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Breeze Session
Multiple Primary and Histology Coding Rules—Renal Pelvis, Ureter and Bladder and Other Urinary Sites
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INTRODUCTION

Hi, everybody. This is Steve Peace and I would like to welcome everyone to today's Web broadcast. Today we will be discussing the renal pelvis, ureter and bladder sites as a group for the next site-specific 2007 Multiple Primary and Histology Coding Rules. We will also be going over the Terms and Definitions that are used to support this particular set of rules. And throughout the presentation today I will be referring to this particular set of rules as the "Urinary Rules" which is kind of a short cut, but on occasion I will call out specific instances for sites within the Urinary Rule Set.

Many of you joining us today have been actively participating in this series of Web broadcasts and I would like to thank you for your interest and attention. We have a really strong attendance today and I'm thrilled about that. For those of you who are new to our broadcasts, I would like to welcome you. The NCI-SEER Program is very happy to be able to continue to make these broadcast sessions available to you both through our Live Breeze Sessions as well as through the Recorded Sessions. Recorded sessions from previous broadcasts are available on the SEER Website. Just click on the "MP/H Rules" button that's under the "Information for Cancer Registrars" and you'll be directed to the recorded sessions as well as to the rules themselves. The recorded sessions are available to anyone who would like to view and listen to them. They are free of charge and are available 24 hours a day 7 days a week. And transcripts are also available for the hearing impaired. If you are joining us through the recorded broadcast we would like to welcome you and are very happy to have you join us after the fact using the special features of recorded Webcast technology.

Today we have an interesting approximately one-hour presentation of the Urinary rules. You will notice that this is a group set of rules and it covers multiple topographic sites all with a common pattern with regard to the primary cancers and specific histologic types. We will follow our didactic presentation with instructions on how to access and work through the practicum cases. Antoinette Percy-Laurry will send each of you an email announcement inviting you to join the Urinary Practicum discussion sometime next week. I believe it's Tuesday, February 20 at 1 PM. So be sure to join us to discuss the cases. This particular set of practicum cases is more extensive than with the other site rules because we do have multiple topographic sites to cover and more cases to work as a result. So the practicum will probably be a little more lengthy than the previous practicums.

If you joined us last week or the week before for the Kidney Rules, we had to reschedule the Kidney Practicum but you'll get notification on that date very soon if you have not received that yet.

Today we're going to go over the general format and structure of the Urinary rules. And, again, the Urinary rules include Renal Pelvis, Ureter and Bladder and the Other Urinary Sites. We will highlight some of the special features of the Urinary Terms and Definitions as well as highlight some of the special features of the Urinary Multiple Primary and Histology Coding Rules. Urinary rules are distinctly different from the Kidney rules that were presented last week and I am sure you will find this presentation and the associated practicum cases to be very interesting.

This is an open session so you are invited to ask questions as we go along. And as I get started I would like to remind everybody to please mute your phones or if you don't have a mute feature on your phone please exercise your best phone courtesy and please don't put your phone on "hold" because many facilities play music when you place a call on hold and we don't want to interrupt the live or recorded broadcast with music or other recordings. And I thank you for that.

I want to begin our session today as I have with the other sessions with a little bit of background. When the rules development team, the Histology Committee, with leadership provided by Co-Chairs Carol Johnson and myself, began to meet in 2002-2003 we were faced with the difficult task of developing a standard set of rules for specific cancer sites or as is the case with the urinary system, site groups like Urinary and like Head and Neck. The goal was to develop a standard set of rules that registrars could use on a daily basis, that are easy to understand and that will result in consistent determination of the number of primary tumors to be abstracted by registrars and consistent and correct histology coding that most appropriately represents the tumor type for each cancer case. We did recognize that our old rules had clearly become outdated since they were thirty years old and we knew that we could improve upon them.

This presentation of the urinary system, when the rules were being developed, they certainly presented some unique challenges. As many of you know, the urinary system can be confusing if you consider all of the urinary sites together. We learned through our investigations that the best way to approach the urinary system was to separate kidney out from the rest of the urinary system since kidney cancers are almost always glandular or adenocarcinoma in origin and the histology of the tumors in the other urinary sites are almost always transitional cell carcinoma. We also learned that our international colleagues at IACR, the WHO, the International Agency for Research on Cancer and the European Network of Cancer Registries had come to the same conclusion when they revised the international rules for multiple primary cancers. So kidney is

separated out from the rest of the urinary system in terms of determining the number of primary tumors and the histology coding for these tumors.

This particular set of rules is pretty straightforward once you get used to them but this particular set takes a little bit of practice.

SLIDE ONE
The Urinary System rules present some new concepts and some special features particularly in the Terms and Definitions as well as some special rules that we'll bring to your attention today. The next set of rules we will present will be melanoma and the date for the melanoma rules presentation is March the 2nd so mark your calendars for that next set of rules because that should be very interesting as well.

As we get started, you should have a few items for reference during our session. You should have the Equivalent Terms and Definitions for Renal Pelvis, Ureter and Bladder available. You should have the Urinary Multiple Primary Rules in your choice of format—[either] text, matrix or flowchart—your choice. And the Urinary Histology Coding Rules in your choice [of format] also. I'm going to be using, I believe, text today in our presentation but you can follow along in whichever format because each set of rules [i.e. the rules in each format] is identical.

We're going to start out with the Terms and Definitions and if you want to pull those up so you can flip along as we go through, do that. You notice I haven't changed my slide here, yet. I want to give a little background as we get going for the Terms and Definitions and when I start to highlight some things particular for this site group set of rules.

SLIDE TWO
You'll notice at the beginning of the Terms and Definitions document that there is a description, an explanation, of "field effect" and "implantation theory." Those are extremely important when we look at this set of rules for renal pelvis, ureter and bladder. And "field effect theory" and "implantation theory" are a little bit, they complement each other and they are specific to these particular sites.

The "field effect theory" suggests that the urothelium-- the transitional epithelium it is also known as-- which lines the renal pelvis, the ureter and the bladder has undergone a widespread change, perhaps in a response to a carcinogen like smoking or solvents or things like that which make it more sensitive to a malignant transformation. As a result, multiple tumors arise more easily in these sites because of this field effect.

There's also the theory of implantation which suggests that tumor cells in one location such as in the renal pelvis, lose their attachment and float in the urine until they attach or implant on another site, either in the ureter or perhaps they

bypass the ureter and don't implant until they start to reside in the bladder. Transitional cell tumors commonly spread in a head-to-toe direction, for example from the renal pelvis to the ureter to the bladder. And whether the theory of field effect or implantation applies this whole series of sites—the renal pelvis, ureter and bladder—all are the same type of epithelium so they are subject to the same types of histology of tumors developing in these sites as a result.

I would also like to bring to your attention that in the next paragraph which brings to everyone's attention that in the United States, transitional cell carcinomas account for more than 90% of all bladder cancers. The remaining ten percent are mostly squamous cell carcinomas with a few adenocarcinomas mixed in but 90% or greater of all the tumors you find in the bladder are transitional cell carcinomas whether they are called carcinoma NOS or papillary transitional cell carcinoma, they are all of origin in the transitional or urothelial epithelium.

Bearing that in mind, that is the context from which these rules have been developed. The transitional epithelium lines the renal pelvis, ureters and the bladder. And, of course, the renal pelvis are bilateral organs and the ureters are bilateral so as they feed down into the bladder and move the urine from the kidneys down into the bladder these issues of field effect or implantation effect may apply.

I'd also like to bring to your attention in the Equivalent or Equal Terms that for the purposes of these rules flat transitional cell, flat urothelial, in situ transitional cell and in situ urothelial are equivalent or equal terms. Urothelial and transitional are interchangeable, equivalent terms. Those of us who have been in cancer registries for a long time have commonly referred to these tumors as transitional cell carcinomas for many years and transitional epithelium. The movement is more to describing these are urothelial rather than transitional cell along the way. We also have under our Equivalent or Equal terms, intramucosal and in situ.

There are some good definitions that I'd like to bring to your attention. And I think I'm going to go ahead and start with the slide now because I don't want to be too repetitious as we go along. One final note before we get into the actual presentation here is that when we look at the prognostic factors for these transitional cell or urothelial tumors, the prognostic factors are really the depth of invasion, the degree of differentiation or grade, the size of the tumor and the number of tumors. So those things all bear in mind for prognosis but when determining multiple primaries or histology we are instructed to follow the rules that are going to be presented here today. Okay?

SLIDE THREE

As part of our introduction I would like to bring to your attention that we now have a change in our site groupings. Historically, kidney, ureter and renal pelvis were grouped together. And the lower urinary tract for bladder, ureter and renal pelvis

now is grouped with kidney broken out separately. Again, all of these are lined by transitional epithelium or urothelium.

SLIDE FOUR
Tumors of the urothelium are more often multifocal compared to other sites. Estimates are that as many as 75% of urothelial tumors are multifocal or multicentric compared to other sites. This is particularly important when we're looking at determination of single vs. multiple primaries.

SLIDE FIVE
The concept of a flat carcinoma in situ vs. a papillary carcinoma-- again these are both transitional cell or urothelial tumors-- is very important for looking at how we're going to distinguish these tumors. Flat carcinoma in situ usually will have direct spread within the epithelium. They can also spread directly along the mucosa by field effect or implantation. When it does spread by field effect or implantation, the areas of involvement may be discontinuous which is kind of unusual compared to our other solid tumor sites. Bearing that in mind, these particular set of rules are developed to address those issues.

SLIDE SIX
In the more rare occurrence of squamous cell carcinoma in the bladder and, again, this is estimated [to be] anywhere between 5 and 8 percent of the bladder tumors in the United States, pure squamous cell carcinoma has a very poor prognosis. You'll see as we go through the rules that squamous cell carcinoma that's mixed with transitional cell carcinoma is treated differently than pure squamous cell carcinoma.

SLIDE SEVEN
One of our rules addresses whether or not multiple tumors that are abstracted as a single primary, you will be coding the most invasive. So a definition for "most invasive" for the bladder is included in your Terms and Definitions. These are the layers of the bladder from the least invasive to the most invasive as you go down through the layers of the bladder wall.

SLIDE EIGHT
And they are somewhat different for renal pelvis and ureter because there are not as many layers that are available to spread through. There is just the epithelial layer, the subepithelial connective tissue or what sometimes is referred to as the submucosa and then the periureteric fat or the peripelvic fat.

Any questions about the Terms and Definitions as we move forward? Okay.

SLIDE NINE
If you would pull out your Multiple Primary Rules and follow along with me, again, these are the rules used to determine whether or not the patient had a single or multiple primaries to abstract one case or multiple abstracts to be submitted.

SLIDE TEN
For those of you who have participated in previous broadcasts, you'll already be familiar with the first rule or module. There are three modules in the Multiple Primary Rules for this site group. The first module addresses the situation where-- it's if you have single or multiple tumors. You can use this module in the case where the central registry, for example, gets a path report of a biopsy that's followed by a hospital report of a resection and the central registry may not be sure if this was a single tumor or multiple tumors; this is when you use this module. A hospital might use this module when they have, for example, an H&P that documents a biopsy in a doctor's office and then the patient comes to the hospital for another biopsy or a resection and the registrar can't confirm whether the patient had a single tumor or multiple tumors. If the information is not available, you use this particular rule.

SLIDE ELEVEN
And the rule [M1] states that: "When it's not possible to determine if there is a single tumor or multiple tumors, opt for a single tumor and abstract as a single primary." And there is a Note that is included here that instructs you to use this rule only after all information sources have been exhausted. And so you don't just automatically go to this rule because it's convenient. You need to check and see if you have information on single or multiple tumors before you apply this rule.

SLIDE TWELVE
The second module is the set of rules for Single Tumors. I say "set of rules" even though this particular set of rules has only one rule.

SLIDE THIRTEEN
And that [M2] is that "a single tumor is always a single primary." There is a Note here that, "The tumor may overlap onto or extend into adjacent or contiguous site or subsite," but it is still a single tumor bearing in mind that for many of these urinary sites up to 75% or perhaps even more, you will have multiple tumors. So the single tumor rule that is most commonly applied for other solid tumors doesn't apply as frequently for this particular site group.

SLIDE FOURTEEN
Here are the most interesting rules and the ones you are going to be using most—more frequently—for this site group and they are the multiple tumors rules.

SLIDE FIFTEEN
The first rule-- or the first two rules--for the Multiple Tumors have to do with the two sites in this site group that have laterality. The first rule [M3] states that: "When no other urinary sites are involved" –and that's a very important distinction—"when no other urinary sites are involved, tumors in both the right

renal pelvis and in the left renal pelvis are multiple primaries." So that means you only have one or more tumors on the right and one or more tumors on the left in the renal pelvis with no other urinary sites involved. And what you do in this case is abstract multiple primaries—one on the right, one on the left. Okay? And there is a Note here that says: Use this rule and abstract as a multiple primary unless you have documentation in your records that one tumor or tumors are metastatic from the opposite side. Okay? And, again, for the purposes of these rules "urinary site" is distinguished as sites that are included in this set of rules for renal pelvis, ureter, bladder and the other urinary sites.

SLIDE SIXTEEN
The following rule, the next rule [M4] is the same rule but for ureter. If you have one or more tumors in the right ureter and one or more tumors in the left ureter but no other urinary sites are involved, you have multiple primaries. Okay? Any questions about those two rules?

You will see as we go along that we are treating this, except for the rare instances, for example, for the laterality of the ureter and the laterality of the renal pelvis as in this set of rules, we are going to start treating all of these as a group of sites.

SLIDE SEVENTEEN
Rule M5 is an interesting rule that some people have a difficult time grasping. We do have some follow up questions that we've received from people for this particular rule not only for the urinary sites, but for other sites. If an invasive tumor occurs less than 60 days after the in situ that's during the workup period, you have a single primary; and then you code the invasive tumor. That's all part of the standard workup procedure and that type of thing. However, this rule is included for situations when you have an invasive tumor that follows the diagnosis of a non-invasive or in situ tumor that are more than 60 days apart. Okay? This may be a new concept for some folks. It's not to the SEER registries. They have been applying this rule for quite a number of years including the bladder sites and other urinary sites. But for some registries this is a little bit more difficult concept to grasp. This is an important rule. Just keep in mind that we're looking at 60 days as the workup period but if you have an in situ tumor later followed by an invasive tumor that is more than 60 days apart you are going to report one primary for the in situ or the non-invasive and you're going to report another primary for the invasive tumor.

SLIDE EIGHTEEN
The purpose of this rule is to ensure that the case is counted as an incident or invasive case when the incidence data are analyzed. Generally speaking, only invasive malignancies are included in the calculations/computations for incidence rates. So this is to make sure that the invasive incident case is counted and both the in situ and the invasive are abstracted if they're more than 60 days apart.

Note 2 says: “Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.” Registrars tend to balk at this Note a little bit but it’s not without merit. I want to make sure that you understand that our consulting pathologists and our consulting urologists and the Commission on Cancer’s (CoC) physicians’ group--the Urinary Site Team-- all were very supportive of this rule and the rationale when these rules were presented to them. The CoC did review all of these rules as a part of the review process and I want to reaffirm that this is an understanding that has moved forward with their consent. Okay?

This is a side note. I want to also explain to folks that the reason we have this rule is so we don’t have survival graphs that show people dying of in situ cancers. We don’t want survival time to be affected by the time between an in situ and an invasive tumor so these are important concepts. This is a very important rule that we need people to make sure that they pay attention to.

I also want to remind people that our rules are in order. You apply each rule, one after the next much like a gumball bank that starts as a full gumball bank and each time you ask a question or apply a rule, some of the gumballs fall out of the bank so the next rule is exclusive of those cases that no longer apply. And if you don’t follow each rule one after the next you can come to the wrong conclusion. And that’s where some people are having some confusion, particularly for the next couple of rules.

SLIDE NINETEEN
Rule M6 is the rule where multiple bladder tumors with any combination of the following histologies: papillary carcinoma (8050), transitional cell carcinoma which includes the codes 8120 through 8124, or papillary transitional cell carcinoma which includes 8130 and 8131, are a single primary. Now recognize this is the rule for bladder tumors and it follows the rules that have come before it. So we need to make sure that these stay in order. Any combination of tumors within these ICD-O-3 ranges are single primaries.

SLIDE TWENTY
The next rule is: “Tumors that are diagnosed more than three years apart are multiple primaries.” We have had a lot of people ask questions about this particular rule when taken out of context with the other rules. What I would like to share with you is that for renal pelvis and ureter cases in the SEER master database there are only two cases of recurrences in the same site with the same histology within a three-year period for these two particular sites (renal pelvis and ureter). Notice that I’m not sharing any data on recurrence of bladder tumors within a three-year period. There is a reason and this is really important. The previous rule, rule M6, instructs you that transitional cell carcinoma of the bladder is a single primary in all these instances. So the gumball bank again, all these bladder tumors are taken out of the decision when it comes to the three years apart rule. So any “recurrences” of transitional cell carcinoma of the bladder are

already handled before you get to this rule. We have had numerous requests to clarify this rule when it's taken out of context and used by itself. So you must follow the rules in order and not pick a single rule that you think applies. This is really important particularly for these urinary rules.

SLIDE TWENTY-ONE
The next rule, rule M8, takes care of the field effect or implantation and the multicentric, multifocal tumors when tumors occur in neighboring organs. This rule applies when two sites or more than two combinations of sites from the urinary system are involved. And, again, by "urinary system" I'm talking about renal pelvis, ureter, bladder and the other urinary sites.

Table 1 in the Terms and Definitions which I accidentally overlooked; I meant to bring it to your attention when we discussed the Terms and Definitions. There is a Table in the Terms and Definitions document and this Table 1 is a listing or a presentation of urothelial tumors, otherwise known as transitional cell tumors that are considered in a group. The urothelial cell, transitional cell tumors include transitional cell carcinoma NOS (8120); transitional cell carcinoma with squamous differentiation; transitional cell carcinoma with glandular differentiation; the rare occurrence of transitional cell carcinoma with trophoblastic differentiation or nested transitional cell or microcystic transitional cell. Those are pretty uncommon. But you may see all of these other transitional cells together. The urothelial tumors also include papillary carcinoma and papillary transitional cell; micropapillary; lymphoepithelioma-like; plasmacytoid; sarcomatoid; giant cell; and undifferentiated. So there's a lot of transitional or urothelial tumor histologies that are grouped together in this transitional cell carcinoma group. So use Table 1. It's called out in multiple rules, particularly in the histology coding rules. Here we have it presented in rule M8 for the multiple primary rules: "Urothelial tumors in two or more of the following sites are a single primary: renal pelvis, ureter, bladder or urethra or prostatic urethra." So if you have a tumor in the renal pelvis—transitional cell or urothelial—and one in the bladder, even though it appears to have skipped the ureter you're going to still abstract this as a single primary. That's new for us. This is a very important rule. If you have a urothelial tumor in the renal pelvis and the ureter we're going to call that a single primary. And that's how this rule applies.

Question 1
Steve, those examples that you have given: What would you then code your site code to?

Response to Question 1
Let's see. I don't have my ICD-O in front of me but I believe that you code it to C68.9 but I would have to refer to my ICD-O-3 and I just don't have one in front of me. I apologize.

Follow-up to Question 1
Okay. So that was the same code that SEER had used previously in the site-grouping table then?

Response to Follow-up to Question 1
Yes. I believe that's correct.

Question 2
Steve? This very question came up on yesterday's NAACCR Webinar. And the answer that was given to determine which site to code the primary site to—first priority was given to, "Code the most invasive site;" and then second, C68.9.

Response to Question 2
Okay. And this answer came from???
[Yesterday's Webinar].
I am not familiar with that. Who hosted this Webinar?
[I think NAACCR?] *Okay. Rather than confirm that site code I would rather submit this question for the Multiple Primary Frequently Asked Questions (FAQ) and make sure that we have a uniform response.*

[Yes. This came from NAACCR].

I would rather not have somebody outside the decision-making group for these rules make that determination as yet. I believe we can have that out in the second group of Frequently Asked Questions, which I believe we'll have done by the end of March. Okay? Thank you very much.

Question 3
Steve? Will that be posted on the Trainers Website so we can have these when we go out and train. Is that correct?

Response to Question 3
Yes. That is correct. We will also be making those Frequently Asked Questions available to the general registry community. Thank you.

SLIDE TWENTY-TWO
Now we'll move on to rule M9. This is the …rule M9 instructs the abstractor that tumors…now remember again we've already made decisions on almost all the tumors that we'll encounter in the renal pelvis, ureter, bladder and the other urinary sites. So now we're looking at a really small number of possibility cases. So here we have "tumors with ICD-O-3 histology codes that are different at the first, second or third number are multiple primaries." You're not going to…you're going to very, very rarely, if ever, use this rule.

SLIDE TWENTY-THREE
This rule M10, the rule that if you have topographic sites' codes with different second and/or third characters, for example, if you have a breast and a bladder or something like that, they're multiple primaries. Remember this set of rules is designed for looking at renal pelvis, ureter and bladder sites so we needed to handle all the specific exceptional rules first before we got to these really broad and general rules so people could get into their answers very quickly.

SLIDE TWENTY-FOUR
And, finally, rule M11: "Tumors that do not meet any of the above criteria are a single primary. " And, again, we have a Note: "When an invasive tumor follows an in situ tumor within 60 days, [you] abstract as a single primary." We already explained that when I went over the rule, I think it was M6, no, M5 earlier. This is for tumors within 60 days with an invasive and an in situ tumor, again, because that's during the workup period.

Any questions about the Multiple Primary Rules? Okay.

SLIDE TWENTY-FIVE
We're going to move on to the histology rules.

SLIDE TWENTY-SIX
Our histology rules: we have two modules. We have the module for single tumors; a Single Tumor, excuse me; and Multiple Tumors Abstracted as a Single Primary.

SLIDE TWENTY-SEVEN
Our first rule is rule H1 and H1 is included to instruct the registrar that when you have no pathology/cytology specimen or the pathology/cytology report is not available you are instructed to code the specific histology where it's documented.

SLIDE TWENTY-EIGHT
And here we have provided a priority order for using documents to code the histology: Documentation in the medical record that refers to pathologic or cytologic findings; that's our first priority. The second priority would be the physician's reference to the type of cancer (or histology) in the medical record. Very rarely will you use a CT, MRI scan or perhaps even a PET scan as one of the priorities for using documents to code the histology.

SLIDE TWENTY-NINE
Note 2 reminds you to code the specific histology when it's documented. And Note 3 is provided to instruct you to code the histology as 8000 (malignant neoplasm or cancer NOS) or 8010 (carcinoma NOS) as stated by the physician when nothing more specific is documented, so that's kind of your last resort.

SLIDE THIRTY
Rule H2: when there is no pathology or cytology specimen from the primary site this rule is provided to instruct you to code the histology from a biopsy of a metastatic site. You'll use this rule occasionally for perhaps metastatic bladder cancers or something, but it's going to be used rarely for this particular set of rules. The example is: the patient may have a lung biopsy that's positive for metastatic transitional cell carcinoma and they don't do any additional workup but the CT maybe confirmed a large mass in the left ureter so you're going to want to know that it's a left ureter primary and you can use the pathology from the metastatic site to code the histology. And, of course, you code the behavior as /3; nothing new in this particular rule.

SLIDE THIRTY-ONE
Rule H3, and again I want to remind people: these rules are in a hierarchy. You use one rule followed by the next rule so you ask each question following the next question. [Rule H3] "Code 8120 (transitional cell/urothelial carcinoma) using Table 1 when there is:

SLIDE THIRTY-TWO
Pure transitional cell carcinoma or
Flat (non-papillary) transitional cell carcinoma or
Transitional cell carcinoma with squamous differentiation…
Now these should start sounding familiar because these are what I read through in the Table.

SLIDE THIRTY-THREE
Transitional cell carcinoma with glandular differentiation or
Transitional cell carcinoma with trophoblastic differentiation…and, again, the other less common…
Nested transitional cell carcinoma or
Microcystic transitional cell carcinoma

These are the instances when you code 8120 (transitional cell or urothelial carcinoma). This rule is provided first because we want to make sure that when you have a situation that meets these criteria, you use the proper code and that is 8120.

SLIDE THIRTY-FOUR
The next rule, H4, instructs you when to use the code 8130 (papillary transitional cell carcinoma) using Table 1. Again, when you have:
Papillary carcinoma or
Papillary transitional cell carcinoma or
Papillary carcinoma and transitional cell carcinoma
in a single tumor.

SLIDE THIRTY-FIVE
Rule H5: “Code the histology when only one histologic type is identified” with a very specific Note that says: “Only code squamous cell carcinoma (8070) when there are no other histologies present.” You have to have pure squamous cell carcinoma of the bladder to use code 8070 for squamous cell carcinoma of the bladder. All other instances are most likely going to be coded using rule H2 which tells you transitional cell carcinoma with squamous differentiation is coded to 8120. Okay? This is very important; only pure squamous cell carcinoma is coded 8070 using rule H5.

SLIDE THIRTY-SIX
Rule H6: “Code the invasive histologic type when a single tumor has invasive and in situ components.” You see it occasionally with the bladder. This is a change from the previous rules so we need to make sure that registrars know, if you have a single tumor with invasive and in situ components you code the invasive histologic type. The invasive histology is the histology that will affect the survival. It will govern the treatment and by coding the invasive type the case will be placed in the correct group when somebody analyzes the data. Even if the in situ portion, even if the in situ description is more specific, it will not...the in situ histology, will not impact survival or the treatment. You code the invasive histologic type even if it looks like the in situ portion is more descriptive or more specific. It’s a new concept.

SLIDE THIRTY-SEVEN
Rule H7 provides instructions for when to code the most specific histologic term. It gives you some examples here: If you have
Cancer/malignant neoplasm NOS and a more specific histology, you code the more specific histology;
if you have carcinoma NOS and a more specific carcinoma, you code the more specific carcinoma;
sarcoma is included here. [If you have] sarcoma NOS and a more specific sarcoma, and again this is for invasive only [you code the more specific sarcoma].

SLIDE THIRTY-EIGHT
There are a couple of important Notes to be used with this particular rule:
Note 1 provides you with descriptors that can be used to describe the in situ tumor and that may be identified by terms such as, “pattern, architecture, type, subtype, predominantly, with features of, major, or with _____ [some type of] differentiation.” You notice the terms “pattern” and “architecture” are included in the in situ list of terms. They are **not** included in the invasive list of terms. So if you see “pattern” or “architecture” when you’re looking at an invasive tumor, you disregard those terms.

SLIDE THIRTY-NINE
Rule H8 is our final rule for single tumors; very rarely you will get to rule H8. H8 instructs you to code the histology with the numerically higher ICD-O-3 code if you have not already arrived at a decision in one of the previous rules. Now, once again, I want to bring and I know that I'm kind of "beating a dead horse" here, but I apologize for anybody who has horses…but remember that 90% of our tumors in this site group are urothelial or transitional cell. Most of the urothelial histologies have been accounted for in the first few rules of our rule set for coding histology. So bear in mind these rules will be used pretty rarely when you get down to rules H7 and H8.

Any questions about the Single Tumor rules for histology?

Question 4
Steve, I have a question on H4? If "micropapillary features" are added to this combination of papillary transitional and transitional cell would you still just code it to the 8130 or do you go up to the 8131 which is in a different part of Table 1?

Response to Question 4
That's a very good question. What I'm going to do is go back a few rules and walk you through this, okay? It's a very good question. I want to demonstrate how this set of rules works. You will have to take a look at Table 1 also. Would you, now that we're getting oriented again here, would you restate your question?

Yes. If you had a histology of papillary transitional cell and transitional cell with micropapillary features, which code would you use?

Okay. Use code 8130 when there is any of these situations [see rule H4]. You also have a situation where you have micropapillary so you would not use this rule. You would move on to the next rule because you have "micropapillary features." Okay? You do not apply rule H6; you do not apply rule H7, but you have a clarification with rule H7 for your "features." And you arrive at rule H8 which tells you to code the numerically higher ICD-O-3 code. So you actually do use the code 8131 for micropapillary because none of the other rules before it apply to your exact situation. Does that help?

Thank you.

Any other questions about the Single Tumor or how we are supposed to use the rules? That was a really good example. I appreciate that. Okay.

SLIDE FORTY
The next module is for situations where after we have used the multiple primary rules we have determined that we have "Multiple Tumors That Are Abstracted As A Single Primary."

SLIDE FORTY-ONE
Rule H9 is the same rule that we saw for single tumors. When you don't have a pathology or cytology specimen or report—it's not available—

SLIDE FORTY-TWO
you can use the priority documents in the medical record to code histology based on:

SLIDE FORTY-THREE
a physician's statement; based on other documents in the medical record or perhaps even based on diagnostic imaging such as CT, MRI, etc. So there's no difference in that rule except applying it to "multiple tumors abstracted as a single primary."

SLIDE FORTY-FOUR
Rule H10 is the same rule that we had for "Single Tumor" but now we're applying it to "Multiple Tumors Abstracted As A Single Primary." If you only have the histology or pathology from the metastatic site, there is no specimen from the primary site, you only have the specimen from the metastatic site you can use that metastatic site pathology report and you code the behavior as /3.

SLIDE FORTY-FIVE
I'm going to stress these rules, again, for when to code transitional cell/urothelial cell carcinoma (8120): [Rule H11] If you have multiple tumors they all have to be in this 8120 group in Table 1 to use the code 8120:
Pure transitional cell carcinoma or
Flat (non-papillary) transitional cell carcinoma or

SLIDE FORTY-SIX
Transitional cell carcinoma with:
*squamous differentiation or
*glandular differentiation or
*trophoblastic differentiation or
Nested [transitional cell carcinoma] or
Microcystic transitional cell carcinoma

These are the only times when you are to use code 8120 [is] if all of your multiple tumors are in that particular grouping of 8120 in Table 1. Okay? If any of the tumors that you have go into the next category like papillary transitional cell you do not code 8120 because you don't have a pure transitional cell carcinoma. Okay?

SLIDE FORTY-SEVEN
Rule H12 tells you when you can code 8130. Now this is after you've taken out all the pure 8120s that fit into those situations that are listed in Table 1.

Remember those are all taken out of the equation and now you can code the remaining cases code 8130/papillary transitional cell carcinoma (Table 1—code 8130) when you have:
Papillary carcinoma or
Papillary transitional cell carcinoma or
Papillary carcinoma and transitional cell carcinoma….in multiple tumors. We keep getting this question asked over and over again: "When one of your biopsies says transitional cell carcinoma and your other says papillary transitional cell carcinoma aren't you supposed to code 8120?" No. 8120 is only used in those situations from Table 1 that are specified; in those situations you would use rule H12 for multiple tumors and you would code 8130 in a situation where you have papillary carcinoma and transitional [cell] carcinoma—together. Okay?

SLIDE FORTY-EIGHT
Rule H13: If you have one histologic type, you code it. And, again, the emphasis is on, only code squamous cell carcinoma, 8070, when there are no other histologies present; when it's pure squamous cell carcinoma. It is very doubtful that you'll have multiple tumors with squamous cell carcinoma; the multiple tumor scenario is generally the urothelial cell carcinoma, not squamous cell.

SLIDE FORTY-NINE
Rule H14: Remember we're looking at multiple tumors. When you get to rule H14 you have already taken out the transitional cell, the papillary transitional cell that are meeting all these different criteria. Okay? So here's our rule that says: "Code the histology of the most invasive tumor." And, again, [the Note] "See the Renal Pelvis, Ureter, Bladder and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations for the definition of most invasive." There are also Tables and Illustrations that include illustrations and definitions of what "most invasive" is depending on what your anatomic site is. Okay?

SLIDE FIFTY
We also have some clarifications:
● If you have one tumor that is in situ and one tumor that is invasive, you code the histology from the invasive tumor.
● If both or all of the histologies are invasive, you code the histology of the most invasive tumor.

And I would like to emphasize, one more time: You do not berry pick these rules. You follow them in a hierarchy-- one following the next. And ask each question, one at a time.

SLIDE FIFTY-ONE
Our final rule here is: [H15] "Code the histology with the numerically higher ICD-O-3 code," which used to be our primary rule and now it's our last rule.

I will open it up for questions but first I would like to thank the members of the Multiple Primary and Histology Task Force that included folks from SEER, NPCR, the Commission on Cancer, the AJCC, NCI, CDC, the National Cancer Institute of Canada and the Canadian Cancer Registries, NIH, NCRA and NAACCR. So we had lots of folks involved in this Task Force and we appreciate everybody's efforts to develop these rules.

I would like to open it up for any final questions.

Question 5
Hi, Steve. I have a question. We don't have CAP as part of this group. Is that true?

Response to Question 5
Review of the CAP Protocol was included and we had some participation by CAP in the process. I don't have their logo included and that is an oversight.

I think that would be helpful because that was a question that came up from several of the registrars.

Okay. We'll make a note of that. Thank you.

Do we have any questions about the rules?

Question 6
Steve, this is Chris. How would you code a case that was transitional cell with neuroendocrine features or differentiation?

Response to Question 6
Hang on one second. This is a single tumor? [Yes] *I'm not going to go back through all the slides but let's walk through the rules. We have a single tumor. Rule H1 does not apply; nor H2. Rule H3 code 8120 with neuroendocrine features is not included in that Table is it? No; so H3 does not apply. 8130, the papillary transitional cell does not apply. You do not have one histologic type or the invasive histologic type. So here we have: Code the most specific histologic term and I think that's where you're going to find the neuroendocrine carcinoma. I think that would be the proper rule to use and I think that that's a very interesting question. And, Chris, I would like to ask you to send me that in an email and I will bring it up for discussion to the Multiple Primary and Histology Coding Rules Team to make sure that we are all in agreement on the response. And I will propose that we include that as a candidate question in the Frequently Asked Questions #2, for the clarifications. Thank you.*

Okay. I'm surprised that we got done in an hour and I'm really pleased. I appreciate your participation. Antoinette will be sending everyone instructions on the Practicum cases. I want to remind you that you are going to have more

practicum cases in this particular set of rules than in the previous rules. I don't know what the total is; I think it's sixteen or eighteen perhaps cases so our practicum discussion will be a little bit longer next time. I encourage you to be patient and methodically work through the cases because this particular set of rules can be a little difficult for people to navigate. People still have a tendency to find the rule they like and use it. I want to remind you to go one rule at a time in working through the cases.

I thank you all for attending. We'll talk with you next time.