

## **NCI-SEER BREEZE SESSION**

**January 29, 2007**

### **Other Sites Multiple Primary and Histology Coding Rules Practicum**

#### **CASE ONE-- OTHER SITES**

We're starting with case one. And case one is a prostate case and one of the more important things about this is that we wanted you to look at mainly the histology for this case. And for this particular case histology is listed as acinar adenocarcinoma and we wanted you to have just a little practice with the change for us to put in a rule that said acinar adenocarcinoma is coded to carcinoma, NOS. So the biggest challenge with this case was really not coding the multiple. If you go through your Multiple Primary Coding [Rules], you very quickly come up to the rule that says this is a single tumor and it comes out as a single primary because it's a single tumor.

And, secondly, on the histology: The first question you ask of course is, "Which Histology Module would I be using?" This is a single tumor so you would ask: "Is it in situ; in situ and invasive; or purely invasive?" In this case the tumor is completely invasive so you would go to the Single Tumor-Invasive Only Module and start with rule H8. As you progressed down the rules you would find rule H10 that tells you that acinar adenocarcinoma of the prostate is [code] 8140.

Are there any questions or problems with this case? Okay. We will go on to the next case, case number two.

#### **CASE 2-- OTHER SITES**

In case number two we would go through the same questions: "Is there a single tumor or are there multiple tumors?" Now, in this particular case, you have a left ovary with endometriosis so that's benign. You have a right ovary showing well-differentiated endometrioid adenocarcinoma and then the other thing of note is that a little further down in the "Comment" there is a note that says: "The patient had a hysterectomy and the hysterectomy showed endometrioid carcinoma. This happened approximately ten weeks prior to the ovarian surgery." And that means that we do have two primaries. This surgery only showed one tumor but there is a history of endometrial carcinoma so the primary number one would be endometrium. From what they tell us it certainly seems like it may be a single tumor; we're not too sure. And either way you would go—whether you decided it was a single invasive tumor or if you decided that you wanted to use the Unknown if Single or Multiple Tumors [Module] you would come to the same conclusion that the endometrium is a single primary. It would be coded to endometrioid carcinoma because that's the only information that you're given; that's 8380/3.

Then the ovary is a single tumor as far as we can see. It says, "There's a well-differentiated endometrioid adenocarcinoma with squamous metaplasia involving the ovarian surface." And everything else is benign in this pathology. So this

looks like a single tumor and again a single tumor would be a single primary. Looking at the final diagnosis it says, "The right ovary shows a well-differentiated endometrioid adenocarcinoma with squamous metaplasia involving the ovarian surface." So going through the histology coding [rules], again, you know this is a single tumor. It is invasive. So you would go directly to the Single Tumor Invasive Only Module that starts with H8. You would go down the coding module starting with H8 [Carol asks the technical expert to mute an attendee's phone that is broadcasting a telephone "hold" message.] I am sorry. It took just a moment to mute that. As you go down the histology coding rules starting with H8 you will see that you end up with coding rule number H11. And H11 says that if you have a single tumor or a single type meaning just one histologic type mentioned, that you code that histology. So the histology coded here would be the endometrioid for the ovarian as well.

Are there any questions or comments on this case?

#### Question 1 Case 2 Other Sites

Hi, Carol. This is Chris. So do we ignore that "squamous metaplasia?" Otherwise, we could go on to endometrioid adenocarcinoma with squamous metaplasia and come out with code 8570 instead.

#### Response to Question 1, Case 2 Other Sites

*That's true. You could have but what we have is "endometrioid adenocarcinoma with squamous metaplasia" and the "squamous metaplasia" is not listed using any of the particular names that we use to identify a subtype. Meaning it's not listed as a type, a subtype, predominantly, with features of, major, or with squamous differentiation. And that's why we coded it as the endometrioid adenocarcinoma.*

Are there any other questions? Okay. Let's go on to case number three.

### **CASE 3--OTHER SITES**

[There is a pause in the audio while the technical expert tries to move the screen to the next case, i.e. case #3. In the interim, participants are asked to use their paper copies of the cases].

Okay. I'm sorry. I can't move off of this case. I just asked Theresa to help me with it. Let's just go physically to case number three as she is working on it.

Case number three is definitely an ovarian primary. There's a right Salpingo-oophorectomy showing "involvement of high-grade poorly differentiated carcinoma with mixed features of high-grade papillary serous carcinoma and endometrioid carcinoma, right ovary and fallopian tube." The left ovary is also involved. There is involvement in the peritoneum. They did a hysterectomy and they are seeing there is high-grade poorly differentiated carcinoma in the uterine serosa and the outer portion of the myometrium.

So the first question is: Is this a single or multiple tumors? Now you would have to count this as a multiple tumor because you have both the right and left ovaries involved. So you really would start on the Multiple Tumor Module with M3--and that's because you have multiple tumors. You will actually continue down until you hit M7. And M7 is a rule that tells you that [You have to wait a minute; I'm shuffling my own papers here because I can't switch] bilateral epithelial tumors of the ovary within 60 days are a single primary. Now, the epithelial tumors are any tumors coded between the range of 8000 and 8799, so that's a very broad range. And the histology on this tumor you would start again, just to prove that you are within this 8000 range as well, you would start again with the Multiple Tumors Module. The Multiple Tumors Module for histology starts with H18. And you will move along the histology rules from H18 which is no pathology or cytology through H19 which says no pathology or cytology from the primary site; H10 [H20] is for prostate primaries; H12, excuse me, H21 is for your VAIN, VIN, AIN; H22 are for glandular epithelial neoplasia; H23 is one histologic type and this really does not meet that criterion. If you read the final diagnosis it's "high grade, poorly differentiated carcinoma with mixed features of high grade papillary serous carcinoma and endometrioid carcinoma." So you go on to rule H24, which is extra mammary Paget disease for the anus, vulva, and perianal region; through H25, which are the polyps; H26—papillary in thyroid; and H27 again is thyroid; H28 is combinations of invasive and in situ which does not fit this case. H29 is specific histology and a less specific—that does not fit. Now you come to rule H30 that says code the appropriate combination or mixed code from Table 2 when there are multiple specific histologies or when there's a non-specific histology with multiple specific and that's exactly what you have here. You have a papillary serous carcinoma and an endometrioid carcinoma so you have two specific histologies. Now if you go to your Equivalent Terms and Definitions and you look at your combination codes, you're going to be looking for a combination code that has both the papillary serous and the endometrioid. And looking through the Table you will see that there is a specific Column [1] entry that says "GYN Malignancies with two or more of the histologies in Column 2." And Column 2 has the endometrioid and it also has the papillary and serous in it. So that tells you that you would code it to the combination code 8323/3.

Are there any questions about that case?

#### Question 1 Case 3 Other Sites

Hi, Carol, this is Elayne. [*Hi, Elayne*] I have a question. As I went through the different Modules, I noticed H5, H16 and H30 are basically the same rule within different modules. But H30, the code is consistent with H5; but H16 instead of saying to code it to the appropriate combination/mixed code and refer to Table 2, H16 says you would code it to the most specific histologic term. Is that a mistake in the printout?

### Response to Question 1 Case 3 Other Sites

*I'm going to H16; give me one second here okay? H16 says, "Code the appropriate combination/mixed code from Table 2 when there are multiple specific histologies or when there is a non—specific histology with multiple specific histologies."*

Is your version from the SEER Website?

Yes.

Okay. A registry printed my version from the SEER Website but that's not what I have.

*When did you print it?*

It was given to me a few weeks ago.

*Something is odd because you seem to have an old version.*

Yes. I'll have to follow-up and verify.

*Yes. Would you please check? [Yes, I will. Thank you.] Because I think you have an old version and if you do not, I mean if you find any problem with what you're downloading from the Website, please do let me know.*

I'll download it again just to compare. If not, and if it's the same, I'll followback with the registry. [Yes. Please do.] I'll let you know.

*Okay. Great. Thank you so much.*

Okay. Let's go on to case four.

### **CASE 4--OTHER SITES**

Case four is a thyroid case; that's very well defined. I don't think on any of these it was a major problem to pick out primary site. If you look at the final diagnosis on case four, it says, "Total thyroidectomy: 3 mm [multifocal] medullary carcinoma with background C-cell hyperplasia." And one of our very astute people in New York pointed out to me that we didn't code the C-cell hyperplasia and what we had on the answer sheet, we should have actually coded it to the C-cell hyperplasia. This is just as background. I want to start with that just so you hear it, okay? Now the other thing that's shown on here is that you have a microscopic or less than 1 mm papillary carcinoma. So, when we start looking at multiple primaries, you actually want to look under Multiple Tumors because you have a 3 mm multifocal medullary and you also have a microscopic papillary. So under Multiple Tumors you would start with M3, that's your module for Multiple Tumors. And, as you go through, you would very quickly go through M4, 5, 6 and

7 because they are specific to retinoblastoma, Kaposi's sarcoma; oh, I'm sorry. M6 is follicular and papillary tumors in the thyroid. This is not follicular and papillary; it's medullary and papillary. M7 are the epithelial tumors of the ovary. M8: "Are tumors on both sides of a paired site?" M10: "Are tumors diagnosed more than 1 year apart?" M11 talks about topography codes that are different. Well, these are both in the thyroid so that rule does not apply. M12 again this narrows it down to topography codes that differ at the subsite level; that does not apply. M13 is a frank in situ adenocarcinoma and a malignant tumor in a polyp; that doesn't apply. M14 is multiple [in situ and/or] malignant polyps. M15 is an invasive following an in situ. M16 would be an NOS and a specific and the papillary and medullary do not qualify for that. Now M17 says tumors with ICD-O-3 histology codes that are different at the first, second or third number are multiple primaries. So that's the rule that would actually get you to saying you do have multiple primaries in the thyroid.

Now coding the histology, you are going to do an abstract for each one of these tumors. So looking at abstracts, it's a single tumor. You are doing one abstract for the medullary. You are doing one abstract for the papillary. So for the histology, you go to Single Tumor, Invasive [Only] Module and that will start with rule H8. And, rule H8, of course, starts with a rather generic, "Code the histology documented by the physician when there is no pathology or cytology." And H9 is code from a metastatic site when you have nothing from the primary. Rule H10 deals with prostate. Rule H11 talks about one histologic type and that's what you do have. You have just medullary for this abstract and that would be histology code 8510/3. You would do exactly the same thing for the papillary carcinoma. You would start again with your Single Tumor [Module] and you would progress through the rules that talk about not having pathology from the primary site, through rule H10 that talks about prostate primaries. Now, we do have, and Chris in Seattle mentioned this, that probably--you're most likely--a registrar would stop with H11. It says, "Code the histology when only one histologic type is mentioned." Actually, we want them to go down to rule H14 that says: "Code papillary carcinoma of the thyroid to 8260." And we have already made a note that in the revision [to the Multiple Primary and Histology Coding Rules] we're going to move that rule and bring it before rule H11 to make sure that a registrar with a single tumor that is just papillary won't stop with rule H11. And we'll make sure we get the right papillary carcinoma code.

So, we've already, "Thank you to Chris," we've already listed that as a change. And, thanks to New York Registry we found the medullary with the C-cell hyperplasia and we already have asked our consulting physicians whether we should put a default rule in saying that most of the medullaries really do start in the C-cell. But does that really mean we should default all medullaries to the C-cell or do we need a rule that tells people, "When you see the C-cell, make sure you code the different code." So we've already contacted our physicians and we are awaiting their answers. We've contacted our pathologist specialist, our Head and Neck and our Endocrine doctors and we've asked whether we

should totally default the medullary to the C-cell or whether we should just specify whenever the C-cell is mentioned, you do not code just medullary.

#### Question 1 Case 4 Other Sites

Carol, could you please tell us the code we would select?

#### Response to Question 1 Case 4 Other Sites

*Certainly. The code that you're going to select is... Oh, that's wonderful. I've got them both written here and I didn't check the one that's the C-cell. Let me grab my answer sheet because this one is not on my answer sheet. Does someone have the answer sheet available? I had to pull paper out at the last minute here; I apologize. I could not switch from electronic document to electronic document so I was literally grabbing paper at the last minute to be able to...*

Carol, it's 8345.

*Thank you so much; 8345.*

Okay. Now we want to go on to Case 5. Well, let me ask first, does anyone have any questions?

#### Question 2, Case 4 Other Sites

Yes, I do. Which one would be coded to 8345, primary one or primary two?

#### Response to Question 2, Case 4 Other Sites

*Primary number one or the one that we designated as number one which was the medullary carcinoma. That's a code for medullary C-cell; that's the medullary carcinoma that typically arises in the C-cells in the thyroid.*

#### Question 3 Case 4 Other Sites

Carol, I'm sorry. You said you're going to..you're talking to your "docs" to verify that? [Yes] I'm not even sure how you would have gotten to that because it says C-cell hyperplasia?

#### Response to Question 3 Case 4 Other Sites

*That's why we're talking to our "docs" because we want to know: 1) does any mention of C-cell make it equal C-cell? And I will get back to all of you. In fact, we'll send an email to this whole group. And we will put an addendum on the practicum when we get the answers from them.*

*So the questions I asked them were: 1) Does any mention of C-cell equal medullary C-cell? 2) Should there be a default automatically to C-cell since it is common but I don't know if it's 90% or more of the medullary? Would it be reasonable to do that? And then thirdly, tell me what it has to say to code it to medullary C-cell?*

Okay.

*And then I'll be able to get back to you with those answers and also [tell you] what we will do as a Note or an Addendum to the rules.*

Okay? [Let's go] on to Case 5.

#### Question 4 Case 4 Other Sites

Carol, this is Chris in Seattle. When we were talking about moving up that rule H14, we also spoke about moving up rule H12 in the other site-specific rules.

*That's correct. Yes.*

We were talking about moving up rule H12 and then when I was sitting down and thinking about it then we would have to do that for each of the tumor groups [modules] as well. For example, in the In Situ Module you would probably move rule C Adenocarcinoma and a polyp up above H2 from one histologic type. And then also for Multiple Tumors Abstracted as a Single Primary you would probably move up rule H25, which is the adenocarcinoma in a polyp and H26, the papillary carcinoma of the thyroid, and those both should precede rule H23. What do you think?

#### Response to Question 4 Case 4 Other Sites

*Well, adenocarcinoma and a polyp are not a single histology. So that one we would, because adenocarcinoma, frank adenocarcinoma is 8140. Adenocarcinoma in a polyp has 3 different codes depending upon the type of polyp; so that's not actually a single histology. The rule we're concerned with is the one that says if there is a single histology, code it. Well, then we have a problem when we have the papillary coding papillary of the thyroid under that rule because nobody will get to that code; so the single ones have to move ahead. But anyone that actually has two histology codes and we're telling you what the default would be, what you should code to, those would stay underneath.*

Okay.

*But, yes, we absolutely will make sure that gets into our notes and it'll be a part of the first revision. The first revision, as I told you, will be announced. We'll do a whole new thing and that's not going to be yet. We do not intend to do a revision until, well, what we intend is probably a year out unless we found something very problematic.*

#### **CASE 5-- OTHER SITES**

Okay for Case Number Five: Again, it's quite easy to pick out the primary site; it's testis. And, the next question, of course, is whether or not this is a single or a multiple tumor. Well, this is quite easy to read because it says very plainly that you have two tumors. It even goes on to say, "Both tumors, [tumor] #1 and

[tumor] #2 extend to the tunica albuginea.” So, absolutely go to “Multiple Tumors.” There’s no question on that one. So we start the M rules, the Multiple Primary Rules, with M3. And, again, you can very quickly go through the rules M4, M5, M6, M7, M8 because they are retinoblastomas, Kaposi’s sarcomas, thyroid, ovary, rule M8: “both sides of a paired organ.” While this may be a paired organ, both sides are not involved. Then, again, rule [M]9 we’re talking about adenomatous polyposis coli. Rule M10: tumors diagnosed more than a year apart. M11 [concerns] topography codes [that are] different at the second or third characters and again this is not [that situation]; it’s in the same primary site. Rule M12: topography codes that differ at the subsite. Now you won’t use that [rule] you can see it’s not: 1) it’s not one of the ones listed and 2) there are no subsites for testis. Rule M13 is adenocarcinoma and a polyp. M14 is [multiple] in situ and/or malignant polyps—that certainly doesn’t fit. [M15: invasive tumor following an in situ tumor more than 60 days after diagnosis]. And M16 is an NOS and a more specific. M17: ICD-O-3 histologies that are different at the first, second or third numbers are different primaries. That’s absolutely the rule that we would use and say we have two primaries. So our next problem then would be to code the histology.

And, when we start with the first tumor, the seminoma, we would say this is a single tumor only because, again, we’re back on this abstract we’re only doing the seminoma. So it’s a single tumor. It is, of course, invasive. So the Single Tumor, Invasive Only [Module] starts with rule H8. And once again, you can go very quickly through rules H8 and H9, which talk about not having a pathology specimen or only having a path specimen from a metastatic site. H10—prostate. Rule H11 says code the histology when only one histology is present; that’s what we have. In tumor number one there is only seminoma so you would code 9061/3. Then back to the second abstract. Again you have a single tumor. That tumor does have a complex or multiple histologies but it is still a single tumor, talked about as a single nodule. And, you would go to Single Tumor and Invasive [Only, Module] so once again starting at rule H8. And, you can very quickly move through rules H8 and [H] 9 that talk about not having pathology and not having pathology from the primary site; through H10, which is a prostate. H11—one histologic type—is not correct for this particular tumor. H12—it’s not a polyp. H13—we certainly don’t have an NOS and a more specific. H14 and thyroid; H15 and thyroid [neither one applies here]. So we are down to H16, which says code the appropriate mixed code when there are multiple specific histologies. Now you do have multiple specific. You’ve got seminoma and embryonal so you would want to go to your Terms and Definitions and check the Table for coding complex histologies Chart. And you’re going to be looking for any combination code that would have seminoma and embryonal together. When you look at that Chart, do you see anything that combines those two? There is nothing in the actual Chart that combines those two so you would go on to the next to #17 and you would code the numerically higher ICD-O-3 code because there was nothing available in Table 2. And the higher ICD-O-3 code is for the embryonal and that’s 9070/3.

Are there any questions about this case?

#### Question 1 Case 5 Other Sites

Carol, it's Elayne. I just want to let you know that while we were going through the cases, I downloaded the SEER Manual from the Website. And there is a mistake in the Matrix Version [of the Multiple Primary and Histology Coding Rules] of Other Sites for H16.

#### Response to Question 1 Case 5 Other Sites

*Okay. Peggy, would you catch that, please?*

Sure. Could you repeat that, please?

H16 in the Histology part of the Other Sites [Rules]; (On the Matrix?) on the Matrix Version, the *code* says, "the most specific histologic term" and it should say, "the appropriate combination/mixed code, Table 2."

Thank you very much. I've got it.

Okay. Thank you.

*That's an error that will be fixed. There will be a little note on the Website.*

#### Question 2 Case 5 Other Sites

Carol, I just have a quick question. So there is no "majority of the tumor rule" anymore? So, for this case it would have been the same answer but since we know that it's 80% and 20% [but] there's no rule anymore to take that into account? If this would have been flip-flopped; if it would have been 80% seminoma we still would have coded it to the embryonal?

#### Response to Question 2 Case 5 Other Sites

*You actually do have it. It's kind of hidden. It's in the...oh, I get what you're asking now. See, we've had a "majority of the tumor rule" and now that is only in effect when it's the same histology. No, we do not have a straight "majority of the tumor rule."*

Okay. You guys are aware of that decision?

Yes.

Okay. I just wanted to make sure.

*Okay.*

Okay. Now on to case six if there are no other questions.

## **CASE 6-- OTHER SITES**

Case number six is, again, the primary site is pretty straightforward and because it says “right eye enucleation.” And it’s certainly a single tumor because it says “choroidal spindle cell malignant melanoma with the following features...” So for multiple primary, you would go to Single Tumor [Module] and a single tumor is always a single primary, even single tumor invasive. A single tumor is a single primary.

So the challenge here is coding the histology. On the histology you would go to the Single Tumor Invasive [Module] because this is certainly, again, a single tumor and it is absolutely invasive. So you would start again with H8. And you can quite quickly go through H8 and 9, which talk about no histologic specimen or having the histology only from a metastatic site. You go past H10, that’s a prostate. You have rule H11 that says, “When only one histologic type is mentioned...” Well, we have “mixed cell type, predominantly Callender spindle B cell type.” That’s certainly not a single histology; and then a malignant melanoma, for an example. Some people may argue that it would be a single. This is one of the reasons that we don’t usually put a rule number on our answers. The rules are set up so whether you would call it a single tumor or whether you would go to H13 and call it a melanoma and a more specific which is what I would do but that would be my, just my personal preference, it doesn’t matter which way you go, you would call this the same thing. You are going to come up with exactly the same answer. And you would end up coding this to spindle cell melanoma, type B. That’s 8774/3. So, as I said, I would call it the more specific term. I would call it a melanoma and a more specific. I know some people would just say this is a single histology and either way you’ll come up with the answer: spindle cell melanoma type B.

Are there any questions or comments on this case?

## **CASE 7-- OTHER SITES**

Okay. Case seven again is actually not too difficult to pick out the primary site. Coding the primary site or finding the primary site was not why we chose these cases. They were more chosen to decide on whether or not they were a multiple primary or whether they were--how to code the histology. So case seven is definitely a left femur and the impression is: “ a diffusely infiltrating lesion of the distal aspect of the femur shaft. There is surrounding soft tissue masses due to the breakdown of the cortex.” But that’s not the important part. They are definitely saying it’s the femur. “The exact etiology of the finding is uncertain but it is felt to represent malignant neoplasm.” So, in coding this case, we would start out with saying you have a diffuse infiltration but it still seems to be a single tumor. So if you default to the single tumor, it’s a single primary. If you feel that there’s not enough information to make that decision and you say it’s unknown if this is a single tumor or multiple [tumors] you will still come out with a single primary.

So we have a single primary and the only information you have for the histologic type is an MRI of the left femur. So in coding the histology let's start out with Single Tumor and it's certainly invasive. [Single Tumor-Invasive Module]. You are seeing that it's a diffusely infiltrating lesion so I don't think there's any question that this is a single tumor, invasive. And you would start with rule H8. And H8 says, "Code the histology documented by the physician when there is no pathology or cytology specimen or the pathology or cytology report is not available." So, this is the rule you are going to use. You don't have a path; you don't have a histology. So you would go down to Note 1 that says, "Priority of Using Documents." And your first priority is documentation in the medical record that refers to the pathologic or cytologic findings and you don't have that. [Secondly,] the "physician's reference to the type of cancer found in the medical record," You could say it was that [reference] because the physician certainly wrote the impression. Or, you can go to bullet number three that says, "Information from a CT scan, or an MRI scan or a PET scan." That's what you do have. And you would code the malignant neoplasm or 8000/3.

Are there any questions or comments on that case?

Okay, if we can go on to case eight.

### **CASE 8-- OTHER SITES**

Case eight is one of the dreaded GIST tumors. And what we have here is a liver core biopsy and the "Comments" say: "In view of the CT scan findings, the morphologic features of the neoplasm are consistent with a metastasis from a primary gastric neoplasm. The differential diagnosis includes leiomyosarcoma/malignant gastro-intestinal stromal tumor (G.I.S.T.) and malignant fibrous histiocytoma." They are going to submit a paraffin block for immunohistochemistry. And then at the very bottom we have an "Amended Diagnosis" and it says: "Based on additional Studies [that were] Requested from ImPath: Metastatic malignant GIST." So, okay, first of all number of tumors: You have absolutely no idea. You don't have any information on the primary site. So you would have to say it's unknown if there are single or multiple tumors. And you would use rule M1 and it would tell you that you would default to a single primary. Then, the second problem that you encounter is actually coding the path report. And you defaulted to a single tumor so you will go to one of the Single Tumor Modules. This is absolutely invasive because you have metastatic tumor to the liver so it is certainly invasive. You would go directly to rule H8 and it says: "Code the histology documented by the physician when there is no pathology specimen or the pathology or cytology report is not available." And that's the case here. They talked about the cytology or pathology. They said, "We're referring it for immunohistochemistry." Well, okay. Let's just say they referred it to the lab; we do know that. We don't have the actual lab report. We don't have that at all. What we have is an amended diagnosis that they say they are basing on studies requested from ImPath. So we are using rule H8. We would say we have documentation that refers to the pathologic or cytologic findings or we could say

we have a physician's reference to cancer because we have an amended diagnosis that says it's malignant GIST. Or, you could say, "Well, I actually found this on a CT scan." So you kind of need all three bullets; it doesn't matter. There's one document; priority doesn't matter. You can't use priority when you only have one document. So it's kind of irrelevant for this case. So you would code the specific histology as it's documented. You would code 8936/3 for malignant GIST.

Are there any comments or questions on that case?

#### Question 1 Case 8 Other Sites

Carol? I would have used H9 because I think this is a pathology report.

#### Response to Question 1 Case 8 Other Sites

*Well, it's... Oh, you're right. It is a pathology report. I'm so sorry. You are correct. It is a path report and I am just looking at it saying, "No, it's not." You're right: H9. I even wrote H9 on the case, which is more pathetic. You code it to the malignant GIST.*

Okay. Let's go on to Case #9.

### **CASE 9-- OTHER SITES**

This is another thyroid. Now in the final diagnosis they talk about a "left inferior parathyroid biopsy" —negative. [They talk about a] "left total and right subtotal thyroid." We have a "papillary carcinoma, 3.5 cm confined to the thyroid." We have a "grossly encapsulated follicular cell carcinoma with one focus of vascular invasion." I would go definitely to the Multiple Tumors Module. Why? Well, you have a definite size for the papillary. You've also got a size for the follicular. The follicular is stated as being "grossly encapsulated" so it is certainly two separate tumors. You'll find the same thing up in the "Gross" [Description] under "B." They will talk about "a large partially cystic mass" and "one separate nodule." So you have multiple tumors. So you would start with your M3 to decide whether or not you have multiple primaries. And M3, of course, is not going to be used; that talks about not having any histology or pathology. Oh, no, I'm sorry. [That talks about] adenocarcinoma of the prostate is always a single primary. M4 is your retinoblastoma. M5—Kaposi's; then you get to M6 and it's follicular and papillary tumors of the thyroid within 60 days of diagnosis are a single primary. And that definitely covers this case. It doesn't matter if they're separate; they are still a single primary.

So to code the histology, again, you're going to start with the Multiple Tumors Module because you are coding both of these tumors as a single primary. For this abstract, you have multiple tumors. You start with H18 and you can very quickly go through H18 and 19, which are no path or cytology specimen and coding from a metastatic site when there's no tissue from the primary site. H20 is a prostate primary. H21 talks about the VINs and VAINs and so on. H22 talks

about intraepithelial neoplasia again. And H23 talks about only one histologic type, which is not the case here. You have both papillary and follicular. Rule H24 talks about extra mammary Paget. H25 is adenocarcinoma in a polyp. H26 is papillary of the thyroid, which is not this case; you have papillary and follicular. You get down to rule H27, which says code follicular and papillary carcinoma of the thyroid to papillary carcinoma, follicular variant, 8340/3.

Are there any questions about case nine? Did any of you have any real problems with the all Other Sites codes? Great!

Well, I thank you for your time today.

#### Comment 1 Case 9 Other Sites

Carol, can I just make one more comment? [*Certainly*] I was talking to you about the rules and speaking about the Equivalent Term of adenocarcinoma is equivalent to glandular carcinoma? And we had talked about maybe moving this term up to the General Instructions and moving it out of the Other Sites [rules].

#### Response to Comment 1 Case 9 Other Sites

*Yes. That's correct. I'm sorry I forgot about mentioning that. Chris had called and said you know there are instructions in Other Sites that talk about glandular carcinoma being the equal of adenocarcinoma. And we are going to check and make sure that there is no exception; then we can move it up to General [Instructions]. Yes. And that's also on our list to check with the physicians to make sure there are no exceptions for any of the site-specific [rules] because we would need to know that; then we will move that definition up to the General.*

Are there any other comments or questions?

#### Comment 2 Case 9 Other Sites

I do--here in Washington. It's just a general one. Just to let you know that it was really helpful to follow you when you also labeled which rule you were using.

#### Response to Comment 2 Case 9 Other Sites

*Oh. Okay. I do try to do that especially after people get used to the rules. I think at first they get quite concerned because they're sure that there must be only one right rule. They must either call it one type or an NOS, you know? You couldn't possibly have two. But after people become a little more accustomed and do a site or two it's very easy to say it and people understand then. So, I think it's a really valuable addition once people have gone through at least one set of rules. [Thank you] But they got pretty confused when we tried to do it on the first set so we did stop doing that. We wait 'till they've gone through one set of rules before we add it.*

### Question 3 Other Sites

Carol I have a question on number eight? The GIST? [*Certainly*] I couldn't clearly hear you. Did you say that that was an unknown primary although in the answer key it says the GI tract NOS you code to the amended diagnosis?

### Response to Question 3 Other Sites

*Oh, no. I said when we start out it's unknown.[ Oh, when you start out it's unknown!] Yes. And then they amend their diagnosis and they state that it is a metastatic GIST and that you would be able to code it not to unknown but you could code it to the gastrointestinal system.*

Okay. Now you'd stick to the sarcoma code for that, right, for the GI?

Yes.

Soft tissue? Okay. Great. Thanks a lot.

*Okay.*

Well, everyone, I want to thank everybody. I'm so sorry we had technical problems. You were really great about it. Thank you so much.