

**NCI-SEER BREEZE SESSION**  
**OTHER SITES—MULTIPLE PRIMARY AND HISTOLOGY CODING RULES**  
**January 23, 2007**

**SLIDE ONE**

We're going to be working today with the set of rules that's entitled, "Other Sites." And, these are the rules for all of the sites excluding the Hematopoietic, the Benign Brain and CNS, Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder and Malignant Brain. In other words, excluding all of the sites that have site-specific rules and the hematopoietic. So we have a little different set of rules today and I'll go in a little different order because they cover so many different sites.

**SLIDE TWO**

First of all, we will look at the Equivalent Terms and Definitions. One of the first things you see in Other Sites is a statement that "acinar carcinoma of the prostate" is the equivalent or the same as adenocarcinoma of the prostate. The reason for this is the fact that acinar carcinoma, when it's used, when the term is used for prostate cancer actually does not refer to a histologic type. Instead, it talks about the origin of the cancer. There are tiny acini in the prostate. They are sacs that contain the fluid for ejaculation and many of the adenocarcinomas of the prostate originate in those acini. So you get the term "acinar carcinoma" of the prostate and you would code that to adenocarcinoma. So that's the first change or new rule that you'll see in all Other Sites.

**SLIDE THREE**

The second thing that really needs to be pointed out is that we have a Table for paired organs and sites with laterality. But there are a couple differences about this Table. First of all the only sites that you will see in this Table are those sites that are included in the Other Sites rules. So in other words you're not going to see lung; you're not going to see Breast because the rules for Lung and Breast are taken care of in the site-specific rules.

One of the things that we need to tell you is that you are going to use this Table when you work with the rules that talk about tumors on both sides of a paired site and you will find that in rule M8; in other words, the multiple primary rules—the eighth rule. We tell you in that rule that any site that is a paired site, if you have a bilateral tumor it's going to be a multiple primary. We refer you to this Table.

**SLIDE FOUR**

This Table will tell you that pleura, long bone, short bones, ribs, pelvic bones, skin of the eyelid...

**SLIDE FIVE**

...skin of the external ear, unspecified parts of the face, the trunk, upper limb and shoulder, lower limb and hip, [and] the peripheral nerves and autonomic

nervous system of the upper limb and shoulder and, again, the peripheral and autonomic nervous system of the lower limb and hip, connective and subcutaneous and soft tissues of the upper limb and shoulder ..

### **SLIDE SIX**

...the connective, [subcutaneous] and soft tissues of the lower limb and hip, the ovary, the Fallopian tube, testis, epididymis, spermatic cord, the eye and the adnexa, adrenal gland, and the carotid body are covered by these rules and they are all paired sites.

### **SLIDE SEVEN**

Now the next Table that is very important is the Combination and Mixed Codes Table. For this site particularly we want to make sure that you understand we want you to apply the multiple primary rules first before you use this Table. The Combination Codes are most often used when these multiple histologies exist in a single tumor. In other words, if you have one tumor with multiple histologies, very, very rarely do we use them for multiple tumors. So what we **don't want** is people thinking that they can use the Combination Code Table, identify two different histologies and say, "I have one tumor with this histology, another tumor with this histology. There's a combination code for these two histologies so therefore I can make it a single primary and code the histology using the combination code," because that's not true. What we want to emphasize is that you use the Multiple Primary Rules first and use the Combination Code Table only when you've already decided that these tumors, or tumor, are a single primary.

### **SLIDE EIGHT**

Now, we have a two-page Table here and that's because there are a lot of sites that are covered with the other codes. And, we again tell you that we want you to compare the terms in the diagnosis to the terms in Columns 1 and 2. If the terms match, you code the case using the ICD-O-3 histology code in Column 4. You use those combination codes [listed] in this Table only when the histologies in the tumor match the histologies listed in the Table.

### **SLIDE NINE**

The Combination Code Table has three [four] columns. Column 1 is "Required Histology" and what that means is this is something you have to have. Now, Column Two gives you different histologies that you can, in essence, mix and match. Look at Column One for your "Required Histologies": The first row is *small cell carcinoma*. So no matter what, you have to have *small cell carcinoma* in order to use the combination code 8045. Now from Column Two you can have any one of the items that are mentioned in Column Two. I'm sorry; that somehow didn't come out. From Column Two you can take your pick of any one of the items listed in Column Two; you can have *large cell* or *squamous cell*; Column 1 is required. Then, Column Three tells you what ICD-O term that combination of

cells is. It's called *combined small cell carcinoma* and the code is 8045. So the Table itself is relatively easy to use.

### **SLIDE TEN**

Let's go on to the next list of codes. And, again, if you look at these codes and I want you to look especially at the code 8255 because I think it's probably become the most popular code for registrars in the past year. And, 8255 has the title: "adenocarcinoma with mixed subtypes," or "adenocarcinoma combined with other types of carcinoma." So you can have the term "adenocarcinoma" and then have, "with papillary and clear cell features," for an example. And that would fit the instructions or descriptions for code 8255. But if you have a description of clear cell and another cell that's not included in Column Two, you cannot use code 8255.

### **SLIDE ELEVEN**

Now I want to call your attention particularly to the GYN malignancies. GYN malignancies are a real problem for a lot of folks. And for this particular set of malignancies *mixed cell adenocarcinoma*, the code 8323, is a combination of two or more of the histologies in Column Two. So you could have a combination of *serous* and *endometrioid*, for example, or a combination of any three that are in that column. So a combination of two or more of these histologies in Column Two and you can use the code 8323. Now notice there's a little difference in the *papillary* and *follicular carcinoma*. That's because it's required that you have both *papillary* and *follicular* in order to code 8340. So you have two requirements: *papillary* and *follicular* and you can use code 8340—*papillary carcinoma, follicular variant*.

### **SLIDE TWELVE**

We also have the liposarcomas in here. There is 8855, a mixed liposarcoma which is a combination of the histologies in Column Two. You can have a combination of two or more histologies. We've got the embryonal rhabdomyosarcoma...

### **SLIDE THIRTEEN**

..the teratomas...one of the problems folks have with the mixed germ cell tumors is not knowing exactly what should be in them. And you can have a combination of seminoma or yolk sac tumor and you'd have a mixed germ cell tumor.

### **SLIDE FOURTEEN**

Now we'll go on to the Multiple Primary Rules.

### **SLIDE FIFTEEN**

As with the other sites the first module in the Multiple Primary Rules is the module called: "Unknown if Single or Multiple Tumors." Again, this is the module that you would use in a central registry, for an example, if you had a pathology report of a biopsy and a hospital report of a resection. And you don't know if

there is a single or multiple tumors. [Example two] The hospital registry may have an H&P that documents a biopsy done in a physician's office. They may have another biopsy that was done in the hospital and you really don't know if there was a single tumor or multiple tumors.

### **SLIDE SIXTEEN**

And in that case you use the default rule M1 and you would code that as a single primary. And, of course, you do have the note that tells you: "Use this rule only after all information sources have been exhausted." It's not a first choice. It's a default to use only if no other information is available. That's the only rule in that module.

### **SLIDE SEVENTEEN**

The next module is [to use when] we know we have a single tumor.

### **SLIDE EIGHTEEN**

And, of course, that tumor is not described as a metastasis. It can include any combination of in situ and invasive. It does not matter if the tumor overlaps or extends into adjacent tissue; it is still a single primary. That is the only rule in the Single Tumor Module.

### **SLIDE NINETEEN**

So we go on to the Multiple Tumors Module.

### **SLIDE TWENTY**

You'll see a bit of a change here from what you've been used to. The first rule in the Multiple Tumors Module says: In prostate cancer you report only one adenocarcinoma of the prostate per lifetime of the patient. I want you to notice that looking at the matrix you can see that there is no information on timing, there is no information on behavior because it's irrelevant; it doesn't matter for this rule. What matters is the site—prostate; the histology—adenocarcinoma; and that is one primary per lifetime. Now Note number two is an information note. [Note] number one explains that there is only one adenocarcinoma of the prostate per patient per lifetime. Note number 2 gives you some extra information. It says that 95% of prostate malignancies are the common (acinar) adenocarcinoma, histology--8140. "See the Equivalent Terms, Definitions and Tables for more information." That's telling you that if you have not read the Equivalent Terms you can go back there and it will explain to you why acinar equals adenocarcinoma.

### **SLIDE TWENTY-ONE**

Rule M4. Now remember we're in all Other Sites so one of the first things that you're going to see here are the specific rules for certain sites. The first one prostate, the second one talks about unilateral or bilateral retinoblastoma is a single primary. So notice the site can be bilateral or unilateral it does not matter and again there are no instructions on timing or about histology because they are irrelevant. Unilateral or bilateral retinoblastomas are always a single primary.

### **SLIDE TWENTY-TWO**

M5 talks about Kaposi sarcoma. And Kaposi sarcoma is kind of a problem. The rule here is telling you that it is always a single primary and again notice the site, any site, irrelevant; the histology --Kaposi sarcoma; timing does not matter; behavior does not matter. It is always a single primary. This is important because the Kaposi's that's related to AIDS or HIV is usually widespread and a patient can appear with lesions of the internal organs; they can have lesions on the skin; there are lesions in the mucosa of the mouth and the mucosa of the epista and so this is frequently a problem for people. A patient may appear with lesions on just the skin and one other site and come back with more lesions elsewhere. It is always a single primary.

### **SLIDE TWENTY-THREE**

Now the next special case in M6 talks about thyroid cancer. And the histology is follicular and papillary. Whenever follicular and papillary carcinoma are together in the thyroid within 60 days of diagnosis --notice the timing does matter for thyroid--then, it is a single primary. So, in other words, we're talking about lesions that are in the thyroid, not necessarily the same lobe. The lesions in the thyroid that are follicular and papillary and they occur within 60 days of diagnosis; they are a single primary.

### **SLIDE TWENTY-FOUR**

The next rule [M7] talks about bilateral ovary. Now, over the years we have worked with ovarian primaries and we know that the bilateral--the fact that both sides are affected--is a part of the staging. It's mentioned in the staging criteria but it's not a part of multiple primaries; they don't care that it's bilateral. And if you have bilateral ovary and it's an epithelial tumor meaning that it falls within this range of 8000-8799; most of them will and it occurs within 60 days of diagnosis and most of them will. You'll be able to see the widespread local metastasis or the widespread regional metastases from these tumors; that's a single primary. So any of the epithelial tumors--it's a huge big range of tumors-- that occur within 60 days of diagnosis are a single primary.

### **SLIDE TWENTY-FIVE**

Now we get to the Table. We looked at the Site Table before. We took out all the exceptions because we already talked about ovary and we said this is an exception; it's going to be a single primary. So we're left only with those sites that we saw on the Site Table and it says if both sides of a paired site listed on the Site Table are involved--multiple primaries. So any of the sites that are left after we have excluded those special sites--the retinoblastomas, the ovarians,--the rest of them will be multiple primaries if both sides are involved.

### **SLIDE TWENTY-SIX**

Now rule M9 again is for a special case and it talks about adenocarcinoma in adenomatous polyposis coli (familial polyposis) with one or more in situ or

malignant polyps. And the Notes say: “Tumors may be in single or multiple segments of the colon, rectosigmoid or rectum.” Why don’t we say “colon?” [We don’t say “colon”] because we don’t want to confuse the abstractor. The fact is that colon has its own coding. You’ve probably gone there and you may have coded there. It may also occur only in the rectum or only in the rectosigmoid or the physician may specify that it’s primary to the rectosigmoid and it may extend throughout the GI tract. Any way it is going to be a single primary. So this particular rule was put in to make sure that nothing was missed. If that patient has familial polyposis with one or more at least in situ or malignant polyps are present, that it will be coded as a single primary even if it’s confined to the rectosigmoid or stated that the rectosigmoid or rectum are the organs of origin.

### **SLIDE TWENTY-SEVEN**

Now M10 is a default rule. We have already gone through a lot of the site-specific rules that we’ve been very used to. We’ve talked about prostate being one primary per lifetime. We’ve talked about the Kaposi’s being a single primary. Now we are down to a default rule and we say tumors that are diagnosed more than one year apart are multiple primaries. So we are giving you a default rule at this point. And we are saying we don’t care where the tumors are. They can be in the same organ, they can be in different organs; it’s irrelevant. If they are diagnosed more than a year apart they are multiple primaries.

### **SLIDE TWENTY-EIGHT**

M11 is a rule you’re familiar with from the topography code table. And it says if the topography codes are different at the second or third character it’s a multiple primary.

### **SLIDE TWENTY-NINE**

So that might cover as an example: 1) a tumor in the penis and a tumor in the rectum have different second characters so they are multiple primaries. [2] A tumor in cervix and a tumor in the vulva have different third characters in their ICD-O-3 topography codes so they are multiple primaries. So now the default rule talks about tumors in different sites are different primaries; they’re multiple primaries.

### **SLIDE THIRTY**

M12: topography codes that differ only at the fourth character or the subsite character in any one of the following primary sites are multiple primaries: anus and anal canal; the bones, joints and articular cartilage; the peripheral nerves and autonomic nervous system; the connective tissue and other soft tissues and the skin. If you recall this is not a change. This is our old rule that says that we have certain sites and colon used to be one of them; we have taken that out and separated it. So we have certain sites where the subsites are separate primary sites. This is the list.

### **SLIDE THIRTY-ONE**

M13 says a frank in situ or malignant adenocarcinoma and an in situ or a malignant tumor in a polyp are a single primary. Why can we say that? We can say that because we already told you that if they were in different primary sites all of those cases are gone. Then the next rule said for these certain sites we count subsites so the only thing that's going to be left here will be the same site or the subsite. So at this point we can say a frank in situ or malignant adenocarcinoma and an in situ or a malignant tumor in a polyp are a single primary.

### **SLIDE THIRTY-TWO**

Now M14 talks about multiple in situ or malignant polyps. Polyps don't just occur in the colon. Polyps also occur in the cervix, in the GYN organs and in the uterus, rectum [and] rectosigmoid. So this takes care of all of those other sites and it says if there are multiple in situ or malignant polyps, it's a single primary. And that includes all combinations of adenomatous, tubular, villous and tubulovillous adenomas or polyps. In other words, we want to make sure that if the patient has a tubular polyp and a villous adenoma in the same site that it's not coded as two separate primaries.

### **SLIDE THIRTY-THREE**

Now the M15 [rule] says if you have a tumor diagnosed more than 60 days after diagnosis and it's an invasive tumor following an in situ tumor, that's a multiple primary.

### **SLIDE THIRTY-FOUR**

The Notes explain as in the other rules, the purpose of this rule is to ensure that the case is counted as an incident case and secondly to make sure that we have all the information on the invasive. We say to "abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease." [There was a brief discussion about music heard over the speaker's voice due to a participant putting the conference on hold.]

### **SLIDE THIRTY-FIVE**

M16 is the same as our previous NOS rule with specific examples and instructions. It says that cancer/malignant neoplasm and another specific histology is a single primary; squamous cell NOS and a specific squamous cell is a single primary; adenocarcinoma NOS and another specific adenocarcinoma [is a single primary]; or a melanoma NOS and another specific melanoma; a sarcoma NOS and another specific sarcoma-- are all single primaries.

### **SLIDE THIRTY-SIX**

And then M17 is where we finally come to the histology codes that differ at the first, second or third number. We have gone through of these; we took out all of the special cases. We've taken care of all of the site codes and now finally we come to the M17 that says: If the histology codes are different at the first, second or third number, these are multiple primaries.

## SLIDE THIRTY-SEVEN

And, our last and final rule [M18] says, Okay. We've gone through all of these and if this case does not meet any of the above criteria it will be a single primary. One of the examples we put on there says: "When an invasive lesion follows an in situ within 60 days, [you] abstract as a single primary." This is kind of a reminder to people to make sure that they understand that this is abstracted as a single primary.

Are there any questions on the multiple primary rules before we go into the histology rules?

### Question 1 Other Sites Rules

Yes. I have one. It's M9: I want to know why in the Notes you put, in the Examples you put the statement of the colon because the colon is excluded in the title of the Other Sites [Rules]. It excludes the colon so why did you put it in the Notes?

### Response to Question 1 Other Sites Rules

*We put it in the Notes because the cancer could...the physician could state that the cancer started in the rectum or in the rectosigmoid but the polyps often extend throughout the entire GI system. So we wanted to make sure they understood that was okay.*

Okay. Thank you.

### Question 2 Other Sites Rules

Carol? Could you clarify the rule M16 starting with melanoma: "melanoma NOS and another [is a] specific melanoma" [is a single primary]. That is not skin, right?

### Response to Question 2 Other Sites Rules

*Correct. Thank you because that was a good one to bring up. On M16 where we talked about the NOS and another specific [term] one of the ones I mentioned was the melanoma NOS and a more specific melanoma. And what we're talking about here is, we have a separate group of rules for melanoma of the skin. So this would be a melanoma **not** of the skin, so, for an example, of a female genital organ, a place that melanomas do occur, and this would be any non-skin melanoma. And the general rule is that a NOS—if it's biopsied and you get a NOS and then it's removed and you get a specific melanoma type that that is still a single primary. That was a good question. Thank you.*

Are there any other questions?

## SLIDE THIRTY-EIGHT

Okay. Let's go on to the Histology Coding Rules.



### **SLIDE THIRTY-NINE**

Again, we start with a “Single Tumor, In Situ Only.” For Other Sites histology coding the registrar has to first decide if there’s a single tumor or multiple tumors. Now if it is a single tumor then there’s a second decision and that’s whether the tumor is in situ; whether there’s both in situ and invasive components; or if it’s all-invasive. So it’s a little different than most of the other sites other than Breast. Breast has a much similar component. So, again, the registrar will make the decision whether there’s a single or multiple tumors. If there are multiple tumors they [the registrars] would go directly to the Multiple Tumors Module. If they are single tumors, there are three sets of Single Tumor Modules. There’s one for in situ only, another for in situ and invasive and a third for invasive. So we’ll start with the “Single Tumor [and] In Situ [Only].”

### **SLIDE FORTY**

The first rule [H1] says if the pathology or cytology report is not available, you would code the histology documented by the physician.

### **SLIDE FORTY-ONE**

You’re given a priority for using documents to code the histology. You’ll find these priorities are a little less specific than the ones you got in the rules for Breast or the rules for Lung and that’s because those are site-specific and we could talk about things like a mammogram. So the priority here says:

- 1) The documentation in the medical record that refers to the pathologic or cytologic findings. So that would be where a physician may dictate: “The patient had a biopsy at the office prior to admission. That biopsy showed adenocarcinoma of the prostate.” That’s documentation that refers to a pathologic finding.

The second priority would be a physician’s reference to the type of cancer in the medical record. That would just be when he had an H&P that said: “This patient presents with known adenocarcinoma of the prostate.” They don’t refer to the path report but they do refer to the type of cancer.

- 2) Now if you don’t have that type of reference, code the specific histology when it’s documented. In other words, it may not be a physician’s statement but if you do have it documented somewhere, code it.
- 3) Number three: code the histology to 8000, (cancer/ malignant neoplasm, NOS) or to 8010, (carcinoma NOS) as stated by the physician. So, in other words if they say this patient has cancer, code 8000. If they say the patient has carcinoma of the whatever, you would code 8010.

### **SLIDE FORTY-TWO**

Then rule H2 says if there’s only one type, code that type. That’s the one that says if the record says that patient had adenocarcinoma, code adenocarcinoma. But we do want to warn you not to code terms that don’t appear in the

description. So, for an example, if the description [i.e. diagnosis] says squamous cell carcinoma, don't assume that means "non-keratinizing" just because it's not keratinizing does not mean it's non-keratinizing. So don't code that unless the words "non-keratinizing" actually appear in the diagnosis.

### **SLIDE FORTY-THREE**

Now H3: If the final diagnosis is adenocarcinoma in a polyp or adenocarcinoma *and* a residual polyp or polyp architecture is recorded in other parts of the path report. There are times you will read a path report and you will see in the gross where it mentions they can see residual architecture of a polyp, that's what they are talking about—somewhere else in the pathology [report] they may refer to either a residual polyp or they might refer to the polyp architecture. The third bullet says "adenocarcinoma and there is reference to a residual or pre-existing polyp." Let's say on the Operative Report the physician dictates, "Patient had a history of a polyp removed by snare. There was evidence of invasion, we're proceeding with..." That would be a mention of a polyp that's pre-existing. Or if it talks about a mucinous, colloid or a signet ring cell adenocarcinoma in a polyp, don't code the mucinous or colloid or signet ring; You're going to code the adenocarcinoma in an adenomatous polyp or adenocarcinoma in a villous adenoma or adenocarcinoma in a tubulovillous adenoma depending on what type of polyp the patient had. What we're telling you is that it's actually more important to know that the adenocarcinoma originated in a polyp than it is to know that it is mucinous or that it is signet ring. So we're telling you to be careful. Take a look. If you see that there was a polyp present you would code adenocarcinoma originating in a polyp.

### **SLIDE FORTY-FOUR**

Now H4 is again our NOS rule. It talks about carcinoma in situ, NOS and a more specific in situ carcinoma; there's a squamous cell carcinoma, NOS and a more specific squamous cell carcinoma; or an adenocarcinoma—**these are all in situ, remember, because we are in the in situ module**—adenocarcinoma and a more specific adenocarcinoma or melanoma and a more specific [melanoma]. You will code the most specific histologic term.

### **SLIDE FORTY-FIVE**

You will remember that for in situ, "The specific histology may be identified as type, subtype, predominantly, with features of, major, or with \_\_\_\_ differentiation, architecture or pattern." Remember those terms "architecture and pattern" are only used for in situ carcinoma. This truly means that you could see adenocarcinoma in situ, keratinizing-- predominantly keratinizing-- and that would identify the more specific histology; that's what you would code.

### **SLIDE FORTY-SIX**

H5: if you have multiple specific histologies or you have a non-specific histology with multiple specific [histologies] then code the appropriate combination or mixed code from Table 2. So they are kind of explaining to you that it might be

written in one of two ways: it could say for an example, “papillary and solid adenocarcinoma”; it could say “adenocarcinoma, papillary and solid types.” That’s why we’re saying multiple specific or they can give you that NOS term followed by multiple specific histologies. When you see any of that kind of format, go to Table 2 and start to match the histologies that you’re seeing to the different columns in Table 2 and see if you find a combination code that fits the histologies used.

#### **SLIDE FORTY-SEVEN**

And if not, then you come to the default rule H6 that says none of the above conditions are met; in other words, none of the other rules fit your case; then you code the numerically higher ICD-O-3 code. And that ends the Single In Situ Tumor [Module]. There are six rules.

#### **SLIDE FORTY-EIGHT**

The next module is “Single Tumor, Invasive and In Situ.”

#### **SLIDE FORTY-NINE**

And H7 says if you have an invasive and in situ, you code the single invasive histology; ignore the in situ terms. The comment over here is an acknowledgement. It says we know that this is a change from the previous rules. We know that it is different from the ICD-O-3 rules. We can assure you the change was made in collaboration with the ICD-O-3 Editors and the consensus of the ICD-O-3 Editors and the special AJCC Disease Site Team physicians was that coding the invasive component better explains the likely disease course and more closely fits the survival. That is the only rule for a single tumor with invasive and in situ components.

#### **SLIDE FIFTY**

Now we’re starting on the third and the last module for single tumors. So this is a single tumor that has only invasive coding or only invasive histology.

#### **SLIDE FIFTY-ONE**

So the first rule again starts with no pathology or cytology specimen or report are available [H8]; so you use the histology as documented by the physician.

#### **SLIDE FIFTY-TWO**

And again, [here is] the priority that tells you to use the documentation in the medical record that refers to a path report or a cytology report and says [for example], “The patient had a biopsy that showed adenocarcinoma;” or use the physician’s reference to the type of cancer, e.g. “the patient presents with an adenocarcinoma of the prostate.” And the third [bullet under point number one] is from PET, CT or MRI scan. You notice that this is an addition; that’s because we’re no longer talking about in situ cases. Now the second, number two, says, “Code the specific histology when it’s documented;” so anywhere you find a document that does give a histologic type. If that’s not available [then go to]

number three: Code the histology to 8000 or 8010, cancer or carcinoma, whichever the physician has designated.

### **SLIDE FIFTY-THREE**

Now H9: H9 says we do not have a path or cytology from the primary site. So we will code the histology from the metastatic site and code the behavior as a /3. This would be for an example, a biopsy of the metastatic site, not the primary site itself and it's cancer; or you have a prostate that is obviously extending; they do a biopsy of the rectal wall and find adenocarcinoma of the prostate. You code the histology from the metastatic site and code the behavior to a /3.

### **SLIDE FIFTY-FOUR**

H10: Primary site is prostate; the histology is acinar adenocarcinoma; it's coded to 8140, adenocarcinoma, NOS.

### **SLIDE FIFTY-FIVE**

H11 says if there is only one histology type code that histology. And, again, it warns not to code terms that don't appear in the description, for an example, do not code a non-keratinizing squamous cell unless it is actually specified in the diagnosis.

### **SLIDE FIFTY-SIX**

H12 again talks about polyps and it says, again, if the final diagnosis is:

- Adenocarcinoma in a polyp or
- Adenocarcinoma and a residual polyp or polyp architecture is recorded or
- If there is adenocarcinoma and any reference to a residual or pre-existing polyp or
- If you have adenocarcinoma and the diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in a polyp---

Code the adenocarcinoma in a polyp. There are three codes: 8210, which is the adenocarcinoma in an adenomatous polyp; 8261, which is adenocarcinoma in a villous adenoma; 8263 [which is adenocarcinoma] in a tubulovillous adenoma. And, again, the Note that says it is important to know that that adenocarcinoma originated in a polyp.

### **SLIDE FIFTY-SEVEN**

H13 says when you have a less specific and more specific histologic term such as cancer or malignant neoplasm NOS and a more specific; a carcinoma and a more specific; a squamous cell and a specific squamous cell; an adenocarcinoma and a specific adenocarcinoma or a melanoma and a specific melanoma or a sarcoma and a more specific sarcoma—you would always code the more specific histologic term.

### **SLIDE FIFTY-EIGHT**

Of course, [we have] the Note that talks to you about the fact that the specific can also be identified as a “type, subtype, predominantly, etc.” You can have a statement: “Adenocarcinoma, predominantly mucinous” and you would code mucinous [adenocarcinoma]; or “Non-small cell carcinoma, papillary squamous cell,” you would code papillary squamous cell [carcinoma]; You have a more specific non-small cell carcinoma.

### **SLIDE FIFTY-NINE**

Rule H14 talks about thyroid. And it says when you have a papillary carcinoma, code 8260, (papillary adenocarcinoma NOS); that’s because we found a lot of cases coded to papillary carcinomas that are not the right category. So this is to guide people and we say that when you have papillary in the thyroid the correct code is 8260.

### **SLIDE SIXTY**

H15 again, guides you on thyroid. And it says when there is follicular and papillary you would use code 8340 (papillary carcinoma, follicular variant).

### **SLIDE SIXTY-ONE**

And H16 again talks about those tumors that have more than one histology. You may have multiple specific histologies indicated or they may have a non-specific histology such as adenocarcinoma with multiple specific histologies listed. When you see that, go to Table 2. Look at the combination codes that are listed on Table 2 and see if there is a combination code that fits that category.

### **SLIDE SIXTY-TWO**

And, again, H16 is going to remind you that the diagnosis may appear in different ways. One example is GYN malignancy with mucinous, serous and papillary adenocarcinoma. Example two is combined small cell and squamous cell carcinoma. Example three is adenocarcinoma with papillary and clear cell. Those are examples of multiple specific histologies and then a non-specific with multiple specific histologies, secondly [i.e. Example 3].

### **SLIDE SIXTY-THREE**

H17 is the default rule. If none of the above conditions were met, you would then code the numerically higher ICD-O-3 code. That ends all of the Single Tumor Modules.

### **SLIDE SIXTY-FOUR**

For “Multiple Tumors Coded [Abstracted] as a Single Primary” [Module] again we start out ...

### **SLIDE SIXTY-FIVE**

...with...When no pathology or cytology specimen [or report] is available, then code the histology documented by the physician...

### **SLIDE SIXTY-SIX**

...in the medical record. Code the one that refers to pathologic or cytologic findings; or the reference to cancer; or from the CT, PET or MRI scan; if those are not available code the specific histology when documented in an H&P for example or in anything you have; number three—code the histology to 8000 or 8010, cancer or carcinoma. as stated by the physician.

### **SLIDE SIXTY-SEVEN**

H19: if there is no pathology or cytology from the primary site, code the histology from the metastatic site. Code the behavior as a /3.

### **SLIDE SIXTY-EIGHT**

H20 again deals with prostate: Even if there are multiple tumors in that prostate, [if there is] acinar (adeno) carcinoma, code it to 8140 (adenocarcinoma NOS).

### **SLIDE SIXTY-NINE**

H21 is a special rule. It talks about sites such as vulva, vagina and anus. When you have the diagnosis of squamous intraepithelial neoplasia grade III such as vulva (VIN III), vagina (VAIN III) or anus (AIN III) if the behavior is in situ, or if specified that it's in situ, use the code 8077/2 (squamous intraepithelial neoplasia, grade III).

### **SLIDE SEVENTY**

And, we're telling you, "By the way, VIN, VAIN and AIN are squamous cell carcinomas. Code 8077 cannot be used for glandular intraepithelial neoplasia such as prostatic intraepithelial neoplasia (PIN) or pancreatic intraepithelial neoplasia (PAIN). Then the second one says you can use this code for "reportable-by-agreement cases," not commenting on reportability. We are simply giving you the code to use because many people do report these histologies so that's an important thing to remember. We're not telling you, you must report them. We're saying if you do, this is the code that you would use.

### **SLIDE SEVENTY-ONE**

Now H22 is for sites such as pancreas. [It says] glandular intraepithelial neoplasia grade III such PAIN III and it's listed as in situ you use the code 8148/2 which is glandular intraepithelial neoplasia.

### **SLIDE SEVENTY-TWO**

And again we say you can use this for reportable-by-agreement cases.

### **SLIDE SEVENTY-THREE**

Rule H23: If there is only one histology [present], code that histology. Do not add "non-keratinizing" or anything that does not appear in the diagnosis.

#### **SLIDE SEVENTY-FOUR**

Rule H24 has to do with the anus and the perianal region and the vulva. If there is extra-mammary Paget disease and there is underlying tumor, code the histology of the underlying tumor.

#### **SLIDE SEVENTY-FIVE**

Rule H25: This again is the polyp rule. If the final diagnosis is:

- adenocarcinoma in a polyp or
- there is any documentation about a polyp existing or having existed, or
- you have adenocarcinoma mucinous/colloid or signet ring cell adenocarcinoma in a polyp--

you would code to adenocarcinoma in a polyp: 8210, 8261 or 8263 depending upon the type of polyp.

#### **SLIDE SEVENTY-SIX**

H26 [says in the] thyroid, papillary carcinoma is always coded to 8260 (papillary adenocarcinoma, NOS).

#### **SLIDE SEVENTY-SEVEN**

[H27] Follicular and papillary carcinoma in the thyroid is coded to the 8340 (papillary carcinoma, follicular variant).

#### **SLIDE SEVENTY-EIGHT**

H28 says if there is invasive and an in situ you code the single, invasive histology. Remember, we are now in Multiple Tumors and it says even when there is multiple tumors you will code the single invasive histology. We know this is a change; it was collaborated. There was a consensus.

#### **SLIDE SEVENTY-NINE**

[H29] When you have tumors that are: Cancer/malignant neoplasm NOS and a more specific. Anytime you have the same, we just want you to understand they must be the same, e.g. we're talking about an adenocarcinoma and a more specific adenocarcinoma not an adenocarcinoma, NOS and a specific squamous cell. If you have a less specific and a more specific of the same cancer, you code the most specific histologic type.

#### **SLIDE EIGHTY**

That type may be identified as a "type, as a subtype, predominantly, with features of," etc.

#### **SLIDE EIGHTY-ONE**

[H30] Now if you have multiple specific histologies or a non-specific histology with multiple specific histologies code the appropriate combination or mixed code. Go to Table 2. Look at the different histologies in Table 2 to see if there is a combination code available and use that combination code.

**SLIDE EIGHTY-TWO**

Again, there are examples of how the multiple specific histologies can be written.

**SLIDE EIGHTY-THREE**

And, finally, your default rule [H31] that says: If none of the other rules have fit, you will then code the numerically higher ICD-O-3 code.

**SLIDE EIGHTY-FOUR**

And that ends the Other Sites rules, the histology coding rules.

Are there any questions?

Okay. The cases will be posted on the Website. We will be sending you an email giving you the Website address and please download the cases and we'll come back with the practicum for all Other Sites. Thank you so much, everyone.