Colon, Rectosigmoid, and Rectum Equivalent Terms and Definitions
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Introduction

Note 1: New terms and codes in these rules are based on the ***WHO Classification of Tumors of the Digestive System*** 2010 edition.

Note 2: Ninety-eight percent of colon cancers are **adenocarcinoma** and adenocarcinoma **subtypes.**

Note 3: **Mixed histologies and specific variants or subtypes of adenocarcinoma** other than mucinous/colloid or signet ring cell are **rare**. A less common combination is **mixed adenoneuroendocrine carcinoma** (**MANEC**) **8244** (previously called adenocarcinoma and carcinoid). The new terminology was originally proposed for tumors arising from goblet cell carcinoid but with more aggressive adenocarcinoma histology. It was also proposed because **carcinoids** are a subgroup of **neuroendocrine carcinoma**. Pathologists **may still diagnose** adenocarcinoma and carcinoid, adenocarcinoid, or adenocarcinoma and a specific neuroendocrine tumor or adenocarcinoma arising from/with a NET (including specific types of **NET-like goblet cell** carcinoid). Over time, the histologic diagnoses will change to MANEC.

Note 4: **De novo (previously called frank) adenocarcinoma** arises in the mucosa of the bowel, not in a polyp.

Note 5: **Terms Seen More Frequently: NET, NEC, GIST**

- **NET** (neuroendocrine tumor): The term NET is gradually replacing **carcinoid;** however, some pathologists still use the term carcinoid
- **NEC** (neuroendocrine carcinoma): The term NEC includes **small cell neuroendocrine** carcinoma, **large cell neuroendocrine** carcinoma, and **poorly differentiated neuroendocrine** carcinoma
- **GIST** (gastrointestinal stromal tumor):
  - GISTs were originally thought to be smooth muscle tumors but are now thought to originate from the interstitial cells of Cajal, neuro-regulatory cells in the GI tract. Prior to the implementation of an ICD-O-3 histology code for GISTs in **2001**, they were reported as a GI sarcoma, usually **leiomyosarcoma**
  - GISTs are more common in the stomach (60%) and small intestine (30%), but 1-2% occur in the colon and 3% in the rectum
  - About a quarter of gastric GISTs are **malignant**
  - It is often difficult for the pathologist to determine the **behavior** of a GIST
  - GIST NOS becomes a reportable neoplasm beginning with cases diagnosed 1/1/2021 forward

Note 6: Tables and rules refer to **ICD-O rather than ICD-O-3**. The version is not specified to allow for updates. Use the currently approved version of ICD-O.

Note 7: 2007 MPH Rules and 2018 Solid Tumor Rules are used based on **date of diagnosis**.

- Tumors diagnosed 01/01/2007 through 12/31/2017: Use 2007 MPH Rules

- Tumors diagnosed 01/01/2018 and later: Use 2018 Solid Tumor Rules
- The original tumor diagnosed before 1/1/2018 and a subsequent tumor diagnosed 1/1/2018 or later **in the same primary site**: Use the 2018 Solid Tumor Rules.

Note 8: For those sites/histologies which have recognized **biomarkers**, the biomarkers are most frequently used to target treatment. Currently, there are clinical trials being conducted to determine whether these biomarkers can be used to identify multiple primaries and/or histologic type. Follow the Multiple Primary Rules; do not code multiple primaries based on biomarkers.

Changes from 2007 MPH Rules

These changes are effective with cases diagnosed 1/1/2018 and later.

1. 2007 Rules instruct "Code the histology from the most representative specimen." For all sites except breast and CNS, 2018 Rules instruct "Code the most specific histology from biopsy or resection. When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor)."
2. **Rectum** and **Rectosigmoid** are now included with the Colon Rules. In the 2007 MPH Rules, they were included with Other Sites.
3. There are new multiple primary rules which address **anastomotic recurrence.**
4. Neuroendocrine tumors (formerly carcinoid) arising in the appendix are reportable for cases diagnosed 1/1/2015 and forward.
5. **Rule clarification: Pseudomyxoma peritonei** (accumulation of mucin-secreting tumor cells in the abdominal or pelvic cavity) now has a **two-tiered system** (WHO 2010) that classifies pseudomyxoma peritonei as either **high-grade** or **low-grade** (see below)**.** Pseudomyxoma peritonei is usually associated with **mucinous** tumors of the appendix and is rarely associated with ovarian mucinous tumors.
    - **High-**grade pseudomyxoma peritonei is **malignant** /3
    - **Low**-grade pseudomyxoma peritonei is **not malignant** /1
    - See **Histology Rules** for **coding instructions**

6. There are **dysplasias** which have been assigned an **in situ behavior** code /2 in **WHO** and in **the ICD-O Update**. Despite becoming a /2, they are **not reportable in the US**. They are reportable in Canada.
    - Dysplasia **was not** collected in the past. If dysplasia is added to the database with the same code as in situ tumors, there will be a **huge upsurge** in the **incidence** of in situ neoplasms. The various agencies are looking for solutions to this issue.
    - There would be no way to **separate** the dysplasias from the in-situ neoplasms in the database, which would cause problems with surveillance (long-term studies) since the prognosis and probabilities of disease progression are different between an in-situ tumor and a dysplasia
    - **Pathologists frequently use the term "severe dysplasia" or "high grade dysplasia" in place of carcinoma in situ. Code CIS only** if the pathologist expressly states "CIS"
7. **Polyps** are now **disregarded** when coding histology. For example, adenocarcinoma in an adenomatous polyp is coded as adenocarcinoma 8140. For the purposes of determining multiple primaries, tumors coded as adenocarcinoma in a polyp for pre-2018 cases should be treated as adenocarcinoma 8140.

New codes/terms are identified by asterisks (*) in the histology table in the Terms and Definitions.

New for 2022

1. Timing changes to rules M7 and M8: The timing for subsequent tumors at the anastomosis has changed from 24 months to 36 months. The change is effective for cases diagnosed beginning 1/1/2022 forward. For cases diagnosed 1/1/2018 through 12/31/2021, the timing rule remains at 24 months.
2. Low grade appendiceal neoplasm (LAMN) will become reportable effective for cases diagnosed 1/1/2022 forward. LAMN may be either in situ 8480/2 or malignant 8480/3 based on physician statement of behavior. LAMN diagnosed prior to 1/1/2022 are not reportable.

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Equivalent or Equal Terms

These terms can be used interchangeably:

- And; with
  Note: "And" and "with" are used as synonyms when **describing multiple histologies** within a **single tumor**.
- Carcinoid; NET; neuroendocrine tumor
- Carcinoma; adenocarcinoma;
  - A histology type must be stated for these terms to be equal
  - **Example**: Mucinous carcinoma and mucinous adenocarcinoma are both coded 8480
- De novo; frank adenocarcinoma (obsolete)
- Familial polyposis; familial adenomatous polyposis (FAP) **8220**
- Intramucosal; lateral extension within the mucosal layer of the GI tract
- Invasion through colon wall; extension through colon wall; transmural
  Note: The term "**transmural**" is used to describe **extension through all layers** of the wall, but not past the wall **OR extension through the serosa into the mesentery**. **Read** the **pathology** report carefully.
- Mucinous; mucoid; mucous; colloid
- Neuroendocrine carcinoma; NEC
- Polyp; adenoma; polyp NOS; adenomatous polyp
  Note 1**:** The term "**polyp**" means projecting from a surface.
  Note 2**:** There are many kinds of polyps. Most common are **adenomas**, which are part of the adenoma-cancer sequence.
  Note 3**: Other types o**f polyps include hyperplastic, juvenile, Peutz-Jeghers and serrated adenoma/polyp.
- Serosa; visceral peritoneum
- Simultaneous; existing at the same time; concurrent; prior to first course treatment
- Site; topography
- Tumor; mass; tumor mass; lesion; neoplasm
  - The terms tumor, mass, tumor mass, lesion, and neoplasm are **not** used in a standard manner in clinical diagnoses, scans, or consults. **Disregard** the terms unless there is a **physician's statement** that the term is malignant/cancer
  - These terms are used **ONLY** to determine multiple primaries
  - **Do not** use these terms for casefinding or determining reportability
- Type; subtype; variant

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Terms that are NOT Equivalent or Equal

These terms are **not equivalent**. There are no casefinding implications.

- Carcinoma, NOS 8010 is not equivalent to adenocarcinoma, NOS 8140
- **Component** is not equivalent to **subtype/type/variant**
  Note: Component is only coded when the pathologist specifies the component as a second **carcinoma.**
- **Exophytic** and **polypoid** are not equivalent to either an **adenoma** or an **adenomatous polyp**. The terms "exophytic" and "polypoid" refer to anything projecting from the bowel mucosa into the lumen. The lesion may be benign, malignant, or inflammatory.
- **Phenotype** is not equivalent to **subtype/type/variant**
- **Polypoid adenocarcinoma** is not equivalent to **adenocarcinoma in a polyp**

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Table 1: Specific Histologies, NOS, and Subtypes/Variants

Use Table 1 as directed by the **Histology Rules** to assign the more common histology codes for malignancies found in the colon, rectosigmoid and rectum.

Note 1: Rare histologies may not be listed in the table. When a histology term is not found, reference ICD-O and all updates.
Note 2: Submit a question to Ask a SEER Registrar when the histology code is not found in Table 1, ICD-O or all updates.
Note 3: Behavior codes are listed when the term has only one possible behavior (either a /2 or /3). For histologies which may be either /2 or /3, a behavior code is not listed. Code behavior from pathology.

Column 1 contains specific and NOS histology terms.
- **Specific** histology terms **do not** have **subtypes/variants**
- **NOS** histology terms **do** have **subtypes/variants**

Column 2 contains **synonyms** for the specific or NOS term. Synonyms have the **same** histology **code** as the specific or NOS term.
Column 3 contains **subtypes/variants** of the **NOS** histology. Subtypes/variants **do not** have the **same** histology code as the NOS term.

Specific and NOS Term and Code	Synonyms for Specific or NOS Term	Subtypes/Variants
Adenocarcinoma 8140 ***Note 1*: See Histology Rules** for instructions on coding adenocarcinoma **subtypes/variants** arising in a polyp ***Note 2*:** When the term **intestinal adenocarcinoma** is used to describe a colon primary, it simply means the	Adenocarcinoma, NOS Adenocarcinoma/carcinoma in a polyp NOS (now coded to 8140) Adenocarcinoma/carcinoma in adenomatous polyp (now coded to 8140) Adenocarcinoma/carcinoma in polypoid adenoma (now coded to 8140) Adenocarcinoma/carcinoma in serrated adenoma (now coded to 8140) Adenocarcinoma and mucinous carcinoma, mucinous documented as	Adenoid cystic carcinoma **8200** Cribriform comedo-type carcinoma/ adenocarcinoma, cribriform comedo-type **8201*** Diffuse adenocarcinoma/carcinoma **8145** High grade appendiceal mucinous neoplasm (HAMN)/Low grade appendiceal mucinous neoplasm **8480- see Note 3** Linitis plastica **8142/3** Medullary adenocarcinoma/carcinoma **8510** Micropapillary carcinoma **8265*** Mucinous/colloid adenocarcinoma/carcinoma **8480** Mucoepidermoid carcinoma **8430** Serrated adenocarcinoma **8213***

Specific and NOS Term and Code	Synonyms for Specific or NOS Term	Subtypes/Variants
appearance is similar to adenocarcinoma seen in the stomach and is coded to adenocarcinoma NOS **8140** **Note 3:** Effective 1/1/2022, LAMN becomes reportable and is coded 8480/2, unless the pathologist indicates invasive behavior, which is coded 8480/3. HAMN can be either /2 or /3 depending on the pathologist statement of behavior.	less than 50% of tumor OR percentage of mucinous unknown/not documented Adenocarcinoma and signet ring cell carcinoma, percentage of signet ring cell carcinoma documented as less than 50% of tumor OR unknown/not documented Adenocarcinoma/carcinoma in tubular polyp (now coded to 8140) Adenocarcinoma/carcinoma in tubulovillous polyp (now coded to 8140) Adenocarcinoma/carcinoma in villous adenoma (now coded to 8140) Adenocarcinoma in any type of polyp Adenocarcinoma, intestinal type Adenocarcinoma and cribriform carcinoma percentage of cribriform documented as less than 50% of tumor OR unknown/not documented Adenocarcinoma with mucinous and signet ring cell features Comedocarcinoma Intestinal adenocarcinoma	Signet ring cell/poorly cohesive adenocarcinoma/carcinoma **8490** Superficial spreading adenocarcinoma **8143** Tubulopapillary carcinoma **8263** Undifferentiated adenocarcinoma/carcinoma **8020**
Adenosquamous carcinoma 8560 ***Note:*** This code **cannot be used** for **adenocarcinoma subtypes/variants** with squamous cell/epidermoid carcinoma	Mixed adenocarcinoma NOS and epidermoid carcinoma Mixed adenocarcinoma NOS and squamous cell carcinoma	

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Specific and NOS Term and Code	Synonyms for Specific or NOS Term	Subtypes/Variants
Combined small cell carcinoma 8045	Small cell carcinoma mixed with • Adenocarcinoma **OR** • Neuroendocrine carcinoma **OR** • Any other type of carcinoma/adenocarcinoma	
Gastrinoma 8153		
Gastrointestinal stromal tumor 8936/3 ***Note*:** See standard setter reportability guidelines.	Gastrointestinal autonomic nerve tumor GANT Gastrointestinal pacemaker cell tumor Gastrointestinal stromal tumor GIST, NOS GIST, malignant GIST, spindle cell type Gastrointestinal stromal sarcoma Succinate dehydrogenase-deficient gastrointestinal stromal tumor	
Mixed adenoneuroendocrine carcinoma 8244	Adenocarcinoma ex-goblet cell Adenocarcinoma mixed with high-grade large cell neuroendocrine carcinoma Adenocarcinoma mixed with high-grade small cell neuroendocrine carcinoma MANEC Mixed neuroendocrine carcinoma	Goblet cell adenocarcinoma/Goblet cell carcinoid **8243**
Mixed neuroendocrine non-neuroendocrine neoplasm 8154	MiNEN	
Neuroendocrine carcinoma 8246	NEC	Large cell NEC **8013** Small cell NEC **8041**

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Specific and NOS Term and Code	Synonyms for Specific or NOS Term	Subtypes/Variants
Neuroendocrine tumor Grade 1 (G1) 8240 ***Note*: When the diagnosis is exactly "carcinoid"** it may be a Grade 1 or Grade 2 NET. Default is coding NET Grade 1 **8240**.	Carcinoid NOS Low-grade neuroendocrine tumor NET Grade 1 (G1) Well differentiated neuroendocrine tumor	EC cell serotonin-producing NET/enterochromaffin cell carcinoid **8241** Neuroendocrine tumor (NET) Grade 2 (G2) **8249** Somatostatin-producing NET **8156**
Sarcoma NOS 8800/3		Angiosarcoma/hemangiosarcoma **9120/3** Leiomyosarcoma **8890/3**
Spindle cell carcinoma 8032		
Squamous cell carcinoma 8070	Epidermoid carcinoma NOS Squamous cell carcinoma NOS Squamous cell epithelioma	

***These new codes were approved by the IARC/WHO Committee for ICD-O.**

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Table 2: Histologies Not Reportable for Colon, Rectosigmoid and Rectum

Column 1 lists the **non-reportable** histology term and code for NOS or specific
Column 2 lists the **synonym**(s) for the term
Column 3 lists the **subtype/variant** of the NOS term with the histology code
Column 4 lists the **reason** these histologies are **not reportable**

Specific or NOS Term and Code	Synonyms	Subtype/Variant of NOS with Histology Code	Reason not reportable
Adenoma 8140/0 ***Note*:** No malignancy in polyps	Adenoma NOS	Tubular adenoma **8211/0** Tubulovillous adenoma **8263/0** Villous adenoma **8261/0**	Non-malignant
Adenomatous polyp, high grade dysplasia 8210/2			Non-reportable terminology
Cowden-associated polyp No code ***Note*:** No malignancy in polyps	Cowden disease Cowden syndrome Multiple hamartoma syndrome		Non-malignant /no code
Dysplasia, high grade 8148/2 ***Note:*** Colorectal primaries only (C180-C189, C199 and C209)	High-grade dysplasia Intraepithelial neoplasia, high grade		**CURRENTLY NOT REPORTABLE**
Dysplasia, low grade 8148/0* ***Note:*** Colorectal primaries only (C180-C189, C199 and C209)	Intraepithelial neoplasia, low grade		Non-malignant

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Specific or NOS Term and Code	Synonyms	Subtype/Variant of NOS with Histology Code	Reason not reportable
Familial adenomatous polyposis (FAP) No code	Adenomatous polyposis coli Bussey-Garder polyposis Familial multiple polyposis Familiar polyposis coli Familial polyposis of the colon and rectum Familial polyposis of the gastrointestinal tract Gardner syndrome Multiple adenomatosis		Reportable only when there is cancer in a polyp
Gangliocytic paraganglioma 8683/0			Non-malignant
Gastrointestinal stromal tumor stated as benign, borderline, or non-malignant 8936/1 (SEE NOTE in column 2)	GIST NOS GIST, behavior not specified ***Note***: Gastrointestinal stromal tumor, NOS is not reportable for cases diagnosed prior to 1/1/2021. Cases diagnosed 1/1/2021 forward are reportable		Non-malignant
Hyperplastic polyp No code			Non-malignant/no code
Inflammatory or pseudopolyp No code			Reactive lesions; mimic carcinoma
Intestinal-type adenoma, high grade 8144/2			Non-reportable terminology

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Specific or NOS Term and Code	Synonyms	Subtype/Variant of NOS with Histology Code	Reason not reportable
Juvenile polyp No code	Combined juvenile polyposis/hereditary Hemorrhagic telangietasis (Osler-Webec-Rendu) syndrome Familial juvenile polyposis Generalized juvenile polyposis Hamartomatous gastrointestinal polyposis; Juvenile polyposis Juvenile polyposis coli Juvenile polyposis of infancy		Non-malignant / no code
L cell glucagon-like peptide and PP/PYY-producing NETs 8152/1*			Non-malignant
Leiomyoma 8890/0			Non-malignant
Lipoma 8850/0			Benign accumulation of fat cells that are circumscribed or encapsulated
Low-grade appendiceal mucinous neoplasm 8480/1 ***Note*:** May have low-grade, non-invasive pseudomyxoma peritonei, mucinous implants in peritoneum or beyond	LAMN		Non-malignant **Note:** LAMN is non-reportable for cases diagnosed **prior to 1/1/2022**. Beginning 1/1/2022, LAMN becomes a reportable neoplasm- See Table 1
Lynch syndrome No code			Non-malignant/no code

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Specific or NOS Term and Code	Synonyms	Subtype/Variant of NOS with Histology Code	Reason not reportable
Mesenchymal tumors		Granular cell tumor **9580/0** Hemangioma **9120/0**	Non-malignant
Peutz-Jeghers polyp No code	Intraepithelial neoplasia in Peutz-Jeghers polyp(s) Periorificial lentiginosis Peutz-Jeghers polyposis Polyps-and-spots syndrome		Non-malignant/no code
Pseudomyxoma peritonei (when pathologist does not designate as malignant OR implants are benign) **8480/1**			Non-malignant. When both implants and site of origin are benign, the case is not reportable.
Serrated dysplasia, high grade 8213/2			Non-reportable terminology
Sessile serrated adenoma/polyp 8213/0* ***Note:*** No malignancy in polyps	Serrated polyposis Sporadic serrated polyps Traditional serrated adenoma		Non-malignant
Tubular adenoma, high grade 8211/2			Non-reportable terminology
Tubular carcinoid, no malignancy 8245/1			Non-malignant
Tubulovillous adenoma, high grade 8263/2			Non-reportable terminology
Villous adenoma, high grade 8261/2			Non-reportable terminology

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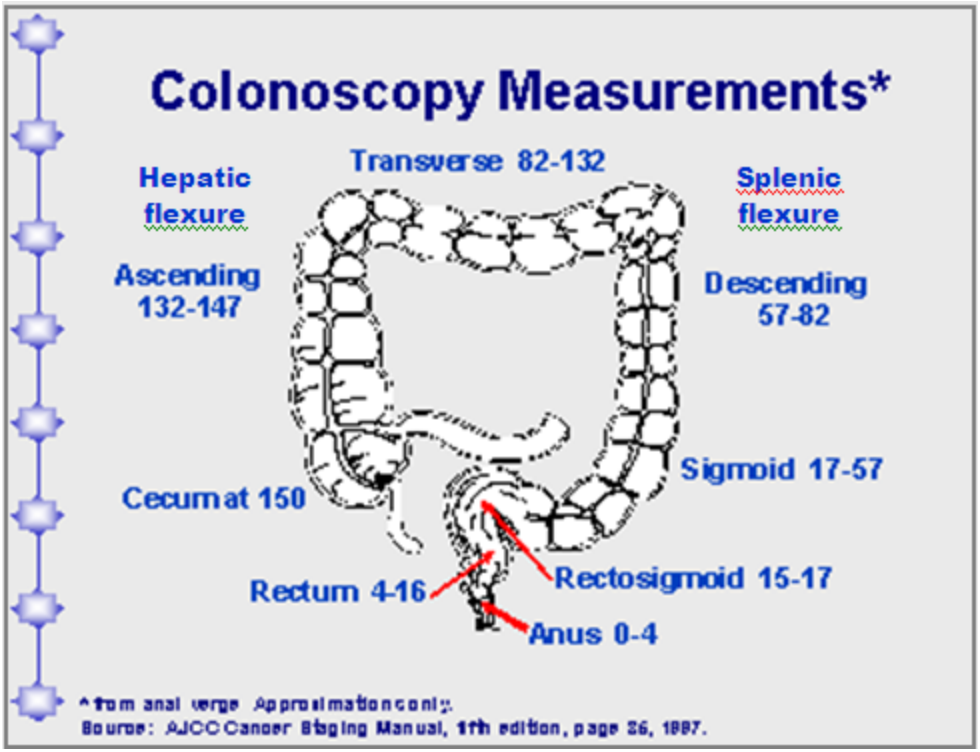
Illustrations

Colonoscopy measurements which may be used to determine primary site when no site is designated



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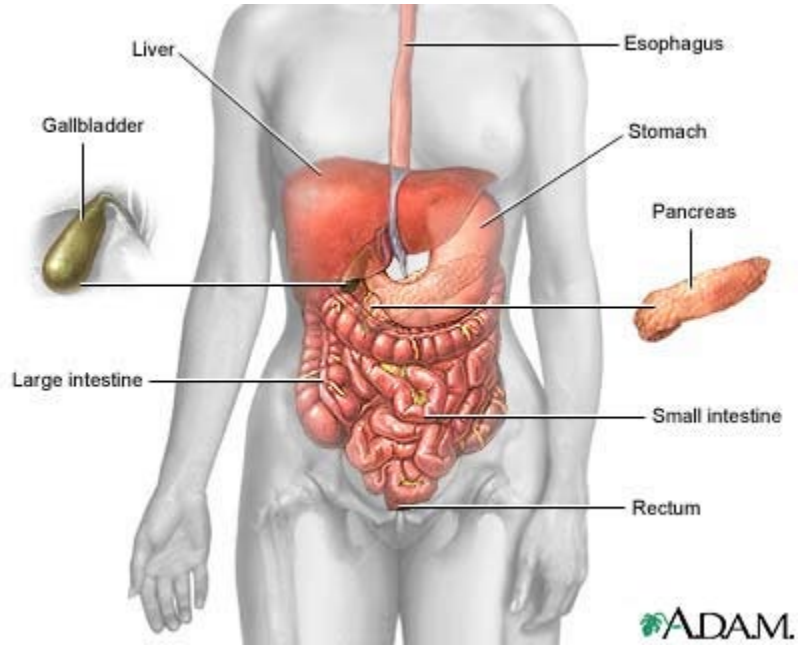
GI System



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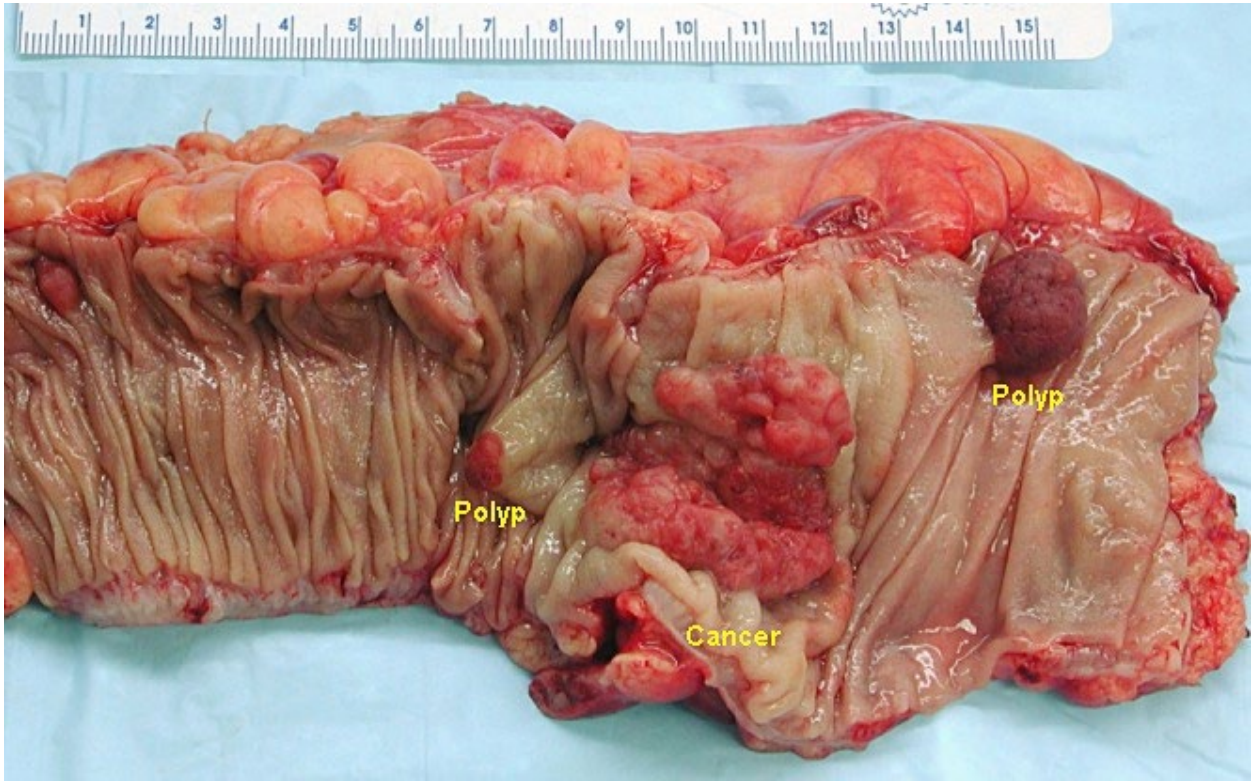
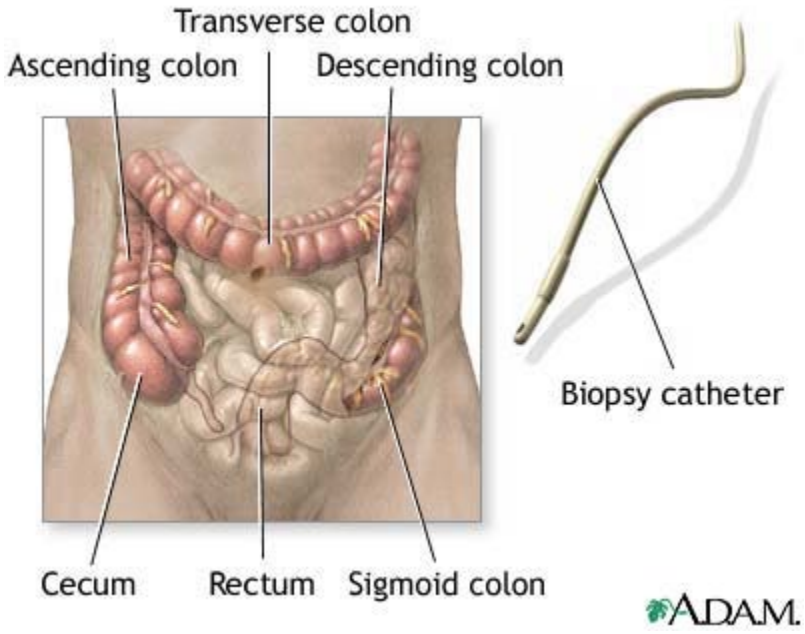
Polyps and de novo or "frank" adenocarcinoma in colon



Source: http://upload.wikimedia.org/wikipedia/commons/4/44/Colon_cancer.jpg

Large intestine; snare instrument to remove polyps



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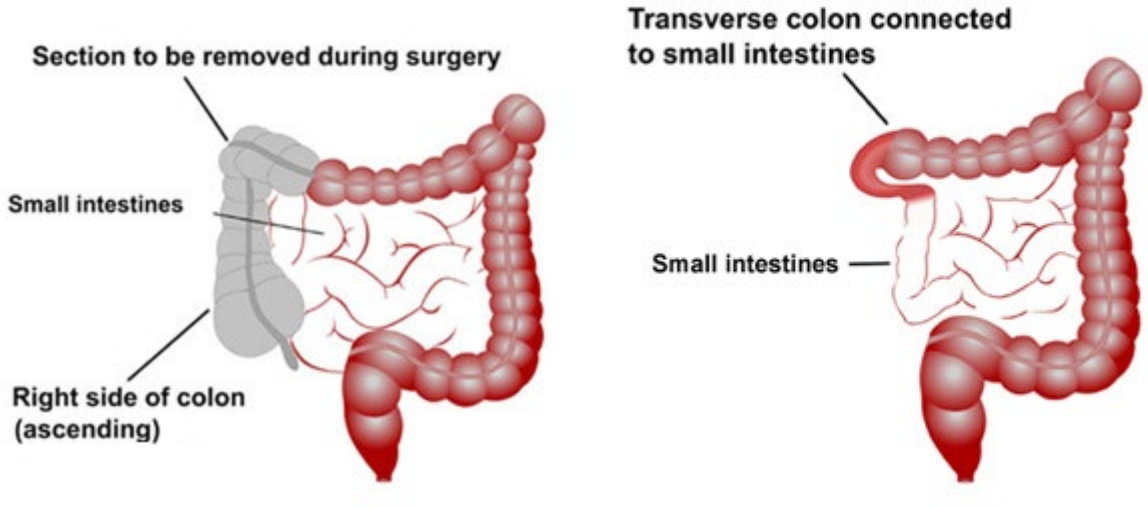
Colon Surgery: Hemicolectomy

The primary treatment for colon cancer is surgery. Part of the large bowel and the surrounding lymph nodes are removed. The remaining bowel is then joined together (anastomosis).



http://www.cedars-sinai.edu/Patients/Programs-and-Services/Colorectal-Cancer-Center/Services-and-Treatments/Rectal-Cancer.aspx

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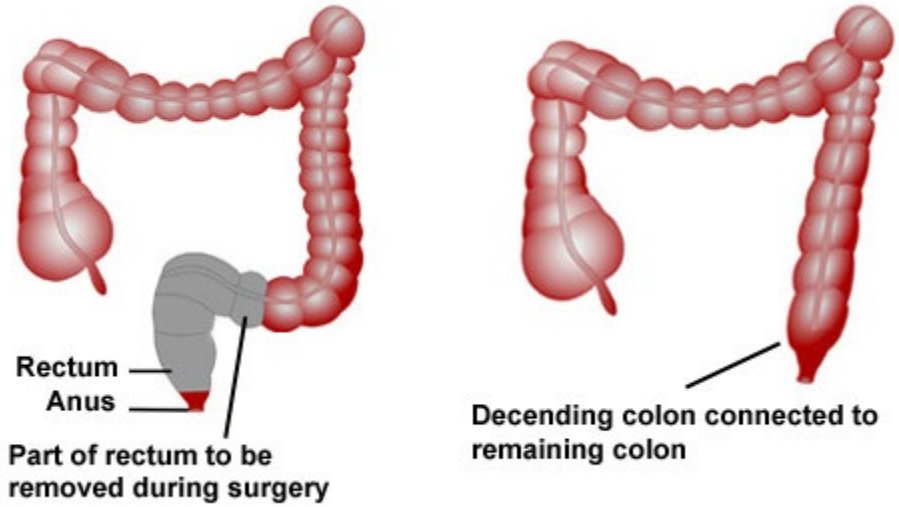
Rectal Surgery



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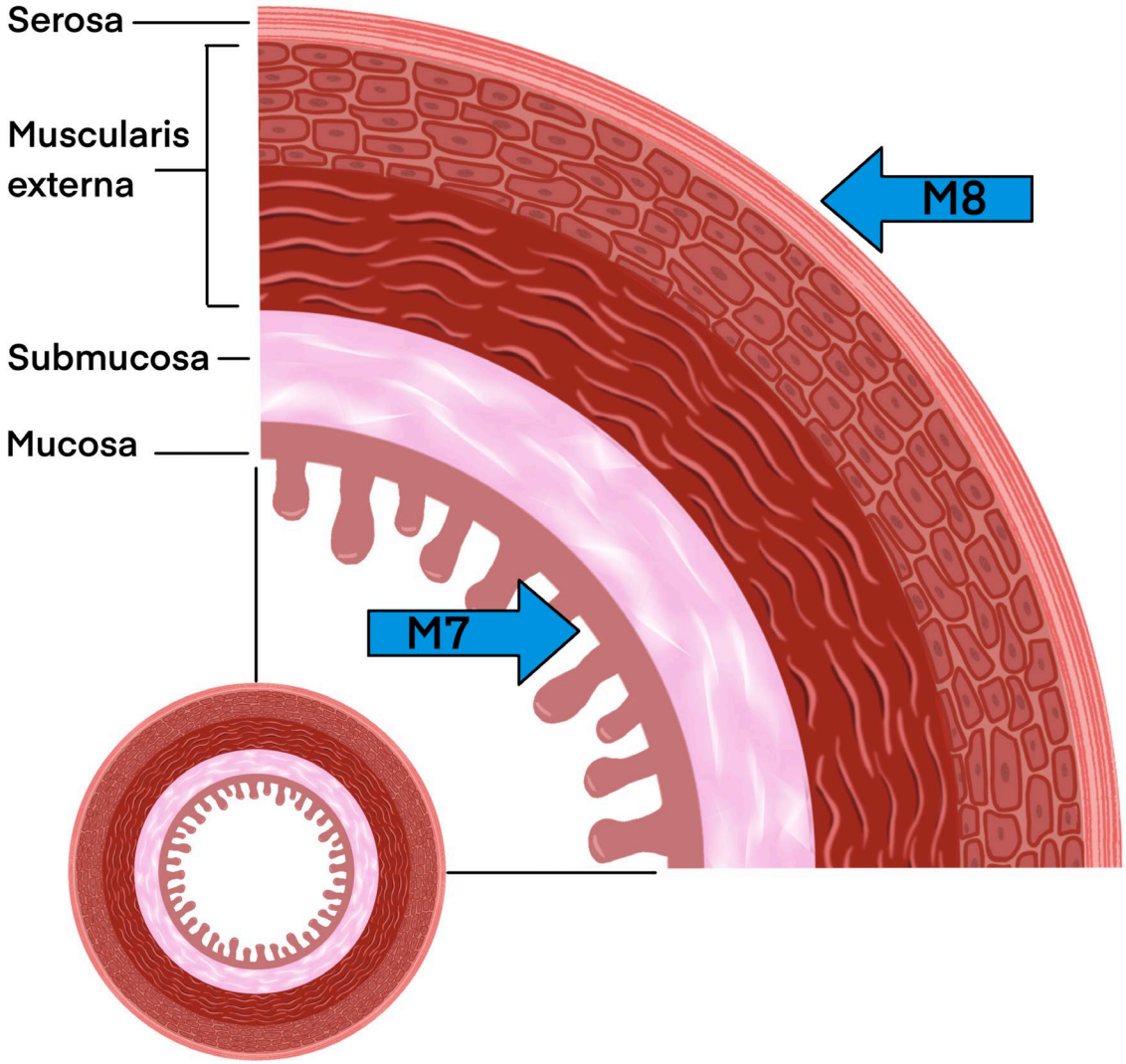

Colon, Rectosigmoid, and Rectum Multiple Primary Rules
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Note 1: These rules are **NOT** used for tumor(s) described as metastases. Metastatic tumors include but are not limited to:

- Discontinuous lesions in soft tissue adjacent to primary site
- Regional or distant lymph nodes for the primary site being abstracted as identified in Summary Staging Manual
- Brain
- Liver
- Lung
- Peritoneum
- Spinal cord (not frequent)

Note 2: 2007 MPH Rules and 2018 Solid Tumor Rules are used based on **date of diagnosis**.

- Tumors diagnosed 01/01/2007 through 12/31/2017: Use 2007 MPH Rules
- Tumors diagnosed 01/01/2018 and later: Use 2018 Solid Tumor Rules
- The original tumor diagnosed before 1/1/2018 and a subsequent tumor diagnosed 1/1/2018 or later **in the same primary site**: Use the 2018 Solid Tumor Rules

Unknown if Single or Multiple Tumors

Note: **Collision tumors** are counted as **two individual** tumors for the purpose of determining multiple primaries. Collision tumors were originally two **separate** tumors that arose in close proximity. As the tumors increased in size, they merged or overlapped each other. Use the Multiple Tumors module.

Rule M1 Abstract a **single primary**[i] when it is not possible to determine if there is a **single** tumor or **multiple** tumors.

Note 1: Use this rule only after all information sources have been exhausted.

Note 2: Examples of cases with minimal information include

- Death certificate only (DCO)
- Cases for which information is limited to pathology report only
  - Outpatient biopsy with no follow-up information available
  - Multiple pathology reports which do not specify whether a single tumor or multiple tumors have been biopsied and/or resected

This is the end of instructions for Unknown if Single or Multiple Tumors

[i] **Prepare one abstract. Use the histology rules to assign the appropriate histology code.**

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Single Tumor

Note: **Collision tumors** are counted as **two individual** tumors for the purpose of determining multiple primaries. Collision tumors were originally two **separate** tumors that arose in close proximity. As the tumors increased in size, they merged or overlapped each other. Use the Multiple Tumors module.

Rule M2 Abstract a **single primary**[i] when there is a **single tumor.**
Note 1: A single tumor is always a single primary.
Note 2: The tumor may overlap onto or extend into adjacent/contiguous site or subsites.
Note 3: The tumor may have in situ and invasive components.
Note 4: The tumor may have two or more histologic components.

This is the end of instructions for Single Tumor

[i] **Prepare one abstract. Use the histology rules to assign the appropriate histology code.**

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Multiple Tumors

Note 1: Multiple tumors may be a single primary or multiple primaries.
Note 2: **Collision tumors** are counted as **two individual** tumors for the purpose of determining multiple primaries. Collision tumors were originally two **separate** tumors that arose in close proximity. As the tumors increased in size, they merged or overlapped each other. Use the Multiple Tumors module to determine if they are a single primary or multiple primaries.

Rule M3 Abstract a **single primary**[i] when there is adenocarcinoma in situ and/or invasive in at least one polyp **AND**

- There is a clinical diagnosis of familial polyposis (FAP) **OR**
- Greater than 100 polyps are documented (no diagnosis of FAP)

Note 1: A diagnosis of familial polyposis (FAP) is made when the patient has **greater than 100** adenomatous polyps. Polyps with adenocarcinoma and benign polyps will be present. Because there are many polyps, the pathologist does not examine every polyp.

Note 2: **In situ /2** and **malignant /3** adenocarcinoma in polyps, malignancies with remnants of a polyp, as well as de novo (previously called frank) malignancies may be present in **multiple segments** of the colon or in both the **colon** and **rectum**. Polyposis **may** be present in other GI sites such as stomach (a de novo does not have to be present; all adenocarcinoma may be in polyps).

Note 3: FAP is a **genetic** disease. The characteristics of FAP are **numerous precancerous polyps** in the colon and rectum when the patient reaches puberty. If not treated, the polyps typically become malignant. Patients often have **total colectomies.**

Note 4: **Multiple polyps** in the colorectum is **not equivalent** to FAP.

Note 5: Code **primary site** as follows:

- Present in more than one segment of colon: **C189** colon, NOS
- Present in colon and rectosigmoid **OR** colon and rectum: **C199** rectosigmoid junction
- Present in colon and small intestine: **C260** intestinal tract, NOS (there is no code for large and small bowel)

  Note: In addition to the colon and small intestine, FAP may also be present in the:
  - Stomach **AND/OR**
  - Rectosigmoid **AND/OR**
  - Rectum

Example: The patient has a diagnosis of FAP. The operative report and physician's documentation say that polyps with adenocarcinoma were present in specimens removed from the ascending colon and the sigmoid colon. The ascending and sigmoid colon are part of the large bowel. Code the primary site **C189** colon NOS.

Colon, Rectosigmoid, and Rectum Multiple Primary Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M4 Abstract **multiple primaries**[ii] when there are separate, non-contiguous tumors in sites with ICD-O site codes that **differ** at the second C**X**xx and/or third Cx**X**x character.

Note 1: Definition of separate/non-contiguous tumors: at least two malignancies which **do not** overlap/merge.

Note 2: **Differences** at either the **second** or **third** characters are different primary sites/multiple primaries.

Example 1: Breast C**50**x and colon C**18**x

Example 2: Colon C**18**x and rectum C**20**9 (This does not include FAP- see earlier rules)

Note: This rule **does not** apply to a single **overlapping** malignancy of colon and rectum.

Rule M5 Abstract **multiple primaries**[ii] when separate/non-contiguous tumors are two or more different **subtypes/variants** in Column 3, **Table 1** in the Equivalent Terms and Definitions. Timing is irrelevant.

Note: The tumors may be subtypes/variants of the **same** or **different** NOS histologies.

- **Same NOS**: Medullary carcinoma NOS 8510/3 and tubulopapillary adenocarcinoma 8263/3 are both subtypes of adenocarcinoma NOS 8140/3 but are distinctly different histologies. Abstract multiple primaries.
- **Different NOS**: Goblet cell carcinoid 8243/3 is a subtype of mixed adenoneuroendocrine carcinoma 8244/3; somatostatin-producing NET 8156/3 is a subtype of neuroendocrine tumor Grade 1 (G1) 8240/3. They are distinctly different histologies. Abstract multiple primaries.

Rule M6 Abstract **multiple primaries**[ii] when separate/non-contiguous tumors are on **different rows in Table 1** in the Equivalent Terms and Definitions. Timing is irrelevant.

Note: Each row in the table is a **distinctly different** histology.

Rule M7 Abstract **multiple primaries**[ii] when a subsequent tumor arises at the **anastomotic** site **AND:**

- One tumor is a **NOS** and the other is a **subtype/variant** of that NOS **OR**
- The subsequent tumor occurs **greater than 36 months** after original tumor resection **OR**
  Note: For cases diagnosed prior to 1/1/2022, the time interval is greater than 24 months.
- The **subsequent** tumor arises in the **mucosa** (see illustration)
  Note: Bullet three does not apply to GIST. GISTs only start in the wall; never in the mucosa.

Example: (For bullet 1: NOS and subtype/variant) The original tumor was adenocarcinoma NOS **8140**. The patient had a hemicolectomy. There was a recurrence at the **anastomotic** site diagnosed exactly as **mucinous** adenocarcinoma **8480.** Mucinous adenocarcinoma is a subtype/variant of the NOS adenocarcinoma, but they are two different histologies. **Code two primaries,** one for the original adenocarcinoma NOS and another for the subsequent anastomotic site mucinous adenocarcinoma.

Note 1: There may or may not be **physician documentation** of anastomotic recurrence. Follow the rules.

Note 2: When the original tumor was diagnosed prior to 1/1/2018 and was coded to adenocarcinoma in a polyp, and the anastomotic site tumor is adenocarcinoma per 2018 rules, the tumors are the same histology. ICD-O codes differ because of changes in histology coding rules.
Note 3: The tumor may or may not invade into the colon wall or adjacent tissue.
Note 4: A "rectal stump" is an anastomotic site.
Note 5: These rules are hierarchical. Only use this rule when previous rules do not apply.

Rule M8 Abstract a **single primary**[i] when a subsequent tumor arises at the **anastomotic** site **AND:**

- The subsequent tumor occurs **less than or equal to 36 months** after original tumor resection **OR**
  Note: For cases diagnosed prior to 1/1/2022, timing is less than or equal to 24 months
- The tumor arises in **colon/rectal wall** and/or surrounding tissue; there is **no involvement** of the **mucosa** (see illustration) **OR**
- The pathologist or clinician documents an **anastomotic recurrence**

Note 1: Bullet two does not apply to GIST. GISTs only start in the wall; never in the mucosa.
Note 2: The physician may stage the subsequent tumor because the depth of invasion determines the second course of treatment.
Note 3: These tumors are a single primary/**recurrence**. Registrars that collect recurrence information should record the information in the recurrence fields.
Note 4: A "rectal stump" is an anastomotic site.

Rule M9 Abstract **multiple primaries**[ii] when there are separate, non-contiguous tumors in sites with ICD-O site codes that **differ** at the fourth characters C18**X**.

Note: Differences at the fourth character include different segments of the colon. Abstract a primary for each separate non-contiguous tumor in a different segment of the colon. This rule is not used for colon NOS C189. C189 is rarely used other than DCO.

Example: The patient has adenocarcinoma in situ in a **sigmoid** polyp and mucinous adenocarcinoma in a polyp in the **descending** colon, the site code differs at the fourth character (sigmoid C18**7** and descending C18**6**). **Code two primaries**, one for the sigmoid and another for the descending colon.

Colon, Rectosigmoid, and Rectum Multiple Primary Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M10 Abstract **multiple primaries**[ii] when the patient has a subsequent tumor after being **clinically disease-free** for **greater than one year** after the original diagnosis or last recurrence.

Note 1: **Clinically** disease-free means that there was **no evidence** of recurrence on follow-up.
- Colonoscopies are NED
- Scans are NED

Note 2: When there is a recurrence less than or equal to one year of diagnosis, the **"clock"** starts over. The time interval is calculated from the **date of last recurrence.** In other words, the patient must have been **disease-free** for **greater than one year** from the date of the last recurrence.

Note 3: When the first course of treatment was a **polypectomy** only, this rule means there were **no recurrences** for greater than one year.

Note 4: When the first course of treatment was a **colectomy or A&P resection**, there were **no anastomotic recurrences** for greater than one year.

Note 5: When it is **unknown/not documented** whether the patient had a recurrence, default to **date of diagnosis** to compute the time interval.

Note 6: The physician may state this is a **recurrence,** meaning the patient had a previous colon tumor and now has another colon tumor. **Follow the rules;** do not attempt to interpret the physician's statement.

Rule M11 Abstract a **single primary**[i] when synchronous, separate/non-contiguous tumors are on **the same row in Table 1** in the Equivalent Terms and Definitions.

Note: The same row means the tumors are:
- The same histology (same four-digit ICD-O code) **OR**
- One is the preferred term (column 1) and the other is a synonym for the preferred term (column 2) **OR**
- A NOS (column 1/column 2) and the other is a subtype/variant of that NOS (column 3)

Rule M12 Abstract a **single primary**[i] (the invasive) when an **in situ** tumor is diagnosed **after** an **invasive** tumor.

Note 1: The rules are **hierarchical**. Only use this rule when none of the previous rules apply.

Note 2: The tumors **may** be a **NOS** and a **subtype/variant** of that NOS. See **Table 1** in the Equivalent Terms and Definitions for listings of NOS and subtype/variants.

Note 3: The **in situ** is recorded as a **recurrence** for those registrars who collect recurrence data.

Colon, Rectosigmoid, and Rectum Multiple Primary Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M13 Abstract a **single primary**[i] (the invasive) when an invasive tumor is diagnosed **less than or equal to 60 days** after an **in situ** tumor.

Note 1: The rules are hierarchical**.** Only use this rule when previous rules do not apply.

Note 2: **Change behavior** code on original abstract from /2 to /3. **Do not** change **date of diagnosis**.

Note 3: If the case has already been submitted to the central registry, **report** all changes.

Note 4: The physician may stage both tumors because staging and determining multiple primaries are done for different reasons. Staging determines which treatment would be most effective. Determining multiple primaries is done to stabilize the data for the study of epidemiology (long-term studies done on incidence, mortality, and causation of a disease with the goal of reducing or eliminating that disease).

Note 5: See the **COC** and **SEER manuals** for **instructions** on coding **data items** such as Date of Diagnosis, Accession Year and Sequence Number.

Rule M14 Abstract **multiple primaries**[ii] when an **invasive** tumor occurs **more than 60 days** after an **in situ** tumor.

Note 1: Abstract both the invasive and in situ tumors.

Note 2: Abstract as multiple primaries even if physician states the invasive tumor is disease recurrence or progression. This rule is based on **long-term epidemiologic** studies of **recurrence intervals.** The specialty medical experts (SMEs) reviewed and approved these rules. Many of the SMEs were authors, co-authors, or editors of the AJCC Staging Manual.

Rule M15 Abstract a **single primary**[i] when tumors do not meet any of the above criteria.

Note: Use caution when applying this default rule. Please confirm that you have not overlooked an applicable rule.

Example: The pathology states adenocarcinoma in situ 8140/2 and a second non-contiguous invasive adenocarcinoma 8140/3 in the sigmoid colon C187. Multiple tumors that are the same histology in the same primary site (same four characters of ICD-O topography code) are a single primary.

This is the end of instructions for Multiple Tumors.

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[i] Prepare one abstract. Use the histology rules to assign the appropriate histology code. For registries collecting recurrence data: When a subsequent tumor is "single primary," record that subsequent tumor as a recurrence.

[ii] Prepare two or more abstracts. Use the histology rules to assign the appropriate histology code to each case abstracted.

Colon, Rectosigmoid, and Rectum Histology Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Priority Order for Using Documentation to Identify Histology

IMPORTANT NOTES

1. Code the histology diagnosed ***prior*** to **neoadjuvant treatment.**
   Note 1: Histology changes may occur following immunotherapy, chemotherapy, targeted therapy, and radiation therapy.
   Note 2: Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.

Exception: If the initial diagnosis is based on histology from **FNA, smears, cytology,** or from a regional or metastatic site, and neoadjuvant treatment is given and followed by resection of primary site which identifies a different or specific histology, code the histology from the primary site.

2. Code the histology using the following priority list and the Histology Rules. Do not change histology in order to make the case applicable to staging.

The priority list is used for **single primaries** (including multiple tumors abstracted as a single primary).

This is a hierarchical list of source documentation.
Code the **most specific** pathology/tissue from either **resection** or **biopsy**.

Note 1: The term "most specific" usually refers to a subtype/variant.
Note 2: The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor.
Note 3: When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).

1. **Tissue or pathology report from primary site** (in priority order)
   A. Addendum(s) and/or comment(s)
   B. Final diagnosis / synoptic report as required by CAP
   C. CAP protocol

   Note 1: Addendums and comments on the pathology report are given a high priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.
   Note 2: The pathologist's diagnosis from the pathology report is always reliable, so the final diagnosis is the second priority.
   Note 3: The CAP protocol is a checklist which:

- Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care
- Allows physicians to check multiple histologies

2. Tissue/pathology from a **metastatic** site
   Note 1: Code the behavior /3.
   Note 2: The tissue from a metastatic site often shows **variations** from the primary tumor. When it is the only tissue available, it is more accurate than a scan.
3. **Scan:** The following list is in **priority order**.
   A. CT
   B. PET
   C. MRI
4. Code the histology **documented** by the physician when none of the above are available. Use the documentation in the following **priority order:**
   A. Treatment plan
   B. Documentation from Tumor Board
   C. Documentation in the medical record that **refers to original pathology, cytology, or scan(s)**
   D. Physician's **reference** to type of cancer (**histology**) in the medical record
   Note 1: Code the specific histology when documented.
   Note 2: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.
5. **Cytology** (seldom used for colon, rectosigmoid and rectum)

Colon, Rectosigmoid, and Rectum Histology Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Coding Histology

Note 1: The priority is to code the most specific histology. **DO NOT USE BREAST HISTOLOGY CODING RULES FOR THIS SITE.**
Note 2: Only use this section for one or more histologies within a single tumor.
Note 3: Do not use this section in place of the Histology Rules.

1. **Code** the **most specific** histology or **subtype/type/variant, regardless of whether it is described as:**
   A. The majority or predominant part of tumor
   B. The minority of tumor
   C. A component
   Note 1: Mucinous and signet ring cell carcinoma must meet a percentage requirement in order to be coded. Refer to the Histology Rules if mucinous and/or signet ring cell carcinoma is present.
   Note 2: The terms above (A, B, C) must describe a **carcinoma** or **sarcoma** in order to code a histology described by those terms.
   Example: When the diagnosis is adenocarcinoma with a component of medullary **carcinoma**, code medullary carcinoma 8510.
   Negative Example: When the diagnosis is simply adenocarcinoma with a medullary component, code adenocarcinoma NOS 8140. Do not assume this is a medullary carcinoma. This could be medullary differentiation or features.
   Note 3: When the most specific histology is described as differentiation or features, see #2.
   Example 1: Diagnosis for a single tumor is adenocarcinoma 8140 with the majority or predominant part of tumor being medullary adenocarcinoma 8510. Code the subtype/variant: medullary adenocarcinoma 8510.
   Example 2: Diagnosis for a single tumor is mixed neuroendocrine carcinoma 8244 with minority of tumor being goblet cell carcinoid 8243. Code the subtype/variant: goblet cell carcinoid 8243.
   Example 3: Diagnosis for a single tumor is sarcoma NOS 8800/3 with a component of leiomyosarcoma 8890/3. Code the subtype/variant: leiomyosarcoma 8890/3.

2. Code the histology described as **differentiation** or **features/features of ONLY** when there is a specific ICD-O code for the "NOS with ____ features" or "NOS with ____ differentiation".
   Note: Do not code differentiation or features when there is no specific ICD-O code.

3. Code the specific histology described by **ambiguous terminology** (list follows) **ONLY** when A or B is true:
   A. The only diagnosis available is **one histology** term described by ambiguous terminology
      - CoC and SEER require reporting of cases diagnosed only by ambiguous terminology

- Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

Example: Outpatient biopsy says probably malignant GIST. The case is accessioned (entered into the database) as required by both SEER and COC. No further information is available. Code the histology malignant GIST. The case meets the criteria in #**3A.**

B. There is a **NOS histology and a more specific** (subtype/variant) described by ambiguous terminology
- Specific histology is clinically confirmed by a physician (attending, pathologist, oncologist, etc.) **OR**
- Patient is receiving treatment based on the specific histology described by ambiguous term

Example 1: The pathology diagnosis is adenocarcinoma consistent with micropapillary carcinoma. The oncology consult says the patient has micropapillary carcinoma of the cecum. This is clinical confirmation of the diagnosis, code micropapillary carcinoma. The case meets the criteria in **bullet 1.**

Example 2: The pathology diagnosis is mixed neuroendocrine carcinoma consistent with goblet cell carcinoid. The treatment plan says the patient will receive the following treatment for goblet cell carcinoid. Treatment plan confirms goblet cell carcinoid; code goblet cell carcinoid. The case meets the criteria in **bullet 2.**

If the specific histology does not meet the criteria in #3B, then code the NOS histology.

List of Ambiguous Terminology

Apparently	Most likely
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect(ed)
Consistent with	Suspicious (for)
Favor(s)	Typical (of)
Malignant appearing	

4. **Do not code** histology when described as:
    - Architecture
    - Foci; focus; focal
    - Pattern

Colon, Rectosigmoid, and Rectum Histology Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Single Tumor

Rule H1 Code adenocarcinoma with neuroendocrine differentiation **8574** when the final diagnosis is **exactly** "adenocarcinoma with neuroendocrine differentiation".

Note: **Do not** use this code when:

- The diagnosis is any subtype/variant of adenocarcinoma with neuroendocrine differentiation
- Any modifier other than differentiation is used, i.e., adenocarcinoma with neuroendocrine features

Rule H2 Code the **histology** and **ignore the polyp** when a carcinoma **originates** in a **polyp.**

Note 1: This is a **change** from the **2007** MPH rules which instructed registrars to use the codes for malignancies in a polyp, such as adenocarcinoma in a polyp **8210.**

Note 2: Sufficient data has been collected to:

- Determine the frequency with which carcinomas arise within polyps
- Establish patient care guidelines for individuals with colon polyps

Example: Colonoscopy with polypectomy finds mucinous adenocarcinoma in the polyp. Code mucinous adenocarcinoma **8480.**

Rule H3 Code combined small cell carcinoma **8045** when the final diagnosis is **small cell** carcinoma **AND any other carcinoma.**

Examples:

- Small cell carcinoma **8041** and adenocarcinoma **8140**
- Small cell carcinoma **8041** and neuroendocrine carcinoma **8246**

Rule H4 Code **mixed mucinous and signet ring cell** as follows:

- Adenocarcinoma with mucinous and signet ring features – code adenocarcinoma **8140**
- Mucinous carcinoma and signet ring cell carcinoma:
  - Mucinous carcinoma documented as **greater than 50%** – code mucinous carcinoma **8480**
  - Signet ring cell carcinoma documented as **greater than 50%** – code signet ring cell carcinoma **8490**
  - Percentage of mucinous carcinoma and signet ring cell carcinoma **unknown/not designated**- code adenocarcinoma mixed subtypes **8255**

Note: This rule is for mucinous carcinoma and signet ring cell carcinoma in a single tumor. For mucinous adenocarcinoma mixed with another histology OR signet ring cell carcinoma mixed with another histology, proceed through the rules.

Rule H5 Code **low grade appendiceal mucinous neoplasm (LAMN)** and **high grade appendiceal mucinous neoplasm (HAMN) 8480/2** when:

- Diagnosis date is 1/1/2022 forward **AND**
- Behavior is stated to be in situ/non-invasive **OR**
- Behavior is not indicated

Note 1: ICD-O-3.2 lists LAMN with behavior of /1. WHO 5th Ed Digestive Systems Tumors indicates this neoplasm is considered in situ. After consulting with WHO Digestive System editors, College of American pathologists, and AJCC GI chapter experts, the standard setting organizations have agreed LAMN should be collected and should be assigned a behavior code of /2 beginning with cases diagnosed 1/1/2022 forward.

Note 2: A diagnosis of LAMN or HAMN does not require the tumor be comprised of greater than 50% mucinous in order to be coded 8480.

Note 3: If the pathologist indicates LAMN or HAMN is invasive or has a malignant behavior, continue through the rules.

Rule H6 Code invasive **mucinous** adenocarcinoma **8480** when the diagnosis is any of the following:

- **Exactly** "**mucinous** adenocarcinoma" (no modifiers)
- High grade appendiceal mucinous neoplasm (HAMN) stated to be invasive (DX 1/1/2022 forward)
- **High-grade** pseudomyxoma peritonei
- **Invasive** pseudomyxoma peritonei
- Low grade appendiceal mucinous neoplasm (LAMN) stated to be invasive (DX 1/1/2022 forward)
- **Malignant** pseudomyxoma peritonei
- Two histologies and mucinous is documented to be **greater than 50%** of the tumor
  - Mucinous carcinoma must meet a percentage requirement in order to be coded. Do not use majority of tumor, predominantly, or predominant part of the tumor to code mucinous 8480.

Note 1: Be very **careful** when **determining primary** site; almost all pseudomyxoma peritonei originate in the appendix C181. However, it **can be metastatic** disease from sites such as bowel, ovary, or bladder. Code the primary site as designated by a physician. When the primary site is not designated, code unknown primary **C809** and the histology as mucinous carcinoma **8480.**

Note 2: Report the appendiceal mucinous neoplasm as malignant /3 using the ICD-O matrix principle and the SEER and COC Manuals when the **pathology** from the appendix is **low-grade mucinous** neoplasm (not reportable prior to 1/1/2022) **AND**

- The pseudomyxoma peritonei are **high-grade**/invasive/malignant **OR**
- Patient is **treated** for malignant pseudomyxoma peritonei OR
- The diagnosis is low grade appendiceal mucinous neoplasm (LAMN) and the physician states it is malignant OR

- The diagnosis is high grade appendiceal mucinous neoplasm (HAMN) and the physician states it is malignant
- The pathologist has staged the LAMN as T3 or T4

Note 3: The following are **non-reportable for cases diagnosed prior to 1/1/2022:**

- Appendiceal neoplasm with **low-grade** pseudomyxoma peritonei **AND no treatment**
- **No designation** of high- or low-grade for the appendiceal neoplasm **AND no treatment** for the pseudomyxoma peritonei

Rule H7 Code invasive **signet ring cell adenocarcinoma 8490** when the diagnosis is any of the following:

- Exactly **signet ring cell carcinoma** (no modifiers)
- **Adenocarcinoma and signet ring cell carcinoma**, where signet ring cell is documented to be **greater than 50%** of the tumor
  - Signet ring cell adenocarcinoma must meet a percentage requirement in order to be coded. Do not use majority of tumor, predominantly, or predominant part of tumor to code signet ring cell 8490.

Rule H8 Code adenocarcinoma NOS **8140** when the final diagnosis is:

- Two histologies:
  - Adenocarcinoma and mucinous carcinoma
    - Percentage of mucinous **unknown/not documented**
    - Mucinous documented as less than or equal to 50% of tumor
  - Adenocarcinoma and signet ring cell carcinoma
    - Percentage of signet ring **unknown/not documented**
    - Signet ring cell documented as less than or equal to 50% of tumor
- **Exactly** adenocarcinoma **OR**
- **Intestinal** type adenocarcinoma **OR** adenocarcinoma intestinal type (no modifiers or additional histologic terms).

Note 1: Code **8140 adenocarcinoma NOS** even if pathology says intestinal type adenocarcinoma.

Note 2: Do **not** use code **8144** adenocarcinoma intestinal type for **colorectal** primaries. Intestinal type adenocarcinoma 8144 is used for tumors which occur in the stomach, head and neck, and specific GYN sites. It is called intestinal because it resembles carcinoma which occurs in the colon, rectosigmoid or rectum.

Note 3: When a diagnosis of intestinal type adenocarcinoma is **further described** by a **specific term** (such as mucinous intestinal type adenocarcinoma or signet ring cell intestinal type adenocarcinoma), it would be treated as an adenocarcinoma with a **subtype/variant**.

Rule H9 Code the histology when only **one histology** is present.

Note 1: Use **Table 1** to code histology. New codes, terms, and synonyms are included in Table 1 and coding errors may occur if the table is not used.

Note 2: Use the ICD-O and all updates when the histology is not listed in Table 1.

Note 3: Submit a question to Ask a SEER Registrar when the histology code is not found in Table 1, ICD-O or all updates.

Rule H10 Code the **invasive** histology **when in situ** and **invasive** histologies are present in the **same tumo**r.

Rule H11 Code the **subtype/variant** when there is a **NOS** and a **single subtype/variant** of that NOS such as the following:

- Adenocarcinoma **8140** and a subtype/variant of adenocarcinoma
- Mixed adenoneuroendocrine carcinoma **8244** and a subtype/variant of mixed adenoneuroendocrine carcinoma
- Neuroendocrine carcinoma **8246** and a subtype/variant of neuroendocrine carcinoma
- Neuroendocrine tumor Grade 1 (G1) **8240** and a subtype/variant of neuroendocrine tumor Grade 1 (G1)
- Sarcoma **8800** and a subtype/variant of sarcoma

Note 1: See **Table 1** in the Equivalent Terms and Definitions to find NOS and subtypes/variants.

Note 2: Only code subtypes/variant when pathology gives an **exact diagnosis**. **Do not** code the subtype/variant when **modified** by terms such as **differentiation, features of, etc., unless** there is a specific code for the histology term with the modifier.

This is the end of instructions for Single Tumor.

Code the histology using the rule that fits the case.

Colon, Rectosigmoid, and Rectum Histology Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Multiple Tumors Abstracted as a Single Primary

Note: Multiple tumors **must be a single primary** to use this module. **See** the **Multiple Primary Rules** to determine whether these tumors are a single primary.

Rule H12 Code adenocarcinoma in familial adenomatous polyposis coli (**FAP**) **8220** when **clinical** history says the patient has **familial polyposis AND**

- The final diagnosis on the **pathology report** from resection is **adenocarcinoma in FAP OR**
- There are **greater than 100 polyps** identified in the resected specimen

Note 1: Use this rule **only** when there are **multiple polyps**. **Do not** use for a single polyp (adenoma) or for a de novo (frank) malignancy and a malignancy in a single polyp.
Note 2: Use this rule **ONLY** for adenocarcinoma in **FAP.**
Note 3: The disease process, treatment, and prognosis for FAP is not as favorable as a single polyp with adenocarcinoma.

Rule H13 Code adenocarcinoma in multiple adenomatous polyps **8221** when FAP is not mentioned **AND**

- There are at least 2 polyps with adenocarcinoma /2 or /3 **AND**
  - Less than or equal to 100 polyps are identified **OR**
  - The exact number of polyps is unknown/not documented

Note 1: **Do not use** this code for a malignancy in **a single polyp** (adenoma) or for a de novo (frank) malignancy.
Note 2: Use this rule **ONLY** for **adenocarcinoma NOS** in multiple polyps**.**

Rule H14 Code the histology of the **invasive** tumor when there are **in situ** /2 and **invasive** /3 tumors.

- One tumor is in situ and the other is invasive
- All tumors are a **mixture** of **in situ** and **invasive** histology

Rule H15 Code the histology when only **one** histology is present in **all** tumors.

Note 1: Use **Table 1** to code histology. New codes, terms, and synonyms are included in **Table 1** and coding errors may occur if the table is not used.
Note 2: When the histology is **not listed** in **Table 1,** use the **ICD-O** and all **updates**.
Note 3: Submit a question to Ask a SEER Registrar when the histology code is not found in Table 1, ICD-O or all updates.

Rule H16 Code the **subtype/variant** when the diagnosis is a **NOS** and a **single subtype/variant** of that NOS such as the following:

- Adenocarcinoma **8140** and a subtype/variant of adenocarcinoma
- Mixed adenoneuroendocrine carcinoma **8244** and a subtype/variant of mixed adenoneuroendocrine carcinoma
- Neuroendocrine carcinoma **8246** and a subtype/variant of neuroendocrine carcinoma
- Neuroendocrine tumor Grade 1 (G1) **8240** and a subtype/variant of neuroendocrine tumor Grade 1 (G1)
- Sarcoma **8800** and a subtype/variant of sarcoma

Note 1: All tumors may be **mixed** histologies (NOS and a subtype/variant of that NOS) **OR** one tumor may be a **NOS** histology and the other tumor a **subtype/variant** of that NOS.

Note 2: See **Table 1** in the Equivalent Terms and Definitions to find NOS and subtypes/variants.

Note 3: Check the **Multiple Primary Rules** to confirm that the tumors are a single primary.

Note 4: Only code subtypes/variant when pathology gives an **exact diagnosis**. **Do not** code the subtype/variant when **modified** by terms such as **differentiation, features of, etc., unless** there is a specific code for the histology term with the modifier.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.

Code the histology using the rule that fits the case.