May 2025 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Coding Tips for Distant Summary Stage Melanoma

Our NJSCR staff is currently conducting an internal quality review on coding of Tumor Size, EOD Primary Tumor, Breslow Tumor Thickness and Unknown LDH Value for Distant Summary Stage (Metastasized) Melanoma.

Please note the following coding reminders:

- Tumor Size is coded as 000 when no primary tumor is found
- Breslow Tumor Thickness is coded as 0.0 when no primary tumor is found
- EOD is coded as 800 when there is no evidence of primary tumor

Most of the patients reviewed have no documented LDH testing; these patients may not be getting the LDH test.

** Tumor Size Summary | EOD Data SEER*RSA

SEER staff is requesting patience when utilizing Ask a SEER Registrar.
Before submitting a question, please first search the SEER Inquiry System and feel free to reach out to your NJSCR representative!

Please include managing/follow-up or hematology/oncology physicians in abstracts when available! While not required, this information is valuable for research studies.

Keratocanthoma, also known as Squamous Cell Carcinoma, Keratinizing (8071/3) is NOT reportable for skin except when they are diagnosed in the labia, clitoris, vulva, prepuce, penis or scrotum.

**SEER SINQ

NEW CODING SHORTS ON FLccSC!!!
Check out the new EOD RSA Changes 2025 video!
Check out the SEER Manual 2025 Changes video!
FCDS - LMS - Frontend - Log In
Submission recommendations for reporting year:
All 2024 records submitted by July 1, 2025.

2025 Changes to EOD Colon and Rectum Circumferential Resection Margin (CRM)

Please see below for additions to 2025 CRM coding notes:

- **Other Names for CRM include:** (in addition to those previously stated) mesenteric excision plane, pericolonic resection margin
- **Note 2:** A surgical resection must be done to evaluate tumor deposits
- **Coding Guideline 7:** Code XX.0 for margins described as greater than 100mm
- **Coding Guideline 8:** Codes 0.1-99.9 are for coding the exact measurement in mm of the negative margin
- **Coding Guideline 11:** Codes XX.3-XX.6 are for when the pathology uses "at least" categories

****Circumferential Resection Margin (CRM) | EOD Data SEER*RSA

Changes to Subsequent Treatment guidelines in 2025 STORE Manual

"First course of therapy ends when there is documentation of disease progression, recurrence, or treatment failure" per SEER Program Coding and Staging Manual 2025

- If first course of treatment changes due to an improvement in the tumor burden, the added treatment is still considered first course.
- If there is no progression and treatment is added because of improvement, this is considered first course of treatment.

Example: Initially, resection of primary tumor was contraindicated due to tumor size and location. Palliative chemotherapy/radiation is recommended and administered per the first course treatment plan. Follow up imaging shows improvement in tumor burden, and treatment plan changed to include surgery since tumor is now resectable. The primary tumor resection was not noted in the original treatment plan, but resection is first course of treatment since no progression of tumor.

**STORE Manual 2025
**SEER Program Coding and Staging Manual 2025

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email. The information provided here is correct as the distribution date of the newsletter. **Always check your manuals!**

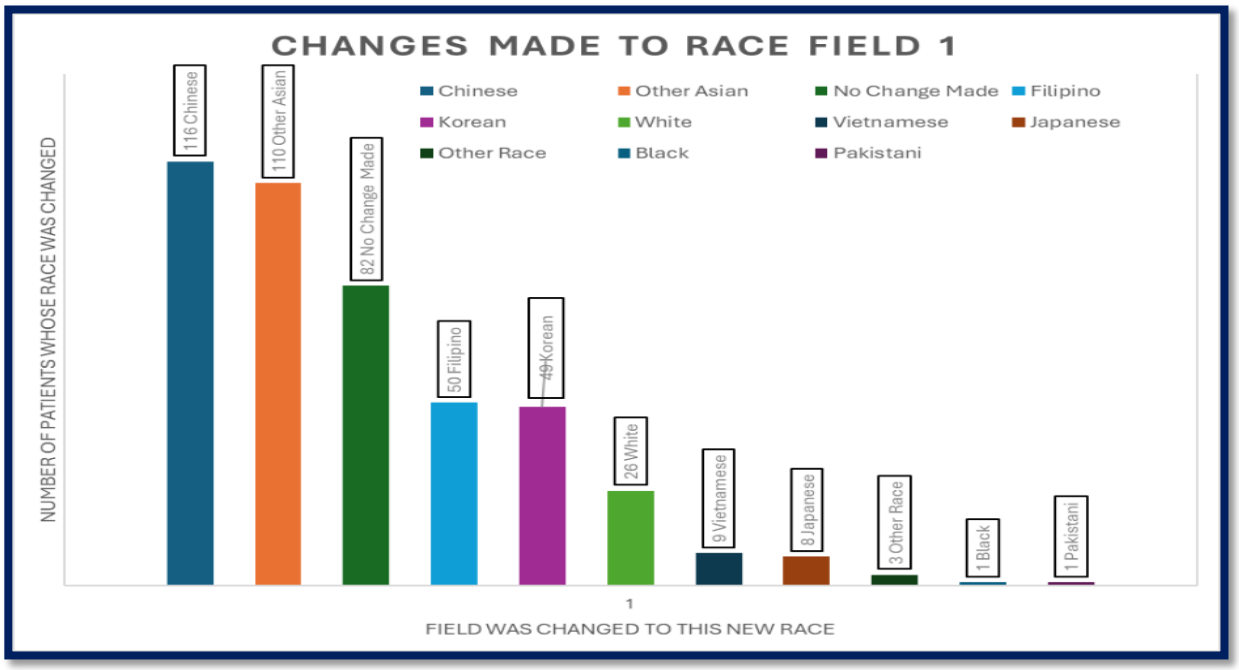
April 2025 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

RACE CODING IS AN IMPORTANT DATA ITEM FOR CANCER RESEARCH!

NJSCR recently performed a Quality Review of Race Codes 15 and 16 for NJ Cases

- Errors were suspected with the coding of **Asian Indian, NOS or Pakistani, NOS (Race code 15) and Asian Indian (Race code 16)** in the NJSCR database (SEER*DMS).
- A data search revealed 3,155 patients diagnosed from 2022-2024 with code 15 or 16 in Race 1.
- We reviewed 455 of these patients, due to having names and birth places characteristic of other Asian races (i.e. Chinese, Filipino, Korean, Vietnamese and Japanese).
- A visual scan of all text fields was done to find documented evidence of another Asian race.
- Much of the text submitted by hospitals simply described the patient as Asian, and not specifically Asian Indian, yet Race 1 was coded to 15 or 16.
- **373 patient sets (nearly 82% of the 455 cases) were changed to another race based on our review.**
- As per below graph, we changed 116 patients to Chinese, 50 to Filipino, 49 to Korean, 26 to White, 9 to Vietnamese, 8 to Japanese, 3 to Other Race, 1 to Black and 1 to Pakistani. 110 were changed to Other Asian, Race code 96. No changes were made to 82 patients, and a second race was added to some.



- **This review demonstrates the importance of providing strong text to increase accuracy in all aspects of our abstraction.**
- **Additionally, we recommend avoiding the use of the abbreviation "AI" in text, as this could be interpreted as Asian Indian or American Indian.**
- **Please don't hesitate to contact your NJSCR representative if you have any questions on race coding.**

NCRA 2025 Conference attendees can visit the NJSCR poster presentation "NJ Review of Race Codes 15 and 16, Asian Indian/Pakistani, NOS or Asian Indian" to learn more on this important topic.

HISTOLOGY CODING TIP!

Urinary Histology

Did you know that Adenocarcinoma, Intestinal Type 8144/3 can also be coded as a Urinary Primary?

*For Urinary sites, 8144/3 is known as **Enteric Adenocarcinoma**.*

**Solid Tumor Rules 2025 Update

NEW CODING SHORT ON FLccSC!!!

Check out the new SEER Manual 2025 Changes video!

FCDS - LMS - Frontend - Log In

Submission recommendations for the reporting year:

All 2024 records submitted by July 1, 2025.

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email. The information provided here is correct as of the distribution date of the newsletter. Always check your manuals!

March 2025 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

EOD REMINDER: PROSTATE PATHOLOGIC EXTENSION CODE 950

While Code 900 is used frequently, please review Note 9 which reminds us of the use of code 950!

Note 2: No radical prostatectomy or autopsy

- ✓ Code 900 if there is no radical prostatectomy or autopsy performed within first course of treatment.

Note 9: Active surveillance, *then* Radical Prostatectomy

- ✓ **Code 950** is used when first course of treatment is active surveillance, but a radical prostatectomy is done at a later date due to disease progression or the patient changed their mind.
- ✓ When code 950 is used, code the following SSDI's as X9: Gleason Patterns Pathological, Gleason Score Pathological, and Gleason Tertiary

**EOD Prostate Pathologic Extension | EOD Data SEER*RSA

REPORTABILITY -- LIVER

QUESTION: Is a 2023 cholangiocarcinoma case with Liver Imaging Reporting And Data System (LI-RADS) M (LR-M) lesion on imaging reportable?
ANSWER: Report LR-M unless there is information to the contrary. The American College of Radiology defines LR-M as "probably or definitely malignant, not necessarily hepatocellular carcinoma (HCC)."
**SEER Inquiry System - Question 20250011 Details

BREAST TUMOR SIZE TIP! Exception to rounding rules for BREAST primaries: **Round tumor sizes greater than 1.0 mm and up to 2.4 mm to 2 mm (002).** The purpose of this exception is so that the size recorded in the Tumor Size Summary data item will derive the correct AJCC TNM Primary Tumor (T) category for breast primaries. Do not apply this instruction to any other site.
**SEER Program Coding and Staging Manual 2025

REPORTABILITY/HISTOLOGY -- ENDOMETRIUM

QUESTION: Are the following terms and diagnoses synonymous with endometrioid intraepithelial neoplasia (EIN) and therefore reportable?
ANSWER: Reportability for EIN became effective in 2021. See scenarios.

1. ATYPICAL GLANDULAR EPITHELIUM
Scenario: Endometrium biopsy with ablation performed at Facility A on 8/7/2024 showed atypical glandular epithelium. Patient was sent to Facility B where the total abdominal hysterectomy/bilateral salpingo-oophorectomy (TAH/BSO) on 9/20/2024 showed other reactive fibrosis and obliterated architecture compatible with history of ablation.
DO NOT REPORT ATYPICAL GLANDULAR EPITHELIUM. Atypical glandular epithelium, also referred to as atypical glandular cells (AGC), refers to abnormal looking cells that may be found in the tissue lining the inside of the endometrium or the cervix. While not malignant, they can be associated with a range of lesions in the female reproductive system.

2. ISTHMIC-TYPE MUCOSA WITH FOCAL SEVERE ATYPIA
Scenario: Endometrium biopsy showed isthmic-type mucosa with focal severe atypia. Then Facility B did TAH/BSO that showed no evidence of high grade dysplasia, atypical hyperplasia, or carcinoma.
DO NOT REPORT ISTHMIC-TYPE MUCOSA WITH FOCAL SEVERE ATYPIA. The NCI data dictionary defines atypia as an abnormality in cells in tissue. Report the case when further defined as atypical hyperplasia.

3. SIMPLE HYPERPLASIA WITHOUT ATYPIA
Scenario: Endometrial biopsy pathology states simple hyperplasia without atypia and the TAH/BSO is either negative or has the same histology; however, the treating physician is stating EIN.
DO NOT REPORT SIMPLE HYPERPLASIA WITHOUT ATYPIA. WHO Classification of Tumors online, Female Genital Tumors (5th ed.), defines endometrial hyperplasia without atypia as a proliferation of endometrial glands of irregular size and shape without significant atypia. There is no ICD-O code for this term. Simple endometrial hyperplasia without atypia is an acceptable related term for endometrial hyperplasia without atypia. Pathology has priority over a physician statement.

4. EIN/CAH OR FOCAL EIN/CAH
Scenario: Biopsy showed EIN/CAH but the total abdominal hysterectomy/bilateral salpingo-oophorectomy (TAH/BSO) pathology or the Mirena IUD treatment operative note states no EIN/CAH/Atypical hyperplasia. Are these reportable, similar to an in situ when the re-excision lumpectomy or mastectomy is negative or no residual disease?
REPORT EIN/CAH OR FOCAL EIN/CAH (8380/2) based on the biopsy. WHO Classification of Tumors online, Female Genital Tumors (5th ed.), defines EAH/EIN as a simultaneous change of epithelial cytology and an increased number of endometrial glands in a defined region. The preferred term is atypical hyperplasia of the endometrium; terms not recommended include complex atypical endometrial hyperplasia; simple atypical endometrial hyperplasia; endometrial intraepithelial neoplasia.
** SEER Inquiry System - Question 20250001 Details

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email. The information provided here is correct as the distribution date of the newsletter. **Always check your manuals!**

February 2025 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

NCCN Updates on Melanoma and Pancreatic Adenocarcinoma

NCCN has published updates to the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) and the NCCN Drugs & Biologics Compendium (NCCN Compendium®) for Melanoma: Cutaneous and for Pancreatic Adenocarcinoma. These NCCN Guidelines® are currently available as Version 2.2025.

**NCCN Update for Melanoma
**NCCN Update for Pancreatic Adenocarcinoma

REMINDER!

Never underestimate the importance of Accurate Text in your abstracting! Please refer to this SEER Module for Common Abbreviations.

**https://training.seer.cancer.gov/abstracting/additional/abbreviations/all.html

SEER Manual 2025 Coding Note Addition

There is a new coding instruction under Surgical Margins of Primary Site!

Assign code 9:

a. When Surgery of Primary Site 2023 (NAACCR Item #1291) is coded to A980 (not applicable)

b. When it is unknown whether a surgical procedure of the primary site was performed or there is no mention in the pathology report or no tissue was sent to pathology SEER Program Coding and Staging Manual 2025 January 2025 Section VII: First Course of Therapy 187

c. When patient has a transurethral biopsy of bladder tumor (TURBT) and surgical margins are not mentioned in the TURBT report. The operative report may mention no residual tumor.

d. For any case coded to primary site C420, C421, C423, C424, C760-C768, C770-C779, or C809

e. For death certificate only (DCO) cases

** SEER Program Coding and Staging Manual 2025

Reportability/Histology

Question:

Conjunctiva- Is low-grade conjunctival melanocytic intraepithelial lesion (LG-CMIL) with focal high-grade features of the conjunctiva (C690) reportable? If reportable, what histology should be assigned?

Discussion: Additional comments in this pathology report state "The entire case was sent in consultation to an ophthalmic pathologist. [Pathologist] assigns a conjunctival melanocytic intraepithelial neoplasia (C-MIN) score of 2-3 due to the upward pagetoid migration of small, dendritic melanocytes. A C-MIN score of 2-3 is between low-grade conjunctival melanocytic intraepithelial lesion (LG-CMIL; C-MIN 2) and high-grade conjunctival intraepithelial lesion (HG-CMIL; C-MIN 3). The older terminology for this lesion would be primary acquired melanosis (PAM) with mild to focally moderate atypia."

This term does not appear in the SEER Program Coding and Staging Manual (SPCSM), Appendix E1 of the SPCSM, or Solid Tumor Rules (specifically rule H3).

Answer: Conjunctival melanocytic intraepithelial neoplasia (C-MIN) is reportable; therefore, low-grade conjunctival melanocytic intraepithelial lesion (LG-CMIL) with focal high-grade features of the conjunctiva (C690) is reportable, 8720/2. We will add this to a future edition of the SEER manual.

** SEER SINQ 20240079

NJSCR will be converting to v25 in late March.

Reporting software must be updated to v25 to submit 2025 cases. NJSCR will not be able to accept 2025 cases in v24.

Check out the 2025 NJSCR Program Manual, along with the Summary of Changes, and the 2025 Reportable List!!
Department of Health | Cancer | NJ State Cancer Registry

Completeness rate recommendation for facilities:
75% of 2024 records submitted by the end of April 2025.
All 2024 records submitted by July 1, 2025.

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email. The information provided here is correct as the distribution date of the newsletter. **Always check your manuals!**

January 2025 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Primary Site Coding Tip from SEER Manual 2025 Summary of Changes:
How do we code primary site for a single tumor overlapping a reportable site and a non-reportable site?

Added Coding Instruction 4.b:

- Single tumor overlapping a reportable site and a non-reportable site: Determine the site of origin or the site with the greatest involvement
- If the site of origin/site with greatest involvement is the reportable site, report the case and assign the appropriate topography code
- If the site of origin/site with greatest involvement is the non-reportable site, do not report the case
- If the site of origin/site with greatest involvement cannot be determined, do not report the case because you cannot confirm reportability

Example: Squamous cell carcinoma overlapping skin and vermillion of upper lip**. If the site of origin is the vermillion, report the case.** If the site of origin cannot be determined and more than 50% of the lesion is on the vermillion, report the case. If less than 50% of the lesion is on the vermillion, do not report the case. If the site with the greatest involvement cannot be determined, do not report the case.

**SEER Manual 2025 Summary of Changes **

Uterine/Cervix Coding Notes

- In situ carcinoma of cervix (/2), any histology, is not reportable
- p16 is a valid test to determine HPV status and can be used to code HPV associated and HPV independent histologies.
- When the diagnosis is a subtype/variant of squamous cell carcinoma and HPV status is also noted, ignore the HPV status and code the subtype/variant.
- *EXCEPTION: When keratinizing or non-keratinizing SCC are included in the diagnosis with HPV status, code the appropriate HPV histology: 8085 or 8086.*
    - **Please note:** The instruction to code the subtype/variant *over* 8085 or 8086 applies to the following sites: oropharynx, cervix, vagina, vulva, anus and penis.

Solid Tumor Rules 2025 Update

Vulvar Intraepithelial Neoplasm Grade 2 (VIN II) is *reportable* when documented alone. Use histology code **8077/2.**
****SEER Inquiry System - Question 20240076 Details**

Primary Site Question:
An 80-year-old post-menopausal female (status post hysterectomy for benign reasons) presents with a retroperitoneal mass on imaging. The pre-operative imaging shows the *cervix* and uterus are absent. What is the primary site code for a final diagnosis of endometrioid adenocarcinoma from a biopsy of a right retroperitoneal mass?

Answer: Code Primary Site to C480 (retroperitoneum). Endometrial tissue may "break away" from the uterus and implant throughout the pelvic and abdominal cavities. This tissue remains behind when surgical removal of the uterus is done. Common sites of implantation are colon, peritoneum, retroperitoneum, and bladder. When the uterus and cervix are no longer present, code the site where the carcinoma was identified.
Please note: The site-morphology combination of C480 and 8380/3 was designated as an unlikely site-morphology combination by the Cancer PathCHART, as this is a rare type of tumor. Assign a value of 1 in the Over-ride Site/Type data item.
**SEER Inquiry System - Question 20240077 Details

Important Announcement
FLccSC is back!!!
Check for an email from FLccSC to reset your password.
Click on link to register for free webinars and CE's.

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email. The information provided here is correct as the distribution date of the newsletter. **Always check your manuals!**