Hematopoietic & Lymphoid Neoplasms

- Baby aspirin is coded as other treatment for essential thrombocythemia.
- If there is no mention of B symptoms and/or HIV status in the medical records code unknown.
- Waldeyer’s ring, thymus, and spleen are considered nodal. Do not use E suffix.
- **REMEMBER!** Pathologic staging for Hematopoietic and lymphoid neoplasms requires a Staging Laparotomy.
- The following histology’s have Mets at DX field always coded to 8:
  - Any case coded to primary site: C420, C421, C423, C424
  - Plasma cell Myeloma 00821
  - Plasma Cell Disorders 00822
  - HemeRetic 0083

**Bulky Disease**

- Hodgkin Lymphoma (HL)
  - If mediastinal, Bulky is defined as greater than 1/3 the size of the cavity.
  - If not mediastinal, “Bulky” is defined as greater than 10cm.
- Non-Hodgkin Lymphoma (NHL)
  - Definition varies based on histology.
  - Look for physician statement of “Bulky”
  - Stage 2 Bulky is a new stage category for 8th edition.
    Make sure you read the summary of changes in your AJCC Staging Manual
- Any extralymphatic involvement with nodal disease above and below the diaphragm is Stage IV.

**Question!**

If there is no clinical information available and all that is available is the post-neoadjuvant information, is it better to code EOD unknown (999) or use the post-neoadjuvant information to code EOD?

**Answer!**

*Code EOD Primary Tumor using the post neoadjuvant information for this case. Since the only information you have is the post neoadjuvant, code that. EOD combines clinical and pathological information.*

**Wondering what radiation fields must be filled out when “No Radiation” or “Unknown” if Radiation done?**

Radiation items carried over from FORDS to STORE:

- Reason for No Radiation [1430] (required 2003+)
  - RX Summ-Surg/Rad Seq [1380]
- Rad—Location of RX [1550] (Required 2003+)
  - Date Radiation Started [1210]
    - RX Date- Radiation Flag [1211]
  - Date Radiation Ended [3220]
    - RX date Rad Ended Flag [3211]

If No Radiation:

- Phase 1 Radiation Primary Treatment Volume is coded 00
- Phase 1 Radiation treatment Modality is coded 00
- All other “Phase” radiation fields may be blank.

**Check out SEER Educate for 2018 EOD Training**

https://educate.fredhutch.org/Assessments/PracticalApplicationTests.aspx

**Sources:**

*NAACCR 2018-2019 Webinar Series Hematogenic &Lymphoid Neoplasms
*NAACCR 2018-2019 Webinar Series Abstracting and Coding Boot Camp

Questions can be sent to your facility’s State Representative or by calling 609-633-0500. DO NOT REPLY to this email.
ER and PR Total Allred Score

The total Allred Score uses IHC to determine the percentage of cells that test positive for the hormone receptors, Estrogen Receptor (ER) and Progesterone Receptor (PR). The intensity is how well the receptors show up after staining. The clinician’s interpretation takes priority. If the physician does not state what the Allred score is and both Positive cells % and intensity are available, then the registrar can calculate it. This information is combined to score on a scale from 0 to 8. Find your percentage in the positive cells’ column for your proportion score, followed by finding your intensity score based on information provided in interpretation. Add the proportion score to the intensity score to find your total Allred score.

<table>
<thead>
<tr>
<th>Proportion Score</th>
<th>Positive Cells, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>&lt;1</td>
</tr>
<tr>
<td>2</td>
<td>1 to 10</td>
</tr>
<tr>
<td>3</td>
<td>11 to 33</td>
</tr>
<tr>
<td>4</td>
<td>34 to 66</td>
</tr>
<tr>
<td>5</td>
<td>≥67</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intensity</th>
<th>Intensity Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>Weak</td>
<td>1</td>
</tr>
<tr>
<td>Intermediate/Moderate</td>
<td>2</td>
</tr>
<tr>
<td>Strong</td>
<td>3</td>
</tr>
</tbody>
</table>

• Example:
  ER Positive 100% nuclear staining, strong average intensity **Allred Score: 08**
  PR Positive 10% nuclear staining, moderate average intensity **Allred Score: 04**

*Abstracting and Coding Boot Camp NAACCR 2018-2019 webinar series

**Testis**

• If post-orchiectomy AFP lab values remain elevated, use lowest post-orchiectomy AFP lab value prior to adjuvant therapy.
• Adjuvant therapy for testicular cancer takes 3 months to decide. This is still considered first course therapy.
• When coding EOD primary tumor remember that code 100 and 150 are for PURE SEMINOMAS ONLY.

*Testis NAACCR 2018-2019 webinar series

**Grade 2018 Coding Exercises Now Available in SEER*Educate**

With diagnosis year 2018, we now have to code three Grade fields instead of one. In fact, Grade now has its very own manual!

Log in or sign up at SEER*Educate today by visiting https://educate.fredhutch.org/ and Learn by Doing!

Free CE’s available!

SEER*Educate is funded by Surveillance, Epidemiology and End Results (SEER) of the National Cancer Institute (NCI) and the Fred Hutchinson Cancer Research Center. (NCI Contract Number HHSN261201800004I)

**SEER Releases New Cancer Statistics Review (CSR) and Latest SEER Data**

The SEER Cancer Statistics Review (CSR), 1975-2016, published by NCI’s Surveillance Research Program, was released on April 15, 2019. The updated Cancer Statistics Review presents the most recent cancer incidence, mortality, survival, and prevalence statistics.

New materials posted include:
• Cancer Statistics Review 1975-2016
• Cancer Stat Fact Sheets (now including female breast cancer subtypes!)
• SEER*Explorer (now with stats by subtype for breast, esophagus, lung, and thyroid!)
• The Cancer Query Systems
• Cancer Statistics Animator
• SEER Incidence Data, 1973-2016
• Specialized Databases


Questions can be sent to your facility’s State Representative or by calling 609-633-0500. DO NOT REPLY to this email.
### Basics of External Beam Radiation Therapy (EBRT) & Coding Implications by Wilson Apollo, MS, CTR, RTT

What is the difference between IMRT and 3D conformal?

**ANSWER:** The main difference between IMRT and 3D-Conformal plans is that when the latter is used, the MLC leaves remain stationary. It still uses multiple fields as with IMRT, and each field conforms to the shape of the target as seen from various angles, but the collimator leaves are static through the duration of treatment.

How do we code the field External Beam Planning Technique if the radiation oncologist just calls it AP/PA?

**ANSWER:** The term AP/PA refers to the direction of the radiation beam only. It provides no information whatsoever on the planning technique code that should be used. AP/PA means that the patient was irradiated with the gantry @ 0 degrees and @ 180 degrees.

What is Gamma Knife and how do you code it?

**ANSWER:** Gamma Knife SRS can target multiple CNS lesions in a single session. Regardless of the number of lesions treated in a single session, abstract as a single phase. Code the maximum prescribed dose use. Remember that Gamma Knife is EBRT and you should code the dose/fx and total dose in cGy.

### Coding Tips for Colon 2018:

**Do not** use histology codes: 8210, 8260, 8261, 8263, 8264 for C18.0-C20.9.

Types of Polyp, Treatment and Stage:

- **Sessile polyp:** Colonoscopy is done giving it a Clinical T. The surgical Resection is treatment.
- **Pedunculated polyp:** Snare polypectomy is the treatment. This would give you a pathologic T. No clinical stage.

**Note:** Component is not equivalent to subtype or variant. Component is **ONLY** coded when the pathologist specifies the component as a second carcinoma.

**NEW** Priority Order for Coding Primary Site

**Resected cases:**
- Operative report with surgeon’s description
- Pathology report
- Imaging

**Polypectomy or excision without resection:**
- Endoscopy report
- Pathology report

Predominantly is more than 50% which is important for coding the subtype!

### Confused on Anastomotic sites. Recurrence or Same Primary?

**Solid Tumor Rules for Colon:**

- **M7:** Abstract multiple primaries when a subsequent tumor arises at the anastomotic site AND: • One tumor is a NOS and the other is a subtype/variant of that NOS OR • The subsequent tumor occurs greater than 24 months after original tumor resection OR • The subsequent tumor arises in the mucosa

Colon 2019 NAACCR 2018-2019 Webinar Series


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**What is CEA?**

CEA is a glycoprotein produced by adenocarcinomas and is measured in blood, plasma or serum. CEA is a prognostic marker for adenocarcinomas of the appendix, colon and rectum is often used to monitor response to treatment.

**Q:** *“If the patient has a polypectomy followed by definitive surgery, can a higher CEA reported after the polypectomy but before the resection be coded?”*

**A:** Record the highest CEA lab value in the medical record prior to treatment or polypectomy. If the tumor was in the polyp, do not use the post-polypectomy CEA even if it is higher. In this situation, the polypectomy would be treatment. If the tumor is a frank adenocarcinoma and the polypectomy only removed a portion, then the post-polypectomy CEA can be used.
Some Highlights from the January 24, 2019 ORANJ Meeting

(Next month we will provide notes from Basics of External Beam Radiation Therapy & Coding Implications)

**Bladder Cancer: Navigating SEER Coding Rules - Presentation by Heather Stabinsky**

- EOD is based on a combined clinical and operative/pathological assessment and priority goes to pathology in a discrepancy.
- Information for EOD from surgical resection after neoadjuvant treatment can be used ONLY if the extent of disease is greater than pretreatment clinical information.
- There are many different descriptive terms for noninvasive papillary transitional cell carcinoma. See Bladder - EOD Primary Tumor for a list of definitive statements and inferred terms.
- Common iliac lymph nodes are coded in REGIONAL LYMPH NODES (Code 700) for bladder BUT are considered distant lymph nodes in SEER Summary Stage. If common iliac nodes are involved for bladder, code them in EOD Regional Nodes. Do not code them in EOD Mets. If common iliac nodes are involved for bladder, code 7 (Distant) in SEER Summary Stage 2018.
- Priority order for coding Bladder Grade:
  - Urothelial cancers: use codes L, H, 9 (if only G1-G3 are documented, code 9)
  - Adenocarcinoma and Squamous Cell Carcinomas: use codes 1-3, 9 (if only L or H are documented, code 9).

**Lymph-vascular Invasion (LVI)**

Lympho-vascular invasion is an indicator of prognosis. It indicates the presence or absence of tumor cells in lymphatic channels (*not* lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist.

Information to code this field can be taken from any specimen from the primary tumor (biopsy or resection).

Use “code 0-Not present/Not identified” for cases of purely in situ carcinoma, which biologically have no access to lymphatic or vascular channels below the basement membrane.

Do not code perineural invasion in this field.

For 2018 cases treated with neoadjuvant therapy, refer to table below from the STORE 2018 manual, p 153.

<table>
<thead>
<tr>
<th>LVI on pathology report PRIOR to neoadjuvant therapy</th>
<th>LVI on pathology report AFTER neoadjuvant therapy</th>
<th>Code LVI to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>D - Not present/Not identified</td>
<td>0 - Not present/Not identified</td>
<td>0 - Not present/Not identified</td>
</tr>
<tr>
<td>D - Not present/Not identified</td>
<td>1 - Present/Identified</td>
<td>1 - Present/Identified</td>
</tr>
<tr>
<td>D - Not present/Not identified</td>
<td>9 - Unknown/Indeterminate</td>
<td>9 - Unknown/Indeterminate</td>
</tr>
<tr>
<td>1 - Present/Identified</td>
<td>0 - Not present/Not identified</td>
<td>0 - Present/Identified</td>
</tr>
<tr>
<td>1 - Present/Identified</td>
<td>1 - Present/Identified</td>
<td>1 - Present/Identified</td>
</tr>
<tr>
<td>1 - Present/Identified</td>
<td>9 - Unknown/Indeterminate</td>
<td>9 - Present/Identified</td>
</tr>
<tr>
<td>9 - Unknown/Indeterminate</td>
<td>0 - Not present/Not identified</td>
<td>9 - Present/Identified</td>
</tr>
<tr>
<td>9 - Unknown/Indeterminate</td>
<td>1 - Present/Identified</td>
<td>1 - Present/Identified</td>
</tr>
<tr>
<td>9 - Unknown/Indeterminate</td>
<td>9 - Unknown/Indeterminate</td>
<td>9 - Unknown/Indeterminate</td>
</tr>
</tbody>
</table>

Check this out! Articles citing NJ State Cancer Registry data:


**New in SEER*Educate! Earn and Learn.**

2018 Solid Tumor Rule Coding Exercises are now available! This is a great way to earn CEs and learn how to apply the 2018 Solid Tumor Rules. Use the 2018 Solid Tumor coding rules to determine the number of primaries to abstract and the histology to code for cases diagnosed 1/1/2018 and forward.

Please note that two remaining sites, Cutaneous Melanoma and Other Sites are currently under revision. Continue to use the 2007 General Instructions, 2007 Other Sites, and 2007 Cutaneous Melanoma for cases diagnosed 2007-2020.

Your Participation is Needed! March 1 to April 15, 2019.

**Complete the 2019 EOD/SS/SSDI Reliability Study!**

NCRA has approved 10 CEs for completion of ten cases. The objectives of this study are to determine training needs. Go to SEER Reliability Studies Site during this period. The study will assess how well registrars assign EOD Primary Tumor, EOD Regional Nodes, EOD Mets, SS2018, Grade, SSDIs, Regional Nodes Positive and Tumor Size.

Questions can be sent to your facility’s NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email.
### IS THIS REPORTABLE?

**Atypical small acinar proliferation (ASAP) PIN 4** - is not reportable. Patients with ASAP found on prostate needle biopsy will likely undergo another biopsy. [https://seer.cancer.gov/seerinquiry/index.php?page=view&id=20180094&type=q](https://seer.cancer.gov/seerinquiry/index.php?page=view&id=20180094&type=q)

**Primary hepatic neuroendocrine tumor (PHNET)** - PHNET is reportable as are other digestive system NETs. There is no specific histology code for PHNET. SINQ 20180097 suggests we use histology code 8240/3. For more details see: [https://seer.cancer.gov/seerinquiry/index.php?page=view&id=20180097&type=q](https://seer.cancer.gov/seerinquiry/index.php?page=view&id=20180097&type=q)


**Monoclonal B-cell lymphocytosis (MBL)** - According to SINQ 20180050 monoclonal B-cell lymphocytosis is not reportable. This term will be removed from 9823/3 since it is a /1 (has its own code). MBL is a condition in which a higher than normal number of identical B cells are found in the blood. Lymphocytosis by itself and without further specification means an increase of lymphocytes. This can be caused by many different factors. Monoclonal B-cell lymphocytosis is a condition that resembles chronic lymphocytic leukemia (CLL) and is defined as the presence of CLL-phenotype cells in the peripheral blood in the absence of other features of CLL or SLL. But follow up should be conducted to assure that this has not evolved into a lymphoma. [https://www.cancer.gov/publications/dictionaries/cancer-terms/def/monoclonal-b-cell-lymphocytosis](https://www.cancer.gov/publications/dictionaries/cancer-terms/def/monoclonal-b-cell-lymphocytosis)


### New Treatment for Gastroenteropancreatic Neuroendocrine Cancers

Peptide Receptor Radionuclide Therapy (PRRT) is a radiopharmaceutical (nuclear medicine therapy) that travels throughout the body looking for a somatostatin receptor within neuroendocrine tumors (NET). NETs that form in the midgut area, from the jejunum to the ascending colon, are the most common cancerous NET. These tumors overexpress receptors for a hormone called somatostatin.

Once absorbed into the tumor the radioactive material starts to break down and kill tumor cells. PRRT was approved in 2018 to treat gastroenteropancreatic neuroendocrine tumors in adult patients. It uses lutetium Lu 177 dotatate, which is being studied in the treatment of other types of cancer. Infusion is typically given every 8 weeks for a total of 4 doses. Look for the drug LUTATHERA®.

According to SINQ 20180106 it is to be coded as Other Therapy, code 1.


### NJSCR Presents: Spend the Day at the Registry

Please join the New Jersey State Cancer Registry for this full-day interactive workshop designed to give hospital registrars a better understanding of the central cancer registry. Meet the NJSCR staff and see first-hand how your data becomes part of our research and publications. Topics covered include data linkages and follow-up, special studies, death clearance and quality control.

135 E State St. Trenton NJ 08608

Earn 5.5 CEs!

To register for this informative event, visit: [https://www.state.nj.us/health/ces/documents/Brochure%20revised%20for%202019%20dates.pdf](https://www.state.nj.us/health/ces/documents/Brochure%20revised%20for%202019%20dates.pdf)

Questions can be sent to your facility’s NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email.