Multiple Primary and Histology Coding Rules

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National Cancer Institute
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Multiple Primary and Histology Coding Manual

The 2007 Multiple Primary and Histology (MP/H) coding rules are available in three formats: flowchart, matrix and text. The different formats were developed to meet the needs of registrars who have different learning styles. The Appendix O of the 2007 Texas Cancer Registry (TCR) Reporting Handbook contains only the text format. The flowchart and matrix formats can be downloaded from the TCR's website www.dshs.state.tx.us/tcr/reporting.shtm#HB. The terms, definitions and coding rules have been incorporated into their respective sites; therefore the page numbers are not sequential.

The TCR will not collect the following data items:

- Date of Conclusive Terminology
- Multiplicity Counter
- Date of Multiple Tumors
- Type of Multiple Tumors Reported as One Primary

Multiple Primary and Histology Coding Rules
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The 2007 Multiple Primary and Histology Coding Rules

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III. Preface

The 2007 Multiple Primary and Histology (MP/H) Coding Rules present the first site-specific multiple primary and histology rules developed to promote consistent and standardized coding by cancer registrars. This project was sponsored by the National Cancer Institute (NCI) Surveillance Epidemiology and End Results (SEER) Program. In January 2003, the Multiple Primary and Histology Task Force was formed to tackle problems identified in existing rules. The MP/H Task Force was a diverse group with membership from all but two SEER regions, the American College of Surgeons (ACoS) Commission on Cancer (CoC), the American Joint Committee on Cancer (AJCC), the Centers for Disease Control and Prevention (CDC) National Program of Cancer Registries (NPCR), the National Cancer Registrars Association (NCRA), North American Association of Central Cancer Registries (NAACCR), 15 central registry representatives, and Canadian Cancer Registries. Physician guidance by specialty pathologists and clinicians was integral to the review and revision process. Regular consultation with the editors of ICD-O-3 clarified ICD-O-3 codes and ensured that the new rules accurately reflect the ICD-O-3 editors' intent and purpose.

The 2007 MP/H Rules include site-specific rules for lung, breast, colon, melanoma of the skin, head and neck, kidney, renal pelvis/ureter/bladder, and malignant brain. A separate set of rules addresses the specific and general rules for malignant solid tumors originating in all other sites. The multiple primary rules guide and standardize the process of determining the number of primaries. The histology rules contain detailed histology coding instructions. For example, there are instructions and guidance for identifying histologic lineages, differentiating between general (NOS) terms and specific histologic types, and correctly assigning mixed and combination codes.

The rules are available in three formats: flowchart, matrix and text. The different formats were developed to meet the needs of registrars who have different learning styles.

The MP/H Task Force also developed three new data items that complement these rules, Multiplicity Counter, Date of Multiple Tumors, and Type of Multiple Tumors Reported as One Primary.

The rules are available in this stand-alone manual and also in the *2007 SEER Coding and Staging Manual.*

A cadre of instructors has been trained to provide in-person education on using the new rules to registrars. Web-based cancer registrar education is available on the SEER training website, http://seer.cancer.gov/. Multiple primary and histology issues are covered in several modules, and a 2007 MP/H rules module will be added. Continuing education units can be requested from the National Cancer Registrars Association. Recorded training webcasts will be available for viewing and provide another option for mass training of registrars who cannot attend an in-person workshop.

IV.
Multiple Primary and Histology Rules General Instructions

Multiple Primary and Histology Coding Rules
General Instructions

EQUIVALENT OR EQUAL TERMS

Multicentric, multifocal
Tumor, mass, lesion, neoplasm

DEFINITIONS

Note: Use these terms and definitions for all reportable cases except lymphoma and leukemia primaries (M9590-9989).

Bilateral: Relating to the right **and** left sides of the body or of a body structure; bilaterality is **not** an indication of single or multiple primaries.

Clinical Diagnosis: A diagnosis that is not microscopically confirmed. It may be based on information from diagnostic imaging or the clinician's expertise.

Contiguous tumor: A single tumor that involves, invades, or bridges adjacent or connecting sites or subsites.

Focal: An adjective meaning limited to one specific area. A focal cancer is limited to one specific area or organ. The area may be microscopic **or** macroscopic.

Foci: Plural of focus.

Focus: A term used by pathologists to describe a group of cells that can be **seen only by a microscope**. The cells are noticeably different from the surrounding tissue either by their appearance, chemical stain, or other testing.

Laterality: Indication of which side of a **paired organ/site** a tumor is located. (See Paired organ/site)

Most representative specimen: The pathologic specimen from the surgical procedure that removed the most **tumor** tissue.

Multiple primaries: More than one reportable case.

Overlapping tumor: The involved sites are adjacent (next to each other) and the tumor is contiguous.

Paired organ/site: There are two sides, one on the left side of the body and one on the right side of the body. (See Laterality)

Recurrence: This term has two meanings:

1. The reappearance of disease that was thought to be cured or inactive (in remission). Recurrent cancer starts from cancer cells that were not removed or destroyed by the original therapy.
2. A new occurrence of cancer arising from cells that have nothing to do with the earlier (first) cancer. A new or another occurrence, incidence, episode, or report of the same disease (cancer) in a general sense – a new occurrence of cancer.

Single primary: One reportable case.

Unilateral: Relating to one side of the body or one side of a body structure.

DETERMINING MULTIPLE PRIMARIES FOR SOLID MALIGNANT TUMORS

Note: The rules do not apply to hematopoietic primaries (lymphoma and leukemia) of any site or to the reportable benign or borderline intracranial or CNS tumors..

A. General Information

1. Use these rules to determine the number of reportable primaries. Do **not** use these rules to determine case reportablility, stage, or grade.
2. The 2007 multiple primary and histology coding rules **replace all previous** multiple primary and histology coding **rules**.
3. The rules are **effective** for cases **diagnosed January 1, 2007** and after. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.
4. Read the **General Instructions** and the **site-specific Equivalent Terms and Definitions** before using the multiple primary rules.
5. The multiple primary and histology coding rules are available in **three formats**: flowchart, text, and matrix. The **rules are identical**, only the formats differ. Use the rules in the format that is easiest for you to follow.
6. **Notes** and **examples** are included with some of the rules to **highlight key points** or to add **clarity** to the rules.
7. **Do not use** a physician's statement to decide whether the patient has a recurrence of a previous cancer or a new primary. Use the multiple primary rules as written **unless** a **pathologist compares** the present tumor to the "original" tumor and states that this tumor is a recurrence of cancer from the previous primary.
8. Use the Determining Multiple Primaries: Hematopoietic Primaries (Lymphoma and Leukemia) rules and table "Definitions of Single and Subsequent Primaries for Hematologic Malignancies" to determine single versus multiple primaries for lymphoma and leukemia cases.

B. How to Use the Multiple Primary Rules

1. **Use** the **Multiple Primary** rules to **make a decision on the number of primary malignancies** to be abstracted for reportable solid malignant tumors.
2. Use the **site-specific rules** for the following primary sites:
   - Brain, malignant (intracranial and CNS)
   - Breast

- Colon
- Head and neck
- Kidney
- Lung
- Malignant melanoma of the skin
- Renal pelvis, ureter, bladder, and other urinary

3. Use the **Other Sites rules** for solid malignant tumors that occur in primary sites not covered by the site-specific rules.
4. Each module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors) is an independent, complete set of coding rules. To determine which set of primary site rules to use:
   a.. When there is no tumor in the primary site, only metastatic lesions are present:
      I. Use the primary site documented by a physician and use the multiple primary and histology coding rules for that primary site.
      II. If no primary site is documented, code the primary site as unknown and use the general multiple primary and histology coding rules. Use the "Unknown if Single or Multiple Tumors" module to determine multiple primaries and the "Single Tumor" module for coding histology.
   b. To choose the appropriate module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors),
      I. Use the multiple primary and histology coding rules for the primary site
      II. Determine the number of tumors
         i. Do not count metastatic lesions
         ii. When the tumor is only described as multicentric or multifocal and the number of tumors is not mentioned, use the "Unknown if Single or Multiple Tumors" module
         iii. When there is a tumor or tumors with separate microscopic foci, ignore the separate microscopic foci and use the "Single Tumor" or "Multiple Tumor" modules as appropriate
         iv. When the patient has a single tumor, use the "Single Tumor" module.
         v. If there are multiple tumors, use the "Multiple Tumor" module.
      III. See the Equivalent Terms and Definitions for Head and Neck for guidance in coding the primary site
      IV. Use the primary site documented by the physician on the medical record
5. If a **single primary**, prepare **one abstract**.
6. If there are **multiple primaries**, prepare **two or more abstracts**.
7. Rules are in hierarchical order within each module (Unknown if Single or Multiple Tumors, Single Tumor, and Multiple Tumors). Use the first rule that applies and

STOP

Histologic Type ICD-O-3

Item Length: 4
NAACCR Item #: 522
NAACCR Name: Histologic Type ICD-O-3

The data item Histologic Type ICD-O-3 describes the microscopic composition of cells and/or tissue for a specific primary. The tumor type or histology is a basis for staging and determination of treatment options. It affects the prognosis and course of the disease.

The *International Classification of Diseases for Oncology*, Third Edition (ICD-O-3) is the standard reference for histology codes for tumors diagnosed in 2001 and later. Do not record the 'M' that precedes the histology code. See sections *Coding Guidelines for Topography and Morphology.* and *Summary of Principal Rules for Using the ICD-O*, Third Edition for guidance in using the ICD-O-3.

Information about the 2007 Histology Coding Rules
Note: Do not use these rules to determine case reportability.

1. The 2007 multiple primary rules **replace all previous** multiple primary **rules**.
2. The rules are **effective** for cases **diagnosed January 1, 2007** and after. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.
3. The histology coding rules are available in **three formats**: flowchart, text, and matrix. The **rules are identical**, only the formats differ. Use the set of rules in the format that is easiest for you to follow.
4. **Notes** and **examples** are included with some of the rules to **highlight key points** or to add **clarity** to the rules.
5. Rules are in **hierarchical** order within each section (Single Tumor and Multiple Tumors Abstracted as a Single Primary).

How to Use the Rules

1. Read the **General Instructions**.
2. Read the **site-specific Equivalent Terms and Definitions**.
3. Use these rules to make a decision on coding the histology for all reportable solid malignant tumors.
4. Use the multiple primary rules to determine whether the patient has a single or multiple primaries before coding the histology.
5. Code the histology for **each** primary in a **separate abstract**.
6. Use the **site-specific rules** for the following primary sites:
   - Brain, malignant (intracranial and CNS)
   - Breast
   - Colon
   - Head and neck
   - Kidney
   - Lung
   - Malignant melanoma of the skin

- Renal pelvis, ureter, bladder, and other urinary

7. Use the **Other Sites rules** for all solid malignant tumors that occur in primary sites **not included** in the site-specific rules.
8. Determine whether the patient has a single tumor or multiple tumors that will be abstracted as a single primary
    a. Do not count metastatic tumors
    b. When the tumor is described as multifocal or multicentric, use the Multiple Tumors module
    c. When there is a tumor or tumors with separate foci of tumor do not count the foci
    d. Only count the tumors that will be used to prepare that abstract. For example, when there are two tumors that will be abstracted as multiple primaries, you would use the Single Tumor modules to determine the histology code for each of the abstracts..
9. **Each section** (Single Tumor and Multiple Tumors Abstracted as a Single Primary) is an independent, **complete set of coding rules**. For example, if the patient has multiple tumors, that will be abstracted as a single primary start with the first rule under the heading Multiple Tumors Abstracted as a Single Primary. Do not use any of the rules under the header Single Tumor.
10. Use the first rule that applies and

STOP

Priority order for using Documents to Code Histology

Medical records frequently include multiple pathology reports and references to histologic diagnosis. Use the following instructions to identify which reports best represent the histology to be coded.

1. Pathology report:
    a. From the **most representative** tumor specimen examined
    b. From the **final diagnosis**
        Note 1: Use information from **addenda** and **comments** associated with the final diagnosis to code the histology.
        Note 2: A **revised/amended diagnosis** replaces the original final diagnosis. Code the histology from the revised/amended diagnosis.
        Note 3: The new rules **limit** the information **to the final diagnosis**. The old rules allowed coding from information in the microscopic description. You will only use information from the microscopic portion of the pathology report when instructed to do so in one of the site-specific rules.
2. Cytology report.
3. When you do not have either a pathology report or cytology report:
    a. Documentation in the medical record that references pathology or cytology findings
    b. From mention of type of cancer (histology) in the medical record

Ambiguous Terms Used to Code Histology

When any of the ambiguous terms are used to describe a more specific histology, code the more specific histology.

Ambiguous terms that are characteristic (used to code histology)
- Apparent(ly)
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Most likely
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- Typical (of)

Example: Non-small cell carcinoma, most likely adenocarcinoma. Code adenocarcinoma.

Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Guidelines for Head and Neck

The head and neck rules cover the following sites: Lip C000-C009, Oral Cavity C019-C069, Salivary Gland C079-C089, Tonsil C090-C099, Oropharynx C100-C109, Nasopharynx C110-C119, Pyriform Sinus C129, Hypopharynx C130-C139, Other and Ill-defined Sites in Lip, Oral cavity and Pharynx C140-C148, Nasal Cavity C300, Middle Ear C301, Accessory Sinuses C310-C319, and Larynx C320-C329.

Head and neck tumors frequently extend into adjacent anatomic sites, or overlap multiple contiguous sites. The workup for these tumors often includes physical examinations, imaging, scans, endoscopies, biopsies and surgical observations. Each of these diagnostic tools provides a unique view of the tumor. More than one anatomic location may be involved with tumor and reports may contain conflicting information regarding the primary site.

Coding the Primary Site

Code the site where the tumor **originated**; do not simply code the biopsy site.

When there are multiple biopsies and the primary site is not documented, or when there is discrepant information, code the primary site using the following priority order.

Priority Order

1. Tumor board
   a. Specialty
   b. General
2. Staging physician's site assignment
   a. AJCC staging form
   b. TNM statement in medical record

If neither 1 nor 2 are available, the priority order for using information depends upon whether the patient had a surgical resection of the primary tumor.

3. Total (complete) resection of primary tumor
   Note: The primary tumor is completely removed. The surgical margins may be microscopically positive.
   a. Surgeon's statement from operative report
   b. Final diagnosis from pathology report

Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

4. No resection (biopsy only):
   Documentation from:
   a. Endoscopy (physical exam with scope)
   b. Radiation oncologist
   c. Diagnosing physician
   d. Primary care physician
   e. Other physician
   f. Radiologist impression from diagnostic imaging
   g. Physician statement based on physical exam (clinical impression)

When the point of origin **cannot be determined**, use a topography code for overlapping sites:

- C02.8 Overlapping lesion of tongue
- C08.8 Overlapping lesion of major salivary glands
- C14.8 Overlapping lesion of lip, oral cavity, and pharynx.

Equivalent or Equal Terms

- In situ, noninvasive, intraepithelial
- Squamous cell carcinoma, squamous cell epithelioma, epidermoid carcinoma
- Tumor, mass, lesion, neoplasm
- Contiguous, continuous

Definitions

In Situ: A tumor that is confined to the epithelium without penetration of the basement membrane

Invasive: A tumor that penetrates the basement membrane and involves at least the lamina propria

Most invasive: The tumor with the greatest continuous extension (see focal and foci definitions in the general instructions). The least to the greatest extension for mouth and oral cavity:

- epithelium
- lamina propria, submucosa (not found in gum and hard palate)
- muscularis propria (not found in gum and hard palate)

Table 1 –Paired Sites
Table Instructions: Use this table to determine multiple primary status for sites listed in Column 1.

Column 1: **Paired Sites**	**Column 2:** **Code**
Parotid Glands	C079
Major Salivary Glands	C080; C081
Tonsils	C090; C091; C098, C099
Nasal Cavity	C300
Accessory Sinuses	C310; C312
Middle Ear	C301

Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Table 2 – Changes to Previous SEER Site Grouping Table

Previous to 2007, tumors in sites on the same row were abstracted as a single primary.

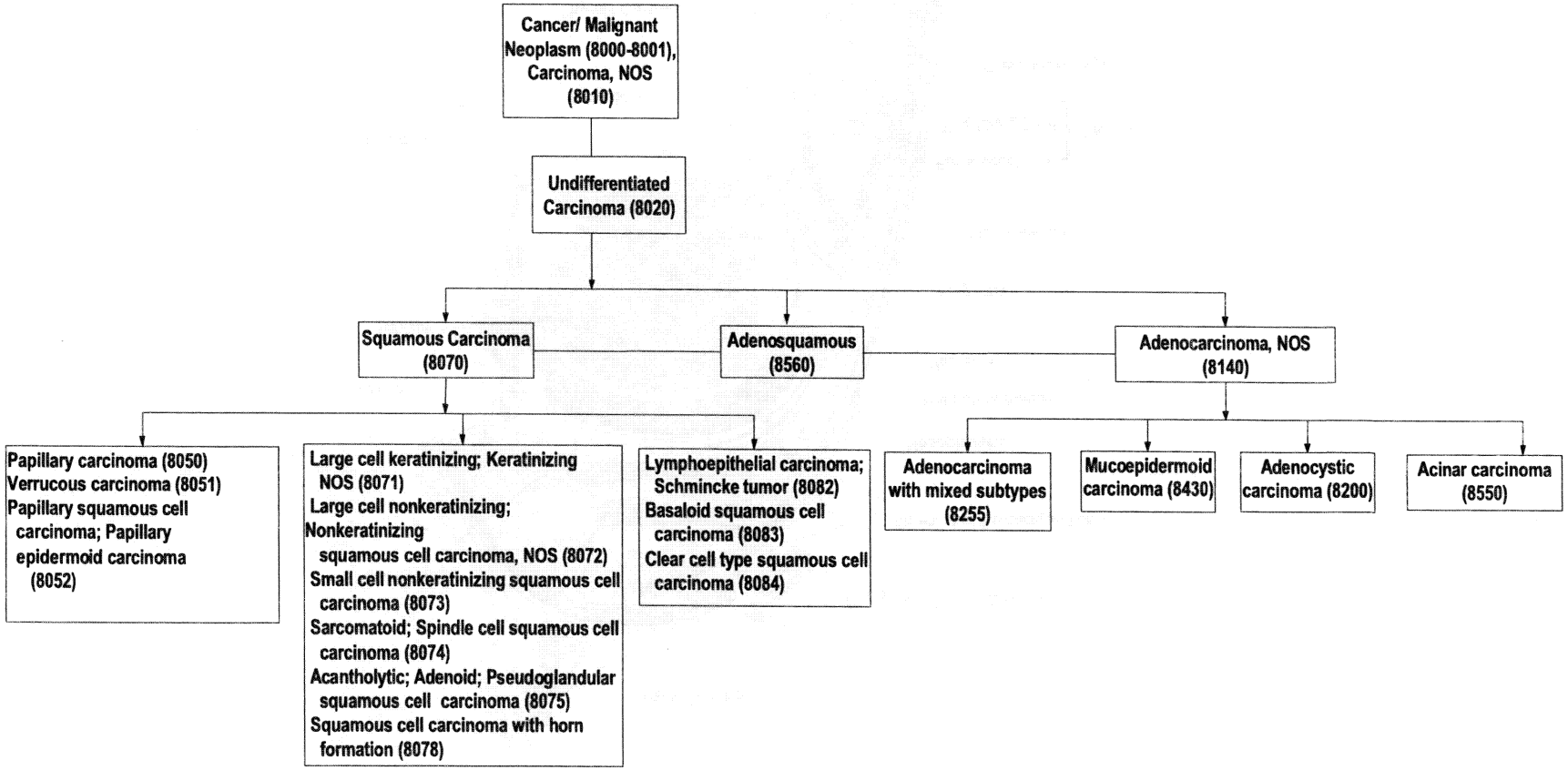
Code	Site Groupings
C01 C02	Base of tongue Other and unspecified parts of tongue
C05 C06	Palate Other and unspecified parts of mouth
C07 C08	Parotid gland Other and unspecified major salivary glands
C09 C10	Tonsil Oropharynx
C12 C13	Pyriform sinus Hypopharynx
C30 C31	Nasal cavity and middle ear Accessory sinuses

Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

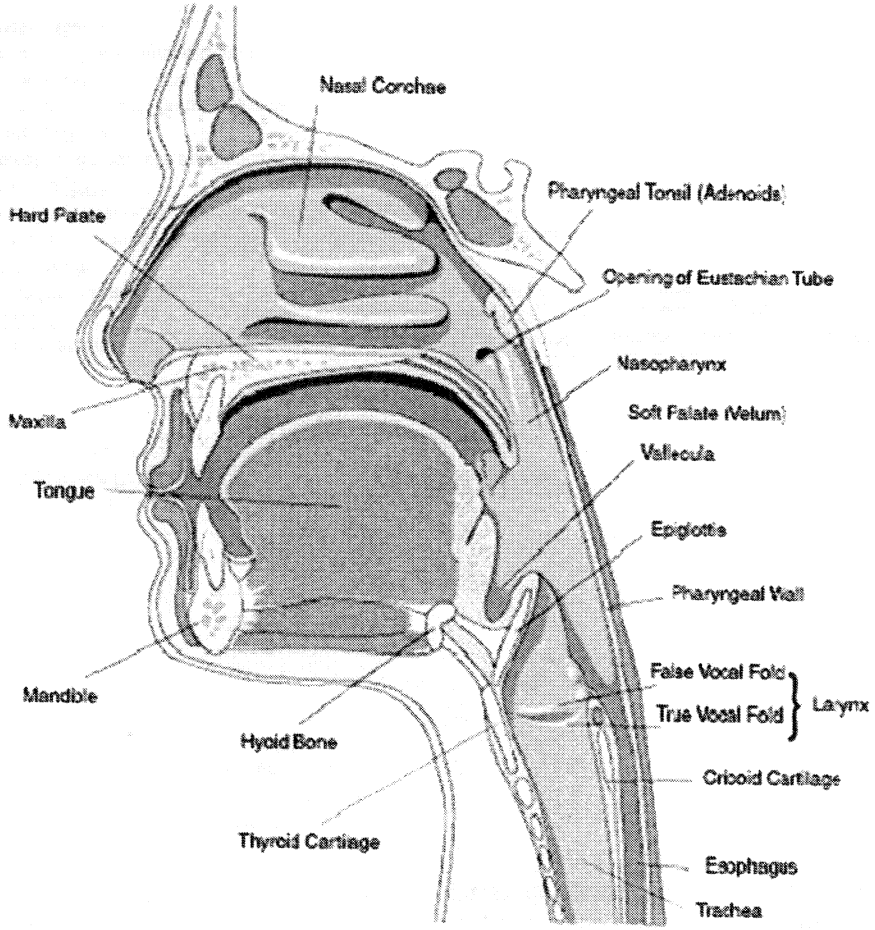
Chart 1 – Head and Neck Histology Groups and Specific types

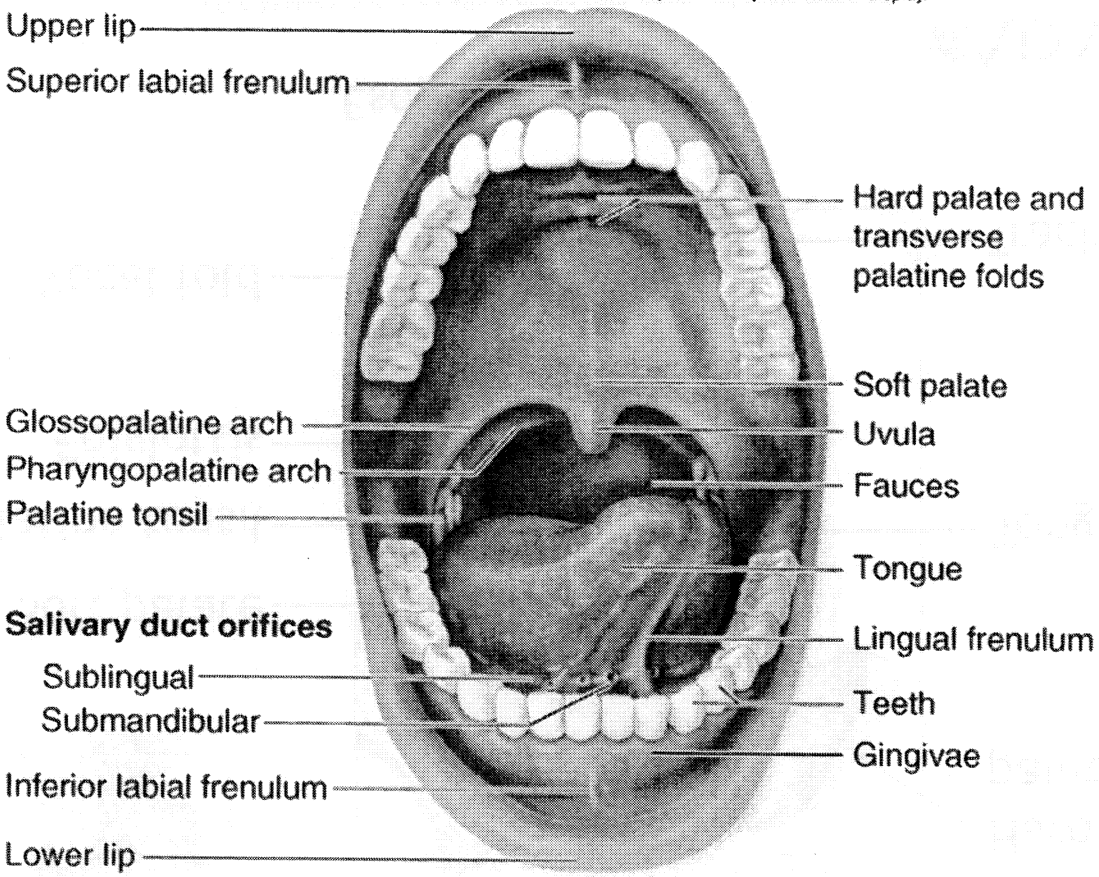
Note: Greater than 85% of cancers in the Head and Neck are squamous cell carcinoma

Chart Instructions: Use this chart with the histology rules to code the most specific histologic term. The tree is arranged in descending order. Each branch is a histology group, starting with the NOS or group terms and descending into the specific types for that group. As you follow the branch down, the terms become more specific.



Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)





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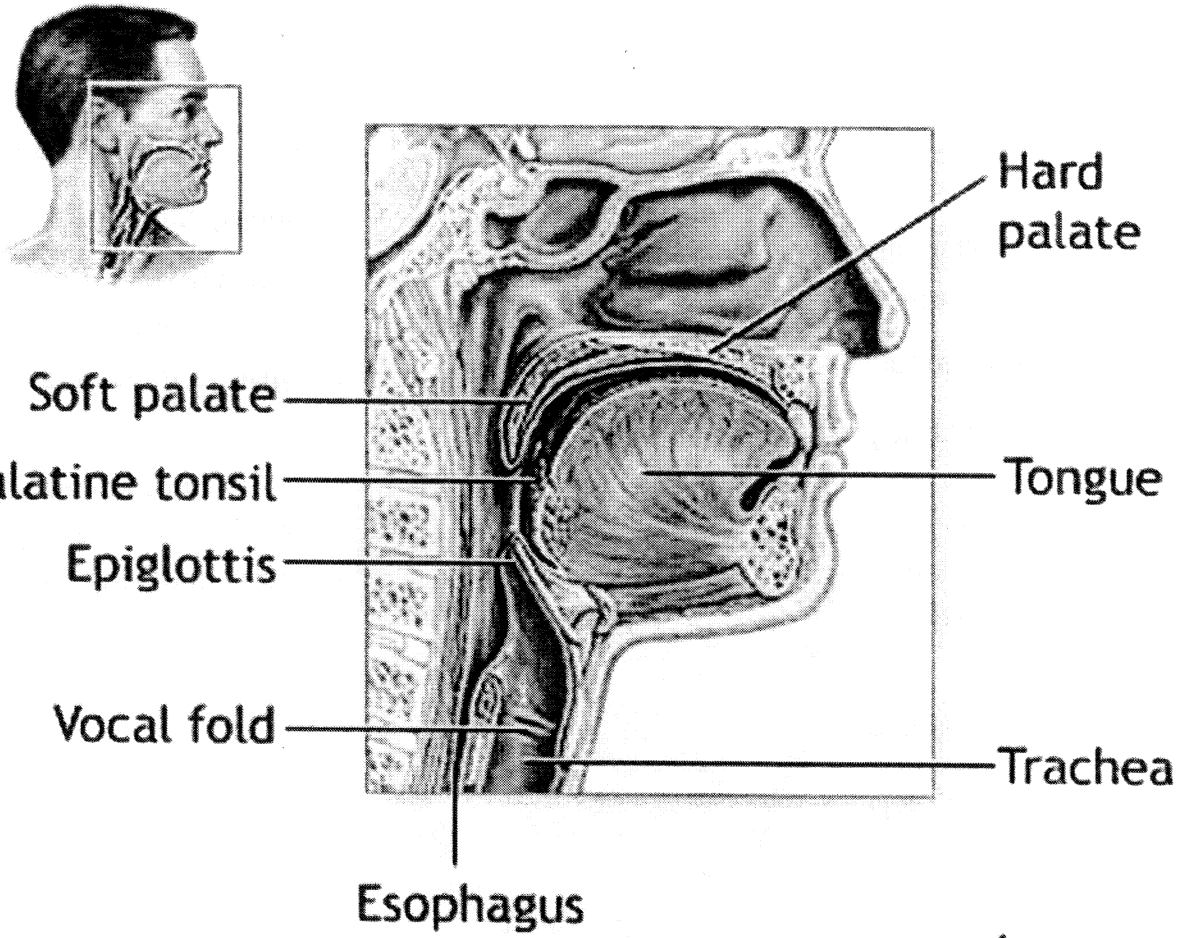
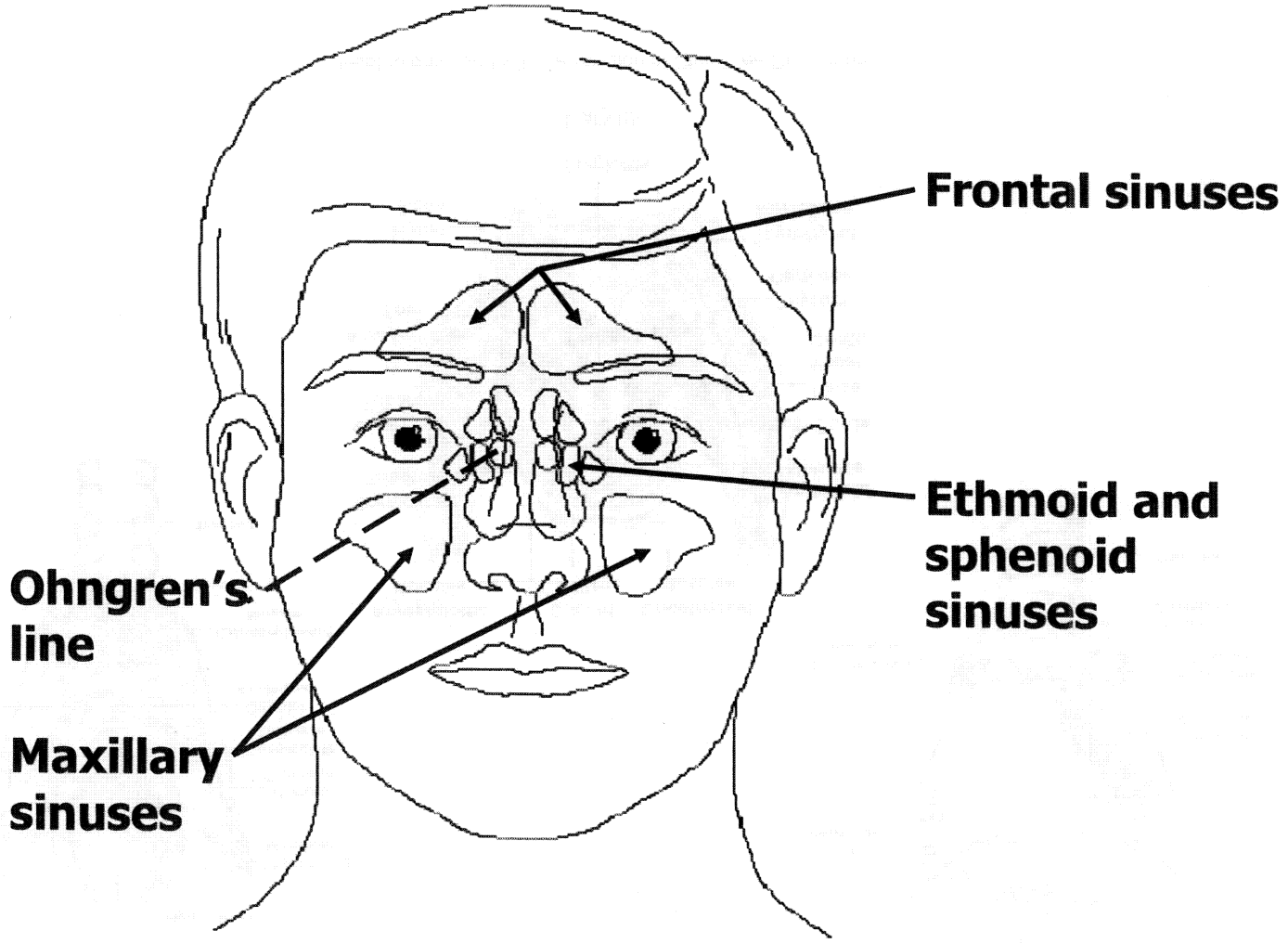
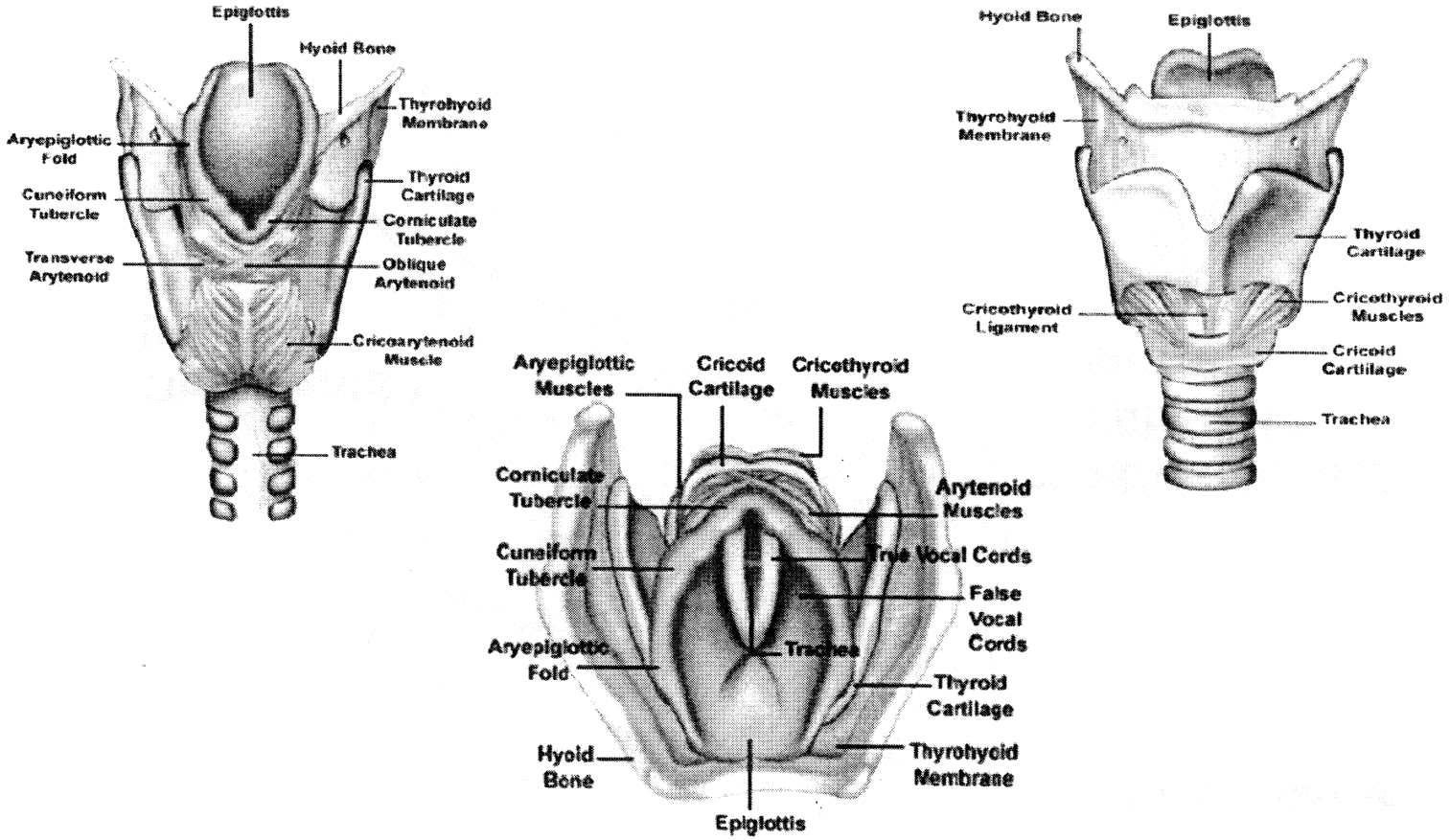
Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)





Nasal Sinuses

Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)



Larynx

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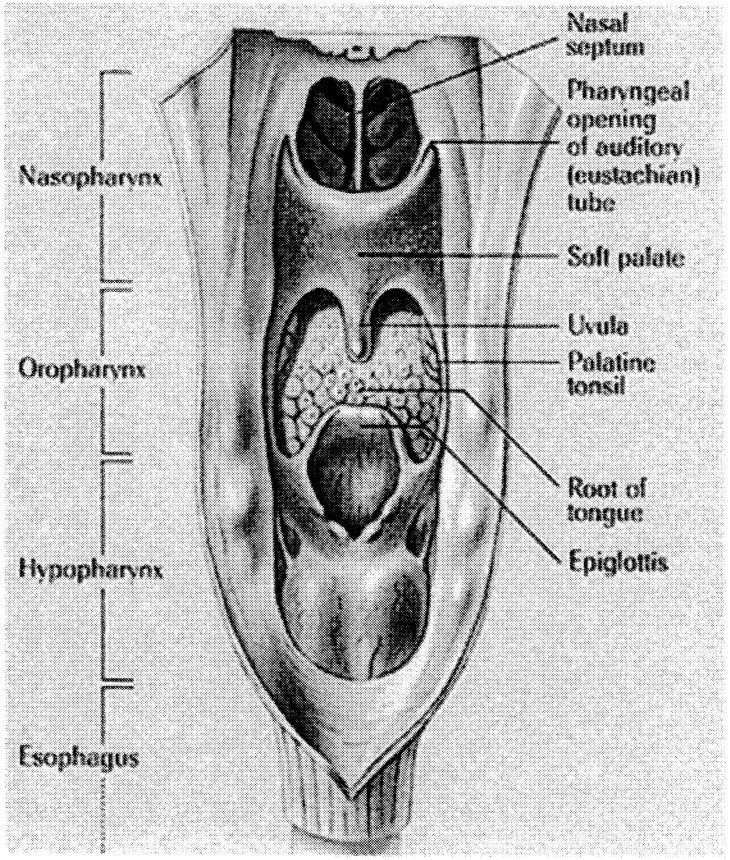

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Head and Neck Multiple Primary Rules - Text
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** tumor **or multiple** tumors, opt for a single tumor and abstract as a single primary.*

Note: Use this rule only after all information sources have been exhausted.

Example 1: History and physical exam states large tumor in nasopharynx. Biopsy base of tongue shows squamous cell carcinoma. No further information available. Abstract as a single primary.

Example 2: Pathology report states extensive squamous cell carcinoma involving nasopharynx and larynx. Fragments of epiglottis positive for squamous cell carcinoma. No other information available. Abstract as a single primary.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Tumors.

SINGLE TUMOR

Note 1: Tumor not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 A **single tumor** is always a single primary. *

Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

This is the end of instructions for Single Tumor.
*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.
Note 1: Tumors not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M3 Tumors on the **right** side **and** the **left** side of a **paired site** are multiple primaries. **

Note: See Table 1 for list of paired sites.

Rule M4 Tumors on the **upper lip** (C000 or C003) **and** the **lower lip** (C001 or C004) are multiple primaries. **

Rule M5 Tumors on the **upper gum** (C030) **and** the **lower gum** (C031) are multiple primaries. **

Head and Neck Multiple Primary Rules - Text
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

Rule M6 Tumors in the **nasal cavity** (C300) **and** the **middle ear** (C301) are multiple primaries. **

Rule M7 Tumors in sites with ICD-O-3 **topography** codes that are **different** at the second (Cxxx) and/or third (Cxxx) character are multiple primaries. **

Rule M8 An **invasive** tumor **following** an **in situ** tumor more than 60 days after diagnosis is a multiple primary. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M9 Tumors diagnosed **more than five (5) years** apart are multiple primaries. **

Rule M10 Abstract as a single primary* when one tumor is:
- **Cancer/malignant neoplasm, NOS** (8000) **and** another is a **specific histology** or
- **Carcinoma, NOS** (8010) **and** another is a **specific carcinoma** or
- **Adenocarcinoma, NOS** (8140) **and** another is a **specific adenocarcinoma** or
- **Squamous cell carcinoma, NOS** (8070) and another is **specific squamous cell carcinoma** or
- **Melanoma**, NOS (8720) and another is a **specific** melanoma
- **Sarcoma, NOS** (8800) and another is a **specific sarcoma**

Rule M11 Tumors with ICD-O-3 **histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M12 Tumors that **do not meet any** of the above **criteria** are abstracted as a single primary. *
Note 1: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.
Note 2: All cases covered by Rule M12 have the same first 3 numbers in ICD-O-3 histology code.

This is the end of instructions for Multiple Tumors.
*** If a single primary, prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
**** If multiple primaries, prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**

Rule M12 Examples: The following are examples of cases that use Rule M12. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. ***Warning: Using only these case examples to determine the number of primaries can result in major errors.***

Example 1: Multifocal tumors in floor of mouth	**Example 2:** An in situ and invasive tumor diagnosed within60 days	**Example 3:** In situ following an invasive tumor more than 60 days apart

Head and Neck Histology Coding Rules - Text
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

Rule H1 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT, PET, or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H2 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site.**

Note: Code the behavior /3.

Rule H3 Code the histology when only **one histologic type** is identified.

Example: Squamous cell carcinoma. Code 8070.

Note: Do not code terms that do not appear in the histology description.

Example: Do not code 8072 (squamous cell carcinoma non-keratinizing) unless the words "non-keratinizing" actually appear in the diagnosis.

Rule H4 Code the **invasive** histologic type when a single tumor has invasive and in situ components.

Example: The final diagnosis is keratinizing squamous cell carcinoma (8073) with areas of squamous cell carcinoma in situ (8070). Code the invasive histologic type, keratinizing squamous cell carcinoma (8073).

Head and Neck Histology Coding Rules - Text
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Rule H5 Code the most **specific** histologic term using Chart 1 when there are multiple histologies within the same branch. Examples of histologies within the same branch are:

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Squamous cell carcinoma, NOS (8070) and a more specific squamous carcinoma or
- Adenocarcinoma, NOS(8140) and a more specific adenocarcinoma or
- Melanoma, NOS (8720) and a more specific melanoma or
- Sarcoma, NOS (8800) and a more specific sarcoma

Note 1: The specific histology for **in situ** lesions may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 2: The specific histology for **invasive** lesions may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation

Example: The final diagnosis is squamous cell carcinoma (8070), papillary (8050). Code the specific type, papillary (8050).

Rule H6 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H7 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT, PET, or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS), or 8010 (carcinoma, NOS) as stated by the physician when no specific histology is documented.

Rule H8 Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Head and Neck Histology Coding Rules - Text
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Rule H9 Code the histology when only **one histologic type** is identified.
Example: Squamous cell carcinoma. Code 8070.
Note: Do not code terms that do not appear in the histology description.
Example: Do not code 8072 (squamous cell carcinoma non-keratinizing) unless the words "non-keratinizing" actually appear in the diagnosis

Rule H10 Code the histology of the **most invasive** tumor.
Note 1: See the Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations for the definition of most invasive.
- One tumor is in situ and one is invasive, code the histology from the invasive tumor.
- Both/all histologies are invasive, code the histology of the more invasive tumor.

Note 2: If tumors are equally invasive, go to the next rule

Rule H11 Code the most **specific** histologic term using Chart 1 when there are multiple histologies within the same branch. Examples of histologies within the same branch are:
- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Squamous cell carcinoma, NOS (8070) and a more specific squamous carcinoma or
- Adenocarcinoma, NOS(8140) and a more specific adenocarcinoma or
- Melanoma, NOS (8720) and a more specific melanoma or
- Sarcoma, NOS (8800) and a more specific sarcoma

Note 1: The specific histology for **in situ** lesions may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation
Note 2: The specific histology for **invasive** lesions may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation
Example: The final diagnosis is squamous cell carcinoma (8070), papillary (8050). Code the specific type, papillary (8050).

Rule H12 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case

Head and Neck Histo

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Colon Equivalent Terms, Definitions and Illustrations
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Introduction

Use these rules only for cases with primary colon cancer.

Ninety-eight percent of colon cancers are adenocarcinoma. Ten to fifteen percent of these cases produce enough mucin to be categorized as mucinous/colloid.* Mixed histologies and specific types other than mucinous/colloid or signet ring cell are rare.

**ACS Clinical Oncology*

Equivalent or Equal Terms

- Familial polyposis, familial adenomatous polyposis, (FAP)
- Intramucosal, lateral extension
- Invasion through colon wall, extension through colon wall, transmural
- Low grade neuroendocrine carcinoma, carcinoid
- Most invasive, most extensive
- Mucin producing, mucin secreting
- Mucinous, colloid
- Polyp, adenoma
- Serosa, visceral peritoneum
- Tumor, mass, lesion, neoplasm
- Type, subtype, predominantly, with features of, major, or with ____differentiation.

Definitions

Adenocarcinoid (8245/3): A specific histology commonly found in the appendix.

Adenocarcinoma with mixed subtypes (8255): Rarely used for colon primaries (see introduction).

Adenocarcinoma, intestinal type (8144) is a form of stomach cancer. Do not use this code when the tumor arises in the colon.

Adenoma: A **benign** lesion composed of tubular or villous structures showing **intraepithelial neoplasia** (See definition of **intraepithelial neoplasia**).

Colon Equivalent Terms, Definitions and Illustrations
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Composite carcinoid (8244): One tumor which contains both carcinoid and adenocarcinoma.

Familial polyposis, familial adenomatous polyposis (FAP), adenocarcinoma in: a condition characterized by the development of many adenomatous polyps, often seen in several members of the same family.

Frank adenocarcinoma: Adenocarcinoma arising from the colon wall (no evidence of a polyp)

In Situ: Noninvasive; intraepithelial; (adeno)carcinoma in a polyp or adenoma, noninvasive.

Intestinal type adenocarcinoma (8144) is a gastric histology term and is not listed in the WHO Histological Classification of Tumors of the Colon and Rectum.

Intraepithelial neoplasia, high grade may be either severe dysplasia or carcinoma in situ. Report cases of carcinoma in situ only.

Intraepithelial neoplasia, low grade is not a reportable condition. A person with intraepithelial neoplasia is at risk for developing invasive cancer.

Intramucosal tumors may be noninvasive or invasive. The term intramucosal may refer to the surface epithelium, the basement membrane, or the lamina propria..

Invasive tumor: A tumor that penetrates the basement membrane and invades the lamina propria.

Most invasive: The tumor with the greatest continuous extension through the wall of the colon. The layers of the colon wall in order of least to greatest extension:

- Mucosa (surface epithelium, lamina propria, basement membrane)
- Submucosa
- Muscularis propria
- Subserosa (pericolic fat, subserosal fat)
- Retroperitoneal fat (pericolic fat)
- Mesenteric fat (pericolic fat)
- Serosa (visceral peritoneum).

Colon Equivalent Terms, Definitions and Illustrations
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Mucinous/colloid adenocarcinoma (8480): An adenocarcinoma containing **extra**-cellular mucin comprising more than 50% of the tumor. Note that "mucin-producing" and "mucin-secreting" are not synonymous with mucinous.

Neuroendocrine carcinoma (8246): Neuroendocrine carcinoma is a group of carcinomas that include typical carcinoid tumor (8240), atypical carcinoid tumor (8249).

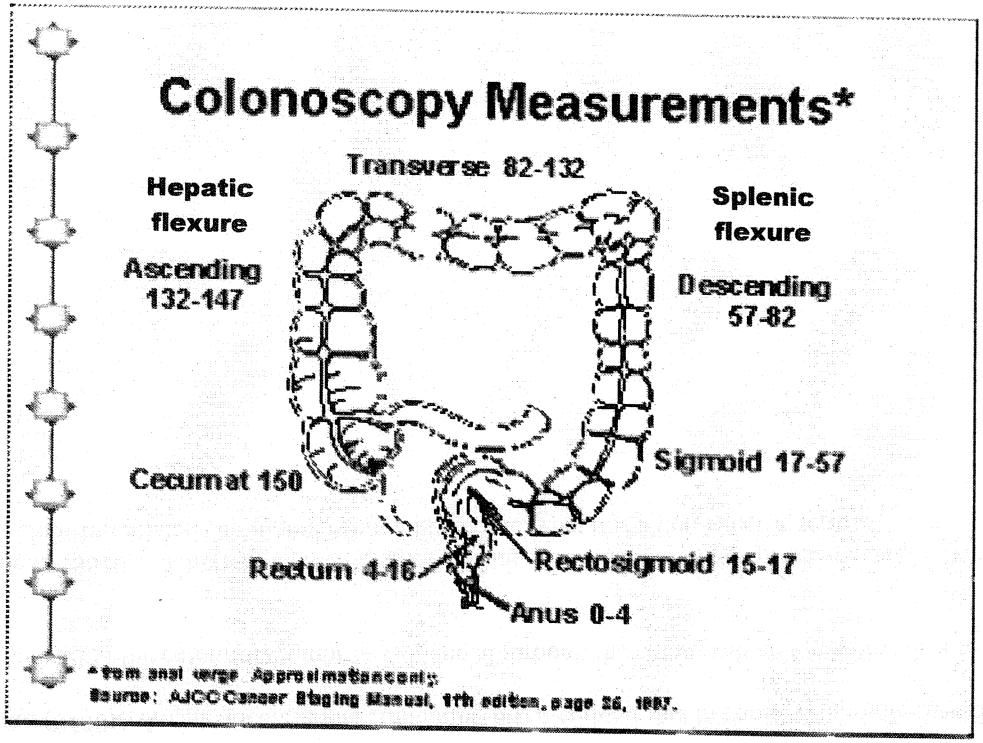
Pericolic fat: A general term for the fat surrounding the colon. Subserosal fat, retroperitoneal fat and mesenteric fat are pericolic fat.

Signet ring cell carcinoma (8490): An adenocarcinoma containing **intra**-cellular mucin comprising more than 50% of the tumor.

Transmural: Through the wall of the colon (the tumor has extended through the colon wall and may invade a regional organ or regional tissue.

Undifferentiated carcinoma (8020): A high grade malignancy lacking glandular structures or other specific features that can be used to better classify the tumor. Undifferentiated carcinoma is not a histologic type; it is a non-specific term.

Colon Equivalent Terms, Definitions and Illustrations
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



Colon Multiple Primary Rules – Text
C180 - C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** tumor **or multiple** tumors, opt for a single tumor and abstract as a single primary.*
Note: Use this rule only after all information sources have been exhausted.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Tumors.

SINGLE TUMOR

Note 1: Tumor not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 A **single tumor** is always a single primary. *
Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Single Tumor.

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.
Note 1: Tumors not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M3 Adenocarcinoma in adenomatous polyposis coli (**familial polyposis**) with one or more malignant polyps is a single primary.*
Note: Tumors may be present in multiple segments of the colon or in a single segment of the colon.

Rule M4 Tumors in sites with **ICD-O-3 topography** codes that are different at the second (C<u>x</u>xx), third, (Cx<u>x</u>x) or fourth (C18<u>x</u>) character are multiple primaries. **

Rule M5 Tumors diagnosed **more than one (1) year** apart are multiple primaries. **

Colon Multiple Primary Rules – Text
C180 - C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule M6 An **invasive** tumor **following** an **in situ** tumor more than 60 days after diagnosis are multiple primaries. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M7 A **frank** malignant or in situ **adenocarcinoma and** an in situ or **malignant** tumor in a **polyp** are a single primary.*

Rule M8 Abstract as a single primary* when one tumor is:
- **Cancer/malignant neoplasm, NOS** (8000) **and** another is a **specific histology** or
- **Carcinoma, NOS** (8010) **and** another is a **specific carcinoma** or
- **Adenocarcinoma, NOS** (8140) **and** another is a **specific adenocarcinoma** or
- **Sarcoma, NOS** (8800) **and** another is a **specific sarcoma**

Rule M9 **Multiple** in situ and/or malignant **polyps** are a single primary.*
Note: Includes all combinations of adenomatous, tubular, villous, and tubulovillous adenomas or polyps.

Rule M10 Tumors with **ICD-O-3 histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M11 Tumors that **do not meet any** of the above **criteria** are a single primary.*
Note 1: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.
Note 2: All cases covered by Rule M11 are in the same segment of the colon.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
**** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**
This is the end of instructions for Multiple Tumors.

Colon Histology Coding Rules – Text
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

Rule H1 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT, PET or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H2 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H3 Code **8140** (adenocarcinoma, NOS) when pathology describes only **intestinal type adenocarcinoma** or adenocarcinoma, intestinal type.

Note 1: Intestinal type adenocarcinoma usually occurs in the stomach.

Note 2: When a diagnosis of intestinal adenocarcinoma is further described by a specific term such as type, continue to the next rule.

Rule H4 Code **8210** (adenocarcinoma in **adenomatous polyp**), **8261** (adenocarcinoma in **villous adenoma**), or **8263** (adenocarcinoma in **tubulovillous adenoma**) when:
- The final diagnosis is adenocarcinoma in a polyp
- The final diagnosis is adenocarcinoma **and** a residual polyp or polyp architecture is recorded in other parts of the pathology report.
- The final diagnosis is adenocarcinoma **and** there is reference to a residual or pre-existing polyp or
- The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in a polyp or
- There is documentation that the patient had a polypectomy

Note: It is important to know that the adenocarcinoma originated in a polyp.

Rule H5 Code **8480** (mucinous/colloid adenocarcinoma) or **8490** (signet ring cell carcinoma) when the final diagnosis is:
- **Mucinous/colloid** (8480) or **signet ring cell** carcinoma (8490) or
- Adenocarcinoma, NOS and the microscopic description documents that **50% or more** of the tumor is **mucinous/colloid** or
- Adenocarcinoma, NOS and the microscopic description documents that **50% or more** of the tumor is **signet ring cell** carcinoma

Colon Histology Coding Rules – Text
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H6 Code **8140** (adenocarcinoma, NOS) when the final diagnosis is **adenocarcinoma** and:
- The microscopic diagnosis states that **less than 50%** of the tumor is **mucinous/colloid** or
- The microscopic diagnosis states that **less than 50%** of the tumor is **signet ring cell** carcinoma or
- The **percentage** of mucinous/colloid or signet ring cell carcinoma is **unknown**

Rule H7 Code **8255** (adenocarcinoma with mixed subtypes) when there is a **combination** of **mucinous/colloid and signet ring cell** carcinoma.

Rule H8 Code **8240** (carcinoid tumor, NOS) when the diagnosis is **neuroendocrine** carcinoma (8246) **and carcinoid tumor** (8240).

Rule H9 Code **8244** (composite carcinoid) when the diagnosis is **adenocarcinoma and carcinoid tumor**.

Rule H10 Code **8245** (adenocarcinoid) when the diagnosis is **exactly "adenocarcinoid."**

Rule H11 Code the histology when only **one histologic type** is identified.

Rule H12 Code the invasive histology when both **invasive and in situ** histologies are present.

Rule H13 **Code the** most **specific** histologic **term when** the diagnosis is:
- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Sarcoma, NOS (8800) and a more specific sarcoma (invasive only)

Note 1: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 2: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H14 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

Colon Histology Coding Rules – Text
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Note: These rules only apply to multiple tumors that are reported as a **single primary**.

Rule H15 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- From CT, PET or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H16 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H17 Code **8220** (adenocarcinoma in adenomatous polyposis coli) when:
- **Clinical** history says **familial polyposis** and final diagnosis on the **pathology report** from resection is **adenocarcinoma in adenomatous polyps** or
- There are **>100 polyps** identified in the resected specimen or
- The number of polyps is not given but the diagnosis is **familial polyposis**

Rule H18 Code **8263** (adenocarcinoma in a tubulovillous adenoma) when multiple in situ or malignant polyps are present, at least one of which is tubulovillous

Rule H19 Code **8221** (adenocarcinoma in multiple adenomatous polyps) when:
- There are **<=100 polyps** identified in the resected specimen or
- There are multiple polyps and the number is not given and **familial polyposis** is **not mentioned**

Colon Histology Coding Rules – Text
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H20 Code the histology of the **most invasive** tumor when:

- There is a frank adenocarcinoma and a carcinoma in a polyp or
- There are in situ and invasive tumors or
- There are multiple invasive tumors

Note 1: See the Colon Equivalent Terms, Definitions and Illustrations for the definition of most invasive.

- One tumor is in situ and one is invasive, code the histology from the invasive tumor.
- Both/all histologies are invasive, code the histology of the most invasive tumor.

Note 2: If tumors are equally invasive, go to the next rule

Rule H21 Code **8210** (adenocarcinoma in **adenomatous polyp**), **8261** (adenocarcinoma in **villous adenoma**), or **8263** (adenocarcinoma in **tubulovillous adenoma**) when:

- The final diagnosis is adenocarcinoma **and** the microscopic description or surgical gross describes polyps or
- The final diagnosis is adenocarcinoma **and** there is reference to residual or pre-existing polyps or
- The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in polyps or
- There is documentation that the patient had a polypectomy

Note: It is important to know that the adenocarcinoma originated in a polyp.

Rule H22 Code the histology when only **one histologic type** is identified.

Rule H23 **Code the** more **specific** histologic **term** when the diagnosis is:

- Cancer/malignant neoplasm, NOS (8000) and a specific histology or
- Carcinoma, NOS (8010) and a specific carcinoma or
- Adenocarcinoma, NOS (8140) and a specific adenocarcinoma or
- Sarcoma, NOS (8800) and a specific sarcoma (invasive only)

Note 1: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 2: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H24 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.

Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Introduction

Use these rules only for cases with primary lung cancer.

Lung carcinomas may be broadly grouped into two categories, small cell and non-small cell carcinoma.
Frequently a patient may have two or more tumors in one lung and may have one or more tumors in the contralateral lung. The physician may biopsy only one of the tumors. Code the case as a single primary (See Rule M1, Note 2) unless one of the tumors is proven to be a different histology. It is irrelevant whether the other tumors are identified as cancer, primary tumors, or metastases.

Equivalent or Equal Terms

- Low grade neuroendocrine carcinoma, carcinoid
- Tumor, mass, lesion, neoplasm (for multiple primary and histology coding rules only)
- Type, subtype, predominantly, with features of, major, or with ___differentiation

Obsolete Terms for Small Cell Carcinoma (Terms that are no longer recognized)

- Intermediate cell carcinoma (8044)
- Mixed small cell/large cell carcinoma (8045) (Code is still used; however current accepted terminology is combined small cell carcinoma)
- Oat cell carcinoma (8042)
- Small cell anaplastic carcinoma (No ICD-O-3 code)
- Undifferentiated small cell carcinoma (No ICD-O-3 code)

Definitions

Adenocarcinoma with mixed subtypes (8255): A mixture of two or more of the subtypes of adenocarcinoma such as acinar, papillary, bronchoalveolar, or solid with mucin formation.

Adenosquamous carcinoma (8560): A single histology in a single tumor composed of both squamous cell carcinoma and adenocarcinoma.

Bilateral lung cancer: This phrase simply means that there is at least one malignancy in the right lung and at least one malignancy in the left lung. Do not base multiple primary decision on this phrase; bilateral does not mean this is a single primary. Use the multiple primary rules to decide whether to code bilateral lung cancers as a single or multiple primary.

Combined small cell carcinoma (8045): A small cell carcinoma that is combined with a non-small cell carcinoma. The combinations are small cell and adenocarcinoma, or squamous cell carcinoma, or large cell carcinoma.

Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Large cell carcinoma (8012): Large cell is a diagnosis that is used when the tumor is a non-small cell carcinoma that is undifferentiated. Because the tumor is undifferentiated, the pathologist cannot find glandular (adeno), or squamous differentiation.

Large cell neuroendocrine carcinoma (8013): A non-small cell carcinoma with neuroendocrine differentiation proven by immunohistochemical stain, currently classified as large cell carcinoma. These tumors require further study before being included as a separate category in a histologic classification.

Most invasive: The tumor with the greatest continuous extension.

Neuroendocrine carcinoma (8246): Neuroendocrine carcinoma is a group of carcinomas that include typical carcinoid tumor and small cell carcinoma. Code the specific histology when given. Code neuroendocrine carcinoma, NOS (8246) when no specific histology is documented.

Non-small cell carcinoma (8046): The term non-small cell is used two ways, as a group term describing all carcinomas that are not small cell; and as a default diagnosis when there isn't enough tissue to classify the tumor beyond the exclusion of small cell.

Pancoast tumor: An anatomic designation (not a specific histology) for a lung cancer that starts in the upper lobe of the lung and extends outward to destroy the ribs and vertebrae. The tumor may compress or directly invade the brachial plexus (nerve bundles) of the neck, causing pain. Pancoast tumor may also be called **superior sulcus tumor**.

Pleomorphic carcinoma (8022): A poorly differentiated non-small cell carcinoma (squamous cell carcinoma, adenocarcinoma, or large cell carcinoma) containing spindle cells and/or giant cells or, a carcinoma containing only spindle cells and giant cells. These fall under the general category of **sarcomatoid carcinoma**.

Sarcomatoid carcinoma: A group of tumors that are non-small cell in type and contain spindle cells and/or giant cells. Depending on the histologic features the tumor may be designated: pleomorphic carcinoma (8022); spindle cell carcinoma (8032); giant cell carcinoma (8031), carcinosarcoma (8980); or pulmonary blastoma (8972)

Small cell carcinoma: Malignant epithelial tumor consisting of small cells. There are many types of lung cancer, but most can be categorized into one of two basic types, "small cell carcinoma" or "non-small cell carcinoma"

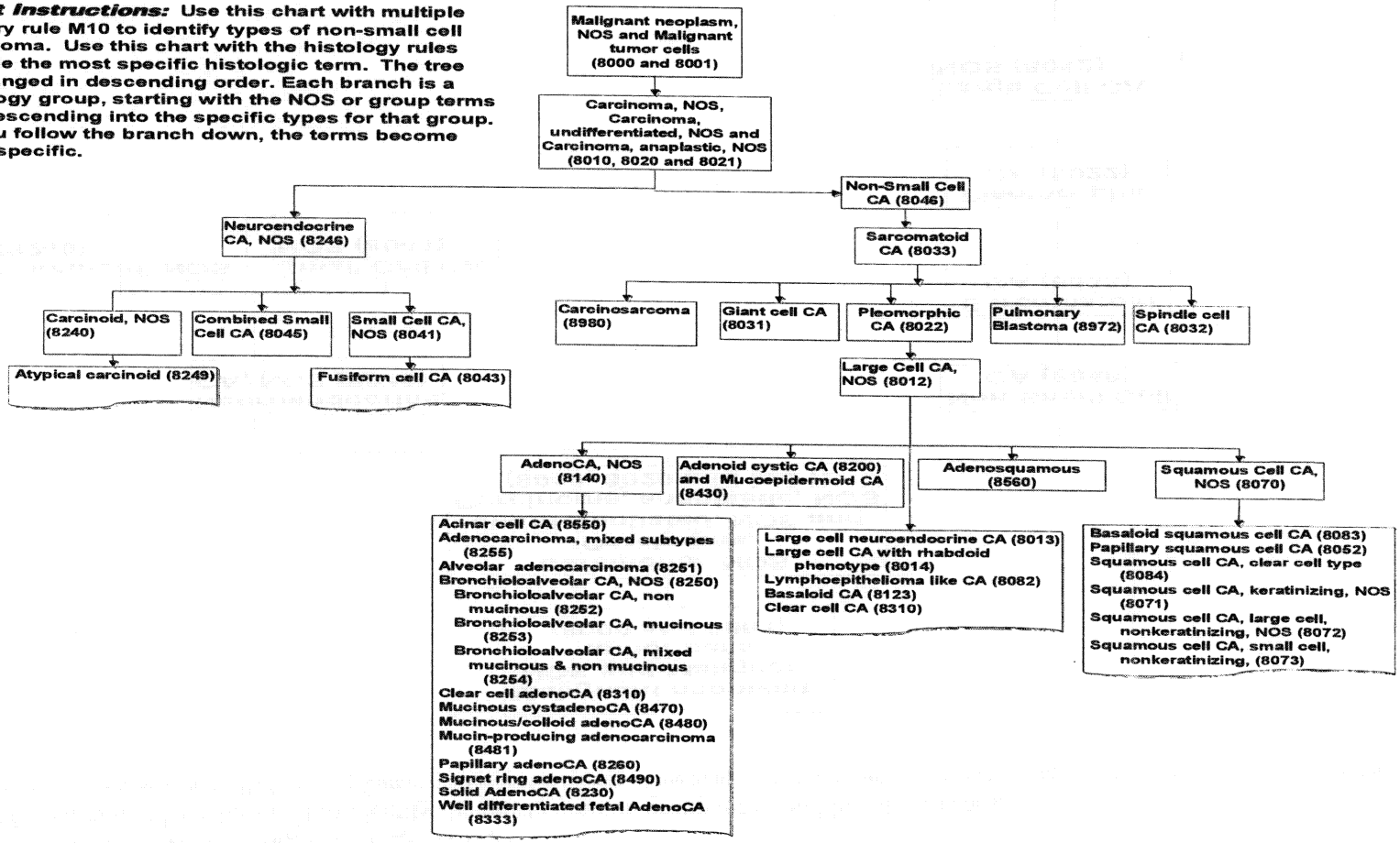
Undifferentiated carcinoma (8020): A high grade malignancy lacking glandular structures or other specific features that can be used to better classify the tumor. Undifferentiated carcinoma is used by pathologists when they believe the tumor is a carcinoma (not lymphoma, melanoma, or sarcoma) but they are not sure if the tumor is small cell or non-small cell.

Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Chart 1 – Lung Histology Groups and Specific Types

Note: This chart is based on the *WHO Classification of Tumors* for tumors of the lung. The chart is **not** a complete listing of histologies that may occur in the lung.

Chart Instructions: **Use this chart with multiple primary rule M10 to identify types of non-small cell carcinoma. Use this chart with the histology rules to code the most specific histologic term. The tree is arranged in descending order. Each branch is a histology group, starting with the NOS or group terms and descending into the specific types for that group. As you follow the branch down, the terms become more specific.**

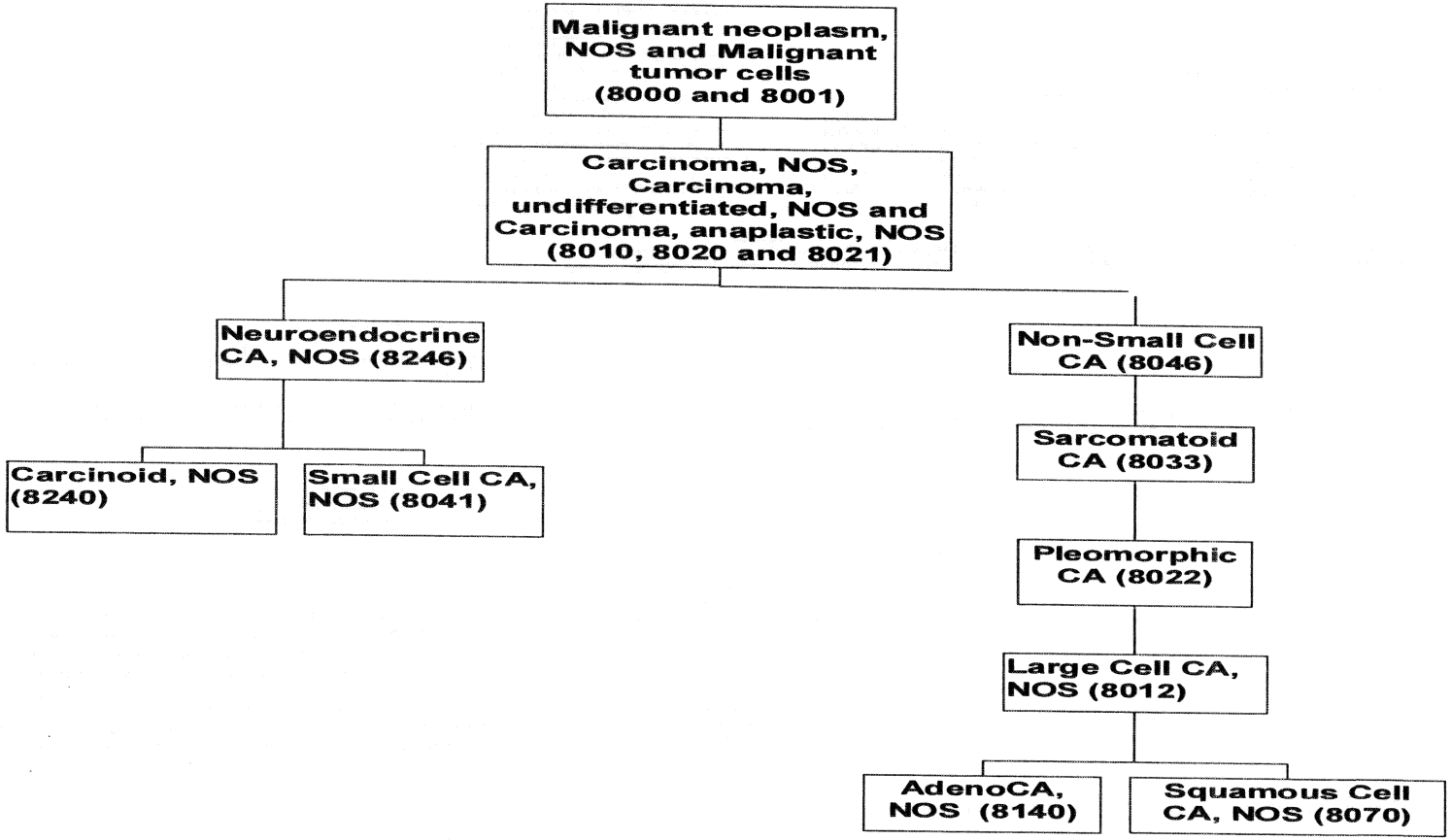


Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Chart 2 – Most Common Lung Histology Groups

Chart Instructions: Use this chart to identify the most common group terms and histology types.

Note: This chart is based on the *WHO Classification of Tumors* for tumors of the lung. The chart is **not** a complete listing of histologies that may occur in the lung.



Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations
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Table 1 –Combination/Mixed Codes for Lung Histologies

Table Instructions: Use this table to select combination/mixed histology codes. Compare the terms in the diagnosis to the terms in columns 1 and 2. If the terms match, abstract the case using the ICD-O-3 histology code in column 4. Use the combination/mixed codes listed in this table only when the histologies in the tumor match the histologies listed below. Use the combination/mixed codes for a **single tumor** when all histologies are present in a single tumor.

Note: This table is not a complete listing of histologies that may occur in the lung.

Column 1: Required Terms	**Column 2: Additional Required Terms**	**Column 3: ICD-O-3 Term**	**Column 4: ICD-O-3 Code**
Giant cell carcinoma AND spindle cell carcinoma		Giant cell and spindle cell carcinoma	8030
Small cell carcinoma AND one of the histologies in Column 2 *Note*: **Diagnosis must be small cell carcinoma (NOS), not a subtype of small cell**	Adenocarcinoma	Combined small cell carcinoma Mixed small cell carcinoma	8045
	Large cell carcinoma		
	Squamous cell carcinoma		
Squamous cell carcinoma* AND large cell nonkeratinizing		Squamous cell carcinoma, large cell, nonkeratinizing	8072
Squamous cell carcinoma AND small cell nonkeratinizing		Squamous cell caricinoma, small cell, nonkeratinizing	8073
Squamous cell carcinoma* AND one of the histologies in Column 2	Spindle cell carcinoma	Squamous cell carcinoma, spindle cell	8074
	Sarcomatoid	Squamous cell carcinoma, sarcomatoid	
A combination of at least two of the histologies in Column 2**	Acinar	Adenocarcinoma with mixed subtypes**	8255**
	Bronchioloalveolar carcinoma		
	Bronchioloalveolar carcinoma non mucinous (Clara cell/type II pneumocyte)		
	Bronchioloalveolar carcinoma mucinous (goblet cell)		
	Bronchioloalveolar carcinoma mixed mucinous and non-mucinous		
	Clear cell adenocarcinoma		
	Papillary adenocarcinoma		
	Solid adenocarcinoma		
	Well-differentiated fetal adenocarcinoma		

Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations
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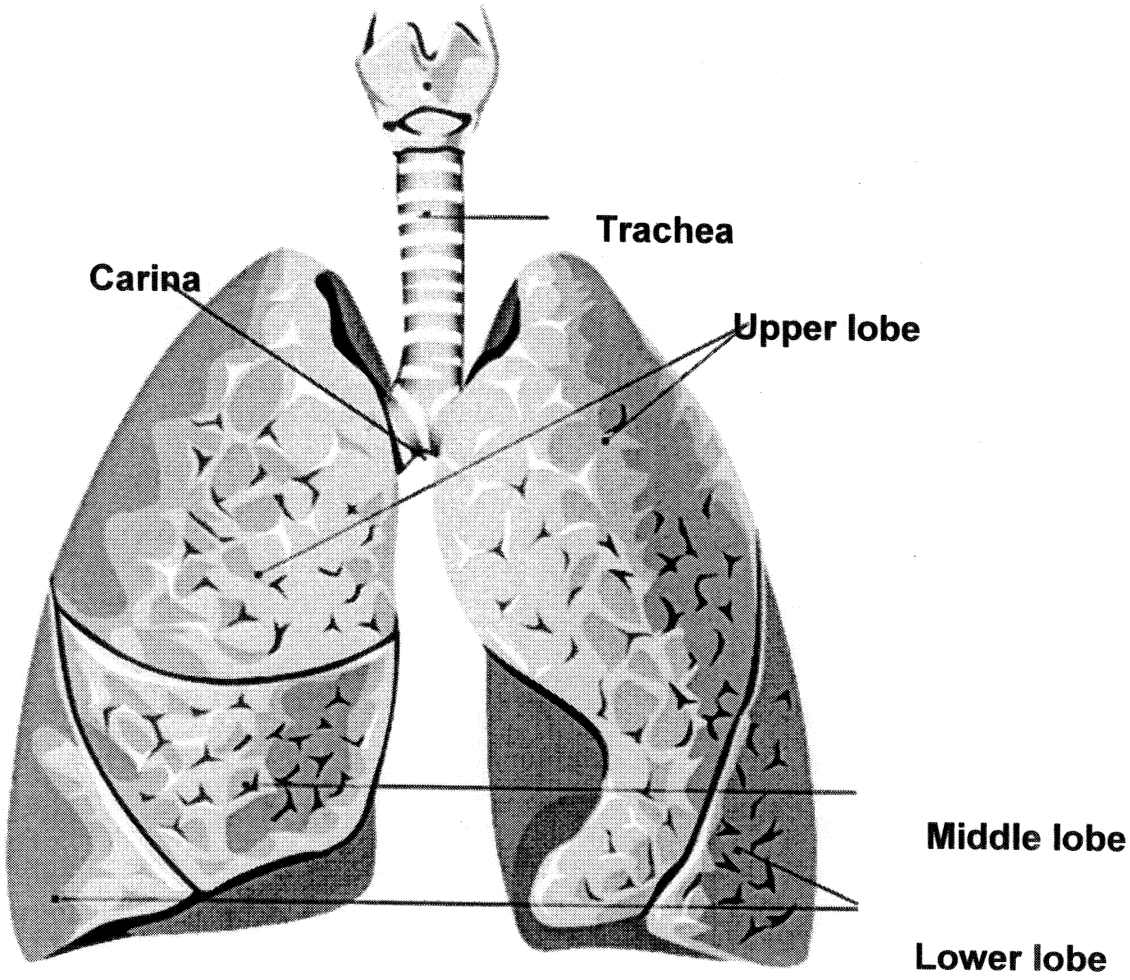
Column 1: Required Terms	**Column 2: Additional Required Terms**	**Column 3: ICD-O-3 Term**	**Column 4: ICD-O-3 Code**
Adenocarcinoma AND squamous cell carcinoma *Note*: **Diagnosis must be adenocarcinoma (NOS), not a subtype of adenocarcinoma**		Adenosquamous carcinoma	8560
Epithelial carcinoma AND myoepithelial carcinoma		Epithelial-myoepithelial carcinoma	8562

* Squamous cell carcinoma and epidermoid carcinoma are synonyms.

** **DO NOT USE** code **8255** for adenocarcinoma combined with mucinous subtypes such as mucinous "colloid" adenocarcinoma (8480) mucinous cystadenocarcinoma (8470) or signet ring adenocarcinoma (8490).

Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



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Lung Multiple Primary Rules – Text
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** tumor **or multiple** tumors, opt for a single tumor and abstract as a single primary.*
Note 1: Use this rule only after all information sources have been exhausted.
Note 2: Use this rule when only one tumor is biopsied but the patient has two or more tumors in one lung and may have one or more tumors in the contralateral lung. (See detailed explanation in Lung Equivalent Terms and Definitions)

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Tumors.

SINGLE TUMOR

Note: Tumor not described as metastasis

Rule M2 A **single tumor** is always a single primary. *
Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Single Tumor.

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.
Note: Tumors not described as metastases

Rule M3 Tumors in sites with ICD-O-3 **topography** codes that are **different** at the second (C**x**xx) and/or third character (Cx**x**x) are multiple primaries. **
Note: This is a change in rules; tumors in the trachea (C33) and in the lung (C34) were a single lung primary in the previous rules.

Rule M4 At least one tumor that is **non-small cell** carcinoma (8046) **and** another tumor that is **small cell** carcinoma (8041-8045) are multiple primaries. **

Rule M5 A tumor that is **adenocarcinoma** with **mixed subtypes** (8255) **and** another that is **bronchioloalveolar** (8250-8254) are multiple primaries. **

Lung Multiple Primary Rules – Text
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule M6 A **single** tumor in **each lung** is multiple primaries. **
Note: When there is a single tumor in each lung abstract as multiple primaries unless stated or proven to be metastatic.

Rule M7 **Multiple** tumors in **both lungs** with ICD-O-3 histology codes that are different at the first (**x**xxx), second (x**x**xx) or third (xx**x**x) number are multiple primaries. **

Rule M8 Tumors diagnosed **more than three (3) years** apart are multiple primaries. **

Rule M9 An **invasive** tumor **following** an **in situ** tumor more than 60 days after diagnosis is a multiple primary. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M10 Tumors with **non-small cell** carcinoma, **NOS** (8046) **and** a more **specific** non-small cell carcinoma **type** (Chart 1) are a single primary.*

Rule M11 Tumors with ICD-O-3 **histology** codes that are **different** at the first (**x**xxx), second (x**x**xx) or third (xx**x**x) number are multiple primaries. **
Note: Adenocarcinoma in one tumor and squamous cell carcinoma in another tumor are multiple primaries.

Rule M12 Tumors that **do not meet any** of the above **criteria** are a single primary.*
Note 1: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.
Note 2: All cases covered by this rule are the same histology.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
**** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**
This is the end of instructions for Multiple Tumors.

Rule M12 Examples: The following are examples of cases that use Rule M12. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. ***Warning: Using only these case examples to determine the number of primaries can result in major errors.***

Example 1: Solitary tumor in one lung, multiple tumors in contralateral lung	**Example 2:** Diffuse bilateral nodules (This is the only condition when laterality = 4)	**Example 3:** An in situ and invasive tumor diagnosed within 60 days
Example 4: Multiple tumors in left lung metastatic from right lung	**Example 5:** Multiple tumors in one lung	**Example 6:** Multiple tumors in both lungs

Lung Histology Coding Rules – Text
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

Rule H1 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT, PET, or MRI scans
- Chest x-rays

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H2 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H3 Code the histology when only **one histologic type** is identified.

Note: Do not code terms that do not appear in the histology description.

Example 1: Do not code squamous cell carcinoma non-keratinizing unless the words "non-keratinizing" actually appear in the diagnosis.

Example 2: Do not code bronchioalveolar non-mucinous unless the words "non-mucinous" actually appear in the diagnosis.

Rule H4 Code the invasive histologic type when a single tumor has **invasive and in situ** components

Rule H5 Code the **most specific** term using Chart 1 **when** there are multiple histologies within the same branch. Examples of histologies within the same branch are:

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma or
- Sarcoma, NOS (8800) and a more specific sarcoma

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation

Example 1: Adenocarcinoma, predominantly mucinous. Code 8480 (mucinous adenocarcinoma).

Example 2: Non-small cell carcinoma, papillary squamous cell. Code 8052 (papillary squamous cell carcinoma).

Lung Histology Coding Rules – Text
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H6 Code the appropriate combination/mixed code (Table 1) when there are **multiple specific histologies** or when there is a non-specific **with multiple specific histologies**

Note: The specific histologies may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.
Example 1 (multiple specific histologies): Solid and papillary adenocarcinoma. Code 8255 (adenocarcinoma with mixed subtypes).
Example 2 (multiple specific histologies): Combined small cell and squamous cell carcinoma. Code 8045 (combined small cell carcinoma).
Example 3 (non-specific with multiple specific histologies): Adenocarcinoma with papillary and clear cell features. Code 8255 (adenocarcinoma with mixed subtypes).

Rule H7 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H8 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT, PET, or MRI scans
- Chest x-rays

Note 2: Code the specific histology when documented.
Note 3: Code the histology to 8000 (cancer/malignant neoplasm), or 8010 (carcinoma) as stated by the physician when nothing more specific is documented.

Rule H9 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.
Note: Code the behavior /3.

Rule H10 Code the histology when only **one histologic type** is identified.
Note: Do not code terms that do not appear in the histology description.
Example 1: Do not code squamous cell carcinoma non-keratinizing unless the words "non-keratinizing" actually appear in the diagnosis.
Example 2: Do not code bronchioalveolar non-mucinous unless the words "non-mucinous" actually appear in the diagnosis.

Lung Histology Coding Rules – Text
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H11 Code the histology of the **most invasive** tumor.

Note 1: This rule should only be used when the first three numbers of the histology codes are identical (This is a single primary.)

Note 2: See the Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations for the definition of most invasive.

- One tumor is in situ and one is invasive, code the histology from the invasive tumor.
- Both/all histologies are invasive, code the histology of the most invasive tumor.

Rule H12 Code the **most specific** term using Chart 1 **when** there are multiple histologies within the same branch. Examples of histologies within the same branch are:

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma or
- Sarcoma, NOS (8800) and a more specific sarcoma

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation

Example 1: Adenocarcinoma, predominantly mucinous. Code 8480 (mucinous adenocarcinoma).

Example 2: Non-small cell carcinoma, papillary squamous cell. Code 8052 (papillary squamous cell carcinoma).

Rule H13 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.

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Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

Introduction

Cutaneous melanoma starts in the melanocyte cells of the skin. Melanocytes lie in the epidermis, the outermost layer of the skin. Melanocytes often cluster together and form moles (nevi). Most moles are benign, but some may go on to become malignant melanomas.

Melanomas are divided into 5 main types, depending on their location, shape and whether they grow outward or downward into the dermis:

- **Acral melanoma:** occurs on the palms of the hand, soles of the feet, or nail beds
- **Desmoplastic melanoma:** is a rare malignant melanoma marked by non-pigmented lesions on sun-exposed areas of the body
- **Lentigo maligna:** usually occur on the faces of elderly people
- **Superficial spreading or flat melanoma:** grows outwards at first to form an irregular pattern on the skin with an uneven color
- **Nodular melanomas:** are lumpy and often blue-black in color and may grow faster and spread downwards

These types account for the majority of melanomas occurring in the US population. For a more complete listing of histologic types of melanoma, see the *AJCC Cancer Staging Manual*, 6th Ed.

Melanoma can also start in the mucous membranes of the mouth, anus and vagina, in the eye or other places in the body where melanocytes are found. This scheme is used only for melanomas that occur on the skin.

Equivalent or Equal Terms

- Tumor, mass, lesion, neoplasm
- Type, subtype, predominantly, with features of, major, or with ____differentiation.
- Giant pigmented nevus, giant congenital nevus
- Mole, Nevus

Synonyms for In Situ

Behavior code 2
Clark level 1 (limited to the epithelium)
Hutchinson freckle (See synonyms for Hutchinson freckle)
Intraepidermal, NOS
Intraepithelial, NOS
Lentigo maligna
Noninvasive
Precancerous melanoma of Dubreuilh
Stage 0
Tis

Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

Synonyms for Hutchinson freckle

Circumscribed precancerous melanosis
Intraepidermal malignant melanoma
Lentigo maligna
Precancerous melanosis of Dubreuilh

Definitions

Amelanotic melanoma: A non-pigmented malignant melanoma.

Atypical melanocytic hyperplasia (dysplasia): Tumor-like lesion or condition may represent precursor stage or stage in development of melanoma. Not reportable.

Different lateralities: The right side of the body, the left side of the body and the midline are separate lateralities in the melanoma coding rules.

Evolving melanoma (borderline evolving melanoma): Evolving melanoma are tumors of uncertain biologic behavior. Histological changes of borderline evolving melanoma are too subtle for a definitive diagnosis of melanoma in situ. The tumors may be described as "proliferation of atypical melanocytes confined to epidermal and adnexal epithelium," "atypical intraepidermal melanocytic proliferation, "atypical intraepidermal melanocytic hyperplasia"; or "severe melanocytic dysplasia." Not reportable.

Familial Atypical Multiple Mole Melanoma Syndrome (FAMM, FAM-M): An inherited condition identified when:

- Melanoma has been diagnosed in a family member, including grandparents, aunts, uncles, and cousins
- Several family members have large numbers of moles (often more than 50) which may be abnormal or atypical moles.

Giant pigmented nevus: Diameter larger than 20 cm; frequently covers large areas of the body in a garment-like fashion. The trunk, head and neck are the most common sites.

Junctional nevus: Smooth, hairless, light to dark brown mole. Can be slightly elevated, usually multiple and can occur on any part of the body. Melanocytes are confined to the dermo-epidermal junction.

Hypodermis: A subcutaneous layer of loose connective tissue containing a varying number of fat cells.
Synonyms: subcutaneous fat; subcutis.

Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

In-transit metastasis: Metastasis found in the lymphatic channels more than 2cm away from the primary melanoma, but not reaching the regional lymph nodes.

Invasive tumor: A tumor that penetrates the basement membrane and invades the dermis.

Laterality: For skin sites, laterality divides the body into a right and left half as though a line were drawn from mid forehead to mid pelvis and from mid skull to mid buttocks. A midline laterality describes a tumor that is in the center of the "line" drawn from the mid forehead to mid pelvis or from the mid skull to the mid buttocks; it is impossible to categorize the tumor as being on the right or left side of the body.

Lentigo maligna: Is a specific histologic type of in situ melanoma. It appears as a brown or black mottled, irregular, lesion with increased numbers of scattered atypical melanocytes in the epidermis. It usually occurs on the face.

Lentigo maligna melanoma: Is an invasive melanoma that begins as lentigo maligna, but usually after many years the dermis is invaded by the tumor. Once invasion has occurred, the lesion is called lentigo maligna **melanoma**.

Midline: the middle dividing line that separates the body into right and left sides.

Most invasive: the histology that has the greatest extension into the dermis or subcutaneous fat.

Non-invasive tumor: A tumor confined to epithelium (intraepithelial), in situ tumor, with no penetration below the basement membrane.

Precancerous melanosis: An obsolete term for lentigo maligna.

Proliferation of atypical melanocytes confined to epidermis: Number of (proliferation) pigmented cells (melanocytes) not showing the normal cell structure (atypical). Not reportable.

Regressing melanoma: The term "regressing melanoma" does not refer to a specific histology; it refers to the physical appearance and size of the lesion. A regressing melanoma is reacting to the body's immune system by shrinking in size. Partial spontaneous regression is not an uncommon finding in invasive primary melanoma; partial regression can be an indicator of poor prognosis. Proven complete regression is very rare; one website stated that only 33 cases of total regression have been reported. A regressive melanoma is usually thinner than it was originally. Although regression is a prognostic factor, the histologic type is more important for histology coding purposes. See Histology coding rules, Rule H5.

Satellite lesion or metastasis: Grossly evident metastatic skin lesion within the immediate vicinity (usually within 2 cm) of a primary malignant tumor; e.g., skin adjacent to primary malignant melanoma. This is a metastasis, not a separate primary.

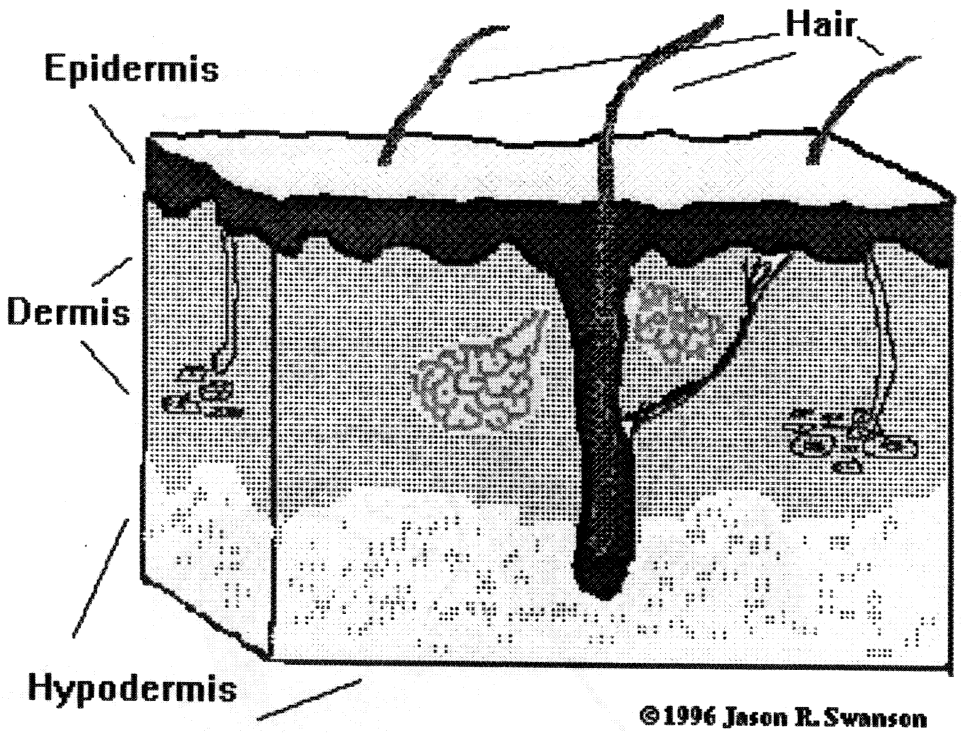
Severe melanotic dysplasia: Tumor-like lesion or condition. Not reportable.

Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

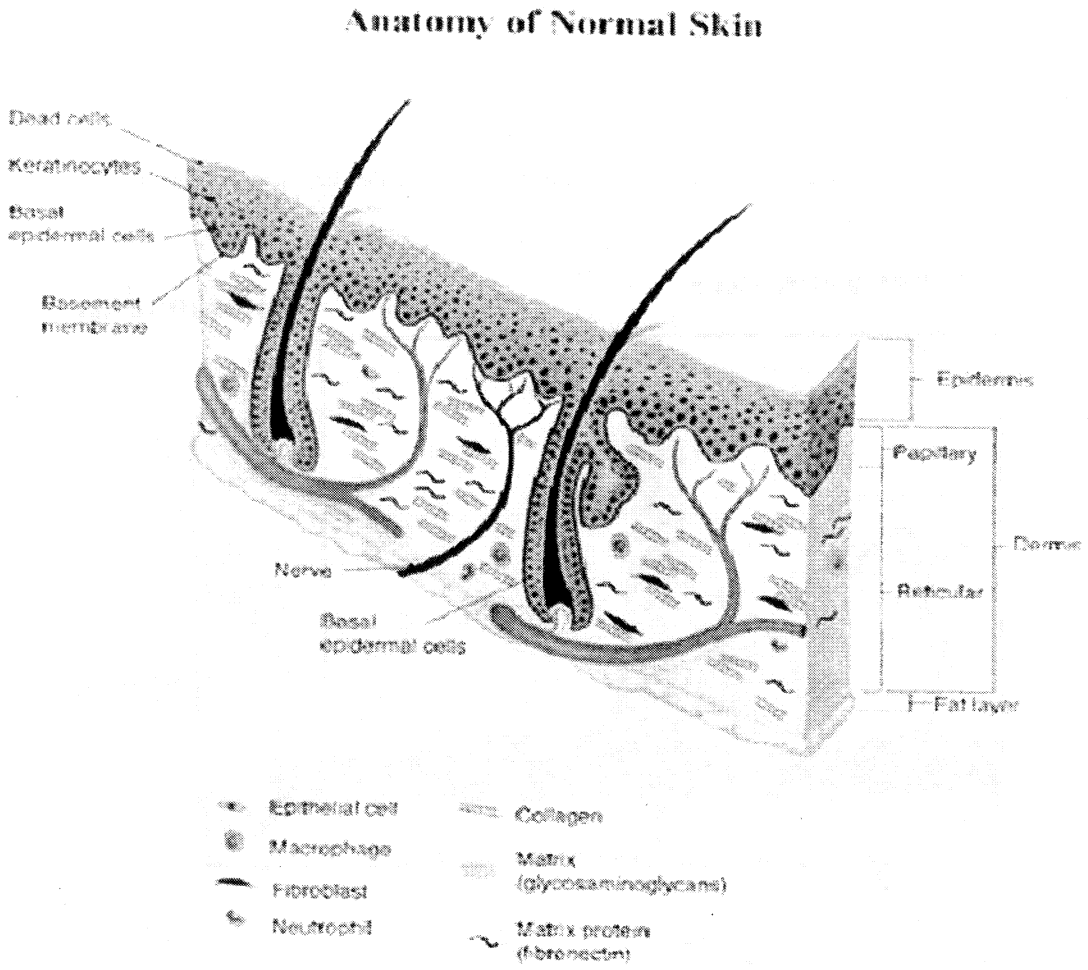
Skin Layers:

- Epidermis – upper surface, thin layer (outermost layer)
- Dermis – lower, intermediate thicker layer (intermediate layer)
- Hypodermis – also called subcutis or subcutaneous fat – lowest layer (innermost layer)

Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)



Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)



Source: Burnsurgery.org

Cutaneous Melanoma Multiple Primary Rules – Text
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

UNKNOWN IF SINGLE OR MULTIPLE MELANOMAS

Note: Melanoma(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** melanoma **or multiple** melanomas, opt for a single melanoma and abstract as a single primary.*
Note: Use this rule only after all information sources have been exhausted

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Melanoma.

SINGLE MELANOMA

Note 1: Melanoma not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 A **single melanoma** is always a single primary. *

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Single Melanoma.

MULTIPLE MELANOMAS

Multiple melanomas may be a single primary or multiple primaries
Note 1: Melanoma not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M3 Melanomas in sites with ICD-O-3 **topography** codes that are **different** at the second (C<u>x</u>xx), third (Cx<u>x</u>x) or fourth (C44<u>x</u>) character are multiple primaries. **

Cutaneous Melanoma Multiple Primary Rules – Text
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

Rule M4 Melanomas with **different laterality** are multiple primaries. **
Note: A **midline** melanoma is a different laterality than right or left.
Example 1: Melanoma of the right side of the chest and a melanoma at midline of the chest are different laterality, multiple primaries
Example 2: A melanoma of the right side of the chest and a melanoma of the left side of the chest are multiple primaries

Rule M5 Melanomas with ICD-O-3 **histology** codes that are **different** at the first (xxxx), second (xxxx) or third number (xxxx) are multiple primaries. **

Rule M6 An **invasive** melanoma that occurs **more than 60 days after** an **in situ** melanoma is a multiple primary. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M7 Melanomas diagnosed **more than 60 days** apart are multiple primaries. **

Rule M8 Melanomas that **do not meet any** of the above **criteria** are abstracted as a single primary. *
Note 1: Use the data item "Multiplicity Counter" to record the number of melanomas abstracted as a single primary.
Note 2: When an invasive melanoma follows an in situ melanoma within 60 days, abstract as a single primary.
Note 3: All cases covered by this rule are the same site and histology.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
**** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**
This is the end of instructions for Multiple Melanomas.

Rule M8 Examples: The following are examples of cases that use Rule M8. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. ***Warning: Using only these case examples to determine the number of primaries can result in major errors.***

Example 1: Solitary melanoma on the left back and another solitary melanoma on the left chest.	**Example 2:** Solitary melanoma on the right thigh and another solitary melanoma on the right ankle.

SINGLE MELANOMA OR MULTIPLE MELANOMAS ABSTRACTED AS A SINGLE PRIMARY

Rule H1 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of melanoma in the medical record
- PET scan

Note 2: Code the specific histology when documented.

Rule H2 Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H3 Code the histology when only **one histologic type** is identified.

Rule H4 Code the invasive histologic type when there are **invasive and in situ** components.

Rule H5 Code the **histologic type** when the diagnosis is **regressing** melanoma **and** a **histologic** type.

Example: Nodular melanoma with features of regression. Code 8721 (Nodular melanoma).

Rule H6 Code 8723 (Malignant melanoma, regressing) when the diagnosis is **regressing melanoma**.

Example: Malignant melanoma with features of regression. Code 8723.

Rule H7 Code the **histologic type** when the diagnosis is **lentigo maligna** melanoma **and** a **histologic** type.

Rule H8 Code 8742 (Lentigo maligna melanoma) when the diagnosis is **lentigo maligna** melanoma.

Rule H9 **Code the** most **specific** histologic **term** when the diagnosis is melanoma, NOS (8720) with a single specific type.

Note 1: The specific type for **in situ** lesions may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 2: The specific type for **invasive** lesions may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Cutaneous Melanoma Histology Coding Rules – Text
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

Rule H10 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Single Melanoma or Multiple Melanomas Abstracted as a Single Primary. Code the histology according to the rule that fits the case.

Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Equivalent or Equal Terms

- And, with (used in histology rules, i.e. duct and lobular is equivalent to duct with lobular)
- Duct, ductal
- Mammary, breast
- Mucinous, colloid
- NOS, NST
- Tumor, mass, lesion, neoplasm

Synonyms for "in situ"

- Behavior code '2'
- DCIS
- Intracystic
- Intraductal
- Noninfiltrating
- Noninvasive

Definitions

Carcinoma with osteoclast-like giant cells (8035): This is a specific type of **duct** carcinoma. The carcinomatous part of the lesion is most commonly an infiltrating duct carcinoma.

Ductular carcinoma (8521): A malignancy that is infrequently found in the breast and may be found with greater frequency in other organs such as pancreas or prostate. Code 8521 is seldom, if ever, applied to the breast. Although the ICD-O-3 suggests that 8521 is a site-associated code; the addition of (C50._) after this code may be misleading. The WHO Histological Classification of Tumours of the Breast does not list 8521, ductular carcinoma.

Duct carcinoma, NOS (8500): The largest group of breast cancers. Duct carcinoma, NOS is not a specific histologic type because it lacks specific features that can be used to better classify the tumor. See Table 1 and Table 2 for intraductal and duct types.

Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Inflammatory breast carcinoma (IBC): A breast cancer with a distinctive clinical presentation believed to be due to lymphatic obstruction from an underlying invasive adenocarcinoma. The vast majority of cases have a prominent dermal lymphatic infiltration by tumor. Dermal lymphatic infiltration without the characteristic clinical picture is insufficient to qualify as inflammatory carcinoma.

Intracystic carcinoma/Intracystic papillary carcinoma: Variant of intraductal carcinoma used to describe encysted forms of papillary carcinoma. Code intracystic carcinoma as in situ /2 unless the histology is described as invasive intracystic carcinoma.

In Situ: A tumor that is confined to the duct system (ductular or lobular) and does not invade surrounding stroma.

Invasive: A tumor that penetrates beyond the ductal basement membrane into the adjacent stroma of the breast parenchyma.

Lobular Carcinoma: Lobular carcinoma includes solid and alveolar patterns. About 5 to 10% of breast cancers are lobular. There is about a 20% chance that the opposite breast will also be involved, and many of them arise multicentrically in the same breast.

Paget Disease: Paget disease of the nipple is a condition where the epidermis of the nipple is infiltrated with neoplastic cells. ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3). Under the matrix system, only if the Paget disease is explicitly specified as in situ or non-invasive by the pathologist, code the behavior in situ (/2).

Phyllodes tumor (cystosarcoma phyllodes): A rare tumor with incidence ranging from 0.3% to 0.9% of all breast cancers. These tumors have a natural history and clinical behavior different from carcinoma of the breast. Criteria to classify benign, borderline and malignant cystosarcoma phyllodes utilize histologic parameters such as cellular atypia, mitotic activity and tumor margins. The reported incidence of malignant cystosarcoma phyllodes is approximately 25% of all phyllodes tumors.

Pleomorphic carcinoma (8022): This is a specific **duct** carcinoma type; A rare variant of high grade ductal carcinoma, NOS.

Sarcoma of breast: Primary sarcomas of the breast are rare accounting for less than 0.1% of all malignant tumors of the breast. Diagnoses may include fibrosarcoma, angiosarcoma, pleomorphic sarcoma, leiomyosarcoma, myxofibrosarcoma, hemangio-pericytoma, and osteosarcoma (extra-osseous osteosarcoma of breast).

Scirrhous Carcinoma: An adenocarcinoma with a firm-hard nodule associated with a dense connective tissue in the stroma. Scirrhous carcinoma is descriptive term, not a specific type of ductal carcinoma.

Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Table 1 – Intraductal(8500/2) and Specific Intraductal Carcinomas

Note: These are the most common specific intraductal carcinomas. This is not intended to be a complete list of all possible intraductal types. If a histology appears only on table 1, it does not mean that it is impossible for that histology to occur with a malignant behavior (/3).

Column 1: Code	Column 2: Type
8201	Cribriform
8230	Solid
8401	Apocrine
8500	Intraductal, NOS
8501	Comedo
8503	Papillary
8504	Intracystic carcinoma
8507	Micropapillary/Clinging

Table 2 – Duct (8500/3) and Specific Duct Carcinomas

Note: These are the most common specific duct carcinomas. This is not intended to be a complete list of all possible duct types. If a histology appears only on table 2, it does not mean that it is impossible for that histology to occur with an in situ behavior (/2).

Column 1: Code	Column 2: Type
8022	Pleomorphic carcinoma
8035	Carcinoma with osteoclast-like giant cells
8500	Duct, NOS
8501	Comedocarcinoma
8502	Secretory carcinoma of breast
8503	Intraductal papillary adenocarcinoma with invasion
8508	Cystic hypersecratory carcinoma

Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Table 3 – Combination Codes for Breast Cancers

Use this **two-page** table with rules H5, H6, H7, H8, H16, H17, H18, H19, H24, H25, H26 and H28 to select combination histology codes. Compare the terms in the diagnosis to the terms in Columns 1 and 2. If the terms match, code the case using the ICD-O-3 histology code in column 4. Use the combination codes listed in this table only when the histologies in the tumor match the histologies listed below.

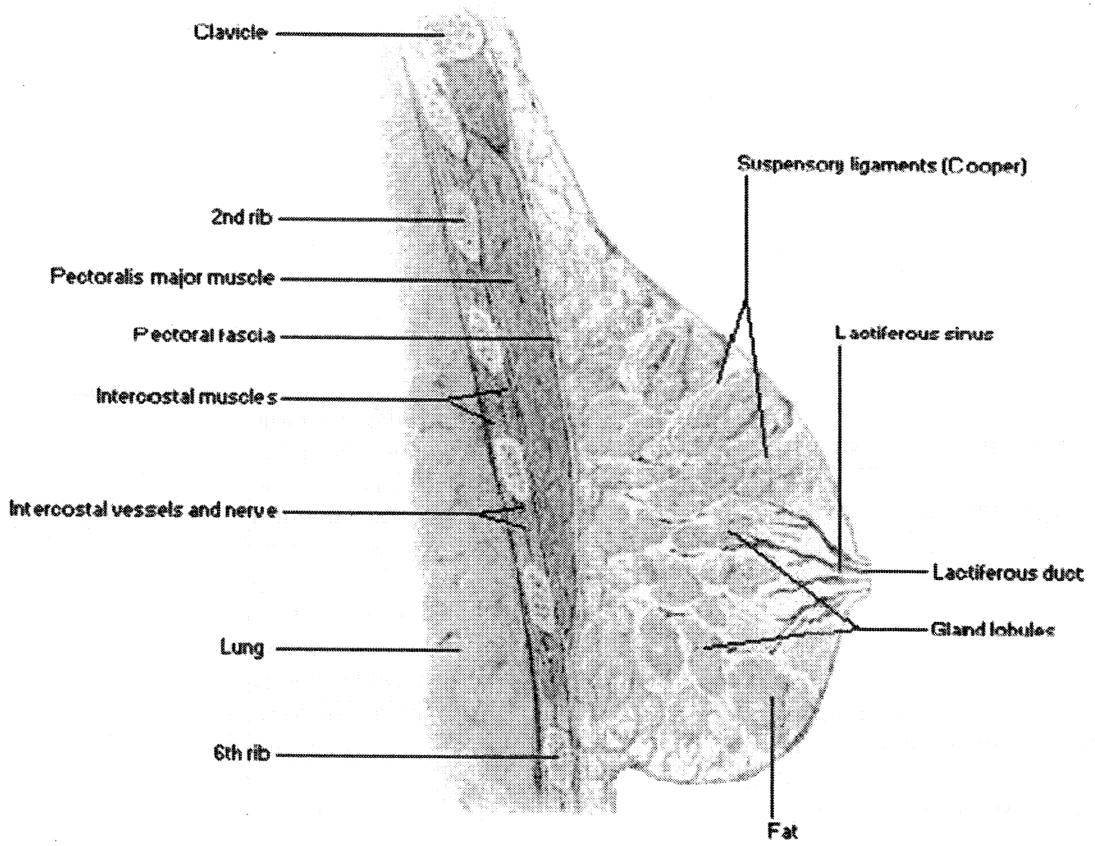
Column 1: Required Histology	**Column 2: Combined with Histology**	**Column 3: Combination Term**	**Column 4: Code**
Any combination excluding lobular and duct histologies from Tables 1 and 2	Other than ductal and lobular	Adenocarcinoma with mixed subtypes*	8255/3*
Intraductal carcinoma and	Lobular carcinoma in situ	Intraductal carcinoma and lobular carcinoma in situ	8522/2
Infiltrating duct and	Infiltrating lobular carcinoma	Infiltrating duct and lobular carcinoma	8522/3
Intraductal and **one or more** of the histologies in Column 2	Cribriform	Intraductal mixed with other types of carcinoma	8523/2
	Solid		
	Apocrine		
	Papillary		
	Micropapillary		
	Clinging		
Infiltrating duct and **one or more** of the histologies in Column 2	Tubular	Infiltrating duct mixed with other types of carcinoma	8523/3
	Apocrine		
	Mucinous		
	Secretory carcinoma		
	Intraductal papillary adenocarcinoma with invasion		
	Intracystic carcinoma, NOS		
	Medullary		

Table 3 continues on the next page

Column 1: Required Histology	**Column 2: Combined with Histology**	**Column 3: Combination Term**	**Column 4: Code**
Table 3 continued			
Infiltrating lobular carcinoma and	Tubular	Infiltrating lobular mixed with other types of carcinoma ***Note:*** Invasive carcinomas only. Do not use this code for in situ	8524/3
	Apocrine		
	Mucinous		
	Secretory carcinoma		
	Intraductal papillary adenocarcinoma with invasion		
	Intracystic carcinoma, NOS		
	Medullary		
	Paget disease (NOS and invasive)		
Paget disease and	Infiltrating duct carcinoma (includes any specific duct type listed in Table 2	Paget disease and infiltrating duct carcinoma	8541/3
Paget disease and	Intraductal carcinoma (includes any specific intraductal type in Table 1)	Paget disease and intraductal carcinoma	8543/3

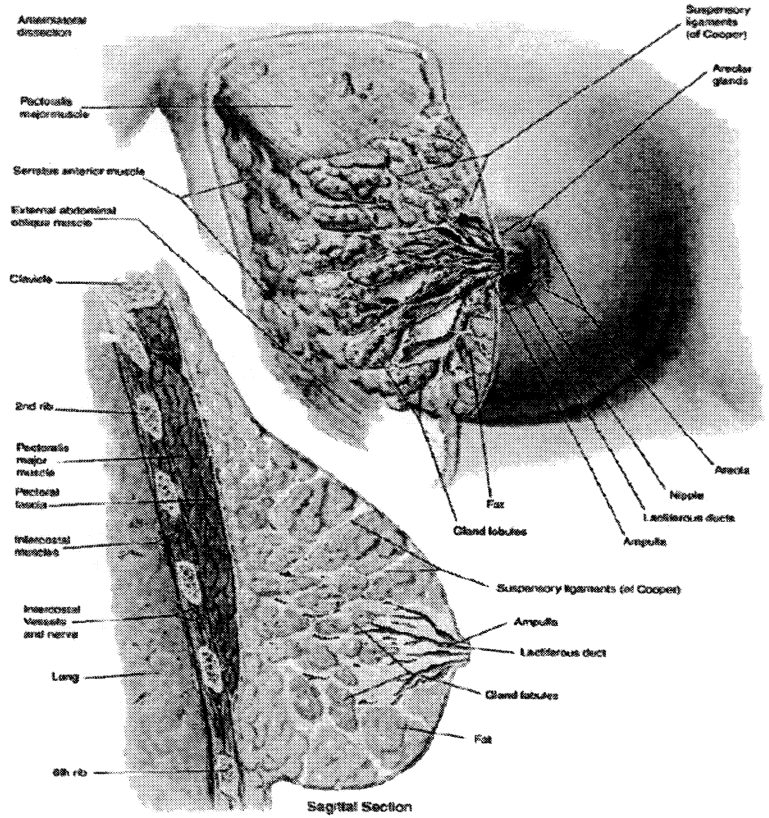
**Rarely used for breast cancer*

Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Mammary Gland



Atlas of Human Anatomy -- Frank H. Netter

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Breast Multiple Primary Rules- Text
C500-C509
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** tumor **or multiple** tumors, opt for a single tumor and abstract as a single primary. *
Note: Use this rule only after all information sources have been exhausted.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Tumors.

SINGLE TUMOR

Note 1: Tumor not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 **Inflammatory carcinoma** in one or both breasts is a single primary. *

Rule M3 A **single tumor** is always a single primary. *
Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Single Tumor.

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.
Note 1: Tumors not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M4 Tumors in sites with ICD-O-3 **topography** codes (Cxxx) with **different** second (C**x**xx) and/or third characters (Cx**x**x) are multiple primaries. **

Rule M5 Tumors diagnosed **more than five (5) years** apart are multiple primaries. **

Breast Multiple Primary Rules- Text
C500-C509
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Rule M6 **Inflammatory carcinoma** in one or both breasts is a single primary. *

Rule M7 Tumors on both sides (**right and left breast**) are multiple primaries. **
Note: Lobular carcinoma in both breasts ("mirror image") is a multiple primary.

Rule M8 An **invasive** tumor **following** an **in situ** tumor more than 60 days after diagnosis is a multiple primary. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M9 Tumors that are intraductal or **duct and Paget Disease** are a single primary. *
Note: Use Table 1 and Table 2 to identify intraductal and duct carcinomas

Rule M10 Tumors that are **lobular** (8520) **and** intraductal or **duct** are a single primary. *
Note: Use Table 1 and Table 2 to identify intraductal and duct carcinomas

Rule M11 **Multiple intraductal and/or duct carcinomas** are a single primary. *
Note: Use Table 1 and Table 2 to identify intraductal and duct carcinomas

Rule M12 Tumors with ICD-O-3 **histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M13 Tumors that **do not meet any** of the above **criteria** are abstracted as a single primary. *
Note 1: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.
Note 2: All cases covered by Rule M13 have the same first 3 numbers in ICD-O-3 histology code.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
**** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**
This is the end of instructions for Multiple Tumors.

Rule M13 Examples: The following are examples of cases that use Rule M13. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. ***Warning: Using only these case examples to determine the number of primaries can result in major errors.***

Example 1: Invasive duct and intraductal carcinoma in the same breast	**Example 2:** Multi-centric lobular carcinoma, left breast

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR: IN SITU CARCINOMA ONLY

(Single Tumor; all parts are in situ)

Rule H1 Code the histology documented by the physician when the **pathology/cytology** report is **not available**.
Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record

Note 2: Code the specific histology when documented.

Rule H2 Code the histology when only **one histologic type** is identified

Rule H3 **Code the** more **specific** histologic **term when** the diagnosis is:
- Carcinoma in situ, NOS (8010) and a specific carcinoma in situ or
- Adenocarcinoma in situ, NOS (8140) and a specific adenocarcinoma in situ or
- Intraductal carcinoma, NOS (8500) and a specific intraductal carcinoma (Table 1)

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, with ___ differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.

Rule H4 Code **8501/2** (comedocarcinoma, non-infiltrating) when there is **non-infiltrating comedocarcinoma and any** other **intraductal** carcinoma (Table 1).
Example: Pathology report reads intraductal carcinoma with comedo and solid features. Code 8501/2 (comedocarcinoma).

Rule H5 Code **8522/2** (intraductal carcinoma and lobular carcinoma in situ) when there is a combination of **in situ lobular** (8520) **and intraductal** carcinoma (Table 1).

Rule H6 Code **8523/2** (intraductal carcinoma mixed with other types of in situ carcinoma) when there is a combination of intraductal carcinoma and one or more specific intraductal types OR there are **two or more specific intraductal** carcinomas.
Note 1: Use Table 1 to identify the histologies.
Note2: Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

Rule H7 Code **8524/2** (in situ lobular mixed with other types of in situ carcinoma) when there is **in situ lobular** (8520) **and any in situ** carcinoma **other than intraductal** carcinoma (Table 1).
Note: Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H8 Code **8255/2** (adenocarcinoma in situ with mixed subtypes) when there is a **combination** of in situ/non-invasive histologies that **does not include** either **intraductal** carcinoma (Table 1) **or in situ lobular** (8520).
Note: Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

This is the end of instructions for a Single Tumor: In Situ Carcinoma Only.
Code the histology according to the rule that fits the case.

SINGLE TUMOR: INVASIVE AND IN SITU CARCINOMA
(Single Tumor; in situ and invasive components)

Rule H9 **Code the invasive histology** when both invasive and in situ components are present.
Note 1: Ignore the in situ terms.
Note 2: This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive duct and in situ lobular are coded to invasive duct (8500/3) rather than the combination code for duct and lobular carcinoma (8522/3).

This is the end of instructions for a Single Tumor: Invasive and In Situ Carcinoma.
Code the histology according to the rule that fits the case.

SINGLE TUMOR: INVASIVE CARCINOMA ONLY
(Single Tumor; all parts are invasive)

Rule H10 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- Mammogram
- PET scan
- Ultrasound

Note 2: Code the specific histology when documented.
Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H11 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site.**
Note: Code the behavior /3.

Rule H12 **Code the** most **specific** histologic **term when** the diagnosis is:
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Duct carcinoma, NOS (8500) and a more specific duct carcinoma (8022, 8035, 8501-8508) or
- Sarcoma, NOS (8800) and a more specific sarcoma

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, with ___ differentiation. The terms architecture and pattern are subtypes only for in situ cancer.

Rule H13 Code **8530** (inflammatory carcinoma) only when the final diagnosis of the **pathology** report specifically **states inflammatory carcinoma**.
Note: Record dermal lymphatic invasion in Collaborative Staging

Rule H14 Code the histology when only **one histologic type** is identified.

Rule H15 Code the histology with the numerically **higher ICD-O-3 code** when there are **two or more** specific **duct** carcinomas.
Note: Use Table 2 to identify duct carcinomas

Rule H16 Code **8522** (duct and lobular) when there is a combination of **lobular** (8520) **and duct** carcinoma.
Note: Use Table 2 to identify duct carcinomas

Rule H17 Code **8523** (duct mixed with other types of carcinoma) when there is a combination of **duct and** any **other** carcinoma.
Note 1: Use Table 2 to identify duct carcinomas
Note 2: Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.

Rule H18 Code **8524** (lobular mixed with other types of carcinoma) when the tumor is **lobular** (8520) **and** any **other carcinoma**.
Note: Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.

Rule H19 Code **8255** (adenocarcinoma with mixed subtypes) for multiple **histologies** that **do not include duct or lobular** (8520).
Note: Use Table 2 to identify duct carcinomas

This is the end of instructions for a Single Tumor: Invasive Carcinoma Only.
Code the histology according to the rule that fits the case.

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H20 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- Mammogram
- PET scan
- Ultrasound

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H21 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H22 Code **8530** (inflammatory carcinoma) only when the final diagnosis of the **pathology** report specifically **states inflammatory carcinoma.**

Note: Record dermal lymphatic invasion in Collaborative Staging

Rule H23 Code the histology when only **one histologic type** is identified.

Rule H24 Code **8543/2** (in situ Paget disease and intraductal carcinoma) when the **pathology** report **specifically states** that the **Paget disease** is **in situ and** the **underlying tumor** is **intraductal** carcinoma (Table 1).

Note: Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

Rule H25 Code **8543/3** (Paget disease and intraductal carcinoma) for **Paget disease and intraductal** carcinoma

Note 1: ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3).

Note 2: Includes both invasive Paget disease and Paget disease with behavior not stated.

Note 3: Use Table 1 to identify intraductal carcinomas

Rule H26 Code **8541/3** (Paget disease and infiltrating duct carcinoma) for **Paget disease and** invasive **duct** carcinoma.

Note 1: ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3).

Note 2: Includes both invasive Paget disease and Paget disease with behavior not stated.

Note 3: Use Table 2 to identify duct carcinomas

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H27 Code the invasive histology when **both invasive and in situ** tumors are present.
Note 1: Ignore the in situ terms.
Note 2: This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive lobular and in situ duct carcinoma are coded to invasive lobular (8520/3) rather than the combination code for duct and lobular carcinoma (8522/3).

Rule H28 Code **8522** (duct and lobular) when there is any combination of **lobular** (8520) **and duct** carcinoma.
Note: Use Table 2 to identify duct carcinomas

Rule H29 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.

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Kidney Equivalent Terms, Definitions, Tables and Illustrations
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

INTRODUCTION

Renal cell carcinoma (8312) is a group term for glandular (adeno) carcinomas of the kidney. Approximately 85% of all malignancies of the kidney are renal cell and specific renal cell types.

Transitional cell carcinoma rarely arises in the kidney parenchyma (C649). Transitional cell carcinoma found in the upper urinary system usually arises in the renal pelvis (C659). Only code transitional cell carcinoma to kidney in the rare instance when pathology confirms the tumor originated in the parenchyma of the kidney.

Equivalent or Equal Terms

- **Multifocal** and **multicentric**
- **Renal cell carcinoma (RCC)** and **hypernephroma (obsolete term)**
- **Tumor, mass, lesion,** and **neoplasm**

Definitions

Adenocarcinoma with mixed subtypes (8255): A mixture of two or more of the specific renal cell carcinoma types listed in Table 1.

Carcinoma of the collecting ducts of Bellini/collecting duct carcinoma (8319) is a malignant epithelial tumor. There is controversy about the relationship between medullary carcinoma and collecting duct carcinoma; some advocate that there is a relationship, others are not convinced. Genetic studies are ongoing. We will code medullary carcinoma originating in the kidney to 8510 so we can differentiate between the medullary and the collecting duct carcinoma.

Chromophobe RCC (8317) is a rare form of kidney cancer. Chromophobe is a renal carcinoma characterized by large pale cells with prominent membranes.

Clear cell RCC (8310) is the most common type of RCC. Clear cell is composed of clear or eosinophilic cytoplasm. Clear cell is architecturally diverse, with solid alveolar and acinar patterns the most common.

Kidney Equivalent Terms, Definitions, Tables and Illustrations
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

Cystic: Cystic may be used to describe the gross appearance or it may be used as a morphologic term. Cysts are common in clear cell renal cell carcinomas. Tumors composed completely of cysts are rare.

Medullary carcinoma of the kidney (8510) is a rare tumor almost exclusively associated with sickle cell trait. There is controversy about the relationship between medullary carcinoma and collecting duct carcinoma; some advocate that there is a relationship, others are not convinced. Genetic studies are ongoing. We will code medullary carcinoma originating in the kidney to 8510 so we can differentiate between the medullary and the collecting duct carcinoma.

Most invasive: The tumor with the greatest continuous extension (see focal and foci/focus definitions).
In hierarchical order, the evaluation of least to greatest extension for **kidney** is based on:

- The largest tumor size
- Extension into major veins, adrenal gland, or perinephric tissue.
- Involvement of Gerota's fascia.

Papillary RCC (8260) form finger-like projections. Some doctors call these cancers chromophilic because the cells take up certain dyes making them appear pink. A malignant renal parenchymal tumor with papillary or tubular papillary architecture.

Renal cell carcinoma (RCC) (8312) is the most common type of kidney cancer. Renal cell is a group name that includes several specific types. See Table 1.

Renal sarcoma is a rare disease of the kidney's connective tissues.

Satellite lesion or metastasis: Metastatic lesion within the immediate vicinity of the primary tumor. This is a metastasis, not a separate primary.

Urinary tract: Structures lined by transitional epithelium also known as urothelium

Wilms Tumor/nephroblastoma, NOS (8960) can arise anywhere in the kidney tissue. Wilms tumor typically appears in children between 2-5 years of age.

Table 1 - Renal cell carcinoma and specific renal cell types

Table Instructions: Use this table to identify specific renal cell carcinoma types.
Note: Renal cell carcinoma, NOS (8312) is the non-specific term under which the specific renal cell carcinoma types are listed. This table **is a complete listing** of specific renal cell carcinoma types.

Column 1: Code	**Column 2: Specific Renal Cell Carcinoma Types**
8260	Papillary (Chromophil) *
8310	Clear Cell
8316	Cyst associated, cystic
8317	Chromophobe *
8318	Sarcomatoid (Spindle cell)
8319	Collecting duct type (Bellini duct)
8320	Granular cell
8510	Medullary carcinoma, NOS; medullary adenocarcinoma
8959	Malignant cystic nephroma; malignant multilocular cystic nephroma
* ***Note:*** Chromophil and chromophobe are different histologies	

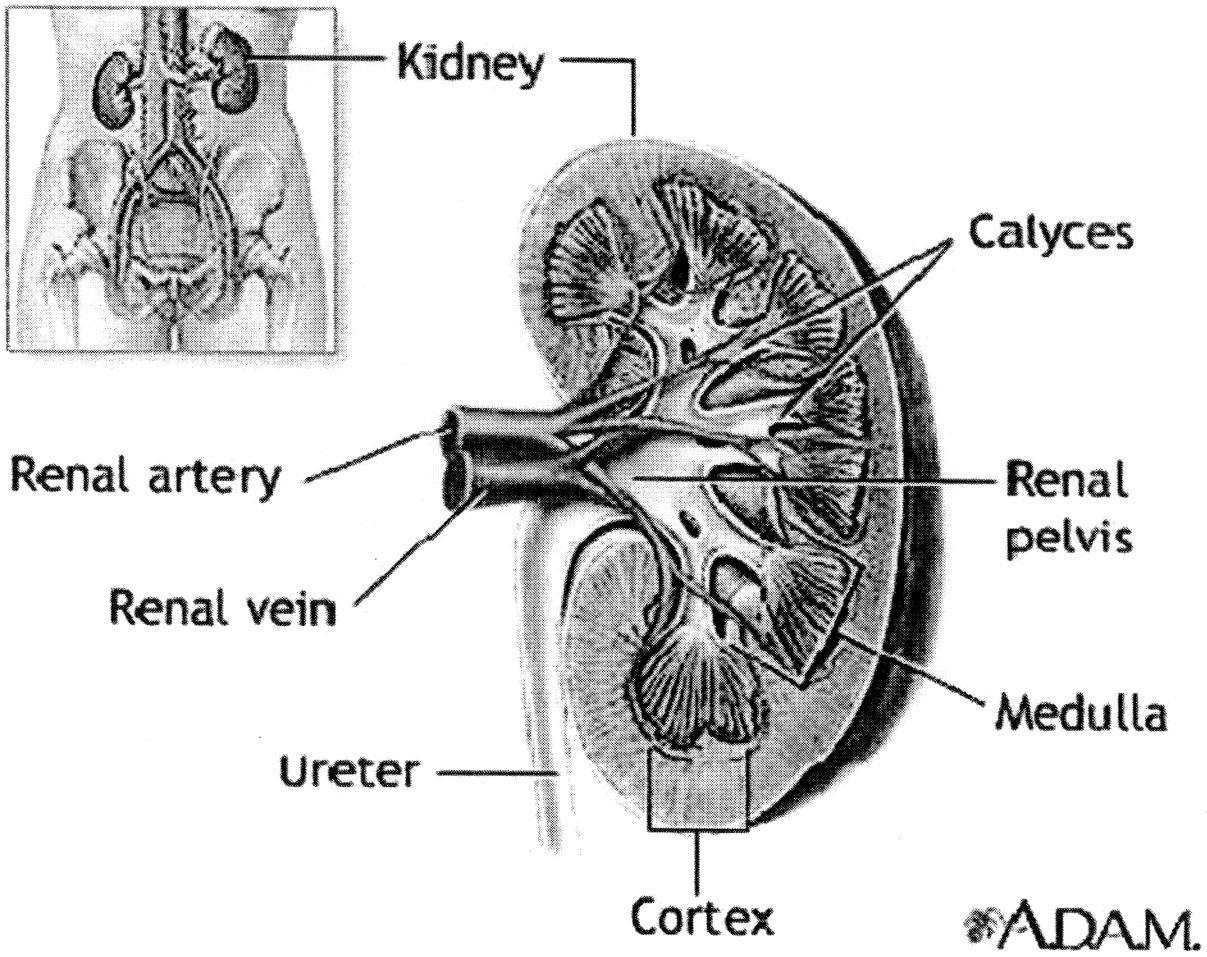
Kidney Equivalent Terms, Definitions, Tables and Illustrations
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

Table 2 – Changes to Previous SEER Site Grouping Table

Previous to 2007, tumors in the sites below were abstracted as a single primary.

Code	Site Grouping
C64	Kidney
C65	Renal pelvis
C66	Ureter
C68	Other and unspecified urinary organs

Kidney Equivalent Terms, Definitions, Tables and Illustrations
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)



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Kidney Multiple Primary Rules - Text
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** tumor **or multiple tumors**, opt for a single tumor and abstract as a single primary.*
Note: Use this rule only after all information sources have been exhausted.

***Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Tumors

SINGLE TUMOR

Note 1: Tumor not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 A **single tumor** is always a single primary. *
Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for single tumors.

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.
Note 1: Tumors not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M3 **Wilms tumors** are a single primary. *

Rule M4 Tumors in sites with **ICD-O-3 topography** codes that are **different** at the second (C**x**xx) and/or third characters (Cx**x**x) are multiple primaries **

Rule M5 Tumors in **both** the **right kidney and** in the **left kidney** are multiple primaries. **
Note: Abstract as a single primary when the tumors in one kidney are documented to be metastatic from the other kidney.

Kidney Multiple Primary Rules - Text
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

Rule M6 Tumors diagnosed more than **three (3) years apart** are multiple primaries. **

Rule M7 An **invasive** tumor **following** an **in situ** tumor more than 60 days after diagnosis are multiple primaries. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M8 **One** tumor with a specific **renal** cell **type and** another tumor with a **different** specific renal cell **type** are multiple primaries (Table 1). **

Rule M9 Abstract as a single primary * when one tumor is

- **Cancer/malignant neoplasm, NOS** (8000) **and** another is a **specific histology** or
- **Carcinoma, NOS** (8010) **and** the other is a **specific carcinoma** or
- **Adenocarcinoma, NOS (8140) and another is a specific adenocarcinoma or**
- **Renal cell carcinoma, NOS** (8312) and the other is a **single renal cell type** (Table 1)

Note 1: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation
Note 2: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule M10 Tumors with **ICD-O-3 histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M11 Tumors that **do not meet any** of the above **criteria** are a single primary.*
Note: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
**** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**
This is the end of instructions for Multiple Tumors.

Rule M11 Examples: The following are examples of cases that use Rule M11. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. ***Warning: Using only these case examples to determine the number of primaries can result in major errors.***

Example 1: Multiple tumors in one kidney with same histology	**Example 2**: An in situ and invasive tumor diagnosed within 60 days

Kidney Histology Coding Rules – Text
C649
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

Rule H1 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the pathology/cytology report is not available.

Note 1: Priority for using documents to code the histology

- Documentation medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS), or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H2 Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H3 Code the **histology** when only one histologic type is identified.

Rule H4 Code the **invasive** histologic type when there are invasive and in situ components.

Rule H5 Code the **specific type** when the diagnosis is

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and one specific adenocarcinoma type or
- Renal cell carcinoma, NOS (8312) and one specific renal cell type

Note 1: Use Table 1 to identify specific renal cell types.

Note 2: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 3: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H6 Code 8255 (adenocarcinoma with mixed subtypes) when there are **two or more specific** renal cell carcinoma types.

Note: Use Table 1 to identify specific renal cell types.

Example: Renal cell carcinoma, papillary and clear cell types. Assign code 8255.

Kidney Histology Coding Rules – Text
C649
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule H7 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H8 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the pathology/cytology report is not available.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS), or 8010 (carcinoma, NOS) as stated by the physician when no specific histology is documented.

Rule H9 Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H10 Code the histology when only **one histologic type** is identified.

Rule H11 Code the histology of the **most invasive** tumor.

Note 1: This rule should only be used when the first three digits of the histology codes are identical (This is a single primary).

Note 2: See the Kidney Equivalent Terms, Definitions, Tables and Illustrations for the definition of most invasive.

- If one tumor is in situ and one is invasive, code the histology from the invasive tumor.
- If both/all histologies are invasive, code the histology of the most invasive tumor.

Kidney Histology Coding Rules – Text
C649
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule H12 Code the **specific type** when the diagnosis is

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and one specific adenocarcinoma type or
- Renal cell carcinoma, NOS (8312) and one specific renal cell type

Note 1: Use Table 1 to identify specific renal cell types.
Note 2: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation
Note 3: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H13 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.

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Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Renal Pelvis, Ureter, Bladder, and Other Urinary

The renal pelvis, ureters, bladder and proximal portion of the urethra are lined by transitional epithelium, also known as urothelium. Tumors of the urothelium are more often multifocal compared to other sites. Two mechanisms have been proposed to explain this phenomenon: 1). a "field effect" and 2) tumor cell implantation.

1. The **field effect** theory suggests that the urothelium has undergone a widespread change, perhaps in response to a carcinogen, making it more sensitive to malignant transformations. As a result, multiple tumors arise more easily.
2. The **implantation** theory suggests that tumor cells in one location lose their attachments and float in the urine until they attach (implant) on another site. Transitional cell tumors commonly spread in a head-to-toe direction, for example from the renal pelvis to the ureter.

Molecular evidence has been found to support both of these theories, but neither has been proven to be the case for all tumors. Similarly, the widespread presence of flat carcinoma in situ may be a result of direct spread of neoplastic cells within the epithelium, direct extension, or due to implantation or field effect. The rules regarding histology and number of primaries are an attempt to reconcile these observations so that incidence data are consistent and reproducible.

Bladder

In the United States, transitional cell carcinomas account for more than 90% of all bladder cancers. Squamous cell carcinomas make up 3-8%, and adenocarcinomas make up about 1-2%. Pure squamous cell carcinoma of the bladder has a poor prognosis. See histology coding rules H5 and H13 for coding instructions.

Equivalent or Equal Terms

- **Flat transitional cell, flat urothelial, in situ transitional cell,** and **in situ urothelial**
- **Tumor, mass, lesion, neoplasm**
- **Urothelial** and **transitional**
- **Urothelium** and **transitional epithelium**
- **Intramucosal** and **in situ**

Definitions

Contiguous Sites:

- Renal pelvis
- Ureter
- Bladder
- Urethra/prostatic urethra

Field effect: Widespread changes in normal or relatively normal tissue that predispose a person to cancer

Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations
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Flat Tumor (bladder)/Noninvasive flat TCC: A flat tumor is a non-papillary bladder tumor that lies flat against the bladder tissue. Flat tumors usually have a poor prognosis. Noninvasive flat TCC (also called carcinoma in situ, or CIS) grows in the layer of cells closest to the inside of the bladder and appears as flat lesions on the inside surface of the bladder. Flat, invasive TCC may invade the deeper layers of the bladder, particularly the muscle layer.

In situ: A tumor confined to epithelium (intraepithelial) with no penetration below the basement membrane

Intraluminal (Ureter): Within the lumen of a tubular or hollow structure. Urinary tumors may spread intraluminally to adjacent urinary organs.

Intramucosal: Within the mucosal surface.

Invasive: A tumor that penetrates beyond the basement membrane.

Most invasive: The tumor with the greatest continuous local/regional extension (see focal and foci/focus definitions).

Bladder

The walls of the **bladder** in order from least to greatest extension are:

- Mucosa
- Lamina propria (some pathologists equate this to submucosa)
- Muscularis mucosae (this layer not always present, may not be mentioned)
- Submucosa
- Muscular layer (muscularis propria, detrusor muscle)
- Serosa, adventitia

Renal pelvis and ureter

The walls of the **renal pelvis** and **ureter** from least to greatest extension are:

- Epithelium
- Subepithelial connective tissue, submucosa
- Periureteric fat, peripelvic fat.

Multicentric, multifocal, and polycentric are often used as synonyms. The tumor has multiple centers. The foci are not contiguous.

Non-invasive tumor: A tumor confined to epithelium (intraepithelial) with no penetration below the basement membrane.