Coding Guidelines
BLADDER
C670–C679

Primary Site

C670 Trigone of bladder
  Base of bladder
  Floor
  Below interureteric ridge (interureteric crest, or interureteric fold)

C671 Dome of bladder
  Vertex
  Roof
  Vault

C672 Lateral wall of bladder
  Right wall
  Left wall
  Lateral to ureteral orifice
  Sidewall

C673 Anterior wall of bladder

C674 Posterior wall of bladder

C675 Bladder neck
  Vesical neck
  Internal urethral orifice

C676 Ureteric orifice
  Just above ureteric orifice

C677 Urachus
  Mid umbilical ligament

C678 Overlapping lesion of bladder
  Lateral-posterior wall (hyphen)
  Fundus

C679 Bladder, NOS
  Lateral posterior wall (no hyphen)
Priority Order for Coding Subsites

Use the information from reports in the following priority order to code a subsite when the medical record contains conflicting information:

Operative report (TURB)
Pathology report

Multifocal Tumors

Invasive tumor in more than one subsite

Assign site code C679 when the tumor is multifocal (separate tumors in more than one subsite of the bladder).

If the TURB or pathology proves invasive tumor in one subsite and in situ tumor in all other involved subsites, code to the subsite involved with invasive tumor.
Bladder Wall Pathology

The bladder wall is composed of three layers. There may be “sub layers” within the major layer of the bladder.

<table>
<thead>
<tr>
<th>Bladder Layer</th>
<th>Sub layer</th>
<th>Synonyms</th>
<th>Staging</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mucosa</td>
<td></td>
<td>Epithelium, transitional epithelium, urothelium, mucosal surface, transitional mucosa</td>
<td>No blood vessels, in situ/noninvasive</td>
<td>First layer on inside of bladder; Lines bladder, ureters, and urethra</td>
</tr>
<tr>
<td>Basement membrane</td>
<td></td>
<td>No invasion of basement membrane is in situ</td>
<td>Invasion/penetration of basement membrane is invasive</td>
<td>Single layer of cells that lies beneath the mucosal layer separating the epithelial layer from the lamina propria</td>
</tr>
<tr>
<td>Submucosa</td>
<td></td>
<td>Submucous coat, lamina propria, areolar connective tissue</td>
<td>Invasive</td>
<td>Areolar connective tissue interlaced with the muscular coat. Contains blood vessels, nerves, and in some regions, glands</td>
</tr>
<tr>
<td>Lamina propria</td>
<td></td>
<td>Submucosa, Suburothelial connective tissue, subepithelial tissue, stroma, muscularis mucosa, transitional epithelium</td>
<td>Invasive</td>
<td></td>
</tr>
<tr>
<td>Muscle</td>
<td>Bladder wall</td>
<td>Muscularis, muscularis propria, muscularis externa, smooth muscle</td>
<td>Invasive</td>
<td></td>
</tr>
</tbody>
</table>

Tumor extends through the bladder wall (invades regional tissue) when the tumor is stated to involve one of the following areas:

**Serosa (Tunica serosa):** The outermost serous coat is a reflection of the peritoneum that covers the superior surface and the upper parts of the lateral surfaces of the urinary bladder. The serosa is part of visceral peritoneum. The serosa is reflected from these bladder surfaces onto the abdominal and pelvic walls.

**Perivesical fat**

**Adventitia:** Some areas of the bladder do not have a serosa. Where there is no serosa, the connective tissue of surrounding structures merges with the connective tissue of the bladder and is called adventitia.
**HISTOLOGY**

More than 90% of bladder tumors are transitional cell carcinoma. About 6-8% of bladder tumors are squamous cell carcinomas. About 2% of bladder tumors are adenocarcinoma. Adenocarcinomas tend to occur in the urachus or, frequently, the trigone of the bladder. Other bladder histologic types include sarcoma, lymphoma, and small cell carcinoma. Rhabdomyosarcoma occurs in children.

**Behavior Code**

Code the behavior as malignant, not in situ, when
- the only surgery performed is a transurethral resection of the bladder (TURB) documenting that depth of invasion cannot be measured because there is no muscle in the specimen
- and
- the physician’s TNM designation is not available

Code the behavior as in situ when the TNM designation is Ta for TURB with no muscle in the specimen.

**Grade**

*Note:* These guidelines pertain to the data item Grade. Refer to the [Collaborative Stage Data Collection Manual](https://cancer.gov/cancerstats) for instructions on coding site-specific factors.

Code grade from the original tumor. Do not code grade from recurrence.

**Non-invasive Urothelial (Transitional) Tumors**

Code grade 9 (unknown) for non-invasive urothelial (transitional) tumors. The grading of urothelial (transitional) tumors is based on the WHO Classification, which is a three grade system. The 3 grade levels describe levels of neoplasia rather than differentiation, although the term grade is used for both. WHO Grade III or WHO High Grade is equivalent to non-invasive carcinoma or carcinoma in situ (for flat lesions). Path reports often omit the words "WHO Grade," shortening the descriptor to just plain "grade." When you see the words "Grade III" or "high grade," do not code in the grade field.

**Invasive Tumors**

Three-Grade System (Nuclear Grade)

There are several sites for which a three-grade system is used. The patterns of cell growth are measured on a scale of 1, 2, and 3 (also referred to as low, medium, and high grade). This system measures the proportion of cancer cells that are growing and making new cells and how closely they resemble the cells of the host tissue. Thus, it is similar to a four-grade system, but simply divides the spectrum into three rather than four categories (see conversion table below). The expected outcome is more favorable for lower grades.

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1 PDQ
2 Clinical Oncology, 8th edition
If a grade is written as 2/3 that means this is a grade 2 of a three-grade system. Do not simply code the numerator. Use the following table to convert the grade to SEER codes.

<table>
<thead>
<tr>
<th>Term</th>
<th>Grade</th>
<th>SEER Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/3, 1/2</td>
<td>Low grade</td>
<td>2</td>
</tr>
<tr>
<td>2/3</td>
<td>Intermediate grade</td>
<td>3</td>
</tr>
<tr>
<td>3/3, 2/2</td>
<td>High grade</td>
<td>4</td>
</tr>
</tbody>
</table>

FIRST COURSE TREATMENT

TREATMENT MODALITIES (most common treatments)

TURB with fulguration
TURB with fulguration followed by intravesical BCG (bacillus Calmette-Guerin) is usually used for patients with multiple tumors or for high-risk patients.
TURB with fulguration followed by intravesical chemotherapy
Photodynamic therapy (PDT) using laser light and chemotherapy
Segmental cystectomy (rare)
Radical cystectomy in patients with extensive or refractory superficial tumor
Internal irradiation (needles, seeds, wires, or catheters placed into or near the tumor) with or without external-beam irradiation
Chemotherapy
Immunotherapy/biologic therapy