Introduction

Note 1: Tables and rules refer to ICD-O rather than ICD-O-3. The version is not specified to allow for updates. Use the currently approved version of ICD-O.

Note 2: 2007 MPH Rules and 2018 Solid Tumor Rules are used based on date of diagnosis.

- Tumors diagnosed 01/01/2007 through 12/31/2017: Use 2007 MPH Rules
- Tumors diagnosed 01/01/2018 and later: Use 2018 Solid Tumor Rules
- The original tumor diagnosed before 1/1/2018 and a subsequent tumor diagnosed 1/1/2018 or later in the same primary site: Use the 2018 Solid Tumor Rules.

Note 3: For those sites/histologies which have recognized biomarkers, the biomarkers are most frequently used to target treatment. Currently, there are clinical trials being conducted to determine whether these biomarkers can be used to identify multiple primaries and/or histologic type. Follow the Multiple Primary Rules; do not code multiple primaries based on biomarkers.

Changes from 2007 MPH Rules

1. 2007 Rules instruct “Code the histology from the most representative specimen.” For all sites except breast and CNS, 2018 Rules instruct “Code the most specific histology from biopsy or resection. When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).”

2. Two bone sites, mandible C411 and maxilla C410, have been added to the Head and Neck Rules.

3. Autonomic nervous system C479 has been added as a primary site for those paragangliomas reported as malignant.
1. The 2018 Solid Tumor Head and Neck Rules, Table 5, instruct squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086) are coded only when HPV status is determined by tests based on ISH, PCR, RT-PCR technologies to detect the viral DNA or RNA. P16 was not a valid test to assign these codes. **Beginning with cases diagnosed 1/1/2022 forward, p16 test results can be used to code squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086).**

2. Beginning 1/1/2022, non-keratinizing squamous cell carcinoma, HPV positive is coded 8085 for sites listed in Table 5 only. A diagnosis of non-keratinizing squamous cell carcinoma, NOS is coded 8072.

3. Beginning 1/1/2022, keratinizing squamous cell carcinoma, HPV negative is coded 8086 for sites listed in Table 5 only. A diagnosis of keratinizing squamous cell carcinoma, NOS is coded 8071.
Head and Neck Equivalent Terms and Definitions
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(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Equivalent or Equal Terms

These terms can be used interchangeably:

• Adenocarcinoma; adenocarcinoma NOS; carcinoma; carcinoma NOS
• And; with
  Note: “And” and “with” are used as synonyms when describing multiple histologies within a single tumor
• Contiguous; continuous
• Hemangiosarcoma; angiosarcoma
• Hypopharynx; laryngopharynx
• In situ; noninvasive; intraepithelial
• Malignant tumor; malignant mass; malignant lesion; malignant neoplasm
• Simultaneous; existing at the same time; concurrent; prior to first course treatment
• Site; topography
• Squamous cell carcinoma; squamous carcinoma; squamous cell epithelioma; epidermoid carcinoma
• Squamous cell carcinoma, HPV-negative; squamous cell carcinoma, HPV-independent (8086)
• Squamous cell carcinoma, HPV-positive; squamous cell carcinoma, HPV-associated; squamous cell carcinoma, HPV-related (8085)
• Squamous cell carcinoma with verrucous growth pattern; squamous cell carcinoma
  o Growth pattern is not a histological type
• Tumor; mass; tumor mass; lesion; neoplasm
  o The terms tumor, mass, tumor mass, lesion, and neoplasm are not used in a standard manner in clinical diagnoses, scans, or consults. Disregard the terms unless there is a physician’s statement that the term is malignant/cancer
  o These terms are used ONLY to determine multiple primaries
  o Do not use these terms for casefinding or determining reportability
• Type; subtype; variant
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Terms that are NOT Equivalent or Equal

These terms are not equivalent. There are no casefinding implications.

- **Component** is not equivalent to **subtype/type/variant**
  
  *Note:* Component is only coded when the pathologist specifies the component as a second carcinoma

- **p16 positive** is not equivalent to **HPV positive (pre-2022)**

- **p16 negative** is not equivalent to **HPV negative (pre-2022)**

- **Phenotype** is not equivalent to **subtype/type/variant**

- **Squamous cell carcinoma with prominent keratinization 8070** is not equivalent to **keratinizing squamous cell carcinoma 8071**

- Salivary **gland** adenocarcinoma 8140 is not equivalent to salivary **duct** carcinoma 8500

Coding Primary Site When There is Conflicting Information

Identifying the primary site is difficult because:

- Workups (PE scans, endoscopies, biopsies) each provide a unique view of the tumor, therefore the medical record often contains conflicting documentation on the primary site.

- The sites/organs are small and right next to each other. Tumors frequently extend into adjacent anatomic sites, or overlap multiple contiguous sites.

**Priority Order for Identifying Primary Site When There is Conflicting Information**

*Note:* Record primary site based on the most definitive indication of primary site in the medical documentation and use the priority order when there is conflicting info without a definitive statement.

1. **Tumor Board**
   A. Specialty
   B. General
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(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

2. **Tissue/pathology** from tumor resection or biopsy
   A. Operative report
   B. Addendum and/or comments on tissue/pathology report
   C. Final diagnosis on issue/pathology report
   D. CAP protocol/summary

3. **Scans**
   A. CT
   B. MRI
   C. PET

4. **Physician documentation.** Use the documentation in the following priority order:
   A. Physician’s **reference** in medical record to primary site from original pathology, cytology, or scan(s), any other documentation
   B. Physician’s **reference** to primary site in the medical record

5. Use **Tables 1-9** to assist in assigning primary site when a SINGLE lesion overlaps two or more sites.
   A. Go to the appropriate table for each involved site (use the hyperlinked index below).
   B. Compare the histology diagnosis to the histologies in the table for each of the involved sites.
   C. When the histology diagnosis is listed for only one primary site (only listed in one table), code that primary site.

6. When the primary site cannot be determined using previous instructions, code as follows for an overlapping lesion:
   A. **C028** Overlapping lesion of tongue (See **Table 4** for subsites of the tongue)
   B. **C058** Overlapping lesion of palate, junction of hard and soft palate (See **Table 4** for subsites of the palate)
   C. **C088** Overlapping lesion of major salivary glands (See **Table 6** for specific salivary glands)
   D. **C148** Overlapping lesion of lip, oral cavity and pharynx
   
   **Note:** Codes and terms for overlapping lesions C__.8 are not included in the tables

7. Code to the NOS region
   A. **C069** Mouth NOS (See **Table 4** for mouth subsites)
   B. **C089** Major Salivary Gland NOS (See **Table 6** for specific salivary glands)
   C. **C099** Tonsil NOS (See **Table 5** for tonsil subsites)
   D. **C109** Oropharynx NOS (See **Table 5** for oropharynx subsites)
   E. **C119** Nasopharynx NOS (See **Table 2** for nasopharynx subsites)
F. **C139** Hypopharynx NOS (See Table 3 for hypopharynx subsites)

G. **C140** Pharynx NOS

*Note*: Pharynx NOS includes the oropharynx, nasopharynx, and hypopharynx.

H. **C760** Head, face, or neck NOS (organs involved unknown/not documented)

*Note*: This code is used in circumstances such as biopsy of lymph node and no information about primary site

- Patient lost to follow-up; no further information available
- Patient/family declined further work-up or treatment
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Table 1: Tumors of Nasal Cavity, Paranasal Sinuses and Skull base

Table 1 lists the more common histologies for the following head and neck subsites:
- **C300** Nasal cavity; naris; nasal cartilage; nasal mucosa; nasal septum NOS; nasal turbinate; nostril; vestibule of nose
- **C310** Maxillary sinus; maxillary antrum; antrum NOS
- **C311** Ethmoid sinus
- **C312** Frontal sinus
- **C313** Sphenoid sinus
- **C318** Overlapping lesion of accessory sinuses
- **C319** Accessory sinus NOS; accessory nasal sinus; paranasal sinus

For hematopoietic neoplasms such as lymphomas, myelomas, etc., see the Hematopoietic Database.

**Note:** Hematopoietic tumors are common to the nasal cavity and paranasal sinuses.

**Column 1** contains specific and NOS histology terms.
- **Specific** histology terms **do not** have subtypes/variants
- **NOS** histology terms **do** have subtypes/variants.

**Column 2** contains synonyms for the specific or NOS term. Synonyms have the same histology code as the specific or NOS term.

**Column 3** contains subtypes/variants of the NOS histology. Subtypes/variants **do not** have the same histology code as the NOS.

Column 3 may contain NOS histologies which are part of a bigger histologic group. For example, sarcoma NOS 8800/3 (column 1) is a generic term which encompasses a number of soft tissue tumors, including rhabdomyosarcoma 8900/3 (column 3). Rhabdomyosarcoma is also a NOS because it has subtypes/variants. The subtypes/variants are indented under the NOS (rhabdomyosarcoma) in column 3. There is also a note in column 1 which calls attention to the fact that rhabdomyosarcoma has subtypes/variants.

When subtypes/variants are indented under a NOS in Column 3, use coding rules for a NOS and a single subtype/variant. For example, rhabdomyosarcoma **8900/3** and Alveolar rhabdomyosarcoma **8920/3** are a NOS and a subtype/variant, **NOT** two different subtypes.
### Head and Neck Equivalent Terms and Definitions

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(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

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<td><em>Note:</em> Adenocarcinoma intestinal-type of the sinonasal tract is morphologically similar to adenocarcinomas of the intestines</td>
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<td>Adenocarcinoma intestinal type</td>
<td>Low-grade adenocarcinoma</td>
<td>Adenocarcinoma intestinal type (ITAC) <strong>8144</strong></td>
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<td>Renal cell-like carcinoma</td>
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<td>Colloid-type adenocarcinoma <strong>8144</strong></td>
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<td>Seromucinous adenocarcinoma</td>
<td></td>
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<td>Tubulopapillary low-grade adenocarcinoma</td>
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<td><strong>Lymphoepithelial carcinoma 8082</strong></td>
<td>LEC</td>
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<td></td>
<td>Lymphoepithelioma-like carcinoma</td>
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<td><strong>Malignant peripheral nerve sheath tumor 9540/3</strong></td>
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<td>Malignant neurilemoma/malignant schwannoma <strong>9560/3</strong></td>
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<td>Neurofibrosarcoma</td>
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<td><strong>Mucoepidermoid carcinoma 8430</strong></td>
<td>Salivary gland-type mucoepidermoid carcinoma</td>
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<td><strong>Mucosal melanoma 8720</strong></td>
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<td><strong>Myoepithelial carcinoma 8982</strong></td>
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<td><strong>NUT carcinoma 8023</strong>*</td>
<td>Midline carcinoma of children and young adults with NUT rearrangement NUT midline carcinoma</td>
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<td><strong>Olfactory neuroblastoma 9522/3</strong></td>
<td>Esthesioneuroblastoma</td>
<td>Esthesioneurocytoma 9521/3</td>
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<tr>
<td>Olfactory placode tumor ONB</td>
<td>Esthesioneuroepithelioma/Olfactory neuroepithelioma 9523/3</td>
<td></td>
</tr>
</tbody>
</table>
# Head and Neck Equivalent Terms and Definitions

C000-C148, C300-C339, C410, C411, C479, C754, C755

(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Specific or NOS Term and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
</table>
| **Primitive neuroectodermal tumor 9364** | Adult neuroblastoma  
Ewings sarcoma  
Peripheral neuroblastoma  
Peripheral neuroectodermal tumor  
Peripheral neuroepithelioma | |

| **Sarcoma 8800/3** |  | |
| **Note 1:** Angiosarcomas are coded to the organ in which they occur. The prognosis and disease process of angiosarcomas differ between sites Contiguous organs, blood vessels, and lymph nodes are not the same for every organ. | |
| **Note 2:** Rhabdomyosarcoma 8900/3 has subtypes/variants:  
Alveolar rhabdomyosarcoma 8920/3  
Embryonal rhabdomyosarcoma 8910/3  
Pleomorphic rhabdomyosarcoma, adult type 8901/3 | Angiosarcoma/hemangiosarcoma 9120/3  
Biphenotypic sinonasal sarcoma (BSNS)/low-grade sinonasal sarcoma with neural and myogenic features 9045/3*  
Epithelioid hemangioendothelioma 9133/3  
Fibrosarcoma/adult-type fibrosarcoma 8810/3  
Leiomyosarcoma 8890/3  
Malignant hemangioendothelioma 9130/3  
Rhabdomyosarcoma 8900/3  
Alveolar rhabdomyosarcoma 8920/3  
Embryonal rhabdomyosarcoma 8910/3  
Pleomorphic rhabdomyosarcoma, adult type 8901/3  
Spindle cell rhabdomyosarcoma 8912/3  
Synovial sarcoma/synovial cell sarcoma 9040/3  
Undifferentiated pleomorphic sarcoma/malignant fibrous histiocytoma 8802/3 |

<p>| <strong>Sinonasal undifferentiated carcinoma 8020</strong> | Sinonasal carcinoma, undifferentiated SNUC |  |</p>
<table>
<thead>
<tr>
<th>Specific or NOS Term and Code</th>
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| **Squamous cell carcinoma 8070** | Squamous cell carcinoma, usual type 8070/3  
Conventional Squamous cell carcinoma NOS  
Epidermoid carcinoma, NOS 8070/3  
Epidermoid carcinoma in situ, NOS 8070/2  
Squamous carcinoma 8070/3  
Squamous cell carcinoma in situ, NOS 8070/2  
Squamous cell epithelioma 8070/3  
Intraepithelial squamous cell carcinoma 8070/2 | Keratinizing squamous cell carcinoma (KSCC) 8071  
Epidermoid carcinoma, keratinizing  
Squamous cell carcinoma, large cell, keratinizing  
Squamous cell carcinoma, large cell, nonkeratinizing/Squamous cell carcinoma, nonkeratinizing, NOS 8072  
Schneiderian carcinoma/cylindrical cell carcinoma 8121  
Sarcomatoid squamous cell carcinoma/spindle cell squamous cell carcinoma (SC-SCC) 8074 |

**Note:** Sinonasal squamous cell tumors account for about 3% of head and neck malignancies.

| **Teratocarcinosarcoma 9081** | Blastoma  
Malignant teratoma  
Teratocarcinoma  
Teratoid carcinosarcoma | |

* These new codes were approved by the IARC/WHO Committee for ICD-O
# Table 2: Tumors of Nasopharynx

Table 2 lists the more common histologies for the following head and neck subsites:

- **C110** Superior wall of nasopharynx; roof of nasopharynx
- **C111** Posterior wall of nasopharynx only (does not include adenoid/pharyngeal tonsil)
- **C112** Lateral wall of nasopharynx; fossa of Rosenmuller
- **C113** Anterior wall of nasopharynx; nasopharyngeal surface of soft palate; pharyngeal fornix; choana; posterior margin of nasal septum
- **C118** Overlapping lesion of nasopharynx. Use only when a single lesion overlaps subsites of the nasopharynx.  
  *Example:* A single tumor overlaps C110 superior wall of nasopharynx and C111 posterior wall of the nasopharynx.
- **C119** Nasopharynx NOS; nasopharyngeal wall; use when a specific subsite cannot be identified.  
  *Example:* The primary site is designated as pharyngeal wall. It is unknown whether it is the superior, posterior lateral, or anterior wall.

**Note 1:** The **nasopharynx** is the upper part of the pharynx. It is above the soft palate and extends to the nasal passages.  
**Note 2:** Nasopharyngeal tumors are usually assigned to the subsite in which they occur.

For hematopoietic neoplasms such as lymphomas, myelomas, etc., see the [Hematopoietic Database](#).  
**Note:** Hematopoietic tumors are common to the nasopharynx.

**Column 1** contains specific and NOS histology terms.
- **Specific** histology terms do not have subtypes/variants
- **NOS** histology terms do have subtypes/variants.

**Column 2** contains synonyms for the specific or NOS term. Synonyms have the same histology code as the specific or NOS term.  
**Column 3** contains subtypes/variants of the NOS histology. Subtypes/variants do not have the same histology code as the NOS.

Table begins on next page.
### Head and Neck Equivalent Terms and Definitions

**C000-C148, C300-C339, C410, C411, C479, C754, C755**

*(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)*

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<th>Specific or NOS Term and Code</th>
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<th>Subtypes/Variants</th>
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</thead>
<tbody>
<tr>
<td>Adenoid cystic carcinoma 8200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chordoma 9370</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Nasopharyngeal papillary adenocarcinoma 8260 | Thyroid-like low-grade nasopharyngeal; papillary adenocarcinoma | Basaloid squamous cell carcinoma 8083  
Keratinizing squamous cell carcinoma 8071  
Non-keratinizing squamous cell carcinoma 8072  
Lymphoepithelial carcinoma 8082  
Undifferentiated carcinoma/Undifferentiated carcinoma with lymphoid stroma 8020 |
| Squamous cell carcinoma NOS 8070 |          |                   |
Table 3 lists the more common histologies for the following head and neck subsites:

- **C129** Pyriform sinus
- **C130** Postcricoid region; cricopharynx cricoid NOS
- **C131** Hypopharyngeal aspect of aryepiglottic fold; aryepiglottic fold NOS; arytenoid fold
- **C132** Posterior wall of hypopharynx
- **C138** Overlapping lesion of hypopharynx. Use only when a single lesion overlaps subsites of the hypopharynx. Example: A single tumor overlaps C130 postcricoid region and C131 aryepiglottic fold.
- **C139** Hypopharynx NOS and parapharyngeal space. Use only when the subsite/site is unknown
- **C320** Glottis; intrinsic larynx; laryngeal commissure; vocal cord NOS; true vocal cord; true cord
- **C321** Supraglottis; epiglottis NOS (excludes anterior surface of epiglottis); extrinsic larynx; laryngeal aspect of aryepiglottic fold; posterior surface of epiglottis; ventricular band of larynx; false vocal cord; false cord
- **C322** Subglottis
- **C323** Laryngeal cartilage; arytenoid cartilage; cricoid cartilage; cuneiform cartilage; thyroid cartilage
- **C328** Overlapping lesion of larynx
- **C329** Larynx NOS
- **C339** Trachea

**Note 1:** The hypopharynx is in the inferior position of the three segments of pharynx. The hypopharynx links the oropharynx to the esophagus, lower part of the pharynx. The pyriform sinus is located in the hypopharynx.

**Note 2:** The larynx is only 1 1/2 inches. It is inferior to the hyoid bone and tongue. It is anterior to the esophagus.

**Note 3:** The trachea starts where larynx ends and continues down the middle of the neck anterior to the esophagus.

**Note 4:** The parapharyngeal space is an equivalent of the lateral pharyngeal space which includes the soft tissue, vessels and skeletal muscles supporting the mechanics of the pharynx. Code the specific site when the soft tissue, vessel, or skeletal muscle is documented. When specific information is not available/not documented, code hypopharynx NOS, C139.

**Note 5:** These primary sites are mostly composed of muscle and cartilage, but the most common tumors arise from the epithelial lining of the structures (squamous cell carcinoma, for example).

For hematopoietic neoplasms such as lymphomas, myelomas, etc., see the [Hematopoietic Database](#).

**Note:** Hematopoietic tumors are common to the hypopharynx, larynx and trachea.
**Head and Neck Equivalent Terms and Definitions**
C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Column 1 contains specific and NOS histology terms.
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Column 3 contains subtypes/variants of the NOS histology. Subtypes/variants do not have the same histology code as the NOS.

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<th>Subtypes/Variants</th>
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</thead>
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<td>ACC (rare)</td>
<td></td>
</tr>
<tr>
<td>Chondrosarcoma 9220</td>
<td>Chondrosarcoma grade 2/3 Chondrosarcoma NOS</td>
<td></td>
</tr>
<tr>
<td>Liposarcoma 8850</td>
<td>Atypical lipomatous tumor Well-differentiated liposarcoma</td>
<td></td>
</tr>
<tr>
<td>Squamous cell carcinoma (SCC) 8070</td>
<td>Epidermoid carcinoma Conventional Squamous cell carcinoma NOS</td>
<td>Adenosquamous carcinoma (ASC) 8560 Basaloid squamous cell carcinoma (BSCC) 8083 Lymphoepithelial carcinoma (LEC)/lymphoepithelioma-like carcinoma 8082 Keratinizing squamous cell carcinoma 8071 Non-keratinizing squamous cell carcinoma 8072 Papillary squamous cell carcinoma (PSCC) 8052 Spindle cell squamous cell carcinoma (SC-SCC) 8074 Verrucous squamous cell carcinoma (VC) 8051</td>
</tr>
<tr>
<td>Well-differentiated neuroendocrine carcinoma 8240</td>
<td>Carcinoid Neuroendocrine carcinoma grade 1</td>
<td>Large cell neuroendocrine carcinoma/LCNEC 8013 Neuroendocrine carcinoma grade 2/moderately-differentiated neuroendocrine carcinoma/atypical carcinoid 8249 Small cell neuroendocrine carcinoma/small cell carcinoma/SmCC 8041</td>
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Head and Neck Solid Tumor Rules
2023 Update

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Table 4: Tumors of Oral Cavity and Mobile Tongue

Table 4 lists the more common histologies for the following head and neck subsites:

The **oral cavity category** includes the following:

**Mobile Tongue:**
- C020 Dorsal surface of tongue NOS
- C021 Border of tongue
- C022 Ventral surface of tongue NOS
- C023 Anterior 2/3 of tongue NOS
- C028 Overlapping lesion of tongue
- C029 Tongue NOS

**Gum:**
- C030 Upper gum, maxillary gingiva, upper alveolar mucosa, upper alveolar ridge mucosa, upper alveolus, upper gingiva
- C031 Lower gum mandibular gingiva, lower alveolar mucosa, lower alveolar ridge mucosa, lower alveolus, lower gingiva
- C039 Gum NOS, gingiva NOS, alveolar mucosa NOS, alveolar ridge mucosa NOS, alveolar NOS periodontal tissue, tooth socket

**Floor of Mouth:**
- C040 Anterior floor of mouth
- C041 Lateral floor of mouth
- C048 Overlapping lesion floor of mouth
- C049 Floor of mouth NOS

**Palate:**
- C050 Hard palate
- C051 Soft palate
- C052 Uvula
- C058 Overlapping lesion of palate, junction of hard and soft palate
- C059 Palate NOS, roof of mouth

**Other and unspecified parts of Mouth:**
- C060 Cheek mucosa, buccal mucosa, internal cheek
- C061 Vestibule of mouth, alveolar sulcus, buccal sulcus, labial sulcus
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(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

C062 Retromolar area, retromolar triangle, retromolar trigone
C068 Overlapping lesion of other and unspecified parts of mouth
C069 Mouth NOS, buccal cavity, oral cavity, oral mucosa, minor salivary gland NOS

Note: There is no ICD-O site code for minor salivary glands. Many minor salivary glands are located in the lips, inner cheek (buccal mucosa) and there are extensive minor salivary glands in the linings of the mouth and throat. Code to the site in which the salivary gland is located.

For hematopoietic neoplasms such as lymphomas, myelomas, etc., see the Hematopoietic Database.

Note: Hematopoietic tumors are common to the oral cavity.

Column 1 contains specific and NOS histology terms.
- Specific histology terms do not have subtypes/variants
- NOS histology terms do have subtypes/variants.

Column 2 contains synonyms for the specific or NOS term. Synonyms have the same histology code as the specific or NOS term.

Column 3 contains subtypes/variants of the NOS histology. Subtypes/variants do not have the same histology code as the NOS term.

<table>
<thead>
<tr>
<th>Specific or NOS Term and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mucoepidermoid carcinoma 8430</td>
<td>Mucoepidermoid tumor</td>
<td></td>
</tr>
<tr>
<td>Myofibroblastic sarcoma 8825</td>
<td>Myofibrosarcoma</td>
<td></td>
</tr>
<tr>
<td>Oral mucosal melanoma 8720</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Squamous cell carcinoma 8070</td>
<td>Conventional Squamous cell carcinoma NOS</td>
<td>Acantholytic squamous cell carcinoma 8075</td>
</tr>
<tr>
<td></td>
<td>Squamous carcinoma</td>
<td>Keratinizing squamous cell carcinoma 8071</td>
</tr>
<tr>
<td></td>
<td>Squamous cell carcinoma NOS</td>
<td>Non-keratinizing squamous cell carcinoma 8072</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Verrucous squamous cell carcinoma 8051</td>
</tr>
</tbody>
</table>

* These new codes were approved by the IARC/WHO Committee for ICD-O
Table 5 lists the more common histologies for the following head and neck subsites and coding histologies for cases diagnosed 1/1/2022 forward:

Cases diagnosed 1/1/2018 to 12/31/2021:
Squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086) are coded only when HPV status is determined by tests based on ISH, PCR, RT-PCR technologies to detect the viral DNA or RNA. p16 is not a valid test to assign these codes.

Cases diagnosed 1/1/2022 forward:
Beginning with cases diagnosed 1/1/2022 forward, p16 test results can be used to code squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086).

**Oropharynx:**
- C100 Vallecula
- C101 Anterior surface of epiglottis
- C102 Lateral wall of oropharynx; lateral wall of nasopharynx
- C103 Posterior wall of oropharynx; posterior wall of nasopharynx
- C104 Brachial cleft
- C108 Overlapping lesion of oropharynx; junctional region of oropharynx
- C109 Oropharynx NOS; mesopharynx NOS; fauces NOS. Use this code only when the subsite has not been identified a subsite as the origin of the lesion.  
  **Note:** Code overlapping lesion of oropharynx; junctional region of oropharynx C108 when a single tumor overlaps subsites of the oropharynx. For example, a single lesion which overlaps the vallecular and the anterior surface of the epiglottis.

- C019 Base of tongue
- C024 Lingual tonsil

**Tonsils:**
- C090 Tonsillar fossa
- C091 Tonsillar pillar
C098 Overlapping lesion of tonsil
C099 Tonsil NOS
C111 Adenoids/pharyngeal tonsil (does not include posterior wall of nasopharynx)

For hematopoietic neoplasms such as lymphomas, myelomas, etc., see the Hematopoietic Database.

Column 1 contains specific and NOS histology terms.
- Specific histology terms do not have subtypes/variants
- NOS histology terms do have subtypes/variants.

Column 2 contains synonyms for the specific or NOS term. Synonyms have the same histology code as the specific or NOS term.

Column 3 contains subtypes/variants of the NOS histology. Subtypes/variants do not have the same histology code as the NOS.
<table>
<thead>
<tr>
<th>Specific or NOS Term and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adenoid cystic carcinoma 8200</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Polymorphous adenocarcinoma 8525</strong></td>
<td>Cribiform adenocarcinoma, Polymorphous low-grade adenocarcinoma, Terminal duct carcinoma</td>
<td></td>
</tr>
<tr>
<td><strong>Squamous cell carcinoma 8070</strong></td>
<td>Conventional Squamous cell carcinoma NOS</td>
<td>Keratinizing squamous cell carcinoma 8071 <em>(see note 1)</em></td>
</tr>
<tr>
<td>Note 1: Beginning 1/1/2022, keratinizing squamous cell carcinoma, HPV negative is coded 8086 for sites listed in Table 5 <em>only</em>. A diagnosis of keratinizing squamous cell carcinoma, NOS is coded 8071.</td>
<td><strong>Non-keratinizing squamous cell carcinoma 8072 <em>(see note 2)</em></strong></td>
<td></td>
</tr>
<tr>
<td>Note 2: Beginning 1/1/2022, non-keratinizing squamous cell carcinoma, HPV positive is coded 8085 for sites listed in Table 5 <em>only</em>. A diagnosis of non-keratinizing squamous cell carcinoma, NOS is coded 8072.</td>
<td><em><em>Squamous cell carcinoma HPV-negative 8086</em> Case diagnosed prior to 1/1/2022:</em>*</td>
<td></td>
</tr>
<tr>
<td><strong>Squamous cell carcinoma HPV-positive 8085</strong></td>
<td></td>
<td><strong>Cases diagnosed prior to 1/1/2022:</strong> Squamous cell carcinoma HPV-positive 8085**</td>
</tr>
<tr>
<td><strong>Cases diagnosed 1/1/2022 forward:</strong> Squamous cell carcinoma HPV-positive 8085**</td>
<td></td>
<td><strong>Note:</strong> HPV mediated (p16-) test results can be used to assign code 8086.</td>
</tr>
</tbody>
</table>

Note: HPV-mediated (p16-) test results can be used to assign code 8086.
## Head and Neck Equivalent Terms and Definitions

C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Specific or NOS Term and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
</table>
|                               |          | **Note:** HPV-positive is not equivalent to HPV-mediated (p16+). According to the 2018 SEER Manual, HPV-type 16 refers to virus type and is different from p16 overexpression (p16+). HPV status is determined by tests designed to detect viral DNA or RNA. Tests based on ISH, PCR, RT-PCR technologies detect the viral DNA or RNA; whereas, the test for p16 expression, a surrogate marker for HPV, is IHC. HPV testing must be positive by viral detection tests in order to code histology as 8085.

**Cases diagnosed 1/1/2022 forward:**

**Note:** HPV mediated (p16+) test results can be used to assign code 8085. |

* These new codes were approved by the IARC/WHO Committee for ICD-O
Table 6: Tumors of Salivary Glands

Table 6 lists the more common histologies for the following head and neck subsites:

- **C079** Parotid gland, parotid NOS Stensen duct, parotid gland duct
- **C080** Submandibular gland, submaxillary gland, Wharton duct, submaxillary gland duct
- **C081** Sublingual gland; sublingual gland duct
- **C088** Overlapping lesion of major salivary glands
- **C089** Major salivary gland NOS; salivary gland NOS

For hematopoietic neoplasms such as lymphomas, myelomas, etc., see the [Hematopoietic Database](http://example.com).

**Note:** Hematopoietic neoplasms are common in the major salivary glands.

Column 1 contains specific and NOS histology terms.

- **Specific** histology terms **do not** have subtypes/variants
- **NOS** histology terms **do** have subtypes/variants

Column 2 contains synonyms for the specific or NOS term. Synonyms have the same histology code as the specific or NOS term.

Column 3 contains subtypes/variants of the NOS histology. Subtypes/variants **do not** have the same histology code as the NOS.

**Note 1:** Salivary duct carcinoma was assigned code 8500 because it resembles high-grade duct carcinoma as found in the breast. These tumors are very aggressive. Code 8500 only when the diagnosis is exactly salivary duct carcinoma.

**Note 2:** Assign code 8140 when the diagnosis is salivary gland adenocarcinoma.

Table begins on next page
<table>
<thead>
<tr>
<th>Specific or NOS Term and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
</table>
| Acinic cell carcinoma 8550   | ACC      | Basal cell adenocarcinoma 8147  
|                               | Acinar cell carcinoma  
|                               | Acinic cell adenocarcinoma |
| Adenocarcinoma 8140          | Adenocarcinoma NOS  
|                               | Unclassified adenocarcinoma |
|                               | Salivary gland adenocarcinoma NOS | Basal cell adenocarcinoma-ex-monomorphic adenoma 8147  
|                               |                                      | Malignant dermal analogue tumor 8147  
|                               |                                      | Carcinoma ex-pleomorphic adenoma 8941  
|                               |                                      | Clear cell carcinoma (CCC)/hyalinizing clear cell carcinoma 8310  
|                               |                                      | Cribriform adenocarcinoma 8201  
|                               |                                      | Intestinal-type adenocarcinoma 8144  
|                               |                                      | Large cell carcinoma NOS/large cell undifferentiated carcinoma 8012  
|                               |                                      | Lobular carcinoma 8520  
|                               |                                      | Mucinous cystadenocarcinoma 8470  
|                               |                                      | Mucoepidermoid carcinoma (MEC)/malignant mucocystepidermoid tumor 8430  
|                               |                                      | Papillary cystadenocarcinoma 8450  
|                               |                                      | Polymorphous adenocarcinoma (PAC) 8525  
|                               |                                      | Polymorphous low-grade adenocarcinoma 8525  
|                               |                                      | Terminal duct carcinoma 8525  
|                               |                                      | Salivary duct carcinoma 8500  
|                               |                                      | Cribriform cystadenocarcinoma low-grade 8500/2  
|                               |                                      | Ductal carcinoma/adenocarcinoma 8500  
|                               |                                      | High-grade ductal carcinoma 8500  
|                               |                                      | Intraductal carcinoma 8500/2  
|                               |                                      | Intraductal carcinoma low-grade 8500/2  
|                               |                                      | Undifferentiated carcinoma 8020  |
# Head and Neck Equivalent Terms and Definitions

C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Specific or NOS Term and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenoid cystic carcinoma 8200</td>
<td>ACC</td>
<td></td>
</tr>
<tr>
<td>Carcinosarcoma 8980</td>
<td>Carcinosarcoma NOS</td>
<td>True malignant mixed tumor</td>
</tr>
<tr>
<td>Cystadenocarcinoma 8440</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epithelial-myoeoepithelial carcinoma 8562</td>
<td>Adenomyoepithelioma</td>
<td></td>
</tr>
<tr>
<td>Lymphoepithelial carcinoma (LEC) 8082</td>
<td>Lymphoepithelioma-like carcinoma</td>
<td>Malignant lymphoepithelial lesion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Undifferentiated carcinoma with lymphoid stroma</td>
</tr>
<tr>
<td>Myoepithelial carcinoma 8982</td>
<td>Malignant myoepithelioma</td>
<td></td>
</tr>
<tr>
<td>Neuroendocrine carcinoma 8246</td>
<td>Neuroendocrine carcinoma NOS</td>
<td>Large-cell neuroendocrine carcinoma 8013</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Small cell carcinoma NOS/small cell neuroendocrine carcinoma 8041</td>
</tr>
<tr>
<td>Oncocytic carcinoma 8290</td>
<td>Malignant oncocytoma</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oncocytic adenocarcinoma</td>
</tr>
<tr>
<td>Sebaceous adenocarcinoma 8410</td>
<td>Sebaceous carcinoma. NOS</td>
<td></td>
</tr>
<tr>
<td>Secretory carcinoma 8502*</td>
<td>Mammary analog secretory carcinoma</td>
<td></td>
</tr>
<tr>
<td>Squamous cell carcinoma 8070</td>
<td>Conventional Squamous cell carcinoma NOS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SCC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Squamous carcinoma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Squamous cell carcinoma NOS</td>
<td></td>
</tr>
</tbody>
</table>

* These new codes were approved by the IARC/WHO Committee for ICD-O
Table 7: Tumors of Odontogenic and Maxillofacial Bone (Mandible, Maxilla)

Table 7 lists the more common histologies for the following head and neck subsites:

- **C410** Bones of skull and face and associated joints; maxilla
- **C411** Mandible; jaw bone NOS; lower jaw bone; temporomandibular joint

**Note:** The term odontogenic means originating in tooth forming tissue and bone. Code the primary site listed on the pathology report. The common primary sites include the maxillofacial skeleton (C410 maxilla and C411 mandible)

There are no hematopoietic neoplasms common to odontogenic bone or tissue. If a hematopoietic neoplasm such as lymphomas, myelomas, plasmacytoma etc., is diagnosed, verify the primary site. If the primary site is correct, see the Hematopoietic Database.

**Column 1** contains specific and NOS histology terms.
- **Specific** histology terms do not have subtypes/variants
- **NOS** histology terms do have subtypes/variants

**Column 2** contains synonyms for the specific or NOS term. Synonyms have the same histology code as the specific or NOS term.

**Column 3** contains subtypes/variants of the NOS histology. Subtypes/variants do not have the same histology code as the NOS.

Column 3 may contain NOS histologies which are part of a bigger histologic group. For example, sarcoma NOS 8800/3 (column 1) is a generic term which encompasses a number of soft tissue tumors, including osteosarcoma 9180/3 (column 3). Osteosarcoma is also a NOS because it has subtypes/variants. The subtypes/variants are indented under the NOS (osteosarcoma) in column 3. There is also a note in column 1 which calls attention to the fact that osteosarcoma has subtypes/variants.

When using the Solid Tumor Rules, osteosarcoma and its subtypes/variants are treated the same as all NOS and subtypes/variants.

**Table begins on next page**
### Head and Neck Equivalent Terms and Definitions

C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Specific or NOS Term and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
</table>
| Ameloblastic carcinoma-primary type 9270/3 | AC
Ameloblastic carcinoma
Ameloblastic carcinoma, dedifferentiated
Ameloblastic carcinoma, secondary type
Primary intraosseous carcinoma NOS (PIOC)
Sclerosing odontogenic carcinoma (SOC) | Metastasizing ameloblastoma 9310/3
*Note:* This is an ameloblastoma which has a benign appearance but metastasizes |
| Clear cell odontogenic carcinoma 9341* | CCOC |  |

*Note: Clear cell odontogenic tumors were classified as benign prior to the 2005 edition of WHO Pathology & Genetics Head and Neck Tumors |
| Ghost cell odontogenic carcinoma 9302* | Aggressive epithelial ghost cell odontogenic tumor
Calciﬁing ghost cell odontogenic carcinoma
Carcinoma arising in calciﬁing odontogenic cyst
Malignant calciﬁying ghost cell odontogenic tumor
Malignant calciﬁying odontogenic cyst
Malignant epithelial odontogenic ghost cell tumor |  |
## Head and Neck Equivalent Terms and Definitions

C000-C148, C300-C339, C410, C411, C479, C754, C755

(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Specific or NOS Term and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Odontogenic carcinosarcoma 8980/3</td>
<td>Ameloblastic carcinosarcoma Malignant odontogenic mixed tumor Mixed odontogenic carcinoma</td>
<td>Odontogenic sarcoma/ameloblastic fibrosarcoma 9330/3</td>
</tr>
<tr>
<td>Sarcoma NOS 8800/3</td>
<td></td>
<td>Chondrosarcoma grade 2/3 9220/3 Mesenchymal chondrosarcoma 9240/3 Osteosarcoma/osteogenic sarcoma 9180/3 Chondroblastic osteosarcoma 9181/3 Intraosseous well-differentiated osteosarcoma/low-grade central osteosarcoma 9187/3 Parosteal osteosarcoma 9192/3 Periosteal osteosarcoma 9193/3</td>
</tr>
</tbody>
</table>

**Note 1:** Osteosarcoma 9180/3 has subtypes/variants:
- Chondroblastic osteosarcoma 9181/3
- Intraosseous well-differentiated osteosarcoma/low-grade central osteosarcoma 9187/3
- Parosteal osteosarcoma 9192/3
- Periosteal osteosarcoma 9193/3

**Note 2:** Chondrosarcoma grade 2/3 9920/3 has a subtype/variant:
- Mesenchymal chondrosarcoma 9240/3

* These new codes were approved by the IARC/WHO Committee for ICD-O.
Table 8 lists the more common histologies for the following head and neck subsites:
- **C301** Middle ear; inner ear; auditory tube; eustachian tube; mastoid antrum; tympanic cavity

For hematopoietic neoplasms such as lymphomas, myelomas, etc., see the [Hematopoietic Database](https://www.cancer.gov/types/hematologic-cancer/hematopoietic-database).

**Column 1** contains specific and NOS histology terms.
- **Specific** histology terms **do not** have subtypes/variants
- **NOS** histology terms **do** have subtypes/variants.

**Column 2** contains synonyms for the specific or NOS term. Synonyms have the **same** histology code as the specific or NOS term.

**Column 3** contains **subtypes/variants** of the NOS histology. Subtypes/variants **do not** have the **same** histology code as the NOS.

<table>
<thead>
<tr>
<th>Specific or NOS Term and Code</th>
<th>Synonyms</th>
</tr>
</thead>
</table>
| Endolymphatic sac tumor 8140 | Adenocarcinoma  
Heftner tumor  
Low-grade papillary adenocarcinoma of endolymphatic sac origin |
| Note: The endolymphatic sac is located within the inner ear C301. |
| Squamous cell carcinoma of the middle ear 8070 | SCC  
Squamous carcinoma  
Squamous cell carcinoma NOS |
| Note: This neoplasm arises in the squamous epithelium within the middle ear C301. |
Table 9: Paraganglioma of Carotid Body, Extra-adrenal, Larynx, Middle Ear, Vagal Nerve

Table 9 lists codes for paragangliomas diagnosed prior to 1/1/2021 and new codes for cases diagnosed 1/1/2021 forward. Table 9 does not list all paragangliomas, only those common to head and neck sites.

Cases diagnosed prior to 1/1/2021:
Only report these neoplasms when the pathology/tissue specifies malignant (/3) behavior. Change the behavior using ICD-O-3 Rule F Matrix Concept.

Cases diagnosed 1/1/2021 forward:
The term “malignant” is no longer required to assign malignant (/3) behavior. Paragangliomas diagnosed 1/1/2021 or after are malignant unless otherwise stated by the pathologist.

Coding Primary Site:
Paragangliomas have a separate chapter in the WHO Classification of Head and Neck Tumors which is why they are included in the Head and Neck Solid Tumor Rules. Some variants of paraganglioma are specific to certain sites but may occur in sites other than the nervous system. Variants that have specific sites are noted with the appropriate C-code in Table 9. Always code the site noted by the physician. If site is not stated or unclear and histology term does not have a specific site noted in Table 9, code to autonomic nervous system C479.

Definitions
- Ganglion: A group of nerve cell bodies located outside the central nervous system.
- Sympathetic nervous system: It is a part of the autonomic nervous system and contains adrenergic fibers which depress secretion, decrease tone and contractility of smooth muscle and increase heart rate.

Column 1 lists ICD-O histology term or NOS term and C-code if appropriate
Column 2 lists ICD-O code for cases diagnosed prior to 1/1/2021 and stated to be malignant (/3)
Column 3 lists ICD-O code for cases diagnosed 1/1/2021 forward
Column 4 lists synonyms for the specific term. Synonyms have the same ICD-O code as the specific term.
### Head and Neck Equivalent Terms and Definitions

*C000-C148, C300-C339, C410, C411, C479, C754, C755 (Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)*

<table>
<thead>
<tr>
<th>Specific or NOS Term and Code</th>
<th>ICD-O Code DX prior to 1/1/2021: Must be stated to be malignant</th>
<th>ICD-O Code DX 1/1/2021 forward: “Malignant” no longer required to assign /3</th>
<th>Synonyms (Per ICD-O-3.2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carotid body paraganglioma (C75.4)</td>
<td>8692/3</td>
<td>8692/3</td>
<td>Carotid body tumor</td>
</tr>
<tr>
<td>Extra-Adrenal paraganglioma, NOS</td>
<td>8693/3</td>
<td>8693/3</td>
<td>Nonchromaffin paraganglioma, NOS Chemodectoma Composite paraganglioma</td>
</tr>
<tr>
<td>Laryngeal paraganglioma</td>
<td>8690/3</td>
<td>8693/3</td>
<td></td>
</tr>
<tr>
<td>Middle ear paraganglioma (C75.5)</td>
<td>8690/3</td>
<td>8690/3</td>
<td>Glomus jugulare tumor Jugulotympanic paraganglioma</td>
</tr>
<tr>
<td>Paraganglioma, NOS</td>
<td>8680/3</td>
<td>8680/3</td>
<td></td>
</tr>
<tr>
<td>Vagal paraganglioma</td>
<td>8690/3</td>
<td>8693/3</td>
<td></td>
</tr>
</tbody>
</table>

*Note:* Vagal paraganglioma has the same histology code as laryngeal paraganglioma. Extra-adrenal, laryngeal and vagal are in separate rows to emphasize primary site.
Laterality **must be coded** for all of the following sites. SEER does allow coding laterality for sites not listed in Table 10.

<table>
<thead>
<tr>
<th>Paired Sites</th>
<th>Site Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frontal sinus</td>
<td>C312</td>
</tr>
<tr>
<td>Maxillary sinus</td>
<td>C310</td>
</tr>
<tr>
<td>Middle ear</td>
<td>C301</td>
</tr>
<tr>
<td>Nasal cavity (excluding nasal cartilage, nasal septum)</td>
<td>C300</td>
</tr>
<tr>
<td>Tonsil</td>
<td>C098, C099</td>
</tr>
<tr>
<td>Parotid gland</td>
<td>C079</td>
</tr>
<tr>
<td>Sublingual gland</td>
<td>C081</td>
</tr>
<tr>
<td>Submandibular gland</td>
<td>C080</td>
</tr>
</tbody>
</table>
Head and Neck Equivalent Terms and Definitions
C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)
Head and Neck Equivalent Terms and Definitions
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(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

![Diagram of nasal sinuses with labels for frontal sinus, ethmoid sinuses, and maxillary sinus.]

Nasal Sinuses

Jump to Multiple Primary Rules
Jump to Histology Coding Rules

Head and Neck Solid Tumor Rules
2023 Update
Head and Neck Equivalent Terms and Definitions
C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Larynx

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Head and Neck Equivalent Terms and Definitions
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(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)
Head and Neck Equivalent Terms and Definitions
C000-C148, C300-C339, C410, C411, C479, C754, C755
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Head and Neck Multiple Primary Rules  
C000-C148, C300-C339, C410, C411, C479, C754, C755  
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

**Note 1:** These rules are **NOT** used for tumor(s) described as metastases. Metastatic tumors include but are not limited to:

- Bone marrow
- Discontinuous lesions/nodules in soft tissue adjacent to primary site
- Regional and distant lymph nodes for the primary site being abstracted as identified in Summary Staging Manual
- Liver
- Lung
- Skin

**Note 2:** 2007 MPH Rules and 2018 Solid Tumor Rules are used based on date of diagnosis.

- Tumors diagnosed 01/01/2007 through 12/31/2017: Use 2007 MPH Rules
- Tumors diagnosed 01/01/2018 and later: Use 2018 Solid Tumor Rules
- The original tumor diagnosed before 1/1/2018 and a subsequent tumor diagnosed 1/1/2018 or later in the same primary site: Use the 2018 Solid Tumor Rules

---

### Unknown if Single or Multiple Tumors

**Rule M1**  
Abstract a **single primary**\(^1\) when it is not possible to determine if there is a **single tumor** or **multiple tumors**.

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

**Note 2:** Examples of cases with minimal information include

- Death certificate only (DCO)
- Cases for which information is limited to pathology report only
  - Outpatient biopsy with no follow-up information available
  - Pathology reports which do not specify whether a single tumor or multiple tumors were biopsied and/or resected

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

**Example 2:** Hospital A reports a biopsy of the upper lip mucosa. Hospital B reports a biopsy of the commissure of the lip. There is no information on whether this is a single tumor or whether there are separate tumors. Code a single primary.

---

\(^1\) Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

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Jump to [Equivalent Terms and Definitions](#)  
Jump to [Histology Coding Rules](#)  
Head and Neck Solid Tumor Rules  
2023 Update  
39
Head and Neck Multiple Primary Rules
C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Single Tumor

**IMPORTANT:** If the current tumor was preceded by a tumor in the same primary site, go to the Multiple Tumors module.

**Rule M2**  Abstract a single primary\(^1\) when there is a single tumor.

*Note 1:* A single tumor is always a single primary.

*Note 2:* The tumor may overlap onto or extend into adjacent/contiguous site or subsites.

*Note 3:* The tumor may have in situ and invasive components.

*Note 4:* The tumor may have two or more histologic components.

This is the end of instructions for Single Tumor.

\(^1\) Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

Multiple Tumors

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

**Rule M3**  Abstract multiple primaries\(^2\) when there are separate/non-contiguous tumors in any two of the following sites:

- Glottis C320 AND/OR supraglottis C321 AND/OR subglottis C322 AND/OR laryngeal cartilage C323
- Hard palate C050 AND/OR soft palate C051 AND/OR uvula C052
- Maxilla C410 AND Mandible C411
- Maxillary sinus C310 AND/OR ethmoid sinus C311 AND/OR frontal sinus C312 AND/OR sphenoid sinus C313
- Nasal cavity C300 AND middle ear C301
- Postcricoid C130 AND/OR hypopharyngeal aspect of aryepiglottic fold C131 AND/OR posterior wall of hypopharynx C132
- Submandibular gland C080 AND sublingual gland C081
- Upper gum C030 AND lower gum C031
- Upper lip C000 or C003 AND lower lip C001 or C004
Note 1: Use this rule only for multiple tumors.
Note 2: Timing is irrelevant.
Note 3: Histology is irrelevant.
Note 4: These primary sites differ at the fourth character of the site code CxxX. Use this rule ONLY for the primary sites listed.

Rule M4  Abstract multiple primaries\(^d\) when separate/non-contiguous tumors are present in sites with ICD-O site codes that differ at the second C\(x\)xx, and/or third characters C\(x\)x.  
Note 1: Use this rule only for multiple tumors.
Note 2: Timing is irrelevant.
Note 3: Histology is irrelevant.

Rule M5  Abstract multiple primaries\(^d\) when there are separate/non-contiguous tumors on both the right side and the left side of a paired site.  
Note 1: See Table 10 for a list of paired sites.
Note 2: Use this rule only for multiple tumors.
Note 3: Timing is irrelevant.
Note 4: Histology is irrelevant.

Rule M6  Abstract multiple primaries\(^d\) when the patient has a subsequent tumor after being clinically disease-free for greater than five years after the original diagnosis or last recurrence.  
Note 1: Clinically disease-free means that there was no evidence of recurrence on follow-up.  
- Scopes are NED  
- Scans are NED  
Note 2: When there is a recurrence less than or equal to five years of diagnosis, the “clock” starts over. The time interval is calculated from the date of last recurrence. In other words, the patient must have been disease-free for greater than five years from the date of the last recurrence.
Note 3: When it is unknown/not documented whether the patient had a recurrence, use date of diagnosis to compute the time interval.
Note 4: When the patient has more than one Head & Neck primary, it is often difficult to determine which primary recurred. Use the last date of recurrence for any tumor to calculate the time interval.
Note 5: The physician may state this is a recurrence, meaning the patient had a previous head and neck tumor and now has another head and neck tumor. Follow the rules; do not attempt to interpret the physician’s statement.
Rule M7  
Abstract **multiple primaries** when separate/non-contiguous tumors are two or more **different subtypes/variants** in Column 3 of the appropriate site table (*Tables 1-9*) in the Equivalent Terms and Definitions. Timing is irrelevant.  
*Note:* The tumors may be subtypes/variants of the **same** or **different** NOS histologies.  
- **Same NOS:** Alveolar rhabdomyosarcoma 8920/3 and embryonal rhabdomyosarcoma 8910/3 are both subtypes of rhabdomyosarcoma 8900/3 but are distinctly different histologies. Abstract multiple primaries.  
- **Different NOS:** Colloid-type adenocarcinoma 8144 is a subtype of adenocarcinoma NOS 8140; Spindle cell squamous cell carcinoma 8074 is a subtype of squamous cell carcinoma 8070. They are distinctly different histologies. Abstract multiple primaries.

Rule M8  
Abstract **multiple primaries** when separate/non-contiguous tumors are on **different rows** in the appropriate site table (*Tables 1-9*) in the Equivalent Terms and Definitions. Timing is irrelevant.  
*Note:* Each row in the table is a **distinctly different** histology.

Rule M9  
Abstract a **single primary** (the invasive) when an **in situ** tumor is diagnosed **after** an invasive tumor **in the same primary site**.  
*Note 1:* The rules are **hierarchical**. Only use this rule when none of the previous rules apply.  
*Note 2:* The tumors may be a **NOS** and a **subtype/variant** of that NOS. See *Tables 1-9* in the Equivalent Terms and Definitions for listings of NOS and subtype/variants.  
*Note 3:* Do **not** change **date of diagnosis**.  
*Note 4:* If the case has already been submitted to the central registry, **report** all changes.  
*Note 5:* The physician **may stage both** tumors because staging and determining multiple primaries are done for different reasons. Staging determines which treatment would be most effective. Determining multiple primaries is done to stabilize the data for the study of epidemiology (long-term studies done on incidence, mortality, and causation of a disease with the goal of reducing or eliminating that disease).  
*Note 6:* See the COC and SEER manuals for instructions on coding **other data items** such as Date of Diagnosis, Accession Year and Sequence Number.

Rule M10  
Abstract a **single primary** (the invasive) when an invasive tumor is diagnosed **less than or equal to 60 days** after an **in situ** tumor **in the same primary site**.  
*Note 1:* The rules are **hierarchical**. Only use this rule when none of the previous rules apply.  
*Note 2:* The tumors may be an **NOS** and a **subtype/variant** of that NOS.  
*Note 3:* When the case has been abstracted, **change behavior** code on original abstract from /2 to /3. Do **not** change **date of diagnosis**.
Note 4: If the case has already been submitted to the central registry, report all changes.

Note 5: The physician may stage both tumors because staging and determining multiple primaries are done for different reasons. Staging determines which treatment would be most effective. Determining multiple primaries is done to stabilize the data for the study of epidemiology (long-term studies done on incidence, mortality, and causation of a disease with the goal of reducing or eliminating that disease).

Note 6: See the COC and SEER manuals for instructions on coding other data items such as Date of Diagnosis, Accession Year and Sequence Number.

Rule M11  Abstract multiple primaries\(^{ii}\) when an invasive tumor occurs more than 60 days after an in situ tumor.

Note 1: The rules are hierarchical. Only use this rule when none of the previous rules apply.

Note 2: Abstract both the invasive and in situ tumors.

Note 3: Abstract as multiple primaries even if physician states the invasive tumor is disease recurrence or progression.

Note 4: This rule is based on long-term epidemiologic studies of recurrence intervals. The specialty medical experts (SMEs) reviewed and approved these rules. Many of the SMEs were also authors, co-authors, or editors of the AJCC Staging Manual.

Rule M12  Abstract a single primary\(^{i}\) when separate/non-contiguous tumors in the same primary site are on the same row in the appropriate site table (Tables 1-9) in the Equivalent Terms and Definitions. Timing is irrelevant.

Note: The same row means the tumors are:
- The same histology (same four-digit ICD-O code)
- One is the preferred term (column 1) and the other is a synonym for the preferred term (column 2)
- A NOS (column 1/column 2) and the other is a subtype/variant of that NOS (column 3)
- A NOS histology in column 3 with an indented subtype/variant

Rule M13  Abstract a single primary\(^{i}\) when none of the previous rules apply.

Note: Use this rule as a last resort. Please confirm that you have not overlooked an applicable rule.

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\(^{i}\) Prepare one abstract. Use the histology coding rules to assign the appropriate histology code. For registries collecting recurrence data: When a subsequent tumor is “single primary,” record that subsequent tumor as a recurrence.

\(^{ii}\) Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.
IMPORTANT NOTES
   Note 1: Histology changes may occur following immunotherapy, chemotherapy, targeted therapy, and radiation therapy.
   Note 2: Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.

Exception: If the initial diagnosis is based on histology from FNA, smears, cytology, or from a regional or metastatic site, and neoadjuvant treatment is given and followed by resection of primary site which identifies a different or specific histology, code the histology from the primary site.

2. Code the histology using the following priority list and the Histology Rules. Do not change histology in order to make the case applicable to staging.

The priority list is used for single primaries (including multiple tumors abstracted as a single primary).

Code the most specific histology from either resection or biopsy.
   Note 1: The term “most specific” usually refers to a subtype/variant.
   Note 2: The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor.
   Note 3: When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).

This is a hierarchical list of source documentation.

1. Tissue or pathology report from biopsy or resection of primary site (in priority order)
   A. Addendum(s) and/or comment(s)
   B. Final diagnosis / synoptic report as required by CAP
   C. CAP protocol
      Note 1: Addendums and comments on the pathology report are given a high priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.
      Note 2: The pathologist's diagnosis from the pathology report is always reliable, so the final diagnosis is the second priority.
      Note 3: The CAP protocol is a checklist which:
Head and Neck Histology Rules
C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

- Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care.
- Allows physicians to check multiple histologies

2. Cytology of primary site (fine needle aspirate (FNA))

3. Tissue/pathology from a metastatic site
   
   Note 1: Code the behavior /3
   
   Note 2: The tissue from a metastatic site often shows variations from the primary tumor. When it is the only tissue available, it is more accurate than a scan.
   
   Note 3: This includes cytology from a regional lymph node.

4. Scan: The following list is in priority order.
   
   A. CT
   B. MRI
   C. PET

5. Code the histology documented by the physician when none of the above are available. Use the documentation in the following priority order:
   
   A. Treatment plan
   B. Tumor Board
   C. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
   D. Physician’s reference to type of cancer (histology) in the medical record

   Note 1: Code the specific histology when documented.
   
   Note 2: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.
### Coding Histology

**Note 1:** The priority is to code the most specific histology. **DO NOT USE BREAST HISTOLOGY CODING RULES FOR THIS SITE.**

**Note 2:** Only use this section for one or more histologies within a single tumor.

**Note 3:** Do not use this section in place of the Histology Rules.

1. **Code the most specific histology or subtype/type/variant, regardless of whether it is described as:**
   - A. The majority or predominant part of tumor
   - B. The minority of tumor
   - C. A component

   **Example 1:** Diagnosis for a single tumor is adenocarcinoma 8140 with the majority or predominant part of tumor being enteric-type adenocarcinoma 8144. Code the subtype/variant: enteric-type adenocarcinoma 8144.

   **Example 2:** Diagnosis for a single tumor is squamous cell carcinoma 8070 with minority of tumor being spindle cell squamous cell carcinoma 8074. Code the subtype/variant: spindle cell squamous cell carcinoma 8074.

   **Example 3:** Diagnosis for a single tumor is sarcoma NOS 8800/3 with a component of leiomyosarcoma 8890/3. Code the subtype/variant: leiomyosarcoma 8890/3.

   **Note 1:** The terms above (A, B, C) must describe a **carcinoma** or **sarcoma** in order to code a histology described by those terms.

   **Example:** When the diagnosis is adenocarcinoma with an enteric-type adenocarcinoma component, code enteric-type adenocarcinoma 8144.

   **Negative Example:** When the diagnosis is simply adenocarcinoma with an enteric-type component, code adenocarcinoma NOS 8140. Do not assume this is enteric-type adenocarcinoma. This could be enteric-type differentiation or features.

2. **Code the histology described as differentiation or features/features of ONLY when there is a specific ICD-O code for the “NOS with ____ features” or “NOS with ____ differentiation”**.

   **Note:** Do not code differentiation or features when there is no specific ICD-O code.
3. Code the specific histology described by ambiguous terminology (list follows) **ONLY** when A or B is true:
   A. The only diagnosis available is one histology term described by ambiguous terminology
      - CoC and SEER require reporting of cases diagnosed only by ambiguous terminology
      - Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documentated
      **Example:** Outpatient biopsy says probably squamous cell carcinoma HPV-negative. The case is accessioned (entered into the database) as required by both SEER and COC. No further information is available. Code the histology squamous cell carcinoma HPV-negative. The case meets the criteria in #3A.

   B. There is a **NOS histology and a more specific** (subtype/variant) described by ambiguous terminology
      - Specific histology is clinically confirmed by a physician (attending, pathologist, oncologist, etc.) **OR**
      - Patient is receiving treatment based on the specific histology described by ambiguous term

      **Example 1:** The pathology diagnosis is adenocarcinoma consistent with intestinal type adenocarcinoma. The oncology consult says the patient has intestinal type adenocarcinoma of the sinonasal tract. This is clinical confirmation of the diagnosis, code intestinal type adenocarcinoma. The case meets the criteria in bullet 1.

      **Example 2:** The pathology diagnosis is squamous cell carcinoma consistent with basaloid squamous cell carcinoma. The treatment plan says the patient will receive the following treatment for basaloid squamous cell carcinoma. Treatment plan confirms basaloid squamous cell carcinoma; code basaloid squamous cell carcinoma. The case meets the criteria in bullet 2.

      **If the specific histology does not meet the criteria in #3B, then code the NOS histology.**
Head and Neck Histology Rules
C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

List of Ambiguous Terminology

<table>
<thead>
<tr>
<th>Term</th>
<th>Equivalent Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apparently</td>
<td>Most likely</td>
</tr>
<tr>
<td>Appears</td>
<td>Presumed</td>
</tr>
<tr>
<td>Comparable with</td>
<td>Probable</td>
</tr>
<tr>
<td>Compatible with</td>
<td>Suspect(ed)</td>
</tr>
<tr>
<td>Consistent with</td>
<td>Suspicious (for)</td>
</tr>
<tr>
<td>Favor(s)</td>
<td>Typical (of)</td>
</tr>
<tr>
<td>Malignant appearing</td>
<td></td>
</tr>
</tbody>
</table>

4. **Do not code** histology when described as:

- Architecture
- Foci; focus; focal
- Pattern
Head and Neck Histology Rules
C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Single Tumor

Rule H1  Code the histology when only one histology is present.

Note 1: Use Tables 1-9 to code histology. New codes, terms, and synonyms are included in Tables 1-9 and coding errors may occur if the table is not used.

Note 2: When the histology is not listed in Tables 1-9, use the ICD-O and all updates.

Note 3: Submit a question to Ask a SEER Registrar when the histology code is not found in Tables 1-9, ICD-O or all updates.

Note 4: Cases diagnosed prior to 1/1/2022: Squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086) are coded only when HPV status is determined by tests based on ISH, PCR, RT-PCR technologies to detect the viral DNA or RNA. p16 is not a valid test to assign these histology codes.

Cases diagnosed 1/1/2022 forward: p16 test results can be used to code squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086).

Rule H2  Code the invasive histology when in situ and invasive histologies are present in the same tumor.

Example: The tissue/pathologic diagnosis is invasive squamous cell carcinoma 8070/3 and keratinizing squamous cell carcinoma in situ 8071/2. Code the invasive histology, SCC 8070/3 even though it is not the most specific histology.

Rule H3  Code the subtype/variant when there is a NOS and a single subtype/variant of that NOS such as the following:

- Adenocarcinoma/endolymphatic sac tumor 8140 and a subtype/variant of adenocarcinoma
- Ameloblastic carcinoma primary type 9270 and a subtype variant of ameloblastic carcinoma primary type
- Chondrosarcoma grade 2/3 9220 and a subtype/variant of chondrosarcoma grade 2/3
- Neuroendocrine carcinoma 8246 and a subtype/variant of neuroendocrine carcinoma
- Odontogenic carcinosarcoma 8980 and a subtype/variant of odontogenic carcinosarcoma
- Sarcoma 8800/3 and a subtype/variant of sarcoma
- Squamous cell carcinoma 8070 and subtype/variant of squamous carcinoma
- Well differentiated neuroendocrine carcinoma 8240 and a subtype/variant of well differentiated neuroendocrine carcinoma

Note: See Tables 1-9 in the Equivalent Terms and Definitions to find NOS and subtypes/variants.

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

Note: Before coding histology, the Multiple Primary Rules must be applied.

Rule H4  Code the histology when only one histologic type is identified for all tumors.

Note 1: Use Tables 1-9 to code histology. New codes, terms, and synonyms are included in Tables 1-9 and coding errors may occur if the table is not used.

Note 2: When the histology is not listed in Tables 1-9, use the ICD-O and all updates.

Note 3: Submit a question to Ask a SEER Registrar when the histology code is not found in Tables 1-9, ICD-O or all updates.

Rule H5  Code the invasive histology when one of the following criteria are met:

• All tumors have both invasive and in situ elements OR
• One or more tumors are invasive and one or more tumors are in situ

Note 1: Multiple Primary Rules must be applied to be certain all tumors are a single primary.

Note 2: When the NOS is invasive and the subtype/variant is situ, code the NOS (invasive).

Rule H6  Code the subtype/variant when all tumors are a NOS and a single subtype/variant of that NOS such as the following:

• Adenocarcinoma/endolymphatic sac tumor 8140 and a subtype/variant of adenocarcinoma
• Ameloblastic carcinoma primary type 9270 and a subtype variant of ameloblastic carcinoma primary type
• Chondrosarcoma grade 2/3 9220 and a subtype/variant of chondrosarcoma grade 2/3
• Neuroendocrine carcinoma 8246 and a subtype/variant of neuroendocrine carcinoma
• Odontogenic carcinomas 8980 and a subtype/variant of odontogenic carcinomas
• Sarcoma 8800/3 and a subtype/variant of sarcoma
• Squamous cell carcinoma 8070 and subtype/variant of squamous carcinoma
• Well differentiated neuroendocrine carcinoma 8240 and a subtype/variant of well differentiated neuroendocrine carcinoma

Note: See Tables 1-9 in the Equivalent Terms and Definitions to find NOS and subtypes/variants.

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