Breast Equivalent Terms and Definitions  
C500-C506, C508-C509  
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Introduction

Note 1: Breast includes Nipple C500; Central portion of breast C501; Upper-inner quadrant C502; Lower-inner quadrant C503; Upper-outer quadrant of breast C504; Lower-outer quadrant C505; Axillary tail C506; Overlapping lesion of breast C508; Breast NOS C509.

Note 2: 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 3: 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 4: For those sites/histologies which have recognized biomarkers, the biomarkers frequently identify the histologic type. Currently, there are clinical trials being conducted to determine whether these biomarkers can be used to identify multiple primaries. Follow the Multiple Primary Rules; do not code multiple primaries based on biomarkers.

Changes from 2007 MPH Rules

These changes are effective with cases diagnosed 1/1/2018 and later.

1. NST (No Special Type), mammary carcinoma NST, and carcinoma NST are the new terms for duct or ductal carcinoma. Previously, it was thought that carcinoma originated in the ducts or lobules of the breast, hence the names duct carcinoma and lobular carcinoma. Current thinking is that carcinoma originates in the “terminal duct lobular unit” therefore the preferred term is NST or carcinoma NST.

2. Mammary carcinoma is a synonym for carcinoma no special type (NST)/duct carcinoma not otherwise specified (NOS) 8500. It will no longer be coded as carcinoma NOS 8010.

3. DCIS/Carcinoma NST in situ has a major classification change.
   A. Subtypes/variant, architecture, pattern, and features ARE NOT CODED. The majority of in situ tumors will be coded to DCIS 8500/2.
Breast Equivalent Terms and Definitions
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B. It is very important to code the grade of all DCIS.
   ii. The current breast WHO edition emphasizes coding the grade of tumor rather than the subtype/variant.
   iii. The WHO editions are used internationally by pathologists to keep their nomenclature and histology identification current.
   iv. Over time, subtypes/variants will be diagnosed less frequently.

4. The invasive subtype/variant is coded ONLY when it comprises greater than or equal to 90% of the tumor. This change has been implemented in both the WHO and in the CAP protocols.

5. New codes/terms are identified by asterisks (*) in the histology table in the Terms and Definitions.

6. Excerpt from the CAP Invasive Breast Protocol (page 17): “A modified list is presented in the protocol based on the most frequent types of invasive carcinomas and terminology that is in widespread usage. The modified list is intended to capture the majority of tumors and reduce the classification of tumors being reported as “other.” The WHO classification is presented for completeness”.

---

**Equivalent or Equal Terms**

- And; with; (duct and lobular is equivalent to duct with lobular)
  Note: “And” and “with” are used as synonyms when describing multiple histologies within a single tumor.
- Behavior code /2; DCIS, intracystic; intraductal; noninfiltrating; noninvasive; carcinoma in situ
- De novo; new tumor; frank (obsolete term)
- Duct; ductal; NST (no special type); carcinoma NST; mammary carcinoma
- Mammary; breast
- Simultaneous; existing at the same time; concurrent; prior to first course treatment
- Topography; site code
- 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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Jump to [Histology Coding Rules](#)
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Table 1: Primary Site Codes

Table 1 contains terms used in mammograms, clinical diagnosis, and less frequently the operative and pathology reports to describe the location of the tumor. Find the term in Column 1 and use the site code in Column 2.

Note: See the “clock” diagram at the end of the Equivalent Terms and Definitions for a graphic of the o’clock designations and corresponding quadrants/subsites of the breast.

Refer to the SEER Manual and COC Manual for a priority list for using documents such as mammograms, operative reports, and pathology reports to determine the tumor location.

Column 1 includes terms used to describe the location/site of the tumor. Column 2 contains the site term and code.

<table>
<thead>
<tr>
<th>Terms and Descriptive Language</th>
<th>Site Term and Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Areolar</td>
<td>Nipple C500</td>
</tr>
<tr>
<td>Nipple</td>
<td></td>
</tr>
<tr>
<td>Paget disease without underlying tumor</td>
<td></td>
</tr>
<tr>
<td>Note: Paget with underlying tumor is coded to the quadrant of breast in which the underlying tumor</td>
<td></td>
</tr>
</tbody>
</table>
## Breast Equivalent Terms and Definitions
### C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Terms and Descriptive Language</th>
<th>Site Term and Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above nipple</td>
<td>Central portion of breast <strong>C501</strong></td>
</tr>
<tr>
<td>Area extending 1 cm around areolar complex</td>
<td></td>
</tr>
<tr>
<td>Behind the nipple</td>
<td></td>
</tr>
<tr>
<td>Below the nipple</td>
<td></td>
</tr>
<tr>
<td>Beneath the nipple</td>
<td></td>
</tr>
<tr>
<td>Central portion of breast</td>
<td></td>
</tr>
<tr>
<td>Cephalad to nipple</td>
<td></td>
</tr>
<tr>
<td>Infra-areolar</td>
<td></td>
</tr>
<tr>
<td>Lower central</td>
<td></td>
</tr>
<tr>
<td>Next to areola NOS</td>
<td></td>
</tr>
<tr>
<td>Next to nipple</td>
<td></td>
</tr>
<tr>
<td>Paget disease <em>with</em> underlying tumor</td>
<td></td>
</tr>
<tr>
<td>Retroareolar</td>
<td></td>
</tr>
<tr>
<td>Subareolar</td>
<td></td>
</tr>
<tr>
<td>Under the nipple</td>
<td></td>
</tr>
<tr>
<td>Underneath the nipple</td>
<td></td>
</tr>
<tr>
<td>Superior inner</td>
<td>Upper inner quadrant of breast <strong>C502</strong></td>
</tr>
<tr>
<td>Superior medial</td>
<td></td>
</tr>
<tr>
<td>Upper inner quadrant (UIQ)</td>
<td></td>
</tr>
<tr>
<td>Upper medial</td>
<td></td>
</tr>
<tr>
<td>Inferior inner</td>
<td>Lower inner quadrant of breast <strong>C503</strong></td>
</tr>
<tr>
<td>Inferior medial</td>
<td></td>
</tr>
<tr>
<td>Lower inner quadrant (LIQ)</td>
<td></td>
</tr>
<tr>
<td>Lower medial</td>
<td></td>
</tr>
<tr>
<td>Superior lateral</td>
<td>Upper outer quadrant of breast <strong>C504</strong></td>
</tr>
<tr>
<td>Superior outer</td>
<td></td>
</tr>
<tr>
<td>Upper lateral</td>
<td></td>
</tr>
<tr>
<td>Upper outer quadrant (UOQ)</td>
<td></td>
</tr>
</tbody>
</table>

Jump to [Multiple Primary Rules](#)
Jump to [Histology Coding Rules](#)

Breast Solid Tumor Rules 2018
Updated 8/20/2018
### Breast Equivalent Terms and Definitions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Terms and Descriptive Language</th>
<th>Site Term and Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inferior lateral</td>
<td>Lower outer quadrant of breast C505</td>
</tr>
<tr>
<td>Inferior outer</td>
<td></td>
</tr>
<tr>
<td>Lower lateral</td>
<td></td>
</tr>
<tr>
<td>Lower outer quadrant (LOQ)</td>
<td></td>
</tr>
<tr>
<td>Axillary tail of breast</td>
<td>Axillary tail of breast C506</td>
</tr>
<tr>
<td>Tail of breast NOS</td>
<td></td>
</tr>
<tr>
<td>Tail of Spence</td>
<td></td>
</tr>
<tr>
<td>12:00 o’clock</td>
<td>Overlapping lesion of breast C508</td>
</tr>
<tr>
<td>3:00 o’clock</td>
<td></td>
</tr>
<tr>
<td>6:00 o’clock</td>
<td></td>
</tr>
<tr>
<td>9:00 o’clock</td>
<td></td>
</tr>
<tr>
<td>Inferior breast NOS</td>
<td></td>
</tr>
<tr>
<td>Inner breast NOS</td>
<td></td>
</tr>
<tr>
<td>Lateral breast NOS</td>
<td></td>
</tr>
<tr>
<td>Lower breast NOS</td>
<td></td>
</tr>
<tr>
<td>Medial breast NOS</td>
<td></td>
</tr>
<tr>
<td>Midline breast NOS</td>
<td></td>
</tr>
<tr>
<td>Outer breast NOS</td>
<td></td>
</tr>
<tr>
<td>Overlapping lesion of breast</td>
<td></td>
</tr>
<tr>
<td>Superior breast NOS</td>
<td></td>
</tr>
<tr>
<td>Upper breast NOS</td>
<td></td>
</tr>
<tr>
<td>¾ or more of breast involved with tumor</td>
<td>Breast NOS C509</td>
</tr>
<tr>
<td>Diffuse (tumor size 998)</td>
<td></td>
</tr>
<tr>
<td>Entire breast</td>
<td></td>
</tr>
<tr>
<td>Inflammatory without palpable mass</td>
<td></td>
</tr>
<tr>
<td>Multiple tumors in different subsites (quadrants) within the same breast</td>
<td></td>
</tr>
</tbody>
</table>

**Note:**

- This is a [**single** tumor](#) which [**overlaps quadrants/subsite**](#).

**Note:**

- Used for:
  - Non-contiguous [**multiple**](#) tumors in [**different quadrants/subsites**](#) of same breast OR
  - [**Unknown/unable to identify**](#) in which [**quadrant/subsite**](#) the tumor is [**located**](#) (Example: Outpatient biopsy with no quadrant identified. Patient lost to follow-up.)
  - Inflammatory carcinoma; diffuse tumor

Jump to [Multiple Primary Rules](#)
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Instructions:
1. Compare the terms in the diagnosis (pathology, cytology, radiographic, clinical) to the terms in Column 1.
2. When the terms match, use the combination code listed in Column 2.
3. The last row in the table is a “last resort” code: adenocarcinoma mixed subtypes 8255.
4. Use the combination codes only when the histologies are in a single tumor OR multiple tumors abstracted as a single primary.
5. Mixed histologies may be described as follows:
   A. A “combination of”
   B. Histology 1 AND histology 2
   C. Histology 1 WITH histology 2
   D. Mixed histology 1 and histology 2

Note 1: Do not use Table 2 in the following situations:
- For tumors with both invasive and in situ behavior. The Histology Rules instruct to code the invasive histology.
- When one of the histologies is described as differentiation or features
- When the terms are a NOS and a subtype/variant of that NOS. See the Histology Rules for instructions on coding a NOS and a subtype/variant in a single tumor or multiple tumors abstracted as a single primary.

Note 2: Some histologies can be in situ or invasive; others are limited to either /2 or /3 behavior code.
- When a code is limited to in situ, /2 will be added to the code (both components are in situ)
- When a code is limited to invasive, /3 will be added to the code (both components are invasive)

Note 3: This table is not a complete listing of histology combinations.

Column 1 contains the required ICD-O histology terms.
Column 2 contains the histology combination term and code.

Table begins on next page.
**Required Histology Terms**

<table>
<thead>
<tr>
<th>DCIS/duct carcinoma/carcinoma NST 8500 AND Lobular carcinoma 8520</th>
</tr>
</thead>
</table>

**Note 1:** Both histologies, duct and lobular must have the same behavior code.

**Note 2:** 8522 is used when:
- Both DCIS/duct carcinoma/carcinoma NST AND lobular carcinoma are present in a single tumor OR
- DCIS/duct carcinoma/carcinoma NST is present in at least one tumor and lobular is present in at least one tumor in the same breast

**Example:** One tumor with invasive duct CA in LOQ RT breast; second tumor with invasive lobular in UOQ RT breast

**Note 3:** Do not use 8522 when the diagnosis is carcinoma NST/duct carcinoma with lobular differentiation. The diagnosis MUST be invasive carcinoma NST/duct and invasive lobular carcinoma. See Histology Rules for instructions on coding differentiation.

**Histology Combination Term and Code**

<table>
<thead>
<tr>
<th>Invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma 8522/3</th>
</tr>
</thead>
</table>

**Note 1:** CAP uses the term Invasive carcinoma with ductal and lobular features ("mixed type carcinoma")

**Note 2:** Carcinoma NST includes carcinoma with osteoclastic-like stromal giant cells 8035/3.

<table>
<thead>
<tr>
<th>DCIS and in situ lobular carcinoma 8522/2</th>
</tr>
</thead>
</table>

**Note:** The lobular carcinoma includes pleomorphic lobular carcinoma in situ 8519/2.

**Histology Combination Term and Code**

<table>
<thead>
<tr>
<th>Carcinoma NST/duct mixed with other types of carcinoma 8523/3</th>
</tr>
</thead>
</table>

**Invasive duct carcinoma/carcinoma NST OR Invasive carcinoma NST/duct carcinoma subtypes/variants AND**

**Any invasive histology in Table 3 with exception of**
- Lobular carcinoma (and subtypes/variants) 8520/3
- Paget disease 8540/3

**Note 1:** See Table 3 for carcinoma NST/duct carcinoma subtypes/variants.

**Note 2:** Do not use combination code for duct with lobular differentiation.

**Note 3:** Lobular subtypes/variants are excluded because they have the same code as lobular 8520.
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<table>
<thead>
<tr>
<th>Required Histology Terms</th>
<th>Histology Combination Term and Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infiltrating/invasive lobular</strong> carcinoma</td>
<td>Infiltrating lobular mixed with other types of carcinoma 8524/3</td>
</tr>
<tr>
<td><strong>AND</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Any invasive</strong> histology in Table 3 with <strong>exception</strong> of</td>
<td></td>
</tr>
<tr>
<td>• Duct carcinoma/carcinoma NST (and subtypes/variants) 8500/3</td>
<td></td>
</tr>
<tr>
<td>• Paget disease 8540/3</td>
<td></td>
</tr>
</tbody>
</table>

*Note 1:* Invasive carcinomas only. Do not use this code for in situ.
*Note 2:* See Table 3 for carcinoma NST/duct carcinoma subtypes/variants.

| Paget disease (invasive or behavior not specified)                                      | Paget disease and DCIS/intraductal carcinoma 8543/3                     |
| **AND**                                                                                |                                                                           |
| **Underlying** DCIS and all subtypes/variants of DCIS (must be a /2)                   |                                                                           |

*Note 1:* See Table 3 for subtypes/variants of DCIS.
*Note 2:* Paget disease is classified as malignant /3 in the ICD-O. Paget disease is coded as in situ /2 ONLY when the pathology states the Paget disease is in situ. When Paget is documented as in situ with underlying DCIS, code 8543/2 using the ICD-O matrix rule.

| Paget disease                                                                         | Paget disease and infiltrating duct carcinoma 8541/3                    |
| **AND**                                                                               |                                                                           |
| **Underlying** infiltrating duct carcinoma/carcinoma NST and all subtypes/variants of|                                                                           |
| infiltrating duct/carcinoma NST (must be a /3)                                        |                                                                           |

*Note:* See Table 3 for subtypes/variants of carcinoma NST/duct carcinoma.

| Any two invasive carcinoma NST subtypes/variants (percentage not stated) abstracted as a| Adenocarcinoma with mixed subtypes 8255/3                                          |
| single primary                                                                        |                                                                           |
| *Note 1:* The diagnosis may be two subtypes/variants and the pathologist may mention  |                                                                           |
| the presence of duct/carcinoma NST. Ignore the mention of carcinoma NST.              |                                                                           |
| *Note 2:* See Table 3.                                                               |                                                                           |

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Table 3: Specific Histologies, NOS/ NST, and Subtypes/Variants

Use Table 3 as directed by the Histology Rules to assign the more common histology codes for breast tumors.

**Note 1:** Rare histologies may not be listed in the table. When a histology term is not found, reference ICD-O and all updates.
**Note 2:** Submit a question to Ask a SEER Registrar when the histology is not found in Table 3, ICD-O or all updates.
**Note 3:** Behavior codes are listed when the term has only one possible behavior (either a /2 or /3). For histologies which may be either /2 or /3, a behavior code is not listed. Code behavior from pathology.
**Note 4:** Only use the histology code from the table when the diagnosis is EXACTLY the term listed.

**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 and NOS/NST Terms and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acinic cell carcinoma 8550</td>
<td>Acinar adenocarcinoma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acinar carcinoma</td>
<td></td>
</tr>
<tr>
<td>Adenoid cystic carcinoma (ACC) 8200</td>
<td>ACC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adenocystic basal cell carcinoma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carcinoma adenoides cysticum</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cylindromatous carcinoma</td>
<td></td>
</tr>
<tr>
<td>Adenomyoepithelioma with carcinoma 8983</td>
<td>AME</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Malignant AME</td>
<td></td>
</tr>
</tbody>
</table>

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### Specific and NOS/NST Terms and Code

<table>
<thead>
<tr>
<th>Specific and NOS/NST Terms and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Apocrine carcinoma 8401</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Note:</em> This is a diagnosis that is EXACTLY apocrine carcinoma, not a carcinoma NST with apocrine features, differentiation, or type.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Carcinoma NST 8500</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carcinoma of no special type (ductal/NST)</td>
<td>Carcinoma with osteoclastic-like stromal giant cells 8035</td>
</tr>
<tr>
<td></td>
<td>Carcinoma/carcinoma NST with choriocarcinomatous features</td>
<td>Cribriform carcinoma 8201/3</td>
</tr>
<tr>
<td></td>
<td>Carcinoma/carcinoma NST with cribriform features</td>
<td>Pleomorphic carcinoma 8022/3</td>
</tr>
<tr>
<td></td>
<td>Carcinoma/carcinoma NST with melanotic features</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carcinoma/carcinoma NST with signet ring differentiation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DCIS 8500/2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Duct/ductal carcinoma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Duct/ductal carcinoma in situ 8500/2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Duct/ductal carcinoma NOS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Duct/ductal carcinoma NST (no special type)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Duct/ductal carcinoma with apocrine features</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Duct/ductal carcinoma with apocrine metaplasia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Duct/ductal carcinoma with lobular features</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Duct/ductal carcinoma with micropapillary features</td>
<td></td>
</tr>
</tbody>
</table>

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Updated 8/20/2018
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<table>
<thead>
<tr>
<th>Specific and NOS/NST Terms and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Duct/ductal carcinoma with squamous metaplasia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Infiltrating ductal carcinoma 8500/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invasive carcinoma with micropapillary features 8500/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invasive mammary carcinoma associated with encysted papillary carcinoma 8500/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invasive carcinoma not otherwise specified (ductal/NOS) 8500/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invasive carcinoma NST with metaplastic features 8500/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invasive carcinoma NST/duct with medullary features 8500/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invasive carcinoma, with signet-ring cell features 8500/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invasive carcinoma of no special type (NST) 8500/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invasive carcinoma with clear cell (glycogen rich) features 8500/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invasive carcinoma, NST 8500/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invasive carcinoma, type cannot be determined 8500/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invasive mammary carcinoma 8500/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invasive mammary carcinoma NST with lobular features 8500/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invasive mammary carcinoma NST with medullary features 8500/3</td>
<td></td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Specific and NOS/NST Terms and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invasive mammary carcinoma NST with mucinous features <strong>8500/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invasive mammary carcinoma NST with tubulo-lobular variant <strong>8500/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invasive mammary carcinoma with apocrine features <strong>8500/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invasive mammary carcinoma with cribriform features <strong>8500/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invasive mammary carcinoma with neuroendocrine features <strong>8500/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invasive mammary carcinoma with tubular features <strong>8500/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammary carcinoma in situ <strong>8500/2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammary carcinoma/cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-invasive mammary carcinoma <strong>8500/2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Glycogen-rich clear cell carcinoma 8315</strong></td>
<td>Glycogen-rich carcinoma</td>
<td>Clear cell carcinoma <strong>8310</strong></td>
</tr>
<tr>
<td><strong>Inflammatory carcinoma 8530</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lipid-rich carcinoma 8314</strong></td>
<td>Lipid-secreting carcinoma</td>
<td></td>
</tr>
</tbody>
</table>

Table continues on next page
### Breast Equivalent Terms and Definitions

**C500-C506, C508-C509**  
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Specific and NOS/NST Terms and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
</table>
| **Lobular carcinoma 8520**          | Alveolar lobular carcinoma  
Classic lobular carcinoma  
Invasive lobular carcinoma, alveolar type/variant **8520/3**  
Invasive lobular carcinoma, solid type **8520/3**  
Mixed lobular carcinoma (lobular carcinoma NOS and one or more variants of lobular carcinoma)  
Invasive pleomorphic lobular carcinoma **8520/3**  
Solid lobular carcinoma  
Tubulolobular carcinoma | Pleomorphic lobular carcinoma in situ **8519/2**  
*Note: 8519/2 is a new code for in situ /2 tumors only.* |
| **Medullary carcinoma 8510**        |                      | **Atypical medullary carcinoma 8513** |
| **Metaplastic carcinoma NOS or of no special type (NST) 8575** | Invasive mammary carcinoma with matrix production  
Metaplastic carcinoma, mixed epithelial and mesenchymal type  
Metaplastic carcinoma with mesenchymal differentiation  
Metaplastic carcinoma with squamous features  
Metaplastic carcinoma with other types of mesenchymal differentiation  
Mixed metaplastic carcinoma | Carcinosarcoma **8980/3**  
Fibromatosis-like metaplastic carcinoma **8572**  
Low grade adenosquamous carcinoma **8570**  
Metaplastic carcinoma spindle-cell type **8032**  
Metaplastic carcinoma with chondroid differentiation/with osseous differentiation **8571**  
Myoepithelial carcinoma **8982**  
Spindle cell carcinoma **8032**  
Squamous cell carcinoma **8070** |
### Breast Equivalent Terms and Definitions

C500-C506, C508-C509

(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Mucinous carcinoma 8480</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note 1: This is a diagnosis that is EXACTLY “mucinous carcinoma,” mucinous duct carcinoma,” “mucinous DCIS” OR “&gt;90% mucinous.” See Histology Rules.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note 2: Mucinous duct carcinoma is listed on the CAP protocol. It is not recognized by WHO or IARC. Mucinous carcinoma is not a subtype/variant of Carcinoma NST/duct carcinoma.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mucoepidermoid carcinoma 8430</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myoepithelial carcinoma 8982</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oncocytic carcinoma 8290</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paget disease of the nipple with no underlying tumor 8540/3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Papillary carcinoma 8503</td>
<td>Intraductal papillary carcinoma 8503/2*</td>
<td>Encapsulated papillary carcinoma 8504/2</td>
</tr>
<tr>
<td></td>
<td>Intraductal papillary carcinoma with DCIS 8503/2*</td>
<td>With invasion 8504/3</td>
</tr>
<tr>
<td></td>
<td>Invasive papillary carcinoma 8503/3</td>
<td>Intraductal papilloma with lobular carcinoma in situ or with lobular neoplasia 8520/2</td>
</tr>
<tr>
<td></td>
<td>Papillary carcinoma non-invasive 8503/2*</td>
<td>Micropapillary carcinoma 8507*</td>
</tr>
<tr>
<td></td>
<td>Papillary ductal carcinoma in situ 8503/2*</td>
<td>Solid papillary carcinoma in situ 8509/2*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>with invasion 8509/3*</td>
</tr>
<tr>
<td>Periductal stromal tumor, low grade 9020/3</td>
<td>Phyllodes tumor, malignant</td>
<td></td>
</tr>
<tr>
<td>Polymorphous carcinoma 8525</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Breast Equivalent Terms and Definitions

C500-C506, C508-C509

(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

<table>
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<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarcoma NOS 8800/3</td>
<td></td>
<td>Angiosarcoma 9120/3</td>
</tr>
<tr>
<td>Note: Rhabdomyosarcoma 8900/3 is also a NOS with the following subtypes/variants:</td>
<td></td>
<td>Hemangiosarcoma</td>
</tr>
<tr>
<td>Alveolar type rhabdomyosarcoma 8920/3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Embryonal type rhabdomyosarcoma 8910/3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pleomorphic rhabdomyosarcoma 8901/3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sebaceous carcinoma 8410</td>
<td></td>
<td>Lymphangiosarcoma</td>
</tr>
<tr>
<td>Secretory carcinoma 8502</td>
<td>Juvenile breast carcinoma</td>
<td>Malignant hemangioendothelioma</td>
</tr>
<tr>
<td>Signet ring carcinoma 8490</td>
<td></td>
<td>Liposarcoma 8850/3</td>
</tr>
<tr>
<td>Small cell carcinoma 8041</td>
<td>Carcinoid tumor of breast</td>
<td>Leiomyosarcoma 8890/3</td>
</tr>
<tr>
<td></td>
<td>Endocrine carcinoma</td>
<td>Osteosarcoma 9180/3</td>
</tr>
<tr>
<td></td>
<td>Neuroendocrine carcinoma, poorly differentiated</td>
<td>Rhabdomyosarcoma 8900/3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alveolar type rhabdomyosarcoma 8920/3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Embryonal type rhabdomyosarcoma 8910/3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pleomorphic rhabdomyosarcoma 8901/3</td>
</tr>
<tr>
<td>Tubular carcinoma 8211</td>
<td></td>
<td>Carcinoma with neuroendocrine differentiation 8574/3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neuroendocrine tumor, well-differentiated 8246</td>
</tr>
</tbody>
</table>

*New codes approved by IARC/WHO Committee for ICD-O*
Breast Equivalent Terms and Definitions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)
Breast Equivalent Terms and Definitions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)
Paget Disease of the nipple. Shows growth pattern of Paget on the pigmented portion of nipple and inside the milk duct opening

Source:
Breast Equivalent Terms and Definitions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)
Breast Equivalent Terms and Definitions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

The position of the tumor in the breast may be described as the positions on a clock

The two circles in the graphic are
innermost circle: Retroareolar (under/behind areola)
outer circle: Central portion of breast
Note 1: These rules are NOT used for tumor(s) described as metastases.

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\textsuperscript{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
  - Multiple pathology reports which do not specify whether a single tumor or multiple tumors have been biopsied and/or resected

This is the end of instructions for Unknown if Single or Multiple Tumors

\textsuperscript{1}Prepare one abstract. Use the histology rules to assign the appropriate histology code.

Single Tumor

IMPORTANT: If the current tumor was preceded by a tumor in the same breast or contralateral breast, go to the Multiple Tumors module.

Rule M2 Abstract a single primary\textsuperscript{1} when the diagnosis is inflammatory carcinoma in:
- Multiple quadrants of same breast OR
- Bilateral breasts
Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Rule M3  Abstract a single primary\(^i\) when there is a single tumor.
\[\text{Note 1:} \quad \text{A single tumor is always a single primary.} \]
\[\text{Note 2:} \quad \text{The tumor may overlap onto or extend into adjacent/contiguous site or subsites/quadrants.} \]
\[\text{Note 3:} \quad \text{The tumor may have in situ and invasive components.} \]
\[\text{Note 4:} \quad \text{The tumor may have two or more histologic components.} \]

This is the end of instructions for Single Tumor

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

Multiple Tumors

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

Rule M4  Abstract a single primary\(^i\) when there is inflammatory carcinoma in:
- Multiple quadrants of same breast OR
- Bilateral breasts

Rule M5  Abstract multiple primaries\(^ii\) when there are separate, non-contiguous tumors in sites with ICD-O site codes (C50_) that differ at the second (C\text{Xxx}) and/or third characters (C\text{X}x).
\[\text{Note 1:} \quad \text{Tumors with site codes that differ at the second or third character are in different primary sites; for example, a breast tumor C50x and a colon tumor C18x differ at the second and third character.} \]
\[\text{Note 2:} \quad \text{This rule does not include metastases. Metastatic tumors are not used to determine multiple primaries; for example, liver metastases from the breast cancer would not be counted as a second primary.} \]

Rule M6  Abstract multiple primaries\(^ii\) when there is bilateral breast cancer (both right and left breast).
\[\text{Note 1:} \quad \text{Physician statement “bilateral breast cancer” should not be interpreted as meaning a single primary. The term is descriptive and not used consistently. The literal definition of bilateral is “cancer in both breasts”.} \]
\[\text{Note 2:} \quad \text{It is irrelevant how many tumors are in each breast. Abstract as separate primaries.} \]
\[\text{Note 3:} \quad \text{The histologies within each breast may be the same or different.} \]
Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Rule M7  Abstract a single primary\(^1\) when the diagnosis is Paget disease with underlying in situ or invasive carcinoma NST (duct/ductal).

Rule M8  Abstract multiple primaries\(^2\) 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: The rules are hierarchical. This rule only applies when there is a subsequent breast tumor.

Note 2: Clinically disease-free means that there was no evidence of recurrence on follow-up.
- Mammograms are NED
- Scans are NED
- Tumor biomarkers are NED

Note 3: 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 4: When it is unknown/not documented whether the patient had a recurrence, use date of diagnosis to compute the time interval.

Note 5: The physician may state this is a recurrence, meaning the patient had a previous breast tumor and now has another breast tumor. Follow the rules; do not attempt to interpret the physician’s statement.

Rule M9  Abstract a single primary\(^1\) when simultaneous multiple tumors are carcinoma NST/duct and lobular.
- Both/all tumors may be a mixture of carcinoma NST/duct and lobular OR
- One tumor may be duct and another tumor lobular

Note 1: Tumors must be in the same breast.

Note 2: Histologies must be the same behavior.

Note 3: Carcinoma NST/duct includes:
- DCIS 8500/2
- Carcinoma NST 8500/3
- Carcinoma with osteoclastic-like stromal giant cells 8035/3 (subtype/variant of carcinoma NST)

Note 4: Lobular carcinoma includes:
- In situ lobular carcinoma 8520/2
- In situ pleomorphic lobular carcinoma 8519/2
- Invasive lobular carcinoma 8520/3
Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Rule M10 Abstract multiple primaries when separate/non-contiguous tumors are two or more different subtypes/variants in Column 3 of Table 3 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**: Encapsulated papillary carcinoma with invasion 8504/3 and solid papillary carcinoma with invasion 8509/3 are both subtypes of invasive papillary carcinoma 8503/3 but are distinctly different histologies. Abstract multiple primaries.
- **Different NOS**: Encapsulated papillary carcinoma 8504/2 is a subtype/variant of in situ papillary carcinoma 8503/2. Pleomorphic lobular carcinoma in situ 8519/2 is a subtype/variant of lobular carcinoma in situ 8520/2. They are distinctly different histologies. Abstract multiple primaries.

Rule M11 Abstract a single primary when separate/non-contiguous tumors are on the same row in Table 3 in the Equivalent Terms and Definitions. Timing is irrelevant.

Note 1: The tumors must be the same behavior. When one tumor is in situ and the other invasive, continue through the rules.

Note 2: The same row means the tumors are:

- The same histology (same four-digit ICD-O code) OR
- One is the preferred term (column 1) and the other is a synonym for the preferred term (column 2) OR
- A NOS (column 1/column 2) and the other is a subtype/variant of that NOS (column 3)

Rule M12 Abstract multiple primaries when separate/non-contiguous tumors are on different rows in Table 3 in the Equivalent Terms and Definitions. Timing is irrelevant.

Note: Each row in the table is a distinctly different histology.

Rule M13 Abstract a single primary (the invasive) when an in situ tumor is diagnosed after an invasive tumor in the same breast.

Note 1: Once the patient has an invasive tumor, the in situ is recorded as a recurrence for those registrars who collect recurrence data.

Note 2: The rules are hierarchical. Only use this rule when none of the previous rules apply.

Note 3: The tumors may be a NOS and a subtype/variant of that NOS.

Rule M14 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 breast.

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.

Note 3: When the case has been abstracted, change behavior code on original abstract from /2 to /3.

Jump to Equivalent Terms and Definitions
Jump to Histology Coding Rules
Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Note 4: Do not change date of diagnosis.
Note 5: If the case has already been submitted to the central registry, report all changes.
Note 6: 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 7: See the COC and SEER manuals for instructions on coding other data items such as Date of Diagnosis, Accession Year and Sequence Number.

Rule M15 Abstract multiple primaries\(^\text{i}\) when an invasive tumor occurs more than 60 days after an in situ tumor in the same breast.
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 M16 Abstract a single primary\(^\text{i}\) 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.

This is the end of instructions for Multiple Tumors.

\(^\text{i}\) Prepare one abstract. Use the histology 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.
\(^\text{ii}\) Prepare two or more abstracts. Use the histology rules to assign the appropriate histology code to each case abstracted.
Breast Histology Coding Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Coding Multiple Histologies in a Single Tumor

1. **Two INVASIVE histologies** (the following list is in priority order)

   A. **NOS and subtype/variant:**
      i. Code the **subtype/variant** (specific histology) ONLY when documented to be **greater than or equal to 90%** of the tumor\(^1\).
         
         **Note:** When a histology is listed as “minimal”, “focus/foci/focal”, “microscopic”, you can assume the other histological portion comprises at least 90% of the tumor.
         
         **Example:** Patient had an excisional biopsy with a pathologic diagnosis of pleomorphic lobular carcinoma in situ 8519/2. There was microscopic involvement of one margin. The patient chose to have a total mastectomy. Pathology from the total mastectomy showed **minimal** residual in situ lobular carcinoma 8520/2. Because the lobular carcinoma in situ was minimal, the subtype/variant pleomorphic lobular carcinoma 8519/2 **must be more than 90% of the tumor**.
      
      ii. Code the **NOS/NST** when the subtype/variant is documented to be **less than 90%** of the tumor OR the percentage of subtype/variant is **unknown/not documented**.

   B. **Different histologies** (excluding NOS and subtype/variant):
      i. Code the histology which comprises the majority of tumor.
         
         **Note:** The majority may be indicated by terms such as “greater than 50%”, “major”, “majority” and “predominantly”.
      
      ii. Code a combination code using **Table 2** in the Equivalent Terms and Definitions when the majority is unknown/not documented.
         
         **Note:** Different histologies includes:
         - Two subtypes/variants of a single NOS OR
         - Different histologies (different rows in **Table 3** in the Equivalent Terms and Definitions)

2. **Do not code** histology (NOS/NST, subtype/variant, or specific) when documented with:

   A. Words that describe the more specific histology (unless documented to be greater than or equal to 90% of the tumor)
      
      - Subtype
      - Type
      - Variant

---

\(^1\) American College of Pathology, Protocol for the Examination of Specimens From Patients with Invasive Carcinoma of the Breast, pg 4
B. Previously used terms which do not describe the majority of tumor

- Architecture
- Component
  
  **Note:** Component does not describe a subtype or the majority of tumor.

- Differentiation
  
  **Note:** Only code differentiation when there is a **specific code** for the NOS with differentiation in Table 3 or the ICD-O and all updates.

  **Example:** Diagnosis is invasive breast carcinoma with neuroendocrine differentiation which has a specific histology code 8574/3. Code the histology 8574/3.

  **Negative example:** The diagnosis is carcinoma NST/duct carcinoma with apocrine features. There is no ICD-O histology code for carcinoma NST/duct carcinoma with apocrine features. Code carcinoma NST/duct carcinoma 8500.

- Features (of)
  
  **Note:** Only code features when there is a **specific code** for the NOS with features in Table 2 or Table 3 or the ICD-O and all updates.

- Foci; focus, focal
- Pattern(s)

C. Ambiguous terminology

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

**Note 1:** See SEER Program Manual and COC Manual. Ambiguous terminology is used to determine reportability.
Breast Histology Coding Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Note 2: Histology described by ambiguous terminology is coded **ONLY** when a case is accessioned based on ambiguous terminology and no other histology information is available/documented.

Note: **Do not** code apocrine carcinoma when the diagnosis specifies apocrine differentiation, features, or type. Apocrine differentiation is frequently present in:
- Carcinoma NST/duct carcinoma
  - Subtypes/variants of carcinoma NST/duct carcinoma
- Lobular carcinoma NOS
  - Pleomorphic lobular carcinoma in situ

Priority Order for Using Documentation to Identify Histology

Use documentation in the following priority order to identify the histology type(s):
1. **Biomarkers**
2. **Tissue or pathology report** (in priority order)
   A. Addendum(s) and/or comment(s)
   B. Final diagnosis
   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:
   - Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care.
   - Allows physicians to check multiple histologies
   
   Note: The CAP protocol must be documented in one location. Most frequently, in the:
   - Pathology final diagnosis
   - Addendum to the path report
3. **Cytology** (nipple discharge or fine needle aspirate (FNA))
4. 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.

5. Radiography: The following list is not in priority order because they are not a reliable method for identifying specific histology(ies). They are, however, valuable in diagnosing a malignancy.
   A. Mammography
   B. Ultrasound
   C. CT
   D. MRI

6. Code the histology documented by the physician when none of the above are available. Use the documentation in the following priority order:
   A. Documentation from Tumor Board
   B. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
   C. 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.

Single Tumor: In Situ Only

Note 1: DCIS is often multifocal/multicentric; use this module.
Note 2: Subtypes/variant, architecture, pattern, and features ARE NOT CODED. The majority of in situ tumors will be coded to DCIS 8500/2.

Rule H1 Code Paget disease in situ 8540/2 when the diagnosis is exactly Paget disease in situ.
   Note 1: This is a de novo primary of the nipple (new tumor) with no underlying tumor.
   Note 2: Paget is coded as in situ /2 only when pathology documents in situ behavior.

Rule H2 Code the histology when only one histology is present.
   Note 1: Use Table 3 to code histology. New codes, terms, and synonyms are included in Table 3 and coding errors may occur if the table is not used.
   Note 2: When the histology is not listed in Table 3, 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 Table 3, ICD-O or all updates.
Rule H3  
Code DCIS and in situ lobular carcinoma **8522/2** when DCIS and in situ lobular carcinoma are present.  
*Note 1:* Although the instructions in the “Coding Multiple Histologies in a Single Tumor” section state, “Code the histology that comprises the majority of tumor”, 8522/2 identifies both DCIS and lobular carcinoma in situ.  
*Note 2:* 8522/2 is the most accurate description of DCIS and lobular carcinoma in situ.

This is the end of instructions for a Single Tumor: In Situ Only

Code the histology according to the rule that fits the case

**Single Tumor: Invasive and In Situ Components**

Rule H4  
Code the **invasive** histology when both invasive and in situ components are present.  
*Note 1:* Ignore the in situ term.  
*Note 2:* This is consistent with the 2007 MPH Rules.

This is the end of instructions for a Single Tumor: Invasive and In Situ Components

Code the histology according to the rule that fits the case
Breast Histology Coding Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Single Tumor: Invasive Only

Rule H5  Code Paget disease 8540/3 when the diagnosis is exactly Paget disease.

*Note 1*: This is a de novo primary of the nipple (new tumor) with no underlying tumor.

*Note 2*: Paget is coded /3 when:
- Pathology documents invasive behavior OR
- Behavior is not documented/unknown

Rule H6  Code the underlying tumor when there is a diagnosis of inflammatory carcinoma.²

*Example*: The patient has a clinical diagnosis of inflammatory breast carcinoma. Pathology shows carcinoma NST with dermal invasion as well as erythema. Code the underlying tumor: carcinoma NST 8500/3.

*Informational item*: The clinical symptoms of inflammatory breast cancer include rapid breast enlargement and skin changes (redness, edema peau d’orange) involving more than a third of the breast. Usually there is a diffuse firmness of the breast and there is no palpable underlying mass.

*Note 1*: Record the inflammatory carcinoma in staging fields.

*Note 2*: Code inflammatory carcinoma 8530/3 when it is the only diagnosis available (DCO, outpatient only, no follow-up).

Rule H7  Code mucinous carcinoma/adenocarcinoma 8480 ONLY when:
- The diagnosis is exactly mucinous carcinoma or mucinous duct carcinoma OR
- Multiple histologies are present and mucinous carcinoma is documented as greater than or equal to 90% of the tumor

*Note 1*: The pure mucinous carcinoma category includes only cases which are diagnosed as exactly mucinous or documented to be 90% or more of the tumor.

*Note 2*: This is a change from the 2007 MPH Rules.

Rule H8  Code the primary invasive histology when there is a carcinoma with signet ring cell differentiation.

*Example*: Resection pathology diagnosis is invasive lobular carcinoma with signet ring cell differentiation. Code the invasive lobular carcinoma 8520/3.

² American College of Pathologists: Protocol for the Examination of Specimens From Patients With Invasive Carcinoma of the Breast: “Inflammatory carcinoma requires the presence of clinical findings of erythema and edema involving at least one-third or more of the skin of the breast”

Jump to Equivalent Terms and Definitions
Jump to Multiple Primary Rules
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(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Rule H9 Code cribriform carcinoma 8201/3 when cribriform is mixed with any other carcinoma AND
• The diagnosis is exactly cribriform carcinoma OR
• Multiple histologies are present and cribriform carcinoma is documented as greater than or equal to 90% of the tumor

Note: This is a change from the 2007 MPH Rules.

Rule H10 Code the histology when only one histology is present.

Note 1: Use Table 3 to code histology. New codes, terms, and synonyms are included in Table 3 and coding errors may occur if the table is not used.

Note 2: When the histology is not listed in Table 3, 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 Table 3, ICD-O or all updates.

Rule H11 Code duct carcinoma and invasive lobular carcinoma 8522/3 when there is both invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma.

Note 1: CAP uses the term Invasive carcinoma with ductal and lobular features (“mixed type carcinoma”) as a synonym for duct carcinoma/carcinoma NST AND invasive lobular carcinoma 8522/3.

Note 2: Although the instructions in the “Coding Multiple Histologies in a Single Tumor” section state, “Code the histology that comprises the majority of tumor”, 8522/3 identifies both invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma and is the most accurate description.

Rule H12 Code the subtype/variant (specific histology) ONLY when there is a NOS/NST and a subtype/variant AND the subtype/variant is documented to be greater than or equal to 90% of the tumor.

Note 1: When a histology is listed as “minimal”, “focus/foci/focal”, “microscopic”, you can assume the other histological portion comprises at least 90% of the tumor.

Note 2: Use Table 3 to identify NOS/NST and subtypes/variants. Examples include the following:
• Carcinoma NST 8500 and a subtype/variant of carcinoma NST
• Glycogen-rich clear cell carcinoma 8315 and a subtype/variant of glycogen-rich clear cell carcinoma
• Lobular carcinoma 8520 and a subtype/variant of lobular carcinoma
• Medullary carcinoma 8510 and a subtype/variant of medullary carcinoma
• Metaplastic carcinoma 8575 and a subtype/variant of metaplastic carcinoma
• Papillary carcinoma 8503 and a subtype/variant of papillary carcinoma
• Sarcoma 8800 and a subtype/variant of sarcoma
• Small cell carcinoma 8041 and a subtype/variant of small cell carcinoma
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(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

**Note 3:** Do not code any histology described as features or differentiation.
**Note 4:** The word component is not equivalent to subtype/variant.

**Example 1:** Pathology from excision shows a 1.4 cm tumor and a diagnosis of pleomorphic lobular carcinoma in situ 8519/2 with a foci of in situ lobular carcinoma NOS 8520/2. Because the in situ lobular carcinoma NOS is just a foci, more than 90% of the tumor is pleomorphic lobular carcinoma in situ. Code the subtype/variant: pleomorphic lobular carcinoma in situ 8519/2.

**Example 2:** Pathology from an excised tumor says tumor is 95% metaplastic carcinoma spindle cell type 8032 and the remainder is metaplastic carcinoma NOS 8575. Code the subtype/variant: metaplastic carcinoma spindle cell type 8032.

**Rule H13** Code the NOS/NST when there is a NOS/NST and a subtype/variant AND
- The subtype/variant is designated as less than 90% of tumor OR
- The percentage of each is unknown/not documented

**Example 1:** Pathology diagnosis is papillary carcinoma in situ 8503/2 and encapsulated papillary carcinoma 8504/2. The percentage of subtype/variant is unknown. Code the NOS: papillary carcinoma in situ 8503/2.

**Example 2:** Pathology says the majority of tumor is metaplastic carcinoma with chondroid differentiation 8571 and the remainder is metaplastic carcinoma NOS 8575. Majority simply means greater than 50%, so it is unknown whether or not the subtype/variant is equal to or greater than 90% of the tumor. Code metaplastic carcinoma NOS 8575.

**Rule H14** Code the histology that comprises the majority of tumor when two histologies are:
- On different rows in Table 3 in the Equivalent Terms and definitions OR
- Different subtypes of the same NOS

**Note 1:** The majority may be indicated by terms such as “greater than 50%”, “major”, “majority” and “predominantly”.
**Note 2:** The rules are hierarchical, so the tumors are NOT a NOS/NST and subtype/variant.

**Example:** Pathology reads the tumor is predominantly carcinoma NST 8500/3 with areas of tubular carcinoma 8211/3. Code the predominant histology: carcinoma NST 8500/3. Carcinoma NST and tubular carcinoma are on different rows in Table 3, so they are distinctly different histologies.

**Rule H15** Code a combination code when there are two histologies (two components) within a single tumor and the majority histology is unknown/not documented.

**Note 1:** Use Table 2 in the Equivalent Terms and Definitions to identify valid combination codes.
**Note 2:** The rules are hierarchical, so the tumors are NOT a NOS/NST and a single subtype/variant.
**Note 3:** The diagnosis may be two subtypes/variants and the pathologist may mention the presence of duct/carcinoma NST. Ignore the mention of carcinoma NST.
Breast Histology Coding Rules
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(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

**Note 4:** Do not use a combination code when the second histology is described as **features or differentiation.**

**Note 5:** The word component may be used when it describes a carcinoma. Do not use the word component when it simply describes features, differentiation, or cell types. For example, carcinoma NST with signet ring cells

**Note 6:** The histologies may be identified as:
- Mixed histologies
- Combination histologies
- Histology 1 **AND** histology 2
- Histology 1 **WITH** histology 2

This is the end of instructions for a Single Tumor: Invasive Only

**Code the histology according to the rule that fits the case**

### Multiple Tumors Abstracted as a Single Primary

**Note 1:** DCIS is often multifocal/multicentric; use the Single Tumor: In Situ module.

**Note 2:** First use the multiple primary rules to ensure that the multiple tumors are to be abstracted as a single primary.

**Rule H16** Code the **underlying tumor** when there is a diagnosis of inflammatory carcinoma:

**Example:** The patient has a clinical diagnosis of inflammatory breast carcinoma. Pathology shows carcinoma NST with dermal invasion as well as erythema. Code the underlying tumor: carcinoma NST 8500/3.

**Informational item:** The **clinical symptoms** of inflammatory breast cancer include rapid breast enlargement and skin changes (redness, edema peau d’orange) involving more than a third of the breast. Usually there is a diffuse firmness of the breast and there is no palpable underlying mass.

**Note 1:** Record the inflammatory carcinoma in **staging** fields.

**Note 2:** Code inflammatory carcinoma 8530/3 when it is the only diagnosis available (DCO, outpatient only, no follow-up).
Rule H17  Code Paget disease and ductal carcinoma as follows when:
- Pathology specifies Paget disease as invasive 8541/3 OR behavior not documented AND
- Underlying tumor is:
  - Invasive carcinoma NST/duct carcinoma 8541/3
  - DCIS 8543/3

  Note: Ignore the presence of lobular carcinoma in situ (LCIS).

Rule H18  Code Paget disease and DCIS 8543/2 when there is Paget disease (specified as in situ) with underlying DCIS.

Rule H19  Code the histology when only one histology is present in all tumors.

  Note 1: Use Table 3 to code histology. New codes, terms, and synonyms are included in Table 3 and coding errors may occur if the table is not used.

  Note 2: When the histology is not listed in Table 3, 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 Table 3, ICD-O or all updates.

Rule H20  Code the invasive histology when there are invasive and in situ histologies:
- Mixed in each of the tumors OR
- In separate tumors (one or more invasive and one or more in situ)

Rule H21  Code 8522 when carcinoma NST and lobular are present in multiple tumors.
- DCIS and in situ lobular 8522/2
- Carcinoma NST/duct carcinoma and invasive lobular 8522/3

  Note 1: CAP uses the term Invasive carcinoma with ductal and lobular features (“mixed type carcinoma”) as a synonym for duct carcinoma/carcinoma NST AND invasive lobular carcinoma 8522/3.

  Note 2: One tumor may be carcinoma NST and the other lobular, or all tumors may be a mixture of carcinoma NST and lobular.

  Note 3: This combination code specifically identifies carcinoma NST and lobular carcinoma. For all other histological combinations, continue through the rules.

  Note 4: These rules are hierarchical. Both histologies must be in situ or both histologies must be invasive. For example, do not use this rule for invasive carcinoma NST and in situ lobular.
Breast Histology Coding Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Rule H22  Code the NOS/NST when there is a NOS/NST and a subtype/variant:
• Mixed in all of the tumors OR
• Separate tumors with different histologies

Note: It is very difficult to determine whether the subtype/variant is greater than or equal to 90% of the tumor mass when there are multiple tumors.

Rule H23  Code a combination code when there are two histologies (two components) within all tumors.

Note 1: Use Table 2 in the Equivalent Terms and Definitions to identify valid combination codes.
Note 2: Do not use a combination code when the second histology is described as features of or differentiation.
Note 3: The histologies may be identified as:
• Mixed histologies
• Combination histology
• Histology 1 AND histology 2
• Histology 1 WITH histology 2

Note 4: Table 2 is used for two histologies. When there are greater than two histologies, use the “last resort” code 8255 because none of the other combinations include greater than two histologies.

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

Code the histology according to the rule that fits the case