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; Upperouter 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 are most frequently used to target treatment. Biomarkers may 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.
   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 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

These terms can be used interchangeably:

- 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; intraductal; noninfiltrating; noninvasive; carcinoma in situ
- Carcinoma; adenocarcinoma
- De novo; new tumor; frank (obsolete term)
- Duct; ductal; NST (no special type); carcinoma NST; mammary carcinoma
- Mammary; breast
- Majority; major; predominantly; greater than 50%
- Simultaneous; synchronous; existing at the same time; concurrent; prior to first course treatment
- Topography; site code

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- Tumor; mass; tumor mass; lesion; neoplasm
  - 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
  - These terms are used **ONLY** to determine multiple primaries
  - **Do not** use these terms for casefinding or determining reportability
- Type; subtype; variant

<table>
<thead>
<tr>
<th>Table 1: Primary Site Codes</th>
</tr>
</thead>
</table>

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 begins on next page
### Breast Equivalent Terms and Definitions
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(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>Areolar</td>
<td></td>
</tr>
<tr>
<td>Nipple</td>
<td></td>
</tr>
<tr>
<td>Paget disease without underlying tumor</td>
<td>Nipple C500</td>
</tr>
<tr>
<td><strong>Note:</strong> Paget with underlying tumor is coded to the quadrant of breast in which the underlying tumor is located</td>
<td></td>
</tr>
</tbody>
</table>

| Above nipple                  | Central portion of breast C501 |
| Area extending 1 cm around areolar complex | |
| Behind the nipple             |                                |
| Below the nipple              |                                |
| Beneath the nipple            |                                |
| Central portion of breast     |                                |
| Cephalad to nipple            |                                |
| Infra-areolar                 |                                |
| Lower central                 |                                |
| Next to areola NOS            |                                |
| Next to nipple                |                                |
| Retroareolar                  |                                |
| Subareolar                    |                                |
| Under the nipple              |                                |
| Underneath the nipple         |                                |

| Superior inner                | Upper inner quadrant of breast C502 |
| Superior medial               | |
| Upper inner quadrant (UIQ)    | |
| Upper medial                  | |

Jump to [Multiple Primary Rules](#)  
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Breast Equivalent Terms and Definitions  
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<table>
<thead>
<tr>
<th>Terms and Descriptive Language</th>
<th>Site Term and Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inferior inner</td>
<td>Lower inner quadrant of breast C503</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 C504</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>
<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>
</tbody>
</table>

*Note: This is a single tumor which overlaps quadrants/subsite.*
### 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>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:** 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](#)  
Jump to [Histology Rules](#)
Instructions:
1. Use Table 2 when instructed to by the Multiple Primary and Histology Rules.
2. Compare the terms in the diagnosis (pathology, cytology, radiographic, clinical) to the terms in Column 1.
3. When the terms match, use the combination code listed in Column 2.
4. The last row in the table is a “last resort” code: adenocarcinoma mixed subtypes 8255.
5. Use the combination codes only when the histologies are in a single tumor OR multiple tumors abstracted as a single primary.
6. 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

<table>
<thead>
<tr>
<th>Table 2: Histology Combination Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instructions:</td>
</tr>
<tr>
<td>1. Use Table 2 when instructed to by the Multiple Primary and Histology Rules.</td>
</tr>
<tr>
<td>2. Compare the terms in the diagnosis (pathology, cytology, radiographic, clinical) to the terms in Column 1.</td>
</tr>
<tr>
<td>3. When the terms match, use the combination code listed in Column 2.</td>
</tr>
<tr>
<td>4. The last row in the table is a “last resort” code: adenocarcinoma mixed subtypes 8255.</td>
</tr>
<tr>
<td>5. Use the combination codes only when the histologies are in a single tumor OR multiple tumors abstracted as a single primary.</td>
</tr>
<tr>
<td>6. Mixed histologies may be described as follows:</td>
</tr>
<tr>
<td>A. A “combination of”</td>
</tr>
<tr>
<td>B. Histology 1 AND histology 2</td>
</tr>
<tr>
<td>C. Histology 1 WITH histology 2</td>
</tr>
<tr>
<td>D. Mixed histology 1 and histology 2</td>
</tr>
</tbody>
</table>

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.

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- 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.
Required Histology Terms | Histology Combination Term and Code
--- | ---
DCIS/duct carcinoma/carcinoma NST 8500 AND | Invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma 8522/3
Lobular carcinoma 8520 | Note 1: CAP uses the term Invasive carcinoma with ductal and lobular features (“mixed type carcinoma”)
Note 2: Carcinoma NST includes all subtypes/variants of carcinoma NST.
| DCIS and in situ lobular carcinoma 8522/2
Note: The lobular carcinoma includes pleomorphic lobular carcinoma in situ 8519/2.

| DCIS/duct carcinoma/carcinoma NST OR any ONE subtype/variant of carcinoma NST AND | Invasive carcinoma NST/duct mixed with other types of invasive carcinoma 8523/3
Any histology in Table 3 with exception of | DCIS mixed with other in situ carcinoma 8500/2
- Lobular carcinoma 8520 and pleomorphic lobular carcinoma in situ 8519/2*
- Paget disease 8540 | Note: Prior to 2018, DCIS and other in situ was coded 8523/2.

Note 1: Both histologies must have the same behavior code.
Note 2: See Table 3 for carcinoma NST/duct carcinoma subtypes/variants.
Note 3: Do not use combination code for duct with lobular differentiation. This is a synonym for carcinoma NST.

* Pleomorphic lobular carcinoma in situ 8519/2* is included in lobular carcinoma 8520.
### Required Histology Terms

<table>
<thead>
<tr>
<th>History Combination Term and Code</th>
<th>Required Histology Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lobular carcinoma AND</td>
<td><strong>Lobular carcinoma</strong></td>
</tr>
<tr>
<td>Any histology in Table 3 with exception of</td>
<td><strong>And</strong></td>
</tr>
<tr>
<td>• Duct carcinoma/carcinoma NST/DCIS (and subtypes/variants) 8500</td>
<td></td>
</tr>
<tr>
<td>• Paget disease, in situ and invasive</td>
<td></td>
</tr>
<tr>
<td>Note 1: See Table 3 for carcinoma NST/duct carcinoma subtypes/variants.</td>
<td></td>
</tr>
<tr>
<td>Note 2: This code does not include lobular and Paget disease. See Multiple Primary Rules. Lobular carcinoma and Paget are separate primaries.</td>
<td></td>
</tr>
</tbody>
</table>

### Histology Combination Term and Code

<table>
<thead>
<tr>
<th>Histology Combination Term and Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infiltrating lobular mixed with other types of carcinoma 8524/3</td>
</tr>
<tr>
<td>In situ lobular mixed with other types of in situ carcinoma 8524/2</td>
</tr>
<tr>
<td>Paget disease (invasive or behavior not specified) and DCIS/intraductal carcinoma 8543/3</td>
</tr>
<tr>
<td>Paget disease (specified as in situ) and DCIS/intraductal carcinoma 8543/2</td>
</tr>
<tr>
<td>Paget disease and infiltrating duct carcinoma 8541/3</td>
</tr>
<tr>
<td>Adenocarcinoma with mixed subtypes 8255/3</td>
</tr>
</tbody>
</table>

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

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

Table begins on next page
### Specific and NOS/NST Terms and Code

<table>
<thead>
<tr>
<th>Term</th>
<th>Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acinic cell carcinoma 8550</td>
<td></td>
<td>Acinar adenocarcinoma</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acinar carcinoma</td>
<td></td>
</tr>
<tr>
<td>Adenoid cystic carcinoma (ACC) 8200</td>
<td></td>
<td>ACC</td>
<td>Adenocystic basal cell carcinoma</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carcinoma adenoides cysticum</td>
<td>Cylindromatous carcinoma</td>
</tr>
<tr>
<td>Adenomyoepithelioma with carcinoma 8983</td>
<td></td>
<td>AME</td>
<td>Malignant AME</td>
</tr>
<tr>
<td>Apocrine carcinoma 8401</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: This is a diagnosis that is EXACTLY apocrine carcinoma, not a carcinoma NST with apocrine features, differentiation, or type.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carcinoma NST 8500</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Cribriform carcinoma may consist of up to 50% tubular formations. The term cribriform/tubular carcinoma is coded as cribriform carcinoma.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<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></td>
<td>Carcinoma/carcinoma NST with choriocarcinomatous features</td>
<td>Cribriform carcinoma 8201/3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carcinoma/carcinoma NST with cribriform features</td>
<td>Pleomorphic carcinoma 8022/3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carcinoma/carcinoma NST with melanotic features</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carcinoma/carcinoma NST with signet ring cell differentiation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>DCIS 8500/2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Duct/ductal carcinoma</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Duct/ductal carcinoma in situ 8500/2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Duct/ductal carcinoma NOS</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>
</table>
| **Duct/ductal carcinoma NST (no special type)** | Duct/ductal carcinoma with apocrine features  
Duct/ductal carcinoma with apocrine metaplasia  
Duct/ductal carcinoma with lobular features  
Duct/ductal carcinoma with micropapillary features  
Duct/ductal carcinoma with mucin production  
Duct/ductal carcinoma with squamous metaplasia  
Infiltrating ductal carcinoma **8500/3**  
Invasive carcinoma with micropapillary features **8500/3**  
Invasive carcinoma not otherwise specified (ductal/NOS) **8500/3**  
Invasive carcinoma NST with metaplastic features **8500/3**  
Invasive carcinoma NST/duct with medullary features **8500/3**  
Invasive carcinoma, with signet-ring cell features **8500/3**  
Invasive carcinoma of no special type (NST) **8500/3**  
Invasive carcinoma with clear cell (glycogen rich) features **8500/3** |
### Breast Equivalent Terms and Definitions

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Invasive carcinoma, NST 8500/3</td>
<td>Invasive carcinoma, type cannot be determined 8500/3</td>
<td></td>
</tr>
<tr>
<td>Invasive mammary carcinoma 8500/3</td>
<td>Invasive mammary carcinoma associated with encysted papillary carcinoma 8500/3</td>
<td></td>
</tr>
<tr>
<td>Invasive mammary carcinoma NST with lobular features 8500/3</td>
<td>Invasive mammary carcinoma NST with medullary features 8500/3</td>
<td></td>
</tr>
<tr>
<td>Invasive mammary carcinoma NST with mucinous features 8500/3</td>
<td>Invasive mammary carcinoma NST with tubulo-lobular variant 8500/3</td>
<td></td>
</tr>
<tr>
<td>Invasive mammary carcinoma with apocrine features 8500/3</td>
<td>Invasive mammary carcinoma with cribriform features 8500/3</td>
<td></td>
</tr>
<tr>
<td>Invasive mammary carcinoma with tubular features 8500/3</td>
<td>Mammary carcinoma in situ 8500/2</td>
<td></td>
</tr>
<tr>
<td>Mammary carcinoma/cancer</td>
<td>Non-invasive mammary carcinoma 8500/2</td>
<td></td>
</tr>
<tr>
<td>Glycogen-rich clear cell carcinoma 8315</td>
<td>Glycogen-rich carcinoma</td>
<td>Clear cell carcinoma 8310</td>
</tr>
<tr>
<td>Inflammatory carcinoma 8530</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lipid-rich carcinoma 8314</td>
<td>Lipid-secreting carcinoma</td>
<td></td>
</tr>
</tbody>
</table>
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<tr>
<td><strong>Lobular carcinoma 8520</strong></td>
<td>Alveolar lobular carcinoma</td>
<td>Pleomorphic lobular carcinoma in situ 8519/2*</td>
</tr>
<tr>
<td></td>
<td>Classic lobular carcinoma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intraductal papilloma with lobular carcinoma in situ 8520/2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invasive lobular carcinoma, alveolar type/variant 8520/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invasive lobular carcinoma, solid type 8520/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lobular carcinoma in situ 8520/2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lobular carcinoma with cribriform features</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mixed lobular carcinoma (lobular carcinoma NOS and one or more variants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of lobular carcinoma)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invasive pleomorphic lobular carcinoma 8520/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Solid lobular carcinoma</td>
<td></td>
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<tr>
<td></td>
<td>Tubulolobular carcinoma</td>
<td></td>
</tr>
<tr>
<td><strong>Medullary carcinoma 8510</strong></td>
<td>MC</td>
<td>Atypical medullary carcinoma (AMC) 8513</td>
</tr>
</tbody>
</table>

*Note:* 8519/2 is a new code for in situ /2 tumors only.

Table continues on next page
<table>
<thead>
<tr>
<th>Specific and NOS/NST Terms and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
</table>
| 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/spindle cell carcinoma 8032  
Metaplastic carcinoma with chondroid differentiation/with osseous differentiation 8571  
Myoepithelial carcinoma 8982  
Sarcomatoid carcinoma 8033  
Squamous cell carcinoma 8070 |
| **Note:** Squamous cell carcinoma of the breast is extremely rare. Carefully check the pathology report to verify the squamous cell originated in the breast parenchyma, rather than the skin of the breast. |                                                                                                                                                                                                                                                                                                                                                                                                              |
| Mucinous carcinoma 8480           | Colloid carcinoma  
Mucinous adenocarcinoma  
Mucoid carcinoma                                                                                     |                                                                                                                                                                                                                                                                             |
<p>| <strong>Note 1:</strong> This is a diagnosis that is EXACTLY “mucinous carcinoma,” mucinous duct carcinoma,” “mucinous DCIS” OR “greater than 90% mucinous.” See Histology Rules. |                                                                                                                                                                                                                                                                                                                                                                                                              |
| <strong>Note 2:</strong> 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. |                                                                                                                                                                                                                                                                                                                                                                                                              |
| Mucoepidermoid carcinoma 8430     |                                                                                                                                                                                                                                                                                                                                                                                                              |
| Oncocytic carcinoma 8290          |                                                                                                                                                                                                                                                                                                                                                                                                              |</p>
<table>
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</thead>
<tbody>
<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 non-infiltrating/intracystic 8504/2 with invasion 8504/3</td>
</tr>
<tr>
<td></td>
<td>Intraductal papillary carcinoma with DCIS 8503/2*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invasive papillary carcinoma 8503/3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Papillary carcinoma non-invasive 8503/2*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Papillary ductal carcinoma in situ 8503/2*</td>
<td></td>
</tr>
<tr>
<td>Periductal stromal tumor, low grade 9020/3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polymorphous carcinoma 8525</td>
<td>Phyllodes tumor, malignant</td>
<td></td>
</tr>
<tr>
<td>Sarcoma NOS 8800/3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Rhabdomyosarcoma 8900/3 is also a NOS with the following subtypes/variants:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alveolar type rhabdomyosarcoma 8920/3</td>
<td>Angiosarcoma 9120/3</td>
<td></td>
</tr>
<tr>
<td>Embryonal type rhabdomyosarcoma 8910/3</td>
<td>Hemangiosarcoma</td>
<td></td>
</tr>
<tr>
<td>Pleomorphic rhabdomyosarcoma 8901/3</td>
<td>Lymphangiosarcoma</td>
<td></td>
</tr>
<tr>
<td>Malignant hemangioendothelioma</td>
<td>Liposarcoma 8850/3</td>
<td></td>
</tr>
<tr>
<td>Leiomyosarcoma 8890/3</td>
<td>Osteosarcoma 9180/3</td>
<td></td>
</tr>
<tr>
<td>Rhabdomyosarcoma 8900/3</td>
<td>Rhabdomyosarcoma 8900/3</td>
<td></td>
</tr>
<tr>
<td>Alveolar type 8920/3</td>
<td>Alveolar type 8920/3</td>
<td></td>
</tr>
<tr>
<td>Embryonal type 8910/3</td>
<td>Embryonal type 8910/3</td>
<td></td>
</tr>
<tr>
<td>Pleomorphic 8901/3</td>
<td>Pleomorphic 8901/3</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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<tr>
<td>Sebaceous carcinoma 8410</td>
<td></td>
<td></td>
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<tr>
<td>Secretory carcinoma 8502</td>
<td></td>
<td></td>
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<tr>
<td>Signet ring carcinoma 8490</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small cell carcinoma 8041</td>
<td></td>
<td>Carcinoma with neuroendocrine differentiation/Invasive mammary carcinoma with neuroendocrine features 8574/3 Neuroendocrine tumor, well-differentiated 8246</td>
</tr>
<tr>
<td>Tubular carcinoma 8211</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*New codes approved by IARC/WHO Committee for ICD-O*
Breast Equivalent Terms and Definitions
C500-C506, C508-C509
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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
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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

"Clock" Positions, Quadrants and ICD-O Codes of the Breast
Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 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:
- Axillary lymph nodes
- Bone
- Brain
- Chest wall
- Discontinuous involvement of skin of breast
- Distant lymph nodes as identified in Summary Staging Manual
- Liver
- Lung

**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

---

**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
  - 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**

\(^1\)Prepare one abstract. Use the [histology rules](#) to assign the appropriate histology code.
Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

**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 when the diagnosis is inflammatory carcinoma in:
- Multiple quadrants of same breast OR
- Bilateral breasts

**Rule M3** Abstract a single primary 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/quadrants.
*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

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 multiple primaries when there are separate, non-contiguous tumors in sites with ICD-O site codes that differ at the second (CXX) and/or third characters (CXx).
*Note 1:* 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.
*Note 2:* 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.
Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Rule M5  Abstract multiple primaries\textsuperscript{ii} when the patient has a subsequent tumor after being clinically disease-free for greater than five years after the original diagnosis or last recurrence.

\textit{Note 1:} The rules are hierarchical. This rule only applies when there is a subsequent breast tumor.

\textit{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

\textit{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.

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

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

Rule M6  Abstract a single primary\textsuperscript{i} when there is inflammatory carcinoma in:
- Multiple quadrants of same breast OR
- Bilateral breasts

Rule M7  Abstract multiple primaries\textsuperscript{ii} when there is bilateral breast cancer (both right and left breast).

\textit{Note 1:} Physician statement of “bilateral breast cancer” should not be interpreted as meaning a single primary. The term is not used consistently. The literal definition of bilateral is “cancer in both breasts”.

\textit{Note 2:} The histologies within each breast may be the same or different.

Rule M8  Abstract a single primary\textsuperscript{i} when the diagnosis is Paget disease with synchronous underlying in situ or invasive carcinoma NST (duct/ductal) or subtypes of duct.

\textit{Note:} If the underlying tumor is any histology other than duct or subtypes of duct, continue through the rules.

Rule M9  Abstract multiple primaries\textsuperscript{ii} when the diagnosis is Paget disease with synchronous underlying tumor which is NOT duct.

\textit{Example:} Paget disease of the nipple with underlying lobular carcinoma are multiple primaries.
Rule M10 Abstract a single primary\(^1\) when synchronous multiple tumors are carcinoma NST/duct and lobular.

- Both/all tumors may be a mixture of carcinoma NST/duct and lobular 8522 OR
- One tumor may be duct and another tumor lobular OR
- One tumor may be mixed duct and lobular 8522, the other tumor either duct or lobular

*Note 1:* Tumors must be in the same breast.

*Note 2:* 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)
- Cribriform carcinoma 8201/3
- Pleomorphic carcinoma 8022/3

*Note 3:* Lobular carcinoma includes:
- In situ lobular carcinoma 8520/2
- In situ pleomorphic lobular carcinoma 8519/2
- Invasive lobular carcinoma 8520/3

Rule M11 Abstract a single primary\(^1\) when a ductal carcinoma occurs after a combination code in the same breast. See the following list:

- **DCIS** following a diagnosis of:
  - DCIS + lobular carcinoma in situ 8522/2 OR
  - DCIS + in situ Paget 8543/2 OR
  - DCIS + Invasive Paget 8543/3 OR
  - DCIS mixed with other in situ 8523/2 (code used for cases diagnosed prior to 1/1/2018)

- **Invasive carcinoma** NST/duct following a diagnosis of:
  - Invasive duct + invasive lobular 8522/3 OR
  - Invasive duct + invasive Paget 8541/3 OR
  - Invasive duct + other invasive carcinoma 8523/3
Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Rule M12 Abstract multiple primaries\(^a\) 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 M13 Abstract a single primary\(^i\) when synchronous, separate/non-contiguous tumors are on the same row in Table 3 in the Equivalent Terms and Definitions.

*Note:* 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 M14 Abstract multiple primaries\(^a\) when separate/non-contiguous tumors are:
- On different rows in Table 3 in the Equivalent Terms and Definitions
- A combination code in Table 2 and a code from Table 3

*Note 1:* Timing is irrelevant. Tumors may be synchronous or non-synchronous.
*Note 2:* Each row in the table is a distinctly different histology.

**Example 1:** Paget disease of the nipple with underlying lobular are multiple primaries. Paget and lobular are on different rows in Table 3.

**Example 2:** Two tumors right breast. One tumor is invasive mixed duct and lobular 8522/3 (combination code from Table 2) and the second tumor is tubular 8211/3 (histology from Table 3). Abstract two primaries: 8522/3 and 8211/3.

Rule M15 Abstract a single primary\(^i\) (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.
Breast Multiple Primary Rules  
C500-C506, C508-C509  
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

**Rule M16**  
Abstract a **single primary**\(^1\) (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.

*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 M17**  
Abstract **multiple primaries**\(^2\) 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 M18**  
Abstract a **single primary**\(^1\) 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.

*Example:* One tumor is invasive carcinoma NST/ductal 8500/3 and a separate non-contiguous tumor in the same breast is DCIS 8500/2. Abstract a single primary: invasive carcinoma NST/ductal 8500/3.

This is the end of instructions for Multiple Tumors.

\(^1\) 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.

\(^2\) 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)

Note: Only code differentiation or features when there is a specific code for the NOS with differentiation or the NOS with features in Table 2 or Table 3 or the ICD-O and all updates. This instruction applies to single and multiple histologies.

Coding Multiple Histologies in a Single Tumor

Note: The rules for coding breast histology are different from the histology coding rules for all other sites. DO NOT USE THESE RULES FOR ANY SITE OTHER THAN BREAST.

Two INVASIVE histologies

Two histologies within a single tumor will be either:
- A NOS and a subtype/variant OR
- Different histologies (different rows in Table 3 OR different subtypes in Table 3 Column 3)

The following instructions are in priority order:

1. NOS and a subtype/variant
   A. Code the subtype/variant (specific histology) ONLY when documented to be greater than 90% of the tumor.
   Note: When a histology is listed as “minimal”, “focus/foci/focal”, “microscopic”, you can assume the other histological portion comprises greater than 90% of the tumor.
   Example: Patient had an excisional biopsy with a pathologic diagnosis of invasive cribriform carcinoma 8201/3. There was microscopic involvement of one margin. The patient chose to have a total mastectomy. Pathology from the total mastectomy showed minimal residual invasive carcinoma NST 8500/3. Because the invasive carcinoma NST was minimal, the subtype/variant invasive cribriform carcinoma 8201/3 is assumed to be greater than 90% of the tumor.
   B. Code the NOS/NST when the subtype/variant is documented to be less than or equal to 90% of the tumor OR the percentage of subtype/variant is unknown/not documented.
2. Different histologies
   A. Code the histology which comprises the majority of tumor.
      
      *Note 1:* The majority may be indicated by terms such as “greater than 50%”, “major”, “majority” and “predominantly”.
      
      *Note 2:* The following terms do not describe the majority of tumor.

      | Architecture | Pattern(s) |
      | Component    | Subtype    |
      | Differentiation* | Type       |
      | Features (of)* | Variant    |
      | Foci; focus, focal |

   B. Code a combination code using Table 2 in the Equivalent Terms and Definitions when the majority is unknown/not documented.

   *Note:* A NOS with features or differentiation is a single histology. Go directly to the rules.

   Do not code apocrine carcinoma when the diagnosis specifies apocrine differentiation or features. 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
Ambiguous Terminology

Code the histology when described by ambiguous terminology ONLY when:

- **Histology is clinically confirmed by a physician (attending, pathologist, oncologist, etc.)**
  
  *Example 1:* The pathology diagnosis is carcinoma NST consistent with pleomorphic carcinoma. The oncology consult says the patient has pleomorphic carcinoma of the right breast. This is clinical confirmation of the diagnosis, code pleomorphic carcinoma. The case meets the criteria in bullet 1.

- **Patient is receiving treatment based on the histology described by an ambiguous term**
  
  *Example 2:* The pathology diagnosis is sarcoma consistent with liposarcoma. The treatment plan says the patient will receive the following treatment for liposarcoma of the breast. Treatment plan confirms liposarcoma; code liposarcoma. The case meets the criteria in bullet 2.

- **Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documentated**
  
  *Example 3:* Outpatient biopsy says probably apocrine carcinoma. The case is accessioned (entered into the database) as required by both SEER and COC. No further information is available. Code the histology apocrine carcinoma. The case meets the criteria in bullet 3.

**List of 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:* If the histology described by ambiguous terminology does not meet any of the criteria in bullets 1, 2, or 3, **DO NOT CODE** the histology.
Breast Histology Coding Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Priority Order for Using Documentation to Identify Histology

IMPORTANT NOTES
   *Note 1:* Histology changes do occur following immunotherapy, chemotherapy and radiation therapy.
   *Note 2:* Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.
2. Code the histology using the following priority list and the Histology Rules. Do not change histology in order to make the case applicable for staging.

Use documentation in the following priority order to identify the histology type(s):
1. Biomarkers
2. Tissue or pathology report from 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. The final diagnosis is often the synoptic CAP report.
      *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
3. Cytology (nipple discharge or fine needle aspirate (FNA) of primary site)
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. Treatment Plan
   B. Documentation from 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.

---

**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 notes preceding the in situ section say most tumors will be coded to DCIS, 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.

Rule H4  
Code DCIS and in situ Paget 8543/2.  

*Note 1:* Although the notes preceding the in situ section say most tumors will be coded to DCIS, 8543/2 identifies both DCIS and in situ Paget.  

*Note 2:* 8543/2 is the most accurate description of DCIS and in situ Paget.

Rule H5  
Code DCIS 8500/2 when there is a combination of DCIS and any other carcinoma in situ.

Rule H6  
Code the histology using Table 2 when there are multiple in situ histologies (2 or more) within a single tumor.  

- Lobular and any histology other than DCIS 8524/2  
- Two or more histologies other than lobular and DCIS 8255/2  

*Note:* This rule does not include DCIS. See previous rules.

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

Code the histology according to the rule that fits the case

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Single Tumor: Invasive and In Situ Components

Rule H7  
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
Rule H8  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 H9  Code the underlying tumor when there is a diagnosis of inflammatory carcinoma.¹
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 H10  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 90% of the tumor
Note 1: The pure mucinous carcinoma category includes only cases which are diagnosed as exactly mucinous or documented to be greater than 90% of the tumor.
Note 2: This is a change from the 2007 MPH Rules.

Rule H11  Code the primary invasive histology when there is a carcinoma with signet ring cells OR signet ring cell differentiation.
Example: Resection pathology diagnosis is invasive lobular carcinoma with signet ring cell differentiation. Code the invasive lobular carcinoma 8520/3.

¹ 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”
Breast Histology Coding Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Rule H12  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 H13  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 H14  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 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 greater than 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

*Note 3:* Do not code any histology described as **features or differentiation** unless it is part of the preferred term.

**Example 1:** Pathology from excision shows a 1.4 cm tumor and a diagnosis of clear cell carcinoma 8310/3 with a focus of glycogen-rich clear cell carcinoma NOS 8315/3. Because the glycogen-rich clear cell carcinoma NOS is just a focus, more than 90% of the tumor is clear cell carcinoma. Code the subtype/variant: clear cell carcinoma 8310/3.

**Example 2:** Pathology from an excised tumor says tumor is 95% metaplastic carcinoma spindle cell type 8032/3 and the remainder is metaplastic carcinoma NOS 8575/3. Code the subtype/variant: metaplastic carcinoma spindle cell type 8032/3.

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

Rule H15  Code the NOS/NST when there is a NOS/NST and a subtype/variant AND
• The subtype/variant is designated as less than or equal to 90% of tumor OR
• The percentage of each is unknown/not documented

Example 1: Pathology diagnosis is carcinoma NST 8500/3 and pleomorphic carcinoma 8022/3. The percentage of subtype/variant is unknown. Code the NOS: carcinoma NST 8500/3.

Example 2: Pathology says the majority of tumor is metaplastic carcinoma with chondroid differentiation 8571/3 and the remainder is metaplastic carcinoma NOS 8575/3. Majority simply means greater than 50%, so it is unknown whether or not the subtype/variant is greater than 90% of the tumor. Code metaplastic carcinoma NOS 8575/3.

Rule H16  Code the histology that comprises the majority (greater than 50%) 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.
Note 3: If the majority histology is unknown/not documented, continue through the rules.

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 H17  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.
Note 4: Do not use a combination code when the second histology is described as features or differentiation unless it is part of the preferred term.
Note 5: The histologies may be identified as:
• Mixed histologies
• Combination histologies
• Histology 1 AND histology 2
• Histology 1 WITH histology 2
Breast Histology Coding Rules  
C500-C506, C508-C509  
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

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 H18**  
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 H19**  
Code Paget disease and ductal carcinoma as follows when:

- Pathology specifies Paget disease as **invasive** /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 H20**  
Code Paget disease and DCIS 8543/2 when there is Paget disease (specified as **in situ**) with underlying DCIS.

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

Rule H21  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 H22  Code the invasive histology when there are invasive and in situ histologies:

- Mixed in each of multiple tumors OR
- In separate tumors (one or more invasive and one or more in situ)

*Example 1:* Multiple tumors, each with invasive carcinoma NST and in situ lobular carcinoma (LCIS) mixed. Code to invasive carcinoma NST 8500/3.

*Example 2:* One tumor is invasive carcinoma NST and the other is lobular carcinoma in situ (LCIS). Code to invasive carcinoma NST 8500/3.

Rule H23  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.

Rule H24  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 90% of the tumor mass when there are multiple tumors.
Rule H25  

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 differentiation or features, unless it is part of the preferred term. 

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