**Modified Radical Mastectomy Surgery Coding over the Years**

**Example:**
A patient with breast cancer had a modified radical mastectomy on her right breast.

**Diagnosis year 2022**
- Assign surgery in field RX Summ--Surg Prim Site 03-2022(1290)
- Use Appendix A of the STORE manual 2022 or SEER 2022 Appendix C
- Assign code 51

**Diagnosis Year 2023**
- Assign surgery in field RX Summ--Surg Prim Site 2023 (1291)
- Use Appendix A of STORE 2023 or SEER 2023 Appendix C
- Assign code A510

**Diagnosis year 2024**
- Assign surgery in field RX Summ--Surg Prim Site 2023 (1291)
- Use Appendix A of STORE 2023
- Assign code B610

**Question:**
Update to Current Manual/2018 EOD Manual/EOD Primary Tumor--Bladder: According to the American Joint Commission on Cancer (AJCC), a transurethral resection of the bladder (TURB) cannot make a distinction between involvement of the superficial muscle-inner half (Stage T2a) and the deep muscle-outer half (Stage T2b). Is the same criteria applied to Extent of Disease (EOD)?

**Answer:**
EOD follows AJCC criteria in this situation and we have confirmed with AJCC that Stage T2a (superficial muscle) and Stage T2b (deep muscle) cannot be assigned when only a TURB is done.

For EOD Primary Tumor, Bladder, codes 200, 250, 300, 350, can only be used when:

- A cystectomy is performed.
- Muscularis propria is involved, AND the pathology report states superficial muscle (200, 250) or deep muscle (300, 350) is involved.

If a TURB is done and there is mention of the muscularis propria invasion (superficial muscle or deep muscle), use EOD codes 370 or 400. If a TURB is done and the pathology report states superficial or deep muscle, ignore and code as “invasion of muscularis propria, NOS” (EOD codes 370 or 400).

Instructions and code descriptions for EOD Primary Tumor have been updated to indicate this. These updated instructions and code descriptions will be available when SEER®RSA is updated for 2024, Version 3.1 (Sept/Oct 2023). These updates are included here for reference and can be applied for cases diagnosed 2018+.

**SEER Inquiry System 20230035**

**Know your Colon Subsites for assigning Primary Site!**
Check out the Colonoscopy Measurements section in the Colon, Appendix, Rectosigmoid, Rectum Solid Tumor Rules in Appendix C

**Colonoscopy Measurements***

**Hepatic flexure**
Hepatic flexure

**Transverse 82-132**
Transverse 82-132

**Splenic flexure**
Splenic flexure

**Ascending 132-147**
Ascending 132-147

**Descending 57-82**
Descending 57-82

**Cecum at 150**
Cecum at 150

**Rectum 4-16**
Rectum 4-16

**Rectosigmoid 15-17**
Rectosigmoid 15-17

**Sigmoid 17-57**
Sigmoid 17-57

**Anus 0-4**
Anus 0-4

*These are approximate distances.


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!
Coding Microsatellite Instability (MSI) for Colon and Rectum

- Physician statement of MSI can be used to code this data item when no other information is available.
- MSI may be recorded for all stages; however, it is primarily performed for invasive neoplasms. For non-invasive neoplasms (behavior /2), code to 9 if no information available.
- Results from nodal or metastatic tissue may be used for Microsatellite Instability.
- If both tests are done and one or both are positive, code 2.
- If all tests done are negative, code 0.

**MSI done by immunology or genetic testing. MSI is looking at instability in informative markers.**

**MSI results are coded as:**

- MSS (Code 0)
- Stable (Code 0)
- Negative (Code 0)
- Low probability of MSI-H (Code 0)
- MSS/MSI-L (Code 0)
- MSI-L (Code 1)
- Unstable, high (Code 2)
- Unstable, NOS (no designation of high or low) (Code 2)
- MSI-H (Code 2)
- MSI-I (intermediate) (Code 9)

**Testing for Mismatch Repair (MMR) is usually done by immunohistochemistry (IHC).**

**MMR results are recorded as:**

- No loss of nuclear expression (code 0)
- Mismatch repair (MMR) intact (code 0)
- MMR proficient (pMMR or MMR-P) (code 0)
- MMR normal (code 0)
- Loss of nuclear expression (code 2)
- MMR deficient (dMMR or MMR-D) (code 2)
- MMR abnormal (code 2)

**Check out EOD RSA Colon and Rectum!**

https://staging.seer.cancer.gov/eod_public/list/3.0/

How is the histology coded for vulvar intraepithelial neoplasia III (VIN III)/Squamous cell carcinoma in situ from a pathology report of the vulva, 8070/2 for squamous cell carcinoma in situ or 8077/2 for VIN III?

**Answer:**

Assign 8077/2 for high-grade squamous intraepithelial lesion, VIN 3 in this case. The WHO Classification of Female Genital Tumors, 5th edition, states that squamous intraepithelial lesions (SILs) of the vulva are also known as vulvar intraepithelial neoplasia, HPV-associated. The term squamous cell carcinoma in situ is not recommended.


**NEW coding video on FLccSC!!!**

Check out the new Neoadjuvant Data items video!

http://njs.fcdslms.med.miami.edu/

Synonyms for Tumor Deposit

Discontinuous Extramural Extension

Malignant Tumor Foci

Malignant peritumoral Deposits

**Satellite Nodule**

*A physician statement for tumor deposit can be used when no other information is available.*

Always check your pathology report and SEER manual.

**https://staging.seer.cancer.gov/eod_public/home/3.0/**

**NAACCR Webinar Series 2023 Lower GI Part 1**

Class of Case 32

Address at Diagnosis

Verify the patient was a New Jersey resident at the time of diagnosis. If there is documentation that the patient was not a NJ resident at the time of diagnosis, use the address at diagnosis, not the patient’s current NJ address.

Check out the SEER Manual for coding instructions.

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!**
Question:
How should Reason for No Surgery of Primary Site be coded for cases when surgery was planned but aborted due to extent of disease seen during planned procedure? Lung abnormality on imaging prompted diagnosis on subsequent biopsy and clinical staging was documented as cT1b N0 M0. There was an attempt at resection, but the patient was found to have chest wall involvement and the procedure was aborted.

Answer:
For 2023 cases and forward, if no part of the surgery was performed, code Surgery of Primary Site 2023 (NAACCR Item #1291) as code A000 or B000 (no surgical procedure of the primary site). Code Reason for No Surgery of Primary Site (NAACCR Item #1340) as code 2 (surgery of the primary site was not recommended/performe because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned surgery, etc.).

In contrast, if any part of the surgery was performed, assign the Surgery of Primary Site 2023 (NAACCR Item #1291) code that best reflects the extent of the surgery performed. Code Reason for No Surgery of Primary Site (NAACCR Item #1340) as code 0 (surgery of the primary site was performed).

Use text fields to record the details.

For cases prior to 2023, apply the same approach using Surgery of Primary Site (NAACCR Item #1290) instead of Surgery of Primary Site 2023 (NAACCR Item #1291).


Scope of Regional Lymph Node Surgery #1292

Add the number of all of the lymph nodes removed during each surgical procedure performed as part of the first course of treatment. The Scope of Regional Lymph Node Surgery data item is cumulative.

Example:
Patient has excision of a positive cervical node. The pathology report from a subsequent node dissection identifies three cervical nodes. Assign code 5 (4 or more regional lymph nodes removed).

Lymph Node Aspirations

Do not double-count when a regional lymph node is aspirated, and that node is in the resection field. Do not add the aspirated node to the total number.

Count as an additional node when a regional lymph node is aspirated, and that node is NOT in the resection field. Add it to the total number.

Assume the lymph node that is aspirated is part of the lymph node chain surgically removed and do not include it in the count when its location is not known.


Surgical Codes for Brain, Central Nervous System, Malignant, Benign and Borderline

A100 Tumor destruction, NOS

[SEER Note: Local tumor destruction, NOS; laser interstitial thermal therapy (LITT) - code A100 if no specimen sent to pathology.]

No specimen sent to pathology from surgical event A100

Do not record stereotactic radiosurgery (SRS), Gamma knife, Cyber knife, or Linac radiosurgery as surgical tumor destruction. All of these modalities are recorded in the radiation treatment fields.

A200 Local excision of tumor, lesion, or mass, excisional biopsy

A210 Subtotal resection of tumor, lesion, or mass in brain

A220 Resection of tumor in spinal cord or nerve

[SEER Note: Assign code A200 for stereotactic biopsy of brain tumor.]


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!
### Coding Guidelines Breast C500-C509

#### Coding Subsites & Laterality

Use the information from reports in the following priority order to code a subsite when there is conflicting information:

1. Operative report
2. Pathology report
3. Mammogram, ultrasound (ultrasound becoming more frequently used)
4. Physical examination

Code the **subsite with the invasive tumor** when the pathology report identifies invasive tumor in one subsite and in situ tumor in a different subsite or subsites.

**Laterality must be coded for all subsites.**

Breast primary with positive nodes and no breast mass found: **Code laterality to the side with the positive nodes.**

Check out the SEER Coding Guidelines by site in Appendix C!


### Coding for Tumor Embolization

**Chemoembolization:** A procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.

**Code as Chemotherapy** when the embolizing agent(s) is a chemotherapeutic drug(s).

**Radioembolization:** Tumor embolization combined with the injection of small radioactive beads or coils into an organ or tumor.

Assign **code 13 Radioisotopes, NOS** for Radiation Treatment Modality for Radioembolization procedures, e.g., intravascular Yttrium-90

**Tumor embolization:** The intentional blockage of an artery or vein to stop the flow of blood through the desired vessel.

Do not code pre-surgical (pre-operative) embolization of hypervascular tumors with agents such as particles, coils, or alcohol as a treatment. Pre-surgical embolization is typically performed to prevent excess bleeding during the resection of the primary tumor.

**SEER Program Coding And Staging Manual 2023**

**SEER Inquiry System - Question 20230013 Details (cancer.gov)**

**Question:**
Is dermatofibrosarcoma protuberans (DFSP) with fibrosarcomatous overgrowth, DFSP with fibrosarcomatous component Grade 2, or DFSP with focal myxoid features (2022) reportable for 2021-2022 diagnoses?

**Answer:** Yes.

DFSP with fibrosarcomatous overgrowth and DFSP with fibrosarcomatous component Grade 2 are synonymous with fibrosarcomatous DFSP (8832/3). Our expert pathologist also advises that DFSP with focal myxoid features is the same as DFSP, myxoid (8832/3).

**SEER Inquiry System - Question 20230013 Details (cancer.gov)**

**Coding Instructions for Carcinosarcoma (8980/3) and malignant mixed Mullerian tumor/MMMT (8950/3)**

Path diagnosis often stated as carcinosarcoma (malignant mixed Mullerian tumor) **code to carcinosarcoma 8980/3.**

If stated as MMMT only, **code 8950/3.**

**SEER SINO 20200082**

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!
2023 Breast Surgery Code Clarification from SEER SINQ

SEER Manual/Surgery of Primary Site 2023--Breast: What instructions should be followed when the 2023 SEER Manual Appendix C 2023 Breast Surgery Codes advise to code 1 in Surgical Procedure of Other Site for a simple bilateral mastectomy but the 2023 STORE Manual does not?

The 2023 SEER Manual, Appendix C 2023 Breast Surgery Codes, note reads:

SEER Note: Assign code A760 for a more extensive bilateral mastectomy. Assign code 0 in Surgical Procedure of Other Site (NAACCR #1294). For a simple bilateral mastectomy, assign code A410 with code 1 in Surgical Procedure of Other Site (NAACCR #1294).

In the 2023 STORE Manual, these notes are not mentioned, and we are instructed not to code surgery to other site. Other education related to 2023 breast coding provided by NAACCR states not to code surgery to other site.

Assign **code 1 in Surgical Procedure of Other Site** (NAACCR #1294) when a **simple** bilateral mastectomy is performed for a single tumor involving both breasts.

This statement was inadvertently omitted from the STORE manual and will be added back in: For single primaries only, code removal of contralateral breast under the data item Surgical Procedure/Other Site (NAACCR Item #1294) or Surgical Procedure/Other Site at This Facility (NAACCR Item #674).

The information presented by NAACCR was intended to be consistent with what is in the SEER manual.


**Bladder: Tips for assigning Behavior Code**

**Code the behavior as malignant (/3) when:**

- The diagnosis is high grade urothelial carcinoma AND there is no information regarding invasion OR
- The pathology report says the submucosa is invaded with tumor OR
- The only surgery performed is a TURB documenting that depth of invasion cannot be measured because there is no muscle in the specimen AND
  - There is no information regarding invasion and the physician’s TNM designation is not available OR
  - The pathology report does not mention whether the submucosa is free of tumor or has been invaded.

**Lymph vascular Invasion Coding for Thyroid and Adrenal Primaries dx year 2022+**

Code lymphovascular invasion to 0, 2, 3, 4, or 9 for the following Schema IDs

- Thyroid 00730
- Thyroid Medullary 00740
- Adrenal Gland 00760

**Code 1 Lymphovascular Invasion Present/Identified (NOT used for thyroid and adrenal gland)**


Welcome to your Central Cancer Registry! June 14th, 2023 9:00am-12:00pm Approved for 2.5 CE’s Don’t wait! Registration will close May 15, 2023.

https://www.nj.gov/health/ces/

**Check out the Coding Guidelines: Bladder for more behavior code coding examples!**


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!
**Neoadjuvant Therapy NAACCR Item #1632**

Neoadjuvant Therapy, effective for cases diagnosed 01/01/2021, or later, records whether the patient had neoadjuvant therapy prior to planned definitive surgical resection of the primary site.

**Neoadjuvant therapy is defined as systemic treatment (chemotherapy, endocrine/hormone therapy, targeted therapy, immunotherapy, or biological therapy) and/or radiation therapy before intended or performed surgical resection to improve local therapy and long-term outcomes during first course of treatment.**

The criteria for neoadjuvant therapy are:

- A physician’s treatment plan and/or statement of patient completing neoadjuvant therapy must be used.
- Treatment must follow the recommended treatment guidelines for the type and duration of treatment for that primary site and/or histology. The length of a full course of neoadjuvant systemic therapy may vary depending on the primary site and/or histology, often from 4-6 months, but could be shorter, of neoadjuvant systemic therapy and/or radiation.
- Neoadjuvant therapy may include systemic therapy alone, radiation alone, or combinations of radiation and systemic therapy (for example, with rectal cancer, esophageal cancer, head and neck cancer)
- Neoadjuvant therapy data items are coded based on treatment/procedures that occur during first course of therapy.
- Neoadjuvant therapy may be given as part of a clinical trial.

Check out the SEER Program Coding and Staging Manual 2023 for more information!


**Reportable Intraepithelial Neoplasia Examples**

- Squamous intraepithelial neoplasia, high grade
- High grade squamous intraepithelial lesion (HSIL)
- Intraepithelial neoplasia grade II/III; II–III
- Squamous dysplasia, high grade for sites other than colon/GI
- Anal intraepithelial neoplasia (AIN), grade II
- Anal intraepithelial neoplasia (AIN), grade III
- Biliary intraepithelial neoplasia, high grade
- Conjunctival intraepithelial neoplasia grade III
- Penile intraepithelial neoplasia (PeIN), undifferentiated
- Squamous intraepithelial neoplasia, grade II
- Vaginal intraepithelial neoplasia (VaIN), grade III
- Vulvar intraepithelial neoplasia (VIN), grade III
- Squamous intraepithelial neoplasia, grade III

**8380/2 (C54_)**

- Endometrioid intraepithelial neoplasia (EIN)
- Intraepithelial neoplasm of endometrium
- Atypical hyperplasia of endometrium


**Question:** Thyroid: Is a case with thyroid fine needle aspirate (FNA) cytology with nodule 1 Bethesda category 5 and nodule 2 Bethesda 6, reportable in 2021? Does the Bethesda category 5 or 6 have any bearing on reportability?

**Answer:** In the absence of information to the contrary, thyroid FNAS designated as Bethesda classification category VI are reportable. Thyroid FNAS designated as Bethesda classification category V are not reportable unless there is additional information confirming a reportable diagnosis. For both Bethesda V and VI, NCCN Guidelines recommend total thyroidectomy or lobectomy (depending on tumor size and nodal involvement) for the purposes of definitive diagnosis/treatment, so additional information should be available. Nodule 1 Bethesda V is not reportable. Nodule 2 Bethesda VI is reportable.


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!
**Question:**

First Course Treatment/Immunotherapy—Other Therapy: **Should all therapies given as part of a clinical trial be coded as Other Therapy (NAACCR #1420), or only those that cannot be classified in one of the other treatment categories (systemic therapy, surgery, radiation) or as ancillary treatments?** Does it matter what is listed in SEER*Rx under Primary Sites or Remarks regarding FDA approvals?

For example, if a patient is given a drug as part of a trial that is categorized in SEER*Rx as immunotherapy, should it be signed both Immunotherapy (NAACCR #1410) code 1 and Other Therapy code 2, or only coded in Immunotherapy since it is classified as such? How should a clinical trial drug be coded if it has a treatment classification in SEER*Rx, but the type of cancer being treated is not listed under the Primary Site or Remarks sections as being FDA approved? A real case scenario is atezolizumab given for colon cancer as part of a trial; this drug's category is Immunotherapy in SEER*Rx but colon is not listed under Primary Sites or in the Remarks detailing FDA approvals.

**Answer:**

**When a drug is being administered as part of a clinical trial and it is not yet approved as treatment for the cancer site for which it is being administered, code in Other Therapy.** Do not code it as Immunotherapy (for the example provided). While a drug may be approved to treat one type of malignancy, it may be in clinical trials to determine its value in treating other malignancies. Coding as immunotherapy is misinformation in this case since there are other types of approved immunotherapeutic agents.  

---

**Grade Coding**

On breast biopsy, Nuclear grade II DCIS. On resection, invasive Nottingham grade 2/3. **Would clinical grade be M and path grade be 2?**

**Answer:**

Clinical grade code M, and pathological grade code 2.  
Since the insitu was on clinical, you can use the insitu grading system for clinical and the invasive system for pathological.  
If the clinical was invasive and the pathological was in situ, you would use the clinical [grade in the pathological grade field] since the case would be invasive.


---

**Date of Diagnosis**

Code the month, day, and year the tumor was first diagnosed, clinically or microscopically, by a recognized medical practitioner.

**Example:** Area of microcalcifications in breast suspicious for malignancy on 02/13/2023. Biopsy positive for ductal carcinoma on 02/28/2023. **The date of diagnosis is 02/13/2023.**

Code the date the procedure was done, not the date the specimen was received or read as positive by the pathologist when the date of diagnosis is coded from a pathology report.  
**Example:** Biopsy was performed on 05/06/2023. The specimen from the biopsy was received and read by the pathologist as positive for cancer on 05/09/2023. **The date of diagnosis is 05/06/2023.**  
(SPM 2023, pg.85 #3)

The first diagnosis of cancer may be clinical (i.e., based on clinical findings or physician’s documentation)  
**Note:** Do not change the date of diagnosis when a clinical diagnosis is subsequently confirmed by positive histology or cytology. **Example:** On May 15, 2023, a physician states that patient has lung cancer based on clinical findings. The patient has a positive biopsy of the lung on June 3, 2023. **The date of diagnosis remains May 15, 2023.**

---

**Submission Update for Hospital Registrars**

Wait to send in your **2023 diagnosis year cases**. A new update is coming soon. You will be notified when these can be sent.  
**Save the date! Spend The day is BACK!**  
NJSCR will be hosting a live “Virtual” Spend the day on **Wednesday, June 14, 2023.** Come see the inner workings of the New Jersey State Cancer Registry. Free CE’s offered. More information coming soon.
**Assign code A220** when a patient has a lumpectomy and an additional margin excision during the same procedure. (Re-excision of the margins intraoperatively during same surgical event does not require additional resources; it is still A220.)

**Assign Code A230** when a subsequent re-excision of lumpectomy margins during separate surgical event requires additional resources: anesthesia, op room, and surgical staff.

**Assign Code A760** when a bilateral mastectomy is performed for a single tumor involving both breasts, as for bilateral inflammatory carcinoma [SEER Note: Assign code A760 for a more extensive bilateral mastectomy. Assign code 0 in Surgical Procedure of Other Site (NAACCR #1294)].

**Assign Code A410** for a simple bilateral mastectomy, assign with code 1 in Surgical Procedure of Other Site (NAACCR #1294).]  


**LCIS is still REPORTABLE for NJSCR!**  
*Lobular Carcinoma insitu is reportable for SEER and NPCR. New Jersey is a SEER state.*  
LCIS should be staged using SS2018.

**Breast 2022 Part 2 NAACCR Webinar**  
**SEER Manual 2023**  
https://seer.cancer.gov/tools/codingmanuals/

**New STORE 2023 Data Items and AJCC Staging Protocols**  
The Standards for Oncology Registry Entry Manual, effective for cases diagnosed January 1, 2023, was released on 10/7/22.  
(https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data) Refer to the chapter “STORE 2023 Summary of Changes” on p. 29 for a description of changes in this year’s STORE.

**NEW Coding Shorts on FLccSC**  
**NEW GRADE Webinar on FLccSC**  
http://njs.fcdslms.med.miami.edu/  
Only have a few minutes and or want to know an answer without combing through a full webinar? Check out NJSCRs coding shorts! New shorts added regularly!

**Coding Tips from New Solid Tumor Rules Other Sites for 2023**

**Ductal Carcinoma 8500/3:** In *Prostate* biopsies, the term “adenocarcinoma prostate with ductal features” should be used in the pathology report and is coded to 8140/3. In order to code ductal adenocarcinoma 8500/3, the ductal component must comprise >50% of the tumor with the percentage reported and from a radical prostatectomy specimen.

**Cholangiocarcinoma:** Intrahepatic cholangiocarcinoma are almost exclusively adenocarcinoma and often diagnosed by cytology. Per histology coding rules, pathology and cytology have priority over clinical/physician diagnosis. If the diagnosis of cholangiocarcinoma is made on a resected specimen, then code this histology.

**Soft Tissue:** Myxofibrosarcoma and fibromyxosarcoma are the same and both coded 8811/3. The word roots have been inverted.

**Anus:** p16 test results can be used to code squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086)  
*Check out the new updated STR for Other sites!*  
**Other Sites Solid Tumor Rules 2023 Update (cancer.gov)**

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!**