Q&A Session for Hematopoietic 2024/2025: Part II

January 8-9, 2025

#	Question	Answer
1.	When you type follicular lymphoma in the database it gives you 96 neoplasms ~~thar~~ that match any term. But, next to that you can click on the 19 neoplasms that match all terms and that narrows it down.	Great tip Loree!!!
2.	If cytogenetics are documented on the path report as neg, but individual genetic data mutation is positive on the same path report, should the dx histo confirmation be coded to a 1 or 3?	Per request, registrar posted question to Ask SEER Registrar. Thank you. ☺ In the question posted to Ask SEER Registrar: Path Report on 01/18/2024 States US BX, R Axilla LN, SLL, FISH CLL pending, cytogenetics reported neg for all panel probes under "test results and summary". and then : Individual Immunophenotyping Reports (and CD results listed with some being positive) In this case, the cytogenetics (genetics data) were documented as negative while there was positive immunophenotyping. So, this is not cytogenetics documented as negative, and then individual genetic data mutation listed as stated in the NAACCR webinar post. This is genetic data (listed under genetics data in the Heme DB) and immunophenotyping data, which are different. Per diagnostic confirmation 3, you can have either positive genetics AND/OR immunophenotyping (positive [CD+] or negative [CD-]) confirming the diagnosis (or identifying a more specific diagnosis).

		So, based on the immunophenotyping, which supported the diagnosis, this would be a Diagnostic Confirmation 3. It looks like the registrar was not aware that genetics and immunophenotyping are different. This is a prime example of why answering questions like this in a webinar is not advisable without all the details.
3.	If we have, for example, a DLBCL and it involves the liver and or other primary sites, where the liver is listed as a common extranodal site in the database, would we code the liver as mets or would we include that in determining our primary site instead?	Registrar asked to submit to Ask a SEER Registrar Although the Heme DB does state that liver is a common primary site for DLBCL (see Abstractor Notes), this does not mean that just because the liver is ~~involved~~ involved that the liver is the primary site. You must look at all involvement and then go through the PH rules to determine the primary site. For DLBCL, liver involvement could be the primary site or metastatic disease.
4.	If the case fits the common sites, would you still go to the primary site rules to see if it was one of those rare cases?	Yes, you still use the primary site rules (unless you have them memorized)
5.	The Primary Physician Diagnosis on the treatment plan stated: Waldenstrom's macroglobulinemia (9761/3)~~.~~, with also possible MBL (9823/1). Would M4 apply? We report MBL in Canada	M15 would be applicable. This would be two primaries. Note that the rules in the Heme Manual are for /3 behavior only since that is the only behavior for Hematopoietic neoplasms that are reportable for the US. For Canadians, any combination of a /3 and a /1 would fall under M15.
6.	When determining site can you use the database and go right to the corresponding module in the manual? For example, mantle cell lymphoma in the database it state see module 7 for primary site.	That's why the Modules are listed there. This helps you to avoid going through the other modules that aren't relevant. Although, as Jim pointed out during the webinar, mantle cell, DLBCL (and many other lymphomas) are in Module 6 as well. The Heme DB will be updated soon to reflect this.

7.	Scenario 4 - 9713/3 says to see Module 7 for primary sites but your slide says Module 7 doesn't apply?	9713/3 was not in scenario 4, it was 9719/3. As mentioned during the webinar, that was a mistake.
8.	Scenario 5 - if we include it in the site code/primary site of 77.9, do we go "0" for mets a Dx?	With primary site C779, skin, bone marrow, bone, etc., would be coded as positive in the mets at dx data items.
9.	Scenario 5 - Would you code the bm involvement to mets at dx other?	Please review the code choices in Mets at Dx Other. Bone marrow involvement is included there.
10.	Scenario 6 - Does it matter if they were still working the patient up for the splenic lymphoma and it took longer than 21 days to get the DLBCL dx?	Timing is not relevant in this case. The first biopsy diagnosed a small B-cell lymphoma, which was later determined to be splenic marginal zone lymphoma from the liver biopsy. There is no mention of a large B-cell component. Even if they came back and did another splenic biopsy a week later with a diagnosis of DLBCL, this would still be 2 primaries. This are 2 different biopsies done on two separate days (not same operative session) with 2 different diagnoses from the spleen.
11.	Confirming there is no timing rule (21 days) for rule M13?	Per the Heme manual: Abstract multiple primaries when a neoplasm is originally diagnosed as acute AND reverts to a chronic neoplasm after treatment
12.	If pt had a transplant for a previous heme primary and then in 2025 develops PTLD this is not reportable, correct?	This is reportable because the PTLD developed in 2025. Previous heme primary does not affect the collection of PTLD (unless PTLD was diagnosed previously, which would be the same primary)
13.	If you have a Follicular Lymphoma, grade 3 and your immunophenotyping lists CD5- can I use code 3 histo plus for my diagnostic confirmation because CD5- is listed under immunophenotyping in the database for follicular lymphoma Grade 3 or do you only use histo plus for positive immunophenotyping?	For purposes of diagnostic confirmation, “positive” immunophenotyping can be CD+ or CD-. See the Heme DB for examples.
14.	If pt develops the PTLD as a result of a bone marrow transplant for a heme primary. The 2025 heme primary would have the SSDI for PTLD as 0 and then develops a PTLD months after the bm transplant	A person with history of a previous bone marrow transplant is at an increased risk of developing PTLD. Any type of transplant (kidney, lung, heart, stem cell) increases a person’s chances for developing PTLD.

	so this PTLD wasn't there when heme was dx, we would then capture the PTLD as a new primary	PTLD will not be diagnosed at the same time as the transplant. The PTLD will not show up for several months to ~~a couple of~~ years after the transplant. When the PTLD does occur, that is when it is captured. PTLD by itself (polymorphic) will be reported as a new primary, 9971/3 in the Heme Retic schema for years 2010-2020, 2025+. Rules M14, PH1 and the PTLD SSDI do not apply to polymorphic PTLD's. PTLD (monomorphic, Hodgkin type, or not listed) WITH an accompanying lymphoma, myeloma, plasmacytoma, would be collected as the accompanying neoplasm. Rules M14 and PH1 would be followed. This is a rule that has been in place since 2010. The PTLD SSDI would also be coded for cases diagnosed 1/1/25+.
15.	Regarding assigning histology- many times I have multiple physicians involved (RadOnc, HemOnc, Surgeon, Pathologist) who may note varying histologies. In these cases, which physician's diagnosis do we use?	In this scenario, we need to see the details and what the histologies are. As a reminder, it can take several months to come up with a final diagnosis, and during that time many diagnosis may be made. In general, the pathology report has the best information, but that is not always the case. For further guidance, please send the details of your cases to Ask a SEER Registrar.
16.	We are seeing an increase in organ only involvement - if they don't tell us certain sites are metastatic would we include them in the information that we use for our PH rules? Ex. lymphoma present in stomach, lung and bone marrow.	You use the Heme DB to determine if there are common primary sites for your histology, Once you determine that, start with the appropriate PH Module, and then work through the rules to determine your primary site.
17.	How do we know it didn't originate in one of those other lymph node regions and metastasize to the lungs?	We don't. But according to the rules as they are written, we go with the lung since regional nodes for the lung are involved.

		As mentioned on the webinar, there is no way to prove where a lymphoma started when multiple lymph nodes or organs are involved. These rules were developed to provide a standard way of defining primary site.
18.	Primary site for a CLL. Diffuse LAD. No bone marrow bx done, no peripheral blood smear, but blood counts abnormal. Rule PH6 code to LN if unknown if BM involved. Can I assume BM is involved because of abnormal CBC?	Never assume that the bone marrow is positive based on blood counts. You are trying to make the diagnosis yourself, which registrars cannot do. If the physician states that the bone marrow is likely involved due to the abnormal blood counts, then you can use that. PH6 is applicable for this case, status of bone marrow is unknown.
19.	Scenario 4 - why does Module 7 not apply? It's listed in the DB.	As stated on the webinar, this was a mistake
20.	Hi Jennifer, I appreciate you making this point. I am a veterinary oncologist. As a doctor I tell my clients that histology of lymphoma is a much more important prognostic factor than anything else. My explanation to pet owners (not the greatest probably) is that "you are either pregnant or you are not". Yes, you can be farther along but you either have (lymphoma) or you don't. Where it started is usually clinically irrelevant	Great analogy!
21.	Instead of assigning C80.9, when there is only organ involv only & no LN involvement, can C77.9 be used if the confirmed pathology dx is Lymphoma?	No. To use C779 (Rule PH22) you MUST have lymph node involvement Just because this is a lymphoma does not mean that it originated in the lymph nodes (review the slides that Juliet did, she addressed this). You cannot make this assumption at any time. As mentioned on both webinars, and followed up with questions from several registrars, organ only involvement of lymphomas is increasing.
22.	Lymphoma takes a longer amount of time to complete. It's not just to assign the correct histology code, it's also coding all of the treatments these patients receive. Some patients then have	Totally agree with you. Lymphomas are some of the hardest cases to abstract.

	persistent or progressive disease, now you have even more treatment to add.	
23.	Can brain be a primary site?	Yes, brain can be a primary site. The most common brain lymphoma is a "Primary CNS Lymphoma." (See 9680/3). Other lymphoma histologies in the brain are probably metastatic disease. You need to review imaging to determine if there is disease elsewhere.
24.	PTLD Effective 2025 Cases & forward, Previous cases 2018-2024- must be blank?	Yes, for the PTLD SSDI, cases diagnosed 2018-2024 will be BLANK.
25.	Scenario 2- why is the histology not B-cell lymphoma?	DLBCL is large B-cell lymphoma- (9680/3).
26.	There is a post on SINQ (20220034) that states "code all treatments the patient received as first course of treatment. For lymphoma and leukemia, first course of treatment may include first-line, second-line....any treatment to achieve remission." My question is, does worsening disease or progression that takes place after initiation of treatment but prior to remission factor into deciding first course vs subsequent course?	All treatment given to achieve remission is first course of treatment.
27.	I had a case today that was "EBV+, CD4+ nodal T/NK cell lymphoma" with only an abdominal wall mass present on imaging. I've used my DB and still have difficulty assigning histology/site.	Please post to Ask SEER Registrar and provide all information available.
28.	Does statement of mediastinal mass with bulky hilar and mediastinal lymph nodes qualify for Stage II Bulky?	Bulky stage is AJCC staging. Please post your question to the AJCC forum.

Commented [JG1]: This should be addressed with future versions of the manual if possible. It's a very confusing grey area, especially for Heme cases. Especially because of that whole "changing categories per SEER Rx" discussion years ago. It's probably still in folks' heads.