

Breast – Multiple Primary and Histology Coding Questions

General

- 1. Does neoadjuvant therapy affect the multiple primary rules?**
 - A. Per SEER (4/25/07), neoadjuvant therapy has no affect on determining histology using the MPH rules.*

- 2. Do these new rules overwrite the “Complex Morphology Coding Rules” ?**
 - A. DSQC Statewide Memo 2006-01 replaced the Complex Morphology Coding Rules. These new rules apply for cases diagnosed January 1, 2007 forward.*

- 3. If you only have the pathology report CAP protocol information and it does not include a final diagnosis, which fields of the protocol would be used to determine the histology and if there is carcinoma in situ present?**
 - A. SINQ 20071048 states: If the CAP protocol is used in lieu of a final diagnosis, use all of the information in the CAP protocol.*

- 4. Why can't we use the microscopic on breast cases?**
 - A. SEER FAQ #1 states: Were your pathologists aware that you coded from the micro before? Pathologists were surprised when they learned that registrars have been incorrectly using the details described in the microscopic for coding and support the use of coding from the final diagnosis. The micro describes everything the pathologist sees (pieces of the puzzle) and not the overall impression of the tumor. When the pathologist dictates the final diagnosis they are describing their overall interpretation and using their expertise to make the diagnosis.*

Multiple Primaries

- 5. M4. If the second digit of the ICD-0-3 code is different isn't that a different primary site?**
 - A. Yes. This rules states if you have different primary sites, you have multiple primaries.*

6. **M6. Inflammatory carcinoma in one or both breasts. It does not state the inflammatory carcinoma must be from the final pathologic diagnosis. Can a clinical diagnosis of inflammatory carcinoma be used to determine multiple primaries?**

A. *M2 and M6 refer to pathologically confirmed inflammatory carcinoma only.*

7. **If there is an inflammatory carcinoma in one breast and a non-inflammatory in the other breast, is this a single or multiple primary?**

A. *M7 states these would be multiple primaries. If you get a case like this, submit it to the CCR Inquiry System. More factors may need to be considered.*

8. **When there is an invasive tumor following an in situ tumor within 60 days, is the behavior coded to invasive?**

A. *Yes, code the behavior to invasive.*

Histology

9. **H1. Can histology from radiology be used?**

A. *Apply the priority order for using documents to code histology when there is no cytology or pathology report available. Histology from radiology cannot be used for in situ tumors.*

10. **What is the difference between H3 and H6?**

A. *H3 states to code a more specific histologic term, if available. An example would be if the pathology report stated "intraductal carcinoma, cribriform type". This would be coded to ductal carcinoma in situ, cribriform type, 8201/2. **H6 has a correction.** It should state that you would have an intraductal carcinoma and two or more specific intraductal types or two or more intraductal carcinomas. An example would be if the pathology report stated "in situ carcinoma, papillary and cribriform type." You would have already eliminated any comedocarcinoma combinations using H4 and the lobular and ductal combinations are eliminated in H5.*

11. H4. Is comedonecrosis the same as comedocarcinoma?

A. No, they are not the same. Comedonecrosis is defined as a type of necrosis occurring with glands in which there is central luminal inflammation with devitalized cells, usually occurring in the breast intraductal carcinoma. Comedocarcinoma is characterized by solid sheets of high grade malignant cells and central necrosis.

12. H6. Should it state “more than one specific type” rather than “one or more specific type”?

A. Yes, there is a correction to H6. It should state that a combination of intraductal carcinoma and two or more specific intraductal types or two or more intraductal carcinomas.

13. If the pathologist does not use terminology in Table 1 or Table 2 can you use it?

A. Only use the terminology in Table 1 or Table 2. Remember, the words “pattern” and “architecture” are not used for invasive tumors. If these terms are used with invasive tumors, consult the pathologist.

14. If a breast cancer has both invasive and in situ components, the in situ component is ignored?

A. Correct, code to the invasive, H9. The invasive component determines prognosis and survival.

15. Usually inflammatory carcinoma of the breast is a clinical diagnosis.

A. Correct. Inflammatory carcinoma is a clinical manifestation of ductal carcinoma. H13, Use the histology code for inflammatory carcinoma only if it is stated in the final diagnosis of the pathology report.

16. How is a ductal and lobular carcinoma combined with other subtypes coded? 8522 or 8523?

A. H16 states to include subtypes of ductal when selecting code 8522.

Cases

17. Case #2. This case has both DCIS with cribriform pattern.

A. *Pattern is a descriptor that indicates a specific type of ductal carcinoma in situ (Table 1), therefore this case is coded to 8201/2 ductal carcinoma in situ, cribriform type.*

18. Case #3. If at diagnosis the tumor was a single ductal carcinoma, and on day 61 during the work-up there is a lobular, how is this abstracted?

A. *This is would be reported as a single primary if the patient is still undergoing diagnostic work-up greater than 60 days. SEER FAQ#17 states: When the invasive component is discovered as part of the work-up phase leading to treatment decisions, the case would be abstracted as a single primary. In the rare instance when a patient has not been treated and is still having diagnostic work-up greater than 60 days after the malignancy is diagnosed, do not count the invasive diagnosis as a new primary.*

19. Case #5. Are the descriptors apocrine and metaplasia ignored?

A. *Yes.*

20. Case #9 It was noted that there was no documentation in the histology rules regarding needing a percentage of mucinous component, such as noted in the colon rules. Do we need a percentage in order to be able to code mucinous carcinoma of the breast? See Breast case #9.

A. *Unlike colon, a percentage of mucin is not needed to code mucinous carcinoma of the breast. Code the histology from the final diagnosis. If the final pathology report states mucinous/colloid carcinoma, code it as such.*

21. Case #9. Answer sheet states to code to colloid carcinoma. Please explain which rule was used to derive that code.

A. *In case #9, there are 2 tumors and Multiple Primary rule M12 applies, which states that "Histology codes are different at the first, second or third number," are multiple primaries. Tumor #1 is an invasive ductal carcinoma. Tumor #2 is invasive ductal carcinoma with extensive mucin production (colloid carcinoma). This is an example of when to apply rule H17, code 8523. Note: This answer is updated from the answer sheet provided at the 2007 Data Changes training. The SEER Breeze session dated*

12/15/06 clarifies the answer. Unlike colon, colloid carcinoma in the breast does not need to have a percentage of mucin identified to code it as such.