Q1: "In keeping with" is considered to be definitive terminology for diagnosing solid tumors. Do we also consider it definitive terminology for hematopoietic cases? Example: B cell lymphoma, in keeping with Follicular Lymphoma grade 2

A1: (Received a question in Ask SEER Registrar about this).

Answer provided: Yes, you may use this. For this case, you would code the histology to the follicular lymphoma, grade 2, especially if the patient is being treated for the follicular lymphoma.

The main thing to remember about these types of questions is to check how the patient is being treated. As I said on the webinar, you need to look at the whole picture of what is going on and not just the diagnosis, especially when there is ambiguous terminology.

Q2: We know we are not to use ambiguous terms to code a more specific histology (#3 Pg. 36 Hematopoietic Coding Manual) Will this continue to be a rule in the 2017 revision?

A2: Yes, this will continue in 2017. No changes to these rules.

Q3: If there is a cytology report and in the microscopic description it says a cell block was made, would that be considered tissue?

A3: We don’t have an answer for this question at the time this document was posted. The question was sent to colleagues for input. Please check SEER SINQ for a response.


Q4: What diagnostic code would you use if bone marrow or tissue/lung biopsy that is not diagnostic, but the immunophenotyping markers are positive for the dx that physician makes clinically?

A4: Code 3. Anytime you have positive immunophenotyping, genetics or JAK2 that confirms the diagnosis or confirms a more specific diagnosis, use code 3.

Q5: We have been seeing in abstracts - FNA/cell block - does this mean tissue was included?

A5: Sent to colleagues for input
Q6: I've seen cases of multiple myeloma where bone marrow biopsy wasn't diagnostic, but immunophenotype markers were positive & physician stated dx was multiple myeloma

A6: Anytime you have positive immunophenotyping, genetics or JAK2 that confirms the diagnosis or confirms a more specific diagnosis, use code 3.

Q7: To clarify the correct diagnostic confirmation code, essential thrombocytosis diagnosed by JAK2 positivity is coded 3?

A7: Yes that is correct.

Q8: Might want to advise to use the diagnosis year drop down menu to get the correct instructions for the specific year the cancer is diagnosed

A8: Thanks Robin for pointing that out! -

Q9: Should "myelodysplastic process" be coded as MPN/MPD?

A9: This can be used to identify MDS (9989/3, which is MDS, NOS).

Q10: Question regarding 9719, here at the central registry we have seen it coded to C779 - lymph node NOS. Based on the database the nasal cavity is the prototype site - is that where the primary site should be coded to if they only diagnosed it in a LN?

A10: It is possible to have C779 as the primary site for 9719, although it is rare. A thorough check of all information regarding the case should be done. If the only involvement is the lymph nodes and the diagnosis is confirmed, then yes, assign C779 with 9719.

Q11: Question 7 - issue is when database proves 2 primaries however physician calls it one; later when follow up is needed on both primaries the physician is really only addressing one primary and how do we update follow-up on the 2nd primary?

A11: You would update both primaries the same way.

Q12: does it have to be stated as "high count?"

A12: This has not been confirmed; however, we will make it clear in the database for the mid-January release.
Q13: We saw these cases when processing edits (don't remember the name of the edit), so we have to use an override?

A13: Yes, use an override

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Q14: Diagnosis of plasma cell neoplasm is not listed as an alternative name for plasma cell myeloma. Is the term plasma cell neoplasm reportable?

A14: Plasma cell neoplasm is a blanket term used for several different neoplasms, many of which are non reportable (see http://seer.cancer.gov/seertools/hemelymph/5331a216e4b0626b192764b4/?q=plasma)

If Plasma cell neoplasm is used in conjunction with a reportable diagnosis, then it can be used; for example, plasma cell neoplasm consistent with plasma cell myeloma.

If the only information you have is “plasma cell neoplasm,” suggest following up with physician. If no other information can be found, do not abstract.

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Q15: Will 9823 still be coded to C421 if lymph node involvement with peripheral blood?

A15: Yes. Follow the rules in the heme database to determine primary site, then use the AJCC manual to determine stage. Remember, with CLL/SLL, if peripheral blood is positive, primary site is C421.

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Q16: For question 1 - is there a date associated with that? Meaning, do we start taking the alternate name starting in 2016?

A16: Yes, we will make it applicable for 2016 (updates will be released no later than mid-January 2017)

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Q17: when I ran #5 through the calculator, DLBLC is 9680/3 not 9640/3 and follicular calculates to a new primary, so I answered D?

A17: The DLBLC code is 9680/3 thanks for catching that. Remember using the multiple primary calculator is only required if the rules tell you to use the calculator. We do not have enough information here to do that. Also the focus on the question was about what the “Transformations to” and “Transformations from” fields in the Hematopoietic Database refer to.

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Q18: So #5 question on Quiz #1 should be the letter D?

A18: We would need to have more information before we determine if this was a same or new primary. Questions 5 focus was about what the “Transformations to” and “Transformations from” fields in the Heme DB refer to.
Q19: Quiz 2, #4-I thought we weren't staging CLL as lymphoma until 2017. Wouldn't the stage group for 2016 be 88?

A19: You have the option to stage or not stage these cases for diagnosis year 2016. Beginning in 2017, you will be required to stage them.

Q20: Shouldn't the stage for the CLL in the second quiz be stage 88 due to the leukemia?

A20: The cases can be staged for cases diagnosed in 2016. We chose to stage them. If you are choosing not to stage them for 2016m, then 88 is an appropriate option.

Q21: The clinical stage descriptors are listed incorrectly on the pop quizzes on pgs 30-31.

A21: Thank you. The correct code for each is 1.

Q22: Would a staging laparotomy have to be done if the lymphoma is present only in one lymph node or organ that has been excised and imaging shows that there is no disease left. Would we not consider this?

A22: Yes. It must be done to meet the rules for classification for pathologic stage. For all intents and purposes, pathologic stage is obsolete for Hodgkin and non-Hodgkin lymphomas.

Q23: For tonsils - what would the stage be for palatine tonsil and lingual tonsil involvement - would you count that as 1 region or 2 - stage 1 or 2

A23: We posted this question to the CAnswer forum. You can follow at http://cancerbulletin.facs.org/forums/node/67782

Q24: If the operative report states the disease started in the pancreas and spread to the spleen, what stage would it be?

A24: I would stage this as Stage IIES since it is an extranodal lymphoma with involvement of the spleen.

Q25: on your slides you have stomach as an extralymphatic site - should that not be extranodal?

A25: Those terms are used interchangeably. Technically, extranodal should be reserved for lymphomas arising in sites that are part of the lymphatic system, but not lymph nodes. Extralymphatic is reserved for sites that are not part of lymphatic system. Stomach is not part of the lymphatic system. I would consider it extralymphatic.
Q26: If involvement is stated as "right at the level of the diaphragm," is that considered above or below the diaphragm?

A26: I don’t feel comfortable giving a blanket statement either way. The best you can do is look at the rest of the record and try to make a determination. You might be able to look at the treatment see if they are treating this more like a patient with stage I or II disease or patient with stage III or higher.

Q27: Would you use a 0 for a TNM Descriptor if all you have is lymphoma in a lymph node - correct?

A27: If your primary site is lymph node, then the descriptor is 0.

Q28: For the pop quiz with a mediastinal mass - can you confirm that the stage descriptor should be 0

A28: The pop quiz shows a large mediastinal mass that extends into the lung. The stage descriptor would be 1-Extranodal.

Q29: Pop quiz page 31, clinical descriptor #1-applies to extranodal and extralymphatic sites? Lung is an extra lymphatic-Correct?

A29: Technically, lung is extralymphatic. However, it looks like they are using these terms interchangeably for this field. The E suffix applies to extralymphatic sites, not to extranodal (lymphatic sites that are part of the lymphatic system).

Q30: Please clarify - Mets at DX field: Lymphoma, organ= as instructed, LN=0; Leukemia =0. Mets BBDLLO: Do we still enter 8 for both Lymphoma and/or Leukemia if no involvement?

A30: For lymphomas, Mets at Dx BBDLLO cannot be 8 (not applicable). For leukemia, Mets at Dx BBDLLO must be 8.

Q31: On the Clinical Stage Descriptor slide, the word extranodal is used. Should this not be extralymphatic and not extranodal?

A31: AJCC uses the terms Extranodal and extralymphatic interchangeable.

Q32: In the clinical descriptor slide code 1 states extranodal, should it be extralymphatic?

A32: Technically it should be extralymphatic. However, it is not written that way in the data item description.
Q33: How do you code Mets at dx - distant LN for lymphoma?
A33: It is always coded as 0.

Q34: Mets at DX for lymphoma did this start with 1-1-2016 cases?
A34: Yes.

Q35: what page?
A35: The lymphoma chapter starts on page 607

Q36: FYI: there is a note in the 8th edition AJCC (pg 954) that Hodgkin lymphoma uses A/B designation with stage group but A/B is no longer used in NHL.
A36: The statement regarding the collection of A and B symptoms was mentioned when I was discussing the changes. There has not been a decision made by many of the standard setters whether they will continue to require the assignment of A and B-

Q37: Case 1 shouldn't clinical stage descriptor be 1 for extralymphastic involvement?
A37: From what i understand you do not code E for metastasis.

Q38: Jim wouldn't surgery of other /distant site be 4 surgery to distant site?
A38: Yes! Thanks!

Q39: For case 1 - They did a craniotomy - should we not code surgery other as 4
A39: You are correct. Surgery Other Regional Sites is coded as 4.

Q40: For case scenario 1 primary site-would we code multiple nodes as C77.8 (first scenario)?
A40: We also had extralymphatic involvement and we can’t where the lymphoma started. Therefore, we code to C77.9. See rule PH22 in the hematopoietic manual.
Q41: Since we had surgery of other site and both radiation and chemo, the systemic/surgery sequence and surgery/radiation sequence are both wrong on scenario one.

A41: You are correct. I forgot sequence includes surgery of other regional distant sites. Good catch.

Q42: Tumor size for Leukemia is it 988 or 999?

A42: FORDS pg 144: Tumor size code 999 is used when size is unknown or not applicable. Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms: histology codes 9590-9992 are one of the sites listed as where tumor size is not applicable.

Q43: I didn't hear if you explained why chemo was 02 instead of 03 for Case 2 -- hydroxyurea then imatinib? Different drug groups?

A43: Sent question to CAnswer Forum.

http://cancerbulletin.facs.org/forums/node/67702

Q44: Staged By for AJCC sites coded to 88's shouldn't stage by be code 00 not staged.

A44: The correct code should be 88 the case is not eligible for staging. Definition in FORDS for Staged by code 88 is the site/histology combination is not defined in the AJCC manual.

Q45: Also, I believe the TNM edition would be 88 for leukemia for case scenario 2.

A45: Correct! Thank you.