REGISTRAR PIP

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May 2025 Registrar PIP
A Casefinding Moment

Background

Staying current professionally can be challenging, but it is necessary for all registrars if the goal is consistent and accurate data collection. As registrars committed to excellence, we need to embrace that it is critical to stay informed about new, omitted, and revised coding guidelines and registry procedures adopted by the different standard setters. This is impossible to do without training.

As most registrars in our region are aware, the Cancer Surveillance System (CSS) team not only develops all the training content available on SEER*Educate, a comprehensive training platform tailored specifically for cancer registry professionals, but we are also active users of the platform at the central registry. The SEER*Educate modules are a key component in our initial training for all new central registry hires.

In addition, all experienced CSS staff beta test every coding and multiple-choice exercise prior to the international release of any education material to the training platform. Recently, our staff completed beta testing the training modules covering the content **in the SEER Program Coding and Staging Manual 2025** and the **ST**andards for **O**ncology **R**egistry **E**ntry **(STORE) 2025**. In addition, shortly after public release in March, over eighty other registrars noticed the new content online and started going through these training exercises too. After reviewing the results of this initial training, we decided to use this as an opportunity to share the issues we identified that proved most challenging for us. It might surprise everyone to learn that it's not always the new stuff we trip over . . . sometimes we need to be reminded of the guidelines that have been in place for a while.

Introduction

Even though the standard setters try hard to inform us of reportability, coding, and procedural changes, we don't always "get the memo" or routinely read through the "change logs" each organization posts online when new manuals are released. Other times, errors creep into the database or into our procedures because we rely on our memories a bit more often than we should. We think to ourselves we ***always*** read the latest updates sent to us. It's not until we challenge our ability to recall specific details when applying the rules during training exercises that we recognize we might not be correctly identifying new case types or accurately coding tumor details. Trust me, it is easier than we might think to make a misstep.

It can be more challenging to retain new information when reading through long memos, change logs, or even the manual, if we do so without a relevant case in front of us. Sometimes it might have been weeks or months since we read about the change before a situation comes up that requires us to recall a rule. This is one reason we have our experienced staff routinely assess their retention of the latest changes by trying to apply the rules. In SEER*Educate there are multiple-choice questions and coding scenarios that challenge our ability to recall the guidelines correctly. For this edition, we are going to focus on the top five issues related to casefinding that we observed after reviewing the initial training results on the 2025 SEER and STORE manuals.

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Casefinding

In this section we are going to provide everyone the opportunity to see how their initial training results compare to the 80+ users who initially went through this training. Write down your answers so you can assess how well you did. We will share the results including the correct answers and rationales in the next section.

1. Which statement does not apply to the use of ambiguous terminology?

    a. There are different ambiguous terminology lists for case reportability and tumor spread.
    b. Generally, ignore modifiers, such as "mildly" suspicious; consider only the use of the ambiguous terms to determine reportability and tumor spread.
    c. Use the reportable ambiguous terms when screening diagnoses on pathology reports, scans, tumor marker reports, ultrasounds, and other diagnostic testing.
    d. If the initially coded diagnosis date includes a reportable ambiguous term, do not change the date of diagnosis to the subsequent date the diagnosis is confirmed by positive histology.

2. Which diagnosis is not coded as a single primary if the patient presents with bilateral disease involvement?

    a. Both breasts when inflammatory carcinoma is bilateral at diagnosis
    b. Bilateral testicular seminoma
    c. Diffuse bilateral lung nodules compatible with malignancy
    d. Synchronous melanomas with one on the right chest and the other on the right back

3. Which statement does not apply to the use of ambiguous terminology?

    a. Accession the case if any of the reportable ambiguous terms precede a word that is synonymous with a reportable in situ or invasive tumor unless the only documentation is a cytology.
    b. Do not accession a case when there is a single report in which a reportable ambiguous term and non-reportable terms are used in different sections of the report.
    c. Do not accession a malignant appearing cytology case.
    d. None of the above

4. Which case type is reportable to the Surveillance, Epidemiology, and End Results (SEER) Program for cases diagnosed in 2025?

    a. Cavernous sinus hemangioma
    b. Neurofibromatosis type 1 (NF1) of the skin
    c. Ovarian mucinous borderline tumor with microinvasion
    d. Venous angioma

5. Which statement(s) applies to urine cytology coding?

    a. Urine cytologies positive for malignancy are reportable since 1973, the Surveillance, Epidemiology, and End Results (SEER) Program's reference date.
    b. Code the primary site to C679 for malignant urine cytologies in the absence of any other information.
    c. Do not report a case of a urine cytology diagnosis of "malignant cells" if a subsequent biopsy of a urinary site is negative.
    d. All of the above

Reality Check Time ANSWERS

We decided to start with the questions with an accuracy rate of 17.8% to 36.8%. There is some work to do to consistently and accurately apply some of the casefinding related guidelines. While some might think an issue represents a "news to me" topic, many more represent old issues that continue to haunt us.

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1. **Correct Response: c**

Rationale: 17.8% got the correct answer

Use the reportable ambiguous terms when screening diagnoses on pathology reports, scans, ultrasounds, and other diagnostic testing ***other than tumor markers***. Do not accession the case if a subsequent resection, excision, biopsy, cytology or physician's statement proves the ambiguous clinical diagnosis is not reportable.

When abstracting, registrars are to use the ***Ambiguous Terms for Reportability*** list for case ***reportability***, and the ***Ambiguous Terms Describing Tumor Spread*** list when identifying tumor spread for ***staging*** purposes. These lists are different and need to be used correctly. In addition, there are only positive ambiguous terms for reportability but positive and negative ambiguous terms for describing tumor spread.

When ambiguous terms are preceded by a modifier, such as "mildly" suspicious, in general, ignore the modifiers or other adjectives and use the reportable ambiguous term to determine reportability and tumor spread.

Code the month, day and year the tumor was first diagnosed, clinically or microscopically, by a recognized medical practitioner. If the initial diagnosis includes ambiguous terminology considered reportable, record the date of that diagnosis. Do not change the date of diagnosis when it is subsequently confirmed by positive histology or cytology.

2. **Correct Response: b**

Rationale: 29.4% got the correct answer

According to the Solid Tumor Rules Other Sites Rule M10, tumors on both sides (right and left) of a site listed in Table 1 of the ***Other Sites*** rules are multiple primaries. The testis [C62_] is listed on that table. Therefore, a patient presenting with bilateral testicular seminoma has a double primary accessioned.

Code 4 [Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary] is seldom used EXCEPT for the following:

- Both ovaries involved simultaneously with a single histology; a single primary according to the Solid Tumor Rules
- Diffuse bilateral lung nodules
- Bilateral retinoblastomas
- Bilateral nephroblastomas (previously called Wilms tumors)
- Both breasts when inflammatory carcinoma is bilateral at diagnosis
- Bilateral involvement at time of diagnosis and lateral origin unknown for a site listed in the *Sites for Which Laterality Must Be Recorded* table found in the SEER Program Coding and Staging Manual 2025

According to the Solid Tumor Rules Cutaneous Melanoma Rule M6, when both skin lesions are located on the right side of the body and sites are chest C445 and back C445, abstract as a single primary. This rule applies for all cutaneous melanomas that have the same site code, are on the same row in Table 2, and are on the same side of the body.

3. **Correct Response: b**

Rationale: 30.3% got the correct answer

When dealing with cases in which there is a discrepancy involving both ***reportable*** and ***non-reportable terms*** in a ***single*** report, the guideline indicates to ***accept the reportable term and accession the case***.

Example: Abdominal CT reveals a 1 cm liver lesion. "The lesion is consistent with hepatocellular carcinoma" appears in the discussion section of the report. The final diagnosis is "1 cm liver lesion, possibly hepatocellular carcinoma." Accession

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the case. "Consistent with" is a reportable ambiguous term. Accept "consistent with" over the non-reportable term "possibly."

If any of the reportable ambiguous terms precede a word that is synonymous with a reportable in situ or invasive tumor (e.g., cancer, carcinoma, malignant neoplasm), accession the case. This general rule applies to all documentation ***except cytologies***.

Do **not** accession a case based on ONLY a **suspicious** cytology. "Malignant appearing" squamous cell carcinoma (SCC) is equivalent to "suspicious for" SCC when it comes to cytologies.

4. **Correct Response: a**

Rationale: 35.7% got the correct answer

For cases diagnosed in 2025, a cavernous sinus hemangioma is reportable. Report the central nervous system (CNS) site in which the hemangioma originates. For a ***cavernous sinus hemangioma***, report the site as cerebral meninges C700.

Appendix E-2 includes some non-reportable histology examples registrars have submitted questions to SEER asking for clarification on reportability.

- ***Neurofibromatosis type 1 (NF1) and Neurofibromatosis type 2 (NF2)*** - It is a genetic disease that produces non-malignant tumors in skin, brain, CNS, and other sites. The brain and CNS tumors spawned by NF1 or NF2 are reportable, the genetic disease is not.

- ***Ovarian mucinous borderline tumor with microinvasio***n - For an ovarian mucinous borderline tumor, the term "microinvasion" is not an indication of malignancy. Low malignant potential/borderline ovarian tumors are defined by the pathology of the primary tumor and are not affected by microinvasion or invasion in implants. Even though a case may be staged, this does not mean it is reportable.

- ***Venous angioma*** - The primary site for a venous (hem)angioma arising in the brain is blood vessel (C490). The combination of 9122/0 and C490 is not reportable. This venous abnormality was previously referred to as a venous angioma, which is currently referred to as developmental venous anomalies (DVA).

5. **Correct Response: c**

Rationale: 36.8% got the correct answer

Urine cytology positive for malignancy is reportable for diagnoses in 2013 and forward for the Surveillance, Epidemiology, and End Results (SEER) Program.

Exception: If a subsequent biopsy of a urinary site is negative, do not report the case.

- Code the primary site to C689 (urinary organ, unspecified) in the absence of any other information.
- Do not implement new/additional casefinding techniques to capture these cases.

Conclusion

It is important for us to read information from the standard setters as it is released so we are aware of changes, even if we cannot recall all the details of those changes when confronted with specific cases in the future. If we've at least read about the changes as they are released, hopefully that will spark a memory that "something" came out about a particular case type or data item rule that should prompt us to check for the details mentioned in the manuals to make certain we correctly process the case. The most critical principle of verification is, "When in doubt, check it out!"

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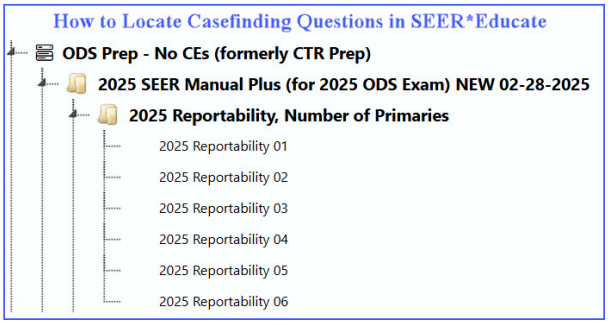
Training can be either self-directed or we can choose to take advantage of many available online and/or in-person training sessions that focus on relevant standards, procedures, and the best data collection and coding practices. Everyone should consider ***training through testing*** as one option to assess performance. According to multiple sources including the National Institutes of Health (NIH) and the e-learning industry, training through testing how we apply new guidelines, such as that used by SEER*Educate, has several advantages:

- Improves long-term performance through the testing effect (i.e., long-term memory is increased when some of the learning period is devoted to retrieving the "to-be-remembered" information through testing that includes a feedback loop)
- Enhances learning through repeated retrieval of new information
- Facilitates a better transfer of knowledge to new contexts and problems

Registry managers interested in assessing whether all their staff members are on the same page when it comes to consistently and accurately handling casefinding-related issues should consider assigning one or more ***"Reportability, Number of Primaries"*** quizzes. There are currently six 5-question reportability quizzes available in SEER*Educate (Seer Educate). See Figure 1. We recommend one quiz per day, an approximate 5- to 10-minute investment each day, closed book, focusing less on one's score and more on the recall event and a thorough reading of the rationale. With a little ***"Learn by Doing"*** training, one can quickly and effectively check whether everyone implements what is expected by our standard setters and documented in their manuals.

Figure 1



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