Reportable Skin Cancers

2014/2015 FCDS Educational Webcast Series

November 20, 2014
Steven Peace, CTR

Anatomy and Physiology of the Integumentary System
WHO Classification of Neoplasms of the Skin
Signs & Symptoms, Prognostic Factors and Tumor Markers
CSv02.05 and SSFs, AJCC TNM 7th ed, SS2000
Plus...NCCN Treatment Guidelines

Sponsorship

The Florida Cancer Data System sincerely thanks the Florida Department of Health, the Centers for Disease Control and Prevention National Program of Cancer Registries, and the University of Miami Miller School of Medicine for their support.
Presentation Outline

- Anatomy and Physiology of the Integumentary System
- Skin or Not Skin - Genital and Non-Genital “Skin” Sites
- Skin Cancer Facts and Figures
- Risk Factors – Signs and Symptoms
- Types of Skin Cancers
- Overview of Melanoma of Skin
- Staging Criteria for Melanoma of Skin
- Overview of Merkel Cell Carcinoma of Skin
- Staging Criteria for Merkel Cell Carcinoma of Skin
- Overview of Other Reportable Skin Neoplasms
- Staging Criteria for Other Reportable Skin Neoplasms

THE INTEGUMENTARY SYSTEM

UNDERSTANDING THE SKIN YOU’RE IN

Source: http://www.healthandbeautyace.com
Physiology

- Defensive Barrier
  - protection from sun
  - protection from injury
  - protection from pathogens
  - protection from environment
- Thermoregulation
  - controls blood flow
  - regulates evaporation
  - controls release of sweat
- Vitamin D Production
- Absorption and Secretion
- Maintain Body Fluids Balance
- Excrete Waste Products in Sweat
- Synthesis of Epidermal Lipids (fats and oils)
- Sensory Perception and Sensation
  - Touch/Feel/Hot/Cold/Pressure/Vibration/Wind

Anatomy

Source: http://visualsonline.cancer.gov
Anatomy

Eye - Skin or Not Skin?
- Eyelid
- Cornea
- Choroid
- Canthus
- Tear Duct
- Conjunctiva
- Ciliary Body

Neoplasms of Eye Sites
- Malignant Melanoma
- Merkel Cell Carcinoma
- Squamous Cell CA
- Adenocarcinoma
- Basal Cell CA
- Lymphoma
- Other
Skin or Not Skin?

- Genital Skin Sites
  - C60.0 – Prepuce
  - C60.0 – Foreskin
  - C60.9 – Penis, NOS
  - C63.2 - Scrotum

- Genital Skin Sites
  - C51.0 – Labia Majora
  - C51.1 – Labia Minora
  - C51.2 – Clitoris
  - C51.8 – Vulva
  - C51.9 – Fourchette
  - C51.9 – Vulva, NOS
  - C52.9 – Vagina, NOS
**Skin or Not Skin?**

- Fingernail - subungual
- Palms of Hands - palmar
- Toenail – subungual
- Bottom of Feet - plantar

Known ICD Coding Limitations for Various Skin Sites

<table>
<thead>
<tr>
<th>ICD-O Skin Sites</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>C44.0 – Lip</td>
<td>o Ventral</td>
</tr>
<tr>
<td>C44.1 – Eyelid</td>
<td>o Dorsal</td>
</tr>
<tr>
<td>C44.2 – External Ear</td>
<td>o Upper</td>
</tr>
<tr>
<td>C44.3 – Face</td>
<td>o Lower</td>
</tr>
<tr>
<td>C44.4 – Scalp/Neck</td>
<td>o Inner</td>
</tr>
<tr>
<td>C44.5 – Trunk</td>
<td>o Outer</td>
</tr>
<tr>
<td>C44.6 – Upper Limb</td>
<td>o Forearm</td>
</tr>
<tr>
<td>C44.7 – Lower Limb</td>
<td>o Calf</td>
</tr>
<tr>
<td>C44.8 – Overlapping</td>
<td>o Thigh</td>
</tr>
<tr>
<td>C44.9 – Skin, NOS</td>
<td>o Plantar</td>
</tr>
</tbody>
</table>

Laterality
- 0 - Not Paired
- 1 - Right
- 2 - Left
- 5 - Midline

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**M Rules – Melanoma Skin**

*Multiple Melanomas*

Multiple Melanomas may be a single primary or multiple primaries.

<table>
<thead>
<tr>
<th>MULTIPLE MELANOMAS</th>
<th>DECISION</th>
<th>NOTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>M3</td>
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</tr>
</tbody>
</table>
M Rules – Melanoma Skin

H Rules – Melanoma Skin
MPH Rules – Other Skin

1. Is the diagnosis Kaposi sarcoma (any site or stage)?
   - Yes: SINGLE Primary
   - No: MULTIPLE Primary

2. Are there tumors in both the left and right sides of a parietal site ("also 15")?
   - Yes: MULTIPLE Primary
   - No: SINGLE Primary

3. Are there tumors in sites with ICD-O-3 topography codes that differ only the fourth character (C)?
   - Yes: MULTIPLE Primary
   - No: SINGLE Primary

Skin Cancer – Facts and Figures

Global irradiance worldwide

http://www.gpiisolar.com
Skin Cancer – Facts and Figures

NEW SKIN CANCER CASES IN THE U.S. THIS YEAR

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>SKIN CANCER (non-melanoma)</td>
<td>3,560,000</td>
</tr>
<tr>
<td>PROSTATE CANCER</td>
<td>238,590</td>
</tr>
<tr>
<td>BREAST CANCER</td>
<td>234,580</td>
</tr>
<tr>
<td>LUNG CANCER</td>
<td>228,190</td>
</tr>
<tr>
<td>COLORECTAL CANCER</td>
<td>142,820</td>
</tr>
</tbody>
</table>

http://cancer.org/acspc-039130

http://globalcancer2008
Skin Cancer – Facts and Figures

Figure 3. Age-Adjusted Melanoma Incidence Rates, Actual and Projected, by Sex, 1975–2020

Note: Data after vertical dotted line are projected rates.


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Skin Cancer – Facts and Figures

http://www.cdc.gov/cancer/skin/statistics/state.htm
Skin Cancer – Facts and Figures


- Local (N=1,359)
- Regional (N=891)
- Unknown (N=301)
- Distant (N=220)

Survival Months

Percent Survival

http://www.cancer.gov/images

Skin Cancer – Facts and Figures


- Merkel cell carcinoma
- Melanoma of the skin
- All races (not Hispanic)
- Both sexes
- All ages

Cases per 100,000 resident population

Year of diagnosis

http://statecancerprofiles.cancer.gov
Skin Cancer – Facts and Figures

http://statecancerprofiles.cancer.gov

Skin Cancer – Facts and Figures

http://fcds.med.miami.edu/inc/statistics Interactive Map/Rates Utility
Skin Cancer Awareness

- History of Excessive Sun Exposure
- Suntan Booth or Suntan Bed Use
- Immune System Disorder
- Outdoor Workers
- Atypical Moles
- Skin Type

Causes and Risk Factors

- Family History of Melanoma
- Personal History of Melanoma
- History of Excessive Sun Exposure
- Live in Hot Climate or High Altitude

- History of Excessive Sun Exposure
- Suntan Booth or Suntan Bed Use
- Immune System Disorder
- Outdoor Workers
- Atypical Moles
- Skin Type

http://cancer.org/acapc-039130
Signs and Symptoms

The ABCDE's of Detecting Melanoma

A  Asymmetry
B  Border
C  Color
D  Diameter
E  Evolving

NORMAL
Symmetrical  Borders Are Even  One Color  Smaller Than 1/4 Inch  Ordinary Moles

MELANOMA
Asymmetrical  Borders Are Uneven  Multiple Colors  Larger Than 1/4 Inch  Changing in Size, Shape and Color

Source: National Cancer Institute

HOT OFF THE PRESS !!!


Gery P. Guy, Jr, PhD, MPH; Steven R. Machin, MS; Donatus Li, Ekuvatrime, PhD, MS; K. Robin Vossoff, PhD, MBA

Background: Skin cancer is the most common cancer in the U.S., is a major public health problem. The incidence of nonmelanoma and melanoma skin cancer is increasing; however, little is known about the economic burden it imposes.

Objectives: To examine trends in the treated prevalence and treatment costs of nonmelanoma and melanoma skin cancers.

Methods: This study used data on adults from the 2002–2011 Medical Expenditure Panel Survey household consolidated files and information from corresponding medical conditions and medical event files to estimate the treated prevalence and treatment cost of nonmelanoma skin cancer, melanoma skin cancer, and all other cancer sites. Analyses were conducted in January 2014.

Results: The unadjusted average total cost to treat all skin cancer increased from $18 billion to $23 billion in 2007–2011 (p<0.001). During this period, the average annual total cost for skin cancer increased from $16 billion to $21 billion (p<0.001), representing an increase of 28.2%, while the average annual total cost for all other cancers increased by 23.3%. During 2007–2011, nearly 3 million adults were treated for skin cancer annually, with average treated costs of $3,700 each.

Conclusions: These findings demonstrate that the health and economic burden of skin cancer treatment is substantial and increasing. Such findings highlight the importance of skin cancer prevention efforts, which may result in future savings to the healthcare system.

(Am J Prev Med 2014;46(3) Published by Elsevier Inc. on behalf of American Journal of Preventive Medicine)

American Journal of Preventive Medicine_2014.08.036
HOT OFF THE PRESS !!!

U.S. SKIN CANCER CASES AND COSTS ON THE RISE FROM 2002-2011

Skin cancer is the most commonly diagnosed cancer in the United States, yet most cases are preventable.

Skin Cancer is a serious public health concern. Use sun protection strategies that work.

FOR MORE INFORMATION: HTTP://WWW.CDC.GOV/CANCER/SKIN/

New research shows that between the years of 2002 and 2011...

- The number of people treated for skin cancer increased from 3.4 million to 4.4 million.
- The average annual cost of skin cancer treatments increased from $3.4 billion to $11.1 billion.
- The annual cost for all skin cancer treatments increased by 116%.

Focus on Prevention

THE SURGEON GENERAL'S CALL TO ACTION TO PREVENT SKIN CANCER

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Prevention

Amazingly Smart Ways To PREVENT SKIN CANCER
1. Apply Sunscreen
2. Seek Shade
3. Understand the Clouds
4. Use Protective Clothing
5. Avoid Tanning Beds
6. Protect Your Eyes
7. Spot Check Moles and Freckles
8. Wear a Hat
9. Notice Reflective Surfaces
10. Beware of Sun Sensitive Medications

Source: http://sterlingmedicaladvice.com and sunsmart.com

Screening

Examine head and face, using one or both mirrors. Use blow-dryer to inspect scalp.

Check hands, including nails. In full-length mirror, examine elbows, arms and underarms.

Focus on neck, chest and torso. Women: check under breasts.

Use mirror to inspect back of neck, shoulders, upper arms, back, buttocks and legs.

Check legs and feet, including soles, heels, and nails. Use hand mirror to examine genitals.

Source: http://www.melanoma.org
Screening

SCREENING FOR SKIN CANCER
CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

Population | Adult General Population*
--- | ---
**"I" Statement: Inadequate Evidence** | No recommendation due to insufficient evidence

Risk Assessment

- Skin cancer risk: family history of skin cancer, considerable history of sun exposure and sunburn
- Groups at increased risk for melanoma:
  - Fair-skinned men and women older than 65 years
  - Patients with atypical moles
  - Patients with more than 50 moles

Screening Tests

- No evidence to assess the balance of benefits and harms of whole-body skin examination by a dermatologist or patient skin self-examination for the early detection of skin cancer.

Suggestions for Practice

- Clinically relevant concerns for skin lesions with malignant features that are noted while performing physical examinations for other purposes. Features associated with increased risk for malignancy include asymmetry, border irregularity, color variation, diameter of at least 6 mm, change in lesion size, shape, or color, rapid growth, tenderness, ulceration, bleeding, or oozing.

Source: U.S. Preventive Services Task Force Recommendation - 2014

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Screening

9 STEPS TO OFFERING A PUBLIC SKIN CANCER SCREENING

1. Choose a time and place for skin cancer screening.
2. Ask for skin cancer screening.
3. Explain skin cancer screening.
4. Schedule skin cancer screening.
5. Complete skin cancer screening.
6. Communicate results of skin cancer screening.
7. Follow up with patients who need it.
8. Make skin cancer screening part of routine skin cancer screening.
9. Provide skin cancer screening information to the community.

For detailed information about planning a skin cancer screening, download the Academy's Plan an Event Toolkit at www.SkinCancer.org.

Source: http://www.aad.org
Digital Dermoscopy

The Latest Tools

The 3-in-1 spectroscopy probe (pictured above on left) is about the size of a pen. Supporting it are spectroscopic and computer equipment that fit on a portable cart. Each reading takes about 4.5 seconds. The graphic on right shows the probe’s assembly with optical elements such as filters, fibers and front lens. (Photo copyright University of Texas.)

Source: University of Texas and http://www.aimatmelanoma.org
...there’s an app for that...

Source: Mole Detective Phone App and Detective Mole Series

Neoplasms of Skin

- Benign
- Atypical
- Malignant
- Metastatic

- Congenital
- Acquired
  - UV Radiation
  - Viral Exposure(s)
  - Toxic Exposure(s)
  - Vitamin Deficiency
  - Mineral Deficiency

Source: http://stophavingaboringlife.com
Neoplasms of Skin

- Keratinocytic Tumors
  - Verruca
  - Acanthoma
  - Actinic Keratosis
  - Basal Cell Carcinoma
  - Squamous Cell Carcinoma

- Melanocytic Tumors
  - Lentigo Maligna
  - Malignant Melanoma
  - Congenital Melanocytic Nevus
  - Bleu Nevi
  - Spitz Nevus
  - Simple Lentigo
  - Dysplastic nevus


Neoplasms of Skin

- Neural Tumors
  - Neuroma
  - Merkel Cell Carcinoma
  - PNET/Extraskletal Ewing Sarcoma

- Appendageal Tumors
  - Eccrine Tumors
  - Apocrine Tumors
  - Follicular Tumors
  - Sebaceous Tumors

- Soft Tissue Tumors
  - Fibroma
  - Leimyosarcoma
  - Dermatofibrosarcoma Protuberans
  - Vascular Tumors (hemangioma, Kaposi sarcoma)

Source: http://www.dermis.net/dermisroot/en
Neoplasms of Skin

- Hematolymphoid Tumors
  - Mastocytosis
  - Parapsoriasis
  - Sezary Syndrome
  - Mycosis Fungoides
  - Hodgkin Lymphoma
  - Cutaneous T-cell Lymphoma
  - Cutaneous B-cell Lymphoma
  - Diffuse Large B-cell Lymphoma
  - Langerhans Cell Histiocytosis
  - CD30+ T-cell Lymphoproliferative Disorder
  - Subcutaneous Panniculitis-like T-cell Lymphoma
  - Hydroa Vacciniforme-like Cutaneous T-cell Lymphoma
  - Cutaneous Aggressive Epidermotropic CD8+ Cytotoxic T-cell Lymphoma


MELANOMA OF THE SKIN
How Melanoma Typically Grows

**Radial or Horizontal Growth Phase** - The early pattern of growth of cutaneous malignant melanoma in which tumor cells spread laterally into the epidermis. During its horizontal phase of growth, a melanoma is normally flat.

**Vertical Growth Phase** - The late pattern of growth of cutaneous malignant melanoma in which tumor cells spread from the epidermis into the dermis. As the vertical phase develops, the melanoma becomes thickened and raised.

Precancerous Terminology

- Pigmented nevi
- Atypical melanosis
- Melanocytic dysplasia
- Benign juvenile melanoma
- Dysplastic melanocytic nevi
- Atypical melanocytic hyperplasia
- Atypical melanocytic proliferation
- Intraepithelial melanocytic neoplasia
- Intraepithelial melanocytic proliferation
- Circumscribed precancerous melanosis
- Intraepithelial atypical melanocytic hyperplasia

Unless Pathologist States “melanoma in-situ”
Types of Melanoma

- Lentigo maligna
- Melanoma in situ
- Nodular melanoma
- Amelanotic melanoma
- Lentigo maligna melanoma
- Superficial spreading melanoma
- Acral lentiginous melanoma
- Malignant melanoma, NOS
- Desmoplastic melanoma
- Spindle cell melanoma
- Epithelioid melanoma
- Melanoma in nevus

Prognostic Factors

Source: http://www.med-ars.it/various/image4.jpg
Clark’s Level

- Breslow Depth or Tumor Thickness measures in millimeters the distance between the upper layer of the epidermis and the deepest point of tumor penetration.

- The thinner the melanoma, the better the chance of cure.

- 1 mm equals 0.04 inch
- Replaced AJCC Depth
- Replaced Clarks Level (except for thin tumors)

<table>
<thead>
<tr>
<th>Breslow Depth</th>
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<tbody>
<tr>
<td>Stage</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>Stage I</td>
</tr>
<tr>
<td>Stage II</td>
</tr>
<tr>
<td>Stage III</td>
</tr>
<tr>
<td>Stage IV</td>
</tr>
<tr>
<td>Stage V</td>
</tr>
</tbody>
</table>
Ulceration and Mitotic Rate

Presence of primary tumor ulceration remains an adverse predictor of survival and is included along with mitotic rate as a primary criterion for defining melanomas.

Primary tumor mitotic rate or the # of mitoses/mm² is an important independent adverse predictor of survival.

Source: http://skincancer.org/publications

In-Transit and Satellite Lesions

Source: Steven Peace Archives
Regional Nodes Positive/Examined

- Although satellite nodules/in-transit metastasis are coded under CS lymph nodes DO NOT INCLUDE the number of satellite nodules as regional LN positive in this field or in the number of nodes examined/positive.

- AJCC “there is no lower threshold of tumor burden defining the presence of regional node metastasis. Specifically, nodal tumor deposits <0.2 mm in diameter (previously used as the threshold for defining nodal metastasis) ARE INCLUDED in staging of nodal disease as a result of the consensus that smaller volumes of metastatic tumor are still clinically significant”.

Workup

NCCN Guidelines – Melanoma – Version 1.2015
Skin Melanoma SSFs

- FCDS Required = White / CoC Req’d = Yellow + White
  - SSF1 - Measured Thickness (Depth)
  - SSF2 - Ulceration
  - SSF3 - Clinical Status of Lymph Nodes
  - SSF4 - LDH
  - SSF5 - CoC Only - LDH Value
  - SSF6 - CoC Only - LDH Upper Limit of Normal
  - SSF7 - Mitotic Count/Rate
SSF1 - Measured Thickness

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CS Site-Specific Factor 1
Measured Thickness (Depth), Breslow Measurement

- Note 1: Code MEASURED THICKNESS (Depth) of tumor (Breslow measurement), not size. Record actual measurement in hundredths of millimeters from the pathology report.
- Note 2: Code the greatest measured thickness from any procedure performed on the lesion, whether it is described as a leggy or an exoctic. For example, if a punch biopsy with a thickness of 0.50 mm is followed by a re-excision with a thickness of residual tumor of 0.20 mm, code 001. Do not add measurements together from different procedures.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>000</td>
<td>No mass/tumor found</td>
</tr>
<tr>
<td>001</td>
<td>0.01 - 0.199 millimeters (Code exact measurement in HUNDREDTHS of millimeter)</td>
</tr>
<tr>
<td></td>
<td>Examples</td>
</tr>
<tr>
<td>001</td>
<td>0.1 millimeter</td>
</tr>
<tr>
<td>002</td>
<td>0.02 millimeters</td>
</tr>
<tr>
<td>010</td>
<td>0.1 millimeter</td>
</tr>
<tr>
<td>074</td>
<td>0.14 millimeters</td>
</tr>
<tr>
<td>100</td>
<td>1 millimeter</td>
</tr>
<tr>
<td>105</td>
<td>1.05 millimeters</td>
</tr>
<tr>
<td>079</td>
<td>0.79 millimeters</td>
</tr>
<tr>
<td>900</td>
<td>0.00 millimeters or larger</td>
</tr>
<tr>
<td></td>
<td>(Includes cases converted from codes 901-909 during conversion to V03300)</td>
</tr>
</tbody>
</table>

Clark’s Level Staging takes precedence over Measured Tumor Thickness Only for Thin Melanoma or Melanoma < 1mm

ALL CASES of Melanoma should have a Measured Thickness.
Most will also include Clark’s Level.

http://i5.photobucket.com/albums/y168/ziwo/melanoma.jpg
SSF2 – Ulceration

MelanomaSkin
CS Site-Specific Factor 2
Ulceration

- Note 1: Melanoma ulceration is the absence of an intact epidermis overlying the primary melanoma based upon histopathological examination.
- Note 2: If there is no documentation or no mention of ulceration in the pathology report, assume ulceration is not present and code 000.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>000</td>
<td>No ulceration present</td>
</tr>
<tr>
<td>001</td>
<td>OBSOLETE DATA CONVERTED 0023</td>
</tr>
<tr>
<td></td>
<td>See code 010</td>
</tr>
<tr>
<td>010</td>
<td>Ulceration present</td>
</tr>
<tr>
<td>901</td>
<td>Unknown or no information</td>
</tr>
<tr>
<td></td>
<td>Not documented in patient record</td>
</tr>
<tr>
<td>905</td>
<td>Ulceration present</td>
</tr>
<tr>
<td>908</td>
<td>Not applicable Information not collected for this case</td>
</tr>
<tr>
<td></td>
<td>(If this item is required by your standard setter, use of code 908 will result in an edit error.)</td>
</tr>
</tbody>
</table>

http://lombardi.georgetown.edu/patient/diseases/skin/melanoma/general.html
### SSF3 - Clinical Status Lymph Nodes

**MelanomaSkin**

**CS Site-Specific Factor 3**

**Clinical Status of Lymph Node Mets**

- Note 1: AJCC defines microscopic lymph node metastases or "micrometastases" as those which are clinically inapparent by palpation and/or imaging but are pathologically positive. Micrometastases are diagnosed after sentinel or other node biopsy or elective lymphadenectomy. "Micrometastases" are clinically detectable nodal metastases confirmed by therapeutic lymphadenectomy or when nodal metastasis arising from extracapsular extension.
- Note 2: Use code 905 if nodes are described as clinically negative and are also negative on pathologic examination, or if pathologic examination is performed. Use code 019 if nodes are described as clinically positive but are negative on pathologic examination.
- Note 3: Use codes 043-050 if nodes are described as clinically positive.
- Note 4: Use code 150 to code information about clinically apparent in transit metastasis with or without occult nodal metastasis. Information about clinically inapparent in transit metastasis ("occult" metastasis found only on pathologic examination) is not collected in this site-specific factor.
- Note 5: Use code 150 to code information about nodal involvement with or without satellite metastases that are both clinically apparent.
- Note 6: Use code 050 if information is not available for clinical status of lymph node metastasis. Information about clinically negative lymph node metastasis is not collected if the clinical status of lymph node metastasis is not available.
- Note 7: Codes 043-050 are shown to be either negative or positive before treatment but not shown to be prior to treatment.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>Clinical status of lymph node metastasis not available</td>
</tr>
<tr>
<td>010</td>
<td>Clinically occult (microscopic) lymph node metastasis only (nodes negative on clinical examination, positive on pathologic examination)</td>
</tr>
<tr>
<td>020</td>
<td>Clinically apparent nodal metastasis in 1 regional node(s)</td>
</tr>
<tr>
<td>021</td>
<td>Clinically apparent nodal metastasis in 2 or more regional nodes</td>
</tr>
<tr>
<td>100</td>
<td>Clinically apparent in transit metastasis WITH or WITHOUT occult regional node metastases</td>
</tr>
</tbody>
</table>

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### SSF4 - LDH

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<thead>
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<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>010</td>
<td>Range 1: Less than 1.5 x upper limit of normal for lactate dehydrogenase (LDH) assay</td>
</tr>
<tr>
<td></td>
<td>Stated as elevated, NOS</td>
</tr>
<tr>
<td>020</td>
<td>Range 2: 1.5 - 10 x upper limit of normal for LDH assay</td>
</tr>
<tr>
<td>030</td>
<td>Range 3: More than 10 x upper limit of normal for LDH assay</td>
</tr>
<tr>
<td>088</td>
<td>Not applicable: Information not collected for this case</td>
</tr>
<tr>
<td></td>
<td>(If this item is required by your standard setter, use of code 088 will result in an edit error.)</td>
</tr>
<tr>
<td>097</td>
<td>Test ordered, results not in chart</td>
</tr>
<tr>
<td>098</td>
<td>Test not done (test not ordered and not performed)</td>
</tr>
<tr>
<td>099</td>
<td>Unknown or no information</td>
</tr>
<tr>
<td></td>
<td>Not documented in patient record</td>
</tr>
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</table>
SSF7 – Primary Tumor Mitotic Rate

MelanomaSkin
CS Site-Specific Factor 7
Primary Tumor Mitotic Count/Rate

- Note 1: According to AJCC, p. 329, "Data from the AJCC Melanoma Staging Database demonstrated a highly significant correlation with increasing mitotic rate and declining survival rates, especially within the melanoma subgroups."
- Note 2: Mitotic rate is assessed on primary melanomas, based on the number of mitotic figures in one square millimeter (mm) surrounding either a "hot spot" with the most mitotic figures or a field with a representative mitotic.
- Note 3: Record the mitotic rate count as documented in the pathology report. If there is more than one pathology report for the same melanoma at initial diagnosis and different mitotic counts are documented, code the highest mitotic count from any of the pathology reports. Use code 999 if there is no documentation or no mention of mitotic rate in any pathology report for the same melanoma.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>0 mitoses per square millimeter (mm)</td>
</tr>
<tr>
<td></td>
<td>Mitoses absent</td>
</tr>
<tr>
<td></td>
<td>No mitoses present</td>
</tr>
<tr>
<td>010</td>
<td>1 - 10 mitoses/square mm</td>
</tr>
<tr>
<td></td>
<td>(If asc measurement in mitoses/square mm)</td>
</tr>
<tr>
<td></td>
<td>Examples:</td>
</tr>
<tr>
<td>001</td>
<td>1 mitosis per square mm</td>
</tr>
<tr>
<td>002</td>
<td>2 mitoses per square mm</td>
</tr>
<tr>
<td>011</td>
<td>&gt;10 mitoses per square mm</td>
</tr>
<tr>
<td>011</td>
<td>11 or more mitoses per square mm</td>
</tr>
<tr>
<td>005</td>
<td>Not applicable: Information not collected for this case</td>
</tr>
<tr>
<td></td>
<td>If this information is required by your standard letter, use code 999 if may result in an edit error</td>
</tr>
</tbody>
</table>

AJCC TNM Stage

<table>
<thead>
<tr>
<th>Tumor Depth</th>
<th>5 year survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 mm</td>
<td>95-100%</td>
</tr>
<tr>
<td>1 - 2 mm</td>
<td>80-96%</td>
</tr>
<tr>
<td>2.1 - 4 mm</td>
<td>60-75%</td>
</tr>
<tr>
<td>&gt;4 mm</td>
<td>50%</td>
</tr>
</tbody>
</table>
AJCC TNM Stage

Source: www.cancer.gov

Summary Stage 2000
Treatment

NCCN Guidelines – Melanoma – Version 1.2015

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AJCC TNM Stage

Source: www.cancer.gov

Treatment

<table>
<thead>
<tr>
<th>CLINICAL/PATHOLOGIC STAGE</th>
<th>WORKUP(\textsuperscript{a})</th>
<th>PRIMARY TREATMENT</th>
<th>ADJACENT TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage III (sentinel node positive)</td>
<td>Consider baseline imaging for staging (category 2B) and to evaluate specific signs or symptoms (CT, PET/CT, MRI)</td>
<td>Complete lymph node dissection</td>
<td>Clinical trial or Observation for Interferon alfa(\textsuperscript{a}) (category 2B)</td>
</tr>
<tr>
<td>Stage III (clinically positive node[3])</td>
<td>FNA preferred, if feasible, or lymph node biopsy. Recommend baseline imaging for staging and to evaluate specific signs or symptoms (CT, PET/CT, MRI)</td>
<td>Wide excision of primary tumor (category 1)</td>
<td>Consider RT to nodal basin in selected patients based on location, size and number of involved nodes, and/or microscopic extranodal extension (category 2B)</td>
</tr>
</tbody>
</table>

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**Treatment**

**SYSTEMIC THERAPY OPTIONS FOR ADVANCED OR METASTATIC MELANOMA**

**Preferred Regimens**
- Ipilimumab (category 1)\(^{1,2,3}\)
- Dabrafenib + trametinib (category 1)\(^{4,5}\)
- Clinical trial

**Other Active Regimens**
- pembrolizumab\(^{1,4}\)
- Vemurafenib (category 1)\(^{6,7,9}\)
- Dabrafenib (category 3)\(^{8,10}\)
- Trametinib (category 3)\(^{6,11}\)
- Imatinib for C-KIT mutated tumors
- Dacarbazine
- Temozolomide
- Alumunium-bound paclitaxel
- High-dose IL-2\(^{12,15}\)
- Dacarbazine- or temozolomide-based combination chemotherapy/immunotherapy (including cisplatin and vinblastine with or without IL-2, interferon alfa) (category 2B)\(^{11}\)
- Paclitaxel (category 2B)
- Paclitaxel/cisplatin (category 2B)

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**Other Melanoma Staging**

**COLLABORATIVE STAGE DATA COLLECTION SYSTEM**

32 Melanoma Schema

Collaborative Stage Version 2

**TMH 7 Schema List**

<table>
<thead>
<tr>
<th>Schema Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MelanomaStage</td>
<td>Melanoma Stage Information</td>
</tr>
<tr>
<td>Stage</td>
<td>Stage Information</td>
</tr>
<tr>
<td>Ulceration</td>
<td>Ulceration Information</td>
</tr>
<tr>
<td>Sex</td>
<td>Patient Sex Information</td>
</tr>
<tr>
<td>Race</td>
<td>Patient Race Information</td>
</tr>
<tr>
<td>Age</td>
<td>Patient Age Information</td>
</tr>
<tr>
<td>Breslow Thickness</td>
<td>Breslow Thickness Information</td>
</tr>
<tr>
<td>Clark Level</td>
<td>Clark Level Information</td>
</tr>
<tr>
<td>Ulcer</td>
<td>Ulcer Information</td>
</tr>
<tr>
<td>Sex</td>
<td>Patient Sex Information</td>
</tr>
<tr>
<td>Race</td>
<td>Patient Race Information</td>
</tr>
<tr>
<td>Age</td>
<td>Patient Age Information</td>
</tr>
<tr>
<td>Breslow Thickness</td>
<td>Breslow Thickness Information</td>
</tr>
<tr>
<td>Clark Level</td>
<td>Clark Level Information</td>
</tr>
<tr>
<td>Ulcer</td>
<td>Ulcer Information</td>
</tr>
<tr>
<td>Tumor Site</td>
<td>Tumor Site Information</td>
</tr>
<tr>
<td>Primary Site</td>
<td>Primary Site Information</td>
</tr>
<tr>
<td>Metastatic Site</td>
<td>Metastatic Site Information</td>
</tr>
<tr>
<td>Other Site</td>
<td>Other Site Information</td>
</tr>
</tbody>
</table>

---

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MERKEL CELL CARCINOMA

Merkel Cell Carcinoma

Image courtesy of Paul Nghiem, MD, PhD
Merkel Cell Carcinoma

Source: http://www.cancer.gov/cancertopics/pdq/treatment/merkelcell

Incidence by Age

Image courtesy of Paul Nghiem, MD, PhD
## Casefinding

<table>
<thead>
<tr>
<th>ICD-9 CM</th>
<th>CONDITION DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>209</td>
<td>Neuroendocrine tumors</td>
</tr>
<tr>
<td>209.3</td>
<td>Malignant poorly differentiated neuroendocrine tumors</td>
</tr>
<tr>
<td>209.31</td>
<td>MCC, face, ear, eyelid, including canthus, lip</td>
</tr>
<tr>
<td>209.32</td>
<td>MCC scalp/neck</td>
</tr>
<tr>
<td>209.33</td>
<td>MCC Upper limb</td>
</tr>
<tr>
<td>209.34</td>
<td>MCC lower limb</td>
</tr>
<tr>
<td>209.35</td>
<td>MCC trunk</td>
</tr>
<tr>
<td>209.36</td>
<td>MCC other unspecified sites, MCC genital, buttock</td>
</tr>
<tr>
<td>209.37</td>
<td>MCC unknown primary site, Nodal presentation, Visceral metastatic</td>
</tr>
</tbody>
</table>

## Prognostic Factors

- Location
- Depth of invasion
- Measured thickness
- Lymph node involvement
- Age and general health (particularly immune status)
- Initial diagnosis or recurrence

### Staging

#### Table 1
American Joint Committee on Cancer (AJCC)
TNM Staging Classification for Merkel Cell Carcinoma
(7th ed., 2010)

<table>
<thead>
<tr>
<th>Primary Tumor (T)</th>
<th>TX</th>
<th>T0</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>T4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary tumor cannot be assessed</td>
<td>No evidence of primary tumor (e.g., nodal/metastatic presentation without associated primary)</td>
<td>Less than or equal to 2 cm maximum tumor dimension</td>
<td>Greater than 2 cm but not more than 5 cm maximum tumor dimension</td>
<td>Over 5 cm maximum tumor dimension</td>
<td>Primary tumor invades bone, muscle, fascia, or cartilage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regional Lymph Nodes (N)</th>
<th>NX</th>
<th>N0</th>
<th>N1</th>
<th>N2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional lymph nodes cannot be assessed</td>
<td>No regional lymph node metastasis</td>
<td>Metastasis in regional lymph node(s)</td>
<td>In-transit metastasis***</td>
<td></td>
</tr>
</tbody>
</table>

- *Clinical detection of nodal disease may be via inspection, palpation, or other imaging.
- **Micrometastases are diagnosed after sentinel or elective lymphadenectomy.
- *** Micrometastases are defined as clinically detectable nodal metastases confirmed by therapeutic lymphadenectomy or needle biopsy.
- **** In transmetastasis: a tumor distinct from the primary lesion and located either (1) between the primary lesion and the draining regional lymph nodes or (2) distal to the primary lesion.

#### Table 1 (continued)
American Joint Committee on Cancer (AJCC)
TNM Staging Classification for Merkel Cell Carcinoma
(7th ed., 2010)

ANATOMIC STAGE/PROGNOSTIC GROUPS
Patients with primary Merkel cell carcinoma with no evidence of regional or distant metastases (either clinically or pathologically) are divided into two stages: Stage I for primary tumors ≤ 2 cm in size and Stage II for primary tumors > 2 cm in size. Stages I and II are further divided into A and B substages based on method of nodal evaluation. Patients who have pathologically proven node negative disease (by microscopic evaluation of their draining lymph nodes) have improved survival compared to those who are only evaluated clinically (substages as B). Stage II has an additional substage (C) for tumors with extratumoral invasion (T4) and negative node status regardless of whether the negative node status was established microscopically or clinically. Stage III is also divided into A and B categories for patients with microscopically positive and clinically occult nodal failures (N0A) and macroscopic nodes (N0B). There are no subgroups of Stage IV Merkel cell carcinoma.
Merkel Cell CA SSFs

- Required by FCDS
  - SSF3 – Clinical Status of Lymph Nodes

- Required by CoC
  - SSF1 – Measured Thickness (Depth)
  - SSF16 – Size of Metastasis in Lymph Nodes
  - SSF17 – Extra capsular Extension of Regional LN
  - SSF18 – Isolated Tumor Cells (ITCs) in Lymph Nodes
  - SSF22 – Profound Immune Suppression

SSF3 – Clinical Status Lymph Nodes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>CSOCLETE DATA RETAINED V2004</td>
</tr>
<tr>
<td>005</td>
<td>Clinically negative lymph node metastasis and no pathologic examination performed or nodes negative on pathologic examination</td>
</tr>
<tr>
<td>010</td>
<td>Clinically occult lymph node metastasis only (micrometastases)</td>
</tr>
<tr>
<td>020</td>
<td>Clinically apparent lymph node metastases (micrometastases)</td>
</tr>
<tr>
<td>100</td>
<td>Clinically apparent in transit metastasis with or without occult nodal metastasis</td>
</tr>
<tr>
<td>150</td>
<td>Clinically apparent in transit metastasis and clinically apparent nodal metastasis</td>
</tr>
</tbody>
</table>
Treatment

- Depends on Primary Tumor Location

- Biopsy Primary Tumor
  - Shave Biopsy
  - Punch Biopsy
  - Excisional Biopsy

- Wide excision with 1 to 2.5 cm margins
  - Depending on site

- Sentinel Lymph Node Biopsy
  - If nodes are not palpable

- Palpable Lymph Nodes – Bx/Resection

- Radiation Therapy
  - Primary site
  - Draining lymph node basin

---

**Treatment**

<table>
<thead>
<tr>
<th>PRINCIPLES OF CHEMOTHERAPY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local Disease:</strong></td>
</tr>
<tr>
<td>- Adjunct chemotherapy not recommended unless clinical judgment dictates otherwise</td>
</tr>
<tr>
<td><strong>Regional Disease:</strong></td>
</tr>
<tr>
<td>- Adjunct chemotherapy not routinely recommended as adequate trials to evaluate usefulness have not been done, but could be used on a case-by-case basis if clinical judgment dictates</td>
</tr>
<tr>
<td>- Carboplatin 1 etoposide</td>
</tr>
<tr>
<td>- Carboplatin 1 etoposide</td>
</tr>
<tr>
<td><strong>Disseminated Disease:</strong></td>
</tr>
<tr>
<td>As clinical judgment indicates:</td>
</tr>
<tr>
<td>- Carboplatin 1 etoposide</td>
</tr>
<tr>
<td>- Tipotecan</td>
</tr>
<tr>
<td>- Cyclophosphamide, doxorubicin (or epirubicin), and vincristine (CAV)</td>
</tr>
</tbody>
</table>

NCCN Guidelines – Merkel Cell Carcinoma – Version 1.2015
Other Merkel Cell Staging

OTHER SKIN CANCERS
Skin

Source: Journal of the American Academy of Dermatology, 2008 Mar;58(3):375-81
Source: http://www.dermis.net/dermisroot/en

BCC and SCC

Source: http://www.skinspecialistcentre.co.nz/assets/image/mohs/mohsproc.jpg
**Dermatofibrosarcoma Protuberans**

**PRINCIPLES OF EXCISION**

**Goal:**
- Every effort should be made to achieve clear surgical margins. Some form of complete histologic surgical margin examination is recommended, whenever possible. Tumor characteristics include long, irregular, subclinical extensions.
- See the NCCN Guidelines for Soft Tissue Sarcoma for Principles of Sarcoma Surgery (SARC-C)

**Varied Approaches:**
- Mohs technique
- Modified Mohs = Mohs technique with additional final margin for permanent section assessment.
- CCPDMA= Complete circumferential and peripheral deep margin assessment.
- 3- to 4-cm margins to investing fascia of muscle or perichondium with clear pathologic margins, when clinically feasible.

**Reconstruction:**
- It is recommended that any reconstruction involving extensive undermining be avoided or tissue movement delayed until negative histologic margins are verified to prevent possible tumor seeding if margins are not histologically clear.
- If there is concern that the surgical margins are not completely clear, consider split-thickness skin grafting (STSG) to monitor for recurrence.

---

**Mycosis Fungoides**

http://www.dermis.net/dermisroot/en/
**Mycosis Fungoides**

Source: http://www.pathguy.com

**Kaposi Sarcoma**

Source: http://virology-online.com/viruses/HHV-6.htm
Kaposi Sarcoma

Other Skin Schema

Skin

Skin (excluding Skin of Eyelid and Malignant Melanoma, Merkel Cell Carcinoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas)

C44.0, C44.2-C44.9

- DISCONTINUED SITE-SPECIFIC FACTORS: SSF10
- C44.0 Skin of lip, NOS
- C44.2 External ear
- C44.3 Skin of other and unspecified parts of face
- C44.4 Skin of scalp and neck
- C44.5 Skin of trunk
- C44.6 Skin of upper limb and shoulder
- C44.7 Skin of lower limb and hip
- C44.8 Overlapping lesion of skin
- C44.9 Skin, NOS

Note: Laterality must be coded for C44.2-C44.3 and C44.5-C44.7. For codes C44.3 and C44.5, code 5 (midline) in the laterality field if the tumor is midline (e.g., chin).
Practice Cases

https://educate.fhcrc.org/Index.aspx

1. Go to Training Menu
2. Select Practical Application Tests
   - Scroll to Bottom of Page
3. Select Type of Practical Application
   - Case Coding – CSv0205
   - Heme 2014 Cases
   - TNM 7th Edition
4. Select Cancer Site – 10+ cases/site
5. Select Case
6. Start Test
Practice Cases

Test Information and Instruction — Melanoma 05

Name: Melanoma 05
Series: Practical Application - Case Coding - CVC050 > Melanoma
Description: A case scenario is a summary of the patient's cancer story as documented in the available medical record. The scenario is used by the cancer registrar to support coding selected for tumor, staging and treatment related data items. While we believe we have recorded the best answer for all fields, we recognize that others might believe a different answer is a better choice. We will track the responses for all data items. The data items with less than 95% agreement with the preferred answer, the CTC panel will review the case scenario again. When necessary, the panel will also contact the appropriate standard setter and request that existing documentation be clarified to improve coding consistency.

The case scenarios used in the CVC05 coding exercises were created from de-identified abstracts. For the purpose of coding this case, assume that the information in the scenario represents the complete information available at the time the case was abstracted. In addition to the abstracted text, the scenarios include the full text of de-identified and modified pathology reports.

Resources:
The coding form you are about to use has lookups that contain descriptions for every data item. The collaborative stage data items display the codes and notes for CVC05.

The cases have been coded using SEER guidelines; therefore, you may want to have the SEER Multiple-Primary and Pathology Coding Rules, SEER Program Coding and Staging Manual for 2014 and SEER Summary Staging Manual 2000 available.

2014 SEER manual
http://seer.cancer.gov/tools/codingmanuals/

2014 Multiple-Primary and Pathology Coding Rules

2010 SEER Summary Staging Manual

Open Case

Practice Cases

Test Information and Instruction — Melanoma 05

Patient Demographics

Sex: [ ] Male [ ] Female
Race: [ ] Black [ ] White [ ] Other
Birth State: [ ] Birth Country: [ ] Birth City: [ ] Last Contact Date: [ ]

Diagnose:

Diagnosis Date: [ ] Primary Site: [ ] Secondary Site: [ ] Malignant: [ ] Benign: [ ]
Grade: [ ] Histology: [ ] Behavior: [ ]

Staging:

Regional: [ ] Distant: [ ] Stage: [ ] Tumor: [ ] Nodes: [ ] Metastases: [ ]

Use Specific Factors & Summary Staging

Histology and staging only apply after one or both criteria are met:

1. Primary Site
2. Histology and staging

Summary Treatment (First Course of Therapy)

Surgery:

Resection: [ ] Radiation: [ ] Surgery Other: [ ]

Radiation:

Radiation Date: [ ] Radiation/Chemotherapy Sequence: [ ]

Chemotherapy:

Chemotherapy Sequence: [ ] Taxane/Other: [ ]

Systemic:

System/Chemotherapy Sequences: [ ]
Practice Cases

Melanoma 05 Scenario

Abstracted Text

On the preponderance of clinical data, and awareness of the information in the scenario, the correct interpretation of the items was not clear.

Social History

CBS-10 score: 15, male with history of obesity, history of smoking, and use of tobacco products.

Physical Exam

Height: 5'10", weight: 180 lbs. Left breast: 4 cm x 4 cm, firm, nontender, fixed to the chest wall. Right breast: 3 cm x 3 cm, firm, mobile, nontender. No axillary or inguinal lymphadenopathy.

Psychiatric History

On psychiatric assessment, the patient reported feelings of sadness, hopelessness, and anxiety. The patient denied suicidal ideation.

Operative Reports

On 11/15/2014, a 2.5 x 2.5 cm, firm, nontender, mobile lesion was noted on the left breast. The lesion was excised with a 1 cm margin. The pathology report indicated a thickness of 2.5 mm, with no evidence of ulceration or invasion. The patient was scheduled for a follow-up appointment on 11/20/2014.

Treatment Plan

11/15/2014 - The patient was referred to a psychologist for counseling and was prescribed an antidepressant. The patient was scheduled for a follow-up appointment on 11/20/2014.

Final Diagnosis:

11/15/2014 - Path Report #1

Carcinoma in situ, limb-sparing mastectomy.

03/15/2014 - Path Report #2

Carcinoma in situ, limb-sparing mastectomy.

11/15/2014 - Path Report #1

Carcinoma in situ, limb-sparing mastectomy.

03/15/2014 - Path Report #2

Carcinoma in situ, limb-sparing mastectomy.

Practice Cases

Melanoma 05 Scenario

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03/15/2014 - Path Report #2

Carcinoma in situ, limb-sparing mastectomy.

11/15/2014 - Path Report #1

Carcinoma in situ, limb-sparing mastectomy.

03/15/2014 - Path Report #2

Carcinoma in situ, limb-sparing mastectomy.
Practice Cases

Scores

Correct: CRITICAL (2.00/2.00)

Data Item: Race

Response: 1

Correct Answer: 1

Rationale:
The Social History indicates the patient is male. Apply code 1 when the patient is male.

Correct: CRITICAL (2.00/2.00)

Data Item: Race 1

Response: 01

Correct Answer: 01

Help Features

PDF

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Practice Cases

Correct

Data Item: Diagnosis Date
Response: 03/15/2014
Correct Answer: 03/15/2014

Rationale:
The data of diagnosis is the date the reportable diasease was first diagnosed, clinically or microscopically, by a recognized medical practitioner. In this case, the first reportable statement of malignancy was on the 03/15/2014 date billing/transaction.

Error

Data Item: Sequence Number
Response: 02
Correct Answer: 00

Rationale:
Sequence is coded to 00 (one in situ malignant primary in the patient’s lifetime) because there is no documentation that the patient has previously been diagnosed with a reportable in situ malignant primary.

Additional Resources

- CDC Information about Skin Cancer and Melanoma
- American Cancer Society and Canadian Cancer Society
- NCI Physician Data Query for Healthcare Professionals
- WHO Classification of Tumors of Skin
- Multiple Primary and Histology Coding Rules, SEER 2007
- Collaborative Stage Data Collection System, AJCC, 2012
- NCCN Evidence Based Treatment Guidelines, NCCN, 2015
- American Society of Clinical Oncology, ASCO, 2015
- NAACCR Cancer Registry Webinar Series
- SEER Training for Cancer Registry Professionals
- SEER Educate for Practice Cases and Other Training
Questions
NCRA CEU # 2014-117