December 2025 E-Tips

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

WISDOM WEDNESDAYS!!!

Thank you for participating in our December **Wisdom Wednesday** quiz! See below correct answers and rationales:

How is histology coded for an ovary case with a dx of "high grade papillary serous carcinoma" in 2023?

Correct response: 8461/3 High Grade Serous Carcinoma

Rationale: In this situation, "high grade papillary serous carcinoma" is considered equivalent to "high grade serous carcinoma" (8461) *rather than* "papillary serous adenocarcinoma" (8441) with high grade captured only in the grade fields, or another histology code.

****SEER Inquiry System - Question 20240068 Details**

A fallopian tube specimen from 6/14/2025 contains: "Serous tubal intraepithelial carcinoma (STIC) without stromal invasion." No invasive carcinoma is present elsewhere. Is this reportable?

Correct response: Yes, STIC is a reportable in situ carcinoma

Rationale: As per Solid Tumor Rules, Serous tubal intrepithelial carcinoma (/2) or STIC (/2) is reportable for the Fallopian Tube as 8441/2.

****https://seer.cancer.gov/tools/solidtumor/current/STM_Combined.pdf**

How would you code the histology for a malignancy arising in a benign teratoma of the ovary as reported on biopsy 2/8/23?

Correct response: 9084/3 Teratoma with malignant transformation

Rationale: For ovarian primaries, code 9084/3 Teratoma with malignant transformation when a malignant (/3) histology arises in a benign teratoma.

****https://seer.cancer.gov/tools/solidtumor/current/STM_Combined.pdf**

REPORTABILITY/HISTOLOGY – Adrenal Gland

Question:

Adrenal Gland: Is a case of pheochromocytoma reportable?
The adrenal resection that was sent out for expert review final diagnosis is: Pheochromocytoma Impression with comment: Benign Pheochromocytoma based on Pheochromocytoma of the Adrenal gland Scaled Score (PASS) of 4.

Answer:

***Report pheochromocytoma (8700/3)**. According to WHO Classification of Endocrine and Neuroendocrine Tumors, 5th edition, patients with pheochromocytomas are currently considered to have a lifelong risk of metastases and therefore conceptually they are all considered 'malignant.'*
**https://seer.cancer.gov/seer-inquiry/inquiry-detail/20250024/

Bonus Tip:
Extra-Adrenal/Kidney

Extra-adrenal pheochromocytoma (8700/0) is not reportable
Extra-adrenal paraganglioma (8693/3) is **reportable for kidney** beginning 1/1/2024
**https://seer.cancer.gov/tools/solidtumor/current/STM_Combined.p

2026 SOLID TUMOR RULES UPDATE!

The Solid Tumor Rules have been updated for 2026. In addition to the standard annual updates, the Solid Tumor Manual underwent a substantial reformatting to improve clarity and usability.
**https://seer.cancer.gov/tools/solidtumor/

FREE EDUCATION OPPORTUNITY!

V26 Updates: Solid Tumor Rules, SSDIs, CPC and More
Participants must register in advance and will be eligible for 2 CE credits!
**NAACCR Online Education:Updates/Implementation

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!

November 2025 E-Tips

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WISDOM WEDNESDAYS!!!

Thank you for participating in our October **Wisdom Wednesday** quiz! See below for correct answers and rationales

A patient presents with metastatic squamous cell carcinoma in a left level II cervical lymph node, and extensive work-up fails to reveal a primary site. What is the correct primary site code?

- **Correct Response: C76.0- Head, face, or neck, NOS**
- **Rationale:** When the medical record does not contain enough information to assign a primary AND you have a positive cervical lymph node, you can assign C760 for occult head and neck primaries per SEER manual note 17**.**
- **https://seer.cancer.gov/manuals/2025/SPCSM_2025_MainDoc.pdf

Pathology report shows excision, lower lip lesion: Invasive squamous cell carcinoma arising on vermillion border. What is the correct primary site code?

- **Correct Response: C00.1- External lower lip**
- **Rationale: Assign C00.1, external lower lip. C00.1 includes vermilion border of lower lip. Vermilion border is synonymous with mucocutaneous junction.**
- **https://seer.cancer.gov/manuals/2025/SPCSM_2025_MainDoc.pdf

A patient with a diagnosis of invasive squamous cell carcinoma arising in the right tonsil undergoes viral detection testing on 3/4/2022 with a result of HPV mediated. What is the correct histology code for this patient's diagnosis?

- **Correct Response: HPV-negative squamous cell carcinoma 8086/3**
- **Rationale: For cases diagnosed 1/1/2022 forward: HPV mediated (p16-) test results can be used to assign code 8086. *This question should have stated "HPV mediated (p16-)." The correct code for HPV mediated (p16+) in the same time frame would be 8085.**
- **https://seer.cancer.gov/tools/solidtumor/current/STM_Combined.pdf

MORE PRIMARY SITE CODING TIPS!!

Melanoma: Assign C449 for melanoma when the primary site is unknown and there is no information suggesting that the melanoma originated in a non-skin site. **Assign C809** when the site of origin is unknown and there is some indication that the primary site of the melanoma is not skin.
**SEER Manual Melanoma Coding Guidelines

Pancreas: For tumors of the islet cells, determine which subsite of the pancreas is involved and use that primary site code. Use the general code for **Islets of Langerhans, C254**, when the subsite cannot be determined.
** SEER Manual Pancreas Coding Guidelines

SURGICAL CODING FOR BRAIN & CNS!!

A100 Tumor destruction, NOS (not sent to pathology)
A200 Local excision of tumor, lesion or mass; excisional biopsy
A210 Subtotal resection of tumor, lesion or mass in brain
A220 Resection of tumor of spinal cord or nerve
SEER Note: Assign code A200 for stereotactic biopsy of brain tumor. This includes a Stealth or StealthStation guided needle biopsy, a type of stereotactic biopsy.
A300 Radical, total, gross resection of tumor, lesion or mass in brain
A400 Partial resection of lobe of brain, when the surgery cannot be coded as 20-30.
A550 Gross total resection of lobe of brain (lobectomy)
Please note that A550 is used much less frequently now.
**Brain Surgical Codes

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 te newsletter. Always check your manuals!

October 2025 E-Tips

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BREAST GRADE CODING REMINDER!

Invasive tumors- USE CODES 1, 2, 3!

- The preferred grading system for invasive tumors is the Nottingham grade/Nottingham Score, also known as the Scarff-Bloom-Richardson or Bloom Richardson.
- The Nottingham score is a combined histologic grade in which three components are evaluated to determine the overall grade: tubule formation, nuclear pleomorphism and mitotic count. Each of these components is assigned a value from 1 (favorable) to 3 (unfavorable) for each feature and then totaling the scores for all three categories. A combined score of 3-5 points is designated as grade 1; a combined score for 6-7 points is grade 2; a combined score of 8-9 points is grade 3
- **If a pathology report for an invasive cancer states, "Grade 1 (or 2, 3)" and there is no further information, assume this is the Nottingham grade and assign the appropriate code.**
- If a pathology report for an invasive cancer states, "well differentiated, moderately differentiated, poorly differentiated, low, medium, high," use grades A-D as appropriate.

Example: Pathology report states invasive ductal carcinoma, well differentiated. Code grade A.

Do not use grades L, M, H for invasive tumors!

Exception: Biopsy diagnosis is DCIS; Lumpectomy is invasive ductal carcinoma. The Clinical Grade would be L, M, H or 9 based on DCIS; the Pathological Grade would be 1, 2, 3, or 9 based on the invasive ductal carcinoma. Behavior would be /3

In situ tumors- USE CODES L, M, H!

- The preferred grading system for in situ tumors is based on a 3 grade Nuclear system, and is defined as Low (L) (Nuclear Grade 1), Intermediate (M) (Nuclear Grade 2), or High (H) (Nuclear Grade 3), or the nuclear component of the Nottingham grade
- Documentation for these grades may be 1/3, 2/3, 3/3. This notation is documenting the nuclear component of the Nottingham grade, not the Nottingham grade (1, 2, 3)
- If a pathologist uses a Nottingham grade (i.e., G2) for an in situ cancer, they are documenting the nuclear component of the Nottingham score. You would still assign L, M, or H as appropriate for the in situ tumor

Do not use grades 1, 2, 3 for in situ tumors!

** Breast Grade Values-Non-invasive vs invasive - CAnswer Forum

WISDOM WEDNESDAYS – Answers and Rationales

1.How would you code EOD Regional Lymph Nodes for the following? 6/15/25 biopsy diagnosing Invasive Ductal Carcinoma in Left Breast, followed by a FNA of Left Axillary Lymph Node, positive for Metastatic Carcinoma. Patient completed a 6 week course of neoadjuvant chemotherapy followed by 9/12/25 Lumpectomy and Lymph Node Dissection with 0/3 Lymph Nodes Positive.

***Correct Response:* 150 Clinical assessment only; Clinically positive movable axillary (level I and II) lymph node(s), ipsilateral; Positive needle core biopsy/FNA**

Rationale: Positive axillary LN was identified via FNA during clinical time frame. Important to differentiate clinical vs pathological in this field.

** SEER EOD RSA

2.How would you code the histology for Mammary Carcinoma with Lobular Features?

***Correct Response:* 8500/3 Invasive Carcinoma of No Special Type**

Rationale: CAP uses the term Invasive carcinoma with ductal and lobular features ("mixed type carcinoma" 8522/3) to indicate both duct and lobular are present. Invasive carcinoma, NST *with lobular features* (8500/3) is not equivalent to invasive carcinoma *with ductal and lobular features* (8522/3).

** STR Breast Histology Codes

3.Which Primary Site would you code for Paget disease without underlying tumor?

***Correct Response:* Nipple C500**

Rationale: Paget disease *without underlying tumor* is coded to Nipple C500. Paget *with underlying tumor* is coded to the quadrant of breast in which the underlying tumor is located.

**STR Breast Primary Site Codes

Additional combinations of duct and lobular coded 8522/3!

Intraductal and lobular carcinoma (includes Invasive pleomorphic lobular carcinoma)
Infiltrating duct and lobular carcinoma in situ (LCIS)
Infiltrating duct and pleomorphic lobular carcinoma in situ
Infiltrating lobular carcinoma and ductal carcinoma in situ (DCIS)
Infiltrating pleomorphic lobular carcinoma and ductal carcinoma in situ (DCIS)

**STR Breast

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September 2025 E-Tips

New Jersey State Cancer Registry
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WISDOM WEDNESDAYS!!!

Thank you for your participation in our first **Wisdom Wednesday** quiz! We are providing targeted education in areas where some discrepancies may exist. Please see below for the correct answers and rationales:

How would you code the following race? A person describes herself as Asian-American born in Iwo Jima.

Correct response: 05: Japanese (56%)

Rationale: Iwo Jiman falls under Race Code 05 (Japanese) in the SEER Race and Nationality Descriptions. We are instructed to use these lists when a particular race is not stated but other information is provided.
****Appendix D Race and Nationality Descriptions From the 2000 U.S. Census Bureau and National Center for Health Statistics**

How should the abstractor code the First Name and Alias fields if a person goes by his nickname, Tony, rather than his given name of Anthony?

Correct response: First Name: Anthony, Alias: Tony (86%)

Rationale: Do not record nicknames in First Name. Record nicknames in the Alias data item.

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

A person reports her race as multiracial. Her father is Chinese and her mother is Hawaiian. How would you code Race field 1?

Correct response: 07: Native Hawaiian (59%)

Rationale: Code 07: Native Hawaiian takes priority over all other race codes.

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

CODING REMINDER FOR COLON!!!!

- It is critical to refer to **Notes 5 and 6 in SEER EOD RSA** when coding EOD PRIMARY TUMOR AND SEER SUMMARY STAGE for Colon related to Invasion Into "Pericolonic/Pericolorectal Tissue"
- **Note 5:** Specifies the degree of peritonealization for each segment of the colon and rectum. Segments may be entirely peritonealized, partially peritonealized or entirely non-peritonealized.
- ***Invasion into "pericolonic/pericolorectal tissue" may be coded either 300 or 400, depending on the primary site and whether it is peritonealized (fully or partially) or not.***
- **Note 6:** Provides guidance when extension is described simply as "pericolonic/pericolorectal" tissue
  - ✓ **Ex. Code 300 may NOT be used for entirely peritonealized sites (Cecum, Transverse Colon, Sigmoid Colon and Rectosigmoid Colon) invading into pericolonic/pericolorectal tissue (code to 400)**
- When EOD Primary Tumor is coded to 300, SEER Summary Stage must be coded to 1 (Localized only)
- When EOD Primary Tumor is coded to 400, SEER Summary Stage must be coded to 2 (Regional by direct extension only)

**SEER EOD RSA

TWO NEW VIDEOS ON FLccSC!!!
Check out the new Cervix 2025 video!
Check out the new coding short Solid Tumor Rules 2025: Other Sites Coding Notes!
****FCDS - LMS - Frontend - Log In**

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August 2025 E-Tips

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DEMOGRAPHICS REMINDERS

NAME

If a person's last name changes, update this data item by recording the most current last name. Enter the previous names in the Alias- Last Name data field.

- **Example:** Original last name is Smith. Last name is changed to Jones after marriage.
  - ✓ Document Jones in Last Name field
  - ✓ Add Smith in **Alias**- Last Name field

ADDRESS

Code the residence where the student is living for:

- College students while attending college
- Exchange students temporarily living in the U.S.

For boarding school students below college level, code the parent's known residence.

**https://seer.cancer.gov/manuals/2024/SPCSM_2024_MainDoc.pdf

LUNG: COMBINATION/MIXED HISTOLOGY TABLES

SARCOMATOID CARCINOMA IS CODED AS A COMBINATION/MIXED HISTOLOGY FOR LUNG

Giant cell carcinoma + Spindle cell carcinoma= Sarcomatoid Carcinoma 8033

Note: Both giant cell carcinoma and spindle cell carcinoma are components of sarcomatoid carcinoma. **The most accurate code for a combination of giant cell and spindle cell carcinoma is sarcomatoid carcinoma.**

Note: *Sarcomatoid carcinoma is not in the histology table for lung because sarcomatoid tumors primarily originate in the mediastinum. The combination code is added for the rare occasion when a tumor occurs within the lung.*

**https://seer.cancer.gov/tools/solidtumor/current/STM_Combined.pdf

GYN TREATMENT NOTES

Code treatment volume to vagina for Intracavitary HDR Brachytherapy after a TAH/BSO.

When intracavitary HDR brachytherapy is administered to the vaginal cuff for endometrial or cervical cancer, post TAH/BSO, primary irradiated volume is vagina (72) because the vaginal surface is the organ at risk for recurrence. Note that in this setting, the effective range of the treatment is limited to the vaginal wall. This is an exception to the general rule of coding to the organ of origin and a code 71 (uterus or cervix) would be technically correct, just less informative.
**https://www.facs.org/media/bfxlv0eu/store-manual-2024.pdf

If a patient has a history of hysterectomy and later undergoes a BSO/omentectomy, use surgery code A570.

A550 Unilateral or bilateral salpingo-oophorectomy WITH OMENTECTOMY, NOS; partial or total; unknown if hysterectomy done
A560 WITHOUT hysterectomy
A570 WITH hysterectomy
**https://www.facs.org/media/bfxlv0eu/store-manual-2024.pdf

IMPORTANT UPDATE for Cancer Reporting Regulations Document N.J.A.C 8:57A!!!
Notice of Readoption Effective Date: June 16, 2025
Expiration Date: June 16, 2032
See NJSCR website for more details:
Department of Health | Cancer | NJ State Cancer Registry

NEW CODING SHORT ON FLccSC!!!
Check out the new "Solid Tumor Rules 2025: Other Sites Coding Notes" video!
FCDS - LMS - Frontend - Log In

COMING IN SEPTEMBER
to a Registry Near You!!!
Be on the Lookout for WISDOM WEDNESDAYS!

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email.
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July 2025 E-Tips

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More Accurate EOD Coding With SEER RSA!

BREAST CODING NOTES

How do I code no regional lymph node involvement for Breast EOD?

Refer to SEER RSA, EOD Regional Nodes for Breast

Note 2: This schema has lymph node codes that are defined as **CLINICAL** assessment only or **PATHOLOGICAL** assessment only. **CLINICAL** assessment only codes (**000**, 150, 350, 400) are used when there is a clinical work up only and there is no surgical resection of the primary tumor or site. This includes FNA, core biopsy, sentinel node biopsy, or lymph node excision

PATHOLOGICAL assessment only codes (030, 050, **070**, 200, 250, 300) are used when:

- Primary tumor or site surgically resected with
  - Any microscopic examination of regional lymph nodes. Includes
    - FNA, core biopsy, sentinel node biopsy or lymph node excision done during the clinical work up and/or
    - Lymph node dissection performed

Do not automatically code 000 when there are no positive lymph nodes for breast!

For no regional lymph node involvement:
CODE 000 for CLINICAL ASESSMENT ONLY
CODE 070 for PATHOLOGICAL ASSESSMENT ONLY (i.e. if a SLN biopsy is performed during a lumpectomy).

**EOD Regional Nodes | EOD Data SEER*RSA

COLON CODING NOTES

How do I code behavior and EOD Primary Tumor for Intramucosal Carcinoma, NOS of the Colon?

Refer to SEER RSA, EOD Primary Tumor for Colon and Rectum

Note 2: Code 050 (behavior /3)

- Code 050 (behavior code 3) includes the following:
- Intramucosal, NOS
- Lamina propria
- Mucosa, NOS
- Confined to, but not through the muscularis mucosa

**EOD Primary Tumor | EOD Data SEER*RSA

SEER Manual/Tumor Size Summary - Breast

Question:
Can the size of a non-mass enhancement (NME) be used if it represents the largest size within the appropriate time frame to code tumor size summary when neoadjuvant therapy is administered? **Reminder: Clinical and pathologic tumor sizes are no longer collected for 2024 and 2025 cases.**

Discussion:
In the SEER Program Coding and Staging Manual 2023, under clinical tumor size (page 115, item #12), it states: "For breast tumors, clinical size may be recorded based on the size of a non-mass enhancement (NME). NME is defined as an enhancing abnormality that is not associated with the three-dimensional volume of a mass, shape, and outlining, and it is separate from Background Parenchymal Enhancement (BPE)." This guidance does not appear to have been carried forward into the Tumor Size Summary coding instructions.

Answer:
Do not use the NME size from MRI to code tumor size when both tumor size and NME size are stated or if NME is the only size available. **The size of the solid tumor mass takes priority over the size of the NME when provided separately and the NME is larger.** BI-RADS defines NME as an area of enhancement on MRI that does not belong to a 3D mass or have distinct features of a mass. It is a descriptor from size including modifiers describing enhancement patterns with a specific MRI pattern.

**SEER Inquiry System - Question 20250019 Details

2025 Thyroid Histology Coding Tip:
For thyroid cancer only, the terms micropapillary and papillary microcarcinoma do not refer to a specific histologic type.
It means that the papillary portion of the tumor is minimal or occult.
** Solid Tumor Rules 2025 Update

June 2025 E-Tips

New Jersey State Cancer Registry
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SOLID TUMOR RULES
Other Sites Histologies 2025

The 2025 STR has additional notes within each histology table. Check out the below example…

Table 4: Testis Histologies

- **The following teratomas are <u>not reportable</u>**
  - Teratoma, prepubertal type 9084/0
  - Teratoma, mature, prepubertal type 9084/0
- **The following yolk sac tumor patterns are <u>all coded 9071</u>**
  - Endodermal sinus/perivascular pattern
  - Glandular/alveolar pattern
  - Hepatoid pattern
  - Macrocystic pattern
  - Microcystic/reticular pattern
  - Myxoid pattern
  - Papillary pattern
  - Parietal pattern
  - Polyvesicular vitelline pattern
  - Sarcomatoid/spindle cell pattern
  - Solid pattern

**https://seer.cancer.gov/tools/solidtumor/current/STM_Combined.pdf

REMEMBER THIS HELPFUL RESOURCE WHEN CODING VARIOUS LAB VALUES!
SSDI Manual - General Rules for Entering Lab Values and Other Measurements

Example: SSDIs without decimals in their code structure – Breast ER/PR

- ✓ Example 1: ER Percent Positive stated as < (less than) 60%. **Record 059 (59%)**
  - This would **NOT** be coded as a range of 51-60%
- ✓ Example 2: PR Percent Positive stated as > (greater than) 75%. **Record 076 (76%)**
  - This would **NOT** be coded as a range of 71-80%

**SSDI Manual

Primary Site/Histology – Heme & Lymphoid Neoplasms

<u>QUESTION:</u> What are the correct primary site and histology for a patient diagnosed with an oropharyngeal soft tissue mass revealing plasma cell neoplasm with 5-10% of marrow cellularity in 2022?

<u>DISCUSSION:</u> Patient underwent excision of an oropharyngeal soft tissue mass revealing plasma cell neoplasm with extensive amyloid deposition. During work-up, bone marrow biopsy also revealed involvement by plasma cell neoplasm, with 5-10% of marrow cellularity. No amyloid seen in bone marrow. Patient was referred for radiation of the oropharyngeal mass. Per medical oncology qualifying best for the diagnosis of solitary extramedullary plasmacytoma with minimal marrow involvement. Decision made for observation by medical oncology in view of "minimal" bone marrow involvement. Question: Is rule M11 correct, and I abstract this case as a plasma cell myeloma, 9732/3, C421?

<u>ANSWER:</u> Code as an oropharyngeal primary site and histology as solitary plasmacytoma (9734/3).
The WHO Classification of Hematopoietic and Lymphoid Tissues defines multiple myeloma as "bone marrow plasma cell percentage >60%." There are several other factors, but the bone marrow involvement is the key point for your case. The pathologist also states that the bone marrow is consistent with "plasma cell neoplasm," which by itself is not the same as multiple myeloma.
This case has 5-10% involvement by plasma cell neoplasm. This does not meet the bone marrow qualifications for multiple myeloma and is consistent with the pathologist's statement that there is minimal bone marrow involvement. We will be updating the Hematopoietic and Lymphoid Neoplasms Database and Manual to clarify this (2025 updates).
** https://seer.cancer.gov/seer-inquiry/inquiry-detail/20240006/

SPOTLIGHT ON CHANGES: STORE 2025
NOTE ADDED TO FIRST COURSE OF TREATMENT

If the first course of treatment plan changes due to an improvement in the tumor burden, the added treatment would still be considered first course.
**store-manual-2025.pdf

FINAL REMINDER!!!

Submission recommendations for the reporting year:
<u>All 2024 records submitted by July 1, 2025</u>

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May 2025 E-Tips

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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

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April 2025 E-Tips

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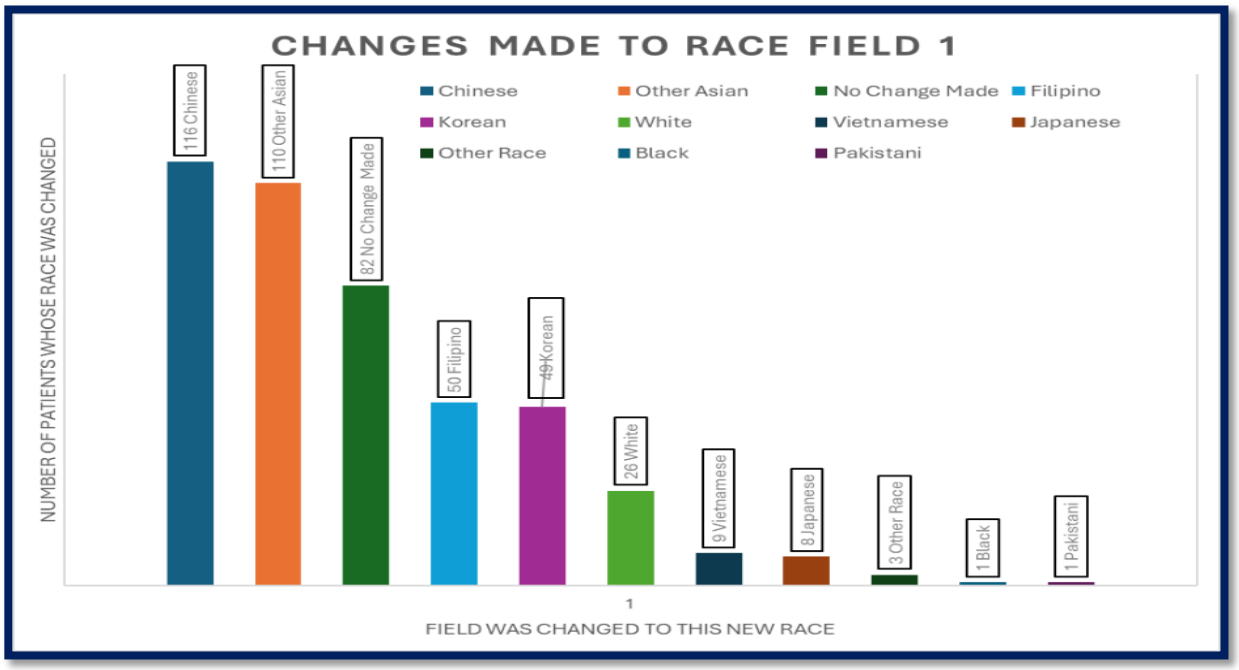
RACE CODING IS AN IMPORTANT DATA ITEM FOR CANCER RESEARCH!

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

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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.

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