Multiple Primary and Histology Coding Rules
General Instructions

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)
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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
Multiple Primary and Histology Coding Rules
General Instructions

- 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.

Revised November 1, 2007
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.

*ACS Clinical Oncology

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

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
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.
Breast Equivalent Terms, Definitions, Tables and Illustrations  
C500-C509  
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

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 Infiltrating lobular carcinoma</td>
<td>Infiltrating duct and 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>Intraductal 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
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.

Revised November 1, 2007
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

C700, C701, C709, C710-C719, C720-725, C728, C729, C751-C753

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

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; oligodendrogial; 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).

Oligodendroglioma: 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
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 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>Acinar</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 OR <strong>two or more</strong> of the histologies from column 2</td>
<td>Papillary</td>
<td>Adenocarcinoma with mixed subtypes Adenocarcinoma combined with other types of carcinoma</td>
<td>8255</td>
</tr>
<tr>
<td></td>
<td>Clear cell</td>
<td></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
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>
<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>

January 1, 2007
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.

<table>
<thead>
<tr>
<th>MULTIPLE TUMORS, continued</th>
<th>DECISION</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>M11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do the tumors have ICD-O-3 **histology codes that are different at the first (xxxx), second (xxx) or third (xx) number?</td>
<td>YES</td>
<td>MULTIPLE Primary**</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>M12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not meet any of the above criteria (M1 through M11).</td>
<td>YES</td>
<td>SINGLE Primary*</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>Tumors not described as metastases.</td>
</tr>
</tbody>
</table>

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.

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.

** 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>Is there no <em>pathology/cytology</em> specimen or is the <em>pathology/cytology</em> report unavailable?</td>
<td><strong>YES</strong> Code the histology documented by the physician.</td>
</tr>
<tr>
<td></td>
<td><strong>NO</strong></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><strong>YES</strong> Code the histology from a metastatic site.</td>
</tr>
<tr>
<td></td>
<td><strong>NO</strong></td>
<td></td>
</tr>
<tr>
<td>H3</td>
<td>Is only one histologic type identified?</td>
<td><strong>YES</strong> Code the histology.</td>
</tr>
<tr>
<td></td>
<td><strong>NO</strong></td>
<td></td>
</tr>
<tr>
<td>H4</td>
<td>Does the tumor have invasive and in situ components?</td>
<td><strong>YES</strong> Code the invasive histology.</td>
</tr>
<tr>
<td></td>
<td><strong>NO</strong></td>
<td></td>
</tr>
</tbody>
</table>

**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.

**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).

Revised November 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 final diagnosis adenocarcinoma and there is reference to a residual or pre-existing polyp?
  - **YES**
    - **NO**
    - **YES**

  Is the final diagnosis mucinous/colloid or signet ring cell adenocarcinoma found in a polyp?
  - **YES**
    - **NO**
    - **YES**

  Is there documentation that the patient had a polypectomy?
  - **YES**
  - **NO**

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**

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

**YES**

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

**NO**

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)

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><strong>YES</strong></td>
</tr>
<tr>
<td></td>
<td>Are there &gt; 100 polyps identified in the resected specimen?</td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td></td>
<td>Is the number of polyps not given and the diagnosis is familial polyposis?</td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Code 8220</strong> (adenocarcinoma in adenomatous polyposis coli)</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>H18</td>
<td>Are there multiple in situ or malignant polyps present, at least one of which is tubulovillous?</td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Code 8263</strong> (adenocarcinoma in a tubulovillous adenoma)</td>
<td><strong>NO</strong></td>
</tr>
</tbody>
</table>

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.
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>H19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there &gt;1 and ≤ 100 polyps identified in the resected specimen?</td>
<td>YES</td>
<td>Code 8221 (adenocarcinoma in adenomatous polyps)</td>
</tr>
<tr>
<td>NO</td>
<td></td>
<td>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).</td>
</tr>
<tr>
<td>Are there multiple polyps and the number is not given and familial polyposis is not mentioned?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a frank adenocarcinoma and a carcinoma in a polyp?</td>
<td>YES</td>
<td>Code the histology of the most invasive tumor.</td>
</tr>
<tr>
<td>NO</td>
<td></td>
<td>1. See the Colon Equivalent Terms, Definitions and Illustrations for the definition of most invasive.</td>
</tr>
<tr>
<td>Are there in situ and invasive tumors?</td>
<td>YES</td>
<td>o If one tumor is in situ and one is invasive, code the histology from the invasive tumor.</td>
</tr>
<tr>
<td>NO</td>
<td></td>
<td>o If both/all histologies are invasive, code the histology of the most invasive tumor.</td>
</tr>
<tr>
<td>Are there multiple invasive tumors?</td>
<td>YES</td>
<td>2. If tumors are equally invasive, go to the next rule.</td>
</tr>
<tr>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next Page</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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>
</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  
|               |                                     | 2. Code the specific histology when documented.                                       |
|               |                                    | 2. 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>
</table>
| **H3** | Is there carcinoma in situ, NOS (8010) and a specific carcinoma in situ? | **YES** | Code the more specific histologic term.  
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. |
| | NO | **YES** |  
Is there adenocarcinoma in situ, NOS (8140) and a specific adenocarcinoma in situ? |
| | NO | **YES** | Is there intraductal NOS (8500) and a specific intraductal carcinoma (Table 1)? |
| | **NO** | |  
**H4** | Does the tumor have non-infiltrating comedocarcinoma and any other intraductal carcinoma (Table 1)? | **YES** | Code 8501/2  
(comedo carcinoma, non-infiltrating).  
**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)? | **YES** | Code 8522/2  
(intraductal and lobular carcinoma in situ) (Table 3). |
| | **NO** | |  
Next Page |
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.

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><strong>YES</strong> Code the histology.</td>
<td></td>
</tr>
</tbody>
</table>

**NO**

<table>
<thead>
<tr>
<th>H15</th>
<th><strong>YES</strong> Code the <strong>numerically higher</strong> ICD-O-3 histology code.</th>
<th><strong>Use Table 2 to identify duct carcinomas</strong></th>
</tr>
</thead>
</table>

**NO**

<table>
<thead>
<tr>
<th>H16</th>
<th><strong>YES</strong> Code <strong>8522</strong> (duct and lobular).</th>
<th><strong>Use Table 2 to identify duct carcinomas</strong></th>
</tr>
</thead>
</table>

**NO**

- **Is only one histologic type identified?**
- **Are there two or more specific duct carcinomas?**
- **Is there a combination oflobular (8520) and duct carcinoma (Table 3)?**
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>Is there a combination of <strong>duct</strong> and any other carcinoma (Table 3)?</td>
<td>Code <strong>8523</strong> (duct mixed with other types of carcinoma).</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>1. Use Table 2 to identify duct carcinomas.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>H18</td>
<td>Does the tumor have <strong>lobular</strong> (8520) and any other carcinoma (Table 3)?</td>
<td>Code <strong>8524</strong> (lobular mixed with other types of carcinoma).</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>H19</td>
<td>Are there multiple histologies that do not include duct or lobular (8520)?</td>
<td>Code <strong>8255</strong> (adenocarcinoma with mixed subtypes) (Table 3).</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>Use Table 2 to identify duct carcinomas</td>
</tr>
<tr>
<td></td>
<td></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.
MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

**Rule:**
- **H20**
  - Is there no pathology/cytology specimen or is the pathology/cytology report unavailable?
    - **YES:** Code the histology documented by the physician.
    - **NO:**

**Action:**
- Code the histology documented by the physician.

**Notes and Examples:**
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.

**Rule:**
- **H21**
  - Is the only specimen from a metastatic site?
    - **YES:** Code the histology from a metastatic site.
    - **NO:**

**Action:**
- Code the histology from a metastatic site.

**Notes and Examples:**
- Code the behavior /3.

**Rule:**
- **H22**
  - Does the final diagnosis of the pathology report specifically state inflammatory carcinoma?
    - **YES:** Code **8530** (inflammatory carcinoma).
    - **NO:**

**Action:**
- Code **8530** (inflammatory carcinoma).

**Notes and Examples:**
- Record dermal lymphatic invasion in Collaborative Staging.
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>
<tbody>
<tr>
<td>H23</td>
<td>Is only <strong>one histologic type</strong> identified?</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td></td>
<td><strong>YES</strong></td>
<td><strong>Code the histology.</strong></td>
</tr>
</tbody>
</table>

| 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).) | **Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).** |
|      | **NO** |

| H25  | Is there **Paget disease and intraductal** carcinoma (Table 3)? | **YES** |
|      | **Code 8543/3** (Paget disease and intraductal carcinoma). | **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.** |
|      | **NO** |

| H26  | Is there **Paget disease and invasive duct** carcinoma (Table 3)? | **YES** |
|      | **Code 8541/3** (Paget disease and infiltrating duct carcinoma). | **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.** |
|      | **NO** |
MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule | Action | Notes and Examples
--- | --- | ---
H27 | Are there invasive and in situ components? YES | Code the invasive histology.  
NO | | 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)
H28 | Is there any combination of lobular (8520) and duct carcinoma (Table 3)? YES | Code 8522 (duct and lobular).  
NO | | Use Table 2 to identify duct carcinomas.
H29 | | 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.

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

NO

SINGLE Primary*

End of instructions for Unknown if Single or Multiple Tumors

NO

Go to Single Tumor or Multiple Tumors

SINGLE TUMOR

DECISION

NOTES

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

SINGLE Primary*

End of instructions for Single Tumor.

M2

Is there a single tumor?

YES

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

NO

Go to Multiple Tumors.

NOTES DECISION

SINGLE TUMOR

NO

YES

UNKNOWN IF SINGLE OR 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.
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.

M3

Is the diagnosis adenocarcinoma of the prostate?

YES

SINGLE Primary*

NO

M4

Is the diagnosis retinoblastoma (unilateral or bilateral)?

YES

SINGLE Primary*

NO

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.
* 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.

---

**Other Sites Multiple Primary Rules - Flowchart**

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

---

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

---

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

**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**

---

Other Sites MP

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**NOTES**

DECISION

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

MULTIPLE TUMORS, continued

M8

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

YES  MULTIPLE Primaries**

NO  Table 1 - Paired Organs and Sites with Laterality

M9

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

YES  SINGLE Primary*

NO  Tumors may be present in a single or multiple segments of the colon, rectosigmoid, rectum.

M10

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

YES  MULTIPLE Primaries**

NO  Next Page

** 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>MULTIPLE TUMORS, continued</th>
<th>DECISION</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>M11 Are there tumors in sites with ICD-O-3 topography codes that are different at the second (Cxxx) and/or third character (Cxx)?</td>
<td>YES MULTIPLE Primaries**</td>
<td>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.</td>
</tr>
<tr>
<td>NO</td>
<td>MULTIPLE Primaries**</td>
<td></td>
</tr>
</tbody>
</table>

| M12 Are there tumors in sites with ICD-O-3 topography codes that differ at only the fourth character (Cxx) and are in any one of the following primary sites: | YES 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) | |
| NO | |

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

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

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)
**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>
| H8       | Is there no pathology/cytology specimen or is the pathology/cytology   | 1. Priority for using documents to code the histology  
|          | report unavailable?                                                     |   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  
| H9       | Is the specimen from a metastatic site? (there is no pathology/cytology | 2. Code the specific histology when documented.  
|          | specimen from the primary site?)                                        | 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
**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>H10</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the diagnosis acinar (adenocarcinoma for prostate primaries?</td>
<td>YES</td>
<td>Code 8140 (adenocarcinoma, NOS)</td>
</tr>
<tr>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>H11</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is only one histologic type identified?</td>
<td>YES</td>
<td>Code the histology.</td>
</tr>
</tbody>
</table>
| 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 |

Revised November 1, 2007
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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>
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<tr>
<th>Rule</th>
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</tr>
</thead>
<tbody>
<tr>
<td>H12</td>
<td>Is the final diagnosis adenocarcinoma in a polyp?</td>
<td>YES</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>NO</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>NO</td>
</tr>
<tr>
<td></td>
<td>Is there documentation that the patient had a polypectomy?</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Code 8210 (adenocarcinoma in adenomatous polyp), 8261 (adenocarcinoma in villous adenoma), or 8263 (adenocarcinoma in tubulovillous adenoma).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>It is important to know that the adenocarcinoma originated in the polyp.</td>
<td></td>
</tr>
</tbody>
</table>

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>
| 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 | Invasive and in situ | 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 |

Revised November 1, 2007
Head and Neck Histology Coding Rules – Matrix
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

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<tr>
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</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 |  
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 |

| H6   | 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>
<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></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<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 |

January 1, 2007
## 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>
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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>I: 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: 1. Adenocarcinoma in a polyp or 2. Adenocarcinoma and a residual polyp or polyp architecture is recorded in other parts of the pathology report or 3. Adenocarcinoma and there is reference to a residual or pre-existing polyp within the medical record or 4. Mucinous/colloid or signet ring cell adenocarcinoma in a polyp or There is documentation that the patient had a polypectomy</td>
<td></td>
<td>I: 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: 1. Mucinous/colloid (8480) or signet ring cell carcinoma (8490) or 2. Adenocarcinoma, NOS and microscopic description documents 50% or more of the tumor is mucinous/colloid or 3. Adenocarcinoma, NOS and microscopic description documents 50% or more of the tumor is signet ring cell carcinoma</td>
<td></td>
<td></td>
<td>8480 (Mucinous/colloid adenocarcinoma) or 8490 (Signet ring cell carcinoma)</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)

<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>
| **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 |

**MUTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY**

These rules only apply to multiple tumors that are reported as a **single primary**.

---

January 1, 2007
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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<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 |          |          |                    | 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)

<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  |                            | • 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) | 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>
</table>
| H23  |                             | • 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) | 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. | The more specific histologic term |
| H24  | None of the above conditions are met | | | The histology with the numerically higher ICD-O-3 code |

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: IN SITU ONLY**  
(Single tumor; all parts are in situ) | | | | | |
| 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>
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<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></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)

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<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) | 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 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 |
| H10 | None from primary site | | Code the behavior /3 | The histology from a metastatic site |
| H11 | | | | |
# 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>8530 (inflammatory carcinoma)</td>
<td></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>8522 (duct and lobular) (Table 3).</td>
<td></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>8523 (duct mixed with other types of carcinoma) (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>
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<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H18</td>
<td></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>
</tr>
<tr>
<td>H19</td>
<td></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>
</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 |
| 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 |
**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>H24</td>
<td></td>
<td>Pathology report specifically states Paget disease is in situ and the underlying tumor is 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>Code 8543/2 (in situ Paget disease and intraductal carcinoma) <em>(Table 3).</em></td>
<td></td>
</tr>
</tbody>
</table>
| H25  |                             | Paget disease and intraductal carcinoma | 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 | Code 8543/3 (Paget disease and intraductal carcinoma) *(Table 3).* |
| H26  |                             | Paget disease and invasive duct carcinoma | 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 | Code 8541/3 (Paget disease and infiltrating duct carcinoma) *(Table 3).* |
| H27  |                             | Invasive and in situ | 1. Ignore the in situ term.  
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) | The invasive histology |

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>The histology with the numerically higher ICD-O-3 code</td>
<td></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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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.

<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>UNKNOWN IF SINGLE OR MULTIPLE TUMORS</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>Tumor(s) not described as metastasis</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>Single TUMOR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M2</td>
<td>Prostate</td>
<td>Adenocarcinoma</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>SINGLE TUMOR</td>
<td></td>
<td>I: Tumor not described as metastasis</td>
<td>2: Includes combinations of in situ and invasive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MULTIPLE TUMORS</td>
<td>Prostate</td>
<td>Adenocarcinoma</td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
<tr>
<td>Multiple tumors may be a single primary or multiple primaries</td>
<td></td>
<td>I: Tumors not described as metastases</td>
<td>2: Includes combinations of in situ and invasive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M3</td>
<td></td>
<td>1: Report only one adenocarcinoma of the prostate per patient per lifetime.</td>
<td>2: 95% of prostate malignancies are the common (acinar) adenocarcinoma histology (8140). See Equivalent Terms, Definitions and Tables for more information</td>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unilateral or bilateral</td>
<td>Retinoblastoma</td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
<tr>
<td>M4</td>
<td>Any site or sites</td>
<td>Kaposi sarcoma</td>
<td></td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
<tr>
<td>M5</td>
<td>Thyroid</td>
<td>Follicular and papillary</td>
<td>Within 60 days</td>
<td></td>
<td></td>
<td>Single*</td>
</tr>
</tbody>
</table>

Revised November 1, 2007
### Other Sites MP

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>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>Tumors may be present in a single or multiple segments of the colon, rectosigmoid, rectum.</td>
<td>Table 1 – Paired Organs and Sites with Laterality</td>
<td>Multiple**</td>
</tr>
<tr>
<td>M10</td>
<td></td>
<td></td>
<td></td>
<td>Diagnosed more than one (1) year apart</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></td>
<td>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</td>
<td>Multiple**</td>
</tr>
</tbody>
</table>
| M12  | Topography codes that differ only at the fourth (Cxxx) 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) | | | | Multiple** |
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>
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<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>One type</td>
<td></td>
<td></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 “non-keratinizing” actually appear in the diagnosis.</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 | 1: It is important to know that the adenocarcinoma originated in a polyp  
2: If this is a papillary carcinoma of the thyroid, go to Rule H14 | 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>
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<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 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</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> 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>
<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>
</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>
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<th>Notes and Examples</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<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. <strong>Example 1 (multiple specific histologies):</strong> Mucinous and papillary adenocarcinoma. Code 8255 (adenocarcinoma with mixed subtypes). <strong>Example 2 (multiple specific histologies):</strong> Combined small cell and squamous cell carcinoma. Code 8045 (combined small cell carcinoma) <strong>Example 3 (non-specific with multiple specific histologies):</strong> 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>

Revised November 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

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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>
<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                                                                                                                                                                                                  |                                   |
| **H20** | Prostate                    |             | Acinar (adenocarcinoma)    |          | The histology from a metastatic site                                                                                                                                                                                   | 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
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.

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.

January 1, 2007
Colon Histo

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

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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.
MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

**Note:** These rules only apply to multiple tumors that are reported as a single primary.

<table>
<thead>
<tr>
<th>Rule H15</th>
<th>Code the histology documented by the physician when there is <strong>no pathology/cytology specimen</strong> or the <strong>pathology/cytology</strong> report is <strong>not available</strong>.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note 1:</strong></td>
<td>Priority for using documents to code the histology</td>
</tr>
<tr>
<td>• Documentation in the medical record that refers to pathologic or cytologic findings</td>
<td></td>
</tr>
<tr>
<td>• Physician’s reference to type of cancer (histology) in the medical record</td>
<td></td>
</tr>
<tr>
<td>• From CT, PET or MRI scans</td>
<td></td>
</tr>
<tr>
<td><strong>Note 2:</strong></td>
<td>Code the specific histology when documented.</td>
</tr>
<tr>
<td><strong>Note 3:</strong></td>
<td>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>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rule H16</th>
<th>Code the histology from a metastatic site when there is <strong>no pathology/cytology specimen from the primary site</strong>.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note:</strong></td>
<td>Code the behavior /3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rule H17</th>
<th>Code 8220 (adenocarcinoma in adenomatous polyposis coli) when:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>Clinical</strong> history says <strong>familial polyposis</strong> and final diagnosis on the <strong>pathology report</strong> from resection is <strong>adenocarcinoma in adenomatous polyps</strong> or</td>
<td></td>
</tr>
<tr>
<td>• There are &gt;100 <strong>polyps</strong> identified in the resected specimen or</td>
<td></td>
</tr>
<tr>
<td>• The number of polyps is not given but the diagnosis is <strong>familial polyposis</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rule H18</th>
<th>Code 8263 (adenocarcinoma in a tubulovillous adenoma) when multiple in situ or malignant polyps are present, at least one of which is tubulovillous</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note:</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rule H19</th>
<th>Code 8221 (adenocarcinoma in multiple adenomatous polyps) when:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• There are &gt;1 and &lt;=100 <strong>polyps</strong> identified in the resected specimen or</td>
<td></td>
</tr>
<tr>
<td>• There are multiple polyps (adenomas) and the number is not given and <strong>familial polyposis</strong> is <strong>not mentioned</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td>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).</td>
</tr>
</tbody>
</table>
Colon Histology Coding Rules – Text
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

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.

January 1, 2007
**Breast Histology Coding Rules – Text**

**C500-C509**

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

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**SINGLE TUMOR: IN SITU CARCINOMA 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 (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.

*Note 1:* Use Table 1 to identify the histologies

*Note 2:* Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

**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).
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.

Revised November 1, 2007
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 2.

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 carcinomas

Revised November 1, 2007
Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

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.
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. *

* 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. *

* 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.

Rule M3  Adenocarcinoma of the prostate 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 Unknown if Single or Multiple Tumors.
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 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 (Cxxxy) 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 Histology Coding Rules – Text
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

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
New Data Item
Effective with cases diagnosed 1/1/2007

Multiplicity Counter

Item Length: 2
NAACCR Item #: 446
NAACCR Name: 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 rules for the specific site to determine whether the tumors are a single primary or multiple primaries.

**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 and enter the number 02 in the data item Multiplicity Counter.

**Example 2:** 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 99 (multiple tumors, unknown how many) in Multiplicity Counter.

**Example 3:** 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 4:** 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 5:** CT of chest shows two lesions in the left lung and a single lesion in the right lung. Biopsy of the right lung lesions shows adenocarcinoma. No other workup is done. Using the multiple primary rules for lung, the case is abstracted as a single primary. Enter the number 03 in the data item Multiplicity Counter.

**Codes**
01 One tumor only
02 Two tumors present
03 Three tumors present
...
...
88 Information on multiple tumors not collected/not applicable for this site
99 Multiple tumors present, unknown how many; unknown if multiple tumors
**New Data Item**

**Effective with cases diagnosed 1/1/2007**

**Coding Instructions**

1. Code the number of tumors being abstracted as a single primary.
2. Do not count metastasis.
3. When there is a tumor or tumors with separate single or multiple foci, ignore/do not count the foci
   a. When the tumor is multifocal or multicentric and the foci of tumor are measured, count them as tumors
   b. When the tumor is multifocal or multicentric and the foci of tumor are not measured, code as 99
4. Use code 01 when
   a. There is a single tumor in the primary site being abstracted
   b. There is a single tumor with separate foci of tumor
5. Use code 88 for:
   a. Leukemia
   b. Lymphoma
   c. Immunoproliferative disease
   d. Unknown primary
6. 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 as multifocal or multicentric and the number of tumors is not mentioned.
   c. The tumor is described as diffuse.
   d. The operative or pathology report describes multiple tumors but does not give an exact number.
   e. 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.
7. Leave this field blank for cases diagnosed prior to 01/01/2007.