

**NATIONAL INSTITUTES OF HEALTH  
NATIONAL CANCER INSTITUTE  
SURVEILLANCE, EPIDEMIOLOGY AND END RESULTS (SEER) PROGRAM  
2007 Multiple Primary and Histology Coding Rules Breeze Sessions  
Malignant Brain Rules  
March 19, 2007**

**SLIDE ONE**

Hello, everyone. This will be the last of the site-specific rules training sessions. We will have one more training on the New Data Items but this is the last training on the site-specific rules. These are the rules for the Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary Gland, Craniopharyngeal Duct and Pineal Gland. One of the things I want all of you to be aware of is that these rules were reviewed by the physician member of the Benign Brain Tumor Committee, by the CBTRUS Executive Board which is a Central Brain Tumor Registry in the United States and also by the AJCC [Brain] Site Team.

**SLIDE TWO**

Now the first thing I want to call your attention to is the Equivalent Terms, Definitions, Charts and Illustrations. I want to make sure that everyone is aware that there is a separate set of rules for the Benign and Borderline Intracranial and CNS Tumors. Do not use this set of rules for the benign tumors.

**SLIDE THREE**

There are two definitions that have caused a lot of problems for folks: PNET and pPNET. The PNET is primitive neuroectodermal tumor. It can be either central or supratentorial. Those terms refer to brain subsites where the tumors are located; pPNET is not a brain primary. When you see that designation it will not be coded to the brain. PNET is primary to the brain and the PNET tumors include the medulloblastoma, pineoblastoma, ependymblastoma, retinoblastoma, neuroblastoma, esthesioneuroblastoma, medulloepithelioma and ganglioneuroblastoma.

**SLIDE FOUR**

We used the World Health Organization (WHO) Classification of Tumors of the brain and central nervous system to devise Chart 1. We want you to know that this Chart is not a listing of every tumor that could possibly arise in the brain or the central nervous system. Any histologies that are not listed on this Chart would be extremely rare.

**SLIDE FIVE**

The Chart itself reads from top down. In other words, the top is the less specific and those tumors on the bottom of the Chart at the end of the "tree" are more specific. There is a difference in this site from all other tables. You will see that you have a series of circles that go across the top of the "tree." Those circles are not actually histopathologic classifications. They are groups of tumors. We put

them there because physicians will frequently speak about these groups. For example, they will talk about glial tumors. We thought that it would be helpful if you could look at these families and see which tumors actually belong to those families. So remember that these circles are not actual histopathologic types. You won't find a code in the ICD-O-3 to code them. They are merely a roadmap for you so you can see the groups of tumors that a physician would be referring to.

One of the special things about Brain tumors—and we'll come to a rule that tells you about this—is that every one of the tumors in the glial branch can recur as a glioblastoma multiforme. That's because a glioblastoma is a malignant, rapidly growing astrocytoma of the central nervous system. The glioblastoma multiforme is an undifferentiated glioblastoma. What actually happens is that one of the tumors on this branch can become more and more undifferentiated over time. So the first diagnosis can be any one of the glial names and a recurrence can happen that will be called a glioblastoma multiforme because the cells have become so undifferentiated that the pathologist can no longer pick out the specific type of glial tumor. In the rules you are told that glioblastoma multiforme is coded to the tumor that preceded it; in other words it's not treated as a new primary. You would not change that histologic classification. You would leave it coded to the type of glial tumor it started as originally. I don't mean to confuse you; that's the only difference in this entire Chart. The Chart itself works the same as every Chart you have looked at.

This is a line that starts to descend and as it descends the tumor names become more and more specific. As you continue down the line this is the same lineage. Anytime you have this name, it would be related to all of the tumors that came before it in the line. So, I am not telling you that there are great differences in the Brain tumor "tree." The only difference is that you do have the family names in circles above the actual histopathologic names and then secondly there is one very strange happening: the fact that these tumors do become undifferentiated—the glial branch. Over time they can present as a glioblastoma multiforme.

### **SLIDE SIX**

As I told you, we based the entire "tree" that you just saw on the *WHO Classification of Tumors* of the brain and central nervous system. Although it is not a complete listing you may never see a histology that is not on this "tree."

### **SLIDE SEVEN**

We gave you another Chart or break out. On this particular Chart are the "Non-Neuroepithelial" tumors, so they are different than the tumors you looked at on Chart 1. Again, the Chart reads from top down, from the least specific to the more specific. The circles show classifications, family names if you will or group names. You can see the terms "Peripheral Nerve" tumor; "Germ Cell" tumor and "Meningioma, malignant." Under these family names you will see the specific tumors that are part of that group.

## **SLIDE EIGHT**

Having looked at the “tree” we will start with the actual Multiple Primary Rules.

## **SLIDE NINE**

You are by now familiar with the fact that the first module is titled: “Unknown if Single or Multiple Tumors.” You use that Module, for example, if a central registry gets a pathology report of a biopsy followed by a hospital report of a resection. They really have no proof that it was a single tumor. Or, perhaps a hospital registry has an H&P documenting a biopsy in the physician’s office. The patient has another biopsy in another facility or a resection. The registrar cannot confirm whether the patient had a single tumor or multiple tumors.

## **SLIDE TEN**

You are looking at the rules in the Matrix format. In looking at this format you see that the two important things are site and behavior. Rule M1 says if the site is Brain and you have an invasive and either a benign or an uncertain borderline tumor, these would be multiple primaries in all cases.

## **SLIDE ELEVEN**

The next rule, M2, is actually a Note and it says, “Use this rule only after all information sources have been exhausted.” The actual rule is used when you do not know if this is a single or multiple tumors. This would be the default for all Brain and CNS sites. You have a default and it says this is a single tumor. So again you would use the rule only after all information sources were exhausted but you would default to a single tumor and it would be a single primary.

## **SLIDE TWELVE**

Now the second Module is the Single Tumor Module.

## **SLIDE THIRTEEN**

It starts with rule M3. And rule M3 has only one major statement: There is a single site meaning it is in the Brain only or it’s a single tumor and the tumor is not described as a metastasis. Now, the tumor may overlap onto or extend into adjacent or contiguous sites or subsites; it is still single and it would always be a single primary.

## **SLIDE FOURTEEN**

We now go on to the Multiple Tumors Module.

## **SLIDE FIFTEEN**

This Module starts with rule M4. This says the multiple tumors may be a single primary or multiple primaries. So don’t make the assumption that when you come into the Multiple Tumors Module that all of the tumors would be a multiple primary. The first says if you have an invasive brain tumor with either a benign or a borderline tumor that would be a multiple primary.

## **SLIDE SIXTEEN**

Rule M5: This particular rule talks about subsites. It says that subsites of the Brain are not separate primaries. It [rule M5] says if the topography codes are different at the second (Cxxx) or third (Cxxx) character they are multiple primaries but the subsite, the last (fourth) character, would be the same primary. So, the difference in the first and the second number of the topography code talks about, for example, a tumor in the Brain or in the CNS and a separate tumor in another site would be multiple primaries. But Brain itself is treated as one organ. There are not multiple primaries if you have, for example, tumors in the right lobe and in the left lobe or in different lobes of the Brain. So any of the subsites are not a separate site for Brain.

## **SLIDE SEVENTEEN**

This is the rule [rule M6] that we talked about when we looked at the Chart. Glioblastoma or glioblastoma multiforme (9440) that follows any glial tumor is a single primary. It refers you to Chart 1 so you can look at the entire glial family and see whether or not the previous tumor was a glial tumor. A glioblastoma multiforme again is a malignant rapidly growing astrocytoma of the central nervous system. The neoplasms grow rapidly. They invade extensively and they occur most frequently in the cerebrum of adults. A glioblastoma multiforme is an undifferentiated glioblastoma. To recap, if a patient has a glial tumor, then subsequently has a glioblastoma multiforme it is not a new primary. It is a recurrence of the previous tumor. Any of the glial tumors can recur in a more differentiated state and remember the other thing: in the Brain there is no timing rule. So it doesn't matter if the tumor recurs one year later or five years later or twenty years later; it would still be a recurrence of that original glial tumor.

## **SLIDE EIGHTEEN**

Now M7 says tumors with histology codes on the same branch in Chart 1 or Chart 2 or recurrence or progression or any reappearance of histologies on the same branch in Chart 1 or Chart 2 is always the same disease process. So you need to use Chart 1 and Chart 2. You need to follow the branches. If you are going in a straight line down you know that this is the same disease. For example, if a patient has an astrocytoma and ten years later the patient is diagnosed with a glioblastoma multiforme, this is a progression or a recurrence of the earlier astrocytoma. Again, any of these tumors that are on the same branch on Chart 1 or Chart 2 will be a recurrence or progression of disease as opposed to a new primary.

## **SLIDE NINETEEN**

Rule M8 says tumors with histology codes on different branches on Chart 1 or Chart 2 are multiple primaries. So again you want to go back to the Chart. When we talk about different branches, we are talking about the tumors descending from a different line or they are on different branches parallel to each other; they may descend from the same one. Let me go back to the Chart. When we say

they are on different branches, if you notice, this comes down and forms one branch. This line coming down forms another branch. Although they are both non-neuroepithelial these tumors and these tumors are on different branches of the table and they would be different primaries. The malignant peripheral nerve sheath tumor is non-neuroepithelial as is the choriocarcinoma but they are on different branches. So if these two specific entities occurred they would be counted as different primaries. When we say tumors with histology codes on different branches on Chart 1 or Chart 2 we mean that they are either descending from a different type of tumor or they are parallel to each other on different branches.

### **SLIDE TWENTY**

M9: "Tumors with histology codes that are different at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries." That's a default rule. If one of the tumors is not on either Chart 1 or on Chart 2 then you would use the histology codes to determine if they were different primaries or the same primary. You will seldom use this but it's a default rule. You use this rule if you have that rare occurrence where at least one of the tumors is not on either Chart; you would use the ICD-O-3 histology codes to determine whether or not they are the same primary.

### **SLIDE TWENTY-ONE**

Now M10 is your huge default rule. It says anything that did not meet any of the above criteria would be a single primary. There are Notes here that are important. They tell you that neither timing nor laterality is used to determine multiple primaries for malignant intracranial and CNS tumors. For example, if the patient is treated for an anaplastic astrocytoma in the right parietal lobe and then three months later is diagnosed with a separate anaplastic astrocytoma in the left parietal lobe this is one primary because laterality is not used to determine multiple primary status. The second example talks about multi-centric Brain tumors that involve different lobes of the Brain. If they do not meet any of the above criteria they are the same disease process.

Before we go on to the Histology Coding Rules, are there any questions about the Multiple Primary Rules?

### **SLIDE TWENTY-TWO**

Okay. We will continue on with the Histology Coding Rules.

### **SLIDE TWENTY-THREE**

The Histology Coding Rules start with the Single Tumor Module.

### **SLIDE TWENTY-FOUR**

Rule H1 is used when there is no pathology or cytology specimen or the pathology or cytology report is not available. It is used only when you don't have a specimen or you cannot get access to the pathology or cytology report. It gives

you a priority for coding the histology in the absence of a pathology report. It says to first use documentation in the medical record that refers to pathology or cytology findings. That would be a physician saying, "The patient had a resection of a Brain tumor that showed an astrocytoma grade II." The second choice is the physician's reference to the type of cancer in the medical record so that would be the physician saying, "The patient is admitted with a known history of astrocytoma." They are talking about the histology but not referencing the pathology or cytology report. The third priority would be CT or MRI scans.

#### **SLIDE TWENTY-FIVE**

This rule tells you to code the specific histology when it's documented. So if that CT scan or MRI talks about actually seeing a glioblastoma, you code it as a glioblastoma. The third choice is to code the histology to 8000 for cancer/malignant neoplasm NOS as stated by the physician when nothing more specific is documented.

#### **SLIDE TWENTY-SIX**

H2 is used if there is no biopsy of the primary site. That's not going to happen often in Brain but for the other CNS sites it is possible. If you do not have a pathology or cytology specimen from the primary site you would code the histology from the metastatic site and code the behavior as /3.

#### **SLIDE TWENTY-SEVEN**

H3 is about histology. It says if you had at least two of the following cells or differentiation: if you have astrocytoma, oligodendroglioma or ependymal histologies use code 9382/3, mixed glioma. When you see a pathology report that mentions astrocytoma and ependymal cells for example then you would use this mixed glioma code; and only [use this rule] when you have two of these three histologic types present.

#### **SLIDE TWENTY-EIGHT**

H4 is the rule that says if there is only one type of histology present, of course you code that histology.

#### **SLIDE TWENTY-NINE**

H5 is the version of the old NOS and a more specific rule. You have to be very careful here to code the more specific only when the two terms are on the same branch. So it says when you have a non-specific term and a specific term or type that are on the same branch [in Chart 1 or Chart 2] you code the more specific type. You want to use Chart 1 and Chart 2 when you have a pathology report that gives you more than one histology code. If you have reached H5 you will go to the histology tree and you will make sure that both of those terms are on the same branch and you will code the specific type, in other words the term that is the farthest down the branch.

### **SLIDE THIRTY**

Now H6 is again a default rule. It says it is a default rule for any cases that did not meet the criteria for the first five rules. So if you went through rules H1 through H5 and that case did not meet any of those rules then you would code the histology with the numerically higher ICD-O-3 code and only then.

### **SLIDE THIRTY-ONE**

Next we have the “Multiple Tumors Abstracted as a Single Primary” Module.

### **SLIDE THIRTY-TWO**

We start with rule H7 that says if no pathology or cytology specimen is available or if you are not able to access the pathology or cytology report you code the histology documented by the physician. The priority of documents to use to code the histology in the absence of a pathology/cytology specimen or report is given. The first priority is to code from the medical record and use the documentation that refers to pathologic or cytologic findings. If that is not available, use the physician’s reference to the type of cancer; third [under the first point in the priority of documents] use CT or MRI scans.

### **SLIDE THIRTY-THREE**

The second priority is to code the specific histology when documented. There used to be an old rule that said unless you have a path report you couldn’t code the specific histology; that’s not true now. If the MRI or CT gives you a specific histology, code it. The third priority is to code the histology to 8000 (cancer/malignant neoplasm NOS) as stated by the physician when nothing more specific is documented.

### **SLIDE THIRTY-FOUR**

H8 talks about not having a pathology or cytology specimen from the primary site but you do have the histology from the metastatic site. Of course you would code that histology and you would add a /3 for malignant behavior to the histology code.

### **SLIDE THIRTY-FIVE**

H9 says if you have only one type or one histology you would of course code that histology. So, for example, if you simply had astrocytoma, you would code astrocytoma.

### **SLIDE THIRTY-SIX**

H10 again is the version of the previous NOS and a more specific rule. Use Chart 1 and Chart 2. Identify the histology and as long as they are on the same branch on that Chart you code the specific histology. The most specific histology is the one farthest down the branch or closer to the bottom of the tree.

## SLIDE THIRTY-SEVEN

H11: again we have the default rule that says if none of the above conditions are met--I have gone through all of the rules in the Multiple Tumors Module and none of them fit the case I am abstracting--so I will code the histology with the numerically higher ICD-O-3 code.

## SLIDE THIRTY-EIGHT

Are there any questions?

### Question 1

I was wondering if you could define with one more example for Chart 1 the definition of a branch? I am running into this issue when I train.

### Response to Question 1

*Yes. Absolutely. I think that's one we have a lot of questions about. Chart 1 is a little more complex than Chart 2.*

Can I give you an example? I am looking at Chart 1.

*Can we go to Chart 2 since I am having problems getting back to Chart 1?*

Okay. But it's kind of difficult because as you say it's less complex than Chart 1. So if you are looking at the top left hand corner of Chart 1 you see Embryonal Tumors [in the oval]. And we have 5 boxes. If you had, for example, an atypical teratoid tumor and medulloblastoma those are on two different branches. Is that correct? [Yes] Okay. So they would be considered separate primaries.

*Exactly. If you use this branch as an example, if I were to go to the very bottom I could follow the line all the way up to the least specific. That means that I am following a branch down, down and down so that is a branch. However, when these branches divide, for example, here and here these two are not related to each other even though they come from the same parentage, if you will. They are from the same lineage, they are all embryonal but if you had any two of these they would be multiple primaries because they are on different branches. The tree branches out. If you were to think of it as a family tree, for example, with brothers and sisters they would be different families even though they have the same parent cells as it were. So starting on here again we see that we can follow all the way down and then we have three branches. As soon as we have these three branches, this, this and this are now different. These would be different primaries because they are now on different branches. Every time this happens you form branches on the tree and even though you can go to the most distant relative you may say and they are related here. They are not related to each other any longer; this is no longer the same tumor [when they are on separate branches]*

Are there any other questions?



## Question 2

I have a question. In H3 it says if you have at least two of the following: astrocytoma, oligodendroglioma or ependymal you code it to 9382/3, mixed glioma. How does that get coded to a mixed glioma when the ependymal is not on the same branch as the glioma?

## Response to Question 2

*They are not and you are correct. It is rather odd that this rule is trying to relate them. The reason we have this coded this way is they occur together rather commonly. Because they do so physicians wanted a way to record this tumor separately from a pure tumor. If we recorded it as a pure tumor we would record it as a single tumor. But those histologies are mixed in that one tumor. The physicians really did not want to code this to the highest histology code because then they would be grouped together with those pure tumors and they don't act like pure tumors. So the mixed code was made that could account for all of these tumors that have these non-related histologies occurring together. Does that answer your question?*

Yes. Thank you.

Are there any other questions?

## Question 3

I just wanted to clarify. Did you say that the multiple primary rule M6 is a change in these multiple primary rules? Where if you had a glioblastoma following a glial tumor they would be the same primary. Is that a change?

## Response to Question 3

*Yes, it is.*

Okay. So that would be starting with 2007 cases.

*Our physicians looked at our databases and saw that we had primary glioblastoma multiforme and they said that would occur rarely. If the patient never had a tumor before and their first tumor occurred in that very undifferentiated stage you would indeed code that but that is not the usual course. In most cases the patients had a glial tumor, then that tumor recurred or reappeared. The history of those tumors is that they tend to reoccur in a more differentiated state, very frequently as a glioblastoma multiforme. We were picking those up as multiple primaries. So this is new with the 2007 codes. We did not have that instruction prior to 2007 and no one is suggesting that you go back and change your whole database.*

Thank you very much. [*You're welcome*]

Are there any other questions?

#### Question 4

I have a question. I was wondering if you could clarify what the rules mean when they say "one type." If I was looking at glioblastoma with a sarcomatous component would that be considered one type?

#### Response to Question 4

*Yes it would because we don't code components.*

#### Follow up to Question 4

If it has a histology code in ICD-O-3 then it would be considered one type?

#### Response to Follow up to Question 4

*Yes. That's exactly correct. That's a very good way of putting it. Thank you.*

#### Question 5

Carol? I have a question on rule M7 about the Examples. Would you please explain that again with the example about the glial tumors? If they branch into a different branch they are still going to be the same tumor, is that correct, in the same glial branch of the tree? As the tree comes down and they branch off, it's still going to be the same tumor?

#### Response to Question 5

*If you can follow the number one tumor, the one that occurred first, then you follow down the branch. What this is saying is if you had a certain type of glial tumor and let's say we started here with diagnosis number one then years later the patient comes back in with another tumor. You looked up the other tumor and found it here so you know this goes directly up to the parent. So they are on the same line. You can follow that line from the less specific and continue to follow it all the way down to the more specific. Then you would not code it as a recurrence—that would be if you were going from here to here, for example. As long as it continues down that same line and the second one just becomes a more specific glial tumor then you code it as the same primary. Does that make sense to you?*

Yes. That makes perfect sense. Thank you.

Are there any other questions?

#### Question 6

Are we going to have a set of rules for Benign Brain, then?

### Response to Question 6

*Yes. The rules that you are using now have not been changed for Benign Brain. We were asked by NAACCR to write them in this MP/H Rules format. We will be sending them back to NAACCR at the end of this month. Then it will be up to NAACCR to distribute them. So there will be a set of rules for the Benign Brain tumors. We have done them in this same way—the Matrix, the Flowchart and the Text formats. Hopefully those will be available to you soon. I don't know how long it takes NAACCR to make them available after we turn them in. I would hope they would be distributed to you before the end of the year. This is not a change in the rules; it's just a change in how they are presented.*

### Question 7

Carol? Getting back to that rule M7—the Example you gave is not the one in the Book. It talks about an astrocytoma and then a glioblastoma multiforme and those are two different branches.

### Response to Question 7

*I will have to look that up. I don't have the Book in front of me at present.*

### Follow-up to Question 7

If you look at your slides, the Example in rule M7 says astrocytoma followed by glioblastoma multiforme ten years later. On this Chart 1 those are on different branches.

### Response to Follow-up to Question 7

*I see what you are talking about. I'm so glad you asked that; thank you. The glioblastoma multiforme is such an odd thing. It is the only time that the whole branch is affected. So the fact is that any tumor, any glial tumor starting here and every single one of these all the way across can recur as a glioblastoma multiforme. That is the only incident that breaks the branch rule. Every tumor on that glial branch, even the ones that separate out, can recur as a glioblastoma multiforme. Thank you so much. I obviously did not make that very clear.*

*So I guess, if you will, there are two differences in the Chart. We put family names up here to help you if you saw these designations in the Chart. Then the second difference is that the glioblastoma multiforme affects everything on this entire branch all the way around—every single one can recur as a glioblastoma multiforme. For everything else, keep these branches in mind. They work on every Chart; they work on every other type of Brain tumor. The glioblastoma multiforme is the one exception and the only exception.*

### Question 8

Carol, would that example then--the astrocytoma followed by the glioblastoma multiforme--actually be a better example for rule M6 than for taking care of the glioblastoma multiforme?

### Response to Question 8

Yes.

### Follow-up to Question 8

That would have been all right for taking care of rule M6 if you had those scenarios so by the time you get to rule M7 it really would be all the other ones besides the glial tumors left, right?

### Response to Follow-up to Question 8

Yes. *That's correct; they would all be gone by that time.*

Thank you.

*They are almost all out of the "gumball machine."* [Right]

Are there any other questions?

### Question/Comment 9

Carol, I have a comment? Do you think that for this glial branch, somewhere in the generic rules you could add a statement that you do not change the original diagnosis?

### Response to Question/Comment 9

*I think that is an absolutely excellent suggestion. We will put that in our next revision. There should be a statement in the General Rules.*

### Question 10

Can we also put in the next revision a move of the Example in rule M7 to rule M6?

### Response to Question 10

Yes. *We will do that.*

### Question 11

Carol, I have one more question about the branches. The branches confuse me. I just want to make sure. Under the "astrocytic tumors" where it does branch off to the astrocytoma NOS, the pilocytic astrocytoma and the pleomorphic xanthoastrocytoma—those again are three different branches, correct?

### Response to Question 11

Yes *they are.*

### Follow-up to Question 11

Okay. So if somebody was diagnosed with an astroblastoma at the same time as a glioblastoma multiforme then those would actually be two separate primaries if they were both diagnosed at the same time?

### Response to Follow-up to Question 11

*If they were separate tumors, then, “Yes.” They would be separate primaries.*

Okay. Got it! Thank you so much!

### Question 12

Carol, that one just threw me a little bit! If I could just bring forward my question: With glial tumors, any glial tumor can recur as a glioblastoma multiforme. [Yes] So I think the question just asked was if this was an astrocytoma and a glioblastoma multiforme at the same time they would be two separate primaries?

### Response to Question 12

*Okay. Let me go back. I will try to “zero-in” on a branch. Can we expand the screen somehow to make it larger?*

*If they were two separate tumors at the same time, they would be two separate primaries.*

### Follow-up to Question 12

What if the astrocytoma were diagnosed, then later the patient was diagnosed with glioblastoma multiforme?

### Response to Follow-up to Question 12

*That would be coded as a progression. The problem you would have if they occurred at the same time would be the fact that you could not relate those two tumors as one being the original. What happens, the reason we count these as progression is because those same cells are still present in the brain. Even though they have had a resection there were cells that were still viable. When those cells started to grow again and form a tumor they were actually more aggressive. They were more differentiated than the parent cell was. But if you have two tumors at the same time you don't know that they started from that same cell and you would have a problem there. That would be an extremely rare occurrence, you know, but if it did happen you would have to treat it as multiple primaries.*

I found that one a little confusing since we don't use the timing rule.

*That's correct. We don't. You would have a problem if you had two separate tumors synchronously at the same time because then—every time one precedes the other the assumption is that the second, the glioblastoma multiforme, actually started from cells from the original tumor. You would have a hard time making that case if you had two separate tumors that occurred at the same time.*

Thank you.

*You may never run into that situation you understand.*

### Question 13

Carol, just to clarify? So M6 does not apply to synchronous tumors?

### Response to Question 13

*Let me get back to rule M6 before I answer. The problem is, we say "following" a tumor and that's the crux of it. The Example given is if they are both diagnosed at the same time. That would not fit rule M6.*

### Follow-up to Question 13

Right. That's what I wanted to verify that the word "following" is really the important part of that rule.

### Response to Follow-up to Question 13

*Yes. It is. Absolutely.*

Okay. Thank you.

### Question 14

Carol? I have one more question. If you have an astrocytoma and a year later you have a giant cell glioblastoma are they two separate entities?

### Response to Question 14

*I have to tell you truly I am having a very hard time seeing my screen on the Chart. It is very blurry. It is really small for others at NCI-SEER also. I will have this Chart blown up so we can get a good representation here next time. I hate to answer when I can't read the writing on that Chart. The resolution is gone and the boxes are not readable now. When I start the cases I will have a couple of these made up so they are very clear and we will start with these questions. I would prefer to do that because I am hesitant to guess what's in the cells. My apologies. I don't know what happened to the resolution. We can't read the writing up on top.*

I will absolutely start the cases with this redone Chart and we will start with any questions you have.

Your suggestions are very helpful. Thank you so much. We will see you for the Practicum. The cases and answers are already posted to the Website.