Quality Improvement Meeting
August 2008

SECTION I: QUESTIONS

1. Can information from the **CAP protocol** portion of the pathology report be used to code histology?
   Yes. The CAP protocol is a summary of the pathologic findings. If there are any discrepancies between the information in the CAP protocol and the pathology report, those discrepancies should be discussed with the pathologist.

2. For the **Lung** rules, do we consider the term "nodules" equivalent to "tumor"?
   Does this question pertain to the multiplicity counter? We will be adding some clarification regarding the number of tumors in a lung when the rules are revised. The term "nodule" is not on the list of equivalent terms. By definition, a nodule is "a small aggregation of cells", OR a "small lump, swelling, or collection of tissue". The advisors to the MPH Committee did not feel this word consistently described a tumor.

3. For the **MP/H Reliability Study**, if it is determined that there are multiple primaries, is the first primary the first one mentioned in the case, or do we follow usual sequencing rules (chronology, worst prognosis first).
   We will be instructing the participants to follow the usual sequencing rules to decide which is case 1 and which is case 2. If the participant makes a sequencing error, our revised software allows us to change the sequence order of the cases. Per Natalie Leotta: We have a Score object that compares the answers and puts them in the order to give the participant the highest score. It should handle any transposition of cases smoothly.

4. For bilateral invasive **ovarian** carcinoma reported as a single primary, is Multiple Invasive Tumors coded to 00 vs 40, and is Multiplicity Counter coded to 01 vs 02?
   Code multiplicity counter 02 and type of multiple tumors 40.

5. How is **Multiplicity Counter/Type of Multiple Tumors** Reported as One Primary applied to Prostate? **Example:** Core biopsy: adenoca in bilateral apices.
   Code these data items for prostate as you would for the other primary sites. For this example you have only biopsy information; do not assume that there are multiple tumors just because there are multiple biopsies. When there is no information about the number of tumors you would code multiplicity counter 99 and type of multiple tumors 99.

6. **Multifocal/Multicentric is not the same as multiple foci.** Are we supposed to count the number of **foci** when measurements are given?
   Per the 2007 clarifications to this data item if the foci are given measurements, count them as tumors. Do not count the foci if they are not measured. Example: Patient has a 2 cm breast tumor with multiple foci of DCIS throughout the breast. Code the Multiplicity Counter 01 (one measurable tumor).

7. Could you please clarify and provide context for the equivalent terms "**tumor," "mass," "lesion," and "neoplasm**." Since these terms are usually not reportable, our staff is confused about using them.
   The equivalent terms are for these rules only and do not pertain to reportability/casefinding. Reportability has already been determined by the time you use the rules. We established the equivalent terms for tumor so that we could simply use the word "tumor" in the rules, rather than writing "Tumor, mass, lesion, neoplasm" in every rule.

8. Are there guidelines for determining the use of terms that can serve as either anatomic location of the tumor or as a specific histologic type? Example: How is histology to be coded for a parotid tumor diagnosed as salivary duct carcinoma?
   Salivary duct carcinoma is coded as duct carcinoma 8500/3. When diagnosis includes a phrase such as "salivary duct carcinoma", the "salivary duct" generally refers to the structure of origin. Examples: mammary ductal carcinoma, pancreatic duct carcinoma and salivary duct carcinoma are all coded 8500. Following this logic, disregard the anatomic designation and code the histology as stated on the pathology report.

9. Has a decision been made about selection of **primary site** for multiple tumors of the urinary **tract**?
   This issue will be addressed when the MP/H rules are revised (expected release date 2010). In the meantime, code urinary tract, NOS C689

SECTION II: CASES

Site	Rules	Scenario	Question	Answer
Brain Benign	MP	MRI showed extra-axial mass in left CP angle consistent with meningioma. There was second extra-axial mass in posterior fossa. Differential includes but is not limited to ependymoma, subependymoma, schwannoma, meningioma or mets. Head CT the next day shows 3 cm mass in left CP angle likely represents meningioma. Second mass inferior to the floor of 4th ventricle. Given the presence of calcifications, differential would include ependymoma but cannot entirely exclude a met lesion. Discharge diagnosis is: Two posterior fossa lesions. Given patient age, opted not to offer surgical intervention.	How many primaries are to be accessioned? How is histology to be coded when a patient presents with two clinically-diagnosed brain tumors that present with a very broad differential diagnosis?	Use M1 and code a single primary. Code the histology as meningioma. ***Information Item:*** Dr. McLendon who served as a neurology expert on the benign brain committee was consulted. His comments were: The idea that one should default to a single diagnosis still sounds like a reasonable approach in cases of questionable multiple tumors. Clearly in such cases, the local radiologist and not the pathologist should be consulted. Suggestions for the 2010 revisions were: **1.** A rule or definition that states multiple tumors in a patient with a CP angle tumor raises the issue of NF2. In such cases, one can be a meningioma and one a schwannoma or both could be schwannomas. If you could go back to the chart and look for a history of NF2, it may solve this case. **2.** We need a priority for diagnosis (CT, MRI, clinical diagnosis, pathologic diagnosis).

Site	Rules	Scenario	Question	Answer
Breast	Hist	**Case 1:** Needle Bxs of lateral mass **left breast**: Invasive carcinoma with neuroendocrine (8240) and mucinous features (8480) combined Nottingham histologic grade 2 of 3 at least 0.8 cm in maximal extent." Needle Bxs of the medial mass **right breast** also showed the same thing. NO intraductal component **Case 2:** Please address the reason why the breast rules do not include a final rule that instructs the coder to code the histology with the numerically higher code. The last rule for breast, rule H19 states: code 8255 (adenocarcinoma with mixed subtypes) for multiple histologies that do not include duct or lobular. Sarcomas and other histologic types can arise in the breast. If these other histologies are mixed, do they get coded to 8255 also?	Histology code?	2 primaries – left and right, M7. Left: use single tumor module, invasive only, H19 and code 8255 Right: same as left Even though 8255 is described as a mixed adenocarcinoma, it is the only default for tumors with two histologies, neither of which are ductal or lobular ***Information item:*** Adding a "code the higher histology" as the last rule in the "Single Tumor, Invasive" module is on our "to do" list for the 2010 revisions.

Site	Rules	Scenario	Question	Answer
Breast	Hist	Tumor described as invasive ductal carcinoma, solid and cribriform types. Per Tables 1 and 2 in the MP/H rules, solid and cribriform are specific ductal carcinomas. Working through the MP/H rules, we arrive at rule H15; code the histology with the numerically higher ICD-O-3 code when there are two or more specific duct carcinomas. Following this rule, histology would be coded 8230. However, ICD-O-3 lists infiltrating duct and cribriform carcinoma under code 8523 (infiltrating duct mixed with other types of carcinoma).	Histology code?	See table 3 – You may use only those histologies listed in the table for 8523/3. ICD-O-3 code 8523/3 does not include solid – do not use. ICD-O-3 editors were emphatic about the histologies to be included in the combination/mixed breast codes. Use H15 and code the numerically higher ICD-O-3 code solid 8230/3 ***Information item:*** We will request an additional code for combinations of duct ca for ICD-O-4.
Breast	Hist	Tumor described as infiltrating ductal and secretory carcinoma? Discussion: per Tables 1 and 2 in the MP/H rules, secretory carcinoma is a specific ductal carcinoma. Per table 3, a tumor with infiltrating ductal and secretory carcinoma would be coded to histology code 8523. Per MP/H rule H12, histology would be coded 8502.	Histology code	H12 applies. Code 8502. ***Information item:*** We will review the tables with the breast cancer experts to determine if secretory belongs in table 2 and/or table 3 when we do the 2010 revision.
Breast	Hist	DCIS with the following characteristics; cribriform and focal micropapillary type.	Do we ignore the term micropapillary because it is described as focal?	Do not code focal. Use H3 and code cribriform 8201/2

Site	Rules	Scenario	Question	Answer
Breast	Hist	Breast lumpectomy showing metaplastic carcinoma with extensive squamous differentiation	The first rule that appears to apply is rule H19: code 8255 for multiple histologies that do not include duct or lobular. However, code 8255 is for adenocarcinoma with mixed subtypes. The tumor in question does not appear to be an adenocarcinoma.	Code adenosquamous carcinoma. Pathologist's comment: Metaplastic carcinoma **of breast** is a broad term covering a number of histologies generally characterized by a mixture of typical adenocarcinoma, with areas of nonglandular pattern (metaplastic) squamous, spindle or mesenchymal differentiation. It has also been used by some pathologists to refer specifically to tumors with squamous features. In general, if a tumor is entirely squamous it is called squamous carcinoma. The case to you cite has some element of glandular component, since there is reference to "extensive" squamous differentiation.
Breast	Hist	Duct carcinoma of the breast, mucinous type (colloid carcinoma)?	Mucinous is not listed in either table as a type of ductal. However rule H12 states that a specific histology may be identified as "type." It does not make reference to the tables.	Use H12 only when you have duct carcinoma and a specific type of duct carcinoma. Mucinous is not a specific type of duct carcinoma. For this case, use H17 and code 8523 per table 3.
Breast	MP	Pt dxd w/DCIS 11/29/07, treated with a lumpectomy. The case was presented at Tumor Board and the recommendation was an MRI of the breast. MRI done on 1/21/08 (< 60 days after dx). The MRI noted another mass suspicious for malignancy. Pt then has another bx 1/31/08 and infiltrating ductal ca is found (> 60 days after dx).	Should this be one primary with date dx of 11/29/07 and coded to infiltrating ductal ca or are there two primaries: one DCIS and two infilt duct ca w/date dx of 1/21/08?	There are 2 separate tumors and the MRI dx was malignant, then it's less than 60 days between in situ and invasive. Skip to M13, single primary. ***Note:*** If these procedures took place at two facilities both facilities are responsible for reporting the case because they both participated in the first course of treatment.

Site	Rules	Scenario	Question	Answer
Breast	MP	An invasive tumor following an in situ tumor more than 60 days after diagnosis is a multiple primary. Example: Biopsy reveals DCIS. Surgery was done after 60 days reveals invasive duct ca.	MP Y/N How does the First Course of Treatment or Treatment Plan or Treatment Timing affects this rule, if any?	When the treatment (surgery) has been delayed because of medical complications/co-morbidity factors the case is treated differently. Please be careful **not to extrapolate** beyond this rare case. If the surgery was delayed due to medical conditions, use both surgery and bx information and code as asingle primary unless there is evidence of disease progression or the time between the surg and bx is significant (more than 6 months). If there were no medical complications or co-morbid conditions preventing the surgery, the invasive tumor would be coded as a second primary.
Colon	MP	5/7/03 Cecal Mass Bx; adenoca 6/19/03 Mod Diff Cecal adenoca Tumor at IC valve w/direct extension into valve & distal terminal ileum 6/19/03 rt colectomy-rt colon mobilized up to prox trans colon along mesentery 5/27/05 colonic mucosal sigmoid colon bx; invasive adenoca, sigmoid colon. 6/9/05 CT: Ill-defined low attenuation lesion involving liver suspicious for mets. Several irregular mesenteric or omental	How many primaries? 2 or 3? If 2007 case is a separate primary, what site do you code? We are wondering how you code a site for a subsequent primary when half or more of the colon has been removed or when the new tumor appears at the anastomosis site since the architecture of the colon would've been altered.	Two primaries: 2003 & 2005 dx using the rules in effect prior to 2007– tumor in different parts of the colon. Compare the 2007 dx to 2005 dx. The 2007 dx is not a new "tumor"; there is no evidence that the patient was ever free of disease. The 2007 rules to not apply. There was no surgery in 2005. Chemo is used for residual or disseminated tumor. That is why it is usually adjuvant. But chemo will not removed a large tumor mass.

Site	Rules	Scenario	Question	Answer
		masses concerning for mets. Note in abstract: there is suspicion of this being a mets from the 1st primary, but no definitive statement. 5/27/05 colonoscopy: obstructing, narrow, circumferential lesion & obvious appearing ca of sigmoid colon, bx of mucosa done (invasive mod diff adenoca, sigmoid) **Rx w/chemo only.** 8/1/07 sigmoid colon bx, invasive mod-diff adenoca 8/5/07 116 cm colectomy, 5x2.8 cm mod well diff colonic adenoca arising at IC anastomosis. . Multiple sm mesocolic & serosal tumor implants. 3/10 mesocolic ln's pos for mets adenoca. Separate 12 cm segmental resection, mets adenoca, serosal implants, microscopically involving one resection mrgn. Sm intestine, 24 cm segmental resection, invasive serosal implants of mets adenoca. Three smaller segmental sm bowel resections, mets ca, serosal implants.		If a tumor appears at the anastomotic site, it could be regional recurrence. We must read the chart carefully when a hemicolectomy has been done to try to determine site. The physicians use landmarks to determine where they are within the colon (relationship of regional organs, IC valve, rectal tissue, etc.) If the physician, especially the surgeon, documents the location of the tumor, we accept this documentation.

Site	Rules	Scenario	Question	Answer
Colon	MP	Rt colon: Moderately to poorly differentiated adenocarcinoma with invasion into the muscularis propria. Surgical margins negative for tumor. Moderately differentiated mucinous adenocarcinoma with invasion into the muscularis propria.	MP Y/N	If these are 2 tumors, use M8, single primary.
Data Item	Multiplicity counter and Type mult tumors	10/17/07: Right axilla soft tissue bx - infiltrating mammary ca with lobular features arising within apparent breast tissue present within axilla. Tumor size 1.2 cm. 11/3/07: Right breast, re-excision lumpectomy - Several foci of infiltrating lobular CA. (2) foci & (5) foci within specimen (multifocal). (1) large focus also present.	**Question:** The abstractor coded it to 10 and 40. We are not sure when to count foci or separate tumor nodules, when to ignore them, and when to code to 99. Coding instruction 3b states, "When the tumor is multifocal or multicentric and the foci of tumor are not measured, code as 99'. Instruction 4b states, "Use code 01 when there is a single tumor with separate foci of tumor". Finally, instruction 6b states, "Use code 99 when the tumor is described as multifocal or multicentric and the number of tumors is not given," which seems to imply that if we know the number of tumors, we would code that number. **Answer**: Multiplicity Counter: Include all tumors abstracted as a single primary. Include foci when measured. Type of Multiple Tumors: Include all tumors abstracted as a single primary. If the case example above is determined to be a single primary,	The tumor tissue seems to be in the tail of Spence in the axilla. Multiplicity Counter: Use 4b and code 01 (there is one tumor measured; ignore the foci). Instruction 3b applies ONLY when there is no measured tumor.. Type Multiple Tumors: 00 (no multiple tumors).

Site	Rules	Scenario	Question	Answer
			assign code 99 [Number unknown] for Multiplicity Counter and assign code 30 [In situ and invasive] for Type of Multiple Tumors. **Per 2007 SEER Manual; p. 90-91 Multiplicity Counter Coding Instructions #3**: When there is a tumor or tumors with separate single or multiple foci, ignore/do not count the foci**. #4: Use code 01 when a)** There is a single tumor in the primary site being abstracted **b)** There is a single tumor with separate foci of tumor **c)** It is unknown if there is a single tumor or multiple tumors and the multiple primary rules instructed you to default to a single primary. **#6 Use code 99 when a)** The original pathology report is not available and the documentation does not specify whether there was a single or multiple tumors in the primary site. **b)** The tumor is described as multifocal or multicentric and the number of tumors is unknown. **c)** The tumor is described as diffuse. **d)** The operative or pathology report describes multiple tumors but does not give an exact number.	

Site	Rules	Scenario	Question	Answer
Data Item	Multiplicity counter Type mult tum	SINQ ID: #20071090 **Original Question:** Multiplicity Counter/Type of Multiple Tumors—Breast: How are these data items coded for a single breast primary composed of both in situ and invasive disease when measurements are provided for both the invasive and in situ components? **Discussion:** Breast cancer, invasive duct carcinoma with DCIS, 1.3cm, DCIS 3.7 cm. "The in situ carcinoma is very extensive in this lumpectomy. It is present contiguously from slides 1A through 1L sparing only the final 8 mm of the medial margin. In situ and invasive carcinoma are prominently present along almost the entire superior margin." Is the mult counter 02 with Type of mult tumor 30 or one tumor? **SINQ Answer:** Because there are individual measurements for each of these tumors, code the multiplicity counter 02 [Two tumors present]. Code Type Multiple Tumors as 30 [in situ and invasive].	Can we please re-visit/re-analyze this SINQ. In my understanding, the question is about a single breast tumor with both invasive and in-situ components and both components were measured. Thus, the revised answer would be: Multiplicity Counter code 01; Type of Multiple Tumors Reported as One Primary code 00. **Reference**: SEER Manual 2007 p.93 All single tumors. Includes single tumors with both in situ and invasive components.	The SINQ answer was given for 2 measured tumors.
Data Item	Multiplicity counter Type mult tum	**ID: #20081066 SINQ** Question (May 28 2008) Multiplicity Counter/Type of Multiple Tumors--Breast: Please see discussion. **Discussion** (May 28 2008) Scenario: 10/17/07: Right axilla soft tissue bx - infiltrating mammary ca	How should Multiplicity Counter and Type of Multiple Tumors be coded for this case? We are not sure when to count foci or separate tumor nodules, when to ignore them, and when to code to 99. The abstractor coded it to 10 and 40. We are not sure when to count foci	Use instruction 4b. Since there is a measurable tumor, code the multiplicity counter 01. Code Type of multiple tumors 00. The sinq answer has been revised.

Site	Rules	Scenario	Question	Answer
		with lobular features arising within apparent breast tissue present within axilla. Tumor size 1.2 cm. 11/3/07: Right breast, reexcision lumpectomy - Several foci of infiltrating lobular CA. (2) foci & (5) foci within specimen (multifocal). (1) large focus also present. No lymphovascular invasion identified. Numerous foci LCIS. Pleomorphic LCIS & CIS with lobular and ductal features. Margins free of invasion however margins diffusely involved with LCIS. **Question:** states, "Use code 01 when there is a single tumor with separate foci of tumor". Finally, instruction 6b states, "Use code 99 when the tumor is described as multifocal or multicentric and the number of tumors is not given," which seems to imply that if we know the number of tumors, we would code that number. **Answer** (Jun 18 2008) Multiplicity Counter: Include all tumors abstracted as a single primary. Include foci when measured. Type of Multiple Tumors: Inlcude all tumors abstracted as a single primary. If the case example above is determined to be a single primary, assign code 99 [Number unknown] for Multiplicity Counter and assign	or separate tumor nodules, when to ignore them, and when to code to 99. Coding instruction 3b states, "When the tumor is multifocal or multicentric and the foci of tumor are not measured, code as 99'. Instruction 4b	

Site	Rules	Scenario	Question	Answer
		code 30 [In situ and invasive] for Type of Multiple Tumors.		
General	MP	**Case 1:** Pt was diagnosed with DCIS of the R breast on 11/12/2001. She had a segmental resection on 12/27/2001 with extensive DCIS and positive margins, followed by a simple mastectomy on 02/04/2002. There was no invasive tumor in either specimen. On 06/22/2007 she was diagnosed with a positive R axillary LN **Case 2:** 90yo woman /w hx lt breast ca s/p MRM 1977 who presents /w SOB. Underwent thoracentesis /w path rpt "Pleural fluid cytology - pos for carcinoma. Tumor cells are both ER/PR pos suggesting breast primary." Throughout the chart (prog notes, disch summary, etc) MDs call this "recurrent" lt breast ca. Due to her age, no addl WU. Pt died. **Case 3:** RT BR cancer since 1990,	**Case 1:** We have had several cases of DCIS with a positive axillary LN diagnosed at the same time as the mastectomy, but this is the first case where the positive node shows up six years later. The node has to be mets from the original tumor, but do we report it as a new primary because it occurred more than 5 years after the first diagnosis or is considered mets and not a second primary?	Nodes, pleura, cervical lymph nodes, and trachea are metastatic/secondary sites. The 2007 rules to not apply to metastases. These cases are recurrence/progression of disease.

Site	Rules	Scenario	Question	Answer
		lumpectomy, no pos nodes, Tamoxifen for 5 yrs. May, 2007, she comes in with a positive RT cervical Ln, metastatic PD ductal carcinoma of the breast. This is the same histology as the other cancer but that is not stated on the path report. **Case 4:** 2006 melanoma case that is to the RT trunk, under RT breast, that now has returned in the Trachea. Dr.'s are calling this metastatic melanoma w/ recurrence in the proximal trachea.		
Kidney		Radical nephrectomy - path reads Clear cell renal cell ca (2.1 cm). Cystic, hemorrhagic clear cell renal cell ca (2.5 cm).	MP Y/N	Both tumors have the same histology, clear cell renal cell carcinoma. Cystic and hemorrhagic are not cell types in this case. They are simply modifiers or descriptors. Use rule M11, single primary. See example 1. You would code cystic/multicystic if the only description was renal cell carcinoma. If a specific renal cell carcinoma (clear cell) is identified, code clear cell.

Site	Rules	Scenario	Question	Answer
Kidney	MP	Renal cell carcinoma, papillary and multicystic. Papillary renal cell carcinoma with maximum tumor size 3 cm. Multicystic renal cell carcinoma with maximum tumor size 4 cm.	MP Y/N	Both are clear cell carcinomas (8310) so they are a single primary, rule M1. Use rule H10 and code clear cell carcinoma. The word multicystic is a modifier or descriptor, not a cell type. You would code cystic/multicystic if the only description was renal cell carcinoma. If a specific renal cell carcinoma (clear cell) is identified, code clear cell.
Lung	Hist	RUL wedge resection path states DX = PD Non-small Cell Squamous CA w/both squamous & glandular features.	Histology code?	One of the definitions of adenocarcinoma is carcinoma occurring in glandular epithelium. We would follow Rule H6 and code adenocarcinoma 8560.
Lung	Hist	Lung (Right Upper Lobe biopsies): Neuroendocrine carcinoma, grade 3 (syn., small cell anaplastic carcinoma).	Histology code	Use Chart 1 to find the more specific term. In this case, small cell is more specific than neurodendocrine. Use H5 and code 8041
Lung	Hist	Non-small cell carcinoma with squamoid features? MP/H rules do not state that "squamoid is synonomous with squamous. Otherwise squamoid just means squamous-like.	Histology code?	Code to non-small cell, H3. Squamoid means "Squamous-like." Do not code squamoid as squamous.
Lung	Hist	Adenocarcinoma, BAC pattern of growth? "Pattern" is not a term indicating a specific histology.	Histology code?	Code adenocarcinoma. Do not code pattern.

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Site	Rules	Scenario	Question	Answer
Lung	MP	Lung bx path that is SCC. This pt has a previous cancer of a tongue, SCC, in 2001. The physician's again are calling this a recurrence and treating that way	This is a new primary because you go by the lung new rules, single tumor. What is right?	According to MD, the tumor in the lung is metastatic. The 2007 rules to not apply to metastases. Code this as a recurrence/disease progression.
Lung	MP	Chest CT showed 3.9 cm RUL lung mass and a 3.5 cm LLL lung mass. There were abnormal right paratracheal lymph nodes. FNA of the RUL was positive for squamous cell carcinoma.	How many primaries are to be coded? If this is one primary, how is multiplicity counter to be coded	Use rule M6: A single tumor in each lung is/are multiple primaries.
Lung	MP	Single lung tumors presenting in each lung but the patient also presents with bone mets? Would rule M6 apply? Or do the bone mets represent additional tumors?	MP Y/N Number of primaries?	A single tumor in each lung is/are multiple primaries. Use Rule M6, multiple primaries. The metastasis do not affect the MP/H rules.
Melanoma	MP	MP/H rules for melanoma do not include a definition for "early melanoma in situ."	Per SINQ 20041034, "early" is a term that is not diagnostic of cancer. This is a pre-2007 SINQ entry. [Sinq 20041034 = "severe dysplasia with features of early melanoma in situ".] Does the ruling still apply for MP/H rules? It is our experience that most clinicians consider the term early melanoma to be diagnostic of melanoma. We are accessioning these cases with diagnostic confirmation code 8.	Early melanoma in situ is a reportable diagnosis. Early melanoma includes melanoma *in situ* and thin invasive lesions less than 1 millimeter in depth." ***Information item:*** We will be sure that this SINQ answer is prefaced with the term "For cases diagnosed prior to 2007"

Site	Rules	Scenario	Question	Answer
Other Sites	Hist	Small Bowel Resection: Carcinoid tumor (neuroendocrine carcinoma, well differentiated). Following the rules in the Other module this would take you to coding the higher code 8246/3 Neuroendocrine.	I want to understand and be able to explain that the rules are different than in colon and in lung where we would be directed to code carcinoid.	Neuroendocrine is an umbrella term for several types of tumors. Carcinoid is a specific type of neuroendocrine tumor. Use H13, code the more specific histology. ***Information item:*** We will add an example like this to H13 in the 2010 revisions.
Other Sites	Hist	**Case 1:** Invasive endometrial adenocarcinoma, endometrioid type with (focal) mucinous differentiation. **Case 2:** Invasive squamous cell carcinoma with focal basaloid features?	What is the histology code?	**Case 1:** Do not code focal. Use rule H13 and code 8380 for adenocarcinoma, endometroid type. **Case 2:** Do not code "focal." Ignore the "focal" basaloid features. Code 8070 per Rule H11. ***Information item:*** We will add further instructions on focal/foci/focus when rules are revised for 2010.

Site	Rules	Scenario	Question	Answer
Other Sites	Hist	Single tumor- Intrahepatic cholangiocarcinoma, papillary type, well differentiated, 7.0 cm. maximum diameter.	Do we stop at H17 and code the numerically higher code 8160? ***	Use rule H17 and code 8160. Papillary is a specific type of intrahepatic cholangiocarcinoma. ICD-O does not have codes for each of the intrahepatic cholangiocarcinoma subtypes. Do not code this as papillary this case must be in the cholangiocarcinoma analysis grouping. Most intrahepatic cholangiocarcinomas are adenocarcinomas showing tubular and/or papillary structures. Other specific histologic types of intrahepatic cholangiocarcinoma include adenocarcinoma, adenosquamous, squamous carcinoma, cholangiocellular carcinoma, mucinous carcinoma, signet ring cell carcinoma, sarcomatous intrahepatic cholangiocarcinoma, lymphoepithelioma-like carcinoma, clear cell variant, and mucoepidermoid carcinoma. ***Information Item:*** We will add information on the cholangiocarcinoma subtypes in the 2010 revision.
Other Sites	Hist	Primary site is C541 - endometrioid adenocarcinoma with squamous differentiation	Histology code?	Following rule H16, and Table 2, this is endometroid and squamous. Code 8323
Other Sites	Hist	Hysterectomy done. Path documented as: clear cell adenoCA with papillary features	Histology code?	For clear cell and papillary, use rule H16 and code 8323

Site	Rules	Scenario	Question	Answer
Other Sites	Hist	Testes: Germ cell tumor with the following features: Histologic type: Cystic teratoma with mature and immature elements. Path comment: The majority of tumor consists of cystic teratoma with mature elements, but focally demonstrates immature stromal elements.	Histology code?	There is a focus of immature teratoma (/3), which makes the case reportable. Code 9080/3 (the reportable dx).
Other Sites	Hist	Mixed serous and endometrioid adenocarcinoma confined to an endometrial polyp?	Would we stop at rule H12 and code the case as adenocarcinoma in a polyp?	Stop at H12 and code adeno in a polyp ***Information item:*** We will look at H12 and the order of these rules when the rules are revised.
Other Sites	Hist	Rule H21 (code 8077/2 for in situ squamous intraepithelial neoplasia grade III….) is included in the multiple tumors scheme.	Why is this rule not included in the single tumor scheme?	***Information item:*** We will add this rule to the single tumor module when the rules are revised
Other Sites	MP	Patient diagnosed in 2003 with an ovarian carcinoma and treated with surgery and chemo. Biopsy of the peritoneum in 2007 stated to be recurrent by physician and she underwent debulking for this recurrent ovarian carcinoma. Slides were not compared by the pathologist.	Is this a new primary?	If pathology report actually identifies the peritoneal tumors as metastases, this is a single primary. If not, use rules and code a new primary of the peritoneum (extraovarian).

Site	Rules	Scenario	Question	Answer
	MP	Final Diagnosis: Total Thyroidectomy: Multifocal Histologic Type: Papillary Carcinoma. Separate focus of diffuse sclerosing variant (1.21 cm.) with capsular penetration into perithyroid soft tissue. Comment: Regarding the tumor size, the largest and only distinct nodule in the thyroid exhibiting papillary carcinoma is 1.15 cm. in greatest dimension. Regarding the staging of the primary tumor as PT4a with penetration of the capsule, this is in reference to the separate focus of diffuse sclerosing variant which is 1.21 cm.	Following the rules I get to M17 Multiple primary. Is this what we would want to do?	Code 8350, diffuse sclerosing papillary carcinoma. Use rule M16 – papillary and specific type of papillary. Not every possible type is listed in M16, these are examples. ***Information item: We*** will clarify that these are examples for M16 in the 2010 revision.
Other Sites	MP and hist	Right thyroid resection: minimally invasive encapsulated follicular carcinoma, Hurthle cell variant 1.9 cm not involving margins. Multifocal Follicular variant of Papillary Microcarcinomas, 4 foci measuring 0.1 cm, 0.3 cm 0.5 cm and 0.7 cm none involving margins.	MP Y/N and hist code	Use rule M6 and code as a single primary. Use H27 and code to mixed papillary and follicular, 8340. Hurtle cell is a variant of follicular carcinoma.

Site	Rules	Scenario	Question	Answer
Other Sites	MP	Pt with TAH, bilateral S&O, omentectomy. Path shows high grade serous ca with stromal invasion and surface involvement in both right & left ovary. Intraepithelial serous ca in both right & left fallopian tubes. Invasive implant of serous ca involving the serosal surface - uterus. Multiple invasive implants of high grade serous ca in omentectomy. GYN surgeon says "most likely arising from the right ovary. Mets in left ovary, peritoneal studding".	MP Y/N	Use rule M7 -single primary. This is an ovarian primary and both ovaries are involved.
Other Sites	MP	Lt testicle resection: Seminoma, tumor size estimate 2.4 cm x 1.5 cm x 1.2 cm appearing limited to testicle. Mixed non-semitomatous germ cell tumor with predominant pattern of embryonal carcinoma, minority pattern of teratoma, tumor size estimate 3.5 cm x 2.7 cm x 2.2 cm appearing limited to testicle.	MP Y/N	We are assuming that these are two separate masses. Use Rule M 17, multiple primaries. The seminoma is 9061/3 (Rule H11). The mixed germ cell tumor is 9081/3 (Rule H16, Table 2).
Unknown	Hist	MP/H rules do not address pre- vs. post- neoadjuvant therapy morphology. How are histology and grade to be coded for tumor that is described as moderately differentiated squamous cell carcinoma on biopsy but is described as adenocarcinoma (no grade stated) with a focal area of neuroendocrine carcinoma at pneumonectomy following neoadjuvant therapy? Discussion: Patient was found to	Does the post-neoadjuvant therapy diagnosis of adenocarcinoma represent the most tumor?	The "most representative tumor" rule does not apply after neoadjuvant therapy unless used very judiciously. That is a case by case decision. Code this case to mixed adenocarcinoma 8255. ***Consultant pathologist comment***: I see 3 histologies – squamous cell carcinoma (biopsy), and adenocarcinoma, and possible

Site	Rules	Scenario	Question	Answer
		have moderately differentiated squamous cell carcinoma on lung biopsy. Patient then underwent neoadjuvant chemo and radiation therapy. Subsequent pneumonectomy showed invasive carcinoma showing the following features: invasive adenocarcinoma with a focal area of neuroendocrine carcinoma. A/P window lymph node showing met carcinoma with neuroendocrine features. Subcarinal lymph node showing met carcinoma with squamous features. The neuroendocrine and squamous carcinomas were the ones that metastasized. MP/H rules do not include rules for modifying terms such as "focal" or "components of." I believe that during the Breeze-online training sessions, we learned that we are not to use descriptions that follow these terms.		neuroendocrine carcinoma (NEC) or adenocarcinoma with neuroendocrine differentiation in the post neoadjuvant resection. In this case (as in lung cases even in the absence of neoadjuvant therapy) the biopsy may not be sufficiently large enough to be representative of the tumor. The description indicates a single lung tumor; the histology is adenocarcinoma with focal NE differentiation, so this is NOT neuroendocrine (8246), rather it is adenocarcinoma with neuroendocrine differentiation (8574), IF we are willing to accept the "focal area" designation (see WHO, pp 19,20, for discussion of this group – it's significance is not yet known, and the authors appear to separate it from the NEC group). The fact that there is a node with "carcinoma with neuroendocrine features" does not change the diagnosis of the primary – it simply represents what may have survived the neoadjuvant therapy, and, in fact doesn't tell us whether this was adeno histologically or not. We also do not know the basis for the neuroendocrine features – histologic, immunocytochemical, or both. The initial biopsy was squamous – the

Site	Rules	Scenario	Question	Answer
				squamous in the subcarinal node supports the original interpretation. We have two choices as I see it – accept the squamous diagnosis and stick with it, or used the mixed carcinoma (adenocarcinoma with mixed subtypes) code, 8255. One could also argue for adenosquamous, but that is not clear from the original histology, though it may well have been the case, and I would prefer to reserve that code for tumors that are diagnosed as such, or are described as such (carcinoma with mixed adeno and squamous features). Calling the tumor squamous leaves a lot of information out. So, 8255 is the best place for this case
Unknown	MP	How many primaries are to be coded for a collision tumor that consists of two histologic types? Example: collision tumor with adenocarcinoma and squamous cell carcinoma	MP Y/N	In researching this, we find "Collision tumors have been reported in various organs and they represent a coexistence of two adjacent but histologically distinct tumors without histologic admixture in an organ." Because these are separate tumors and not one mixed tumor, follow the MP rules for multiple tumors for the applicable primary site. In this case the patient would have two primaries, one coded to adenocarcinoma and the other to squamous cell carcinoma.

Site	Rules	Scenario	Question	Answer
Urinary Sites	Hist	Bladder biopsy, single tumor: High Grade Urothelial Carcinoma, predominantly small cell type, with focal squamous differentiation.	What is the correct histology code?	Ignore "focal" squamous diff. Small cell is not a more specific type of urothelial carcinoma. Use Rule H8 and code the higher number, 8120.
Urinary Sites	Hist	Dx: mixed urothelial papillary and small cell neuroendocrine carcinoma of the bladder? Per SINQ 20041104, for pre-2007 cases, we would code histology to combined small cell carcinoma [8045]. The SINQ comment states that "this mixed carcinoma is both urothelial and small cell. It is important to capture the small cell information in the code because the prognosis for small cell is different from pure urothelial carcinoma."	The MP/H rules for urinary tract do not include an instruction for use of a combination/mixed code. Working through the MP/H rules for our example case, we end up at rule H8, "code the histology with the numerically higher ICD-O code." Would histology for this case be coded 8130?	For a case diagnosed 2007 or later, use the MP/H rules. Use Rule H8 and code the higher number, 8130. ***Informational item:*** The logic behind the SINQ answer is correct. We will address combination codes for the bladder in future revisions.
Urinary Sites	Hist	TURB: invasive urotehlial ca, high grade, with predominant small cell/neuroendocrine and focal glandular differentiation. **Question:** How is histology to be coded for this case? (No rule to code a combo code).	Histology code	Ignore "focal" glandular diff. Small cell is not a more specific type of urothelial carcinoma. Use Rule H8 and code the higher number, 8120.

Site	Rules	Scenario	Question	Answer
Urinary Sites	MP	Pt dx with TCC invasive in 10-2004 and TCC, invasive 11-2007..... do you make a new primary for the 2007 path report? The registrar thinks that rule M6 is about a path report that had a 'combination" histology. She went on the rule M7, and abstracted a second primary. I wanted to bring it to your attention; if it can happen to one it could be many. I know the MPH rules did not change overtly the old MP rules; expanded yes to incorporate the papillary and transitional cell micropapillary. The registrar did not read the MPH rules to be equivalent to the old language for bladder: invasive bladder cancers, site codes C67.0 - C67.9, with histology codes 8120-8130, are the exceptions to the above rule. For these cancers, a single abstract is required for the first invasive lesion only.	MP Y/N	This is an important educational issue. It should be emphasized in all MP/H training materials and sessions. M6 covers papillary OR TCC OR papillary TCC OR a combination. M6 is used when these histologies are on one path report or on several path reports years apart. M6 covers situations where the patient had (for example) papillary tumor at diagnosis and then had a dx of TCC/urothelial. Because the histology for the 2004 and the 2007 cases are both listed in the M6 rule, this case is a single primary. ***Note:*** we did not stop at M5 because these were both invasive tumors.
Urinary Sites	MP	Urinary bladder transurethral resection, posterior wall: Urothelial (transitional cell) carcinoma, low grade, with focal invasion of lamina propria. Prostatic urethra, transurethral specimen: Urothelial (transitional cell) carcinoma, low grade, w/focal invasion of submucosa	MP Y/N	Follow Rule M8 and abstract a single primary.