

**NATIONAL INSTITUTES OF HEALTH  
NATIONAL CANCER INSTITUTE  
SURVEILLANCE, EPIDEMIOLOGY AND END RESULTS (SEER) PROGRAM**

**2007 Multiple Primary and Histology Coding Rules**

**Beyond the Basics—Breeze Sessions**

**Breast**

**June 20, 2007**

**Slide 1**

Hello. This is Peggy Adamo. This is the Beyond the Basics Breeze Session on the Multiple Primary and Histology Coding Rules for Breast.

**Slide 2**

We will cover some helpful and important items in coding breast cancer cases with some specific insights into the rationale behind some of the new MP/H Rules for Breast.

**Slide 3**

We will talk about:

- when to code Mucinous Carcinoma
- some issues in coding Duct Carcinoma and Duct Carcinoma in situ (DCIS)
- Lobular Carcinoma and Lobular Carcinoma in situ (LCIS)
- Tables 1, 2 and 3 in the Breast MP/H Rules

**Slide 4**

Then we will:

- work on some Beyond the Basics items in the Multiple Primary Rules for Breast
- provide some Beyond the Basics training on the Histology Coding Rules for Breast
- do a Practice Case

**Slide 5**

We will begin with training on when you code Mucinous. Mucinous is a good example of the reason we have site-specific rules. The instructions for Mucinous differ in the Breast Rules from the Mucinous instructions in the Colon Rules. “Mucin-producing” is synonymous with “Mucinous” in the Breast MP/H Rules as is “Colloid.” All three terms

are coded in the same manner for Breast cases. However, these terms are not synonymous in the Colon Rules.

Also, in Breast, you do **not** have to have a statement that Mucinous comprises 50% or more of the tumor; that applies to Colon but not to Breast. The rules are different so make sure you use the correct rules for the primary site in your case.

## Slide 6

For Duct Carcinoma, NOS (code 8500) we would like to provide some helpful facts for you:

- This is the largest group of breast cancers
- Duct Carcinoma, NOS is often mistaken for a specific histology when it is not a specific histologic type
- Duct Carcinoma, NOS lacks specific features

Duct Carcinoma gets its name because it starts in the breast ducts.

## Slide 7

DCIS is often described as:

- multifocal
- multicentric
- diffuse

DCIS is usually not a solid or measurable tumor. It is common to see DCIS that is multifocal, multicentric or diffuse.

To determine which module in the rules to use:

- If the case is described as “multifocal DCIS” with no information on the number of tumors and no actual tumor mass, you default to the “Unknown if Single or Multiple Tumors” Module which will lead you to code the case as a single primary.
- If you have one measurable mass accompanied by multifocal DCIS, you use the “Single Tumor” Module.

## Slide 8

Lobular, in contrast to DCIS, **is** a specific type of breast cancer. It does not have subtypes. You may see a histology, “tubulolobular,” in breast cases. This is not a specific type of Lobular; it is both Tubular and Lobular histologies. For the tubulolobular histology you use the combination code for Lobular and Other—8524. Remember that tubular is **not** a type of Duct Carcinoma which is the reason you don’t code Lobular and Duct (8522).

## **Slide 9**

There is much debate about Lobular Carcinoma in situ (LCIS). Some doctors say it is not really cancer but it is one of our reportable diagnoses. LCIS is often found by chance, usually when a patient has a mastectomy. It is not usually seen in a mammogram. LCIS originates in the breast lobes and is often bilateral.

## **Slide 10**

These pictures visually show you Duct Carcinoma, which starts in the ducts and Lobular Carcinoma which starts in the breast lobes.

## **Slide 11**

Next we'll discuss Table 1 in the "Equivalent Terms and Definitions" in the Breast MP/H Rules. Table 1 shows the most common types of Intraductal Carcinoma. Not all possible types of Intraductal Carcinoma are found on this Table but you will find most of the commonly diagnosed types of Intraductal Carcinoma on it.

Notice that not all of these histologies are in the 8500s; for example, Cribriform, Solid and Apocrine are not in the 8500 codes. One of the reasons we developed these Tables was to illustrate the fact that the old ICD-O-3 "3-digit rule" no longer applies.

Any of the histologies listed in Table 1 could be invasive (with a behavior code of 3 or "/3") if the pathology report (or other valid documentation) states that the tumor is invasive. This Table does not limit you to coding these histologies as /2.

## **Slide 12**

Table 2 lists the commonly seen types of Duct Carcinoma. Again, note that not all of these histologies in Table 2 are in the 8500 series such as Pleomorphic Carcinoma (8022) and Carcinoma with Osteoclast-like giant cells (8035). Remember that these histologies, like those found in Table 1, may (rarely) be coded as in situ with a behavior of /2. Use the information on behavior stated in the documentation for the case. Table 2 again illustrates that the old ICD-O-3 "3-digit rule" no longer universally applies.

## **Slide 13**

Table 3 is the Combination Code Table. We will demonstrate how to use this Table. Notice that in the first column, "Required," you can use "any combination excluding Lobular and Duct histologies from Tables 1 and 2." Tables 1 and 2 are the ones we just reviewed: Table 1 is Intraductal (8500/2) and Specific Intraductal Carcinomas and Table 2 is Duct (8500/3) and Specific Duct Carcinomas. If you see combinations of cancers that are not on Tables 1 and 2 and are not Lobular, you code 8255/3 (Adenocarcinoma with Mixed Subtypes). You won't use this code very often. We want you to know that in order to use Table 3 effectively you must first check Tables 1 and 2.

## Slide 14

We'll look at another example from Table 3. Notice that in the first column, "Required," it says you must have "Intraductal and **two or more** of the histologies in Column 2." There is a typographical error in Table 3 in the MP/H Rules; it says, "One or more" instead of **two or more.**" Please make that correction in your copy of Table 3 now. If it were "one" you would code the subtype and that rule comes before you get to the rule(s) pertaining to Table 3. This is not a critical point but the rules flow better if you correct the wording here to "two or more."

Also, please make sure that in your choice of format for the rules, Rule H6 should say, "Is there a combination of Intraductal and **two or more specific Intraductals**, or are there two or more specific Intraductals?" Please make this correction in Breast Histology Coding Rule H6 and use it now. Remember that if you only had one specific type you would code that type; that rule comes before Rule H6. Again, this is not a major typographical error in the MP/H Rules but you will find that the rules will flow better if you make this correction.

The new wording in Column 1 now says if you have "Intraductal and two or more of the histologies in Column 2," meaning you would have Intraductal and, for example, Cribriform and Solid. The Table tells you to use code 8523 for this example because you have Intraductal with at least two of the terms in Column 2, i.e. "Intraductal mixed with other types of carcinoma."

## Slide 15

We'll clarify some points of confusion in the Breast Multiple Primary Rules.

## Slide 16

Rule M11 says: "**Multiple Intraductal and/or Duct Carcinomas** are a single primary. Note: Use Table 1 and Table 2 to identify Intraductal and Duct Carcinomas."

Tables 1 and 2 are found in the Equivalent Terms and Definitions in the Breast MP/H Rules. If you try to use Rule M11 without consulting the Tables you will make mistakes. You need to look at the histologies listed on the pathology report and compare those to the histologies on Tables 1 and 2. You then use Rule M11 if you get a match doing those comparisons.

## Slide 17

We will next talk a little about the Breast Histology Coding Rules.

## Slide 18

We will start with the “Single Tumor—Invasive Carcinoma Only” Module

## Slide 19

Rule H13 says, “Code **8530** (Inflammatory Carcinoma) only when the final diagnosis on the pathology report **specifically states Inflammatory Carcinoma**.

Note: Record dermal lymphatic invasion in Collaborative Staging.”

When the clinical information is recorded in Collaborative Staging and the pathology information is recorded in the histology fields, researchers are able to identify cases that have both the clinical diagnosis and the pathology diagnosis. If you code the clinical information in the histology fields, it is not possible to identify those cases; hence, the reason this rule and its associated Note were created. If you do not follow the rule, you will lose information so it is important to follow the rule. Hopefully, this background information will help explain the reason for coding according to this rule.

## Slide 20

There are three rules that deal with Duct Carcinoma: H15, H16 and H17. All three of these rules show you how to use the combination codes. The rules are in hierarchical order. When you come to Rule H15, that rule eliminates all the cases that have Duct Carcinoma and specific Duct Carcinoma types from the “gumball machine.” Then, Rule H16 eliminates all the cases that have Lobular and Duct. Rule H17 removes the remaining cases that have Duct Carcinoma and any other carcinoma out of the “gumball machine.” If you are still looking for the rule that fits your case and you pass Rule H17, your case should not have any Duct Carcinoma histologies in it. If you use the rules in hierarchical order, as we have demonstrated, you will easily assign the correct combination codes. To reiterate, by the time you get to Rule H17, if you have not yet found the correct code, your case should not have any Duct histology in it.

## Slide 21

For the breast rules, we use the analogy of a “gumball machine.” In the Breast Rules, first, all the Duct Carcinomas and Duct subtypes are dispensed; then the Duct and Lobular cases; then the group with Duct and other types of carcinoma. By the time you get to Rule H18 the only cases left in the gumball machine are cases with no Duct histology in them. This is our way of illustrating how these rules function in a hierarchical manner.

## Slide 22

Rule H18 says to “code **8524** (Lobular mixed with other types of carcinoma) when the tumor is **Lobular (8520) and any other carcinoma**.” After discussing the hierarchy and the symbolic “gumball machine,” we understand more clearly that when Rule H18 talks

about “any other carcinoma” that means anything other than Duct Carcinoma because all of the Duct histologies are out of the gumball machine by the time you reach Rule H18. This further shows the necessity of using the rules in their hierarchical order. Remember that Lobular is a specific histologic type.

### Slide 23

Rule H19 says, “Code **8255** (Adenocarcinoma with Mixed Subtypes) for **multiple histologies that do not include Duct or Lobular** (8520).” By the time you reach Rule H19 you know that:

- All the Duct histologies were taken out of the gumball machine after Rule H17;
- Rule H18 eliminated the last of the Lobular and any other carcinoma;
- By the time you get to Rule H19 you truly have “others.”

You have “others” that are not Lobular and not Duct. This further shows the critical importance of using these rules in their hierarchical order. This is why we tell you **not** to “berry pick” the rules; using the rules in their hierarchical order allows you to correctly use Rule H19 in this example, as having no Duct and no Lobular. Code 8255 is a code not often used in Breast cases.

### Slide 24

We will work the Practice Case, which you can find posted on the Website. This case has three pathology reports. The first one is dated December 17, 2007. The diagnosis from stereotactic needle biopsies is **DCIS, comedo type**. The second pathology report dated December 28, 2007 from a needle localization is **DCIS Solid, Cribriform and Papillary Type**. The third pathology report dated January 11, 2008 from a mastectomy states that there are **residual foci of DCIS and LCIS** in the immediate vicinity of the biopsy cavities.

### Slide 25

First, we determine the number of primaries. To do that, first, we need to determine the number of tumors. Don’t assume that there are multiple tumors just because there were multiple procedures with associated pathology reports. We don’t know how many tumors there are in this case so we will use the “Unknown if Single or Multiple Tumors” Module and we will start and stop with Rule M1. That rule says this case should be abstracted as a single primary.

### Slide 26

Next, we code the histology. To code the histology we will first decide which pathology report contains information from the “most representative specimen.” So we are looking for the pathology report with the most tumor tissue. For this Practice Case the most representative specimen appears to be in the second pathology report. The diagnosis from that pathology report is “DCIS Solid, Cribriform and Papillary.” This is DCIS with

at least two specific DCIS types. We go to the “Single Tumor: In Situ Only” Module in the Breast Histology Coding Rules and start with Rule H1.

**Slide 27**

We will follow the rules down the hierarchy until we get to Rule H6. We stop at Rule H6 and code 8523/2, Duct Carcinoma with Other Types of Carcinoma.

This is how we approach cases. More Practice Cases with their associated answers and rationale are posted on the Website. You can work those cases at your convenience.

We hope you find these Beyond the Basics Breeze Sessions on the 2007 Multiple Primary and Histology Coding Rules useful and informative.

Thank you for joining us.