November 2024 E-Tips	New Jersey State Cancer Registry Cancer Epidemiology Services http://www.nj.gov/health/ces (609) 633-0500

*****NJSCR v25 update*** NJSCR will upgrade to NAACCR v25 in March 2025.**

LUNG HISTOLOGY UPDATE

QUESTION: Solid Tumor Rules/Histology--Lung: Table 3 in Lung Solid Tumor Rules, 2023 Update, lists neuroendocrine carcinoma, NOS 8246 as a specific subtype/variant for small cell carcinoma 8041/3. Should the table be updated?

DISCUSSION: Small cell carcinoma is a specific type of neuroendocrine carcinoma for the lung. However, Table 3 lists neuroendocrine carcinoma, NOS as the more specific subtype/variant in Column 3.Using Lung Solid Tumor Rules, Rule H6, a diagnosis of poorly differentiated neuroendocrine carcinoma (small cell carcinoma) would be coded as 8246, instead of 8041, because there are two histologies under consideration (an NOS and a subtype/variant in Table 3), and the rule tells us to code the subtype/variant. However, small cell carcinoma is more specific than the NOS diagnosis (neuroendocrine carcinoma, NOS).

ANSWER: ***The Solid Tumor Rules for Lung have been updated for 2024***. The row for Small cell carcinoma 8041/3 has been deleted and new separate rows have been added for Neuroendocrine carcinoma (NEC) 8246 and Neuroendocrine tumor, NOS (NET) 8240. This change is based on the WHO Classification of Thoracic Tumors, 5th edition, and current concepts. In addition, Table 3 now reflects that Small cell carcinoma/small cell neuroendocrine carcinoma 8041 (located in Column 3) is a subtype/variant of neuroendocrine carcinoma, NEC 8246 (Column 1). As a result, application of Rule H6 to a diagnosis of poorly differentiated neuroendocrine carcinoma (small cell carcinoma)" would be coded as 8041, instead of 8246.

Note: The most recent Solid Tumor Rules update should be used as soon as it is released and can be applied to 2018+ cases

SEER Inquiry System - Question 20230066 Details

REMINDER: LUNG HISTOLOGY EXCEPTION

Rule H7 Code the histology that comprises the greatest percentage of tumor when two or more of the listed histologies are present (please refer to this detailed rule in STR for those specific histologies).

Note 3: CAP Lung Protocol now allows pathologists to identify the bulleted histologies as **pattern** along with percentages. The histology pattern with the greatest percentage can be coded. This is an **exception** to the histology coding instruction to not code pattern. Solid Tumor Rules 2025 Update

PANCREAS REPORTABILITY UPDATE - IPMN

QUESTION: Update to Current Manual/Reportability--Pancreas: For cases diagnosed 2024+, is a diagnosis of pancreatic intraepithelial neoplasia II (PanIN II) reportable? How should histology be coded?

DISCUSSION: SEER Program Coding and Staging Manual: Reportability – Reportable Diagnosis List indicates pancreatic intraepithelial neoplasia (PanIN II) (C250-C259) is reportable. However, the ICD-O-3.2 lists "Glandular intraepithelial neoplasia, grade II" and "Glandular intraepithelial neoplasia, low grade" as histology code 8148 with behavior of /0 (benign).

ANSWER: ***Do not report PanIN II.*** WHO Classification of Digestive Tumors, 5th edition, now categorizes PanIN into two categories, low grade (8148/0) and high grade (8148/2). PanIN grade I and PanIN grade II are categorized as PanIN low grade; PanIN grade III is categorized as PanIN high grade. **We will update the Reportability section of the manual.** SEER Inquiry System - Question 20240026 Details

IMPORTANT PANCREAS HISTOLOGY NOTE

STR Other, Table 11: Pancreas Histologies
Specific and NOS Term: Intraductal papillary mucinous neoplasm 8453
Note: Intraductal papillary mucinous neoplasm is an umbrella term and must include one of the terms in the synonym column to report

Synonyms:
Intraductal papillary mucinous neoplasm with high grade-dysplasia 8453/2
High-grade IPMN 8453/2
Intraductal papillary mucinous carcinoma, non-invasive 8453/2
Intraductal papillary mucinous carcinoma, invasive 8453/3
Intraductal papillary mucinous neoplasm with associated invasive carcinoma 8453/3

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

October 2024 E-Tips

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AVOID BREAST LN CODING EDITS

You may have come across the Edit "IFN6089-*LN Positive Axillary Level I-II conflicts with Regional Nodes Positive"* in your work on breast cases. This edit occurs when Reg LN Pos and SSDI LN Positive Axillary Level I-II conflict. Please note that when Reg LN Pos= 98 (no LN examined *pathologically*), SSDI LN Positive Axillary Level I-II must = X9 (Level I-II axillary nodes not assessed or unknown if assessed). This SSDI **must not be coded as 0** (all ipsilateral axillary nodes examined negative) **when no LN were examined pathologically. ****Site-Specific Data Item (SSDI) Manual (naaccr.org)

HISTOLOGY CODING REMINDER

Prior to 2018, DCIS and other in situ carcinoma was coded as 8523/2
Please note that for 2018 and beyond, DCIS mixed with other in situ carcinoma should be coded as 8500/2.

Required Histology Terms	Histology Combination Term and Code
DCIS/duct carcinoma/carcinoma NST **OR** any ONE subtype/variant of carcinoma NST **AND** **Any** histology in **Table 3 with exception** of • Lobular carcinoma **8520** and pleomorphic lobular carcinoma in situ **8519/2*** • Paget disease **8540** ***Note 1:*** Both histologies **must have** the **same behavior** code. ***Note 2:*** See **Table 3** for carcinoma NST/duct carcinoma subtypes/variants. ***Note 3:*** **Do not** use combination code for duct with lobular **differentiation.** This is a synonym for carcinoma NST.	Invasive carcinoma NST/duct mixed with other types of invasive carcinoma **8523/3** DCIS mixed with other in situ carcinoma **8500/2** ***Note***: Prior to 2018, DCIS and other in situ was coded **8523/2**. **Breast Solid Tumor Rules 2024 Update (cancer.gov)

CODING TUMOR SIZE AFTER NEOADJUVANT TREATMENT:

QUESTION: Update to the Current Manual/Tumor Size Summary—Neoadjuvant Treatment: Would you clarify instructions in the 2024 SEER Program Coding and Staging Manual (SPCSM) for *Tumor Size Summary* when a patient receives neoadjuvant treatment? There seems to be a conflict with the STORE Manual. See Discussion.

DISCUSSION: Starting for cases diagnosed in 2024, the SPCSM manual no longer requires the data items for clinical and pathologic tumor size. Instead, it appears to align with the CoC data item of *Tumor Size Summary*. The two manuals contradict each other when it comes to coding tumor size summary for neoadjuvant chemotherapy (NAC) treated cancers.
STORE states: "If neoadjuvant therapy followed by surgery, do not record the size from the pathologic specimen. Code the largest size of the tumor prior to neoadjuvant treatment; if unknown code size as 999."
2024 SPCSM states "If neoadjuvant therapy followed by surgery, do not record the size from the pathologic specimen. Code the largest size of the tumor prior to neoadjuvant treatment; if unknown code size as 999." It continues to state

> *12. Assign code 000 when…. (a) no residual tumor is found…(i) Neoadjuvant therapy has been administered *and* **the resection shows no residual tumor &**
> 14. Assign code 999 when...(d) Neoadjuvant therapy has been administered and resection was performed. Do not use a post-neoadjuvant size to code pathologic tumor size; however, you may use the clinical tumor size if available

ANSWER: When there is neoadjuvant therapy followed by surgery, do not record the size from the pathologic specimen. Code the largest size of the tumor prior to neoadjuvant treatment; if unknown code size as 999. *We will remove Coding Instruction 12.a.i in the next version of the manual.

NJSCR UPDATE: The 2025 Casefinding List has been posted. Casefinding Lists - SEER (cancer.gov)

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email.
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September 2024 E-Tips

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LEUKEMIA AND LYMPHOMA CODING UPDATES

PRIMARY SITE

THE QUESTION:
Primary Site/Heme & Lymphoid Neoplasms--CLL/SLL: Should the primary site be coded C421 (bone marrow) for a diagnosis of chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) when the managing physician provides a Rai stage?

THE DISCUSSION:
The SSDI Manual notes, "Rai stage is only applicable for CLL, in which the bone marrow and/or peripheral blood are involved (primary site C421 for bone marrow, see Hematopoietic Manual, Module 3: PH 5, 6)." Should primary site default to C421 if the physician provides a Rai Stage in the absence of definitive peripheral blood or bone marrow involvement documented in the medical record?

THE ANSWER: Assign primary site C421.The Site-Specific Data item (SSDI) Manual, Rai Classification section, states: Per confirmation from medical oncologists, Rai stage is only recorded for patients who have bone marrow and/or peripheral blood involvement.

** SEER Inquiry System - Question 20230078 Details (cancer.gov)

DID YOU KNOW?

Lymphoplasmacytic Lymphoma (LPL) is an NOS which has two variants. All three diseases are diagnosed by an increased number of immunoglobulins. WM is caused by increased lymphocytes which causes an increase in IgM. Gamma heavy chain disease is caused by increased plasma cells which results in an increase of IgG. LPL has mixed abnormalities, both the lymphocytes and plasma cells are increased which results in an abnormally high IgM AND IgG.

1. Waldenstrom Macroglobulinemia (WM) (9761/3) is a subset of LPL. WM is caused by increased lymphocytes which causes an increase in IgM. See the abstractor notes for WM for more information.

2. Gamma heavy chain disease (9762/3) is a variant of LPL. Gamma heavy chain disease is caused by increased plasma cells which results in an increase of IgG. See the abstractor notes for Gamma heavy chain disease for more information.

**SEER Hematopoietic and Lymphoid Neoplasm Database (cancer.gov)

METS AT DIAGNOSIS

Reminder when coding for Lymphoma:
Use Code 8 for **Distant LN** for the following: when primary site is C420, C421, C423, C424, C770-C779 or histology is 9671, 9734, 9731 or 9761 for any primary site.
For Leukemia: All Mets at Dx fields should be **coded to 8**.

Mets at Dx-Bone: *Do Not* use this field to code Bone Marrow involvement for Lymphomas. Rather, please use Mets at Dx-Other and Code 1 for Bone Marrow involvement.

**SEER Program Coding and Staging Manual 2024

REPORTABILITY

THE QUESTION:
Reportability/Histology--Heme and Lymphoid Neoplasms: Is "the differential diagnoses include, but not limited to, mantle cell lymphoma, atypical chronic lymphocytic leukemia/small lymphocytic lymphoma and a variant of marginal zone lymphoma" reportable? In the Heme manual, they use differential diagnosis that include reportable conditions as reportable. This can be found under Code 1: positive histology in the Diagnostic Confirmation Coding Instruction section page 18. The phrase "include, but not limited to" makes this not clear.

THE ANSWER:
This is reportable as 9591/3, B-cell lymphoma, NOS. All diagnoses in the differential are all B-cell lymphomas. The pathologist knows it a B-cell lymphoma but has not determined the subtype. If at a later time a specific lymphoma is determined, update the histology code accordingly.
** SEER Inquiry System - Question 20230055 Details (cancer.gov)

Save the date: ORANJ 2024 Annual Meeting
October 24-25, 2024
Tropicana Atlantic City

Check out a new short on FLccSC!!!
Coding Diagnostic Confirmation for Hematopoietic and Lymphoid Neoplasms

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email.
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August 2024 E-Tips

New Jersey State Cancer Registry
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GYN CODING UPDATES

REPORTABILITY

THE QUESTION:

Reportability/Histology--Endometrium: Is "high grade serous intraepithelial neoplasm" of the endometrium reportable?

THE DISCUSSION:

The patient had a 2023 endometrial polypectomy and curettage with final diagnosis of "at least serous intraepithelial neoplasia arising in association with an endometrial polyp." Diagnosis comment states, "There are multiple tissue fragments with highly atypical glandular lining consistent with a high-grade serous neoplasm. There are focal areas which are suspicious, but not conclusive, for stromal invasion." Subsequent hysterectomy and BSO showed no residual carcinoma.

According to previous SINQ 20210043, serous tubal intraepithelial neoplasm (STIN) is reportable when stated to be high grade. Does the same logic apply to a similar neoplasm in the endometrium and/or endometrial polyp?

THE ANSWER:

Report high grade serous intraepithelial neoplasm of the endometrium.

**https://seer.cancer.gov/seer-inquiry/inquiry-detail/20240047/

HISTOLOGY

Are you aware of the subtype coding for serous carcinoma of the ovary, NOS 8441?

If serous carcinoma of the ovary is differentiated by high or low grade, please code the following:

High-grade serous carcinoma/HGSC **8461/3**

Low-grade serous carcinoma/micropapillary serous carcinoma **8460/3**

Serous carcinoma, non-invasive, low grade **8460/2**

****STR, Other Sites Table 13: Ovary Histologies** Other Sites Solid Tumor Rules 2024 Update (cancer.gov)

HISTOLOGY

Endometrial Adenocarcinoma is a synonym of Endometrioid Adenocarcinoma 8380/3 for specific GYN primary sites as shown in STR, Other Sites Table 16 and Table 17: Uterine Corpus/Cervix Histologies

Other Sites Solid Tumor Rules 2024 Update (cancer.gov)

STAGING

THE QUESTION:

Summary Stage 2018--Ovary: What is the summary stage for an ovarian primary in 2024, in which the ovary capsule was ruptured with surgical spill?

THE DISCUSSION:

In this case, the surgeon ruptured the ovarian tumor to drain it prior to removal causing the surgical spill. Regional lymph nodes are negative and there is no metastasis. The capsule was then noted as ruptured on pathology.

Does it matter if the surgeon was the one who ruptured the capsule? Would the stage change if the surgeon intentionally ruptured the capsule to drain the tumor intraoperatively causing some surgical spill? The scenarios of an intentional and not intentional rupture are not specified in SEER Summary Stage 2018.

THE ANSWER:

Code SEER Summary Stage 2018 to Localized, Code 1. Per consult with AJCC and noted in the Primary Peritoneal Chapter in AJCC 8th edition, an intraoperative rupture is coded as a surgical spill.

A capsule rupture is when the capsule ruptures prior to the surgery (Summary Stage Regional, Code 2).

****SEER Inquiry System - Question 20240058 Details (cancer.gov)**

Save the date: ORANJ 2024 Annual Meeting
October 24-25, 2024
Tropicana Atlantic City

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Coding Diagnostic Confirmation for Hematopoietic and Lymphoid Neoplasms

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July 2024 E-Tips

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Reportability/Ambiguous Terminology—Prostate

Should cases be reported and abstracted based on ambiguous terminology, e.g., suspicious for prostate cancer, when the physician is not treating the case as malignant? **SEER SINQ 20240045**

A prostate biopsy is suspicious for adenocarcinoma, but the urologist is not considering this malignant, nor is the urologist treating for malignancy, but there is no clear statement from the physician that this is not reportable. ***Should this case be abstracted?***	A prostate biopsy is suspicious for adenocarcinoma, and there is a statement by the physician that this is not yet malignant. ***Should this case be abstracted?***	Prostate MRI with PIRADS 4 or 5; however, the treating urologist does not call this malignant and is not treating patient for prostate cancer. [Example: 2024 Prostate MRI - PI-RADS 4. Follow up with Urologist states patient to repeat Prostate MRI in 1 year and continue with yearly PSA levels and there is no mention of prostate cancer other than the PI-RADS score]. ***Should this case be abstracted?***

Answer:

For each of [these] scenarios, the medical record information indicates that the case is not reportable based on physician opinion. **Do not abstract these cases.**

The ambiguous terms list is to be used as a last resort.

See the SEER Program Manual (pg19) for abstracting instructions when the medical record does not provide a clear diagnosis of cancer. SEER Program Coding and Staging Manual 2024 (cancer.gov)

Kidney: SSDI Invasion Beyond Capsule Coding

Perinephric/sinus fat invasion should be confirmed microscopically and is invasion into fat by tumor cells, with or without desmoplastic reaction, and vascular invasion into perinephric/sinus soft tissue.

Synonyms include: renal sinus fat, and medial invasion

Do not code invasion of renal hilum in this data item.

Invasion of the renal hilum is invasion of vessels, nerves, lymphatics, and/or ureter before they enter the kidney parenchyma.

If the only information you have is that the renal hilum is involved, code to 9 (unknown).

Do not use imaging findings to code this data item.

**NAACCR Version 3.1 Changes for SSDI and Grade Manual

Coding Surgical Margins of the Primary Site

- Assign **code 0** when all margins are negative both microscopically and macroscopically (grossly)
- Assign **code 1** for involvement of margins but not otherwise specified
- Assign **code 2** for involvement of margins microscopically but not grossly (cannot be seen by the naked eye). Use the Margins section of the CAP protocol or the Microscopic Description from the pathology report to identify microscopic findings.
- Assign **code 3** for involvement of margins grossly (seen by the naked eye). Use the Margin section of the CAP protocol or the Gross Description from the pathology report to identify macroscopic findings.

** **Check out the** SEER Program Coding and Staging Manual 2024 **for more coding instructions for margin status**

NEW coding videos on FLccSC!! http://njs.fcdslms.med.miami.edu/ **Check out the updated 2024 NJSCR Program Manual and Reportable List** Department of Health | Cancer | Cancer Registrars (nj.gov)

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June 2024 E-Tips

New Jersey State Cancer Registry
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Race Coding Updates

Update to Current Manual (2024)/Race

For the Example #15 under Race Coding Examples in the 2024 SEER manual, ***could coding these as 97 result in an under-reporting of Native Hawaiians?***

What race code should be used in a situation where the only available information is "Native Hawaiian/Pacific Islander?"

Answer

Change to current instructions. We will update this example in the next edition of the manual. The new example will instruct registrars to look for other descriptions of the patient's race. When no other information is available, assign 07, Native Hawaiian, in Race 1 and assign 97, Pacific Islander, NOS in Race 2. Begin following this new instruction now.

SEER SINQ 20240039

How is Race coded when stated as Hispanic and there is no other information?

There appears to be discrepant information in the 2024 (and prior) SEER manual regarding race coding when the patient is described only as Hispanic/Latina.

[SEER Manual] page 78 tells us to Code as 01 (White) when**: (b.)** There is a statement that the patient is Hispanic or Latino(a) and no further information is available. A person of Spanish origin may be any race; however, for coding race when there is no further information other than "Hispanic" or "Latino(a)," assign race as White as a last resort instead of coding unknown. ***However***, Appendix D, under "Other Race descriptions", [states] that "If no further information is available, code as 99 Unknown." The list includes "Hispanic."

Answer

Assign code 01 (White) for Hispanic when there is no additional information. It is listed in the 2024 SEER Manual, Race Coding Instruction 6.b.i. and in Appendix D for code 01. We will remove Hispanic from the list in Appendix D under code 99 in the next version of the manual.

SEER SINQ 20240036

Melanoma Surgery Coding Updates for 2023+

- Margins are no longer incorporated into the surgery codes. This is captured separately in the SSDI for 2023+ Clinical Margin Width.

Excisional, Shave, Punch, Elliptical Biopsies are ALWAYS coded as surgery.

- Assign biopsy procedures to Surgical Diagnostic and Staging Procedures **ONLY** when there is a small specimen of tissue taken from the melanoma tumor such as a needle or core biopsy.

- Assign the surgery code based on the description of the procedure. Priority Order for assigning surgery code:
  1) Operative report
  2) Statement from a physician
  3) Description of the surgical procedure on a pathology report
  4) Results of the pathology report

**NAACCR Melanoma 2023 Webinar &SEER Melanoma Surgery Codes

Lymphoma Primary Site Coding Tips

- Do not assume that the lymphoma originated in the biopsied lymph node chain.
- Remember providers will usually biopsy the most accessible lymph nodes or other involved tissues.
- **Always look for lymphadenopathy on the PET/CT and follow the rules in the HP manual for assigning primary site.**

**NAACCR Boot Camp 2024 Webinar

2024 Fall Virtual SEER Workshop
Advanced Topics for Registry Professionals

September 24-26, 2024

Registration is through NCRA.
Workshop exercises are posted on SEER Educate. Complete by August 15, 2024.

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email.
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May 2024 E-Tips

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Cancer PathCHART Site-Morphology Combination Standards

The 2024 Cancer PathCHART ICD-O-3 Site Morphology Validation List (CPC SMVL), output directly from the Cancer PathCHART database, is a comprehensive table that *replaces both the ICD-O-3 SEER Site/Histology Validation List and the list of impossible site and histology combinations included in the Primary Site, Morphology-Imposs ICDO3 (SEER IF38) edit*.

The downloadable list can be found at https://seer.cancer.gov/cancerpathchart/products.html.

Cancer PathCHART SVML Search Tool:
For January 2024 implementation, a webtool is now available on the Cancer PathCHART website that will allow searches for tumor topography, histology, and behavior codes and terms and whether the site-morphology combinations are biologically valid, impossible, or unlikely.

**SEER Program Coding and Staging Manual 2024
**Cancer PathCHART Search Tool

Looking for ICD-10-CM Codes for Intraepithelial neoplasia???
Check out SEER SINQ 20240020

Behavior Coding for Intracranial and CNS Tumors

Intracranial and CNS tumors with behavior codes 0 (benign) and 1 (borderline malignancy) are reportable beginning with January 1, 2004 diagnoses.

Code the behavior from CT scan, Magnetic Resonance Imaging (MRI), or Positron Emission Tomography (PET) report when there is no tissue diagnosis (pathology or cytology report). ***Code the behavior listed on the scan. Do not use the WHO grade to code behavior.***

**SEER Program Coding and Staging Manual 2024

Question:
Breast: Is ductal carcinoma in situ (DCIS), solid type coded as 8500/2 or 8230/2?

In the NAACCR Coding Pitfalls 2023 webinar, the example of DCIS, solid type is given. The webinar advised us to code 8230/2 (ductal carcinoma in situ, solid type). When going through the beginning of the solid tumor rules in the Changes from 2007 MPH Rules section it states "DCIS/Carcinoma NST in situ has a major classification change. Subtypes/variant, architecture, pattern, and features ARE NOT CODED. The majority of in situ tumors will be coded to DCIS 8500/2." In the equivalent or equal terms section it lists "Type, subtype, variant" can be used interchangeably.

Since the example has it listed as ductal carcinoma in situ, solid "type," would we code 8500/2 or 8230/2?

Answer:
Assign 8230/2 (ductal carcinoma in situ, solid type/intraductal carcinoma, solid type) using Breast Solid Tumor Rules Table 3 as instructed in Rule H2 for in situ tumors. The carcinoma, NST row lists this histology in the subtype/variant column 3.

Coding histology for in situ breast tumor differs from invasive. While the majority of in situ breast primaries will be coded to DCIS 8500/2, there are others that are listed in Table 3 that should be coded according to the specific histology. Some codes have the word subtype or type as part of their histologic term so these can be coded based on the histologic term as listed in the table. We suggest you routinely review the histology tables to see if a term is listed.

**SEER SINQ 20240015

Submission recommendations for the reporting year:
All 2023 records submitted by July 1, 2024.

Check out new shorts on FLccSC!!!
Address at Diagnosis
Race

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April 2024 E-Tips

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Histology coding for Digestive Sites:

SEER Program Coding and Staging Manual indicates high grade dysplasia of esophagus, stomach, and small intestine are reportable. The ICD-O-3.2 does not include "high grade dysplasia" as equivalent to "high grade squamous dysplasia."

What is the correct histology code for "high grade dysplasia" (not specified to be squamous or glandular) for esophagus, stomach, and small intestine for cases diagnosed beginning in 2024?

According to SEER Sinq 20240021, the correct histology for "high grade dysplasia NOS" (not specified to be squamous or glandular) that originates in the stomach, small intestine, and esophagus is:

Stomach: Assign code 8148/2 glandular intraepithelial neoplasia, high grade using the Other Sites Solid Tumor Rules, Table 6: Stomach Histologies and as described in the WHO Classification of Digestive Tumors, 5th edition.

Small intestine and Esophagus: Assign code 8148/2 glandular intraepithelial neoplasia, high grade, using the Other Sites Solid Tumor Rules, Other Sites Histology Rules, Rule H4/H26. The following note is listed for both of these rules.

Note: This list may not include all reportable neoplasms for 8148/2. See SEER Program Coding and Staging Manual or STORE manual for reportable neoplasms.

SEER SINQ 20240021

Recurrence

When there is a recurrence less than or equal to ***X*** years of diagnosis, the "clock" starts over.

- The time interval is calculated from the date of last recurrence.
- The patient must have been disease-free for greater than ***X*** years from the date of the last recurrence.
- When it is unknown/not documented whether the patient had a recurrence, default to date of diagnosis to compute the time interval.
- 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".

Use the Multiple Primary Rules as written to determine whether a subsequent tumor is a new primary or a recurrence.

See full definition of *Recurrence* in the Solid Tumor Rules General Instructions

What cancer should be reported to NJSCR?

Both analytic and non-analytic cases with active disease are required to be reported to the NJSCR.

Patients diagnosed elsewhere and admitted for additional work-up and/or treatment, cancer- directed or non cancer-directed must be reported.

Patients with a clinical diagnosis of cancer which was based on clinical judgment only must be reported.

Patients with a history of cancer with active disease must be reported.

Consult-only cases are reportable. A consult may be done to confirm a diagnosis or treatment plan.

Private outpatient specimens are reportable.
These specimens are submitted from a physician's office to be read by the hospital pathologist and the patient is not registered as an inpatient or outpatient at the hospital.

Check out the 2024 NJSCR Program Manual for more information.

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March 2024 E-Tips

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Diagnostic Confirmation Coding for Solid Tumors

- These codes are in priority order; code 1 had the highest priority.
- *Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple methods.*
- Change to a higher-priority code, if at **any time during the course of disease** the patient has a diagnositic confirmation with a higher priority.
  - *Example:* Benign brain tumor diagnosed on MRI. Assign diagnostic confirmation code 7. Patient later becomes symptomatic and the tumor is surgically removed. Change the diagnostic confirmation code to 1.

Check out SEER Manual Diagnostic Coding Section for more information and full list of notes!

Codes for Solid Tumors

Microscopically Confirmed

Code	Description
1	Positive histology
2	Positive cytology
4	Positive microscopic confirmation, method not specified

Not Microscopically Confirmed

Code	Description
5	Positive laboratory test/marker study
6	Direct visualization without microscopic confirmation
7	Radiology and other imaging techniques without microscopic confirmation
8	Clinical diagnosis only (other than 5, 6, or 7)

Confirmation Unknown

Code	Description
9	Unknown whether or not microscopically confirmed; death certificate only

Hormone Therapy Coding for Thyroid Primaries

Code **Hormone Therapy as 01** for follicular and/or papillary thyroid cancer when thyroid hormone therapy is given.
Example: Levothyroxine, Synthroid

Do not code replacement therapy as treatment unless the tumor is papillary and/or follicular.

The thyroid gland produces hormones that influence essentially every organ, tissue and cell in the body. When the thyroid is partially or totally removed, it is no longer able to secrete these essential hormones and the patient is placed on hormone replacement therapy.
SEER Coding Guidelines for Thyroid

Check out the 2024 NJSCR Program Manual!!!
Department of Health | Cancer | NJ State Cancer Registry

New Short on FLccSC covering Address at Diagnosis
FCDS - LMS - Frontend - Log In (miami.edu)

Completeness rate Recommendation for facilities
75% of 2023 records submitted by the end of April 2024.
All 2023 records submitted by July 1 2024.

Question:
Head & Neck: How is histology coded for laryngeal intraepithelial neoplasia II-III (LIN II or LIN III)? See Discussion.

Laryngeal intraepithelial neoplasia II-III is not included in the ICD-O-3.2 and, while the SEER Program Coding and Staging Manual (SPCSM) confirms this is reportable, neither the SPCSM nor the Solid Tumor Rules Manual provide the specific histology to use for LIN II or LIN III. Should this be coded as 8077/2 since this is most like a high grade squamous dysplasia?

Answer:
Assign histology code, 8077/2 (squamous intraepithelial neoplasia, high grade) for LIN III and for LIN II. *ICD-O-3.2 lists squamous intraepithelial neoplasia, grade II and grade III as 8077/2 indicating it is reportable.* ICD-O-3.2 does not list every site-specific type of intraepithelial neoplasia. Check the SEER manual for reportable and non-reportable examples.

SEER Ask A Registrar 20240003

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

February 2024 E-Tips

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

Radiation Coding: Breast Phase I-II-III Radiation Primary Treatment Volume
NAACCR Coding Pitfalls 2023 Webinar

Code 40 (Breast- whole)
Patients who had whole breast radiation after a lumpectomy or partial mastectomy
Code 41 (Breast- partial)
Patients who had partial radiation after a lumpectomy
Code 42 (Chest wall)
Patients who received radiation after mastectomy

If the breast AND lymph nodes are being treated
Code the Primary Treatment Volume to Breast (codes 40 and 41) and Breast/chest wall lymph nodes (code 04) in radiation to Draining Lymph Nodes.

Check out the
CTR Guide to Coding Radiation Therapy Treatment in the STORE Manual

Melanoma SSDI Clinical Margin Width

This SSDI is effective for diagnosis year 2023+

Code the peripheral surgical margins from the operative report from a wide excision.

- *Do not use the pathology report to code this data item.*
- Margins from wide excision-measured from the edge of the lesion or the prior excision scar to the peripheral margin of the specimen, do not use deep margin
- Do not add margins together
- *If multiple wide excisions are performed, code the clinical margin width from the procedure with the largest margin.*

Order of priority:

1. **Operative Note**
2. **Physician statement in medical record**

Record stated margin in centimeters. Include decimal point. ***Example:*** 0.5 cm - 0.5

Physician statement of clinical margin width can be used to code this data item when no other information is available, or the available information is ambiguous.

**https://staging.seer.cancer.gov/eod_public/schema/3.1/melanoma_skin/?breadcrumbs=(~schema_list~)

Question:
Histology--Prostate: Is histology coded as 8045 (Combined small cell carcinoma) for a 2023 diagnosis of two-component carcinoma comprised of both acinar adenocarcinoma and small cell neuroendocrine carcinoma of the prostate?

Discussion:
This patient does not have a previous diagnosis of prostate adenocarcinoma nor a previous history of androgen-deprivation therapy. Does the logic in the Other Sites Solid Tumor Rules (STRs) noted in SINQ 20200052 still apply? This SINQ confirms a diagnosis of mixed prostatic adenocarcinoma and small cell neuroendocrine carcinoma is 8045. This matches the STRs instructions for Rule H21 and Table 2 (Mixed and Combination Codes), row 1. Row 1 indicates a mixed small cell carcinoma and adenocarcinoma is combined small cell carcinoma (8045). For a patient without previous treatment, is this the correct mixed histology code?

Answer:
Code histology as combined small cell carcinoma (8045) based on the Other Sites Solid Tumor Rules, May 2023 Update, Table 2, Mixed and Combination Codes, for this mixed histology prostate carcinoma consisting of adenocarcinoma and small cell neuroendocrine carcinoma regardless of treatment status. This is similar to SINQ 20200052 that applies to one tumor with mixed histologies.

**https://seer.cancer.gov/seer-inquiry/inquiry-detail/20230065/

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January 2024 E-Tips

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

EOD and SS2018 Version 9 Update

AJCC released version 9 for NET (excluding Adrenal Gland) and Vulva diseases which will be effective for cases diagnosed 1/1/2024 or later. There are now 2 schemas for each. SEER*RSA has been updated to reflect these changes.

The Registrar Staging Assistant (SEER*RSA) website is intended for use by cancer registrars to help with diagnosis 2018 and forward coding:

- Extent of Disease (EOD) 2018
- Summary Stage 2018 (SS2018)
- Site-Specific Data Items
- Grade

Visit SEER*RSA
https://staging.seer.cancer.gov/

Current sites that have both AJCC 8th Edition and version 9 coding guidelines include: Anus, Appendix, Brain, Cervix, CNS Other, Intracranial Gland, NET tumors, Vulva

Breast Histology Coding

Mammary carcinoma is a synonym for carcinoma no special type (NST)/duct carcinoma not otherwise specified (NOS) use **code 8500.**

Invasive carcinoma, NST with lobular features is not equivalent to invasive carcinoma with ductal and lobular features.

Invasive mammary carcinoma NST with lobular features use code 8500/3

Breast Solid Tumor Rules

2024 Coding Instructions for Primary Site: GYN Sites

When the choice is between ovary, fallopian tube, or primary peritoneal without designation of the site of origin, **any indication of fallopian tube involvement indicates the primary tumor is a tubal primary**.

Fallopian tube primary carcinomas can be confirmed by reviewing the fallopian tube sections as described on the pathology report to document the presence of either serous tubal intraepithelial carcinoma (STIC) and/or tubal mucosal invasive serous carcinoma. **In the absence of fallopian tube involvement, refer to the histology and look at the treatment plans for the patient.**

If all else fails, assign ***C579*** as a last resort.
Check out the 2024 SEER Manual Coding Instructions!!

Coding Guidelines for Bladder!

Use the information from reports in the following priority order to code a subsite when the medical record contains conflicting information:

- Operative report (TURB)
- Pathology report
- Multifocal Tumors

Coding Bladder subsites

C679 Assign when there are multifocal tumors all of the same behavior in more than one subsite of the bladder and the specific subsite of origin is not known.
C678 Assing when:

- A single tumor of any histology overlaps subsites of the bladder
- A single tumor or non-contiguous tumors which are:
  - Urothelial carcinoma in situ 8120/2 ***AND*** involves only bladder and one or both ureters (no other urinary sites involved) *Note*: Overlapping non-invasive tumors of the bladder and ureter almost always originate in the bladder

C688 Assign when a single tumor overlaps two urinary sites and the origin is unknown/not documented

If the TURB or pathology proves invasive tumor in one subsite and in situ tumor in all other involved subsites, code to the subsite involved with invasive tumor.

2023 and 2024 Solid Tumor Rules (cancer.gov)