

CLARIFICATIONS FOR ABSTRACTING AND CODING HEMATOPOIETIC DISEASES

Hematopoietic Primaries Table

1. Due to a printer's error on the printed fold-out version of the hematopoietic diseases primaries table, there is no column 52. However, the cells in column 52 are identical to the cells in column 51. Please mark your fold-out to indicate that columns 51 and 52 are identical except for the title. This problem does not affect the multi-page PDF document that can be downloaded from the SEER web site.
2. On the ICD-O-3 hematopoietic primaries tables, some of the row headings had to be shortened because the length of the term did not fit in the column heading. These are not typographical errors, they are simply abbreviations of the term to retain as much meaning and consistency as possible in both the row and column descriptions. For a completely written category name, see the "Complete Diagnostic Terms for Table" list included in the document.
3. The ICD-O-3 version of the hematopoietic primaries table is very different from the ICD-O-2 version in both format and medical understanding of these diseases. For example, a first diagnosis of leukemia and later diagnosis of lymphoma in the same patient may be considered two primaries in one version and one primary in the other version. As a result, it is not possible to use the tables interchangeably. The page "Definitions of Single and Subsequent Primaries" explains the reasoning underlying the ICD-O-3 table. If both diagnoses are prior to January 1, 2001, use the ICD-O-2 table. If both diseases are diagnosed after 01/01/2001, use the ICD-O-3 table. If the first diagnosis was prior to 2001 and the second diagnosis was after 01/01/2001, use the ICD-O-3 table.

Coding Treatment for Hematopoietic Diseases

4. For many of the newly reportable hematopoietic diseases, the principal treatment is either supportive care, observation, or another type of treatment that does not meet the usual definition that treatment "modifies, controls, removes or destroys proliferating cancer tissue." Such treatments include phlebotomy, transfusions, aspirin, supportive care and observation. In order to document that patients with hematopoietic diseases did have some medical treatment, SEER and the Commission on Cancer have agreed to record these treatments as "Other Treatment" (code 1) for the hematopoietic diseases ONLY. A complete description of the treatment plan should be recorded in the text field for "Other Treatment" on the abstract.
 - Transfusions may include whole blood, RBCs, platelets, plateletpheresis, fresh frozen plasma (FFP), and cryoprecipitate.
 - Phlebotomy may be called blood removal, blood letting, or venisection.
 - Aspirin (also known as ASA or acetylsalicylic acid and many brand names) is used as a treatment for essential thrombocythemia. To determine whether aspirin is administered for pain, cardiovascular protection or thinning of platelets in the blood, use the following general guideline: pain control: 325-1000 mg every 3-4 hours; cardio-vascular protection: starts at about 160 mg/day; aspirin treatment for essential thrombocythemia is low dose (70-100 mg/day). Record ONLY aspirin therapy intended to thin the blood for symptomatic control of thrombocythemia.

Standard cancer treatments such as chemotherapy, radiation (including P32 for polycythemia) and surgery (such as splenectomy for myelofibrosis) should be recorded in the appropriate data fields.

Additional Hematopoietic Diseases Coding Clarifications (abridged from ICD-O-3 Errata and Clarifications, May 22, 2001)

5. **Rule D: coding extranodal lymphomas** Due to a printer's error, the wording of Rule D on page 20 of the hardcover version is not the same as the wording of Rule D on page 26 in the hardcover version and Rule D on pages 20 and 26 in the softcover version. Please replace the text of Rule D on page 20 in the hardcover version with the text of Rule D on page 26. The softcover version is correct as printed. The difference occurred in the late stages of ICD-O-3 editorial review when the following statement was added to the rule: "If no site is indicated for a lymphoma and it is suspected to be extranodal, code to C80.9 (unknown primary site)." This statement was added to reduce the number of extranodal lymphomas coded to lymph node, NOS (C77.9) when the site of origin is unknown, and it will apply only in a very limited set of circumstances. In most cases, the site of origin of an extranodal lymphoma is known, and the topography should be coded to that site, such as a primary lymphoma of the stomach. However, if the site of origin is

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unclear and there is no evidence of lymphoma in lymph nodes, it would be appropriate to code the lymphoma to unknown primary site. For example, if the patient has bulky disease in both the lung and paraspinal soft tissues (without lymph nodes involved), it may not be possible to determine which location is the site of origin; therefore, coding to C80.9 is correct. Another example would be a death certificate only case or one diagnosed at a different facility and reported as an “extranodal” lymphoma but the site of origin is not specified. This case is also appropriately coded to C80.9. Bear in mind that there is no change in coding guidelines for lymphomas arising in lymph nodes or in lymphoid tissues. It is understood that coding lymphomas to an unknown primary is a new concept; computer edits are being revised to accommodate them.

6. Using a grade designation to assign 6th digit differentiation In some instances, the term “grade” does not imply differentiation and should not be used to code the 6th digit of the morphology code. For example, in describing some diseases, pathologists use the term “grade” as a synonym for “type” or “category.” Registrars, on the other hand, recognize the term “grade” as an indicator of cell differentiation that is coded in the 6th digit of the ICD-O morphology code. It is important to recognize when the term “grade” refers to category and when it refers to biologic activity. For example, the grades of nodular sclerosing Hodgkin lymphoma and follicular lymphoma are actually types or categories of these diseases. The 6th digit should NOT be coded as grade 1, 2 or 3 for these cases. However, a poorly-differentiated lymphocytic lymphoma or a B-cell or T-cell lymphoma should be coded in the 6th digit of the morphology code. Other terms described as high grade or low grade as part of the diagnostic term may be used to code the 6th digit of the morphology code.

7. Assigning 6th digit immunophenotype Sixth digit codes for T-cell, B-cell, and NK-cell phenotyping of lymphomas and leukemias should be based on the diagnosis as specifically stated in the pathology report. Sixth digit phenotype codes should not be used when T- or B- cell is implied from the boldface header in the morphology numeric list. In other words, if no T- or B-cell designation is provided in the pathology or laboratory report, do NOT code the T- or B- cell designation based on the boldface header in ICD-O-3. For example, a diffuse large B-cell lymphoma would be coded to 9680/36; a diffuse centroblastic lymphoma would be coded to 9680/39. When cases are analyzed, they can be grouped by cell line as stated in the category headings in the Lymphoma and leukemia sections of the morphology numeric list.

8. Assigning topography for hematopoietic diseases According to the medical understanding on which the World Health Organization Classification of Hematopoietic Neoplasms is based, some lymphomas and leukemias are the same disease process with different presentations. For example, the WHO Classification lists B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma (BCCLL/SLL) as a single entity, the same disease at different stages. The hematopathologists on the ICD-O-3 development committee recommended a single code number to represent the disease. However, since ICD-O is a subset of ICD-10 and ICD-10 is used to code mortality throughout the world, if a single ICD-O-3 code were used, there would be no way to determine whether a death was due to lymphoma or leukemia which are coded separately in ICD-10. As a result, it was necessary to retain separate codes for chronic lymphocytic leukemia and small lymphocytic lymphoma and link them. Thus, for the first time in ICD-O editions, some single disease entities are listed in two different categories and cross-referenced with the notation (see also M-9----). The topographic or primary site code for a diagnosis such as BCCLL/SLL depends on where the disease is diagnosed: if disease is diagnosed only in the blood or bone marrow, code the primary site to C42.1, bone marrow and assign the leukemia morphology code. If the diagnosis is made on any other tissue (typically lymph nodes, lymphatic structures, breast, and stomach), code to the tissue involved and assign the lymphoma morphology. If the diagnosis is made on both blood or bone marrow and a tissue biopsy, code the tissue involved and assign the lymphoma morphology. The sequence of the biopsies (whether the blood/bone marrow biopsy is done before the tissue biopsy or vice versa) is not a factor in deciding which primary site and morphology code to use. For purposes of analysis according to the WHO Classification, cases from both morphology codes should be aggregated.

9. “Code to the higher morphology code” The general ICD-O-3 guideline to use the numerically higher morphology code if the diagnosis of a single tumor includes two modifying adjectives with different code numbers (Rule K) does not apply to the hematopoietic diseases (M-9590-9989) in general. For the hematopoietic diseases, code to the more specific morphology, if that can be determined, which may not be the numerically higher code number. For example, if the facility pathology report states “diffuse large B-cell lymphoma” (M-9680/3) and a consultant reports the same tissue to be “mantle cell lymphoma” (M-9673/3), code the case to M-9673/3. The primary term for M-9680/3 includes the term NOS (not otherwise specified) and the code contains 27 synonyms; thus it can be considered a non-specific diagnosis. On the other hand, the primary term for M-9673/3 does not include the term NOS and may therefore be considered more specific. When in doubt which code to use, consult a medical advisor or pathologist.