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

- These terms are used **ONLY** to determine multiple primaries
- **Do not** use these terms for casefinding or determining reportability

- Type; subtype; variant

### 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 <em>without</em> underlying tumor</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Paget with underlying tumor is coded to the quadrant of breast in which the underlying tumor is located.
## 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>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></td>
</tr>
<tr>
<td>Superior medial</td>
<td></td>
</tr>
<tr>
<td>Upper inner quadrant (UIQ)</td>
<td>Upper inner quadrant of breast <strong>C502</strong></td>
</tr>
<tr>
<td>Upper medial</td>
<td></td>
</tr>
<tr>
<td>Inferior inner</td>
<td></td>
</tr>
<tr>
<td>Inferior medial</td>
<td></td>
</tr>
<tr>
<td>Lower inner quadrant (LIQ)</td>
<td>Lower inner quadrant of breast <strong>C503</strong></td>
</tr>
<tr>
<td>Lower medial</td>
<td></td>
</tr>
<tr>
<td>Superior lateral</td>
<td></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>Upper outer quadrant of breast <strong>C504</strong></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>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>⅔ 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>
<tr>
<td>Note: This is a <strong>single tumor</strong> which <strong>overlaps quadrants/subsite</strong>.</td>
<td></td>
</tr>
<tr>
<td>Note: Used for:</td>
<td></td>
</tr>
<tr>
<td>- Non-contiguous <strong>multiple</strong> tumors in <strong>different quadrants/subsites</strong> of same breast <strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td>- <strong>Unknown/unable to identify</strong> in which <strong>quadrant/subsite</strong> the tumor is <strong>located</strong> (Example: Outpatient biopsy with no quadrant identified. Patient lost to follow-up.)</td>
<td></td>
</tr>
<tr>
<td>- Inflammatory carcinoma; diffuse tumor</td>
<td></td>
</tr>
</tbody>
</table>

Jump to [Multiple Primary Rules](#)  
Jump to [Histology Rules](#)  
Breast Solid Tumor Rules 2018  
January 2019 Update
Table 2: Histology Combination Codes

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 (unless differentiation or features are part of the preferred term)
- 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

Breast Equivalent Terms and Definitions
C500-C506, C508-C509
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### Required Histology Terms

**DCIS/duct carcinoma/carcinoma NST 8500**  
AND

**Lobular carcinoma 8520**  

**Note 1:** Both histologies, duct and lobular, **must have** the same behavior code.  
**Note 2:** 8522 is used when:  
- Duct **AND** lobular carcinoma are present in a **single tumor OR**  
- Duct is present in at least one tumor and lobular is present in at least one tumor in the **same breast**  
- One tumor is mixed duct and lobular; the other tumor is either duct or lobular  
- All tumors may be mixed duct and lobular  

**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. See Histology Rules for instructions on coding differentiation.

**DCIS/duct carcinoma/carcinoma NST OR any ONE subtype/variant of carcinoma NST**  
AND

**Any** histology in Table 3 with **exception** of  
- Lobular carcinoma 8520 and pleomorphic lobular carcinoma in situ 8519/2*  
- Paget disease 8540

**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.

### Histology Combination Term and Code

**Invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma 8522/3**  

**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.

**DCIS and in situ lobular carcinoma 8522/2**  

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

**Invasive carcinoma NST/duct mixed with other types of invasive carcinoma 8523/3**  

**DCIS mixed with other in situ carcinoma 8500/2**  

**Note:** Prior to 2018, DCIS and other in situ was coded 8523/2.
### Breast Equivalent Terms and Definitions

C500-C506, C508-C509  
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#### Required Histology Terms

<table>
<thead>
<tr>
<th>Lobular carcinoma</th>
<th>Histology Combination Term and Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AND</strong></td>
<td>Infiltrating lobular mixed with other types of carcinoma 8524/3</td>
</tr>
<tr>
<td>Any histology in Table 3 with exception of</td>
<td></td>
</tr>
<tr>
<td>• Duct carcinoma/carcinoma NST/DCIS (and subtypes/variants) 8500</td>
<td></td>
</tr>
</tbody>
</table>

*Note 1:* See Table 3 for carcinoma NST/duct carcinoma subtypes/variants.  
*Note 2:* This code does not include lobular and Paget disease. See Multiple Primary Rules. Lobular carcinoma and Paget are separate primaries.

#### Paget disease

<table>
<thead>
<tr>
<th>Paget disease</th>
<th>Histology Combination Term and Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AND</strong></td>
<td>Paget disease (invasive or behavior not specified) and DCIS/intraductal carcinoma 8543/3</td>
</tr>
<tr>
<td>Underlying DCIS</td>
<td>Paget disease (specified as in situ) and DCIS/intraductal carcinoma 8543/2</td>
</tr>
</tbody>
</table>

*Note:* 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.

#### Paget disease

<table>
<thead>
<tr>
<th>Paget disease</th>
<th>Histology Combination Term and Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AND</strong></td>
<td>Paget disease and infiltrating duct carcinoma 8541/3</td>
</tr>
<tr>
<td>Underlying infiltrating duct carcinoma/carcinoma NST and all subtypes/variants of infiltrating duct/carcinoma NST (must be a /3)</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Any two invasive carcinoma NST subtypes/variants (percentage not stated) abstracted as a single primary</th>
<th>Histology Combination Term and Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note 1:</strong> The diagnosis may be two subtypes/variants and the pathologist may mention the presence of duct/carcinoma NST. Ignore the mention of carcinoma NST.</td>
<td></td>
</tr>
<tr>
<td><strong>Note 2:</strong> See Table 3.</td>
<td></td>
</tr>
<tr>
<td>Adenocarcinoma with mixed subtypes 8255/3</td>
<td></td>
</tr>
</tbody>
</table>
Breast Equivalent Terms and Definitions
C500-C506, C508-C509
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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.

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
**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>
| Acinic cell carcinoma 8550         | Acinar adenocarcinoma  
Acinar carcinoma                  |         |                   |
| Adenoid cystic carcinoma (ACC) 8200 | ACC  
Adenocystic basal cell carcinoma  
Carcinoma adenoides cysticum  
Cylindromatous carcinoma       |         |                   |
| Adenomyoepithelioma with carcinoma 8983 | AME  
Malignant AME                       |         |                   |
| Apocrine carcinoma 8401            |         |                   |
| **Note:** This is a diagnosis that is EXACTLY apocrine carcinoma, not a carcinoma NST with apocrine features, differentiation, or type. |         |                   |
| Carcinoma NST 8500                |         |                   |
| **Note:** Cribriform carcinoma may consist of up to 50% tubular formations. The term cribriform/tubular carcinoma is coded as cribriform carcinoma. | Carcinoma of no special type (ductal/NST)  
Carcinoma/carcinoma NST with choriocarcinomatous features  
Carcinoma/carcinoma NST with cribriform features  
Carcinoma/carcinoma NST with melanotic features  
Carcinoma/carcinoma NST with signet ring cell differentiation  
DCIS 8500/2  
Duct/ductal carcinoma  
Duct/ductal carcinoma in situ 8500/2  
Duct/ductal carcinoma NOS | Carcinoma with osteoclast-like stromal giant cells 8035  
Cribriform carcinoma 8201/3  
Pleomorphic carcinoma 8022/3 |
<table>
<thead>
<tr>
<th>Specific and NOS/NST Terms and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duct/ductal carcinoma NST (no special type)</td>
<td>Duct/ductal carcinoma with apocrine features</td>
<td></td>
</tr>
<tr>
<td>Duct/ductal carcinoma with apocrine features</td>
<td>Duct/ductal carcinoma with apocrine metaplasia</td>
<td></td>
</tr>
<tr>
<td>Duct/ductal carcinoma with lobular features</td>
<td>Duct/ductal carcinoma with micropapillary features</td>
<td></td>
</tr>
<tr>
<td>Duct/ductal carcinoma with micropapillary features</td>
<td>Duct/ductal carcinoma with mucin production</td>
<td></td>
</tr>
<tr>
<td>Duct/ductal carcinoma with squamous metaplasia</td>
<td>Infiltrating ductal carcinoma \textbf{8500/3}</td>
<td></td>
</tr>
<tr>
<td>Infiltrating ductal carcinoma \textbf{8500/3}</td>
<td>Invasive carcinoma with micropapillary features \textbf{8500/3}</td>
<td></td>
</tr>
<tr>
<td>Invasive carcinoma not otherwise specified (ductal/NOS) \textbf{8500/3}</td>
<td>Invasive carcinoma NST with metaplastic features \textbf{8500/3}</td>
<td></td>
</tr>
<tr>
<td>Invasive carcinoma NST with medullary features \textbf{8500/3}</td>
<td>Invasive carcinoma NST/duct with medullary features \textbf{8500/3}</td>
<td></td>
</tr>
<tr>
<td>Invasive carcinoma, with signet-ring cell features \textbf{8500/3}</td>
<td>Invasive carcinoma of no special type (NST) \textbf{8500/3}</td>
<td></td>
</tr>
<tr>
<td>Invasive carcinoma with clear cell (glycogen rich) features \textbf{8500/3}</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>
<thead>
<tr>
<th>Specific and NOS/NST Terms and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</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 8500/3</td>
<td>Non-invasive mammary carcinoma 8500/2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Glycogen-rich clear cell carcinoma 8315</th>
<th>Glycogen-rich carcinoma</th>
<th>Clear cell carcinoma 8310</th>
</tr>
</thead>
<tbody>
<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>
## Breast Equivalent Terms and Definitions

**C500-C506, C508-C509**

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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>Lobular carcinoma 8520</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 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>
</tr>
<tr>
<td></td>
<td>Tubulolobular carcinoma</td>
<td></td>
</tr>
<tr>
<td>Medullary carcinoma 8510</td>
<td>MC</td>
<td>Atypical medullary carcinoma (AMC) 8513</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>
| 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 |

| Mucinous carcinoma 8480 | Colloid carcinoma  
Mucinous adenocarcinoma  
Mucoepidermoid carcinoma |                                                                 |

**Note 1:** This is a diagnosis that is EXACTLY “mucinous carcinoma,” mucinous duct carcinoma,” “mucinous DCIS” OR “greater than 90% mucinous.” See Histology Rules.

**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.

| Mucoepidermoid carcinoma 8430 |                                                                 |
| Myoepithelial carcinoma 8982 |                                                                 |
| Oncocytic carcinoma 8290 |                                                                 |
Breast Equivalent Terms and Definitions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

<table>
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<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>Micropapillary carcinoma 8507*</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>Solid papillary carcinoma in situ 8509/2* 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>
<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: Alveolar type rhabdomyosarcoma 8920/3 Embryonal type rhabdomyosarcoma 8910/3 Pleomorphic rhabdomyosarcoma 8901/3</td>
<td>Angiosarcoma 9120/3 Hemangiosarcoma Lymphangiosarcoma Malignant hemangioendothelioma Liposarcoma 8850/3 Leiomyosarcoma 8890/3 Osteosarcoma 9180/3 Rhabdomyosarcoma 8900/3 Alveolar type 8920/3 Embryonal type 8910/3 Pleomorphic 8901/3</td>
<td></td>
</tr>
</tbody>
</table>
### Specific and NOS/NST Terms and Code

<table>
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<tbody>
<tr>
<td>Sebaceous carcinoma 8410</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secretary carcinoma 8502</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signet ring carcinoma 8490</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small cell carcinoma 8041</td>
<td>Carcinoid tumor of breast Endocrine carcinoma Neuroendocrine carcinoma, poorly differentiated</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
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Illustrations

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Jump to Multiple Primary Rules
Jump to Histology Rules
Breast Solid Tumor Rules 2018
January 2019 Update
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
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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-0 Codes of the Breast

RIGHT BREAST

LEFT BREAST

Jump to Multiple Primary Rules
Jump to Histology Rules

Breast Solid Tumor Rules 2018
January 2019 Update
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\(^1\) when the diagnosis is inflammatory carcinoma in:
- Multiple quadrants of same breast OR
- Bilateral breasts

**Rule M3** Abstract a single primary\(^1\) when there is a single tumor.

*Note 1:* A single tumor is always a single primary.
*Note 2:* The tumor may overlap onto or extend into adjacent/contiguous site or subsites/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

\(^1\) 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\(^2\) when there are separate, non-contiguous tumors in sites with ICD-O site codes that differ at the second (CxXx) and/or third characters (CxXX).

*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.
Rule M5  Abstract multiple primaries 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 M6  Abstract a single primary when there is inflammatory carcinoma in:
- Multiple quadrants of same breast OR
- Bilateral breasts

Rule M7  Abstract multiple primaries when there is bilateral breast cancer (both right and left breast).

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”.

Note 2: When there are multiple tumors in one breast, follow the Multiple Primary Rules to determine if they are single or multiple primaries.

Note 3: The histologies within each breast may be the same or different.

Rule M8  Abstract a single primary when the diagnosis is Paget disease with underlying in situ or invasive carcinoma NST (duct/ductal).
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 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: Histologies must be the same behavior.
Note 2: Tumors must be in the same breast.
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

Note 5: One or more tumors with combination duct and lobular histology 8522 AND a separate tumor with any other histology in Table 3 are multiple primaries.

Example: Two tumors right breast. One tumor is invasive mixed duct and lobular 8522/3 and the second tumor is tubular 8211/3. Abstract two primaries: 8522/3 and 8211/3.

Rule M10  Abstract a single primary\(^1\) when any of the following conditions are met in the same breast:
- DCIS subsequent to a diagnosis of mixed DCIS AND:
  - Lobular carcinoma in situ 8522/2 OR
  - In situ Paget 8543/2 OR
  - Invasive Paget 8543/3 OR
  - Other in situ 8500/2 (prior to 2018, DCIS and other in situ was coded 8523/2)
- Invasive carcinoma NST/duct subsequent to a diagnosis of mixed invasive carcinoma NST/duct AND:
  - Invasive lobular 8522/3 OR
  - Invasive Paget 8541/3 OR
  - Other invasive carcinoma 8523/3
Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

**Rule M11** 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 M12** Abstract a single primary when synchronous, separate/non-contiguous tumors are on the same row in Table 3 in the Equivalent Terms and Definitions.

*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 M13** 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.

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

**Rule M14** 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.
Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Rule M15  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 M16  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 M17  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 or 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 or equal to 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**.
Breast Histology Coding Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

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  
      Component  
      Differentiation* 
      Features (of)* 
      Foci; focus, focal

      Pattern(s) 
      Subtype 
      Type 
      Variant

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

*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.

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.

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
Ambiguous Terminology

Code the histology when described by ambiguous terminology (list follows) ONLY when:

- Histology is clinically confirmed by a physician (attending, pathologist, oncologist, etc.)
- Patient is receiving treatment based on the histology described by an ambiguous term
- Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documentated

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)

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.

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.

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.

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.

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)

**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 assigned by the physician. Do not change histology in order to make the case applicable to 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  
   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) 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

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)

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

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

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

Single Tumor: Invasive Only

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”
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.
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.
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