Breast Equivalent Terms and Definitions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Introduction

Note 1: Breast includes Nipple C500; Central portion of breast C501; Upper-inner quadrant C502; Lower-inner quadrant C503; Upper-outer quadrant of breast C504; Lower-outer quadrant C505; Axillary tail C506; Overlapping lesion of breast C508; Breast NOS C509.

Note 2: 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 3: 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 4: For those sites/histologies which have recognized **biomarkers**, the biomarkers are most frequently used to target treatment. Biomarkers may identify the histologic type. Currently, there are clinical trials being conducted to determine whether these biomarkers can be used to identify multiple primaries. Follow the Multiple Primary Rules; do not code multiple primaries based on biomarkers.

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Changes from 2007 MPH Rules

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

1. **NST (No Special Type), mammary carcinoma NST, and carcinoma NST** are the new terms for duct or ductal carcinoma. Previously, it was thought that carcinoma originated in the ducts or lobules of the breast, hence the names duct carcinoma and lobular carcinoma. Current thinking is that carcinoma originates in the "terminal duct lobular unit" therefore the preferred term is NST or carcinoma NST.
2. **Mammary carcinoma** is a synonym for carcinoma no special type (NST)/duct carcinoma not otherwise specified (NOS) **8500.** It will **no longer** be coded as carcinoma NOS **8010.**
3. **DCIS/Carcinoma NST in situ** has a major classification change.
   A. Subtypes/variant, architecture, pattern, and features **ARE NOT CODED**. The majority of in situ tumors will be coded to DCIS **8500/2.**
   B. It is very important to code the grade of all DCIS.
      i. Code grade as designated in current AJCC Manual, SEER Coding Manual, and COC Coding Manual.
      ii. The current breast **WHO** edition emphasizes coding the **grade** of tumor rather than the **subtype/variant**.
      iii. The WHO editions are used internationally by pathologists to keep their nomenclature and histology identification current.
      iv. Over time, **subtypes/variants** will be diagnosed **less frequently.**
4. The invasive subtype/variant is coded **ONLY** when it comprises **greater than 90%** of the tumor. This change has been implemented in both the WHO and in the CAP protocols.
5. **New codes/terms** are identified by asterisks (*) in the histology table in the Terms and Definitions.
6. Excerpt from the CAP Invasive Breast Protocol (page 17): "A modified list is presented in the protocol based on the most frequent types of invasive carcinomas and terminology that is in widespread usage. The modified list is intended to capture the majority of tumors and reduce the classification of tumors being reported as 'other.' The WHO classification is presented for completeness".

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New for 2023

The rules for determining single versus multiple primaries in tumors with carcinoma NST/duct and lobular carcinoma have been revised and now align with ICD-O-3.2. Applicable Histology Rules have also been revised to reflect ICD-O-3.2 histology terminology and corresponding ICD-O codes.

New for 2024

1. Beginning with cases diagnosed 1/1/2024 forward, in situ lobular carcinoma with other types of in situ carcinoma 8524/2 has been deemed biologically impossible based on expert pathologist review for the Cancer PathCHART project. Table 2 has been updated with coding instructions and new H rules were added to the in situ histology section.

2. Cancer PathCHART Specialty Matter Expert review of breast histologies determined some histologies with individual ICD-O codes are to be considered synonyms for the NOS term for cases diagnosed 1/1/2024 forward. Therefore, they have been moved from the subtype/variant column 3 to synonym column 2. These terms have been identified with the symbol **++.** Terms and codes which were moved to column 2 are still listed in column 3 with the corresponding ICD-O code and note indicating valid for cases diagnosed prior to 1/1/2024.

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Equivalent or Equal Terms

These terms can be used interchangeably:

- And; with; (duct **and** lobular is equivalent to duct **with** lobular)
  Note: "And" and "with" are used as synonyms when **describing multiple histologies** within a **single tumor**.
- Behavior code /2; DCIS; intraductal; noninfiltrating; noninvasive; carcinoma in situ
- Carcinoma; adenocarcinoma
- De novo; new tumor; frank (obsolete term)
- Duct; ductal; NST (no special type); carcinoma NST; mammary carcinoma
- Mammary; breast
- Simultaneous; synchronous; existing at the same time; concurrent; prior to first course treatment
- Topography; site code
- 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

Terms that are NOT Equivalent or Equal

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

- **Phenotype** is not equivalent to **subtype/type/variant**
- **Invasive carcinoma, NST with lobular features** is not equivalent to **invasive carcinoma with ductal and lobular features**

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Table 1: Primary Site Codes

Table 1 contains terms used in **mammograms, clinical diagnosis,** and less frequently the **operative and pathology reports** to describe the **location** of the tumor. Find the **term** in Column 1 and use the **site code** in Column 2.

Note: See the **"clock" diagram** at the end of the Equivalent Terms and Definitions for a graphic of the o'clock designations and corresponding **quadrants/subsites** of the breast.

Refer to the **SEER Manual** and **COC Manual** for a **priority list** for using documents such as mammograms, operative reports, and pathology reports to determine the tumor location.

Column 1 includes terms used to describe the **location/site** of the tumor.
Column 2 contains the **site term and code.**

Terms and Descriptive Language	Site Term and Code
Areolar Nipple Paget disease **without** underlying tumor ***Note:*** Paget with underlying tumor is coded to the quadrant of breast in which the underlying tumor is located	Nipple **C500**

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Terms and Descriptive Language	Site Term and Code
Above nipple Area extending 1 cm around areolar complex Behind the nipple Below the nipple Beneath the nipple Central portion of breast Cephalad to nipple Infra-areolar Lower central Next to areola NOS Next to nipple Retroareolar Subareolar Under the nipple Underneath the nipple	Central portion of breast **C501**
Superior inner Superior medial Upper inner quadrant (UIQ) Upper medial	Upper inner quadrant of breast **C502**
Inferior inner Inferior medial Lower inner quadrant (LIQ) Lower medial	Lower inner quadrant of breast **C503**
Superior lateral Superior outer Upper lateral Upper outer quadrant (UOQ)	Upper outer quadrant of breast **C504**

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Terms and Descriptive Language	Site Term and Code
Inferior lateral Inferior outer Lower lateral Lower outer quadrant (LOQ)	Lower outer quadrant of breast **C505**
Axillary tail of breast Tail of breast NOS Tail of Spence	Axillary tail of breast **C506**
12:00 o'clock 3:00 o'clock 6:00 o'clock 9:00 o'clock Inferior breast NOS Inner breast NOS Lateral breast NOS Lower breast NOS Medial breast NOS Midline breast NOS Outer breast NOS Overlapping lesion of breast Superior breast NOS Upper breast NOS	Overlapping lesion of breast C**508** ***Note:*** This is a **single tumor** which **overlaps quadrants/subsite.**
¾ or more of breast involved with tumor Diffuse (tumor size 998) Entire breast Inflammatory without palpable mass Multiple tumors in different subsites (quadrants) within the same breast	Breast NOS **C509** ***Note:*** Used for: • Non-contiguous **multiple** tumors in **different quadrants/subsites** of same breast **OR** • **Unknown/unable to identify** in which **quadrant/subsite** the tumor is l**ocated** (Example: Outpatient biopsy with no quadrant identified. Patient lost to follow-up.) • Inflammatory carcinoma; diffuse tumor

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Table 2: Histology Combination Codes

Instructions:

1. Use Table 2 when instructed to by the Multiple Primary and Histology Rules.
2. Compare the **terms** in the **diagnosis** (pathology, cytology, radiographic, clinical) to the terms in **Column 1.**
3. When the terms **match**, use the **combination code** listed in **Column 2.**
4. The **last row** in the table is a **"last resort"** code: adenocarcinoma mixed subtypes **8255**.
5. Use the combination codes only when the histologies are in a **single** tumor **OR multiple tumors** abstracted as a single primary.
6. Mixed histologies may be described as follows:
   A. A "**combination** of"
   B. Histology 1 **AND** histology 2
   C. Histology 1 **WITH** histology 2
   D. **Mixed** histology 1 and histology 2

Note 1: **Do not** use Table 2 in the following situations:

- For tumors with both **invasive** and **in situ** behavior. The **Histology Rules** instruct to code the invasive histology.
- When one of the histologies is described as **differentiation or features**
- When the terms are a **NOS** and a **subtype/variant** of that NOS. See the **Histology Rules** for instructions on coding a NOS and a subtype/variant in a single tumor or multiple tumors abstracted as a single primary.

Note 2: Some histologies can be in situ or invasive; others are limited to either /2 or /3 behavior code.

- When a code is **limited to in situ, /2** will be **added** to the code (both components are in situ)
- When a code is **limited to invasive, /3** will be **added** to the code (both components are invasive)

Note 3: This table is not a complete listing of histology combinations.

Column 1 contains the required ICD-O histology terms.
Column 2 contains the histology **combination term** and **code.**

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Required Histology Terms	Histology Combination Term and Code
DCIS/duct carcinoma/carcinoma NST **8500** **AND** LCIS/lobular carcinoma **8520 or 8519** ***Note 1:*** Histologies may be a mix of in situ and invasive ***Note 2:*** 8522 is used when: • Duct and lobular carcinoma are present in a single tumor **OR** • Duct is present in at least one tumor and lobular present in a least one tumor in the same breast **OR** • One tumor is mixed duct and lobular; the other tumor in the same breast is either duct or lobular **OR** • All tumors in the same breast are mixed duct and lobular ***Example:*** One tumor with invasive duct carcinoma in LOQ RT breast; second tumor with invasive lobular carcinoma in UOQ RT breast ***Note 3:*** **Do not** use 8522 when the diagnosis is carcinoma NST/duct carcinoma with lobular **differentiation.** See Histology Rules for instructions on **coding differentiation**.	DCIS and in situ lobular carcinoma **8522/2** Note: The lobular includes pleomorphic lobular carcinoma in situ **8519/2** Invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma **8522/3** ***Note 1:*** CAP uses the term Invasive carcinoma with ductal and lobular features ("mixed type carcinoma") to indicate both duct and lobular are present. ***Note 2:*** This is an exception to the instruction that features are not coded. ***Note 3:*** Carcinoma NST includes all subtypes of carcinoma NST ***Note 4:*** Lobular carcinoma includes invasive pleomorphic lobular carcinoma **Additional combinations of duct and lobular coded 8522/3**: • Intraductal and lobular carcinoma (includes invasive pleomorphic lobular carcinoma) • Infiltrating duct and lobular carcinoma in situ (LCIS) • Infiltrating duct and pleomorphic lobular carcinoma in situ • Infiltrating lobular carcinoma and ductal carcinoma in situ (DCIS) Infiltrating pleomorphic lobular carcinoma and ductal carcinoma in situ (DCIS)

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Required Histology Terms	Histology Combination Term and Code
DCIS/duct carcinoma/carcinoma NST **OR** any ONE subtype/variant of carcinoma NST **AND** **Any** histology in **Table 3 with exception** of • Lobular carcinoma **8520** and pleomorphic lobular carcinoma in situ **8519/2*** • Paget disease **8540** ***Note 1:*** Both histologies **must have** the **same behavior** code. ***Note 2:*** See **Table 3** for carcinoma NST/duct carcinoma subtypes/variants. ***Note 3:*** **Do not** use combination code for duct with lobular **differentiation.** This is a synonym for carcinoma NST.	Invasive carcinoma NST/duct mixed with other types of invasive carcinoma **8523/3** DCIS mixed with other in situ carcinoma **8500/2** ***Note***: Prior to 2018, DCIS and other in situ was coded **8523/2**.
Lobular carcinoma **AND** **Any** histology in **Table 3 with exception** of • Duct carcinoma/carcinoma NST/DCIS (and subtypes/variants) **8500** • Paget disease, in situ and invasive ***Note 1:*** See **Table 3** for carcinoma NST/duct carcinoma subtypes/variants. ***Note 2:*** This code does not include lobular and Paget disease. See Multiple Primary Rules. Lobular carcinoma and Paget are separate primaries.	Infiltrating lobular mixed with other types of carcinoma **8524/3** In situ lobular mixed with other types of in situ carcinoma **8524/2** **(Cases diagnosed prior to 1/1/2024 only)** ***Note***: Beginning with cases diagnosed 1/1/2024 forward, in situ lobular carcinoma with other types of in situ carcinoma 8524/2 has been deemed biologically impossible based on expert pathologist review for the Cancer PathCHART project. See Rule H7 and H8 for coding instructions.

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Required Histology Terms	Histology Combination Term and Code
Metaplastic carcinoma OR any ONE subtype/variant of metaplastic carcinoma **AND** **Duct carcinoma/carcinoma NST OR** **Lobular carcinoma**	Code metaplastic carcinoma **8575** OR Subtype/variant of metaplastic carcinoma **Note**: Metaplastic carcinoma, NOS and subtypes are almost always mixed with invasive mammary carcinoma, NST and at times lobular carcinoma. These tumors should be coded to metaplastic regardless of percent invasive mammary carcinoma or lobular carcinoma present.
Paget disease **AND** **Underlying** DCIS ***Note:*** Paget disease is classified as malignant /3 in the ICD-O. Paget disease is coded as in situ /2 **ONLY** when the pathology states the Paget disease is in situ.	Paget disease (invasive or behavior not specified) and DCIS/intraductal carcinoma **8543/3** **Paget disease** (specified as in situ) and DCIS/intraductal carcinoma **8543/2**
Paget disease **AND** **Underlying** infiltrating **duct** carcinoma/carcinoma NST and **all subtypes/variants** of infiltrating duct/carcinoma NST (must be a /3) ***Note:*** See **Table 3** for subtypes/variants of carcinoma NST/duct carcinoma.	Paget disease and infiltrating duct carcinoma **8541/3**

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Required Histology Terms	Histology Combination Term and Code
Any two invasive carcinoma NST subtypes/variants (percentage not stated) abstracted as a single primary ***Note 1:*** The diagnosis may be two subtypes/variants and the pathologist may mention the presence of duct/carcinoma NST. Ignore the mention of carcinoma NST. ***Note 2:*** See **Table 3** for subtypes/variants of carcinoma NST/duct carcinoma.	Adenocarcinoma with mixed subtypes **8255/3**

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Table 3: Specific Histologies, NOS/NST, and Subtypes/Variants

Use Table 3 as directed by the **Histology Rules** to assign the more common histology codes for breast tumors.

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 is not found in Table 3, 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.
Note 4: Only use the histology code from the table when the diagnosis is **EXACTLY** the term listed.

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.

Column 3 may contain NOS histologies which are part of a bigger histologic group. For example, sarcoma NOS 8800/3 (column 1) is a generic term which encompasses a number of soft tissue tumors, including rhabdomyosarcoma 8900/3 (column 3). Rhabdomyosarcoma is also a NOS because it has subtypes/variants. The subtypes/variants are indented under the NOS (rhabdomyosarcoma) in column 3. There is also a note in column 1 which calls attention to the fact that rhabdomyosarcoma has subtypes/variants.
When subtypes/variants are indented under a NOS in Column 3, use coding rules for a NOS and a single subtype/variant. For example, rhabdomyosarcoma **8900/3** and alveolar type rhabdomyosarcoma **8920/3** are a NOS and a subtype/variant, **NOT** two different subtypes.

Table begins on next page

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Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
Acinic cell carcinoma 8550	Acinar adenocarcinoma Acinar carcinoma	
Adenoid cystic carcinoma (ACC) 8200	ACC Adenocystic basal cell carcinoma Carcinoma adenoides cysticum Cylindromatous carcinoma	
Adenomyoepithelioma with carcinoma 8983	AME Malignant AME	
Apocrine carcinoma 8401 ***Note:*** This is a diagnosis that is **EXACTLY** apocrine **carcinoma**, **not** a carcinoma **NST** with apocrine **features**, **differentiation**, **or type.**		
Carcinoma NST 8500 ***Note***: Cribriform carcinoma may consist of up to 50% tubular formations. The term cribriform/tubular carcinoma is coded as cribriform carcinoma.	Carcinoma, NOS Carcinoma of no special type (ductal/NST) Carcinoma/carcinoma NST with choriocarcinomatous features Carcinoma/carcinoma NST with cribriform features Carcinoma/carcinoma NST with melanotic features Carcinoma/carcinoma NST with neuroendocrine features Carcinoma/carcinoma NST with signet ring cell differentiation DCIS **8500/2** DCIS of high nuclear grade **8500/2**	Carcinoma with osteoclastic-like stromal giant cells **8035** Cribriform carcinoma/Ductal carcinoma, cribriform type **8201/3;** Cribriform carcinoma in situ **8201/2** Pleomorphic carcinoma **8022/3** Ductal carcinoma in situ, solid type/intraductal carcinoma, solid type **8230/2** Solid carcinoma/solid adenocarcinoma **8230/3 ++(cases diagnosed prior to 1/1/2024 only)**

Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
	DCIS of intermediate nuclear grade **8500/2** DCIS of low nuclear grade **8500/2** Duct/ductal carcinoma Duct/ductal carcinoma in situ **8500/2** Duct/ductal carcinoma NOS Duct/ductal carcinoma NST (no special type) Duct/ductal carcinoma with apocrine features Duct/ductal carcinoma with apocrine metaplasia Duct/ductal carcinoma with lobular features Duct/ductal carcinoma with micropapillary features Duct/ductal carcinoma with mucin production Duct/ductal carcinoma with neuroendocrine features Duct/ductal carcinoma with squamous metaplasia Infiltrating ductal carcinoma **8500/3** Intraductal carcinoma **8500/2** Invasive carcinoma with medullary features **8500/3** Invasive carcinoma with micropapillary features **8500/3** Invasive carcinoma with neuroendocrine features **8500/3** Invasive carcinoma not otherwise specified (ductal/NOS) **8500/3** Invasive carcinoma NST with metaplastic features **8500/3**	

Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
	Invasive carcinoma NST/duct with medullary features **8500/3** Invasive carcinoma, with signet-ring cell features **8500/3** Invasive carcinoma of no special type (NST) **8500/3** Invasive carcinoma with clear cell (glycogen rich) features **8500/3** Invasive carcinoma, NST **8500/3** Invasive carcinoma, type cannot be determined **8500/3** Invasive mammary carcinoma **8500/3** Invasive mammary carcinoma associated with encysted papillary carcinoma **8500/3** Invasive mammary carcinoma NST with lobular features **8500/3** Invasive mammary carcinoma NST with medullary features **8500/3** Invasive mammary carcinoma NST with mucinous features **8500/3** Invasive mammary carcinoma NST with neuroendocrine features **8500/3** Invasive mammary carcinoma NST with tubulo-lobular variant **8500/3** Invasive mammary carcinoma with apocrine features **8500/3** Invasive mammary carcinoma with cribriform features **8500/3**	

Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
	Invasive mammary carcinoma with tubular features **8500/3** Invasive solid carcinoma/ adenocarcinoma **8500/3 ++(cases diagnosed 1/1/2024 forward)** Mammary carcinoma in situ **8500/2** Mammary carcinoma/cancer Non-invasive mammary carcinoma **8500/2**	
Glycogen-rich clear cell carcinoma 8315	Glycogen-rich carcinoma	Clear cell carcinoma **8310**
Inflammatory carcinoma 8530		
Lipid-rich carcinoma 8314	Lipid-secreting carcinoma	
Lobular carcinoma 8520	Alveolar lobular carcinoma Classic lobular carcinoma Florid lobular carcinoma **8520/2** Intraductal papilloma with lobular carcinoma in situ **8520/2** Invasive lobular carcinoma, alveolar type/variant **8520/3** Invasive lobular carcinoma, solid type **8520/3** Lobular carcinoma in situ **8520/2** Lobular carcinoma with cribriform features Mixed lobular carcinoma (lobular carcinoma NOS and one or more variants of lobular carcinoma) Invasive pleomorphic lobular carcinoma **8520/3** Solid lobular carcinoma Tubulolobular carcinoma	Pleomorphic lobular carcinoma in situ **8519/2*** ***Note:*** 8519/2 is a new code for in situ /2 tumors only.

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Medullary carcinoma 8510	MC	Atypical medullary carcinoma (AMC) **8513**
Metaplastic carcinoma NOS or of no special type (NST) 8575 ***Note 1*:** Squamous cell carcinoma of the breast is **extremely rare.** Carefully **check** the **pathology** report to verify the squamous cell originated in the breast parenchyma, rather than the skin of the breast. ***Note 2*:** Metaplastic carcinoma, NOS and subtypes are almost always mixed with invasive mammary carcinoma, NST and at times lobular carcinoma. These tumors should be coded to metaplastic regardless of percent invasive mammary carcinoma or lobular carcinoma present.	Invasive mammary carcinoma with matrix production Metaplastic carcinoma, mixed epithelial and mesenchymal type Metaplastic carcinoma with mesenchymal differentiation Metaplastic carcinoma with squamous features Metaplastic carcinoma with other types of mesenchymal differentiation Mixed metaplastic carcinoma Metaplastic carcinoma spindle- cell type/spindle cell carcinoma ++**(cases diagnosed 1/1/2024 forward)**	Carcinosarcoma **8980/3** Fibromatosis-like metaplastic carcinoma **8572** Low grade adenosquamous carcinoma **8560** Metaplastic carcinoma spindle-cell type/spindle cell carcinoma **8032 ++(cases diagnosed prior to 1/1/2024)** Metaplastic carcinoma with chondroid differentiation/with osseous differentiation **8571** Myoepithelial carcinoma **8982** Squamous cell carcinoma **8070**

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Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
Mucinous carcinoma 8480 *Note 1:* This is a diagnosis that is **EXACTLY** "mucinous carcinoma," "mucinous duct carcinoma," "mucinous DCIS" OR "greater than 90% mucinous." **See Histology Rules**. *Note 2:* Mucinous duct carcinoma is listed on the CAP protocol. It is not recognized by WHO or IARC. Mucinous carcinoma is not a subtype/variant of Carcinoma NST/duct carcinoma.	Colloid carcinoma Mucinous adenocarcinoma Mucoid carcinoma	
Mucoepidermoid carcinoma 8430		
Oncocytic carcinoma 8290		
Paget disease of the nipple with no underlying tumor 8540		
Papillary carcinoma 8503	Intraductal papillary carcinoma **8503/2*** Intraductal papillary carcinoma with DCIS **8503/2*** Intraductal papilloma with ductal carcinoma in situ **8503/2** Invasive ductal papillary carcinoma **8503/3** Invasive papillary carcinoma **8503/3** Papillary carcinoma of breast, NOS **8503/3** Papillary carcinoma non-invasive **8503/2*** Papillary ductal carcinoma in situ **8503/2***	Encapsulated papillary carcinoma, NOS/non-infiltrating/intracystic **8504/2** with invasion **8504/3** with invasive carcinoma, NST/invasive duct carcinoma **8504/3** Micropapillary carcinoma **8507*** Tall cell carcinoma with reverse polarity **8509/3;** Solid papillary carcinoma in situ **8509/2*** with invasion **8509/3***

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Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
Phyllodes tumor, malignant 9020/3	Cystosarcoma phyllodes, malignant Periductal stromal tumor, low grade	
Polymorphous carcinoma 8525		
Sarcoma NOS 8800/3 ***Note 1:*** Angiosarcoma **9120/3** is also a NOS with the following subtypes/variants: Lymphangiosarcoma 9170/3 Malignant hemangioendothelioma 9130/3 ***Note 2*:** Rhabdomyosarcoma **8900/3** is also a NOS with the following subtypes/variants: Alveolar type rhabdomyosarcoma **8920/3** Embryonal type rhabdomyosarcoma **8910/3** Pleomorphic rhabdomyosarcoma **8901/3** ***Note 3:*** Angiosarcoma has the following synonyms (they are not subtypes/variants): Epithelioid angiosarcoma Hemangiosarcoma Post radiation angiosarcoma of breast		Angiosarcoma **9120/3** Epithelioid angiosarcoma Hemangiosarcoma Post radiation angiosarcoma of breast Lymphangiosarcoma **9170/3** Malignant hemangioendothelioma **9130/3** Liposarcoma **8850/3** Leiomyosarcoma **8890/3** Osteosarcoma **9180/3** Rhabdomyosarcoma **8900/3** Alveolar type **8920/3** Embryonal type **8910/3** Pleomorphic **8901/3**

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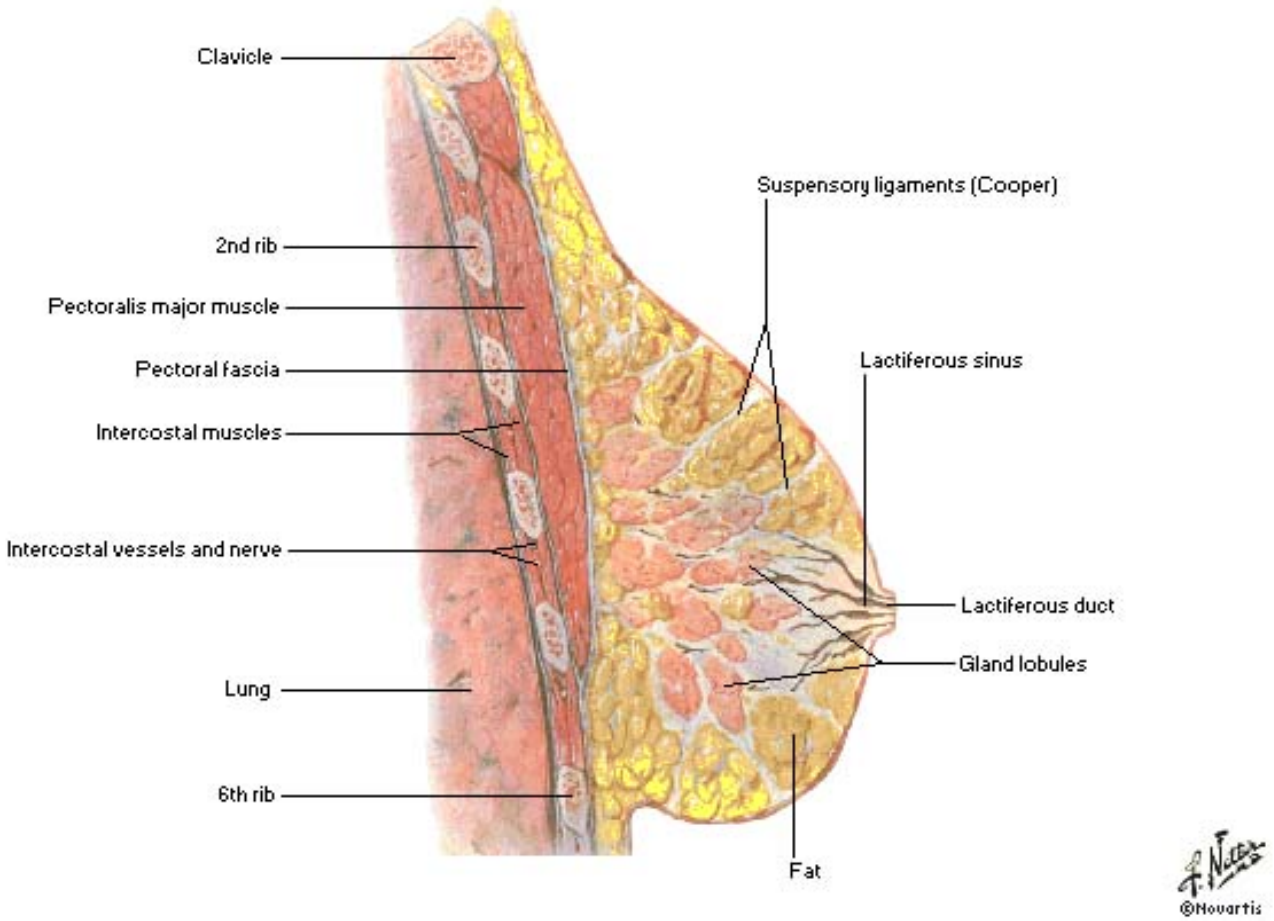
Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
Sebaceous carcinoma 8410		
Secretory carcinoma 8502	Juvenile breast carcinoma	
Signet ring carcinoma 8490		
Small cell carcinoma 8041	Carcinoid tumor of breast Endocrine carcinoma Neuroendocrine carcinoma, poorly differentiated	Carcinoma with neuroendocrine differentiation **8574/3** Neuroendocrine tumor, well-differentiated **8246/3**
Tubular carcinoma 8211		

***New codes approved by IARC/WHO Committee for ICD-O**

++Denotes change per Cancer PathCHART Specialty Matter Expert review. ICD-O codes and terms with ++ have a separate ICD-O code, however, per the expert review, are considered a synonym for the NOS term. This change applies to cases diagnosed 1/1/2024 forward. The terms and ICD-O codes remain subtype/variants for cases diagnosed prior to 1/1/2024.

Illustrations



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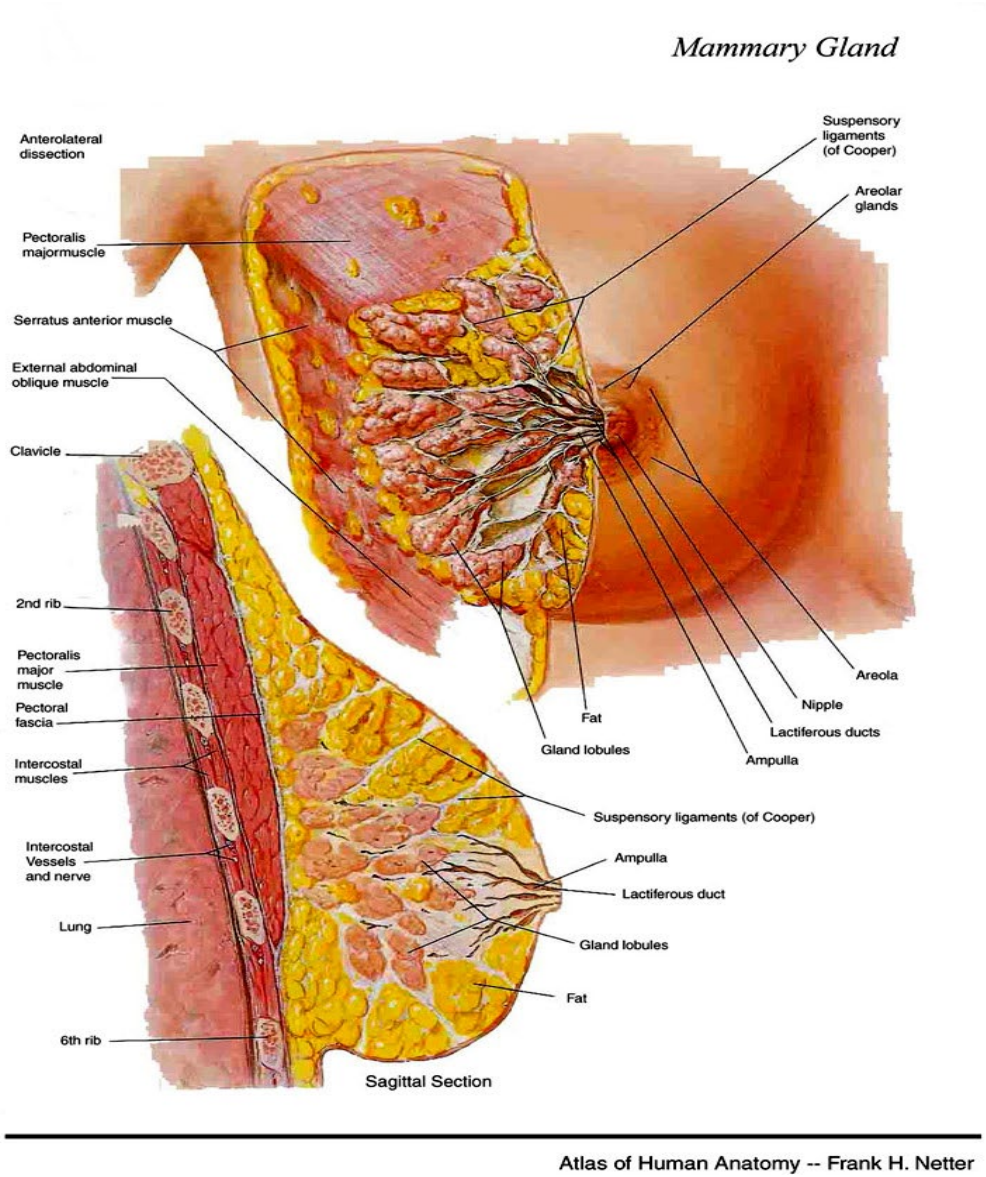
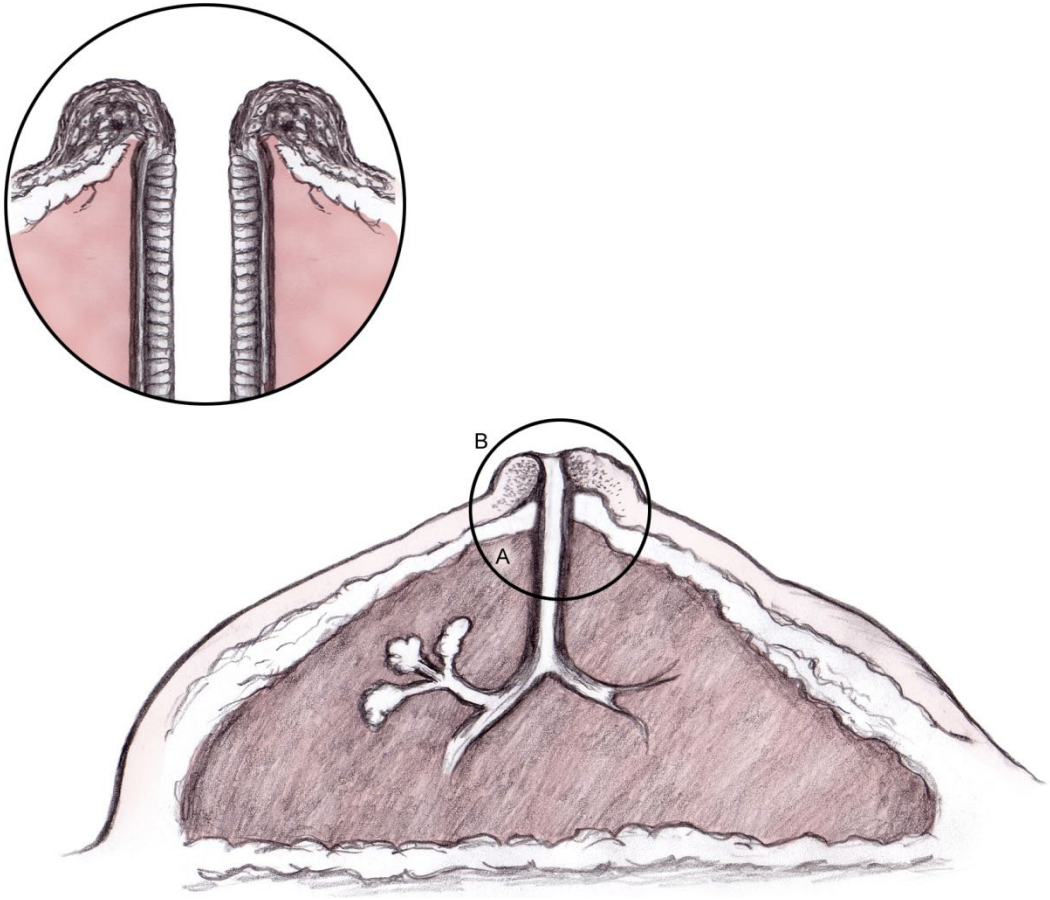
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)



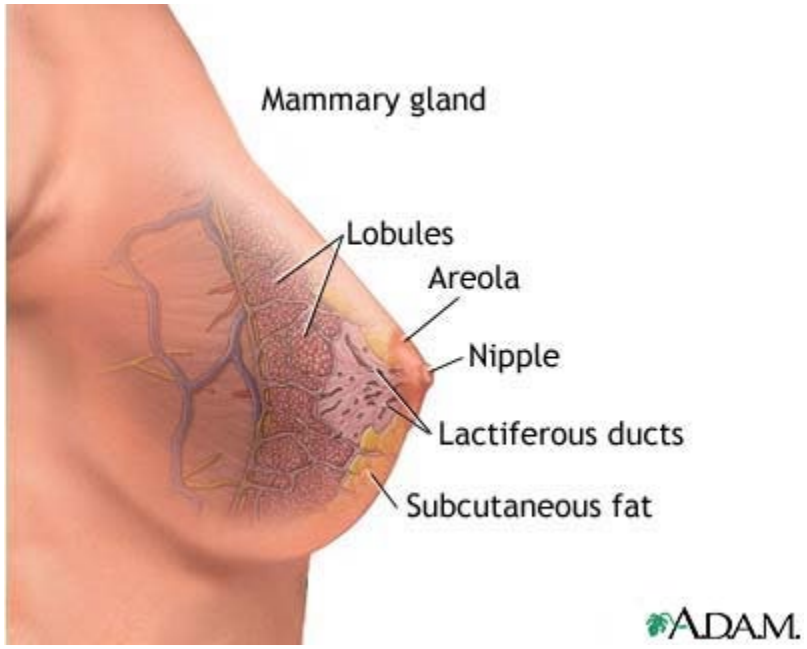
Breast Equivalent Terms and Definitions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)



Paget Disease of the nipple. Shows growth pattern of Paget on the pigmented portion of nipple and inside the milk duct opening

Source:
*"Image reprinted with permission from eMedicine.com, 2010. Available at: **http://emedicine.medscape.com/article/1101235-overview***

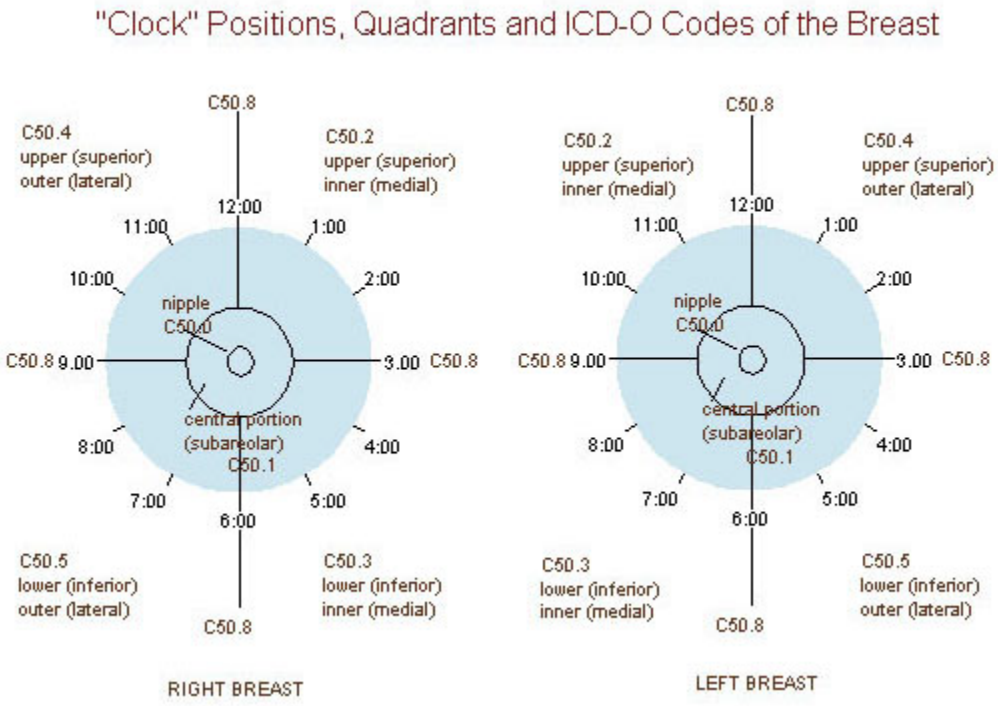
Breast Equivalent Terms and Definitions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)



Breast Equivalent Terms and Definitions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

The position of the tumor in the breast may be described as the positions on a clock

The two circles in the graphic are
Innermost circle: Retroareolar (under/behind areola)
Outer circle: Central portion of breast



Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Note 1: These rules are **NOT** used for tumor(s) described as metastases. Metastatic tumors include but are not limited to:

- Axillary lymph nodes
- Bone
- Brain
- Chest wall
- Discontinuous involvement of skin of breast
- Distant lymph nodes as identified in Summary Staging Manual
- Liver
- Lung

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

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.**

Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Single Tumor

IMPORTANT: If the current tumor was **preceded** by a tumor in the same breast or contralateral breast, go to the **Multiple Tumors module.**

Rule M2 Abstract a **single primary**[i] when the diagnosis is **inflammatory carcinoma** in:

- Multiple quadrants of same breast **OR**
- Bilateral breasts

Rule M3 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/quadrants.
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.

Multiple Tumors

Note 1: Multiple tumors may be single primary or multiple primaries**.**
***Note 2*:** ER, PR, and/or HER2 are not used to determine multiple primaries.
Note 3: A subsequent tumor in the chest wall or surgical scar **without** evidence of residual breast tissue is regional metastasis.

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 characters (Cx**X**x).

Note 1: Tumors with site codes that differ at the second or third character are in **different primary sites;** for example, a breast tumor C**50x** and a colon tumor C**18**x differ at the second and third character.
Note 2: This rule **does not** include metastases. Metastatic tumors are not used to determine multiple primaries; for example, liver metastases from the breast cancer would not be counted as a second primary.

Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M5 Abstract **multiple primaries**[ii] when the patient has a subsequent tumor after being **clinically disease-free** for **greater than five years** after the original diagnosis or last recurrence.

Note 1: The rules are hierarchical. This rule **only** applies when there is a **subsequent tumor in the same breast.** In other words, a primary in the contralateral breast does not start the "clock" over.

Note 2: **Clinically** disease-free means that there was **no evidence** of recurrence on follow-up.

- Mammograms are NED
- Scans are NED

Note 3: When there is a recurrence less than or equal to five years 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 five years from the date of the last recurrence.

Note 4: When it is **unknown/not documented** whether the patient had a recurrence, use **date of diagnosis** to compute the time interval.

Note 5: The physician may state this is a **recurrence,** meaning the patient had a previous breast tumor and now has another breast tumor. **Follow the rules;** do not attempt to interpret the physician's statement.

Note 6: When a breast resection was done and a subsequent tumor is identified in the remaining chest wall, muscle, or skin AND there was no residual breast tissue identified in the resected specimen, this is a recurrence and not a new primary.

Rule M6 Abstract a **single primary**[i] when there is **inflammatory carcinoma** in:

- Multiple quadrants of same breast **OR**
- Bilateral breasts

Rule M7 Abstract **multiple primaries**[ii] when there is **bilateral** breast cancer (both right and left breast).

Note 1: Physician statement of "bilateral breast cancer" should **not be interpreted** as meaning a single primary. The term is not used consistently. The literal definition of bilateral is "cancer in both breasts".

Note 2: The histologies within each breast may be the same or different.

Rule M8 Abstract a **single primary**[i] when the diagnosis is **Paget disease with synchronous underlying** in situ or invasive carcinoma NST (duct/ductal) or subtypes of duct.

Note: If the underlying tumor is any histology **other than** duct or subtypes of duct, continue through the rules.

Rule M9 Abstract **multiple primaries**[ii] when the diagnosis is **Paget disease with underlying** tumor which is NOT duct.

Example: Paget disease of the nipple with underlying lobular carcinoma are multiple primaries.

Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M10 Abstract a **single primary**[i] when there are multiple tumors of **carcinoma NST/duct and lobular**.

- Both/all tumors may be a mixture of carcinoma NST/duct and lobular 8522 **OR**
- One tumor may be duct and another tumor lobular **OR**
- One tumor may be mixed duct and lobular 8522, the other tumor either duct or lobular

Note 1: Tumors must be in the same breast.

Note 2: Carcinoma NST/duct includes:

- DCIS **8500/2**
- Carcinoma NST **8500/3**
- Carcinoma with osteoclastic-like stromal giant cells **8035/3** (subtype/variant of carcinoma NST)
- Cribriform carcinoma **8201/3**
- Pleomorphic carcinoma **8022/3**

Note 3: Lobular carcinoma includes:

- In situ lobular carcinoma **8520/2**
- In situ pleomorphic lobular carcinoma **8519/2**
- Invasive lobular carcinoma **8520/3**
- Invasive pleomorphic lobular carcinoma **8520/3**

Note 4: **When a mixture of behaviors is present in carcinoma, NST and lobular carcinoma, follow the H rules to determine the correct histology code.**

Note 5: For cases initially diagnosed as in situ with subsequent invasive tumor and stated to be a single primary per M10, edit the original abstract as follows:

- Do not change date of diagnosis.
- For cases which have been abstracted, change behavior code on original abstract from /2 to 8522/3.
- Report all data changes for cases which have been submitted to the central registry.

Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M11 Abstract a **single primary**[i] when a **ductal** carcinoma occurs **after a combination code** in the same breast. See the following list:

- **DCIS** following a diagnosis of:
  - DCIS + lobular carcinoma in situ **8522/2 OR**
  - DCIS + in situ Paget **8543/2 OR**
  - DCIS + Invasive Paget **8543/3 OR**
  - DCIS mixed with other in situ **8523/2** (code used for cases diagnosed prior to 1/1/2018)
- **Invasive carcinoma NST/duct** following a diagnosis of:
  - Invasive duct + invasive lobular **8522/3 OR**
  - Invasive duct + invasive Paget **8541/3 OR**
  - Invasive duct + other invasive carcinoma **8523/3**

Rule M12 Abstract **multiple primaries**[ii] when separate/non-contiguous tumors are two or more **different subtypes/variants** in Column 3 of **Table 3** 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**: Encapsulated papillary carcinoma with invasion 8504/3 and solid papillary carcinoma with invasion 8509/3 are both subtypes of invasive papillary carcinoma 8503/3 but are distinctly different histologies. Abstract multiple primaries.
- **Different NOS**: Encapsulated papillary carcinoma 8504/2 is a subtype/variant of in situ papillary carcinoma 8503/2. Pleomorphic lobular carcinoma in situ 8519/2 is a subtype/variant of lobular carcinoma in situ 8520/2. They are distinctly different histologies. Abstract multiple primaries.

Rule M13 Abstract a **single primary**[i] when **synchronous**, separate/non-contiguous tumors are on the **same row** in **Table 3** 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) **OR**
- A NOS histology in column 3 with an indented subtype/variant

Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M14 Abstract **multiple primaries**[ii] when separate/non-contiguous tumors are:

- On **different rows** in **Table 3** in the Equivalent Terms and Definitions
- A combination code in **Table 2** and a code from **Table 3**

Note 1: Timing is irrelevant. Tumors may be synchronous or non-synchronous.

Note 2: Each row in the table is a distinctly different histology.

Example 1: Paget disease of the nipple with underlying lobular are multiple primaries. Paget and lobular are on different rows in Table 3.

Example 2: Two tumors right breast. One tumor is invasive mixed duct and lobular 8522/3 (combination code from Table 2) and the second tumor is tubular 8211/3 (histology from Table 3). Abstract two primaries: 8522/3 and 8211/3.

Rule M15 Abstract a **single primary**[i] (the invasive) when an **in situ** tumor is diagnosed **after** an **invasive** tumor in the same breast.

Note 1: Once the patient has an invasive tumor, the **in situ** is recorded as a **recurrence** for those registrars who collect recurrence data.

Note 2: The rules are **hierarchical.** Only use this rule when none of the previous rules apply.

Note 3: The tumors may be a **NOS** and a **subtype/variant** of that NOS.

Rule M16 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 in the same breast.

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.

Note 3: When the case has been abstracted, **change behavior** code on original abstract from /2 to /3.

Note 4: Do **not** change **date of diagnosis**.

Note 5: If the case has already been submitted to the central registry, **report** all changes.

Note 6: 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 7: See the **COC** and **SEER manuals** for instructions on coding **other data items** such as Date of Diagnosis, Accession Year and Sequence Number.

Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M17 Abstract **multiple primaries**[ii] when an **invasive** tumor occurs **more than 60** days after an **in situ** tumor in the same breast.

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

Note 2: Abstract **both** the invasive and in situ tumors.

Note 3: Abstract as multiple primaries even if physician states the invasive tumor is disease recurrence or progression.

Note 4: 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 also authors, co-authors, or editors of the **AJCC** Staging Manual.

Rule M18 Abstract a **single primary**[i] when none of the previous rules apply.

Note: Use this rule as a last resort. Please confirm that you have not overlooked an applicable rule.

Example: One tumor is invasive carcinoma NST/ductal 8500/3 and a separate non-contiguous tumor in the same breast is DCIS 8500/2. Abstract a single primary: invasive carcinoma NST/ductal 8500/3.

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.

Note: Only code **differentiation** or **features** when there is a **specific code** for the NOS with differentiation or the NOS with features in **Table 2 or Table 3** or the ICD-O and all updates.

Breast Histology Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Coding Histology

Note 1: The rules for coding breast histology are different from the histology coding rules for all other sites. **DO NOT USE THESE RULES FOR ANY SITE OTHER THAN BREAST.**
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.

Two INVASIVE histologies

Two histologies within a single tumor will be either:

- A NOS and a subtype/variant **OR**
- Different histologies (different rows in Table 3 **OR** different subtypes in Table 3 Column 3 **OR** a combination code from Table 2 and a code from Table 3)

The following instructions are in priority order:

1. **NOS and a subtype/variant**
   A. Code the **subtype/variant** (specific histology) **ONLY** when documented to be **greater than 90%** of the tumor.
      Note: When a histology is listed as "minimal", "focus/foci/focal", "microscopic", you can assume the other histological portion comprises greater than 90% of the tumor.
      Example: Patient had an excisional biopsy with a pathologic diagnosis of invasive cribriform carcinoma 8201/3. There was microscopic involvement of one margin. The patient chose to have a total mastectomy. Pathology from the total mastectomy showed minimal residual invasive carcinoma NST 8500/3. Because the invasive carcinoma NST was minimal, the subtype/variant invasive cribriform carcinoma 8201/3 is assumed to be greater than 90% of the tumor.
   B. Code the **NOS/NST** when the subtype/variant is documented to be **less than or equal to 90%** of the tumor **OR** the percentage of subtype/variant is **unknown/not documented**.

2. Different histologies
   A. Code the histology which comprises the majority of tumor.
      Note 1: This instruction **does not apply** to:
      - Invasive carcinoma NST/ductal and lobular carcinoma (use the combination code 8522/3).
      - Mucinous carcinoma and a different histology (see Histology Rules)
      - Metaplastic carcinoma, NOS and subtypes/variants and invasive carcinoma, NST (see Histology Rules)

      Note 2: The following terms **do not** describe the majority of tumor.

Architecture	Pattern(s)
Component	Subtype
Differentiation*	Type
Features (of)*	Variant
Foci; focus, focal	

*Unless there is an exact ICD-O term that includes "differentiation" or "features"

   B. Code a combination code using **Table 2** in the Equivalent Terms and Definitions when the majority is unknown/not documented.

      Do not code **apocrine carcinoma** when the diagnosis specifies apocrine differentiation or features. **Apocrine differentiation** is frequently present in:
      - Carcinoma NST/duct carcinoma
        - Subtypes/variants of carcinoma NST/duct carcinoma
      - Lobular carcinoma NOS
        - Pleomorphic lobular carcinoma in situ

Ambiguous Terminology

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 apocrine carcinoma. The case is accessioned (entered into the database) as required by both SEER and COC. No further information is available. Code the histology apocrine carcinoma. 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 carcinoma NST consistent with pleomorphic carcinoma. The oncology consult says the patient has pleomorphic carcinoma of the right breast. This is clinical confirmation of the diagnosis. Code pleomorphic carcinoma. The case meets the criteria in bullet 1.

Example 2: The pathology diagnosis is sarcoma consistent with liposarcoma. The treatment plan says the patient will receive the following treatment for liposarcoma of the breast. Treatment plan confirms liposarcoma. Code liposarcoma. 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	

Breast Histology Rules
C500-C506, C508-C509
(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 do occur following immunotherapy, chemotherapy, hormone, 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, core biopsy, 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. For breast primaries, you cannot determine if histology comprises greater than 90% of the tumor by these diagnostic methods.

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

Use documentation in the following priority order to identify the histology type(s):

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. The final diagnosis is often the synoptic CAP report.
   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. **Cytology** (nipple discharge or fine needle aspirate (FNA) of primary site)

3. **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 imaging.

4. **Radiography:** The following list is **not in priority** order because they are not a reliable method for **identifying** specific **histology**(ies). They are, however, valuable in diagnosing a malignancy.
   A. Mammography
   B. Ultrasound
   C. CT
   D. MRI

5. 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.

Breast Histology Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Single Tumor: In Situ Only

Note 1: DCIS is often multifocal/multicentric; use this module.
Note 2: Subtypes/variant, architecture, pattern, and features **ARE NOT CODED**. The majority of in situ tumors will be coded to DCIS 8500/2.

Rule H1 Code Paget disease in situ **8540/2** when the diagnosis is **exactly** Paget disease in situ.
Note 1: This is a **de novo** primary of the **nipple** (new tumor) with **no underlying** tumor.
Note 2: Paget is coded as in situ /2 **only** when **pathology documents** in situ behavior.

Rule H2 Code the histology when only **one histology** is present.
Note 1: Use **Table 3** to code histology. New codes, terms, and synonyms are included in **Table 3** and coding errors may occur if the table is not used.
Note 2: When the histology is **not listed** in **Table 3,** 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 3, ICD-O or all updates.

Rule H3 Code DCIS and in situ lobular carcinoma **8522/2** when DCIS and in situ lobular carcinoma are present.
Note 1: Although the notes preceding the in situ section say most tumors will be coded to DCIS, 8522/2 identifies both DCIS and lobular carcinoma in situ.
Note 2: 8522/2 is the most accurate description of DCIS and lobular carcinoma in situ.
Note 3: 8522/2 includes DCIS and pleomorphic lobular carcinoma in situ.

Rule H4 Code DCIS and in situ Paget **8543/2.**
Note 1: Although the notes preceding the in situ section say most tumors will be coded to DCIS, 8543/2 identifies both DCIS and in situ Paget.
Note 2: 8543/2 is the most accurate description of DCIS and in situ Paget.

Rule H5 Code DCIS **8500/2** when there is a combination of DCIS and any other carcinoma in situ. See **Table 2**.

Rule H6 Code pleomorphic lobular carcinoma in situ **8519/2** when there is a combination of lobular carcinoma in situ and pleomorphic lobular carcinoma in situ.

Rule H7 Code in situ lobular carcinoma **8520/2** when there is a combination of lobular carcinoma in situ and one histology other than DCIS **AND**

- The percentage of lobular in situ comprises greater than 50% of the tumor **OR**
- Percentage of lobular in situ is unknown/not documented

Note: This is a new rule and applies to cases diagnosed 1/1/2024 forward. See H9 for cases diagnosed prior to 1/1/2024.

Rule H8 Code the histology that comprises greater than 50% of the tumor when two histologies are in situ lobular AND any histology other than DCIS.

Note: This is a new rule and applies to cases diagnosed 1/1/2024 forward. See H9 for cases diagnosed prior to 1/1/2024.

Rule H9 Code the histology using **Table 2** when there are multiple in situ histologies (2 or more) within a single tumor.

- Lobular and any histology other than DCIS **8524/2**
- Two or more histologies other than lobular and DCIS **8255/2**

Note: This rule does not include DCIS. See previous rules.

This is the end of instructions for a Single Tumor: In Situ Only

Code the histology according to the rule that fits the case

Single Tumor: Invasive and In Situ Components

Rule H10 Code the **invasive** histology when both invasive and in situ components are present (see Notes 2 and 3).

Note 1: **Ignore** the in situ term.

- This is consistent with the 2007 MPH Rules.

Note 2: When a single tumor has one of the histologies listed, see Table 3. These are specific histology terms that capture both invasive and in situ components.

- Encapsulated papillary carcinoma with invasion/with invasive carcinoma, NST/invasive duct carcinoma
- Solid papillary carcinoma with invasion

Note 3: When a single tumor has carcinoma NST/duct and lobular with different behaviors, continue through the rules.

Rule H11 Code duct and lobular **8522/3** when the final diagnosis is any of the following:

- Intraductal and invasive lobular carcinoma (includes invasive pleomorphic lobular carcinoma)
- Infiltrating duct and lobular carcinoma in situ (LCIS)
- Infiltrating duct and pleomorphic lobular carcinoma in situ
- Infiltrating lobular carcinoma and ductal carcinoma in situ (DCIS)
- Infiltrating pleomorphic lobular carcinoma and ductal carcinoma in situ (DCIS)

Note 1: Assign behavior code /3 even when an **in situ** histology is mixed with an **invasive**. This aligns with ICD-O-3.2 and was vetted with specialty matter experts.

Note 2: CAP uses the term **Invasive carcinoma with ductal and lobular features** ("mixed type carcinoma") as a synonym for duct carcinoma/carcinoma NST AND lobular carcinoma 8522/3.

Note 3: Although the instructions in the "Coding Multiple Histologies in a Single Tumor" section state, "Code the histology that comprises the majority of tumor", 8522/3 identifies both invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma and is the most accurate description.

This is the end of instructions for a Single Tumor: Invasive and In Situ Components

Code the histology according to the rule that fits the case

Single Tumor: Invasive Only

Rule H12 Code Paget disease **8540/3** when the diagnosis is **exactly** Paget disease.

Note 1: This is a **de novo** primary of the **nipple** (new tumor) with **no underlying** tumor.

Note 2: Paget is coded /3 when:

- Pathology documents invasive behavior **OR**
- Behavior is not documented/unknown

Rule H13 Code the **underlying tumor** when there is a diagnosis of **inflammatory carcinoma**.[1]

Example: The patient has a clinical diagnosis of inflammatory breast carcinoma. Pathology shows carcinoma NST with dermal invasion as well as erythema. Code the underlying tumor: carcinoma NST 8500/3.

Informational item: The **clinical symptoms** of inflammatory breast cancer include rapid breast enlargement and skin changes (redness, edema peau d'orange) involving more than a third of the breast. Usually there is a diffuse firmness of the breast and there is no palpable underlying mass.

Note 1: Record the inflammatory carcinoma in **staging** fields.

Note 2: **Code inflammatory** carcinoma 8530/3 when it is the **only diagnosis** available (DCO, outpatient only, no follow-up).

Rule H14 Code mucinous carcinoma/adenocarcinoma **8480 ONLY** when:

- The diagnosis is **exactly** mucinous carcinoma or mucinous duct carcinoma **OR**
- Multiple histologies are present and mucinous carcinoma is documented as **greater than 90%** of the tumor

Note 1: The **pure** mucinous carcinoma category includes only cases which are diagnosed as exactly mucinous or documented to be greater than 90% of the tumor.

Note 2: This is a change from the 2007 MPH Rules.

Note 3: When a tumor has both mucinous carcinoma and a different histology, and mucinous is less than or equal to 90% of the tumor (or the percentage is not documented), **code the other histology.**

[1] American College of Pathologists: **Protocol for the Examination of Specimens From Patients With Invasive Carcinoma of the Breast: "Inflammatory carcinoma requires the presence of clinical findings of erythema and edema involving at least one-third or more of the skin of the breast"**

Rule H15 Code the **primary invasive histology** when there is a carcinoma with **signet ring cells OR signet ring cell differentiation**.

Example: Resection pathology diagnosis is invasive lobular carcinoma with signet ring cell differentiation. Code the invasive lobular carcinoma **8520/3.**

Rule H16 Code **metaplastic carcinoma**, NOS, or subtype/variant of metaplastic carcinoma, NOS when **invasive carcinoma, NST OR invasive lobular carcinoma** is present along with the metaplastic carcinoma.

Example: Resection pathology diagnosis is invasive mammary carcinoma, NST with extensive metaplastic carcinoma present. Code metaplastic carcinoma **8575/3**.

Rule H17 Code the histology when only **one histology** is present.

Note 1: Use **Table 3** to code histology. New codes, terms, and synonyms are included in **Table 3** and coding errors may occur if the table is not used.

Note 2: When the histology is **not listed** in **Table 3,** 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 3, ICD-O or all updates.

Rule H18 Code duct carcinoma and lobular carcinoma **8522/3** when the final diagnosis is invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma (includes invasive pleomorphic lobular carcinoma)

Note 1: CAP uses the term **Invasive carcinoma with ductal and lobular features** ("mixed type carcinoma") as a synonym for duct carcinoma/carcinoma NST AND lobular carcinoma 8522/3.

Note 2: Although the instructions in the "Coding Multiple Histologies in a Single Tumor" section state, "Code the histology that comprises the majority of tumor", 8522/3 identifies both invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma and is the most accurate description.

Rule H19 Code the **subtype/variant** (specific histology) **ONLY** when there is a NOS/NST and a subtype/variant **AND** the subtype/variant is documented to be **greater than 90%** of the tumor.

Note 1: When a histology is listed as "minimal", "focus/foci/focal", "microscopic", you can assume the other histological portion comprises greater than 90% of the tumor.

Note 2: Use **Table 3** to identify **NOS/NST** and subtypes/variants. Examples include the following:

- Carcinoma NST **8500** and a subtype/variant of carcinoma NST
- Glycogen-rich clear cell carcinoma **8315** and a subtype/variant of glycogen-rich clear cell carcinoma
- Lobular carcinoma **8520** and a subtype/variant of lobular carcinoma
- Medullary carcinoma **8510** and a subtype/variant of medullary carcinoma
- Metaplastic carcinoma **8575** and a subtype/variant of metaplastic carcinoma
- Papillary carcinoma **8503** and a subtype/variant of papillary carcinoma
- Sarcoma **8800** and a subtype/variant of sarcoma
- Small cell carcinoma **8041** and a subtype/variant of small cell carcinoma

Note 3: **Do not** code any histology described as **features or differentiation** unless it is part of the preferred term.

Example 1: Pathology from excision shows a 1.4 cm tumor and a diagnosis of clear cell carcinoma 8310/3 with a focus of glycogen-rich clear cell carcinoma NOS 8315/3. Because the glycogen-rich clear cell carcinoma NOS is just a focus, more than 90% of the tumor is clear cell carcinoma. Code the subtype/variant: clear cell carcinoma 8310/3.

Example 2: Pathology from an excised tumor says tumor is 95% metaplastic carcinoma squamous cell carcinoma 8070/3 and the remainder is metaplastic carcinoma NOS 8575/3. Code the subtype/variant: squamous cell carcinoma 8070/3.

Rule H20 Code the **NOS/NST** when there is a NOS/NST and a subtype/variant **AND**

- The subtype/variant is designated as **less than or equal to 90%** of tumor **OR**
- The percentage of each is **unknown/not documented**

Example 1: Pathology diagnosis is carcinoma NST 8500/3 and pleomorphic carcinoma 8022/3. The percentage of subtype/variant is unknown. Code the NOS: carcinoma NST 8500/3.

Example 2: Pathology says the majority of tumor is metaplastic carcinoma with chondroid differentiation 8571/3 and the remainder is metaplastic carcinoma NOS 8575/3. Majority simply means greater than 50%, so it is unknown whether or not the subtype/variant is greater than 90% of the tumor. Code metaplastic carcinoma NOS 8575/3.

Rule H21 Code the histology that comprises **greater than 50%** of tumor when **two histologies** are:

- On **different rows** in **Table 3** in the Equivalent Terms and definitions **OR**
- **Different subtypes** of the same NOS **OR**
- A **combination code** from **Table 2** and a code from **Table 3**

Note 1: This rule does not apply to mucinous. See previous rules.
Note 2: The rules are hierarchical, so the tumors are **NOT** a NOS/NST and subtype/variant.
Note 3: If the majority histology is unknown/not documented, continue through the rules.
Example: Pathology reads the tumor is predominantly carcinoma NST 8500/3 with areas of tubular carcinoma 8211/3. Code the predominant histology: carcinoma NST 8500/3. Carcinoma NST and tubular carcinoma are on different rows in Table 3, so they are distinctly different histologies.

Rule H22 Code a **combination code** when there are **two histologies** (two components) within a single tumor and the majority histology is unknown/not documented.

Note 1: Use **Table 2** in the Equivalent Terms and Definitions to identify valid combination codes.
Note 2: The rules are hierarchical, so the tumors are **NOT** a NOS/NST and a single subtype/variant.
Note 3: The diagnosis may be two subtypes/variants and the pathologist may mention the presence of duct/carcinoma NST. Ignore the mention of carcinoma NST.
Note 4: **Do not** use a combination code when the second histology is described as **features or differentiation** unless it is part of the preferred term.
Note 5: The histologies may be identified as:

- Mixed histologies
- Combination histologies
- Histology 1 **AND** histology 2
- Histology 1 **WITH** histology 2

This is the end of instructions for a Single Tumor: Invasive Only

Code the histology according to the rule that fits the case

Multiple Tumors Abstracted as a Single Primary

Note 1: DCIS is often multifocal/multicentric; use the Single Tumor: In Situ module.
Note 2: First use the multiple primary rules to ensure that the multiple tumors are to be abstracted as a single primary.

Rule H23 Code the **underlying tumor** when there is a diagnosis of inflammatory carcinoma[2]:

Example: The patient has a clinical diagnosis of inflammatory breast carcinoma. Pathology shows carcinoma NST with dermal invasion as well as erythema. Code the underlying tumor: carcinoma NST 8500/3.

Informational item: The **clinical symptoms** of inflammatory breast cancer include rapid breast enlargement and skin changes (redness, edema peau d'orange) involving more than a third of the breast. Usually there is a diffuse firmness of the breast and there is no palpable underlying mass.

Note 1: Record the inflammatory carcinoma in **staging** fields.
Note 2: Code inflammatory carcinoma 8530/3 when it is the only diagnosis available (DCO, outpatient only, no follow-up).

Rule H24 Code **Paget disease** and **ductal carcinoma** as follows when:

- Pathology specifies Paget disease as **invasive** /3 **OR** behavior not documented **AND**
- Underlying tumor is:
  - Invasive carcinoma NST/duct carcinoma **8541/3**
  - DCIS **8543/3**

Note: Ignore the presence of lobular carcinoma in situ (LCIS).

Rule H25 Code Paget disease and DCIS **8543/2** when there is Paget disease (specified as **in situ**) with underlying **DCIS**.

Rule H26 Code the histology when only **one histology** is present in **all** tumors.

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

Rule H27 Code the **invasive** histology when there are both invasive and in situ histologies.

Exception: Continue through the rules when there are multiple tumors of ductal and lobular carcinoma with different behaviors.

Rule H28 Code **8522** when carcinoma NST and lobular are present in multiple tumors.

- DCIS and in situ lobular **8522/2**
- DCIS and pleomorphic lobular carcinoma in situ **8522/2**
- Invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma (includes invasive pleomorphic lobular carcinoma) **8522/3**
- Intraductal and invasive lobular carcinoma (includes invasive pleomorphic lobular carcinoma) **8522/3**
- Infiltrating duct and lobular carcinoma in situ (LCIS) **8522/3**
- Infiltrating duct and pleomorphic lobular carcinoma in situ **8522/3**
- Infiltrating lobular carcinoma and ductal carcinoma in situ (DCIS) **8522/3**
- Infiltrating pleomorphic lobular carcinoma and ductal carcinoma in situ (DCIS) **8522/3**

Note 1: Assign behavior code /3 even when an in situ histology is mixed with an invasive. This aligns with ICD-O-3.2 and was vetted with specialty matter experts.

Note 2: CAP uses the term **Invasive carcinoma with ductal and lobular features** ("mixed type carcinoma") as a synonym for duct carcinoma/carcinoma NST AND lobular carcinoma 8522/3.

Note 3: One tumor may be carcinoma NST and the other lobular, or all tumors may be a mixture of carcinoma NST and lobular.

Note 4: This combination code specifically identifies carcinoma NST and lobular carcinoma. For all other histological combinations, continue through the rules.

Rule H29 Code the **NOS/NST** when there is a NOS/NST and a subtype/variant:

- Mixed in all of the tumors **OR**
- Separate tumors with different histologies

Note: It is very difficult to determine whether the subtype/variant is greater than 90% of the tumor mass when there are multiple tumors.

Breast Histology Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule H30 Code a **combination code** when there are **two histologies** (two components) within all tumors.

Note 1: Use **Table 2** in the Equivalent Terms and Definitions to identify valid combination codes.

Note 2: **Do not** use a combination code when the second histology is described as **differentiation or features,** unless it is part of the preferred term.

Note 3: The histologies may be identified as:

- Mixed histologies
- Combination histology
- Histology 1 **AND** histology 2
- Histology 1 **WITH** histology 2

Note 4: Table 2 is used for **two** histologies. When there are **greater than two** histologies, use the "last resort" code **8255** because none of the other combinations include greater than two histologies.

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