Q&A Session for Unusual Sites 2025

February 6, 2025

#	Question	Answer
1.	Is asbestos exposure also related to the non-pleural (peritoneum, pericardium, testicular) types of mesotheliomas?	I found an interesting article on peritoneal mesothelioma. Based on the article, asbestos is associated with about 80-90% of pleural mesothelioma and about 30-40% of peritoneal mesotheliomas. They do consider asbestos a risk factor for peritoneal mesothelioma.
2.	If the MD had not stated malignant pleural effusion, would you still code +malignant pleural effusion based on path report verbiage of "strongly favor malignant mesothelioma"?	I always look for information from the treating physician. Even if they don't "say" malignant, if they are indicating they think it was, then I would code it as such.
3.	Is immunotherapy also coded as palliative therapy along with the palliative radiation?	I would not code the immunotherapy as palliative as only the radiation was stated to be palliative. They were treating with immunotherapy and only added the radiation as she was having chest pain.
4.	What to do when all the metrics that indicate disease progression are documented, but the word 'progression' is not used?	Again, I always take the lead from the treating physicians. I look for cues from them – i.e. this "treatment" is not working so we will change to second course or some other terminology. I do not make this decision on my own.
5.	If there's no evidence of primary, how can dx stag proc be an 02?	You are absolutely correct; it was the metastatic nodules and should be an 01.
6.	If the physicians did not state bilateral involvement, how could you stage this case? I find details are often lacking in the radiology reports and the doctor's notes for mesothelioma cases.	I always try to take my cue from the physician and would look to see if they were saying anything to give me a cue (i.e. the patient not being a surgery candidate because of the bilateral disease, etc.)
7.	Seeking confirmation on whether or not new parameters for AJCC V9 can be based on either a 'radiology report' and/or 'clinician note'? Apparently for Lung in 2026, clinician	We will see what we can find out - I don't see anything browsing through the V9 right now but will definitely see what we can find.

	statement will be disallowed, in favor of the new CAP synoptic report.	
8.	We have this note in our registry: Pleural mesothelioma with malignant pleural effusion, positive cytology: This isn't part of the staging criteria in the TNM system. Also in Cancer Forum, it's stated that "pleural effusion is not considered in the staging since it doesn't affect prognosis." However, in Summary Staging pleural effusion is distant, stage 7. Also, a NAACCR edit requires us to code pM1 (and metastasis to other site) when we code SSDI Pleural Effusion 2, confirmed to be malignant. We are staging pleural mesothelioma with malignant pleural effusion to pM1, metastasis to other site.	Thanks Mary! I will have Jim confirm with the edits Vicki…I looked through the last 2 metafile version and cannot find an edit that requires pM1 if Pleural effusion is 2. I found a statement in the v9 protocol stating pleural effusion is T4. I did not see that in 8th edition. Is that correct? I agree – I see "malignant pleural effusion" as part of the T4 in V9, but do not see it in the 8th edition.
9.	With case #1 I don't think I agree with code 02 for palliative care. The patient is receiving palliative radiation, immunotherapy (which for stage 4 might be considered palliative?), had therapeutic removal of pleural fluid, talc pleurodesis, and it was mentioned patient was on pain meds prior to radiation. Would it be coded as 7-does not fit descriptions for codes 1-6?	Hi Amanda - thanks for the great question and we will try to get confirmation. I only code "palliative" care when the physician states it is palliative, and the only thing stated to be palliative was the XRT. The rest was stated to be treatment for the malignancy.
10.	Is right eye OU?	OU is both eyes - OS is left and OD is right.
11.	So basically, for the eye, disease progression does not exist. And the potential for enucleation is always implied in first course planning. That's what we are supposed to assume?	I wouldn't go that far. Technically, a tumor is always "progressing". Our job is to determine if the disease has progressed enough that the physician has to create a new treatment plan. This is not an easy distinction to make. If the physician is treating with something like laser, Intravitreal chemo, plaque radiation, etc, they know that if the tumor does not respond they may have to do an enucleation. That is part of the treatment plan. If they are treating with laser, chemo, etc and a new tumor forms or the tumor increases in size, that probably will not change the treatment plan. They will either continue to treat with laser, chemo, etc or they will proceed with the enucleation.
12.	Ocular Adnexal Lymphoma has four SSDI: Grade.	Technically, grade is an SSDI. However, typically, when we refer to SSDIs we are not referring to Grade

13.	I don't know if I recorded the radiation therapy answers wrong for case #3, but dose per fraction was 200 (not 150) and number of fractions was 12 (not 16).	I will check that before we send out the answer sheets. You are correct it was 200 and 12, the answer sheet has been updated.
14.	Thanks for discussing grade for ocular lymphoma. Since the heme/lymph database just says grade 8 for histology 9699/3, I would notice the Grade Table 23 only when I went to code the grade (and notice there is no Grade 8). Or when I was in the TNM manual.	You are welcome!
15.	If they just call thymoma "B", which histo code do you use?	I don't see a code for Thymoma, Type B (NOS). I searched the SINQ and did not see anything either. If you run across a case with Thymoma, Type B and they do not distinguish between B1, B2, or B3, please send the scenario to Ask a SEER Registrar. If you send me their response, I'll update this document with the response.
16.	Why was Thymoma clinically staged? Imaging stated neoplasm and physician stated thymectomy curative intent.	I would say because they did see it clinically and suspected it was a thymoma - they took the patient to the OR to remove the mediastinal mass they suspected of being a thymoma, so the T1a N0 was their guess at what they were dealing with.
17.	So we're assuming that as long as the patient goes in to remove a mass of an unknown histology and path turns out to be malig/reportable we'll have clinical stage?	Ideally, the physician would have assigned a clinical stage before the surgery or we would have had a definitive statement from the physician stating they thought this was a thymoma. However, all we have to work with is this limited information. In my judgement, the fact they are going to do a thymectomy and the intent is curative, is enough to indicate they suspected a thymus primary. Therefore, a clinical stage can be assigned. If we didn't have that statement at the end of the first paragraph, I would not have felt comfortable assigning a clinical stage.
18.	Can we use ambiguous terms to determine histology? Favor malignant mesothelioma.	You have to follow the STR for each particular site. For the "other" sites you can only use ambiguous terms if... See page 492 of the newest STR for the conditions.

19.	If we did not have the physician statement of positive malignant, can "favor" ambiguous term be used in lieu of "suspicious" ambiguous term? Coding Guidelines 4: Code 2, c. Pleural fluid cytology described as suspicious or suspicious for mesothelioma.	I don't know if we can use all ambiguous terms or just suspicious - but since I had the definitive physician statement, I used that.
20.	Thank you for pointing out that progression needs to be stated by the physician - that is definitely helpful when there are many subsequent scans with varying information on them.	I think we hate to leave blanks or unknowns, so people are too often trying to read the scans themselves.
21.	Since this was reviewed in tumor board & pathology generally participates in tumor boards, wouldn't you be able to take that for the histology?	The STR state it has to be on the tissue pathology report, so I always go with that.
22.	Can you explain your rationale for coding the XRT as first course? I would not have because it was not planned or noted as FCoT in Tumor Board; it was added later.	The patient was going to be continuing immunotherapy as first course (no progression) and they were just adding the XRT because the patient was having so much chest pain as a palliative procedure.
23.	Since the pleura is a paired site, what would you code the laterality for this case since there was no evidence of primary site. Would you code 9?	I think somewhere in the records they stated this was a "right" site with mets to the left, so I would have coded right, but without that you would likely have to code 9.
24.	Would the Trilateral Retinoblastoma be a separate primary?	A “trilateral retinoblastoma” is when a patient has bilateral retinoblastomas and a brain tumor of a similar histology. It is often referred to as a pineoblastoma. Even though it may have a similar histology, the brain tumor is not metastasis. We would treat it like any other brain tumor. It would most likely be a second primary.
25.	How would trilateral RBL be worked through the STM rules?	If the tumor is a pineoplastoma we would use the malignant CNS rules. Pineoblastoma is WHO Grade 4 per Table 1: WHO Grades for Select CNS Neoplasms.
26.	I thought the pineal gland tumor would be coded separately from the RBL, but it's good to have it confirmed - TYSM!	You are welcome!
27.	OD for right eye as opposed to OU?	OU should actually be both eyes :) OD is right, and OS is left.
28.	To code cancer direct surgery for pediatric cases, we should use SEER RSA instead of the STORE manual correct?	If you are talking about coding Surgery of Primary Site, the codes should be the same. There may be some additional notes in the SEER. If you are talking about the new pediatric data items, you will find them on different website than SEER RSA.

29.	https://staging.seer.cancer.gov/pediatric/home/1.2/	I'm pretty sure that site is intended for registries participating in the pediatric initiative. For 2025, there will only be about 2 registries from each SEER state participating. I don't think anyone else is supposed to be using that site. However, the surgery codes included on the site are the same as the codes in the STORE or SEER manual.
30.	Is physician statement of Malignant Thymoma enough without other testing/documentation stating the same?	That would be a definitive diagnosis.
31.	I didn't see where you can use cN for pathologic staging GIST	See AJCC note status is not required rare circumstances document - it includes chapter 43 GIST. In this case, they did actually remove 1 node, so pN0 is correct, but if no nodes were removed, cN0 can be used.