# Solid Tumor Webinar 8/30/18 Q&A

1. "IF THERE WERE A simple explanation of exactly what changed with each subsequent revision we would know if a simple edit vs printing the entire section is required. Is this possible?"
	1. We extend our apologies for the ongoing revisions to the final rules. Because the rules had to be coordinated with other major 2018 projects, the final project was delayed beyond our expectations. Priorities did not allow for beta testing prior to the release, and as a result, registrars using the rules are identifying issues which we will continue to correct. We understand the major impact this has had upon registrars and we appreciate your feedback. We will do everything within our control to communicate the importance and priority of the solid tumor rules.
	2. We also realize that it has been difficult to determine what changes have been made. Changes fall in two categories;
		1. **Major changes** which are posted in the change log. Major changes are those which would or could affect coding. From now on the change log will be as follows:
			1. Date of change
			2. Version 1.1 to Version 1.2
			3. M3 Added Note 2
		2. **Minor changes** which do not affect coding. When there is a revision date added with no change log entry, the change does not affect the rules or usage of the rules. Minor changes include
			1. Correcting a misspelled word
			2. Changing a word, such as: When preparing for this webinar, I noticed a preface which said there are “two” major site groups. The bullets correctly showed three site groups. The word “two” was changed to “three.”
2. There were multiple questions regarding ambiguous terminology:
	1. Can you talk about using ambiguous terms please? ex: breast malignancy consistent with ductal carcinoma (see bi1); lung bx non-small cell carcinoma consistent with adenocarcinoma (see ii1): colon consistent with adenocarcinoma- thanks
	2. Regarding ambiguous terminology, it's not a matter of a pathologist diagnosing only as, "consistent with adenocarcinoma." Pathologists frequently diagnose tumors using ambiguous terminology and we are missing out on specific histologies. Here are several common examples we see: "non-small cell carcinoma, most consistent with squamous cell carcinoma, (see ii1)" or "malignant tumor, consistent with squamous cell carcinoma (see bii2)," or "carcinoma, most consistent with ductal carcinoma (see bi2) ." Is it really the intention that 8010 or 8000 are really the best histologies to code?
	3. Can you provide more info regarding Ambig terms used? Example: Carol said that if path report says; Non-small cell consist with Adenoca (see ii1). Verbage it should be coded as?? I missed that comment? I'd like to provide info to the pathology groups in our region.
	4. Can you please re-clarify the histology coding for the NSCLC consistent with squamous cell= code as NSCLC (see ii1)
	5. Second example for NSCLC consistent with NSCLC, squamous cell carcinoma would be coded to squamous cell (see ii1)
	6. So if path reads "mass c/w menigioma" we may code menigioma but if path states "neoplasm c/w meningioma" we would have to code histology to neoplasm NOS?
	7. The questions are about different primary sites I will answer them in groups (breast, lung, etc.)
	8. **Breast:** Priorities for coding multiple histologies in a single tumor are different than the priorities for all other sites.
		1. **Breast examples within questions**
			1. breast malignancy consistent with ductal carcinoma
				1. First point is that ductal carcinoma is NOT a subtype/variant
				2. Second point is that “breast malignancy” is not an actual diagnosis. You can find malignant tumor in the ICD-O, but that is not what the pathologist is saying, rather, they are establishing that this is a breast malignancy, not a benign mass/tumor. The wording s rather important in this diagnosis.
				3. So, the diagnosis is, literally, a malignancy which is consistent with duct carcinoma.
				4. In this case, using the unusual wording, the diagnosis is “consistent with duct carcinoma,” ignoring the term “breast malignancy” which is not equivalent to malignant tumor
				5. See histology rules; **header**: Coding Multiple Histologies in a Single Tumor
				6. #**2** Do not code histology when diagnosed with…
				7. **2C** Ambiguous terminology. The list includes “consistent with
				8. See **Note 2** which says histology described by ambiguous terminology is coded ONLY when a case is accessioned based on ambiguous terminology (the case you cite meets these criteria – the case was put in your database because the diagnosis was c/w ductal CA) and no other histology information is available/documented (again, this case meets the criteria because no further histology information is available)
				9. Answer: Code invasive carcinoma NST/duct carcinoma 8500/3.
			2. carcinoma, most consistent with ductal carcinoma
				1. The term “ductal carcinoma” is no longer recommended; the term carcinoma NST (no special type) is the preferred term. The first part of this diagnosis is carcinoma (no special type specified)
				2. The term “mammary carcinoma” is listed in the histology table as a synonym for carcinoma NST 8500. This is specified as a breast primary (mammary) and diagnosed as carcinoma with no special type assigned
				3. Code to carcinoma NST 8500/3
		2. **Lung**
			1. "non-small cell carcinoma, most consistent with squamous cell carcinoma;” “Non-small cell consistent with Adenoca;” “the NSCLC consistent with squamous cell= code as NSCLC;” “NSCLC consistent with NSCLC, squamous cell carcinoma would be coded to squamous cell”
				1. In each of these examples there is a definitive diagnosis of non-small cell carcinoma 8046 (no ambiguous terminology used)
				2. The definition of non-small cell lung cancer in National Cancer Institute dictionary and Medicine Met is “a group of lung cancers; there main types are adenocarcinoma, squamous cell carcinoma, and large cell undifferentiated carcinoma.”
				3. When you have a diagnosis of NSCLC, c/w any of the subtypes/variants. You code NSCLC.
				4. Always check for biomarkers. As far back as 2014 the following statement was made regarding NSCLC: NSCLC, as a stand-alone diagnosis, in either tissue or cytological samples, should be avoided whenever possible. In some situations (when the tumor sample is restricted to a smear from a bronchial brushing of a poorly differentiated carcinoma, for example), further characterization might be impossible. However, in our experience, further characterization, particularly with the help of special histochemical stains for the detection of mucin (often with the use of PAS-D or mucicarmin), and/or immunocytochemistry, can be achieved in the majority of cases. From a practical point of view, samples containing adenocarcinoma (ADC) either pure or mixed should undergo biomarker testing. In small samples, the recommendations are less stringent, and**, as long as an ADC component cannot be excluded, the tissue should undergo biomarker testing** (**irrespective** of the **main tumor component** identified).
				5. Current biomarkers for lung include EGFR mutation, EML4ALK; KRAS mutation; Her/2neu amplification; BRAF mutation; PIK3CA mutation; FGFR1 amplification; DOR2 mutation; RET translocation; ROS translocation
			2. "malignant tumor, consistent with squamous cell carcinoma,"
				1. In this case, the term “malignant tumor” simply means this is not benign. Although “tumor, malignant” is issued an ICD-O code of 8000, you should evaluate the wording of this diagnosis seems to indicate the pathologist is stating that there is a tumor; the tumor is malignant, and it is consistent with squamous cell carcinoma. After carefully checking for biomarkers, either code the histology identified by a biomarker OR code squamous cell carcinoma. This is a very difficult diagnosis to ponder. I would suggest checking with the pathologist if/when biomarkers are not available. If all else fails, code to squamous cell carcinoma simply based on the way in which this is worded. In other words, code squamous cell as a last resort.
		3. CNS: “mass c/w meningioma” and “neoplasm consistent with meningioma”
			1. Mass c/w meningioma would be coded as a meningioma using Note 2.
			2. Neoplasm consistent with meningioma would be coded as a meningioma using Note 2. The term neoplasm means “new growth.” Since the neoplasm is not described as malignant or cancer, it is not equivalent to the ICD-O term “Neoplasm, malignant.”
	9. we are missing out on specific histologies.
		1. No, we are making sure the cases are in the correct analytic category.
		2. For years, we have used a list of terms published by the SEER Coding Manual, COC, and the 2007 rules. That list of ambiguous terms was intended for casefinding, not identifying histologies.
		3. Researchers have found that our histology categories are not homogenous. Instead they show variances in frequency of recurrence, treatment, and mortality. The emphasis is on making sure the specific categories are correct (such as not coding a squamous cell carcinoma without verification from biomarkers, treatment plan, or physician. That case may have been an adenocarcinoma and should not be placed in the squamous cell category unless it is verified.
3. Am I correct in applying the rules, that we DO NOT code the TYPE of DCIS anymore. For example, DCIS solid type, would be coded to 8500/2, instead of 8230/2?
	1. You are correct
4. Please walk us in coding Invasive ductal carcinoma with lobular features per 2018 STM
	1. Use the search feature. Click on the icon that resembles a magnifying glass. A search box will open. Enter the words “lobular features”
	2. The first “hit” is in table 2, Note 1 which says CAP uses the term “invasive carcinoma with ductal and lobular features” as a synonym for the combination code 8522/3. This does not fit the case you cite, duct is listed as “invasive ductal **carcinoma**” not as a feature.
	3. “Hit” 2 is in Table 3. Duct/ductal carcinoma with lobular features is listed as a synonym of carcinoma NST8500/. This is exactly your diagnosis. Code 8500/3.
5. What if the final diagnosis refers us to the CAP protocols? Lung example: Final Diagnosis: Well Differentiated Adenocarcinoma. See Template. The template states under histologic type: Invasive adenocarcinoma, acinar predominant; other subtypes present: lepidic component, minimal.
	1. Although CAP requires a summary report, that is not always done. When the final DX refers you to the CAP protocol, use it.
	2. You have to sort through the check-list to see what should be coded. Start by excluding anything that cannot or should not be coded. Exclude:
		1. Other subtypes. You have no idea which subtypes and cannot code what you do not know.
		2. Lepidic component. Although lepidic carcinoma is now a valid histology, the term “component” does not tell us whether or not it is lepidic carcinoma or the previously used term for lepidic growth pattern. If you can confirm this us lepidic carcinoma with the pathologist, you would have adenocarcinoma with mixed subtypes 8255/3 (See Table 2, Acinar and lepidic are coded 8255/3)
	3. If you cannot confirm lepidic carcinoma, you are left with the diagnosis of adenocarcinoma, acinar prominent. This is a NOS (adenocarcinoma) and a subtype/variant (acinar adenocarcinoma). Use H12 and code 8551 acinar carcinoma (lung only). H12 has a hyperlink taking you to Table 3 so you can find the correct code for acinar adenocarcinoma.
6. Did I just see a glioblastoma in that cartoon?
	1. I think so!
7. For Carol: What version of adobe pdf did you say we need our browser to open the files in?
	1. Use the URL<https://get.adobe.com/reader/>
		1. There are other sites which offer readers. There is no guarantee that these readers will perform all of the functions or that the version will be free.
		2. The current version is 2018.011.20058
8. We prefer to print the manuals we work with, but these seem to be optimized for on-screen viewing. What is the reason for this? We can't have every manual up on our screens (in addition to many other programs used in abstracting).
	1. The H&N final rules have been posted. The web-developers will create a file which will allow you to print a copy of the rules or to use them in a combined file.
	2. You are correct. The rules are optimized for on-screen viewing. We no longer have funding to print manuals. Since we are limited to an online version of the manual, the online tools have been made available. There are, of course, pros and cons to using an online version. The pros are that you always have the latest version and that the tools are available for search, highlight, sticky notes, etc. The cons are that there is a limit to the number of programs which can be open on the computer at any given time. There is a time factor in opening and reopening a program as well as searching through the open programs to find the one you need to use.
9. If a meningioma is resected and then you see it again maybe 2 years later. that is a recurrence?
	1. You are correct, it is a recurrence. See next question.
10. Please explain what "no timing rule" means for CNS neoplasms. How are new tumors determined if not by time?
	1. By site (for example, brain and pituitary gland are different sites/different primaries)
	2. By histology. Separate non-contiguous tumors that are different subtypes/variants (column 3) are different primaries. Separate non-contiguous tumors on different rows of the histology table are different primaries.
11. Has using the operative report for primary site changed then or is this just for B9 Brain site?
	1. The operative report is particularly helpful in determining the primary site for both malignant and non-malignant CNS neoplasms.
	2. One example would be identifying whether a cranial nerve was within the skull or, for example, the surgery was on the neck, thorax, etc.
12. I noticed a few of the words on the non-malignant solid tumor rules on the presenter's screen are different than our downloaded version. Can you tell me when this portion of the manual was last updated? We have one from 07.31.18. Thank you!!!
	1. Non-malignant was updated 8/13/2018
13. For non-malg CNS, Rule 3. Is there some research that backs up that the un-resected tumors always were malignant? Rather than transforming over time? Can you point us to journal articles?
	1. I apologize if I gave the wrong impression. The unresected tumors could be either of the following
		1. A malignant foci was present at the time of the original diagnosis. Over time it has increased in size and is now causing symptoms or is apparent on the scans **OR**
		2. The tumor behavior transformed from non-malignant to malignant
		3. In either case, there is a single tumor/single primary. We cannot keep the benign behavior because mortality would be attributed to the benign tumor.
14. The MPH rules advised us to use the most representative specimen to code histology. I cannot find this stated in the solid tumor rules. Did this change? And if so, do we use the histology from the biopsy and also from the resection to code histology.
	1. Yes, this was a change. You are correct, you look at the histology from the biopsy and the resection to determine which histology should be coded.
15. We would appreciate an overview of the layout of the manual and how best to use it. We will read the details of specific sites when we abstract.
	1. Noted!
16. When the Multiple Primary rules came out they were presented in 3 different forms. Flow Chart, Matrix and something else. I loved the Flow Chart. Will these rules ever come out in the Flow Chart form? Thanks
	1. As a fellow flow-chart user, I understand your frustration There was not enough funding available to create all three formats, so the rules are presented in text format only.
17. Cavernous hemangioma in the brain - reportable? Sometimes it is hard to know if this is a blood vessel tumor or a white/gray matter tumor.
	1. See the explanation under cavernous tumor in the Equivalent Terms and Definitions. Cavernous sinus tumors originate in the cranial nerve passing through the sinus or in the cerebral meninges covering the cranial nerve.
18. Pathology report states: Glioblastoma multiforme, astrocytoma grade 4. Which histology would be used when these two histologies are used on one path report? What rule or instruction guides us in this situation?
	1. Code glioblastoma multiforme. Astrocytoma grade 4 is not listed in the WHO grade table. (anaplastic astrocytoma is a WHO grade 3). Because glioblastoma multiforme is a WHO Grade 4, GBM is described in pathology outlines as an astrocytic neoplasm.

1. Is astrocytoma and glioma is the same
	1. No Glioma is a broad grouping of histologies which includes the subtypes/variants astrocytoma, ependymoma, glioblastoma, oligodendroglioma, and gliomatosis cerebri.
	2. Most common glioma
2. Statements in the new solid tumor rules advise us not to take information form the CAP checklist over a final diagnosis. Does that refer specifically/only to the actual 'checklist'? ie. many path reports list CAP information such as: Tumor location...; Histology: LVI... and details pertaining to that header. This isn't a 'checklist' so where does it fall in the priority order?
	1. You are correct, the instructions are not to use the actual checklist.
	2. The pathology reports frequently summarize the CAP checklist and give the histology. You definitely will use that summary.
3. When will SEER have a solid tumor database like the Hematopoietic Database?
	1. There is currently no funding for this project.
4. If the pt has a recurrence of breast cancer >5yrs, but the pathologist compares the new tumor to the previous one and states that they are histologically the same, would you then code it as a recurrence instead of a new primary?
	1. Yes, code as a recurrence. When you have the pathologist’s diagnosis after comparing the slides, use it.
5. Is it a single or multiple tumor when you have in the same breast?
	1. Depends on timing between tumors as well asthe histology of the tumors.
6. It's confusing that they used and in situ example in a rule that pertains ONLY to 2 invasive histologies, Page 26, #1
	1. Yes, that was confusing It has been corrected.
7. so now the cases that are subtype comedocarcinoma are no longer classified in their own category.... they will now be 8500/2? Is that right?
	1. You are correct, it would be coded as DCIS 8500/2.
8. I think it is very helpful to know why the rules have been changed. It helps to understand the reasoning behind the change so the change makes more sense.
	1. Thank you for that feedback. We will include the rationale in future educational programs.
9. Confused now on when to go by "greater than 90%" and then in 1B you said "greater than 50%". Which is it?
	1. Breast primaries have two categories: NOS and subtype/variant and multiple histologies.
	2. When there is a NOS and a subtype/variant you
		1. Code the subtype/variant when documented to be equal to or greater than 90% of the tumor
		2. Code the NOS when the subtype/variant is
			1. Documented to be less than 90% of the tumor **OR**
			2. The percentage is not documented
		3. When there are multiple histologies (in different rows in Table 3)
			1. Code the histology that comprises the majority of tumor (more than 50%)
			2. When the majority of tumor is not specified, use a combination code
10. Would Breast IDC w/ 60% mucinous 'features' be coded to mucinous carcinoma?
	1. Do not code mucinous carcinoma. Features are not coded
11. Breast: Coding Multiple Histologies, section 1b: Different histologies not only means "on different rows" as CJ stated, but also two different subtypes (on the SAME ROW, column 3)
	1. That is correct. Thank you, good clarification.
12. Five-year timing rule for Breast: Pt diagnosed with Ductal Carcinoma of rt br 2015, treated w/lumpectomy, one year later comes in for a mammogram and states "benign", exam unremarkable. In 2017, pt has another mammogram and it states suspicious for malignancy in rt breast. Will this be two primaries?
	1. There was no recurrence between the 2015 primary and the 2017 mammogram. There is less than five years between the two tumors.
	2. Because you only have a mammogram with “suspicious for malignancy” it is impossible to know the histology.
	3. If the second tumor were a different histology, it would be a second primary. If it was the same histology, it would be a recurrence.
	4. Until more information is available, treat as a recurrence.
13. How does it fall on registry to educate/dictate to pathology how they classify terminology? Have these terms and rules been shared with CAP and clinicians at all yet?
	1. Let me answer the question about whether rules have been shared with CAP Yes, Lois is in contact with CAP physicians and rules have been shared.
	2. Next, I apologize if I gave the impression that you would dictate classification of tumors to the pathologist(s). The intent was to say
		1. Registrars need to present changes to tumor board, in particular changes which will affect the manner in which data are collected and entered into the DB.
		2. Pathologists and other members of the tumor board only know about these changes when/if the registrar presents them.
		3. It is mandated that a representative from pathology be on the tumor board. In most cases, when they understand that the rules have changed and a c/w diagnosis cannot be coded (for example, a lung case entered as NSCLC because dx NSCLC c/w adenocarcinoma) they usually speak to their fellow pathologists on their own initiative.
14. We were always told that Non-Small Cell Ca is not really it's own histology, but a description meaning that the tumor is Not Small Cell.
	1. NSCLC is an actual diagnosis. When there is no tissue (bronchial brushing) or a minimal amount of tissue, biomarkers may not be effective. If the patient’s co-morbidities and/or age prevent further work-up, NSCLC will be the only diagnosis available (and is the correct diagnosis).
	2. NSCLC is not a diagnosis most pathologists accept when there is a resection (enough tissue). That is because there are biomarkers that should be used to determine whether the tumor is adenocarcinoma, squamous cell carcinoma, or large cell carcinoma undifferentiated.
15. The reasoning given by presenters for amb term and why we are NOT to use it anymore for histologies was very helpful to make these rules stick. Thanks!! :)
	1. Thank you. It is nice to hear what does work when training. We will definitely use the rationale in further training.
	2. Again, thank you. It is so nice to hear an encouraging word.