Q:
If patient only comes into the ER for a cold when they have cancer, but no cancer directed treatment was given at my facility- Do I have to pick that up?

GIST

- What is the diagnosis date for a patient with a GIST tumor, NOS that was originally diagnosed 6/25/2015 treated w/ observation. Then on 11/1/2016 CT Pelvis found multiple liver mets from GIST?

  a. 6/25/2015
  b. 11/1/2016
  c. Not Reportable

GIST

- Which of the following are reportable (assuming you do not have special instructions from your pathologist or cancer committee). Circle all that apply.

  a. Gastrointestinal Stromal Tumor (GIST), NOS
  b. High risk GIST
  c. AJCC Stage I GIST
  d. Malignant GIST

GIST

- Is it reportable, if so, what is the diagnosis date?
  5/11/16 Large gastric mass, partially resected, Final Path Dx: Low Grade GIST, staged as pT3 N0.
  6/1/2016 Pt begins imatinib (Gleevec) for GIST.

  a. Not Reportable
  b. Reportable- 5/11/2016
  c. Reportable- 6/1/2016

LIVER

- Is Hepatoma of the liver reportable?
  a. YES
  b. NO

  Source: ICD-03- Hepatoma, NOS has an ICD-03 of 8170/3

- Is Cirrhosis synonymous with liver cancer?
  a. YES
  b. NO

MENINGIOMA

- Is the following sphenoid wing meningioma reportable?.
  6/15/2016 Sphenoid wing meningioma resection: final dx- intraosseous meningioma of the sphenoid.
  a. Yes
  b. No

  Source: SINQ# 20160068

Q: When would you use the code C709- meninges, NOS?

CYTOLOGY & AMBIGUOUS TERMS

- What is the correct diagnosis date when 1/10/2016 FNA RT Thyroid nodule final dx is suspicious for papillary carcinoma & 3/5/2016 Total thyroidectomy: 1.2 cm papillary carcinoma?

  a. 1/10/2016 (FNA date)
  b. 3/5/2016 (resection date)

CYTOLOGY & AMBIGUOUS TERMS

- What is the correct diagnosis date when suspicious cytology is followed by negative histology?

  2/12/2016 Urine for Cytology: positive for malignancy, suspicious for transitional cell carcinoma.
  2/25/2016 Cystoscopy w/ multiple bx's: no evidence of malignancy, all B9.

  a. 2/12/2016
  b. 2/25/2016
  c. Not Reportable

CYTOLOGY & AMBIGUOUS TERMS

- Urine Cytology: Positive malignant cells

  a. Reportable
  b. Not Reportable

What is the Primary Site?

a. C679- Urinary Bladder
b. C649- Kidney
c. C689- Urinary System, NOS

➢ UNKNOWN HEAD & NECK PRIMARY

- Code the primary site:

  5/5/2016 FNA of Rt Neck mass: Positive for squamous cell carcinoma. 5/10/16 Scope: no suspicious lesions seen. 5/10/15 Random Biopsies: B9. 5/2/16 PET: 2.5cm enlarged cervical LN. No other malignancy seen. 6/15/2016 Med Onc Consult: occult head and neck primary, patient has refused chemo and XRT.

  a. C809 (unknown primary)
  b. C148 (overlapping lesion lip, oral cavity, pharynx)
  c. C444 (skin of head and neck)

THYROID

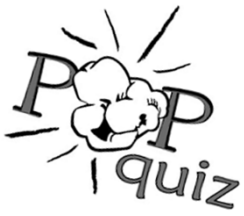
- Biopsy of a right thyroid nodule reveals papillary carcinoma. What is the correct histology code?
  a. 8050/3 - Papillary carcinoma
  b. 8260/3 - Papillary adenocarcinoma

THYROID

- What is the histology code for micropapillary carcinoma of the Thyroid?
  a. 8341/3 papillary microcarcinoma
  b. 8260/3 papillary adenocarcinoma

HEME & LYMPHOID

- What is the correct histology code for Follicular lymphoma grade 1-2?
  - 9690/3 Follicular Lymphoma NOS
  - 9691/3 Follicular lymphoma grade 2
  - 9695/3 Follicular Lymphoma grade 1



- How is the tumor grade field coded (Tumor Grade, differentiation, cell indicator field)
  a. 2 (grade 2, M-Diff)
  b. 6 (B-cell)
  c. 9 (unknown)

HEME & LYMPHOID

- What is the correct histology for 12/2/16 Cervical LN Core Bx: Classical Hodgkin Lymphoma, favor Nodular Sclerosis Subtype. Flow cytometry interpretation: No flow IHC evidence of a lymphoproliferative disorder. No further path testing done

  a. (9663/3) Nodular sclerosis classical Hodgkin lymphoma
  b. (9650/3) Classical Hodgkin lymphoma, NOS

  Source: Heme Manual, p 36: Rule 3

Q: What is the correct Diagnostic Confirmation Code on the above case?

a. Code 1 (positive histology)
b. Code 3 (histology and genetics)

BREAST

- What is the correct histology for a "Mammary Carcinoma" of the breast diagnosed in 2016?
  a. 8010/3 Carcinoma NOS
  b. 8500/3 Invasive Ductal Carcinoma

  Source: SEER SINQ 20130170 and Ask A SEER Registrar ASW07222

- Ductal and Ductular are synonyms for ductal carcinoma, frequently found in the breast.
  a. True
  b. False

COLON

- What is the correct histology for a mucinous adenocarcinoma of the cecum diagnosed by polypectomy?
  a. 8140/3- Adenocarcinoma
  b. 8210/3 –Adenocarcinoma arising in a tubular adenoma
  c. 8480/3- Mucinous Adenocarcinoma

- What is the correct histology for Adenocarcinoma w/ Signet Ring Cell features of the Transverse Colon.
  a. 8140/3- Adenocarcinoma, NOS
  b. 8490/3- Signet Ring Cell Carcinoma

COLON

- What is the correct histology-

  Rt hemicolectomy: Mucinous Adenocarcinoma. (Comment: Mucinous componet is >50%)

  a. 8140/3- Adenocarcinoma, NOS
  b. 8480/3- Mucinous Adenocarcinoma

GYN

Patient diagnosed with high grade endometrioid adenocarcinoma with squamous differentiation. What is the correct histology code?

a. 8560/3-Adenosquamous carcinoma
b. 8380/3- Endometrioid Adenocarcinoma
c. 8570/3-Adenocarcinoma with squamous metaplasia

Source:

GYN

Site Corpus Uteri. Histology is papillary serous adenocarcinoma. What is the correct histology code?

a. 8323/3 Mixed cell adenocarcinoma
b. 8260/3 Papillary adenocarcinoma, NOS
c. 8460/3 Papillary serous cystadenocarcinoma (C56.9)

GENERAL

- What is the histology code for a breast tumor that is invasive ductal ca with **focal** tubular differentiation?
  a. 8500/3 Invasive Ductal Carcinoma, NOS
  b. 8523/3- Infiltrating Duct mixed with other subtypes of carcinoma
  c. 8211/3- Tubular Carcinoma

  Source:

GENERAL

- What is the histology code-
  - TURBT Bladder Tumor: Transitional Cell Carcinoma. (Comment: tumor configuration is papillary)

a. 8130/3- Papillary Transitional Cell Carcinoma
b. 8120/3- Transitional Cell Carcinoma

Source:

GENERAL

Question: When you see the below Dx, do you code the first Dx, the one in parenthesis or do you look for a combination code.

- RT Ovary: Positive for malignancy, consistent with carcinosarcoma (malignant mixed Mullerian tumor).

a. 8950/3- Mullerian Mixed Tumor
b. 8980/3- Carcinosarcoma, NOS

One Case, 3 scenarios (1 of 3)

- Bone Marrow Bx: "findings consistent with low grade B cell lymphoma. SLL/CLL is favored."
- Final pathology report from outside lab for genetic testing: "The result is abnormal and indicates trisomy 5 in 7.5% of nuclei. Chromosome analysis and CLL FISH studies are normal. Taken together, these results are most consistent with a lymphoproliferative neoplasm."
- Med Onc Chart Note: B-Cell Lymphoma, on observation

- ❑ Is it reportable?
  a. Yes
  b. No
- ❑ What is the correct Histology?
  a. Low grade B-Cell Lymphoma
  b. CLL/SLL
  c. Lymphoproliferative Neoplasm
- ❑ What is the Dx Confirmation Code
  a. 1- Positive Histology
  b. 3- Positive Histology and IHC or Genetic Testing
  c. 8- Clinical Dx Only

One Case, 3 scenarios (2 of 3)

- Bone Marrow Bx: "findings consistent with low grade B cell lymphoma, SLL/CLL is favored."
- Final pathology report from outside lab for genetic testing: "Chromosome analysis and CLL FISH studies, final Dx: CLL/SLL"

- ❑ Is it reportable?
  a. Yes
  b. No
- ❑ What is the correct Histology?
  a. Low grade B-Cell Lymphoma
  b. CLL/SLL
  c. Lymphoproliferative Neoplasm
- ❑ What is the Dx Confirmation Code
  a. 1- Positive Histology
  b. 3- Positive Histology and IHC or Genetic Testing
  c. 8- Clinical Dx Only

One Case, 3 scenarios (3 of 3)

- Bone Marrow Bx: lymphoproliferative neoplasm.
- Final pathology report from outside lab for genetic testing: "The result is abnormal and indicates trisomy 5 in 7.5% of nuclei. Chromosome analysis and CLL FISH studies are normal. Taken together, these results are most consistent with a lymphoproliferative neoplasm, suspicious/f CLL/SLL"
- Med Onc Chart Note: CLL/SLL starting chemo next week.

- ❑ Is it reportable?
  a. Yes
  b. No

- ❑ What is the correct Histology?
  a. Low grade B-Cell Lymphoma
  b. CLL/SLL
  c. Lymphoproliferative Neoplasm

- ❑ What is the Dx Confirmation Code
  a. 1- Positive Histology
  b. 3- Positive Histology and IHC or Genetic Testing
  c. 8- Clinical Dx Only

Case 4:

1/13/14 Ct Chest Abd/Pelv: Diffuse lytic met's throughout bony spine, ribs, skull & questionably within pelvis & prox femurs. Findings consist/w Multiple Myeloma.

1/16/14 Bone marrow Bx & Asp: plasma cell dyscrasia. Flow Cytometry and Genetics performed: Final Dx, consist/w a plasma cell dyscrasia. Correlation with clinical and laboratory data suggested.

Pt discharged from facility w/ dx of MM, referred to Med Onc where he began treatment with Velcade, Dexamethasone and Lenalidomide. Final Impression: Multiple Myeloma.

What is the dx confirmation code?

a. 1- Positive Histology
b. 3- Positive Histology and IHC or Genetic Testing
c. 7- Radiographic
d. 8- Clinical Dx Only

QUESTION

Bone Marrow Bx 2/5/16: Plasma cell neoplasm. Follow back to the Med Onc who states on 2/15/16 the Bone Marrow Bx was positive for Multiple Myeloma. Is the case reportable and what is the Dx confirmation code?

What is the diagnosis date?

a. 2/5/16
b. 2/15/16

Diagnostic Confirmation Code?

a. 1- Positive Histology
b. 3- Positive Histology and IHC or Genetic Testing
c. 8- Clinical Dx Only

DIAGNOSTIC STAGING: THORACENTESIS

- How do you code the Diagnostic Staging Procedure for the following Thoracentesis: , positive for metastatic carcinoma?

a. 00 (No surgical diagnostic or staging procedure was performed)
b. 01 (A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site)
c. 02 (A biopsy (incisional, needle, or aspiration) was done of the primary site)

DIAGNOSTIC STAGING:
BRUSHINGS / WASHINGS

- LUL Lung Bx w/ brushing's, washings. Core Bx showed necrotic tissue. Brushings positive for malignancy and susp/f squamous cell carcinoma of lung .

    a. 00 (No surgical diagnostic or staging procedure was performed)
    b. 01 (A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site)
    c. 02 (A biopsy (incisional, needle, or aspiration) was done of the primary site)

CASE 1

8/3/15 PT Presents for bx of abnormal LT axillary mass
Final Pathologic Dx: Metastatic carcinoma of breast origin.
No primary tumor found during workup. Pt to undergo neoadjuvant chemo, possible XRT.

Surgery of Primary Site	
Scope Regional LN Surgery	
Surgery of other Site	
Date of First Cancer Directed Surgery	
Most Definitive Surgery	
Diagnostic Staging Procedure & Date	

Case 1 Rationale:

- **Reason for No Cancer Directed Surgery**: 1 not recommended.
  - No primary tumor found
- **Surgery of Primary Site:** 00 no primary site surgery was performed
- **Scope Regional LN Surgery**: 1 (biopsy or aspiration)
  - Record all surgical procedures that remove, biopsy, or aspirate regional lymph node(s) whether or not there were any surgical procedures of the primary site. The regional lymph node surgical procedure(s) may be done to diagnose cancer, stage the disease, or as a part of the initial treatment. (SPCSM 2015, pg. 133, #3)
- **Surgery of other Site**: 0
- **Date of Cancer Directed Surgery 8/3/2015**
  - Date of procedure coded in scope of regional LN surgery
- **Most Definitive Surgery**: 00/00/0000
  - Date of most definitive surgical resection of the primary site performed as part of the first course of treatment. (FORDS 2016, pg. 138)
- **Diagnostic Staging Procedure & Date**: **00 00/00/0000 (not performed)**
  - Do not code surgical procedures that aspirate or bx regional LNs that are used to dx and/or stage disease in this data item (FORDS 2016, pg 137)

CASE 2

8/3/15 Bx of abnormal LT axillary mass showing metastatic carcinoma of breast origin.
8/15/15 Mod Rad Mastectomy w/ AX LND (10 LNs removed)

Surgery of Primary Site	
Scope Regional LN Surgery	
Surgery of other Site	
Date of First Cancer Directed Surgery	
Most Definitive Surgery	
Diagnostic Staging Procedure & Date	

Case 2 Rationale:

- **Surgery of Primary Site:** 51 mod rad mast w/o removal of the other breast
- **Scope Regional LN Surgery**: 5 (4 or more regional LNs removed)
  - This field is cumulative- code the most definitive procedure
- **Surgery of other Site**: 0
- **Date of first Cancer Directed Surgery 8/3/2015**
  - Date of the LN Bx
- **Most Definitive Surgery**: 08/15/2015
  - Date of most definitive surgical resection of the primary site performed as part of the first course of treatment. (FORDS 2016, pg. 138)
- **Diagnostic Staging Procedure & Date**: **00 00/00/0000 (not performed)**
  - Do not code surgical procedures that aspirate or bx regional LNs that are used to dx and/or stage disease in this data item (FORDS 2016, pg 137)

CASE 3

Pt presents with lump in groin area present x2 mos otherwise asymptomatic.
7/29/16 CT ABD/Pelv: retroperitoneal and LT inguinal LAD, considerations are lymphoma and mets.
9/1/15 Lt Inguinal LN Excision: follicular lymphoma, low grade.

Surgery of Primary Site	
Scope Regional LN Surgery	
Surgery of other Site	
Date of Cancer Directed Surgery	
Most Definitive Surgery	
Diagnostic Staging Procedure & Date	

Case 3 Rationale:

- **Reason for No Cancer Directed Surgery**: 1 not performed.
  - Multiple LN regions involved- no procedure to primary site
- **Surgery of Primary Site:** 00
  - No surgery of primary site
- **Scope Regional LN Surgery**: 9 (Not applicable)
  - Not applicable, LNs are primary site.
- **Surgery of other Site**: 0
- **Date of Cancer Directed Surgery/ Most Definative SUrgery**: 00/00/0000
  - No surgical procedure performed
- **Diagnostic Staging Procedure & Date**: 02 08/01/2016
  - If a LN is biopsied or removed to dx or stage lymphoma, and that LN is NOT the only node involved, use code 02 (FORDS 2016, pg 137)

CASE 4

Case 4
Pt presents with lump in groin area present x2 mos otherwise asymptomatic.
7/29/16 CT ABD/Pelv: LT inguinal LAD, considerations are lymphoma and mets.
9/1/15 Lt Inguinal LN Excision: follicular lymphoma, low grade.
9/15/15 Pt begins chemo.

Surgery of Primary Site	
Scope Regional LN Surgery	
Surgery of other Site	
Date of Cancer Directed Surgery	
Most Definitive Surgery	
Diagnostic Staging Procedure & Date	

Case 4 Source:

- **Reason for No Cancer Directed Surgery**: 0 procedure performed.
- **Surgery of Primary Site:** 25 (local tumor excision)
  - A single LN was removed, this was the only site involved
  - Use of code 25 is for a primary in one and ONLY ONE LN. The single involved LN is removed by an excisional biopsy. (https://seer.cancer.gov/archive/manuals/2013/AppendixC/lymphoma/surgery_codes.pdf)
- **Scope Regional LN Surgery**: 9 (Not applicable)
  - Not applicable, LNs are primary site.- LNs don't have LNs
- **Surgery of other Site**: 0
- **Date of Cancer Directed Surgery/ Most Definitive Surgery**: 09/01/2015
  - Date of excisional bx
- **Diagnostic Staging Procedure & Date**: 00 00/00/0000
  - If a single LN or single LN chain involved with lymphoma, use the data item Surgical Procedure of Primary Site(FORDS 2016, pg 137).

CASE 5

PTA patient was diagnosed with sigmoid colon cancer by colonoscopy on 08/17/2016. Tumor was obviously malignant, but not biopsied.

8/20/16 Sigmoid colectomy, coloproctostomy and BSO: large mid-sigmoid tumor that involved the full thickness of the colon with large nodes in the adjacent mesentery. There was no obvious carcinomatosis, but given the extensive tumor in the pelvis, the surgeon elected to proceed with a BSO to prevent development of metachronous ovarian metastases.

Path: 8/20/16 sigmoid colectomy: Invasive Mucinous Adenoca, meas 6.5 cm, ext into subserosa only. Bilateral fallopian tubes/ ovaries: Neg. 05/14 Reg LNs (+).

Surgery of Primary Site	
Scope Regional LN Surgery	
Surgery of other Site	
Date of Cancer Directed Surgery	
Most Definitive Surgery	
Diagnostic Staging Procedure & Date	

Case 5 Source:

- **Surgery of Primary Site:** 30 (segmental resection/partial colectomy)
  - The operative report and pathology report indicate this was a segmental resection of the sigmoid colon alone.
  - BSO is not recorded as removal of an adjacent/contiguous site and was not removed en-bloc
- **Scope Regional LN Surgery**: 5 (4 or more regional LNs removed)
  - 14 mesenteric (regional) lymph nodes removed at the time of the resection
- **Surgery of other Site**: 2 (non-primary surgical procedure to other regional sites)
  - The operative report indicates the BSO was performed to prevent development of metachronous ovarian metastasis, as there was extensive tumor in the pelvis. The BSO was not an incidental resection. (2016 SEER Manual, SINQ 20041036)
- **Date of Cancer Directed Surgery/ Most Definitive Surgery**: 08/20/2016
  - Date of surgical procedure, only one performed
- **Diagnostic Staging Procedure & Date**: 00 00/00/0000
  - Pt underwent a colonoscopy however no biopsy was performed at that time.

CASE 6

Patient presents with trouble swallowing and thickening noted on scans.

Op Report: 11/11/16 EGD w/ biopsy and placement of Esophageal Stent for tracheoesophageal fistula @ 22-25cm from incisors.

11/11/16 Esophagus Bx at 22cm: Squamous Cell Carcinoma.

No further surgical procedures documented.

Surgery of Primary Site	
Scope Regional LN Surgery	
Surgery of other Site	
Date of Cancer Directed Surgery	
Most Definitive Surgery	
Diagnostic Staging Procedure & Date	

Per FORDS: Stent placement should be coded as Paliative- other

Case 6 Rationale:

- **Surgery of Primary Site:** 00 (no surgery of primary site)
  - The operative report indicates only a stent was placed, no cancer was removed or destroyed.
- **Scope Regional LN Surgery**: 0 (No regional LNs removed)
- **Surgery of other Site**: 0 (None)
  - The operative report indicates a stent was placed due to a fistula formation.
  - Use code 0 when no surgical procedures removed distant LN or other tissue(s), organ(s) beyond the primary site. Procedure is performed to remove or prevent spread of cancer.
- **Date of Cancer Directed Surgery/ Most Definitive Surgery**: 00/00/0000
  - No surgery performed
- **Diagnostic Staging Procedure & Date**: 02 11/11/2016
  - Pt underwent a biopsy, positive for cancer.

CASE 7

78 BM w/end stage kidney disease, w/ recent CT ABD showing very lg 10 cm Lt adrenal mass.

10/19/16 LT Adrenalectomy performed, positive for metastatic P-Diff carcinoma. Differential Dx includes but is not limited to origin from the lung & gastrointestinal system. Pt was placed in hospice and expired on 12/08/15.

Surgery of Primary Site	
Scope Regional LN Surgery	
Surgery of other Site	
Date of Cancer Directed Surgery	
Most Definitive Surgery	
Diagnostic Staging Procedure & Date	

Case 7 Source:

- **Surgery of Primary Site:** 98 (all unknown and ill defined sites)
  - The path report indicates metastatic tumor, no definite site of origin found.
  - Use code 98 for all unknown and ill-defined disease sites, with or without surgical treatment (SPCSM: Surgery of Primary Site)
- **Scope Regional LN Surgery**: 9 (not applicable)
- **Surgery of other Site**: 1 (Non-primary surgical procedure performed)
  - The path report indicates the tumor is metastatic and no primary site can be identified.
  - Assign code 1 when surgery is performed to remove tumors and the primary site is unknown or ill defined. (SPCSM: Surgery of Other Site)
- **Date of Cancer Directed Surgery** 10/19/2016
  - Date the first surgery was performed as part of first course of therapy.
  - This is either the date of the Surgery of Primary Site, Scope of Regional Lymph Node Surgery, or Surgical Procedure of Other Site, whichever is earliest. (SPCSM: Date of first surgical procedure)
- **Most Definitive Surgery**: 00/00/0000
  - No Primary Site surgery performed (FORDS 2016, p 236)
- **Diagnostic Staging Procedure & Date**: 00 00/00/0000
  - No procedure performed.

QUESTION: BLADDER

Please explain how to code intravesicular treatment with mitomycin c when given at the same time as surgery.

Answer: Code the surgical procedure if it's a 20 or higher (polypectomy, TURBT) and code the Mitomycin as single agent chemo.

- Only use codes 15 or 16 if intravesical therapy or BCG were given along with "local tumor destruction" (laser, cryotherapy, etc)- no specimen sent to pathology. AND code the BCG or intravesical chemo in BRM or Chemo.
- If the BCG or intravesical chemo was given on a different day than the surgery code 20 or higher, the BCG or Intravesical therapy would only be coded in Chemo or BRM. Do not code as a more definitive surgery.

MULTIPLE TUMORS Multiple tumors may be a single primary or multiple primaries					Tumors not described as metastases	
M3	Sites with topography codes that are different at the second (C**x**xx) and/or third (Cx**x**x) character				This is a change in rules; tumors in the trachea (C33) and in the lung (C34) were a single primary in the previous rules.	Multiple**
M4		Non-small cell carcinoma (8046) and another tumor that is small cell carcinoma (8041-8045)				Multiple**
M5		Adenocarcinoma with mixed subtypes (8255) and another that is bronchioloalveolar (8250-8254)				Multiple**
M6	Single tumor in each lung				When there is a single tumor in each lung abstract as multiple primaries unless stated or proven to be metastatic.	Multiple**
M7	Multiple tumors in both lungs	Histology codes are different at the first (**x**xxx), second (x**x**xx), or third (xx**x**x) number				Multiple**
M8			Diagnosed more than three (3) years apart			Multiple**
M9			More than 60 days after diagnosis	An invasive tumor following an in situ tumor	*1:* The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed. *2:* Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.	Multiple**
M10		Non-small cell carcinoma, NOS (8046) and a more specific non-small cell carcinoma type (Chart 1)				Single *
M11		Histology codes are different at the first (**x**xxx), second (x**x**xx), or third (xx**x**x) number			Adenocarcinoma in one tumor and squamous cell carcinoma in another tumor are multiple primaries.	Multiple**

LUNG

3/1/16 CT Chest: Bilat lung nodules meas 3cm LUL & 2.9cm RUL w/ hilar and mediastinal LAD. Taken together, findings are consistent with met Lung Ca.
LUL Lung biopsy: Squamous Cell Carcinoma. Rt Lung not biopsied.
Med Onc Consult: Met squamous cell carcinoma of the lung, PLAN: Chemo.

How many primaries does the patient have?

URINARY BLADDER- MP RULES

Rule	Site	Histology	Timing	Behavior	Notes/Examples	Primary
M6	Bladder	Any combination of: • Papillary carcinoma (8050) or • Transitional cell carcinoma (8120-8124) or • Papillary transitional cell carcinoma (8130-8131)				Single*
M7			More than three (3) years apart			Multiple**
M8	Two or more of the following sites • Renal pelvis (C659) • Ureter(C669) • Bladder (C670-C679) • Urethra /prostatic urethra (C680)	Urothelial tumors (See Table 1)*				Single*
M9		Tumors with histology codes different at the first (xxxx), second (xxxx), or third (xxxx) number				Multiple**
M10	Tumors with topography codes different at the second (Cxxx) and/or third (Cxxx) character					Multiple**
M11	Does not meet any of the above criteria				When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.	Single*

URINARY BLADDER- CASE 1

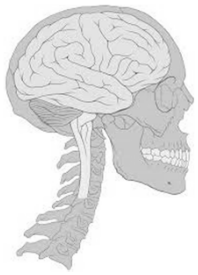
1/5/13 Bladder base TURBT: Non-invasive urothelial carcinoma in situ.
3/5/16 Cystoscopy W/ TURBT 3cm tumor on Trigone: Non-invasive urothelial carcinoma in situ

- ❑ How many primaries should be reported?

URINARY BLADDER- CASE 2

1/5/15 Bladder base TURBT: Non-invasive urothelial carcinoma in situ.
1/5/16 CT Abd/Pelvis: 3cm tumor in Rt Renal Pelvis.
2/11/16 Rt partial nephrectomy: non invasive transistional cell carcinoma.

- How many primaries should be reported?



- What is the Summary Stage for a benign brain tumor such as meningioma?

  0: In Situ
  1: Localized
  5: Regional, NOS
  8: Not applicable
  9: Unstaged

TREATMENT

Q & A

QUESTION

- When coding Radiation Treatment Modality, do we assume 6mv for breast is always 3D or when clarified by Rad Onc?