Colon, Rectosigmoid, and Rectum Equivalent Terms and Definitions
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590-M9992 and Kaposi sarcoma M9140)

Introduction

- New terms and codes in these rules are based on the ***WHO Classification of Tumors of the Digestive System*** 2010 edition
- Ninety-eight percent of colon cancers are **adenocarcinoma** and adenocarcinoma **subtypes**
- **Mixed histologies and specific variants or subtypes of adenocarcinoma** other than mucinous/colloid or signet ring cell are **rare**. A less common combination is **mixed adenoneuroendocrine carcinoma** (**MANEC**) **8244** (previously called adenocarcinoma and carcinoid). The new terminology was **originally** proposed for tumors arising from goblet cell carcinoid but with more aggressive adenocarcinoma histology. It was also proposed because **carcinoids** are a subgroup of **neuroendocrine carcinoma**. Pathologists **may still diagnose** adenocarcinoma and carcinoid, adenocarcinoid, or adenocarcinoma and a specific neuroendocrine tumor or adenocarcinoma arising from/with a NET (including specific types of **NET-like goblet cell** carcinoid). Over time, the histologic diagnoses will change to MANEC.
- **De novo (previously called frank) adenocarcinoma** arises in the mucosa of the bowel, not in a polyp

Terms Seen More Frequently: NET, NEC, GIST

- **NET** (neuroendocrine tumor): The term NET is gradually replacing **carcinoid;** however, some pathologists still use the term carcinoid
- **NEC** (neuroendocrine carcinoma): The term NEC includes **small cell neuroendocrine** carcinoma, **large cell neuroendocrine** carcinoma, and **poorly differentiated neuroendocrine** carcinoma
- **GIST** (gastrointestinal stromal tumor):
  - GISTs were originally thought to be smooth muscle tumors but are now thought to originate from the interstitial cells of Cajal, neuro-regulatory cells in the GI tract. Prior to the implementation of an ICD-O-3 histology code for GISTs in **2001**, they were reported as a GI sarcoma, usually **leiomyosarcoma**
  - GISTs are more common in the stomach (60%) and small intestine (30%), but 1-2% occur in the colon and 3% in the rectum
  - About a quarter of gastric GISTs are **malignant**
  - It is often difficult for the pathologist to determine the **behavior** of a GIST

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

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

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

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Changes from 2007 MPH Rules

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

1. **Rectum** and **Rectosigmoid** are now included with the Colon Rules. In the 2007 MPH Rules, they were included with Other Sites.
2. There are new multiple primary rules which address **anastomotic recurrence.**
3. Neuroendocrine tumors (formerly carcinoid) arising in the appendix are reportable for cases diagnosed 1/1/2015 and forward.
4. **Rule clarification: Pseudomyxoma peritonei** (accumulation of mucin in the abdominal or pelvic cavity) now has a **two-tiered system** (WHO 2010) that classifies pseudomyxoma peritonei as either **high-grade** or **low-grade** (see below)**.** Pseudomyxoma peritonei is usually associated with **mucinous** tumors of the appendix and is rarely associated with ovarian mucinous tumors.
    - **High**-grade pseudomyxoma peritonei is **malignant** /3
    - **Low**-grade pseudomyxoma peritonei is **not malignant** /0
    - See **Histology Rules** for **coding instructions**
5. There are **dysplasias** which have been assigned an **in situ behavior** code /2 in **WHO** and in **the ICD-O Update**. Despite becoming a /2, they are **not reportable in the US**. They are reportable in Canada.
    A. Dysplasia **was not** collected in the past. If dysplasia is added to the database with the same code as in situ tumors, there will be a **huge upsurge** in the **incidence** of in situ neoplasms.
        - There would be no way to **separate** the dysplasias from the in-situ neoplasms in the database, which would cause problems with surveillance (long-term studies) since the prognosis and probabilities of disease progression are different between an in-situ tumor and a dysplasia
        - **Pathologists frequently use the term "severe dysplasia" or "high grade dysplasia" in place of carcinoma in situ. Code CIS only** if the pathologist expressly states "CIS"
    B. The various agencies are looking for solutions to this issue
6. **Polyps** are now **disregarded** when coding histology. For example, adenocarcinoma in an adenomatous polyp is coded as adenocarcinoma 8140.
7. New codes/terms are identified by asterisks (*) in the histology table in the Terms and Definitions.

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Equivalent or Equal Terms

These terms can be used interchangeably:

- And; with
  Note: "And" and "with" are used as synonyms when **describing multiple histologies** within a **single tumor**.
- Carcinoid; NET; neuroendocrine tumor
- Carcinoma; carcinoma NOS; adenocarcinoma; adenocarcinoma NOS; intestinal type adenocarcinoma **8140**
- De novo; frank adenocarcinoma (obsolete)
- Familial polyposis; familial adenomatous polyposis (FAP) **8220**
- Intramucosal; lateral extension within the mucosal layer of the GI tract
- Invasion through colon wall; extension through colon wall; transmural
  Note: The term "**transmural**" is used to describe **extension through all layers** of the wall, but not past the wall **OR extension through the serosa into the mesentery**. **Read** the **pathology** report carefully.
- Mucinous; mucoid; mucous; colloid
- Neuroendocrine carcinoma; NEC
- Polyp; adenoma; polyp NOS; adenomatous polyp
  Note 1**:** The term "**polyp**" means projecting from a surface.
  Note 2**:** There are many kinds of polyps. Most common are **adenomas**, which are part of the adenoma-cancer sequence.
  Note 3**: Other types o**f polyps include hyperplastic, juvenile, Peutz-Jeghers and serrated adenoma/polyp.
- Serosa; visceral peritoneum
- Simultaneous; existing at the same time; concurrent; prior to first course treatment
- Site; topography
- 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

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Terms that are NOT Equivalent or Equal

This is a **list of terms** that are **not equivalent**. There are no casefinding implications.

- **Component** is not equivalent to subtype/variant
  Note: Component is **only** coded when the pathologist specifies the component as a second **carcinoma**
- The words "exophytic" and "polypoid" are **not** synonymous with either an adenoma or an adenomatous polyp. The terms "exophytic" and "polypoid" refer to **anything** projecting from the bowel mucosa into the lumen. The lesion may be benign, malignant, or inflammatory
- Polypoid adenocarcinoma is **not equivalent to** adenocarcinoma in a polyp

Table 1: Specific Histologies, NOS, and Subtypes/Variants

Use Table 1 as directed by the **Histology Rules** to assign the more common histology codes for malignancies found in the colon, rectosigmoid and rectum.

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 code is not found in Table 1, 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*:** Typical colon, rectal, and appendiceal carcinomas may exhibit **comedo features** or **differentiation**. Comedo describes the tumor appearance rather than a true histologic subtype/variant of adenocarcinoma. Code to adenocarcinoma 8140.

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.

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Specific and NOS Term and Code	Synonyms for Specific or NOS Term	Subtypes/Variants
Adenocarcinoma 8140 ***Note 1*: See Histology Rules** for instructions on coding adenocarcinoma **subtypes/variants** arising in a polyp ***Note 2*:** When the term **intestinal adenocarcinoma** is used to describe a colon primary, it simply means the **appearance** is similar to adenocarcinoma seen in the stomach and is coded to adenocarcinoma NOS **8140**	Adenocarcinoma, NOS Adenocarcinoma/carcinoma in a polyp NOS (now coded to 8140) Adenocarcinoma/carcinoma in adenomatous polyp (now coded to 8140) Adenocarcinoma/carcinoma in polypoid adenoma (now coded to 8140) Adenocarcinoma/carcinoma in serrated adenoma (now coded to 8140) Adenocarcinoma and mucinous carcinoma, mucinous documented as less than 50% of tumor OR percentage of mucinous unknown/not documented Adenocarcinoma and signet ring cell carcinoma, percentage of signet ring cell carcinoma documented as less than 50% of tumor OR percentage of signet ring cell carcinoma unknown/not documented Adenocarcinoma/carcinoma in tubular polyp (now coded to 8140) Adenocarcinoma/carcinoma in tubulovillous polyp (now coded to 8140) Adenocarcinoma/carcinoma in villous adenoma (now coded to 8140) Adenocarcinoma in any type of polyp Adenocarcinoma, intestinal type Adenocarcinoma and cribriform carcinoma percentage of cribriform documented as less than 50% of tumor OR percentage of cribriform carcinoma unknown/not documented	Undifferentiated adenocarcinoma/carcinoma **8020** Adenoid cystic carcinoma **8200** Cribriform comedo-type carcinoma/ adenocarcinoma, cribriform comedo-type **8201*** Diffuse adenocarcinoma/carcinoma **8145** Linitis plastica **8142/3** Medullary adenocarcinoma/carcinoma **8510** Micropapillary carcinoma **8265*** Mucinous/colloid adenocarcinoma/carcinoma **8480** Mucoepidermoid carcinoma **8430** Serrated adenocarcinoma **8213*** Signet ring cell/poorly cohesive adenocarcinoma/carcinoma **8490** Superficial spreading adenocarcinoma **8143** Tubulopapillary carcinoma **8263**

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Specific and NOS Term and Code	Synonyms for Specific or NOS Term	Subtypes/Variants
	Adenocarcinoma with mucinous and signet ring cell features Adenoma (now coded to 8140) Comedocarcinoma Intestinal adenocarcinoma	
Adenosquamous carcinoma 8560	Mixed adenocarcinoma NOS and epidermoid carcinoma Mixed adenocarcinoma NOS and squamous cell carcinoma ***Note:*** This code **cannot be used** for **adenocarcinoma subtypes/variants** with squamous cell/epidermoid carcinoma	
Combined small cell carcinoma 8045	Small cell carcinoma mixed with • Adenocarcinoma **OR** • Neuroendocrine carcinoma **OR** • Any other type of carcinoma/adenocarcinoma	
Gastrinoma 8153		
Gastrointestinal stromal tumor classified as malignant 8936/3	Gastrointestinal stromal tumor, malignant GIST, malignant	
Mixed adenoneuroendocrine carcinoma 8244	Adenocarcinoma mixed with high-grade large cell neuroendocrine carcinoma Adenocarcinoma mixed with high-grade small cell neuroendocrine carcinoma Any carcinoid mixed with neuroendocrine carcinoma MANEC	Goblet cell carcinoid **8243**
Neuroendocrine carcinoma 8246	NEC	Large cell NEC **8013** Small cell NEC **8041**

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Specific and NOS Term and Code	Synonyms for Specific or NOS Term	Subtypes/Variants
Neuroendocrine tumor Grade 1 (G1) 8240 ***Note*: When the diagnosis is exactly "carcinoid"** it may be a Grade 1 or Grade 2 NET. Default is coding NET Grade 1 **8240**.	Carcinoid NOS Low-grade neuroendocrine tumor NET Grade 1 (G1) Well differentiated neuroendocrine tumor	EC cell serotonin-producing NET/enterochromaffin cell carcinoid **8241** Neuroendocrine tumor (NET) Grade 2 (G2) **8249** Somatostatin-producing NET **8156**
Sarcoma NOS 8800/3		Angiosarcoma/hemangiosarcoma **9120/3** Leiomyosarcoma **8890/3**
Spindle cell carcinoma 8032		
Squamous cell carcinoma 8070	Epidermoid carcinoma NOS Squamous cell carcinoma NOS Squamous cell epithelioma	

***These new codes were approved by the IARC/WHO Committee for ICD-O**

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Table 2: Histologies Not Reportable for Colon, Rectosigmoid and Rectum

Column 1 lists the **non-reportable** histology term and code for NOS or specific
Column 2 lists the **synonym**(s) for the term
Column 3 lists the **subtype/variant** of the NOS term with the histology code
Column 4 lists the **reason** these histologies are **not reportable**

Specific or NOS Term and Code	Synonyms	Subtype/Variant of NOS with Histology Code	Reason not reportable
Adenoma 8140/0 ***Note*:** No malignancy in polyps	Adenoma NOS	Tubular adenoma **8211/0** Tubulovillous adenoma **8263/0** Villous adenoma **8261/0**	Non-malignant
Cowden-associated polyp No code ***Note*:** No malignancy in polyps	Cowden disease Cowden syndrome Multiple hamartoma syndrome		Non-malignant /no code
Dysplasia, high grade 8148/2 ***Note:*** Colorectal primaries only (C180-C189, C199 and C209)	High-grade dysplasia Intraepithelial neoplasia, high grade ***Note:*** Canada collects these neoplasms as adenocarcinoma in situ in a polyp		**NOT REPORTABLE in US:** Currently the United States is not collecting dysplasia
Dysplasia, low grade 8148/0* ***Note:*** Colorectal primaries only (C180-C189, C199 and C209)	Intraepithelial neoplasia, low grade		Non-malignant

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Specific or NOS Term and Code	Synonyms	Subtype/Variant of NOS with Histology Code	Reason not reportable
Familial adenomatous polyposis (FAP) No code	Adenomatous polyposis coli Bussey-Garder polyposis Familial multiple polyposis Familiar polyposis coli Familial polyposis of the colon and rectum Familial polyposis of the gastrointestinal tract Gardner syndrome Multiple adenomatosis		Reportable only when there is cancer in a polyp
Gangliocytic paraganglioma 8683/0			Non-malignant
Gastrointestinal stromal tumor 8936/1	GIST NOS GIST, behavior not specified		
Hyperplastic polyp No code			Non-malignant/no code
Inflammatory or pseudopolyp No code			Reactive lesions; mimic carcinoma
Juvenile polyp No code	Combined juvenile polyposis/hereditary Hemorrhagic telangietasis (Osler-Webec-Rendu) syndrome Familial juvenile polyposis Generalized juvenile polyposis Hamartomatous gastrointestinal polyposis; Juvenile polyposis Juvenile polyposis coli Juvenile polyposis of infancy		Non-malignant / no code

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Specific or NOS Term and Code	Synonyms	Subtype/Variant of NOS with Histology Code	Reason not reportable
L cell glucagon-like peptide and PP/PYY-producing NETs 8152/1*			Non-malignant
Leiomyoma 8890/0			Non-malignant
Lipoma 8850/0			Benign accumulation of fat cells that are circumscribed or encapsulated
Low-grade appendiceal mucinous neoplasm 8480/1 ***Note*:** May have low-grade, non-invasive pseudomyxoma peritonei, mucinous implants in peritoneum or beyond	LAMN		Non-malignant
Lynch syndrome No code			Non-malignant/no code
Mesenchymal tumors		Granular cell tumor **9580/0** Hemangioma **9120/0**	Non-malignant
Peutz-Jeghers polyp No code	Intraepithelial neoplasia in Peutz-Jeghers polyp(s) Periorificial lentiginosis Peutz-Jeghers polyposis Polyps-and-spots syndrome		Non-malignant/no code

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Specific or NOS Term and Code	Synonyms	Subtype/Variant of NOS with Histology Code	Reason not reportable
Pseudomyxoma peritonei (when pathologist does not designate as malignant OR implants are benign) **8480/1**			Non-malignant. When both implants and site of origin are benign, the case is not reportable.
Sessile serrated adenoma/polyp 8213/0* ***Note:*** No malignancy in polyps	Serrated polyposis Sporadic serrated polyps Traditional serrated adenoma		Non-malignant
Tubular carcinoid, no malignancy 8245/1			Non-malignant

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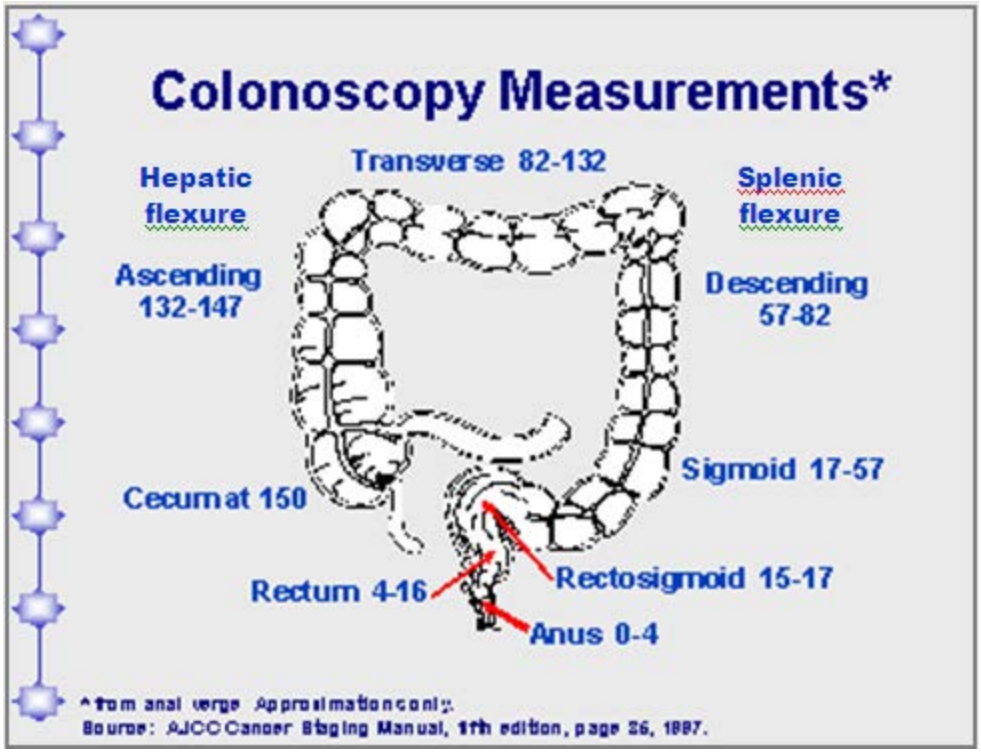
Illustrations

Colonoscopy measurements which may be used to determine primary site when no site is designated



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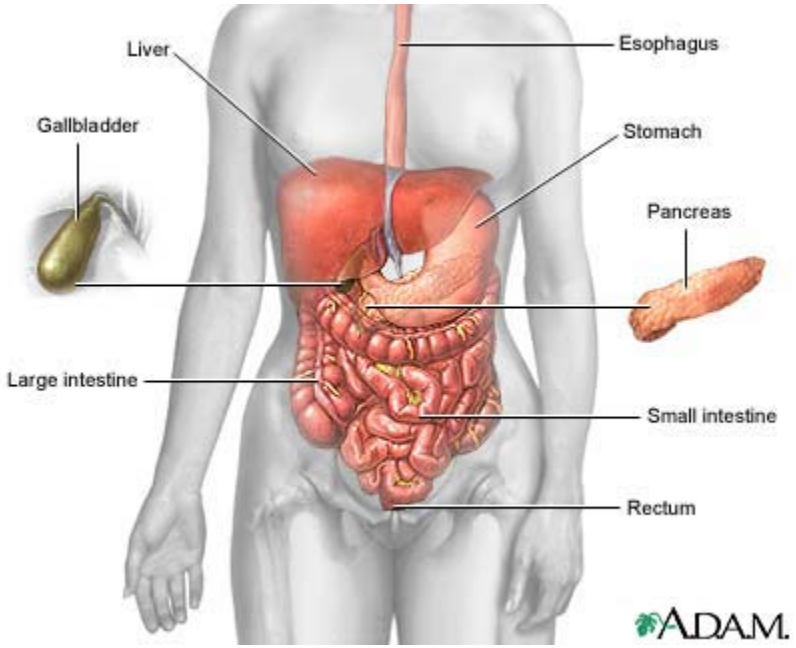
GI System



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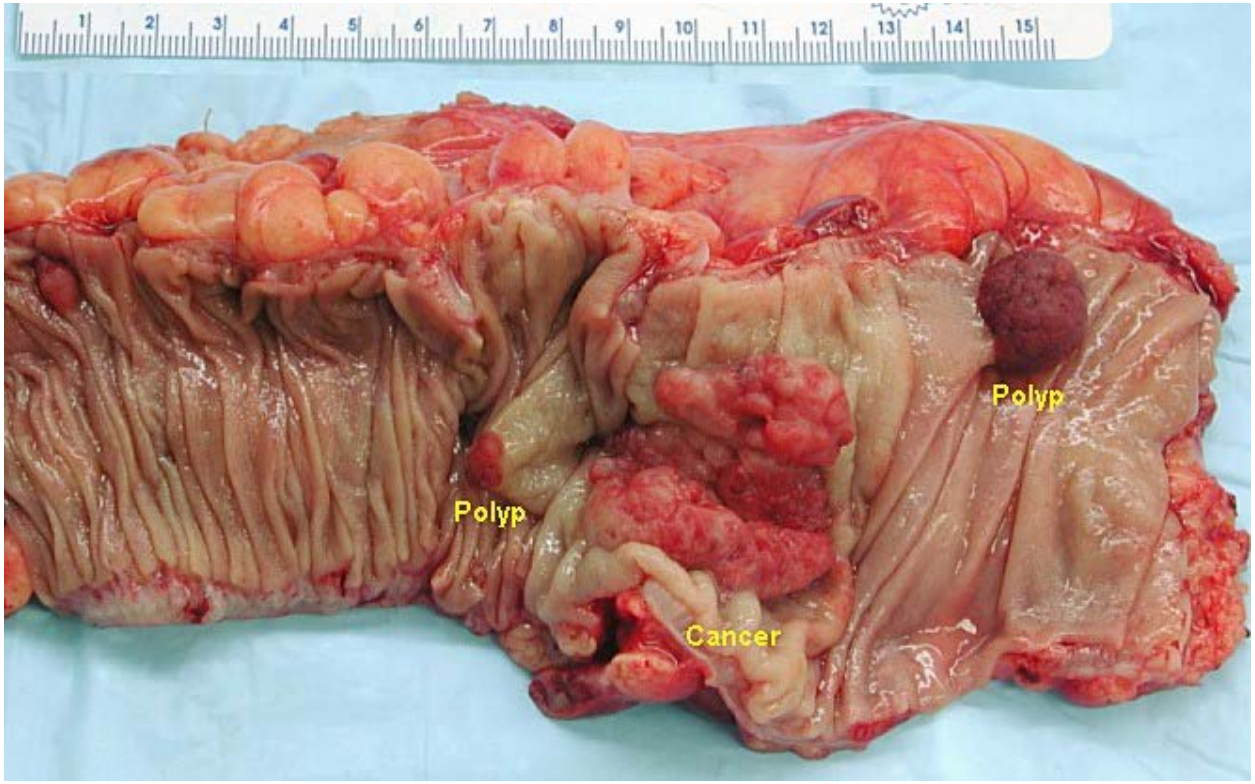
Polyps and de novo or "frank" adenocarcinoma in colon



Source: http://upload.wikimedia.org/wikipedia/commons/4/44/Colon_cancer.jpg

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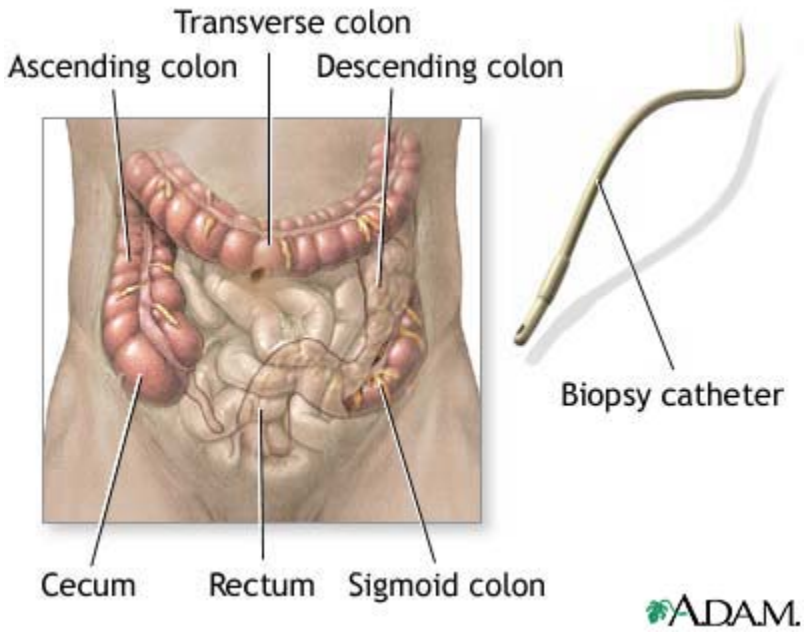
Large intestine; snare instrument to remove polyps



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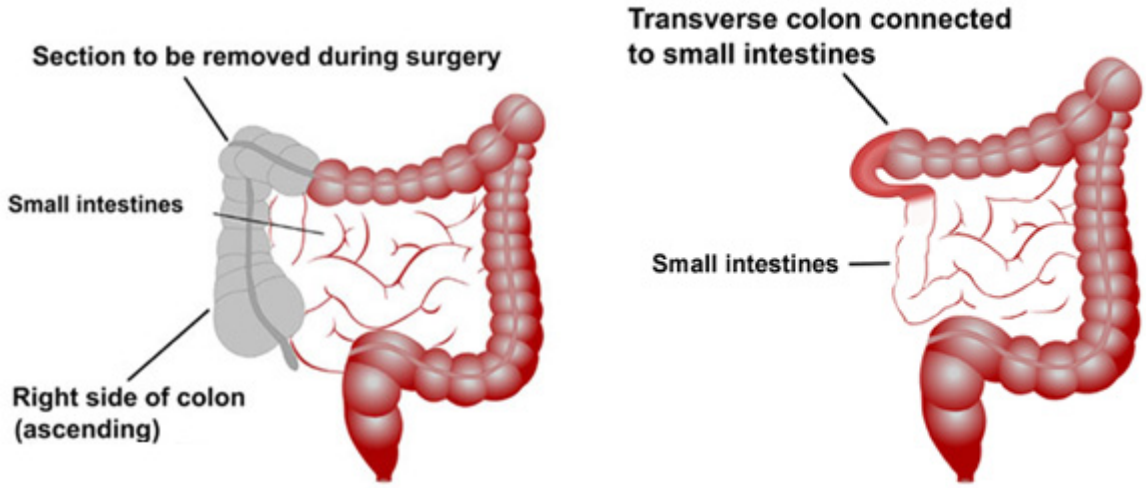
Colon Surgery: Hemicolectomy

The primary treatment for colon cancer is surgery. Part of the large bowel and surrounding lymph nodes are removed. The remaining bowel is then joined together (anastomosis).



http://www.cedars-sinai.edu/Patients/Programs-and-Services/Colorectal-Cancer-Center/Services-and-Treatments/Rectal-Cancer.aspx

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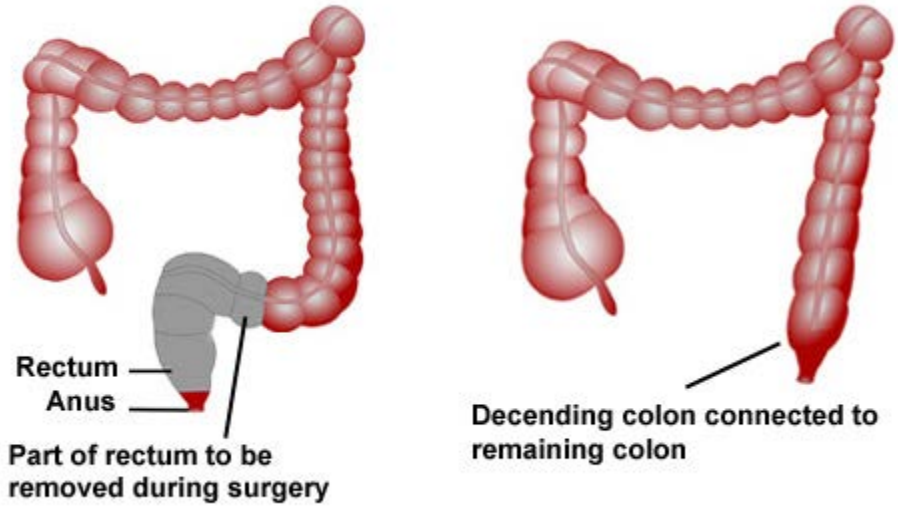
Rectal Surgery



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Note 1: These rules are **NOT** used for tumor(s) described as metastases.
Note 2: 2007 MPH Rules and 2018 Solid Tumor Rules are used based on **date of diagnosis**.

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

Unknown if Single or Multiple Tumors

Note: **Collision tumors** are counted as **two individual** tumors for the purpose of determining multiple primaries. Collision tumors were originally two **separate** tumors that arose in close proximity. As the tumors increased in size, they merged or overlapped each other. Use the Multiple Tumors module.

Rule M1 Abstract a **single primary**[i] 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

[i] **Prepare one abstract. Use the histology rules to assign the appropriate histology code.**

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Single Tumor

Note: **Collision tumors** are counted as **two individual** tumors for the purpose of determining multiple primaries. Collision tumors were originally two **separate** tumors that arose in close proximity. As the tumors increased in size, they merged or overlapped each other. Use the Multiple Tumors module.

Rule M2 Abstract a **single primary**[i] when there is a **single tumor.**
Note 1: A single tumor is always a single primary.
Note 2: The tumor may overlap onto or extend into adjacent/contiguous site or subsites.
Note 3: The tumor may have in situ and invasive components.
Note 4: The tumor may have two or more histologic components.

This is the end of instructions for Single Tumor

[i] **Prepare one abstract. Use the histology rules to assign the appropriate histology code.**

Multiple Tumors

Note 1: Multiple tumors may be a single primary or multiple primaries.
Note 2: **Collision tumors** are counted as **two individual** tumors for the purpose of determining multiple primaries. Collision tumors were originally two **separate** tumors that arose in close proximity. As the tumors increased in size, they merged or overlapped each other. Use the Multiple Tumors module.

Rule M3 Abstract a **single primary**[i] when
- The diagnosis is **adenomatous polyposis coli** (familial polyposis/FAP) **OR**
- There is no diagnosis of FAP **BUT**
  - Greater than 100 polyps are documented **AND**
  - Adenocarcinoma in situ /2 or invasive /3 is present in at least one polyp

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Note 1: A diagnosis of adenomatous polyposis coli (**familial polyposis/FAP**) is made when the patient has **greater than 100** adenomatous polyps. Polyps with adenocarcinoma and benign polyps will be present. Because there are many polyps, the pathologist does not examine every polyp.

Note 2: **In situ /2** and **malignant /3** adenocarcinoma in polyps, malignancies with remnants of a polyp, as well as de novo (previously called frank) malignancies may be present in **multiple segments** of the colon or in both the **colon** and **rectum**. Polyposis **may** be present in other GI sites such as stomach (a de novo does not have to be present; all adenocarcinoma may be in polyps).

Note 3: FAP is a **genetic** disease. The characteristics of FAP are **numerous precancerous polyps** in the colon and rectum when the patient reaches puberty. If not treated, the polyps typically become malignant. Patients often have **total colectomies.**

Note 4: **Multiple polyps** in the colorectum is **not equivalent** to FAP.

Note 5: Code **primary site** as follows:

- Present in more than one segment of colon: **C189** colon, NOS
- Present in colon and rectosigmoid **OR** colon and rectum: **C199** rectosigmoid junction
- Present in colon and small intestine: **C260** intestinal tract, NOS (there is no code for large and small bowel)

Note: In addition to the colon and small intestine, FAP may also be present in the:

- Stomach **AND/OR**
- Rectosigmoid **AND/OR**
- Rectum

Example: The patient has a diagnosis of FAP. The operative report and physician's documentation say that polyps with adenocarcinoma were present in specimens removed from the ascending colon and the sigmoid colon. The ascending and sigmoid colon are part of the large bowel. Code the primary site **C189** colon NOS.

Rule M4 Abstract **multiple primaries**[ii] when there are separate, non-contiguous tumors in sites with ICD-O site codes that **differ** at the second C**X**xx and/or third Cx**X**x character.

Note 1: Definition of separate/non-contiguous tumors: at least two malignancies which **do not** overlap/merge.

Note 2: **Differences** at either the **second** or **third** characters are different primary sites/multiple primaries.

Example 1: Breast C**50**x and colon C**18**x

Example 2: Colon C**18**x and rectum C**20**9 (This does not include FAP- see earlier rules)

Note: This rule **does not** apply to a single **overlapping** malignancy of colon and rectum.

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

Rule M5 Abstract **multiple primaries**[ii] when separate/non-contiguous tumors are two or more different **subtypes/variants** in Column 3, **Table 1** 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**: Medullary carcinoma NOS 8510/3 and tubulopapillary adenocarcinoma 8263/3 are both subtypes of adenocarcinoma NOS 8140/3 but are distinctly different histologies. Abstract multiple primaries.
- **Different NOS**: Goblet cell carcinoid 8243/3 is a subtype of mixed adenoneuroendocrine carcinoma 8244/3; somatostatin-producing NET 8156/3 is a subtype of neuroendocrine tumor Grade 1 (G1) 8240/3. They are distinctly different histologies. Abstract multiple primaries.

Rule M6 Abstract **multiple primaries**[ii] when separate/non-contiguous tumors are on **different rows in Table 1** in the Equivalent Terms and Definitions. Timing is irrelevant.

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

Rule M7 Abstract **multiple primaries**[ii] when a subsequent tumor arises at the **anastomotic** site **AND:**

- One tumor is a **NOS** and the other is a **subtype/variant** of that NOS **OR**
- The subsequent tumor occurs **greater than 24 months** after original tumor resection **OR**
- The **subsequent** tumor arises in the **mucosa**

Note: Bullet three does not apply to GIST. GISTs only start in the wall; never in the mucosa.

Example: (For bullet 1: NOS and subtype/variant) The original tumor was adenocarcinoma NOS **8140**. The patient had a hemicolectomy. There was a recurrence at the **anastomotic** site diagnosed exactly as **mucinous** adenocarcinoma **8480.** Mucinous adenocarcinoma is a subtype/variant of the NOS adenocarcinoma, but they are two different histologies. **Code two primaries,** one for the original adenocarcinoma NOS and another for the subsequent anastomotic site mucinous adenocarcinoma.

Note 1: There may or may not be **physician documentation** of anastomotic recurrence. Follow the rules.

Note 2: When the original tumor was diagnosed prior to 1/1/2018 and was coded to adenocarcinoma in a polyp, and the anastomotic site tumor is adenocarcinoma per 2018 rules, the tumors are the same histology. ICD-O codes differ because of changes in histology coding rules. Continue through the rules.

Note 3: The tumor may or may not invade into the colon wall or adjacent tissue.

Note 4: These rules are hierarchical. Only use this rule when previous rules do not apply.

Jump to **Equivalent Terms and Definitions**
Jump to **Histology Coding Rules**

Colon, Rectosigmoid, and Rectum Multiple Primary Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590-M9992 and Kaposi sarcoma M9140)

Rule M8 Abstract a **single primary**[i] when a subsequent tumor arises at the **anastomotic** site **AND:**

- The subsequent tumor occurs **less than or equal to 24 months** after original tumor resection **OR**
- The tumor arises in **colon/rectal wall** and/or surrounding tissue; there is **no involvement** of the **mucosa OR**
- The pathologist or clinician documents an **anastomotic recurrence**

Note 1: The physician may stage the subsequent tumor because the depth of invasion determines the second course of treatment.

Note 2: These tumors are a single primary/**recurrence**. Registrars that collect recurrence information should record the information in the recurrence fields.

Rule M9 Abstract **multiple primaries**[ii] when there are separate, non-contiguous tumors in sites with ICD-O site codes that **differ** at the fourth characters C18**X**.

Note: Differences at the fourth character include different segments of the colon. Abstract a primary for each separate non-contiguous tumor in a different segment of the colon. This rule is not used for colon NOS C189. C189 is rarely used other than DCO.

Example: The patient has adenocarcinoma in situ in a **sigmoid** polyp and mucinous adenocarcinoma in a polyp in the **descending** colon, the site code differs at the fourth character (sigmoid C18**7** and descending C18**6**). **Code two primaries**, one for the sigmoid and another for the descending colon.

Rule M10 Abstract **multiple primaries**[ii] when the patient has a subsequent tumor after being **clinically disease-free** for **greater than one year** after the original diagnosis or last recurrence.

Note 1: **Clinically** disease-free means that there was **no evidence** of recurrence on follow-up.

- Colonoscopies are NED
- Scans are NED

Note 2: When there is a recurrence less than or equal to one year 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 one year** from the date of the last recurrence.

Note 3: When the first course of treatment was a **polypectomy** only, this rule means there were **no recurrences** for greater than one year.

Note 4: When the first course of treatment was a **colectomy or A&P resection**, there were **no anastomotic recurrences** for greater than one year.

Note 5: When it is **unknown/not documented** whether the patient had a recurrence, default to **date of diagnosis** to compute the time interval.

Note 6: The physician may state this is a **recurrence,** meaning the patient had a previous colon tumor and now has another colon tumor. **Follow the rules;** do not attempt to interpret the physician's statement.

Jump to **Equivalent Terms and Definitions**
Jump to **Histology Coding Rules**

Colon, Rectosigmoid, and Rectum Multiple Primary Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590-M9992 and Kaposi sarcoma M9140)

Rule M11 Abstract a **single primary**[i] when separate/non-contiguous tumors are on **the same row in Table 1** in the Equivalent Terms and Definitions. Timing is irrelevant.

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

Note 2: The same row means the tumors are:

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

Note 3: The tumors may be de novo (formerly called frank) and carcinoma in a polyp.

Note 4: The tumors may be adenocarcinoma in multiple polyps **8221**.

Rule M12 Abstract a **single primary**[i] (the invasive) when an **in situ** tumor is diagnosed **after** an **invasive** tumor.

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

Note 2: The tumors **may** be a **NOS** and a **subtype/variant** of that NOS. See **Table 1** in the Equivalent Terms and Definitions for listings of NOS and subtype/variants.

Note 3: The **in situ** is recorded as a **recurrence** for those registrars who collect recurrence data.

Rule M13 Abstract a **single primary**[i] (the invasive) when an invasive tumor is diagnosed **less than or equal to 60 days** after an **in situ** tumor.

Note 1: The rules are hierarchical**.** Only use this rule when previous rules do not apply.

Note 2: **Change behavior** code on original abstract from /2 to /3. **Do not** change **date of diagnosis**.

Note 3: If the case has already been submitted to the central registry, **report** all changes.

Note 4: 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 5: See the **COC** and **SEER manuals** for **instructions** on coding **data items** such as Date of Diagnosis, Accession Year and Sequence Number.

Rule M14 Abstract **multiple primaries**[ii] when an **invasive** tumor occurs **more than 60 days** after an **in situ** tumor.

Note 1: Abstract both the invasive and in situ tumors.

Note 2: Abstract as multiple primaries even if physician states the invasive tumor is disease recurrence or progression. 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 authors, co-authors, or editors of the AJCC Staging Manual.

Jump to **Equivalent Terms and Definitions**
Jump to **Histology Coding Rules**

Rule M15 Abstract a **single primary**[i] when tumors do not meet any of the above criteria.
Note: Use caution when applying this default rule. Please confirm that you have not overlooked an applicable rule.

This is the end of instructions for Multiple Tumors.

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[i] Prepare one abstract. Use the histology rules to assign the appropriate histology code. For registries collecting recurrence data: When a subsequent tumor is "single primary," record that subsequent tumor as a recurrence.
[ii] Prepare two or more abstracts. Use the histology rules to assign the appropriate histology code to each case abstracted.

Jump to **Equivalent Terms and Definitions**
Jump to **Histology Coding Rules**

Note 1: **Ignore** the terms "**cribriform**" and "**comedo**" when they are used to describe the histology or are mentioned in the microscopic portion of the path report.

Note 2: **Collision tumors** are counted as two individual tumors for the purpose of determining multiple primaries. Collision tumors were originally two separate tumors that arose in close proximity. As the tumors increased in size, they merged or overlapped each other. Use the Multiple Tumors module.

Priority Order for Using Documentation to Identify Histology

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

This is a hierarchical list of source documentation.
Code the **most specific** pathology/tissue from either **resection** or **biopsy**.
Note: The term "most specific" usually refers to a subtype/variant.

1. **Biomarkers**
2. **Tissue or pathology report** (in priority order)
   A. Addendum(s) and/or comment(s)
   B. Final diagnosis
   C. CAP protocol

   Note 1: Addendums and comments on the pathology report are given a high priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.

   Note 2: The pathologist's diagnosis from the pathology report is always reliable, so the final diagnosis is the second priority.

   Note 3: The CAP protocol is a checklist which:
   - Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care
   - Allows physicians to check multiple histologies

   Note: The CAP protocol must be documented in one location. Most frequently, in the:
   - The pathology final diagnosis
   - Addendum to the path report
3. Tissue/pathology from a **metastatic** site

   Note 1: Code the behavior /3.

Jump to **Equivalent Terms and Definitions**
Jump to **Multiple Primary Rules**

Note 2: The tissue from a **metastatic s**ite often shows **variations** from the primary tumor. When it is the only tissue available, it is more accurate than a scan.

4. **Scan:** The following list is in **priority order**.
   A. CT
   B. PET
   C. MRI
5. 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.
6. **Cytology** (seldom used for colon, rectosigmoid and rectum)

Coding Multiple Histologies

1. **Code** histology when the:
   A. **Exact term is documented OR**
   B. **Histology is described as**
      - Subtype
      - Type
      - Variant
2. **Do not** code the histology when:
   A. The following **modifiers** are used as a descriptor:
      - Architecture
      - Differentiation

      Note: Only **code differentiation** when there is **a specific code** for the NOS with differentiation in **Table 1** in the Equivalent Terms and Definitions, **ICD-O** and all **updates.**

Jump to **Equivalent Terms and Definitions**
Jump to **Multiple Primary Rules**

- Features (of)/with features of
  Note: Only **code features** when there is **a specific code** for the NOS with features in **Table 1** in the Equivalent Terms and Definitions, **ICD-O** and all **updates.**
- Foci; focus, focal
- Major/majority of
  Note: Major/majority describes the greater amount of tumor.
- Pattern(s)
- Predominantly
  Note: Predominantly describes the greater amount of tumor.

Example 1: Adenocarcinoma with papillary features is coded 8140/3 (features is ignored).
Example 2: Adenocarcinoma with neuroendocrine differentiation is coded 8574/3 (there is a specific code for adenocarcinoma with neuroendocrine differentiation).

B. The following **ambiguous terminology** is used as a modifier:

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

Note 1: See **SEER Program Manual** and COC Manual. **Ambiguous** terminology is used to **determine reportability.**
Note 2: Histology described by ambiguous terminology is coded **ONLY** when a case is accessioned based on ambiguous terminology and no other histology information is available/documented.

Jump to **Equivalent Terms and Definitions**
Jump to **Multiple Primary Rules**

Colon, Rectosigmoid, and Rectum Histology Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590-M9992 and Kaposi sarcoma M9140)

Single Tumor

Rule H1 Code adenocarcinoma with neuroendocrine differentiation **8574** when the final diagnosis is **exactly** "adenocarcinoma with neuroendocrine differentiation".

Note: **Do not** use this code when:

- The diagnosis is any subtype/variant of adenocarcinoma with neuroendocrine differentiation
- Any modifier other than differentiation is used, i.e. adenocarcinoma with neuroendocrine features

Rule H2 Code the **specific histology** and **ignore the polyp** when a carcinoma **originates** in a **polyp.**

Note 1: This is a **change** from the **2007** MPH rules which instructed registrars to use the codes for malignancies in a polyp, such as adenocarcinoma in a polyp **8210.**

Note 2: Sufficient data has been collected to:

- Determine the frequency with which carcinomas arise within polyps
- Establish patient care guidelines for individuals with colon polyps

Example: Colonoscopy with polypectomy finds mucinous adenocarcinoma in the polyp. Code mucinous adenocarcinoma **8480.**

Rule H3 Code combined small cell carcinoma **8045** when the final diagnosis is **small cell** carcinoma **AND any other carcinoma.**

Examples:

- Small cell carcinoma **8041** and adenocarcinoma **8140**
- Small cell carcinoma **8041** and neuroendocrine carcinoma **8246**

Rule H4 Code **mixed mucinous and signet ring cell** as follows:

- Adenocarcinoma with mucinous and signet ring features – code adenocarcinoma **8140**
- Mucinous carcinoma and signet ring cell carcinoma:
  - Mucinous carcinoma documented as **greater than 50%** – code mucinous carcinoma **8480**
  - Signet ring cell carcinoma documented as **greater than 50%** – code signet ring cell carcinoma **8490**
  - Percentage of mucinous carcinoma and signet ring cell carcinoma **unknown/not designated**- code adenocarcinoma mixed subtypes **8255**

Jump to **Equivalent Terms and Definitions**
Jump to **Multiple Primary Rules**

Rule H5 Code adenocarcinoma NOS **8140** when the final diagnosis is:

- Two histologies:
  - Adenocarcinoma and mucinous carcinoma
    - Percentage of mucinous **unknown/not documented**
    - Mucinous documented as less than 50% of tumor
  - Adenocarcinoma and signet ring cell carcinoma
    - Percentage of signet ring **unknown/not documented**
    - Signet ring cell documented as less than 50% of tumor
- Adenocarcinoma in a polyp **OR**

  Note 1: This is a **change** from **2007** MPH rules.

  Note 2: **Sufficient data** has been collected to determine the frequency with which carcinomas arise within polyps as well as establish patient care guidelines for individuals with colon polyps**.**
- **Exactly** adenocarcinoma **OR**
- **Intestinal** type adenocarcinoma **OR** adenocarcinoma intestinal type (no modifiers or additional histologic terms).

  Note 1: Code **8140 adenocarcinoma NOS** even if pathology says intestinal type adenocarcinoma.

  Note 2: Do **not** use code **8144** adenocarcinoma intestinal type in **colorectal** primaries. Intestinal type adenocarcinoma 8144 is used for tumors which occur in the stomach, head and neck, and specific GYN sites. It is called intestinal because it resembles carcinoma which occurs in the colon, rectosigmoid or rectum.

  Note 3: When a diagnosis of intestinal type adenocarcinoma is **further described** by a **specific term** (such as mucinous intestinal type adenocarcinoma or signet ring cell intestinal type adenocarcinoma), it would be treated as an adenocarcinoma with a **subtype/variant**.

Rule H6 Code invasive **mucinous** adenocarcinoma **8480** when the diagnosis is any of the following:

- **Exactly** "**mucinous** adenocarcinoma" (no modifiers)
- **High-grade** pseudomyxoma peritonei
- **Invasive** pseudomyxoma peritonei
- **Malignant** pseudomyxoma peritonei

Note 1: Be very **careful** when **determining primary** site; almost all pseudomyxoma peritonei originate in the appendix C181. However, it **can be metastatic** disease from sites such as bowel, ovary, or bladder. Code the primary site as designated by a physician. When the primary site is not designated, code unknown primary **C809** and the histology as mucinous carcinoma **8480.**

Jump to **Equivalent Terms and Definitions**
Jump to **Multiple Primary Rules**

Note 2: Report the appendiceal mucinous neoplasm as malignant /3 using the ICD-O matrix principle and the SEER and COC Manuals when the **pathology** from the appendix is **low-grade mucinous** neoplasm (not reportable) **AND**

- The pseudomyxoma peritonei are **high-grade**/invasive/malignant **OR**
- Patient is **treated** for malignant pseudomyxoma peritonei

Note 3: The following are **non-reportable:**

- Appendiceal neoplasm with **low-grade** pseudomyxoma peritonei **AND no treatment**
- **No designation** of high- or low-grade for the appendiceal neoplasm **AND no treatment** for the pseudomyxoma peritonei

Rule H7 Code the histology when only **one histology** is present.

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

Note 2: Use the ICD-O and all updates when the histology is not listed in Table 1.

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

Rule H8 Code the **invasive** histology **when in situ** and **invasive** histologies are present in the **same tumo**r.

Rule H9 Code the **subtype/variant** when there is a **NOS** and a **single subtype/variant** of that NOS such as the following:

- Adenocarcinoma **8140** and a subtype/variant of adenocarcinoma
- Mixed adenoneuroendocrine carcinoma **8244** and a subtype/variant of mixed adenoneuroendocrine carcinoma
- Neuroendocrine carcinoma **8246** and a subtype/variant of neuroendocrine carcinoma
- Neuroendocrine tumor Grade 1 (G1) **8240** and a subtype/variant of neuroendocrine tumor Grade 1 (G1)
- Sarcoma **8800** and a subtype/variant of sarcoma

Note 1: See **Table 1** in the Equivalent Terms and Definitions to find NOS and subtypes/variants.

Note 2: Only code subtypes/variant when pathology gives an **exact diagnosis**. **Do not** code the subtype/variant when **modified** by terms such as **differentiation, features of, etc., unless** there is a specific code for the histology term with the modifier.

This is the end of instructions for Single Tumor.

Code the histology using the rule that fits the case.

Jump to **Equivalent Terms and Definitions**
Jump to **Multiple Primary Rules**

Colon, Rectosigmoid, and Rectum Histology Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590-M9992 and Kaposi sarcoma M9140)

Multiple Tumors Abstracted as a Single Primary

Note: Multiple tumors **must be a single primary** to use this module. **See** the **Multiple Primary Rules** to determine whether these tumors are a single primary.

Rule H10 Code adenocarcinoma in familial adenomatous polyposis coli (**FAP**) **8220** when:

- **Clinical** history says the patient has **familial polyposis AND**
  - The final diagnosis on the **pathology report** from resection is **adenocarcinoma in FAP OR**
  - There are **greater than 100 polyps** identified in the resected specimen

Note 1: Use this rule **only** when there are **multiple polyps**. **Do not** use for a single polyp (adenoma) or for a de novo (frank) malignancy and a malignancy in a single polyp.
Note 2: Use this rule **ONLY** for adenocarcinoma in **FAP.**
Note 3: The disease process, treatment, and prognosis for FAP is not as favorable as a single polyp with adenocarcinoma.

Rule H11 Code adenocarcinoma in multiple adenomatous polyps **8221** when FAP is not mentioned **AND**

- There are at least 2 polyps with adenocarcinoma /2 or /3 **AND**
  - Less than or equal to 100 polyps are identified **OR**
  - The exact number of polyps is unknown/not documented

Note 1: **Do not use** this code for a malignancy in **a single polyp** (adenoma) or for a de novo (frank) malignancy.
Note 2: Use this rule **ONLY** for **adenocarcinoma NOS** in multiple polyps**.**

Rule H12 Code the histology of the **invasive** tumor when there are **in situ** /2 and **invasive** /3 tumors.

- One tumor is in situ and the other is invasive
- All tumors are a **mixture** of **in situ** and **invasive** histology

Rule H13 Code the histology when only **one** histology is present in **all** tumors.

Note 1: Use **Table 1** to code histology. New codes, terms, and synonyms are included in **Table 1** and coding errors may occur if the table is not used.
Note 2: When the histology is **not listed** in **Table 1,** 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 1, ICD-O or all updates.

Jump to **Equivalent Terms and Definitions**
Jump to **Multiple Primary Rules**

Rule H14 Code the **subtype/variant** when the diagnosis is a **NOS** and a **single subtype/variant** of that NOS such as the following:

- Adenocarcinoma **8140** and a subtype/variant of adenocarcinoma
- Mixed adenoneuroendocrine carcinoma **8244** and a subtype/variant of mixed adenoneuroendocrine carcinoma
- Neuroendocrine carcinoma **8246** and a subtype/variant of neuroendocrine carcinoma
- Neuroendocrine tumor Grade 1 (G1) **8240** and a subtype/variant of neuroendocrine tumor Grade 1 (G1)
- Sarcoma **8800** and a subtype/variant of sarcoma

Note 1: All tumors may be **mixed** histologies (NOS and a subtype/variant of that NOS) **OR** one tumor may be a **NOS** histology and the other tumor a **subtype/variant** of that NOS.

Note 2: See **Table 1** in the Equivalent Terms and Definitions to find NOS and subtypes/variants.

Note 3: Check the **Multiple Primary Rules** to confirm that the tumors are a single primary.

Note 4: Only code subtypes/variant when pathology gives an **exact diagnosis**. **Do not** code the subtype/variant when **modified** by terms such as **differentiation, features of, etc., unless** there is a specific code for the histology term with the modifier.

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

Code the histology using the rule that fits the case.

Jump to **Equivalent Terms and Definitions**
Jump to **Multiple Primary Rules**