**NATIONAL INSTITUTES OF HEALTH**
**NATIONAL CANCER INSTITUTE**
**SURVEILLANCE, EPIDEMIOLOGY AND END RESULTS (SEER) PROGRAM**
**2007 Multiple Primary and Histology Coding Rules Breeze Sessions**
**New Data Items Practicum**
**April 4, 2007**

## INTRODUCTION

Thank you for joining us today for the discussion of the cases, answers and rationale for the New Data Items that were presented last week. This is the last in the series of Webcasts on the new 2007 Multiple Primary and Histology Coding Rules. We want to remind you that these Breeze Sessions are available as recorded sessions on the Web. Transcripts of those Breeze Sessions are also available on the SEER Website.

We will start today with the cases and answers for the New Data Items. I would like to remind people that the Ambiguous Terminology Data Items are to be used to identify whether or not a case is accessioned based on ambiguous terminology. When we discuss the Multiplicity Counter Data Items we will review some of the nuances of these items covered in the last Breeze Session.

## CASE #1

In case #1 a renal ultrasound shows a 5 centimeter mass in the upper pole of the right kidney which is suspicious for renal cell carcinoma. The Assessment reads: "Possible renal cell carcinoma." We have a couple of ambiguous terms in this case that are in the list of ambiguous terms. Now the Surgical Pathology Report dated February 20, about one month later than the Renal Ultrasound, reports on a nephrectomy specimen from the right kidney. The Final Diagnosis is renal cell carcinoma, clear cell type.

In terms of Ambiguous Terminology, we do have a conclusive diagnosis within 60 days of the initial diagnosis. So the Ambiguous Terminology answer is 0—Conclusive term. The Date of Conclusive Terminology is coded as 88888888, meaning "not applicable" since the case is accessioned based on a conclusive diagnosis. The 88888888 code is a special code to use when there is a 0 in the Ambiguous Terminology field. Most of the cases you will see-- probably as many as 99% of the cases---will be coded with 0 in the Ambiguous Terminology field and 88888888 in the Date of Conclusive Terminology field. After a few years of collecting data on cases abstracted based on ambiguous terminology we will be able to assess how many cases actually never had a conclusive diagnosis.

The Multiplicity Counter for this case is coded as 01 since there is one tumor in this case. The Date of Multiple Tumors is coded with the special code of 00000000 to indicate that this is a single tumor. The Type of Multiple Tumors is also coded as 00 to indicate that this is a single tumor.

This is a simple case and shows us the type of case we will see most of the time in abstracting. Are there any questions on case #1?

**CASE #2**

In case #2 we have one Surgical Pathology Report from a cystectomy specimen that shows, “Poorly differentiated transitional cell carcinoma of the bladder trigone” that is 3.2 cm in size. There are two separate papillary transitional cell carcinomas within the dome of the bladder. We start out with the Ambiguous Terminology Data Item. We definitely have a conclusive diagnosis for this case at the time of diagnosis so the Ambiguous Terminology code for this case is 0 since there is a conclusive term that this case was, in fact, cancer. The Date of Conclusive Terminology is a special code of all 8s, i.e. 88888888, to indicate that the case was accessioned based on a conclusive diagnosis.

We move on to coding the Multiplicity Data Item and we note from the Pathology Report that there were three separate tumors: one in the bladder trigone and two separate papillary transitional cell tumors in the dome of the bladder. All of them were malignant. So we count those tumors and we have a Multiplicity Counter code of 03 indicating that three tumors were present. The Date of Multiple Tumors is the date of that Pathology Report that showed these tumors, January 4, 2007 with the rationale that, “Multiple tumors were present at the time of the original diagnosis and were abstracted as a single primary.” You will also see at the top of these cases there is a “Note” informing you that you do not have to go through the Multiple Primary Rules for the purpose of these exercises. The Note tells you that this case was already abstracted as a single primary—multiple tumors abstracted as a single primary: “This case is one primary with multiple tumors reported as a single primary.” This will be fairly common for you, especially with the bladder cases.

For the Data Item, Type of Multiple Tumors we are trying to describe the nature and behavior of the multiple tumors abstracted as a single primary. We have three tumors present in this cystectomy specimen and all of them were invasive. Since we code those as multiple tumors abstracted as one primary we go to code 40 which indicates that there are at least two invasive tumors in the same organ that were abstracted as one primary.

Are there any questions on case #2?

**CASE #3**

For case #3 we have a left breast mastectomy specimen that shows “widespread, multicentric infiltrating lobular carcinoma associated with extensive multicentric lobular carcinoma in situ.” There is also an infiltrating duct carcinoma that is a separate tumor of 1.5 cm. The “Note” at the top again says that this case is reported as one primary; it has multiple tumors that are reported as a single primary so you don’t have to go through all the rules to determine whether or not

this is reported as a single or as multiple primaries. It tells you right at the beginning.

So we begin again with the Ambiguous Terminology Data Item. The mastectomy specimen in this case has a conclusive diagnosis of cancer so the Ambiguous Terminology Data Item is coded as 0--conclusive term. The Date of Conclusive Terminology is a special code of all 8s, i.e. 88888888, indicating that the case was accessioned based on a conclusive diagnosis.

Then we move to the Multiplicity Counter. We have widespread multicentric infiltrating lobular carcinoma associated with multicentric lobular carcinoma in situ. We have multiple tumors present at the time of the original diagnosis so we don't know exactly how many there are. Again, I would like to remind everybody, especially those who missed last week's Breeze Session, that the coding instructions on page 340 of the Coding Manual under coding instruction 4c (we will send a notice that this correction will be forthcoming) that instruction should be moved down under number 6. It inadvertently continued under number 4 and this is an indication of when to use code 99. Use code 99 when it is unknown whether there is a single tumor or multiple tumors. Under # 6 on page 340 you will see instructions regarding when to use code 99. This case clearly indicates that code 99 is the most appropriate code to use here since there are widespread, multicentric/multifocal tumors present and the number of tumors present is unknown.

We do have a Date of Multiple Tumors for this case. A number of people have questioned how we can have a date when using code 99 in the Multiplicity Counter. It is very clear that there were multiple tumors present in the resected specimen for this case. So we can have a definite date for the time of the Pathology Report –July 27, 2007--when it was known that there were multiple tumors present. That is how that date field is used in conjunction with the Multiplicity Counter even when the code for that field is 99.

For the Type of Multiple Tumors we have noted that there are in situ and invasive tumors present in this case. We have multicentric lobular carcinoma in situ and we have invasive ductal carcinoma. So code 30 says one or more in situ tumors and one or more invasive tumors are present in the same organ or primary site and the case is abstracted as a single primary. So code 30 is the appropriate code here where we have mixed in situ and invasive tumors abstracted as a single primary.

Are there any questions about case #3?

### Question 1

Could you clarify point 3 on page 340 and the difference between that one and point 6b? [Note: point 3 on page 340 reads: "When there is a tumor or tumors with separate single or multiple foci, ignore/do not count the foci." Point 6b reads: "The tumor is described as multifocal or multicentric and the number of tumors is not mentioned."] The first one says to

ignore multiple foci and 6b says when you have multifocal or multicentric and the number of tumors is not mentioned you use code 99. I am kind of confused.

### Response to Question 1

*I understand the confusion. We are planning to issue a clarification for this issue because it has come to our attention that this particular instruction regarding multifocal and multicentric is still not as clear as we would like it to be. We will add clarification to this so people can interpret it consistently in coding.*

Carol Johnson: I would just like to add that you need to look under the Equivalent Terms and Definitions in the General Instructions for the term "focal" which means limited to an organ or to a certain area and "foci" which is the microscopic. Part of the comment there is that you don't code "foci"—little microscopic particles but you do code "focal."

Steve Peace: Thank you, Carol, for that clarification. That's absolutely correct. In those Equivalent Terms and Definitions in the General Instructions there are definitions for foci, focal and focus. Foci does indicate that there is microscopic involvement so these foci are what they would determine under the microscope. Multifocal and multicentric are visible disease or measurable disease.

### Question 2

I am getting more confused. You said you have to move 4c under point 6. I was not here last week but I think it is better to keep it where it is now. I think it's better to use code 01 "if it is unknown if there is a single tumor or multiple tumors and the multiple primary rules instructed you to default to a single tumor." So if you defaulted to a single tumor then it has to be code 01; that would be better than "unknown."

### Response to Question 2

*We will offer a correction to that. It will say "single primary" instead of "single tumor" because the suggestion here is that we are defaulting to abstracting the case as a single primary, not as a single tumor. That is where the confusion has arisen.*

That makes sense. Thank you.

*These are excellent questions and I appreciate them very much.*

### Question 3

I have a similar question. It has to do with code 80 versus 99.

### Response to Question 3

*There is no code 80.*

### Follow-up to Question 3

For the Type of Tumors Reported as One Primary code 80 is used for "unknown if in situ or invasive." Then code 99 is used when the information is unknown. So if you don't know then you don't know. I don't understand how to use code 80 versus code 99.

### Response to Follow-up to Question 3

*As I said previously, we will add clarification to these Data Items in the near future. We will distribute those clarifications. Until these Data Items started being used we did not know what was unclear to people; that is common among Data Items when they are introduced.*

### Question 4

If it just said "multicentric" and we did not have any distinct tumors involved, would we still code that Date of Multiple Tumors?

### Response to Question 4

*Yes, you would still code the date.*

**CASE #4**

Let's move on to case #4. In this case we have a Renal Ultrasound from October 16, 2007 then we have a Surgical Pathology Report from a radical nephrectomy of the right kidney on October 17, 2007. The Renal Ultrasound Assessment says, "Probable renal cell carcinoma, however benign cyst is included in the differential diagnosis." The Final Diagnosis from the radical nephrectomy of the right kidney says, "Adenocarcinoma, probable clear cell type of renal cell carcinoma." This is the conclusive diagnosis but it does say "probable clear cell type." We included this case specifically to show everybody that when ambiguous terms are used to clarify a type of cancer you do not use this Data Item for that purpose. The Ambiguous Terminology Data Item is used when ambiguous terms identify whether or not a case is reportable. In this case we know the patient has cancer: "Adenocarcinoma." The "probable" refers only to the type of cancer. We included this case specifically, therefore, to illustrate this situation where the ambiguous term is used to clarify the type of cancer, not to describe whether or not the case is actually cancer. So Ambiguous Terminology in this case is coded to 0 because we do have a conclusive diagnosis that this is adenocarcinoma. That conclusive diagnosis was received within two months (i.e. 60 days) of the original diagnosis. We have included a "Note" in the rationale for the answer for this field: "*The phrase 'probably clear cell type of renal cell carcinoma' is used to qualify the type of adenocarcinoma, not whether or not the case must be accessioned."*

The Date of Conclusive Terminology is the special 88888888 since the case was accessioned based on a conclusive diagnosis. The Multiplicity Counter is coded 01 since there is a single tumor: "5 cm mass in the upper pole right kidney." And the special code of all 0s is used for the Date of Multiple Tumors when you only

have a single tumor. The Type of Multiple Tumors is the special code 00 to indicate that it's a single tumor.

Are there any questions on case #4?

**CASE #5**

For case #5 we have a Surgical Pathology Report on June 2, 2007 from some biopsies of the prostate. The Final Diagnosis from those biopsies showed: "focal atypical small glands suspicious for minimal prostatic adenocarcinoma associated with high-grade prostatic intraepithelial neoplasia (PIN)." In October 2007 we have a conclusive diagnosis from the prostatectomy of prostatic adenocarcinoma. So this time period between the first and second pathology reports is greater than 60 days. The first pathology report has the ambiguous term "suspicious" which is a positive word from the ambiguous terms list; then greater than 60 days elapse until we get the definitive diagnosis. So this case is an example of when to use the Ambiguous Terminology code 2. Depending upon when you abstract the case you may originally enter this as a code 01 if you did not have the second pathology report yet. For the Date of Conclusive Terminology you would not have an explicit term yet if you abstracted at the time prior to the second procedure in October.

Because we do have individual pathology reports with a conclusive diagnosis our answer is 2 for the Ambiguous Terminology field. The Date of Conclusive Terminology is the date of the prostatectomy when adenocarcinoma is definitely confirmed on October 14, 2007. You would code the Multiplicity Counter as 01 since this is a single tumor of the prostate. The default code of all 0s in the Date of Multiple Tumors indicates that this was a single tumor. The Type of Multiple Tumors is also 00 with the same rationale.

Are there any questions about case #5?

**CASE #6**

For case six we have two pathology reports: one on February 1 and the other on February 17. The first pathology report from a biopsy on the right upper arm reads: "spindle cell proliferation showing features of dermatofibrosarcoma protuberans…incompletely excised." The Final Diagnosis from the re-excision discussed in the second pathology report revealed residual spindle cell proliferation and the margins of excision are clear. The Comments say, "The stains show features compatible with a dermatofibrosarcoma protuberans." So in this case we do have a conclusive diagnosis within the two months of the original biopsy. Both the biopsy and the re-excision were submitted for special staining and both are positive for dermatofibrosarcoma protuberans using the DAKO immunostainer and the LSAB kit.

### Question 5
Do we just ignore that “features compatible with a dermatofibrosarcoma protuberans” in the Comments? When we were looking at this [case] we went with the review—the special stains that were done. Those were just “compatible with,” they were not real conclusive terms. So I am curious about whether or not you would say that was ambiguous terminology.

### Response to Question 5
*I had not looked at it in that way. The stains were done to differentiate between whether or not it was a dermatofibroma or a dermatofibrosarcoma. The conclusion was that this was a dermatofibrosarcoma so it is definitive in that sense. You have to think a little bit and not just try to match up exact words. In this case they trying to see if this is benign or malignant and the stains showed that this was malignant and they had a conclusive diagnosis at that point.*

### Follow-up to Question 5
But I am curious. The fibroma was non-reportable so wouldn’t it still be an inconclusive term—the “compatible with” was their final diagnosis?

### Response to Follow-up to Question 5
*I suppose that’s splitting hairs but it’s a reasonable question. My response is the test was done to say whether it was benign or malignant and the test concluded that it was malignant so it would be reportable.*

### Question 6
I have the same question. The reason I think I thought it through that way is in the presentations we have had one of the examples given was a path report of a prostate biopsy “compatible with” or “consistent with” --one or the other--with adenocarcinoma. It was labeled as inconclusive.

### Response to Question 6
*Okay. I think what we are leaning toward is saying that this continues to be an ambiguous term. We are going to report the case as “ambiguous term only” so for case #6 our Ambiguous Terminology answer is 1 for “ambiguous term only. The case was accessioned based only on ambiguous terminology.” The Date of Conclusive Terminology is 00000000, not all 8888888888 indicating the case was accessioned based on ambiguous terminology only. Our response for the Multiplicity Counter still indicates that this is a single tumor so we have 01 for single tumor only. The Date of Multiple Tumors will have the special code of all 0s to indicate that this is a single tumor. The Type of Multiple Tumors again is 00 for single tumor.*

You presented a reasonable argument that makes sense. We still had the term “compatible with” in the Comments so we did not have a conclusive diagnosis even on the special stains.

That was a good discussion. Thank you everybody.

### Question 7

In the initial resection there is no question that the diagnosis is dermatofibrosarcoma protuberans. If you have definitive terminology then why would you then turn around and use ambiguous terminology after that?

### Additional Comment on Question 7

In the Final Diagnosis that I think she's talking about the Final Diagnosis says "spindle cell proliferation showing features of dermatofibrosarcoma protuberans." Is "features of" definitive terminology?

### Response to Question 7

*That is correct. Let me walk through this a little bit more. In the initial pathology report the Final Diagnosis is spindle cell proliferation. Now, there are "features of dermatofibrosarcoma protuberans" on immunohistochemical stains. Then the Comments from the second pathology report from the re-excision were still a little bit fuzzy. What we are trying to do with this Data Item is identify cases where we do not have a definitive diagnosis. This case does illustrate a non-conclusive diagnosis. The first biopsy was spindle cell proliferation. The second one leans more toward a diagnosis of dermatofibrosarcoma protuberans but what we have is a case where we could have made it more clear in the actual report what we were dealing with. In daily practice you would have more information available. This would be a case in daily practice where you would probably go to the pathologist and ask for clarification. This is probably not the best case we could have used. We could have worded it more clearly for illustrative purposes. At the same time this case brings out the discussion of exactly what we are trying to capture with these new Data Items.*

Let's move on to case #7.

**CASE #7**

For Case #7 we have one pathology report. There is a polypectomy in the sigmoid and some biopsies in the colon. The Final Diagnosis shows "tubular adenoma with focus suspicious for invasive adenocarcinoma." The colon biopsies are negative. Then the Notes/Comments say, "The foci suspicious for invasive adenocarcinoma are characterized by groups of glands invading below the apparent muscularis mucosa. …A more definitive diagnosis of invasive adenocarcinoma is not possible on the current material given the cautery artifact." That is pretty clear in this case. We are going to abstract this case based only on ambiguous terminology. Our Ambiguous Terminology code is going to be 1 to indicate that [the case is accessioned based on inconclusive terminology.] We do not have a Date of Conclusive Terminology so the special code of all 0s is used for that Data Item. We have only one tumor so we code the Multiplicity Counter as 01. The Date of Multiple Tumors and Type of Multiple Tumors are coded to the special code of 0s to indicate that this is a single tumor.

Are there any questions on case #7?

**CASE #8**

We have one Surgical Pathology Report for this case. The Clinical History says: "The patient is a 43 year old female who is referred to me for MEN 2A syndrome (multiple endocrine neoplasia, type 2)." We thought this was interesting to add this case for you. The Final Diagnosis from the thyroidectomy shows "3mm multifocal medullary carcinoma." There are also some benign glands and one positive node. The Comments say, "There are at least three foci of medullary carcinoma within the thyroid gland. The largest is 3 mm and in the right lobe; the smallest is in the left lobe. The lymph node metastasis of medullary carcinoma is 0.7 mm." Here we actually have measurements of the foci. We also see that "foci" occasionally may be used by a pathologist to indicate non-microscopic disease, as is the case here where we have measurement information on multiplicity. We do have a conclusive term; we know this is medullary carcinoma so our answer to the Ambiguous Terminology question is 0 since the case is accessioned based on a conclusive term within 60 days of the original diagnosis. The Date of Conclusive Terminology is all 8s indicating that the case is accessioned based upon a conclusive diagnosis. The Multiplicity Counter is assigned a code 99 to indicate that the tumor is multifocal. That code goes along with instruction 6b (*The tumor is described as multifocal or multicentric and the number of tumors is not mentioned*). The Date of Multiple Tumors is the date of the original diagnosis, i.e. the date of the Pathology Report which is September 12. The Type of Multiple Tumors is coded 40 since we have multiple invasive and all of them are indicated to be medullary carcinoma, therefore invasive. Code 40 indicates that at least two invasive tumors were present.

Are there any questions about case #8?

Question 8

For the Type of Multiple Tumors, when you've got …I guess I'm reading this wrong. For code 99 it says you use 99 when there is a 99 in the Multiplicity Counter.

Response to Question 8

*You don't carry over those 99s and you actually raised a very good point that I would like to emphasize while I have folks here. Registrars are accustomed to carrying a code of 99 through all the associated Data Items. There is the assumption that if you code the Multiplicity Counter to 99 that all these other fields are coded to 99. That is incorrect. You have to read the definitions for each of the Data Items to know when those special codes are to be used. In this case we don't know the number of tumors but we do know the Date and we do know the Type. Okay? Does that help?*

Follow-up to Question 8
Why does it give that as an Example on page 343?

Response to Follow-up to Question 8
*There are times when that code 99 can be used in association with code 99 in the Multiplicity Counter also but it's not to be used as the default. That is a good question. We will include that in the clarifications for this Data Item as well. Thank you.*

Let's go ahead and move on to case #9.

**CASE #9**
Case #9 again has the Note at the top, which says, "This case is One Primary; when unknown whether single or multiple melanomas on scalp, default to single melanoma and single primary. See Melanoma Case #2." So this case is actually used in our Multiple Primary and Histology Coding Rules presentation for Melanoma. In this case we have a Pathology Report on May 5. There is a Clinical History that says, "Two biopsies left frontal medial and lateral scalp, approximately 5 mm from each other. Shave biopsies." Both of those showed invasive malignant melanoma. There are some Comments. Here we definitely have a conclusive diagnosis so our Ambiguous Terminology code is 0 to indicate that the case was accessioned based on a conclusive term within 60 days of the original diagnosis. The Date of Conclusive Terminology is the special code of all 8s to indicate that the case is accessioned based on a conclusive diagnosis. The Multiplicity Counter is 01 on your answer sheet but I don't think that's correct.

Comment/Clarification 9
We don't think it should be 01 either; we think it should be 99. Since you moved that rule down, now it becomes 99.

Response to Comment/Clarification 9
*That's correct. And we're not really sure if these are satellite lesions or primary lesions so that even suggests further that this would be code 99. So, absolutely, this is code 99 for the Multiplicity Counter. .*

The Date of Multiple Tumors would be the date of this Pathology Report, May 5, 2007. The Type of Multiple Tumors would be 40—multiple invasive tumors.

This is interesting. We can't really tell what the primary and what the satellites are. This is a good case for showing us. Unfortunately, our original answers did not follow this rationale but our Multiplicity Counter is 99; Date of Multiple Tumors is May 5, 2007 and Type of Multiple Tumors is 40.

### Question 10
The way this is worded in the Comments it sounds like it could be one of two things: Either it's two separate biopsies in the same melanoma or one is a primary and one is a satellite and if one is a satellite you don't count those so it would still make it one.

### Response to Question 10
*But we don't know the answer; it's unknown.*

### Follow-up to Question 10
Yes but in either scenario aren't you supposed to default to a single primary?

### Response to Follow-up to Question 10
*You default to a single primary and abstract a single case but as far as Multiplicity we don't know if this is one tumor or multiple tumors abstracted as a single primary.*

### Question 11
My question is on the last element, the Type of Multiple Tumors reported. I guess I don't understand why it would be 40 because I am looking at it as you don't know if they are separate or not so I would have coded that as 99.

### Response to Question 11
*But you know that it's all invasive. This particular Data Item is the Type of Multiple Tumors and you know that everything is invasive, so it's very clear that this is definitely a 40.*

### Follow-up to Question 11
I'm still stuck on whether or not it's a multiple tumor. I don't know if it's multiple tumors. I know they're all invasive. I just don't know if they're multiple tumors, which is why I would have coded 9s.

### Response to Follow-up to Question 11
*These are all good discussion points. We will be providing some additional clarifications for these Data Items. There has been confusion over applying some of these codes particularly when the Multiplicity is unknown. We will be getting some additional clarifications out for those. We will also do some additional follow-up with our Education and Training and answers to questions about these Items.*

Are there any additional questions? I know you have raised some questions as we covered these New Data Items and those questions will be addressed. We will send information out from the Multiple Primary and Histology Coding Rules Team offering some clarifications. I don't have an exact timeline on that but I know it is a priority for the group. The clarifications will be widely distributed and will be sent as soon as we are able to get them out to you.

Question 12
Will you be sending out a revised Answer Sheet with Rationale for this page?

Response to Question 12
*There will be a revised Answer Sheet posted. It will be done quickly.*

Question 13
For Case #9, another reason I would have chosen 99 for the Type of Multiple Tumors is: If you look at the box under 99 for the example it says, “Code 99 in Multiplicity Counter.”

Response to Question 13
*You said that as part of your argument previously. We will offer some clarifications for the Data Items as well as for Case #9 and we will get those out to you.*

Question 14
My other question goes back to case #6. Up in the third Pathology Report where they talk about “features of,” are we ignoring that information because of the word “features?” Also down in the Comments it says “compatible with.”

Response to Question 14
*First of all, I have to make sure people understand which Ambiguous Terms List you are looking at. “Features of” is not included on the Ambiguous Terms List for the New Data Item on ambiguous terms that are reportable.*

Follow-up to Question 14
Correct. But down in the Comments it says the stain showed “features compatible with.”

Response to Follow-up to Question 14
*I understand your question. I think where people are getting bogged down is registrars are very literal. They would like to see exact words in exact order. What we are trying to do is provide guidelines and rules that make some assumptions that phrases and words will be used in a reasonable consistent manner even in our exercise cases and that is not always the case. What again I am suggesting is that both for case #6 and for case #9 we will offer some additional clarifications and some corrections to the answers and to the rationale. We will also provide some clarifications for coding these New Data Items because we understand that there is some frustration and some confusion.*

The only reason I brought it up is it confirms that the correct Ambiguous Terminology code would be a 01. That is why I bring it up.

I understand people are trying to make points and arguments for getting the correct answer, i.e. what they perceive to be the correct answer. That is not the intent of these exercises. The intent is to try to illustrate how codes should be used. For this particular situation these two cases offer some confusion rather than clarifying the use of these codes. This identifies where there is a need for clarifications and we will take care of that.

### Question 15

I have a question about case #5, the prostate primary? Lots of time prostate primaries are multifocal so I am just kind of wondering. This case doesn't have any information about number of tumors in the prostate so why do we assume this is one tumor?

### Response to Question 15

*That is a good argument and you would have more information available if you were doing an actual case. For illustrative purposes this case was intended to be shown as a single tumor. There could be some argument that it could be multifocal. There is no indication in the Pathology Report that it's multifocal based on the prostatectomy which is why we indicated that it was a single tumor. The prostatectomy specimen did not say multifocal.*

Carol Johnson:
Let me make a comment: We have been discussing adding a code to this Data Item that the only information is multifocal or multicentric. The reason this Data Item was added was that clinicians and researchers wanted a way to identify in the database those patients who had more than one tumor in the primary site. And their supposition was that these patients may have worse prognoses and may be treated more aggressively and perhaps should not even be grouped with the other patients in analyses. So this is the "first shot" and it's apparent that perhaps we need to put in a default for something like multifocal or multicentric; that would make it easier for you to code.

Steve Peace:
These discussions and the comments are incredibly helpful and we really do appreciate that. Until we had additional discussions and more people working these cases—many people had already worked these cases previously--but having additional feedback helps us to know where we need to add clarifications. As Carol suggested we might even add at least one additional code to make it clear how these cases should be coded when there is a question.

Carol Johnson:
The things you have brought to us as you have started to use these new rules and Data Items and using these cases have been great. We actually have a list of all your comments and suggestions under each of the sites. We are very appreciative of your feedback.

On that note I would like to thank everybody for joining us for this series of 21 Webcasts; that is a pretty impressive series of Breeze Sessions. We have had lots of good discussions, presentations of the 2007 Multiple Primary and Histology Coding Rules, all of the site-specific rules, the General Instructions, the Other Sites and the New Data Items. All of these are available as recordings on the SEER Website. Your comments and suggestions will be used for additional clarifications. We appreciate everybody's participation.