September 2026 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 September **Wisdom Wednesday** quiz! See below for answers and rationales.

* **True/False: True or False: Registrars should NOT update the histology based on genetics or immunophenotyping without a pathologist's/physician's statement. *Correct Response:*** *True* **Rationale:** See Histology Coding Instructions Page 57 Note 7** SEER Hematopoietic and Lymphoid Neoplasm Coding Manual
* **Select all that apply to form an accurate statement: "transforms from"... *Correct Response:*** *a chronic neoplasm, a neoplasm that requires long term management, or CLL/SLL 9823/3.* **Rationale:** Refer to Transformations: Chronic and Acute Neoplasms Page 11** SEER Hematopoietic and Lymphoid Neoplasm Coding Manual
* **67 YO M presented with weight loss and fatigue . CT scan showed enlarged lymph nodes above and below the diaphragm. A FNA of the left cervical lymph node was performed showing B cell lymphoma. What is the correct primary site? *Response:*** *Multiple Lymph Nodes, C778* **Rationale** Code the primary site to lymph nodes of multiple regions (C778) when multiple lymph node regions are involved. Refer to Module 7, Rule PH21 ** SEER Hematopoietic and Lymphoid Neoplasm Coding Manual
* **What is the correct histology: Myelodysplastic neoplasm favor MDS with low blasts and isolated 5q deletion (MDS-5q-)? *Correct Response:*** *Myelodysplastic neoplasm, NOS 9989/3* **Rationale:** Favor is not one of the new definitive diagnosis ambiguous terms. See Histology Coding Instructions, notes 3 and 4 ** SEER Hematopoietic and Lymphoid Neoplasm Coding Manual

Multiple Primaries/Histology--Heme & Lymphoid Neoplasms:

QUESTION: Should histology be coded as 9895 when the pathologist's diagnosis on the bone marrow biopsy is "consistent with transformation of the patient's known polycythemia vera to acute myeloid leukemia?" .
DISCUSSION: The patient has a known history of polycythemia vera (PV). The Heme Database entry for myelodysplasia-related acute myeloid leukemia ("acute myeloid leukemia post myelodysplastic-myeloproliferative neoplasm") states, "The pathologist must make the diagnosis of being myelodysplasia-related." However, it's unclear if the pathologist's statement of an acute myeloid leukemia (AML) "transforming from" counts as the AML being myelodysplasia-related since AML can arise/transform from PV. The Heme DB does indicate histology 9895 should not automatically be used just because the patient has a history of MPN. The bone marrow did not identify any of the specific cytogenetic or molecular abnormalities listed in the Heme DB. However, next generation sequencing identified mutations. The managing physician's clinical diagnosis was "AML arising from polycythemia vera."
ANSWER: Assign a second primary as Acute Myeloid Leukemia, NOS (9861/3), per Rule M10, the first being polycythemia vera (9950/3).
The physician states "consistent with transformation of the patient's known polycythemia vera to acute myeloid leukemia." This is not the same thing as "Acute myeloid leukemia with myelodysplasia-related changes." **https://seer.cancer.gov/seer-inquiry/inquiry-detail/20260017/

TIME TO REGISTER!!!

2026 ORANJ ANNUAL MEETING

October 14, 2026
NJ Hospital Association

Approved for 5.5 CEIP Credits and 3.25 Cat A Credits!!!
**ORANJ REGISTRATION
Register through 10/7/26

CHECK OUT two new educational videos on FLccSC!!!

New Short :
Date of Diagnosis The Old and New
NEW Full-Length Video:
Coding SSDI Lab Values
** FLccSC

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August 2026 E-Tips

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WISDOM WEDNESDAYS!!!

Thank you for your participation in our **Wisdom Wednesday** quiz! See below for the correct answers and rationales:

* **Which is the correct histology code for Intestinal adenocarcinoma, originating in the colon C189?**
  Correct Response: *Adenocarcinoma 8140* **Rationale:** When the term intestinal adenocarcinoma is used to describe a colon primary, it simply means the appearance is similar to adenocarcinoma seen in the stomach and is coded to adenocarcinoma NOS 8140 ** Solid Tumor Rules 2026 Colon Table 1
* **Which of the following would not be considered a regional lymph node group for the stomach?**
  Correct Response: *Superior Mesenteric* **Rationale:** Lymph nodes regional to the stomach include: inferior (right) gastric (including infrapyloric), superior (left) gastric (including paracardial), splenic, perigastric, NOS, celiac and hepatic ** Regional Lymph Nodes | SEER Training
* **True or False: A GIST (Gastrointestinal stromal tumor 8936) originating in the stomach, diagnosed in 2023 must have the word malignant included for the histology to be reportable.**
  Correct Response: *False* **Rationale:** Beginning with cases diagnosed 1/1/2021 forward, the word malignant is no longer required to be reportable. ** Solid Tumor Rules 2026 Other Sites Table 6
* **For consideration when coding EOD Primary Tumor, how many layers does the wall of the stomach have?**
  Correct Response: *5* **Rationale:** The 5 layers of the stomach include: Mucosal (code 100), Submucosal (Code 200), Muscular (Code 400), Subserosal (Code 500) and Serosal (Code 600) ** SEER EOD RSA
* **How would we code primary site for a tumor originating in the incisura of the stomach, as per the synoptic report?**
  Correct Response: *C163 Gastric antrum; antrum of stomach; pyloric antrum* **Rationale:** Incisura is listed with the Topography Code C163 in the SEER Manual **SEER Coding and Staging Manual

REPORTABILITY REMINDER!!!

Please note that **Stromal endometriosis is a REPORTABLE DIAGNOSIS!** Stromal endometriosis is a synonym for Endometrial stromal sarcoma, low grade **8931/3**. It has been reportable since 2001, unless the pathologist also states, "no evidence of carcinoma".
**SEER Training Modules Behavior Code Changes

HISTOLOGY UPDATE!!!

In our May Wisdom Wednesday quiz, we included a question regarding **Adenocarcinoma with mixed subtypes 8255** not applying to GYN primaries, as per Solid Tumor Rules 2026 Table 2: Mixed and Combination Codes; note 2.

- This note has since been removed from Solid Tumor Rules 2026.1 Update, due to mid-year alignment with Cancer PathCHART. **8255 IS POSSIBLE for GYN primaries!**
- An additional inaccurate note was deleted from LUNG H4 and H13, regarding carcinoma in situ 8010/2 being impossible for lung. **8010/2 is UNLIKELY for LUNG, NOT IMPOSSIBLE!** **Solid Tumor Rules 2026.1 Update

NAME FIELD CODING TIP!!! For pediatric patients do **NOT** type placeholders like "Baby Boy", "Infant", or "Twin A" into the legal first name field. Computer linkage software will flag these variations as invalid names. Rather, **leave blank** or enter a single space if required by software. Use alias or text fields to elaborate.
**SEER Program Coding and Staging Manual 2026, First Name

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!

July 2026 E-Tips

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CHECK IT OUT!!! New educational video posted on SEER (6 minutes) covering Ambiguous and Definitive Terms for Determining Histology in the Solid Tumor Rules 2026 Update.
**Solid Tumor Rules Registrar Education

REPORTABILITY/PRIMARY SITE -- SKIN

QUESTION: Is vulvar intraepithelial neoplasia III (VIN III) or associated invasive squamous cell carcinoma reportable when stated to be of the perineum or skin of the perineum?

DISCUSSION: Example: Operative report states, partial simple vulvectomy, anoscopy with normal-appearing clitoris, clitoral prepuce, bilateral labia majora, and labia minora. There is a 1.5 x 1 cm raised, hyperpigmented lesion which appears consistent with VIN 3 on the perineal body, just to the right of midline, and not touching the midline. It goes quite close to the anus but is not touching the anus. Final diagnosis on resection is Invasive squamous cell carcinoma arising in a background of high-grade squamous intraepithelial neoplasia (VIN III) with the following features: Location: perineum. Focal invasion arising in setting of 1 cm area of VIN III.

ANSWER: Squamous carcinoma and squamous intraepithelial neoplasia III arising in the skin of the perineum (C445) are not reportable. Even though the abbreviation "VIN III" is used in this example, this lesion does not involve the vulva. Since it involves the perineum, and skin of perineum is coded to C445, it is not reportable.

Neoplasms arising in skin (C44) with the following histologies are not reportable:

--Malignant neoplasm (8000-8005)
--Epithelial carcinoma (8010-8046)
--Papillary and squamous cell carcinoma (8050-8084)
--Squamous intraepithelial neoplasia III (8077) arising in perianal skin (C445)
--Basal cell carcinoma (8090-8110)** SEER Inquiry System - Question 20180100 Details

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

* **Tumor size is documented on a pathology report as 14.5 cm. How should tumor size summary be coded upon abstraction? *Correct Response:*** *145mm* **Rationale:** Do not round tumor size expressed in centimeters to the nearest whole centimeter; rather, convert the measurement to millimeters by moving the decimal point one space to the right **SEER Program Coding and Staging Manual 2026, Tumor Size Summary
* **On 3/1/2026, a patient was diagnosed with 8140/3 Adenocarcinoma, NOS of the Sigmoid Colon C187. Upon surgery on 4/4/2026, this tumor was found to have directly invaded the ureter. Two regional lymph nodes were also dissected during this surgery and determined to be positive for 8140/3. How would you code the Summary Stage for this case? *Correct Response:*** *7 Distant site(s)/lymph node(s) involved* **Rationale:** Summary Stage 7 includes further contiguous extension into distant sites. Ureter is a distant site for the Sigmoid Colon **Summary Stage 2018 Coding Manual v3.3
* **Estrogen/Progesterone Receptor testing is performed on a breast cancer case, with the following results: ER >90%, PR 59-62%. How would we code these results upon abstraction? *Correct Response:*** *ER = 091, PR = R60* **Rationale:** For SSDI's without decimals in their structure, code 1 greater for >. If the range is less than or equal to 10, then code the appropriate R code based on the lower number **SSDI Manual General Lab Values
* **For the same breast case, Ki-67 is reported as >30%. How would we code this result upon abstraction? *Correct Response:*** *30.1%* **Rationale:** One less or one more may refer to a whole number (1), or a decimal (0.1), depending on the code structure of the field. **SSDI Manual General Lab Values

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June 2026 E-Tips

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WISDOM WEDNESDAYS!!!

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

* **True/False: "suggestive of" is considered an ambiguous term for determining histology of Colon sites?** ***Correct Response:*** *True* **Rationale:** See Table 4: List of Ambiguous Terminology, under Coding Histology for Colon ** Solid Tumor Rules 2026 Update
* **How many primaries and which histologies would we code for this diagnostic work-up on March 3, 2026? Biopsy of a 2 mm mass in L breast, positive for DCIS. Biopsy of a 2.2 mm mass in R breast, positive for Invasive Ductal Carcinoma. Biopsy of 3.1 mm mass in R breast, positive for Invasive Lobular Carcinoma?** ***Correct Response:*** *3 primaries: L Breast 8500/2 Ductal Carcinoma In Situ, R Breast 8500/3 Ductal Carcinoma, R Breast 8520/3 Lobular Carcinoma* **Rationale:** Refer to Breast Multiple Primary Rules M7 and M13 ** Solid Tumor Rules 2026 Update
* **Which of the following could NOT have transformed from a chronic hematopoietic histology?** ***Correct Response:*** *9808/3 Mixed-phenotype acute leukemia (MPAL), B/myeloid* **Rationale** There are no known transformations (to or from) for this histology ** Heme Database
* **A biopsy is taken on May 2, 2026 of a R upper lobe lung mass. The final diagnosis from the pathology report states "adenocarcinoma, most likely lepidic pattern." Due to his comorbid conditions, the patient is placed on hospice care. There is no further physician statement referring to his lung cancer. What histology would we code?** ***Correct Response:*** *8250/3 Lepidic Adenocarcinoma, NOS* **Rationale:** Refer to Table 25: List of Definitive Terminology, and note 4 directly below it, under Lung Histology Coding ** Solid Tumor Rules 2026 Update

SOLID TUMOR RULES/HISTOLOGY--THYROID

QUESTION: What is the correct histology for invasive encapsulated follicular variant of papillary thyroid carcinoma (IEFVPTC)? The 2026 Solid Tumor Rules, Other Sites Table 12, conflicts with the ICD-O-3.2.
DISCUSSION: STR Manual, Table 12, Thyroid Histologies, includes "Invasive encapsulated follicular variant of papillary thyroid carcinoma" as histology 8340/3 and is on its own row from other papillary thyroid carcinomas (PTC). A new footnote was added which states, "IEFVPTC and Infiltrative follicular variant of papillary thyroid carcinoma (a PTC subtype) share a histology code, but they are distinctly different histologies. They are on different rows of the table and are different primaries." However, IEFVPTC (and its synonyms) are listed in the ICD-O-3.2 as 8343/3, and 8343/3 was listed as a subtype/variant of papillary thyroid carcinoma in previous versions of the STR Manual.
ANSWER: Assign histology as 8340/3 for IEFVPTC using the STR, 2026 Update. Rule M18, Note 2, of Other Sites STR state: Invasive encapsulated follicular variant of papillary thyroid carcinoma and Infiltrative follicular variant of papillary thyroid carcinoma share a histology code (8340) but are different entitieson on separate rows of the table. ** SEER Inquiry System - Question 20260003 Details

ANNOUNCEMENTS:

CHECK OUT the NAACCR Pediatric Stage Training Series!!!

The NAACCR Pediatric SSDI Working Group has designed a series of **FREE** virtual training modules to assist registrars in collecting pediatric staging data elements as part of the new Pediatric Data Collection System (PDCS). There are 5 sessions, each focusing on a specific cancer site.
** NAACCR Online Education: Home

CHECK OUT a new short on FLccSC!!!

Primary Payer at Diagnosis 2026
** FLccSC

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May 2026 E-Tips

New Jersey State Cancer Registry
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PRIMARY SITE CODING FOR COLON!!!

QUESTION: Primary Site--Colon: How is primary site assigned when the only documented term is "colorectal cancer?"

DISCUSSION: Patient is diagnosed with adenocarcinoma documented by the physician as "colorectal cancer." The medical record does not specify colon, rectosigmoid, rectum, or any specific segment of the large intestine. There is also no imaging, operative, endoscopic, or pathology documentation identifying a more precise site of origin. Specifically, should the registrar assign: C18.9 Colon, NOS, C19.9 Rectosigmoid junction, C20.9 Rectum, etc.

ANSWER: Assign primary site as colon, NOS (C18.9) when the only information about the diagnosis you have is "colorectal cancer." We consulted with a subject matter expert who believes that colon, NOS is closest to being correct and that rectosigmoid is not appropriate. If further information becomes available through further workup and/or treatment, update the primary site as appropriate. We will add clarification to the 2027 SEER Manual, Appendix C, Colon Coding Guidelines. **SEER SINQ 20260013

2026 LUNG CODING UPDATE!!!

DO NOT CODE histology described as:
- Architecture
- Foci; focus; focal
- **Pattern – EXCEPT FOR THESE SPECIFIC LUNG HISTOLOGIES!**

✓ Acinar pattern: Adenocarcinoma, acinar predominant 8551
✓ Lepidic (growth) pattern: Adenocarcinoma, lepidic predominant 8250
✓ Micropapillary pattern: Adenocarcinoma, micropapillary predominant 8265
✓ Papillary pattern: Adenocarcinoma, papillary predominant 8260
✓ Solid pattern: Adenocarcinoma, solid predominant 8230

**Solid Tumor Rules 2026

WISDOM WEDNESDAYS!!!

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

* **A tumor is found in the upper lobe of the left lung, comprised of adenocarcinoma and squamous cell carcinoma. Which is the appropriate histology code for this tumor?**
  Correct Response: *Adenosquamous carcinoma 8560* **Rationale:** Table 2: Combination/Mixed Histology Codes **Solid Tumor Rules 2026 Lung Site-group Instructions
* **Adenocarcinoma with mixed subtypes 8255/3 cannot be used for?**
  Correct Response: *GYN Primaries* **Rationale:** Table 2: Mixed and Combination Codes; note 2 **Solid Tumor Rules 2026 Other Sites Site-group Instructions
* **Metaplastic carcinoma of the breast mixed with Ductal carcinoma NST or Lobular carcinoma should be coded as Metaplastic carcinoma 8575 when the percentage of Ductal or Lobular carcinoma is?**
  Correct Response: *Code to 8575 regardless of percentages* **Rationale:** Table 2: Histology Combination Codes; note 9 **Solid Tumor Rules 2026 Breast Site-group Instructions
* **What is the correct histology code for Squamous cell carcinoma, keratinizing and Squamous cell carcinoma, non-keratinizing found in the same tumor in the lung?**
  Correct Response: *Squamous cell carcinoma NOS 8070* **Rationale:** Table 2: Combination/Mixed Histology Codes **Solid Tumor Rules 2026 Lung Site-group Instructions
* **Which histology cannot be combined with Large cell neuroendocrine carcinoma to code Combined large cell neuroendocrine carcinoma 8013?** ***Correct Response:*** *Adenosquamous carcinoma 8560* **Rationale:** Table 2: Combination/Mixed Histology Codes ** Solid Tumor Rules 2026 Lung Site-group Instructions

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April 2026 E-Tips

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WISDOM WEDNESDAYS!!!

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

1. Which of the following combinations should ***not*** be coded as a Mixed germ cell tumor 9085/3?
***Correct Response:* Teratoma and choriocarcinoma**
Rationale: Any combination of the following can be coded as Mixed germ cell tumor:
• Embryonal carcinoma • Seminoma • Teratoma • Yolk sac tumor
Choriocarcinoma combined with embryonal carcinoma, seminoma or teratoma would be coded as Choriocarcinoma combined with other germ cell elements 9101/3.
** Solid Tumor Rules 2026 Update Other Sites, Table 2: Mixed and Combination Codes

2. In order to code Mucinous adenocarcinoma 8480/3 of the prostate, the mucinous adenocarcinoma component must comprise
***Correct Response:* ≥ 25% of the tumor**
Rationale: Please note that the dx must be made only in excision specimens to determine percentage.
** Solid Tumor Rules 2026 Update Other Sites, Table 3: Prostate Histologies

3. True or False: Micropapillary serous borderline tumor found in the testis upon radical orchiectomy on 4/12/2023 is reportable.
***Correct Response:* True**
Rationale: ** https://seer.cancer.gov/seer-inquiry/inquiry-detail/20220032/

4. If a patient has a known history of Acinar adenocarcinoma 8140/3 of the prostate treated with radiation in 2022, and subsequent findings of Squamous cell carcinoma upon biopsy of the prostate in 2025, how would the new findings be coded?
***Correct Response:* This would be considered a recurrence of the Acinar adenocarcinoma**
Rationale: If a patient has a known history of Acinar adenocarcinoma of prostate treated with hormone and/or radiation and subsequent findings of Squamous cell carcinoma, this is recurrence and not a new primary. Code 8070/3 only when there is no history of the patient receiving radiation and/or androgen deprivation therapy for previously-diagnosed prostate adenocarcinoma.
** Solid Tumor Rules 2026 Update Note 5, under Other Sites Table 3: Prostate Histologies

5. Which of the following should ***not*** be coded as Acinar adenocarcinoma 8140/3 when the primary site is prostate? ***Correct Response:* Solid adenocarcinoma**
Rationale: Solid adenocarcinoma 8230 is a subtype of Acinar adenocarcinoma, while the other choices are synonyms **Solid Tumor Rules 2026 Update

IMPORTANT UPDATE REGARDING PI-RADS AND LI-RADS REPORTABILITY!!!

NCI SEER has decided to adopt the same instructions for PI-RADS and LI-RADS as the STORE manual (CoC) putting both standard setters back in alignment. This is applicable as of **NOW** (your next prostate or liver case)!!!
Per the 2026 STORE Manual: PI-RADS and/or LI-RADS results alone are not reportable to CoC. PI-RADS and/or LI-RADS confirmed with biopsy or physician statement *are reportable* to CoC. *The date of the biopsy or definitive statement from the physician is the Date of Diagnosis.
**SEER Program Coding and Staging Manual

2026 NCRA CONFERENCE!

Hope to see you at our joint presentation with the Maine Cancer Registry in the Concurrent Tracks on Friday, 5/8/26 **"How to Use Internship Programs and Student Practicums to Help Staff Your Registry"**

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March 2026 E-Tips

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WISDOM WEDNESDAYS!!!

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

* **Which of the following would be considered reportable terminology for benign or borderline CNS? *Correct Response:*** *Probable neoplasm* **Rationale:** "Neoplasm" and "tumor" are reportable terms for benign and borderline primary intracranial and CNS because they are listed in ICD-O-3.2 with behavior codes of /0 and /1. Accession the case when any of the reportable ambiguous terms precede either the word "tumor" or the word "neoplasm" ** SEER Program and Staging Manual 2026
* **Tumor described as "thalamic glioma extending into midbrain." Majority of tumor bulk is documented in the thalamus. What is the correct primary site? *Correct Response:*** *C71.0 Cerebrum, NOS* **Rationale:** Thalamus is coded to C71.0 (cerebrum, NOS). When one subsite predominates, do not use overlapping. **SEER Training Modules, Topographic Sites
* **Midline tumors are most common for which of the following histologies? *Correct Response:*** *Glioblastoma multiforme 9440* **Rationale:** Please refer to Non-Malignant CNS Table 6: Paired Sites, Note 1 **Solid Tumor Rules 2026 Update

CHECK OUT OUR 2026 UPDATES!!!

The updated 2026 NJSCR Manual and 2026 Reportable List are now live on the **NJSCR Website along with the summary of changes for each.

!!! IMPORTANT UPDATE REGARDING SOLID TUMOR RULES/MULTIPLE PRIMARIES: BREAST !!!

QUESTION: How many primaries and which Breast Solid Tumor Rules (STR) M Rule applies when a patient has synchronous, separate/non-contiguous breast tumors which are a ductal carcinoma and a separate lobular carcinoma?

DISCUSSION: Historically, synchronous ductal and lobular tumors have been accessioned as a single primary. These were previously covered under Rule M10, which was removed from the (STR) Manual 2026 Update. While the previous iteration of Rule M10 was problematic, the main issue related to the lack of a timing component within the rule (i.e., indicating it applied to synchronous ductal and lobular tumors).

Using the current Breast STR, when there are two (or more) simultaneous tumors which are not mixed lobular and ductal within each tumor, the applicable M Rule is Rule M13: Abstract multiple primaries when separate/non-contiguous tumors are on different rows in Table 3. To apply the M Rules, a provisional histology must be assigned to EACH tumor so we cannot code each tumor as 8522 before we start applying the M Rules. These provisional histologies would be 8500 and 8520, and these are on different rows in Table 3.

ANSWER: Accession TWO primaries when a patient has synchronous, separate ductal and lobular tumors using Rule M13, Breast STRs, 2026 Update. Ductal carcinoma (8500/3) and lobular carcinoma (8520/3) are distinct histology terms and codes that are in different rows in Table 3. This is a modification of Rules M10 and H28 from prior versions of the STR Manual.

** SEER SINQ 20260004

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February 2026 E-Tips

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Check out this IMPORTANT CHANGE!!!
The table below includes terms previously included in the list of ambiguous terms for *coding histology*. These terms should be treated as supporting a definitive diagnosis of a histologic subtype. A definitive term does not require clinical verification of the subtype/variant.
**Solid Tumor Rules General Instructions

List of Definitive Terminology	
Comparable with	Most likely
Compatible with	Probable
Consistent with	Typical (of)

MELANOMA CODING REMINDER FOR EOD REGIONAL NODES!!!

Clinically Occult Lymph Nodes: not enough melanoma in the lymph node to be palpated or detected on imaging (found positive by microscopic examination)

Isolated Tumor Cells: single tumor cells or small clusters not greater than 0.2mm. ITCs *are counted as positive lymph nodes* for melanoma

Code 000 may be used when: Pathology report **only** with a localized tumor based on Breslow's depth and/or Clark's Level (see EOD Primary Tumor or Summary Stage) AND
No information on regional lymph nodes or metastasis

Note: If the tumor is noted to be regional or distant based on Breslow's Depth and/or Clark's Level then you cannot assume that the nodes are negative and would need to assign 999.
** SEER EOD RSA Melanoma

WISDOM WEDNESDAYS!!!

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

* **Which of the following is not coded to upper lobe lung C34.1 for primary site?**
  Correct Response: *Hilus* **Rationale:** Hilus of lung should be coded as Mainstem bronchus C34.0 **Solid Tumor Rules Lung Site Group Instructions
* **True or False: Paraganglioma 8693/3 is reportable for kidney C64.9.**
  Correct Response: *True* **Rationale:** Paraganglioma 8693/3 is reportable for kidney beginning 1/1/2024**Solid Tumor Rules Kidney Histologies
* **How should Treatment Volume for the I-131 radioisotope be coded for papillary adenocarcinoma, follicular variant 8340/3 in the right lobe of the thyroid C73.9?**
  Correct Response: *98 Other* **Rationale:** Technically I-131 may be effective wherever there are thyroid cancer cells in the body, so there is no specific anatomic treatment volume here. **STORE MANUAL
* **A patient is diagnosed with adenocarcinoma 8140/3 of the cecum C18.0 on 2/2025. Cytology reveals carcinomatosis, and lesions in the liver and femur are found to be suspicious for metastasis. Distant lymphadenopathy is noted upon imaging, but results are inconclusive. How should you code EOD Mets?**
  Correct Response: *50 Peritoneal surface metastasis (peritoneum) with or without distant lymph node(s) or distant organ(s); carcinomatosis* **Rationale:** Carcinomatosis is the most extensive verified level of metastasis for this patient **SEER EOD RSA Colon and Rectum
* **Which of the following is considered definitive terminology for coding histology?**
  Correct Response: *Most likely* **Rationale:** Specific terms were re-classified as definitive terminology based on the recommendation of a panel of pathologists and subject matter experts **Solid Tumor Rules General Instructions

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January 2026 E-Tips

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WISDOM WEDNESDAYS!!!

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

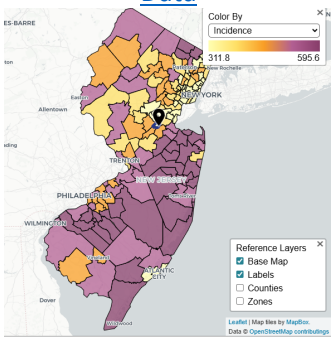
1. What is the correct histology code for Acute Myelogenous Leukemia (AML) with monocytic differentiation?
***Correct Response:* 9861/3 Acute myeloid leukemia (AML), NOS**
Rationale: Code AML with monocytic differentiation as acute myeloid leukemia, NOS (9861/3) as per SEER SINQ and Heme Database
** SEER SINQ **SEER Hematopoietic and Lymphoid Neoplasm Database

2. How would you code EOD Primary Tumor for 9591/3 Malignant lymphoma, non-Hodgkin, NOS involving 2 or more lymph node regions on the same side of the diaphragm, with liver involvement?
***Correct Response:* 800 Diffuse or disseminated - Bone, Central nervous system (CNS); Any involvement of: Bone marrow, Cerebrospinal fluid (CSF), Liver, Lung, multiple lesions (other than by direct extension in code 400), Peripheral blood involvement WITH other involvement; Distant metastasis, NOS**
Rationale: Any involvement of liver (including primary liver lymphoma) is coded as 800
** EOD Primary Tumor | EOD Data SEER*RSA

3. What is the correct primary site when a patient has adenopathy in multiple lymph node regions above and below the diaphragm, a lymph node biopsy showed 9823/3 chronic lymphocytic leukemia (CLL)/small cell lymphocytic lymphoma (SLL) and the peripheral blood is involved?
***Correct Response:* C42.1 Bone marrow**
Rationale: As per Module 3, Rule PH5 in the Heme Manual, code the primary site to bone marrow (C421) when the bone marrow and/or peripheral blood are involved.
** Hematopoietic Instructions and Rules

4. 9870/3 Acute basophilic leukemia may transform...
***Correct Response:* from 9980/3 Myelodysplastic neoplasm with low blasts and single lineage dysplasia (MDS-LB-SLD)**
Rationale: As per the Heme Database, 9980/3 is listed under possible histologies that 9870/3 may transfer from. An acute histology will not transform *into* another histology but may transform *from* one.
** SEER Hematopoietic and Lymphoid Neoplasm Database

Curious about Cancer Rates in your area??
Check out our NJ Cancer Zone Map and
New Instructional Video!!!
Scroll to the last video in the demo section.
Department of Health | Cancer | Interactive Cancer Data



ERROR IN 2018 EOD MANUAL/EOD REGIONAL NODES!!!
OROPHARYNX

Code 550 is missing "< equal to 6 cm." In addition, code 650 should include ipsilateral lymph nodes as well.

PLEASE FOLLOW THESE REVISED CODES:

Code 550
CLINICAL ASSESSMENT only
Bilateral or contralateral lymph nodes, < equal to 6 cm WITH clinical evidence of ENE

Code 650
CLINICAL ASSESSMENT only
Ipsilateral, Bilateral or Contralateral lymph nodes > 6 cm WITH or WITHOUT clinical evidence of ENE

Changes will be implemented in Version 3.4 (10/2026).
****SEER Inquiry System - Question 20250029 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 of the distribution date of the newsletter. Always check your manuals!