March 2024 E-Tips

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

Diagnostic Confirmation Coding for Solid Tumors

- These codes are in priority order; code 1 had the highest priority.
- *Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple methods.*
- Change to a higher-priority code, if at **any time during the course of disease** the patient has a diagnositic confirmation with a higher priority.
  - *Example:* Benign brain tumor diagnosed on MRI. Assign diagnostic confirmation code 7. Patient later becomes symptomatic and the tumor is surgically removed. Change the diagnostic confirmation code to 1.

Check out SEER Manual Diagnostic Coding Section for more information and full list of notes!

Codes for Solid Tumors

Microscopically Confirmed

Code	Description
1	Positive histology
2	Positive cytology
4	Positive microscopic confirmation, method not specified

Not Microscopically Confirmed

Code	Description
5	Positive laboratory test/marker study
6	Direct visualization without microscopic confirmation
7	Radiology and other imaging techniques without microscopic confirmation
8	Clinical diagnosis only (other than 5, 6, or 7)

Confirmation Unknown

Code	Description
9	Unknown whether or not microscopically confirmed; death certificate only

Hormone Therapy Coding for Thyroid Primaries

Code **Hormone Therapy as 01** for follicular and/or papillary thyroid cancer when thyroid hormone therapy is given.
Example: Levothyroxine, Synthroid

Do not code replacement therapy as treatment unless the tumor is papillary and/or follicular.

The thyroid gland produces hormones that influence essentially every organ, tissue and cell in the body. When the thyroid is partially or totally removed, it is no longer able to secrete these essential hormones and the patient is placed on hormone replacement therapy.
SEER Coding Guidelines for Thyroid

Check out the 2024 NJSCR Program Manual!!!
Department of Health | Cancer | NJ State Cancer Registry

New Short on FLccSC covering Address at Diagnosis
FCDS - LMS - Frontend - Log In (miami.edu)

Completeness rate Recommendation for facilities
75% of 2023 records submitted by the end of April 2024.
All 2023 records submitted by July 1 2024.

Question:
Head & Neck: How is histology coded for laryngeal intraepithelial neoplasia II-III (LIN II or LIN III)? See Discussion.

Laryngeal intraepithelial neoplasia II-III is not included in the ICD-O-3.2 and, while the SEER Program Coding and Staging Manual (SPCSM) confirms this is reportable, neither the SPCSM nor the Solid Tumor Rules Manual provide the specific histology to use for LIN II or LIN III. Should this be coded as 8077/2 since this is most like a high grade squamous dysplasia?

Answer:
Assign histology code, 8077/2 (squamous intraepithelial neoplasia, high grade) for LIN III and for LIN II. *ICD-O-3.2 lists squamous intraepithelial neoplasia, grade II and grade III as 8077/2 indicating it is reportable.* ICD-O-3.2 does not list every site-specific type of intraepithelial neoplasia. Check the SEER manual for reportable and non-reportable examples.

SEER Ask A Registrar 20240003

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!**

February 2024 E-Tips	New Jersey State Cancer Registry Cancer Epidemiology Services http://www.nj.gov/health/ces (609) 633-0500

Radiation Coding: Breast Phase I-II-III Radiation Primary Treatment Volume
NAACCR Coding Pitfalls 2023 Webinar

Code 40 (Breast- whole)
Patients who had whole breast radiation after a lumpectomy or partial mastectomy
Code 41 (Breast- partial)
Patients who had partial radiation after a lumpectomy
Code 42 (Chest wall)
Patients who received radiation after mastectomy

If the breast AND lymph nodes are being treated
Code the Primary Treatment Volume to Breast (codes 40 and 41) and Breast/chest wall lymph nodes (code 04) in radiation to Draining Lymph Nodes.

Check out the
CTR Guide to Coding Radiation Therapy Treatment in the STORE Manual

Melanoma SSDI Clinical Margin Width

This SSDI is effective for diagnosis year 2023+

Code the peripheral surgical margins from the operative report from a wide excision.

- *Do not use the pathology report to code this data item.*
- Margins from wide excision-measured from the edge of the lesion or the prior excision scar to the peripheral margin of the specimen, do not use deep margin
- Do not add margins together
- *If multiple wide excisions are performed, code the clinical margin width from the procedure with the largest margin.*

Order of priority:

1. **Operative Note**
2. **Physician statement in medical record**

Record stated margin in centimeters. Include decimal point. ***Example:*** 0.5 cm - 0.5

Physician statement of clinical margin width can be used to code this data item when no other information is available, or the available information is ambiguous.

**https://staging.seer.cancer.gov/eod_public/schema/3.1/melanoma_skin/?breadcrumbs=(~schema_list~)

Question:
Histology--Prostate: Is histology coded as 8045 (Combined small cell carcinoma) for a 2023 diagnosis of two-component carcinoma comprised of both acinar adenocarcinoma and small cell neuroendocrine carcinoma of the prostate?

Discussion:
This patient does not have a previous diagnosis of prostate adenocarcinoma nor a previous history of androgen-deprivation therapy. Does the logic in the Other Sites Solid Tumor Rules (STRs) noted in SINQ 20200052 still apply? This SINQ confirms a diagnosis of mixed prostatic adenocarcinoma and small cell neuroendocrine carcinoma is 8045. This matches the STRs instructions for Rule H21 and Table 2 (Mixed and Combination Codes), row 1. Row 1 indicates a mixed small cell carcinoma and adenocarcinoma is combined small cell carcinoma (8045). For a patient without previous treatment, is this the correct mixed histology code?

Answer:
Code histology as combined small cell carcinoma (8045) based on the Other Sites Solid Tumor Rules, May 2023 Update, Table 2, Mixed and Combination Codes, for this mixed histology prostate carcinoma consisting of adenocarcinoma and small cell neuroendocrine carcinoma regardless of treatment status. This is similar to SINQ 20200052 that applies to one tumor with mixed histologies.

**https://seer.cancer.gov/seer-inquiry/inquiry-detail/20230065/

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January 2024 E-Tips	**New Jersey State Cancer Registry** **Cancer Epidemiology Services** **http://www.nj.gov/health/ces** **(609) 633-0500**

EOD and SS2018 Version 9 Update

AJCC released version 9 for NET (excluding Adrenal Gland) and Vulva diseases which will be effective for cases diagnosed 1/1/2024 or later. There are now 2 schemas for each. SEER*RSA has been updated to reflect these changes.

The Registrar Staging Assistant (SEER*RSA) website is intended for use by cancer registrars to help with diagnosis 2018 and forward coding:

- Extent of Disease (EOD) 2018
- Summary Stage 2018 (SS2018)
- Site-Specific Data Items
- Grade

Visit SEER*RSA
https://staging.seer.cancer.gov/

Current sites that have both AJCC 8th Edition and version 9 coding guidelines include: Anus, Appendix, Brain, Cervix, CNS Other, Intracranial Gland, NET tumors, Vulva

Breast Histology Coding

Mammary carcinoma is a synonym for carcinoma no special type (NST)/duct carcinoma not otherwise specified (NOS) use **code 8500.**

Invasive carcinoma, NST with lobular features is not equivalent to invasive carcinoma with ductal and lobular features**.**

Invasive mammary carcinoma NST with lobular features use code 8500/3

Breast Solid Tumor Rules

2024 Coding Instructions for Primary Site: GYN Sites

When the choice is between ovary, fallopian tube, or primary peritoneal without designation of the site of origin, **any indication of fallopian tube involvement indicates the primary tumor is a tubal primary**.

Fallopian tube primary carcinomas can be confirmed by reviewing the fallopian tube sections as described on the pathology report to document the presence of either serous tubal intraepithelial carcinoma (STIC) and/or tubal mucosal invasive serous carcinoma. **In the absence of fallopian tube involvement, refer to the histology and look at the treatment plans for the patient.**

If all else fails, assign ***C579*** as a last resort.
Check out the 2024 SEER Manual Coding Instructions!!

Coding Guidelines for Bladder!

Use the information from reports in the following priority order to code a subsite when the medical record contains conflicting information:

- Operative report (TURB)
- Pathology report
- Multifocal Tumors

Coding Bladder subsites

C679 Assign when there are multifocal tumors all of the same behavior in more than one subsite of the bladder and the specific subsite of origin is not known.

C678 Assing when:

- A single tumor of any histology overlaps subsites of the bladder
- A single tumor or non-contiguous tumors which are:
    - Urothelial carcinoma in situ 8120/2 ***AND*** involves only bladder and one or both ureters (no other urinary sites involved) *Note*: Overlapping non-invasive tumors of the bladder and ureter almost always originate in the bladder

C688 Assign when a single tumor overlaps two urinary sites and the origin is unknown/not documented

If the TURB or pathology proves invasive tumor in one subsite and in situ tumor in all other involved subsites, code to the subsite involved with invasive tumor.

2023 and 2024 Solid Tumor Rules (cancer.gov)

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