3.	Glioma, NOS is not listed in the non-malignant histology table, but it is listed in malignant histology table. The correct histology is 9380/3 for Glioma, NOS. A low-grade glioma is considered a borderline tumor and should be assigned a histology code of 9380/1. This note will be added to the next update of the Solid Tumor Manual. Currently there is a SINQ post confirming this https://seer.cancer.gov/seer-inquiry/inquiry-detail/20230080/ The term Glioma, NOS is not a term WHO recommends using. The preferred term is Astrocytoma, NOS. Starting with cases diagnosed in 2025, an edit will trigger when the histology 9380/3 is used for a brain primary. The edit can be over-ridden, but the registrar should review the case carefully to see if a more specific histology can be used. 9421/1 should only be used with the specific histologic terms listed in table 6 of the Non-Malignant site module.
14.	DIPG code 9385/3 with diagnostic confirmation code 7. Is this possible? All the definitions for 9385/3 include information that is only available if there was pathology, for instance H3 K27-altered. I understand that the primary site often is too risky for a biopsy, but how can 9385/3 be used without pathology? Would a radiographic diagnosis of DIPG be code 9380/3? I see this in SINQ but can it "be" this diagnosis without pathology?	DIPG is frequently diagnosed solely by radiology and diagnostic confirmation is coded to 7. If you look at the synonyms in table 3 of the malignant tumor rules, you will see *Diffuse midline glioma H3 K27M (9385)* in the Specific and NOS column. In the synonym's column for that row, you will see both *diffuse intrinsic pontine glioma* and *DIPG*. Because we have so many terms associated with the same code, it is important to code the SSDI Brain Molecular Marker. If the patient is diagnosed by radiology only and the histology is DIPG without any of the molecular markers, then Brain Molecular Marker will be coded 99.
15.	I'm reviewing an abstract coded to 9421/1 when the diagnosis (with pathology) is low grade hemispheric glioma infant-type. The code for this histology is 9385/3, and I	I agree 9421/1 is not the correct histology. I'm guessing the term "low grade" is causing the registrar problems. The term "low grade" should NOT be used to determine if the histology is malignant or

	think the abstractor "guessed" at 9421/1 because of "low grade."	non-malignant. The term “low grade” with glioma is a unique exception. When assigning the code for *low grade hemispheric glioma infant-type,* we would ignore the term “low grade”. If you look at the synonyms for Diffuse midline glioma H3 K27M mutant, you will find *Infant-type hemispheric glioma* . The correct code for this histology is 9385/3.