

Solid Tumor Rules: December 2020 Update

ICD-0-3.2 changes have also been added to applicable site modules. Most changes are minor: terminology, additional definitions, new notes and examples. In order to **clarify** histology coding instructions, new rules have been added and histology tables updated. These updates **do not** require review of already abstracted cases. The December 2020 rules replace the current rules and should be used now. **SEER Strongly recommends reading the December 2020 Change Log to understand what changes were made.**

The updated Solid Tumor Rules may be accessed at: <https://seer.cancer.gov/tools/solidtumor/>

Radiation Coding Total Dose (1533)

If doses across phases to a single point of region, **code Sum of all phases. ** (see 2019 update below)**
 If doses are to multiple metastatic sites, **code highest dose site.**
 If doses are to primary site and metastatic site, **code dose from the primary site only.**
When you have two different sites, you cannot add the doses together to get the total dose.

Radiation Tips and updates for 2019

If dose/fraction and total dose is provided in Gy or cGy units for any brachytherapy procedure, capture this information in your abstract. **Do not use codes 99998 or 999998.**

If brachytherapy is only mode of treatment and dose is not provided in cGy, code to 999999 for total dose.

****You cannot add dose from EBRT phase to that of brachytherapy phase to get a total dose (1533).****

Updated Instructions for coding multiple phases for radiation treatment

- 1) Code the phases from the earliest to latest start date.
- 2) If there are multiple phases with the same start date, code the phases from highest to lowest total dose.
- 3) If there are multiple phases with the same start date and same total dose, then any order is acceptable.

*NAACCR 2020-2021 Webinar Series: Prostate
 * Guidelines for Coding RT Treatments for Prostate Cancer-An overview- Wilson Apollo, S, CTR

Reportability Changes for 2021

Starting 01/01/2021 the following terms are **reportable**:

Early or evolving melanoma in situ, or any other early or evolving melanoma, are reportable.

All GIST tumors are reportable and classified as 8936/3 in ICD-O-3.2.

Nearly all thymomas are reportable; the exceptions are microscopic thymoma or thymoma benign (8580/0), micronodular thymoma with lymphoid stroma (8580/1), and ectopic hamartomatous thymoma (8587/0).

* https://www.naacr.org/wp-content/uploads/2020/10/2021-Implementation-Guidelines_20201009.pdf

Question:
Is Bosniak 4 cystic lesion of right kidney reportable?

Answer
 Bosniak 4 is defined as "clearly malignant; ~100% malignant." **The case is reportable** as of the first date it is diagnosed as a Bosniak 4 lesion unless further workup (especially biopsy or resection) disproves the CT findings.
 * <https://seer.cancer.gov/seerlookup/index.php?page=view&id=2020059&type=q>

Question:
What is the primary site for a case of metastatic melanoma with an unknown primary site?

Answer
Code primary site C449 (Skin, NOS). C449 is the default primary site code for melanoma of unknown primary site.
 * <https://seer.cancer.gov/seerlookup/index.php?page=view&id=2020051&type=q>

Don't Forget Your Text!

You should be able to abstract your case using your text.

Make sure you ***include dates, surgical description (from Op Report), pathology and any descriptors to validate your codes.***

Positive COVID-19 test be recorded in the Lab Text Field

Consistently use the following abstracting format.



COVID-19 [testing type: viral or antibody] [interpretation: POS, NEG] [date: mm/dd/yyyy]

Example: COVID-19 Viral POS 10/15/2020

Recording Delay in Treatment Due to Covid in Text Field

(type of treatment) Delayed D/T COVID-19

Examples: SURG TX Delayed D/T COVID-19

EBRT Delayed D/T COVID-19 [substitute XRT or RT for EBRT as appropriate]

Check out more tips for Coding COVID in Text! <https://seer.cancer.gov/tools/covid-19/COVID-19-Abstraction-Guidance.pdf>

Non-Analytic Class of Case Code Examples

- Diagnostic workup, Consult only [30].
- In-transit care [31] Use 31 if all your facility does for a patient is stent placement, port catheters, or other care that facilitates treatment but is not treatment.
- Recurrence or persistence of disease (with disease, first course treatment failure) [32].
- History of disease only (nonapparent now) [33]
- Diagnosed at autopsy, cancer not suspected earlier [38].
- Type of cancer not required by CoC to be reported [34,36].
- Diagnosed before Reference Date [35,37]

*NAACCR 2020 Coding Pitfalls Webinar

Question:

Should the Surgery of Primary Site for the 2020 diagnosis be coded 51 (Modified radical mastectomy without removal of uninvolved contralateral breast) when a partial mastectomy and axillary lymph node dissection are performed for a 2011 right breast primary and a subsequent 2020 right breast primary is treated with a total mastectomy only?

Answer:

Yes, assign surgery of primary site **code 51** for the 2020 diagnosis in this case. Code the cumulative effect of all surgeries to the primary site. This means that for the 2020 primary, code the cumulative effect of the surgery done in 2011 plus the surgery performed in 2020. Use text fields on both abstracts to record the details.

*<https://seer.cancer.gov/seer inquiry/index.php?page=view&id=20200050&type=q>

Coding Lymphovascular Invasion

In STORE, ambiguous terms are used for reportability and AJCC staging as indicated by NCDB Staff in response to jvogel22. "When abstracting, registrars are to use the Ambiguous Terms at Diagnosis list with respect to case reportability, and the Ambiguous Terms Describing Tumor Spread list with respect to tumor spread for staging purposes.

Do not use ambiguous terms for LVI.

Use code 9 (Unknown/Indeterminate/not mentioned in path report) when LVI is described as **suspicious**.

*<http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/other-general-questions/106340-lymphovascular-invasion-suspicious>

Use code 0 when the pathology report indicates that there is no Lymphovascular invasion. This includes cases of purely **in situ carcinoma**, which biologically have no access to lymphatic or vascular channels below the basement membrane.

*<http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/other-general-questions/104180-lvi-bladder-ta-case>

* NAACCR 2020 Coding Pitfalls Webinar

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October 2020 E-Tips

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

Node Status Not Required in Rare Circumstances

For some cancer sites in which lymph node involvement is rare, patients whose nodal status is not determined to be positive for tumor should be designated as cNO. These circumstances are identified in specific disease site chapters for these sites; NX may not be listed as a category.

All chapter exceptions where cNO may be used for cN & pN category:

- 38 Bone
- 40 Soft Tissue Sarcoma of the Head and Neck
- 41 Soft Tissue Sarcoma of the Trunk and Extremities
- 42 Soft Tissue Sarcoma of the Abdomen and Thoracic
- 43 Gastrointestinal Stromal Tumor
- 44 Soft Tissue Sarcoma of the Retroperitoneum
- 53 Corpus Uteri Carcinoma and Carcinosarcoma
- 54 Corpus Uteri Sarcoma
- 67 Uveal Melanoma
- 68 Retinoblastoma

Limited exception where cNO may be used for pN category:

- 47 Melanoma: only used for pT1

*<https://cancerstaging.org/CSE/Registrar/Documents/Node%20Status%20Not%20Required%20Rare%20Circumstances.pdf>

EOD Regional Node Coding for Inaccessible Lymph Nodes

For certain primary sites, regional lymph nodes are not easily examined by palpation, observation, physical examination, or other clinical methods. These are lymph nodes within body cavities that in most situations cannot be palpated, making them inaccessible.

Bladder, colon, corpus uteri, esophagus, kidney, liver, lung, ovary, prostate, and stomach are examples of inaccessible sites (this is not an all-inclusive list).

When EOD Primary Tumor is low stage/Localized and standard treatment is done, it is sufficient to code 000 for negative regional lymph nodes.

*<https://seer.cancer.gov/tools/staging/eod/general-instructions.pdf>

Corpus Uteri Histology

Malignant Mixed Mullerian Tumor (8950/3) is now a synonym for carcinosarcoma (8980/3).

According to SINQ 20180071,

if both terms are used in pathology description, code Carcinosarcoma (8980/3).

if only MMMT is used in pathology report, code Malignant Mixed Mullerian Tumor (8950/3).

*NAACCR Corpus Uteri 2020

*https://seer.cancer.gov/seerlookup/index.php?page=search_results&cords=n&search_results_show=first&search_type=quick_search&search_within_results=0&quicksearch=20180071&Question_1=1&Question_3=1&search_display_format=1#results

Question:

How many primary tumors should be abstracted for a 2018 breast excision with a final diagnosis of invasive mucinous adenocarcinoma (0.7 cm) with ductal carcinoma in situ (DCIS) present as discontinuous foci, spanning 12 cm?

Answer:

Abstract two primaries, invasive mucinous and DCIS, using 2018 Solid Tumor Rules for Breast, M14, as **the discontinuous foci are separate tumors** in this example and the histologies are on different rows of Table 3 of the rules.

*[https://urldefense.com/v3/_https://seer.cancer.gov/seerlookup/index.php?page=view&id=20200033&type=q_!!J30X0ZrnC1oQtbA!d-timrzODCaQ7z76pTmVzyRiALnDYxmERFp4_UvCeNKW5zLi-CnWeGEeViHJnRwYA7uerV7no67G\\$](https://urldefense.com/v3/_https://seer.cancer.gov/seerlookup/index.php?page=view&id=20200033&type=q_!!J30X0ZrnC1oQtbA!d-timrzODCaQ7z76pTmVzyRiALnDYxmERFp4_UvCeNKW5zLi-CnWeGEeViHJnRwYA7uerV7no67G$)

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Questions can be sent to your facility's State Representative or by calling 609-633-0500. DO NOT REPLY to this email.

I-131 for Thyroid

Code Phase 1 Radiation Primary Treatment Volume for I-131 for Thyroid Code 98 (Other). 

It is **no longer** code 50 (Thyroid).

4/4/2019 STORE Data Item Clarification: (Version 1.0), technically, I-131 is effective wherever there are thyroid cancer cells in the body, so there is no specific anatomic treatment volume involved. ***Therefore, it is recommended coding radioisotope treatments as 98 (Other).*** While another reasonable option would be to code the volume as 93 (Whole Body), code 93 (Whole Body) has traditionally been reserved for whole body treatment with external beam radiation such as is done prior to bone marrow transplantation. **For historical consistency purposes, please use 98 (Other).** The next version of STORE will reflect this change.

* https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/ncdb_store_addendum.ashx

*NCRA Clarifying Common Abstracting Misconceptions by Karen Mace, CTR & Janet Vogel, CTR

Check out the **CTR Guide to Coding Radiation Therapy Treatment in the STORE** for help in coding.

*https://www.facs.org/~media/files/quality%20programs/cancer/ncdb/case_studies_coding_radiation_treatment.ashx

Lung EOD

Question:

Is EOD Primary Tumor coded to 500 and EOD Mets 10 when there are bilateral lung nodules with nodules in same lobe as the primary tumor? How is EOD Primary Tumor coded when separate tumor nodes are in an ipsilateral lung but there is no documentation as to whether it is in the same or different ipsilateral lobe from the primary tumor?

Answer:

Assign 999 to EOD Primary Tumor if this is the only information you have for your case. The mention of nodules does not automatically mean that you have separate tumor nodules. There are many reasons for the appearance of nodules in the lung, some of which are not due to cancer. Unless you have further information on whether the physician has determined that they are related to the lung cancer, then assume that they are not related.

Assign 00 to EOD Mets. Do not code EOD Mets to 10 since you cannot determine whether those nodules are based on the tumor or not.

*<https://seer.cancer.gov/seerinqury/index.php?page=view&id=20200028&type=q>

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Coding Margins

Code 9 if the pathology report makes no mention of margins or no tissue was sent to pathology.

Bladder cancer is often treated with a Transurethral resection of Bladder (TURB). TURB pathology does not often have an actual statement of margins. This would be coded with a margin status of 9. Code 7 WOULD NOT be used.

*<http://cancerbulletin.facs.org/forums/forum/for-ords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/99331-turb-no-mention-of-surgical-margins-in-path-use-code-7-vs-9>

Important Pathologic Grade Notes

- If a resection is done of a primary tumor and there is **no grade documented** from the surgical resection, use the grade from the clinical workup.
- If a resection is done of a primary tumor and there is **no residual cancer**, use the grade from the clinical workup.

* <https://www.naacrr.org/SSDI/Grade-Manual.pdf>

Coding Tips during COVID for Breast Primaries

Per Chapter 1 AJCC the short term (<4-6 month) use of endocrine therapy is NOT considered neoadjuvant therapy **for AJCC staging purposes.**

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/breast-chapter-48/breast-chapter-48-aa/104092-neoadj-endocrine-therapy-covid19>

For ER/PR/HER 2, code pre-“neoadjuvant” values due to possible alteration to tumor.

<http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/107325-breast-ssdi-response-to-neoadjuvant-therapy-covid-19>

Coding Tips during COVID for Prostate Primaries

Question:

What I’m starting to see specifically for prostate cases is that before the COVID pandemic started, a PSA was done. Then the Prostate BX was delayed due to Outpatient procedures being delayed due to COVID. Should registrars record the PSA lab value if more than 3 months prior to diagnostic BX the procedure was delayed due to the COVID pandemic?

Answer:

This issue was discussed with the SSDI work group, AJCC/CoC and SEER. For **all lab values**, you are to follow the current rules as they are written.

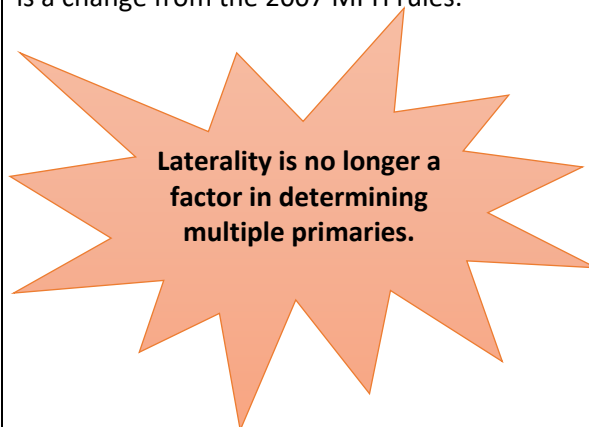
So, for this case, **you would not record the PSA lab value.**

The PSA lab value should be recorded in the text portion of your abstract and documented to why it was not coded.

*<http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/105556-recording-lab-values-timing-rules-w-covid>

Central Nervous System Rule Changes

Glioblastoma Multiform (GBM) occurring after glial or astrocytic tumor is a new primary. This is a change from the 2007 MPH rules.



NF, NF1, NF2 and schwannomatosis are NOT REPORTABLE. (Genetic Syndromes code for NR is NA for 01/01/2018+)

Midline Shift does not equal crossing the midline. *It must state that tumor crosses the midline to be coded.*

Assign SEER Summary Stage 2018 code 8 and the EOD primary tumor to code 050 for benign or borderline brain tumors.

*NAACCR Central Nervous System 2019-2020

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Coding EOD Lymph Nodes for Thyroid:

Code	Description
000	No regional lymph node involvement CYTOLOGICALLY or HISTOLOGICALLY confirmed to be benign node(s)
050	No regional lymph node involvement RADIOLOGICALLY or CLINICALLY confirmed
070	No regional lymph node involvement UNKNOWN how confirmed

Code 000 is only for lymph nodes that have been pathologically examined and came back negative.

*[https://staging.seer.cancer.gov/eod_public/input/1.7/thyroid/eod_regiona_l_nodes/?breadcrumbs=\(~schema list~\),\(~view schema~,~thyroid~\)](https://staging.seer.cancer.gov/eod_public/input/1.7/thyroid/eod_regiona_l_nodes/?breadcrumbs=(~schema list~),(~view schema~,~thyroid~))



IMPORTANT UPDATES:

Please read the new Guidelines ICD-O-3 Guidelines

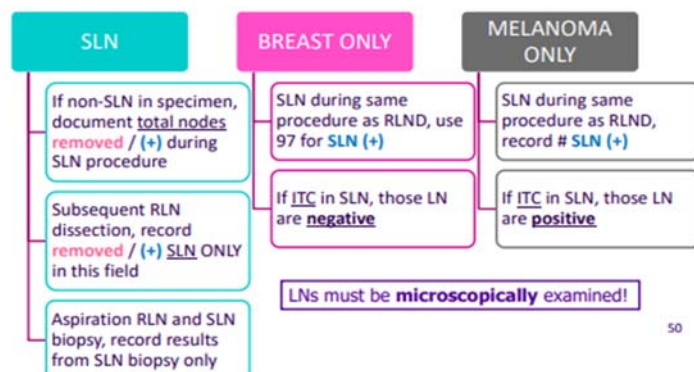


The revised [2018 Guidelines for ICD-O-3 Histology Code and Behavior Update](#) for cases diagnosed 1/1/2018 forward are now available on the NAACCR website. The update includes links to tables listing new codes and other changes and is available in two formats: PDF and Excel. Also available are the 2018 ICD-O-3 Update Guidelines and 1/10/2018 Errata/Change document. <https://seer.cancer.gov/icd-o-3/>

Coding Lymph Nodes for Melanoma

- Microscopic LN defined as clinically occult. The nodal metastasis is identified on the sentinel lymph node biopsy
- Macroscopic LN defined as clinically detected
- T1 melanomas use cN0 when no LNs examined microscopically

*Sentinel LN Examined Positive
 Breast & Cutaneous Melanoma*



*2019-2020 NAACCR Webinar Series: Melanoma

Coding Positive Prostate Cores

- Count the "suspicious for carcinoma" or "suspicious for adenocarcinoma" cores as positive.
- In the event that you have "suspicious for, but not diagnostic of," do not include those cores.
- Only use the "suspicious for" when there is no further information available.
- Do not count fragments, chips or pieces.

*<http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/83279-ssdi-prostate-number-of-cores-positive-examined>

**New Primary Site coding for
 Waldenstrom Macroglobulinemia**

Primary site must be **bone marrow (C421)** for cases diagnosed 1/1/2018 and forward. For cases diagnosed 2010-2017, primary site must be blood (C420).

*<https://seer.cancer.gov/seertools/hemelymph/51f6cf59e3e27c3994bd5480/?q=waldenstrom%20macrob>

Question:

A patient is diagnosed with lung cancer at your facility. The patient does not return for staging work-up or treatment consultation. You do not know if the patient went elsewhere for additional work-up or treatment. What would the class of case be?

Answer: 10

Initial diagnosis at the reporting facility or in a staff physician's office AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS

Tip: You must confirm the patient was treated elsewhere to code class of case 00.

Question:

Since the LN bx is coded is surgery, wouldn't that be considered part of first course of TX, and a class of case 21?

Answer:

Even though an FNA of a lymph node is coded in scope of regional lymph nodes, an FNA is not treatment.

* NAACCR Abstracting and Coding Boot Camp 2019-2020

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SSDI Tips

Timing for Recording Lab Values

All lab values must be done no earlier than approximately three months before diagnosis AND unless instructions for a specific laboratory test state otherwise, **record only test result obtained before any cancer-directed treatment is given** (neoadjuvant therapy or surgical) AND if multiple lab tests are available, **record the highest value.**

New Coding for Kidney- Note 2

Invasion beyond Capsule (3864) must be based on surgical resection. For AJCC staging, if tumor is T1 or T2, then "invasion beyond capsule" would be coded to 0. Invasion beyond capsule is captured in T3a.

Ipsilateral adrenal Gland Involvement (3861) must be based on surgical resection and tumor is "confined to kidney" and staging is based on size, then there is no involvement of adrenal gland. For AJCC staging, if tumor is T1 or T2, then "ipsilateral adrenal gland involvement" would be 0. Involvement is captured in T4.

Major Vein Involvement (3866) must be based on surgical resection and tumor is "confined to kidney" For AJCC staging T1 or T2, "major vein involvement" would be 0. Major vein involvement is captured in T3a or T3b.

If surgical resection is done and the tumor is not confined to kidney AND there is no mention of the three SSDIs then Note 6 applies and you code unknown (9).

Melanoma

Breslow Thickness (3817) If there are multiple procedures and the **pathologist adds the measurements** together to get a final Breslow's depth, the registrar can code that. If the pathologist does not add the measurements the registrar CANNOT add them. Record the depth from the procedure that has the larger depth documented.

Ulceration (3936) The pathology report must say ulceration is negative or you can infer using the T category is A is present. **DO NOT AUTOMATICALLY ASSIGN CODE 0 (NONE) FOR INSITU TUMORS without statement on pathology report.**

***2019-2020 NAACCR Webinar series: SSDI an In-Depth Look*

**Clinical Grade Field for Acoustic Neuroma and Meningioma**

A recent review of the accuracy of the coding of the Clinical Grade

field in 44 acoustic neuroma cases and 620 meningioma cases that did not undergo surgical treatment revealed an accuracy rate of 4.5% for acoustic neuroma and 8.7% for meningioma cases.

Benign brain tumors (behavior 0) may automatically be assigned a Grade 1 in the Clinical Grade field.

NOTE: Code the WHO grading system for selected tumors of the CNS as noted in the AJCC 8th edition Table 72.2 where WHO grade is not documented in the record.

NAACCR Grade Coding Instructions and Tables. <https://www.naacccr.org/SSDI/Grade-Manual.pdf> pg. 112 Grade ID 24- Clinical Grade Instructions CAnswer Forum.

<http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/96019-who-grade-for-prolactinoma>

Congratulations to the New Jersey State Cancer Registry!

National Program of Cancer Registries

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In recognition of providing complete and timely National Program of Cancer Registries data in

2019

Vicki Benardi

May 15, 2020

State Registrar, NCR
Chief, Cancer Surveillance Branch
Division of Cancer Prevention and Control

Date



New Jersey has earned the honor of a Registry of Distinction by NPCR for the 2019 submission of data. This achievement indicates that the New Jersey State Cancer Registry has met the CDC NPCR National Data Completeness and Quality Standard. **We congratulate and thank the Registrars of New Jersey for their dedication to quality data and working together to achieve this honor.**

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email.

May 2020 E-Tips

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

Priority for Coding Histology

Code histology prior to neoadjuvant therapy; code histology using priority list and H rules; do not change histology to make the case eligible for staging

1. Tissue/Path from primary
 - a. Addendum and/or comment
 - b. Final diagnosis/synoptic report
 - c. CAP protocol
2. Cytology (FNA, pleural fluid)
3. Tissue/path from metastatic site
4. Scans Priority (CT>PET>MRI>CXR)
5. Physician documentation
 - a. Treatment Plan
 - b. Tumor Board
 - c. Medical Record documentation, original path, cytology, scan
 - d. MD reference to histology

**2019-2020 NAACCR Webinar Coding Pitfalls

Reportable Cases for NJSCR

- Patients with a history of cancer with active disease must be reported. (Class of Case 32)
- Analytic/Non-Analytic Cases Both analytic and non-analytic cases with active disease are required to be reported to the NJSCR.
- Registrars are responsible for including all required data items in the abstract, regardless of class of case.
- Consult-only cases are reportable. A consult may be done to confirm a diagnosis or treatment plan.

Check out the NJSCR website for the Program Manual and other helpful tools and information.

<https://www.nj.gov/health/ces/reporting-entities/registrars/>

What is a NAACCR Modified Record?

Tumor records (Abstracts) that have already been transmitted to the state but that have had an update to any field and are resubmitted. They should be resubmitted in "M" format. Please contact your system vendor for information on how to submit a modified record.

** <https://www.naacccr.org/wp-content/uploads/2018/05/Standards-Volume-I-Version-18.pdf>

Prostate Coding

Prostate Clinical T

- Clinical T value is based on DRE
- Imaging should not be used for Clinical T

EOD Primary Tumor

- This is based primarily on the DRE only
- DO NOT use biopsy results UNLESS they prove extraprostatic extension
- DO NOT use imaging UNLESS physician clearly incorporates findings into evaluation
- DRE does not mention a palpable "tumor" "mass" or "nodule", infer the prostate as clinically inapparent

EOD Regional Nodes

- Prostate is considered an inaccessible site for regional lymph nodes
- Assume negative when workup done with no mention of lymph nodes, low/localized stage and standard therapy done
- Regional nodes include contralateral or bilateral nodes

Prostate Grading

Code E if stated as "Gleason score 7" with no patterns documented or any Gleason patterns combination equal to 7 not specified in 2 or 3

A TURP does NOT qualify as a surgical resection for pathologic grading purposes

Clinical Grade	Pathological Grade
TURP	Prostatectomy
Assign highest grade from primary tumor even it happens to be a clinical grade	

General Grading Instructions

- Code the grade from the primary tumor only
- If more than 1 grade available: priority goes to recommended AJCC Grade listed
- If no recommended Grade- record the highest grade
- Do not code grade for dysplasia
- In situ/invasive combination- Code invasive only (even if it is unknown)

**2019-2020 NAACCR Webinar series Prostate

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email.

**Anastomotic Site for Colon, Rectosigmoid and Rectum: Single or Multiple Primary?
 A new tumor at the anatomic site must be stated to arise in the mucosa to qualify as a new primary. See Solid Tumor Rules.**

Example: New tumor at the ileocolic anastomosis, described as a, Circumferential centrally ulcerated mass with raised borders. Tumor extension: Tumor invades through muscularis propria into subserosal adipose tissue, no involvement of the serosal surface identified. The only mention of mucosa on the resection is the uninvolved enteric mucosa or uninvolved colonic mucosa in the otherwise uninvolved portions of the ileum/colon. *If neither bullet 1 or 2 apply, is this a new primary per M7 bullet 3?*

Answer: Assuming the first and second tumors are not different histologies or they occurred less than or equal to 24 months apart (M7 Bullets 1 and 2 do not apply), **abstract a single primary** as the pathology states uninvolved enteric mucosa or uninvolved colonic mucosa (no involvement noted).

Example: Right colon with anastomosis site. Tumor site: Anastomosis. Tumor extension: Tumor invades through the muscularis propria. Gross description does not describe mucosa, only noting, at the central area of anastomosis is an ill-defined, slightly raised, tan-brown to purple mass measuring 2.2 x 2 cm, which is nearly circumferential, causing obstruction at the site of anastomosis. *If neither bullet 1 or 2 apply, is this a new primary per M7 bullet 3?*

Answer: Assuming the first and second tumors are not different histologies or they occurred less than or equal to 24 months apart (M7 bullets 1 and 2 do not apply), **abstract a single primary** as there is no mention of mucosal involvement.

Example: Polyp at ileocolonic anastomosis, polyp biopsy final diagnosis was, Invasive moderately differentiated colonic adenocarcinoma in association with adenoma. No mention of mucosa on the biopsy final diagnosis or gross description. Clinical info indicates, There is an ulcerated 5 cm mass at the ileo-colonic anastomosis that was biopsied. *If neither bullet 1 or 2 apply, is this a new primary per M7 bullet 3?*

Answer: Assuming the first and second polyps/tumors are not different histologies or they occurred less than or equal to 24 months apart (M7 bullets 1 and 2 do not apply), **abstract a single primary** as there is no mention of mucosal involvement.

Of note in the case of the polyp, tumors coded as adenocarcinoma in a polyp, should be treated as adenocarcinoma (8140) for cases prior to 2018. Also, if the pathologist states the new tumor/polyp originated in the mucosa, it is a new primary.

* <https://seer.cancer.gov/seerquery/index.php?page=view&id=20200013&type=q>
 * https://seer.cancer.gov/tools/solidtumor/Colon_STM.pdf

Radiation Tips

- SBRT does not target lymph nodes.
- IORT for breast cancer *does not target lymph nodes.*
- Chest wall or lumpectomy tumor bed/cavity boost (either photons or electrons) **does not include** lymph nodes.
- For pelvic sites, if pelvic/whole pelvis irradiation is mentioned, assume the regional lymph nodes for that site are included.
- Interstitial or intracavitary brachytherapy (HDR or LDR) does not target regional lymph nodes.

When a radiation treatment summary has multiple PHASES (aka delivered prescriptions):

- A. Code the phases from the earliest to latest start date.
- B. If there are multiple phases with the same start date, code the phases from highest to lowest total dose.
- C. If there are multiple phases with the same start date and same total dose, then any order is acceptable.

*NAACCR 2019-2020 Webinar- Base of Tongue 2019-Radiation

**Head and Neck: Oropharynx
 Histology coding for HPV status**

- Squamous Cell Carcinoma **8070**
- Squamous cell carcinoma HPV-positive **8085**
- Squamous cell carcinoma HPV-negative **8086**



A statement of “Squamous cell carcinoma HPV-Positive” or “Squamous cell carcinoma HPV-Negative” or results from an HPV viral detection test must be noted in to code 8085 or 8086.

DO NOT USE A P16 only test to code 8085 or 8086.

**Chapter 11 Oropharynx (P16-) and Hypopharynx
 Staging**

- T0 is not valid value for this chapter.
- T values are different for oropharynx and hypopharynx.
- **If neck dissection is completed for lymph nodes, a stage group may be assigned even if the primary site is not resected.**

*NAACCR 2019-2020 Webinar- Base of Tongue 2019

March 2020 E-Tips

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

Coding Lymph Vascular Invasion

LVI on pathology report PRIOR to neoadjuvant (preoperative) therapy	LVI on pathology report AFTER neoadjuvant (preoperative) therapy	Code LVI to
0 – Not present/Not identified	0 – Not present/Not identified	0 – Not present/Not identified
0 – Not present/Not identified	1 – Present/Identified	1 – Present/Identified
0 – Not present/Not identified	9 – Unknown/Indeterminate	9 – Unknown/Indeterminate
1 – Present/Identified	0 – Not present/Not identified	1 – Present/Identified
1 – Present/Identified	1 – Present/Identified	1 – Present/Identified
1 – Present/Identified	9 – Unknown/Indeterminate	1 – Present/Identified
9 – Unknown/Indeterminate	0 – Not present/Not identified	9 – Unknown/Indeterminate
9 – Unknown/Indeterminate	1 – Present/Identified	1 – Present/Identified
9 – Unknown/Indeterminate	9 – Unknown/Indeterminate	9 – Unknown/Indeterminate

If initial biopsy has no mention of Lymph vascular invasion and patient has neoadjuvant therapy followed by surgery with a statement of **NO lymph vascular invasion code 9**.

*https://seer.cancer.gov/manuals/2018/SPCSM_2018_maindoc.pdf

Question:

Is an **omentectomy** performed with a hysterectomy for an endometrial primary site recorded under Surgery of Other Site?

Answer:

Continue to record an omentectomy performed with a hysterectomy under Surgery of Primary Site and not as a separate procedure under Surgical Procedure of Other Site.

*<https://seer.cancer.gov/seerlookup/index.php?page=view&id=20200009&type=q>

Question:

Patient presents for colon surgery on 8/1/18 and Operative Note stated Rectosigmoid Colon and the Pathology Report stated Sigmoid Colon. How would Primary Site be coded?

Answer: Rectosigmoid Colon

See Priority order for Coding Primary Site for Resected cases

- Operative report with surgeon’s description
- Pathology report
- Imaging

*https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guide_lines_Colon_2018.pdf

*NAACCR 2018-2019 Webinar Series Coding Pitfalls

Melanoma Surgery Codes Questions and Answers

Question:

Is a shave biopsy or punch biopsy of a melanoma with negative margins coded as biopsy (diagnostic procedure 02) or as an excisional biopsy (surgical procedure 20 or 27)?

Answer:

➡ Code 27 based on the negative margins.

*<http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/surgery/61441-melanoma-biopsy-with-negative-margins>

Question:

What surgical codes would I use for the shave biopsy with negative margins followed by a wide excision? Also, would you clarify code 45- wide excision or re-excision of lesion with margins more than 1cm NOS, margins must be microscopically negative. (Does this mean we can use this if there is no mention of the margins size?)

Answer:

Shave biopsy 05/14/12, margins clean, code 27.

Wide excision 06/27/12, no residual.

The FORDS says the wide excision is qualified for code 45 IF the microscopically negative margins are more than 1 cm. Clarify with the pathologist whether the margins around the biopsy scar are more than 1 cm and code 45-47, otherwise, if less, code 31.

*<http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/surgical-diagnostic-and-staging-procedure/6099-melanoma-clear-margs>

Questions can be sent to your facility’s State Representative or by calling 609-633-0500. DO NOT REPLY to this email.

SEER Reliability Study Review Release

The results from the *2019: Extent of Disease (EOD), Summary Stage, and Site-Specific Data Items (SSDI) Reliability Study* have been posted on the SEER website.

<https://seer.cancer.gov/qi/tools/reliability.html>

The study required review and coding of EOD 2018 Data Items (Primary Tumor, Regional Nodes, Mets), SS2018, Grade, SSDI (scheme specific), Regional Nodes Positive and Tumor Size Field. 10 schemas were used: Brain, Breast, Colon/Rectum, Lung, Lymphoma (CLL/SLL), Melanoma/Skin, Ovary, Prostate, Soft Tissue, and Tongue Anterior.

995 data items in the study were distributed among five groups consisting of 199 data items each. Preferred answers with less than 85% agreement by study participants were reviewed as well as all comments provided by study participants.

Of the 995 items, 77 (7.7%) preferred answers and rationales were modified after review and reconciliation of the preferred answers.

Based on feedback, comments and suggestions, many clarifications were added to Version 1.7 released of the SSDI and Grade Manuals, EOD and Summary Stage. SEER noted an appreciation to the over 800 people that participated in the study.

EOD Primary Tumor for Breast

For Extensive Skin involvement, inflammation, erythema, edema, peau d'orange, or other terms describing skin changes without a stated diagnosis of inflammatory carcinoma assign

CODE 400!

EOD Regional Nodes for Breast

Codes 030, 050, and 070 are for nodes that are pathologically negative but are positive for ITCs or RT-PCR.

Code 030: Negative nodes pathologically with positive ITCs OR positive ITCs AND positive RT-PCR

Code 050: Negative nodes pathologically with positive RT-PCR, negative ITCs

Code 070: Negative nodes pathologically, unknown if ITCs or RT-PCR

Lymph Nodes examined and negative!? No mention of ITCs or RT-PCR!?

Code 070 not 000.

*https://staging.seer.cancer.gov/eod_public/schema/1.7/breast/?breadcrumbs=~schema_list~

STORE UPDATES!**Radiation:**

- If any phase of treatment to a volume has the **Treatment Modality coded to anything between 07 and 16, the dose for that phase should be coded in cGy, when available.** If there is only one phase in the entire course of radiation, then the phase dose can be used to record the course Total Dose. However, **if there are multiple phases in a radiation course and any of the phases use a brachytherapy, radioisotopes or infusion therapy, then the Total Dose should be coded to 999998** (five 9s).

Date of First Course Treatment/Palliative Care:

- When a patient receives *palliative care for pain management* **only** with no other cancer-directed treatment, Date of First Course of Treatment, NAACCR Data Item #1270, **would be the date in which a patient decides on palliative care for pain management only, as recommended by the physician.** "No therapy" is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given, or the physician recommends palliative care for pain management only.

SEE STORE Addendum!

*https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/ncdb_store_addendum.ashx

January 2020 E-Tips

Coding Lymph node FNA/Biopsy

Removal, biopsy or aspiration (FNA) of a lymph node is considered a surgery. Record all surgical procedures that remove, biopsy, or aspirate regional lymph node(s) whether or not there were any surgical procedures of the primary site. The regional lymph node surgical procedure(s) may be done to diagnose cancer, stage the disease, or as a part of the initial treatment.

Example: Patient has a sentinel node biopsy of a single lymph node. Assign code 2 (Sentinel lymph node biopsy [only]) in Scope of Regional Lymph node Surgery. Use date of lymph node biopsy in surgery date as treatment.

*https://seer.cancer.gov/manuals/2018/SPCSM_2018_maindoc.pdf

Check out SEER SINQ for some coding help with Lymph node Dissection!
<https://seer.cancer.gov/seerinqury/index.php?page=view&id=20190092&type=q>

Solid Tumor Rules

Lung histology

Code the histology that comprises the greatest percentage of tumor when two or more of the following histologies are present:

- Acinar adenocarcinoma/
Adenocarcinoma, acinar predominant
8551
 - Lepidic adenocarcinoma/
Adenocarcinoma, lepidic predominant
8250
 - Micropapillary adenocarcinoma/
Adenocarcinoma, micropapillary
predominant 8265
 - Papillary adenocarcinoma/
Adenocarcinoma, papillary predominant
8260
 - Solid adenocarcinoma/
Adenocarcinoma, solid predominant
8230
- *https://seer.cancer.gov/tools/solidtumor/Lung_STM.pdf

General Equivalent or Equal Terms

These terms can be used interchangeably for all sites:
Adenocarcinoma; glandular carcinoma;
carcinoma.

Recurrence

Use the Multiple Primary Rules as written to determine whether a subsequent tumor is a new primary or a recurrence. **The ONLY exception is when a pathologist compares slides from the subsequent tumor to the "original" tumor and documents the subsequent tumor is a recurrence of the previous primary.** Never code multiple primaries based only on a physician's statement of "recurrence" or "recurrent".

*<https://seer.cancer.gov/tools/solidtumor/>

SSDI Coding Tips

(from "Coding Pitfalls" NAACCR 2018-2019 Webinar Series)

Breast ER/PR Percent

- >95% Code 96 because when "greater than" is used, code one above
- <95% Code 94 because when the term "less than" is used, code one below.
- 1-5%. Code R10 if the range on the report uses steps smaller than 10 and the range is fully or at least 80% contained within a range provided in the table, code to the range that contains the low number of the range in the report.
- 75-85% Code R80 almost all the range is contained with code R80.
- 76-100% look at the lowest value and find the range that would fall in, code R80.
- Close to 100%, code 99 ("close to" means almost that value, code one less than stated value.)
- Approximately 1% Code 001 (Since they are staging a single value, code to that value).

Breast Ki-67

- <10% code 9.9 (when "less than" is used, code the next lowest number.)
- >90% Code 90.1 (When "greater than" is used, code the next highest number.)
- 30-40% Code 30.1. (Since Ki-67 doesn't have range codes, code one above the lower range.)

Prostate Cores: Number of Cores Positive/ Number of Cores Examined

Always check to make sure the number of cores positive is less than or equal to the number of cores examined.

NJSCR hosts Student Day

When: March 25th, 2020

Who: Cancer registry students who have completed 80 hours of clinical practicum or are nearing the end of their training and need to complete a central registry experience requirement.

Spots are limited! If interested in attending, email Taylor.Hessler@doh.nj.gov to register.