

March 2025 E-Tips

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


EOD REMINDER: **PROSTATE PATHOLOGIC EXTENSION** **CODE 950**

While Code 900 is used frequently, please review Note 9 which reminds us of the use of code 950!

Note 2: No radical prostatectomy or autopsy

- ✓ Code 900 if there is no radical prostatectomy or autopsy performed within first course of treatment.

Note 9: Active surveillance, *then* Radical Prostatectomy

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- ✓ Code 950 is used when first course of treatment is active surveillance, but a radical prostatectomy is done at a later date due to disease progression or the patient changed their mind.
 - ✓ When code 950 is used, code the following SSDI's as X9: Gleason Patterns Pathological, Gleason Score Pathological, and Gleason Tertiary

****[EOD Prostate Pathologic Extension | EOD Data SEER*RSA](#)**

REPORTABILITY -- LIVER

QUESTION: Is a 2023 cholangiocarcinoma case with Liver Imaging Reporting And Data System (LI-RADS) M (LR-M) lesion on imaging reportable?

ANSWER: Report LR-M unless there is information to the contrary. The American College of Radiology defines LR-M as "probably or definitely malignant, not necessarily hepatocellular carcinoma (HCC)."

****[SEER Inquiry System - Question 20250011 Details](#)**

BREAST TUMOR SIZE TIP! Exception to rounding rules for BREAST primaries: **Round tumor sizes greater than 1.0 mm and up to 2.4 mm to 2 mm (002).** The purpose of this exception is so that the size recorded in the Tumor Size Summary data item will derive the correct AJCC TNM Primary Tumor (T) category for breast primaries. Do not apply this instruction to any other site.

****[SEER Program Coding and Staging Manual 2025](#)**

REPORTABILITY/HISTOLOGY -- ENDOMETRIUM

QUESTION: Are the following terms and diagnoses synonymous with endometrioid intraepithelial neoplasia (EIN) and therefore reportable?

ANSWER: Reportability for EIN became effective in 2021. See scenarios.

1. ATYPICAL GLANDULAR EPITHELIUM

Scenario: Endometrium biopsy with ablation performed at Facility A on 8/7/2024 showed atypical glandular epithelium. Patient was sent to Facility B where the total abdominal hysterectomy/bilateral salpingo-oophorectomy (TAH/BSO) on 9/20/2024 showed other reactive fibrosis and obliterated architecture compatible with history of ablation.

DO NOT REPORT ATYPICAL GLANDULAR EPITHELIUM. Atypical glandular epithelium, also referred to as atypical glandular cells (AGC), refers to abnormal looking cells that may be found in the tissue lining the inside of the endometrium or the cervix. While not malignant, they can be associated with a range of lesions in the female reproductive system.

2. ISTHMIC-TYPE MUCOSA WITH FOCAL SEVERE ATYPIA

Scenario: Endometrium biopsy showed isthmic-type mucosa with focal severe atypia. Then Facility B did TAH/BSO that showed no evidence of high grade dysplasia, atypical hyperplasia, or carcinoma.

DO NOT REPORT ISTHMIC-TYPE MUCOSA WITH FOCAL SEVERE ATYPIA. The NCI data dictionary defines atypia as an abnormality in cells in tissue. Report the case when further defined as atypical hyperplasia.

3. SIMPLE HYPERPLASIA WITHOUT ATYPIA

Scenario: Endometrial biopsy pathology states simple hyperplasia without atypia and the TAH/BSO is either negative or has the same histology; however, the treating physician is stating EIN.

DO NOT REPORT SIMPLE HYPERPLASIA WITHOUT ATYPIA. WHO Classification of Tumors online, Female Genital Tumors (5th ed.), defines endometrial hyperplasia without atypia as a proliferation of endometrial glands of irregular size and shape without significant atypia. There is no ICD-O code for this term. Simple endometrial hyperplasia without atypia is an acceptable related term for endometrial hyperplasia without atypia. Pathology has priority over a physician statement.



4. EIN/CAH OR FOCAL EIN/CAH

Scenario: Biopsy showed EIN/CAH but the total abdominal hysterectomy/bilateral salpingo-oophorectomy (TAH/BSO) pathology or the Mirena IUD treatment operative note states no EIN/CAH/Atypical hyperplasia. Are these reportable, similar to an in situ when the re-excision lumpectomy or mastectomy is negative or no residual disease?

REPORT EIN/CAH OR FOCAL EIN/CAH (8380/2) based on the biopsy. WHO Classification of Tumors online, Female Genital Tumors (5th ed.), defines EAH/EIN as a simultaneous change of epithelial cytology and an increased number of endometrial glands in a defined region. The preferred term is atypical hyperplasia of the endometrium; terms not recommended include complex atypical endometrial hyperplasia; simple atypical endometrial hyperplasia; endometrial intraepithelial neoplasia.

****[SEER Inquiry System - Question 20250001 Details](#)**

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!**

<p>February 2025 E-Tips</p>	<p>New Jersey State Cancer Registry Cancer Epidemiology Services http://www.nj.gov/health/ces (609) 633-0500</p>
<p><u>NCCN Updates on Melanoma and Pancreatic Adenocarcinoma</u></p> <p>NCCN has published updates to the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) and the NCCN Drugs & Biologics Compendium (NCCN Compendium®) for Melanoma: Cutaneous and for Pancreatic Adenocarcinoma. These NCCN Guidelines® are currently available as Version 2.2025.</p> <p>**NCCN Update for Melanoma **NCCN Update for Pancreatic Adenocarcinoma</p>	<p><u>Reportability/Histology</u></p> <p>Question:</p> <p><u>Conjunctiva- Is low-grade conjunctival melanocytic intraepithelial lesion (LG-CMIL) with focal high-grade features of the conjunctiva (C690) reportable? If reportable, what histology should be assigned?</u></p> <p>Discussion: Additional comments in this pathology report state "The entire case was sent in consultation to an ophthalmic pathologist. [Pathologist] assigns a conjunctival melanocytic intraepithelial neoplasia (C-MIN) score of 2-3 due to the upward pagetoid migration of small, dendritic melanocytes. A C-MIN score of 2-3 is between low-grade conjunctival melanocytic intraepithelial lesion (LG-CMIL; C-MIN 2) and high-grade conjunctival intraepithelial lesion (HG-CMIL; C-MIN 3). The older terminology for this lesion would be primary acquired melanosis (PAM) with mild to focally moderate atypia."</p> <p>This term does not appear in the SEER Program Coding and Staging Manual (SPCSM), Appendix E1 of the SPCSM, or Solid Tumor Rules (specifically rule H3).</p> <p>Answer: <u>Conjunctival melanocytic intraepithelial neoplasia (C-MIN) is reportable; therefore, low-grade conjunctival melanocytic intraepithelial lesion (LG-CMIL) with focal high-grade features of the conjunctiva (C690) is reportable, 8720/2.</u> We will add this to a future edition of the SEER manual.</p> <p>** SEER SINQ 20240079</p>
<p> <u>REMINDER!</u> </p> <p>Never underestimate the importance of Accurate Text in your abstracting! Please refer to this SEER Module for Common Abbreviations.</p> <p>**https://training.seer.cancer.gov/abstracting/additional/abbreviations/all.html</p>	<p><u>NJSCR will be converting to v25 in late March.</u></p> <p>Reporting software must be updated to v25 to submit 2025 cases. <u>NJSCR will not be able to accept 2025 cases in v24.</u></p> <p>Check out the 2025 NJSCR Program Manual, along with the Summary of Changes, and the 2025 Reportable List!! Department of Health Cancer NJ State Cancer Registry</p> <p>Completeness rate recommendation for facilities: 75% of 2024 records submitted by the end of April 2025. <u>All 2024 records submitted by July 1, 2025.</u></p>
<p><u>SEER Manual 2025 Coding Note Addition</u></p> <p>There is a new coding instruction under Surgical Margins of Primary Site!</p> <p>Assign code 9:</p> <p>a. When Surgery of Primary Site 2023 (NAACCR Item #1291) is coded to A980 (not applicable)</p> <p>b. When it is unknown whether a surgical procedure of the primary site was performed or there is no mention in the pathology report or no tissue was sent to pathology SEER Program Coding and Staging Manual 2025 January 2025 Section VII: First Course of Therapy 187</p> <p><i>c. When patient has a transurethral biopsy of bladder tumor (TURBT) and surgical margins are not mentioned in the TURBT report. The operative report may mention no residual tumor.</i></p> <p>d. For any case coded to primary site C420, C421, C423, C424, C760-C768, C770-C779, or C809</p> <p>e. For death certificate only (DCO) cases</p> <p>** SEER Program Coding and Staging Manual 2025</p>	
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January 2025 E-Tips

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Primary Site Coding Tip from SEER Manual 2025 Summary of Changes:

How do we code primary site for a single tumor overlapping a reportable site and a non-reportable site?

Added Coding Instruction 4.b:

- ❖ Single tumor overlapping a reportable site and a non-reportable site: Determine the site of origin or the site with the greatest involvement
- ❖ If the site of origin/site with greatest involvement is the reportable site, report the case and assign the appropriate topography code
- ❖ If the site of origin/site with greatest involvement is the non-reportable site, do not report the case
- ❖ If the site of origin/site with greatest involvement cannot be determined, do not report the case because you cannot confirm reportability

Example: Squamous cell carcinoma overlapping skin and vermillion of upper lip. **If the site of origin is the vermillion, report the case.** If the site of origin cannot be determined and more than 50% of the lesion is on the vermillion, report the case. If less than 50% of the lesion is on the vermillion, do not report the case. If the site with the greatest involvement cannot be determined, do not report the case.

****[SEER Manual 2025 Summary of Changes](#)****



Uterine/Cervix Coding Notes



- ❖ In situ carcinoma of cervix (/2), any histology, is not reportable
- ❖ p16 is a valid test to determine HPV status and can be used to code HPV associated and HPV independent histologies.
- ❖ When the diagnosis is a subtype/variant of squamous cell carcinoma and HPV status is also noted, ignore the HPV status and code the subtype/variant.
- ❖ **EXCEPTION:** When keratinizing or non-keratinizing SCC are included in the diagnosis with HPV status, code the appropriate HPV histology: 8085 or 8086.
 - **Please note:** The instruction to code the subtype/variant over 8085 or 8086 applies to the following sites: oropharynx, cervix, vagina, vulva, anus and penis.

****[Solid Tumor Rules 2025 Update](#)****

Vulvar Intraepithelial Neoplasm Grade 2 (VIN II) is reportable when documented alone. Use histology code **8077/2**.

****[SEER Inquiry System - Question 20240076 Details](#)****

Primary Site Question:

An 80-year-old post-menopausal female (status post hysterectomy for benign reasons) presents with a retroperitoneal mass on imaging. The pre-operative imaging shows the *cervix* and uterus are absent. What is the primary site code for a final diagnosis of endometrioid adenocarcinoma from a biopsy of a right retroperitoneal mass?

Answer: Code Primary Site to C480 (retroperitoneum). Endometrial tissue may "break away" from the uterus and implant throughout the pelvic and abdominal cavities. This tissue remains behind when surgical removal of the uterus is done. Common sites of implantation are colon, peritoneum, retroperitoneum, and bladder. When the uterus and cervix are no longer present, code the site where the carcinoma was identified.

Please note: The site-morphology combination of C480 and 8380/3 was designated as an unlikely site-morphology combination by the Cancer PathCHART, as this is a rare type of tumor. Assign a value of 1 in the Over-ride Site/Type data item.

****[SEER Inquiry System - Question 20240077 Details](#)****

Important Announcement

FLccSC is back!!!

Check for an email from FLccSC to reset your password.

Click on link to register for free webinars and CE's.

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