Included in this Additional Handout are:

- Summary of Issues

(Brain and Other Sites Scenarios are not included in this package. We will be discussing trends and the relevant portions of the scenarios will be displayed on the slides.)

Please have the Presentation Slides (PDF) open during the presentation. We have learned from prior years that the display of the online slides may be blurry depending on connectivity and bandwidth issues. Displaying the pdf of the slides concurrently gives you better visual accessibility.

Summary of Issues Identified in SEER*Educate Workshop Exercises:

General Issue Impacting ALL Solid Tumor Rules Schemas:

1. SINQ 20210065 is still conflicting with the Ambiguous Terminology Rules in the Solid Tumor Rules manual. If very non-specific histologies like 8000, 8001, 8010 are not included in the Ambiguous Terminology Rules (as this SINQ implies), then the Solid Tumor Rules must be updated AND the Solid Tumor Rules need to clearly define which NOS histologies are excluded. SINQ is not used consistently by registrars across the country and conflicting instructions lead to inconsistent coding between registries.
    a. If the Solid Tumor Rules are correct as written, then SINQ 20210065 either needs to be removed or the answer needs to be updated to follow the Solid Tumor Rules.
    b. We received a Disagreement email based on these conflicting instructions so it's clear some registries are following the SINQ and others are following the Solid Tumor Rules manual. Which is correct?

Malignant CNS/Non-Malignant CNS:

1. Provide clarification about the priority order of histology coding sources and an explanation of why the annotated histology lists are not the same as the full 2021 ICD-O-3.2 histology lists. We had multiple users unable to find the applicable histology in the ICD-O-3.2 (i.e., the site-specific table did not include the histology) because they were using the annotated histology list and could not find the complete list of related terms or synonyms for the histology code.
    a. For example, the ICD-O-3.2 lists Medulloblastoma, SHH-activated, NOS as a related term for 9471/3, but many users were unable to find this valid histology because they were using the annotated histology list, not the ICD-O-3.2.

2. There are typos in the 2023 Annotated Histology List and the 2023 ICD-O-3.2 Update tables (Tables 1 & 2) (the NAACCR Implementation Guidelines). These standard setter references indicate the New Term for morphology 9500/3 is "CNS tumor with BC**C**R internal tandem duplication," but this should be "CNS tumor with BC**O**R internal tandem duplication" per both the WHO Blue Book and the Solid Tumor Rules (Table 3: Specific Histologies, NOS, and Subtypes/Variants, Malignant CNS).
    a. This typo confused several users and resulted in the histology for a 2023 diagnosis of "CNS tumor with BCOR internal tandem duplication" being coded to another histology instead of 9500/3.

3. There is a possible typo in Table 6: Specific Histologies, NOS, and Subtypes/Variants (Non-Malignant CNS). In the Papillary glioneuronal tumor 9509/1 row, Column 1, should Note 2 state, "Beginning with cases diagnosed 1/1/2023 forward, diffuse leptomeningeal glioneuronal tumor is coded 9509/3. See the Malignant CNS rules"? Currently the Note only states, "leptomeningeal glioneuronal tumor," but the histology that changed behavior is listed in both Table 6 (Non-Malignant CNS) and Table 3 (Malignant CNS) as, "Diffuse leptomeningeal glioneuronal tumor."

4. Users asked, "Why isn't high grade astrocytoma with piloid features grouped together with the other astrocytoma histologies as a subtype/variant of astrocytoma"?

a. It appears there was some confusion about finding this new malignant HGAP tumor (2023+). If this isn't a specific subtype/variant of astrocytoma, can clarification be added to the New for 2023 entry for HGAP?

5. SINQ 20180102 needs a date range added to the answer because it no longer applies to a 2023 diagnosis of CNS tumor with BCOR internal tandem duplication. This SINQ provided a provisional morphology for these tumors prior to the NEW TERM being added to the 2023 ICD-O-3.2 update. The provisional morphology now should only apply to diagnoses prior to 2023.

6. Why don't the Solid Tumor Rules provide abbreviations and definitions for all situations? The abbreviations or definitions used in these presentations did cause confusion as they are not covered in the Solid Tumor Rules manual, but these are valid abbreviations and are being used in medical records (these exercises came from **real** de-identified cases). Examples (not a complete list):
    a. SHH = Sonic hedgehog, sometimes this abbreviation is defined in the medical record, but SHH is not defined anywhere.
    b. Internal tandem duplication = ITD. BCOR-ITD is the same as BCOR-internal tandem duplication.
    c. Rosette-forming glioneuronal tumor = RGNT. This is often abbreviated in medical records as RGNT, but this isn't defined in the Solid Tumor Rules. However, other complex histology terms have abbreviations provided (i.e., DLGNT is listed as a synonym for "Diffuse leptomeningeal glioneuronal tumor").

Other Sites:

1. New SINQ entry recently submitted by Seattle SEER registry; included here to provide a complete list of issues: **Question:** When no other information is available regarding the origin of the tumor, can an overlapping cervical adenocarcinoma (C538, 8140/3) be coded to the endocervix (C530) based on the histology? **Discussion:** Adenocarcinoma is a glandular tumor, and the endocervix is generally the origin of glandular tissue for the cervix. However, if the only available information is pathology proving a single tumor overlapping the endocervix and exocervix, can we code the site to C530 instead of C538 based on the histology? Applying the current primary site coding instructions, primary site would be coded as C538 because there is no specific statement of the tumor origin, the primary site coding instructions state the tumor is coded to an overlapping site in the absence of a specific statement of origin, and there is no existing SINQ confirming the site can be assumed to be the endocervix based on the histology.

2. New SINQ entry recently submitted by Seattle SEER registry; included here to provide a complete list of issues: **Question:** Should histology be coded as 8045 (Combined small cell carcinoma) for a 2023 diagnosis of two-component carcinoma comprised of both acinar adenocarcinoma and small cell neuroendocrine carcinoma of the prostate? **Discussion:** This patient does not have a previous diagnosis of prostate adenocarcinoma or a previous history of androgen-deprivation therapy. While not applicable to the Solid Tumor Rules (STR), does the logic in the MPH Other Sites SINQ 20200052 still apply to the STR Other Sites? This SINQ confirms a diagnosis of mixed prostatic adenocarcinoma and small cell neuroendocrine carcinoma is 8045. This matches the STR instructions for Rule H21 and Table 2 (Mixed and Combination Codes), row 1. Row 1 indicates the histology combination term

and code for a mixed small cell carcinoma and adenocarcinoma is combined small cell carcinoma (8045). For a patient without previous treatment, is this the correct mixed histology code?

3. Table 3 (Prostate Histologies) either has an error in the Notes for the Adenocarcinoma with neuroendocrine differentiation 8574/3 row, or it requires further clarification because Note 1 conflicts with Note 2 currently. Note 1 states, " This histology is considered treatment-related neuroendocrine prostatic carcinoma demonstrating complete neuroendocrine differentiation or partial neuroendocrine differentiation with adenocarcinoma after androgen-deprivation therapy." However, then Note 2 states, "Code 8574/3 only when there is no history of previous prostate adenocarcinoma or history of androgen-deprivation therapy."
    a. If the definition of this histology is literally **treatment-related**, WHY would we use this code for patient without a history of prostate adenocarcinoma or androgen-deprivation therapy? The WHO Blue Book does confirm this is a treatment-related histology, so it seems we would **ONLY** use this for an adenocarcinoma with neuroendocrine differentiation (or even possibly a mixed histology tumor comprised of adenocarcinoma and small cell carcinoma) ***IF*** the patient had previous treatment.
    b. Should Note 2 be corrected?
    c. Does this histology apply to a **post-treatment** diagnosis of mixed adenocarcinoma and small cell carcinoma? If yes, should this clarification be added?
        i. Histology 8574 was a frequent response for Workshop Case 03, but in this exercise there was no previous prostate primary or previous androgen-deprivation therapy (and the diagnosis was not exactly "adenocarcinoma with neuroendocrine differentiation"), so it does not seem appropriate to use 8574.

4. Table 2 (Mixed and Combination Codes) requires site designations. There are MULTIPLE possible entries (rows) for a tumor comprised of a neuroendocrine component and non-neuroendocrine component, but these rows do not specify which primary sites are applicable. Row 1 (Combined small carcinoma, 8045) seems applicable to a prostate primary, but not to a GI primary since GI primaries are now generally referred to as MiNENs (mixed neuroendocrine non-neuroendocrine tumors), but Table 2 doesn't provide any instructions on how to determine the difference between 8045 and 8154 (or 8244). For Workshop Case 03 (that mixed prostate case again), many users selected 8154 or 8244 as the mixed histology code per Table 2, but these histology codes are not listed as applicable in Table 3 (Prostate Histologies). Per the WHO Blue Books, these histologies are not listed as applicable to the prostate. How are registrars to determine the correct mixed code without site designations, especially if they don't have access to the WHO Blue Book or to a pathologist who may be able to clarify the codes?

5. Other Sites Rule H13: Should an additional Note be added to Rule H12 to indicate if the diagnosis is an NOS histology in a polyp, continue on through the rules? OR should Rule H13 be moved ahead of Rule H12 in order to capture this specific histology? The accuracy rate for Workshop Case 04 (a duodenal invasive adenocarcinoma in an adenomatous polyp) was very low because Rule H13 was either being ignored or users were stopping at Rule H12 to code adenocarcinoma. If the presence of an NOS histology in a polyp is still clinically relevant for the Other Sites module, this information will be missed due to the order of the H Rules or the lack of a Note being associated with the "Code the histology when only one histologic type is identified" rule.

a. If a change is made to Rule H12 (Single Tumor: Invasive Only module), then changes must also be made to the Single Tumor: In Situ Only module and the Multiple Tumors Abstracted as a Single Primary module because both these modules include the same polyp coding H Rule.

6. Table 11 (Pancreas Histologies) contains an error in the Intraductal papillary mucinous neoplasm 8453 row. The synonyms in Column 2 includes, "Intraductal oncocytic papillary neoplasm with an associated invasive carcinoma 8453/3," but "Intraductal oncocytic papillary neoplasm with an associated invasive carcinoma" is a different histology and is listed on a different row in Table 11. This specific histology is 8455, not 8453. Should this synonym be removed? Or is the term "mucinous" missing from the 8453 row?

7. It may be helpful to add a definition for "Teratoma with somatic-type malignancy" (9084) to the Solid Tumor Rules manual because we included this histology in Workshop Case 12 and the histology coding accuracy was less than 40%. From emails we received, it's clear that registrars are unaware that the "somatic type malignancy" can vary, but we'd still use this code when the diagnosis is teratoma WITH any non-germ cell tumor component.