NATIONAL INSTITUTES OF HEALTH
NATIONAL CANCER INSTITUTE
SURVEILLANCE, EPIDEMIOLOGY AND END RESULTS (SEER) PROGRAM
2007 Multiple Primary and Histology Coding Rules Breeze Sessions
Melanoma Rules Practicum
March 9, 2007

INTRODUCTION

Hello and welcome to the Malignant Melanoma Practicum. Before we begin the Practicum I want to discuss two questions with which we closed the Breeze Session on the Cutaneous Melanoma MP/H Rules. I said I would answer those prior to starting the Practicum on those rules.

The first question had to do with rule H7—the rule that says "Code the **histologic type** when the diagnosis is **lentigo maligna** melanoma **and** a **histologic** type." Lentigo maligna melanoma is a histologic type. This rule is in place because if you had a lentigo maligna melanoma and you also had another histologic type it would be more important to record the other histologic type rather than the lentigo maligna.

The second question concerned rule H6 that says: "Code 8723 (malignant melanoma regressing) when the diagnosis is regressing melanoma. Example: Malignant melanoma with features of regression. Code 8723." The question had to do with, "Do you intend to code a partial regression or any regression that's less than total?" The answer is, "Yes." I consulted with our pathology expert. His comment was that there is much controversy about the importance of regressing melanoma. Some people say a partial or incomplete regression does not have much significance while other pathologists say it has a great deal of significance. There is really no consensus among the experts on the importance of a partially regressed melanoma. The decision was to code the partial regression when that is the only information we have. In analysis we can group all of these partial regressions under malignant melanoma. We could also very easily change the code to malignant melanoma if it were proven that this had no significance but we couldn't pull those out if they were all coded as malignant melanoma. This is the rationale given for coding a partial regression.

Are there any questions about either of those?

Question 1

Carol, would it ever say "foci of regression?"

Response to Question 1

Not often. No. In most cases the regression is often "partial" or words similar to partial. A complete regression is rather rare. That's when they find a lymph node for example, that has malignant melanoma and there's no sign of a primary. That's actually a complete regression.

Thank you. [*Certainly*]

Let's go on with Case 1.

MELANOMA CASE #1

Case one is rather interesting. This is a patient who has two melanomas. The first melanoma is on her left foot and the second melanoma is on her right thigh. I want to remind you that using the topography codes foot and thigh both have the same topography code. So going through the Malignant Melanoma Multiple Primary Rules, rule M1, of course, is for "Unknown if Single or Multiple Melanomas" and we would go straight to the Module for Multiple Melanomas that starts with rule M3. Rule M3 says, "Melanomas in sites with ICD-O-3 topography codes that are different at the second (C**x**xx), third (Cx**x**x) or fourth (Cxx**x**) character are multiple primaries." That does not apply to this case. Both of these are actually coded to the same topography code so we would go on to rule M4, which is a new rule. It's the one that says, "Melanomas with **different laterality** are multiple primaries." If you look at this case, the first specimen is from the left foot; the second specimen or melanoma is from the right thigh so that rule would apply and this would be counted as a multiple primary.

To code the histology we will first do the primary on the right thigh. One of the biggest questions you have here is one frequently encountered in melanoma--trying to decide which of the pathology reports pertains to "the most representative specimen." Your first pathology report talks about the "first interspace, left foot." The second pathology report is from the specimen on the right thigh. The final diagnosis from the right thigh, shave biopsy says it is "consistent with malignant melanoma, superficial spreading type, invasive to a Clark level II/III and a Breslow thickness of 0.79 mm." The final diagnosis also says "melanoma in situ extends to inked biopsy margins." In going through the rules you will find rule H1 is histology documented by the physician if there is no path report; that does not apply to this case. You would not use rule H2 because it pertains to histology from a metastatic site if you do not have a specimen from the primary site. Rule H3 says to code the histology when only one histologic type is identified. That is really where I would put this particular case. It simply says "malignant melanoma" then gives a specific type, which is a "superficial spreading." If you wanted to call this a subtype, you could continue on to rule H9 that says, "**Code the** most **specific** histologic **term** when the diagnosis is melanoma NOS (8720) with a single specific type." My point is to tell you once again that no matter what the registrar calls it—if he/she calls this a single histology or if she calls it a histology with a specific type, he/she will come to the same conclusion to code superficial spreading malignant melanoma, 8743/3.

For the primary on the left foot if you look at the first pathology report it's called a "punch biopsy." You have a "malignant melanoma with features of acral lentiginous type, invasive to a Clark level IV and an approximate Breslow

thickness of 3.25 mm extending to the bilateral biopsy margins." The second pathology report is from a specimen on the right thigh. The third pathology report says that we have a specimen from a "wide excision on the left foot, wide excision right thigh." The final diagnosis is malignant melanoma with Breslow depth of 3.40 mm of the skin between the amputated first and second toes of the left foot; margins free of tumor. In this case I would choose to use the first specimen because in the best estimation I can give it talks about the entire melanoma with positive margins so it sounds as though the majority of the melanoma was probably removed during the first procedure. It is difficult to ascertain which report concerns "the most representative specimen." You don't have a positive statement saying this is "the most representative specimen." There are actually three pathology reports for this case. This first specimen, however, has the most information. It talks about a malignant melanoma extending to bilateral biopsy margins. This seems to be the most representative specimen. The actual diagnosis is acral lentiginous melanoma. You look at this diagnosis and see it is a NOS, a malignant melanoma, with features of acral lentiginous type. The word "type" is used in this diagnosis. When you go through the Histology Coding Rules you see, again, that H1 talks about not having a pathology specimen and H2 talks about having a specimen only from a metastatic site. H3 says, "Code the histology when only **one histologic type** is identified." H4 says, "Code the invasive histologic type when there are **invasive and in situ** components." H5 and H6 both deal with regressing melanomas; there is no mention of regression in this case. H7 talks about the lentigo maligna melanoma and a histologic type. H8 says to code lentigo maligna when that is the diagnosis. H9 says, "Code the specific term when the diagnosis is melanoma NOS with a single specific type." The type may be qualified by using the words "type, subtype, with features of," etc. So using rule H9 you would code this as an acral lentiginous melanoma, 8744/3.

Are there any questions about this case?

Question 2

I have one, Carol. In this case I also had a hard time determining which path report to code the histology from and I looked at the depth of invasion. And the depth of invasion from the third pathology report (wide excision left foot) is greater than the one from the punch biopsy (pathology report #1). Is there any indication if you take that depth into account in deciding which pathology report you would use?

Response to Question 2

It's one of the things that I wish in hindsight that we had set up some priorities or guidelines. This issue did not arise in the first cases we did. When we started choosing cases for these exercises we had about three cases where we had to really look to see which was the most representative specimen. So it's not something that came up when we originally developed and beta tested these rules. This is something we will review when we do revisions. The decision here

as we talked about this case was that we seem to have the most information with the first diagnosis, which usually is your largest specimen. It is very hard for a pathologist to give a specific diagnosis when he/she has a small specimen. The second thing we talked about was the fact that the depth of invasion is not necessarily directly in the middle of the melanoma. So it doesn't really mean that they took a huge portion; they just happened to get that spot that invaded a little further than the spot that was looked at under a microscope from the punch biopsy. In working on these rules we talked to physicians about punch biopsies. They said punch biopsies for the most part take the visible melanoma; they really don't go in a center and core it out; they usually take what they can see clinically. So that kind of cemented our decision to use specimen 1 as the most representative specimen. I really anticipate that we will write some instructions on these points in the first revision now that we have seen these cases since the rules were written.

Does that answer your question about how we ended up making that choice? I am not getting a reply so I will assume this answers the question.

Are there any other questions on case one?

Question 3

I thought that in these cases we would be coding "the most invasive," not necessarily "the most representative." Is that in conflict? The Definitions give a definition of "most invasive."

Response to Question 3

I do hear what you are saying. It does indeed give a definition of "the most invasive" in the Equivalent Terms and Definitions. We do have a rule, rule H4 that talks about coding the invasive when there is an invasive and an in situ. But unlike the other sites you don't actually have a rule that tells you to code the most invasive. Part of that is because malignant melanomas don't usually have multiple histologies. When we use that rule about coding the most invasive it's when there is more than one histologic type present in the tumor. The most invasive is usually the one that controls the prognosis. But with malignant melanomas it is not often that you have more than one histology present in a single melanoma so that rule was not written into this set of rules.

Question 4

Carol, I find it confusing. In "the most invasive" definition it refers to depth of invasion.

Response to Question 4

That's correct. That's because with melanomas of the skin the "most invasive" as it's used in these rules actually means the greatest stage of disease, if you will, based just on that primary tumor. So in each one of the sites the definition of invasion is the same definition that is used in staging. So for hollow organs like

colon it's depth of invasion. For solid organs such as breast it's based on the size of the tumor itself. So, yes, it is "depth of invasion" for melanoma. It is the same thing that "T" is based on in the AJCC coding and the same thing the "extension" is based on in Collaborative Staging.

Question 5

Carol are you saying for this case then or for all melanomas that the General Definition that is given in the General Instructions that "the most representative specimen" is "the specimen in the surgical procedure that removed the most tumor," does not apply to melanomas?

Response to Question 5

No. The question was, "Wouldn't you code from the specimen that showed the most invasion?" The answer was, "No," because we don't have a rule that says to code the most invasive histology.

I understand that. I was getting back to the very first question we had or I think to someone's question that was asking wouldn't we take the malignant melanoma NOS from the August 19th path report because that removed more tissue than the punch biopsy?

How are you defining "more tissue?"

When you do a wide excision and you're amputating a toe.

They removed more tissue but did they remove more tumor tissue?

I don't know because the path report doesn't give size. But a punch biopsy doesn't remove that much tissue. I don't know, but I think this is another one of those cases that I think is not a good case to use for training.

It's confusing because 3.25 mm [punch biopsy specimen] with positive margins gives you a different histology than the August 19th path report, which is just malignant melanoma, but it's 3.40 mm with negative margins.

The 3.40 mm measures the depth of the excision. It doesn't measure the amount of tumor tissue. They've already excised a core. They go back and do a wide excision. The wide excision is on the lateral margins and it's also on the deep margins. They go on both sides of the punch. They also go deeper than the punch. So when they're talking about a deeper penetration when they looked at the deep margins they found melanoma at the deep margins.

I still don't really follow you on that because isn't the Breslow thickness the thickness of the tumor?

Yes. Exactly.

That's what we're saying. The August 19th has a Breslow depth of 3.40 mm and the August 11th [path report] has a Breslow depth of 3.25 mm.

Right. That's absolutely correct.

So it's giving you a thicker piece of the tumor. I think this is another one of those cases that is confusing. I think we should suggest not to use it for training.

I think it is very confusing but I don't think it's a totally unusual case for melanoma. I think it points out something that we need to add to the instructions. We were quite surprised as I said when this issue arose. We went through all the beta testing; we went through all the cases we had and it was not until we started these training sessions that we started to see these cases. And we didn't see just one or two; we saw a number of them. So that made us aware that we probably needed to add a default. We need to add instructions so that every registrar who works with this kind of case will make the same decision as to which pathology report they would use.

I understand that but we're supposed to use the rules as they are now. I think with the rules as they are now in this case, I think it's confusing. That's the point I'm trying to make.

Okay. I understand and yes, you're right it is. It's a very difficult case in which to make a decision on which path report to use. We can't change these cases right now. We can certainly put notes on them.

End of Question 5 and Its Associated Responses

Are there any more comments or suggestions? We are keeping track of all the suggestions and we will make changes and revisions based upon all the suggestions we receive.

MELANOMA CASE #2

For case #2 the clinical history talks about two biopsies: "the left frontal medial and lateral scalp, approximately 5 mm from each other." They are shave biopsies. The final diagnosis is: "A. Left frontal medial scalp." We also have "B: Left frontal lateral scalp." The first question is whether or not this is a multiple primary. I want to call your attention to something that's important in the "Comments" in this case: "If the biopsies from part A and B are separated by a region of uninvolved skin, it is likely that one of these biopsies represents a satellite lesion." The pathologist is saying he/she does not know if there is uninvolved skin in-between, or if this is a part of one nodule. He goes on to say, "Histologically these appear to be two distinct nodules but both have an intraepidermal component associated with them. The possibility also exists that there are two nodular foci of invasion arising in a broad melanoma." We tell you in the General Instructions to use the "Comments." This information in the

"Comments" section of the pathology report is saying that the pathologist does not know if this is one or two melanomas. For the question regarding if this is a single or multiple primaries, we would go to the "Unknown if Single or Multiple Tumors Module." Rule M1 says when it's not possible to determine if there is a single melanoma or multiple melanomas opt for a single and abstract as a single primary. So this case would be abstracted as a single primary.

To code the histology, if you look at the diagnosis from A it says that there is an "invasive malignant melanoma anaplastic, nodular type with anaplastic and spindle cell features." B says there is an "invasive malignant melanoma with ulceration, histologically similar to the tumor present in specimen A, transected at base and edges of the biopsy." When you go back down to the "Comments" the pathologist does not change the histology that was in the final diagnosis. The pathologist again stresses [in the "Comments"] that "histologically these appear to be two distinct nodules but both have an intraepidermal component associated with them." As far as coding histology, the only information you have is in the final diagnosis, "A," and "B." The most specific information is in "A: invasive malignant melanoma, anaplastic, nodular type with anaplastic and spindle cell features." When you code the histology for case #2 you have the words "malignant melanoma" and "nodular type" and you have "spindle cell features." So you are going to use the two words "type" and "features" as you go through the Histology Coding Rules. You will come to rule H9 that says "Code the most specific histologic term." You will see both "type" and "features" listed as specific terms. You have no preference for either one of those terms so you continue on to rule H10 and you code the histology with the numerically higher ICD-O-3 term which is spindle cell melanoma, NOS (8772/3).

Are there any questions about this case?

Question 6

Carol, I was wondering about the "Comments?" Is there an example stating that we can use the "Comments" along with the final diagnosis or is this just kind of like an unwritten rule for this site?

Response to Question 6

No. It's in the General Rules. If you go back to the General Rules it tells you to use the final diagnosis and the Comments and Addendum(a).

In the General Rules? [*Yes*] All right. Thank you.

Question/Comment 7

It's on page 13, Note 1 under 1b –"Priority Order for Using Documents to Code Histology" in the General Rules.

Response to Question/Comment 7

Yes. I don't have the General Rules in front of me but in the General Rules where it tells you to code from the final diagnosis it also tells you to use the associated Addenda and Comments. It's on page 13.

Are there any other questions on case #2?

Question 8

I just wanted to know if there's going to be a revision of the ICD-O? Is there going to be a fourth edition or ICD-O-4? And also if they're going to have more of the sites grouped together?

Response to Question 8

There is an ICD-O-4 that's being worked on right now so the answer to that question is, "Yes." In terms of site groupings, as we mentioned when we talked about taking Kidney out of the urinary sites—we changed them around so Kidney is by itself- bladder, renal pelvis and ureter are grouped together. Those changes were also done by the international group. The international group met about a year or a year and a half ago and made some decisions including a change in the site groupings. Those changes have already been made in these (MP/H) sites. So, "Yes," there are changes and we have already made them in our 2007 rules. They actually agree with the decisions made by IARC.

Thank you. [You're welcome]

Are there any other questions?

MELANOMA CASE #3

In case #3 we again have two lesions. There is one on the left upper back. There is another lesion on the right lower back. Looking at the final diagnosis you see that "1. [skin, upper back excision] severely atypical junctional melanocytic proliferation." Number 2 [skin, lower back excision] is: "Malignant melanoma in situ." You want to go down to the "Amended Diagnosis" to make sure that everything you have in the final is in the amended. Lesion #1 [skin, upper back excision] was melanoma in situ. Lesion #2 [skin, lower back excision] was also melanoma in situ, superficial spreading type. You have to know that you have two reportable lesions before you start making your decisions. So we have melanoma on the upper back and melanoma on the lower back. If we go to our multiple primary rules we start with the Multiple Melanomas Module, rule M3. The first rule says, "Melanomas in sites with ICD-O-3 **topography** codes that are **different** at the second (C**x**xx), third (Cx**x**x) or fourth (Cxx**x**) character are multiple primaries." In this case the topography codes are the same because skin of upper and lower back are both the same topography code. Next, rule M4 says, "Melanomas with **different laterality** are multiple primaries." Let's go back to see if there are different lateralities. This says we have right lower back under Clinical History and we have left upper back also in Clinical History. Using rule M4 these

would be multiple primaries because you have different lateralities. So primary one will be the upper back and going down to the Amended Diagnosis, for skin of the upper back the final diagnosis is melanoma in situ. Using the histology coding rules you would go to the Single Tumor Module. It starts with H1 , which is no pathology report; H2 says the only pathology is from a metastatic site. H3 says code the histology when only one histologic type is mentioned and that's exactly what you have. Melanoma in situ is the only histologic type that's mentioned so you would code 8720/2. For the second melanoma, the one on the lower back, again you go to the Amended Diagnosis and it says the diagnosis for this tumor is "malignant melanoma in situ, superficial spreading type." Again using the Histology Coding Rules, you go past H1, which is no pathology report; past H2 which you would use when the only specimen is from a metastatic site; past H3 which says to code the histology when only one histologic type is identified. The next rule is H4, which talks about invasive and in situ. Go past H5, which says code the histologic type when there's regressing melanoma and a histologic type. H6 says code regressing when the diagnosis is regressing melanoma. H7 is about the lentigo maligna and a specific histologic type. H8 says code lentigo maligna when that's the only diagnosis you have. Then finally H9 says, "Code the **most specific** histologic **term** when the diagnosis is melanoma NOS (8720) with a single specific type." You do have a superficial spreading type so you would code the superficial spreading melanoma, 8743/2.

Are there any questions about this case?

MELANOMA CASE #4

For case #4 the first question, of course, is how many lesions are there? We have in the final diagnosis in the first pathology report: "skin of abdomen, left lower, shave biopsy." Then we have"skin of thigh, left lower medial, punch biopsy." Both of those are positive for melanoma so we have two lesions and we would go to the Multiple Melanomas Module starting with rule M3. Rule M3 says, "Melanomas in sites with ICD-O-3 **topography** codes that are **different** at the second (C**x**xx), third (Cx**x**x) or fourth (Cxx**x**) character are multiple primaries." In this case we have skin of the abdomen and that's C44.5. The thigh and skin of the thigh is C44.7. So using that rule, M3, we have two primary melanomas.

In coding the histology we will start by looking at the melanoma on the skin of the abdomen. So you have: "Melanoma in situ. Confined to the epidermis (Clark's level I). And on the second path report when they looked at the skin of the abdomen doing a wide excision, they say that all they see is scar tissue; there is no residual malignant melanoma. So this one is pretty easy. The most representative specimen is of course in the shave biopsy. So you will look at that and your diagnosis is "melanoma in situ." That is a single histology. So going through the Histology Coding Rules, you would go all the way down to H3. You would bypass H1 which talks about having no pathologic specimen; bypass H2 that talks about the only specimen being from a metastatic site. Then H3 is, "Code the histology when only one histologic type is mentioned." This is the rule

where you would stop. Now for the primary number two on the skin of the thigh, (left lower medial), the punch biopsy says they have a melanoma in situ and it says "arising in association with a congenital melanocytic nevus, compound type. Melanoma confined to the epidermis." You also have a "Comment: Both biopsies consist of a melanocytic proliferation with an intraepidermal component that shows features of melanoma in situ including pagetoid migration of atypical melanocytes. In the biopsy from the 'left lower medial thigh' there is a dermal melanocytic component that is composed primarily of small melanocytes and is interpreted as a pre-existing nevus." So again the "Comment" is confirming that this melanoma arose in a nevus. You need to go down again to the wide excision. Again the wide excision shows no residual malignant melanoma in situ. So you are going to take your histologic information from "the most representative specimen" which is the biopsy from October 1st. It says: "Melanoma in situ arising in association with a congenital melanocytic nevus." So you are going to actually code "melanoma arising in a congenital melanocytic nevus" which is 8761/3. You would base that again on H3 because you are going to go past H1, the rule for no pathology report; past H2 which is the rule to use if you have a biopsy from a metastatic site only and you will use rule H3 which says when only one histologic type is mentioned, you code that type.

Are there any questions on case #4?

Question 9
I have a question. Why would we not give it a grade of "/2" since it's melanoma in situ for the skin of the thigh?

Response to Question 9
We don't have a note about it in our rationale but I thought I saw something in these cases. I am looking for that. I keep seeing in situ; I do not see any invasive. You are correct. That should be a /2. I will make that change in the cases and answers that are posted on the Website. We will make the change also in the answer sheet.

Thank you.

Thank you for bringing that to our attention. I appreciate that.

Are there any further questions?

MELANOMA CASE #5
We have a melanoma on the left trunk and a lymph node and on skin of trunk but there is only one lesion. As you are well aware, one melanoma is a single primary. For the histology you have histologic type: "spindle cell histology with superficial spreading (radial growth) pattern; single focus of nodular, superficially invasive (vertical growth phase) with epitheliod cytology." So you are going to go through the Histology Coding Rules. You will bypass H1 and H2 which are no

pathology/cytology report [H1] and specimen only from a metastatic site [H2]. Go past H3, which is only one histologic type and you actually have two. H4 says, "Code the invasive histologic type when there are invasive and in situ components." You have spindle cell and you have nodular but both are invasive. The histologic type for regressing melanoma is covered in H5 and H6; this case does not have regressing. H7 is talking about lentigo maligna. H8 is also lentigo maligna. Neither of those rules applies. H9 is an NOS and a more specific—that does not apply. You come to H10, which says to code the numerically higher ICD-O-3 code and that is spindle cell melanoma NOS. Remember you do not code "pattern" for invasive tumors. So the superficial spreading is not in the running for this coding.

Are there any questions about case #5?

MELANOMA CASE #6

For case #6 the first question is, "Is this a multiple primary?" The answer again is, "No," because you have one single melanoma. For histology the final diagnosis says, "Nodular melanoma, spindle cell variant excised." A little further down it says:
"Summary of Malignant Neoplasm:
Skin—malignant melanoma
Histopathologic subtype: Nodular, spindle cell variant."

The one thing that is important to remember at this case is that you have to look at reportable terms. The fact is that "variant" is not listed as a reportable term. So for case #6 you would ignore the spindle cell because the spindle cell is modified by the word "variant." You would code the specific type of melanoma-- nodular melanoma, 8721/3.

Are there any questions about case #6?

MELANOMA CASE #7

Case #7 has two melanomas. When you look at the final diagnosis you see they are both reportable melanomas. You have two melanomas, both the same histology. They are the same site, the same laterality so they are going to be coded as a single primary. This is one of the cases where the multiple tumor counter the "Multiplicity Counter," becomes quite important. You are going to show that there was more than one tumor here and it was coded as a multiple primary.

Looking at the first melanoma, the final diagnosis is, "In situ melanoma, appearing excised" for A. For B the final diagnosis is, "In situ melanoma, appearing excised." The only information on the actual final diagnosis is "in situ melanoma." You have evidence of regression but that's in the "Microscopic" and you don't code that. The final code is going to be melanoma in situ, 8720/2.

Are there any questions on case #7?

MELANOMA CASE #8

On case #8 you have again only one melanoma. Looking at the final diagnosis it says, “Amelanotic malignant melanoma, invasive (lentigo maligna melanoma).” But you have a “Comment” down here. The “Comment” says, “The biopsy consists of ulcerated malignant melanoma with little melanin pigment (amelanotic melanoma). Invasive melanoma is transected at the base of the biopsy.” That is path report #1. Pathology report #2 again says in the final diagnosis: “…residual melanoma in situ. See comment.” The “Comment” says, “The wide excision specimen shows residual melanoma in situ flanking the biopsy site. No residual invasive melanoma is identified.” That is all the information that you have. On this particular one again we chose to take the information from the shave biopsy because they had a lot of information here. They talked about melanoma extending into the papillary dermis, and so on. On the wide excision they talked only about some residual in situ from the biopsy site. So we thought that for this one, the most representative specimen was the shave biopsy. So we identified the histology as being amelanotic melanoma, 8730/3. There was a single histologic type.

MELANOMA CASE #9

Case #9 was an interesting case. You have a single melanoma so of course you have a single primary. There are some tricky parts in this case. You have a shave biopsy that was “consistent with malignant melanoma with nevoid features, invasive to a Clark level III …with features of regression.” You have a second pathology report from a wide excision. It says a “1.85 mm melanoma, right chest [showed] skin with biopsy-related changes; no residual invasive melanoma identified.” So we use the information from the original shave biopsy. One of the things that we need to mention is that we looked in the ICD-O-3 for a nevoid type malignant melanoma because it says that this was a melanoma with nevoid features. We found no code for that so we coded it to a regressing melanoma, 8723/3 using rule H6, which says if you only have malignant melanoma and then information about the regression, code the regression.

MELANOMA CASE #10

Now case #10 is one we really wanted to talk to you about because it points out a huge need in the melanomas. We were able to put in information on coding laterality. We could not add a new data item with instructions on coding interior and anterior, upper and lower due to the time constraints for adding a new data item. This is a case that illustrates so well what is needed for melanoma. You have a lesion on the abdomen here and another lesion on the back. The problem is both of them are coded to “skin of trunk.” This particular case doesn’t tell us right or left so we have to end up saying this is a single primary. We are depending upon the multiple tumor counter-- the “Multiplicity Counter”-- to be able to pull this case out as one that had two lesions. But this case points out the need for further information on these malignant melanomas so we can code them

well. We are hoping that when we get information back from the"Multiplicity Counter" that we can make some recommendations for the type of data item that might be needed. So we have to consider coding, for example, the skin of the hand and the skin of the upper arm or the skin on a toe and the skin on a thigh. Presently this case with melanoma on the abdomen and on the back ends up being a problem because they are both trunk. We are saved on this one simply because the histology codes end up being different at the third digit so we can call this one a multiple primary. If we didn't have a difference in the actual histology codes this would have been a single primary. This is a case we wanted you to see. We wanted you to see the problems we have in defining the differences in sites. It can't just be a site code and it can't be just laterality. So for this one because we have a melanoma in situ and we have a superficial spreading melanoma we can say there's a difference in the histology codes. It's not the best definition we can make. We can certainly argue that a superficially spreading melanoma and a melanoma in situ are very similar but the codes are different. Melanoma in situ is 8720/2. The superficial spreading melanoma is 8743/3. So using that we can make the statement that there are two primaries. The first primary is the skin of the abdomen and we have a focus of in situ melanoma so that's coded to melanoma in situ (8720/2). For our second primary on the skin of the back, that one is a malignant melanoma, superficial spreading type (8743/3).

Are there any questions or comments about that case?

I want to thank you very much for participating. Our final presentation on the actual sites will be the malignant brain. The final presentation will be on the New Data Items.

Thank you for participating.