

**NATIONAL INSTITUTES OF HEALTH
NATIONAL CANCER INSTITUTE
SURVEILLANCE, EPIDEMIOLOGY AND END RESULTS (SEER) PROGRAM
BREEZE SESSION
Practicum on the Breast Multiple Primary and Histology Coding Rules
December 15, 2007**

Okay. I think we are ready to go. This is Steve Peace and I would like to welcome everybody. Thank you for joining us today to go over the breast practicum following our presentation last week of the Breast Multiple Primary and Histology Coding Rules.

I would like to remind everybody again to please mute your phones if you haven't already, but don't forget to "un-mute" them if you have a question that you'd like to ask.

We are going to go through the cases one at a time. You will have an opportunity to ask questions as we go along. And, we are being recorded, so everybody knows that. And, I think we are ready to go.

As we get started, we did have a question at the end of the Breast Multiple Primary and Histology Coding Rules discussion. And that question was: "How would you use 'with focal _____ differentiation' when you were applying the rules?" We discussed that issue here going back into the General Instructions and the Definitions that are included in the General Instructions. We do have definitions for "focal," "foci" and "focus." And, the definition for focal is: "An adjective meaning limited to one specific area. A focal cancer is limited to one specific area or organ. The area may be microscopic or macroscopic." So it's kind of a, can be kind of a fuzzy word but it generally means that whatever is being described as "focal" is limited to one specific area and it's not necessarily representative of the larger tumor or organ or whatever it may be. So, if you encounter "with focal _____ differentiation" or with focal papillary—it wouldn't be papillary differentiation-- but "with focal (some type of) differentiation," you would actually *not* use that description that follows focal. It is not equivalent to "with _____ differentiation" as it is further described by "focal."

[Are there] any questions about that as we get started?

We will be including this in the Frequently Asked Questions that will be available on the SEER website with the Multiple Primary and Histology Coding Rules. And, that Frequently Asked Questions document should be up here, on the website, in the next few days or a week—before the first of the year. Thank you for that excellent question.

Breast Case 1

Let's start with our first case. Our first case is described in the microscopic summary as invasive inflammatory duct carcinoma. However, in the final diagnosis [*Excuse me, Steve? Are we supposed to be able to view this on screen because right now I see two pages and I can't read the text.*] Oh? I wonder why?

Steve: Can you put it back on full screen? It is on full screen. [*Here it comes now.*] Okay. Thank you. Thank you, John.

So, you do have the case presented here before you. In the microscopic we have the histologic type described: "invasive inflammatory duct carcinoma." However, in the final diagnosis there is no mention of inflammatory carcinoma. There is a mention of dermal lymphatic invasion and even in the comment there is no description of inflammatory. So our first decision that we must make is: Is this a single primary or multiple primaries? And, I am going to be bouncing back and forth a little bit so I can also show you the rules while we are having our discussion. We'll see how quickly we can bounce back and forth between documents.

Here we are in the Breast Multiple Primary Rules. And both, if you recall, under the "Single Tumor" or "Multiple Tumors"—you will have-- there is a rule [that] if there is inflammatory carcinoma in one or both breasts, you have a single primary. So, no matter what our case is, if it is described as inflammatory carcinoma and in this case we actually have a single tumor, we will call this a single primary.

Once we have made that decision then we can go to the Histology Coding Rules. And, again, we are not looking at in situ carcinoma. We are not looking at invasive and in situ carcinoma. We are looking at a case of invasive carcinoma only and, again, we go through these rules in a hierarchy, one rule at a time. Rule H10 does not apply. Rule H11 does not apply. Rule H12 does not apply. Rule H13 is the one that we are kind of going to have a question about. It reads: "Does the final diagnosis on the pathology report specifically state inflammatory carcinoma?" And, in our situation with case number one it does not, so we go to the next rule. And, we will say, one histologic type is identified and we will code the histology as infiltrating duct carcinoma.

Does anybody have any questions about case number one?

Okay. We'll go on to case number two.

I think rather than going back and forth between the cases what I am going to do is stay in the rules.

Question 1 Breast Case 1

Excuse me, Steve? I do have a question regarding case number one. [Okay] At the very beginning when we are determining whether or not it's a multiple primary, yes we know that there is one tumor here. But we do have a mention of inflammatory. Now, I know we haven't gone through the histology to code our histology code yet but we do have a mention, a clinical diagnosis of inflammatory. So when we are going through our multiple primary rules and M2 asks if there is inflammatory carcinoma, does that mean in the final diagnosis or can we use the clinical diagnosis to answer this question?

Response to Question 1, Breast Case 1

You were supposed to actually be using the final diagnosis on the path for both, but you'll notice between Rules M2 and M3 both of the answers are a single primary and they are built that way. We constructed it this way so you would arrive at the same answer no matter how you interpreted that particular case. Okay? So that's one of the built-in catches to make sure that whether the registrar interprets this case as inflammatory or as a single tumor, you are going to determine this to be a single primary.

Okay. Thank you.

You are very welcome. Great question.

Breast Case Two

Okay. We will move on to case number two. And, case number two—I am not going to display it on the screen, so I will stay in the rules—but we have a description on a surgical pathology report; we have a gross examination and a micro. But as you recall from our General Instructions we are to use the final diagnosis. And, the final diagnosis says: “Left breast lumpectomy: ductal carcinoma in situ with low nuclear grade, cribriform pattern and microcalcifications.” We do have, again, a single tumor here and you can determine that by both looking at the gross and also in the final; it still is just a single tumor. If we have a single tumor, using the Multiple Primary Rules, Rule M3, we have a single tumor and it's a single primary.

Then we move on to our Histology Coding Rules. And we recognize here that we are dealing with in situ carcinoma only so you will use the rules for in situ carcinoma only and follow the hierarchy. Rule H1 does not apply; Rule H2 we have more descriptors than just one histologic type. We have ductal carcinoma in situ and we also have cribriform pattern. So we move on to Rule H3. This is the rule that is going to apply here. We'll move down to the third section of the rule: “Is there intraductal, NOS [which we do have in the description] and a specific intraductal carcinoma from Table 1?” And, Table 1 shows the cribriform pattern and you will notice over here in our Notes and Examples that “architecture” and “pattern” are subtypes—are used to describe subtypes for in situ tumors so we will use cribriform in this particular case.

[Are there] any questions on case number two? Okay. We'll have questions eventually.

Breast Case 3

We'll move on to case number three. [In] case number three we have a left breast mastectomy with a gross description. And in the final diagnosis we have a description of two separate foci of invasive carcinoma. We are going to move to "Multiple Tumors" for our Multiple Primary Rules. And, we don't have different sites like colon and breast so Rule M4 does not apply. Rule M5 is the rule for timing and we're not, we don't have tumors that are more than five years apart. We are not looking at inflammatory [Rule M6] and we're not looking at tumors in each breast [M7]. Those rules we quickly pass by. It's easier for you to read through them than for me to describe them. Rule M8 does not apply. Rule M9 is duct and Paget Disease; it does not apply. We finally arrive at Rule M10 which is: "Are the tumors lobular (8520) and intraductal or duct?" And the answer here is, "Yes." We have duct and lobular and it will be a single primary.

[Let me go back to the full screen. It might be easier for folks to see].

Question 1, Breast Case 3

Steve, I have a question? [Yes] I understand that lobular and duct; if that had read intraductal or lobular and intraductal would you still use Rule M10?

Response to Question 1, Breast Case 3

Yes. It would still be a single primary then you would, just coding the histology using the histology coding rules.

Okay. It just threw me where intraductal wasn't bolded?

Under?

Under M10.

Under M10?

I understand.

This is the same issue. Yes. Okay.

Is this easier to read at a full screen for everybody?

"It was easier to read before; it's real hard to see right now."

That's surprising. Okay.

I don't know whether there's—John, can you fix it?

I'll just take it back to the smaller screen.

Question 2, Breast Case 3

Steve, can you give the histology codes as you go along?

Response to Question 2, Breast Case 3

We haven't coded histology yet, so we are not there. Oh, you mean the numbers? [Yes, please] Would you like me to go back to Case 1? [Yes, please].

Okay. The histology for the single tumor in Breast Case number one is code 8500 with a behavior of 3, infiltrating duct carcinoma, NOS. The histology for the single tumor in Breast Case number two is 8201/2—behavior 2—duct carcinoma in situ, cribriform type. We are now on Breast Case number three and we have yet to code the histology.

Breast Case 3 Histology

We have two foci of invasive carcinoma so we are looking at multiple tumors. We have to go to the Multiple Tumor Module. Here we go: “Multiple Tumors Abstracted as a Single Primary.” And, we are going one rule at a time. Remember always to use the hierarchy: H20—our answer is, “No;” H21—our answer is, “No;” H22—we're not looking at inflammatory carcinoma, so our answer is, “No.” We have more than one histologic type [H23] so we continue down. Paget Disease and intraductal is not what we have here so Rules H24, 25 and 26 we move beyond. And, Rule H27 does not apply. So, finally we get to Rule H28: “Is there any combination of lobular and duct carcinoma?” And, we do have a combination of duct and lobular so our code is 8522 with a behavior of 3—the combination code for duct and lobular.

Any questions about case number three?

Okay. We move on to case number four.

Breast Case 4

It's not as easy to navigate. That's the breast.

Case number four: we have a right modified radical mastectomy, which the diagnosis reads: “Adenocarcinoma in two locations.” Specimen A is infiltrating duct cell type, 1.8 cm in size. Specimen B is also infiltrating duct carcinoma, 1.0 cm in size. So we start going through our Multiple Primary Rules. We know that it's not a single tumor so we go to the Multiple Tumors rules. And, we have two infiltrating duct carcinomas. Rule M4 does not apply. M5 the answer is, “No.” M6 the answer is, “No.” It's not inflammatory. M7: These two tumors are in the same breast, both on the right, so M7 does not apply. M8 does not apply; we do not have invasive following an in situ. M9 is duct and Paget and that is not our case.

M10 is lobular and duct. And, finally we get to Rule M11: “Are there multiple intraductal and/or duct carcinomas?” and that fits our bill, right? So M11 tells us we have a single primary. You will record the number of tumors abstracted as a single primary in the “Multiplicity Counter.” We have not yet provided a Breeze training on the new data items such as the Multiplicity Counter. It’s a new data item where you will code multiple tumors that are abstracted as a single primary and you will record the number “2” in that data item and associate the dates that go with this diagnosis and the other fields that go with that. So stay tuned and make sure that you attend the new data items presentation to get an orientation to those new data items and how to use them.

So, now we know we have a single primary—“Multiple Tumors Abstracted as a Single Primary.” So we go to our Breast Histology Rules. We know it’s not a single tumor so we pass by all the single tumor rules until we get to Rule H20, which is where the “Multiple Tumors Abstracted as a Single Primary” Module begins. And, Rule H20 does not apply because we have the pathology report. Rule H21 does not apply because we have the primary tumor, not a metastatic biopsy. It is not inflammatory carcinoma [Rule H22]. H23: “Is one histologic type identified?” Well, they are both infiltrating duct, correct? So, we will just code the histology here as 8500 with a behavior of 3, infiltrating duct carcinoma.

Any questions about case four?

Questions/Comments

Comment 1, Breast Case 4

Steve, I have no questions but I do have a comment. [Yes] Allowing to where our term final diagnosis more specifically because of inflammatory breast carcinoma—we had so many issues with it? [Yes]. But on this Paget form, it’s not stated to be the final diagnosis.

Response to Comment 1, Breast Case 4

Yes. I think that that was just an oversight in organizing this particular case. [Okay. No problem]. Yeah. I think the entire description here was, we expected folks to look at the entire description here as the final diagnosis.

Yes. That’s how I interpreted it but I am just wondering if this was a scenario where it was inflammatory, you know, it could be problematical but it doesn’t apply here so we’re good.

Yeah. Right. Okay. Thank you.

Breast Case 5

Move on to case number five. Case five might be a little more interesting. [Is] everybody keeping up pretty well for us? Let’s start out with the easier ones, of course. We’re trying to emphasize certain points along the way as we go.

Case number five we have a left breast mastectomy and as you read through the final diagnosis we also have a right breast mastectomy that's not listed under the "Specimen." The left breast mastectomy shows multicentric lobular carcinoma, no evidence of the previously excised invasive lobular carcinoma is identified. The right breast shows lobular carcinoma in situ with no invasive carcinoma or ductal carcinoma in situ identified. We start looking through our Multiple Primary rules to decide how many abstracts we are going to create. We know that we have cancer in the right breast and cancer in the left breast so we have multiple tumors so we go right to the Multiple Tumors Module. And, again, going through the hierarchy, M4 does not apply so you go on to M5; the tumors are not more than five years apart so you go to M6. It is not inflammatory carcinoma [M6] so you go to M7: "Is there a tumor or tumors in each breast?" And for this case, the answer to that is, "Yes." So we have multiple primaries. There is also a Note just in case you are confused and wanted some additional direction to clarify that lobular carcinoma in both breasts is a multiple primary. This is to make sure that you are on track.

Now that we know that we are going to be abstracting two cases we can move onto our Histology Coding Rules. And, the first is lobular carcinoma in situ but there was a previously excised invasive lobular carcinoma. We haven't looked yet at the rules for when we have both in situ and invasive carcinoma. Here is the rule for "Single Tumor—Invasive and In Situ Carcinoma." We always code the invasive histology. Now in this particular case both the invasive and the in situ tumor are lobular carcinoma but this is just to begin to introduce you to the concept that you always code the invasive histology when you have both invasive and in situ components in your histologic makeup. Some registrars may have interpreted this lobular carcinoma as multiple tumors so I want to point out that for the histology rules, "Multiple Tumors Abstracted as a Single Primary," you have as you go through the hierarchy, Rule H27 when you finally get down here: "Are there invasive and in situ components?" You code the invasive histology. Just recognize again that this is a change from the previous histology coding rules and it's different from the ICD-O-3 rules but made in collaboration with the ICD-O-3 Editors and [with] approval by the ICD-O-3 Editors. For histology coding for the right breast tumor, we only have lobular carcinoma in situ so the codes for our two primaries: the left breast we use the code 8520 with a behavior of 3, lobular carcinoma invasive because there was a previously excised invasive lobular carcinoma in the left breast with only in situ residual. And on the right, we have a code of 8520 with a behavior of 2, lobular carcinoma in situ.

Any questions about case number five?

Question 1, Breast Case 5

I have a question. This is Dolores in Oklahoma. If, on the in situ, you're using Rule H7? Are you using that for both breasts because there's only in situ in the right breast and there's both invasive and in situ in the right?

Response to Question 1, Breast Case 5

There's only in situ in the right. So, you would use the single tumor. You have a single tumor on the right and you use the Single Tumor rules and we only have lobular carcinoma in situ. So we go to the in situ rules for single tumor, which start with rule H1. H1 does not apply; H2—one histologic type—lobular carcinoma in situ so you code the histology. Okay?

Question 2, Breast Case 5

What rule did you use for the right breast? No. For the first one was it the left breast? Was it Rule H7 or H27?

Response to Question 2, Breast Case 5

It doesn't really matter how you interpreted it because it's another built-in fall so you will arrive at the same answer no matter which rule, how you interpreted the case. That's "Multiple Tumors Abstracted as a Single Primary" or a Single Tumor that is multicentric. That's one of the reasons that we have built in these extra cautions within the rules that allow for registrars to—who can-- interpret a case slightly differently and arrive at the same answer.

Question 3, Breast Case 5

Steve, I believe for that one it would have been H9 versus H27 rather than H7?

Response to Question 3, Breast Case 5

Okay. H7, yes. H7 does not apply because H7 is in situ lobular with in situ carcinoma other than intraductal. Okay. You are correct. H9 is the rule. For the left breast, "No." You have the invasive lobular was identified earlier so it's Rule H7. I'm having trouble reading this on the screen; I apologize. Yes. That's Rule H9; that's correct. Okay?

[Are there] any other questions on case five?

Breast Case 6

Case number six is an interesting case. It's a little bit tricky. When I looked at the case this morning I had to look at it a couple of times myself. Don't forget that February the 14th this individual had a left breast biopsy that showed infiltrating lobular carcinoma. So this is invasive lobular carcinoma diagnosed on the initial biopsy on the left breast. A month and a half later she had a right breast biopsy and a left breast lumpectomy. The right breast biopsy showed duct carcinoma which is invasive duct and also showed lobular carcinoma—invasive lobular. The left breast specimen, the lumpectomy: the biopsy showed invasive lobular and the lumpectomy showed infiltrating duct carcinoma with duct carcinoma in situ, comedo and non-comedo types. Then another, item number seven under this same pathology report showed the new anterior needle margin on the left showing infiltrating duct carcinoma and lobular carcinoma in situ with extension

into the ducts. So there's a lot of stuff. It's kind of a typical case that you'll see. So let's start with our Multiple Primary rules. We know that we have multiple tumors. So we go right—don't even pay any attention to Rule M1 or the Single Tumor rules. Go right to the Multiple Tumor rules. Rule M4 again does not apply. Rule M5: they are not more than five years apart. Rule M6: it's not inflammatory. Rule M7: tumors in each breast; that's looks like our winner again.

So we have multiple primaries, one on the right and one on the left and we take those one at a time when we determine the histology. So let's start with the left breast because that was our initial diagnosis was from the left breast biopsy. And it appears that we have a single tumor on the left with invasive lobular, infiltrating duct, duct in situ and lobular in situ. So we have all kinds of good stuff in here. And, we've already identified that when we have invasive and in situ that we're going to focus on the invasive histology. So what we are looking at here is invasive lobular and invasive duct in this is the single tumor on the left. So we don't look at the in situ[s] [rules]; we don't look at the "invasive and in situ" rules—we go to the next set of rules ["Single Tumor—Invasive Only]. Now we are trying to identify the rule in the hierarchy where we have invasive duct and invasive lobular in a single tumor. Rule H10 does not apply. Rule H11 does not apply because we are not looking at a specimen from a metastatic site. Rule H12 is looking at again a non-specific term and more a specific term so that rule does not apply. The inflammatory Rule H13 does not apply. Rule H14—we have more than one histologic type so that does not apply. Rule H15: Are there two or more specific duct carcinomas? No, because we have a lobular and a duct. Finally, we arrive at Rule H16: "Is there a combination of lobular and duct carcinoma?" Yes. I find code 8522 (duct and lobular) and our behavior will be 3 because both are invasive, of course, and this is our combination.

You can also reference the combination Table that's in the Terms and Definitions and this will take you to the same, you'll arrive at the same point along the way for coding that.

The right breast also shows invasive duct and invasive lobular. So using the same hierarchy and the same set of rules—I won't walk through them again—we arrive at the identical code for the right breast with code 8522, with a behavior of 3, infiltrating duct and infiltrating lobular carcinoma.

Any questions about case number six?

Question 1, Breast Case 6

I have one, Steve. [Yes] Explain the left breast. You have some in situ along with the invasive? [Yes] I went through these modules to see the invasive and in situ and chose H9; it tells you to code based on the invasive, then I just referred myself to Table 3.

Response to Question 1, Breast Case 6

Yes. That is, again, the way that the rules are built. We would prefer that you—take you through the hierarchy and arrive at the rule that specifically addresses the lobular and duct, Rule H16; but we are not going to be asking you which rule you used to arrive at your conclusion.

But, was I wrong to go to that module--the invasive and in situ?

No. That is exactly what leads you to the next set of rules. So, No.” You were absolutely correct and that’s how you determine that you ignore the in situ component.

So then we tell people to go on to the next module?

Yes.

Okay. Thank you.

Question 2, Breast Case 6

Hi, Steve. This is Chris in Seattle. [Yes]. I have a question about coding from the biopsy specimen because the general guidelines say that we should code from the most representative tissue. So I should think that we would code from the lumpectomy specimen [the surgical pathology report] and not from the biopsy.

Response to Question 2, Breast Case 6

Chris, the response to that would be an invasive tumor always trumps an in situ. So you will use the information for invasiveness in the coding of any histology diagnosis for that particular instance. But that’s a good question.

Question 3, Breast Case 6

Steve, this is Cheryl Bellis from the State of New York. We have a question about choosing the left breast tumor from two different path reports? I am not sure where it says anywhere that you would actually do that? When I look at the March 29th path report and I see the infiltrating duct and then I am going to ignore the lobular in situ we all, well not we all, but I came up with 8500 with an invasion of 3 but I don’t understand where it is stated anywhere in your documents that you would actually go from, you would actually take from more than one path report. This came up a lot in our training. There was no slide that referred to that so could you address that, please?

Response to Question 3, Breast Case 6

Sure. Using multiple path reports to code the histology? [Yes; that’s what I’m asking]. I think that that’s a very good question and we didn’t really, I don’t think, specifically address that in the General Instructions. I’m not...I don’t have the General Instructions in front of me but there may be some information in the General Instructions about using multiple pathology reports and if there is not,

then what we will do is add this to some suggestions that we are gathering for additional clarifications.

Steve? There are instructions for multiple path reports under the Histology Instructions—the General Histology Instructions. And do I have them right in front of me? No. And I can't... let me see if I can...

Okay. Thank you, Carol. That was Carol Johnson and what we will want to do is, again, refer people to the General Instructions because they do provide the framework upon which the rest of the rules are constructed.

Question 4, Breast Case 6

Steve, would you not consider the timing rule when you're looking at multiple pathology reports?

The timing rule here is five years. So, yes, you would but I doubt you would be looking at pathology reports in the same breast five years apart. Okay?

Question 5, Breast Case 6

Steve, this is Chris again. I'm sorry I was on mute before when I tried to follow up with you because you said that the invasiveness trumps the in situ, right? [Yes] For histology that mastectomy [lumpectomy] specimen also had infiltrating duct, which is invasive. And if we were going to code from the most representative specimen we would go with that infiltrating duct and we would arrive at the histology of infiltrating duct. And I would also like to mention that I know that a lot of path reports that I review it is difficult for them to tell whether it's lobular or ductular. Then they go something that I can't pronounce to prove the ductal nature of the tumor and it doesn't look like they did that on this particular tumor. I am kind of wondering why you didn't go with that most invasive from the most representative tissue?

Response to Question 5, Breast Case 6

Right. And, Chris, again, the biggest issue here is these are representative cases. They are not fully vetted cases where you have all the information. If you were coding the case from a medical record you would likely have more information available to you. We don't know how extensive the left breast mass biopsy was with the information that we have provided. It is used for illustrative purposes only and I think that your argument has some merit. My suggestion is that you would have more information available when you were actually using this case and perhaps we could have put in some additional information on this particular set of pathology reports to make it a little bit less confusing.

Question 6, Breast Case 6

Steve, this is Cheryl again. I just want to say, taking a look at the General Histology, Histologic type ICD-O-3 handout, it's nowhere that I can see where it says that you would actually take from more than one path report. The path

report says: A--most representative tumor specimen; B—final diagnosis. And Note 3 in 1 b is: “The new rules limit the information to the final diagnosis. The old rules allowed coding from the microscopic description and you will only do that when a site specific rule tells you to do it.” So, I think that is something you are going to want to add if, in fact, you do feel that the lobular and ductal is the correct histology for that left breast.

Response to Question 6, Breast Case 6

Okay. Thank you and I appreciate that. I was just handed the same set of information and it is not entirely clear how to use multiple path reports in this General Instruction and we will take that information and include it in our suggested clarifications. And, we appreciate those comments.

Thank you.

Okay.

Question 7, Breast Case 6

Excuse me, Steve? So, what's the bottom line then? We use the rules that we have now in print?

Response to Question 7, Breast Case 6

That's right. Yes.

We use the “most representative?” Because the answer to the one we just did is wrong then.

No. I am not saying the one we just did is wrong.

Well, it is if we're supposed to use these rules and we're supposed to use the “most representative”—the biopsy wouldn't be the most representative? It's where the lobular was.

We don't really know what's the most representative from this information that's provided. So, what I will do is, the SEER team will take this case under advisement, review it once again and if we have any revisions to the case we will post them with an explanation. And in the interest of time and continuing on with the discussion we will move on to case number seven but the discussion here has brought forward some good, thoughtful discussion and some good suggestions for some clarifications. We appreciate that.

Breast Case 7

We're going to move on to case number seven. And for case number seven—we'll go back to the Multiple Primary rules. This one's for melanoma. I don't think we want to start getting melanoma mixed in here, do we? Case number seven we have a pathology report from May the 4th that shows for a final diagnosis the

right breast with adenocarcinoma, invasive, lobular type with focal duct carcinoma in situ, (DCIS) cribriform pattern. That's all good information that we can use. And the surgical pathology report from the partial mastectomy on the right a month and a half later shows invasive lobular adenocarcinoma, three foci of residual tumor, lobular carcinoma in situ is not identified, etc. etc. So, we are looking at-- it appears to be a single tumor. Does everybody agree with that? Okay. We move to our Multiple Primary rules. We go to our single tumor. Is this a single tumor? Yes? It's a single primary. So that's a pretty easy rule for us to follow. So we are abstracting one case, one primary. We have a single tumor so we go to the histology rules and we have invasive lobular carcinoma and focal duct carcinoma in situ. So we have a combination of invasive and in situ. So we go to the module for invasive and in situ, which begins with Rule H9 and ends with Rule H9. The question is: "Does the tumor have invasive and in situ components?" Our answer is, "Yes." We code the invasive histology. And the invasive histology for breast case number seven is invasive lobular carcinoma. The code is 8520 with a behavior of 3.

Any questions on case number seven?

Okay.

Breast Case 8

Let's go on to case number eight. You notice that every time we start a case I go right back to Rule M1 and start at the beginning. And, that's how these rules were designed and set-up to be used. You start always at the first rule, go to the module that you need and apply the rules as you go. Case number eight we have, first of all, on November 16th, a final diagnosis from a right breast biopsy that shows ductal carcinoma in situ, cribriform type. The patient then went on to have a lumpectomy in December, which, [showed] invasive duct carcinoma, duct carcinoma in situ with solid, cribriform and papillary types. The DCIS constitutes 25% of the tumor mass and lobular carcinoma in situ is also identified and it's the classical type A lobular carcinoma. So, this is a pretty typical case in which you have lots of different subtypes of ductal carcinoma in situ; you also have lobular carcinoma in situ and an invasive duct carcinoma.

We have one tumor so again going back to our multiple primary rules. We have a single tumor so we drop down to Rule M3. We know it's a single primary. We have invasive and in situ components in a single tumor. So, again, we go to that module which begins and ends with Rule H9 and we are instructed to code the invasive histology. The invasive histology here is duct carcinoma, NOS—8500— with a behavior of 3, infiltrating duct carcinoma. You ignore all of the DCIS including the all the descriptions of solid and cribriform and papillary--all those subtypes of DCIS and you ignore the lobular carcinoma in situ. Code only the invasive duct carcinoma.

Any questions on Breast Case number eight?

Breast Case 9

Breast Case number nine: We have two pathology reports. The first pathology report is from two biopsies in the right breast. One biopsy shows infiltrating ductal carcinoma with extensive high-grade ductal carcinoma in situ. The second breast mass shows colloid carcinoma with extensive high grade ductal carcinoma in situ and, again, because of the rules that we are now becoming more familiar with we are looking at the invasive components for both of these breast masses. The April 22nd pathology report shows some residual ductal carcinoma and some ductal carcinoma in situ close to the margins. So what have we got here? We have two breast masses in the same breast. So we go to the multiple primary rules. We go to “Multiple Tumors.” Rule M4 does not apply. Rule M5: this is the timing rule; they are not more than five years apart. Rule M6: it’s not inflammatory. Rule M7: there is not a tumor on the left and the right breasts. So, now we get to the interesting breast multiple primary rules where we are looking at multiple tumors in the same breast. “Invasive tumor following an in situ tumor,” [Rule M8]: No, that doesn’t apply. “Duct and Paget” [Rule M9]: No. “Lobular and intraductal or duct?” [Rule M10] No, that doesn’t apply. “Multiple intraductal and/or duct carcinomas?” [Rule M11] We have—this is an interesting case because the general idea when we look at intraductal and ductal carcinomas and just looking at the words, we may think that this rule applies. However, we are referred to Tables 1 and 2 to identify the intraductal and duct carcinomas. And the second breast mass is identified as colloid carcinoma and colloid carcinoma is a mucinous, mucin secreting carcinoma of the breast and it is not included as a specific duct subtype in Table 2. It was left out intentionally so these tumors in a situation like this would be counted as two primaries. Colloid carcinoma has a better prognosis than most of the other duct carcinomas. And in this case because we have a colloid carcinoma and a duct carcinoma Rule M11 does not apply and we go on to Rule M12. And, we determine that this case is, in fact, multiple primaries.

Question 1, Breast Case 9

Steve, I’ve got a question. [Yes] I went to Table 3 and used the combination code and thought it was one primary because the colloid is synonymous with mucinous. [Yes]

Response to Question 1, Breast Case 9

And, we have also received an excellent suggestion to add a Note to Table 2 specifically about colloid carcinoma so people don’t think that they are on the right track or the wrong track; then we can add some additional clarification to this and that’s one reason, another reason why this case was included so we could discuss it and provide you a rationale for that. But what we will likely do is add a description of colloid and mucinous adenocarcinoma of the breast to our Definitions for breast and also add a footnote to Table 2 and Table 3. Okay? We think that that will be very helpful. You don’t see a lot of colloid carcinomas in the breast, but in conjunction with multiple tumors, but you will on occasion.

Coding the histology for Breast Case number nine our first tumor, actually, the first, we kind of coded in the reverse order. The first tumor is an invasive duct carcinoma. It's a single tumor. When we apply our histology coding rules we are looking at invasive—oh, this is invasive and in situ for the first breast mass. So we would code the usual H9 and code the invasive histology, which is infiltrating duct carcinoma. The second tumor that's reported is colloid carcinoma with ductal carcinoma in situ so again, you code the invasive histology for the second tumor as colloid carcinoma.

Any other questions on case number nine?

Question 2, Breast Case 9

I didn't get that answer, Steve. I ah, for case number nine, for Specimen B? [Yes] I coded infiltrating duct carcinoma with mucin production, 8523/3 (infiltrating duct mixed with other types of carcinoma).

Response to Question 2, Breast Case 9

8523/3? And could you tell me how you arrived at that decision?

I used Rule H17.

But H17 is a rule for multiple tumors and we have a single tumor. So, you don't use any of the rules past H19 in a case like this because this is a single tumor. So, all the multiple tumor rules, you ignore.

I used Rule H17.

Oh, H17." Duct and any other carcinoma." Hum.

I used that because there is infiltrating ductal carcinoma with colloid rather than just calling it a colloid.

But in parentheses it does call it colloid carcinoma; that usually is the clearer description. We have not provided that level of detail in the General Instructions on how to interpret final diagnoses. But usually when you have a histologic description that's followed by a term that's in parentheses it's the term that's in parentheses that you code. I don't think that we have fully included situations like that our descriptions in the General Instructions. Carol would you like to comment about that?

I am trying to very quickly pull up a set of rules. I want to see. Let me see Table 1 and Table 2. Could you flip to those?

All I have are the Flow Charts on here.

You just have the Flow Charts? Okay. Hang on. I'm getting them pulled up as we are trying, I know.

Question 2a, Breast Case 9

And, Steve, may I just make a point? I haven't used the previous SEER rules. [Ah ha] So, when I looked at this I didn't have that background.

Right. Right.

So, I find these rules strictly...I came up with 8523/3 using H17.

Okay. Okay.

Steve, Table 3 addresses the mixed histologies: ductal and it has mucinous. And then if you go back to the Definitions, "mucinous" and "colloid" are synonymous. So I would put that in parentheses and [would have] thought you were getting the synonym. And, I came up with the 8523 as well.

That may be a valid argument, you know. I'm looking at Table 3 and with the description where we have "and" and "with" as equivalent terms, in the Terms and Definitions, I...

[Carol Johnson] I frankly agree with 8523 as I'm looking at it.

[Steve Peace] *I am too. I am too. And I think that with the discussion and the comments we would/will be changing this answer and the rationale to 8523 with a behavior of 3. And we would have arrived at this using Rule H17 to code this histology. I... You presented a valid argument and using the rules, the information and the Tables as they were designed we believe you are correct. Thank you very much.*

You're welcome. [Carol Johnson]: "Good job."

Question/Comment 3, Breast Case 9

I want to, I'm finding...this is Elayne from Canada. And, we didn't have the SEER rules before so we were using our own rules and we didn't actually have histology rules so these were very useful. By following the rules, I came up with all the correct answers you did including the rationale except for one. I came up with the right answer but I went to the wrong module. [Ah ha] So I am finding the rules are very helpful, very straightforward and easy to follow.

Response to Question/Comment 3, Breast Case 9

Great. Great. And we really appreciate the feedback on this particular one and I think that we just-- we didn't follow the rules.

Question/Comment 4, Breast Case 9

And just as another point: There's three trainers in Canada and three of us emailed each other and that was...we all had the same error on this one. [*Oh good*]. It turns out to be a good thing.

Response to Question/Comment 4, Breast Case 9

Wonderful. Wonderful. We appreciate that and we really appreciate the feedback. Thank you.

Okay.

Any other questions on case number nine before we move on?

Question 5, Breast Case 9

Yes, Steve. This is Angela from Missouri. [Yes]. You had said earlier this was a multiple primary? [Yes] Okay. I just wanted to make sure I had that correct.

Response to Question 5, Breast Case 9

Yes. That's correct.

Thank you.

Finally, we get to....

Question 6, Breast Case 9

This is Evonka from New York State. [Yes] I would just want to get a clarification from you cause um I have been part of the training from the beginning and I do remember when you initially said in order to code a combination code there has to be a certain wording. And if we go to ICD-O-3 for the combination code for infiltrating duct with mucin production there is a word "and." We don't see that in this specific path report.

Response to Question 6, Breast Case 9

Yes, but in the Terms and Definitions we have an Equivalent Term and for the Breast Rules "and" and "with" can be used synonymously.

Oh...Okay.

Okay? So with this clarification that this is the combination 8523/3 that is the correct use of the rules as written.

Okay. Thank you.

Yeah, yeah. Thank you.

Question 7, Breast Case 9

Steve? We have a question in Louisiana. [Okay] We're questioning the use of Rule H17 only because um in Specimen B-- the biopsy-- it's does mention also that there's a high grade ductal carcinoma in situ so you'd be using H17 from the section for invasive carcinoma only.

Response to Question 7, Breast Case 9

Once you've determined that you're not going to use the in situ component, then you have to use the invasive rules. So, yes; if you have multiple decisions that you have to make along the way.

Okay. Use the rules for invasive only?

Yes. That's a good question.

Question 8, Breast Case 9

So, Steve? Why wouldn't you just stop at the "Single Tumor—Invasive and In Situ [Carcinoma] Module?"

Response to Question 8, Breast Case 9

That was just the question that was just asked. And that would instruct you to code the invasive component but you still have some questions on how to code the invasive component so you would then look at the invasive tumor rules for some additional instruction and direction on how to do that. So you just follow through the rules.

Breast Case 10

I'm going to go on to case number ten so we can finish up today. And, case number ten is our last case. And let me get back to the beginning of the rules again. We have a left breast mastectomy with invasive ductal adenocarcinoma, multifocal with the largest focus, the one that's up to 2 cm and there's some low to intermediate grade DCIS present in several foci as a minor component of this neoplasm. So, we have a breast that has quite a lot of tumor in it. All the foci of carcinoma are in the same breast and all are duct carcinoma or duct carcinoma in situ. So, we are looking at multiple tumors. All of them are duct so Rule M4 does not apply; M5 does not apply; it's not inflammatory so M6 doesn't [apply]. They're not in the right and left breasts so M7 doesn't apply. Again, we continue down the rules until we arrive at Rule M11—multiple intraductal and/or duct carcinomas are a single primary and then you can reference Tables 1 and 2 to identify those. So we know that we are looking at a single primary here. And then we need to code the histology and we have duct carcinoma in situ and invasive duct carcinoma. So, again, we're looking at invasive and in situ which takes us again to Rule H9: code the invasive component. So our determination for histology here is code 8500/3—the behavior of 3--infiltrating duct carcinoma, NOS.

Any questions on case number ten?

Question 1, Breast Case 10

I have one question or a comment, Steve. [Yes] I thought this was an example where, because it's multifocal and the number of tumors is not mentioned, I used the module for "Unknown Whether Single or Multiple [Tumors]"?

Response to Question/Comment 1, Breast Case 10

And that would...and that is an excellent use of the rules and again brings out another set of rules that will, no matter how you interpret the case you will arrive at the same answer that you have a single primary using Rule M1 whether you could determine if this was multifocal or multiple tumors, you arrive at the same answer. So that's, that's...I appreciate you pointing that out. That's excellent.

Great! Okay. Well, we thank you for joining us and going through these cases. You brought some good discussion and we appreciate all of your comments and your time.

Question 2, Breast Case 10

Steve? Can I ask one more question before we close? [Sure] Okay. I have a question about where Table 3 fits into the whole picture?

Response to Question 2, Breast Case 10

Table 3 is provided generally as a reference. We haven't...ah..at an earlier stage in the development of the rules we had specific rules pointing the abstractors to using Table 3. We revised those rules but we kept Table 3 in as a reference.

Okay. Because it almost looks like Table 3 actually conflicts with Rule H6.

Okay. And we'll take a closer look at that, Chris, and we'll double-check that.

Okay, thank you.

Okay. Thanks.

And we appreciate you joining us today. If you are going to participate in the next set of Breeze Sessions, I don't have the schedule in front of me but I think that the next set is either "Head and Neck" or "All Other Cancer Sites." Thank you very much for your time today and I look forward to seeing you again.

"Thank you."