**Q&A Session**

**Using the Multiple Primary and Histology (MP/H) Coding Rules**

**December 4, 2014**

**COLON**

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Q: ­Should metachronous tumors for colon be considered a single primary? ­

A: ­You use the M rules to determine if metachronous colon tumors are a single or multiple primaries.­

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Q: ­if a patient has adenocarcinoma of two different sub-sites of colon and after being treated a few years later it metastasizes to some distant site, which primary tumor would we consider to be responsible for the metastasis? ­

A: “When a patient with multiple primaries develops metastases, a biopsy may distinguish the source of distant disease. Stage both primaries as having metastatic disease if the physician is unable to conclude which primary has metastasized. If, at a later time, the physician identifies which primary has metastasized, update the stage(s) as appropriate.” FORDS 2013 page 18; FORDS 2015 page 21

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Q: ­What would the primary site be if the anastomotic junction is involved? C189­?

A: We sent this question to SEER and they replied that the primary site would be based on what the physician documents. If the physician states the primary site is the same as the original primary site, you would code it as such. However rule M4 would still apply. Even though both tumors would share the same topography code, they are still considered to be in different segments of colon. The original segment of colon was removed so the new tumor would be considered to be in a new segment. This will be clarified in the next update.

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Q: ­ Can we code number of polyps in case of malignant polyposis in multiple tumors field as 02, 03 etc.?­

A: If the number of malignant tumors is not available, use code 99. <http://seer.cancer.gov/seerinquiry/index.php?page=view&id=20081069&type=q>

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Q: ­Would you use H4 for carcinoid tumor arising in a polyp? ­

A: *My answer during the webinar was incorrect. I sent the question to SEER and their response is below.*

*H4 does not apply as carcinoid in a polyp is not a final diagnosis listed in the histology column. Rule H11 applies, and the histology should be coded to carcinoid.*

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Q: ­In the colon Pop Quiz with the total colectomy does it make a difference that you have a frank adenocarcinoma and polyposis coli? Does this make it 2 primaries? ­

A: ­No, it does not.­ It would be considered a single primary per rule M3 (the first of the multiple tumor rules).

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Q: ­If you have adenocarcinoma with mucinous type, you would not get to H13. Would you not stop at H6 with no mention of %­?

A: Rule M6 would be used if the histology was Adenocarcinoma, NOS. Adenocarcinoma, mucinous type would be assigned 8480/3 per rule H13.

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Q: ­Can you clarify....adenocarcinoma with features of mucinous adenocarcinoma is coded to mucinous adenocarcinoma? ­

A: That is correct per rule H13.

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Q: ­How many polyps will determine FAP when there isn't a statement from the physician that the patient has FAP? ­

A: ­There are >100­ polyps identified in the resected specimen.

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Q: Question about coding primary site based on SEER SINQ 20130090. If we code a patient with familial polyposis to C199 wouldn’t it force us to use the “Other” rules? The “Other” rules don’t include instructions on familial polyposis.

A: We sent this to SEER for clarification. Their response is below.

*We used the colon rules because the sigmoid colon was involved. The primary site is C199 because the rectum is also involved. I wouldn’t use other sites, this is obviously familial polyposis.*

*Other sites rule M9 is specific to familial polyposis and includes a note that states the tumors may be present in a single or multiple segments of the colon, rectosigmoid, or rectum. The colon rule is M3. Both of these rules state it is a single primary. Remember, the rules do not include what primary site to code.*

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Q: ­We had a scenario where the patient had recurrence at the anastomosis greater than 1 year after the original diagnosis. Path stated metastatic adenocarcinoma at anastomosis. Would this be considered a new primary per the timing rule or metastasis per the statement in the path? Does M1 apply here?

­A: ­That is a tough one. I think rule M11 would apply. You could make an argument for rule M1. Usually, if the metastasis is in the primary site we ignore the term metastasis. Bottom line is I can't think of a rule that would make this a second primary.­

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**URINARY**

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Q: ­For pop quiz on M8, would you not assign the code for the invasive site rather than using the NOS code (C68.9)? If they were both invasive, I could see C689.­

A: ­I checked with SEER prior to the webinar because of invasive vs. noninvasive, and they said their subject matter experts instructed to use C68.9 in that case and that behavior does not factor in.

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Q: ­When you have synchronous tumors, one invasive and one non-invasive, why would the primary site not be the site of the invasive tumor? ­

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A: I checked with SEER prior to the webinar because of invasive vs. noninvasive, and they said their subject matter experts instructed to use C68.9 in that case and that behavior does not factor in.

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Q: ­Per H7 it was noted not to use the term component; why was component appropriate in pop quiz example? ­

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A: ­I included it because it is an exception as documented in SINQ. Small cell in the urothelial carcinoma is much more aggressive and the info researchers want.­

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Q: ­In the bladder if you have an invasive cancer first and 1 1/2 years later you have an in-situ cancer with same histology, how many primaries do you have?­

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A: ­If all urothelial carcinoma, M6 applies and it is a single tumor.­

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Q: ­In the last quiz, H14 states it should only be used when first three digits of histology are identical. Can you explain this again? I would think H12 is more appropriate.­

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A: ­My first thought was that H12 applied. I was concerned, however, by invasive vs. noninvasive histology in multiple tumors considered a single primary. So, I checked with SEER, and they said H14 applies and invasive histology should be coded.­

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Q: ­The 3 year timing rule does not apply to PTCC and TCC because these histologies are covered in rule M6. So the remaining types of bladder histologies (maybe 2% of all urinary cancers), is addressed by the 3 year timing rule in M7.

­ A: ­Urothelial carcinomas of the bladder are all a single primary per M6. However, if there are urothelial carcinomas in other urinary sites more than 3 years apart, M7 may apply.­

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Q: ­This is causing over counting of bladder cancers. Can better instructions be included for this rule? ­

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A: ­It is my understanding that instructions will be clarified in the revised rules.­

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**LUNG**

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Q: ­If you have a lung tumor that path reads "adenocarcinoma with features of papillary carcinoma and patterns of acinar and bronchioalveolar", would you code this to adenocarcinoma mixed or papillary adenocarcinoma? ­

A: ­I would ignore the histologies after the modifier "patterns". I would go with papillary adenocarcinoma per rule H5. Patterns is not listed as a modifier.­

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Q: ­When talking about the change in thinking about bronchioloalveolar carcinoma (BAC), if you see a path report final diagnosis of adenocarcinoma in situ, do you code 8140/2 or 8140/3?­

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A: ­If the path report says adenocarcinoma in situ, assign code 8140/2.­

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Q: ­For rule M10, are you saying you don't need to have an NOS and another specific histology on Chart 1, you can have any two in chart 1? It is a bit misleading where 8046 is listed first then a more specific histology. We don't need 8046 at all to apply M10? ­

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A: From SEER: One of the tumors must have the histology of 8046. If two specific non-small cell carcinomas are present, then they need to go back thru the rules to determine number of primaries.

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Q: ­Lung case- Notes from H5-"The specific histology may be identified as type, subtype, predominantly, with features of, major, or with \_\_\_differentiation.­ Based on note, shouldn't you code he histology as 8140 instead of 8255? ­

A: ­Rule H5 applies when there is only one subtype. Since multiple subtypes were present we move on to rule H6.

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Q: ­The note with rule M6 Lung states, “When there is a single tumor in each lung abstract as multiple tumors unless stated or proven to be metastasis.” Wouldn't your explanation disagree with the rule?

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A: ­In the example you are referring to the patient had a single tumor in the right lung and a single tumor in the left lung. The right lung was biopsied and proven to be adenocarcinoma. The left lung tumor was not biopsied. The physician stated that the left lung biopsy was metastasis from the right lung. Per rule M6 a single tumor in each lung should be considered multiple primaries. However, there is a note under rule M6 that says *“When there is a single tumor in each lung abstract as multiple tumors unless stated or proven to be metastasis.”*

We sent this question to SEER and they said the note under rule M6 needs to be updated. They said it would by highly unusual for a primary consisting of a single tumor to metastasize to the opposite lung and create only a single metastatic tumor. Their experts agreed that unless the second tumor was histologically confirmed as metastasis, rule M6 would apply and these would be two primaries.

The treatment for this patient would probably be more consistent with treatment for two localized tumors than a patient with stage IV disease.

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Q: How many primaries would be reported when a patient has a history of RLL adenocarcinoma diagnosed on 10/8/2009 followed by diagnoses of LUL adenocarcinoma on 10/5/2012 and a RUL adenocarcinoma on 3/26/2014? The answer is two primaries but I believe it should be three primaries and my colleagues agree with me.

A: The answer is two primaries per SEER SINQ 20140062. We sent this to SEER for further clarification and received the following response.

*The MP/H rules have always been taught that a newly diagnosed tumor is compared to the most recent abstracted primary. The rules were never intended to be used to compare a newly diagnosed tumor to the first diagnosis, or an earlier diagnosis, skipping over abstracted primaries diagnosed in between. If this concept isn’t clear, we will make sure it is documented in the new instructions*

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**BREAST**

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Q: ­Does the inflammatory carcinoma in both breast rule (M6) refer to histological or clinical inflammatory carcinoma? ­

A: ­Inflammatory carcinoma is a clinical presentation; however, if a tumor is histologically diagnosed as inflammatory carcinoma, it should also have the clinical presentation.­

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Q: ­So will we now code mammary carcinoma as 8500/3 instead of 8010/3? ­

A: We sent this question to SEER for clarification. Their response is below.

*Mammary carcinoma should still be coded to 8010/3. We think a previous statement was misinterpreted.*

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Q: ­For breast Pop Quiz with ductal carcinoma mixed with apocrine adenocarcinoma, should this be coded to 84103 (apocrine) based on rule H12 as SEER SINQ 20081031 states that apocrine is a type of ductal carcinoma? It further states this will be added to Table 2.­

A: The question was sent to SEER for clarification. Their response is below.

­*Per WHO, apocrine is a carcinoma showing cytologic features of apocrine cells in >90% of cells.*

*Any type of breast cancer can display apocrine differentiation including invasive ductal, tubular, medullary, papillary, neuroendocrine, micropapillary, and even lobular. Our breast SME’s instructed that when apocrine appears with infiltrating duct, the mixed code was the correct option. If the pathologist states the histology is only apocrine, then 8401 is correct.*

*(The 4th Edition WHO Tumors of the Breast state that carcinomas with apocrine differentiation should be coded to the primary invasive type. This instruction will be updated in the coming revisions but is not to be applied now.)*

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