December 2023 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Coding Squamous Cell Carcinoma HPV Positive/HPV Negative

Beginning with cases diagnosed 1/1/2022 forward:

- p16 test results can be used to code squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086).
- Non-keratinizing squamous cell carcinoma, HPV positive is coded 8085 for sites listed in Table 5 only. A diagnosis of non-keratinizing squamous cell carcinoma, NOS is coded 8072.
- Keratinizing squamous cell carcinoma, HPV negative is coded 8086 for sites listed in Table 5 only. A diagnosis of keratinizing squamous cell carcinoma, NOS is coded 8071.

Examples of primary sites:
Vallecula, Oropharynx, Base of Tongue, Tonsils

See Solid Tumor Rules: Head and Neck Table 5 for full list of primary sites!
https://seer.cancer.gov/tools/solidtumor/2023/Head_Neck_STM.pdf

Priorities for Coding Multiple Races

- Code **07** takes priority over all other codes

Example: *Patient is described as Japanese and Hawaiian. Code Race 1 as 07 (Native Hawaiian), Race 2 as 05 (Japanese).*

- **Codes 02-32, 96-98 take priority over code 01**
- Code only the specific race when both a specific race code and a non-specific race code apply.
  - **Codes 04-17 take priority over code 96**
  - **Codes 16-17 take priority over code 15**
  - **Codes 20-32 take priority over code 97**
  - **Codes 02-32 and 96-97 take priority over code 98**
  - **Code 98 takes priority over code 99**

Do not use patient name as the basis for coding race.

See SEER Manual Race 1,2,3,4,5 Coding Instructions for more information!

ODS Toolkit

NCRA created this ODS Toolkit to help credential holders, human resources departments, affiliated organizations, and NCRA-accredited education programs make the transition.

NCRA will start implementing the use of ODS on January 1, 2024.

** https://www.ncra-usa.org/ODSToolkit

NJSCR Monthly Submission Reminder!

Once your cases have been a submitted, check your submission confirmation email. **This will show if the cases have been accepted or rejected**. Please email a confirmation back to njscrdat@doh.nj.gov that the file name and number of records sent/received is correct. Always check your confirmation email and monthly completeness email from your facility representative.

Submission recommendations for the reporting year are 50% of cases by December and 75% by April. Regular reporting ensures a continuous data flow and helps monitor completeness.

Cholangiocarcinoma Coding

Intrahepatic cholangiocarcinomas are almost exclusively adenocarcinomas and often diagnosed by cytology. Additional diagnostic molecular tests and clinical collaboration are needed to define a diagnosis of cholangiocarcinoma.

Clinicians often indicate a clinical diagnosis of cholangiocarcinoma without pathologic confirmation.

Per histology coding rules, pathology and cytology have priority over clinical/physician diagnosis.
If the diagnosis of cholangiocarcinoma is made on a resected specimen, then code this histology.

**https://seer.cancer.gov/tools/solidtumor/2023/STM_Other_Sites.pdf

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email. The information provided here is correct as the distribution date of the newsletter. **Always check your manuals!**

November 2023 E-Tips

New Jersey State Cancer Registry
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Other Sites Solid Tumor Rules 2023

Rules are in hierarchical order within each module. Use the first rule that applies and STOP.

Rule H13 advises to code 8210 (adenocarcinoma in adenomatous polyp), 8261 (adenocarcinoma in villous adenoma), or 8263 (adenocarcinoma in tubulovillous adenoma) **only** when:

- The final diagnosis is adenocarcinoma/carcinoma in a polyp ***OR***
- The final diagnosis is adenocarcinoma/carcinoma, and a Residual polyp or polyp architecture is recorded in other parts of the pathology report ***OR***
- The final diagnosis is adenocarcinoma/carcinoma and there is reference to residual or pre-existing polyp ***OR***
- There is documentation that the patient had a polypectomy

Polyp-specific ICD-O codes remain valid for ***small bowel/intestine sites***

Important note for cases diagnosed 1/1/2023 forward: If the final diagnosis indicates a histology other than adenocarcinoma/carcinoma arising in a polyp, code the specific histology.

Example: Cervix biopsy shows endometrioid adenocarcinoma arising in multiple polyps. Code endometrioid adenocarcinoma

**https://seer.cancer.gov/tools/solidtumor/2023/STM_Other_Sites.pdf

Question:
Thyroid: Is a diagnosis of papillary carcinoma, follicular variant, encapsulated/well demarcated, non-invasive reportable?

The final diagnosis for a left thyroid lobectomy was Papillary thyroid microcarcinoma, further stated to be Histologic Type: Papillary carcinoma, follicular variant, encapsulated/well demarcated, non-invasive. The diagnosis comment states there is a small follicular pattern papillary microcarcinoma.

Is the designation of "non-invasive" for this papillary follicular tumor equivalent to a non-reportable diagnosis of Non-invasive follicular thyroid neoplasm with papillary-like nuclear features (NIFTP), 8349/1? Or should this be accessioned as either a reportable in situ (non-invasive) papillary follicular thyroid carcinoma or a papillary microcarcinoma per the diagnosis comment?

Answer:

Your case is equivalent to encapsulated follicular variant of papillary thyroid carcinoma, non-invasive (non-invasive EFVPTC) and is not reportable for cases diagnosed in 2021 or later even though it says "carcinoma." That is because the WHO assigned a behavior code of /1 to this entity (8349/1). NIFTP is assigned to the same histology and behavior code.

**https://seer.cancer.gov/seer-inquiry/inquiry-detail/20230032/

Surgical Procedure of Other Site 2023

Do not code tissue or organs such as an appendix that were removed incidentally, and the organ was not involved with cancer.

Note: Incidental removal of organs means that tissue was removed for reasons other than removing cancer or preventing the spread of cancer. *Examples of incidental removal of organ(s) would be removal of appendix, gallbladder, etc., during abdominal surgery.*

Do not code removal of uninvolved contralateral breast in this data item.
See Surgery Codes for Breast in Appendix C.

Do not include organs beyond the primary site that are included in the Surgery of Primary Site 2023 codes.

Example: A hemicolectomy including removal of the small bowel. Surgery of Primary Site 2023 code A410 for colon includes resection of contiguous organ such as small bowel or bladder. Do not code removal of small bowel or bladder performed with a subtotal colectomy/hemicolectomy in Surgical Procedure of Other Site.

**https://seer.cancer.gov/manuals/2023/SPCSM_2023_MainDoc.pdf

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email. The information provided here is correct as the distribution date of the newsletter. Always check your manuals!

October 2023 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Breast Grade Value: When assigning grade, can the values L,M, and H be used for invasive tumors? What about codes 1, 2, and 3? Can they be assigned to in situ tumors?

Codes L, M, H should only be used for in situ tumors. Never for invasive tumors.
Codes 1, 2, 3 should only be used for invasive tumors. Never for in situ tumors.

CAForum Breast Grade Values

Invasive tumors

- The preferred grading system for Invasive tumors is the Nottingham grade/Nottingham Score, also known as the Scarff-Bloom-Richardson or Bloom Richardson.
- The Nottingham score is a combined histologic grade in which three components are evaluated to determine the overall grade: tubule formation, nuclear pleomorphism and mitotic count. Each of these components is assigned a value from 1 (favorable) to 3 (unfavorable) for each feature and then totaling the scores for all three categories. A combined score of 3-5 points is designated as grade 1; a combined score for 6-7 points is grade 2; a combined score of 8-9 points is grade 3
- If a pathology report for an invasive cancer states, “Grade 1 (or 2, 3)” and there is no further information, assume this is the Nottingham grade and assign the appropriate code.
- If a pathology report for an invasive cancer states, “well differentiated, moderately differentiated, poorly differentiated, low, medium, high,” use grades A-D as appropriate

Example: Pathology report states invasive ductal carcinoma, well differentiated. Code grade A.

Do not use grades L, M, H for invasive tumors

Exception: Biopsy diagnosis is DCIS; Lumpectomy is invasive ductal carcinoma. The Clinical Grade would be L, M, H or 9 based on DCIS; the Pathological Grade would be 1, 2, 3, or 9 based on the invasive ductal carcinoma. Behavior would be /3

In situ tumors

- The preferred grading system for in situ tumors is based on a 3 grade Nuclear system, and is defined as Low (L) (Nuclear Grade 1), Intermediate (M) (Nuclear Grade 2), or High (H) (Nuclear Grade 3), or the nuclear component of the Nottingham grade
- Documentation for these grades may be 1/3, 2/3, 3/3. This notation is documenting the nuclear component of the Nottingham grade, not the Nottingham grade (1, 2, 3)
- If a pathologist uses a Nottingham grade (i.e., G2) for an in situ cancer, they are documenting the nuclear component of the Nottingham score. You would still assign L, M, or H as appropriate for the in situ tumor

Do not use grades 1, 2, 3 for in situ tumors

Reportability/Histology Question
Testis

Is micropapillary serous borderline tumor reportable? Pathology states Testis radical orchiectomy: Micropapillary serous borderline tumor.

Answer:

We consulted an expert genitourinary pathologist who advises that **micropapillary serous borderline tumor of the testis is reportable.** He states "it is the same neoplasm as in the ovary. It arises from tissue (tunica vaginalis) surrounding the testis so is a paratesticular neoplasm."

Please note: not all borderline tumors are reportable and this diagnosis is an exception because it is assigned /2 in ICD-O-3.2. It is reportable for cases diagnosed Jan 1, 2021 and later.

**SEER Inquiry

Primary Myelofibrosis is Reportable. Use histology **code 9961/3.**

Myelofibrosis (NOS) and secondary myelofibrosis by themselves are *non-reportable*.

Check out SEER Heme for more information on heme Reportability!

NAACCR #1117 Mets at Diagnosis--Other

Carcinomatosis has a special code. ***Code 2 is Generalized metastases such as carcinomatosis.***

Check out the SEER Manual for description on the codes for Mets at Diagnosis categories and Instructions!

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September 2023 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Surgery of Primary Site 2023--Melanoma:

Considering the 2023 melanoma surgery codes for punch biopsy NOS (B220) and shave biopsy NOS (B230), how is Date of First Surgical Procedure coded when the punch or shave biopsy is not excisional?

Example: On 01/01/2023, patient has a frontal scalp shave biopsy showing melanoma, margins involved. On 02/01/2023, frontal scalp excision shows residual melanoma. Surgery code is assigned B520 (shave followed by wide excision). How is Date of First Surgical Procedure coded now that there is an additional surgery code for the shave biopsy?

Answer:

Code the Date of First Surgical Procedure as 01/01/2023 in the example provided where the shave biopsy is followed by wide excision. **Beginning in 2023, significant changes were made in that shave, punch, and elliptical biopsies are coded as surgical procedure regardless of margin status.** Appendix C Skin Surgery Codes state that an incisional biopsy would be a needle or core biopsy of the primary tumor.

Please see Appendix M: Case Studies for Coding Melanoma in STORE v23, Case study 2: Shave Biopsy followed by WLE (page 412), for an explicit example of how to code your example case.

** https://seer.cancer.gov/seer-inquiry/inquiry-detail/20230034/

Address at Diagnosis

Record the **number and street address or the rural mailing address of the patient's usual residence when the tumor was diagnosed.**

"The place where he or she lives and sleeps most of the time or the place the person says is his or her usual home."

Code the place of usual residence rather than the temporary address for persons temporarily residing with family during cancer treatment.

** SEER Program Coding and Staging Manual 2023

NJSCR News and Updates

Completeness Rate
NJSCR recommends hospitals have *at least* **25%** of 2023 cases reported by the end of September 2023.

New Videos posted on FLccSC

Neoadjuvant Data Items webinar available.

Don't have time for a long webinar, check out Shorts on Flccsc!

Videos under 10 minutes covering:

LVI

Date of Diagnosis

Resources

FCDS - LMS - Frontend - Log In (miami.edu)

Melanoma of the Skin: EOD Primary Tumor

Note 1: If there is a discrepancy between the Clark level and the pathological description of extent (invasion into the layers of the dermis), ***use the higher (more extensive) code***.

Note 2: Code the greatest extent of invasion from any procedure performed on the lesion, whether it is described as a biopsy or an excision. For example, if a punch biopsy with involvement of Clark level IV is followed by a re-excision with residual tumor involving Clark level II, code 300 (Clark level IV).

Note 3: Satellite lesions/nodules or in-transit metastases are coded in EOD Regional Nodes.

Note 4: If a Breslow's depth is given in the pathology report and there is no other indication of involvement, the following guidelines may be used (Note: If a physician documents a different Clark's Level then provided by these guidelines, go with the physician's Clark Level).

Code 000: Level I (In situ)
Code 100: Level II (< 0.75 mm Breslow's Depth)
Code 200: Level III (0.76 mm to 1.50 mm Breslow's Depth)
Code 300: Level IV (> 1.50 mm Breslow's Depth)

Note 5: In addition to EOD Primary Tumor, the following data items are also collected to determine the extent of the primary tumor: Breslow's Thickness [NAACCR Data Item #3817] and Ulceration [NAACCR Data Item #3936].

** https://staging.seer.cancer.gov/eod_public/list/3.0/

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email. The information provided here is correct as the distribution date of the newsletter. Always check your manuals!

August 2023 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Modified Radical Mastectomy Surgery Coding over the Years

Example:
A patient with breast cancer had a modified radical mastectomy on her right breast.

Diagnosis year 2022
- Assign surgery in field RX Summ--Surg Prim Site 03-2022(1290)
- Use Appendix A of the STORE manual 2022 or SEER 2022 Appendix C
- **Assign code 51**

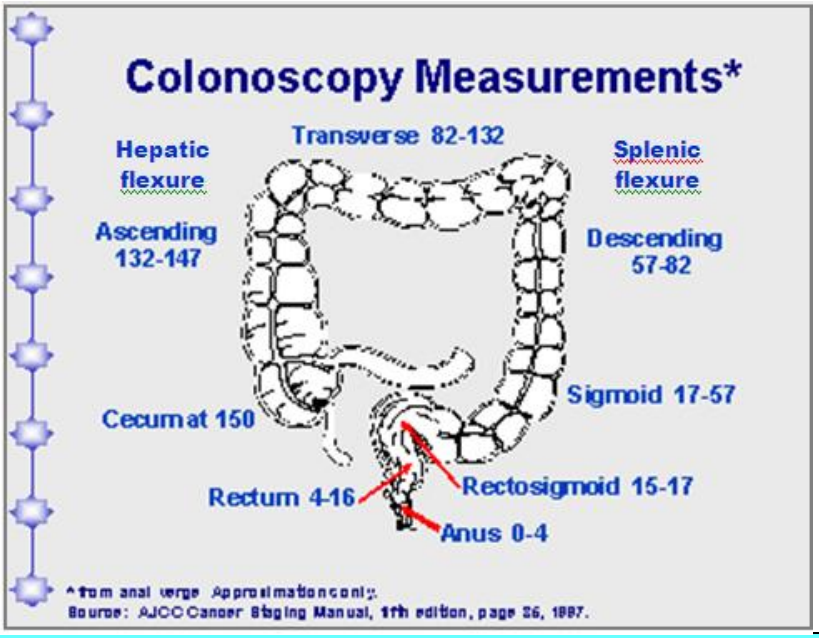
Diagnosis Year 2023
- Assign surgery in field RX Summ--Surg Prim Site 2023 (1291)
- Use Appendix A of STORE 2023 or SEER 2023 Appendix C
- **Assign code A510**

Diagnosis year 2024
- Assign surgery in field RX Summ-Surg Prim Site 2023 (1291)
- Use Appendix A of STORE 2023
- **Assign code B610**

** 2023 ETC Training RX Summary Primary site/RX Regional Lymph Node Summary Webinar by Jim Hofferkamp

Know your Colon Subsites for assigning Primary Site!

Check out the Colonoscopy Measurements section in the Colon, Appendix, Rectosigmoid, Rectum Solid Tumor Rules in Appendix C



Question:
Update to Current Manual/2018 EOD Manual/EOD Primary Tumor--Bladder: According to the American Joint Commission on Cancer (AJCC), a transurethral resection of the bladder (TURB) cannot make a distinction between involvement of the superficial muscle-inner half (Stage T2a) and the deep muscle-outer half (Stage T2b). **Is the same criteria applied to Extent of Disease (EOD)?**

Answer:
EOD follows AJCC criteria in this situation and we have confirmed with AJCC that Stage T2a (superficial muscle) and Stage T2b (deep muscle) cannot be assigned when only a TURB is done.

For EOD Primary Tumor, Bladder, codes 200, 250, 300, 350, can only be used when:

- **A cystectomy is performed.**
- **Muscularis propria is involved, *AND* the pathology report states superficial muscle (200, 250) or deep muscle (300, 350) is involved.**

If a TURB is done and there is mention of the muscularis propria invasion (superficial muscle or deep muscle), **use EOD codes 370 or 400**. If a TURB is done and the pathology report states superficial or deep muscle, ignore and code as "invasion of muscularis propria, NOS" (**EOD codes 370 or 400**).

*Instructions and code descriptions for EOD Primary Tumor have been updated to indicate this. These updated instructions and code descriptions will be available when SEER*RSA is updated for 2024, Version 3.1 (Sept/Oct 2023). These updates are included here for reference and can be applied for cases diagnosed 2018+.*

***SEER Inquiry System 20230035*

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email. The information provided here is correct as the distribution date of the newsletter. Always check your manuals!

July 2023 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Coding Microsatellite Instability (MSI) for Colon and Rectum

- Physician statement of MSI can be used to code this data item when no other information is available.
- MSI may be recorded for all stages; however, it is primarily performed for invasive neoplasms**. For non-invasive neoplasms (behavior /2), code to 9 if no information available.**
- Results from nodal or metastatic tissue may be used for Microsatellite Instability.
- If both tests are done and one or both are positive, code 2.
- *If all tests done are negative, code 0.*

MSI done by immunology or genetic testing. MSI is looking at instability in informative markers.

MSI results are coded as:

- MSS (Code 0)
- Stable (Code 0)
- Negative (Code 0)
- Low probability of MSI-H (Code 0)
- MSS/MSI-L (Code 0)
- MSI-L (Code 1)
- Unstable, high (Code 2)
- Unstable, NOS (no designation of high or low) (Code 2)
- MSI-H (Code 2)
- MSI-I (intermediate) (Code 9)

Testing for Mismatch Repair (MMR) is usually done by immunohistochemistry (IHC).

MMR results are recorded as:

- No loss of nuclear expression (code 0)
- Mismatch repair (MMR) intact (code 0)
- MMR proficient (pMMR or MMR-P) (code 0)
- MMR normal (code 0)
- Loss of nuclear expression (code 2)
- MMR deficient (dMMR or MMR-D) (code 2)
- MMR abnormal (code 2)

Check out EOD RSA Colon and Rectum!
https://staging.seer.cancer.gov/eod_public/list/3.0/

How is the histology coded for vulvar intraepithelial neoplasia III (VIN III)/Squamous cell carcinoma in situ from a pathology report of the vulva, 8070/2 for squamous cell carcinoma in situ or 8077/2 for VIN III?

Answer:

Assign **8077/2** for high-grade squamous intraepithelial lesion, VIN 3 in this case. The WHO Classification of Female Genital Tumors, 5th edition, states that squamous intraepithelial lesions (SILs) of the vulva are also known as vulvar intraepithelial neoplasia, HPV-associated. The term squamous cell carcinoma in situ is not recommended.

**https://seer.cancer.gov/seer-inquiry/inquiry-detail/20230028/

NEW coding video on FLccSC!!!
Check out the new Neoadjuvant Data items video!
http://njs.fcdslms.med.miami.edu/

Synonyms for Tumor Deposit

- **Discontinuous Extramural Extension**
- **Malignant Tumor Foci**
- **Malignant peritumoral Deposits**
- **Satellite Nodule**

A physician statement for tumor deposit can be used when no other information is available.

Always check your pathology report and SEER manual.
**https://staging.seer.cancer.gov/eod_public/home/3.0/
** NAACCR Webinar Series 2023 Lower GI Part 1

Class of Case 32
Address at Diagnosis

Verify the patient was a New Jersey resident at the time of diagnosis. If there is documentation that the patient was **not a NJ resident at the time of diagnosis, use the address at diagnosis,** not the patient's current NJ address.
Check out the SEER Manual for coding instructions.

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June 2023 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Question:

How should Reason for No Surgery of Primary Site be coded for cases when surgery was planned but aborted due to extent of disease seen during planned procedure? Lung abnormality on imaging prompted diagnosis on subsequent biopsy and clinical staging was documented as cT1b N0 M0. There was an attempt at resection, but the patient was found to have chest wall involvement and the procedure was aborted.

Answer:

For 2023 cases and forward, if no part of the surgery was performed, code *Surgery of Primary Site 2023* (NAACCR Item #1291) as code A000 or B000 (no surgical procedure of the primary site). Code *Reason for No Surgery of Primary Site* (NAACCR Item #1340) as code 2 (surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned surgery, etc.).

In contrast, if any part of the surgery was performed, assign the *Surgery of Primary Site 2023* (NAACCR Item #1291) code that best reflects the extent of the surgery performed. Code *Reason for No Surgery of Primary Site* (NAACCR Item #1340) as code 0 (surgery of the primary site was performed).

Use text fields to record the details.

For cases prior to 2023, apply the same approach using *Surgery of Primary Site* (NAACCR Item #1290) instead of *Surgery of Primary Site 2023* (NAACCR Item #1291).

** https://seer.cancer.gov/seer-inquiry/inquiry-detail/20230020/

Scope of Regional Lymph Node Surgery #1292

Add the number of all of the lymph nodes removed during each surgical procedure performed as part of the first course of treatment. The Scope of Regional Lymph Node Surgery data item is cumulative.

Example:

Patient has excision of a positive cervical node. The pathology report from a subsequent node dissection identifies three cervical nodes. **Assign code 5** (4 or more regional lymph nodes removed).

Lymph Node Aspirations

- Do not double-count when a regional lymph node is aspirated, and that node is in the resection field. Do **not** add the aspirated node to the total number.
- Count as an additional node when a regional lymph node is aspirated, and that node is **NOT** in the resection field. **Add** it to the total number.
- Assume the lymph node that is aspirated is part of the lymph node chain surgically removed and do not include it in the count when its location is **not known**.

**https://seer.cancer.gov/manuals/2023/SPCSM_2023_MainDoc.pdf

Surgical Codes for Brain, Central Nervous System, Malignant, Benign and Borderline

A100 Tumor destruction, NOS

[***SEER Note***: Local tumor destruction, NOS; laser interstitial thermal therapy (LITT) - code A100 if no specimen sent to pathology.]

No specimen sent to pathology from surgical event A100

Do not record stereotactic radiosurgery (SRS), Gamma knife, Cyber knife, or Linac radiosurgery as surgical tumor destruction. All of these modalities are recorded in the radiation treatment fields.

A200 Local excision of tumor, lesion, or mass, excisional biopsy

A210 Subtotal resection of tumor, lesion, or mass in brain

A220 Resection of tumor in spinal cord or nerve

[*SEER Note:* Assign code A200 for stereotactic biopsy of brain tumor.]

** https://seer.cancer.gov/manuals/2023/appendixc.html

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May 2023 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Coding Guidelines Breast C500-C509
Coding Subsites & Laterality

Use the information from reports in the following priority order to code a subsite when there is conflicting information:

1. Operative report
2. Pathology report
3. Mammogram, ultrasound (ultrasound becoming more frequently used)
4. Physical examination

Code the **subsite with the invasive tumor** when the pathology report identifies invasive tumor in one subsite and in situ tumor in a different subsite or subsites.

Laterality must be coded for all subsites.

Breast primary with positive nodes and no breast mass found: **Code laterality to the side with the positive nodes.**

Check out the SEER Coding Guidelines by site in Appendix C!

**https://seer.cancer.gov/manuals/2023/AppendixC/Coding_Guidelines_Breast_2023.pdf

Coding for Tumor Embolization

Chemoembolization: A procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.

Code as Chemotherapy when the embolizing agent(s) is a chemotherapeutic drug(s).

Radioembolization: Tumor embolization combined with the injection of small radioactive beads or coils into an organ or tumor.

Assign **code 13 Radioisotopes, NOS** for Radiation Treatment Modality for Radioembolization procedures, e.g., intravascular Yttrium-90

Tumor embolization: The intentional blockage of an artery or vein to stop the flow of blood through the desired vessel.

Do not code pre-surgical (pre-operative) embolization of hypervascular tumors with agents such as particles, coils, or alcohol as a treatment. Pre-surgical embolization is typically performed to prevent excess bleeding during the resection of the primary tumor.

** SEER Program Coding And Staging Manual 2023

Question:

Is dermatofibrosarcoma protuberans (DFSP) with fibrosarcomatous overgrowth, DFSP with fibrosarcomatous component Grade 2, or DFSP with focal myxoid features (2022) reportable for 2021-2022 diagnoses?

Answer: Yes.
DFSP with fibrosarcomatous overgrowth and DFSP with fibrosarcomatous component Grade 2 are synonymous with fibrosarcomatous DFSP (8832/3). Our expert pathologist also advises **that DFSP with focal myxoid features is the same as DFSP, myxoid (8832/3).**

** SEER Inquiry System - Question 20230013 Details (cancer.gov)

Coding Instructions for Carcinosarcoma (8980/3) and malignant mixed Mullerian tumor/MMMT (8950/3)

Path diagnosis often stated as carcinosarcoma (malignant mixed Mullerian tumor) **code to carcinosarcoma 8980/3.**

If stated as MMMT only, **code 8950/3.**

** SEER SINQ 20200082

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email. The information provided here is correct as of the distribution date of the newsletter. Always check your manuals!

April 2023 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
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(609) 633-0500

2023 Breast Surgery Code Clarification from SEER SINQ

SEER Manual/Surgery of Primary Site 2023--Breast: **What instructions should be followed when the 2023 SEER Manual Appendix C 2023 Breast Surgery Codes advise to code 1 in Surgical Procedure of Other Site for a simple bilateral mastectomy but the 2023 STORE Manual does not?**

The 2023 SEER Manual, Appendix C 2023 Breast Surgery Codes, note reads:
SEER Note: Assign code A760 for a more extensive bilateral mastectomy. Assign code 0 in Surgical Procedure of Other Site (NAACCR #1294). For a simple bilateral mastectomy, assign code A410 with code 1 in Surgical Procedure of Other Site (NAACCR #1294).
In the 2023 STORE Manual, these notes are not mentioned, and we are instructed not to code surgery to other site. Other education related to 2023 breast coding provided by NAACCR states to not code surgery to other site.

Answer

*Assign **code 1 in Surgical Procedure of Other Site** (NAACCR #1294) when a **simple** bilateral mastectomy is performed for a single tumor involving both breasts.*
This statement was inadvertently omitted from the STORE manual and will be added back in: For single primaries only, code removal of contralateral breast under the data item Surgical Procedure/Other Site *(NAACCR Item #1294) or* Surgical Procedure/Other Site at This Facility *(NAACCR Item #674).*
The information presented by NAACCR was intended to be consistent with what is in the SEER manual.
** https://seer.cancer.gov/seer-inquiry/inquiry-detail/20230008/

Bladder: Tips for assigning Behavior Code

Code the behavior as **malignant (/3)** when:

- The diagnosis is high grade urothelial carcinoma AND there is no information regarding invasion **OR**
- The pathology report says the submucosa is invaded with tumor **OR**
- The only surgery performed is a TURB documenting that depth of invasion cannot be measured because there is no muscle in the specimen **AND**
  - There is no information regarding invasion and the physician's TNM designation is not available **OR**
  - The pathology report does not mention whether the submucosa is free of tumor or has been invaded.

Check out the Coding Guidelines: Bladder for more behavior code coding examples!

**https://seer.cancer.gov/manuals/2023/appendixc.html
**https://seer.cancer.gov/manuals/2023/AppendixC/Coding_Guidelines_Bladder_2023.pdf

Lymph vascular Invasion Coding for Thyroid and Adrenal Primaries dx year 2022+

Code lymphovascular invasion to 0, 2, 3, 4, or 9 for the following Schema IDs
Thyroid 00730
Thyroid Medullary 00740
Adrenal Gland 00760

Code 1 Lymphovascular Invasion Present/Identified (NOT used for thyroid and adrenal gland)

**https://seer.cancer.gov/manuals/2023/SPCSM_2023_MainDoc.pdf

Welcome to your Central Cancer Registry!
June 14th, 2023 9:00am-12:00pm
Approved for 2.5 CE's
Don't wait! Registration **will close May 15, 2023.**
https://www.nj.gov/health/ces/

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email. The information provided here is correct as of the distribution date of the newsletter. Always check your manuals!

March 2023 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Neoadjuvant Therapy NAACCR Item #1632

Neoadjuvant Therapy, effective for cases diagnosed 01/01/2021, or later, records whether the patient had neoadjuvant therapy prior to planned definitive surgical resection of the primary site.

Neoadjuvant therapy is defined as systemic treatment (chemotherapy, endocrine/hormone therapy, targeted therapy, immunotherapy, or biological therapy) and/or radiation therapy before intended or performed surgical resection to improve local therapy and long-term outcomes during first course of treatment.

The criteria for neoadjuvant therapy are:

- A physician's treatment plan and/or statement of patient completing neoadjuvant therapy must be used.
- Treatment must follow the recommended treatment guidelines for the type and duration of treatment for that primary site and/or histology. The length of a full course of neoadjuvant systemic therapy may vary depending on the primary site and/or histology, often from 4-6 months, but could be shorter, of neoadjuvant systemic therapy and/or radiation.
- Neoadjuvant therapy may include systemic therapy alone, radiation alone, or combinations of radiation and systemic therapy (for example, with rectal cancer, esophageal cancer, head and neck cancer)
- Neoadjuvant therapy data items are coded based on treatment/procedures that occur during first course of therapy.
- Neoadjuvant therapy may be given as part of a clinical trial.

Check out the SEER Program Coding and Staging Manual 2023 for more information!
**https://seer.cancer.gov/manuals/2023/SPCSM_2023_MainDoc.pdf

Reportable Intraepithelial Neoplasia Examples

- Squamous intraepithelial neoplasia, high grade
- High grade squamous intraepithelial lesion (HSIL)
- Intraepithelial neoplasia grade II/III; II-III
- Squamous dysplasia, high grade for sites other than colon/GI
- Anal intraepithelial neoplasia (AIN), grade II
- Anal intraepithelial neoplasia (AIN), grade III
- Biliary intraepithelial neoplasia, high grade
- Conjunctival intraepithelial neoplasia grade III
- Penile intraepithelial neoplasia (PeIN), undifferentiated
- Squamous intraepithelial neoplasia, grade II
- Vaginal intraepithelial neoplasia (VaIN), grade III
- Vulvar intraepithelial neoplasia (VIN), grade III
- Squamous intraepithelial neoplasia, grade III

8380/2 (C54_)

- Endometrioid intraepithelial neoplasia (EIN)
- Intraepithelial neoplasm of endometrium
- Atypical hyperplasia of endometrium

**https://seer.cancer.gov/manuals/2023/SPCSM_2023_Changelog.pdf

Question:

Thyroid: Is a case with thyroid fine needle aspirate (FNA) cytology with nodule 1 Bethesda category 5 and nodule 2 Bethesda 6, reportable in 2021? Does the Bethesda category 5 or 6 have any bearing on reportability?

Answer:

In the absence of information to the contrary, **thyroid FNAs designated as Bethesda classification category VI are reportable**. Thyroid FNAs designated as Bethesda classification category V are not reportable unless there is additional information confirming a reportable diagnosis. For both Bethesda V and VI, NCCN Guidelines recommend total thyroidectomy or lobectomy (depending on tumor size and nodal involvement) for the purposes of definitive diagnosis/treatment, so additional information should be available.

Nodule 1 Bethesda V is not reportable. Nodule 2 **Bethesda VI is reportable.**

**https://seer.cancer.gov/seer-inquiry/inquiry-detail/20230014/

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February 2023 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Question:

First Course Treatment/Immunotherapy--Other Therapy: **Should all therapies given as part of a clinical trial be coded as Other Therapy (NAACCR #1420), or only those that cannot be classified in one of the other treatment categories (systemic therapy, surgery, radiation) or as ancillary treatments?** Does it matter what is listed in SEER*Rx under Primary Sites or Remarks regarding FDA approvals?

For example, if a patient is given a drug as part of a trial that is categorized in SEER*Rx as immunotherapy, should it be assigned both Immunotherapy (NAACCR #1410) code 1 and Other Therapy code 2, or only coded in Immunotherapy since it is classified as such? How should a clinical trial drug be coded if it has a treatment classification in SEER*Rx, but the type of cancer being treated is not listed under the Primary Site or Remarks sections as being FDA approved? A real case scenario is atezolizumab given for colon cancer as part of a trial; this drug's category is Immunotherapy in SEER*Rx but colon is not listed under Primary Sites or in the Remarks detailing FDA approvals.

Answer:

When a drug is being administered as part of a clinical trial and it is not yet approved as treatment for the cancer site for which it is being administered, code in Other Therapy. Do not code it as Immunotherapy (for the example provided). While a drug may be approved to treat one type of malignancy, it may be in clinical trials to determine its value in treating other malignancies. Coding as immunotherapy is misinformation in this case since there are other types of approved immunotherapeutic agents.

** https://seer.cancer.gov/seer-inquiry/inquiry-detail/20220048/

Grade Coding

On breast biopsy, Nuclear grade II DCIS. On resection, invasive Nottingham grade 2/3. ***Would clinical grade be M and path grade be 2?***

Answer:

Clinical grade code M, and pathological grade code 2. Since the insitu was on clinical, you can use the insitu grading system for clinical and the invasive system for pathological.

If the clinical was invasive and the pathological was in situ, you would use the clinical [*grade in the pathological grade field]* since the case would be invasive.

**https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/86148-breast-case-clinically-insitu-and-path-invasive-clinical-grade

NJSCR News and Updates

The 2023 NJSCR Program Manual and 2023 Reportable List are now LIVE on the NJSCR Website! Check it out!
https://www.nj.gov/health/ces/reporting-entities/registrars/

Submission Update for Hospital Registrars

Wait to send in your **2023 diagnosis year** cases. A new update is coming soon. You will be notified when these can be sent.

Save the date! Spend The day is BACK!

NJSCR will be hosting a live "Virtual" Spend the day on **Wednesday, June 14, 2023**. Come see the inner workings of the New Jersey Sate Cancer Registry. Free CE's offered. More information coming soon.

Date of Diagnosis

Code the month, day, and year the tumor was first diagnosed, clinically or microscopically, by a recognized medical practitioner.

When the first diagnosis includes reportable ambiguous terminology, record the date of that diagnosis.	**Example:** Area of microcalcifications in breast suspicious for malignancy on 02/13/2023. Biopsy positive for ductal carcinoma on 02/28/2023. **The date of diagnosis is 02/13/2023.**

Code the date the procedure was done, not the date the specimen was received or read as positive by the pathologist when the date of diagnosis is coded from a pathology report. ***Example***: Biopsy was performed on 05/06/2023. The specimen from the biopsy was received and read by the pathologist as positive for cancer on 05/09/2023. **The date of diagnosis is 05/06/2023.** (SPM 2023, pg.85 #3)

The first diagnosis of cancer may be clinical (i.e., based on clinical findings or physician's documentation)

Note: Do not change the date of diagnosis when a clinical diagnosis is subsequently confirmed by positive histology or cytology. ***Example***: On May 15, 2023, a physician states that patient has lung cancer based on clinical findings. The patient has a positive biopsy of the lung on June 3, 2023. **The date of diagnosis remains May 15, 2023.**

SEER Program Coding and Staging Manual (cancer.gov) 2023

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January 2023 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

2023 Breast Surgery Code Updates and Clarifications

Assign code A220 when a patient has a lumpectomy and an additional margin excision during the same procedure. (Re-excision of the margins intraoperatively during same surgical event does not require additional resources; it is still A220.)

Assign Code A230 when a Subsequent re-excision of lumpectomy margins during separate surgical event requires additional resources: anesthesia, op room, and surgical staff.

Assign Code A760 when a Bilateral mastectomy is performed for a single tumor involving both breasts, as for bilateral inflammatory carcinoma [SEER Note: Assign code A760 for a more extensive bilateral mastectomy. Assign code 0 in Surgical Procedure of Other Site (NAACCR #1294).

Assign Code A410 for a simple bilateral mastectomy, assign with code 1 in Surgical Procedure of Other Site (NAACCR #1294).]

A total (simple) mastectomy removes all breast tissue, the nipple, and the areolar complex. An axillary dissection is not done, but sentinel lymph nodes may be removed.

Check out your Breast Surgical Codes. This can be found in the 2023 Appendix C: Site Specific Coding Modules (*link below*)

https://seer.cancer.gov/manuals/2023/appendixc.html

LCIS is still REPORTABLE for NJSCR!

Lobular Carcinoma insitu is reportable for SEER and NPCR. New Jersey is a SEER state.
LCIS should be staged using SS2018.

** Breast 2022 Part 2 NAACCR Webinar
** SEER Manual 2023
https://seer.cancer.gov/tools/codingmanuals/

New STORE 2023 Data Items and AJCC Staging Protocols

The Standards for Oncology Registry Entry Manual, effective for cases diagnosed January 1, 2023, was released on 10/7/22. (https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data) Refer to the chapter "STORE 2023 Summary of Changes" on p. 29 for a description of changes in this year's STORE.

NEW Coding Shorts on FLccSC
NEW GRADE Webinar on FLccSC

http://njs.fcdslms.med.miami.edu/
Only have a few minutes and or want to know an answer without combing through a full webinar? Check out NJSCRs coding shorts!
New shorts added regularly!

Coding Tips from New Solid Tumor Rules Other Sites for 2023

Ductal Carcinoma 8500/3: In **Prostate** biopsies, the term "adenocarcinoma prostate with ductal features" should be used in the pathology report and is coded to 8140/3. In order to code ductal adenocarcinoma 8500/3, the ductal component must comprise >50% of the tumor with the percentage reported and from a radical prostatectomy specimen.

Cholangiocarcinoma: Intrahepatic cholangiocarcinoma are almost exclusively adenocarcinoma and often diagnosed by cytology. Per histology coding rules, pathology and cytology have priority over clinical/physician diagnosis. If the diagnosis of cholangiocarcinoma is made on a resected specimen, then code this histology.

Soft Tissue: Myxofibrosarcoma and fibromyxosarcoma are the same and both coded 8811/3. The word roots have been inverted.

Anus: p16 test results can be used to code squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086)

Check out the new updated STR for Other sites!
** Other Sites Solid Tumor Rules 2023 Update (cancer.gov)

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