**Q&A Session for 2022 Updates: ICD O, Solid Tumor Rules, SSDIs**

December 10, 2021

|  |  |  |
| --- | --- | --- |
| # | Question | Answer |
|  | Will it be easy to find 2021 changes vs 2022 changes on the ICD-O-3.2 web page? | Yes...the 2022 changes show on the page. There is a tab for "previous guidelines". This is where you'll find the 2021 changes.<https://apps.naaccr.org/ssdi/list/2.1>  |
|  | When you see topography codes in parenthesis next to the histology does that mean the histology only applies for those primary sites? | Yes. The updates are based on site specific WHO Tumor Classification books. It’s possible in the future or when ICD-O-4 is released, the codes and terms will be valid for other sites as well.  |
|  | Has HAMN always been 8480/2 ? | The term HAMN and the associated ICD-O code were proposed in the 5th Ed WHO GI book. The term did not “officially” exist prior to the 5th Ed. HAMN becomes reportable 1/1/2022. HAMN is a rare tumor with specific diagnostic criteria. |
|  | Are these changes on the reportable list on the SEER web page? | Yes. Also see Appendix E which provides examples of reportable versus non-reportable neoplasms. |
|  | HAMN was not documented in the STR prior to 2022, so prior to 2022 this is not reportable, correct? | Correct. |
|  | We do not usually have a statement of malignancy of the LAMN or the pseudomyxoma peritonei. So we would stop at H5 and code to /2 regardless if they received chemo or not? We would not move on to H6. | Answer is pending… |
|  | If a HAMN or LAMN is malignant what should we be looking for? Wouldn't they call it mucinous adenocarcinoma if it was malignant ? | Pathologist don’t often state LAMN/HAMN are malignant. Malignant disease usually presents as widespread peritoneal dissemination of the tumor Because these neoplasms are rare, they are identified using specific criteria so the pathologist shouldn’t be calling them “mucinous”.  |
|  | Rule H5 is in STR September 2021 Update, correct? | Yes, H5 is included in the Sept. 2021 update and has applicable dates included in the rule. Tables 1 and 2 have also been updated to reflect the change in reportability. |
|  | Can you discuss why 8 (not applicable) is no longer used for mets to lung, liver, brain, bone for lymphoma cases? | Code 8 should never have been used with a lymphoma arising in the lymph nodes for mets at dx lung, liver, brain, or bone. There was a typo in the STORE manual that said it should be used. |
|  | Our pathology department considers high grade dysplasia of the colon in-situ tumors, so we have been reporting them. Would it be best for us to stop this practice? | If this is the standard practice in your facility, then clearly document it in your registry procedure policies or manual. In the event you are audited, undergo a case review, or asked by your state registry about these cases, you have the rationale prepared.  |
|  | Are these new changes included in the SEER case finding list? Oddly that list is effective October 1 and these changes are effective January 1, 2022. | The casefinding list is based on ICD-10-CM and they release their updates on October 1st, so we follow that schedule. When it is released, it will include all applicable changes at that time. |
|  | Do the C codes for reportability on Lois's tables and slides match those in WHO publications for ICD-0 and the blue books? | Yes. The C codes were provided in the WHO books. |
|  | Does HPV-dependent mean p16 positive or is the terminology only for cases confirmed with DNA/RNA testing for HPV? | HPV-dependent is synonymous with HPV-positive. Beginning 1/1/2022, p16 results are valid for coding one of the new specific HPV histology codes for the applicable site9s).  |
|  | Are the billable codes for the newly reportable high grade dysplasia’s of the stomach and small intestine included in SEER's ICD-10-CM Case finding List for CY22? Possibly D131. or K31. codes?? | The changes in these histologies do not affect the casefinding list. Should be D13.1, for in situ of colon |
|  | P16 positive on IHC or genetics or just a statement of P16 positivity? | Just a statement of p16 findings is sufficient to code HPV status related histologies. |
|  | Some States require Cervix In situ cases, so the Cervix insitu histologies would be reportable STATE Specific? | Yes. If your state collects cervical in situ, you may use the new ICD-O codes and terms beginning 1/1/2022. |
|  | Is there a full list of ICD-0 codes for us to give to IT to update our lists for our case finding for 2022? | The ICD-O updated posted by NAACCR includes the 2022 Annotated Table which was developed for software drop downs. The updated casefinding list is available at: <https://seer.cancer.gov/tools/casefinding/> |
|  | So can you clarify, in-situ of the cervix IF Path shows P16 positive, that WOULD be reportable going forward? | SCC in-situ and adenocarcinoma in-situ are reportable only if your state registry requires them. Most states do not collect these cases. Check your state reporting requirements. If cervical I situ cases are collected by your state or facility, then you may use the new codes beginning 1/1/2022. P16 does not automatically make them reportable.  |
|  | HPV mediated....that’s same as p16+...same as non-keratinizing, correct? | See the H&N Solid Tumor updated September 2021 for information on coding HPV related tumors and associated terminology.  |
|  | So cases previously not picked up because HPV not mentioned and only had p10 reported, should they be picked up? | Beginning with cases diagnosed 1/1/2022 forward, p16 results can be used to code the HPV related histologies. Do not go back and review cases and change them.  |
|  | Do we need to purchase a new ICD-O book to reflect these changes? | There is not a new ICDO book to purchase. as of yet. |
|  | In str's, the synonym column 2 for histology is extremely confusing as which to use -the particular histology-column 1 or subtype/variant-column 3 depending on histology. Do we just ignore the synonym column? | The synonym column lists the histology terms that have the SAME ICD-O code as the NOS. It may also list new terms which have not been assigned a specific ICD-O code that by default are coded to the NOS. This information was added to help registrars interpret pathology reports as pathologist often use inconsistent terminology. |
|  | What would someone use to take the exam is it this new information? | For the CTR Exam you have to use the resources that are listed by NCRA. You can find that list here <https://www.ncra-usa.org/Portals/68/PDFs/CertificationPDFs/CTRExam_Resources2022.pdf>  |
|  | Question for Lois - per the prostate histology table preview you shared, does this mean multiple primary rule for prostate for the adenocarcinoma histology specifically will be updated as well? Or will all the subtypes be considered "adenocarcinoma" for the purpose of multiple primary rules? | Any change to determining multiple prostate primaries will be discussed with our GU experts. The Other sites histology tables will be a reference only to assist with coding histologies. In prostate for example, I receive numerous questions about coding ductal carcinoma as registrars are used to it being a breast histology.  |
|  | The old ICD-O-3 manual has the Primary Site Codes. Will there be a separate document for those so we move away from the ICD-O-3 manual? I understand that the CTR Exam 2022 is doing away with using the ICD-O manual and I was informed that the STR is replacing that but STR doesn't have all site and sub site codes | I was not aware of NCRA changing the testing manuals. I will need to check with IARC ICD-O Committee to see if I can replicate the C code tables or will need to create them myself. Ideally the table would be an appendix to the solid tumor rules. Thank you for bringing this to my attention. |
|  | Which pathology report should you go by when your hospital requires all outside slides be reviewed internally before treatment is given? Do you use the original path report or our pathology department's report when they differ? | In general, use the pathology findings that treatment is based on. Otherwise, I would ask your cancer committee to confirm which report(s) have priority in your facility. Be sure to document this in your registry procedure manual. |
|  | What do you do when the Synoptic Report differs from the Final Diagnosis?  | In the Solid Tumor General Instructions, page 13, we provide information on which report has priority.  |
|  | What should we do for documentation priority on path reports when there are inconsistencies/conflicting info between the final diagnosis and synoptic report? | In the Solid Tumor General Instructions, page 13, we provide information on which report has priority. |
|  | Are the document priority discussed going to apply to the Other Sites as well? | Yes. |
|  | Will we ever get a new ICD-0 manual that can be purchased? | At this time, the IARC ICD-O committee chair and WHO have not provided an update on if or when we can expect either a book or .pdf version of ICD-O-3.2  |
|  | Where/when can we get a copy of Lois' ppt? It is EXCELLENT!! | https://education.naaccr.org/updates-implementation |
|  | Will the ICD O 3.2 Coding Table Excel be re-released to "include" the new codes for 2022? The current list on the website does not include them. | The annotated histology list dated 7/2021 has the 2022 updates included.  |
|  | On histology when there is a discrepancy between ICD-O-3.2 or Solid Tumor Rules. Which one takes priority? | Use ICD-O-3.2. It’s possible a code/term may have been unintentionally left out of the Solid tumor rules.  |
|  | Are the Solid Tumor Rules still the first place to go when coding the histology for 2022 cases? | Yes.  |
|  | Re: ICD-O 3rd edition C codes. Are these still effective? | Yes. The C codes have not changed. WHO may propose new C codes, but they need to be vetted and approved before implementation in North America. |
|  | Currently, when we submit questions regarding histology/STR to SINQ, they are not visible for everyone to view. Are there plans to make responses visible to everyone to view? | There are currently over 30000 questions in Ask SEER Registrar so searching for similar questions would be difficult if not impossible. We do at times, add questions received via AASR to SINQ which you can search. |
|  | Jennifer - I think this was asked in CAnswer Forum but don't recall answer, for the PSA >3 months example that only affects the SSDI, right? Would still use that PSA for AJCC staging? | This directly affects the SSDI. For AJCC staging, you can only use the PSA if the physician incorporates that PSA into their staging. The registrar cannot stage the case  |
|  | If colon polypectomy is the diagnostic procedure and not the definitive treatment, can we still not use CEA acquired between polypectomy and definitive surgery? | Yes, if CEA is done prior to polypectomy, you can use it |
|  | Isn’t it true that we can still use the PSA for staging even if it is older than 3 months because AJCC has different rules than the SSDIs? | You can only use the PSA if the physician documents the stage |
|  | The general rule for lab values says take highest. For lab values, aren't there any instances where the lowest instead of the highest is the value of concern? Maybe blood counts? | This would be addressed in SSDI specific instructions |
|  | I'm reviewing the SSDI manual, where can you locate the tables that are being referenced? | Here is a link to the upcoming version of the SSDI manual https://apps.naaccr.org/ssdi/list/2.1 |
|  | What about Guardant testing? It's a blood draw, but can tell you KRAS, BRAF, etc. | Liquid biopsies, or tests done on blood, have not been approved for KRAS, BRAF, etc. This has been covered in the SSDI forum.  |
|  | Can you clarify p16 for cervix yes go back or not do not for 2021 cases? The slides seem to indicate no then yes | You will have to code p16 results for 2021 cases if you are in a CoC hospital. On the slide we were trying to stress that the p16 data item is coded based on results of a p16 test. Saying a patient is HPV positive is not good enough to code this data item. It has to be coded based on a p16 test. (If the path diagnosis is SCC HPV-associated assign code 8085/3. Or the DX is SCC, NOS and p16 stated to be positive assign code 8085/3).  |
|  | Can this presentation be use foe CE credit? | There will be a CE survey link quiz that you will fill out to get your CE certificate. |
|  | Cervix AJCC 9th edition went into effect with 2021 cases - thought to keep in step with AJCC could we use HPV associated histology codes?  | The HPV related codes for cervix are valid for cases diagnosed 1/1/2022 forward. |
|  | Can insitu melanoma be ulcerated? | Yes, they can be ulcerated, although unusual |
|  | AJCC Cervix V9 which is for cases diagnosed 1/1/2021 forward shows SCC, HPV associated code 8085/3. Why can't we use 8085/3 for cases diagnosed in 2021? | AJCC does not determine reportability. The standard setters agreed codes 8085 and 8086 are valid for cases diagnosed 1/1/2022 forward. This is done for cancer surveillance purposes. |
|  | Melanoma: often our surgeon states a wide excision with 1cm margins was performed, but pathology shows tumor less than 1cm from margin. Do you code surgery according to surgical description or the pathology results? | At this point, you would code based on pathology. |
|  | Regarding SSDI, x6 is for "Positive aspiration OR needle core bx" not just FNA as mentioned by Jennifer.  | Correct |
|  | I want to clarify using PSA value, the SSDI manual states to use the highest pre bx value (which is a change from the 3 month rule) ? | First it has to be within the 3-month time frame, and then specific instructions apply. The 3 month rule applies to ALL SSDIs, then the general rules or specific rules go into effect |
|  | In the breast case with primary tumor with dcis, would you be able to code the lymph nodes? Without a /3 histology, would lns pass edits as a mets? | For this discussion, we were not discussing behavior, we were discussing what was going on with the primary tumor. ER and PR are to be coded based on the primary tumor only. A tumor with only DCIS in the primary tumor, with positive nodes would be a /3 |
|  | For the example DCIS with positive LN why would this note not work, note 3: Results from nodal or metastatic tissue may be used ONLY when there is no evidence of primary tumor. Why would you not want the ER/PR from the invasive? | As noted during the presentation, in situ in the primary tumor IS evidence of primary tumor.  |
|  | Will there be a list of things to go back and update for 2021 cases when the 2022 updates are available? | Yes, these are the implementation guidelines. |
|  | On the ER/PR marker slide, why don't the positive LNs indicate that there is an invasive nature to the cancer? Doesn't the fact that the LNs are positive indicate some type of invasion? Normally, we consider "in situ" as non-invasive. | There is an invasive nature to the case; however, it was not found in the primary tumor. ER and PR are to be taken from the primary tumor when in situ or invasive cancer is present. The only time you can use the lymph nodes ER/PR is when there is no evidence of the primary tumor anywhere. Presence of a breast tumor only on imaging (mammography or ultrasound), is NOT a T0 either. |
|  | Most CLL/SLL's are diagnosed on peripheral blood only. The Heme DB & Manual state to code these as primary site Bone Marrow- C42.1. AJCC states peripheral blood and bone marrow are not the same. What are registrars supposed to do with the SSDI's when we have a case for CLL/SLL w/ positive peripheral blood only (primary site- C42.1) and no bone marrow tested? | The statement in the AJCC manual does not impact the rules in the Heme DB and Manual.  |
|  | Will the STR General Guidelines be applied to the other sites rules for cases diagnosed in 2022 or 2023 ? | The STR General Instructions will apply to Other sites beginning 1/1/2023. Revisions to Other sites are currently underway and will be implemented in 2023.  |
|  | Idea! Many years ago we had binder dividers that had abstracting hints on the cardboard dividers for each site. This would be helpful if we could make up binders each year with the current abstracting hits. I am more than willing to pay for this type of publication each year! Please consider. | Major issue with this is the lack of people to work on this. The standard setters are short staffed along with many of the hospital and central registries.  |
|  | When data elements are added such as SSDI's, why aren't data edits provided? I feel it will improve data collection standardization and would decrease blank data fields. | For 2018, the edits were released a year or two later due to time constraints and available people to work on the changes. Now, edits are implemented the same time as the new data items.  |
|  | One reason for the data to be all over the place on ER/PR is patients who are less than 5% ER and PR% positive are being treated as negative. Since there is little benefit from the hormone. Per our physicians. | This is happening across the board, not just to patients with ER/PR less than 5%.  |
|  | Will the new changes effect the time/increase the time in which cases are abstracted?  | Probably not. |
|  | On the SEER Reliability studies, the last 4 on it made no sense to me. I could not figure out what to do. | They were simply asking if the information was available in your hospital. |
|  | Where is the link to do the Field Testing? | <https://reliability.seer.cancer.gov/>  |