Indiana Department of Health

MELISSA CHAPMAN, RHIT, CTR
Educational Coordinator
MeChapman@isdh.IN.gov

Monthly E-Newsletter
September 2021

A Focus On: Melanoma

Save the Date:
ICRA Fall Conference
When: November 4-5, 2021
Where: Drury Plaza Hotel,
9625 N Meridian St,
Indianapolis, IN 46290

Spotlight

Article of Interest

"Desmoplastic Melanoma Masquerading as Neurofibroma".

05/2021, https://www.mdedge.com/dermatology/article/239897/melanoma/desmoplastic-melanoma-masquerading-neurofibroma

Written by Evan Stokar, MD,Carlos Rodriguez, MD, Jerry Feldman, MD

Article Overview:
Desmoplastic Melanoma remains a diagnostic challenge both clinically and histologically. This article provides an overview on the subtle differences between DMM (Desmoplastic Melanoma) and other benign tumors. Several case samples are provided to highlight the ongoing challenges of diagnosing DMM. This article also provides assistance with pathologic diagnosis of a DMM with inclusion of common risk factors, IHC staining and the use of high-power evaluation.

Article Summarization:

- Desmoplastic melanoma (DMM) is a rare variant of melanoma that presents major diagnostic challenges. Although a bland-appearing lesion, key clinical features prompting a biopsy include recent growth of the lesion, a personal history of melanoma, fair skin type, a history of heavy sun exposure, and the location of the lesion.
- It can mimic both benign or other malignant tumors and may be easily confused by clinicians and pathologists. DMM is an asymmetrical and deeply infiltrative spindle cell lesion in severely sun-damaged skin. By definition, the individual melanocytes are separated by connective tissue components, giving the tumor a paucicellular (or as sparsely distributed cell) appearance. Although the low cellularity can give a deceptively bland scanning aspect, on high-power examination there usually *are* identifiable atypical spindled cells with enlarged elongated, and hyperchromatic nuclei. S-100 is usually diffusely positive in DMM. Other markers include HMB45 and Melan-A and are typically negative in DMM. DMM is also further characterized by degree of fibrosis. Fibrosis may only represent a portion of an otherwise non-desmoplastic melanoma, which is known as combined DMM.
- Detection of a melanoma in situ component associated with a malignant spindle cell tumor can help establish the diagnosis of DMM. In the absence of melanoma in situ, a strong diffuse immunoreactivity for S-100 and lack of epithelial markers support the diagnosis. In many cases DMM mimics other benign or malignant proliferations. Reports have been described in which the diagnosis of DMM was later found to resemble a sarcoma and malignant peripheral nerve sheath tumor. Consensus between more than one Dermatopathologist is sometimes required to make the diagnosis histologically.

Inspirational Quote

"If I have seen further than others, it is by standing upon the shoulders of giants."

-Isaac Newton

Melanoma Training:

Optional Melanoma Training

- SEER*Educate, Training, Practical Application Tests, Dx 2021 Solid Tumor Rules Melanoma, 5 quizzes (Up to 5 CE's Available)

Link: https://educate.fredhutch.org/Assessments/PracticalApplicationTests.aspx

Upcoming Training (09/28/2021 @ 12pm est)

REGISTRATION REQUIRED: 1 CE Available with quiz submission

(FLccSC) ***https://ins.fcdslms.med.miami.edu/ords/f?p=105:LOGIN_DESKTOP:4104313359654:::::***

Abstracting Melanoma: An IDOH Educational Series

Overview: In this presentation we will review Melanoma incidence for the state of Indiana, navigate through the Solid Tumor Rules, review Melanoma staging requirements, review the 2021 SSDI's, and put training into practice by reviewing sample Melanoma cases.

Coding Help

Appendix C: Coding Guide for recording Breslow Thickness & Surgery Codes:

Surgery Codes for skin (C440-C449), SEER notes provide assistance and rationale

(Ex. [SEER Note: Assign code 34 for shave biopsy followed by Mohs surgery for melanoma of the skin. Assign code 34 for Mohs surgery with unknown margins.]

https://seer.cancer.gov/archive/manuals/2018/appendixc.html?&url=/manuals/2018/appendixc.html

SEER*RSA Melanoma: Get help with Coding Data Items!

Use v2.1 (01/01/2021+ Diagnosis): Click on each EOD Item, Grade, SSDI's 2021+, RLN, SLN

There are older versions for pre-2021 diagnosis year (v2.0)-change version in top right corner of site

https://staging.seer.cancer.gov/eod_public/schema/2.0/melanoma_skin/?breadcrumbs=(~schema_list~)

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Which statements are True or False? Can you tell?
****Use your Solid Tumor Manual and SSDI 2021 manual .**

1. **A nodular melanoma of the skin of Rt Forearm biopsied 01/15/2021 & a spindle cell melanoma of the skin of Rt Forearm biopsied 01/19/2020 are the same primary. (True/False)**
2. **Shave biopsy from a 75 YO M, pathology states Malignant Melanoma with regressing features. The histology is coded to Malignant Melanoma (8720/3). (True/False)**
3. **02/20/2021 Wide Excision of lesion on Lt Leg, Breslow 0.5mm, ulceration present. Biopsy was performed 01/30/2021. The LDH is 620 on 2/20/2021 but the LDH was 382 on 1/20/2021. LDH 620 is recorded in the SSDI-Pretreatment. (True/False)**

Coding Practice

67 YOF with a suspicious 4mm lesion rt upper shoulder, bleeding and changing color. 03/17/2021 Shave Biopsy, Rt upper shoulder, Melanoma, Nodular; Breslow 0.3MM, Clarks level II, No ulceration, 0 mitosis per mm/2, peripheral margins positive, pathologist staged pT1a. On Physical Exam 03/22/2021 the surgeon states no residual visible lesion, bx site w/ no visible gross lesion, no palpable right axillary or cervical Lymphadenopathy. PET/CT 03/25/21 Uptake in upper rt back. No RLN uptake. No dist mets. 03/31/2021 Wide Local Excision, Residual Melanoma, nodular type with features of regression melanoma, completely excised. All final margins negative. Final staging by pathologist pT1a (taking into consideration biopsy specimen from 3/17/21). Pt declined SLN procedure.

1. What is the appropriate histology?
2. What is the clinical tumor size?
3. What is the clinical staging (cTNM and stage group)?
4. What is the pathologic staging (pTNM and stage group)?
5. What is the 03/17/2021 procedure coded to?
6. What is the 03/31/2021 procedure coded to?

Answers to Coding Practice

1. What is the appropriate histology? Nodular Melanoma. Per the STR Cutaneous Melanoma 2021+, Histology Rules, #2-Do not code differentiation or features when there is no specific ICD-O code.
2. What is the clinical tumor size? 4mm. Prior to biopsy the size of the lesion was stated. This is not the tumor thickness, it is the largest dimension of the lesion.
3. What is the clinical staging (cTNM and stage group)? Clinical Stage: cT1a cN0 cM0 Stage 1A. The tumor was 0.3mm, no ulceration. See the AJCC "Definition of Primary Tumor (T)" chart on page 577. Clinical staging includes the biopsy of the primary melanoma and clinical assessment for regional and distant mets. A wide local excision or more definitive procedure, must be performed to be considered pathologic. cN0 based on physical exam (no LAD) and no stated distant mets. Stage 1a.
4. What is the pathologic staging (pTNM and stage group)? Pathologic Stage: pT1a cN0 cM0 Stage IA. pT1a (biopsy plus WLE pathology results). Patient declined SLN procedure however, pathologic stage 0 and pathological T1 does not require pathological evaluation of LN's. We may use cN0 to assign pathological stage per the AJCC 8th edition note under pathological (pTNM) staging table, page 578. cM0 is used as no pathologic microscopic mets were identified. pT1a, cN0, cM0 Stage 1a.
5. What is the 03/17/2021 procedure coded to? 27-Excisional bx. The only margins that were pos were microscopic peripheral and there was no gross visible tumor on PE. SEER note states codes 20-27 include shave and wedge resection.

Answers to Q/A Questions

1. This is False- Review the Solid Tumor Rules, Stop first at Rule M5-Abstract multiple primaries when separate/non-contiguous tumors are two or more different subtypes/variants in Column 3, Table 2 in the Equivalent Terms and Definitions. Timing is irrelevant.
2. This is True-Histology Rule #2 in Solid Tumor Rules-Code the histology described as differentiation or features/features of ONLY when there is a specific ICD-O code for the "NOS" with____features" or "NOS with _____differentiaton".)
3. This is True- the LDH is taken either pre or post surgery and is the highest LDH level during 1st course but prior to systemic treatment. See Note3 on SEER*RSA v2.0)

Tips & Tricks

TIP 1: Clinical N0 can be used within pathological staging for pTIS and pT1 if no nodes were examined during surgery per AJCC 8th Chapter 47, Melanoma.

TIP 2: C449 (Unknown Skin), Laterality should be coded to 0- Not a paired site. See the STORE 2021 list of paired sites, C449 is not listed.