Kentucky Cancer Registry SPRING Training 2019

Topics to be covered

- Changes since SEER Manual 2019 Draft to Final version
- Updates to Solid Tumor Rules – Jan. 2019
- Updates to EOD, Summary Stage, SSDI, and Grade
- Using Tools and Resources
- Examples and Questions

SEER MANUAL 2019 Final

- Originally, the draft SEER Manual for 2018 said that the date of a 'suspicious cytology' could be used for the diagnosis date, if further workup confirmed the reportability of the tumor
- **The exception regarding the use of 'suspicious cytology' as diagnosis date has been removed.** Therefore, a diagnosis of cancer based on ambiguous terminology for a cytology specimen alone is NOT reportable; and even if it is later confirmed, you do NOT use the cytology date as the date of diagnosis.

Reportability change

Early or evolving melanoma of any type is not reportable, starting Jan. 1 2019.

This includes both invasive and in situ melanomas, if described as early or evolving.

Smoldering systemic mastocytosis is reportable (9741/3). Indolent systemic mastocytosis is NOT reportable (9741/1).

These terms are not synonymous; smoldering includes a high burden of disease that can progress aggressively.

Coding primary site

- Rule: Code the last digit of the primary site code to '8' when a **single tumor overlaps** an adjacent **subsite**(s) of an organ and the point of origin cannot be determined.
- New exception to this rule:
  - ***Note:* Skin cancers overlapping sites in the head and neck ONLY**. Assign the primary site code for the site where the bulk of the tumor is, or where the epicenter is; do **not** use code C44.8**.**

Coding primary site

- Rule: When the medical record does **not** contain **enough information** to assign a primary, then
  - A. Consult a physician advisor to assign the site code
  - B. Use the NOS category for the organ system or the Ill-Defined Sites (C760-C768) if the physician advisor cannot identify a primary site
- ***Note***: **Assign C760 for Occult Head and Neck primaries** with positive cervical lymph nodes. Schema Discriminator 1: Occult Head and Neck Lymph Nodes is used to discriminate between these cases and other uses of C760.

  Previously, you were instructed to code these as C14.8.

Coding primary site for Sarcoma

- Sarcomas may also arise in the walls of hollow organs and in the viscera covering an organ. **Code the primary site to the organ of origin.**
- Code the organ of origin as the primary site when leiomyosarcoma arises in an organ. Do not code soft tissue as the primary site in this situation.
- ***Example 1:*** Leiomyosarcoma arises in kidney. Code the primary site to kidney (C64.9).
- ***Example 2:*** Leiomyosarcoma arises in prostate. Code primary site to prostate (C61.9).

Tumor size pathological

- Code 999 when
  - Unknown; size not stated
  - Not documented in patient record
  - Size of tumor cannot be assessed
  - No excisional biopsy or tumor resection done
  - **The only measurement(s) describes pieces or chips**
  - **Not applicable**

  (These last two were added to the definition of code 999)

Lymphovascular Invasion

- Use Code 0 – Lymphovascular invasion not present – **for all in situ cases**
- Use Code 8 – Not applicable – **for benign and borderline tumors**
- **Use code 8 for other specific schemas listed in the Abstractors Manual**

Mets at Diagnosis – Bone, Brain, Liver, Lung, Distant Nodes, Other sites

- **New instruction for all sites of mets at diagnosis:**

Code this field for all solid tumor EOD schemas (including Kaposi Sarcoma and Ill-Defined and Unknown Primary sites) **and the following Hematopoietic schemas:**

- i. Lymphoma Ocular Adnexa
- ii. Lymphoma (excluding CLL/SLL)
- iii. Lymphoma (CLL/SLL)
- iv. Mycosis Fungoides
- v. Primary Cutaneous Lymphoma (excluding MF and SS)

Surgery at the Primary Site

Added instruction for code 98:

- Code **98** for the following sites/schema:
  - a. Any case coded to primary site C420, C421, C423, or C424
  - b. Cervical Lymph Nodes and Unknown Primary
  - c. Plasma Cell Myeloma
  - d. Plasma Cell Disorders
  - e. Hematopoietic and Reticuloendothelial Neoplasms
  - f. Ill-defined and Unknown Primary Site

Surgical Margins

Revised coding instructions for code 9. Assign code 9:

- a. When it is unknown whether a surgical procedure of the primary site was performed **or** there is no mention of margins in the pathology report **or** no tissue was sent to pathology
- b. For death certificate only (DCO) cases
- c. For lymphomas with a lymph node primary site (C770-C779)
- d. Any case coded to primary site C420, C421, C423, or C424
- e. Cervical Lymph Nodes and Unknown Primary
- f. Plasma Cell Myeloma
- g. Plasma Cell Disorders
- h. Hematopoietic and Reticuloendothelial Neoplasms
- i. Ill-Defined and Unknown Primary Site

Scope of Regional LN Surgery

Assign code 9 for

- i. Any Schema ID with primary site: C420, C421, C423, C424, C700-C709, C710-C729, C751-C753, C761-C768, C809)
- ii. Brain
- iii. CNS Other
- iv. Intracranial Gland
- v. Lymphoma (excluding CLL/SLL) (Primary sites C770-C779 only)
- vi. Lymphoma that is CLL/SLL (Primary sites C770-C779 only)
- vii. Plasma Cell Myeloma
- viii. Plasma Cell Disorders (excluding histology 9734/3)
- ix. Hematopoietic and Reticuloendothelial Neoplasms
- x. Ill defined Other and Unknown Primary Site

Surgical Procedure of Other Site

Added instruction under using code 1

Assign code 1 – Non-primary site surgical procedure performed

When any surgery is performed for

- i. Plasma Cell Myeloma
- ii. Plasma Cell Disorder
- iii. Hematopoietic and Reticuloendothelial Neoplasms

Solid Tumor Rules

Updates were made to the General Instructions and to the site specific rules in **January 2019 for:**

Head & Neck, Colon, Lung, Breast, Kidney, Urinary, Malignant and Non-malignant Brain

The **2007 MP/H Rules had only minor changes** and became the 2018 Solid Tumor Rules these sites:

Cutaneous melanoma, Other sites

The Cutaneous melanoma and Other sites rules are listed as 2007-2020.

Changes to General Instructions

- The 2007 Rules instruct 'Code the histology from the most representative specimen'.
- The 2018 Rules instruct "For **all sites except breast and CNS**, 'Code the **most specific histology from biopsy or resection.** When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).' "

Exception for breast:

- For breast, **use code 8500/2 for DCIS** or carcinoma NST, in situ. Subtypes/ variants/features and patterns are NOT CODED.
- For **invasive** carcinoma of the breast, **subtypes/variants are ONLY coded when they comprise more that 90% of the tumor**.

Changes to General Instructions

- The 2018 Rules instruct "For **all sites except breast and CNS**, 'Code the **most specific histology from biopsy or resection.** When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).' "

Exception for CNS:

- **For Malignant and Non-malignant CNS tumors, code histology from a resection, if available**, using biomarker information, then addenda, comments and the final diagnosis. Use information from a biopsy as a second priority, if information from a resection is not available.

Changes to General Instructions

Added Notes to Priority Order for Using Documentation to Identify Histology

- **Added:** Code histology prior to neoadjuvant therapy
- **Added**: **Do not change the histology in order make the case applicable for staging**
- **Added:** "Note 2: The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor."
- **Added:** "Note 3: When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor)."

Changes to General Instructions

Equivalent terms:

- **Added:** "Majority; major; predominantly; greater than 50%"
- **Added:** "Carcinoma; adenocarcinoma"

  Adenocarcinoma and carcinoma are **considered equivalent when used with another term** such as acinar adenocarcinoma and acinar carcinoma. Both are coded the same. If a path report states only carcinoma, then that is what should be coded 8010 not 8140. SEER will provide either an example or note to clarify these terms in the next update.

Updates to Breast rules

Table 2 – Histology Combination Codes

- **Table 2, Duct + any histology row**
  - **Added:** "DCIS mixed with other in situ carcinoma 8500/2"
  - **Added:** "Note: Prior to 2018, DCIS and other in situ was coded 8523/2"
  - **Added:** "Note 1: Both histologies must have the same behavior code"
- **Table 2, Lobular carcinoma + Other Row**
  - **Added:** "In situ lobular mixed with other types of in situ carcinoma 8524/2"
- **Table 2, Paget disease + DCIS Row**
  - **Added:** "Paget disease (**specified as in situ**) and DCIS/intraductal carcinoma 8543/2"
  - **Modified:** "Paget disease (**invasive or behavior not specified**) and DCIS/intraductal carcinoma 8543/3"

Updates to Breast rules

Table 3: Specific Histologies, NOS/ NST, and Subtypes/Variants

- **Table 3, Invasive Ductal Carcinoma 8500 Row**
  - **Removed:** "Invasive mammary carcinoma with neuroendocrine features" **from row of synonyms and added as a subtype of small cell carcinoma**
  - **Added:** "Duct/Ductal carcinoma with mucin production" as a synonym
- **Table 3, Metaplastic Carcinoma Row**
  - **Added:** "Sarcomatoid Carcinoma 8033" to subtype/variants in column 3
  - **Added:** "Spindle cell carcinoma" as a synonym of the subtype 8032

Updates to Breast MP rules

NEW RULE - Rule M10: Abstract a single primary when any of the following conditions are met in the same breast:

- DCIS subsequent to a diagnosis of mixed DCIS AND:
  - Lobular carcinoma in situ 8522/2 OR
  - In situ Paget 8543/2 OR
  - Invasive Paget 8543/3
  - Other in situ 8523/2 (prior to 2018, DCIS and other in situ was coded 8523/2)
- Invasive carcinoma NST/duct subsequent to a diagnosis of mixed invasive carcinoma NST/duct AND:
  - Invasive lobular 8522/3 OR
  - Invasive Paget 8541/3 OR
  - Other invasive carcinoma 8523/3

Updates to Breast MP rules

Multiple Primary Rules

- **Rule M12:** Abstract a single primary when synchronous, separate/non-contiguous tumors are on the same row in Table 3. (Added the word 'synchronous' – meaning at the same time)
- **Rule M17: Last Resort Rule**
  - **Added:** "Example: One tumor is invasive carcinoma NST/ductal 8500/3 and a separate non-contiguous tumor in the same breast is DCIS 8500/2. Abstract a single primary: invasive carcinoma NST/ductal 8500/3."
- **NOTE: ALL BREAST MP RULES: Hierarchy was reordered. Please be sure you follow the rules in order.**

Updates to Breast Histology rules

NEW RULES

- **Rule H4:** Code DCIS and in situ Paget 8543/2.
- **Rule H5:** Code DCIS 8500/2 when there is a combination of DCIS and any other carcinoma in situ.
- **Rule H6:** Code the histology using Table 2 when there are multiple in situ histologies (2 or more) within a single tumor.
- **Rule H10 (modified):** Code mucinous carcinoma/adenocarcinoma 8480 ONLY when… "greater than or equal to 90% of the tumor" changed to "greater than 90%"

Updates to Colon MP rules

- **Rule M11 Modified:** Abstract a single primary when synchronous, separate/non-contiguous tumors are on the same row in Table 1 in the Equivalent Terms and Definitions.

  Added: "Synchronous"

- **Rule M15:** Abstract a single primary when tumors do not meet any of the above criteria.
  - Example added: adenocarcinoma in situ 8140/2 and a second non-contiguous invasive adenocarcinoma 8140/3 in the sigmoid colon C187. Multiple tumors that are the same histology in the same primary site (same four characters of colon topography code) are a single primary.

Updates to Head & Neck rules

Table 10 Paired Sites: Tonsillar fossa C090 and tonsillar pillar C091 **removed from sites where laterality must be coded**

MP Rule M3: Abstract multiple primaries when there are separate/non-contiguous tumors in any two of the following sites: **Site codes added:**

- Hard palate C050 AND/OR soft palate C051 AND/OR uvula C052
- Maxillary sinus C310 AND/OR ethmoid sinus C311 AND/OR frontal sinus C312 AND/OR sphenoid sinus C313
- Submandibular gland C080 AND sublingual gland C081

Updates to Head & Neck rules

- **Rule M9** Abstract a single primary (the invasive) when an in situ tumor is diagnosed after an invasive tumor in the same primary site.
  - **Added:** "In the same primary site"
- **Rule M10:** Abstract a single primary (the invasive) when an invasive tumor is diagnosed less than or equal to 60 days after an in situ tumor in the same primary site.
  - **Added:** "In the same primary site"
- **Rule M12:** Abstract a single primary when separate/non-contiguous tumors in the same primary site are on the same row in the appropriate site table
  - **Added:** "In the same primary site"

Updates to Kidney rules

- **Rule M8 Modified:** Abstract a single primary when synchronous, separate/non-contiguous tumors are on the same row in Table 1 in the Equivalent Terms and Definitions.

  Added: "Synchronous"
- **NEW RULE: M11** Abstract a single primary (the invasive) when an invasive tumor is diagnosed less than or equal to 60 days after an in situ tumor in the same kidney.
- **NEW RULE: M12** Abstract multiple primaries when an invasive tumor occurs more than 60 days after an in situ tumor in the same kidney.

Updates to Lung rules

Coding Multiple Histologies

Do code the most specific histology when an exact term is documented or when the histology is described as type, subtype or variant.

- ***Note 1***: The **most specific histology** may be described as **component**, **majority/majority of**, or **predominantly**.
- ***Note 2:*** Per the CAP protocol, the term predominant is acceptable for the following specific subtypes of adenocarcinoma. For these subtypes only, the word predominant is used to describe the subtype of the tumor. Table 3 has Histology coding instructions for these terms.
- • Adenocarcinoma, acinar predominant (lung only) **8551**
- • Adenocarcinoma, lepidic predominant **8250**
- • Adenocarcinoma, micropapillary predominant **8265**
- • Adenocarcinoma, papillary predominant **8260**
- • Adenocarcinoma, solid predominant **8230**

Updates to Lung rules

Rule H3 Code the specific histology when the diagnosis is **non-small cell lung carcinoma** (NSCLC) **consistent with** (or any other ambiguous term) **a specific carcinoma** (such as adenocarcinoma, squamous cell carcinoma, etc.) when:

- • The histology is clinically confirmed by a physician (attending, pathologist, oncologist, pulmonologist, etc.)
- • The patient is treated for the histology described by an ambiguous term
- • The case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

Example 1: The pathology diagnosis is NSCLC consistent with adenocarcinoma. The oncology consult says the patient has adenocarcinoma of the right lung. This is clinical confirmation of the diagnosis, code adenocarcinoma.

Updates to Malignant CNS rules

Table 3 Specific Histologies:

Astrocytoma 9400 - Subtype variant added: "Pleomorphic xanthroastrocytoma/anaplastic pleomorphic xanthroastrocytoma 9424"

Oligodendroglioma 9450 – ~~Anaplastic oligodendroglioma, NOS~~ **deleted**

MP Rule Rule M7: Abstract a single primary when there are separate, non-contiguous tumors in the brain (multicentric/multifocal) with the same histology XXXX (added 'with the same histology XXXX').

Updates to Malignant CNS rules

- **Rule M8:** Abstract multiple primaries when multiple tumors are present in any of the following sites or subsites (the following bullets were added)
  - Cauda equina C721 AND any other part of CNS
  - Any two or more of the cranial nerves: C722 Olfactory, C723 Optic, C724 Acoustic, C725 Cranial nerves NOS
- **NEW RULE: Rule H1** Code the reportable CNS tumor when a patient has NF1, NF2, Schwannomatosis

Note 3: Schwannomatosis is a newer term for a distinct subtype/variant of the genetic diseases NF1 and NF2.

Example: Patient presents with vestibular schwannoma (acoustic neuroma). Genetic testing proves the patient has NF2. Report the acoustic nerve neuroma.

Updates to Non-malignant CNS rules

Section 2: Reportable Primary Sites and Histologies

- **Added:** "Cavernous sinus hemangiomas are reportable. Code primary site cerebral meninges C700".

Table 6: Specific Histologies, NOS, and Subtypes/Variants

- **Meningioma Row:** "Psammomatous meningioma 9533/0" added as a subtype
- **Lipoma Row:** Code for Lipoma corrected from "8850" to "8860"
- **Added:** "Prolactinoma 8271/0" added as a new row

Updates to Non-malignant CNS rules

Major Changes to MP rules

- **M Rule:** Abstract multiple primaries when multiple tumors are present in any of the following sites: …
  - **This Rule was moved from M12 to M7. All subsequent rules were renumbered.**

Updates to Urinary rules

- **Table 2: Specific Histologies, NOS, and Subtypes/Variants**
  - Adenocarcinoma 8140 and Carcinoma 8010 rows combined into one row
  - Micropapillary urothelial carcinoma 8131 moved to be a subtype of papillary urothelial 8130
- **Table 2: Specific Histologies, NOS, and Subtypes/Variants**
  - **8140 Row:** "Urachal adenocarcinoma/carcinoma" added as a synonym

Urinary rules

- **The Solid Tumor rules for Urinary sites are currently being revised. New updates out at the end of March.**
- **Stay tuned!**

Changes to EOD and Summary Stage 2018

Additions to and Removals from Schemas

- Anus: C210 with 8720-8790 was added to this schema; it is not eligible for AJCC staging
- Melanoma Skin: C210 with 8720-8790 was removed from this schema (see Anus)
- Ill-Defined Other: C809 with 8041 was added to this schema
- Merkel Cell Skin: C809 with 8041 was removed from this schema (see Ill-Defined Other)

CLL/SLL

- Note 3: changed to state CLL/SLL is always 'staged' as a lymphoma
- EOD Primary Tumor: Primary site bone marrow (C421): Code 800 – This means that Summary Stage 2018 will be distant

Colon and Rectum, NET Colon and Rectum Changes

- EOD Regional Nodes: Code 300, for Rectum (C209), 'Iliac (hypogastric, internal, obturator) (see EOD Mets for common, external, NOS)' was added
- EOD Mets: for Colon, 'Iliac (common, external, hypogastric, internal, obturator, NOS)' was added (Notes in Colon and Rectum; code 20 in NET Colon and Rectum)
- EOD Mets: Rectum and Rectosigmoid were separated (Notes in Colon and Rectum; code 20 in NET Colon and Rectum)
- SS2018: Code 3, for Rectum (C209), 'Iliac (hypogastric, internal, obturator) (see code 7 for common, external, NOS)' was added
- SS2018: Code 7, for Distant Lymph Nodes, NOS, Rectum and Rectosigmoid were separated

Fallopian Tube, Ovary, Primary Peritoneal

Note 3: Both extension to and/or discontinuous metastasis to any of the following pelvic organs are included in code 450

- Bladder and bladder serosa
- Broad ligament (mesovarium)
- Cul de sac
- Parametrium
- Pelvic peritoneum
- Pelvic wall
- Rectosigmoid
- Rectum
- Sigmoid colon
- Sigmoid mesentery
- Ureter, pelvic

Note 4: Peritoneal implants may also be called seeding, salting, talcum powder appearance, or studding.

Note 5: If implants are mentioned, determine whether they are in the pelvis or in the abdomen and code appropriately. If the location of the implants is not specified, code 750.

Note 6: Both extension to and/or discontinuous metastasis to any of the following abdominal organs by way of peritoneal seeding or implants are included in codes 600-750

- Abdominal mesentery
- Diaphragm
- Gallbladder
- Intestine, large (except rectum)

rectosigmoid and sigmoid colon

Lung Changes

- EOD Primary Tumor: '(AIS)' Adenocarcinoma in situ was removed from code 100.
- Code 550 was changed to be code 675.
- EOD Regional Nodes: 'Cervical' removed from code 700
- SS2018: removed "Chest wall (thoracic wall)" from code 7; added "Brachial Plexus" and "Chest wall (thoracic wall)" to code 2

Prostate Changes

- EOD Primary Tumor: in code 700, Bone was removed from 'Further Contiguous extension'
- Prostate Path Extension: in code 700, Bone was removed from 'Further Contiguous extension'

700	Extension to or fixation to pelvic wall or pelvic bone "Frozen pelvis", NOS Further contiguous extension including › Other organs › Penis › Sigmoid colon › Soft tissue other than periprostatic	D

SSDI and Grade 2019 Updates

Breast

- ER/PR Total Allred Score SSDI
  - A note was added in the version 1.5 of SEER RSA referencing you back to the SSDI Manual in order to view instructions for calculating an Allred Score, when possible

> **Note 3:** The Allred system looks at what percentage of cells test positive for hormone receptors, along with how well the receptors show up after staining (this is called "intensity"). This information is then combined to score the sample on a scale from 0 to 8. The higher the score, the more receptors were found and the easier they were to see in the sample.
>
> - The registrar should not calculate the intensity score unless both components are available (proportion score and intensity)
> - See the "Allred Score for Estrogen and Progesterone Receptor Evaluation" table in the SSDI manual for assistance in determining the Allred Score

Cervix, Vagina, Vulva

- **Note 3:** If there is no mention of femoral-inguinal lymph node involvement in the workup, and the status data item: *LN Status Femoral-Inguinal, Para-aortic, Pelvic* does not indicate positive femoral-inguinal nodes, code 0.
- **Note 4:** The assessment results are recorded in LN Status Femoral-Inguinal, Para-aortic and Pelvic

LN Status Femoral-Inguinal, Para-aortic, Pelvic
Lymph Nodes Assessment Method Femoral-Inguinal
Lymph Nodes Assessment Method Para-aortic
Lymph Nodes Assessment Method Pelvic

Colon and Rectum

- CEA Pretreatment Lab Value: The note for how to code uncertain values was moved to the general instructions
- KRAS: Note 4 changed to be "Results from nodal or metastatic tissue may be used for KRAS."
- Microsatellite Instability (MSI): MMR proficient is to be coded to 0
- Perineural Invasion: Code 9 if surgical resection of the primary site is performed and there is no mention of perineural invasion.

Plasma Cell Myeloma

- Added a note to all SSDIs that stated if the schema discriminator was coded as 1 or 9, then SSDIs should be blank.

Note 5: If Schema Discriminator 1: Plasma Cell Myeloma Terminology is coded to 1 or 9, leave this SSDI blank.

Code	Description	Staging
0	Multiple myeloma Myeloma, NOS Non-secretory myeloma Plasma cell myeloma (PCM) Ultra-High-Risk Smoldering MM (SMM)	RISS Stage
1	Smoldering plasma cell myeloma (SPCM) Asymptomatic plasma cell myeloma Early myeloma Evolving myeloma	No RISS Stage
9	Other terminology describing myeloma Unknown terminology used	No RISS Stage

Common EOD Edit Error

- Edit: Derived EOD 2018 Stage Group (SEER)
- E: 90 is not a valid value for Derived EOD 2018 Stage Group
- Derived EOD 2018 Stage Group (971) = [90]
- Edit: Derived EOD 2018 T (SEER)
- E: 90 is not a valid value for Derived EOD 2018 T
- Derived EOD 2018 T (926) = [90]

https://staging.seer.cancer.gov/eod_public/stage/1.5/

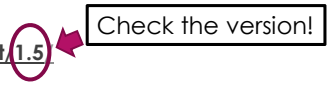
Resources

Codes, Coding Instructions, and Manuals

- STORE Manual
  - https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals
- SEER Program Coding Manual
  - https://seer.cancer.gov/tools/codingmanuals/index.html
- Solid Tumor Rules
  - https://seer.cancer.gov/tools/solidtumor/
- 2018 ICD-O-3 Coding Tables
  - https://www.naaccr.org/implementation-guidelines/#ICDO3
- ICD-O-3 Manual
  - https://www.ncra-usa.org/Portals/68/PDFs/Certification%20PDFs/ICDO3_9241545348.pdf
- Hematopoietic Manual
  - https://seer.cancer.gov/tools/heme/

Codes, Coding Instructions, and Manuals

- SEER RSA
  - Schema lists (tumor size, eod, summary stage, grade, ssdi, etc.)
  - Manuals for EOD and Summary Stage 2018
  - https://staging.seer.cancer.gov/eod_public/list/1.5/
- NAACCR SSDI/Grade
  - Schema lists (SSDI and Grade only)
  - Manuals for SSDI and Grade
  - https://apps.naaccr.org/ssdi/list/



Questions to Standard Setters

- CAnswer forum
  - http://cancerbulletin.facs.org/forums/
- SEER Inquiry System (SINQ)
  - https://seer.cancer.gov/seerinquiry/index.php?page=search
- Ask a SEER Registrar
  - https://seer.cancer.gov/registrars/contact.html

Steps for Coding Primary Site for Solid Tumors

1. ICD-O-3 Manual
   - Alpha index
   - Topography-Numerical
2. 2018 Solid Tumor Rule Manual
   - Head & neck, Lung, Urinary, CNS, and Breast
3. Program manuals
   - SEER Program Coding and Staging Manual/ Appendix C
   - STORE manual
4. SEER SINQ
5. Ask a SEER Registrar

Steps for Coding Histology for Solid Tumors

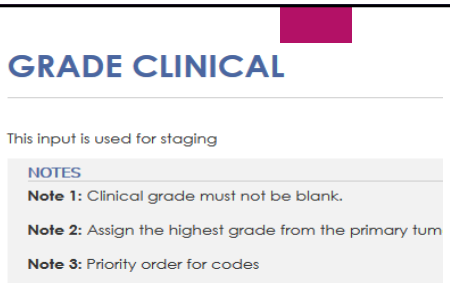
1. Solid Tumor Manual
2. 2018 ICD-O-3 Coding Tables (Make sure you have the most up to date version)
3. ICD-O-3 Manual
4. SEER SINQ
5. Ask a SEER Registrar

Steps for Coding Primary Site for Hematopoietic and Lymphoid Primaries

1. Hematopoietic and Lymphoid Neoplasm Coding Manual/Database to code primary Site.
2. SEER SINQ
3. Ask a SEER Registrar

Steps for Coding Grade

1. Review Coding Notes
2. Review Grade Coding Manual
   - Introduction to 2018 Changes in Grade Coding-Item Specific Data Dictionary and Coding Guidelines-pages 18-34.
   - Table Specific guidelines
     - Use the grade tables to determine which table applies.
3. Review/submit question to CAnswer Forum
   - SSDI/Grade forum



GRADE CLINICAL

This input is used for staging

NOTES

Note 1: Clinical grade must not be blank.

Note 2: Assign the highest grade from the primary tum

Note 3: Priority order for codes

Steps for Coding Summary Stage 2018

1. Review coding notes
2. Review General Instructions For Using The Summary Stage 2018 Manual
3. If applicable, cross reference other staging systems
   - EOD
   - AJCC
4. Check SEER Inquiry System
5. Submit questions to Ask a SEER Registrar

Steps to Code SSDI

1. Review coding notes
   - NAACCR Site Specific Data Items (SSDI)/ Grade
   - SEER RSA
2. Review SSDI Manual
   - General instructions
   - Site-specific notes in SSDI Manual
   - Review instructions for similar SSDI's (if applicable)
3. CAnswer Forum
   - Search
   - Submit a question

SSDI Example 1

- Pathology from a core biopsy of a breast tumor shows ductal carcinoma. The ER is documented as "75-100%".
  - How should I code ER (Estrogen Receptor) Percent Positive value?

If the range on the report uses steps larger than 10 or uses steps of 10 that are different from those provided in the table, code to the **range** that contains the **low number of the range** in the report.

- ***Examples:***
  - Report says **75**-100%.
  - Code R80 (71-80%, meaning at least 71%)

Code	Description
000	ER negative, or stated as less than 1%
001-100	1-100 percent
R10	Stated as 1-10%
R20	Stated as 11-20%
R30	Stated as 21-30%
R40	Stated as 31-40%
R50	Stated as 41-50%
R60	Stated as 51-60%
R70	Stated as 61-70%
R80	Stated as 71-80%
R90	Stated as 81-90%
R99	Stated as 91-100%
XX7	Test done, results not in chart
XX8	Not applicable: Information not collected (If this item is required by your standard se
XX9	Not documented in medical record ER (Estrogen Receptor) Percent Positive o

http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/86277-er-pr-percent-positive

SSDI Example 2

- A pathology report for a breast cancer patient showed
  - ER= 100% 3+ (Strongly positive)
  - PR= 95% 3+ (Strongly positive)
- Do I have enough information to code the Allred score?

1. Review coding notes
   - Not applicable
2. Review SSDI Manual
   - General instructions-N/A
   - Site-specific notes in SSDI Manual-N/A
   - Review instructions for similar SSDI's (if applicable)
     - See section on Estrogen Receptor and Progesterone Receptors

Assign Allred score of 08 for both ER and PR.

Allred Score* for Estrogen and Progesterone Receptor Evaluation

The Allred Score is a method of quantifying ER and PR using both intensity and percentage of positive cells. The Allred Score is calculated by adding the Proportion Score, as defined in the following table, and the Intensity Score.

Proportion Score	Positive Cells, %	Intensity	Intensity Score
0	0	None	0
1	<1	Weak	1
2	1 to 10	Intermediate/Moderate	2
3	11 to 33	Strong	3
4	34 to 66		
5	≥67		

* The Allred score combines the percentage of positive cells and the intensity of the reaction product in most of the carcinoma. The 2 scores are added together for a final score with 8 possible values.

Recently Asked Questions

Recently Asked Question

- When is a lymph node coded as a non-definitive therapy?

1. You would code a lymph node surgery as non-definitive when the node is not regional; in other words a distant lymph node.
2. Any lymphoma case where a lymph node is biopsied or removed that doesn't remove all involved lymph nodes.
   - Example left axillary mass seen and other lymph nodes in neck, chest, and abdomen are seen in imaging, so this is a stage 3 Non-Hodgkin Lymphoma. A left axillary node excision would be non-definitive (code 01 –biopsy of the primary site) due to other involved lymph nodes. If the axillary mass was all there was and it was excised it would be definite surgery code 25.

Recently Asked Question

- If you have ER/PR performed on an in situ cancer with microinvasion and the ER/PR was only performed on the DCIS can you code it?

1. No, if you have DCIS and Invasion the ER/PR must come from the invasion.
2. This was recently verified by AJCC physicians.
   - See http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/88623-dcis-w-microinv-idc-receptors-perfromed-on-dcis-only for more details

What Histology Would You Code?

- A patient was noted to have a left tonsil ulcerated nodule noted on exam. A left tonsillectomy performed at an outside facility proved "Invasive Squamous Cell Carcinoma, Keratinizing, Well-Differentiated". HPV test was negative and performed separately.
- Would you code 8071/3 for Squamous Cell Carcinoma, Keratinizing or 8086/3 to SCC, HPV neg?
- Per Ask a SEER Registrar, "The final diagnosis should be SCC, HPV-negative rather than relying on separate HPV test results in order to code 8086/3. Code histology to 8071/3."

How to code Radiation to Draining Lymph Nodes?

- Lung
  - Radiation to Lung and then boost to chest
  - Code Primary Treatment Volume for lung to 30
  - Code Radiation to Draining Lymph Nodes 02
  - Code Primary Treatment Volume for Chest to 39
  - Code Radiation to Draining Lymph Nodes 00

How to code Radiation to Draining Lymph Nodes?

- Breast after Lumpectomy
  - Radiation to Whole Breast and then boost to Tumor Bed
  - Code Primary Treatment Volume for breast to 40
  - Code Radiation to Draining Lymph Nodes 04
  - Code Primary Treatment Volume for Tumor Bed to 41
  - Code Radiation to Draining Lymph Nodes 00
- Breast after Mastectomy
  - Radiation to Chest Wall Code 42
  - Code Radiation to Draining Lymph Nodes 04

How to code I-131 for Thyroid?

- Code Primary Treatment Volume to 26
- Code Radiation to Draining Lymph Nodes 00

Prostate AJCC Clinical T

- Per the AJCC 8th Edition, "Clinical T category should always reflect DRE findings only."
- If you do not have a DRE documented you have to code Clinical cT blank per http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/male-genital-organs-chapters-57-59/prostate-chapter-58/85679-psa-and-biopsy-but-no-dre-info

Amin, Mahul B.; Gress, Donna M.; Meyer Vega, Laura R.; Edge, Stephen B.. AJCC Cancer Staging Manual, Eighth Edition (Page 745). American College of Surgeons. Kindle Edition.

SINQ 20180107

- Solid Tumor Rules (2018)/Histology--Lung: If the pathology **states non-small cell carcinoma of the lung (NSCLC), consistent with squamous cell carcinoma,** is the code non-small cell carcinoma according to the Solid Tumor Rules? The **Medical Oncologist states that the tumor is a squamous cell carcinoma.** In these instances would you code the squamous cell carcinoma since you have a definite physician statement?
- **Yes, Code the histology to SCC 8070/3 when:**
  - Clinically confirmed by a physician (attending, pathologist, oncologist, pulmonologist, etc.)
  - Patient is treated for the histology described by an ambiguous term
  - The case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

SINQ 20180112

- Solid Tumor Rules (2018)/Histology--Lung: What is the histology code of a non-small cell lung cancer (NSCLC), NOS as this is not on the AJCC list of histologies? See Discussion.
- **Code NSCLC to 8046/3.**
- Do not change a histology code simply to assign TNM to the case. ***AJCC does not determine histology coding***. While pathologists are no longer encouraged to use NSCLC, it does not mean the term and code are obsolete. NSCLC could be any number of histologies such as adenocarcinoma or squamous carcinoma. A diagnosis of NSCLC indicates that the initial exam of the tissue did not identify a more specific type of NSCLC. Additional immunohistochemical testing is needed to determine the histology. Update the case if better information becomes available from subsequent tests/review.

SINQ 20180113

- Solid Tumor Rules (2018)/Histology--Lung: What is the histology code of a 2018 lung cancer case with **invasive non-mucinous adenocarcinoma**? For non-mucinous carcinoma/adenocarcinoma, the Solid Tumor Rules have codes for microinvasive, minimally invasive, preinvasive, and in situ. Do we default to the microinvasive/minimally invasive code?
- **Code histology to adenocarcinoma, NOS (8140/3)**. The World Health Organization and the College of American Pathologists no longer recognize non-mucinous carcinoma/adenocarcinoma, NOS. Pathologists are discouraged from using this term. Microinvasive/minimally invasive lung tumors have very specific criteria and these criteria do not apply to non-mucinous carcinoma, NOS.

SINQ 20180093

Question: What is the histology for a case diagnosed on **biopsy with adenocarcinoma with acinar predominant pattern**, and with subsequent **lobectomy showing adenocarcinoma with solid growth pattern and a separate adenocarcinoma with lepidic predominant pattern**?

Answer: This is a single primary; coded 8140/3 -adenocarcinoma. In the biopsy and the two tumors found on lobectomy the specific adenocarcinoma histology is described as PATTERN. You do not code a PATTERN, so rule M7 above applies and this is a single primary.

Any questions?