# KCR newsletter July 2018

## KCR 2018 Fall Workshop/Regional Meeting

# SAVE THE DATE!

## 2018 Tri-State Regional Cancer Registrars' Meeting

**Presented by:**

**Kentucky Cancer Registry,**
**Indiana Cancer Consortium, and**
**Ohio Cancer Incidence Surveillance System**

**Thursday, August 16, 2018 8:30 AM - 4:30 PM and**
**Friday, August 17, 2018 8:30 AM – 12:00 PM**
**Crowne Plaza**
**830 Phillips Lane**
**Louisville, KY 40209**

*Registration and agenda information will come out soon. We will officially begin accepting registrations on July 2, 2018

## 9.5 CEUs will be awarded

For those who will need overnight accommodations, we have reserved a block of rooms at the Crowne Plaza Louisville at the rate of $119.00 plus tax. The reservation link for booking your room online is:

**BOOK YOUR GROUP RATE FOR THE 2018 TRI-STATE REGIONAL CANCER REGISTRARS' MEETING**

The deadline for room reservations has passed, but if you still need to book a room, please call the hotel directly to see if any rooms are still available.

If you need additional information regarding the workshop, please contact Paula Cole at pcole@kcr.uky.edu or call (859) 218-3192.

We hope you all will be able to join us.

## KCR 2018 Spring Training Clarifications/Updates

Frances Ross and Tonya Brandenburg presented two separate Spring Training Updates Webinars on July 9 (2-4p) and July 10 (9-11a). The webinar was recorded is posted on the KCR website www.kcr.uky.edu under training.

## Calendar of Events

*August 16-17, 2018 TriState Regional Meeting hosted by KCR/Inidiana/Ohio*
*September 3, 2018 Holiday – Labor Day – KCR offices closed*
*September 25, 2018 CTR exam application deadline*
*October 15 – November 3 CTR exam testing window*

## People News

**New Hires:**
Marie Brown – University of Louisville
Dorene Johnson – University of Louisville
Elizabeth Metje – Norton Healthcare
Deborah Thompson – Norton Healthcare
Bobbie Harbolt – King's Daughters Medical Center

**Position Changes:**
Shannon Ladd – E-Radiation Coordinator, KCR

**Resignations:**
Danielle Price – Taylor Regional Hospital
Marie Brown – KentuckyOne Health
Dorene Johnson – KentuckyOne Health Louisville
Sharon Isaacs – Frankfort Regional Medical Center
Chriselle Pereira – Greenview Regional Hospital

**New CTRs:**
John Sickles – Hardin Memorial Hospital
Brittany Farris – Baptist Health Louisville
Whitney Smiley – KentuckyOne Health Lexington
Ellen Pardue – Medical Center Bowling Green
Danielle Price – Formerly at Taylor Regional Hospital

# KCR FES

Frances Ross = Director of KCR will upload errata reports.
Tonya Brandenburg = QA Manager of Casefinding will upload QA audits.
Stephanie Carmack = Epath coordinator who will upload epath audits.
Lindsey Baker = Death Clearance coordinator who will upload death clearance followback forms.
Vicki Larue = Casefinding coordinator who will upload PMCs (possible missed cases) & casefinding audits.

# Coding Hints/Reminders

***Topography Reminders from SEER Appendix C coding guidelines***

Breast = Multifocal breast tumors in different subsites of the breast are coded to C50.9 breast, NOS.
Lung = Suprahilar masses are coded to C34.1 upper lobe.
Lung = Infrahilar masses are coded to C34.9 lung, NOS.
Bladder = Bladder base masses are coded to C67.0 trigone.

***Histology Reminder***

Transitional cell carcinoma/urothelial carcinoma rarely arises in the kidney parenchyma and should only be coded to C64.9 when pathologist states 'unequivocally that the tumor arose from the kidney parenchyma. Most of these will be coded to C65.9 Renal Pelvis per MPH manual.

***Clarification for coding I-131 radiation for Thyroid:***

For cases diagnosed prior to 2018 continue to code radiation volume to whole body (code 33). There was a recent post on the CAnswer forum that stated to code the volume 50 thyroid (code 50). In KY, beginning with 2018 cases you will NOW use thyroid (code 50) for I-131.

***Topography Reminder***

Squamous cell carcinoma of the skin is NOT REPORTABLE.
Skin primary sites that ARE REPORTABLE:

- Skin of Penis (C60.9)
- Skin of vulva (C51._)
- Skin of scrotum (C63.2)
- Skin of upper/lower vermillion border lip (C00.1, C00.2, C00.3)
- Skin of upper/lower lip mucosa (C00.3, C00.4, C00.5)

# Melanoma Surgery Coding

Assigning surgery codes for melanoma cases can be difficult. Here are some tips to help clarify surgery coding.

1. ***ALWAYS*** obtain ***ALL*** pathology reports from ***ALL*** sources along with operative and office notes. These sources of documentation will be helpful in your decision-making process.

2. Review the PE (physical exam) of the skin area and lymph nodes to help determine if the surgeon intended to remove the lesion on the original/initial biopsy. Any surgeon performing a wide excision of a proven melanoma should be documenting their clinical exam findings and those exams should be documented in your text.

3. Try to determine the intent of the procedure performed. Often, shave, punch or excisional biopsies will be done prior to the patient presenting to your facility.

    a. If a biopsy (shave, punch, excision, etc.) was done simply to establish a diagnosis ***AND DOES NOT*** remove the entire mole/lesion, then the procedure is to be coded as a **non-definitive therapy**.

    b. If a biopsy (shave, punch, excision, etc.) was done ***WITH THE INTENT*** to remove the ***ENTIRE*** mole/lesion (with or without establishing a diagnosis), then the procedure is to be coded as a **definitive surgery**. This is known as an excisional biopsy

4. The biopsy of the primary tumor is normally followed by a wide excision which removes a margin of healthy or normal tissue around the tumor, so look for two procedures.

5. Code the subsequent wide excision based on the surgical margin measurements: Use the margin measurement from the PATHOLOGY report.

6. Document everything in text. Text documentation will help support your choice of surgery coding and give insight into your thought process when you were coding the procedure.

| Appearance of Mole/Lesion | Intent of Procedure | Code as: |
|---|---|---|
| • A biopsy (incisional, shave, punch, elliptical, biopsy nos) with GROSS positive margins.<br>• Mole/Lesion ***STILL*** visible (may present with crusted area from biopsy). | Diagnostic:<br>• Biopsied to remove small portion of mole/lesion for analysis to establish diagnosis. | Non-Definitive Therapy:<br>Use Diagnostic Code 02 |
| • A biopsy removes all gross disease.<br>• Mole/Lesion ***NOT*** visible (presented with healing biopsy site and no mole/lesion visibly remains). | Treatment:<br>• Removal of entire mole/lesion and pathology report shows no residual melanoma.<br>• Referred to as an excisional biopsy | Definitive Treatment:<br>Use Surgery Codes: (00, 10-14, 20-27, 30-36, 45-47, 60, 90, 99) |

| Definitive Treatment | | |
|---|---|---|
| Diagnostic and Staging Code | Skin C44.0 - C44.9 (Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992) Description | |
| **Surgery Code** | **Description** | **Special Notations** |
| 00 | None; no surgery of primary site; autopsy ***ONLY*** | |
| **Local Tumor Destruction: Codes (10-14)** | | |
| 10 | Local tumor destruction, NOS | ❖ **Code 10 - 14:**<br>♦ ***NO*** specimen sent to pathology from surgical events. |
| 11 | Photodynamic therapy (PDT) | |
| 12 | Electrocautery; fulguration (includes use of hot forceps for tumor destruction) | |
| 13 | Cryosurgery | |
| 14 | Laser ablation | |
| **Local Tumor Excision: Codes (20-27)** | | |
| 20 | Local tumor excision, NOS | ❖ **Code 21 - 27:**<br>♦ There ***is*** a pathology specimen from surgical events.<br>❖ **Code 27:**<br>♦ If the biopsy removes *all of the tumor.*<br>♦ If the biopsy removes all gross disease and there is only microscopic residual at the margin.<br>♦ If initial biopsy is done elsewhere and no information is available, assume it is excisional biopsy.<br>❖ **Codes 20 - 27** include shave and wedge resection |
| 26 | Polypectomy | |
| 27 | Excisional biopsy | |
| *Any combination of 20 or 26–27 ***WITH***: | | |
| 21* | Photodynamic therapy (PDT) | |
| 22* | Electrocautery | |
| 23* | Cryosurgery | |
| 24* | Laser ablation | |
| 25 | Laser excision | |

<table>
<tr><th colspan="3">Biopsy of primary tumor followed by gross wide excision: Codes (30-36)</th></tr>
<tr><td>30</td><td>Biopsy of primary tumor followed by a gross excision of the lesion</td><td rowspan="8">❖ Specimen sent to pathology from surgical events.<br><br>❖ Code wide excision based on the surgical margin measurements: Use the margin measurement from the PATHOLOGY report.<br><br>❖ Codes 30 - 36:<br>⬩ Margins are more than 1 cm <u>BUT</u> are not microscopically confirmed, use the appropriate code<br><br>❖ Codes 30 - 35:<br>⬩ If the excision or reexcision has microscopically negative margins less than 1 cm<br>⬩ If status of margin is unknown.<br><br>❖ Code 30:<br>⬩ If it is stated to be a wide excision or reexcision, but the margins are unknown.<br>⬩ If the initial biopsy is an excisional biopsy not stated to be shave or punch biopsy.<br><br>❖ Code to 30 - 33:<br>⬩ If the margin of tissue is less than or equal to 1 cm.<br>⬩ If the margin of tissue is unknown or not stated<br><br>❖ Codes 34 - 36:<br>⬩ If procedure is a Mohs<br><br>❖ Codes 34:<br>⬩ If shave biopsy followed by Mohs surgery NOS<br>⬩ If Mohs surgery with unknown margins<br><br>❖ Code 35:<br>⬩ If shave biopsy followed by Mohs with 1 cm margin or less.<br><br>❖ Code 36:<br>⬩ If shave biopsy followed by Mohs with more than 1 cm margin.</td></tr>
<tr><td>31</td><td>Shave biopsy followed by a gross excision of the lesion</td></tr>
<tr><td>32</td><td>Punch biopsy followed by a gross excision of the lesion</td></tr>
<tr><td>33</td><td>Incisional biopsy followed by a gross excision of the lesion</td></tr>
<tr><td colspan="2">Mohs Surgery</td></tr>
<tr><td>34</td><td>Mohs surgery, NOS</td></tr>
<tr><td>35</td><td>Mohs with 1 cm margin or less</td></tr>
<tr><td>36</td><td>Mohs with more than 1 cm margin</td></tr>
<tr><th colspan="3">Wide excision or reexcision of lesion or minor (local) amputation: Codes (45-47, 60)</th></tr>
<tr><td>45</td><td>Wide excision or reexcision of lesion or minor (local) amputation with margins more than 1 cm, NOS.</td><td rowspan="4">❖ Specimen sent to pathology from surgical events<br><br>❖ Margins <u>MUST</u> be microscopically negative<br><br>❖ Code 45:<br>⬩ When there is a wide excision <u>AND</u> it is known that the margins of excision are greater than 1 cm.<br><br>❖ Code 47:<br>⬩ For amputation of finger</td></tr>
<tr><td>46</td><td>WITH margins more than 1 cm and less than or equal to 2 cm</td></tr>
<tr><td>47</td><td>WITH margins greater than 2 cm</td></tr>
<tr><td>60</td><td>Major amputation</td></tr>
<tr><th colspan="3">Surgery, NOS: Codes (90,99)</th></tr>
<tr><td>90</td><td>Surgery, NOS</td><td rowspan="2">N/A</td></tr>
<tr><td>99</td><td>Unknown if surgery performed; death certificate ONLY</td></tr>
</table>

# Grade Code Guide

## General Grade Coding Instructions for Solid Tumors

1. Code the grade from the primary tumor only:
   a. Do NOT code grade based on metastatic tumor or recurrence. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site
   b. If primary site is unknown, code grade to 9.

2. If there is more than one grade available for an individual grade data item (i.e. within the same time frame):
   a. Priority goes to the recommended AJCC grade listed in the applicable AJCC chapter i. If none of the specified grades are from the recommended AJCC grade system, record the highest grade
   b. If there is no recommended AJCC grade, code the highest grade

3. In situ and/or combined in situ/invasive components:
   a. If a grade is given for an in situ tumor, code it. Do NOT code grade for dysplasia such as high-grade dysplasia.
   b. If there are both in situ and invasive components, code only the grade for the invasive portion even if its grade is unknown.

4. Systemic treatment and radiation can alter a tumor's grade. Therefore, it is important to code clinical grade based on information prior to neoadjuvant therapy even if grade is unknown during the clinical timeframe. Grade can now be collected in grade post-therapy cases when grade is available from post-neoadjuvant surgery.

| What is the Same: | What is Different: |
|---|---|
| ❖ **Basic core coding concepts unchanged:** | ❖ **2018 Grade items apply only when DX Date 2018+** |
| ♦ Code grade from the primary tumor- not metastatic site | ♦ Priority goes to the recommended AJCC grade listed in the applicable AJCC chapter |
| ♦ If more than one grade available from same time period code the higher | ♦ If none of the specified grades documented are from the recommended AJCC grade system, record the highest [documented] grade |
| ♦ If grade given for an in situ tumor, code it | ♦ If there is no recommended AJCC grade [for that site], code the highest [documented] grade |
| ♦ Do NOT code grade for dysplasia or high grade dysplasia | ♦ **Grade for hematopoietic and lymphoid neoplasms NO LONGER COLLECTED for DX Date 2018+ *** |
| ♦ If both in situ and invasive components, code grade of invasive component | |

***See complete coding instructions in the 2018 Grade manual***

## Coding Guidelines for Generic Grade Categories

❖ Generic grade categories are used for:
- AJCC chapters where the preferred grading system is not available and the generic grade categories are available (e.g., Breast, Prostate, Soft tissue)
- AJCC chapters that do not have a recommended grade table (e.g., Nasopharynx, Merkel Cell, Melanoma, Thyroid)
- Primary sites that do not have an AJCC chapter (e.g., Digestive other, Middle ear, Trachea)

❖ Beginning with cases diagnosed in 2018:
- Registrars will use codes A-D.
- Numeric codes are being reserved to record grades recommended by AJCC.
- However, code 9 will continue to be used for unknown for all cases.

| Two-Grade System | |
|---|---|
| **Code** | **Description** |
| L | Low grade |
| H | High grade |
| 9 | Grade cannot be assessed (GX); Unknown |
| Blank | See Note 1 |
| | |

| Three-Grade System | |
|---|---|
| **Code** | **Description** |
| 1 | G1: Well differentiated |
| 2 | G2: Moderately differentiated |
| 3 | G3: Poorly differentiated; or undifferentiated |
| 9 | Grade cannot be assessed (GX); Unknown |
| Blank | See Note 1 |

| Four-Grade System | |
|---|---|
| **Code** | **Description** |
| 1 | G1: Well differentiated |
| 2 | G2: Moderately differentiated |
| 3 | G3: Poorly differentiated |
| 4 | G4: Undifferentiated or anaplastic |
| 9 | Grade cannot be assessed (GX); Unknown |
| Blank | See Note 1 |

| Generic Four Grade System | |
|---|---|
| **Code** | **Description** |
| A | Well differentiated |
| B | Moderately differentiated |
| C | Poorly differentiated |
| D | Undifferentiated or anaplastic |
| 9 | Grade cannot be assessed (GX); Unknown |
| Blank | See Note 1 |

***See actual grade table for complete list of coding instructions***

**Mapping/Crosswalk terms for generic 4-grade categories A-D**

| Rules | Description | Grade | Assigned Grade Code |
|---|---|---|---|
| ❖ **When to use:**<br>♦ Only use when the appropriate grade table for a cancer uses the generic 4-grade categories with alphabetic codes A-D.<br><br>❖ **When not to use:**<br>♦ Do not use for a cancer that uses the generic categories but assigns numeric codes 1-4.<br>♦ Do not use to code terms from a 2 or 3 grade system.<br><br>❖ Can be found on Pages 32-33 in Grade Manual. | Differentiated,NOS | I | A |
| | Well differentiated | I | A |
| | Only stated as 'Grade I' | I | A |
| | Fairly well differentiated | I-II | B |
| | Intermediate differentiation | I-II | B |
| | Low grade | I-II | B |
| | Mid differentiated | I-II | B |
| | Moderately differentiated | I-II | B |
| | Moderately well differentiated | I-II | B |
| | Partially differentiated | I-II | B |
| | Partially well differentiated | I-II | B |
| | Relatively or generally well differentiated | I-II | B |
| | Only stated as 'Grade II' | I-II | B |
| | Medium grade, intermediate grade | II-III | C |
| | Moderately poorly undifferentiated | II-III | C |
| | Moderately undifferentiated | II-III | C |
| | Poorly differentiated | II-III | C |
| | Relatively poorly differentiated | II-III | C |
| | Relatively undifferentiated | II-III | C |
| | Slightly differentiated | II-III | C |
| | Dedifferentiated | II-III | C |
| | Only stated as 'Grade III' | II-III | C |
| | High grade | II-III | D |

| | | | |
|---|---|---|---|
| | | - I V | |
| | Undifferentiated, anaplastic, not differentiated | I V | D |
| | Only stated as 'Grade IV' | I V | D |
| | Non-high grade | - - | 9 |

**The 3 Grade Data Items:**

- **Grade Clinical:**
  - Collects grade during clinical time frame – usually from a biopsy or FNA and ***BEFORE*** any treatment such as surgical resection or neoadjuvant therapy, etc.
  - Will be defined most of the time - unless no Dx until surgery
- **Grade Pathological:**
  - Collects grade from the primary tumor which **has been resected** (unless microscopic clinical grade is higher or surgical resection grade is unknown), and neoadjuvant therapy was ***NOT*** administered.
  - If Pathological grade is recorded, the Post-therapy grade will ***ALWAYS*** be **BLANK.**
- **Grade Post-therapy:**
  - Collects grade from a tumor resection ***AFTER*** completion of neoadjuvant therapy.
  - If Post-Therapy grade is recorded, the Pathological grade will ***ALWAYS*** be coded **9.**

# Coding Instructions

**Example: Grade 01 (3 grade system)**
**23 sites use these grade tables**

| Clinical | |
|---|---|
| **Code** | Grade Description |
| 1 | G1: Well differentiated |
| 2 | G2: Moderately differentiated |
| 3 | G3: Poorly differentiated |
| 9 | Grade cannot be assessed (GX); Unknown |

- Clinical grade **cannot be blank**
- Code 9 when:
  - No grade documented
  - Cancer incidental finding during surgery

| Pathological | |
|---|---|
| **Code** | Grade Description |
| 1 | G1: Well differentiated |
| 2 | G2: Moderately differentiated |
| 3 | G3: Poorly differentiated |
| 9 | Grade cannot be assessed (GX); Unknown |

- Pathological grade **cannot be blank**
- Code 9 when:
  - No resection of primary tumor
  - Neoadjuvant therapy given prior to surgical resection (see post-therapy grade)

| Post-therapy | |
|---|---|
| **Code** | Grade Description |
| 1 | G1: Well differentiated |
| 2 | G2: Moderately differentiated |
| 3 | G3: Poorly differentiated |
| 9 | Grade cannot be assessed (GX); Unknown |
| Blank | See Note 1 |

**Note 1:** Leave post-therapy grade blank when:
- No neoadjuvant therapy
- Clinical or Pathological case only

 **Rule of Thumb** 

TWO (2) *GRADES are* ***usually*** defined per case…..however….

***sometimes*** just one (1) will be define…..but….

**NEVER ALL 3**

**GOT IT!**

## The 3 Grade Data Items:

✷ **See actual grade table for complete list of coding instructions**

| Grade Clinical | | |
|---|---|---|
| **Description:** | **Allowable values and format:** | **Coding Guidelines** |
| This data item records the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant). | 1-5, 8, 9,<br><br>A, B, C, D, E, L, H, M, S | ❖ **Note 1:** Clinical grade is recorded for cases where a histological (microscopic) exam is done and tissue is available and grade is recorded. This includes FNA, biopsy, needle core biopsy, etc.<br><br>❖ **Note 2:** Clinical grade must not be blank.<br><br>❖ **Note 3:** Assign the highest grade from the primary tumor assessed during the clinical time frame.<br><br>❖ **Note 4:** Code 9 (unknown) when:<br>♦ Grade is not documented<br>♦ Clinical staging is not applicable.<br>♦ Grade checked "not applicable" on CAP Protocol (if available) and no other grade information is available<br>♦ If there is only one grade available and it cannot be determined if it is clinical or pathological, assign the clinical grade appropriately and code unknown (9) for pathological grade, and blank for post-therapy grade. |
| **Grade Pathological** | | |
| **Description:** | **Allowable values and format:** | **Coding Guidelines** |
| This data item records the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered.<br><br>If AJCC staging is being assigned, the tumor must meet the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup. | 1-5, 8, 9<br><br>A, B, C, D, E, L, H, M, S | ❖ **Note 1:** Pathological grade is recorded for cases where a surgical resection has been done.<br><br>❖ **Note 2:** Pathological grade must not be blank.<br><br>❖ **Note 3:**<br>♦ Assign the highest grade from the primary tumor. If the clinical grade is the highest grade identified, use the grade that was identified during the clinical time frame for both the clinical grade and the pathological grade.<br>♦ 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.<br><br>❖ **Note 4:** Code 9 (unknown) when:<br>♦ Grade not documented<br>♦ No resection of the primary site<br>♦ Neoadjuvant therapy followed by a resection (see post-therapy grade)<br>♦ Clinical case only (see clinical grade)<br>♦ There is only one grade available and it cannot be determined if it is clinical or pathological |

| | | |
|---|---|---|
| | | • Grade checked "not applicable" on CAP Protocol (if available) and no other grade information is available |

| Grade Post-Therapy | | |
|---|---|---|
| **Description:** | **Allowable values and format:** | **Coding Guidelines** |
| This data item records the grade of a solid primary tumor that has been resected following neoadjuvant therapy.<br><br>If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. | 1-5, 8, 9,<br><br>A, B, C, D, E, L, H, M, S,<br><br>Blank | ❖ **Note 1:** Leave post-therapy grade blank when:<br>• No neoadjuvant therapy<br>• Clinical or pathological case only<br>• There is only one grade available and it cannot be determined if it is clinical, pathological or post-therapy.<br><br>❖ **Note 2:** Assign the highest grade from the resected primary tumor assessed after the completion of neoadjuvant therapy.<br><br>❖ **Note 3:** Code 9 when:<br>• Surgical resection is done after neoadjuvant therapy and grade from the primary site is not documented.<br>• Grade checked "not applicable" on CAP Protocol (if available) and no other grade information is available. |

## SEER Coding Questions

**Question**
Histology--Ovary: What is the correct ICD-O-3 histology code for sertoliform endometrioid carcinoma of the ovary?

**Answer**
Assign 8380/3. Sertoliform endometrioid carcinoma is a variant of endometrioid carcinoma according to the WHO Classification of Tumors of Female Reproductive Organs, 4th edition. (SINQ 2018-0015; Date Finalized 05/01/2018; WHO Class Female Reproductive Organs 4th edition)

**Question**
First course of treatment: What is the correct code to use for allogenic stem cell transplant?

**Answer**
Code an allogenic stem cell transplant as 20 (Stem cell harvest (stem cell transplant) and infusion) in Hematologic Transplant and Endocrine Procedures in the 2016 SEER Manual. (SINQ 2018-0012; Date Finalized 5/1/2018; 2016 SEER Manual)

**Question**
MP/H Rules/Behavior--Breast: How many primaries are to be abstracted for a patient with a history of left breast ductal carcinoma in situ (DCIS) diagnosed in 2014 and bone lesions showing metastatic carcinoma consistent with a breast primary in 2017? See Discussion.

**Answer**
Assuming there were no other breast or any other tumors for this patient, change the behavior code to /3 on the original abstract for the 2014 breast primary.

Similar to SINQ 20110111, there was likely a focus of invasion present in the original tumor that was not identified by the pathologist. The behavior code on the original abstract must be changed from a /2 to a /3 and the stage must be changed from in situ to localized.

The MP/H rules do not apply to metastases. Therefore, rule M8 cannot be used. (SINQ 2017-0075; Date Finalized 1/10/2018; 2016 SEER Manual; SINQ 2011-0111)