Multiple Primary and Histology Coding Rules

January 01, 2007

National Cancer Institute
Surveillance Epidemiology and End Results Program
Bethesda, MD
### Multiple Primary and Histology Coding Rules

#### Table of Contents

I. Cover Page  
II. Table of Contents  
III. Preface  
IV. Multiple Primary and Histology Rules General Instructions  
V. Terms & Definitions - Multiple Primary and Histology Coding Rules  
   i. Head and Neck  
   ii. Colon  
   iii. Lung  
   iv. Melanoma  
   v. Breast  
   vi. Kidney  
   vii. Ureter/Renal Pelvis/Bladder  
   viii. Benign Brain  
   ix. Malignant Brain  
   x. Other Sites  
VI. Flowchart Format - Multiple Primary and Histology Coding Rules  
   i. Head and Neck – Multiple primary  
   Head and Neck – Histology  
   ii. Colon – Multiple primary  
   Colon – Histology  
   iii. Lung – Multiple primary  
   Lung – Histology  
   iv. Melanoma – MP  
   Melanoma - Histology  
   v. Breast – MP  
   Breast - Histology  
   vi. Kidney – MP  
   Kidney - Histology  
   vii. Ureter/Renal Pelvis/Bladder – MP  
   Ureter/Renal Pelvis/Bladder – Histo  
   viii. Benign Brain – MP  
   Benign Brain – Histo  
   ix. Malignant Brain – MP  
   Malignant Brain – Histo  
   x. Other Sites – Multiple primary  
   Other Sites – Histology  

Revised April 30, 2008
Multiple Primary and Histology Coding Rules
Table of Contents

VII. Table Matrix Format - Multiple Primary and Histology Coding Rules
   i.  Head and Neck – Multiple primary 203
       Head and Neck – Histology 207
   ii. Colon – Multiple primary 211
       Colon – Histology 213
   iii. Lung – Multiple primary 221
        Lung – Histology 224
   iv.  Melanoma – MP 229
        Melanoma – Histology 231
   v.  Breast – MP 233
       Breast – Histology 235
   vi.  Kidney – MP 243
        Kidney - Histology 246
   vii. Ureter/Renal Pelvis/Bladder – MP 249
        Ureter/Renal Pelvis/Bladder – Histo 251
   viii. Benign Brain – MP 254.1
        Benign Brain – Histo 254.5
   ix.  Malignant Brain – MP 255
        Malignant Brain – Histo 257
   x.  Other Sites – Multiple primary 259
       Other Sites – Histology 263

VIII. Text Format - Multiple Primary and Histology Coding Rules
   i.  Head and Neck – Multiple primary 277
       Head and Neck – Histology 279
   ii. Colon – Multiple primary 283
       Colon – Histology 285
   iii. Lung – Multiple primary 289
        Lung – Histology 291
   iv.  Melanoma – MP 295
        Melanoma – Histology 297
   v.  Breast – MP 299
       Breast – Histology 301
   vi.  Kidney – MP 307
       Kidney - Histology 309
   vii. Ureter/Renal Pelvis/Bladder – MP 313
        Ureter/Renal Pelvis/Bladder – Histo 315

Revised April 30, 2008
## Multiple Primary and Histology Coding Rules
### Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>viii.</td>
<td>Benign Brain – MP</td>
<td>318.1</td>
</tr>
<tr>
<td></td>
<td>Benign Brain – Histo</td>
<td>318.3</td>
</tr>
<tr>
<td>ix.</td>
<td>Malignant Brain – MP</td>
<td>319</td>
</tr>
<tr>
<td></td>
<td>Malignant Brain – Histo</td>
<td>321</td>
</tr>
<tr>
<td>x.</td>
<td>Other Sites – Multiple primary</td>
<td>323</td>
</tr>
<tr>
<td></td>
<td>Other Sites – Histology</td>
<td>326</td>
</tr>
<tr>
<td>IX.</td>
<td>New Data Items</td>
<td>333</td>
</tr>
<tr>
<td>Appendix A</td>
<td>Histology Coding Committee and Project Roster</td>
<td>345</td>
</tr>
<tr>
<td>Appendix B</td>
<td>Commission on Cancer Site Teams</td>
<td>349</td>
</tr>
</tbody>
</table>
The 2007 Multiple Primary and Histology Coding Rules
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III. Preface

The 2007 Multiple Primary and Histology (MP/H) Coding Rules present the first site-specific multiple primary and histology rules developed to promote consistent and standardized coding by cancer registrars. This project was sponsored by the National Cancer Institute (NCI) Surveillance Epidemiology and End Results (SEER) Program. In January 2003, the Multiple Primary and Histology Task Force was formed to tackle problems identified in existing rules. The MP/H Task Force was a diverse group with membership from all but two SEER regions, the American College of Surgeons (ACoS) Commission on Cancer (CoC), the American Joint Committee on Cancer (AJCC), the Centers for Disease Control and Prevention (CDC) National Program of Cancer Registries (NPCR), the National Cancer Registrars Association (NCRA), North American Association of Central Cancer Registries (NAACCR), 15 central registry representatives, and Canadian Cancer Registries. Physician guidance by specialty pathologists and clinicians was integral to the review and revision process. Regular consultation with the editors of ICD-O-3 clarified ICD-O-3 codes and ensured that the new rules accurately reflect the ICD-O-3 editors’ intent and purpose.

The 2007 MP/H Rules include site-specific rules for lung, breast, colon, melanoma of the skin, head and neck, kidney, renal pelvis/ureter/bladder, and malignant brain. A separate set of rules addresses the specific and general rules for malignant solid tumors originating in all other sites. The multiple primary rules guide and standardize the process of determining the number of primaries. The histology rules contain detailed histology coding instructions. For example, there are instructions and guidance for identifying histologic lineages, differentiating between general (NOS) terms and specific histologic types, and correctly assigning mixed and combination codes.

The rules are available in three formats: flowchart, matrix and text. The different formats were developed to meet the needs of registrars who have different learning styles.

The MP/H Task Force also developed three new data items that complement these rules, Multiplicity Counter, Date of Multiple Tumors, and Type of Multiple Tumors Reported as One Primary.

The rules are available in this stand-alone manual and also in the 2007 SEER Coding and Staging Manual.

A cadre of instructors has been trained to provide in-person education on using the new rules to registrars. Web-based cancer registrar education is available on the SEER training website, http://seer.cancer.gov/. Multiple primary and histology issues are covered in several modules, and a 2007 MP/H rules module will be added. Continuing education units can be requested from the National Cancer Registrars Association. Recorded training webcasts will be available for viewing and provide another option for mass training of registrars who cannot attend an in-person workshop.
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IV.
General Instructions and Histology Type ICD-O-3
EQUIVALENT OR EQUAL TERMS
  Adenocarcinoma, glandular carcinoma
  Multicentric, multifocal
  Tumor, mass, lesion, neoplasm

DEFINITIONS

Note: Use these terms and definitions for all reportable cases except lymphoma and leukemia primaries (M9590-9989).

Bilateral: Relating to the right and left sides of the body or of a body structure; bilaterality is not an indication of single or multiple primaries.

Clinical Diagnosis: A diagnosis that is not microscopically confirmed. It may be based on information from diagnostic imaging or the clinician’s expertise.

Contiguous tumor: A single tumor that involves, invades, or bridges adjacent or connecting sites or subsites.

Focal: An adjective meaning limited to one specific area. A focal cancer is limited to one specific area or organ. The area may be microscopic or macroscopic.

Foci: Plural of focus.

Focus: A term used by pathologists to describe a group of cells that can be seen only by a microscope. The cells are noticeably different from the surrounding tissue either by their appearance, chemical stain, or other testing.

Laterality: Indication of which side of a paired organ/site a tumor is located. (See Paired organ/site)

Most representative specimen: The pathologic specimen from the surgical procedure that removed the most tumor tissue.

Multiple primaries: More than one reportable case.

Overlapping tumor: The involved sites are adjacent (next to each other) and the tumor is contiguous.

Paired organ/site: There are two sides, one on the left side of the body and one on the right side of the body. (See Laterality)
Recurrence: This term has two meanings:
1. The reappearance of disease that was thought to be cured or inactive (in remission). Recurrent cancer starts from cancer cells that were not removed or destroyed by the original therapy.
2. A new occurrence of cancer arising from cells that have nothing to do with the earlier (first) cancer. A new or another occurrence, incidence, episode, or report of the same disease (cancer) in a general sense – a new occurrence of cancer.

Single primary: One reportable case.

Unilateral: Relating to one side of the body or one side of a body structure.

DETERMINING MULTIPLE PRIMARIES FOR SOLID MALIGNANT TUMORS
Note: The rules do not apply to hematopoietic primaries (lymphoma and leukemia) of any site or to the reportable benign or borderline intracranial or CNS tumors.

A. General Information
1. Use these rules to determine the number of reportable primaries. Do not use these rules to determine case reportability, stage, or grade.
2. The 2007 multiple primary and histology coding rules replace all previous multiple primary and histology coding rules.
3. The rules are effective for cases diagnosed January 1, 2007 and after. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.
4. Read the General Instructions and the site-specific Equivalent Terms and Definitions before using the multiple primary rules.
5. The multiple primary and histology coding rules are available in three formats: flowchart, text, and matrix. The rules are identical, only the formats differ. Use the rules in the format that is easiest for you to follow.
6. Notes and examples are included with some of the rules to highlight key points or to add clarity to the rules.
7. Do not use a physician’s statement to decide whether the patient has a recurrence of a previous cancer or a new primary. Use the multiple primary rules as written unless a pathologist compares the present tumor to the “original” tumor and states that this tumor is a recurrence of cancer from the previous primary.
8. Use the Determining Multiple Primaries: Hematopoietic Primaries (Lymphoma and Leukemia) rules and table “Definitions of Single and Subsequent Primaries for Hematologic Malignancies” to determine single versus multiple primaries for lymphoma and leukemia cases.

B. How to Use the Multiple Primary Rules
1. Use the Multiple Primary rules to make a decision on the number of primary malignancies to be abstracted for reportable solid malignant tumors.
2. Use the site-specific rules for the following primary sites:
   - Brain, malignant (intracranial and CNS)
   - Breast

January 1, 2007
3. Use the **Other Sites rules** for solid malignant tumors that occur in primary sites not covered by the site-specific rules.

4. Each module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors) is an independent, complete set of coding rules. To determine which set of primary site rules to use:
   a. When there is no tumor in the primary site, only metastatic lesions are present:
      I. Use the primary site documented by a physician and use the multiple primary and histology coding rules for that primary site.
      II. If no primary site is documented, code the primary site as unknown and use the general multiple primary and histology coding rules. Use the “Unknown if Single or Multiple Tumors” module to determine multiple primaries and the “Single Tumor” module for coding histology.
   b. To choose the appropriate module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors),
      I. Use the multiple primary and histology coding rules for the primary site
      II. Determine the number of tumors
         i. Do not count metastatic lesions
         ii. When the tumor is only described as multicentric or multifocal and the number of tumors is not mentioned, use the “Unknown if Single or Multiple Tumors” module
         iii. When there is a tumor or tumors with separate microscopic foci, ignore the separate microscopic foci and use the “Single Tumor” or “Multiple Tumor” modules as appropriate
         iv. When the patient has a single tumor, use the “Single Tumor” module.
         v. If there are multiple tumors, use the “Multiple Tumor” module.
      III. See the Equivalent Terms and Definitions for Head and Neck for guidance in coding the primary site
      IV. Use the primary site documented by the physician on the medical record

5. If a single primary, prepare one abstract.
6. If there are multiple primaries, prepare two or more abstracts.
7. Rules are in hierarchical order within each module (Unknown if Single or Multiple Tumors, Single Tumor, and Multiple Tumors). Use the first rule that applies and

**STOP**
Histologic Type ICD-O-3

The data item Histologic Type ICD-O-3 describes the microscopic composition of cells and/or tissue for a specific primary. The tumor type or histology is a basis for staging and determination of treatment options. It affects the prognosis and course of the disease.


Information about the 2007 Histology Coding Rules
Note: Do not use these rules to determine case reportability.
1. The 2007 multiple primary rules replace all previous multiple primary rules.
2. The rules are effective for cases diagnosed January 1, 2007 and after. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.
3. The histology coding rules are available in three formats: flowchart, text, and matrix. The rules are identical, only the formats differ. Use the set of rules in the format that is easiest for you to follow.
4. Notes and examples are included with some of the rules to highlight key points or to add clarity to the rules.
5. Rules are in hierarchical order within each section (Single Tumor and Multiple Tumors Abstracted as a Single Primary).

How to Use the Rules
1. Read the General Instructions.
2. Read the site-specific Equivalent Terms and Definitions.
3. Use these rules to make a decision on coding the histology for all reportable solid malignant tumors.
4. Use the multiple primary rules to determine whether the patient has a single or multiple primaries before coding the histology.
5. Code the histology for each primary in a separate abstract.
6. Use the site-specific rules for the following primary sites:
   - Brain, malignant (intracranial and CNS)
   - Breast
   - Colon
   - Head and neck
   - Kidney
   - Lung
   - Malignant melanoma of the skin

January 1, 2007
Renal pelvis, ureter, bladder, and other urinary

7. Use the Other Sites rules for all solid malignant tumors that occur in primary sites not included in the site-specific rules.
8. Determine whether the patient has a single tumor or multiple tumors that will be abstracted as a single primary
   a. Do not count metastatic tumors
   b. When the tumor is described as multifocal or multicentric, use the Multiple Tumors module
   c. When there is a tumor or tumors with separate foci of tumor do not count the foci
   d. Only count the tumors that will be used to prepare that abstract. For example, when there are two tumors that will be abstracted as multiple primaries, you would use the Single Tumor modules to determine the histology code for each of the abstracts.
9. Each section (Single Tumor and Multiple Tumors Abstracted as a Single Primary) is an independent, complete set of coding rules. For example, if the patient has multiple tumors, that will be abstracted as a single primary start with the first rule under the heading Multiple Tumors Abstracted as a Single Primary. Do not use any of the rules under the header Single Tumor.
10. Use the first rule that applies and

STOP

Priority order for using Documents to Code Histology
Medical records frequently include multiple pathology reports and references to histologic diagnosis. Use the following instructions to identify which reports best represent the histology to be coded.
1. Pathology report:
   a. From the most representative tumor specimen examined
   b. From the final diagnosis
      Note 1: Use information from addenda and comments associated with the final diagnosis to code the histology.
      Note 2: A revised/amended diagnosis replaces the original final diagnosis. Code the histology from the revised/amended diagnosis.
      Note 3: The new rules limit the information to the final diagnosis. The old rules allowed coding from information in the microscopic description. You will only use information from the microscopic portion of the pathology report when instructed to do so in one of the site-specific rules.
2. Cytology report.
3. When you do not have either a pathology report or cytology report:
   a. Documentation in the medical record that references pathology or cytology findings
   b. From mention of type of cancer (histology) in the medical record
Ambiguous Terms Used to Code Histology

When any of the ambiguous terms are used to describe a more specific histology, code the more specific histology.

**Ambiguous terms that are characteristic (used to code histology)**

- Apparent(ly)
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Most likely
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- Typical (of)

**Example:** Non-small cell carcinoma, most likely adenocarcinoma. Code adenocarcinoma.

---

**General Instructions Histology Coding Rules**

When using rule (see note) that states “Code the histology documented by the physician when the pathology/cytology report is not available” code the histology from the document with the highest priority. Make a second pass through the histology rules to determine which histology code should be recorded. Start with the appropriate module, Single Tumor or Multiple Tumors, and continue through the rules until you reach the rule that fits the case you are coding.

**Note:** For most sites this will be rule H1 and the first rule in the Multiple Tumors module

When using rule (see note) that states “When the only histology is from a metastatic site” make a second pass through the histology rules to determine which histology code should be recorded. Start with the appropriate module, Single Tumor or Multiple Tumors, and continue through the rules until you reach the rule that fits the case you are coding.

**Note:** For most sites this will be rule H2 and the second rule in the Multiple Tumors module

When the patient has a previous or subsequent unknown primary site (80.9) or an ill-defined primary site, check carefully to see if this abstract or document should be consolidated into the previous abstract rather than making it a new primary.
V.
Terms & Definitions – Multiple Primary and Histology Coding Rules
Guidelines for Head and Neck

The head and neck rules cover the following sites: Lip C000-C009, Oral Cavity C019-C069, Salivary Gland C079-C089, Tonsil C090-C099, Oropharynx C100-C109, Nasopharynx C110-C119, Pyriform Sinus C129, Hypopharynx C130-C139, Other and Ill-defined Sites in Lip, Oral cavity and Pharynx C140-C148, Nasal Cavity C300, Middle Ear C301, Accessory Sinuses C310-C319, and Larynx C320-C329.

Head and neck tumors frequently extend into adjacent anatomic sites, or overlap multiple contiguous sites. The workup for these tumors often includes physical examinations, imaging, scans, endoscopies, biopsies and surgical observations. Each of these diagnostic tools provides a unique view of the tumor. More than one anatomic location may be involved with tumor and reports may contain conflicting information regarding the primary site.

Coding the Primary Site

Code the site where the tumor originated; do not simply code the biopsy site.

When there are multiple biopsies and the primary site is not documented, or when there is discrepant information, code the primary site using the following priority order.

**Priority Order**

1. Tumor board
   a. Specialty
   b. General
2. Staging physician’s site assignment
   a. AJCC staging form
   b. TNM statement in medical record

If neither 1 nor 2 are available, the priority order for using information depends upon whether the patient had a surgical resection of the primary tumor.

3. Total (complete) resection of primary tumor
   **Note:** The primary tumor is completely removed. The surgical margins may be microscopically positive.
   a. Surgeon’s statement from operative report
   b. Final diagnosis from pathology report
4. No resection (biopsy only):
   Documentation from:
   a. Endoscopy (physical exam with scope)
   b. Radiation oncologist
   c. Diagnosing physician
   d. Primary care physician
   e. Other physician
   f. Radiologist impression from diagnostic imaging
   g. Physician statement based on physical exam (clinical impression)

When the point of origin cannot be determined, use a topography code for overlapping sites:
   - C02.8 Overlapping lesion of tongue
   - C08.8 Overlapping lesion of major salivary glands
   - C14.8 Overlapping lesion of lip, oral cavity, and pharynx.

Equivalent or Equal Terms
   - In situ, noninvasive, intraepithelial
   - Squamous cell carcinoma, squamous cell epithelioma, epidermoid carcinoma
   - Tumor, mass, lesion, neoplasm
   - Contiguous, continuous

Definitions

In Situ: A tumor that is confined to the epithelium without penetration of the basement membrane

Invasive: A tumor that penetrates the basement membrane and involves at least the lamina propria

Most invasive: The tumor with the greatest continuous extension (see focal and foci definitions in the general instructions). The least to the greatest extension for mouth and oral cavity:
   - epithelium
   - lamina propria, submucosa (not found in gum and hard palate)
   - muscularis propria (not found in gum and hard palate)

January 1, 2007
Table 1 – Paired Sites

*Table Instructions:* Use this table to determine multiple primary status for sites listed in Column 1.

<table>
<thead>
<tr>
<th>Column 1: Paired Sites</th>
<th>Column 2: Code</th>
</tr>
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<tbody>
<tr>
<td>Parotid Glands</td>
<td>C079</td>
</tr>
<tr>
<td>Major Salivary Glands</td>
<td>C080; C081</td>
</tr>
<tr>
<td>Tonsils</td>
<td>C090; C091; C098, C099</td>
</tr>
<tr>
<td>Nasal Cavity</td>
<td>C300</td>
</tr>
<tr>
<td>Accessory Sinuses</td>
<td>C310; C312</td>
</tr>
<tr>
<td>Middle Ear</td>
<td>C301</td>
</tr>
</tbody>
</table>
Table 2 – Changes to Previous SEER Site Grouping Table

Previous to 2007, tumors in sites on the same row were abstracted as a single primary.

<table>
<thead>
<tr>
<th>Code</th>
<th>Site Groupings</th>
</tr>
</thead>
<tbody>
<tr>
<td>C01</td>
<td>Base of tongue</td>
</tr>
<tr>
<td>C02</td>
<td>Other and unspecified parts of tongue</td>
</tr>
<tr>
<td>C05</td>
<td>Palate</td>
</tr>
<tr>
<td>C06</td>
<td>Other and unspecified parts of mouth</td>
</tr>
<tr>
<td>C07</td>
<td>Parotid gland</td>
</tr>
<tr>
<td>C08</td>
<td>Other and unspecified major salivary glands</td>
</tr>
<tr>
<td>C09</td>
<td>Tonsil</td>
</tr>
<tr>
<td>C10</td>
<td>Oropharynx</td>
</tr>
<tr>
<td>C12</td>
<td>Pyriform sinus</td>
</tr>
<tr>
<td>C13</td>
<td>Hypopharynx</td>
</tr>
<tr>
<td>C30</td>
<td>Nasal cavity and middle ear</td>
</tr>
<tr>
<td>C31</td>
<td>Accessory sinuses</td>
</tr>
</tbody>
</table>

January 1, 2007
Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

Chart 1 – Head and Neck Histology Groups and Specific types

Note: Greater than 85% of cancers in the Head and Neck are squamous cell carcinoma

Chart Instructions: Use this chart with the histology rules to code the most specific histologic term. The tree is arranged in descending order. Each branch is a histology group, starting with the NOS or group terms and descending into the specific types for that group. As you follow the branch down, the terms become more specific.
Head and Neck Terms and Definitions

Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

January 1, 2007
Head and Neck Terms and Definitions

Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

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Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
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Nasal Sinuses

- Frontal sinuses
- Ethmoid and sphenoid sinuses
- Ohngren’s line
- Maxillary sinuses
Head and Neck Terms and Definitions

Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Larynx

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Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

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Colon Equivalent Terms, Definitions and Illustrations
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Introduction

*Note 1: Rectum and rectosigmoid are covered by The Other Sites rules.
*Note 2: For the purpose of these rules, the words "exophytic" and "polypoid" are not synonymous with a polyp.

Use these rules only for cases with primary colon cancer.

Ninety-eight percent of colon cancers are adenocarcinoma. Ten to fifteen percent of these cases produce enough mucin to be categorized as mucinous/colloid.* Mixed histologies and specific types other than mucinous/colloid or signet ring cell are rare.

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Equivalent or Equal Terms

*Note: For the purpose of these rules, the words “exophytic” and “polypoid” are not synonymous with a polyp

- Familial polyposis, familial adenomatous polyposis, (FAP)
- Intramucosal, lateral extension
- Invasion through colon wall, extension through colon wall, transmural
- Low grade neuroendocrine carcinoma, carcinoid
- Most invasive, most extensive
- Mucin producing, mucin secreting
- Mucinous, colloid
- Polyp, adenoma
- Serosa, visceral peritoneum
- Tumor, mass, lesion, neoplasm
- Type, subtype, predominantly, with features of, major, or with ____differentiation.

Definitions

Adenocarcinoid (8245/3): A specific histology commonly found in the appendix.

Adenocarcinoma with mixed subtypes (8255): Rarely used for colon primaries (see introduction).

Adenocarcinoma, intestinal type (8144) is a form of stomach cancer. Do not use this code when the tumor arises in the colon.

Adenoma: A benign lesion composed of tubular or villous structures showing intraepithelial neoplasia (See definition of intraepithelial neoplasia).
Colon Equivalent Terms, Definitions and Illustrations
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

**Composite carcinoid (8244):** One tumor which contains both carcinoid and adenocarcinoma.

**Familial polyposis, familial adenomatous polyposis (FAP), adenocarcinoma in:** A condition characterized by the development of many adenomatous polyps, often seen in several members of the same family.

**Frank adenocarcinoma:** Adenocarcinoma arising from the colon wall (no evidence of a polyp)

**In Situ:** Noninvasive; intraepithelial; (adeno)carcinoma in a polyp or adenoma, noninvasive.

**Intestinal type adenocarcinoma (8144)** is a gastric histology term and is not listed in the WHO Histological Classification of Tumors of the Colon and Rectum.

**Intraepithelial neoplasia, high grade** may be either severe dysplasia or carcinoma in situ. Report cases of carcinoma in situ only.

**Intraepithelial neoplasia, low grade** is not a reportable condition. A person with intraepithelial neoplasia is at risk for developing invasive cancer.

**Intramucosal** tumors may be noninvasive or invasive. The term intramucosal may refer to the surface epithelium, the basement membrane, or the lamina propria.

**Invasive tumor:** A tumor that penetrates the basement membrane and invades the lamina propria.

**Most invasive:** The tumor with the greatest continuous extension through the wall of the colon. The layers of the colon wall in order of least to greatest extension:
- Mucosa (surface epithelium, lamina propria, basement membrane)
- Submucosa
- Muscularis propria
- Subserosa (pericolic fat, subserosal fat)
- Retroperitoneal fat (pericolic fat)
- Mesenteric fat (pericolic fat)
- Serosa (visceral peritoneum).
Mucinous/colloid adenocarcinoma (8480): An adenocarcinoma containing extra-cellular mucin comprising more than 50% of the tumor. Note that “mucin-producing” and “mucin-secreting” are not synonymous with mucinous.

Neuroendocrine carcinoma (8246): Neuroendocrine carcinoma is a group of carcinomas that include typical carcinoid tumor (8240), atypical carcinoid tumor (8249).

Pericolic fat: A general term for the fat surrounding the colon. Subserosal fat, retroperitoneal fat and mesenteric fat are pericolic fat.

Signet ring cell carcinoma (8490): An adenocarcinoma containing intra-cellular mucin comprising more than 50% of the tumor.

Transmural: Through the wall of the colon (the tumor has extended through the colon wall and may invade a regional organ or regional tissue.

Undifferentiated carcinoma (8020): A high grade malignancy lacking glandular structures or other specific features that can be used to better classify the tumor. Undifferentiated carcinoma is not a histologic type; it is a non-specific term.
Colon Equivalent Terms, Definitions and Illustrations
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)
Introduction

Use these rules only for cases with primary lung cancer.

Lung carcinomas may be broadly grouped into two categories, small cell and non-small cell carcinoma. Frequently a patient may have two or more tumors in one lung and may have one or more tumors in the contralateral lung. The physician may biopsy only one of the tumors. Code the case as a single primary (See Rule M1, Note 2) unless one of the tumors is proven to be a different histology. It is irrelevant whether the other tumors are identified as cancer, primary tumors, or metastases.

Equivalent or Equal Terms

- Low grade neuroendocrine carcinoma, carcinoid
- Tumor, mass, lesion, neoplasm (for multiple primary and histology coding rules only)
- Type, subtype, predominantly, with features of, major, or with ___differentiation

Obsolete Terms for Small Cell Carcinoma (Terms that are no longer recognized)

- Intermediate cell carcinoma (8044)
- Mixed small cell/large cell carcinoma (8045) (Code is still used; however current accepted terminology is combined small cell carcinoma)
- Oat cell carcinoma (8042)
- Small cell anaplastic carcinoma (No ICD-O-3 code)
- Undifferentiated small cell carcinoma (No ICD-O-3 code)

Definitions

Adenocarcinoma with mixed subtypes (8255): A mixture of two or more of the subtypes of adenocarcinoma such as acinar, papillary, bronchoalveolar, or solid with mucin formation.

Adenosquamous carcinoma (8560): A single histology in a single tumor composed of both squamous cell carcinoma and adenocarcinoma.

Bilateral lung cancer: This phrase simply means that there is at least one malignancy in the right lung and at least one malignancy in the left lung. Do not base multiple primary decision on this phrase; bilateral does not mean this is a single primary. Use the multiple primary rules to decide whether to code bilateral lung cancers as a single or multiple primary.

Combined small cell carcinoma (8045): A small cell carcinoma that is combined with a non-small cell carcinoma. The combinations are small cell and adenocarcinoma, or squamous cell carcinoma, or large cell carcinoma.
Large cell carcinoma (8012): Large cell is a diagnosis that is used when the tumor is a non-small cell carcinoma that is undifferentiated. Because the tumor is undifferentiated, the pathologist cannot find glandular (adeno), or squamous differentiation.

Large cell neuroendocrine carcinoma (8013): A non-small cell carcinoma with neuroendocrine differentiation proven by immunohistochemical stain, currently classified as large cell carcinoma. These tumors require further study before being included as a separate category in a histologic classification.

Most invasive: The tumor with the greatest continuous extension.

Neuroendocrine carcinoma (8246): Neuroendocrine carcinoma is a group of carcinomas that include typical carcinoid tumor and small cell carcinoma. Code the specific histology when given. Code neuroendocrine carcinoma, NOS (8246) when no specific histology is documented.

Non-small cell carcinoma (8046): The term non-small is used two ways, as a group term describing all carcinomas that are not small cell; and as a default diagnosis when there isn’t enough tissue to classify the tumor beyond the exclusion of small cell.

Pancoast tumor: An anatomic designation (not a specific histology) for a lung cancer that starts in the upper lobe of the lung and extends outward to destroy the ribs and vertebrae. The tumor may compress or directly invade the brachial plexus (nerve bundles) of the neck, causing pain. Pancoast tumor may also be called superior sulcus tumor.

Pleomorphic carcinoma (8022): A poorly differentiated non-small cell carcinoma (squamous cell carcinoma, adenocarcinoma, or large cell carcinoma) containing spindle cells and/or giant cells or, a carcinoma containing only spindle cells and giant cells. These fall under the general category of sarcomatoid carcinoma.

Sarcomatoid carcinoma: A group of tumors that are non-small cell in type and contain spindle cells and/or giant cells. Depending on the histologic features the tumor may be designated: pleomorphic carcinoma (8022); spindle cell carcinoma (8032); giant cell carcinoma (8031), carcinosarcoma (8980); or pulmonary blastoma (8972)

Small cell carcinoma: Malignant epithelial tumor consisting of small cells. There are many types of lung cancer, but most can be categorized into one of two basic types, "small cell carcinoma" or “non-small cell carcinoma”

Undifferentiated carcinoma (8020): A high grade malignancy lacking glandular structures or other specific features that can be used to better classify the tumor. Undifferentiated carcinoma is used by pathologists when they believe the tumor is a carcinoma (not lymphoma, melanoma, or sarcoma) but they are not sure if the tumor is small cell or non-small cell.
Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Chart 1 – Lung Histology Groups and Specific Types

Note: This chart is based on the WHO Classification of Tumors for tumors of the lung. The chart is not a complete listing of histologies that may occur in the lung.

Chart Instructions: Use this chart with multiple primary rule M10 to identify types of non-small cell carcinoma. Use this chart with the histology rules to code the most specific histologic term. The tree is arranged in descending order. Each branch is a histology group, starting with the NOS or group terms and descending into the specific types for that group. As you follow the branch down, the terms become more specific.
Chart 2 – Most Common Lung Histology Groups

*Chart Instructions:* Use this chart to identify the most common group terms and histology types.

*Note:* This chart is based on the *WHO Classification of Tumors* for tumors of the lung. The chart is *not* a complete listing of histologies that may occur in the lung.
### Table 1 – Combination/Mixed Codes for Lung Histologies

**Table Instructions:** Use this table to select combination/mixed histology codes. Compare the terms in the diagnosis to the terms in columns 1 and 2. If the terms match, abstract the case using the ICD-O-3 histology code in column 4. Use the combination/mixed codes listed in this table only when the histologies in the tumor match the histologies listed below. Use the combination/mixed codes for a **single tumor** when all histologies are present in a single tumor.

**Note:** This table is not a complete listing of histologies that may occur in the lung.

<table>
<thead>
<tr>
<th>Column 1: Required Terms</th>
<th>Column 2: Additional Required Terms</th>
<th>Column 3: ICD-O-3 Term</th>
<th>Column 4: ICD-O-3 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Giant cell carcinoma AND</td>
<td>Adenocarcinoma</td>
<td>Giant cell and spindle cell carcinoma</td>
<td>8030</td>
</tr>
<tr>
<td>spindle cell carcinoma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small cell carcinoma AND</td>
<td>Adenocarcinoma</td>
<td>Combined small cell carcinoma</td>
<td>8045</td>
</tr>
<tr>
<td>one of the histologies in</td>
<td>Large cell carcinoma</td>
<td>Mixed small cell carcinoma</td>
<td>8045</td>
</tr>
<tr>
<td>Column 2 <strong>Note:</strong> Diagnosis must be small cell carcinoma (NOS), not a subtype of small cell</td>
<td>Squamous cell carcinoma</td>
<td>Sqaudous cell carcinoma, large cell, nonkeratinizing</td>
<td>8072</td>
</tr>
<tr>
<td>Squamous cell carcinoma* AND</td>
<td>Squamous cell carcinoma, spindle cell</td>
<td>8074</td>
<td></td>
</tr>
<tr>
<td>large cell nonkeratinizing</td>
<td>sarcomatoid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Squamous cell carcinoma AND</td>
<td>Spindle cell carcinoma</td>
<td>Squamous cell carcinoma, spindle cell</td>
<td>8074</td>
</tr>
<tr>
<td>small cell nonkeratinizing</td>
<td>Sarcomatoid</td>
<td>Squamous cell carcinoma, sarcomatoid</td>
<td>8074</td>
</tr>
<tr>
<td>Squamous cell carcinoma* AND</td>
<td>Acinar</td>
<td>Adenocarcinoma with mixed subtypes**</td>
<td>8255**</td>
</tr>
<tr>
<td>one of the histologies in</td>
<td>Bronchioloalveolar carcinoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Column 2 <strong>Note:</strong> Diagnosis must be small cell carcinoma (NOS), not a subtype of small cell</td>
<td>Bronchioloalveolar carcinoma non mucinous (Clara cell/type II pneumocyte)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A combination of at least two of</td>
<td>Bronchioloalveolar carcinoma mucinous (goblet cell)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the histologies in Column 2**</td>
<td>Bronchioloalveolar carcinoma mixed mucinous and non-mucinous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear cell adenocarcinoma</td>
<td>Papillary adenocarcinoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solid adenocarcinoma</td>
<td>Well-differentiated fetal adenocarcinoma</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations

**C340-C349**

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Column 1: Required Terms</th>
<th>Column 2: Additional Required Terms</th>
<th>Column 3: ICD-O-3 Term</th>
<th>Column 4: ICD-O-3 Code</th>
</tr>
</thead>
</table>
| Adenocarcinoma AND squamous cell carcinoma  
*Note: Diagnosis must be adenocarcinoma (NOS), not a subtype of adenocarcinoma* | | Adenosquamous carcinoma | 8560 |
| Epithelial carcinoma AND myoepithelial carcinoma | | Epithelial-myoeipithelial carcinoma | 8562 |

* Squamous cell carcinoma and epidermoid carcinoma are synonyms.

**DO NOT USE** code 8255 for adenocarcinoma combined with mucinous subtypes such as mucinous “colloid” adenocarcinoma (8480) mucinous cystadenocarcinoma (8470) or signet ring adenocarcinoma (8490).
Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)
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Introduction
Cutaneous melanoma starts in the melanocyte cells of the skin. Melanocytes lie in the epidermis, the outermost layer of the skin. Melanocytes often cluster together and form moles (nevi). Most moles are benign, but some may go on to become malignant melanomas.

Melanomas are divided into 5 main types, depending on their location, shape and whether they grow outward or downward into the dermis:

- **Acral melanoma**: occurs on the palms of the hand, soles of the feet, or nail beds
- **Desmoplastic melanoma**: is a rare malignant melanoma marked by non-pigmented lesions on sun-exposed areas of the body
- **Lentigo maligna**: usually occur on the faces of elderly people
- **Superficial spreading or flat melanoma**: grows outwards at first to form an irregular pattern on the skin with an uneven color
- **Nodular melanomas**: are lumpy and often blue-black in color and may grow faster and spread downwards

These types account for the majority of melanomas occurring in the US population. For a more complete listing of histologic types of melanoma, see the *AJCC Cancer Staging Manual, 6th Ed.*

Melanoma can also start in the mucous membranes of the mouth, anus and vagina, in the eye or other places in the body where melanocytes are found. This scheme is used only for melanomas that occur on the skin.

Equivalent or Equal Terms
- Tumor, mass, lesion, neoplasm
- Type, subtype, predominantly, with features of, major, or with ____differentiation.
- Giant pigmented nevus, giant congenital nevus
- Mole, Nevus
- Mixed epithelioid and spindle cell melanoma (8770): Epithelioid melanoma and spindle cell melanoma

Synonyms for In Situ
Behavior code 2
Clark level 1 (limited to the epithelium)
Hutchinson freckle (See synonyms for Hutchinson freckle)
Intraepidermal, NOS
Intraepithelial, NOS
Lentigo maligna
Noninvasive
Precancerous melanoma of Dubreuilh
Stage 0
Tis
Melanoma Terms and Definitions

Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

Synonyms for Hutchinson freckle
Circumscribed precancerous melanosis
Intraepidermal malignant melanoma
Lentigo maligna
Precancerous melanosis of Dubreuilh

Definitions
Amelanotic melanoma: A non-pigmented malignant melanoma.

Atypical melanocytic hyperplasia (dysplasia): Tumor-like lesion or condition may represent precursor stage or stage in development of melanoma. Not reportable.

Different lateralities: The right side of the body, the left side of the body and the midline are separate lateralities in the melanoma coding rules.

Evolving melanoma (borderline evolving melanoma): Evolving melanoma are tumors of uncertain biologic behavior. Histological changes of borderline evolving melanoma are too subtle for a definitive diagnosis of melanoma in situ. The tumors may be described as "proliferation of atypical melanocytes confined to epidermal and adnexal epithelium," "atypical intraepidermal melanocytic proliferation, "atypical intraepidermal melanocytic hyperplasia"; or "severe melanocytic dysplasia.” Not reportable.

Familial Atypical Multiple Mole Melanoma Syndrome (FAMM, FAM-M): An inherited condition identified when:
- Melanoma has been diagnosed in a family member, including grandparents, aunts, uncles, and cousins
- Several family members have large numbers of moles (often more than 50) which may be abnormal or atypical moles.

Giant pigmented nevus: Diameter larger than 20 cm; frequently covers large areas of the body in a garment-like fashion. The trunk, head and neck are the most common sites.

Junctional nevus: Smooth, hairless, light to dark brown mole. Can be slightly elevated, usually multiple and can occur on any part of the body. Melanocytes are confined to the dermo-epidermal junction.

Hypodermis: A subcutaneous layer of loose connective tissue containing a varying number of fat cells.
Synonyms: subcutaneous fat; subcutis.
Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

**In-transit metastasis**: Metastasis found in the lymphatic channels more than 2cm away from the primary melanoma, but not reaching the regional lymph nodes.

**Invasive tumor**: A tumor that penetrates the basement membrane and invades the dermis.

**Laterality**: For skin sites, laterality divides the body into a right and left half as though a line were drawn from mid forehead to mid pelvis and from mid skull to mid buttocks. A midline laterality describes a tumor that is in the center of the “line” drawn from the mid forehead to mid pelvis or from the mid skull to the mid buttocks; it is impossible to categorize the tumor as being on the right or left side of the body.

**Lentigo maligna**: Is a specific histologic type of in situ melanoma. It appears as a brown or black mottled, irregular, lesion with increased numbers of scattered atypical melanocytes in the epidermis. It usually occurs on the face.

**Lentigo maligna melanoma**: Is an invasive melanoma that begins as lentigo maligna, but usually after many years the dermis is invaded by the tumor. Once invasion has occurred, the lesion is called lentigo maligna melanoma.

**Midline**: the middle dividing line that separates the body into right and left sides.

**Most invasive**: the histology that has the greatest extension into the dermis or subcutaneous fat.

**Non-invasive tumor**: A tumor confined to epithelium (intraepithelial), in situ tumor, with no penetration below the basement membrane.

**Precancerous melanosis**: An obsolete term for lentigo maligna.

**Proliferation of atypical melanocytes confined to epidermis**: Number of (proliferation) pigmented cells (melanocytes) not showing the normal cell structure (atypical). Not reportable.

**Regressing melanoma**: The term “regressing melanoma” does not refer to a specific histology; it refers to the physical appearance and size of the lesion. A regressing melanoma is reacting to the body’s immune system by shrinking in size. Partial spontaneous regression is not an uncommon finding in invasive primary melanoma; partial regression can be an indicator of poor prognosis. Proven complete regression is very rare; one website stated that only 33 cases of total regression have been reported. A regressive melanoma is usually thinner than it was originally. Although regression is a prognostic factor, the histologic type is more important for histology coding purposes. See Histology coding rules, Rule H5.

**Satellite lesion or metastasis**: Grossly evident metastatic skin lesion within the immediate vicinity (usually within 2 cm) of a primary malignant tumor; e.g., skin adjacent to primary malignant melanoma. This is a metastasis, not a separate primary.

**Severe melanotic dysplasia**: Tumor-like lesion or condition. Not reportable.
Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

Skin Layers:
- Epidermis – upper surface, thin layer (outermost layer)
- Dermis – lower, intermediate thicker layer (intermediate layer)
- Hypodermis – also called subcutis or subcutaneous fat – lowest layer (innermost layer)
Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

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Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
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Anatomy of Normal Skin

Source: Burnsurgery.org
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Equivalent or Equal Terms

- And, with (used in histology rules, i.e. duct and lobular is equivalent to duct with lobular)
- Duct, ductal
- Mammary, breast
- Mucinous, colloid
- NOS, NST
- Tumor, mass, lesion, neoplasm

Synonyms for “in situ”

- Behavior code ‘2’
- DCIS
- Intracystic
- Intraductal
- Noninfiltrating
- Noninvasive

Definitions

Carcinoma with osteoclast-like giant cells (8035): This is a specific type of duct carcinoma. The carcinomatous part of the lesion is most commonly an infiltrating duct carcinoma.

Ductular carcinoma (8521): A malignancy that is infrequently found in the breast and may be found with greater frequency in other organs such as pancreas or prostate. Code 8521 is seldom, if ever, applied to the breast. Although the ICD-O-3 suggests that 8521 is a site-associated code; the addition of (C50._) after this code may be misleading. The WHO Histological Classification of Tumours of the Breast does not list 8521, ductular carcinoma.

Duct carcinoma, NOS (8500): The largest group of breast cancers. Duct carcinoma, NOS is not a specific histologic type because it lacks specific features that can be used to better classify the tumor. See Table 1 and Table 2 for intraductal and duct types.
Inflammatory breast carcinoma (IBC): A breast cancer with a distinctive clinical presentation believed to be due to lymphatic obstruction from an underlying invasive adenocarcinoma. The vast majority of cases have a prominent dermal lymphatic infiltration by tumor. Dermal lymphatic infiltration without the characteristic clinical picture is insufficient to qualify as inflammatory carcinoma.

Intracystic carcinoma/Intracystic papillary carcinoma: Variant of intraductal carcinoma used to describe encysted forms of papillary carcinoma. Code intracystic carcinoma as in situ /2 unless the histology is described as invasive intracystic carcinoma.

In Situ: A tumor that is confined to the duct system (ductular or lobular) and does not invade surrounding stroma.

Invasive: A tumor that penetrates beyond the ductal basement membrane into the adjacent stroma of the breast parenchyma.

Lobular Carcinoma: Lobular carcinoma includes solid and alveolar patterns. About 5 to 10% of breast cancers are lobular. There is about a 20% chance that the opposite breast will also be involved, and many of them arise multicentrically in the same breast.

Paget Disease: Paget disease of the nipple is a condition where the epidermis of the nipple is infiltrated with neoplastic cells. ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3). Under the matrix system, only if the Paget disease is explicitly specified as in situ or non-invasive by the pathologist, code the behavior in situ (/2).

Phyllodes tumor (cystosarcoma phyllodes): A rare tumor with incidence ranging from 0.3% to 0.9% of all breast cancers. These tumors have a natural history and clinical behavior different from carcinoma of the breast. Criteria to classify benign, borderline and malignant cystosarcoma phyllodes utilize histologic parameters such as cellular atypia, mitotic activity and tumor margins. The reported incidence of malignant cystosarcoma phyllodes is approximately 25% of all phyllodes tumors.

Pleomorphic carcinoma (8022): This is a specific duct carcinoma type; A rare variant of high grade ductal carcinoma, NOS.

Sarcoma of breast: Primary sarcomas of the breast are rare accounting for less than 0.1% of all malignant tumors of the breast. Diagnoses may include fibrosarcoma, angiosarcoma, pleomorphic sarcoma, leiomyosarcoma, myxofibrosarcoma, hemangio-pericytoma, and osteosarcoma (extra-osseous osteosarcoma of breast).

Scirrhous Carcinoma: An adenocarcinoma with a firm-hard nodule associated with a dense connective tissue in the stroma. Scirrhous carcinoma is descriptive term, not a specific type of ductal carcinoma.
## Table 1 – Intraductal(8500/2) and Specific Intraductal Carcinomas

*Note:* These are the most common specific intraductal carcinomas. This is not intended to be a complete list of all possible intraductal types. If a histology appears only on table 1, it does not mean that it is impossible for that histology to occur with a malignant behavior (/3).

<table>
<thead>
<tr>
<th>Column 1: Code</th>
<th>Column 2: Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>8201</td>
<td>Cribriform</td>
</tr>
<tr>
<td>8230</td>
<td>Solid</td>
</tr>
<tr>
<td>8401</td>
<td>Apocrine</td>
</tr>
<tr>
<td>8500</td>
<td>Intraductal, NOS</td>
</tr>
<tr>
<td>8501</td>
<td>Comedo</td>
</tr>
<tr>
<td>8503</td>
<td>Papillary</td>
</tr>
<tr>
<td>8504</td>
<td>Intracystic carcinoma</td>
</tr>
<tr>
<td>8507</td>
<td>Micropapillary/Clinging</td>
</tr>
</tbody>
</table>

## Table 2 – Duct (8500/3) and Specific Duct Carcinomas

*Note:* These are the most common specific duct carcinomas. This is not intended to be a complete list of all possible duct types. If a histology appears only on table 2, it does not mean that it is impossible for that histology to occur with an in situ behavior (/2).

<table>
<thead>
<tr>
<th>Column 1: Code</th>
<th>Column 2: Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>8022</td>
<td>Pleomorphic carcinoma</td>
</tr>
<tr>
<td>8035</td>
<td>Carcinoma with osteoclast-like giant cells</td>
</tr>
<tr>
<td>8500</td>
<td>Duct, NOS</td>
</tr>
<tr>
<td>8501</td>
<td>Comedocarcinoma</td>
</tr>
<tr>
<td>8502</td>
<td>Secretory carcinoma of breast</td>
</tr>
<tr>
<td>8503</td>
<td>Intraductal papillary adenocarcinoma with invasion</td>
</tr>
<tr>
<td>8508</td>
<td>Cystic hypersecretory carcinoma</td>
</tr>
</tbody>
</table>
Table 3 – Combination Codes for Breast Cancers

Use this two-page table with rules H5, H6, H7, H8, H16, H17, H18, H19, H24, H25, H26 and H28 to select combination histology codes. Compare the terms in the diagnosis to the terms in Columns 1 and 2. If the terms match, code the case using the ICD-O-3 histology code in column 4. Use the combination codes listed in this table only when the histologies in the tumor match the histologies listed below.

<table>
<thead>
<tr>
<th>Column 1: Required Histology</th>
<th>Column 2: Combined with Histology</th>
<th>Column 3: Combination Term</th>
<th>Column 4: Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any combination excluding lobular and duct histologies from Tables 1 and 2</td>
<td>Other than ductal and lobular</td>
<td>Adenocarcinoma with mixed subtypes*</td>
<td>8255/3*</td>
</tr>
<tr>
<td>Intraductal carcinoma and</td>
<td>Lobular carcinoma in situ</td>
<td>Intraductal carcinoma and lobular carcinoma in situ</td>
<td>8522/2</td>
</tr>
<tr>
<td>Infiltrating duct and</td>
<td>Infiltrating lobular carcinoma</td>
<td>Infiltrating duct and lobular carcinoma</td>
<td>8522/3</td>
</tr>
<tr>
<td>Intraductal and two or more of the histologies in Column 2 OR two or more of the histologies in Column 2</td>
<td>Cribriform</td>
<td>Infiltrating duct mixed with other types of carcinoma</td>
<td>8523/2</td>
</tr>
<tr>
<td></td>
<td>Solid</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Apocrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Papillary</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Micropapillary</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infiltrating duct and one or more of the histologies in Column 2</td>
<td>Tubular</td>
<td>Infiltrating duct mixed with other types of carcinoma</td>
<td>8523/3</td>
</tr>
<tr>
<td></td>
<td>Apocrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mucinous</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Secretory carcinoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intraductal papillary adenocarcinoma with invasion</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intracystic carcinoma, NOS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medullary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3 continues on the next page
<table>
<thead>
<tr>
<th>Column 1: Required Histology</th>
<th>Column 2: Combined with Histology</th>
<th>Column 3: Combination Term</th>
<th>Column 4: Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infiltrating lobular carcinoma and</td>
<td>Tubular</td>
<td>Infiltrating lobular mixed with other types of carcinoma</td>
<td>8524/3</td>
</tr>
<tr>
<td></td>
<td>Apocrine</td>
<td>Note: Invasive carcinomas only. Do not use this code for in situ</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mucinous</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Secretory carcinoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intraductal papillary adenocarcinoma with invasion</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intracystic carcinoma, NOS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medullary</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paget disease (NOS and invasive)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paget disease and</td>
<td>Infiltrating duct carcinoma (includes any specific duct type listed in Table 2)</td>
<td>Paget disease and infiltrating duct carcinoma</td>
<td>8541/3</td>
</tr>
<tr>
<td>Paget disease and</td>
<td>Intraductal carcinoma (includes any specific intraductal type in Table 1)</td>
<td>Paget disease and intraductal carcinoma</td>
<td>8543/3</td>
</tr>
</tbody>
</table>

*Rarely used for breast cancer*
Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Mammary Gland

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Kidney Equivalent Terms, Definitions, Tables and Illustrations
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

INTRODUCTION

Renal cell carcinoma (8312) is a group term for glandular (adeno) carcinomas of the kidney. Approximately 85% of all malignancies of the kidney are renal cell and specific renal cell types.

Transitional cell carcinoma rarely arises in the kidney parenchyma (C649). Transitional cell carcinoma found in the upper urinary system usually arises in the renal pelvis (C659). Only code transitional cell carcinoma to kidney in the rare instance when pathology confirms the tumor originated in the parenchyma of the kidney.

Equivalent or Equal Terms

- Multifocal and multicentric
- Renal cell carcinoma (RCC) and hypernephroma (obsolete term)
- Tumor, mass, lesion, and neoplasm

Definitions

Adenocarcinoma with mixed subtypes (8255): A mixture of two or more of the specific renal cell carcinoma types listed in Table 1.

Carcinoma of the collecting ducts of Bellini/collecting duct carcinoma (8319) is a malignant epithelial tumor. There is controversy about the relationship between medullary carcinoma and collecting duct carcinoma; some advocate that there is a relationship, others are not convinced. Genetic studies are ongoing. We will code medullary carcinoma originating in the kidney to 8510 so we can differentiate between the medullary and the collecting duct carcinoma.

Chromophobe RCC (8317) is a rare form of kidney cancer. Chromophobe is a renal carcinoma characterized by large pale cells with prominent membranes.

Clear cell RCC (8310) is the most common type of RCC. Clear cell is composed of clear or eosinophilic cytoplasm. Clear cell is architecturally diverse, with solid alveolar and acinar patterns the most common.
Cystic: Cystic may be used to describe the gross appearance or it may be used as a morphologic term. Cysts are common in clear cell renal cell carcinomas. Tumors composed completely of cysts are rare.

Medullary carcinoma of the kidney (8510) is a rare tumor almost exclusively associated with sickle cell trait. There is controversy about the relationship between medullary carcinoma and collecting duct carcinoma; some advocate that there is a relationship, others are not convinced. Genetic studies are ongoing. We will code medullary carcinoma originating in the kidney to 8510 so we can differentiate between the medullary and the collecting duct carcinoma.

Most invasive: The tumor with the greatest continuous extension (see focal and foci/focus definitions).

In hierarchical order, the evaluation of least to greatest extension for kidney is based on:
- The largest tumor size
- Extension into major veins, adrenal gland, or perinephric tissue.
- Involvement of Gerota’s fascia.

Papillary RCC (8260) form finger-like projections. Some doctors call these cancers chromophilic because the cells take up certain dyes making them appear pink. A malignant renal parenchymal tumor with papillary or tubular papillary architecture.

Renal cell carcinoma (RCC) (8312) is the most common type of kidney cancer. Renal cell is a group name that includes several specific types. See Table 1.

Renal sarcoma is a rare disease of the kidney’s connective tissues.

Satellite lesion or metastasis: Metastatic lesion within the immediate vicinity of the primary tumor. This is a metastasis, not a separate primary.

Urinary tract: Structures lined by transitional epithelium also known as urothelium

Wilms Tumor/nephroblastoma, NOS (8960) can arise anywhere in the kidney tissue. Wilms tumor typically appears in children between 2-5 years of age.
**Table 1 - Renal cell carcinoma and specific renal cell types**

*Table Instructions:* Use this table to identify specific renal cell carcinoma types. 
*Note:* Renal cell carcinoma, NOS (8312) is the non-specific term under which the specific renal cell carcinoma types are listed. This table is a complete listing of specific renal cell carcinoma types.

<table>
<thead>
<tr>
<th>Column 1: Code</th>
<th>Column 2: Specific Renal Cell Carcinoma Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>8260</td>
<td>Papillary (Chromophil) *</td>
</tr>
<tr>
<td>8310</td>
<td>Clear Cell</td>
</tr>
<tr>
<td>8316</td>
<td>Cyst associated, cystic</td>
</tr>
<tr>
<td>8317</td>
<td>Chromophobe *</td>
</tr>
<tr>
<td>8318</td>
<td>Sarcomatoid (Spindle cell)</td>
</tr>
<tr>
<td>8319</td>
<td>Collecting duct type (Bellini duct)</td>
</tr>
<tr>
<td>8320</td>
<td>Granular cell</td>
</tr>
<tr>
<td>8510</td>
<td>Medullary carcinoma, NOS; medullary adenocarcinoma</td>
</tr>
<tr>
<td>8959</td>
<td>Malignant cystic nephroma; malignant multilocular cystic nephroma</td>
</tr>
</tbody>
</table>

*Note:* Chromophil and chromophobe are different histologies.
Kidney Terms and Definitions

Kidney Equivalent Terms, Definitions, Tables and Illustrations
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

Table 2 – Changes to Previous SEER Site Grouping Table

Previous to 2007, tumors in the sites below were abstracted as a single primary.

<table>
<thead>
<tr>
<th>Code</th>
<th>Site Grouping</th>
</tr>
</thead>
<tbody>
<tr>
<td>C64</td>
<td>Kidney</td>
</tr>
<tr>
<td>C65</td>
<td>Renal pelvis</td>
</tr>
<tr>
<td>C66</td>
<td>Ureter</td>
</tr>
<tr>
<td>C68</td>
<td>Other and unspecified urinary organs</td>
</tr>
</tbody>
</table>

January 1, 2007
Kidney Equivalent Terms, Definitions, Tables and Illustrations

C649

(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

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Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Renal Pelvis, Ureter, Bladder, and Other Urinary

The renal pelvis, ureters, bladder and proximal portion of the urethra are lined by transitional epithelium, also known as urothelium. Tumors of the urothelium are more often multifocal compared to other sites. Two mechanisms have been proposed to explain this phenomenon: 1) a “field effect” and 2) tumor cell implantation.

1. The **field effect** theory suggests that the urothelium has undergone a widespread change, perhaps in response to a carcinogen, making it more sensitive to malignant transformations. As a result, multiple tumors arise more easily.

2. The **implantation** theory suggests that tumor cells in one location lose their attachments and float in the urine until they attach (implant) on another site. Transitional cell tumors commonly spread in a head-to-toe direction, for example from the renal pelvis to the ureter. Molecular evidence has been found to support both of these theories, but neither has been proven to be the case for all tumors. Similarly, the widespread presence of flat carcinoma in situ may be a result of direct spread of neoplastic cells within the epithelium, direct extension, or due to implantation or field effect. The rules regarding histology and number of primaries are an attempt to reconcile these observations so that incidence data are consistent and reproducible.

Bladder

In the United States, transitional cell carcinomas account for more than 90% of all bladder cancers. Squamous cell carcinomas make up 3-8%, and adenocarcinomas make up about 1-2%. Pure squamous cell carcinoma of the bladder has a poor prognosis. See histology coding rules H5 and H13 for coding instructions.

Equivalent or Equal Terms

- Flat transitional cell, flat urothelial
- In situ transitional cell carcinoma, in situ urothelial carcinoma
- Tumor, mass, lesion, neoplasm
- Urothelial and transitional
- Urothelium and transitional epithelium
- Intramucosal and in situ
- Papillary transitional cell carcinoma, papillary urothelial carcinoma

Definitions

**Contiguous Sites:**
- Renal pelvis
- Ureter
- Bladder
- Urethra/prostatic urethra

**Field effect:** Widespread changes in normal or relatively normal tissue that predispose a person to cancer
Flat Tumor (bladder)/Noninvasive flat TCC: A flat tumor is a non-papillary bladder tumor that lies flat against the bladder tissue. Flat tumors usually have a poor prognosis. Noninvasive flat TCC (also called carcinoma in situ, or CIS) grows in the layer of cells closest to the inside of the bladder and appears as flat lesions on the inside surface of the bladder. Flat, invasive TCC may invade the deeper layers of the bladder, particularly the muscle layer.

- **Note 1:** Flat tumors may have foci or focus of invasion. This definition is for those flat tumors described as being carcinoma in situ, CIS, or non-invasive.
- **Note 2:** Flat tumors could be called in situ or non-invasive. If the term “non-invasive” is used to describe flat carcinoma, be aware that for staging this would be an in situ carcinoma.

In situ: A tumor confined to epithelium (intraepithelial) with no penetration below the basement membrane

Intraluminal (Ureter): Within the lumen of a tubular or hollow structure. Urinary tumors may spread intraluminally to adjacent urinary organs.

Intramucosal: Within the mucosal surface.

Invasive: A tumor that penetrates beyond the basement membrane.

Most invasive: The tumor with the greatest continuous local/regional extension (see focal and foci/focus definitions).

**Bladder**
- The walls of the **bladder** in order from least to greatest extension are:
  - Mucosa
  - Lamina propria (some pathologists equate this to submucosa)
  - Muscularis mucosae (this layer not always present, may not be mentioned)
  - Submucosa
  - Muscular layer (muscularis propria, detrusor muscle)
  - Serosa, adventitia

**Renal pelvis and ureter**
- The walls of the **renal pelvis** and **ureter** from least to greatest extension are:
  - Epithelium
  - Subepithelial connective tissue, submucosa
  - Muscularis mucosa
  - Adventitia, periureteric fat, peripelvic fat

**Multicentric, multifocal, and polycentric are often used as synonyms.** The tumor has multiple centers. The foci are not contiguous.

**Non-invasive tumor:** A tumor confined to epithelium (intraepithelial) with no penetration below the basement membrane.
Papillary tumor: A papillary bladder, ureter, or renal pelvis tumor is a warty growth that is attached to the wall by a stalk.

Papillary and Flat Carcinomas: Urothelial carcinomas may be either flat or papillary. The terms papillary and flat describe the structure or architecture of the tumor, not a specific histologic type. Both are transitional cell/urothelial carcinoma, although there are behavioral differences between the two.

Prostatic Urethra: Adenocarcinoma of the prostatic urethra is usually an extension of adenocarcinoma of the prostate. Transitional cell/urothelial carcinoma in the prostatic urethra may be an extension from the bladder or may be primary in the prostatic urethra.

Satellite lesion or metastasis: Metastatic lesion within the immediate vicinity of the primary tumor.

Transitional cell carcinoma usually begins in the renal pelvis, not in the kidney. The cancer cells are different from renal cell carcinoma.

Transitional epithelium: A highly expandable epithelium that has a layered appearance with large cube-shaped cells in the relaxed state that transform and stretch into broad and flat cells in the expanded or distended state.

Urinary tract: Structures lined by transitional epithelium also known as urothelium.

Urothelium: The transitional epithelium lining the wall of the bladder, ureter, and renal pelvis, external to the basement membrane.
Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Table 1 – Urothelial Tumors
Note: Excludes pure squamous carcinoma, glandular (adenocarcinoma), or other bladder tumor histologies.

<table>
<thead>
<tr>
<th>Urothelial/Transitional Cell Tumors</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>With squamous differentiation</td>
<td>8120</td>
</tr>
<tr>
<td>With glandular differentiation</td>
<td></td>
</tr>
<tr>
<td>With trophoblastic differentiation</td>
<td></td>
</tr>
<tr>
<td>Nested</td>
<td></td>
</tr>
<tr>
<td>Microcystic</td>
<td></td>
</tr>
<tr>
<td>Transitional cell, NOS</td>
<td></td>
</tr>
<tr>
<td>Papillary carcinoma</td>
<td>8130</td>
</tr>
<tr>
<td>Papillary transitional cell</td>
<td></td>
</tr>
<tr>
<td>Micropapillary</td>
<td>8131</td>
</tr>
<tr>
<td>Lymphoepithelioma-like</td>
<td>8082</td>
</tr>
<tr>
<td>Plasmacytoid</td>
<td></td>
</tr>
<tr>
<td>Sarcomatoid</td>
<td>8122</td>
</tr>
<tr>
<td>Giant cell</td>
<td>8031</td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>8020</td>
</tr>
</tbody>
</table>

Table 2 – Changes to Previous SEER Site Grouping Table

Previous to 2007, tumors in the sites below were abstracted as a single primary.

<table>
<thead>
<tr>
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<tr>
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January 1, 2007
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Urachus
Dome
Posterior wall
Lateral wall
Anterior wall
Ureteral orifice
Trigone
Bladder neck
Prostate

Source: TNM Atlas, 3rd edition, 2nd revision
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Benign and Borderline Intracranial and CNS Tumors
Equivalent Terms, Definitions, Charts and Illustrations
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

Note: Malignant intracranial and CNS tumors have a separate set of rules.

Do not change the behavior code when during the lifetime of the patient when a tumor(s) progresses from a benign /0 to an uncertain whether benign or malignant /1 behavior.

These rules apply to tumors that occur within the cranial vault or within the spinal canal (reportable)

Note: Non-malignant peripheral nerve tumors are not reportable

Equivalent or Equal Terms (Terms that can be used interchangeably)

- Tumor, mass, lesion, neoplasm
- Type, subtype, variant

Definitions

Benign: ICD-O-3 behavior code of /0.

Borderline: ICD-O-3 behavior code of /1.

Cerebellum: The part of the brain below the back of the cerebrum. It regulates balance, posture, movement, and muscle coordination.

Corpus Callosum: A large bundle of nerve fibers that connect the left and right cerebral hemispheres. In the lateral section, it looks a bit like a "C" on its side.

Different lateralities: The right side of a site and the left side of a site are different lateralities.

Frontal Lobe of the Cerebrum: The top, front region of each of the cerebral hemispheres. Used for reasoning, emotions, judgment, and voluntary movement.

Infratentorial: Tumors located in the posterior fossa, cerebellum, or fourth ventricle.

Invasive: ICD-O-3 behavior code of /3.

Medulla Oblongata: The lowest section of the brainstem (at the top end of the spinal cord). It controls automatic functions including heartbeat, breathing, etc.
Meninges: The three membranes that cover the brain and spinal cord. The outside layer is the dura mater and is the most resilient. The center layer is the arachnoid membrane. The thin innermost layer is the pia mater.

Mesencephalon: The region of the brainstem located above the pons.

Nerve sheath: A protective covering around nerves.

Occipital Lobe of the Cerebrum: The region at the back of each cerebral hemisphere that contains the centers of vision and reading ability (located at the back of the head).

Parietal Lobe of the Cerebrum: The middle lobe of each cerebral hemisphere between the frontal and occipital lobes. It contains important sensory centers (located at the upper rear of the head).

Pituitary Gland: A gland attached to the base of the brain that secretes hormones. It is located between the Pons and the Corpus Callosum, above the Medulla Oblongata. Synonym: Hypophysis.

Pons: The region of the brainstem located below the mesencephalon and above the medulla oblongata.

Progression of disease: For the purposes of these rules, progression is defined as a change to a more aggressive behavior (Example: a change from /0 to /1).

Spinal Cord: A thick bundle of nerve fibers that runs from the base of the brain to the hip area, running through the spine (vertebrae).

Supratentorial: Tumors located in the sellar or suprasellar region or in other areas of the cerebrum.

Temporal Lobe of the Cerebrum: The region at the lower side of each cerebral hemisphere; contains centers of hearing and memory (located at the sides of the head).

Timing: The amount of time between the original and subsequent tumors is not used to determine multiple primaries because the natural biology of non-malignant tumors is that of expansive, localized growth.

Transformation: The histology of a disease process may change over time.
Table 1 – Paired Sites

*Table Instructions:* Use this table to identify paired sites (Rule M5).

<table>
<thead>
<tr>
<th>Column 1: Paired Sites</th>
<th>Column 2: Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebral meninges, NOS</td>
<td>C700</td>
</tr>
<tr>
<td>Cerebrum</td>
<td>C710</td>
</tr>
<tr>
<td>Frontal lobe</td>
<td>C711</td>
</tr>
<tr>
<td>Temporal lobe</td>
<td>C712</td>
</tr>
<tr>
<td>Parietal lobe</td>
<td>C713</td>
</tr>
<tr>
<td>Occipital lobe</td>
<td>C714</td>
</tr>
<tr>
<td>Olfactory nerve</td>
<td>C722</td>
</tr>
<tr>
<td>Optic nerve</td>
<td>C723</td>
</tr>
<tr>
<td>Acoustic nerve</td>
<td>C724</td>
</tr>
<tr>
<td>Cranial nerve</td>
<td>C725</td>
</tr>
</tbody>
</table>
Chart 1: Benign and Borderline Intracranial and CNS Tumors

Note: This chart is based on the WHO Classification of Tumors of the Benign Brain. Use this chart to determine multiple primaries and to code histology as instructed in the coding rules.
Meninges

URL: www.cardioliving.com/consumer/Stroke/Hemorrhagic_Stroke.sht 7/18/03
Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland
Equivalent Terms, Definitions, Charts and Illustrations
C700, C701, C709, C710-C719, C720-725, C728, C729, C751-C753
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Note: Benign and borderline intracranial and CNS tumors have a separate set of rules.

There are two types of cells that make up the nervous system: neurons and neuroglia. Neurons send and receive nerve messages. Neuroglia, otherwise known as glial cells, often surround the neurons. Glial cells play a supportive role by nourishing, protecting and supporting neurons. There are six kinds of glial cells: oligodendrocytes, astrocytes, ependymal cells, Schwann cells, microglia, and satellite cells.

It is important to know that any of the glial tumors (Chart 1) can recur as a glioblastoma or glioblastoma multiforme.

Equivalent or Equal Terms (Terms that can be used interchangeably)
- Tumor, mass, lesion, neoplasm
- Type, subtype, variant

Definitions

Anaplastic Ependymomas (9392) are ependymal tumors that do not look like normal cells and grow more quickly than well-differentiated ependymal tumors

Astrocytoma: A tumor that begins in the brain or spinal cord in small, star-shaped cells called astrocytes. “Astrocytoma” is a term that applies to a group of neoplasms that can be divided into the following clinical-pathological components: Diffuse astrocytomas, anaplastic astrocytomas (grade III), and glioblastoma multiforme (grade IV).

Cerebellum: The part of the brain below the back of the cerebrum. It regulates balance, posture, movement, and muscle coordination.

Corpus Callosum: A large bundle of nerve fibers that connect the left and right cerebral hemispheres. In the lateral section, it looks a bit like a "C" on its side.

Ependymoblastoma (9302) is an embryonal tumor

Ependymoma: A glioma derived from relatively undifferentiated ependymal cells, comprising approximately 1–3% of all intracranial neoplasms. Ependymomas occur in all age groups and may originate from the lining of any of the ventricles or, more commonly, from the central canal of the spinal cord. Histologically, the neoplastic cells tend to be arranged radially around blood vessels, to which they are attached by means of fibrillary processes.

Frontal Lobe of the Cerebrum: The top, front region of each of the cerebral hemispheres. Used for reasoning, emotions, judgment, and voluntary movement.
Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland
Equivalent Terms, Definitions, Charts and Illustrations
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Glioblastoma: A malignant rapidly growing Astrocytoma of the central nervous system. These neoplasms grow rapidly, invade extensively, and occur most frequently in the cerebrum of adults. Any glial tumor can recur as a glioblastoma or a glioblastoma multiforme (see Chart 1)

Glioma: Any neoplasm derived from one of the various types of cells that form the interstitial tissue of the brain, spinal cord, pineal gland, posterior pituitary gland, and retina. About half of all primary brain tumors and one-fifth of all primary spinal cord tumors form from glial cells. Gliomas tend to grow in the cerebral hemispheres, but may also occur in the brain stem, optic nerves, spinal cord, and cerebellum. Gliomas are divided into subgroups depending on the origin of the glial cells. The most common type of glioma is an astrocytoma.

Infratentorial: Tumors located in the posterior fossa, cerebellum, or fourth ventricle.

Medulla Oblongata: The lowest section of the brainstem (at the top end of the spinal cord). It controls automatic functions including heartbeat, breathing, etc.

Medulloblastoma: A tumor consisting of neoplastic cells that resemble the undifferentiated cells of the primitive medullary tube; medulloblastomas are usually located in the vermis of the cerebellum, and may be implanted discretely or coalescently on the surfaces of the cerebellum, brainstem, and spinal cord. They comprise approximately 3% of all intracranial neoplasms, and occur most frequently in children. A type of primitive neuroectodermal tumor.

Mixed glioma: The presence of at least two of the following cells/differentiation in a single tumor: astrocytic; oligodendroglial; ependymal

Occipital Lobe of the Cerebrum - the region at the back of each cerebral hemisphere that contains the centers of vision and reading ability (located at the back of the head).

Oligodendrogloma: A relatively rare, relatively slowly growing glioma derived from oligodendrocytes that occurs most frequently in the cerebrum of adults

Parietal Lobe of the Cerebrum: The middle lobe of each cerebral hemisphere between the frontal and occipital lobes. It contains important sensory centers (located at the upper rear of the head).

Pituitary Gland: A gland attached to the base of the brain that secretes hormones. It is located between the Pons and the Corpus Callosum, above the Medulla Oblongata. Synonym: Hypophysis.

Revised November 1, 2007
PNET (Primitive Neuroectodermal Tumor): A group of malignant central nervous system tumors that includes medulloblastoma, pineoblastoma, ependymoblastoma, retinoblastoma, neuroblastoma, esthesioneuroblastoma, medulloepithelioma and ganglioneuroblastoma. Tumors are composed of primitive, undifferentiated embryonal cell lines and frequently classified according to anatomic location. Also known as central PNET or supratentorial PNET, depending on location of the tumor.

pPNET (peripheral Primitive Neuroectodermal Tumor): These tumors usually occur in the soft tissues of the chest, pelvis, and retroperitoneum and are rarely intracranial. There is known clinical and histological association between pPNET and both extraosseous Ewing sarcoma and peripheral neuroblastoma. Peripheral PNET is clinically and pathologically distinct from central PNET.

Satellite lesion or metastasis: Metastatic lesion within the immediate vicinity of the primary tumor. This is a metastasis, not a separate primary.

Spinal Cord: A thick bundle of nerve fibers that runs from the base of the brain to the hip area, running through the spine (vertebrae).

Supratentorial: Tumors located in the sellar or suprasellar region or in other areas of the cerebrum.

Temporal Lobe of the Cerebrum: The region at the lower side of each cerebral hemisphere; contains centers of hearing and memory (located at the sides of the head).
Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland

Equivalent Terms, Definitions, Charts and Illustrations
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Chart 1 –Neuroepithelial Malignant Brain and Central Nervous System Tumors

Note: This chart is based on the WHO Classification of Tumors of the brain and central nervous system. The chart is not a complete listing of histologies that may occur in the brain or central nervous system.

Chart Instructions: Use this chart to code histology. The tree is arranged in descending order. Each branch is a histology group, starting at the top with the least specific terms and descending into more specific terms.

Key: The ovals ( ) represent group terms.
Chart 2 – Non-neuroepithelial Malignant Brain and Central Nervous System Tumors

**Chart Instructions:** Use this chart to code histology. The tree is arranged in descending order. Each branch is a histology group, starting at the top with the least specific terms and descending into more specific terms.

**Note:** Chart 2 is based on the *WHO Classification of Tumors* of the brain and central nervous system. This chart is **not** a complete listing of histologies that may occur in the brain or central nervous system.

- **Peripheral Nerve**
  - Malignant peripheral nerve sheath tumor (9540)
  - Malignant peripheral nerve sheath tumor with rhabdomyoblastic differentiation (MPNST) (9561)
  - Neurilemoma, malignant (9560)
  - Perineurioma, malignant (9571)

- **Germ Cell Tumors**
  - Choriocarcinoma (9100)
  - Embryonal carcinoma (9070)
  - Germinoma (9064)
  - Immature teratoma (9080)
  - Mixed germ cell tumor (9085)
  - Teratoma with malignant transformation (9084)
  - Yolk sac tumor (9071)

- **Meningioma, malignant**
  - Meningeal sarcomatosis (9539)
  - Papillary meningioma, rhabdoid meningioma (9538)
Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland
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www.gender.org.uk/about/07neur/74_brain.htm

Revised November 1, 2007
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C700, C701, C709, C710-C719, C720-725, C728, C729, C751-C753

(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)
INTRODUCTION

The Other Sites rules cover rectosigmoid, rectum and all sites not included in the site-specific rules.

EQUIVALENT TERMS

Acinar adenocarcinoma, adenocarcinoma (For prostate primaries only)
Adenocarcinoma, glandular carcinoma

DEFINITIONS

Acinar adenocarcinoma of the prostate: The prostate gland is sponge-like consisting primarily of acini or very tiny sacs that produce the fluids for ejaculation. Acinar adenocarcinoma is not a specific histologic type. The term acinar refers to the fact that the adenocarcinoma originates in the prostatic acini. 95% of all prostate cancers are (acinar) adenocarcinoma.

Adenoacanthoma: Adenocarcinoma with squamous metaplasia.

Parametrium: The connective tissue of the pelvic floor extending from the fibrous subserous coat of the supracervical portion of the uterus laterally between the layers of the broad ligament.

Uterine adnexa: The appendages of the uterus, namely the ovaries, fallopian tubes, and ligaments that hold the uterus in place.
### Other Sites Terms and Definitions

**Other Sites Equivalent Terms, Definitions and Tables**
*Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia*

#### Table 1 – Paired Organs and Sites with Laterality

*Note: This table only includes anatomic sites covered by the Other Sites Rules.*

<table>
<thead>
<tr>
<th>Site Code</th>
<th>Site or Subsite</th>
</tr>
</thead>
<tbody>
<tr>
<td>C384</td>
<td>Pleura</td>
</tr>
<tr>
<td>C400</td>
<td>Long bones of upper limb, scapula, and associated joints</td>
</tr>
<tr>
<td>C401</td>
<td>Short bones of upper limb and associated joints</td>
</tr>
<tr>
<td>C402</td>
<td>Long bones of lower limb and associated joints</td>
</tr>
<tr>
<td>C403</td>
<td>Short bones of lower limb and associated joints</td>
</tr>
<tr>
<td>C413</td>
<td>Rib, clavicle (excluding sternum)</td>
</tr>
<tr>
<td>C414</td>
<td>Pelvic bones (excluding sacrum, coccyx, symphysis pubis)</td>
</tr>
<tr>
<td>C441</td>
<td>Skin of the eyelid</td>
</tr>
<tr>
<td>C442</td>
<td>Skin of the external ear</td>
</tr>
<tr>
<td>C443</td>
<td>Skin of other and unspecific parts of the face (if midline, assign code 9)</td>
</tr>
<tr>
<td>C445</td>
<td>Skin of the trunk (if midline, assign code 9)</td>
</tr>
<tr>
<td>C446</td>
<td>Skin of upper limb and shoulder</td>
</tr>
<tr>
<td>C447</td>
<td>Skin of the lower limb and hip</td>
</tr>
<tr>
<td>C471</td>
<td>Peripheral nerves and autonomic nervous system of upper limb and shoulder</td>
</tr>
<tr>
<td>C472</td>
<td>Peripheral nerves and autonomic nervous system of the lower limb and hip</td>
</tr>
<tr>
<td>C491</td>
<td>Connective, subcutaneous, and other soft tissues of upper limb and shoulder</td>
</tr>
<tr>
<td>C492</td>
<td>Connective, subcutaneous, and other soft tissues of the lower limb and hip</td>
</tr>
<tr>
<td>C569</td>
<td>Ovary</td>
</tr>
<tr>
<td>C570</td>
<td>Fallopian tube</td>
</tr>
<tr>
<td>C620-C629</td>
<td>Testis</td>
</tr>
<tr>
<td>C630</td>
<td>Epididymis</td>
</tr>
<tr>
<td>C631</td>
<td>Spermatic cord</td>
</tr>
<tr>
<td>C690-C699</td>
<td>Eye and adnexa</td>
</tr>
<tr>
<td>C740-C749</td>
<td>Adrenal gland</td>
</tr>
<tr>
<td>C754</td>
<td>Carotid body</td>
</tr>
</tbody>
</table>

Revised November 1, 2007
Table 2 – Mixed and Combination Codes
This table is used to determine mixed and combination codes ONLY
Apply the multiple primary rules FIRST. Combination codes are most often used when multiple histologies are present in a single tumor; they are rarely used for multiple tumors. Use a combination code for multiple tumors ONLY when the tumors meet the rules for a single primary.

Use this **two-page** table to select combination histology codes. Compare the terms in the diagnosis to the terms in Columns 1 and 2. If the terms match, code the case using the ICD-O-3 histology code in column 4. Use the combination codes listed in this table only when the histologies in the tumor match the histologies listed below.

<table>
<thead>
<tr>
<th>Column 1: Required Histology</th>
<th>Column 2: Combined with Histology</th>
<th>Column 3: Combination Term</th>
<th>Column 4: Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small cell carcinoma</td>
<td>Large cell carcinoma</td>
<td>Combined small cell carcinoma</td>
<td>8045</td>
</tr>
<tr>
<td></td>
<td>Adenocarcinoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Squamous cell carcinoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Squamous carcinoma</td>
<td>Basal cell carcinoma</td>
<td>Basosquamous carcinoma</td>
<td>8094</td>
</tr>
<tr>
<td>Islet cell</td>
<td>Exocrine</td>
<td>Mixed islet cell and exocrine adenocarcinoma (pancreas)</td>
<td>8154</td>
</tr>
<tr>
<td>Aciar</td>
<td>Endocrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatocellular carcinoma</td>
<td>Cholangiocarcinoma</td>
<td>Combined hepatocellular carcinoma and cholangiocarcinoma</td>
<td>8180</td>
</tr>
<tr>
<td>Adenocarcinoma</td>
<td>Carcinoid</td>
<td>Composite carcinoid</td>
<td>8244</td>
</tr>
<tr>
<td>Adenocarcinoma and <strong>two or more</strong> of the histologies from column 2</td>
<td>Papillary</td>
<td>Adenocarcinoma with mixed subtypes</td>
<td>8255</td>
</tr>
<tr>
<td><strong>two or more</strong> of the histologies from column 2</td>
<td>Clear cell</td>
<td>Adenocarcinoma combined with other types of carcinoma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mucinous (colloid)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Signet ring</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acinar</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2 continues on the next page
### Table 2 continued

<table>
<thead>
<tr>
<th>Column 1: Required Histology</th>
<th>Column 2: Combined with Histology</th>
<th>Column 3: Combination Term</th>
<th>Column 4: Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gyn malignancies with two or more of the histologies in column 2</td>
<td>Clear cell Endometroid Mucinous Papillary Serous Squamous Transitional (Brenner)</td>
<td>Mixed cell adenocarcinoma</td>
<td>8323</td>
</tr>
<tr>
<td>Papillary and Follicular</td>
<td></td>
<td>Papillary carcinoma, follicular variant</td>
<td>8340</td>
</tr>
<tr>
<td>Medullary</td>
<td>Follicular</td>
<td>Mixed medullary-follicular carcinoma</td>
<td>8346</td>
</tr>
<tr>
<td>Medullary</td>
<td>Papillary</td>
<td>Mixed medullary-papillary carcinoma</td>
<td>8347</td>
</tr>
<tr>
<td>Squamous carcinoma and Adenocarcinoma</td>
<td></td>
<td>Adenosquamous carcinoma</td>
<td>8560</td>
</tr>
<tr>
<td>Any combination of histologies in Column 2</td>
<td>Myxoid Round cell Pleomorphic</td>
<td>Mixed liposarcoma</td>
<td>8855</td>
</tr>
<tr>
<td>Embryonal rhabdomyosarcoma</td>
<td>Alveolar rhabdomyosarcoma</td>
<td>Mixed type rhabdomyosarcoma</td>
<td>8902</td>
</tr>
<tr>
<td>Teratoma</td>
<td>Embryonal carcinoma</td>
<td>Teratocarcinoma</td>
<td>9081</td>
</tr>
<tr>
<td>Teratoma and one or more of the histologies in Column 2</td>
<td>Seminoma Yolk sac tumor</td>
<td>Mixed germ cell tumor</td>
<td>9085</td>
</tr>
<tr>
<td>Choriocarcinoma</td>
<td>Teratoma Seminoma Embryonal</td>
<td>Choriocarcinoma combined with other germ cell elements</td>
<td>9101</td>
</tr>
</tbody>
</table>
Table 3 – Changes to Previous SEER Site Grouping Table

Previous to 2007, tumors in sites on the same row were abstracted as a single primary.

<table>
<thead>
<tr>
<th>Code</th>
<th>Site Groupings</th>
</tr>
</thead>
<tbody>
<tr>
<td>C23</td>
<td>Gallbladder</td>
</tr>
<tr>
<td>C24</td>
<td>Other and unspecified parts of the biliary tract</td>
</tr>
<tr>
<td>C37</td>
<td>Thymus</td>
</tr>
<tr>
<td>C380</td>
<td>Heart</td>
</tr>
<tr>
<td>C381-3</td>
<td>Mediastinum</td>
</tr>
<tr>
<td>C388</td>
<td>Overlapping lesion of heart, mediastinum, and pleura</td>
</tr>
<tr>
<td>C51</td>
<td>Vulva</td>
</tr>
<tr>
<td>C52</td>
<td>Vagina</td>
</tr>
<tr>
<td>C577</td>
<td>Other specified female genital organs</td>
</tr>
<tr>
<td>C578-9</td>
<td>Unspecified female genital organs</td>
</tr>
<tr>
<td>C569</td>
<td>Ovary</td>
</tr>
<tr>
<td>C570</td>
<td>Fallopian tube</td>
</tr>
<tr>
<td>C571</td>
<td>Broad ligament</td>
</tr>
<tr>
<td>C572</td>
<td>Round ligament</td>
</tr>
<tr>
<td>C573</td>
<td>Parametrium</td>
</tr>
<tr>
<td>C574</td>
<td>Uterine adnexa</td>
</tr>
<tr>
<td>C60</td>
<td>Penis</td>
</tr>
<tr>
<td>C63</td>
<td>Other and unspecified male genital organs</td>
</tr>
<tr>
<td>C74</td>
<td>Adrenal gland</td>
</tr>
<tr>
<td>C75</td>
<td>Other endocrine glands and related structures</td>
</tr>
</tbody>
</table>
VI.
Flowchart Format – Multiple Primary and Histology Coding Rules
**Head and Neck Multiple Primary Rules-Flowchart**

*(C000-C148, C300-C329)*

*(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)*

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

---

**UNKNOWN IF SINGLE OR MULTIPLE TUMORS**

<table>
<thead>
<tr>
<th>DECISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tumor(s) not described as metastasis.</td>
</tr>
</tbody>
</table>

**NOTES**

* Use this rule only after all information sources have been exhausted.

**Example 1:** History and physical exam states large tumor in nasopharynx. Biopsy base of tongue shows squamous cell carcinoma. No further information available. Abstract as a single primary.

**Example 2:** Pathology report states extensive squamous cell carcinoma involving nasopharynx and larynx. Fragments of epiglottis positive for squamous cell carcinoma. No other information available. Abstract as a single primary.

---

**SINGLE TUMOR**

<table>
<thead>
<tr>
<th>DECISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>The tumor may overlap onto or extend into adjacent/contiguous site or subsite.</td>
</tr>
</tbody>
</table>

**NOTES**

1. Tumor not described as metastasis.
2. Includes combinations of in situ and invasive

---

**FLOWCHART KEY**

- **Flow Direction**
- **Decision**
- **Note**
- **Question**

---

**M1**

Is it impossible to determine if there is a single tumor or multiple tumors?

- **YES**
  - SINGLE Primary* (End of instructions for Unknown if Single or Multiple Tumors)
- **NO**
  - Go to Single Tumor or Multiple Tumors

**M2**

Is there a single tumor?

- **YES**
  - SINGLE Primary* (End of instructions for Single Tumor)
- **NO**
  - Go to Multiple Tumors.
Head and Neck Multiple Primary Rules-Flowchart
(C000-C148, C300-C329)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi's sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

MULTIPLE TUMORS
Multiple tumors may be a single primary or multiple primaries.

<table>
<thead>
<tr>
<th>DECISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tumors not described as metastases.</td>
</tr>
<tr>
<td>2. Includes combinations of in situ and invasive.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>See Table 1 for list of paired sites.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Are there tumors in both the left and right sides of a paired site?</strong></td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Are there tumors on the upper lip (C000 or C003) and the lower lip (C001 or C004)?</strong></td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Are there tumors on the upper gum (C030) and the lower gum (C031)?</strong></td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Are there tumors in the nasal cavity (C300) and the middle ear (C301)?</strong></td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>NO</td>
</tr>
</tbody>
</table>
Head and Neck Multiple Primary Rules-Flowchart
(C000-C148, C300-C329)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

MULTIPLE TUMORS, continued

1. Tumors not described as metastases.
2. Includes combinations of in situ and invasive.

M7
Are there tumors in sites with ICD-O-3 topography codes that are different at the second (Cxx) and/or third character (Cxxx)?

YES
MULTIPLE Primaries**

NO

M8
Is there an invasive tumor following an in situ tumor more than 60 days after diagnosis?

YES
MULTIPLE Primaries**

NO

M9
Are there tumors diagnosed more than five (5) years apart?

YES
MULTIPLE Primaries**

NO

NOTES

1. The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
2. Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.
Head and Neck Multiple Primary Rules-Flowchart

(C000-C148, C300-C329)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

M10 - Is there cancer/malignant neoplasm, NOS (8000) and another is a specific histology?

NOTES
1. Tumors not described as metastases.
2. Includes combinations of in situ and invasive.
**Head and Neck Multiple Primary Rules**

(C000-C148, C300-C329)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

---

### MULTIPLE TUMORS, continued

#### M11

- Do the tumors have ICD-O-3 histology codes that are different at the first (xxxx), second (xxyy) or third (xxxy) number?

  - **YES**
    - MULTIPLE Primary*
  
  - **NO**

#### M12

- Does not meet any of the above criteria (M1 through M11).

  - **YES**
    - SINGLE Primary*
      - 1. When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.
      - 2. All cases covered by Rule M12 have the same first 3 numbers in ICD-O-3 histology code.

  - **NO**

**NOTES**

- Tumors not described as metastases.

**ERROR:** Recheck rules. Stop when a match is found.

---

**Rule M12 Examples:** The following are examples of cases that use Rule M12. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary.

**Warning:** Using only these case examples to determine the number of primaries can result in major errors.

- Example 1. Multifocal tumors in floor of mouth
- Example 2. An in situ and invasive tumor diagnosed within 60 days
- Example 3. In situ following an invasive tumor more than 60 days apart
Head and Neck Histology Coding Rules-Flowchart
(C000-C148, C300-C329)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

**SINGLE TUMOR**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1</td>
<td>Code the histology documented by the physician.</td>
<td>1. Priority for using documents to code the histology&lt;br&gt;○ Documentation in the medical record that refers to pathologic or cytologic findings&lt;br&gt;○ Physician’s reference to type of cancer (histology) in the medical record&lt;br&gt;○ CT, PET or MRI scans&lt;br&gt;2. Code the specific histology when documented.&lt;br&gt;3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.</td>
</tr>
<tr>
<td>H2</td>
<td>Code the histology from a metastatic site.</td>
<td>Code the behavior /3.</td>
</tr>
<tr>
<td>H4</td>
<td>Code the invasive histology.</td>
<td></td>
</tr>
</tbody>
</table>
Head and Neck Histology Coding Rules-Flowchart
(C000-C148, C300-C329)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

**Rule**

H5

Are there multiple histologies within the same branch such as:
- cancer/malignant neoplasm, NOS (8000) and a more specific histology? OR
- carcinoma, NOS (8010) and a more specific carcinoma? OR
- squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma? OR
- adenocarcinoma, NOS (8140) and a more specific adenocarcinoma? OR
- melanoma, NOS (8720) and a more specific melanoma? OR
- sarcoma, NOS (8800) and a more specific sarcoma?

**Action**

Yes

Code the most specific histologic term using Chart 1

NO

**Notes and Examples**

1. The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ______ differentiation.

2. The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ______ differentiation.

**Example:** The final diagnosis is squamous cell carcinoma (8070), papillary (8050). Code the specific type, papillary (8050)

**H6**

Code the **numerically higher** ICD-O-3 histology code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.
Head and Neck Histology Coding Rules-Flowchart
(C000-C148, C300-C329)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H7</td>
<td>Code the histology documented by the physician.</td>
<td>1. Priority for using documents to code the histology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Documentation in the medical record that refers to pathologic or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>cytologic findings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Physician's reference to type of cancer (histology) in the medical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>record</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o CT, PET or MRI scans</td>
</tr>
<tr>
<td></td>
<td>Code the histology from a metastatic site.</td>
<td>2. Code the specific histology when documented.</td>
</tr>
<tr>
<td>H8</td>
<td>Code the histology from a metastatic site.</td>
<td>3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8010 (carcinoma, NOS) as stated by the physician when nothing more specific is</td>
</tr>
<tr>
<td>H9</td>
<td>Code the histology.</td>
<td>documented.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Example: Squamous cell carcinoma. Code 8070.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do not code terms that do not appear in the histology description.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Example: Do not code 8072 (squamous cell carcinoma non-keratinizing) unless the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>words &quot;non-keratinizing&quot; actually appear in the diagnosis.</td>
</tr>
</tbody>
</table>
Head and Neck Histology Coding Rules-Flowchart
(C000-C148, C300-C329)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is one tumor in situ and the other invasive or are both tumors invasive?  

- **YES**  
  - Code the histology of the most invasive tumor.
    - One tumor is in situ and one is invasive, code the histology from the invasive tumor.
    - Both/all histologies are invasive, code the histology of the most invasive tumor.

- **NO**  
  - If tumors are equally invasive, go to the next rule.

Next Page
# Head and Neck Histology Coding Rules-Flowchart

(C000-C148, C300-C329)  
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

**MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| **H11** | Are there multiple histologies within the same branch such as:  
- cancer/malignant neoplasm, NOS (8000) and a more specific histology? OR  
- carcinoma, NOS (8010) and a more specific carcinoma? OR  
- squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma? OR  
- adenocarcinoma, NOS (8140) and a more specific adenocarcinoma? OR  
- melanoma, NOS (8720) and a more specific melanoma? OR  
- sarcoma, NOS (8800) and a more specific sarcoma? | Yes  
1. The specific histology for *in situ* tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ______ differentiation.  
2. The specific histology for *invasive* tumors may be identified as type, subtype, predominantly, with features of, major, or with ______ differentiation.  

**Example:** The final diagnosis is squamous cell carcinoma (8070), papillary (8050). Code the specific type, papillary (8050) |

| **H12** | Code the numerically higher ICD-O-3 histology code. | |

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.  
Code the histology according to the rule that fits the case.

---

January 1, 2007
Colon Multiple Primary Rules - Flowchart

(C180-C189)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

<table>
<thead>
<tr>
<th>UNKNOWN IF SINGLE OR MULTIPLE TUMORS</th>
<th>DECISION</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M1</strong> Is it impossible to determine if there is a single tumor or multiple tumors?</td>
<td>YES</td>
<td>Tumor(s) not described as metastasis</td>
</tr>
<tr>
<td>NO</td>
<td>SINGLE Primary*</td>
<td>Use this rule only after all information sources have been exhausted.</td>
</tr>
<tr>
<td></td>
<td>Go to Single Tumor or Multiple Tumors</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SINGLE TUMOR</th>
<th>DECISION</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M2</strong> Is there a single tumor?</td>
<td>YES</td>
<td>1. Tumor not described as metastasis</td>
</tr>
<tr>
<td>NO</td>
<td>SINGLE Primary*</td>
<td>2. Includes combinations of in situ and invasive.</td>
</tr>
<tr>
<td></td>
<td>Go to Multiple Tumors.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The tumor may overlap onto or extend into adjacent/contiguous site or subsite.</td>
</tr>
</tbody>
</table>
 Colon Multiple Primary Rules - Flowchart
(C180-C189)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

** Flowchart Key **

** Flowchart Direction **

** Notes **

** Decision **

** MULTIPLE TUMORS **

** Is there adenocarcinoma in adenomatous polyposis coli (familial polyposis) with one or more malignant polyps? **

YES

SINGLE Primary

** Are there tumors in sites with ICD-O-3 topography codes that are different at the second (Cxx), third (Cxxx) and/or fourth (C18xx) character? **

YES

MULTIPLE Primaries**

** Are there tumors diagnosed more than one (1) year apart? **

YES

MULTIPLE Primaries**

** Tumors may be present in multiple segments of the colon or in a single segment of the colon. **

January 1, 2007
Colon Multiple Primary Rules - Flowchart

(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

---

M6

Is there an invasive tumor following an in situ tumor more than 60 days after diagnosis?

YES

MULTIPLE Primaries**

NO

---

M7

Is there a frank malignant or in situ adenocarcinoma and an in situ or malignant tumor in a polyp?

YES

SINGLE Primary*

NO

---

1. Tumors not described as metastases.
2. Includes combinations of in situ and invasive.

1. The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.

2. Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.
Colon Multiple Primary Rules - Flowchart
(C180-C189)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

### MULTIPLE TUMORS, continued

<table>
<thead>
<tr>
<th>DECISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>SINGLE Primary*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tumors not described as metastases.</td>
</tr>
<tr>
<td>2. Includes combinations of in situ and invasive.</td>
</tr>
</tbody>
</table>

**Flowchart Key**
- Question
- Decision
- Note
- Flow Direction

#### MB

1. Is there cancer/malignant neoplasm, NOS (8000) and another is a specific histology?
   - NO
   - YES

2. Is there carcinoma, NOS (8010) and another is a specific carcinoma?
   - NO
   - YES

3. Is there adenocarcinoma, NOS (8140) and another is a specific adenocarcinoma?
   - NO
   - YES

4. Is there sarcoma, NOS (8800) and another is a specific sarcoma?
   - NO
   - YES

5. Next Page
Do the tumors have ICD-O-3 histology codes that are different at the first (xxx), second (xxx), or third (xxx) number?

YES

M9

Are there multiple in situ and/or malignant polyps?

YES

SINGLE Primary*

M10

Do the tumors have ICD-O-3 histology codes that are different at the first (xxx), second (xxx), or third (xxx) number?

YES

MULTIPLE Primaries**

NO

M11

Does not meet any of the above criteria. (M1 through M10)

YES

SINGLE Primary*

NO

ERROR: Recheck rules. Stop when a match is found.

End of instructions for Multiple Tumors.
Colon Histology Coding Rules - Flowchart

(C180-C189)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| H1   | Code the histology documented by the physician. | 1. Priority for using documents to code the histology  
   o Documentation in the medical record that refers to pathologic or cytologic findings  
   o Physician's reference to type of cancer (histology) in the medical record  
   o CT, PET or MRI scans  
2. Code the specific histology when documented.  
3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented. |
| H2   | Code the histology from a metastatic site. | 1. Intestinal type adenocarcinoma usually occurs in the stomach.  
2. When a diagnosis of intestinal adenocarcinoma is further described by a specific term such as type, continue to the next rule. |
| H3   | Code 8140 (adenocarcinoma, NOS). | 1. Intestinal type adenocarcinoma usually occurs in the stomach.  
2. When a diagnosis of intestinal adenocarcinoma is further described by a specific term such as type, continue to the next rule. |
**Colon Histology Coding Rules - Flowchart**

**Rule**: Is the final diagnosis adenocarcinoma in a polyp?

**Action**: YES

**Notes and Examples**

1. It is important to know that the adenocarcinoma originated in the polyp.
2. Code adenocarcinoma in a polyp only when the malignancy is in the residual polyp (adenoma) or references to a pre-existing polyp (adenoma) indicate that the malignancy and the polyp (adenoma) are the same lesion.
Colon Histology Coding Rules - Flowchart

(C180-C189)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is the final diagnosis **mucinous/colloid** (8480) or **signet ring cell** carcinoma (8490)?

- **YES**
- **NO**

Is the final diagnosis adenocarcinoma, NOS and the microscopic description documents that **50% or more** of the tumor is **mucinous/colloid**?

- **YES**
- **NO**

Code **8480** (mucinous/colloid adenocarcinoma) or **8490** (signet ring cell carcinoma)

Is the final diagnosis adenocarcinoma, NOS and the microscopic description documents that **50% or more** of the tumor is **signet ring cell** carcinoma?

- **YES**
- **NO**

Next Page
Colon Histology Coding Rules - Flowchart
(C180-C189)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H6</strong></td>
<td>Is the final diagnosis adenocarcinoma, NOS and the microscopic description states that less than 50% the tumor is mucinous/colloid?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is the final diagnosis adenocarcinoma, NOS and the microscopic description states that less than 50% of the tumor is signet ring cell carcinoma?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is the final diagnosis adenocarcinoma, NOS and the percentage of mucinous/colloid or signet ring cell carcinoma is unknown?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td><strong>H7</strong></td>
<td>Is there a combination of mucinous/colloid and signet ring cell adenocarcinoma?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>
## Colon Histology Coding Rules - Flowchart

(C180-C189)

*(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)*

### SINGLE TUMOR

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H8</td>
<td>If the diagnosis <strong>neuroendocrine</strong> (8246) <em>and carcinoid</em> tumor (8240)?</td>
<td>Code <strong>8240</strong> (carcinoid tumor, NOS).</td>
</tr>
<tr>
<td></td>
<td><strong>YES</strong></td>
<td></td>
</tr>
<tr>
<td>H9</td>
<td>Is the diagnosis <strong>adenocarcinoma and carcinoid tumor</strong>?</td>
<td>Code <strong>8244</strong> (composite carcinoid).</td>
</tr>
<tr>
<td></td>
<td><strong>NO</strong></td>
<td></td>
</tr>
<tr>
<td>H10</td>
<td>Is the diagnosis <strong>exactly</strong> &quot;adenocarcinoid&quot;?</td>
<td>Code <strong>8245</strong> (adenocarcinoid)</td>
</tr>
<tr>
<td></td>
<td><strong>NO</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>YES</strong></td>
<td></td>
</tr>
<tr>
<td>H11</td>
<td>Is only <strong>one histologic type</strong> identified?</td>
<td>Code the histology.</td>
</tr>
<tr>
<td></td>
<td><strong>NO</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>YES</strong></td>
<td></td>
</tr>
<tr>
<td>H12</td>
<td>Does the tumor have <strong>invasive and in situ</strong> components?</td>
<td>Code the invasive histologic type.</td>
</tr>
<tr>
<td></td>
<td><strong>NO</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>YES</strong></td>
<td></td>
</tr>
</tbody>
</table>

*January 1, 2007*
Colon Histology Coding Rules - Flowchart
(C180-C189)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

**Rule**

<table>
<thead>
<tr>
<th>H13</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there cancer/malignant neoplasm, NOS (8000) and a more specific histology?</td>
<td>YES</td>
<td>1. The specific histology for <strong>in situ</strong> tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ______ differentiation.</td>
</tr>
<tr>
<td>NO</td>
<td>Is there carcinoma, NOS (8010) and a more specific carcinoma?</td>
<td>YES</td>
</tr>
<tr>
<td>NO</td>
<td>Is there adenocarcinoma, NOS (8140) and a more specific adenocarcinoma?</td>
<td>YES</td>
</tr>
<tr>
<td>NO</td>
<td>Is there sarcoma, NOS (8800) and a more specific sarcoma (invasive only)?</td>
<td>YES</td>
</tr>
<tr>
<td>NO</td>
<td>Code the most specific histologic term.</td>
<td></td>
</tr>
</tbody>
</table>

This is the end of instructions for Single Tumor. Code the histology according to the rule that fits the case.
Colon Histology Coding Rules - Flowchart
(C180-C189)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H15</td>
<td>Is there no pathology/cytology specimen or is the pathology/cytology report unavailable?</td>
<td>YES Code the histology documented by the physician.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>H16</td>
<td>Is the specimen from a metastatic site? (There is no pathology/cytology specimen from the primary site)</td>
<td>YES Code the histology from a metastatic site.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>Code the behavior /3.</td>
</tr>
</tbody>
</table>

1. Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT, PET or MRI scans

2. Code the specific histology when documented.

3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.
### Colon Histology Coding Rules - Flowchart

(C180-C189)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

**MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H17</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Does the clinical history say familial polyposis and the final diagnosis on the pathology report from resection is adenocarcinoma in adenomatous polyps?</strong></td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td><strong>Are there &gt; 100 polyps identified in the resected specimen?</strong></td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td><strong>Is the number of polyps not given and the diagnosis is familial polyposis?</strong></td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td><strong>NO</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Are there &gt; 100 polyps identified in the resected specimen?</strong></td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td><strong>Is the number of polyps not given and the diagnosis is familial polyposis?</strong></td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td><strong>NO</strong></td>
<td></td>
</tr>
</tbody>
</table>

Revised November 1, 2007
**Colon Histology Coding Rules - Flowchart**

(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

**MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| **H19** | Are there \( >1 \) and \( \leq 100 \) polyps identified in the resected specimen? | **YES**<br>Code 8221 (adenocarcinoma in adenomatous polyps)<br>**NO**<br>Are there multiple polyps and the number is not given and familial polyposis is not mentioned? | **YES**<br>Use this rule only when there are multiple polyps. Do not use for a single polyp (adenoma) or for a frank malignancy and a malignancy in a single polyp (adenoma).<br>**NO**
| **H20** | Is there a frank adenocarcinoma and a carcinoma in a polyp? | **YES**<br>Code the histology of the most invasive tumor.<br>**NO**<br>Are there in situ and invasive tumors? | **YES**<br>1. See the Colon Equivalent Terms, Definitions and Illustrations for the definition of most invasive.<br>2. If tumors are equally invasive, go to the next rule.<br>**NO**<br>Are there multiple invasive tumors? | **NO**<br>Next Page

Revised November 1, 2007
Colon Histology Coding Rules - Flowchart
(C180-C189)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H21</td>
<td>Is the final diagnosis adenocarcinoma and the microscopic description or surgical gross describes polyps?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Is the final diagnosis adenocarcinoma and there is reference to a residual or pre-existing polyp?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Is the final diagnosis mucinous/colloid or signet ring cell adenocarcinoma found in a polyp?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Is there documentation that the patient had a polypectomy?</td>
<td>YES</td>
</tr>
<tr>
<td>H22</td>
<td>Is only one histologic type identified?</td>
<td>Code the histology.</td>
</tr>
</tbody>
</table>

It is important to know that the adenocarcinoma originated in the polyp.
Colon Histology Coding Rules - Flowchart  
(C180-C189)  
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)  

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H23</td>
<td>Is there cancer/malignant neoplasm, NOS (8000) and a specific histology?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Is there carcinoma, NOS (8010) and a specific carcinoma?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Code the more specific histologic term.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is there adenocarcinoma, NOS (8140) and a specific adenocarcinoma?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Is there sarcoma, NOS (8800) and a specific sarcoma (invasive only)?</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>Code the histology with the numerically higher ICD-O-3 histology code.</td>
<td></td>
</tr>
<tr>
<td>H24</td>
<td>YES</td>
<td></td>
</tr>
</tbody>
</table>

1. The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ______ differentiation.  
2. The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with ______ differentiation.  

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.  
Code the histology according to the rule that fits the case.
Is it impossible to determine if there is a single tumor or multiple tumors?

YES

SINGLE Primary*

End of instructions for Unknown if Single or Multiple Tumors

NO

Go to Single Tumor or Multiple Tumors

NO TESDECISION

1. Use this rule only after all information sources have been exhausted.

2. Use this rule when only one tumor is biopsied but the patient has two or more tumors in one lung and may have one or more tumors in the contralateral lung. (See detailed explanation in Lung Equivalent Terms and Definitions)

Is there a single tumor?

YES

SINGLE Primary*

End of instructions for Single Tumor.

NO

Go to Multiple Tumors.

Tumor(s) not described as metastasis.

Tumor not described as metastasis.

The tumor may overlap onto or extend into adjacent/contiguous site or subsite.
Lung Multiple Primary Rules - Flowchart
(C340 - C349)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

** MULTIPLE TUMORS **
Multiple tumors may be a single primary or multiple primaries.

** M3 **
Are there tumors in sites with ICD-O-3 topography codes that are different at the second (Cxxx) and/or third character (Cxxxx)?

** Decision **
MULTIPLE Primaries**

** Notes **
Tumors not described as metastases.

** M4 **
Is at least one tumor non-small cell carcinoma (8046) and another tumor small cell carcinoma (8041-8045)?

** Decision **
MULTIPLE Primaries**

** M5 **
Is there a tumor that is adenocarcinoma with mixed subtypes (8255) and another that is bronchioalveolar (8250-8254)?

** Decision **
MULTIPLE Primaries**

This is a change in rules; tumors in the trachea (C33) and in the lung (C34) were a single lung primary in the previous rules.
When there is a single tumor in each lung abstract as multiple primaries unless stated or proven to be metastatic.

Are there multiple tumors in both lungs with ICD-O-3 histology codes that are different at the first (xxx), second (xxx) or third (xxx) number?

Are there tumors diagnosed more than three (3) years apart?

Tumors not described as metastases.

When there is a single tumor in each lung abstract as multiple primaries unless stated or proven to be metastatic.
Lung Multiple Primary Rules - Flowchart
(C340 - C349)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

1. The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.

2. Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.
Do the tumors have ICD-O-3 histology codes that are different at the first (xxx), second (xxx), or third (xxx) number?

YES

MULTIPLE Primaries**

Adenocarcinoma in one tumor and squamous cell carcinoma in another tumor are multiple primaries.

NO

Tumors not described as metastases.

Does not meet any of the above criteria (M1 through M11).

YES

SINGLE Primary*

1. When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.

NO

End of instructions for Multiple Tumors.

ERROR: Recheck rules. Stop when a match is found.

Rule M12 Examples: The following are examples of cases that use Rule M12. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary.

Warning: Using only these case examples to determine the number of primaries can result in major errors.

Example 1. Solitary tumor in one lung, multiple tumors in contralateral lung
Example 2. Diffuse bilateral nodules (This is the only condition when laterality = 4)
Example 3. An in situ and invasive tumor diagnosed within 60 days
Example 4. Multiple tumors in left lung metastatic from right lung
Example 5. Multiple tumors in one lung
Example 6: Multiple tumors in both lungs

Lung MP

January 1, 2007

115
LUNG Histology Coding Rules - Flowchart
(C340 - C349)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)
SINGLE TUMOR

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1</td>
<td>Is there no pathology/cytology specimen or is the pathology/cytology report unavailable?</td>
<td>YES Code the histology documented by the physician.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>H2</td>
<td>Is the specimen from a metastatic site? (there is no pathology/cytology specimen from the primary site)</td>
<td>YES Code the histology from a metastatic site.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>H3</td>
<td>Is only one histologic type identified?</td>
<td>YES Code the histology.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>Do not code terms that do not appear in the histology description.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Example 1: Do not code squamous cell carcinoma non-keratinizing unless the words &quot;non-keratinizing&quot; actually appear in the diagnosis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Example 2: Do not code bronchioalveolar non-mucinous unless the words &quot;non-mucinous&quot; actually appear in the diagnosis.</td>
</tr>
</tbody>
</table>

1. Priority for using documents to code the histology:
   - Documentation in the medical record that refers to pathologic or cytologic findings
   - Physician's reference to type of cancer (histology) in the medical record
   - CT, PET, or MRI scans
   - Chest x-rays
2. Code the specific histology when documented.
3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

January 1, 2007
Does the tumor have invasive and in situ components?

- **YES**: Code the invasive histologic type.

Are there multiple histologies within the same branch such as:
- cancer/malignant neoplasm, NOS (8000) and a more specific histology? OR
- carcinoma, NOS (8010) and a more specific carcinoma? OR
- adenocarcinoma, NOS (8140) and a more specific adenocarcinoma? OR
- squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma? OR
- sarcoma, NOS (8800) and a more specific sarcoma?

- **YES**: Code the most specific histologic term using Chart 1.

- **NO**: The specific histology may be identified as type, subtype, predominantly, with features of, major, or with _____ differentiation.

Examples:
- **Example 1**: Adenocarcinoma, predominantly mucinous. Code mucinous adenocarcinoma 8480.
- **Example 2**: Non-small cell carcinoma, papillary squamous cell. Code papillary squamous cell carcinoma 8052.
**LUNG Histology Coding Rules - Flowchart**

(C340 - C349)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

**SINGLE TUMOR**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H6</td>
<td>Are there <strong>multiple specific histologies</strong> or is there a non-specific <strong>with multiple specific histologies</strong>?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

The specific histologies may be identified as type, subtype, predominantly, with features of, major or with differentiation.


**Example 2** (multiple specific histologies): Combined small cell and squamous cell carcinoma. Code combined small cell carcinoma 8045.

**Example 3** (non-specific with multiple specific histologies): Adenocarcinoma with papillary and clear cell features. Code adenocarcinoma with mixed subtypes 8255.

| H7   | Code the **numerically higher** ICD-O-3 code. | |

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.
LUNG Histology Coding Rules - Flowchart
(C340 - C349)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H8</td>
<td>Is there no pathology/cytology specimen or is the pathology/cytology report unavailable?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>H9</td>
<td>Is the specimen from a metastatic site? (there is no pathology/cytology specimen from the primary site)</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>Code the behavior /3.</td>
</tr>
</tbody>
</table>

1. Priority for using documents to code the histology
   - Documentation in the medical record that refers to pathologic or cytologic findings
   - Physician’s reference to type of cancer (histology) in the medical record
   - CT, PET, or MRI scans
   - Chest x-rays
2. Code the specific histology when documented.
3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Next Page
LUNG Histology Coding Rules - - Flowchart

(C340 - C349)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| H10  | Code the histology. | Do not code terms that do not appear in the histology description.  
Example 1: Do not code squamous cell carcinoma non-keratinizing unless the words “non-keratinizing” actually appear in the diagnosis.  
Example 2: Do not code bronchioalveolar non-mucinous unless the words “non-mucinous” actually appear in the diagnosis. |
|      | Is only **one histologic type** identified? | YES |
|      | NO |

| H11  | Code the histology of the most invasive tumor. | 1. This rule should only be used when the first three numbers of the histology codes are identical. (This is a single primary.)  
2. See the Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations for the definition of most invasive.  
   - If one tumor is in situ and one is invasive, code the histology from the invasive tumor.  
   - If both/all histologies are invasive, code the histology of the most invasive tumor. |
|      | Is one tumor in situ and the other invasive or are both tumors invasive? | YES |
|      | NO |

Next Page
The specific histology may be identified as type, subtype, predominantly, with features of, major, or with _______ differentiation.

Example 1: Adenocarcinoma, predominantly mucinous. Code mucinous adenocarcinoma 8480.


Rule 12

Are there multiple histologies within the same branch such as:
- cancer/malignant neoplasm, NOS (8000) and a more specific histology? OR
- carcinoma, NOS (8010) and a more specific carcinoma? OR
- adenocarcinoma, NOS (8140) and a more specific adenocarcinoma? OR
- squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma? OR
- sarcoma, NOS (8800) and a more specific sarcoma?

YES:

Code the most specific histologic term using Chart 1.

NO:

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.

Code the histology according to the rule that fits the case.
This page left blank
Cutaneous Melanoma Multiple Primary Rules - Flowchart

(C440 - C449 with Histology 8720 - 8780)
(Excludes melanoma of any other site)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

<table>
<thead>
<tr>
<th>UNKNOWN IF SINGLE OR MULTIPLE MELANOMAS</th>
<th>DECISION</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it impossible to determine if there is a single melanoma or multiple melanomas?</td>
<td>YES</td>
<td>(\text{SINGLE Primary}^*)</td>
</tr>
<tr>
<td>NO</td>
<td>(\text{SINGLE Primary}^*)</td>
<td>Use this rule only after all information sources have been exhausted.</td>
</tr>
<tr>
<td>(\text{Go to Single Melanoma or Multiple Melanomas})</td>
<td>(\text{End of instructions for Unknown if Single or Multiple Melanoma.})</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SINGLE MELANOMA</th>
<th>DECISION</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a single melanoma?</td>
<td>YES</td>
<td>(\text{SINGLE Primary}^*)</td>
</tr>
<tr>
<td>NO</td>
<td>(\text{SINGLE Primary}^*)</td>
<td>(\text{End of instructions for Single Melanoma.})</td>
</tr>
<tr>
<td>(\text{Go to Multiple Melanomas.})</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(\text{Melanoma(s) not described as metastasis.}\)
Cutaneous Melanoma Multiple Primary Rules - Flowchart

(C440 - C449 with Histology 8720 - 8780)
(Excludes melanoma of any other site)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

**MULTIPLE MELANOMAS**

Multiple Melanomas may be a single primary or multiple primaries.

M3

Are there melanomas in sites with ICD-O-3 topography codes that are different at the second (Cxxx), third (Cxxx), and/or fourth character (C44xxx)?

YES

MULTIPLE Primaries**

NO

M4

Do the melanomas have different lateralities?

YES

MULTIPLE Primaries**

NO

M5

Do the melanomas have ICD-O-3 histology codes that are different at the first (xxxx), second (xxxx), or third (xxxx) number?

YES

MULTIPLE Primaries**

NO

A midline melanoma is a different laterality than right or left.

Example 1: Melanoma on the right side of the chest and a melanoma at midline on the chest are different laterality, multiple primaries.

Example 2: A melanoma on the right side of the chest and a melanoma on the left side of the chest are multiple primaries.

NOTES

1. Melanoma not described as metastases.
2. Includes combinations of in situ and invasive.
**Cutaneous Melanoma Multiple Primary Rules - Flowchart**

(C440 - C449 with Histology 8720 - 8780)
(Excludes melanoma of any other site)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

---

**MULTIPLE Melanomas, continued**

**DECISION**

---

**M6**

Is there an **invasive** melanoma following an **in situ** melanoma **more than 60 days after** diagnosis?

YES → MULTIPLE Primaries**

NO

---

**M7**

Are there melanomas diagnosed **more than 60 days apart**?

YES → MULTIPLE Primaries**

NO

---

**M8**

Does not meet any of the above criteria (M1 through M7)

YES → SINGLE Primary*

NO → ERROR: Recheck rules. Stop when a match is found.

---

**NOTES**

1. Melanomas not described as metastases.
2. Includes combinations of in situ and invasive.

---

**Rule M8 Examples:**

The following are examples of cases that use Rule M8.

**Warning:** Using only these case examples to determine the number of primaries can result in major errors.

Example 1. Solitary melanoma on the left back and another solitary melanoma on the left chest.

Example 2. Solitary melanoma on the right thigh and another solitary melanoma on the right ankle.

---

**End of instructions for Multiple Melanomas.**
Cutaneous Melanoma Histology Coding Rules - Flowchart
(C440 - C449 with Histology 8720 - 8780)
(Excludes melanoma of any other site)

SINGLE MELANOMA OR MULTIPLE MELANOMAS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1</td>
<td>YES</td>
<td>Code the histology documented by the physician.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>Code the histology.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Code the behavior /3.</td>
</tr>
<tr>
<td>H2</td>
<td>YES</td>
<td>Code the histology from a metastatic site.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>Code the histology from a metastatic site.</td>
</tr>
<tr>
<td>H3</td>
<td>YES</td>
<td>Code the histology.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>Code the histology.</td>
</tr>
</tbody>
</table>

1. Priority for using documents to code the histology
   - Documentation in the medical record that refers to pathologic or cytologic findings
   - Physician's reference to type of melanoma in the medical record
   - PET scan
2. Code the specific histology when documented.
Cutaneous Melanoma Histology Coding Rules - Flowchart
(C440 - C449 with Histology 8720 - 8780)
(Excludes melanoma of any other site)

**SINGLE MELANOMA OR MULTIPLE MELANOMAS ABSTRACTED AS A SINGLE PRIMARY**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H4</td>
<td><strong>Does the melanoma have <em>invasive and in situ</em> components?</strong>&lt;br&gt;YES</td>
<td>Code the invasive histologic type.</td>
</tr>
<tr>
<td></td>
<td><strong>NO</strong></td>
<td></td>
</tr>
</tbody>
</table>
| H5   | **Is the diagnosis regressing melanoma and a histologic type?**<br>YES | Code the histologic type.  
**Example:** Nodular melanoma with features of regression. Code 8721 (Nodular melanoma). |
|      | **NO** |                     |
| H6   | **Is the diagnosis regressing melanoma?**<br>YES | Code 8723 (Malignant melanoma, regressing).  
**Example:** Malignant melanoma with features of regression. Code 8723.  |
|      | **NO** |                     |

Flowchart Key

- **Rule**
- **Action**
- **Notes and Examples**

Flow Direction
Cutaneous Melanoma Histology Coding Rules - Flowchart
(C440 - C449 with Histology 8720 - 8780)
(Excludes melanoma of any other site)

SINGLE MELANOMA OR MULTIPLE MELANOMAS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H7</td>
<td>Is the diagnosis lentigo maligna melanoma and a histologic type?</td>
<td>Code the histologic type</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>H8</td>
<td>Is the diagnosis lentigo maligna melanoma?</td>
<td>Code 8742 (Lentigo maligna melanoma)</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>
Cutaneous Melanoma Histology Coding Rules - Flowchart

(C440 - C449 with Histology 8720 - 8780)
(Excludes melanoma of any other site)

SINGLE MELANOMA OR MULTIPLE MELANOMAS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H9</td>
<td>Is the diagnosis Melanoma, NOS (8720) with a single specific type?</td>
<td>Code the most specific histologic term.</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>1. The specific type for \textit{in situ} lesions may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with _____ differentiation.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>2. The specific type for \textit{invasive} lesions may be identified as type, subtype, predominantly, with features of, major, or with _____ differentiation.</td>
</tr>
<tr>
<td>H10</td>
<td>Code the numerically higher ICD-O-3 histology code.</td>
<td></td>
</tr>
</tbody>
</table>

This is the end of instructions for Single Melanoma or Multiple Melanomas Abstracted as a Single Primary.  
Code the histology according to the rule that fits the case.
This page left blank
Breast Multiple Primary Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

**Notes**

**Unknown if Single or Multiple Tumors**

M1

Is it impossible to determine if there is a single tumor or multiple tumors?

YES

SINGLE Primary*

End of instructions for Unknown if Single or Multiple Tumors

NO

Go to Single Tumor or Multiple Tumors

**Single Tumor**

M2

Is there *inflammatory carcinoma* in one or both breasts?

YES

SINGLE Primary*

End of instructions for Single Tumor.

NO

M3

Is there a single tumor?

YES

NO

Go to Multiple Tumors.
Breast Multiple Primary Rules - Flowchart
(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

### MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.

- **M4** Are there tumors in sites with ICD-O-3 topography codes that are different at the second (Cxx) and/or third character (Cxxx)?
  - YES: MULTIPLE Primaries**
  - NO

- **M5** Are there tumors diagnosed more than five (5) years apart?
  - YES: MULTIPLE Primaries**
  - NO

- **M6** Is there inflammatory carcinoma in one or both breasts?
  - YES: SINGLE Primary*
  - NO

- **M7** Is there a tumor(s) in each breast?
  - YES: MULTIPLE Primaries**
  - NO

---

**NOTES**

1. Tumors not described as metastasis.
2. Includes combinations of in situ and invasive.

---

Lobular carcinoma in both breasts ("mirror image") is a multiple primary.
Breast Multiple Primary Rules - Flowchart
(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

<table>
<thead>
<tr>
<th>MULTIPLE TUMORS, continued</th>
<th>DECISION</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M8</strong> Is there an <strong>invasive</strong> tumor following an <strong>in situ</strong> tumor more than 60 days after diagnosis?</td>
<td><strong>YES</strong> MULTIPLE Primaries**</td>
<td>1. The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed. 2. Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.</td>
</tr>
<tr>
<td><strong>NO</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| M9 | Are the tumors intraductal or **duct and Paget Disease**? | **YES** SINGLE Primary* | Use Table 1 and Table 2 to identify intraductal and duct carcinomas |
| **NO** | | |

| M10 | Are the tumors lobular (8520) and intraductal or **duct**? | **YES** SINGLE Primary* |
| **NO** | | |

| M11 | Are there multiple intraductal and/or duct carcinomas? | **YES** SINGLE Primary* |
| **NO** | | |

Next Page
Breast Multiple Primary Rules - Flowchart
(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

<table>
<thead>
<tr>
<th>MULTIPLE TUMORS, continued</th>
<th>DECISION</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Includes combinations of in situ and invasive. 2. Tumors are not described as a metastasis.</td>
<td></td>
</tr>
</tbody>
</table>

**M12**

- Do the tumors have ICD-O-3 histology codes that are **different** at the first (xxx), second (xxxx), or third (xxxx) number?
  - **YES**
    - MULTIPLE Primaries**
  - **NO**

**M13**

- Does not meet any of the above criteria (M1 through M12).
  - **YES**
    - SINGLE Primary*
  - **NO**

**ERROR:** Recheck rules. Stop when a match is found.

End of instructions for Multiple Tumors.

**Rule M13 Examples:** The following are examples of cases that use Rule M13.
This is **NOT** intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. **Warning:** Using only these case examples to determine the number of primaries can result in major errors.

- Example 1. Invasive duct and intraductal carcinoma in the same breast
- Example 2. Multicentric lobular carcinoma, left breast

January 1, 2007
Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR: IN SITU CARCINOMA ONLY
(Single Tumor; all parts are in situ)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1</td>
<td>Is the <em>pathology/cytology</em> report unavailable?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Code the histology documented by the physician</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>1. Priority for using documents to code the histology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Documentation in the medical record that refers to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Physician’s reference to type of cancer (histology)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>in the medical record</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Code the specific histology when documented.</td>
</tr>
</tbody>
</table>

| H2   | Is only *one histologic type* identified? | YES |
|      | Code the histology. | |
|      | NO | |

Next Page
Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

**SINGLE TUMOR: IN SITU CARCINOMA ONLY**
(Single Tumor; all parts are in situ)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H3</strong></td>
<td>Is there carcinoma in situ, NOS (8010) and a specific carcinoma in situ?</td>
<td>Code the more specific histologic term.</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>The specific histology may be identified as type, subtype, predominantly, with features of, major, or with _____ differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is there adenocarcinoma in situ, NOS (8140) and a specific adenocarcinoma in situ?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is there intraductal NOS (8500) and a specific intraductal carcinoma (Table 1)?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

| **H4** | Does the tumor have non-infiltrating comedocarcinoma and any other intraductal carcinoma (Table 1)? | Code 8501/2 (comedo-carcinoma, non-infiltrating). |
| | YES | Example: Pathology report reads intraductal carcinoma with comedo and solid features. Code comedocarcinoma (8501/2). |
| | NO | |

| **H5** | Does the tumor have a combination of in situ lobular (8520) and intraductal carcinoma (Table 1)? | Code 8522/2 (intraductal and lobular carcinoma in situ) (Table 3). |
| | YES | |
| | NO | |
This is the end of instructions for Single Tumor: In Situ Carcinoma Only. Code the histology according to the rule that fits the case.
Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

**SINGLE TUMOR: INVASIVE AND IN SITU CARCINOMA**
(Single Tumor; in situ and invasive components)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does the tumor have invasive and in situ components?

**YES**

- Code the **Invasive** histology.

**NO**

ERROR: Confirm Multiple Primary
Rule application and then go to H1 - H8 or H10 - H29

1. Ignore the in situ terms.

2. This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was the invasive component of the tumor better explains the likely disease course and survival category. Using these new rules, combinations of invasive duct and in situ lobular are coded to invasive duct (8500/3) rather than the combination code for duct and lobular carcinoma (8522/3).

This is the end of instructions for Single Tumor: Invasive and In Situ Carcinoma.
Code the histology according to the rule that fits the case.
Breast Histology Coding Rules - Flowchart
(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

**SINGLE TUMOR: INVASIVE CARCINOMA ONLY**
(Single Tumor; all parts are invasive)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| H10 Is there **no pathology/cytology** specimen or is the **pathology/cytology** report unavailable? | YES: Code the histology documented by the physician. | 1. Priority for using documents to code the histology
   o Documentation in the medical record that refers to pathologic or cytologic findings
   o Physician’s reference to type of cancer (histology) in the medical record
   o Mammogram
   o PET scan
   o Ultrasound
   2. Code the specific histology when documented.
   3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented. |
| H11 Is the only specimen from a metastatic site?  (there is no pathology/cytology specimen from the primary site) | YES: Code the histology from the metastatic site. | Code the behavior /3. |

Next Page
**Breast Histology Coding Rules - Flowchart**
(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

**SINGLE TUMOR: INVASIVE CARCINOMA ONLY**
(Single Tumor; all parts are invasive)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H12</td>
<td>YES</td>
<td><strong>Code the most specific histologic term.</strong> The specific histology may be identified as type, subtype, predominantly, with features of, major, or with _____ differentiation. The terms architecture and pattern are subtypes only for in situ cancer.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>H13</td>
<td>YES</td>
<td><strong>Code 8530</strong> (inflammatory carcinoma).</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>Record dermal lymphatic invasion in Collaborative Staging.</td>
</tr>
</tbody>
</table>

January 1, 2007
Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

**SINGLE TUMOR: INVASIVE CARCINOMA ONLY**
(Single Tumor; all parts are invasive)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H14</td>
<td>Is only one histologic type identified?</td>
<td>Code the histology.</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>H15</td>
<td>Are there two or more specific duct carcinomas?</td>
<td>Code the numerically higher ICD-O-3 histology code.</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>Use Table 2 to identify duct carcinomas</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>H16</td>
<td>Is there a combination of lobular (8520) and duct carcinoma (Table 3)?</td>
<td>Code 8522 (duct and lobular).</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>Use Table 2 to identify duct carcinomas</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

Next Page
Breast Histology Coding Rules - Flowchart

(C500-C509)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR: INVASIVE CARCINOMA ONLY

(Single Tumor; all parts are invasive)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H17</td>
<td>Code 8523 (duct mixed with other types of carcinoma).</td>
<td>1. Use Table 2 to identify duct carcinomas. 2. Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.</td>
</tr>
<tr>
<td></td>
<td>1. Is there a combination of duct and any other carcinoma (Table 3)?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>H18</td>
<td>Code 8524 (lobular mixed with other types of carcinoma).</td>
<td>Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>H19</td>
<td>Code 8255 (adenocarcinoma with mixed subtypes) (Table 3).</td>
<td>Use Table 2 to identify duct carcinomas</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

This is the end of instructions for Single Tumor: Invasive Carcinoma Only. Code the histology according to the rule that fits the case.
Breast Histology Coding Rules - Flowchart
(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| H20  | Is there **no pathology/cytology specimen or is the pathology/cytology report unavailable?** | **YES** Code the histology documented by the physician. **NO** 1. Priority for using documents to code the histology  
   - Documentation in the medical record that refers to pathologic or cytologic findings  
   - Physician’s reference to type of cancer (histology) in the medical record  
   - Mammogram  
   - PET Scan  
   - Ultrasound  
2. Code the specific histology when documented.  
3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented. |
| H21  | Is the only specimen from a metastatic site?  
(there is no pathology/cytology specimen from the primary site) | **YES** Code the histology from a metastatic site. **NO**  |
| H22  | Does the final diagnosis of the pathology report specifically state inflammatory carcinoma? | **YES** Code 8530 (inflammatory carcinoma). **NO** Record dermal lymphatic invasion in Collaborative Staging. |
MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

**Rule**

**H23**

Is only one histologic type identified?

- **YES** Code the histology.
- **NO**

**H24**

Does the pathology report specifically state that the Paget disease is in situ and the underlying tumor is intraductal carcinoma (Table 1)?

- **YES** Code 8543/2 (in situ Paget disease and intraductal carcinoma (Table 3).
- **NO** Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

**H25**

Is there Paget disease and intraductal carcinoma (Table 3)?

- **YES** Code 8543/3 (Paget disease and intraductal carcinoma).
- **NO**

**H26**

Is there Paget disease and invasive duct carcinoma (Table 3)?

- **YES** Code 8541/3 (Paget disease and infiltrating duct carcinoma).
- **NO**

---

1. ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3).
2. Includes both invasive Paget disease and Paget disease with behavior not stated.
3. Use Table 1 to identify intraductal carcinomas.

---

Revised November 1, 2007
MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H27</td>
<td>Are there invasive and in situ components?</td>
<td>YES: Code the invasive histology. NO: Ignore the in situ terms. This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive lobular and in situ duct carcinoma are coded to invasive lobular (8520/3) rather than the combination code for duct and lobular carcinoma (8522/3).</td>
</tr>
<tr>
<td>H28</td>
<td>Is there any combination of lobular (8520) and duct carcinoma (Table 3)?</td>
<td>YES: Code 8522 (duct and lobular). NO: Use Table 2 to identify duct carcinomas.</td>
</tr>
<tr>
<td>H29</td>
<td></td>
<td>Code the numerically higher ICD-O-3 histology code.</td>
</tr>
</tbody>
</table>

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary. Code the histology according to the rule that fits the case.
Kidney Multiple Primary Rules - Flowchart

(C649)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

### Unknown if Single or Multiple Tumors

<table>
<thead>
<tr>
<th>M1</th>
<th>Is it impossible to determine if there is a single tumor or multiple tumors?</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>Go to Single Tumor or Multiple Tumors</td>
</tr>
<tr>
<td>YES</td>
<td>SINGLE Primary*</td>
</tr>
</tbody>
</table>

**Notes**

- Tumor(s) not described as metastasis.
- Use this rule only after all information sources have been exhausted.

### Single Tumor

<table>
<thead>
<tr>
<th>M2</th>
<th>Is there a single tumor?</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>Go to Multiple Tumors.</td>
</tr>
<tr>
<td>YES</td>
<td>SINGLE Primary*</td>
</tr>
</tbody>
</table>

**Notes**

- The tumor may overlap onto or extend into adjacent/contiguous site or subsite.
- 1. Tumor not described as metastasis.
- 2. Includes combinations of in situ and invasive

End of instructions for Unknown if Single or Multiple Tumors

End of instructions for Single Tumor.
Kidney Multiple Primary Rules - Flowchart
(C649)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

** MULTIPLE TUMORS **
Multiple tumors may be a single primary or multiple primaries.

** M3 **
Is the diagnosis Wilm's tumor?  
YES  
SINGLE Primary*

NO

** M4 **
Are there tumors in sites with ICD-O-3 topography codes that are different at the second (Cxx) and/or third character (Cx xx)?
YES  
MULTIPLE Primaries**

NO

** M5 **
Are there tumors in both the left and right kidney?
YES  
MULTIPLE Primaries**

NO

Abstract as a single primary when the tumors in one kidney are documented to be metastatic from the other kidney.

NOTES
1. Tumors not described as metastases.
2. Includes combinations of in situ and invasive.
Is there one tumor with a specific renal cell type and another tumor with a different specific renal cell type (Table 1)?

M6: Are there tumors diagnosed more than three (3) years apart?
   - YES: MULTIPLE Primaries**
   - NO: Is there an invasive tumor following an in situ tumor more than 60 days after diagnosis?
     - YES: MULTIPLE Primaries**
     - NO: Is there one tumor with a specific renal cell type and another tumor with a different specific renal cell type (Table 1)?
       - YES: MULTIPLE Primaries**
       - NO: Next Page

NOTES

1. Tumors not described as metastases.
2. Includes combinations of in situ and invasive.

1. The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
2. Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.
Kidney Multiple Primary Rules - Flowchart

(C649)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

**Flowchart Key**

- **question**
- **Decision**
- **Note**
- **FlowDirection**

---

**NOTES**

1. Tumors not described as metastases.
2. Includes combinations of in situ and invasive.

---

**SINGLE Primary**

1: The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

2: The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

---

January 1, 2007
Kidney Multiple Primary Rules - Flowchart

(C649)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

<table>
<thead>
<tr>
<th>MULTIPLE TUMORS, continued</th>
<th>DECISION</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M1</strong></td>
<td></td>
<td>1. Tumors not described as metastases.</td>
</tr>
<tr>
<td>Does not meet any of the</td>
<td></td>
<td>2. Includes combinations of in situ and invasive.</td>
</tr>
<tr>
<td>above criteria (M1 through</td>
<td></td>
<td>When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.</td>
</tr>
<tr>
<td>M10).</td>
<td></td>
<td>End of instructions for Multiple Tumors.</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>ERROR: Recheck rules. Stop when a match is found.</td>
</tr>
</tbody>
</table>

Rule M11 Examples: The following are examples of cases that use Rule M11.
This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary.
Warning: Using only these case examples to determine the number of primaries can result in major errors.

| Example 1. Multiple tumors in one kidney with the same histology | Example 2. An in situ and invasive tumor diagnosed within 60 days |
**Kidney Histology Coding Rules - Flowchart**

(C649)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

**SINGLE TUMOR**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| H1 YES       | Code the histology documented by the physician.                        | 1. Priority for using documents to code the histology  
|              |                                                                         | o Documentation in the medical record that refers to pathologic or cytologic findings  
|              |                                                                         | o Physician’s reference to type of cancer (histology) in the medical record  
|              |                                                                         | o CT or MRI scans  
|              |                                                                         | 2. Code the specific histology when documented.  
|              |                                                                         | 3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented. |
| H1 NO        |                                                                         |                                                                                                                                                                                                                    |
| H2 YES       | Code the histology from a metastatic site.                             | Code the behavior /3.                                                                                                                                                                                                   |
|              |                                                                         |                                                                                                                                                                                                                    |
| H2 NO        |                                                                         | Code the histology from a metastatic site.                                                                                                                                                                               |
| H3 YES       | Code the histology.                                                    |                                                                                                                                                                                                                    |
| H3 NO        |                                                                         |                                                                                                                                                                                                                    |
### Kidney Histology Coding Rules - Flowchart

**Rule** | **Action** | **Notes and Examples**
--- | --- | ---
H4. **Does the tumor have invasive and in situ components?** | YES: Code the **Invasive** histology. NO | 1. Use Table 1 to identify specific renal cell types.

H5. **Is there cancer/malignant neoplasm, NOS (8000) and a more specific histology?**

| YES | Code the specific type. |
| **NO** | | 2. The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ___differentiation.

| **NO** | | 3. The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ___differentiation.

| **NO** | | 1. Use Table 1 to identify specific renal cell types.

---

**SINGLE TUMOR**

**Kidney Histology Coding Rules - Flowchart**

(C649)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

January 1, 2007

153
## Kidney Histology Coding Rules - Flowchart

(C649)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

### SINGLE TUMOR

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H6</strong></td>
<td>Are there <em>two or more</em> <strong>specific</strong> renal cell carcinoma types?</td>
<td>Code 8255 (adenocarcinoma with mixed subtypes).</td>
</tr>
<tr>
<td>YES</td>
<td>Use Table 1 to identify specific renal cell types.</td>
<td>Example: Renal cell carcinoma, papillary and clear cell types. Assign code 8255.</td>
</tr>
<tr>
<td>NO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **H7** | Code the **numerically higher** ICD-O-3 histology code. | |

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.
**Kidney Histology Coding Rules - Flowchart**

(C649)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

**MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H8</strong></td>
<td>Is there no <strong>pathology/cytology</strong> specimen or is the <strong>pathology/cytology</strong> report unavailable?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO</td>
</tr>
<tr>
<td><strong>H9</strong></td>
<td>Is the specimen from a metastatic site? (there is no pathology/cytology specimen from the primary site)</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO</td>
</tr>
</tbody>
</table>

1. Priority for using documents to code the histology
   - Documentation in the medical record refers to pathologic or cytologic findings
   - Physician’s reference to type of cancer (histology) in the medical record
   - CT or MRI scans
2. Code the specific histology when documented.
3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.
Kidney Histology Coding Rules - Flowchart
(C649)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H10</td>
<td>Code the histology.</td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Is only <strong>one histologic type</strong> identified?</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>NO</strong></td>
</tr>
</tbody>
</table>

H11

<table>
<thead>
<tr>
<th>Rule</th>
<th>Code the histology of the most invasive tumor</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>YES</strong></td>
<td>1. This rule should only be used when the first three numbers of the histology codes are identical. (This is a single primary.)</td>
</tr>
<tr>
<td></td>
<td><strong>NO</strong></td>
<td>2. See the Kidney Equivalent Terms, Definitions, Tables and Illustrations for the definition of most invasive.</td>
</tr>
<tr>
<td></td>
<td><strong>Flow Direction</strong></td>
<td>- If one tumor is in situ and one is invasive, code the histology from the invasive tumor.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- If both/all histologies are invasive, code the histology of the most invasive tumor.</td>
</tr>
</tbody>
</table>

Next Page
Kidney Histology Coding Rules - Flowchart

(C649)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H12</td>
<td></td>
<td>1. Use Table 1 to identify specific renal cell types</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.</td>
</tr>
</tbody>
</table>

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary. Code the histology according to the rule that fits the case.
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Renal Pelvis, Ureter, Bladder and Other Urinary Multiple Primary Rules - Flowchart
(C659, C669, C670-C679, C680-C689)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

**Flowchart Key**
- Question
- Decision
- Note
- Flow Direction

**Unknown if Single or Multiple Tumors**

**M1**
Is it impossible to determine if there is a single tumor or multiple tumors?

- **YES**
  - **SINGLE Primary**
  - End of instructions for Unknown if Single or Multiple Tumors
  - **NOTES**
  - Tumor(s) not described as metastasis.
  - Use this rule only after all information sources have been exhausted.

- **NO**
  - Go to Single Tumor or Multiple Tumors

**SINGLE TUMOR**

**M2**
Is there a single tumor?

- **YES**
  - **SINGLE Primary**
  - End of instructions for Single Tumor.
  - **NOTES**
  - The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

- **NO**
  - Go to Multiple Tumors.
Renal Pelvis, Ureter, Bladder and Other Urinary Multiple Primary Rules - Flowchart

(M659, C689, C670-C679, C680-C689)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

### MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.

<table>
<thead>
<tr>
<th>M3</th>
<th>Are there tumors in both the right renal pelvis and the left renal pelvis and no other urinary sites are involved?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td></td>
<td>MULTIPLE Primaries**</td>
</tr>
</tbody>
</table>
|    | **NOTES**
|    | Use this rule and abstract as a multiple primary unless documented to be metastatic.                         |

<table>
<thead>
<tr>
<th>M4</th>
<th>Are there tumors in both the right ureter and the left ureter and no other urinary sites are involved?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td></td>
<td>MULTIPLE Primaries**</td>
</tr>
</tbody>
</table>
|    | **NOTES**
|    | Use this rule and abstract as a multiple primary unless documented to be metastatic.                         |

<table>
<thead>
<tr>
<th>M5</th>
<th>Is there an invasive tumor following a non-invasive or an in situ tumor more than 60 days after diagnosis?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td></td>
<td>MULTIPLE Primaries**</td>
</tr>
</tbody>
</table>
|    | **NOTES**
|    | 1. The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed. |
|    | 2. Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease. |
Are there urothelial tumors (See Table 1) in two or more of the following sites: Renal pelvis (C659)? Ureter (C669)? Bladder (C670-C679)? Urethra/prostatic urethra (C680-C689)?

Are there tumors diagnosed more than three (3) years apart?

Are there bladder tumors with any combination of the following histologies: papillary carcinoma (8050) transitional cell carcinoma (8120-8124) papillary transitional cell carcinoma (8130-8131)?

1. Tumors not described as metastases.
2. Includes combinations of in situ and invasive.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.
Renal Pelvis, Ureter, Bladder and Other Urinary Multiple Primary Rules - Flowchart
(C659, C669, C670-C679, C680-C689)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

<table>
<thead>
<tr>
<th>MULTIPLE TUMORS, continued</th>
<th>DECISION</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M9</strong> Are there tumors with ICD-O-3 histology codes that are <strong>different</strong> at the first (x000), second (x00) or third number (xx)?</td>
<td>YES</td>
<td>1. Tumors not described as metastases. 2. Includes combinations of in situ and invasive.</td>
</tr>
<tr>
<td>NO</td>
<td>MULTIPLE Primaries**</td>
<td></td>
</tr>
<tr>
<td><strong>M10</strong> Are there tumors in sites with ICD-O-3 topography codes that are <strong>different</strong> at the second (C000) and/or third character (C00)?</td>
<td>YES</td>
<td>MULTIPLE Primaries**</td>
</tr>
<tr>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>M11</strong> Does not meet any of the above criteria (M1 through M10).</td>
<td>YES</td>
<td>SINGLE Primary*</td>
</tr>
<tr>
<td>NO</td>
<td>End of instructions for Multiple Tumors</td>
<td></td>
</tr>
</tbody>
</table>

ERROR: Recheck rules. Stop when a match is found.
Renal Pelvis, Ureter, Bladder and Other Urinary Histology Rules - Flowchart
(C659, C669, C670-C679, C680-C689)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

**SINGLE TUMOR**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| **H1** | Is there no pathology/cytology specimen or is the pathology/cytology report unavailable? | YES | Code the histology documented by the physician.  
1. Priority for using documents to code the histology  
   o Documentation in the medical record that refers to pathologic or cytologic findings  
   o Physician's reference to type of cancer (histology) in the medical record  
   o CT or MRI scans  
2. Code the specific histology when documented.  
3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented. |
| | NO | |
| **H2** | Is the specimen from a metastatic site? (there is no pathology/cytology specimen from the primary site) | YES | Code the histology from the metastatic site.  
Code the behavior /3. |
| | NO | |

Next Page
Renal Pelvis, Ureter, Bladder and Other Urinary Histology Rules - Flowchart
(C659, C669, C670-C679, C680-C689)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| H3   | Is the histology:  
- Pure transitional cell carcinoma? or  
- Flat (non-papillary) transitional carcinoma? or  
- Transitional cell carcinoma with squamous differentiation? or  
- Transitional cell carcinoma with glandular differentiation? or  
- Transitional cell carcinoma with trophoblastic differentiation? or  
- Nested transitional cell carcinoma? or  
- Microcystic transitional cell carcinoma?  |
|      | YES    | Flat transitional cell carcinoma is a more important prognostic indicator than papillary, and is likely to be treated more aggressively. |
|      | NO     |                     |
| H4   | Is the histology:  
- Papillary carcinoma? or  
- Papillary transitional cell carcinoma? or  
- Papillary carcinoma and Transitional cell carcinoma?  |
|      | YES    | Code 8130 (papillary transitional cell carcinoma) (Table 1 - Code 8130). |
|      | NO     |                     |
| H5   | Is only one histologic type identified?  |
|      | YES    | Code the histology. Only code squamous cell carcinoma (8070) when there are no other histologies present (pure squamous cell carcinoma). |
|      | NO     |                     |
Renal Pelvis, Ureter, Bladder and Other Urinary Histology Rules - Flowchart

(C659, C669, C670-C679, C680-C689)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

**SINGLE TUMOR**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| H6   | **YES** Code the invasive histology. | **Examples**
- Cancer/malignant neoplasm, NOS (8000) and a more specific histology
- Carcinoma, NOS (8010) and a more specific carcinoma
- Sarcoma, NOS (8800) and a more specific sarcoma (invasive only)

| H7   | **YES** Code the most specific histologic term. | 1. The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with _____ differentiation.
2. The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with _____ differentiation.

| H8   | Code the numerically higher ICD-O-3 histology code. | |

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.
Renal Pelvis, Ureter, Bladder and Other Urinary Histology Rules - Flowchart
(C659, C669, C670-C679, C680-C689)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| H9   | Code the histology documented by the physician. | 1. Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of cancer (histology) in the medical record
- CT or MRI scans |
| H10  | Code the histology from the metastatic site. | 2. Code the specific histology when documented.
3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Next Page
Is the histology:
- Pure transitional cell carcinoma? or
- Flat (non-papillary) transitional cell carcinoma? or
- Transitional cell carcinoma with squamous differentiation? or
- Transitional cell carcinoma with glandular differentiation? or
- Transitional cell carcinoma with glandular differentiation? or
- Transitional cell carcinoma with trophoblastic differentiation? or
- Nested transitional cell carcinoma? or
- Microcystic transitional cell carcinoma?

**H11**

**Rule:** Is the histology:
- Pure transitional cell carcinoma? or
- Flat (non-papillary) transitional cell carcinoma? or
- Transitional cell carcinoma with squamous differentiation? or
- Transitional cell carcinoma with glandular differentiation? or
- Transitional cell carcinoma with trophoblastic differentiation? or
- Nested transitional cell carcinoma? or
- Microcystic transitional cell carcinoma?

**Action:**
- **YES**
  - Code 8120 (transitional cell/urothelial carcinoma) (Table 1 - Code 8120).

  Flat transitional cell carcinoma is a more important prognostic indicator than papillary, and is likely to be treated more aggressively.

**H12**

**Rule:** Is the histology:
- Papillary carcinoma? or
- Papillary transitional carcinoma? or
- Papillary carcinoma and Transitional carcinoma?

**Action:**
- **YES**
  - Code 8130 (papillary transitional cell carcinoma) (Table 1 - Code 8130).
Renal Pelvis, Ureter, Bladder and Other Urinary Histology Coding Rules - Flowchart

(C659, C669, C670-C679, C680-C689)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H13</td>
<td>Only code squamous cell carcinoma (8070) when there are no other histologies present (pure squamous cell carcinoma).</td>
<td></td>
</tr>
<tr>
<td>H14</td>
<td>Code the histology of the most invasive tumor.</td>
<td></td>
</tr>
</tbody>
</table>
|      | 1. This rule should only be used when the first three numbers of the histology codes are identical (This is a single primary).  
   2. See the Renal Pelvis, Ureter, Bladder and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations for the definition of most invasive.  
   o If one tumor is in situ and one is invasive, code the histology from the invasive tumor.  
   o If both/all histologies are invasive, code the histology of the most invasive tumor. |
| H15  | Code the numerically higher ICD-O-3 code. |

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary. Code the histology according to the rule that fits the case.
Benign and Borderline Intracranial and CNS Tumors Multiple Primary Rules - Flowchart

(C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753)

Note: Malignant intracranial and CNS tumors have a separate set of rules.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

**UNKNOWN IF SINGLE OR MULTIPLE TUMORS**

**DECISION**

NOTES

Tumor(s) not described as metastasis.

**M1**

Is it impossible to determine if there is a single tumor or multiple tumors?

YES

SINGLE Primary*

End of instructions for Unknown if Single or Multiple Tumors

NO

Error: Choose appropriate module

**SINGLE TUMOR**

**DECISION**

NOTES

Tumor not described as metastasis.

**M2**

Is there a single tumor?

YES

SINGLE Primary*

End of instructions for Single Tumor.

NO

Error: Choose appropriate module

Note: Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

**End of instructions for Unknown if Single or Multiple Tumors**

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** End of instructions for Single Tumor.**

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

**The tumor may overlap onto or extend into adjacent/contiguous site or subsite.**

Revised April 30, 2008
Benign and Borderline Intracranial and CNS Tumors Multiple Primary Rules - Flowchart

(C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753)

Note: Malignant intracranial and CNS tumors have a separate set of rules.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

<table>
<thead>
<tr>
<th>MULTIPLE TUMORS</th>
<th>DECISION</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple tumors may be a single primary or multiple primaries.</td>
<td></td>
<td>Tumors not described as metastases.</td>
</tr>
</tbody>
</table>

M3

Is there an invasive tumor (/3) and either a benign brain tumor (/0) or an uncertain/borderline brain tumor (/1)?

YES

MULTIPLE Primaries**

NO

M4

Are there tumors in sites with ICD-O-3 topography codes that are different at the second (Cxx), third character (Cxx) and/or fourth character (Cxxx)?

YES

MULTIPLE Primaries**

NO

M5

Are there tumors on both sides (left and right) of a paired site (See Table 1)?

YES

MULTIPLE Primaries**

NO

Next Page

Revised April 30, 2008
Benign and Borderline Intracranial and CNS Tumors Multiple Primary Rules - Flowchart
(C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753)

Note: Malignant intracranial and CNS tumors have a separate set of rules.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

**Flowchart Key**
- Flow Direction
- Notes
- Questions
- End

**Multiple Tumors, continued**

**M6**

Is there an atypical choroid plexus papilloma (9390/1) following a choroid plexus papilloma, NOS (9390/0)?

- YES
  - SINGLE Primary*

- NO

**M7**

Is there a neurofibromatosis, NOS (9540/1) following a neurofibroma, NOS (9540/0)?

- YES
  - SINGLE Primary*

- NO

**M8**

Do the tumors have two or more histologic types on the same branch in Chart 1?

- YES
  - SINGLE Primary*

- NO

**Decision**

Tumors not described as metastases.

**Notes**

Do not code progression of disease as multiple primaries.

Revised April 30, 2008
Benign and Borderline Intracranial and CNS Tumors Multiple Primary Rules - Flowchart
(C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753)

Note: Malignant intracranial and CNS tumors have a separate set of rules.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

### MULTIPLE TUMORS, continued

<table>
<thead>
<tr>
<th>M9</th>
<th>Do the tumors have multiple histologic types on different branches in Chart 1?</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>MULTIPLE Primaries**</td>
</tr>
<tr>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M10</th>
<th>Do the tumors have two or more histologic types and at least one of the histologies is not listed in Chart 1?</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>MULTIPLE Primaries**</td>
</tr>
<tr>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M11</th>
<th>Do the tumors have ICD-O-3 histology codes that are different at the first (xxx), second (xxx), or third (xxx) number?</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>MULTIPLE Primaries**</td>
</tr>
<tr>
<td>NO</td>
<td>Use this rule when none of the histology codes are listed in Chart 1.</td>
</tr>
</tbody>
</table>

Tumors not described as metastases.

Revised April 30, 2008
Benign and Borderline Intracranial and CNS Tumors Multiple Primary Rules - Flowchart
(C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753)

Note: Malignant intracranial and CNS tumors have a separate set of rules.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

---

![Flowchart Image]

---

**Rule M12 Examples:** The following are examples of cases that use Rule M12. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary.

*Warning:* Using only these case examples to determine the number of primaries can result in major errors.

<table>
<thead>
<tr>
<th>Example 1</th>
<th>Example 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tumors in the same site with the same histology (Chart 1) and the same laterality as the original tumor are a single primary.</td>
<td>Tumors in the same site with the same histology (Chart 1) and it is unknown if laterality is the same as the original tumor are a single primary.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tumors in the same site and same laterality with histology codes not listed in Chart 1 that have the same first three numbers are a single primary.</td>
<td></td>
</tr>
</tbody>
</table>
Benign and Borderline Intracranial and CNS Tumors Histology Coding Rules - Flowchart
(C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753)

Note: Malignant intracranial and CNS tumors have a separate set of rules.

**SINGLE TUMOR**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1</td>
<td>Yes</td>
<td>Code the histology documented by the physician.</td>
</tr>
</tbody>
</table>
|      | No     | 1. Priority for using documents to code the histology  
|      |        | o Documentation in the medical record that refers to pathologic or cytologic findings  
|      |        | o Physician’s reference to type of tumor (histology) in the medical record  
|      |        | o PET, CT or MRI scans  
|      |        | 2. Code the specific histology when documented.  
|      |        | 3. Code the histology to 8000 (neoplasm, NOS) as stated by the physician when nothing more specific is documented. |
| H2   | Yes    | Code the histology. |
|      | No     | Next Page |
Note: Malignant intracranial and CNS tumors have a separate set of rules.

SINGLE TUMOR

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H3</td>
<td>YES</td>
<td>Code the more specific histology.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>Code the numerically higher ICD-O-3 code.</td>
</tr>
</tbody>
</table>

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

Revised April 30, 2008
Benign and Borderline Intracranial and CNS Tumors Histology Coding Rules - Flowchart
(C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753)

Note: Malignant intracranial and CNS tumors have a separate set of rules.

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| H5   | Is there no pathology/cytology specimen or is the pathology/cytology report unavailable? | Yes: Code the histology documented by the physician. 
No: Are there multiple meningiomas of uncertain behavior? |
|      |        | 1. Priority for using documents to code the histology: 
Document in the medical record that refers to pathologic or cytologic findings 
Physician's reference to type of tumor (histology) in the medical record 
PET, CT or MRI scans  
2. Code the specific histology when documented. 
3. Code the histology to 8000 (neoplasm, NOS) or as stated by the physician when nothing more specific is documented. |
| H6   | Are there multiple meningiomas of uncertain behavior? | Yes: Code to 9530/1 
No: Next Page |
|      |        | 1. This is a rare condition that is usually associated with neurofibromatosis type 2 and other genetic disorders. 
2. Use this code only for meningiomas with uncertain behavior; do not use this code for multiple benign or malignant meningiomas. |

Revised April 30, 2008
Benign and Borderline Intracranial and CNS Tumors Histology Coding Rules - Flowchart
(C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753)

Note: Malignant intracranial and CNS tumors have a separate set of rules.

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H7</td>
<td>Is only <strong>one histologic type</strong> identified?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>H8</td>
<td>Was there a previous tumor(s)?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>Do not change the behavior code when a later tumor(s) shows progression of disease.</td>
</tr>
<tr>
<td>H9</td>
<td>Are there <strong>multiple histologies</strong> and all histologies are in the same branch on Chart 1?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>H10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.

Revised April 30, 2008
This page left blank
Is there a single tumor?

M1

Is there an invasive tumor (/3) and either a benign (/0) or an uncertain/borderline tumor (/1)?

YES

MULTIPLE Primaries**

NO

Is it impossible to determine if there is a single tumor or multiple tumors?

YES

SINGLE Primary*

NOTES

Use this rule only after all information sources have been exhausted.

NO

End of instructions for Unknown if Single or Multiple Tumors

Go to Single Tumor or Multiple Tumors

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

DECISION

NOTES

Tumor(s) not described as metastasis.

SINGLE TUMOR

Is there a single tumor?

YES

SINGLE Primary*

End of instructions for Single Tumor.

NO

Go to Multiple Tumors.

M2

M3

Tumor not described as metastasis.

The tumor may overlap onto or extend into adjacent/contiguous site or subsite.
Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary Gland, Craniopharyngeal duct and Pineal Gland Multiple Primary Rules - Flowchart

C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Note: Benign and borderline intracranial and CNS tumors have separate set of rules.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

**  MULTIPLE PRIMARIES**

Are there tumors in sites with ICD-O-3 topography codes that are different at the second (Cx) and/or third character (Cx)?

Is there an invasive tumor (/3) and either a benign (/0) or an uncertain/borderline tumor (/1)?

Is there a glioblastoma or glioblastoma multiforme (9440) following a glial tumor (See Chart 1)?

Tumors not described as metastases.
Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary Gland, Craniopharyngeal duct and Pineal Gland Multiple Primary Rules - Flowchart

C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Note: Benign and borderline intracranial and CNS tumors have separate set of rules.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

**Flowchart Key**

- **Decision**: Branches in Chart 1 or Chart 2
- **Notes**: Branches in Chart 1 or Chart 2
- **Question**: Branches in Chart 1 or Chart 2

**M7**

Do the tumors have ICD-O-3 histology on the same branch in Chart 1 or Chart 2?

- **YES**: SINGLE Primary
- **NO**: MULTIPLE Primaries

**M8**

Do the tumors have ICD-O-3 histology codes on different branches in Chart 1 or Chart 2?

- **YES**: MULTIPLE Primaries
- **NO**: SINGLE Primary

**Recurrence, progression, or any reappearance of histologies on the same branch in Chart 1 or Chart 2 is always the same disease process.**

**Example**

Patient has an astrocytoma. Ten years later the patient is diagnosed with glioblastoma multiforme. This is a progression or recurrence of the earlier astrocytoma.

**January 1, 2007**
Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary Gland, Craniopharyngeal duct and Pineal Gland Multiple Primary Rules - Flowchart

C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Note: Benign and borderline intracranial and CNS tumors have separate set of rules.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

**MULTIPLE TUMORS, continued**

**DECISION**

Tumors not described as metastases.

**NOTES**

1. Neither timing nor laterality is used to determine multiple primaries for malignant intracranial and CNS tumors.

   **Example:** The patient is treated for an anaplastic astrocytoma (9401) in the right parietal lobe. Three months later the patient is diagnosed with a separate anaplastic astrocytoma in the left parietal lobe. This is one primary because laterality is not used to determine multiple primary status.

2. Multicentric brain tumors which involve different lobes of the brain that do not meet any of the above criteria are the same disease process.

**ERROR:** Recheck rules. Stop when a match is found.

January 1, 2007
Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary Gland, Craniopharyngeal duct and Pineal Gland Histology Coding Rules - Flowchart

C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Note: Benign and borderline intracranial and CNS tumors have separate set of rules.

SINGLE TUMOR

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| H1 Is there **no pathology/cytology** specimen or is the **pathology/cytology** report unavailable? | **YES** Code the histology documented by the physician. | 1. Priority for using documents to code the histology  
  - Documentation in the medical record that refers to pathologic or cytologic findings  
  - Physician's reference to type of cancer (histology) in the medical record  
  - CT or MRI scans  
  2. Code the specific histology when documented.  
  3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) as stated by the physician when nothing more specific is documented. |
| H2 Is the only specimen from a metastatic site? (there is no pathology/cytology specimen from the primary site) | **YES** Code the histology from a metastatic site. | Code the behavior /3. |
| H3 Are at least two of the following cells and/or differentiation present:  
  - Astrocytoma  
  - Oligodendroglioma  
  - Ependymal? | **YES** Code 9382/3 (mixed glioma). | |

Brain and CNS Histo

January 1, 2007 173
Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary Gland, Cranioopharyngeal duct and Pineal Gland Histology Rules - Flowchart  
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753  
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)  
Note: Benign and borderline intracranial and CNS tumors have a separate set of rules.

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| **H4** | Is only one histologic type identified?  
YES | Code the histology. |
| | NO | |
| **H5** | Does the diagnosis include a non-specific term and a specific term or type on the same branch in Chart 1 or Chart 2?  
YES | Code the specific type |
| | NO | |
| **H6** | | Code the numerically higher ICD-O-3 code. |

This is the end of instructions for Single Tumor.  
Code the histology according to the rule that fits the case.
Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary Gland, Craniopharyngeal duct and Pineal Gland Histology Rules - Flowchart
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)
Note: Benign and borderline intracranial and CNS tumors have a separate set of rules

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H7</td>
<td></td>
<td>Is there no pathology/cytology specimen or is the pathology/cytology report unavailable?</td>
</tr>
</tbody>
</table>
|      | Code the histology documented by the physician. | 1. Priority for using documents to code the histology  
   o Documentation in the medical record that refers to pathologic or cytologic findings  
   o Physician’s reference to type of cancer (histology) in the medical record  
   o CT or MRI scans |
|      |        | 2. Code the specific histology when documented. |
|      |        | 3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented. |
| H8   | Code the histology from a metastatic site. | Code the behavior /3. |

Is the only specimen from a metastatic site?  
(there is no pathology/cytology specimen from the primary site)

Next Page
Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary Gland, Craniopharyngeal duct and Pineal Gland Histology Rules - Flowchart

C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Note: Benign and borderline intracranial and CNS tumors have a separate set of rules.

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| H9   | Yes: Code the histology.  
      No: Is only one histologic type identified? | |
| H10  | Yes: Code the specific type.  
      No: Does the diagnosis include a non-specific term and a specific term or type on the same branch in Chart 1 or Chart 2? | |
|      |       | |
| H11  | Code the numerically higher ICD-O-3 histology code. | |

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.  
Code the histology according to the rule that fits the case.
Is there a single tumor?

M1: Is it impossible to determine if there is a single tumor or multiple tumors?

YES: Tumor(s) not described as metastasis.

NO: Go to Single Tumor or Multiple Tumors.

M2: Is there a single tumor?

YES: SINGLE Primary

NO: Go to Multiple Tumors.

End of instructions for Unknown if Single or Multiple Tumors.

End of instructions for Single Tumor.

NOTES DECISION

SINGLE TUMOR

End of instructions for Unknown if Single or Multiple Tumors.

NOTES

Go to Single Tumor or Multiple Tumors.
Other Sites Multiple Primary Rules - Flowchart

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

**MULTIPLE TUMORS**

Multiple tumors may be a single primary or multiple primaries.

**DECISION**

NOTES

1. Tumors not described as metastases.
2. Includes combinations of in situ and invasive.

1. Report only one adenocarcinoma of the prostate per patient per lifetime.
2. 95% of prostate malignancies are common (acinar) adenocarcinoma histology (8140). See Equivalent Terms, Definitions and Tables for more information.
3. If patient has a previous acinar adenocarcinoma of the prostate in the database and is diagnosed with adenocarcinoma in 2007 it is a single primary.

MB

Is the diagnosis adenocarcinoma of the prostate? 

YES

SINGLE Primary*

NO

M1

Is the diagnosis retinoblastoma (unilateral or bilateral)?

YES

SINGLE Primary*

NO
Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

Multiple tumors may be a single primary or multiple primaries.

1. Tumors not described as metastases.
2. Includes combinations of in situ and invasive.

**M5**

Is the diagnosis Kaposi sarcoma (any site or sites)?

**YES**

SINGLE Primary*

**NO**

**M6**

Are there follicular and papillary tumors of the thyroid within 60 days of diagnosis?

**YES**

SINGLE Primary*

**NO**

**M7**

Are there bilateral epithelial tumors (8000-8799) of the ovary within 60 days of diagnosis?

**YES**

SINGLE Primary*

**NO**

Next Page
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OTHER SITES MULTIPLE PRIMARY RULES - FLOWCHART

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney,
Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

* Prepare one abstract.  Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts.  Use the histology coding rules to assign the appropriate histology code to each case abstracted.

**MULTIPLE TUMORS, continued**

**DECISION**

1. Tumors not described as metastases.
2. Includes combinations of in situ and invasive.

**NOTES**

Table 1 - Paired Organs and Sites with Laterality

Tumors may be present in a single or multiple segments of the colon, rectosigmoid, rectum.

---

**M8**

Are there tumors in both the left and right sides of a paired site (Table 1)?

- **YES**
  - **MULTIPLE PRIMARIES**

- **NO**

**M9**

Is the diagnosis adenocarcinoma in adenomatous polyposis coli (familial polyposis) with one or more malignant polyps?

- **YES**
  - **SINGLE PRIMARY**

- **NO**

**M10**

Are there tumors diagnosed more than one (1) year apart?

- **YES**
  - **MULTIPLE PRIMARIES**

- **NO**

---

Other Sites MP

Revised November 1, 2007
**Other Sites Multiple Primary Rules - Flowchart**

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

**MULTIPLE TUMORS, continued**

**DECISION**

**NOTES**

1. Tumors not described as metastases.
2. Includes combinations of in situ and invasive.

Example 1: A tumor in the penis C609 and a tumor in the rectum C209 have different second characters in their ICD-O-3 topography codes, so they are multiple primaries.

Example 2: Example 1: A tumor in the cervix C539 and a tumor in the vulva C519 have different second characters in their ICD-O-3 topography codes, so they are multiple primaries.

---

**M11**

Are there tumors in sites with ICD-O-3 topography codes that are different at the second (Cxxx) and/or third character (Cxx)?

YES

NO

MULTIPLE Primaries**

---

**M12**

Are there tumors in sites with ICD-O-3 topography codes that differ at only the fourth character (Cxxx) and are in any one of the following primary sites:

- Anus and anal canal (C21)
- Bones, joints, and articular cartilage (C40-C41)
- Peripheral nerves and autonomic nervous system (C47)
- Connective subcutaneous and other soft tissues (C49)
- Skin (C44)

YES

NO

MULTIPLE Primaries**
Other Sites Multiple Primary Rules - Flowchart

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

<table>
<thead>
<tr>
<th>MULTIPLE TUMORS, continued</th>
<th>DECISION</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>M13</td>
<td>Is there a <strong>frank</strong> in situ or malignant adenocarcinoma and an in situ or malignant tumor in a polyp?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>M14</td>
<td>Are there multiple in situ and/or malignant polyps?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>M15</td>
<td>Is there an <strong>invasive</strong> tumor following an <strong>in situ</strong> tumor more than 60 days after diagnosis?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Other Sites Multiple Primary Rules - Flowchart

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

**NOTES**

1. Tumors not described as metastases.
2. Includes combinations of in situ and invasive.

**DECISION**

**M16**

Is there cancer/malignant neoplasm, NOS (8000) and another is a specific histology?

YES

NO

Is there carcinoma, NOS (8010) and another is a specific carcinoma?

YES

NO

Is there squamous cell carcinoma, NOS (8070) and another is a specific squamous carcinoma?

YES

NO

Is there adenocarcinoma, NOS (8140) and another is a specific adenocarcinoma?

YES

NO

Is there melanoma, NOS (8720) and another is a specific melanoma?

YES

NO

Is there sarcoma, NOS (8800) and another is a specific sarcoma?

YES

NO

SINGLE

Primary*

NOTES

January 1, 2007
Do the tumors have ICD-O-3 histology codes that are different at the first (xxxx), second (xxx), or third (xxx) number?

- **YES**: MULTIPLE Primaries**

- **NO**: ERROR: Recheck rules. Stop when a match is found.

**iamo**

Does not meet any of the above criteria (M1 through M17).

- **YES**: SINGLE Primary*

- **NO**: End of instructions for Multiple Tumors.

1. Tumors not described as metastases.
2. Includes combinations of in situ and invasive.
Other Sites Histology Coding Rules - Flowchart

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

SINGLE TUMOR: IN SITU ONLY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| H1   | Is the **pathology/cytology** report unavailable? | **YES**  
Code the histology documented by the physician  
1. Priority for using documents to code the histology  
   - Documentation in the medical record that refers to pathologic or cytologic findings  
   - Physician’s reference to type of cancer (histology) in the medical record  
2. Code the specific histology when documented.  
3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented. |
|      | **NO** | |
| H2   | Is only **one histologic type** identified? | **YES**  
Code the histology.  
1. Do not code terms that do not appear in the histology diagnosis.  
   **Example:** Do not code squamous cell carcinoma non-keratinizing unless the words "non-keratinizing" actually appear in the diagnosis. |
|      | **NO** | |

January 1, 2007
Is the final diagnosis adenocarcinoma in a polyp?  

**YES**

Is the final diagnosis adenocarcinoma and a residual polyp or polyp architecture is recorded in other parts of the pathology report?  

**YES**

**Code 8210** (adenocarcinoma in **adenomatous polyp**), **8261** (adenocarcinoma in **villous adenoma**), or **8263** (adenocarcinoma in **tubulovillous adenoma**).  

**NO**

Is there documentation that the patient had a polypectomy?  

**YES**

**NO**

It is important to know that the adenocarcinoma originated in the polyp.

---

**Notes and Examples**

- Is the final diagnosis mucinous/colloid or signet ring cell adenocarcinoma found in a polyp?  
  
- Is there documentation that the patient had a polypectomy?
Other Sites Histology Coding Rules - Flowchart

(Single Tumor: In Situ Only
(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ______ differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.

Yes

No

Yes

No

Yes

No


Code the most specific histologic term.

Is there carcinoma, NOS (8010) and a specific in situ carcinoma?

Is there adenocarcinoma in situ, NOS (8140) and a specific in situ adenocarcinoma?

Is there squamous cell carcinoma in situ, NOS (8070) and a specific in situ squamous cell carcinoma?

Is there melanoma in situ, NOS (8720) and a specific in situ melanoma?
Other Sites Histology Coding Rules - Flowchart

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

SINGLE TUMOR: IN SITU ONLY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H5</td>
<td>Does the tumor have <strong>multiple specific histologies</strong> or is there a non-specific histology with <strong>multiple specific histologies</strong>?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>The specific histology may be identified as type, subtype, predominantly, with features of, major, or with differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.</td>
</tr>
<tr>
<td>H6</td>
<td>Code the <strong>numerically higher</strong> ICD-O-3 code.</td>
<td></td>
</tr>
</tbody>
</table>

This is the end of instructions for Single Tumor: In Situ Carcinoma Only.
Code the histology according to the rule that fits the case.
Other Sites Histology Coding Rules - Flowchart

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

SINGLE TUMOR: INVASIVE AND IN SITU

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H7</td>
<td>Code the single invasive histology. <strong>Ignore the in situ terms.</strong></td>
<td>This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category.</td>
</tr>
</tbody>
</table>

This is the end of instructions for Single Tumor: Invasive and In Situ Carcinoma. Code the histology according to the rule that fits the case.
Other Sites Histology Coding Rules - Flowchart
(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

**SINGLE TUMOR: INVASIVE ONLY**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H8</strong></td>
<td>Is there NO pathology/cytology specimen or is the pathology/cytology report unavailable?</td>
<td></td>
</tr>
<tr>
<td>YES</td>
<td>Code the histology documented by the physician</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>Code the behavior /3.</td>
<td></td>
</tr>
</tbody>
</table>

1. Priority for using documents to code the histology:
   - Documentation in the medical record that refers to pathologic or cytologic findings
   - Physician's reference to type of cancer (histology) in the medical record
   - CT, PET or MRI scans
2. Code the specific histology when documented.
3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

| **H9** | Is the specimen from a metastatic site? (there is no pathology/cytology specimen from the primary site?) |
| YES | Code the histology from a metastatic site. |
| NO | Code the behavior /3. |
SINGLE TUMOR: INVASIVE ONLY

**Rule**

H10

Is the diagnosis acinar (adenocarcinoma) for prostate primaries?

**Yes**

Code 8140 (adenocarcinoma, NOS)

**No**

H11

Is only one histologic type identified?

**Yes**

Code the histology.

**No**

1. Do not code terms that do not appear in the histology description.
   Example: Do not code squamous cell carcinoma non-keratinizing unless the words "non-keratinizing" actually appear in the diagnosis.

2. If this is a papillary carcinoma of the thyroid, go to Rule H14

Next Page
Other Sites Histology Coding Rules - Flowchart
(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

SINGLE TUMOR: INVASIVE ONLY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| H12  | Is the final diagnosis adenocarcinoma in a polyp?  
Yes | YES | Code 8210 (adenocarcinoma in adenomatous polyp), 8261 (adenocarcinoma in villous adenoma), or 8263 (adenocarcinoma in tubulovillous adenoma). |
|     | NO | NO | |
|     | Is the final diagnosis adenocarcinoma and a residual polyp or polyp architecture is recorded in other parts of the pathology report?  
Yes | YES | It is important to know that the adenocarcinoma originated in the polyp. |
|     | NO | NO | |
|     | Is the final diagnosis adenocarcinoma and there is reference to a residual or pre-existing polyp?  
Yes | YES | |
|     | NO | NO | |
|     | Is the final diagnosis mucinous/colloid or signet ring cell adenocarcinoma found in a polyp?  
Yes | YES | |
|     | NO | NO | |
|     | Is there documentation that the patient had a polypectomy?  
Yes | YES | |
|     | NO | NO | |

January 1, 2007
**Other Sites Histology Coding Rules - Flowchart**

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

**SINGLE TUMOR: INVASIVE ONLY**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H13</td>
<td>Is there cancer/malignant neoplasm, NOS (8000) and a more specific histology?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Is there carcinoma, NOS (8010) and a more specific carcinoma?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Is there squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma?</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>Is there adenocarcinoma, NOS (8140) and a more specific adenocarcinoma?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Is there melanoma, NOS (8720) and a more specific melanoma?</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>Is there sarcoma, NOS (8800) and a more specific sarcoma?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NO</td>
</tr>
</tbody>
</table>

Other Sites Histology Coding Rules - Flowchart

January 1, 2007

191
Other Sites Histology Coding Rules - Flowchart

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

**SINGLE TUMOR: INVASIVE ONLY**

<table>
<thead>
<tr>
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<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H14</td>
<td>Is the tumor in the thyroid papillary carcinoma?</td>
<td><strong>YES</strong> Code papillary adenocarcinoma, NOS (8260)</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>H15</td>
<td>Does the tumor in the thyroid have follicular and papillary carcinoma?</td>
<td><strong>YES</strong> Code papillary carcinoma, follicular variant (8340)</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

Next Page

January 1, 2007
Other Sites Histology Coding Rules - Flowchart

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

SINGLE TUMOR: INVASIVE ONLY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H16</td>
<td>Does the tumor have <strong>multiple specific histologies</strong> or is there a non-specific histology with <strong>multiple specific histologies</strong>?</td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td></td>
<td><strong>NO</strong></td>
<td>Code the <strong>numerically higher</strong> ICD-O-3 code.</td>
</tr>
</tbody>
</table>

This is the end of instructions for Single Tumor: Invasive Carcinoma Only. Code the histology according to the rule that fits the case.
**Other Sites Histology Coding Rules -Flowchart**  
(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

### MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
</table>
| **H18** | Is there **no** *pathology/cytology* specimen or is the *pathology/cytology* report unavailable? | **YES** | Code the histology documented by the physician.  
1. Priority for using documents to code the histology  
   - Documentation in the medical record that refers to pathologic or cytologic findings  
   - Physicians reference to type of cancer (histology) in the medical record  
   - CT, PET or MRI scans  
2. Code the specific histology when documented.  
3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented. |
| **H19** | Is the specimen from a metastatic site? (there is no *pathology/cytology* specimen from the primary site?) | **YES** | Code the histology from a metastatic site.  
Code the behavior /3. |
| **H20** | Is the diagnosis acinar (adenocarcinoma for prostate primaries)? | **YES** | Code 8140 (adenocarcinoma, NOS) |

---

*January 1, 2007*
Is the diagnosis in situ squamous intraepithelial neoplasia grade III of the vulva (VIN III), vagina (VAIN III), or anus (AIN III)?

**NO**

**YES**

Code 8077/2 (squamous intraepithelial neoplasia, grade III).

1. 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).

2. This code may be used for reportable by agreement cases.

Is the diagnosis in situ glandular intraepithelial neoplasia grade III of the pancreas (PAIN III)?

**NO**

**YES**

Code 8148/2 (glandular intraepithelial neoplasia grade III).

1. This code may be used for reportable by agreement cases such as intraepithelial neoplasia of the prostate (PIN III).
### Other Sites Histology Coding Rules - Flowchart

*(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)*

#### MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is only <strong>one histologic type</strong> identified?</td>
<td>Code the histology</td>
<td>Do not code terms that do not appear in the histology description. <strong>Example:</strong> Do not code squamous cell carcinoma non-keratinizing unless the words &quot;non-keratinizing&quot; actually appear in the diagnosis.</td>
</tr>
<tr>
<td>NO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| H24  |        |                    |
| Is there **extramammary Paget disease** and an underlying tumor of the **anus**, **perianal** region, or **vulva**? | Code the histology of the underlying tumor | |
| YES  |        |                    |
| NO   |        |                    |
Other Sites Histology Coding Rules - Flowchart
(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H25</td>
<td>Is the final diagnosis adenocarcinoma in a polyp?</td>
<td>It is important to know that the adenocarcinoma originated in the polyp.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is the final diagnosis adenocarcinoma and a residual polyp or polyp architecture is recorded in other parts of the pathology report?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>Code 8210 (adenocarcinoma in adenomatous polyp), 8261 (adenocarcinoma in villous adenoma), or 8263 (adenocarcinoma in tubulovillous adenoma).</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is the final diagnosis adenocarcinoma and there is reference to a residual or pre-existing polyp?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>Code 8210 (adenocarcinoma in adenomatous polyp), 8261 (adenocarcinoma in villous adenoma), or 8263 (adenocarcinoma in tubulovillous adenoma).</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is the final diagnosis mucinous/colloid or signet ring cell adenocarcinoma found in a polyp?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is there documentation that the patient had a polypectomy?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td></td>
</tr>
</tbody>
</table>

Other Sites Histology Coding Rules - Flowchart
(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)
Other Sites Histo

**Other Sites Histology Coding Rules - Flowchart**

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

**MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H26</td>
<td>Code papillary adenocarcinoma, NOS (8260)</td>
<td></td>
</tr>
<tr>
<td><strong>YES</strong></td>
<td>Are the tumors in the thyroid papillary carcinomas?</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>Code papillary carcinoma, follicular variant (8340)</td>
<td></td>
</tr>
<tr>
<td><strong>YES</strong></td>
<td>Do the tumors in the thyroid have follicular and papillary carcinoma?</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>Code the single invasive histology. <strong>Ignore the in situ terms.</strong></td>
<td>This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category.</td>
</tr>
</tbody>
</table>
**Other Sites Histology Coding Rules - Flowchart**

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

**MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Action</th>
<th>Notes and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>H29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there cancer/malignant neoplasm, NOS (8000) and a more specific histology?</td>
<td>YES</td>
<td>Code the most specific histologic term. The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ______ differentiation. The terms architecture and pattern are subtypes only for in situ cancer. Example 1: Adenocarcinoma, predominantly mucinous. Code mucinous adenocarcinoma 8480. Example 2: Non-small cell carcinoma, papillary squamous cell. Code papillary squamous cell carcinoma 8052.</td>
</tr>
<tr>
<td>Is there carcinoma, NOS (8010) and a more specific carcinoma?</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Is there squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Is there adenocarcinoma, NOS (8140) and a more specific adenocarcinoma?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Is there melanoma, NOS (8720) and a more specific melanoma?</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Is there sarcoma, NOS (8800) and a more specific sarcoma?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Next Page
**MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY**

<table>
<thead>
<tr>
<th><strong>Rule</strong></th>
<th><strong>Action</strong></th>
<th><strong>Notes and Examples</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H30</strong></td>
<td><strong>Code the histology with the numerically higher ICD-O-3 code.</strong></td>
<td>The specific histologies may be identified as a type, subtype, predominantly, with features of, major, or with differentiation.</td>
</tr>
<tr>
<td><strong>Does the tumor have multiple specific histologies or is there a non-specific histology with multiple specific histologies?</strong></td>
<td><strong>YES</strong></td>
<td><strong>Example 1</strong> (multiple specific histologies): Gyn malignancy with mucinous, serous and papillary adenocarcinoma. Code 8323 (mixed cell adenocarcinoma)</td>
</tr>
<tr>
<td></td>
<td><strong>NO</strong></td>
<td><strong>Example 2</strong> (multiple specific histologies): Combined small cell and squamous cell carcinoma. Code 8045 (combined small cell carcinoma)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Example 3</strong> (non-specific with multiple specific histologies): Adenocarcinoma with papillary and clear cell features. Code 8255 (adenocarcinoma with mixed subtypes)</td>
</tr>
</tbody>
</table>

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary. Code the histology according to the rule that fits the case.
VII.
Matrix Format – Multiple Primary and Histology Coding Rules
Head and Neck Multiple Primary Rules – Matrix
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1</td>
<td></td>
<td>Tumor(s) not described as metastasis</td>
<td></td>
<td></td>
<td>Use this rule only after all information sources have been exhausted.</td>
<td>Single*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Example 1: History and physical exam states large tumor in nasopharynx. Biopsy base of tongue shows squamous cell carcinoma. No further information available. Abstract as a single primary.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Example 2: Pathology report states extensive squamous cell carcinoma involving nasopharynx and larynx. Fragments of epiglottis positive for squamous cell carcinoma. No other information available. Abstract as a single primary.</td>
<td></td>
</tr>
</tbody>
</table>

**SINGLE TUMOR**

1. Tumor not described as metastasis
2. Includes combinations of in situ and invasive

| M2   | Single |                        |        |          | The tumor may overlap onto or extend into adjacent/contiguous site or subsite. | Single*  |

**MULTIPLE TUMORS**

Multiple tumors may be a single primary or multiple primaries

1. Tumors not described as metastases
2. Includes combinations of in situ and invasive

| M3   | Right side and left side of a paired site |        |          | See Table 1 for list of paired sites | Multiple** |
| M4   | Upper lip (C000 or C003) and lower lip (C001 or C004) |        |          |                                    | Multiple** |
| M5   | Upper gum (C030) and lower gum (C031)     |        |          |                                    | Multiple** |
Head and Neck Multiple Primary Rules – Matrix  
C000-C148, C300-C329  
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>M6</td>
<td>Nasal cavity (C300) and middle ear (C301)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M7</td>
<td>Topography codes that are different at the second (C_xxx) and/or third (C_xx) character</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
</tbody>
</table>
| M8   | | More than 60 days after diagnosis | An invasive following an in situ | | 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.  
2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease. | Multiple** |
| M9   | | Diagnosed more than five (5) years apart | | | | Multiple** |
### Head and Neck Multiple Primary Rules – Matrix
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
</table>
| M10  |      | - Cancer/malignant neoplasm, NOS (8000) and another is a specific histology; or  
     |      | - Carcinoma, NOS (8010) and another is a specific carcinoma; or  
     |      | - Adenocarcinoma, NOS (8140) and another is a specific adenocarcinoma; or  
     |      | - Squamous cell carcinoma, NOS (8070) and another is specific squamous cell carcinoma or  
     |      | - Melanoma and another is a specific melanoma; or  
     |      | - Sarcoma, NOS (8800) and another is a specific sarcoma |        |        | Single* |         |
| M11  |      | Different at the first (xxxx), second (xxx), or third (xxx) number |        |          |                | Multiple** |

*Single*  
*Multiple**
Head and Neck Multiple Primary Rules – Matrix  
C000-C148, C300-C329  
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
</table>
| M12  | Does not meet any of the above criteria |          |        |          | 1. When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.  
2. All cases covered by rule M12 have the same first 3 numbers in ICD-O-3 histologic code.  
**Rule M12 Examples:** The following are examples of cases that use Rule M12. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. **Warning:** **Using only these case examples to determine the number of primaries can result in major errors**  
**Example 1:** Multifocal tumors in floor of mouth  
**Example 2:** An in situ and invasive tumor diagnosed within 60 days  
**Example 3:** In situ following an invasive tumor more than 60 days apart | Single* |
# Head and Neck Histology Coding Rules - Matrix

C000-C148, C300-C329

(Excludes lymphoma and leukemia - M-9590 - 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
</table>
| **H1** | No pathology/cytology specimen or the pathology/cytology report is not available | | | 1: Priority for using documents to code the histology  
   • Documentation in the medical record that refers to pathologic or cytologic findings  
   • Physician’s reference to type of cancer (histology) in the medical record  
   • CT, PET or MRI scans  
2: Code the specific histology when documented.  
3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented | The histology documented by the physician |
| **H2** | None from primary site | | Code the behavior /3 | The histology from metastatic site |
| **H3** | One type | | Example: Squamous cell carcinoma. Code 8070.  
Do not code terms that do not appear in the histology description.  
Example: Do not code 8072 (squamous cell carcinoma non-keratinizing) unless the words “non-keratinizing” actually appear in the diagnosis | The histology |
| **H4** | | Invasive and in situ | Example: The final diagnosis is keratinizing squamous cell carcinoma (8071) with areas of squamous cell carcinoma in situ (8070). Code the invasive histologic type, keratinizing squamous cell carcinoma (8071). | The invasive histologic type |
**Head and Neck Histology Coding Rules – Matrix**

C000-C148, C300-C329

(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
</table>
| **H5** | Multiple histologies all within the same branch on Chart 1. Examples of histologies within same branch:  
- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or  
- Carcinoma, NOS (8010) and a more specific carcinoma or  
- Squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma or  
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or  
- Melanoma, NOS (8720) and a more specific melanoma or  
- Sarcoma, NOS (8800) and a more specific sarcoma | | I. The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ___ differentiation.  
2. The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with ___ differentiation.  
Example: The final diagnosis is squamous cell carcinoma (8070), papillary (8050). Code the specific type, papillary (8050). | | The most specific term using Chart 1 |
| **H6** | None of the above conditions are met | | | | The histology with the numerically higher ICD-O-3 code |

January 1, 2007
## Head and Neck Histology Coding Rules – Matrix

C000-C148, C300-C329

(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
</table>
| H7   | No pathology/cytology specimen or the pathology/cytology report is not available |          |          | **I:** Priority for using documents to code the histology  
- Documentation in the medical record that refers to pathologic or cytologic findings  
- Physician’s reference to type of cancer (histology) in the medical record  
- CT, PET or MRI scans  
**2:** Code the specific histology when documented  
**3:** Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented |  
The histology documented by the physician | |
| H8   | None from primary site      |          |          | Code the behavior /3 | The histology from a metastatic site | |
| H9   | One type                   |          |          | **Example:** Squamous cell carcinoma. Code 8070.  
Do not code terms that do not appear in the histology description.  
**Example:** Do not code 8072 (squamous cell carcinoma non-keratinizing) unless the words “non-keratinizing” actually appear in the diagnosis |  
The histology | |
| H10  | One tumor is in situ and one is invasive, code the histology from the invasive tumor  
Both/all histologies are invasive, code the histology of the more invasive tumor  
If tumors are equally invasive, go to the next rule |          |          | **I:** See the Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations for the definition of most invasive.  
- One tumor is in situ and one is invasive, code the histology from the invasive tumor  
- Both/all histologies are invasive, code the histology of the more invasive tumor  
**2:** If tumors are equally invasive, go to the next rule |  
The histology of the most invasive tumor | |
## Head and Neck Histology Coding Rules – Matrix

**C000-C148, C300-C329**  
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
</table>
| H11   | Multiple histologies all within the same branch on Chart 1. Examples of histologies within same branch:  
- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or  
- Carcinoma, NOS (8010) and a more specific carcinoma or  
- Squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma or  
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or  
- Melanoma, NOS (8720) and a more specific melanoma or  
- Sarcoma, NOS (8800) and a more specific sarcoma | | 1. The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____ differentiation.  
2. The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with ____ differentiation. Example: The final diagnosis is squamous cell carcinoma (8070), papillary (8050). Code the specific type, papillary (8050). | The most specific term using Chart 1 |
| H12   | None of the conditions are met | | | The histology with the numerically higher ICD-O-3 code |
Colon Multiple Primary Rules – Matrix
C180-C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UNKNOWN IF SINGLE OR MULTIPLE TUMORS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tumor(s) not described as metastasis</td>
<td>Single*</td>
</tr>
<tr>
<td><strong>M1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Use this rule only after all information sources have been exhausted.</td>
<td>Single*</td>
</tr>
<tr>
<td><strong>SINGLE TUMOR</strong></td>
<td>Single</td>
<td></td>
<td></td>
<td></td>
<td>Tumor not described as metastasis</td>
<td>Single*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1. Includes combinations of in situ and invasive</td>
<td>Single*</td>
</tr>
<tr>
<td><strong>M2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tumor may overlap onto or extend into adjacent/contiguous site or subsite</td>
<td>Single*</td>
</tr>
<tr>
<td><strong>MULTIPLE TUMORS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tumors not described as metastases</td>
<td>Multiple**</td>
</tr>
<tr>
<td>Multiple tumors may be a single primary or multiple primaries</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1. Includes combinations of in situ and invasive</td>
<td>Multiple**</td>
</tr>
<tr>
<td><strong>M3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Adenocarcinoma in adenomatous polyposis (familial polyposis) with one or more malignant polyps</td>
<td>Single*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tumors may be present in multiple segments of the colon or in a single segment of the colon.</td>
<td>Single*</td>
</tr>
<tr>
<td><strong>M4</strong></td>
<td>Sites with topography codes that are different at the second (Cxx), third (Cxxx) or fourth (C18x) character</td>
<td></td>
<td></td>
<td></td>
<td>Diagnosed more than one (1) year apart</td>
<td>Multiple**</td>
</tr>
<tr>
<td><strong>M5</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td><strong>M6</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>More than 60 days after diagnosis</td>
<td>Multiple**</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>An invasive tumor following an in situ tumor</td>
<td>Multiple**</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.</td>
<td>Multiple**</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.</td>
<td>Multiple**</td>
</tr>
</tbody>
</table>
## Colon Multiple Primary Rules – Matrix

**C180-C189**

(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>M7</td>
<td></td>
<td>A frank in situ or malignant adenocarcinoma and an in situ or malignant tumor in a polyp</td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
<tr>
<td>M8</td>
<td></td>
<td>• Cancer/malignant neoplasm, NOS (8000) and a specific histology; OR • Carcinoma, NOS (8010) and a specific carcinoma; OR • Adenocarcinoma, NOS (8140) and a specific adenocarcinoma; OR • Sarcoma, NOS (8800) and a specific sarcoma</td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
<tr>
<td>M9</td>
<td></td>
<td>Multiple in situ and/or malignant polyps</td>
<td></td>
<td></td>
<td>Includes all combinations of adenomatous, tubular, villous, and tubulovillous adenomas or polyps.</td>
<td>Single*</td>
</tr>
<tr>
<td>M10</td>
<td></td>
<td>Histology codes are different at the first (xxxx), second (xgx), or third (xgx) number</td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M11</td>
<td></td>
<td>Does not meet any of the above criteria</td>
<td></td>
<td></td>
<td>1: When an invasive lesion follows an in situ within 60 days, abstract as a single primary. 2: All cases covered by Rule M11 are in the same segment of the colon</td>
<td>Single*</td>
</tr>
</tbody>
</table>
## Colon Histology Coding Rules – Matrix
### C180 – C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SINGLE TUMOR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| H1 | No pathology/cytology specimen or the pathology/cytology report is not available | | | 1: Priority for using documents to code the histology  
   • Documentation in the medical record that refers to pathologic or cytologic findings  
   • Physician’s reference to type of cancer (histology) in the medical record  
   • CT, PET or MRI scans  
   2: Code the specific histology when documented.  
   3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented | The histology documented by the physician |
| H2 | None from primary site | | | Code the behavior | The histology from metastatic site |
Colon Histology Coding Rules - Matrix
C180 - C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
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</tr>
</thead>
<tbody>
<tr>
<td>H3</td>
<td></td>
<td>Intestinal type adenocarcinoma or adenocarcinoma, intestinal type</td>
<td></td>
<td>1: Intestinal type adenocarcinoma usually occurs in the stomach. 2: When a diagnosis of intestinal adenocarcinoma is further described by a specific term such as type, continue to the next rule.</td>
<td>8140 (Adenocarcinoma, NOS)</td>
</tr>
<tr>
<td>H4</td>
<td></td>
<td>Final diagnosis:  Adenocarcinoma in a polyp or Adenocarcinoma and a residual polyp or polyp architecture is recorded in other parts of the pathology report or Adenocarcinoma and there is reference to a residual or pre-existing polyp within the medical record or Mucinous/colloid or signet ring cell adenocarcinoma in a polyp or There is documentation that the patient had a polypectomy</td>
<td></td>
<td>1: It is important to know that the adenocarcinoma originated in a polyp. 2: Code adenocarcinoma in a polyp only when the malignancy is in the residual polyp (adenoma) or references to a pre-existing polyp (adenoma) indicate that the malignancy and the polyp (adenoma) are the same lesion.</td>
<td>8210 (Adenocarcinoma arising in polyp), or 8261 (Adenocarcinoma in a villous adenoma), or 8263 (Adenocarcinoma in a tubulovillous adenoma)</td>
</tr>
<tr>
<td>H5</td>
<td></td>
<td>Final diagnosis is: Mucinous/colloid (8480) or signet ring cell carcinoma (8490) or Adenocarcinoma, NOS and microscopic description documents 50% or more of the tumor is mucinous/colloid or Adenocarcinoma, NOS and microscopic description documents 50% or more of the tumor is signet ring cell carcinoma</td>
<td></td>
<td>8480 (Mucinous/colloid adenocarcinoma) or 8490 (Signet ring cell carcinoma)</td>
<td></td>
</tr>
</tbody>
</table>

Revised November 1, 2007
## Colon Histology Coding Rules – Matrix
### C180 – C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

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<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H6</td>
<td></td>
<td>Final diagnosis is adenocarcinoma and:</td>
<td></td>
<td></td>
<td>8140 (Adenocarcinoma, NOS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Microscopic description states less than 50% of the tumor is mucinous/colloid, or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Microscopic description states less than 50% of the tumor is signet ring cell carcinoma, or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Percentage of Mucinous/colloid or signet ring cell carcinoma is unknown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H7</td>
<td></td>
<td>Combination of mucinous/colloid and signet ring cell carcinoma</td>
<td></td>
<td></td>
<td>8255 (Adenocarcinoma with mixed subtypes)</td>
</tr>
<tr>
<td>H8</td>
<td></td>
<td>Neuroendocrine carcinoma (8246) and carcinoid tumor (8240)</td>
<td></td>
<td></td>
<td>8240 (Carcinoid tumor, NOS)</td>
</tr>
<tr>
<td>H9</td>
<td></td>
<td>Adenocarcinoma and carcinoid tumor</td>
<td></td>
<td></td>
<td>8244 (Composite carcinoid)</td>
</tr>
<tr>
<td>H10</td>
<td></td>
<td>Exactly “adenocarcinoid”</td>
<td></td>
<td></td>
<td>8245 (Adenocarcinoid)</td>
</tr>
<tr>
<td>H11</td>
<td></td>
<td>One type</td>
<td></td>
<td></td>
<td>The histology</td>
</tr>
<tr>
<td>H12</td>
<td></td>
<td></td>
<td>Invasive and in situ</td>
<td>The invasive histologic type</td>
<td></td>
</tr>
</tbody>
</table>
## Colon Histology Coding Rules – Matrix

### C180 – C189

(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

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<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
</table>
| H13  |                             | • Cancer/malignant neoplasm, NOS (8000) and a more specific histology or  
|      |                             | • Carcinoma, NOS (8010) and a more specific carcinoma or  
|      |                             | • Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or  
|      |                             | • Sarcoma, NOS (8800) and a more specific sarcoma (invasive only) | 1. The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with _____ differentiation.  
|      |                             |           |          | 2. The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with _____ differentiation. |      |
|      |                             | None of the above conditions are met |          | The histology with the numerically higher ICD-O-3 code |
Colon Histology Coding Rules – Matrix
C180 – C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

<table>
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<tr>
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<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY</strong>&lt;br&gt;These rules only apply to multiple tumors that are reported as a single primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| H15 | No pathology/cytology specimen or the pathology/cytology report is not available | | 1: Priority for using documents to code the histology  
- Documentation in the medical record that refers to pathologic or cytologic findings  
- Physician’s reference to type of cancer (histology) in the medical record  
- CT, PET or MRI scans  
2: Code the specific histology when documented  
3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented | The histology documented by the physician | |
| H16 | None from primary site | | Code the behavior | The histology from a metastatic site | |

Colon Histo

January 1, 2007 217
# Colon Histology Coding Rules - Matrix

**C180 - C189**

(Excludes lymphoma and leukemia M9590 - 9989 and Kaposi sarcoma M9140)

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<tr>
<th>Rule</th>
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<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
</table>
| H17  |                              | • Clinical history says familial polyposis and final diagnosis on pathology report from resection is adenocarcinoma in adenomatous polyps, or  
<100 polyps in resected specimen or  
Number of polyps is not given but the diagnosis is familial polyposis |          | Use this rule only when there are multiple polyps or adenomas. Do not use this rule if there is a frank adenocarcinoma and a malignancy in a single polyp or adenoma. | 8220 (Adenocarcinoma in adenomatous polyposis coli) |
| H18  | Multiple in situ or malignant polyps are present, at least one of which is tubulovillous |          | Use this rule only when there are multiple polyps or adenomas. Do not use this rule if there is a frank adenocarcinoma and a malignancy in a single polyp or adenoma. | 8263 (Adenocarcinoma in a tubulovillous adenoma) |
| H19  | • >1 and <= 100 polyps identified in resected specimen, or  
• Multiple polyps (adenomas) and the number is not given and familial polyposis is not mentioned |          | Use this rule only when there are multiple polyps. Do not use for a single polyp (adenoma) or for a frank malignancy and a malignancy in a single polyp (adenoma). | 8221 (adenocarcinoma in multiple adenomatous polyps) |

Revised November 1, 2007
### Colon Histology Coding Rules - Matrix

**C180 - C189**

(Excludes lymphoma and leukemia M9590 - 9989 and Kaposi sarcoma M9140)

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<tr>
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<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
</table>
| H20  |                             | Frank adenocarcinoma and a carcinoma in a polyp, or  
|      |                             | In situ and invasive tumors or  
|      |                             | Multiple invasive tumors | 1: See the Colon Equivalent Terms, Definitions and Illustrations for the definition of most invasive,  
|      |                             |                       | • One tumor is in situ and one is invasive, code the histology from the invasive tumor.  
|      |                             |                       | • Both/all histologies are invasive, code the histology of the most invasive tumor.  
|      |                             |                       | 2: If tumors are equally invasive, go to the next rule  
|      |                             |                       | The histology of the most invasive tumor |
| H21  |                             | Final diagnosis:  
|      |                             | • Adenocarcinoma and the microscopic description or surgical gross describes polyps or  
|      |                             | • Adenocarcinoma and there is reference to residual or pre-existing polyps or  
|      |                             | • Mucinous/colloid or signet ring cell adenocarcinoma in polyps or  
|      |                             | There is documentation that the patient had a polypectomy | It is important to know that the adenocarcinoma originated in a polyp. | 8210 (Adenocarcinoma arising in polyp), or 8261 (Adenocarcinoma in a villous adenoma), or 8263 (Adenocarcinoma in a tubulovillous adenocarcinoma) |
| H22  |                             | One type | | | The histology |
### Colon Histology Coding Rules - Matrix

**C180 - C189**

(Excludes lymphoma and leukemia M9590 - 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H23</td>
<td></td>
<td>• Cancer/malignant neoplasm, NOS (8000) and a specific histology or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Carcinoma, NOS (8010) and a specific carcinoma or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Adenocarcinoma, NOS (8140) and a specific adenocarcinoma or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sarcoma, NOS (8800) and a specific sarcoma (invasive only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H24</td>
<td>None of the above conditions are met</td>
<td></td>
<td></td>
<td>The histology with the numerically higher ICD-O-3 code</td>
<td></td>
</tr>
</tbody>
</table>

1: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____ differentiation

2: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____ differentiation.

Revised November 1, 2007
**Lung Multiple Primary Rules – Matrix**  
C340-C349  
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.  
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UNKNOWN IF SINGLE OR MULTIPLE TUMORS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tumor(s) not described as metastasis</td>
<td></td>
</tr>
</tbody>
</table>
| M1 | | | | | 1: Use this rule only after all information sources have been exhausted.  
2: Use this rule when only one tumor is biopsied but the patient has two or more tumors in one lung and may have one or more tumors in the contralateral lung. (See detailed explanation in Lung Equivalent Terms and Definitions) | Single* |
<p>| <strong>SINGLE TUMOR</strong> | | | | | Tumor not described as metastasis | |
| M2 | Single | | | | The tumor may overlap onto or extend into adjacent/contiguous site or subsite. | Single* |
| <strong>MULTIPLE TUMORS</strong> | | | | | Tumors not described as metastases | |
| M3 | Sites with topography codes that are different at the second (Cxx) and/or third (Cxxx) character | | | | This is a change in rules; tumors in the trachea (C33) and in the lung (C34) were a single primary in the previous rules. | Multiple** |
| M4 | Non-small cell carcinoma (8046) and another tumor that is small cell carcinoma (8041-8045) | | | | | Multiple** |
| M5 | Adenocarcinoma with mixed subtypes (8255) and another that is bronchioloalveolar (8250-8254) | | | | | Multiple** |
| M6 | Single tumor in each lung | | | | When there is a single tumor in each lung abstract as multiple primaries unless stated or proven to be metastatic. | Multiple** |</p>
<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>M7</td>
<td>Multiple tumors in both lungs</td>
<td>Histology codes are different at the first (xxx), second (xx), or third (xxx) number</td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M8</td>
<td></td>
<td></td>
<td>Diagnosed more than three (3) years apart</td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M9</td>
<td></td>
<td></td>
<td>More than 60 days after diagnosis</td>
<td>An invasive tumor following an in situ tumor</td>
<td>1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed. 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.</td>
<td>Multiple**</td>
</tr>
<tr>
<td>M10</td>
<td>Non-small cell carcinoma, NOS (8046) and a more specific non-small cell carcinoma type (Chart 1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Single *</td>
</tr>
<tr>
<td>M11</td>
<td>Histology codes are different at the first (xxx), second (xx), or third (xxx) number</td>
<td></td>
<td></td>
<td></td>
<td>A adenocarcinoma in one tumor and squamous cell carcinoma in another tumor are multiple primaries.</td>
<td>Multiple**</td>
</tr>
</tbody>
</table>
### Lung Multiple Primary Rules – Matrix

C340-C349
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
</table>
| M12  |      | Does not meet any of the above criteria |        |          | 1: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.  
2: All cases covered by this rule are the same histology  
**Rule M12 Examples**  
The following are examples of the types of cases that use Rule M12. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. **Warning:** Using only these case examples to determine the number of primaries can result in major errors.  
**Example 1:** Solitary tumor in one lung, multiple tumors in contralateral lung  
**Example 2:** Diffuse bilateral nodules (This is the only condition when laterality = 4)  
**Example 3:** An in situ and invasive tumor diagnosed within 60 days  
**Example 4:** Multiple tumors in the left lung metastatic from right lung  
**Example 5:** Multiple tumors in one lung  
**Example 6:** Multiple tumors in both lungs. | Single* |
Lung Histology Coding Rules – Matrix
C340-C349
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

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<tr>
<th>Rule</th>
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<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SINGLE TUMOR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| H1 | No pathology/cytology specimen or the pathology/cytology report is not available | | | 1: Priority for using documents to code the histology  
• Documentation in the medical record that refers to pathologic or cytologic findings  
• Physician’s reference to type of cancer (histology) in the medical record  
• CT, PET, or MRI scans  
• Chest x-rays  
2: Code the specific histology when documented.  
3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented | The histology documented by the physician |
| H2 | None from primary site | | | Code the behavior /3 | The histology from metastatic site |
| H3 | One type | | | Do not code terms that do not appear in the histology description  
**Example 1:** Do not code squamous cell carcinoma non-keratinizing unless the words “non-keratinizing” actually appear in the diagnosis  
**Example 2:** Do not code bronchioloalveolar non-mucinous unless the words “non-mucinous” actually appear in the diagnosis | The histology |
| H4 | Invasive and in situ | | | The invasive histologic type | |
# Lung Histology Coding Rules – Matrix

**C340-C349**

(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

## Rule Pathology/Cytology Specimen

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<th>Code</th>
</tr>
</thead>
</table>
| H5   |                             | Multiple histologies all within the same branch on Chart 1. Examples of histologies within same branch:  - Carcinoma, NOS (8010) and a more specific carcinoma or  - Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or  - Squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma or  - Sarcoma, NOS (8800) and a more specific sarcoma. | The specific histology may be identified as type, subtype, predominantly, with features of, major, or with differentiation. The specific histology may also be identified as follows: adenocarcinoma, clear cell or clear cell adenocarcinoma.  
**Example 1:** Adenocarcinoma, predominantly mucinous. Code 8480 (mucinous adenocarcinoma).  
**Example 2:** Non-small cell carcinoma, papillary squamous cell. Code 8052 (papillary squamous cell carcinoma). | The most specific term using Chart 1 |
| H6   |                             | Multiple specific or a non-specific with multiple specific (Table 1) | The specific histologies may be identified as type, subtype, predominantly, with features of, major, or with differentiation  
**Example 1 (multiple specific histologies):** Solid and papillary adenocarcinoma. Code 8255 (adenocarcinoma with mixed subtypes).  
**Example 2 (multiple specific histologies):** Combined small cell and squamous cell carcinoma. Code 8045 (combined small cell carcinoma).  
**Example 3 (non-specific with multiple specific histologies):** Adenocarcinoma with papillary and clear cell features. Code 8255 (adenocarcinoma with mixed subtypes). | The appropriate combination/mixed code (Table 1) |
Lung Histology Coding Rules – Matrix  
C340-C349  
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

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<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H7</td>
<td>None of the above conditions are met</td>
<td></td>
<td></td>
<td>The histology with the numerically higher ICD-O-3 code</td>
<td></td>
</tr>
</tbody>
</table>
| H8   | No pathology/cytology specimen or the pathology/cytology report is not available | | | 1: Priority for using documents to code the histology  
• Documentation in the medical record that refers to pathologic or cytologic findings  
• Physician’s reference to type of cancer (histology) in the medical record  
• CT, PET, or MRI scans  
• Chest x-rays  
2: Code the specific histology when documented  
3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented | The histology documented by the physician |
| H9   | None from primary site | | | Code the behavior /3 | The histology from a metastatic site |
| H10  | One type | | | Do not code terms that do not appear in the histology description  

**Example 1:** Do not code squamous cell carcinoma non-keratinizing unless the words “non-keratinizing” actually appear in the diagnosis.  

**Example 2:** Do not code bronchioloalveolar non-mucinous unless the words “non-mucinous” actually appear in the diagnosis. | The histology |
# Lung Histology Coding Rules – Matrix

**C340-C349**

(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

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<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H11</td>
<td></td>
<td></td>
<td></td>
<td>1: This rule should only be used when the first three digits of the histology codes are identical (This is a single primary). 2: See the Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations for the definition of most invasive. • One tumor is in situ and one is invasive, code the histology from the invasive tumor • Both/all histologies are invasive, code the histology of the most invasive tumor.</td>
<td>The histology of the most invasive tumor</td>
</tr>
<tr>
<td>H12</td>
<td>Multiple histologies all within the same branch on Chart 1. Examples of histologies within same branch: • Carcinoma, NOS (8010) and a more specific carcinoma or • Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or • Squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma or • Sarcoma, NOS (8800) and a more specific sarcoma.</td>
<td>The specific histology may be identified as type, subtype, predominantly, with features of, major, or with __differentiation. The specific histology may also be identified as follows: adenocarcinoma, clear cell or clear cell adenocarcinoma.  <strong>Example 1:</strong> Adenocarcinoma, predominantly mucinous. Code 8480 (mucinous adenocarcinoma).  <strong>Example 2:</strong> Non-small cell carcinoma, papillary squamous cell. Code 8052 (papillary squamous cell carcinoma).</td>
<td>The most specific term using Chart 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H13</td>
<td>None of the above conditions are met</td>
<td>The histology with the numerically higher ICD-O-3 code</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This page left blank
**Cutaneous Melanoma Multiple Primary Rules – Matrix**

*C440 – C449*

*(Excludes melanoma of any other site)*

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UNKNOWN IF SINGLE OR MULTIPLE MELANOMAS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Melanoma(s) not described as metastasis</td>
<td></td>
</tr>
<tr>
<td>M1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Use this rule only after all information sources have been exhausted.</td>
<td>Single*</td>
</tr>
<tr>
<td><strong>SINGLE MELANOMA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1: Melanoma not described as metastasis 2: Includes combinations of in situ and invasive</td>
<td>Single*</td>
</tr>
<tr>
<td>M2</td>
<td>Single</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MULTIPLE MELANOMAS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1: Melanoma not described as metastases 2: Includes combinations of in situ and invasive</td>
<td>Multiple**</td>
</tr>
<tr>
<td>M3</td>
<td>Topography codes are different at the second (C_xx), third (C_x_x) or fourth (C_x_x_x) character</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M4</td>
<td>Different laterality</td>
<td></td>
<td></td>
<td></td>
<td>A midline melanoma is a different laterality than right or left. <em>Example 1:</em> A melanoma on the right side of the chest and a melanoma at midline on the chest are different laterality, multiple primaries. <em>Example 2:</em> A melanoma on the right side of the chest and a melanoma on the left side of the chest are multiple primaries.</td>
<td>Multiple**</td>
</tr>
<tr>
<td>M5</td>
<td>Histology codes are different at the first (x_xxx), second (x_x_xx), or third (x_xx_x) number</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
</tbody>
</table>

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

---

January 1, 2007
# Cutaneous Melanoma Multiple Primary Rules – Matrix

**C440 – C449**

(Excludes melanoma of any other site)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M6</strong></td>
<td></td>
<td></td>
<td>More than 60 days after diagnosis</td>
<td>An invasive melanoma following an in situ melanoma</td>
<td>1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed. 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.</td>
<td>Multiple**</td>
</tr>
<tr>
<td><strong>M7</strong></td>
<td></td>
<td></td>
<td>Diagnosed more than 60 days apart</td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td><strong>M8</strong></td>
<td>Does not meet any of the above criteria</td>
<td></td>
<td></td>
<td></td>
<td>1: Use the data item “Multiplicity Counter” to record the number of melanomas abstracted as a single primary. 2: When an invasive melanoma follows an in situ melanoma within 60 days, abstract as a single primary. 3: All cases covered by this rule are the same site and histology. <strong>Rule M8 Examples</strong> The following are examples of the types of cases that use Rule M8. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. <strong>Warning</strong>: Using only these case examples to determine the number of primaries can result in major errors. <strong>Example 1</strong>: Solitary melanoma on the left back and another solitary melanoma on the left chest <strong>Example 2</strong>: Solitary melanoma on the right thigh and another solitary melanoma on the right ankle</td>
<td>Single*</td>
</tr>
</tbody>
</table>
### Cutaneous Melanoma Histology Coding Rules – Matrix

**C440-C449**

(Excludes melanoma of all other sites)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Melanoma Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
</table>
| H1   | No pathology/cytology specimen or the pathology/cytology report is not available | Invasive and in situ | 1: Priority for using documents to code the histology  
   • Documentation in the medical record that refers to pathologic or cytologic findings  
   • Physician's reference to type of melanoma in the medical record  
   • PET scan  
   2: Code the specific histology when documented. | The histology documented by the physician | |
| H2   | None from primary site | Code the behavior | 3 | The histology from metastatic site | |
| H3   | One type | | | The histology | |
| H4   | Invasive and in situ | | | The invasive histologic type | |
| H5   | Regressing melanoma and a histologic type | Example: Nodular melanoma with features of regression. Code 8721 (Nodular melanoma). | | The histologic type | |
| H6   | Regressing melanoma | Example: Malignant melanoma with features of regression. Code 8723. | | 8723 (Malignant melanoma, regressing) | |
| H7   | Lentigo maligna melanoma and a histologic type | | | The histologic type | |
| H8   | Lentigo maligna melanoma | | | 8742 (Lentigo maligna melanoma) | |
| H9   | Melanoma, NOS (8720) with a single specific type | | 1. The specific type for in situ lesions may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ___ differentiation.  
   2. The specific type for invasive lesions may be identified as type, subtype, predominantly, with features of, major, or with ___ differentiation. | The most specific histologic term | |

**Melanoma Histo**
<table>
<thead>
<tr>
<th>Rule</th>
<th>Melanoma Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H10</td>
<td>None of the above conditions are met</td>
<td></td>
<td></td>
<td></td>
<td>The histology with the numerically higher ICD-O-3 code</td>
</tr>
</tbody>
</table>
**Breast Multiple Primary Rules – Matrix**  
* C500 – C509  
* Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.  
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UNKNOWN IF SINGLE OR MULTIPLE TUMORS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tumor(s) not described as metastasis</td>
<td>Single*</td>
</tr>
<tr>
<td>M1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Use this rule only after all information sources have been exhausted.</td>
<td>Single*</td>
</tr>
<tr>
<td><strong>SINGLE TUMOR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1: Tumor not described as metastasis 2: Includes combinations of in situ and invasive</td>
<td>Single*</td>
</tr>
<tr>
<td>M2</td>
<td>One or both breasts</td>
<td>Inflammatory carcinoma</td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
<tr>
<td>M3</td>
<td>Single</td>
<td></td>
<td></td>
<td></td>
<td>The tumor may overlap onto or extend into adjacent/contiguous site or subsite</td>
<td>Single*</td>
</tr>
<tr>
<td><strong>MULTIPLE TUMORS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1: Tumors not described as metastases 2: Includes combinations of in situ and invasive</td>
<td>Multiple**</td>
</tr>
<tr>
<td>Multiple tumors may be a single primary or multiple primaries</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M4</td>
<td>Topography codes different at the second (C\textsubscript{x}xx) and/or third (C\textsubscript{xx}x) character</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M5</td>
<td></td>
<td>Diagnosed more than five (5) years apart</td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M6</td>
<td>One or both breasts</td>
<td>Inflammatory carcinoma</td>
<td></td>
<td></td>
<td>Lobular carcinoma in both breasts (&quot;mirror image&quot;) is a multiple primary</td>
<td>Single*</td>
</tr>
<tr>
<td>M7</td>
<td>Both breasts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M8</td>
<td></td>
<td>More than 60 days after diagnosis</td>
<td>An invasive tumor following an in situ tumor</td>
<td>1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed. 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.</td>
<td>Multiple**</td>
<td></td>
</tr>
</tbody>
</table>
## Breast Multiple Primary Rules – Matrix
### C500 – C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>M9</td>
<td>M9</td>
<td>Intraductal and/or duct and Paget Disease</td>
<td></td>
<td></td>
<td>Use Table 1 and Table 2 to identify intraductal and duct carcinomas</td>
<td>Single*</td>
</tr>
<tr>
<td>M10</td>
<td>M10</td>
<td>Lobular (8520) and intraductal or duct</td>
<td></td>
<td></td>
<td>Use Table 1 and Table 2 to identify intraductal and duct carcinomas</td>
<td>Single*</td>
</tr>
<tr>
<td>M11</td>
<td>M11</td>
<td>Multiple intraductal and/or duct carcinomas</td>
<td></td>
<td></td>
<td>Use Table 1 and Table 2 to identify intraductal and duct carcinomas</td>
<td>Single*</td>
</tr>
<tr>
<td>M12</td>
<td>M12</td>
<td>Histology codes are different at the first (xxxx), second (xxxx), or third (xxxx) number</td>
<td></td>
<td></td>
<td>Multiple**</td>
<td></td>
</tr>
<tr>
<td>M13</td>
<td>M13</td>
<td>Does not meet any of the above criteria</td>
<td></td>
<td></td>
<td>1: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary. 2: All cases covered by Rule M13 have the same first 3 numbers in ICD-O-3 histology code. Rule M13 Examples The following are examples of the types of cases that use Rule M13. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. Warning: Using only these case examples to determine the number of primaries can result in major errors. Example 1: Invasive duct and intraductal carcinoma in the same breast. Example 2: Multi-centric lobular carcinoma, left breast.</td>
<td>Single*</td>
</tr>
</tbody>
</table>

January 1, 2007
Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
</table>
| H1   | The pathology/cytology report is not available | | 1: Priority for using documents to code the histology  
- Documentation in the medical record that refers to pathologic or cytologic findings  
- From clinician reference to type of cancer (histology) in the medical record | The histology documented by the physician | |
| H2   | One type | | | | |
| H3   | Carcinoma in situ, NOS (8010) and a specific carcinoma in situ or  
- Adenocarcinoma in situ, NOS (8140) and a specific adenocarcinoma in situ or  
- Intraductal carcinoma, NOS (8500) and a specific intraductal carcinoma (Table 1) | | The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ____ differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer. | The more specific histologic term | |
| H4   | Non-infiltrating comedocarcinoma and any other intraductal carcinoma (Table 1) | | Example: Pathology report reads intraductal carcinoma with comedo and solid features. Code 8501/2 (comedocarcinoma). | | 8501/2 (comedocarcinoma, non-infiltrating) |
| H5   | In situ lobular (8520) and intraductal carcinoma (Table 1) | | | | 8522/2 (intraductal carcinoma and lobular carcinoma in situ) (Table 3). |
## Breast Histology Coding Rules – Matrix

C500-C509

(Excludes lymphoma and leukemia M9590 - 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H6</td>
<td></td>
<td>• Combination of intraductal carcinoma and two or more specific and two or more specific intraductal types OR • Two or more specific intraductal carcinomas</td>
<td>1: Use Table 1 to identify the histologies 2: Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F.)</td>
<td>8523/2 (intraductal carcinoma mixed with other types of in situ carcinoma) (Table 3).</td>
<td></td>
</tr>
<tr>
<td>H7</td>
<td></td>
<td>In situ lobular (8520) and any in situ carcinoma other than intraductal carcinoma (Table 1)</td>
<td>Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F.)</td>
<td>8524/2 (in situ lobular mixed with other types of in situ carcinoma) (Table 3).</td>
<td></td>
</tr>
<tr>
<td>H8</td>
<td></td>
<td>Combination of in situ/non-invasive histologies that does not include either intraductal carcinoma (Table 1) or in situ lobular (8520)</td>
<td>Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F.)</td>
<td>8255/2 (adenocarcinoma in situ with mixed subtypes) (Table 3).</td>
<td></td>
</tr>
</tbody>
</table>

Revised November 1, 2007
# Breast Histology Coding Rules - Matrix

**C500-C509**

(Excludes lymphoma and leukemia M9590 - 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
</table>
| **SINGLE TUMOR: INVASIVE AND IN SITU**  
(Single tumor; in situ and invasive components) | | Invasive and in situ | | 1. Ignore the in situ terms.  
2. This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive duct and in situ lobular are coded to invasive duct (8500/3) rather than the combination code for duct and lobular carcinoma (8522/3). | The invasive histology |
| **H9** | | | | |
| **SINGLE TUMOR: INVASIVE ONLY**  
(Single tumor; all parts are invasive) | | | | |
| **H10** | No pathology/cytology specimen or the pathology/cytology report is not available | | | 3: Priority for using documents to code the histology  
- Documentation in the medical record that refers to pathologic or cytologic findings  
- Physician's reference to type of cancer (histology) in the medical record  
- Mammogram  
- PET scan  
- Ultrasound  
2: Code the specific histology when documented  
3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented | The histology documented by the physician |
| **H11** | None from primary site | | Code the behavior /3 | The histology from a metastatic site |

Revised November 1, 2007
Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H12</td>
<td></td>
<td>Carcinoma, NOS (8010) and a more specific carcinoma or adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or duct carcinoma, NOS (8500) and a more specific duct carcinoma (8022, 8035, 8501-8508) or sarcoma, NOS (8800) and a more specific sarcoma.</td>
<td>The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ____ differentiation. The terms architecture and pattern are subtypes only for in situ cancer.</td>
<td>The most specific histologic term</td>
<td></td>
</tr>
<tr>
<td>H13</td>
<td></td>
<td>Final diagnosis of the pathology report specifically states inflammatory carcinoma.</td>
<td>Record dermal lymphatic invasion in Collaborative Staging</td>
<td></td>
<td>8530 (inflammatory carcinoma)</td>
</tr>
<tr>
<td>H14</td>
<td></td>
<td>One type</td>
<td></td>
<td>The histology</td>
<td></td>
</tr>
<tr>
<td>H15</td>
<td></td>
<td>Two or more specific duct carcinomas</td>
<td>Use Table 2 to identify duct carcinomas</td>
<td>The histology with the numerically higher ICD-O-3 code</td>
<td></td>
</tr>
<tr>
<td>H16</td>
<td></td>
<td>Combination of lobular (8520) and duct carcinoma</td>
<td>Use Table 2 to identify duct carcinomas</td>
<td></td>
<td>8522 (duct and lobular) (Table 3).</td>
</tr>
<tr>
<td>H17</td>
<td></td>
<td>Combination of duct and any other carcinoma</td>
<td>1: Use Table 2 to identify duct carcinomas 2: Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.</td>
<td></td>
<td>8523 (duct mixed with other types of carcinoma) (Table 3).</td>
</tr>
</tbody>
</table>

Revised November 1, 2007
## Breast Histology Coding Rules - Matrix

**C500-C509**  
(Excludes lymphoma and leukemia M9590 - 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H18</td>
<td>Lobular (8520) and any other carcinoma</td>
<td>Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2</td>
<td>8524 (lobular mixed with other types of carcinoma) (Table 3).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H19</td>
<td>Multiple histologies that do not include duct or lobular (8520)</td>
<td>Use Table 2 to identify duct carcinomas</td>
<td>8255 (adenocarcinoma with mixed subtypes) (Table 3).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
</table>
| H20  | No pathology/cytology specimen or the pathology/cytology report is not available | 1: Priority for using documents to code the histology  
- Documentation in the medical record that refers to pathologic or cytologic findings  
- Physician’s reference to type of cancer (histology) in the medical record  
- Mammogram  
- PET scan  
- Ultrasound  
2: Code the specific histology when documented  
3: Code the histology to cancer/malignant neoplasm, NOS (8000) or carcinoma, NOS (8010) as stated by the physician when nothing more specific is documented | The histology documented by the physician |
<p>| H21  | None from primary site | Code the behavior /3 | The histology from a metastatic site |
| H22  | Final diagnosis of the pathology report specifically states inflammatory carcinoma | Note: Record dermal lymphatic invasion in Collaborative Staging | 8530 (inflammatory carcinoma) |
| H23  | One type | The histology |</p>
<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H24</td>
<td>Pathology report specifically states Paget disease is in situ and the underlying tumor is intraductal carcinoma (Table 1)</td>
<td></td>
<td>Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F.)</td>
<td>Code 8543/2 (in situ Paget disease and intraductal carcinoma) (Table 3).</td>
<td></td>
</tr>
<tr>
<td>H25</td>
<td>Paget disease and intraductal carcinoma</td>
<td></td>
<td></td>
<td>1. ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3). 2. Includes both invasive Paget disease and Paget disease with behavior not stated. 3. Use Table 1 to identify intraductal carcinomas</td>
<td>Code 8543/3 (Paget disease and intraductal carcinoma) (Table 3).</td>
</tr>
<tr>
<td>H26</td>
<td>Paget disease and invasive duct carcinoma</td>
<td></td>
<td></td>
<td>1. ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3). 2. Includes both invasive Paget disease and Paget disease with behavior not stated. 3. Use Table 2 to identify duct carcinomas</td>
<td>Code 8541/3 (Paget disease and infiltrating duct carcinoma) (Table 3).</td>
</tr>
<tr>
<td>H27</td>
<td>Invasive and in situ</td>
<td></td>
<td></td>
<td>1. Ignore the in situ terms. 2. This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive lobular and in situ duct carcinoma are coded to invasive lobular (8520/3) rather than the combination code for duct and lobular carcinoma (8522/3).</td>
<td>The invasive histology</td>
</tr>
</tbody>
</table>

Revised November 1, 2007
Breast Histology Coding Rules - Matrix  
C500-C509  
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H28</td>
<td></td>
<td>Lobular (8520) and duct carcinoma</td>
<td></td>
<td>Use Table 2 to identify duct carcinomas</td>
<td>8522 (duct and lobular) (Table 3).</td>
</tr>
<tr>
<td>H29</td>
<td>None of the conditions are met</td>
<td></td>
<td></td>
<td></td>
<td>The histology with the numerically higher ICD-O-3 code</td>
</tr>
</tbody>
</table>
Breast Histology Coding Rules - Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 - 9989 and Kaposi sarcoma M9140)

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Kidney Multiple Primary Rules – Matrix
C649
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UNKNOWN IF SINGLE OR MULTIPLE TUMORS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tumor(s) not described as metastasis</td>
<td></td>
</tr>
<tr>
<td>M1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Use this rule only after all information sources have been exhausted.</td>
<td>Single*</td>
</tr>
<tr>
<td><strong>SINGLE TUMOR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M2</td>
<td>Single</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
<tr>
<td><strong>MULTIPLE TUMORS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M3</td>
<td>Wilms tumors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
<tr>
<td>M4</td>
<td>Tumors with topography codes that differ at the second (Cx xx) and/or third (Cx xx) character</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M5</td>
<td>Tumors in both right and left kidneys</td>
<td></td>
<td></td>
<td></td>
<td>Abstract as a single primary when the tumors in one kidney are documented to be metastatic from the other kidney</td>
<td>Multiple**</td>
</tr>
<tr>
<td>M6</td>
<td></td>
<td></td>
<td></td>
<td>Diagnosed more than three (3) years apart</td>
<td></td>
<td>Multiple**</td>
</tr>
</tbody>
</table>

January 1, 2007
# Kidney Multiple Primary Rules – Matrix

## C649

(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
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<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>M7</td>
<td></td>
<td></td>
<td>More than 60 days after diagnosis</td>
<td>An invasive tumor following an in situ tumor</td>
<td>1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed. 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.</td>
<td>Multiple**</td>
</tr>
<tr>
<td>M8</td>
<td></td>
<td>A renal cell type in one tumor and a different specific renal cell type in another (Table 1)</td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
</tbody>
</table>
| M9   |      | - Cancer/malignant neoplasm, NOS (8000) and another is a specific histology or  
- Carcinoma, NOS (8010) and another is a specific carcinoma or  
- Adenocarcinoma, NOS (8140) and another is a specific adenocarcinoma or  
- Renal cell carcinoma, NOS (8312) and the other is a single renal cell type (Table 1) | | | 1: The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation  
2: The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation. | Single* |
| M10  |      | Histology codes are different at the first (xxx), second (x0xx), or third (x02x) number | | | | Multiple** |
Kidney Multiple Primary Rules – Matrix
C649
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

<table>
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<tr>
<th>Rule</th>
<th>Site</th>
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<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>M11</td>
<td></td>
<td>Does not meet any of the above criteria</td>
<td></td>
<td></td>
<td>When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.</td>
<td>Single*</td>
</tr>
</tbody>
</table>

**Rule M11 Examples**
The following are examples of the types of cases that use Rule M11. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary.

*Warning: Using only these case examples to determine the number of primaries can result in major errors.*

**Example 1:** Multiple tumors in one kidney with the same histology

**Example 2:** An in situ and invasive tumor diagnosed within 60 days
# Kidney Histology Coding Rules – Matrix

*C649*

(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

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<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SINGLE TUMOR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **H1** | None or the pathology report is not available | | | 1: Priority for using documents to code the histology  
   - Documentation in the medical record that refers to pathologic or cytologic findings  
   - Physician’s reference to type of cancer (histology) in the medical record  
   - CT or MRI scans  
   2: Code the specific histology when documented.  
   3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented | | The histology documented by the physician |
| **H2** | None from primary site | | | Code the behavior /3 | The histology from metastatic site |
| **H3** | One type | | | | The histology |
| **H4** | | Invasive and in situ | | | The invasive histologic type |
| **H5** | - Cancer/malignant neoplasm, NOS (8000) and a more specific histology or  
   - Carcinoma, NOS (8010) and a more specific carcinoma or A adenocarcinoma, NOS (8041) and one specific adenocarcinoma type or  
   - Renal cell carcinoma (8312) and one specific renal cell type. | | | 1: Use Table 1 to identify specific renal cell types.  
   2: The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation  
   3: The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation. | The specific type |
## Kidney Histology Coding Rules – Matrix

**C649**

*(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)*

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<tr>
<th>Rule</th>
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<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
</table>
| H6   |                             | Two or more specific types of renal cell carcinoma. | Use Table 1 to identify specific renal cell types  
*Example:* Renal cell carcinoma, papillary and clear cell types.  
Assign code 8255. | 8255 (Adenocarcinoma with mixed subtypes) |
| H7   | None of the above conditions are met | | | The histology with the numerically higher ICD-O-3 code |

### MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H8</td>
<td>No pathology/cytology specimen or the pathology/cytology report is not available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
*I:* Priority for using documents to code the histology  
- Documentation in the medical record that refers to pathologic or cytologic findings  
- Physician’s reference to type of cancer (histology) in the medical record  
- CT or MRI scans  
*2:* Code the specific histology when documented  
*3:* Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented | The histology documented by the physician |
| H9   | None from primary site | | Code the behavior /3 | The histology from a metastatic site |
| H10  | One type | | | The histology |

*January 1, 2007*
# Kidney Histology Coding Rules – Matrix

**C649**

(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H11</td>
<td></td>
<td></td>
<td></td>
<td>1: This rule should only be used when the first three digits of the histology codes are identical (This is a single primary). 2: See the Kidney Equivalent Terms, Definitions, Tables and Illustrations for the definition of most invasive. - One tumor is in situ and one is invasive, code the histology from the invasive tumor - Both/all histologies are invasive, code the histology of the most invasive tumor.</td>
<td>The histology of the most invasive tumor</td>
</tr>
<tr>
<td>H12</td>
<td></td>
<td>- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or - Carcinoma, NOS (8010) and a more specific carcinoma or - Adenocarcinoma, NOS (8140) and one specific adenocarcinoma type or - Renal cell carcinoma (8312) and one specific renal cell type</td>
<td>1: Use Table 1 to identify specific renal cell types. 2: The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____ differentiation 3: The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with ____ differentiation.</td>
<td>The specific type</td>
<td></td>
</tr>
<tr>
<td>H13</td>
<td>None of the above conditions are met</td>
<td></td>
<td></td>
<td>The histology with the numerically higher ICD-O-3 code</td>
<td></td>
</tr>
</tbody>
</table>
### Urinary MP

#### Renal Pelvis, Ureter, Bladder, and Other Urinary Multiple Primary Rules – Matrix

C659, C669, C670-C679, C680-C689

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UNKNOWN IF SINGLE OR MULTIPLE TUMORS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tumor(s) not described as metastasis</td>
<td></td>
</tr>
<tr>
<td>M1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Use this rule only after all information sources have been exhausted.</td>
<td>Single*</td>
</tr>
<tr>
<td></td>
<td><strong>SINGLE TUMOR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M2</td>
<td>Single</td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The tumor may overlap onto or extend into adjacent/contiguous site or subsite</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>MULTIPLE TUMORS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>M3</strong></td>
<td>When no other urinary sites are involved, tumor(s) in the right renal pelvis and tumor(s) the left renal pelvis</td>
<td></td>
<td></td>
<td>Use this rule and abstract as a multiple primary unless documented to be metastatic.</td>
<td>Multiple**</td>
</tr>
<tr>
<td></td>
<td>M4</td>
<td>When no other urinary sites are involved, tumor(s) in the right ureter and tumor(s) in the left ureter</td>
<td></td>
<td></td>
<td>Use this rule and abstract as a multiple primary unless documented to be metastatic.</td>
<td>Multiple**</td>
</tr>
<tr>
<td></td>
<td>M5</td>
<td></td>
<td>More than 60 days after diagnosis</td>
<td>An invasive following an in situ</td>
<td></td>
<td>Multiple**</td>
</tr>
</tbody>
</table>

* The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.

** A bstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.
Renal Pelvis, Ureter, Bladder, and Other Urinary Multiple Primary Rules – Matrix
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>M6</td>
<td>Bladder</td>
<td>Any combination of: • Papillary carcinoma (8050) or • Transitional cell carcinoma (8120-8124) or • Papillary transitional cell carcinoma (8130-8131)</td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
<tr>
<td>M7</td>
<td></td>
<td></td>
<td></td>
<td>More than three (3) years apart</td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M8</td>
<td>Two or more of the following sites • Renal pelvis (C659) • Ureter(C669) • Bladder (C670-C679) • Urethra /prostatic urethra (C680)</td>
<td>Urothelial tumors (See Table 1)*</td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
<tr>
<td>M9</td>
<td></td>
<td>Tumors with histology codes different at the first (xxx), second (xx), or third (xx) number</td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M10</td>
<td>Tumors with topography codes different at the second (Cxxx) and/or third (Cxx) character</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M11</td>
<td>Does not meet any of the above criteria</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
</tbody>
</table>

When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.
Renal Pelvis, Ureter, Bladder, and Other Urinary Histology Coding Rules – Matrix  
C659, C669, C670-C679, C680-C689  
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

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<tr>
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</tr>
</thead>
</table>
| H1   | None from primary site      | Pure transitional carcinoma or Flat (non— papillary) transitional cell carcinoma or Transition cell carcinoma with squamous differentiation or Transitional cell carcinoma with glandular differentiation or Transitional cell carcinoma with trophoblastic differentiation or Nested transitional cell carcinoma or Micocystic transitional cell carcinoma | I: Priority for using documents to code the histology  
• Documentation in the medical record that refers to pathologic or cytologic findings  
• Physician’s reference to type of cancer (histology) in the medical record  
• CT or MRI scans  
2: Code the specific histology when documented.  
3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented | The histology documented by the physician |
| H2   | None from primary site      | Code the behavior /3 | The histology from metastatic site |
| H3   | None from primary site      | Flat transitional cell carcinoma is a more important prognostic indicator than papillary, and is likely to be treated more aggressively. | 8120 (transitional cell/urothelial carcinoma) (Table 1 - Code 8120) |
# Renal Pelvis, Ureter, Bladder, and Other Urinary Histology Coding Rules – Matrix

C659, C669, C670-C679, C680-C689

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>H4</td>
<td></td>
<td>• Papillary carcinoma or&lt;br&gt;• Papillary transitional carcinoma or&lt;br&gt;• Papillary carcinoma and transitional cell carcinoma</td>
<td></td>
<td></td>
<td>8130 (papillary transitional cell carcinoma)&lt;br&gt;(Table 1 - Code 8130)</td>
</tr>
<tr>
<td>H5</td>
<td></td>
<td>One type</td>
<td></td>
<td>Only code squamous cell carcinoma (8070)&lt;br&gt;when there are no other histologies present (pure squamous cell carcinoma)</td>
<td>The histology</td>
</tr>
<tr>
<td>H6</td>
<td></td>
<td></td>
<td>Invasive and in situ</td>
<td>The invasive histologic type</td>
<td></td>
</tr>
<tr>
<td>H7</td>
<td></td>
<td>Examples&lt;br&gt;• Cancer/malignant neoplasm, NOS (8000) and a more specific histology; or&lt;br&gt;• Carcinoma, NOS (8010) and a more specific carcinoma; or&lt;br&gt;• Sarcoma, NOS (8800) and a more specific sarcoma (invasive only)</td>
<td></td>
<td>1: The specific histology for <strong>in situ</strong> lesions may be identified as pattern, architecture, type, subtype, predominantly, with features of, or with _____ differentiation.&lt;br&gt;2: The specific histology for <strong>invasive</strong> lesions may be identified as type, subtype, predominantly, with features of, or with _____ differentiation.</td>
<td>The most specific histologic term</td>
</tr>
<tr>
<td>H8</td>
<td>None of the above conditions are met</td>
<td></td>
<td></td>
<td>The histology with the numerically higher ICD-O-3 code</td>
<td></td>
</tr>
</tbody>
</table>
### MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

<table>
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<tr>
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<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H9</strong></td>
<td>None or the pathology/cytology report is not available</td>
<td></td>
<td></td>
<td>1: Priority for using documents to code the histology - From reports or notes in the medical record that document or reference pathologic or cytologic findings - From clinician reference to type of cancer in the medical record - From CT or MRI scans 2: Code the specific histology when documented 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented</td>
<td></td>
</tr>
<tr>
<td><strong>H10</strong></td>
<td>None from primary site</td>
<td></td>
<td></td>
<td>Code the behavior /3</td>
<td>The histology from a metastatic site</td>
</tr>
<tr>
<td><strong>H11</strong></td>
<td></td>
<td>Pure transitional carcinoma or Flat (non—papillary) transitional cell carcinoma or Transition cell carcinoma with squamous differentiation or Transitional cell carcinoma with glandular differentiation or Transitional cell carcinoma with trophoblastic differentiation or Nested transitional cell carcinoma or Microcystic transitional cell carcinoma</td>
<td>Flat transitional cell carcinoma is a more important prognostic indicator than papillary, and is likely to be treated more aggressively.</td>
<td>8120 (transitional cell/urothelial carcinoma) (Table 1 - Code 8120)</td>
<td></td>
</tr>
</tbody>
</table>
### Renal Pelvis, Ureter, Bladder, and Other Urinary Histology Coding Rules – Matrix

**C659, C669, C670-C679, C680-C689**

*Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140*

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<th>Notes and Examples</th>
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</tr>
</thead>
</table>
| H12  |                             | • Papillary carcinoma or  
|      |                             | • Papillary transitional carcinoma or  
|      |                             | • Papillary carcinoma and transitional cell carcinoma |         | 8130 (papillary transitional cell carcinoma)  
|      |                             |           |          | (Table 1 – Code 8130) |
| H13  |                             | One type  |          | Only code squamous cell carcinoma (8070) when there are no other histologies present (pure squamous cell carcinoma). | The histology |
| H14  |                             |           |          | 1: This rule should only be used when the first three digits of the histology codes are identical (This is a single primary).  
|      |                             |           |          | 2: See the Renal Pelvis, Ureter, Bladder and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations for the definition of most invasive.  
|      |                             |           |          | • One tumor is in situ and one is invasive, code the histology from the invasive tumor  
|      |                             |           |          | • Both/all histologies are invasive, code the histology of the most invasive tumor. | The histology of the most invasive tumor |
| H15  | None of the above conditions are met |           |          | The histology with the numerically higher ICD-O-3 code |      |
Benign and Borderline Intracranial and CNS Tumors
Multiple Primary Rules – Matrix
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

Note: Malignant intracranial and CNS tumors have a separate set of rules.

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Laterality</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UNKNOWN IF SINGLE OR MULTIPLE TUMOR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tumor(s) not described as metastasis</td>
<td></td>
</tr>
<tr>
<td>M1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Use this rule only after all information sources have been exhausted</td>
<td>Single*</td>
</tr>
<tr>
<td><strong>SINGLE TUMOR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tumor not described as metastasis</td>
<td></td>
</tr>
<tr>
<td>M2</td>
<td>Single</td>
<td></td>
<td></td>
<td></td>
<td>The tumor may overlap onto or extend into adjacent/contiguous site or subsite</td>
<td>Single*</td>
</tr>
<tr>
<td><strong>MULTIPLE TUMORS</strong></td>
<td>Multiple tumors may be a single primary or multiple primaries</td>
<td></td>
<td></td>
<td></td>
<td>Tumors not described as metastases</td>
<td></td>
</tr>
<tr>
<td>M3</td>
<td>Brain</td>
<td></td>
<td></td>
<td>Invasive (/3) and either a benign (/0) or uncertain/borderline (/1)</td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M4</td>
<td>Topography codes different at the second (Cxxxx) and/or third (Cxxx) character, ), or fourth (Cxxx) are multiple primaries.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M5</td>
<td></td>
<td>Both sides (left and right) of a paired site (Table 1)</td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M6</td>
<td>Atypical choroid plexus papilloma (9390/1) following Choroid plexus papilloma, NOS (9390/0)</td>
<td></td>
<td></td>
<td>Do not code progression of disease as multiple primaries</td>
<td>Single*</td>
<td></td>
</tr>
</tbody>
</table>

Revised April 30, 2008
### Benign and Borderline Intracranial and CNS Tumors
#### Multiple Primary Rules – Matrix

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
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<th>Laterality</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>M7</td>
<td></td>
<td>Neurofibromatosis, NOS (9540/1) Following Neurofibroma, NOS (9540/0)</td>
<td></td>
<td></td>
<td>Do not code progression of disease as multiple primaries</td>
<td>Single*</td>
</tr>
<tr>
<td>M8</td>
<td></td>
<td>Multiple types on the same branch in Chart 1</td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
<tr>
<td>M9</td>
<td></td>
<td>Multiple types on different branches in Chart 1</td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M10</td>
<td></td>
<td>Multiple types, at least one not listed in Chart 1</td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M11</td>
<td></td>
<td>Codes are different at the first (xxxx), second (xxxx) or third (xxxx) number</td>
<td></td>
<td></td>
<td>Use this rule when none of the histology codes are listed in Chart 1</td>
<td>Multiple**</td>
</tr>
</tbody>
</table>

Revised April 30, 2008
Benign and Borderline Intracranial and CNS Tumors
Multiple Primary Rules – Matrix
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

<table>
<thead>
<tr>
<th>Rule</th>
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<th>Histology</th>
<th>Laterality</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>M12</td>
<td>Does not meet any of the above criteria</td>
<td></td>
<td></td>
<td></td>
<td>Timing is not used to determine multiple primaries for benign and borderline intracranial and CNS tumors. Examples: The following are examples of cases that use Rule M12. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. Warning: Using only these case examples to determine the number of primaries can result in major errors. Example 1: Tumors in the same site with the same histology (Chart 1) and the same laterality as the original tumor are a single primary Example 2: Tumors in the same site with the same histology (Chart 1) and it is unknown if laterality is the same as the original tumor are a single primary. Example 3: Tumors in the same site and same laterality with histology codes not listed in Chart 1 that have the same first three numbers are a single primary.</td>
<td>Single*</td>
</tr>
</tbody>
</table>

Revised April 30, 2008

254.3
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### Benign and Borderline Intracranial and CNS Tumors
### Histology Coding Rules – Matrix
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

*Note:* Malignant intracranial and CNS tumors have a separate set of rules.

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</tr>
</thead>
<tbody>
<tr>
<td><strong>SINGLE TUMOR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **H1** | No specimen or report available |           |          | 1: Priority for using documents to code the histology  
  ● Documentation in the medical record that refers to pathologic or cytologic findings  
  ● Physician’s reference to type of tumor (histology) in the medical record  
  ● PET, CT or MRI scans  
  2: Code the specific histology when documented  
  3: Code the histology to 8000 (neoplasm, NOS) as stated by the physician when nothing more specific is documented |      |
| **H2** | One type |           |          | The histology documented by the physician                                                                                                           |      |
| **H3** | Multiple, all in the same branch on Chart 1 |           |          | The more specific histology                                                                                                                         |      |
| **H4** | None of the above conditions are met |           |          | The histology with the numerically higher ICD-O-3 code                                                                                              |      |
| **MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY**                                                                                               |      |
| **H5** | No specimen or report available |           |          | 1: Priority for using documents to code the histology  
  ● Documentation in the medical record that refers to pathologic or cytologic findings  
  ● Physician’s reference to type of tumor (histology) in the medical record  
  ● PET, CT or MRI scans  
  2: Code the specific histology when documented  
  3: Code the histology to 8000 (neoplasm, NOS) as stated by the physician when nothing more specific is documented |      |
|      |                                    |           |          | Histology documented by the physician                                                                                                              |      |
### Benign and Borderline Intracranial and CNS Tumors
#### Histology Coding Rules – Matrix
**C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753**

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<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H6</td>
<td>Multiple meningiomas</td>
<td>Uncertain behavior (/1)</td>
<td>1: This is a rare condition that is usually associated with neurofibromatosis type 2 and other genetic disorders 2: Use this code only for meningiomas with uncertain behavior; do not use this code for multiple benign or malignant meningiomas</td>
<td>9530/1</td>
<td></td>
</tr>
<tr>
<td>H7</td>
<td>One type</td>
<td></td>
<td></td>
<td>The histology</td>
<td></td>
</tr>
<tr>
<td>H8</td>
<td>Original diagnosis</td>
<td></td>
<td>Do not change the histology code when a later tumor(s) shows progression of disease</td>
<td>The histology from the original diagnosis.</td>
<td></td>
</tr>
<tr>
<td>H9</td>
<td>Multiple, all in the same branch on Chart 1</td>
<td></td>
<td></td>
<td>The more specific histology</td>
<td></td>
</tr>
<tr>
<td>H10</td>
<td>None of the above conditions are met</td>
<td></td>
<td></td>
<td>The histology with the numerically higher ICD-O-3 code</td>
<td></td>
</tr>
</tbody>
</table>

Revised April 30, 2008
Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland

Multiple Primary Rules – Matrix

C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

Note: Benign and borderline intracranial and CNS tumors have a separate set of rules.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

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<tr>
<th>Rule</th>
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<th>Timing</th>
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<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1</td>
<td>Brain</td>
<td></td>
<td></td>
<td></td>
<td>Tumor(s) not described as metastasis</td>
<td>Multiple**</td>
</tr>
<tr>
<td>M2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Use this rule only after all information sources have been exhausted.</td>
<td>Single*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tumor not described as metastasis</td>
<td>Single*</td>
</tr>
<tr>
<td>M3</td>
<td>Single</td>
<td></td>
<td></td>
<td></td>
<td>The tumor may overlap onto or extend into adjacent/contiguous site or subsite</td>
<td>Single*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tumors not described as metastases</td>
<td>Single*</td>
</tr>
<tr>
<td>M4</td>
<td>Brain</td>
<td></td>
<td></td>
<td></td>
<td>Tumor(s) not described as metastasis</td>
<td>Multiple**</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tumors not described as metastases</td>
<td>Multiple**</td>
</tr>
<tr>
<td>M5</td>
<td>Tumors with topography codes different at the second (C(x)) and/or third (C(x)) character</td>
<td></td>
<td></td>
<td>Tumor(s) not described as metastasis</td>
<td>Multiple**</td>
<td></td>
</tr>
<tr>
<td>M6</td>
<td>Glioblastoma or glioblastoma multiforme (9440) following a glial tumor (See Chart 1)</td>
<td></td>
<td></td>
<td>Tumor(s) not described as metastasis</td>
<td>Single*</td>
<td></td>
</tr>
</tbody>
</table>
# Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland

## Multiple Primary Rules – Matrix

**C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753**

*(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)*

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>M7</td>
<td></td>
<td>Tumors with histology codes on the same branch in Chart 1 or Chart 2</td>
<td></td>
<td></td>
<td>Recurrence, progression or any reappearance of histologies on the same branch in Chart 1 or Chart 2 is always the same disease process. <em>Example:</em> Patient has astrocytoma. Ten years later the patient is diagnosed with glioblastom multiforme. This is a progression or recurrence of the earlier astrocytoma.</td>
<td>Single*</td>
</tr>
<tr>
<td>M8</td>
<td></td>
<td>Tumors with histology codes on different branches in Chart 1 or Chart 2</td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M9</td>
<td></td>
<td>Tumors with histology codes different at the first (xxxx), second (x×xx), or third (xx×x) number</td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M10</td>
<td>Does not meet any of the above criteria</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
</tbody>
</table>

1. Neither timing nor laterality is used to determine multiple primaries for malignant intracranial and CNS tumors. *Example:* The patient is treated for an anaplastic astrocytoma (9401) in the right parietal lobe. Three months later the patient is diagnosed with a separate anaplastic astrocytoma in the left parietal lobe. This is one primary because laterality is not used to determine multiple primary status.

2. Multi-centric brain tumors which involve different lobes of the brain that do not meet any of the above criteria are the same disease process.
Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland

Histology Coding Rules – Matrix

C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

*Note:* Benign and borderline intracranial and CNS tumors have a separate set of rules.

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H1</strong></td>
<td>No pathology/cytology specimen or the pathology/cytology report is not available</td>
<td></td>
<td></td>
<td>1: Priority for using documents to code the histology&lt;br&gt;• Documentation in the medical record that refers to pathologic or cytologic findings&lt;br&gt;• Physician’s reference to type of cancer (histology) in the medical record&lt;br&gt;• CT or MRI scans</td>
<td>The histology documented by the physician</td>
</tr>
<tr>
<td><strong>H2</strong></td>
<td>None from primary site</td>
<td></td>
<td>Code the behavior /3</td>
<td>The histology from metastatic site</td>
<td></td>
</tr>
<tr>
<td><strong>H3</strong></td>
<td>At least two of the following cells and/or differentiation are present:&lt;br&gt;• Astrocytoma&lt;br&gt;• Oligodendroglioma&lt;br&gt;• Ependymal</td>
<td></td>
<td></td>
<td>Code 9382/3 (mixed glioma)</td>
<td></td>
</tr>
<tr>
<td><strong>H4</strong></td>
<td>One type</td>
<td></td>
<td></td>
<td>The histology</td>
<td></td>
</tr>
<tr>
<td><strong>H5</strong></td>
<td>Diagnosis includes a non-specific term and a specific term or type on the same branch in Chart 1 or Chart 2</td>
<td></td>
<td></td>
<td>The specific type</td>
<td></td>
</tr>
<tr>
<td><strong>H6</strong></td>
<td>None of the above conditions are met</td>
<td></td>
<td></td>
<td>The histology with the numerically higher ICD-O-3 code</td>
<td></td>
</tr>
</tbody>
</table>

January 1, 2007
### Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland

**Histology Coding Rules – Matrix**

C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
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<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| H7   | No pathology/cytology specimen or the pathology/cytology report is not available | | | 1: Priority for using documents to code the histology  
   - Documentation in the medical record that refers to pathologic or cytologic findings  
   - Physician’s reference to type of cancer (histology) in the medical record  
   - CT or MRI scans  
   2: Code the specific histology when documented  
   3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) as stated by the physician when nothing more specific is documented | The histology documented by the physician |
| H8   | None from primary site | | Code the behavior /3 | The histology from a metastatic site |
| H9   | One type | | | The histology |
| H10  | Diagnosis includes a non-specific term and a specific term or type on the same branch in Chart 1 or Chart 2 | | The specific type |
| H11  | None of the above conditions are met | | | The histology with the numerically higher ICD-O-3 code |
Other Sites Multiple Primary Rules – Matrix
Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

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<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1</td>
<td>UNKNOWN IF SINGLE OR MULTIPLE TUMORS</td>
<td>Tumor(s) not described as metastasis</td>
<td></td>
<td></td>
<td>Use this rule only after all information sources have been exhausted.</td>
<td>Single*</td>
</tr>
</tbody>
</table>
| M2       | SINGLE TUMOR                  | 1: Tumor not described as metastasis  
2: Includes combinations of in situ and invasive |        |          | The tumor may overlap onto or extend into adjacent/contiguous site or subsite. | Single*  |
| M3       | MULTIPLE TUMORS               | 1: Tumors not described as metastases  
2: Includes combinations of in situ and invasive |        |          | 1: Report only one adenocarcinoma of the prostate per patient per lifetime.  
2: 95% of prostate malignancies are the common (acinar) adenocarcinoma histology (8140). See Equivalent Terms, Definitions and Tables for more information  
3: If patient has a previous acinar adenocarcinoma of the prostate in the database and is diagnosed with adenocarcinoma in 2007 it is a single primary. | Single*  |
| M4       | Unilateral or bilateral       | Retinoblastoma    |        |          |                                                                                | Single*  |
| M5       | Any site or sites             | Kaposi sarcoma    |        |          |                                                                                | Single*  |
| M6       | Thyroid                       | Follicular and papillary | Within 60 days |          |                                                                                | Single*  |

Revised November 1, 2007
## Other Sites Multiple Primary Rules - Matrix

Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

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</tr>
</thead>
<tbody>
<tr>
<td>M7</td>
<td>Bilateral ovary</td>
<td>Epithelial tumors (8000-8799)</td>
<td>Within 60 days of diagnosis</td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
<tr>
<td>M8</td>
<td>Both sides of a paired site (Table 1)</td>
<td>Adenocarcinoma in adenomatous polyposis coli (familial polyposis) with one or more in situ or malignant polyps</td>
<td></td>
<td></td>
<td>Table 1 – Paired Organs and Sites with Laterality</td>
<td>Multiple**</td>
</tr>
<tr>
<td>M9</td>
<td></td>
<td>Tumors may be present in a single or multiple segments of the colon, rectosigmoid, rectum.</td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
<tr>
<td>M10</td>
<td></td>
<td>Diagnosed more than one (1) year apart</td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M11</td>
<td>Topography codes that are different at the second (Cxx) and/or third (Cxx) character</td>
<td></td>
<td></td>
<td>Example 1: A tumor in the penis C6109 and a tumor in the rectum C209 have different second characters in their ICD-O-3 topography codes, so they are multiple primaries. Example 2: A tumor in the cervix C5339 and a tumor in the vulva C519 have different third characters in their ICD-O-3 topography codes, so they are multiple primaries</td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M12</td>
<td>Topography codes that differ only at the fourth (Cxx) character in any one of the following primary sites: Anus and anal canal C21, Bones, joints and articular cartilage (C40-C41), Peripheral nerves and autonomic nervous system (C47), Connective tissue and other soft tissues (C49), Skin (C44)</td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
<td></td>
</tr>
</tbody>
</table>

Revised November 1, 2007
## Other Sites Multiple Primary Rules – Matrix

Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

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<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>M13</td>
<td></td>
<td>Frank in situ or malignant adenocarcinoma and an in situ or malignant tumor in a polyp</td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
<tr>
<td>M14</td>
<td></td>
<td>Multiple in situ and/or malignant polyps</td>
<td></td>
<td></td>
<td>Note: Includes all combinations of adenomatous, tubular, villous, and tubulovillous adenomas or polyps.</td>
<td>Single*</td>
</tr>
<tr>
<td>M15</td>
<td></td>
<td>More than 60 days after diagnosis</td>
<td>An invasive tumor following an in situ tumor</td>
<td>1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed. 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.</td>
<td>Multiple**</td>
<td></td>
</tr>
</tbody>
</table>
Other Sites Multiple Primary Rules – Matrix
Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

<table>
<thead>
<tr>
<th>Rule</th>
<th>Site</th>
<th>Histology</th>
<th>Timing</th>
<th>Behavior</th>
<th>Notes/Examples</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>M16</td>
<td></td>
<td>- Cancer/malignant neoplasm, NOS (8000) and another is a specific histology; or &lt;br&gt; - Carcinoma, NOS (8010) and another is a specific carcinoma; or &lt;br&gt; - Squamous cell carcinoma, NOS (8070) and another is a specific squamous cell carcinoma; or &lt;br&gt; - Adenocarcinoma, NOS (8140) and another is a specific adenocarcinoma; or &lt;br&gt; - Melanoma, NOS (8720) and another is a specific melanoma; or &lt;br&gt; - Sarcoma, NOS (8800) and another is a specific sarcoma</td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
<tr>
<td>M17</td>
<td></td>
<td><strong>Histology codes are different at the first (xxx), second (xxy), or third (xyx) number</strong></td>
<td></td>
<td></td>
<td></td>
<td>Multiple**</td>
</tr>
<tr>
<td>M18</td>
<td></td>
<td><strong>Does not meet any of the above criteria</strong></td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
</tbody>
</table>

When an invasive lesion follows an in situ within 60 days, abstract as a single primary.
### Other Sites Histology Coding Rules – Matrix

Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Primary Site</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
</table>
| **SINGLE TUMOR: IN SITU ONLY**  
(Single Tumor; all parts are in situ) | | | | | | |
| H1   | The pathology/cytology report is not available | | | | | The histology documented by the physician |
| H2   | | One type | | Do not code terms that do not appear in the histology description. **Example:** Do not code squamous cell carcinoma non-keratinizing unless the words “non-keratinizing” actually appear in the diagnosis. | | The histology |
### Other Sites Histology Coding Rules – Matrix

Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

<table>
<thead>
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<th>Primary Site</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
</table>
| H3   |                             |              | The final diagnosis is  
- A denocarcinoma in a polyp or  
- A denocarcinoma and a residual polyp or polyp architecture is recorded in other parts of the pathology report.  
- A denocarcinoma and there is reference to a residual or pre-existing polyp or  
- Mucinous/colloid or signet ring cell adenocarcinoma in a polyp or  
There is documentation that the patient had a polypectomy | It is important to know that the adenocarcinoma originated in a polyp | 8210 (adenocarcinoma in adenomatous polyp) or 8261 (adenocarcinoma in villous adenoma) or 8263 (adenocarcinoma in tubulovillous adenoma) |
### Other Sites Histology Coding Rules – Matrix

Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Primary Site</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H4</strong></td>
<td>Carcinoma in situ, NOS (8010) and a specific in situ carcinoma or Squamous cell carcinoma in situ, NOS (8070) and a specific in situ squamous cell carcinoma or A denocarcinoma in situ, NOS (8140) and a specific in situ adenocarcinoma or Melanoma in situ, NOS (8720) and a specific in situ melanoma</td>
<td></td>
<td>The specific histology may be identified as type, subtype, predominantly, with features of, major, or with differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.</td>
<td></td>
<td></td>
<td>The most specific histologic term</td>
</tr>
<tr>
<td><strong>H5</strong></td>
<td>Multiple specific histologies or A non-specific histology with multiple specific histologies</td>
<td></td>
<td>The specific histology may be identified as type, subtype, predominantly, with features of, major, or with differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.</td>
<td></td>
<td></td>
<td>The appropriate combination/ mixed code (Table 2)</td>
</tr>
<tr>
<td><strong>H6</strong></td>
<td>None of the above conditions are met</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The numerically higher ICD-O-3 code</td>
</tr>
</tbody>
</table>

[Other Sites Histo]
### Other Sites Histology Coding Rules – Matrix

**Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Primary Site</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H7</td>
<td>Invasive and in situ</td>
<td></td>
<td></td>
<td></td>
<td>This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category.</td>
<td>The single invasive histology. Ignore the in situ terms.</td>
</tr>
</tbody>
</table>
| H8   | No pathology/cytology specimen or the pathology/cytology report is not available |              |           |          | 1: Priority for using documents to code the histology  
  • Documentation in the medical record that refers to pathologic or cytologic findings  
  • Physician’s reference to type of cancer (histology) in the medical record  
  • CT, PET or MRI scans  
  2: Code the specific histology when documented  
  3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented | The histology documented by the physician |
| H9   | None from primary site       |              |           |          | Code the behavior /3 | The histology from a metastatic site |
Other Sites Histology Coding Rules – Matrix
Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Primary Site</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H10</td>
<td></td>
<td>Prostate</td>
<td>Acinar (adeno)carcinoma</td>
<td></td>
<td></td>
<td>8140 (adenocarcinoma NOS)</td>
</tr>
<tr>
<td>H11</td>
<td></td>
<td></td>
<td>One type</td>
<td></td>
<td></td>
<td>The histology</td>
</tr>
</tbody>
</table>
| H12  |                             |             | Final diagnosis is:  
- Adenocarcinoma in a polyp or  
- Adenocarcinoma and a residual polyp or polyp architecture is recorded in other parts of the pathology report or  
- Adenocarcinoma and there is reference to a residual or pre-existing polyp or  
- Mucinous/colloid or signet ring cell adenocarcinoma in a polyp or  
There is documentation that the patient had a polypectomy | It is important to know that the adenocarcinoma originated in a polyp | 8210 (adenocarcinoma in adenomatous polyp) or 8261 (adenocarcinoma in villous adenoma) or 8263 (adenocarcinoma in tubulovillous adenoma) |

Revised February 4, 2008
**Other Sites Histology Coding Rules – Matrix**

Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Primary Site</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H13</td>
<td></td>
<td></td>
<td>• Cancer/malignant neoplasm, NOS (8000) and a more specific histology or • Carcinoma, NOS (8010) and a more specific carcinoma or • Squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma or • A denocarcinoma, NOS (8140) and a more specific adenocarcinoma or • Melanoma, NOS (8720) and a more specific melanoma or • Sarcoma, NOS (8800) and a more specific sarcoma</td>
<td>The specific histology may be identified as type, subtype, predominantly, with features of, major, or with _____ differentiation. The terms architecture and pattern are subtypes only for in situ cancer. <strong>Example 1:</strong> A denocarcinoma, predominantly mucinous. Code mucinous adenocarcinoma (8480). <strong>Example 2:</strong> Non-small cell carcinoma, papillary squamous cell. Code papillary squamous cell carcinoma (8052).</td>
<td>The most specific histologic term</td>
<td></td>
</tr>
<tr>
<td>H14</td>
<td>Thyroid</td>
<td>Papillary carcinoma</td>
<td></td>
<td></td>
<td>8260 (papillary adenocarcinoma, NOS)</td>
<td></td>
</tr>
<tr>
<td>H15</td>
<td>Thyroid</td>
<td>Follicular and papillary carcinoma</td>
<td></td>
<td></td>
<td>8340 (Papillary carcinoma, follicular variant)</td>
<td></td>
</tr>
<tr>
<td>Rule</td>
<td>Pathology/Cytology Specimen</td>
<td>Primary Site</td>
<td>Histology</td>
<td>Behavior</td>
<td>Notes and Examples</td>
<td>Code</td>
</tr>
<tr>
<td>------</td>
<td>----------------------------</td>
<td>--------------</td>
<td>-----------</td>
<td>----------</td>
<td>--------------------</td>
<td>------</td>
</tr>
<tr>
<td>H16</td>
<td></td>
<td></td>
<td>Multiple specific histologies or A non-specific histology with multiple specific histologies</td>
<td>The specific histology may be identified as type, subtype, predominantly, with features of, major or with _____ differentiation. <em>Example 1 (multiple specific histologies):</em> Mucinous and papillary adenocarcinoma. Code 8255 (adenocarcinoma with mixed subtypes). <em>Example 2 (multiple specific histologies):</em> Combined small cell and squamous cell carcinoma. Code 8045 (combined small cell carcinoma) <em>Example 3 (non-specific with multiple specific histologies):</em> Adenocarcinoma with papillary and clear cell features. Code 8255 (adenocarcinoma with mixed subtypes)</td>
<td>The appropriate combination code (Table 2)</td>
<td></td>
</tr>
<tr>
<td>H17</td>
<td>None of the above conditions are met</td>
<td></td>
<td></td>
<td></td>
<td>The numerically higher ICD-O-3 code</td>
<td></td>
</tr>
</tbody>
</table>
Other Sites Histology Coding Rules – Matrix
Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Primary Site</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| H18  | No pathology/cytology specimen or the pathology/cytology report is not available | | | | 1: Priority for using documents to code the histology  
• Documentation in the medical record that refers to pathologic or cytologic findings  
• Physician’s reference to type of cancer (histology) in the medical record  
• CT, PET or MRI scans  
2: Code the specific histology when documented  
3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented | The histology documented by the physician |
| H19  | None from primary site | | | Code the behavior /3 | The histology from a metastatic site |
| H20  | Prostate | Acinar (adenocarcinoma) | | | 8140 (adenocarcinoma NOS) |
| H21  | Sites such as: Vulva, Vagina, Anus | Squamous intraepithelial neoplasia grade III such as: vulva (VIN III), vagina (VAIN III), anus (AIN III). | In situ | 1: 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).  
2: This code may be used for reportable-by-agreement cases | 8077/2 (Squamous intraepithelial neoplasia, grade III) |

January 1, 2007
Other Sites Histology Coding Rules – Matrix
Excludes Head and Neck, Colon, Lung, Melanoma, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

<table>
<thead>
<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Primary Site</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H22</td>
<td></td>
<td>Sites such as: Pancreas</td>
<td>Glandular intraepithelial neoplasia grade III such as: • pancreas (PAIN III)</td>
<td>In situ</td>
<td>This code may be used for reportable-by-agreement cases such as intraepithelial neoplasia of the prostate (PIN III)</td>
<td>8148/2 (Glandular intraepithelial neoplasia grade III)</td>
</tr>
<tr>
<td>H23</td>
<td></td>
<td>One type</td>
<td></td>
<td></td>
<td>Do not code terms that do not appear in the histology description. <em>Example:</em> Do not code squamous cell carcinoma non-keratinizing unless the words “non-keratinizing” actually appear in the diagnosis.</td>
<td>The histology</td>
</tr>
<tr>
<td>H24</td>
<td>Anus Perianal region Vulva</td>
<td>Extramammary Paget disease and an underlying tumor</td>
<td></td>
<td></td>
<td>The histology of the underlying tumor</td>
<td></td>
</tr>
</tbody>
</table>
### Other Sites Histology Coding Rules – Matrix

Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

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<tr>
<th>Rule</th>
<th>Pathology/Cytology Specimen</th>
<th>Primary Site</th>
<th>Histology</th>
<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
</table>
| H25  |                             |              | Final diagnosis is:  
- A adenocarcinoma in a polyp or  
- A adenocarcinoma and a residual polyp or polyp architecture is recorded in other parts of the pathology report or  
- A adenocarcinoma and there is reference to a residual or pre-existing polyp or  
- Mucinous/colloid or signet ring cell adenocarcinoma in a polyp or  
There is documentation that the patient had a polypectomy | It is important to know that the adenocarcinoma originated in a polyp | | 8210 (adenocarcinoma in adenomatous polyp) or 8261 (adenocarcinoma in villous adenoma) or 8263 (adenocarcinoma in tubulovillous adenoma) |
| H26  | Thyroid                     |              | Papillary carcinoma | | | 8260 (papillary adenocarcinoma, NOS) |
| H27  | Thyroid                     |              | Follicular and papillary carcinoma | | | 8340 (Papillary carcinoma, follicular variant) |
**Other Sites Histology Coding Rules – Matrix**
Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

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<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H28</td>
<td></td>
<td></td>
<td></td>
<td>Invasive and in situ</td>
<td>This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category.</td>
<td>The single invasive histology. Ignore the in situ terms</td>
</tr>
<tr>
<td>H29</td>
<td></td>
<td></td>
<td>• Cancer/malignant neoplasm, NOS (8000) and a more specific histology or • Carcinoma, NOS (8010) and a more specific carcinoma or • Squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma or • A denocarcinoma, NOS (8140) and a more specific adenocarcinoma or • Melanoma, NOS (8720) and a more specific melanoma or • Sarcoma, NOS (8800) and a more specific sarcoma</td>
<td>The specific histology may be identified as type, subtype, predominantly, with features of, major, or with differentiation. The terms architecture and pattern are subtypes only for in situ cancer. <strong>Example 1:</strong> A adenocarcinoma, predominantly mucinous. Code mucinous adenocarcinoma (8480). <strong>Example 2:</strong> Non-small cell carcinoma, papillary squamous cell. Code papillary squamous cell carcinoma (8052).</td>
<td>The most specific histologic term</td>
<td></td>
</tr>
</tbody>
</table>
Other Sites Histology Coding Rules – Matrix
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<th>Behavior</th>
<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
</table>
| H30  |                            |              | Multiple specific histologies or A non-specific histology with multiple specific histologies | The specific histologies may be identified as a type, subtype, predominantly, with features of, major, or with _____ differentiation.  
*Example 1 (multiple specific histologies):* Gyn malignancy with mucinous, serous and papillary adenocarcinoma. Code 8323 (mixed cell adenocarcinoma)  
*Example 2 (multiple specific histologies):* Combined small cell and squamous cell carcinoma. Code 8045 (combined small cell carcinoma).  
*Example 3 (non-specific with multiple specific histologies):* Adenocarcinoma with papillary and clear cell features. Code 8255 (adenocarcinoma with mixed subtypes) | The appropriate combination/mixed code (Table 2) |      |
| H31  | None of the above conditions are met |              |          |          | The numerically higher ICD-O-3 code |      |
VIII.

Text Format – Multiple Primary and Histology Coding Rules
# Head and Neck Multiple Primary Rules - Text

**C000-C148, C300-C329**

*(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)*

## UNKNOWN IF SINGLE OR MULTIPLE TUMORS

*Note:* Tumor(s) not described as metastasis

**Rule M1**

When it is not possible to determine if there is a **single** tumor or **multiple** tumors, opt for a single tumor and abstract as a single primary.*

*Note:* Use this rule only after all information sources have been exhausted.

**Example 1:** History and physical exam states large tumor in nasopharynx. Biopsy base of tongue shows squamous cell carcinoma. No further information available. Abstract as a single primary.

**Example 2:** Pathology report states extensive squamous cell carcinoma involving nasopharynx and larynx. Fragments of epiglottis positive for squamous cell carcinoma. No other information available. Abstract as a single primary.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

This is the end of instructions for Unknown if Single or Multiple Tumors.

## SINGLE TUMOR

*Note 1:* Tumor not described as metastasis  
*Note 2:* Includes combinations of in situ and invasive

**Rule M2**

A **single tumor** is always a single primary. *

*Note:* The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

This is the end of instructions for Single Tumor.  
* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

## MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.

*Note 1:* Tumors not described as metastases  
*Note 2:* Includes combinations of in situ and invasive

**Rule M3**

Tumors on the **right** side and the **left** side of a **paired site** are multiple primaries. **

*Note:* See Table 1 for list of paired sites.

**Rule M4**

Tumors on the **upper lip** (C000 or C003) and the **lower lip** (C001 or C004) are multiple primaries. **

**Rule M5**

Tumors on the **upper gum** (C030) and the **lower gum** (C031) are multiple primaries. **
Head and Neck Multiple Primary Rules - Text
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

Rule M6 Tumors in the nasal cavity (C300) and the middle ear (C301) are multiple primaries. **

Rule M7 Tumors in sites with ICD-O-3 topography codes that are different at the second (Cxxx) and/or third (Cxxxx) character are multiple primaries. **

Rule M8 An invasive tumor following an in situ tumor more than 60 days after diagnosis is a multiple primary. **

Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M9 Tumors diagnosed more than five (5) years apart are multiple primaries. **

Rule M10 Abstract as a single primary* when one tumor is:
- Cancer/malignant neoplasm, NOS (8000) and another is a specific histology or
- Carcinoma, NOS (8010) and another is a specific carcinoma or
- Adenocarcinoma, NOS (8140) and another is a specific adenocarcinoma or
- Squamous cell carcinoma, NOS (8070) and another is specific squamous cell carcinoma or
- Melanoma, NOS (8720) and another is a specific melanoma
- Sarcoma, NOS (8800) and another is a specific sarcoma

Rule M11 Tumors with ICD-O-3 histology codes that are different at the first (xxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M12 Tumors that do not meet any of the above criteria are abstracted as a single primary. *

Note 1: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.
Note 2: All cases covered by Rule M12 have the same first 3 numbers in ICD-O-3 histology code.

This is the end of instructions for Multiple Tumors.
* If a single primary, prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** If multiple primaries, prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

Rule M12 Examples: The following are examples of cases that use Rule M12. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. Warning: Using only these case examples to determine the number of primaries can result in major errors.

| Example 1: Multifocal tumors in floor of mouth | Example 2: An in situ and invasive tumor diagnosed within 60 days | Example 3: In situ following an invasive tumor more than 60 days apart |

January 1, 2007
Head and Neck Histology Coding Rules - Text  
C000-C148, C300-C329  
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

**SINGLE TUMOR**

**Rule H1** Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

*Note 1:* Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of cancer (histology) in the medical record
- CT, PET, or MRI scans

*Note 2:* Code the specific histology when documented.

*Note 3:* Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

**Rule H2** Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

*Note:* Code the behavior /3.

**Rule H3** Code the histology when only **one histologic type** is identified.

*Example:* Squamous cell carcinoma. Code 8070.

*Note:* Do not code terms that do not appear in the histology description.

*Example:* Do not code 8072 (squamous cell carcinoma non-keratinizing) unless the words “non-keratinizing” actually appear in the diagnosis.

**Rule H4** Code the **invasive** histologic type when a single tumor has invasive and in situ components.

*Example:* The final diagnosis is keratinizing squamous cell carcinoma (8071) with areas of squamous cell carcinoma in situ (8070). Code the invasive histologic type, keratinizing squamous cell carcinoma (8071).
Head and Neck Histology Coding Rules - Text
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Rule H5  Code the most specific histologic term using Chart 1 when there are multiple histologies within the same branch. Examples of histologies within the same branch are:
- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Squamous cell carcinoma, NOS (8070) and a more specific squamous carcinoma or
- Adenocarcinoma, NOS(8140) and a more specific adenocarcinoma or
- Melanoma, NOS (8720) and a more specific melanoma or
- Sarcoma, NOS (8800) and a more specific sarcoma

*Note 1:* The specific histology for in situ lesions may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

*Note 2:* The specific histology for invasive lesions may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation

*Example:* The final diagnosis is squamous cell carcinoma (8070), papillary (8050). Code the specific type, papillary (8050).

Rule H6  Code the histology with the numerically higher ICD-O-3 code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

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MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H7  Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.

*Note 1:* Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of cancer (histology) in the medical record
- CT, PET, or MRI scans

*Note 2:* Code the specific histology when documented.

*Note 3:* Code the histology to 8000 (cancer/malignant neoplasm, NOS), or 8010 (carcinoma, NOS) as stated by the physician when no specific histology is documented.

Rule H8  Code the histology from the metastatic site when there is no pathology/cytology specimen from the primary site.

*Note:* Code the behavior /3.
Head and Neck Histology Coding Rules - Text
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Rule H9  Code the histology when only one histologic type is identified.

Example: Squamous cell carcinoma. Code 8070.

Note: Do not code terms that do not appear in the histology description.

Example: Do not code 8072 (squamous cell carcinoma non-keratinizing) unless the words “non-keratinizing” actually appear in the diagnosis.

Rule H10  Code the histology of the most invasive tumor.

Note 1: See the Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations for the definition of most invasive.

- One tumor is in situ and one is invasive, code the histology from the invasive tumor.
- Both/all histologies are invasive, code the histology of the more invasive tumor.

Note 2: If tumors are equally invasive, go to the next rule.

Rule H11  Code the most specific histologic term using Chart 1 when there are multiple histologies within the same branch. Examples of histologies within the same branch are:

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Squamous cell carcinoma, NOS (8070) and a more specific squamous carcinoma or
- Adenocarcinoma, NOS(8140) and a more specific adenocarcinoma or
- Melanoma, NOS (8720) and a more specific melanoma or
- Sarcoma, NOS (8800) and a more specific sarcoma

Note 1: The specific histology for in situ lesions may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 2: The specific histology for invasive lesions may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation

Example: The final diagnosis is squamous cell carcinoma (8070), papillary (8050). Code the specific type, papillary (8050).

Rule H12  Code the histology with the numerically higher ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.
Colon Multiple Primary Rules – Text  
C180 - C189  
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

**UNKNOWN IF SINGLE OR MULTIPLE TUMORS**

*Note: Tumor(s) not described as metastasis*

**Rule M1** When it is not possible to determine if there is a **single** tumor or **multiple** tumors, opt for a single tumor and abstract as a single primary.*  
*Note: Use this rule only after all information sources have been exhausted.*  

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.  
This is the end of instructions for Unknown if Single or Multiple Tumors.

**SINGLE TUMOR**

*Note 1: Tumor not described as metastasis*  
*Note 2: Includes combinations of in situ and invasive*

**Rule M2** A **single tumor** is always a single primary. *  
*Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.*  

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.  
This is the end of instructions for Single Tumor.

**MULTIPLE TUMORS**

Multiple tumors may be a single primary or multiple primaries.  
*Note 1: Tumors not described as metastases*  
*Note 2: Includes combinations of in situ and invasive*

**Rule M3** Adenocarcinoma in adenomatous polyposis coli (familial polyposis) with one or more malignant polyps is a single primary.*  
*Note: Tumors may be present in multiple segments of the colon or in a single segment of the colon.*  

**Rule M4** Tumors in sites with **ICD-O-3 topography** codes that are different at the second (Cxxx), third, (Cxx) or fourth (C18x) character are multiple primaries. **

**Rule M5** Tumors diagnosed **more than one (1) year** apart are multiple primaries. **
Colon Multiple Primary Rules – Text
C180 - C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule M6  An invasive tumor following an in situ tumor more than 60 days after diagnosis are multiple primaries. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M7  A frank malignant or in situ adenocarcinoma and an in situ or malignant tumor in a polyp are a single primary.*

Rule M8  Abstract as a single primary* when one tumor is:
- Cancer/malignant neoplasm, NOS (8000) and another is a specific histology or
- Carcinoma, NOS (8010) and another is a specific carcinoma or
- Adenocarcinoma, NOS (8140) and another is a specific adenocarcinoma or
- Sarcoma, NOS (8800) and another is a specific sarcoma

Rule M9  Multiple in situ and/or malignant polyps are a single primary.*
Note: Includes all combinations of adenomatous, tubular, villous, and tubulovillous adenomas or polyps.

Rule M10  Tumors with ICD-O-3 histology codes that are different at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M11  Tumors that do not meet any of the above criteria are a single primary.*
Note 1: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.
Note 2: All cases covered by Rule M11 are in the same segment of the colon.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.
This is the end of instructions for Multiple Tumors.
Colon Histology Coding Rules – Text
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

Rule H1  Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.
Note 1: Priority for using documents to code the histology
● Documentation in the medical record that refers to pathologic or cytologic findings
● Physician’s reference to type of cancer (histology) in the medical record
● CT, PET or MRI scans
Note 2: Code the specific histology when documented.
Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H2  Code the histology from a metastatic site when there is no pathology/cytology specimen from the primary site.
Note: Code the behavior /3.

Rule H3  Code 8140 (adenocarcinoma, NOS) when pathology describes only intestinal type adenocarcinoma or adenocarcinoma, intestinal type.
Note 1: Intestinal type adenocarcinoma usually occurs in the stomach.
Note 2: When a diagnosis of intestinal adenocarcinoma is further described by a specific term such as type, continue to the next rule.

Rule H4  Code 8210 (adenocarcinoma in adenomatous polyp), 8261 (adenocarcinoma in villous adenoma), or 8263 (adenocarcinoma in tubulovillous adenoma) when:
● The final diagnosis is adenocarcinoma in a polyp
● The final diagnosis is adenocarcinoma and a residual polyp or polyp architecture is recorded in other parts of the pathology report.
● The final diagnosis is adenocarcinoma and there is reference to a residual or pre-existing polyp or
● The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in a polyp or
● There is documentation that the patient had a polypectomy
Note 1: It is important to know that the adenocarcinoma originated in a polyp.
Note 2: Code adenocarcinoma in a polyp only when the malignancy is in the residual polyp (adenoma) or references to a pre-existing polyp (adenoma) indicate that the malignancy and the polyp (adenoma) are the same lesion.

Rule H5  Code 8480 (mucinous/colloid adenocarcinoma) or 8490 (signet ring cell carcinoma) when the final diagnosis is:
● Mucinous/colloid (8480) or signet ring cell carcinoma (8490) or
● Adenocarcinoma, NOS and the microscopic description documents that 50% or more of the tumor is mucinous/colloid or
● Adenocarcinoma, NOS and the microscopic description documents that 50% or more of the tumor is signet ring cell carcinoma

Revised November 1, 2007
Colon Histo

Colon Histology Coding Rules – Text
C180-C189

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H6  Code 8140 (adenocarcinoma, NOS) when the final diagnosis is adenocarcinoma and:
- The microscopic diagnosis states that less than 50% of the tumor is mucinous/colloid or
- The microscopic diagnosis states that less than 50% of the tumor is signet ring cell carcinoma or
- The percentage of mucinous/colloid or signet ring cell carcinoma is unknown.

Rule H7  Code 8255 (adenocarcinoma with mixed subtypes) when there is a combination of mucinous/colloid and signet ring cell carcinoma.

Rule H8  Code 8240 (carcinoid tumor, NOS) when the diagnosis is neuroendocrine carcinoma (8246) and carcinoid tumor (8240).

Rule H9  Code 8244 (composite carcinoid) when the diagnosis is adenocarcinoma and carcinoid tumor.

Rule H10 Code 8245 (adenocarcinoid) when the diagnosis is exactly “adenocarcinoid.”

Rule H11 Code the histology when only one histologic type is identified.

Rule H12 Code the invasive histology when both invasive and in situ histologies are present.

Rule H13 Code the most specific histologic term when the diagnosis is:
- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Sarcoma, NOS (8800) and a more specific sarcoma (invasive only)

Note 1: The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ___differentiation

Note 2: The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with ___differentiation.

Rule H14 Code the histology with the numerically higher ICD-O-3 code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.
Colon Histology Coding Rules – Text
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Note: These rules only apply to multiple tumors that are reported as a single primary.

Rule H15 Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of cancer (histology) in the medical record
- From CT, PET or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H16 Code the histology from a metastatic site when there is no pathology/cytology specimen from the primary site.

Note: Code the behavior /3.

Rule H17 Code 8220 (adenocarcinoma in adenomatous polyposis coli) when:
- Clinical history says familial polyposis and final diagnosis on the pathology report from resection is adenocarcinoma in adenomatous polyps or
- There are >100 polyps identified in the resected specimen or
- The number of polyps is not given but the diagnosis is familial polyposis

Rule H18 Code 8263 (adenocarcinoma in a tubulovillous adenoma) when multiple in situ or malignant polyps are present, at least one of which is tubulovillous

Note: Use this rule only when there are multiple polyps or adenomas. Do not use this rule if there is a frank adenocarcinoma and a malignancy in a single polyp or adenoma.

Rule H19 Code 8221 (adenocarcinoma in multiple adenomatous polyps) when:
- There are >1 and <=100 polyps identified in the resected specimen or
- There are multiple polyps (adenomas) and the number is not given and familial polyposis is not mentioned

Note: Use this rule only when there are multiple polyps. Do not use for a single polyp (adenoma) or for a frank malignancy and a malignancy in a single polyp (adenoma).
Rule H20  Code the histology of the most invasive tumor when:
- There is a frank adenocarcinoma and a carcinoma in a polyp or
- There are in situ and invasive tumors or
- There are multiple invasive tumors

*Note 1:* See the Colon Equivalent Terms, Definitions and Illustrations for the definition of most invasive.
- One tumor is in situ and one is invasive, code the histology from the invasive tumor.
- Both/all histologies are invasive, code the histology of the most invasive tumor.

*Note 2:* If tumors are equally invasive, go to the next rule

Rule H21  Code 8210 (adenocarcinoma in adenomatous polyp), 8261 (adenocarcinoma in villous adenoma), or 8263 (adenocarcinoma in tubulovillous adenoma) when:
- The final diagnosis is adenocarcinoma and the microscopic description or surgical gross describes polyps or
- The final diagnosis is adenocarcinoma and there is reference to residual or pre-existing polyps or
- The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in polyps or
- There is documentation that the patient had a polypectomy

*Note:* It is important to know that the adenocarcinoma originated in a polyp.

Rule H22  Code the histology when only one histologic type is identified.

Rule H23  Code the more specific histologic term when the diagnosis is:
- Cancer/malignant neoplasm, NOS (8000) and a specific histology or
- Carcinoma, NOS (8010) and a specific carcinoma or
- Adenocarcinoma, NOS (8140) and a specific adenocarcinoma or
- Sarcoma, NOS (8800) and a specific sarcoma (invasive only)

*Note 1:* The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

*Note 2:* The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H24  Code the histology with the numerically higher ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.
Lung Multiple Primary Rules – Text
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

*Note: Tumor(s) not described as metastasis*

**Rule M1** When it is not possible to determine if there is a **single** tumor or **multiple** tumors, opt for a single tumor and abstract as a single primary.*

*Note 1:* Use this rule only after all information sources have been exhausted.

*Note 2:* Use this rule when only one tumor is biopsied but the patient has two or more tumors in one lung and may have one or more tumors in the contralateral lung. (See detailed explanation in Lung Equivalent Terms and Definitions)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
This is the end of instructions for Unknown if Single or Multiple Tumors.

**SINGLE TUMOR**

*Note: Tumor not described as metastasis*

**Rule M2** A **single tumor** is always a single primary. *

*Note:* The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
This is the end of instructions for Single Tumor.

**MULTIPLE TUMORS**

Multiple tumors may be a single primary or multiple primaries.

*Note: Tumors not described as metastases*

**Rule M3** Tumors in sites with ICD-O-3 **topography** codes that are **different** at the second (Cx̂x) and/or third character (Ĉx̂x) are multiple primaries. **

*Note:* This is a change in rules; tumors in the trachea (C33) and in the lung (C34) were a single lung primary in the previous rules.

**Rule M4** At least one tumor that is **non-small cell** carcinoma (8046) and another tumor that is **small cell** carcinoma (8041-8045) are multiple primaries. **

**Rule M5** A tumor that is **adenocarcinoma** with **mixed subtypes** (8255) and another that is **bronchioloalveolar** (8250-8254) are multiple primaries. **

Lung MP
Rule M6  A single tumor in each lung is multiple primaries. **

Note: When there is a single tumor in each lung abstract as multiple primaries unless stated or proven to be metastatic.

Rule M7  Multiple tumors in both lungs with ICD-O-3 histology codes that are different at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M8  Tumors diagnosed more than three (3) years apart are multiple primaries. **

Rule M9  An invasive tumor following an in situ tumor more than 60 days after diagnosis is a multiple primary. **

Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.

Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M10  Tumors with non-small cell carcinoma, NOS (8046) and a more specific non-small cell carcinoma type (Chart 1) are a single primary.*

Rule M11  Tumors with ICD-O-3 histology codes that are different at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Note: Adenocarcinoma in one tumor and squamous cell carcinoma in another tumor are multiple primaries.

Rule M12  Tumors that do not meet any of the above criteria are a single primary.*

Note 1: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.

Note 2: All cases covered by this rule are the same histology.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

This is the end of instructions for Multiple Tumors.

Rule M12 Examples: The following are examples of cases that use Rule M12. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. Warning: Using only these case examples to determine the number of primaries can result in major errors.

<table>
<thead>
<tr>
<th>Example 1: Solitary tumor in one lung, multiple tumors in contralateral lung</th>
<th>Example 2: Diffuse bilateral nodules (This is the only condition when laterality = 4)</th>
<th>Example 3: An in situ and invasive tumor diagnosed within 60 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example 4: Multiple tumors in left lung metastatic from right lung</td>
<td>Example 5: Multiple tumors in one lung</td>
<td>Example 6: Multiple tumors in both lungs</td>
</tr>
</tbody>
</table>

January 1, 2007
Lung Histology Coding Rules – Text
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

Rule H1  Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.

*Note 1:* Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of cancer (histology) in the medical record
- CT, PET, or MRI scans
- Chest x-rays

*Note 2:* Code the specific histology when documented.

*Note 3:* Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H2  Code the histology from a metastatic site when there is no pathology/cytology specimen from the primary site.

*Note:* Code the behavior /3.

Rule H3  Code the histology when only one histologic type is identified.

*Note:* Do not code terms that do not appear in the histology description.

**Example 1:** Do not code squamous cell carcinoma non-keratinizing unless the words “non-keratinizing” actually appear in the diagnosis.

**Example 2:** Do not code bronchioalveolar non-mucinous unless the words “non-mucinous” actually appear in the diagnosis.

Rule H4  Code the invasive histologic type when a single tumor has invasive and in situ components

Rule H5  Code the most specific term using Chart 1 when there are multiple histologies within the same branch. Examples of histologies within the same branch are:
- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma or
- Sarcoma, NOS (8800) and a more specific sarcoma

*Note:* The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation

**Example 1:** Adenocarcinoma, predominantly mucinous. Code 8480 (mucinous adenocarcinoma).

**Example 2:** Non-small cell carcinoma, papillary squamous cell. Code 8052 (papillary squamous cell carcinoma).
Lung Histology Coding Rules – Text
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H6  Code the appropriate combination/mixed code (Table 1) when there are multiple specific histologies or when there is a non-specific with multiple specific histologies

Note: The specific histologies may be identified as type, subtype, predominantly, with features of, major, or with ____ differentiation.


Example 3 (non-specific with multiple specific histologies): Adenocarcinoma with papillary and clear cell features. Code 8255 (adenocarcinoma with mixed subtypes).

Rule H7  Code the histology with the numerically higher ICD-O-3 code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H8  Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of cancer (histology) in the medical record
- CT, PET, or MRI scans
- Chest x-rays

Note 2: Code the specific histology when documented.
Note 3: Code the histology to 8000 (cancer/malignant neoplasm), or 8010 (carcinoma) as stated by the physician when nothing more specific is documented.

Rule H9  Code the histology from a metastatic site when there is no pathology/cytology specimen from the primary site.

Note: Code the behavior /3.

Rule H10  Code the histology when only one histologic type is identified.

Note: Do not code terms that do not appear in the histology description.

Example 1: Do not code squamous cell carcinoma non-keratinizing unless the words “non-keratinizing” actually appear in the diagnosis.

Example 2: Do not code bronchioalveolar non-mucinous unless the words “non-mucinous” actually appear in the diagnosis.

January 1, 2007
Lung Histology Coding Rules – Text
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H11  Code the histology of the most invasive tumor.
           Note 1: This rule should only be used when the first three numbers of the histology codes are identical (This is a single primary.)
           Note 2: See the Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations for the definition of most invasive.
           • One tumor is in situ and one is invasive, code the histology from the invasive tumor.
           • Both/all histologies are invasive, code the histology of the most invasive tumor.

Rule H12  Code the most specific term using Chart 1 when there are multiple histologies within the same branch. Examples of histologies within the same branch are:
           • Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
           • Carcinoma, NOS (8010) and a more specific carcinoma or
           • Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
           • Squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma or
           • Sarcoma, NOS (8800) and a more specific sarcoma
           Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ____ differentiation
           Example 1: Adenocarcinoma, predominantly mucinous. Code 8480 (mucinous adenocarcinoma).

Rule H13  Code the histology with the numerically higher ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.
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Melanoma MP

Cutaneous Melanoma Multiple Primary Rules – Text
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

UNKNOWN IF SINGLE OR MULTIPLE MELANOMAS
Note: Melanoma(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a single melanoma or multiple melanomas, opt for a single melanoma and abstract as a single primary.∗
Note: Use this rule only after all information sources have been exhausted

∗ Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
This is the end of instructions for Unknown if Single or Multiple Melanoma.

SINGLE MELANOMA
Note 1: Melanoma not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 A single melanoma is always a single primary. *

∗ Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
This is the end of instructions for Single Melanoma.

MULTIPLE MELANOMAS
Multiple melanomas may be a single primary or multiple primaries
Note 1: Melanoma not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M3 Melanomas in sites with ICD-O-3 topology codes that are different at the second (Cxx), third (Cxx) or fourth (C44x) character are multiple primaries. **

January 1, 2007

[295]
Cutaneous Melanoma Multiple Primary Rules – Text
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

Rule M4  Melanomas with different laterality are multiple primaries. **
  
  Note: A midline melanoma is a different laterality than right or left.
  Example 1: Melanoma of the right side of the chest and a melanoma at midline of the chest are different laterality, multiple primaries
  Example 2: A melanoma of the right side of the chest and a melanoma of the left side of the chest are multiple primaries

Rule M5  Melanomas with ICD-O-3 histology codes that are different at the first (xxxx), second (x.xxx) or third number (xxx) are multiple primaries. **

Rule M6  An invasive melanoma that occurs more than 60 days after an in situ melanoma is a multiple primary. **
  
  Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
  Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M7  Melanomas diagnosed more than 60 days apart are multiple primaries. **

Rule M8  Melanomas that do not meet any of the above criteria are abstracted as a single primary. *
  
  Note 1: Use the data item “Multiplicity Counter” to record the number of melanomas abstracted as a single primary.
  Note 2: When an invasive melanoma follows an in situ melanoma within 60 days, abstract as a single primary.
  Note 3: All cases covered by this rule are the same site and histology.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

This is the end of instructions for Multiple Melanomas.

Rule M8 Examples: The following are examples of cases that use Rule M8. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. Warning: Using only these case examples to determine the number of primaries can result in major errors.

Example 1: Solitary melanoma on the left back and another solitary melanoma on the left chest.
Example 2: Solitary melanoma on the right thigh and another solitary melanoma on the right ankle.
SINGLE MELANOMA OR MULTIPLE MELANOMAS ABSTRACTED AS A SINGLE PRIMARY

Rule H1  Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.

Note 1:  Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of melanoma in the medical record
- PET scan

Note 2:  Code the specific histology when documented.

Rule H2  Code the histology from the metastatic site when there is no pathology/cytology specimen from the primary site.

Note:  Code the behavior /3.

Rule H3  Code the histology when only one histologic type is identified.

Rule H4  Code the invasive histologic type when there are invasive and in situ components.

Rule H5  Code the histologic type when the diagnosis is regressing melanoma and a histologic type.

Example:  Nodular melanoma with features of regression.  Code 8721 (Nodular melanoma).

Rule H6  Code 8723 (Malignant melanoma, regressing) when the diagnosis is regressing melanoma.

Example:  Malignant melanoma with features of regression.  Code 8723.

Rule H7  Code the histologic type when the diagnosis is lentigo maligna melanoma and a histologic type.

Rule H8  Code 8742 (Lentigo maligna melanoma) when the diagnosis is lentigo maligna melanoma.

Rule H9  Code the most specific histologic term when the diagnosis is melanoma, NOS (8720) with a single specific type.

Note 1:  The specific type for in situ lesions may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ___differentiation

Note 2:  The specific type for invasive lesions may be identified as type, subtype, predominantly, with features of, major, or with ___differentiation.
Cutaneous Melanoma Histology Coding Rules – Text
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

**Rule H10**   Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Single Melanoma or Multiple Melanomas Abstracted as a Single Primary. Code the histology according to the rule that fits the case.
Breast Multiple Primary Rules- Text
C500-C509
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** tumor or **multiple** tumors, opt for a single tumor and abstract as a single primary. *

Note: Use this rule only after all information sources have been exhausted.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
This is the end of instructions for Unknown if Single or Multiple Tumors.

SINGLE TUMOR

Note 1: Tumor not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 **Inflammatory carcinoma** in one or both breasts is a single primary. *

Rule M3 A **single tumor** is always a single primary. *

Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
This is the end of instructions for Single Tumor.

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.

Note 1: Tumors not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M4 Tumors in sites with ICD-O-3 **topography** codes (Cxxx) with **different** second (Cxxx) and/or third characters (Cxxx) are multiple primaries. **

Rule M5 Tumors diagnosed **more than five (5) years** apart are multiple primaries. **
Breast Multiple Primary Rules- Text  
C500-C509  
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Rule M6  Inflammatory carcinoma in one or both breasts is a single primary. *

Rule M7  Tumors on both sides (right and left breast) are multiple primaries. **

Note: Lobular carcinoma in both breasts (“mirror image”) is a multiple primary.

Rule M8  An invasive tumor following an in situ tumor more than 60 days after diagnosis is a multiple primary. **

Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.

Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M9  Tumors that are intraductal or duct and Paget Disease are a single primary. *

Note: Use Table 1 and Table 2 to identify intraductal and duct carcinomas

Rule M10  Tumors that are lobular (8520) and intraductal or duct are a single primary. *

Note: Use Table 1 and Table 2 to identify intraductal and duct carcinomas

Rule M11  Multiple intraductal and/or duct carcinomas are a single primary. *

Note: Use Table 1 and Table 2 to identify intraductal and duct carcinomas

Rule M12  Tumors with ICD-O-3 histology codes that are different at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M13  Tumors that do not meet any of the above criteria are abstracted as a single primary. *

Note 1: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.

Note 2: All cases covered by Rule M13 have the same first 3 numbers in ICD-O-3 histology code.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

This is the end of instructions for Multiple Tumors.

Rule M13 Examples: The following are examples of cases that use Rule M13. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. Warning: Using only these case examples to determine the number of primaries can result in major errors.

Example 1: Invasive duct and intraductal carcinoma in the same breast  
Example 2: Multi-centric lobular carcinoma, left breast

January 1, 2007
Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>SINGLE TUMOR: IN SITU CARCINOMA ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Single Tumor; all parts are in situ)</td>
</tr>
</tbody>
</table>

**Rule H1**  
Code the histology documented by the physician when the *pathology/cytology* report is **not available**.

*Note 1:* Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of cancer (histology) in the medical record

*Note 2:* Code the specific histology when documented.

**Rule H2**  
Code the histology when only **one histologic type** is identified

**Rule H3**  
**Code the more specific histologic term when** the diagnosis is:
- Carcinoma in situ, NOS (8010) and a specific carcinoma in situ or
- Adenocarcinoma in situ, NOS (8140) and a specific adenocarcinoma in situ or
- Intraductal carcinoma, NOS (8500) and a specific intraductal carcinoma (Table 1)

*Note:* The specific histology may be identified as type, subtype, predominantly, with features of, major, with ___ differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.

**Rule H4**  
Code **8501/2** (comedocarcinoma, non-infiltrating) when there is **non-infiltrating comedocarcinoma and any other intraductal** carcinoma (Table 1).

*Example:* Pathology report reads intraductal carcinoma with comedo and solid features. Code 8501/2 (comedocarcinoma).

**Rule H5**  
Code **8522/2** (intraductal carcinoma and lobular carcinoma in situ) (Table 3) when there is a combination of **in situ lobular** (8520) and **intraductal** carcinoma (Table 1).

**Rule H6**  
Code **8523/2** (intraductal carcinoma mixed with other types of in situ carcinoma) (Table 3) when there is a combination of intraductal carcinoma and **two or more specific intraductal types** OR there are **two or more specific intraductal carcinomas**.

**Rule H7**  
Code **8524/2** (in situ lobular mixed with other types of in situ carcinoma) (Table 3) when there is **in situ lobular** (8520) and **any in situ carcinoma other than intraductal** carcinoma (Table 1).

*Note:* Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

Revised November 1, 2007
Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H8  Code 8255/2 (adenocarcinoma in situ with mixed subtypes) (Table 3) when there is a combination of in situ/non-invasive histologies that does not include either intraductal carcinoma (Table 1) or in situ lobular (8520).

Note: Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

This is the end of instructions for a Single Tumor: In Situ Carcinoma Only.
Code the histology according to the rule that fits the case.

SINGLE TUMOR: INVASIVE AND IN SITU CARCINOMA
(Single Tumor; in situ and invasive components)

Rule H9  Code the invasive histology when both invasive and in situ components are present.

Note 1: Ignore the in situ terms.

Note 2: This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive duct and in situ lobular are coded to invasive duct (8500/3) rather than the combination code for duct and lobular carcinoma (8522/3).

This is the end of instructions for a Single Tumor: Invasive and In Situ Carcinoma.
Code the histology according to the rule that fits the case.

SINGLE TUMOR: INVASIVE CARCINOMA ONLY
(Single Tumor; all parts are invasive)

Rule H10  Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.

Note 1: Priority for using documents to code the histology

• Documentation in the medical record that refers to pathologic or cytologic findings
• Physician’s reference to type of cancer (histology) in the medical record
• Mammogram
• PET scan
• Ultrasound

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.
Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H11  Code the histology from a metastatic site when there is no pathology/cytology specimen from the primary site.
Note: Code the behavior /3.

Rule H12  Code the most specific histologic term when the diagnosis is:
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Duct carcinoma, NOS (8500) and a more specific duct carcinoma (8022, 8035, 8501-8508) or
- Sarcoma, NOS (8800) and a more specific sarcoma
Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, with ___ differentiation. The terms architecture and pattern are subtypes only for in situ cancer.

Rule H13  Code 8530 (inflammatory carcinoma) only when the final diagnosis of the pathology report specifically states inflammatory carcinoma.
Note: Record dermal lymphatic invasion in Collaborative Staging

Rule H14  Code the histology when only one histologic type is identified.

Rule H15  Code the histology with the numerically higher ICD-O-3 code when there are two or more specific duct carcinomas.
Note: Use Table 2 to identify duct carcinomas

Rule H16  Code 8522 (duct and lobular) when there is a combination of lobular (8520) and duct carcinoma (Table 3).
Note: Use Table 2 to identify duct carcinomas

Rule H17  Code 8523 (duct mixed with other types of carcinoma) when there is a combination of duct and any other carcinoma (Table 3).
Note 1: Use Table 2 to identify duct carcinomas
Note 2: Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table

Rule H18  Code 8524 (lobular mixed with other types of carcinoma) when the tumor is lobular (8520) and any other carcinoma (Table 3).
Note: Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.

Rule H19  Code 8255 (adenocarcinoma with mixed subtypes) (Table 3) for multiple histologies that do not include duct or lobular (8520).
Note: Use Table 2 to identify duct carcinomas

This is the end of instructions for a Single Tumor: Invasive Carcinoma Only.
Code the histology according to the rule that fits the case.
MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H20  Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.

*Note 1:* Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of cancer (histology) in the medical record
- Mammogram
- PET scan
- Ultrasound

*Note 2:* Code the specific histology when documented.

*Note 3:* Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H21  Code the histology from a metastatic site when there is no pathology/cytology specimen from the primary site.

*Note:* Code the behavior /3.

Rule H22  Code 8530 (inflammatory carcinoma) only when the final diagnosis of the pathology report specifically states inflammatory carcinoma.

*Note:* Record dermal lymphatic invasion in Collaborative Staging

Rule H23  Code the histology when only one histologic type is identified.

Rule H24  Code 8543/2 (in situ Paget disease and intraductal carcinoma) *(Table 3)* when the pathology report specifically states that the Paget disease is in situ and the underlying tumor is intraductal carcinoma (Table 1).

*Note:* Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

Rule H25  Code 8543/3 (Paget disease and intraductal carcinoma) for Paget disease and intraductal carcinoma *(Table 3).*

*Note 1:* ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3).

*Note 2:* Includes both invasive Paget disease and Paget disease with behavior not stated.

*Note 3:* Use Table 1 to identify intraductal carcinomas.

Rule H26  Code 8541/3 (Paget disease and infiltrating duct carcinoma) for Paget disease and invasive duct carcinoma *(Table 3).*

*Note 1:* ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3).

*Note 2:* Includes both invasive Paget disease and Paget disease with behavior not stated.

*Note 3:* Use Table 2 to identify duct intraductal carcinomas

Revised November 1, 2007
Rule H27 Code the invasive histology when both invasive and in situ tumors are present.

*Note 1:* Ignore the in situ terms.

*Note 2:* This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive lobular and in situ duct carcinoma are coded to invasive lobular (8520/3) rather than the combination code for duct and lobular carcinoma (8522/3).

Rule H28 Code 8522 (duct and lobular) when there is any combination of lobular (8520) and duct carcinoma. *(Table 3).*

*Note:* Use Table 2 to identify duct carcinomas

Rule H29 Code the histology with the numerically higher ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.

Code the histology according to the rule that fits the case.
Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

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**UNKNOWN IF SINGLE OR MULTIPLE TUMORS**

*Note:* Tumor(s) not described as metastasis

**Rule M1** When it is not possible to determine if there is a single tumor or multiple tumors, opt for a single tumor and abstract as a single primary.*

*Note:* Use this rule only after all information sources have been exhausted.

*Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.*

This is the end of instructions for Unknown if Single or Multiple Tumors.

**SINGLE TUMOR**

*Note 1:* Tumor not described as metastasis
*Note 2:* Includes combinations of in situ and invasive

**Rule M2** A single tumor is always a single primary. *

*Note:* The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

*Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.*

This is the end of instructions for single tumors.

**MULTIPLE TUMORS**

Multiple tumors may be a single primary or multiple primaries.

*Note 1:* Tumors not described as metastases
*Note 2:* Includes combinations of in situ and invasive

**Rule M3** Wilms tumors are a single primary. *

**Rule M4** Tumors in sites with ICD-O-3 topography codes that are different at the second (Cxxx) and/or third characters (Cxxx) are multiple primaries **

**Rule M5** Tumors in both the right kidney and in the left kidney are multiple primaries. **

*Note:* Abstract as a single primary when the tumors in one kidney are documented to be metastatic from the other kidney.
Kidney Multiple Primary Rules - Text
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

**Rule M6**
Tumors diagnosed more than three (3) years apart are multiple primaries. **

**Rule M7**
An **invasive** tumor following an **in situ** tumor more than 60 days after diagnosis are multiple primaries. **

*Note 1:* The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.

*Note 2:* Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

**Rule M8**
One tumor with a specific **renal** cell type and another tumor with a **different** specific renal cell type are multiple primaries (Table 1). **

**Rule M9**
Abstract as a single primary * when one tumor is

- **Cancer/malignant neoplasm, NOS (8000) and another is a specific histology** or
- **Carcinoma, NOS (8010) and the other is a specific carcinoma** or
- **Adenocarcinoma, NOS (8140) and another is a specific adenocarcinoma** or
- **Renal cell carcinoma, NOS (8312) and the other is a single renal cell type** (Table 1)

*Note 1:* The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

*Note 2:* The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

**Rule M10**
Tumors with ICD-O-3 histology codes that are **different** at the first (xxxx), second (xxxx) or third (xxxy) number are multiple primaries. **

**Rule M11**
Tumors that **do not meet any** of the above criteria are a single primary.*

* **Note:** When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.

* Prepare one abstract.  Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts.  Use the histology coding rules to assign the appropriate histology code to each case abstracted.

This is the end of instructions for Multiple Tumors.

**Rule M11 Examples:** The following are examples of cases that use Rule M11. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. **Warning:** Using only these case examples to determine the number of primaries can result in major errors.

<table>
<thead>
<tr>
<th>Example 1: Multiple tumors in one kidney with same histology</th>
<th>Example 2: An in situ and invasive tumor diagnosed within 60 days</th>
</tr>
</thead>
</table>

January 1, 2007
Kidney Histology Coding Rules – Text
C649
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

Rule H1  Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.

Note 1:  Priority for using documents to code the histology
- Documentation medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of cancer (histology) in the medical record
- CT or MRI scans

Note 2:  Code the specific histology when documented.

Note 3:  Code the histology to 8000 (cancer/malignant neoplasm, NOS), or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H2  Code the histology from the metastatic site when there is no pathology/cytology specimen from the primary site.

Note:  Code the behavior /3.

Rule H3  Code the histology when only one histologic type is identified.

Rule H4  Code the invasive histologic type when there are invasive and in situ components.

Rule H5  Code the specific type when the diagnosis is
- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and one specific adenocarcinoma type or
- Renal cell carcinoma, NOS (8312) and one specific renal cell type

Note 1:  Use Table 1 to identify specific renal cell types.

Note 2:  The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 3:  The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H6  Code 8255 (adenocarcinoma with mixed subtypes) when there are two or more specific renal cell carcinoma types.

Note:  Use Table 1 to identify specific renal cell types.

Example:  Renal cell carcinoma, papillary and clear cell types.  Assign code 8255.
Kidney Histology Coding Rules – Text
C649
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule H7  Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

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**MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY**

Rule H8  Code the histology documented by the physician when there is **no pathology/cytology specimen** or the pathology/cytology report is not available.

*Note 1:* Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of cancer (histology) in the medical record
- CT or MRI scans

*Note 2:* Code the specific histology when documented.

*Note 3:* Code the histology to 8000 (cancer/malignant neoplasm, NOS), or 8010 (carcinoma, NOS) as stated by the physician when no specific histology is documented.

Rule H9  Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site**.

*Note:* Code the behavior /3.

Rule H10  Code the histology when only **one histologic type** is identified.

Rule H11  Code the histology of the **most invasive** tumor.

*Note 1:* This rule should only be used when the first three digits of the histology codes are identical (This is a single primary).

*Note 2:* See the Kidney Equivalent Terms, Definitions, Tables and Illustrations for the definition of most invasive.
- If one tumor is in situ and one is invasive, code the histology from the invasive tumor.
- If both/all histologies are invasive, code the histology of the most invasive tumor.
Rule H12  Code the specific type when the diagnosis is
  • Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
  • Carcinoma, NOS (8010) and a more specific carcinoma or
  • Adenocarcinoma, NOS (8140) and one specific adenocarcinoma type or
  • Renal cell carcinoma, NOS (8312) and one specific renal cell type

  **Note 1:** Use Table 1 to identify specific renal cell types.
  **Note 2:** The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation
  **Note 3:** The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H13  Code the histology with the numerically higher ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
**Code the histology according to the rule that fits the case.**
Renal Pelvis, Ureter, Bladder, and Other Urinary Multiple Primary Rules – Text
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Rule M1 When it is not possible to determine if there is a single tumor or multiple tumors, opt for a single tumor and abstract as a single primary.*

Note: Use this rule only after all information sources have been exhausted.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
This is the end of instructions for Unknown if Single or Multiple Tumors.

SINGLE TUMOR

Rule M2 A single tumor is always a single primary. *

Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

This is the end of instructions for Single Tumor.
* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.

Rule M3 When no other urinary sites are involved, tumor(s) in the right renal pelvis AND tumor(s) in the left renal pelvis are multiple primaries. **

Note: Use this rule and abstract as a multiple primary unless documented to be metastatic

Rule M4 When no other urinary sites are involved, tumor(s) in both the right ureter AND tumor(s) in the left ureter are multiple primaries. **

Note: Use this rule and abstract as a multiple primary unless documented to be metastatic
Renal Pelvis, Ureter, Bladder, and Other Urinary Multiple Primary Rules – Text
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule M5  An invasive tumor following a non-invasive or in situ tumor more than 60 days after diagnosis is a multiple primary. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease

Rule M6  Bladder tumors with any combination of the following histologies: papillary carcinoma (8050), transitional cell carcinoma (8120-8124), or papillary transitional cell carcinoma (8130-8131), are a single primary. *

Rule M7  Tumors diagnosed more than three (3) years apart are multiple primaries. **

Rule M8  Urothelial tumors in two or more of the following sites are a single primary* (See Table 1)
  - Renal pelvis (C659)
  - Ureter(C669)
  - Bladder (C670-C679)
  - Urethra /prostatic urethra (C680)

Rule M9  Tumors with ICD-O-3 histology codes that are different at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M10 Tumors in sites with ICD-O-3 topology codes with different second (Cxxx) and/or third characters (Cxxx) are multiple primaries*

Rule M11 Tumors that do not meet any of the above criteria are a single primary.*
Note: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.

This is the end of instructions for Multiple Tumors.
* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.
Renal Pelvis, Ureter, Bladder, and Other Urinary Histology Coding Rules – Text
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

**SINGLE TUMOR**

**Rule H1** Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.

*Note 1:* Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of cancer (histology) in the medical record
- CT or MRI scans

*Note 2:* Code the specific histology when documented.

*Note 3:* Code the histology to 8000 (cancer/malignant neoplasm) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

**Rule H2** Code the histology from the metastatic site when there is no pathology/cytology specimen from the primary site.

*Note:* Code the behavior /3.

**Rule H3** Code 8120 (transitional cell/urothelial carcinoma) (Table 1 - Code 8120) when there is:
- Pure transitional cell carcinoma or
- Flat (non-papillary) transitional cell carcinoma or
- Transitional cell carcinoma with squamous differentiation or
- Transitional cell carcinoma with glandular differentiation or
- Transitional cell carcinoma with trophoblastic differentiation or
- Nested transitional cell carcinoma or
- Microcystic transitional cell carcinoma

**Rule H4** Code 8130 (papillary transitional cell carcinoma) (Table 1 - Code 8130) when there is:
- Papillary carcinoma or
- Papillary transitional cell carcinoma or
- Papillary carcinoma and transitional cell carcinoma

**Rule H5** Code the histology when only one histologic type is identified

*Note:* Only code squamous cell carcinoma (8070) when there are no other histologies present (pure squamous cell carcinoma).

**Rule H6** Code the invasive histologic type when a single tumor has invasive and in situ components.
Renal Pelvis, Ureter, Bladder, and Other Urinary Histology Coding Rules – Text

C659, C669, C670-C679, C680-C689

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H7  Code the most specific histologic term:

Examples
- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Sarcoma, NOS (8800) and a more specific sarcoma (invasive only)

Note 1: The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 2: The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H8  Code the histology with the numerically higher ICD-O-3 code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H9  Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of cancer (histology) in the medical record
- CT or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H10  Code the histology from the metastatic site when there is no pathology/cytology specimen from the primary site.

Note: Code the behavior /3.
Renal Pelvis, Ureter, Bladder, and Other Urinary Histology Coding Rules – Text
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H11  Code 8120 (transitional cell/urothelial carcinoma) (Table 1 – Code 8120) when there is:
   • Pure transitional cell carcinoma or
   • Flat (non-papillary) transitional cell carcinoma or
   • Transitional cell carcinoma with squamous differentiation or
   • Transitional cell carcinoma with glandular differentiation or
   • Transitional cell carcinoma with trophoblastic differentiation or
   • Nested transitional cell carcinoma or
   • Microcystic transitional cell carcinoma

   Note: Flat transitional cell carcinoma is a more important prognostic indicator than papillary, and is likely to be treated more aggressively.

Rule H12  Code 8130 (papillary transitional cell carcinoma) (Table 1 – Code 8130) when there is:
   • Papillary carcinoma or
   • Papillary transitional cell carcinoma or
   • Papillary carcinoma and transitional cell carcinoma

Rule H13  Code the histology when only one histologic type is identified
   Note: Only code squamous cell carcinoma (8070) when there are no other histologies present (pure squamous cell carcinoma).

Rule H14  Code the histology of the most invasive tumor.
   Note: See the Renal Pelvis, Ureter, Bladder and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations for the definition of most invasive.
   • If one tumor is in situ and one is invasive, code the histology from the invasive tumor.
   • If both/all histologies are invasive, code the histology of the most invasive tumor.

Rule H15  Code the histology with the numerically higher ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.
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Benign and Borderline Intracranial and CNS Tumors
Multiple Primary Rules – Text
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

Note: Malignant intracranial and CNS tumors have a separate set of rules.

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1  When it is not possible to determine if there is a single tumor or multiple tumors, opt for a single tumor and abstract as a single primary.*
  Note: Use this rule only after all information sources have been exhausted.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
This is the end of instructions for Unknown if Single or Multiple Tumors.

SINGLE TUMOR

Note: Tumor not described as metastasis

Rule M2  A single tumor is always a single primary.*
  Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
This is the end of instructions for Single Tumor.

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.

Note: Tumors not described as metastases

Rule M3  An invasive brain tumor (/3) and either a benign brain tumor (/0) or an uncertain/borderline brain tumor (/1) are always multiple primaries. **

Rule M4  Tumors with ICD-O-3 topography codes that are different at the second (Cxxx) and/or third characters (Cxx), or fourth (Cxx) are multiple primaries. **

Rule M5  Tumors on both sides (left and right) of a paired site (Table 1) are multiple primaries. **

Revised April 30, 2008
Benign and Borderline Intracranial and CNS Tumors
Multiple Primary Rules – Text
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

Rule M6  An atypical choroid plexus papilloma (9390/1) following a choroid plexus papilloma, NOS (9390/0) is a single primary. *
Note: Do not code progression of disease as multiple primaries.

Rule M7  A neurofibromatosis, NOS (9540/1) following a neurofibroma, NOS (9540/0) is a single primary. *
Note: Do not code progression of disease as multiple primaries.

Rule M8  Tumors with two or more histologic types on the same branch in Chart 1 are a single primary. *

Rule M9  Tumors with multiple histologic types on different branches in Chart 1 are multiple primaries. **

Rule M10 Tumors with two or more histologic types and at least one of the histologies is not listed in Chart 1 are multiple primaries. **

Rule M11 Tumors with ICD-O-3 histology codes that are different at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **
Note: Use this rule when none of the histology codes are listed in Chart 1.

Rule M12 Tumors that do not meet any of the above criteria are a single primary. *
Note: Timing is not used to determine multiple primaries for benign and borderline intracranial and CNS tumors.

Rule M12 Examples: The following are examples of cases that use Rule M12. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. ** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted. This is the end of instructions for Multiple Tumors.
Benign and Borderline Intracranial and CNS Tumors
Histology Coding Rules – Text
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

Note: Malignant intracranial and CNS tumors have a separate set of rules.

SINGLE TUMOR

Rule H1 Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of tumor (histology) in the medical record
- PET, CT or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (neoplasm, NOS) or as stated by the physician when nothing more specific is documented.

Rule H2 Code the histology when only one histologic type is identified.

Rule H3 When there are multiple histologies and all histologies are in the same branch on Chart 1, code the more specific histology.

Rule H4 Code the histology with the numerically higher ICD-O-3 code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H5 Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of tumor (histology) in the medical record
- PET, CT or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (neoplasm, NOS) or as stated by the physician when nothing more specific is documented.

Revised April 30, 2008
Rule H6  Code multiple meningiomas of uncertain behavior to 9530/1
Note 1: This is a rare condition that is usually associated with neurofibromatosis type 2 and other genetic disorders
Note 2: Use this code only for meningiomas with uncertain behavior; do not use this code for multiple benign or malignant meningiomas

Rule H7  Code the histology when only one histologic type is identified.

Rule H8  Code the histology from the original diagnosis.
Note: Do not change the behavior code when a later tumor(s) shows progression of disease.

Rule H9  When there are multiple histologies and all histologies are in the same branch on Chart 1, code the more specific histology

Rule H10  Code the histology with the numerically higher ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.

Revised April 30, 2008
Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland

Multiple Primary Rules – Text

C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

*Note: Benign and borderline intracranial and CNS tumors have a separate set of rules.*

<table>
<thead>
<tr>
<th>UNKNOWN IF SINGLE OR MULTIPLE TUMORS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note:</strong> Tumor(s) not described as metastasis</td>
</tr>
</tbody>
</table>

|Rule M1| An invasive brain tumor (/3) and either a benign brain tumor (/0) or an uncertain/borderline brain tumor (/1) are always multiple primaries. **|

<table>
<thead>
<tr>
<th>Rule M2</th>
<th>When it is not possible to determine if there is a single tumor or multiple tumors, opt for a single tumor and abstract as a single primary.*</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Note:</em> Use this rule only after all information sources have been exhausted</td>
<td></td>
</tr>
</tbody>
</table>

This is the end of instructions for Unknown if Single or Multiple Tumors.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

<table>
<thead>
<tr>
<th>SINGLE TUMOR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note:</strong> Tumor not described as metastasis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rule M3</th>
<th>A single tumor is always a single primary. *</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Note:</em> The tumor may overlap onto or extend into adjacent/contiguous site or subsite.</td>
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</tr>
</tbody>
</table>

This is the end of instructions for Single Tumor.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

<table>
<thead>
<tr>
<th>MULTIPLE TUMORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple tumors may be a single primary or multiple primaries.</td>
</tr>
<tr>
<td><strong>Note:</strong> Tumors not described as metastases</td>
</tr>
</tbody>
</table>

|Rule M4| An invasive brain tumor (/3) and either a benign brain tumor (/0) or an uncertain/borderline brain tumor (/1) are always multiple primaries. **|
Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland

Multiple Primary Rules – Text

C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

**Rule M5**
Tumors in sites with ICD-O-3 topography codes with different second (Cxx) and/or third characters (Cxxx) are multiple primaries. **

**Rule M6**
A glioblastoma or glioblastoma multiforme (9440) following a glial tumor is a single primary* (See Chart 1)

**Rule M7**
Tumors with ICD-O-3 histology codes on the same branch in Chart 1 or Chart 2 are a single primary.*

*Note:* Recurrence, progression, or any reappearance of histologies on the same branch in Chart 1 or Chart 2 is always the same disease process.

*Example:* Patient has an astrocytoma. Ten years later the patient is diagnosed with glioblastoma multiforme. This is a progression or recurrence of the earlier astrocytoma.

**Rule M8**
Tumors with ICD-O-3 histology codes on different branches in Chart 1 or Chart 2 are multiple primaries. **

**Rule M9**
Tumors with ICD-O-3 histology codes that are different at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

**Rule M10**
Tumors that do not meet any of the above criteria are a single primary. *

*Note 1:* Neither timing nor laterality is used to determine multiple primaries for malignant intracranial and CNS tumors.

*Example:* The patient is treated for an anaplastic astrocytoma (9401) in the right parietal lobe. Three months later the patient is diagnosed with a separate anaplastic astrocytoma in the left parietal lobe. This is one primary because laterality is not used to determine multiple primary status.

*Note 2:* Multicentric brain tumors which involve different lobes of the brain that do not meet any of the above criteria are the same disease process.

This is the end of instructions for Multiple Tumors.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.
Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland

Histology Coding Rules – Text

C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

Note: Benign and borderline intracranial and CNS tumors have a separate set of rules.

<table>
<thead>
<tr>
<th>SINGLE TUMOR</th>
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<tbody>
<tr>
<td><strong>Rule H1</strong></td>
</tr>
<tr>
<td><strong>Note 1:</strong></td>
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<tr>
<td><strong>Note 2:</strong></td>
</tr>
<tr>
<td><strong>Note 3:</strong></td>
</tr>
</tbody>
</table>

**Rule H2**  Code the histology from a metastatic site when there is no pathology/cytology specimen from the primary site.  
**Note:** Code the behavior /3.

**Rule H3**  Code 9382/3 (mixed glioma) when at least two of the following cells and/or differentiation are present:  
• Astrocytic  
• Oligodendroglial  
• Ependymal

**Rule H4**  Code the histology when only one histologic type is identified.

**Rule H5**  Code the specific type when the diagnosis includes a non-specific term and a specific term or type on the same branch in Chart 1 or Chart 2.

**Rule H6**  Code the histology with the numerically higher ICD-O-3 code.

This is the end of instructions for Single Tumor.  
Code the histology according to the rule that fits the case.
Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland

Histology Coding Rules – Text

C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY</th>
</tr>
</thead>
</table>

**Rule H7**  
Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

*Note 1:* Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of cancer (histology) in the medical record
- CT or MRI scans

*Note 2:* Code the specific histology when documented.
*Note 3:* Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.

**Rule H8**  
Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

*Note:* Code the behavior /3.

**Rule H9**  
Code the histology when only **one histologic type** is identified.

**Rule H10**  
Code the specific type when the diagnosis includes a **non-specific** term and a **specific** term or type on the **same branch** in Chart 1 or Chart 2.

**Rule H11**  
Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.

Code the histology according to the rule that fits the case.
Other Sites Multiple Primary Rules – Text
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

*Note:* Tumor(s) not described as metastasis

**Rule M1** When it is not possible to determine if there is a *single* tumor or *multiple* tumors, opt for a single tumor and abstract as a single primary. *

*Note:* Use this rule only after all information sources have been exhausted.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

This is the end of instructions for Unknown if Single or Multiple Tumors.

SINGLE TUMOR

*Note 1:* Tumor not described as metastasis

*Note 2:* Includes combinations of in situ and invasive

**Rule M2** A *single tumor* is always a single primary. *

*Note:* The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

This is the end of instructions for Single Tumor.

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.

*Note 1:* Tumors not described as metastases

*Note 2:* Includes combinations of in situ and invasive

**Rule M3** *Adenocarcinoma* of the *prostate* is always a single primary. *

*Note 1:* Report only one adenocarcinoma of the prostate per patient per lifetime.

*Note 2:* 95% of prostate malignancies are the common (acinar) adenocarcinoma histology (8140). See Equivalent Terms, Definitions and Tables for more information.

*Note 3:* If patient has a previous acinar adenocarcinoma of the prostate in the database and is diagnosed with adenocarcinoma in 2007 it is a single primary.

Revised November 1, 2007
Other Sites Multiple Primary Rules – Text
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemi

Rule M4 Retinoblastoma is always a single primary (unilateral or bilateral). *
Rule M5 Kaposi sarcoma (any site or sites) is always a single primary. *
Rule M6 Follicular and papillary tumors in the thyroid within 60 days of diagnosis are a single primary. *
Rule M7 Bilateral epithelial tumors (8000-8799) of the ovary within 60 days are a single primary. *
Rule M8 Tumors on both sides (right and left) of a site listed in Table 1 are multiple primaries. **
  Note: Table 1 – Paired Organs and Sites with Laterality
Rule M9 Adenocarcinoma in adenomatous polyposis coli (familial polyposis) with one or more in situ or malignant polyps is a single primary.*
  Note: Tumors may be present in a single or multiple segments of the colon, rectosigmoid, rectum.
Rule M10 Tumors diagnosed more than one (1) year apart are multiple primaries. **
Rule M11 Tumors with ICD-O-3 topography codes that are different at the second (Cxxx) and/or third characters (Cxxx) are multiple primaries. **
  Example 1: A tumor in the penis C609 and a tumor in the rectum C209 have different second characters in their ICD-O-3 topography codes, so they are multiple primaries.
  Example 2: A tumor in the cervix C539 and a tumor in the vulva C519 have different third characters in their ICD-O-3 topography codes, so they are multiple primaries.
Rule M12 Tumors with ICD-O-3 topography codes that differ only at the fourth character (Cxxx) and are in any one of the following primary sites are multiple primaries. **
  • Anus and anal canal (C21_)
  • Bones, joints, and articular cartilage (C40_ - C41_)
  • Peripheral nerves and autonomic nervous system (C47_)
  • Connective subcutaneous and other soft tissues (C49_)
  • Skin (C44_)

January 1, 2007
Other Sites Multiple Primary Rules – Text
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

Rule M13 A frank in situ or malignant adenocarcinoma and an in situ or malignant tumor in a polyp are a single primary.*

Rule M14 Multiple in situ and/or malignant polyps are a single primary.*
Note: Includes all combinations of adenomatous, tubular, villous, and tubulovillous adenomas or polyps.

Rule M15 An invasive tumor following an in situ tumor more than 60 days after diagnosis is a multiple primary.**
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M16 Abstract as a single primary* when one tumor is:
- Cancer/malignant neoplasm, NOS (8000) and another is a specific histology or
- Carcinoma, NOS (8010) and another is a specific carcinoma or
- Squamous cell carcinoma, NOS (8070) and another is specific squamous cell carcinoma or
- Adenocarcinoma, NOS (8140) and another is a specific adenocarcinoma or
- Melanoma, NOS (8720) and another is a specific melanoma
- Sarcoma, NOS (8800) and another is a specific sarcoma

Rule M17 Tumors with ICD-O-3 histology codes that are different at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries.**

Rule M18 Tumors that do not meet any of the above criteria are a single primary.*
Note: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.
This is the end of instructions for Multiple Tumors.
Other Sites Histology Coding Rules – Text
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

**SINGLE TUMOR: IN SITU ONLY**
(Single Tumor; all parts are in situ)

**Rule H1**  Code the histology documented by the physician when the *pathology/cytology* report is not available.

*Note 1:* Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of cancer in the medical record

*Note 2:* Code the specific histology when documented.

*Note 3:* Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

**Rule H2**  Code the histology when only one histologic type is identified.

*Note:* Do not code terms that do not appear in the histology description.

*Example:* Do not code squamous cell carcinoma non-keratinizing unless the words “non-keratinizing” actually appear in the diagnosis.

**Rule H3**  Code 8210 (adenocarcinoma in *adenomatous polyp*), 8261 (adenocarcinoma in *villous adenoma*), or 8263 (adenocarcinoma in *tubulovillous adenoma*) when:
- The final diagnosis is adenocarcinoma in a polyp or
- The final diagnosis is adenocarcinoma and a residual polyp or polyp architecture is recorded in other parts of the pathology report or
- The final diagnosis is adenocarcinoma and there is reference to a residual or pre-existing polyp or
- The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in a polyp or
- There is documentation that the patient had a polypectomy

*Note:* It is important to know that the adenocarcinoma originated in a polyp.

**Rule H4**  Code the most specific histologic term when the diagnosis is:
- Carcinoma in situ, NOS (8010) and a specific in situ carcinoma or
- Squamous cell carcinoma in situ, NOS (8070) and a specific in situ squamous cell carcinoma or
- Adenocarcinoma in situ, NOS (8140) and a specific in situ adenocarcinoma or
- Melanoma in situ, NOS (8720) and a specific in situ melanoma

*Note:* The specific histology may be identified as type, subtype, predominantly, with features of, major, with differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.
Rule H5  Code the appropriate combination/mixed code (Table 2) when there are multiple specific histologies or when there is a non-specific histology with multiple specific histologies

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, with ___ differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.

Rule H6  Code the histology with the numerically higher ICD-O-3 code.

This is the end of instructions for a Single Tumor: In Situ Carcinoma Only.
Code the histology according to the rule that fits the case.

SINGLE TUMOR: INVASIVE AND IN SITU
(Single Tumor; in situ and invasive components)

Rule H7  Code the single invasive histology. Ignore the in situ terms.

Note: This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category.

This is the end of instructions for a Single Tumor: Invasive and In Situ Carcinoma.
Code the histology according to the rule that fits the case.
Other Sites Histology Coding Rules – Text
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

SINGLE TUMOR: INVASIVE ONLY
(Single Tumor; all parts are invasive)

Rule H8 Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician’s reference to type of cancer (histology) in the medical record
- CT, PET, or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H9 Code the histology from a metastatic site when there is no pathology/cytology specimen from the primary site.

Note: Code the behavior /3.

Rule H10 Code 8140 (adenocarcinoma, NOS) for prostate primaries when the diagnosis is acinar (adeno)carcinoma.

Rule H11 Code the histology when only one histologic type is identified

Note 1: Do not code terms that do not appear in the histology description.

Example: Do not code squamous cell carcinoma non-keratinizing unless the words “non-keratinizing” actually appear in the diagnosis.

Note 2: If this is a papillary carcinoma of the thyroid, go to Rule H14

Rule H12 Code 8210 (adenocarcinoma in adenomatous polyp), 8261 (adenocarcinoma in villous adenoma), or 8263 (adenocarcinoma in tubulovillous adenoma) when:
- The final diagnosis is adenocarcinoma in a polyp or
- The final diagnosis is adenocarcinoma and a residual polyp or polyp architecture is recorded in other parts of the pathology report or
- The final diagnosis is adenocarcinoma and there is reference to a residual or pre-existing polyp or
- The final diagnosis is adenocarcinoma mucinous/colloid or signet ring cell adenocarcinoma in a polyp or
- There is documentation that the patient had a polypectomy

Note: It is important to know that the adenocarcinoma originated in a polyp.

Revised November 1, 2007
Other Sites Histology Coding Rules – Text
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

**Rule H13** Code the most specific histologic term. Examples include:
- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Melanoma, NOS (8720) and a more specific melanoma or
- Sarcoma, NOS (8800) and a more specific sarcoma

*Note:* The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ___ differentiation. The terms architecture and pattern are subtypes only for in situ cancer.

**Example 1:** Adenocarcinoma, predominantly mucinous. Code mucinous adenocarcinoma 8480.

**Example 2:** Non-small cell carcinoma, papillary squamous cell. Code papillary squamous cell carcinoma 8052.

**Rule H14** Code papillary carcinoma of the thyroid to papillary adenocarcinoma, NOS (8260).

**Rule H15** Code follicular and papillary carcinoma of the thyroid to papillary carcinoma, follicular variant (8340).

**Rule H16** Code the appropriate combination/mixed code (Table 2) when there are multiple specific histologies or when there is a non-specific histology with multiple specific histologies

*Note:* The specific histologies may be identified as a type, subtype, predominantly, with features of, major, or with ____ differentiation.

**Example 1 (multiple specific histologies):** Mucinous and papillary adenocarcinoma. Code 8255 (adenocarcinoma with mixed subtypes)

**Example 2 (multiple specific histologies):** Combined small cell and squamous cell carcinoma. Code 8045 (combined small cell carcinoma)

**Example 3 (non-specific with multiple specific histologies):** Adenocarcinoma with papillary and clear cell features. Code 8255 (adenocarcinoma with mixed subtypes)

**Rule H17** Code the histology with the numerically higher ICD-O-3 code.

This is the end of instructions for a Single Tumor: Invasive Carcinoma Only.
Code the histology according to the rule that fits the case.
MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H18  Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.

Note 1: Priority for using documents to code the histology
- From reports or notes in the medical record that document or reference pathologic or cytologic findings
- From clinician reference to type of cancer (histology) in the medical record
- CT, PET or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H19  Code the histology from a metastatic site when there is no pathology/cytology specimen from the primary site.

Note: Code the behavior /3.

Rule H20  Code 8140 (adenocarcinoma, NOS) for prostate primaries when the diagnosis is acinar (adeno)carcinoma.

Rule H21  Code 8077/2 (Squamous intraepithelial neoplasia, grade III) for in situ squamous intraepithelial neoplasia grade III in sites such as the vulva (VIN III) vagina (VAIN III), or anus (AIN III).

Note 1: 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).

Note 2: This code may be used for reportable-by-agreement cases

Rule H22  Code 8148/2 (Glandular intraepithelial neoplasia grade III) for in situ glandular intraepithelial neoplasia grade III in sites such as the pancreas (PAIN III).

Note: This code may be used for reportable-by-agreement cases such as intraepithelial neoplasia of the prostate (PIN III)

Rule H23  Code the histology when only one histologic type is identified

Note: Do not code terms that do not appear in the histology description.

Example: Do not code squamous cell carcinoma non-keratinizing unless the words “non-keratinizing” actually appear in the diagnosis.

January 1, 2007
Other Sites Histology Coding Rules – Text
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

Rule H24  Code the histology of the underlying tumor when there is extramammary Paget disease and an underlying tumor of the anus, perianal region, or vulva.

Rule H25  Code 8210 (adenocarcinoma in adenomatous polyp), 8261 (adenocarcinoma in villous adenoma), or 8263 (adenocarcinoma in tubulovillous adenoma) when:
- The final diagnosis is adenocarcinoma in a polyp or
- The final diagnosis is adenocarcinoma and a residual polyp or polyp architecture is recorded in other parts of the pathology report or
- The final diagnosis is adenocarcinoma and there is reference to a residual or pre-existing polyp or
- The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in a polyp or
- There is documentation that the patient had a polypectomy

Note: It is important to know that the adenocarcinoma originated in a polyp.

Rule H26  Code papillary carcinoma of the thyroid to papillary adenocarcinoma, NOS (8260).

Rule H27  Code follicular and papillary carcinoma of the thyroid to papillary carcinoma, follicular variant (8340).

Rule H28  Code the single invasive histology for combinations of invasive and in situ. Ignore the in situ terms.

Note: This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category.

Rule H29  Code the most specific histologic term. Examples include:
- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Melanoma, NOS (8720) and a more specific melanoma or
- Sarcoma, NOS (8800) and a more specific sarcoma

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ___ differentiation. The terms architecture and pattern are subtypes only for in situ cancer.

Example 1: Adenocarcinoma, predominantly mucinous. Code mucinous adenocarcinoma 8480.
Other Sites Histology Coding Rules – Text
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

Rule H30  Code the appropriate combination/mixed code (Table 2) when there are multiple specific histologies or when there is a non-specific histology with multiple specific histologies

Note: The specific histologies may be identified as a type, subtype, predominantly, with features of, major, or with ____ differentiation.

Example 1 (multiple specific histologies):  Gyn malignancy with mucinous, serous and papillary adenocarcinoma. Code 8323 (mixed cell adenocarcinoma)

Example 2 (multiple specific histologies):  Combined small cell and squamous cell carcinoma. Code 8045 (combined small cell carcinoma)

Example 3 (non-specific with multiple specific histologies): Adenocarcinoma with papillary and clear cell features. Code 8255 (adenocarcinoma with mixed subtypes)

Rule H31  Code the histology with the numerically higher ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.
IX.
Data Items

Effective with cases diagnosed 1/1/2010
Data Items
Effective with cases diagnosed 1/1/2010

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Data Items
Effective with cases diagnosed 1/1/2010

Ambiguous Terminology

Item Length: 1  
NAACCR Item #: 442  
NAACCR Name: Ambiguous Terminology

This data item identifies all cases, including DCO and autopsy-only cases that are accessioned based only on ambiguous terminology (see the list of “ambiguous terms” below). Registrars are required to collect cases with ambiguous terminology and it is advantageous to be able to identify those cases in the database.

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Definition</th>
<th>Time Frame</th>
<th>Examples</th>
</tr>
</thead>
</table>
| 0    | Conclusive term | A conclusive diagnosis was made within 60 days of the original diagnosis. Case was accessioned based on conclusive terminology. Includes all diagnostic methods such as clinical diagnosis, cytology, pathology, etc. | Within 60 days of the date of initial diagnosis. | 1. Adenocarcinoma in TURP chips.  
2. Mammogram suspicious for DCIS. Excisional biopsy 1 week later positive for DCIS. |
| 1    | Ambiguous term only | The case was accessioned based only on ambiguous terminology. No conclusive terminology was documented during the 60 days following the initial diagnosis. Includes all diagnostic methods except cytology.  
Note: Cytology is excluded because registrars are not required to collect cases with ambiguous terms describing a cytology diagnosis. | N/A | 1. Chest MRI shows a malignant-appearing lesion in the right upper lobe. Patient refused further workup or treatment.  
2. Pt with elevated PSA admitted for TRUS. Pathology final diagnosis: consistent with adenocarcinoma. No further information is available |
| 2    | Ambiguous term followed by conclusive term | The case was originally assigned a code 1 (was accessioned based only on ambiguous terminology). More than 60 days after the initial diagnosis, a conclusive diagnosis was made by any diagnostic method including clinical diagnosis, cytology, pathology, autopsy, etc. | Sixty (60) days or more after the date of diagnosis | Biopsy of the thyroid reads: most likely thyroid cancer. Coded 1 in Ambiguous Terminology (Ambiguous term only). Three months later a biopsy is positive for papillary follicular cancer. Change the code to 2, (Ambiguous term followed by conclusive term). |

(Table continues)
### Data Items
Effective with cases diagnosed 1/1/2010

<table>
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<tr>
<th>Code</th>
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<th>Definition</th>
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<th>Examples</th>
</tr>
</thead>
</table>
| 9    | Unknown term| There is no information about ambiguous terminology.                       | N/A        | Code 9 should seldom be used because the registrar knows why the case was accessioned  
• There was a conclusive diagnosis of malignancy (assign code 0 or 2)  
OR  
• The reportable histology was described by one of the ambiguous terms, such as probable or most likely (assign code 1) |

### Definitions

<table>
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<tr>
<th>Phrase</th>
<th>Definition</th>
<th>Examples</th>
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</table>
| Ambiguous terminology   | Terms mandated as reportable when used in a diagnosis. See the reportable list below for a complete listing of those terms. See reportability section of this manual, the 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual, or the FORDS Manual for detailed instructions on how to use the list. | Clinical: physician’s statement that patient most likely has lung cancer.             
Laboratory tests: CBC suspicious for leukemia.  
Pathology: prostate biopsy compatible with adenocarcinoma |
| Conclusive terminology   | A clear and definite statement of cancer. The statement may be from a physician (clinical diagnosis); or may be from a laboratory test, autopsy, cytologic findings, and/or pathology | Clinical: physician’s statement that the patient has lung cancer.             
Laboratory tests: CBC diagnostic of acute leukemia.  
Cytologic findings: FNA (fine needle aspiration) with findings of infiltrating duct carcinoma of the breast.  
Pathology: colon biopsy showing adenocarcinoma |
Ambiguous terms that are reportable

Apparent(ly)
Appears
Comparable with
Compatible with
Consistent with
Favor(s)
Malignant appearing
Most likely
Presumed
Probable
Suspect(ed)
Suspicious (for)
Typical (of)

Coding Instructions

1. Use Code 0 when a case is accessioned based on conclusive terminology. The diagnosis is based on clear and definite terminology describing the malignancy within 60 days of the original diagnosis.

   Note: Usually the patient undergoes a diagnostic work-up because of a suspicion of cancer (ambiguous terminology). For example, a mammogram may show calcifications suspicious for intraductal carcinoma; the date of the mammogram is the date of initial diagnosis. When there is a clear and definite diagnosis within 60 days of that mammogram (date of initial diagnosis) such as the pathology from an excisional biopsy showing intraductal carcinoma, assign code 0.

2. Use Code 1 when a case is accessioned based on ambiguous terminology and no definitive terminology is used to describe the malignancy within 60 days of the date of initial diagnosis. The diagnosis may be from a pathology report, a radiology report, an imaging report, or on the medical record.

3. Use Code 2 when a case is accessioned based on ambiguous terminology followed by definitive terminology more than 60 days after the initial diagnosis.
Data Items
Effective with cases diagnosed 1/1/2010

a. Follow-back to a physician or subsequent readmission (following the initial 60 day period) may eventually confirm cancer. Assign Code 2

*Example:* Prostate biopsy with diagnosis of probable adenocarcinoma. Two years later, another biopsy is performed with diagnosis of prostate adenocarcinoma. Assign code 2 (Ambiguous term followed by conclusive term).

4. Leave this data item blank for cases diagnosed prior to 01/01/2007.

*Note:* Cases accessioned based on ambiguous terminology (Code 1) should be excluded from case selection in research studies. Direct patient contact is not recommended.
Date of Conclusive Terminology

For those cases originally accessioned based on ambiguous terminology only, this data item documents the date of a definite statement of malignancy. The abstractor will change the code for the data item “Ambiguous Terminology” from a 1 to a 2 and enter the date that the malignancy was described definitively in Date of Conclusive Terminology.

Date of Conclusive Terminology must be transmitted in the YYYYMMDD format. Date of Conclusive Terminology may be recorded in the transmission format, or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

Transmitting Dates

Transmit date fields in the year, month, day format (YYYYMMDD). Leave the year, month and/or day blank when they cannot be estimated or are unknown.

Common Formats

- YYYYMMDD    Complete date is known
- YYYYMM    Year and month are known/estimated; day is unknown
- YYYY    Year is known/estimated; month and day cannot be estimated or are unknown

Transmit Instructions

1. Transmit date fields in the year, month, day format (YYYYMMDD).
2. Leave the year, month and/or day blank when they cannot be estimated or are unknown.
3. Most SEER registries collect the month, day, and year of conclusive terminology. When the full date (YYYYMMDD) is transmitted, the seventh and eighth digits (day) will be deleted when the data are received by SEER.
Data Items
Effective with cases diagnosed 1/1/2010

Codes for Year

Code the four-digit year of conclusive terminology

Codes for Month

<table>
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Codes for Day

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<tr>
<td>31</td>
<td></td>
</tr>
</tbody>
</table>

January 1, 2010
Data Items
Effective with cases diagnosed 1/1/2010

Coding Instructions

1. Leave this field blank for cases diagnosed prior to 01/01/2007

Estimating Dates

Estimating the month
1. Code “spring of” to April
2. Code “summer” or “middle of the year” to July
3. Code “fall” or “autumn” as October
4. For “winter of,” try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is available to calculate the month.
5. Code “early in year” to January
6. Code “late in year” to December
7. Use whatever information is available to calculate the month
8. Code the month of admission when there is no basis for estimation
9. Leave month blank if there is no basis for approximation

Estimating the year
1. Code “a couple of years” to two years earlier
2. Code “a few years” to three years earlier
3. Use whatever information is available to calculate the year
4. Code the year of admission when there is no basis for estimation
Data Items
Effective with cases diagnosed 1/1/2010

Date of Conclusive Diagnosis Flag

Item Length: 2
NAACCR Item #: 448
NAACCR Name: Date Conclusive DX Flag

Date flag fields were added beginning with diagnoses on or after 1/1/2010 as part of an initiative to standardize date fields. Date flags replace nondate information that had previously been transmitted in date fields. Coding 9’s to indicate “unknown” for year, month or day is an example of nondate information that was previously transmitted in date fields.

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>A valid date value is provided in Date of Conclusive Diagnosis</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>No information</td>
<td>No information whatsoever can be inferred</td>
</tr>
<tr>
<td>11</td>
<td>Not applicable</td>
<td>No proper value is applicable in this context</td>
</tr>
<tr>
<td>12</td>
<td>Unknown</td>
<td>A proper value is applicable but not known</td>
</tr>
<tr>
<td>15</td>
<td>Temporarily unavailable</td>
<td>Accessioned based on ambiguous terminology only</td>
</tr>
</tbody>
</table>

Coding Instructions

1. Leave this item blank if Date of Conclusive Diagnosis has a full or partial date recorded
2. Assign code 10 when it is unknown whether the diagnosis was based on ambiguous terminology (Ambiguous Terminology coded 9 and Date of Conclusive Diagnosis is blank)
3. Assign code 11 when the case was diagnosed originally, or within 60 days of initial diagnosis, using unambiguous terminology (Ambiguous Terminology coded 0)
4. Assign code 12 when the date of conclusive diagnosis cannot be determined. The case was originally diagnosed using ambiguous terminology, was conclusively diagnosed more than 60 days later, and the date of conclusive diagnosis is unknown (Ambiguous Terminology coded 2 and Date of Conclusive Diagnosis is blank).
5. Assign code 15 when the case was diagnosed using ambiguous terminology and no conclusive (unambiguous) diagnosis followed (Ambiguous Terminology coded 1)
Data Items
Effective with cases diagnosed 1/1/2011

Multiplicity Counter

This data item is used to count the number of tumors (multiplicity) reported as a single primary. Do not count metastatic tumors. Use the [Multiple Primary and Histology Coding Rules](#) manual multiple primary rules for the specific site to determine whether the tumors are a single primary or multiple primaries.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>No primary tumor identified (effective for cases diagnosed 1/1/2011 and forward)</td>
</tr>
<tr>
<td>01</td>
<td>One tumor only</td>
</tr>
<tr>
<td>02</td>
<td>Two tumors present; bilateral ovaries involved with cystic carcinoma</td>
</tr>
<tr>
<td>03</td>
<td>Three tumors present</td>
</tr>
<tr>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td>88</td>
<td>Information on multiple tumors not collected/not applicable for this site</td>
</tr>
<tr>
<td>89</td>
<td>Multicentric, multifocal, number unknown (effective for cases diagnosed 1/1/2011 and forward)</td>
</tr>
<tr>
<td>99</td>
<td>Unknown if multiple tumors; not documented</td>
</tr>
</tbody>
</table>

**Coding Instructions**

1. Code the number of tumors being abstracted as a **single** primary.

2. Use any part of the medical record to obtain information on the number of tumors
   
   a. Source of information is **not** limited to the pathology report final diagnosis
   
   b. The pathology report is the most accurate source of information for some primary sites, for example, a breast primary
   
   c. It is necessary to use other sources such as scans, operative reports, or documentation in the medical record
      
      i. For primary sites such as urinary, head and neck, etc.
      
      ii. When the operative report and pathology report are not available

3. Do **not** count tumors documented as metastases

January 1, 2011
4. Include foci in the multiplicity counter when there is a tumor or tumors with separate measured single or multiple foci
   a. Ignore/do not count unmeasured foci
   b. Record the number of foci that are measured when the tumor description is multifocal or multicentric
   c. See instruction number 11 for coding multifocal or multicentric tumors with unmeasured foci

5. Do not include satellite lesions in the multiplicity counter

6. Use code 00 when the primary tumor is not found
   
   **Example 1:** Metastatic melanoma with an unknown primary site
   **Example 2:** Axillary nodes with metastatic duct carcinoma; no primary tumor found in breast

7. Use code 01 when
   a. There is a single tumor in the primary site
   b. There is a single tumor with separate unmeasured foci of tumor

   **Example 1:** Pathology from colon resection shows a 3 cm adenocarcinoma in the ascending colon. Biopsy of liver shows a solitary metastatic lesion compatible with the colon primary. Record 01 in Multiplicity Counter (do not count the metastatic lesion).
   **Example 2:** Pathology from mastectomy shows a 2 cm invasive duct carcinoma with foci of duct carcinoma in situ. No measurement is given for any of the foci of in situ duct carcinoma. Record 01 in Multiplicity Counter.

8. Use code 02 when
   a. The tumor description is multifocal or multicentric and there are two measured foci
   b. There is a single tumor with separate multiple foci and one focus is measured

   **Example 1:** The patient has a 2 cm infiltrating duct carcinoma in the LIQ and a 1 cm infiltrating duct carcinoma in the UIQ of the left breast. Accession as a single primary in accordance with the multiple primary rules, and code 02 in Multiplicity Counter.
   **Example 2:** A single breast primary composed of both in situ and invasive disease. Measurements are provided for both the invasive and in situ components. Code the multiplicity counter 02 because there are individual measurements for each of these tumors.
Example 3: Pathology report for debulking: Cystadenocarcinoma, right and left ovaries. Biopsy of peritoneal implants is positive for metastatic cystadenocarcinoma. Code 02 (Two tumors present; because both ovaries are involved with cystadenocarcinoma). Do not include the peritoneal tumors; metastatic tumors are not included in the multiplicity counter.

9. Use codes 00-87 and code 99 for solid tumors including the following sites and histologies
   a. Dendritic cell sarcoma (9757)
   b. Follicular dendritic cell sarcoma, extranodal (9758)
   c. Histiocytic sarcoma (9755)
   d. Ill-defined sites (C760-C768)
   e. Interdigitating dendritic cell sarcoma (9757)
   f. Kaposi sarcoma (9140)
   g. Langerhans cell histiocytosis (9751)
   h. Langerhans cell sarcoma (9756)
   i. Lymphoma, extranodal primary site (9590-9729, 9735-9738)
   j. Malignant histiocytosis (9750)
   k. Mast cell sarcoma (9740)
   l. Myeloid sarcoma (9930)
   m. Plasmacytoma, extramedullary (9734) (not occurring in bone)
   n. Plasmacytoma, solitary (9731) (occurring in bone)

10. Use code 88 for
   a. Immunoproliferative disease and certain other hematopoietic neoplasms (9732, 9733, 9741, 9742, 9759, 9760, 9761, 9762, 9764-9950, 9960-9961. 9962, 9965, 9966, 9967, 9971, 9975, 9980, 9982, 9983, 9984, 9985, 9986, 9987, 9989, 9991, 9992)
   b. Leukemia (9800-9920, 9931-9948, 9963, 9964)
   c. Lymphoma, lymph node(s) or bone marrow primary site (9590-9729, 9735-9738)
   d. Unknown primary (C809)

11. Use code 89 when the tumor description is multicentric or multifocal AND the number of tumors is unknown

Example 1: Operative report for TURB mentions multiple bladder tumors. Pathology report: Papillary transitional cell carcinoma present in tissue from bladder neck, dome, and posterior wall. Record 89 in Multiplicity Counter.
Example 2: Multinodular carcinoma of the thyroid. Code the number of tumors if known. When the number of tumors is not stated, count the number of measured nodules. If the nodules are not measured, code 89.

12. Use code 99 when
   a. The original pathology report is not available and the documentation does not specify whether there was a single or multiple tumors in the primary site
   b. The tumor is described only as diffuse or disseminated
   c. The operative or pathology report describes multiple tumors but does not give an exact number.
   d. It is unknown if there is a single tumor or multiple tumors and the multiple primary rules instructed you to default to a single tumor.
   e. The number of tumors is not specified for prostate primaries, including those with positive biopsy results in different lobes of the prostate
      Example: Prostate, positive biopsy of both lobes. No statement to indicate whether there is one or more nodules. Code the multiplicity counter 99.
   f. The only information available for clinically inapparent prostate cancer is positive needle biopsy(ies)

13. Leave this field blank for cases diagnosed prior to 01/01/2007

Death Certificate Only (DCO) Cases
See the NAACCR Death Clearance Manual for coding instructions.

Coding Examples

Example 1: Patient has an excisional biopsy of the soft palate. The pathology shows clear margins. Record 01 in the Multiplicity Counter. Within six months another lesion is excised from the soft palate. Use the head and neck multiple primary rules to determine this tumor is not accessioned as a second primary. Change the Multiplicity Counter to code 02 to reflect the fact that there were two separate tumors abstracted as a single primary.

Example 2: CT of chest shows two lesions in the left lung and a single lesion in the right lung. Biopsy of the right lung lesion shows adenocarcinoma. No other workup is done. Review the multiple primary rules for lung. For lung ONLY, the tumors in the contralateral lung are assumed to be additional primary tumors. The case is abstracted as a single primary. Enter the number 03 in the data item Multiplicity Counter.
Data Items
Effective with cases diagnosed 1/1/2010

Date of Multiple Tumors

Item Length: 8
NAACCR Item #: 445
NAACCR Name: Date of Multiple Tumors

This data item is used to identify the month, day and year the patient is diagnosed with multiple tumors reported as a single primary. Use the multiple primary rules for that specific site to determine whether the tumors are a single primary or multiple primaries.

Date of Multiple Tumors must be transmitted in the YYYYMMDD format. Date of Multiple Tumors may be recorded in the transmission format, or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

Transmiting Dates

Transmit date fields in the year, month, day format (YYYYMMDD). Leave the year, month and/or day blank when they cannot be estimated or are unknown.

Common Formats

<table>
<thead>
<tr>
<th>Format</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>YYYYMMDD</td>
<td>Complete date is known</td>
</tr>
<tr>
<td>YYYYMM</td>
<td>Year and month are known/estimated; day is unknown</td>
</tr>
<tr>
<td>YYYY</td>
<td>Year is known/estimated; month and day cannot be estimated or are unknown</td>
</tr>
</tbody>
</table>

Transmit Instructions

1. Transmit date fields in the year, month, day format (YYYYMMDD).
2. Leave the year, month and/or day blank when they cannot be estimated or are unknown.
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Data Items
Effective with cases diagnosed 1/1/2010

Codes for Year
Code the four-digit year

Codes for Month

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<th>Code</th>
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</tbody>
</table>
Coding Instructions

1. Record the date of diagnosis when multiple tumors are present at diagnosis.

   **Example 1:** The patient has multiple tumors: a 2 cm infiltrating duct in the lower inner quadrant and a 1 cm infiltrating duct carcinoma in the upper inner quadrant of the left breast. According to the breast multiple primary rules, these tumors are accessioned as a single primary. Enter the date of diagnosis in Date of Multiple Tumors.

   **Example 2:** Operative report for TURB (transurethral resection of bladder) mentions multiple bladder tumors. Pathology report: Papillary transitional cell carcinoma present in tissue from bladder neck, dome, and posterior wall. According to the Bladder, Renal Pelvis, and Ureter multiple primary rules these tumors are accessioned as a single primary. Enter the date of diagnosis in Date of Multiple Tumors.

2. Record the date of diagnosis when
   a. The number of tumors is unknown (code 99 in Multiplicity Counter)
   b. It is unknown whether there is a single tumor or there are multiple tumors (code 99 in Multiplicity Counter)

   **Example:** Prostate biopsy performed 10/20/10, both lobes involved with tumor, unknown how many tumors. Enter the date of diagnosis (the date of the biopsy in this case) in Date of Multiple Tumors.

3. Record the earliest date that multiple tumors were diagnosed when subsequent tumor(s) are counted as the same primary.

   **Example 1:** Patient has an excisional biopsy of a single tumor in the soft palate on January 2, 2010. The pathology shows clear margins. Record 01 in Multiplicity Counter. On July 10, 2010 another tumor is excised from the soft palate. The multiple primary rules for head and neck state that this tumor is the same primary. Change the 01 in Multiplicity Counter to 02 and enter the date the second tumor was diagnosed (July 10, 2010) in Date of Multiple Tumors.

   **Example 2:** A single primary composed of multiple tumors of the breast is diagnosed on 02/23/10. Additional breast tumors diagnosed on 08/15/10 are determined to be the same primary. Date of multiple tumors is February 23, 2010. Do not update using the later date since multiple tumors were present initially.

4. Leave this field blank for cases diagnosed prior to 01/01/2007.
Data Items
Effective with cases diagnosed 1/1/2010

Death Certificate Only (DCO) Cases

See the *NAACCR Death Clearance Manual* for coding instructions

Estimating Dates

Estimating the **month**
1. Code “spring of” to April
2. Code “summer” or “middle of the year” to July
3. Code “fall” or “autumn” as October
4. For “winter of,” try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is available to calculate the month.
5. Code “early in year” to January
6. Code “late in year” to December
7. Use whatever information is available to calculate the month
8. Code the month of admission when there is no basis for estimation
9. Leave month blank if there is no basis for approximation

Estimating the **year**
1. Code “a couple of years” to two years earlier
2. Code “a few years” to three years earlier
3. Use whatever information is available to calculate the year
4. Code the year of admission when there is no basis for estimation

January 1, 2010
Data Items
Effective with cases diagnosed 1/1/2010

Date of Multiple Tumors Flag

Date flag fields were added beginning with diagnoses on or after 1/1/2010 as part of an initiative to standardize date fields. Date flags replace nondate information that had previously been transmitted in date fields. Coding 99999999 to indicate “unknown” is an example of nondate information that was previously transmitted in date fields.

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Not applicable</td>
<td>No proper value is applicable in this context</td>
</tr>
<tr>
<td>12</td>
<td>Unknown</td>
<td>A proper value is applicable but not known</td>
</tr>
<tr>
<td>15</td>
<td>Temporarily unavailable</td>
<td>Information is not available at this time, but it is expected that it will be available later</td>
</tr>
</tbody>
</table>

Coding Instructions
1. Leave this item blank when Date of Multiple Tumors has a full or partial date recorded
2. Assign code 11 when Multiplicity Counter is coded 88
3. Assign code 12 when the date of multiple tumors cannot be determined, and it is known that there are multiple tumors for this primary
4. Assign code 15 when Multiplicity Counter is coded 01
5. Change code 15 to blank or another code **the first time** the patient is diagnosed with multiple tumors that are determined to be the same primary; i.e. when Multiplicity Counter code is changed from 01 to 02-87 or 89.
Type of Multiple Tumors Reported as One Primary

This data item is used to identify the type of multiple tumors that are abstracted as a single primary. Ignore metastatic tumors for this data item.

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Description</th>
<th>Example(s) / Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Single tumor</td>
<td>All single tumors. Includes single tumors with both in situ and invasive components</td>
<td>Code 01 in the Multiplicity Counter</td>
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<tr>
<td>10</td>
<td>Multiple benign</td>
<td>At least two benign tumors in same organ/primary site</td>
<td>Use this code for nonmalignant tumors in intracranial and CNS sites. May also be used for reportable-by-agreement cases.</td>
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<tr>
<td>11</td>
<td>Multiple borderline</td>
<td>At least two borderline tumors in the same organ/primary site</td>
<td>Use this code for nonmalignant tumors in intracranial and CNS sites. May also be used for reportable-by-agreement cases.</td>
</tr>
<tr>
<td>12</td>
<td>Benign and borderline</td>
<td>At least one benign and at least one borderline tumor in the same organ/primary site</td>
<td>Use this code for nonmalignant tumors in intracranial and CNS sites. May also be used for reportable-by-agreement cases.</td>
</tr>
<tr>
<td>20</td>
<td>Multiple in situ</td>
<td>At least two in situ tumors in the same organ/primary site</td>
<td>Cystoscopy report documents multiple (or multicentric / multifocal) bladder tumors. Pathology: Flat transitional cell carcinoma of bladder.</td>
</tr>
</tbody>
</table>
| 30   | In situ and invasive | One or more in situ tumor(s) and one or more invasive tumors in the same organ/primary site | 1. A single breast primary composed of in situ tumor(s) and invasive tumor(s)  
2. Multiple polyps, some with non-invasive adenocarcinoma and some with invasive adenocarcinoma, all in the same segment of the colon |
### Data Items
Effective with cases diagnosed 1/1/2010

<table>
<thead>
<tr>
<th>Code</th>
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<th>Description</th>
<th>Example(s) / Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>Polyp and adenocarcinoma</td>
<td>One or more polyps with either • In situ carcinoma or • Invasive carcinoma</td>
<td>AND one or more frank adenocarcinoma(s) in the same segment of colon, rectosigmoid, and/or rectum</td>
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<tr>
<td>32</td>
<td>FAP with carcinoma</td>
<td>Diagnosis of familial polyposis (FAP) AND carcinoma (in situ or invasive) is present in at least one of the polyps</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Multiple invasive</td>
<td>At least two invasive tumors in the same organ</td>
<td>1. Lung primary with multiple nodules identified on scans. Only one nodule is biopsied. For lung only, it is assumed that all of the tumors are the same histology and that all are invasive. 2. Bladder tumors described as multicentric or multifocal. Pathology from TURB is invasive urothelial carcinoma.</td>
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<tr>
<td>80</td>
<td>Unk in situ or invasive</td>
<td>Multiple tumors present in the same organ/primary site, unknown if in situ or invasive</td>
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<tr>
<td>88</td>
<td>NA</td>
<td>Information on multiple tumors not collected/not applicable for this site</td>
<td>Code 88 in Multiplicity Counter</td>
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<td>Unk</td>
<td>Unknown</td>
<td>Code 99 in Multiplicity counter &quot;Disseminated&quot; or &quot;Diffuse&quot; with no further information</td>
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**Death Certificate Only (DCO) Cases**

See the [NAACCR Death Clearance Manual](#) for coding instructions
Data Items
Effective with cases diagnosed 1/1/2010

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## Multiple Primary and Histology Coding Rules Project
### Roster

Co-Chairs: Carol Johnson, BS, CTR  
Steven Peace, BS, CTR

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### Inactive Committee members

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### Cancer Site Subcommittees

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January 1, 2007
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The Commission on Cancer Clinical Advisory Panels – Disease Site Teams

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<th>Cancer Site</th>
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Central Brain Tumor Registry of the United States

Board of Directors
Carol Kruchko – President & Administrator
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Donald Segal - Treasurer
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Edwin L Jones, Jr
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Robert Tufel, MSW, MPH
Michael D Walker, MD

January 1, 2007