The Solid Tumor Editors recommend coding histology using **in priority order**:

1. The Solid Tumor Rules
2. The 2021 Cutaneous Melanoma Solid Tumor Rules
3. Updated ICD-O histology codes and terms which can be found at: [https://seer.cancer.gov/icd-o-3/](https://seer.cancer.gov/icd-o-3/)
4. The ICD-O-3.2

**Using Solid Tumor Rules to code Histology**

Code the histology diagnosis prior to **neoadjuvant therapy**. Neoadjuvant therapy can change the histological profile of the tumor.  *See site-specific Histology modules for exceptions to this rule.*

**Priority order for using documentation to code Histology**

For each site, priorities include tissue/histology, cytology, radiography/scans, and physician diagnoses, and biomarkers.

**You must use the priority order that precedes the histology rules for each site.**

Tissue pathology (and/or biomarkers, if applicable) always takes precedence.

**Tissue pathology**- for all sites except breast and CNS, 2018 Rules instruct “**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).”


**Grade for Non-Malignant CNS and Malignant CNS Tumors**

Check out the grade manual and Solid Tumor Rules for grade codes associated with CNS histology.

CNS WHO classifications use a grading scheme that is a “malignancy scale” ranging across a wide variety of neoplasms rather than a strict histologic grading system that can be applied equally to all tumor types.

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

**Examples:**

- Meningioma diagnosed clinically  
  Clinical grade code 1
- Medulloblastoma (including all subtypes) resected  
  Pathologic grade code 4
- Schwannoma diagnosed clinically  
  Clinical grade code 1.


**[https://apps.naaccr.org/ssdi/list/](https://apps.naaccr.org/ssdi/list/)**

**Ovary and Fallopian Tube**

**Residual Tumor Volume Post Cytoreduction**

Information for this SSDI can be found in the operative report, procedure report or managing physician notes.

The surgery to remove as much cancer in the pelvis and/or abdomen as possible, reducing the “bulk” of the cancer, is called “debulking” or “cytoreductive” surgery.

Physicians should record the presence or absence of residual disease, if residual disease is observed, the size of the largest visible lesion should be documented.

**Code 97** should be used if no cytoreductive surgery was performed.

**[https://staging.seer.cancer.gov/eod_public/home/2.2/](https://staging.seer.cancer.gov/eod_public/home/2.2/)**

**Hospital Registrars!**

2023 SEER Program and Staging Manual is available on the SEER website.  

You still have access to the 2022 SEER Manual here:  

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!**
### Determining reportability using Radiology Reporting and Data Systems (RADS)

The following cancer cases are reportable unless there is information to the contrary:
- Liver cases with an LI-RADS category LR-4 or LR-5 (LR-3, see below)
- Prostate cases with a PI-RADS category 4 or 5

The following are NOT reportable without additional information:
- Breast cases designated BI-RADS 4, 4A, 4B, 4C or BI-RADS 5
- Lung cases designated Lung-RADS 4A, 4B, or 4X
- Liver cases based only on an LI-RADS category of LR-3
- Colon cases with only C-RADS information (C-RADS category C4 is not reportable by itself)
- Head and Neck cases with only NI-RADS information (NI-RADS category 3 is not reportable by itself)
- Ovarian or fallopian tube cases with only O-RADS information (none of the O-RADS categories are reportable without additional information)
- Thyroid cases with only TI-RADS information (none of the TI-RADS categories are reportable without additional information)

### Borderline Ovarian Tumor Reportability

**Ovarian mucinous borderline tumor with microinvasion** is **NOT Reportable**

For an ovarian mucinous borderline tumor, the term "microinvasion" is not an indication of malignancy. Low malignant potential/borderline ovarian tumors are defined by the pathology of the primary tumor and are not affected by microinvasion or invasion in implants. **Though a case may be staged, this does not mean it is reportable.**

**Ovarian mucinous borderline tumor with foci of intraepithelial carcinoma** is **Reportable**

This case is reportable because there are foci of intraepithelial carcinoma (carcinoma in situ).

**See Appendix E1 of the 2022 SEER Program Coding and Staging Manual for more examples of reportability!**

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### Clinical and Pathologic Tumor Size (TS)

**TS Clinical, TS Pathologic, and TS Summary are all required data items (SEER).**

**Code 998**: Alternate descriptions of tumor size for specific sites:

- Familial/multiple polyposis
  - Rectosigmoid and rectum (C19.9, C20.9)
  - Colon (C18.0, C18.2-C18.9)

- **If no size is documented in the following situations:**
  - Circumferential
    - Esophagus (C15.0-C15.5, C15.8-C15.9)
  - Diffuse; widespread: three-fourths or more; linitis plastica
    - Stomach and Esophagus GE Junction (C16.0-C16.6, C16.8-C16.9)
  - Diffuse, entire lung or NOS
    - Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9)
  - Diffuse
    - Breast (C50.0-C50.6, C50.8-C50.9)


### Solid Tumor Rules 2018 General Instructions:

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

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

### NJSCR Data Updates for 2022

**https://www.cancer-rates.info/nj/**, New Jersey's official source for cancer statistics has been updated with cancer incidence data through 2019. Statewide and county-level cancer incidence data are available by cancer site, gender, race, and ethnicity. NEW to this site are incidence data for childhood cancers in New Jersey, also through 2019.

**https://www.nj.gov/health/ces/cancer-researchers/cancer-data/index.shtml**

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**Congratulations Registrars!**

The New Jersey State Cancer Registry has been awarded the Registry of Distinction award by the Center for Disease Control and Prevention (CDC) and National Program for Cancer Registries (NPCR). This achievement indicates that the New Jersey State Cancer Registry met the CDC NPCR National Data Completeness and Quality Standard.

NJSCR recognizes this achievement would not have been possible without the hard work and dedication of all the registrars of New Jersey. Thank you for your continued commitment to providing high quality cancer data.

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Copyright and distribution rights for this document are held by the New Jersey State Cancer Registry. 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!**
Hematopoietic Coding Tips

New Note for Diagnostic Confirmation for cases diagnosed 2022+

Use Code 3 “Positive histology PLUS positive immunophenotyping or genetic testing” for histologies:
- Myelodysplastic Syndromes
- Acute Leukemias of ambiguous lineage
- Precursor Lymphoid Neoplasms
- Acute Myeloid Leukemia and related Precursor Neoplasms

**Summary Stage 2018 and EOD Primary Tumor for Myeloma and Plasma Cell Disorders**

**EOD Primary Tumor**

Plasma cell myeloma/multiple myeloma (9732) is a widely disseminated plasma cell neoplasm, characterized by a single clone of plasma cells derived from B cells that grows in the bone marrow.

It is always coded to 700 for systemic involvement.

**SEER Summary Stage 2018**

Note 4: Lymphoplasmacytic lymphoma (9671) and Waldenstrom Macroglobulinemia (9761) are now collected with the plasma cell disorders. **These are systemic diseases and should always be coded 7.**

**Summary Stage 2018: Myeloma and Plasma Cell Disorders | EOD Data SEER*RSA (cancer.gov)**

**NAACCR Hematopoietic and Lymphocytic Neoplasms Webinar**

NCRA’s Central Registry Badge Program

A new program designed to help hospital registrars understand the general operations and responsibilities of central registries. Earn six (6) CE hours upon successful completion of this program. The enrollment period for this activity is 180 days.

http://www.cancerregistryeducation.org/products/1739/npras-central-registry-badge-program

**NEWLY UPDATED!**

2022 NJSCR Program Manual and 2022 Reportable List are posted!

Look at the NJSCR website for more information!

https://www.state.nj.us/health/ces/reporting-entities/njscr/

SEER SINQ Updated as of 05/27/2022

**Question:**
Should neoadjuvant chemotherapy be coded for an incidental second primary discovered at the time of surgery? If so, how is the diagnosis date coded?

The patient had neoadjuvant chemotherapy for rectal carcinoma. An AP resection revealed an incidental second primary intramucosal carcinoma in adenomatous polyp in the descending colon. Is the chemotherapy coded as therapy for the intramucosal carcinoma of the descending colon?

**Answer:**
Record the neoadjuvant therapy only for the first primary and do not record the neoadjuvant therapy for the incidental new primary found on surgery.

**History:**

*Answer for cases diagnosed prior to 2022*

The neoadjuvant chemotherapy is recorded for both primaries. For the second primary, code the actual diagnosis date and use the date of diagnosis as the date of systemic therapy.


Questions can be sent to your facility’s NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email.
### Lymph Node Coding Tips

**Date of First Surgical Procedure for 2021+ for FNA/Biopsy of Regional Lymph Node**

- Record the date of the first/earliest surgery if Surgery of Primary Site, Sentinel Lymph Node Biopsy, Scope of Regional Lymph Node Surgery *(excluding cases coded to 1)*, or Surgical Procedure of Other Site was recorded as part of the first course of therapy. Scope of Reg LN Surg Code 1 (Biopsy or aspiration of regional lymph node, NOS) is *not considered treatment*.

- If surgery was not performed, then RX Date surgery Flag must =11. Surgery is considered “not performed”.

- Do not code surgery to distant lymph nodes in scope of regional lymph node surgery.

**Coding Sentinel Lymph Nodes Positive for Breast ONLY**

- Use code 97 in this data item and record the total number of positive regional lymph nodes biopsied/dissected (both sentinel and regional) in Regional Nodes Positive (NAACCR Item #820) *when a sentinel lymph node biopsy is performed during the same procedure as the regional node dissection*.


### Race abbreviations in Text!

Abbreviations can generate confusion, as they may vary among different institutions and different specialties. Because abbreviations should be understood by any reader, only those that are clear and precise should be used.


- Do not make up abbreviations to describe race.
- If no abbreviation can be found on list, **provide fully texted word**.
- Text is used to confirm the codes provided within your abstract.

### Radiation Updates for 2021+

- If primary site in pelvic region is **surgically removed**, code to primary site.

- When intracavitary HDR brachytherapy is administered to the vaginal cuff for endometrial cancer or cervical cancer, post therapy, **primary treatment volume is Vagina**.

**NAACCR Webinar: Treatment 2021**

### Timing Guidelines for PSA

- Record the **last pre-diagnosis PSA lab value prior to diagnostic biopsy** of prostate and initiation of treatment
- All lab values must be done no earlier than approximately three months before diagnosis
- **Example**:
  - 12/5/19 PSA: 44.8
  - 3/2/20 PSA: 42.2
  - 5/5/20 biopsy: adenocarcinoma
  - SSDI PSA= **42.2**


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### April 2022 E-Tips

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

<table>
<thead>
<tr>
<th>Solid Tumor Rules Changes for 2022 highlights</th>
</tr>
</thead>
</table>
| **Colon Solid Tumor Rules**  
Timing changes to rules M7 and M8:  
The timing for subsequent tumors at the anastomosis has changed from 24 months to 36 months.  
The change is effective for cases diagnosed beginning 1/1/2022 forward.  
For cases diagnosed 1/1/2018 through 12/31/2021, the timing rule remains at 24 months. |
| **Low grade appendiceal neoplasm (LAMN) will become reportable effective for cases diagnosed 1/1/2022 forward.**  
LAMN may be either in situ 8480/2 or malignant 8480/3 based on physician statement of behavior.  
LAMN diagnosed prior to 1/1/2022 are not reportable |

<table>
<thead>
<tr>
<th>Head and Neck Solid Tumor Rules</th>
</tr>
</thead>
</table>
| Cases diagnosed 1/1/2022 forward:  
Beginning with cases diagnosed 1/1/2022 forward, **p16 test results can be used to code:**  
Squamous cell carcinoma, HPV positive (8085) and Squamous cell carcinoma, HPV negative (8086) |

**For more information on STR changes, see the SEER Site Specific Modules page**  
**https://seer.cancer.gov/tools/solidtumor/revisions.html**

### Common coding issues found on EOD Primary Tumor for Testis Primary

**Pay close attention to the extension found on the orchiectomy.**

- **Code 100**  
  Pathologic assessment Only. For Pure Seminomas Only: Tumor **less than 3cm**, limited to the testis **Without** LVI or **unknown** LVI

- **Code 150**  
  Pathologic assessment only. For pure seminomas only. Tumor **greater than or equal to 3 cm**, limited to the testis **WITHOUT** LVI or **unknown** if LVI

- **Code 300**  
  Pathological assessment only. Tumor limited to testis (including rete testis invasion) **WITH** lymphovascular invasion

- **Code 400**  
  Pathological assessment only  
  Epididymis, **Hilar soft tissue**, Mediastinum (of testis),  
  Visceral mesothelial layer

**Check out the EOD RSA site**  
[https://staging.seer.cancer.gov/eod_public/input/2.1/testis/eod_primary_tumor/?breadcrumbs=(~schema_list~),(~view_schema~,~testis~)]**

### Common coding issues found on Surgery codes for Testis Primary

**When coding the surgery, make sure you use the most specific information from the Operative Report.**

- **Code 40**  
  Excision of testicle with cord or cord not mentioned (Radical Orchiectomy)

- **Code 80**  
  Orchiectomy, NOS (unspecified whether partial or total testicle removed)

**Select Testis, Surgery codes**  
**https://seer.cancer.gov/manuals/2022/appendixc.html**

**Exciting News!**  
NJSCR is updating the Program Manual and Reportable List for 2022!  
Anticipated completion is June 2022.  
Hospital Registrars feel free to reach out to your representative with questions.

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!
Curious how cancer registry data items are created?
Check out the NAACCR’s poster found in the Journal of Registry Management
https://www.ncra-usa.org/About/Publications/Journal-of-Registry-Management

A Standard is Born: An Inside Look at How Cancer Registry Data Items are Made and Modified

Coding Pathologic Grade
The grade from clinical work up from the primary tumor can be used for grade pathologic in different scenarios based on behavior or surgical resection:

**Behavior**
Tumor behavior for the clinical and the pathological diagnoses are the same AND the clinical grade is the highest grade.
Tumor behavior for clinical diagnosis is invasive, and the tumor behavior for the pathological diagnosis is in situ.

**Surgical Resection**
Surgical resection is done of the primary tumor and there is no grade documented from the surgical resection.
Surgical resection is done of the primary tumor and there is no residual cancer.

**No Surgical Resection**
Surgical resection of the primary tumor has not been done, but there is positive confirmation of distant metastases during the clinical time frame.

Question:
Summary Stage 2018/Extension—Prostate: Can imaging be used to code SEER Summary Stage 2018? MRI shows tumor involved the seminal vesicles and the patient did not have surgery. AJCC does not use imaging to clinically TNM stage a prostate case.

Answer:
Per Note 5 of the 2018 SEER Summary Stage Prostate chapter: Imaging is not used to determine the clinical extension unless the physician clearly incorporates imaging findings into their evaluation. This note was added to be in line with how AJCC stages; therefore, AJCC and Summary Stage agree. Do not use the MRI findings when that is all you have, and the physician does not document agreement with the MRI.


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**February 2022 E-Tips**

**Effective for Cases Diagnosed 01/01/2022**

Do not accession a case based ONLY on suspicious cytology. Accession the case when a reportable diagnosis is confirmed later.

*The date of diagnosis is the date of the suspicious cytology.*

*This is a change to previous instructions. The date of a suspicious cytology may be used as the date of diagnosis when a definitive diagnosis follows the suspicious cytology.*

See Date of Diagnosis for more information.

**Note:** “Suspicious cytology” means any cytology report diagnosis that uses an ambiguous term, including ambiguous terms that are listed as reportable in this manual. Cytology refers to the microscopic examination of cells in body fluids obtained from aspirations, washings, scrapings, and smears; usually a function of the pathology department.

**Updated SSDI PSA (Prostatic Specific Antigen) Lab Value**

2 new codes have been added for the PSA Lab Value SSDI.

- **XXX.2** Lab value not available, physician states PSA is negative/normal
- **XXX.3** Lab value not available, physician states PSA is positive/elevated/high

A known lab value takes priority over codes XXX.2 and XXX.3

The **lab value takes priority** even if the physician documents the interpretation.

Example: Patient noted to have a PSA of 7.6. Physician notes that the value is elevated
Code 7.6 instead of XXX.3 (elevated)

**Tips for Coding Primary Site: Bladder**

**C67.8 Bladder, overlapping lesion**
Single tumor (any histology) that overlaps subsites in bladder OR Single or discontinuous tumors which are urothelial CA in situ (8120/2) AND ONLY bladder and 1 or both ureters are involved

**C67.9 Bladder, NOS**
Multiple non-contiguous tumors within bladder and subsite not documented

**C68.8 Overlapping lesions of urinary organs**
Single tumor overlaps 2 urinary sites and site of origin unknown (Renal pelvis C68.8 and ureter; bladder and urethra; bladder & ureter*)

**C68.9 Urinary system, NOS**
Multiple discontinuous tumors in multiple organs within urinary system C68.9 (Renal pelvis and ureter; bladder and urethra; bladder & ureter*)

* See C67.8 for 8120/2 when only bladder and ureter(s) are involved

**Clarification for Coding Liver Fibrosis Score**

**Note 6:** Use code 7 if there is a clinical diagnosis (no microscopic confirmation) of severe fibrosis or cirrhosis.

Physician statement of cirrhosis can be used.

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**Radiation Coding Information and Tips**

- “Whole Pelvis” implies RT to primary site or tumor bed and regional lymph nodes.
- “Vagina cuff” implies intracavitary brachytherapy.
- If dose/fraction and total dose is provided in Gy or cGy units for any brachytherapy procedure, capture this information in your abstract. **Do not use codes 99998 or 999998 if this information is found in treatment summary!**
- If brachytherapy is only mode of treatment and dose is not provided in cGy, code to 999999 for total dose.
- You cannot, add dose from EBRT phase to that of brachytherapy phase to get total dose!

**GYN Guidelines for Coding EBRT & Brachytherapy Treatments by Wilson Apollo, MS, CTR, RTT WHA Consulting NAACCR 2021-2022 Webinar Series Uterus 2021**

**Check out the NJSCR Website**

Updated Reportable list, current and previous Etips can be found on the NJSCR website.  
[https://www.state.nj.us/health/ces/reporting-entities/registrars/](https://www.state.nj.us/health/ces/reporting-entities/registrars/)

**Registry Resources**

- **2021 NJSCR Program Manual**
- Cancer Registry Statute (New Updated 2018)
- Reportable List, Word Format (NEW updated 2021)
- Reportable List, PDF Format (NEW updated 2021)
- SEER ICD-10-CM Case Finding List

**E-Tips**

- Current 2021 E-Tips: Helpful tips from the NJSCR
- 2020 E-Tips
- 2019 E-Tips

**Hospital Registrars!**

The reporting deadline for 2021 cases remains July 1.

Facilities should look to have at least 50% of their cases reported by the end of January 2022.

Make sure to let your NJSCR Representative know if you have had any personnel changes.

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