**NATIONAL INSTITUTES OF HEALTH**
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**SURVEILLANCE, EPIDEMIOLOGY AND END RESULTS (SEER) PROGRAM**
**2007 Multiple Primary and Histology Coding Rules**
**Breeze Session-Melanoma Rules**
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**SLIDE ONE**
Hello and welcome to the malignant melanoma presentation. I want you to notice that this is malignant melanoma for the skin sites only; in other words, for the C440-C449 sites only. That's why we have called it "Cutaneous Melanoma" on our presentation to make sure we emphasize that this is only for C440 through C449.

**SLIDE TWO**
One of the things I want to call your attention to is that if you look at the Equivalent Terms and Definitions we have a number of definitions that talk about a melanoma [term] being "reportable" or "not reportable." We've gotten a number of questions on different things like "evolving melanoma" asking whether these terms are reportable or not. We decided that in the Definitions list we would add the "reportable" or "not reportable" data behind each of the definitions. I think you'll probably find that quite helpful as you're doing your casefinding.

**SLIDE THREE**
The second thing I want to call your attention to in the Equivalent Terms and Definitions is the "Familial Atypical Multiple Mole Melanoma Syndrome" (FAMM or FAM-M). This is a very particular syndrome that does run in family members. Those family members have multiple moles. Most people who have been diagnosed with this syndrome are checked by a dermatologist twice a year. During their lifetimes they will develop a number of multiple melanomas in moles. It is a very unsettling case if you don't know that there is a familial syndrome involved with this.

**SLIDE FOUR**
Next, before we start talking about the rules I wanted to make sure you understood the regressing melanoma decision made by the Task Force. "Regressing melanoma" is something you hear very often. You see it documented on pathology reports. It talks about the fact that the melanoma was once more invasive than it is at the time that it's excised; in other words when they looked at this pathology specimen they could tell that at one time that melanoma had been deeper and had more invasion than it has presently. This happens frequently with melanomas. It is prognostically significant because the staging will be off. You will stage it as a lesser stage than it had been or perhaps should have been. Many times these melanomas don't behave in the same way as the other cohorts in that stage. So it's a really good explanation of why this particular case might be an outlier when plotting survival.

The problem is that the term is really not a histology. It's a physical attribute that's prognostically significant. The Task Force decided that since it is not a histology we would not record this histology in the Histology Data Item. We decided to talk to the Collaborative Staging (CS) Steering Committee about making "regressing" part of the site-specific factors. We felt that was a more appropriate place for this information to be captured. It would be associated with the staging, which indeed it is, and collecting the data in that way we would have that information to give to physicians. We would tell them the actual histology of the melanoma and provide the additional information that at the time of excision it showed signs of regression. Capturing the data in this manner would be the "better of the two worlds."

**SLIDE FIVE**
Much in melanoma depends upon the extension, i.e. how far the melanoma has penetrated in the cells. The rules talk in one place about the "most invasive tumor." So in the Equivalent Terms and Definitions" we give you the skin layers:
● the epidermis which is the outer layer of skin
● the dermis which is the underlying layer
● and then there is the hypodermis or subcutis or subcutaneous fat—it's known by several names.

**SLIDE SIX**
Now that we have gone over a few of the items from the Equivalent Terms and Definitions we'll start on the rules themselves.

**SLIDE SEVEN**
You have now become accustomed to the first module which is called "Unknown if Single or Multiple Tumors" or in this case, "Melanomas" [Module].

**SLIDE EIGHT**
M1 is the default rule. It is used when it is not possible to determine if there is a single or a multiple melanoma. You will opt for a single melanoma and abstract as a single primary. Again, there is the Note or warning saying: "Use this rule only after all information sources have been exhausted."

**SLIDE NINE**
The second Module is for "Single Melanoma."

**SLIDE TEN**
It starts with rule M2: A single melanoma is always a single primary.

**SLIDE ELEVEN**
The next Module is "Multiple Melanomas."

**SLIDE TWELVE**
When we get into multiple melanomas we will encounter one of the most obvious problems we have in doing multiple melanomas. There were two big problems. This rule [M3] says: "Melanomas in sites with ICD-O-3 codes that are different at the second (C**x**xx), third (Cx**x**x) or fourth (Cxx**x**) character are multiple primaries." This tells us that for skin the subsites are a new primary. That sounds good until you look at the actual subsites; they are huge classifications. You have one subsite for ear (0); another for eyelid (.1); one for face. Then you have a subsite for the torso, which is a lot of territory: chest--right side/left side; back-- right side, left side. We knew that people had been coding melanomas differently. Some people said if the melanoma was on the right side and another was on the left side they were two primaries. We also had registries that called that a single primary. So the Task Force had to decide if laterality constituted another primary. They had to make the instructions very clear so all would code in the same way. That part wasn't too difficult.

**SLIDE THIRTEEN**
Rule M4 says, "Melanomas with different laterality are multiple primaries." We have a right laterality; we have a left laterality. We also have a Note saying a midline melanoma is a third laterality. It really is different than left or right.

**SLIDE FOURTEEN**
In other words, if you have a melanoma on the right side of the chest and another at the midline, they are different lateralities so they are going to be multiple primaries.

**SLIDE FIFTEEN**
That was relative easy; relatively not challenging but we were still left with the challenge of having a melanoma on the right chest and a melanoma on the right groin abstracted as a single primary. So we discussed having another Data Item that could capture posterior and anterior but that would not solve the chest and groin problem or upper and lower back. The decision was made to actually use the Multiplicity Counter so people could tell when looking at a case, for example, that we were saying there was a single primary; on the upper back there were actually two melanomas. Collecting the data this way we would not impact incidence and we could find those cases that have more than one melanoma with the same site code. By looking at data as it comes in we may add codes or change the rules and still be able to explain the jump in cases without having it documented as an increase in the incidence of skin melanomas. This was the choice made by the Task Force. We will count laterality as one criterion for deciding whether or not a tumor is a different primary. We will continue to count subsites as we always have but we will use the Multiplicity Counter to count multiple tumors in that subsite so we can perhaps do better in the future. In the meantime, we can identify all of these cases that have multiple tumors in the same subsite.

**SLIDE SIXTEEN**
Let's go on to M5 that talks about another problem. It says, "Melanomas with ICD-O-3 histology codes that are different at the first (**x**xxx), second (x**x**xx) or third number (xx**x**x) are multiple primaries." This rule means that, for example, a melanoma and an adenocarcinoma would be a different primary; a melanoma and a squamous cell would be a different primary.

**SLIDE SEVENTEEN**
Rule M6 says, "An **invasive** melanoma that occurs **more than 60 days after** an **in situ** melanoma is a multiple primary." This is a rule that you have seen in all of the other sites. It tells you that we need to report the invasive melanoma when it happens.

**SLIDE EIGHTEEN**
We are doing this to make sure we count the invasive melanoma in the incidence. We want to make sure we record all of the information from that invasive melanoma.

**SLIDE NINETEEN**
We also tell you that you will report that as another primary even if the physician states it is a recurrence or progression of disease, which will probably be very rare with melanoma.

**SLIDE TWENTY**
Rule M7 says, "Melanomas diagnosed **more than 60 days apart** are multiple primaries." In all the other sites we have presented to you we have talked about looking at the data and seeing overwhelming proof in the data that these time limits were accurate. We would talk about tens of thousands of cases and having maybe one hundred that occurred within the time limit we had given you such as one year or three years, for example. Melanomas are not the same. We do see melanomas recurring within a year. We did not find anything in the literature or in the data itself that gave us any substantive reason to change the time period from 60 days. It is the same as it has always been.

**SLIDE TWENTY-ONE**
M8 is the default rule. "Melanomas that **do not meet any** of the above **criteria** are abstracted as a single primary." Anything that was not taken out using the previous rules will always be a single primary.

**SLIDE TWENTY-TWO**
We added a Note because we really wanted to remind people to: "Use the Data Item 'Multiplicity Counter' to record the number of melanomas abstracted as a single primary." For melanomas this will be a very important Data Item. We want to make sure, for example, that if we have a melanoma on the right chest and another melanoma on the right groin within 60 days it will be coded as a single primary because the site codes are the same; they are both skin and trunk. But

we can collect the information that there were two melanomas in the Data Item "Multiplicity Counter."

**SLIDE TWENTY-THREE**
Note 2 in rule M8 says, "When an invasive melanoma follows an in situ melanoma within 60 days, abstract as a single primary" and code it as invasive. Note 3 says that all cases covered by this rule end up being the same site and the same histology because you won't get to M8 unless they are.

**SLIDE TWENTY-FOUR**
We give you some examples here. It is unusual for most registrars to end up at the default rule. You can't point to this rule and say the site matches, the histology matches, this is the rule I'm going to use. Instead, this is a rule by exclusion. We have given you a number of examples. We want to make sure that people don't code just using the examples. If they do that they will have errors which could be major ones.

**SLIDE TWENTY-FIVE**
Example one says if there was a solitary melanoma on the left back and another solitary melanoma on the left chest this would be a single primary. You should fall through and end up using rule M8.

Example two is: a solitary melanoma on the right thigh and another solitary melanoma on the right ankle would be a single primary.

Are there any questions about the Multiple Primary Rules?

Okay.

**SLIDE TWENTY-SIX**
We will continue with the Histology Coding Rules.

**SLIDE TWENTY-SEVEN**
The first Module of course is "Single Melanoma or Multiple Melanomas Abstracted as a Single Primary." The Single and the Multiple Melanomas Modules were really the same thing. Although you are used to seeing two modules it seemed redundant to make two modules when the rules were exactly the same so we put them together. So for this site only you have a single module and you will use that if it is a single melanoma or if it's a multiple melanoma that you're abstracting as a single primary.

**SLIDE TWENTY-EIGHT**
The first rule says if there is no pathology or cytology specimen you code what the physician documents.

**SLIDE TWENTY-NINE**
The priority for using documents to code would be first documentation in the medical record that refers to the pathologic or cytologic findings. So if you have documentation that says, "The patient had a melanoma removed in the office and it was a _____ _____melanoma," you would code exactly what they said. If the physician said the pathology showed it to be a certain type of melanoma, that's what you would code. If it refers to the path report you would use that documentation in preference to anything else. If you don't have that documentation then a physician's reference to the type of melanoma could be used, for example: "The patient was admitted for a wide excision of a nodular melanoma." They are referring to the type but not to the path report. The third choice in the priority order for using documents to code histology is a PET scan.

**SLIDE THIRTY**
The Note tells you to code the specific histology when it's documented.

**SLIDE THIRTY-ONE**
Rule H2 says to code the histology from a metastatic site when there is no pathology or cytology specimen from the primary site. This happens with melanoma; this is probably one of the sites where you do see this happen frequently. There will be a positive lymph node then the lymph node will show a malignant melanoma. So you code the histology from the metastatic site if there is no cytology or pathology specimen from the primary site. And, of course, you do code the behavior as /3 for malignant.

**SLIDE THIRTY-TWO**
H3: Code the histology when only **one histologic type** is mentioned. If the path report says nodular malignant melanoma you code that histology.

**SLIDE THIRTY-THREE**
H4: you code the invasive histologic type when there are both invasive and in situ components.

**SLIDE THIRTY-FOUR**
H5:" Code the histologic type when the diagnosis is regressing melanoma and a histologic type." For example, if the diagnosis is nodular melanoma with features of regression, you code the histologic type—the nodular melanoma.

**SLIDE THIRTY-FIVE**
There is an ICD-O code for "regressing melanoma" and H6 tells you when you would use that. You would code 8723 (malignant melanoma, regressing) when that's the only diagnosis you have, when it says "regressing melanoma" or "malignant melanoma with features of regression." If you don't have any specific information about the type of melanoma then you would code the regression and only then.

**SLIDE THIRTY-SIX**
H7 says, “Code the **histologic type** when the diagnosis is **lentigo maligna** melanoma and a histologic type.” The lentigo maligna actually talks about the physical growth pattern of the melanoma; it’s similar to talking about a regressing melanoma. It is not a histologic type. It talks about the appearance and the way the melanoma is growing. So when you have a diagnosis of a certain type of melanoma, for example, a nodular lentigo maligna melanoma, you code the nodular.

**SLIDE THIRTY-SEVEN**
[H8] You use the lentigo maligna code when all you have is lentigo maligna melanoma. In other words, you don’t have a histologic type to code. You know it’s a melanoma, of course, because the code tells you so. But if the best information you have is lentigo maligna melanoma then you would code the lentigo maligna, the 8742. But if there’s any histologic diagnosis that would take precedence.

**SLIDE THIRTY-EIGHT**
H9: Code the most **specific histologic term** when the diagnosis is melanoma, NOS (8720) with a single specific type.

**SLIDE THIRTY-NINE**
Now, remember that, “the specific type for **in situ** lesions are identified by pattern, architecture, type, subtype, predominantly, with features of, major, or with _____differentiation.”

**SLIDE FORTY**
The specific type for **invasive** lesions does not use the first two terms we talked about so you will not see “architecture” or “pattern” for the invasive lesions. They [invasive lesions] are identified as “type, subtype, predominantly, with features of, major, or with ____differentiation.”

**SLIDE FORTY-ONE**
H10 is our default-coding rule again. We have gone through a number of melanomas. We have talked about the regressing melanomas. We have talked about the lentigo maligna melanomas. We have talked about the melanoma NOS (not-otherwise-specified) with a specific melanoma and now we are down to the default-coding rule. That rule says if none of the other rules fit your case then you code the histology with the numerically higher ICD-O-3 code.

That is the end of the multiple melanomas. They are not the most difficult. The biggest challenge was in addressing how to code the laterality-- the skin codes for the large sites such as the trunk, which is one large subsite.

Are there any questions about the malignant melanoma codes?

Question 1

1. Let's say you have a malignant melanoma which is coded 8720. In the same subsite you also have a lentigo melanoma and that would be coded 8742. So those would have different histology codes so would that be coded as two primaries?

Response to Question 1

*That's one of the reasons we spent some time talking about lentigo maligna and the fact that it does not describe an histology. So do you have two histologic types? No. You have a histologic type. You have your first melanoma and then the second one is also a melanoma but it's just talking to you about its growth pattern. So it's very important to remember that lentigo maligna is a growth pattern, not a histologic type.*

Question 2

Carol, how would you get to that though by just going through the Multiple Primary Rules first?

Response to Question 2

*You know you're right; that should be in the Multiple Primary Rules. We need to add that because a lentigo maligna and any type of melanoma are not a different primary. That's similar to regressing, which is not a type of melanoma either and you don't want to code a different primary based on a growth pattern as opposed to an histology. That's a really good catch.*

Question 3

Would the same hold true for the superficial spreading melanoma as well?

Response to Question 3

*Yes. We're going to have to look at that because we're going to have to make up a rule that says these growth patterns are not to be used to decide whether or not you have another primary.*

Question 4

I think our group is also saying that if you have, for example, a melanoma, NOS and any other kind of melanoma that that would be two primaries. What if you had a melanoma in situ, NOS and an invasive superficial spreading melanoma both in the same subsite?

Response to Question 4

*If you have them in the same subsite they're still going to be a single primary and you'll code the invasive.*

Follow-up to Question 4

What rule would you use? I would stop at rule 5 saying they are different.

Response to Follow-up to Question 4
*Yes, I know. We have to put something in that tells you not to do that; not to make multiple primary choices based on a growth pattern.*

Question 5
Regarding the same issue, on page 43 under your Equivalent Terms and Definitions your definition of **lentigo maligna** it says it "is a specific histologic type of in situ melanoma" so you may want to clarify that.

Response to Question 5
*We will go through all of those. The definition of lentigo maligna says it's a specific histologic type of in situ. We will go through and clarify these issues at the beginning of the Practicum. I need to do some research. I will have this ready for the Practicum.*

Question 6
Carol, I have a question. What would you do if you had a case that's described as a malignant melanoma with partial regression?

Response to Question 6
*If it's described as a malignant melanoma with partial regression it's coded as a regressing melanoma. You don't have a specific histologic type so it's going to be defaulted to a regressing melanoma code. You don't have to worry about the degree of regression.*

Question 7
Carol? I have a question on the Multiplicity Counter. The patient had a melanoma in 2006 and then in the same subsite in 2007. Is that one or two?

Response to Question 7
*If it's more than two months that's going to be counted as another primary.*

Okay. So is do you count it in the Multiplicity Counter?

*No. That's only if more than one melanoma is counted as a single primary on that abstract.*

Okay. Thank you.

Are there any other questions?

When we start the Practicum we will begin with discussing the regressing melanomas, the lentigo malignas and the lateral growth. We will research the answers and provide those at the Practicum. Thank you, everybody. We appreciate your time. We will see you again for the Practicum.