SEER Inquiry System - Report

Produced: 04/23/2024 3:25 PM

Question 20091084

References:

2007 SEER Manual, 69

Question:

Primary site--Colon: How do you determine the correct subsite when there is conflicting information in different reports? Are there priority rules for coding subsite for sites other than Head and Neck? See Discussion.

Discussion:

The path report for a hemicolectomy says, " Specimen: left colon..." and the microscopic says, "...received in formalin designated left colon..." The Operative procedure report says, "Postoperative diagnosis - splenic flexure tumor." The text of this report says, "Mobilizing the splenic flexure mass was incredibly difficult..." and then goes on to describe exactly how and where it was resected. The discharge summary says adenosquamous carcinoma of the splenic flexure. SINQ20051010 says to use the pathology report first, but this was written before the new MP/H rules.

Answer:

Use the operative report information to code primary site in this case. It is more accurate.

The operative report is usually a better source of location information compared to the pathology report. The pathologist can only reiterate the location as it was reported to him/her.

The 2007 SEER manual states "Unless otherwise instructed, use all available information to code the site," page 69.

Cancer Site Category:

Colon

Data Item Category:

Primary site

Other Category:

N/A

Year:

2009