NATIONAL INSTITUTES OF HEALTH
NATIONAL CANCER INSTITUTE
SURVEILLANCE, EPIDEMIOLOGY AND END RESULTS (SEER) PROGRAM
2007 Multiple Primary and Histology Coding Rules—Breeze Sessions
"Beyond the Basics"
General Instructions
June 15, 2007

Slide 1
Hello, everybody. This is Peggy Adamo. We are starting a new series of Web-based trainings. Carol Johnson and I created a series of training sessions for the SEER Coders and Abstractors Workshop and we received requests to make those available to a wider audience. These Breeze Sessions will be recorded and posted on the Website with written transcripts so they will be available to anyone who wishes to access them.

Slide 2
This first session pertains to the General Instructions. As Carol Johnson and I were putting together the site-specific presentations we noticed there were several useful points that apply across all the rules. We put those points into this General Instructions Session in this series of Breeze Sessions which we have titled: *Beyond the Basics*.

Slide 3
In this General Instructions Session we will cover:
● the order of the rules—when to use them and how to use them
● counting tumors
● the most representative specimen
● invasive and in situ
● recurrence—"*Where did it go?"*

Slide 4
Let's review when to use the rules. The rules are effective for cases diagnosed January 1, 2007 and after. Do not use these rules to abstract cases diagnosed prior to January 1, 2007. That is the way the rules are written, but what does that actually mean?

Slide 5
It means that you use these rules when the 2007 tumor is the first tumor that the patient has. You also use these rules when the patient has a history of cancer and develops another tumor on or after January 1, 2007. In the latter case, you use the *Multiple Tumors Module* to evaluate the subsequent tumor.

Slide 6
We have received many questions about timing. The first part of our response is to always compare the diagnosis date of the current tumor to the diagnosis date

of the original tumor. This applies even if the patient had six occurrences in-between these dates; you still evaluate the current (2007) tumor to the diagnosis date of the original tumor and ignore recurrences in this process. Go through the Multiple Primary Rules and make a decision.

Let's illustrate how to do this. Let's say, for example, that you get a report of a new tumor. First, you make sure it is a reportable tumor, not a metastasis or a benign tumor. You then look at the available information on the previous primary—not recurrences, not metastases, not progression but the previous primary; then you look at the rules. Go to the *Multiple Tumor Module* for the *appropriate site* in making your decision. Go through the rules systematically until you find the rule that fits the situation encountered with these two tumors. For example, if you have a right breast tumor diagnosed in 2007 and the patient has a history of a right breast cancer diagnosed in 1999, you would go to the *Multiple Tumors Module* in the *Breast Multiple Primary Rules* to determine whether or not the tumor diagnosed in 2007 is to be abstracted as a new primary.

Slide 7
We do not use these 2007 Multiple Primary and Histology Coding Rules for metastases. Here are a couple of examples:
● a patient with a history of melanoma presents with positive nodes---you do not apply the MP/H rules to that situation
● another example is a person with a history of breast cancer who presents with malignant pleural effusion; you do not apply the rules to this situation.

If you know the current situation is metastatic, the 2007 Multiple Primary and Histology (MP/H) Coding Rules do not apply; these rules are not to be used with metastases. This is not new; this is the way it has always been.

Slide 8
This is another general point that we find needs to be reinforced: It is crucial that you use the rules in hierarchical order. Do not skip to a section just because it seems to match your case. Do not go directly to a rule that seems to work. You will make major errors if you do those things. We call that "berry picking" when you go jumping around in the rules to pick the one you think will work. We keep emphasizing that you must not do that. Use the rules in order. Go through them systematically one by one until you come to the one that fits your case.

Slide 9
When you find the rule that fits, stop! People ask what we mean by "the rule that fits." When we talk about a "fit" we mean that the statement in the rule is true for that case. For example, if a patient had tumors in the right and left breasts, in the past there was a rule that said that tumors on the right and left breasts with the same histology were multiple primaries. There was also another rule that said tumors on both sides with different histologies were multiple primaries.

Rule M7 in the *2007 Breast Multiple Primary* Rules states: "*Tumors on both sides (**right and left breasts**) are multiple primaries.* " Now, let's say you keep looking through the 2007 MP/H Rules to find a rule that also mentions tumors with the same histology because histology was not mentioned in this particular rule M7; you will make huge errors using that approach.

Slide 10
If, for example, your case has tumors on both the right and the left breasts and both happen to be duct carcinoma, if you go through the rules and berry pick or keep going through the rules because you do not see anything about histology in a previous rule, you will end up at M11, which says: *"Multiple intraductal and/or duct carcinomas are a single primary."* If you jump to that rule you will get the wrong answer because these tumors are in separate breasts; you have to stop at the rule prior to M11. Don't berry pick! Stop thinking about the old rules in which you looked for site, histology, timing, etc. all in one rule. That is not the way these rules work; they are hierarchical.

Slide 11
Let's talk a little bit about counting tumors. In the General Instructions it says: *"When there is a tumor or tumors with separate microscopic foci, ignore the separate microscopic foci and use the 'Single Tumor' or 'Multiple Tumor' modules as appropriate."* Let's talk about how to use that instruction.

Slide 12
First the term **focus: Focus** is used by pathologists to describe a group of cells that can be **seen only by a microscope**. **Focus** is a tiny speck that you cannot see with the naked eye; that's why we don't count them as tumors. **Foci** is the plural of focus. **Foci** means there are at least two, tiny specs that cannot be seen with the naked eye. We still don't count foci as tumors for the purpose of these rules, even if there is more than one.

Slide 13
Those words should not be confused with **focal**. The word **focal** is an adjective meaning "confined or limited to a specific area or to a specific organ." When It is used to describe cancers it most frequently means "limited to the organ of origin, or limited to a quadrant of the organ of origin," for example. We know this word is misused often; **don't assume** that it is a synonym for focus or foci. Focal is a very ambiguous word but if focal is the only word used, you default to macroscopic. Never assume it means microscopic.

Slide 14
We receive a number of questions on how to choose a Tumor Module. We have Single Tumor Modules and Multiple Tumor Modules. We want to emphasize that just because there was a single biopsy that does **not** necessarily mean there was a single tumor. Likewise, just because there were multiple biopsies, you

should not assume there were multiple tumors. Also, as emphasized on the previous slide, **never** interpret “multiple foci” to mean “multiple tumors.”

Slide 15
Additionally, when choosing the appropriate tumor module, you do not count metastasis and you do not count benign tumors; you only count malignant primaries.

Slide 16
Now we are going to discuss histology. We want to emphasize that you **never** change the histology at diagnosis. The histology may evolve, be a recurrence or transformation and there are a number of tumors that recur with a histology that has a different ICD-O-3 code; for example, astrocytoma may recur as a glioblastoma multiforme. Other types of malignancies may transform, for example, malignant histiofibrosarcoma may transform to a fibrosarcoma. But you never change the original histology code assigned at diagnosis with the caveat that we do know you would correct any errors you found.

Slide 17
We are now going to talk about the “most representative specimen.” Look at your pathology report and see which report covers the most **tumor tissue**. The ”most extensive surgery” does **not automatically mean** that report covers the “most tumor tissue.” For example, an excisional breast biopsy may remove the majority of the tumor tissue. A mastectomy specimen by contrast may have very little or no residual tumor tissue. In that case, the “most representative specimen” is the excisional biopsy.

We know there are times when it is impossible to determine which pathology report has the most tumor tissue. In those situations, use the best information available to you on either pathology report.

Slide 18
We’re going to discuss invasive and in situ histologies. There may be times when you have in situ and more than one invasive histology. When you go to the rules in the module for invasive/in situ, the rules will instruct you to code only the invasive histology. Sometimes there is more than one invasive histology in a case and you need to decide between two or more invasive histologies in determining what histology to code. In that situation, you would go back through the Histology Coding Rules using the appropriate module—Single Tumor Module or Multiple Tumors Module—to determine which histology code to use for the invasive histologies. So we are telling you to make a “second pass” through the Histology Coding Rules when the first pass does not completely answer the questions for your case. In this example, the first pass told you to code the invasive histology. You still have a decision to make for this particular case in determining which of the invasive histologies to code. That’s when you make a second pass through the Histology Coding Rules to find the rule that applies and

tells you which of the invasive histologies to code. This is a new concept. It is something we want to widely disseminate to all in the field.

Slide 19
We get questions about one of the New Data Items—"Date of Multiple Tumors." There is only one field in which to record the Date of Multiple Tumors. Record the date that a subsequent or simultaneous tumor was first diagnosed in the field, "Date of Multiple Tumors." You never update this field regardless of how many other (additional) tumors the patient has; just record the information from the first occurrence (i.e. the date that the subsequent or simultaneous tumor was first diagnosed) and don't update the field.

Slide 20
Lastly, we receive many questions asking, "What happened to 'recurrence'? Where did it go?" It did not disappear. When the patient has a subsequent tumor and using the Multiple Primary Rules to assess the original and the subsequent tumor you get the answer that the case is a single primary—that is a recurrence. You record the date of diagnosis of that subsequent tumor as the date of the recurrence. Use the information available about the subsequent tumor to complete the other recurrence Data Items. Recurrence therefore did not disappear; it is still there.

These are the current, key items that Carol Johnson and I found that apply across all sets of rules. There will be other Breeze Sessions recorded and available to you on site-specific rules so please join us for those. Thank you for your time and attention.