The WHO Classification of Tumors of the Digestive System was updated in 2010. The new terms and the new codes are based on the 2010 edition.

Most Frequent Histologies
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 adeno 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 a neuroendocrine carcinoma arising from with a NET (including specific types of NET-like goblet cell carcinoid). Over time, the histologic diagnoses will change to MANEC.

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 intestinal cells of Cajal, neuro-regulatory cells in the GI tract. Prior to the implementation of an ICD-O-3 histology/morphology 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
Colon, Rectosigmoid, and Rectum Equivalent Terms, Definitions
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(Excludes lymphoma and leukemia M9590-9992 and Kaposi sarcoma M9140)

Major Changes from 2007 MP/H Rules

1. Neuroendocrine tumors (formerly carcinoid) arising in the appendix are reportable.
2. 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
3. There are dysplasias which have an in situ behavior code /2 in WHO and in the ICD-O-3 Addendum. 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
4. Polyps are disregarded when coding histology. For example, adenocarcinoma in an adenomatous polyp is coded as adenocarcinoma 8140.

Equivalent or Equal Terms

- Carcinoid, NET, neuroendocrine tumor
- Carcinoma, carcinoma NOS, adenocarcinoma; adenocarcinoma NOS, intestinal type adenocarcinoma 8140
- Familial polyposis, familial adenomatous polyposis (FAP) 8220
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- Intramucosal, lateral extension
- Invasion through colon wall, extension through colon wall, transmural
  
  **Note 1:** The term “transmural” to be 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.

  **Note 2:** These words are used for determining multiple primaries **ONLY.** **DO NOT** use these terms for reportability (casefinding).

- 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 of polyps include hyperplastic, juvenile, Peutz-Jeghers and serrated adenoma/polyp.

- Serosa, visceral peritoneum
- Tumor, mass, lesion, neoplasm

### Terms that are NOT Equivalent or Equal

- 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.

- Mucin-producing adenocarcinoma 8481 and mucin-secreting adenocarcinoma 8481 are **not** synonymous with mucinous/colloid adenocarcinoma 8480.

- Polypoid adenocarcinoma is **not equivalent to** adenocarcinoma in a polyp

### Solid Tumor Rules Do NOT Apply to Tumors Described as Metastases

Each of the sections in the Multiple Primary Rules begins with a note that reads “These rules are **not** used for tumor(s) described as metastases”. This means a tumor in the primary site and a tumor in a metastatic site are **not counted as multiple tumors** when

- Using the Multiple Primary rules
- Deciding whether to use the single or multiple tumor modules in the Histology Rules

For colon and rectal primaries, **metastatic tumors include**

- Tumors in the colon or rectum that are metastatic from another site AND
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(Excludes lymphoma and leukemia M9590-9992 and Kaposi sarcoma M9140)

- **Metastases from** the primary tumor in the colon or rectum which may be **local**, **regional** or **distant**

  See the following: examples of metastases  
  1. **L**=Discontinuous local metastatic deposits/foci and local recurrence at site of anastomosis: (See Multiple Primary rules)  
  2. Regional metastases  
     a. Discontinuous metastases in a contiguous tissue/organ/site(s)  
     b. Regional lymph node metastases  
  3. Distant metastases  
     a. Distant lymph nodes (not listed as regional in current AJCC Manual)  
     b. Distant sites such as liver, lung, peritoneum, bones, brain and spinal cord

### Table 1: Colon, Rectum, and Appendix Histologies; NOS and Variants or Subtypes

**Terms that CAN be used to identify subtypes/variants**

1. Majority  
2. Predominantly  
3. Subtype  
4. Type  
5. Variant

**Terms that CANNOT be used to identify subtypes/variants**

Note: Only **code differentiation** or **features** when there is a **specific code** for the NOS with differentiation, features or type in **Table 1** or the **ICD-O**.

1. Architecture  
2. Component  
   a. The word “component” simply means there is another histology  
   b. Component does not describe the majority of tumor
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3. Differentiation
4. Features (of)
5. Foci; focus, focal
6. Pattern(s)

Table Instructions
This table includes the most common types of malignancies found in the colon, rectum, and appendix.

Note 1: In an effort to shorten the table:
- Behavior codes are not listed. Code the behavior in situ /2 or malignant /3 as listed in the pathology report
- NOS and specific histologies are combined in Column 1
  - NOS histologies have subtype(s) variant(s)
  - Specific histologies do not have subtypes/variants

Note 2: Typical colon, rectal, and appendiceal carcinomas may exhibit comedo features or differentiation. Comedo carcinoma describes the type of tumor rather than a true histologic subtype/variant of adenocarcinoma. It is therefore coded to adenocarcinoma 8140.

Note 3: There are rare colon/rectum histologies which are not listed in the table. Code the rare histologies to the proper primary site and ICD-O-3 code. Edit overrides may be necessary in some cases.

Note 4: The terms diffuse carcinoma and adenocarcinoma diffuse type are not commonly used.

Column 1 lists the NOS or specific ICD-O histology/morphology term and code
Column 2 lists Synonyms for the NOS term. Synonyms have the same ICD-O histology/morphology code as the NOS term in Column 1.
Column 3 lists the subtypes/variants of the NOS followed by the ICD-O histology code in bold
  - Subtypes/variants do not have the same ICD-O histology code as the NOS

<table>
<thead>
<tr>
<th>Specific and NOS Term and Code</th>
<th>Synonyms for Specific or NOS Term</th>
<th>Subtypes/variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenocarcinoma 8140</td>
<td>Adenocarcinoma, NOS</td>
<td>Adenocarcinoma, cribriform comedo-type 8201*</td>
</tr>
<tr>
<td>Adenocarcinoma/carcinoma in a polyp NOS (now coded to 8140)</td>
<td>Adenocarcinoma/carcinoma in adenomatous polyp (now coded to 8140)</td>
<td>Adenocarcinoma, undifferentiated type 8020</td>
</tr>
<tr>
<td>Adenocarcinoma/carcinoma in polyp (now coded to 8140)</td>
<td>Adenocarcinoma, mucinous and signet ring cell features (% not specified) 8255</td>
<td>Adenocarcinoma, diffuse type 8145</td>
</tr>
</tbody>
</table>

**Note 1:** See Histology Rule H4 for instructions on coding adenocarcinoma
Colon Terms and Definitions
Colon, Rectosigmoid, and Rectum Equivalent Terms, Definitions
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590-9992 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Specific and NOS Term and Code</th>
<th>Synonyms for Specific or NOS Term</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>subtypes/variants</strong> arising in a polyp</td>
<td>Adenocarcinoma/carcinoma in polypoid adenoma (now coded to 8140)</td>
<td>Adenoid cystic carcinoma 8200</td>
</tr>
<tr>
<td></td>
<td>Adenocarcinoma/carcinoma in serrated adenoma (now coded to 8140)</td>
<td>Carcinoma, diffuse type 8145</td>
</tr>
<tr>
<td></td>
<td>Adenocarcinoma/carcinoma in tubular polyp/adenoma (now coded to 8140)</td>
<td>Carcinoma, undifferentiated type NOS 8020</td>
</tr>
<tr>
<td></td>
<td>Adenocarcinoma/carcinoma in tubulovillous polyp/adenoma (now coded to 8140)</td>
<td>Colloid adenocarcinoma 8480</td>
</tr>
<tr>
<td></td>
<td>Adenocarcinoma/carcinoma in villous adenoma (now coded to 8140)</td>
<td>Colloid carcinoma 8480</td>
</tr>
<tr>
<td></td>
<td>Adenocarcinoma in any type of polyp Adenocarcinoma, intestinal type</td>
<td>Cribriform carcinoma NOS 8201*</td>
</tr>
<tr>
<td></td>
<td>Adenocarcinoma with &lt;50% composed of cribriform carcinoma</td>
<td>Cribriform comedo-type adenocarcinoma 8201*</td>
</tr>
<tr>
<td></td>
<td>Comedo carcinoma</td>
<td>Diffuse adenocarcinoma 8145</td>
</tr>
<tr>
<td></td>
<td>Intestinal adenocarcinoma</td>
<td>Gelatinous adenocarcinoma [OBS] 8480</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gelatinous carcinoma [OBS] 8480</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Linitis plastica 8142/3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medullary adenocarcinoma 8510</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medullary carcinoma NOS 8510</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Micropapillary carcinoma 8265*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mucinous adenocarcinoma 8480</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mucinous carcinoma and signet ring cell carcinoma (% not specified) 8255</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mucinous carcinoma and signet ring cell carcinoma (&gt;50% mucinous) 8480</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mucoepidermoid carcinoma 8430</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mucoepidermoid carcinoma 8480</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Micropapillary carcinoma 8265*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mucous adenocarcinoma 8480</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mucous carcinoma 8480</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Papillotubular adenocarcinoma 8263</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Poorly cohesive carcinoma 8490</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Serrated adenocarcinoma 8213*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Signet ring cell adenocarcinoma 8490</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Signet ring cell carcinoma 8490</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Superficial spreading adenocarcinoma 8143</td>
</tr>
</tbody>
</table>

**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.
## Colon, Rectosigmoid, and Rectum Equivalent Terms, Definitions
### C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590-9992 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Specific and NOS Term and Code</th>
<th>Synonyms for Specific or NOS Term</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
</table>
| **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 and squamous cell/epidermoid carcinoma* | Tubulopapillary carcinoma **8263** |
| **Angiosarcoma 9120** | Hemangiosarcoma | |
| **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** | Gastrointestinal stromal tumor, malignant  
GIST, malignant | |
| **Invasive high-grade pseudomyxoma peritonei 8480** | | |
| *Note 1: Common site: appendix (See Histology Rule H6-Pseudomyxoma peritonei may originate in other organs)*  
*Note 2: Invasive and/or high-grade must be designated by pathologist* | | |
| **Leiomyosarcoma 8890** | Leiomyosarcoma NOS | |
| **Mixed adenoneuroendocrine carcinoma 8244** | Adenocarcinoma mixed with high-grade large cell neuroendocrine carcinoma | Goblet cell carcinoid **8243** |
Colon, Rectosigmoid, and Rectum Equivalent Terms, Definitions
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590-9992 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>Specific and NOS Term and Code</th>
<th>Synonyms for Specific or NOS Term</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neuroendocrine carcinoma 8246</strong></td>
<td>Adenocarcinoma mixed with high-grade small cell neuroendocrine carcinoma Any type of carcinoid mixed with neuroendocrine carcinoma MANEC</td>
<td></td>
</tr>
<tr>
<td>Neuroendocrine tumor Grade 1 8240</td>
<td>Carcinoid NOS Low-grade neuroendocrine tumor NET G1 NET Grade 1 Well differentiated neuroendocrine tumor</td>
<td>EC cell serotonin-producing NET 8241 Enterochromaffin cell carcinoid 8241 NET G2 8249 NET Grade 2 8249 Neuroendocrine tumor Grade 2 8249 Somatostatin-producing NET 8156</td>
</tr>
<tr>
<td>Poorly cohesive carcinoma 8490</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spindle cell carcinoma 8032</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Squamous cell carcinoma 8070</td>
<td>Epidermoid carcinoma NOS Squamous cell carcinoma NOS Squamous cell epithelioma</td>
<td></td>
</tr>
<tr>
<td>Undifferentiated carcinoma 8020</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Table 2: ICD-O Histology/Morphology Not Reportable for Colon, Rectum, and Appendix

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

*Note*: For this table ONLY, the term **benign** is used to describe tumors that are **non-malignant** (0 or 1). The table would become cumbersome if every term contained both a benign and borderline entry and code.

<table>
<thead>
<tr>
<th>ICD-O Histology/Morphology Specific or NOS Term and Code</th>
<th>Synonym(s) of Specific or NOS</th>
<th>Subtype/Variant of NOS with ICD-O Histology/Morphology Code in Bold</th>
<th>Why not reportable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenoma 8140/0</td>
<td>Adenoma NOS</td>
<td>Tubular adenoma 8211/0 Tubulovillous adenoma 8263/0 Villous adenoma 8261/0</td>
<td>Non-malignant</td>
</tr>
<tr>
<td><em>Note</em>: No malignancy in polyps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cowden-associated polyp No code</td>
<td>Cowden disease Cowden syndrome Multiple hamartoma syndrome</td>
<td></td>
<td>Non-malignant /no code</td>
</tr>
<tr>
<td><em>Note</em>: No malignancy in polyps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dysplasia, high grade 8148/2</td>
<td>High-grade dysplasia</td>
<td></td>
<td><strong>NOT REPORTABLE in US</strong>: Currently the United States is not collecting dysplasia</td>
</tr>
<tr>
<td><em>Note</em>: Colorectal primaries only (C190-C189 and C209)</td>
<td>Intraepithelial neoplasia, high grade</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Note</em>: Canada collects these neoplasms as adenocarcinoma in situ in a polyp</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dysplasia, low grade 8148/0*</td>
<td>Intraepithelial neoplasia, low grade</td>
<td></td>
<td>Non-malignant</td>
</tr>
<tr>
<td><em>Note</em>: Colorectal primaries only (C190-C189 and C209)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Colon Terms and Definitions**

**Colon, Rectosigmoid, and Rectum Equivalent Terms, Definitions**  
C180-C189, C199, C209  
(Excludes lymphoma and leukemia M9590-9992 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>ICD-O Histology/Morphology Specific or NOS Term and Code</th>
<th>Synonym(s) of Specific or NOS</th>
<th>Subtype/Variant of NOS with ICD-O Histology/Morphology Code in Bold</th>
<th>Why not reportable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Familial adenomatous polyposis (FAP) No code</td>
<td>Adenomatous polyposis coli</td>
<td></td>
<td>Reportable only when there is cancer in a polyp</td>
</tr>
<tr>
<td></td>
<td>Bussey-Garder polyposis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Familial multiple polyposis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Familial polyposis coli</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Familial polyposis of the colon and rectum</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Familial polyposis of the gastrointestinal tract</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gardner syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Multiple adenomatosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gangliocytic paraganglioma 8683</td>
<td></td>
<td></td>
<td>Non-malignant</td>
</tr>
<tr>
<td>Gastrointestinal stromal tumor</td>
<td>GIST NOS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>GIST, behavior not specified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperplastic polyp No code</td>
<td></td>
<td></td>
<td>Non-malignant/no code</td>
</tr>
<tr>
<td>Inflammatory or pseudopolyp No code</td>
<td></td>
<td></td>
<td>Reactive lesions; mimic carcinoma</td>
</tr>
</tbody>
</table>

10
<table>
<thead>
<tr>
<th>ICD-O Histology/Morphology Specific or NOS Term and Code</th>
<th>Synonym(s) of Specific or NOS</th>
<th>Subtype/Variant of NOS with ICD-O Histology/Morphology Code in Bold</th>
<th>Why not reportable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Juvenile polyp No code</strong></td>
<td>Combined juvenile polyposis/hereditary Combined juvenile polyposis/'hereditary hemorrhagic telangiectasis (Osler-Webec-Rendu) syndrome Familial juvenile polyposis Generalized juvenile polyposis Hamartomatous gastrointestinal polyposis; Juvenile polyposis Juvenile polyposis coli Juvenile polyposis of infancy</td>
<td></td>
<td>Non-malignant / no code</td>
</tr>
<tr>
<td><strong>L cell glucagon-like peptide and PP/PYY-producing NETs 8152/1</strong>*</td>
<td></td>
<td></td>
<td>Non-malignant</td>
</tr>
<tr>
<td><strong>Leiomyoma 8890/0</strong></td>
<td></td>
<td></td>
<td>Non-malignant</td>
</tr>
<tr>
<td><strong>Lipoma 8850/0</strong></td>
<td></td>
<td></td>
<td>Benign accumulation of fat cells that are circumscribed or encapsulated</td>
</tr>
<tr>
<td><strong>Low-grade appendiceal mucinous neoplasm 8480/1</strong></td>
<td>LAMN</td>
<td></td>
<td>Non-malignant</td>
</tr>
</tbody>
</table>

*Note:* May have low-grade, non-invasive pseudomyxoma peritonei, mucinous implants in peritoneum or beyond
## Colon Terms and Definitions

### Colon, Rectosigmoid, and Rectum Equivalent Terms, Definitions

C180-C189, C199, C209

(Excludes lymphoma and leukemia M9590-9992 and Kaposi sarcoma M9140)

<table>
<thead>
<tr>
<th>ICD-O Histology/Morphology Specific or NOS Term and Code</th>
<th>Synonym(s) of Specific or NOS</th>
<th>Subtype/Variant of NOS with ICD-O Histology/Morphology Code in Bold</th>
<th>Why not reportable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lynch syndrome No code</td>
<td></td>
<td></td>
<td>Non-malignant/ no code</td>
</tr>
<tr>
<td>Mesenchymal tumors</td>
<td>Granular cell tumor 9580</td>
<td></td>
<td>Benign</td>
</tr>
<tr>
<td></td>
<td>Hemangioma 9120</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Peutz-Jeghers polyp No code                              | Intraepithelial neoplasia in Peutz-Jeghers polyp(s)  
|                                                           | Periorificial lentiginosis    |                                                                     | Non-malignant/ no code |
|                                                           | Peutz-Jeghers polyposis      |                                                                     |                   |
|                                                           | Polyps-and-spots syndrome    |                                                                     |                   |
| 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*                   | Serrated polyposis           |                                                                     | Non-malignant      |
|                                                           | Sporadic serrated polyps     |                                                                     |                   |
|                                                           | Traditional serrated adenoma |                                                                     |                   |
|                                                           | Note: No malignancy in polyps|                                                                     |                   |
|                                                           | Note: No malignancy          |                                                                     |                   |
| Tubular carcinoid, no malignancy 8245/1                  |                              |                                                                     | Non-malignant      |

*These new codes were approved by the IARC/WHO Committee for ICD-O*
Colon, Rectosigmoid, and Rectum Equivalent Terms, Definitions
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(Excludes lymphoma and leukemia M9590-9992 and Kaposi sarcoma M9140)

Illustrations

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

[Diagram of Colonoscopy Measurements with measurements and sites labeled]
Colon, Rectosigmoid, and Rectum Equivalent Terms, Definitions
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590-9992 and Kaposi sarcoma M9140)
Colon, Rectosigmoid, and Rectum Equivalent Terms, Definitions
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590-9992 and Kaposi sarcoma M9140)

Polyps and de novo or “frank” adenocarcinoma in colon

Source: http://upload.wikimedia.org/wikipedia/commons/4/44/Colon_cancer.jpg
Colon, Rectosigmoid, and Rectum Equivalent Terms, Definitions
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590-9992 and Kaposi sarcoma M9140)

Large intestine; snare instrument to remove polyps
Colon Surgery: Hemicolecctomy

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
Colon, Rectosigmoid, and Rectum Equivalent Terms, Definitions
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590-9992 and Kaposi sarcoma M9140)

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

*Note 1:* If a patient had a previous colon cancer and presents with a new tumor in 2018 or later, use 2018 rules to determine whether or not the subsequent tumor is a new primary or a recurrence (same primary).  
*Note 2:* Rules do not apply to metastatic tumors. See Equivalent Terms and Definitions for information on metastatic tumors.

### UNKNOWN IF SINGLE OR MULTIPLE TUMORS

**Rule M1** Abstract a single primary when it is not possible to determine if there is a single tumor or multiple tumors (one abstract).  
*Note:* Use this rule only after all information sources have been exhausted.  
**Example 1:** Central registry receives a biopsy report from Hospital A and a resection report from Hospital B. There is no information on whether the biopsy and resection were the same tumor.  
**Example 2:** A patient is admitted to the hospital for treatment. There is a reference to a biopsy in another hospital, but no documentation of whether or not the biopsy was taken from the same tumor being treated.

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

### SINGLE TUMOR

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

This is the end of instructions for Single Tumor
Colon MP

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

MULTIPLE TUMORS

Note 1: Multiple tumors may be a single primary or multiple primaries.
Note 2: Rules include multiple tumors that are in situ and invasive.
Note 3: Collision tumors are treated 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. They are not always called “collision tumors.” Use the multiple tumors module.

Rule M3 Abstract a single primary when

- The diagnosis is adenomatous polyposis coli (familial polyposis/FAP) OR
- There is no diagnosis of FAP BUT
  - >100 polyps are documented AND
  - Adenocarcinoma (in situ /2 or invasive /3) is present in at least one polyp

Note 1: A diagnosis of adenomatous polyposis coli (familial polyposis/FAP) is made when the patient has > 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 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. In summary, multiple polyps in the colorectum is not equivalent to FAP. FAP is a genetic disorder which gives rise to more than a hundred polyps. Patients often have total colectomies.

Note 4: Code primary site as follows

- Present in more than one segment of colon: code C189 colon, NOS
- Present in colon and rectosigmoid OR colon and rectum: code C199 rectosigmoid junction
- Present in colon and small intestine: code C260 intestinal tract, NOS (there is no code for large and small bowel)
- Present in colon and small intestine (may also involve rectum): code C269 gastrointestinal tract, NOS
Colon, Rectosigmoid, and Rectum Multiple Primary Rules  
C180-C189, C199, C209  
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

**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 when tumors are diagnosed more than 1 year apart.  
**Note 1:** The rules are hierarchical. Do not use this rule when rules M1-3 apply.  
**Note 2:** The time interval means the patient has been clinically disease-free for more than one year.  
- Clinically disease-free means there are no clinical evidence of disease. Colonoscopies, scans, and all other work-ups show no evidence of disease (NED)  
- When the first course of treatment was a polypectomy only, this rule means there were no recurrences in the same segment of colon for >1 year  
- When the first course of treatment was a colectomy or A&P resection, there were no anastomotic recurrences for >1 year  
**Note 3:** When the patient has a recurrence less than or equal to 1 year after the original diagnosis, the “clock” starts over. The one-year disease-free interval is no longer computed from the date of diagnosis, it starts from the date of the last known recurrence. In other words, the patient must have been disease-free for >1 year after the last recurrence.  
**Note 4:** When it is unknown whether there was a recurrence, default to date of diagnosis to compute the >1-year interval.

**Rule M5** Abstract multiple primaries when a subsequent tumor with a different histology arises at the anastomotic site such as:  
- Two different subtypes/variants of a NOS  
  **Example:** The original tumor was micropapillary carcinoma 8265 and the tumor at the anastomosis was medullary carcinoma 8510. Although both are subtype/variants of adenocarcinoma, they are different histologies. Code two primaries, one for the original micropapillary tumor and another for the medullary tumor at the anastomotic site.  
- One tumor is a NOS and the other is a subtype/variant of the NOS  
  **Example:** The original tumor was adenocarcinoma NOS 8140. The patient had a hemicolecetomy. 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.  
- Original tumor is a cancer adenocarcinoma and recurrence is a sarcoma (leiomyosarcoma or angiosarcoma)  
  **Example:** First course therapy for a rectal primary is surgery and radiation therapy. The diagnosis from first surgical resection was adenocarcinoma 8140. The diagnosis from the anastomotic site tumor was leiomyosarcoma 8890. It is believed the etiology of sarcomas is radiation therapy in lower rectosigmoid and rectal primaries.
Colon, Rectosigmoid, and Rectum Multiple Primary Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

**Rule M6** Abstract a **single primary** when a subsequent tumor arises at the **anastomotic** site AND
- The tumor arises in colon/rectal wall and/or surrounding tissue; there is **no involvement** of the mucosa AND/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 M7** Abstract **multiple primaries** when a subsequent tumor arises at the **anastomotic** site AND
- Arises in the mucosa AND
- No documentation of an anastomotic recurrence

**Note 1:** The tumor may or may not invade into the colon wall or adjacent tissue.
**Note 2:** These rules are hierarchical. Use this rule only when rules M1-M6 do not apply.

**Rule M8** Abstract **multiple primaries** when separate, non-contiguous tumors (any histology) are present in sites where the ICD-O site/topography codes differ at the second character CXX, third character CXX or the fourth character C18X.

**Note 1:** Definition of separate/non-contiguous tumors: at least two malignancies which do not overlap/merge.
**Note 2:** The rules are **hierarchical. Do not** use this rule if M3 applies (the patient has FAP).
**Note 3:** 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.

**Example:** The patient has adenocarcinoma in situ in a sigmoid polyp and mucinous adenocarcinoma in a polyp in the descending colon, the ICD-O site/topography code differs at the fourth character (sigmoid C187 and descending C186). **Code two primaries**, one for the sigmoid and another for the descending colon.

**Note 4:** Differences at either the second or third characters are different primary sites/multiple primaries.

**Example 1:** Breast C50x and colon C18x

**Example 2:** Colon C18x and rectum C209

**Note:** This rule does not apply to a single overlapping malignancy of colon and rectum.
Colon, Rectosigmoid, and Rectum Multiple Primary Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Rule M9  Abstract a single primary when any of the following tumor combinations are present simultaneously:
- A de novo (formerly called “frank”) carcinoma and carcinoma in a polyp OR
- A NOS and a variant/subtype of that NOS OR
  Note: The NOS may be in situ and the variant/subtype malignant/invasive OR the NOS may be malignant/invasive and the variant/subtype in situ
- Adenocarcinoma in multiple polyps OR
- An in situ and an invasive tumor OR
  Note: The in situ may be in a polyp and the invasive may be de novo OR the in situ may be de novo and the invasive in a polyp.
- The same adenocarcinoma subtype/variant (in situ /2 or invasive /3) in multiple polyps

Note 1: Rules are hierarchical. Do not use this rule when rule M8 applies (tumors must be in the same segment of colon OR only in the rectum).
Note 2: See Table 1 in Equivalent Terms and Definitions for adenocarcinoma subtypes/variants.
Note 3: See Histology Coding Rules for coding instructions.

Rule M10  Abstract a single primary when there is a subsequent invasive tumor less than or equal to 60 days after an in situ tumor.

Note 1: Abstract the invasive tumor.
Note 2: Change behavior code. If an in situ tumor has been reported to central registry, report all changes to central registry.
Note 3: See the COC and SEER manuals for instructions on coding other data items such as Date of Diagnosis, Accession Year and Sequence Number.
Note 4: The physician may stage both tumors.

Rule M11  Abstract multiple primaries when there is an invasive tumor more than 60 day after an in situ tumor AND
- The patient had a resection of the in situ tumor AND
- The subsequent invasive tumor occurs more than 60 days after the last in situ tumor was resected

Note 1: The in situ tumor was resected so the invasive is a new tumor. The resection may be a polypectomy or hemicolecotomy.
Note 2: The purpose of this rule is to ensure that the case is counted as an incidence (invasive) case when incidence data are analyzed
Note 3: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease
Note 4: The physician may stage each of the tumors because the depth of invasion will determine first and second course of treatment.
Colon, Rectosigmoid, and Rectum Multiple Primary Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Rule M12  Abstract multiple primaries\(^\text{II}\) when there are tumors with ICD-O histology/morphology codes that differ at the first (Xxxx) AND/OR second (xXxx) AND/OR third digit (xxXx).

Rule M13  Abstract multiple primaries\(^\text{II}\) when there are
- Collision tumors OR
- An in situ and an invasive tumor OR
- De novo and polyp OR
- Two de novo separate, non-contiguous malignancies

Note 1: Do not use this rule when M8, M9 or M12 apply.
- M8: Tumors are multiple primaries when they occur
  - In different sections of colon OR
  - One in colon, one in rectum
- M9: A de novo and polyp in same segment of colon are a single primary
- M12: Code multiple primaries when ICD-O codes differ at the first, second, or third digits

Note 2: Collision tumors were originally two separate tumors that arose in close proximity. As the tumors increase in size, they merge or overlap each other. They are most frequently different histologies.

Rule M14  Abstract a single primary\(^\text{I}\) when rules M1-M13 do not apply.

This is the end of instructions for Multiple Tumors.

\(^\text{I}\) Prepare one abstract. When there are two tumors, the term “abstract a single primary” means either that only one of the tumors is abstracted OR that the subsequent tumor is a recurrence. Use the histology coding rules to assign the appropriate histology code.

\(^\text{II}\) Prepare two abstracts.
Colon, Rectosigmoid, and Rectum Histology Rules
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(Excludes lymphoma and leukemia M9590-M9992 and Kaposi sarcoma M9140)

Priority Order for Using Documentation to Code Histology

Use the documents/documentation below in priority order with 1 having the highest priority. Go to 2 when 1 does not apply.

1. Code the histology from the tissue/pathology report with the most specific histology diagnosis.
   a. Use the following priority order:
      i. **Addendums and/or comments**
         
         **Note:** The addendums and comments usually contain information on stains, immunophenotyping, and/or genetic testing which were not available when the final diagnosis was written.
      ii. **Final diagnosis** on the pathology report
         
         **Note:** Use the final diagnosis when there are no addendums or comments.
      iii. **CAP synoptic report**
         
         **Note:** The CAP report is usually done at the same time as the pathology report which means information included in addendums and comments are not available. CAP has specific histologies listed for each site. If the pathologist diagnoses a histology that is not on the CAP schema, the histology should be coded from the pathology report

      **Note 1:** Code the **most specific** histology regardless of whether it came from the most representative specimen. Since pathologists can provide a more accurate diagnosis when they are able to examine more tumor tissue, the most representative specimen usually does provide the most specific diagnosis; however, this is not always the case.

      **Note 2:** Biopsies done during **colonoscopy** provide a small amount of tissue. In the **rare instance** when a biopsy does provide the **most specific** diagnosis, code that histology.

      **Example 1:** Patient had a biopsy of the colon with a diagnosis of adenocarcinoma. The resection pathology diagnosis was mucinous adenocarcinoma. Code the most specific histology from the resection, mucinous adenocarcinoma (8480).

      **Example 2:** The pathology from a biopsy of a rectosigmoid mass was micropapillary carcinoma. Resection pathology showed adenocarcinoma NOS. Code the most specific diagnosis which is from the biopsy, micropapillary carcinoma (8265).

      **Note 3:** Code the histology from the tissue/pathology report. Stage using TNM.

2. Code the histology based on **positive cytology** (seldom the **only option** for colon, rectosigmoid, and rectum). Cytology is **not tissue**.

   **Note:** DO NOT accession cases based only on **suspicious/ambiguous cytology**, except when any of the following criteria are met:
   - Subsequent **positive tissue** from a biopsy or resection (histologic diagnosis)
   - Subsequent **positive cytology** (cytologic diagnosis)
Colon, Rectosigmoid, and Rectum Histology Rules
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- The patient is treated for cancer based on the suspicious/ambiguous cytology (clinical diagnosis)
- A physician confirms the diagnosis of cancer based on the suspicious/ambiguous cytology (clinical diagnosis)

3. Code the histology from a metastatic site when no other pathology is available.
   Note: Code the behavior /3.

4. Code the histology documented by the physician when there is no tissue or cytology specimen or the pathology/cytology report is not available.
   Note 1: Priority order for using documentation to code the histology:
   1. Reference to original pathologic or cytological findings
   2. Physician’s reference to type of cancer (histology) in the medical record
   3. CT, PET or MRI scans

   Note 2: Code the histology to 8000 (cancer/malignant neoplasm NOS) or 8010 (carcinoma NOS) as stated by the physician when nothing more specific is documented.

General Notes for All Modules

Note 1: Use the histology terminology and ICD-O resources in the following priority order:
1. Table 1 in the Equivalent Terms and Definitions
2. ICD-O with all updates

Note 2: Ignore the terms “cribriform” and “comedo” when coding multiple histologies.

Note 3: Collision tumors are treated as two individual tumors for the purpose of determining multiple primaries. You must first determine whether this is a single primary before using the histology coding rules.
- Definition collision tumors: two separate, non-contiguous tumors in close proximity which expanded to create an area where tumors mingle or “collide”, forming one single mass
- Collision tumors are usually different histologies, commonly a carcinoma and a sarcoma

Note 4: Subtypes/variants are coded when definitively described in the diagnosis, such as a diagnosis that is exactly mucinous adenocarcinoma (no modifiers).

Note 5: Ambiguous terminology such as “with features of”, etc. are no longer used to determine a subtype OR to determine which histology should be coded. See the following histology rules for instructions on coding multiple histologies.

Note 6: When a tumor is called malignant in retrospect (after the original diagnosis), use the matrix principle in ICD-O and change the behavior code to /3. Follow the instructions in the SEER and COC Manuals to code accession year, date of diagnosis, and first course of treatment.
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 the histology when only one histologic type is identified.

*Note:* Code the histology using Table 1 in Equivalent Terms and Definitions.
- The pathologist may use histologic terms which are not in ICD-O
- If the term is not in the table, go to ICD-O. When the pathologist uses an older term that is “not recommended” in WHO, the older term will not be in Table 1

Rule H2  Code 8574 adenocarcinoma with neuroendocrine differentiation when the final diagnosis is exactly “adenocarcinoma with neuroendocrine differentiation”.

*Note:* Do not use this code if the diagnosis is any subtype/variant of adenocarcinoma with neuroendocrine differentiation.

Rule H3  Code 8140 adenocarcinoma NOS when the final diagnosis is:
- Exactly adenocarcinoma (no modifiers) OR
- 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.
- Intestinal type adenocarcinoma OR adenocarcinoma, intestinal type (no modifiers or additional histologic terms).
  *Note 1:* Do not use code 8144 adenocarcinoma, intestinal type for colorectal primaries. Intestinal type adenocarcinoma is a term used for tumors occurring in the stomach, with histology similar to those in the large intestine. The diagnosis intestinal type adenocarcinoma of the colon or rectum is redundant because the term means adenocarcinoma of the intestine. Code 8140 adenocarcinoma NOS, even if pathology says intestinal type adenocarcinoma.
  *Note 2:* When a diagnosis of intestinal type adenocarcinoma is further described by a specific term (such as mucinous or signet ring), continue through the rules. It would be treated as an adenocarcinoma with a subtype/variant.

Rule H4  Code the histology when a carcinoma originates in a polyp.

*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.

*Example:* Colonoscopy with polypectomy finds mucinous adenocarcinoma in the polyp. Code mucinous adenocarcinoma.
Colon, Rectosigmoid, and Rectum Histology Rules
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(Excludes lymphoma and leukemia M9590-9992 and Kaposi sarcoma M9140)

Rule H5  Code 8045 combined small cell carcinoma when the final diagnosis is small cell carcinoma AND
  •  Adenocarcinoma OR
  •  Neuroendocrine carcinoma OR
  Note: Do not use code 8574 adenocarcinoma with neuroendocrine differentiation.
  •  Any other carcinoma.

Rule H6  Code 8480 invasive mucinous adenocarcinoma when the diagnosis is:
  •  Exactly “mucinous adenocarcinoma” (no modifiers) OR
  •  High-grade pseudomyxoma peritonei OR
  •  Invasive pseudomyxoma peritonei OR
  •  Malignant pseudomyxoma peritonei
  Note 1: NOT REPORTABLE
  •  Low-grade pseudomyxoma peritonei AND no treatment
  •  No designation of high- or low-grade AND no treatment for the pseudomyxoma peritonei
  Note 2: 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; otherwise code C809.
  Note 3: Follow instructions from ICD-O matrix principle, 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

Rule H7  Code the invasive histology when both invasive and in situ are present in a single tumor.
Colon, Rectosigmoid, and Rectum Histology Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590-M9992 and Kaposi sarcoma M9140)

Rule H8  Code the subtype/variant when the diagnosis is a NOS and a subtype/variant of that NOS. See Table 1 in Equivalent Terms and Definitions for NOS and subtype/variant.
- Adenocarcinoma NOS (8140) and a subtype/variant of adenocarcinoma OR
- Cancer/malignant neoplasm NOS (8000) and a subtype/variant of cancer/malignant neoplasm OR
- Carcinoma NOS (8010) and a subtype/variant of carcinoma OR
- Neuroendocrine carcinoma NOS (8246) and a subtype/variant of neuroendocrine carcinoma OR
- Sarcoma NOS (8800) and a subtype/variant of sarcoma

Note: Only code subtypes/variants when pathology gives exact diagnosis (no modifiers). Do not code the subtype/variant when modified by terms such as differentiation, features of, etc., unless there is a specific code for the modifier.

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).

Rule H9  Code the majority histology when there are multiple histologies within a single tumor. The majority is identified as:
- \( \geq 50\% \) of tumor OR
- Majority OR
- Prominent (when only term available)
- Predominant

Note: If the majority of tumor histology cannot be identified, go to next rule.

Rule H10  Code 8255 adenocarcinoma with mixed subtypes when:
- The majority of tumor histology is not identified OR
- When the diagnosis is mucinous/colloid carcinoma AND signet cell carcinoma

Rule H11  Code the histology with the numerically higher ICD-O histology code.

Note: These rules are hierarchical. Do not use if any of the rules H1-H10 apply.

This is the end of instructions for Single Tumor.

Code the histology using the rule that fits the case.
Colon, Rectosigmoid, and Rectum Histology Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590-9992 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Note: Before coding histology, use the Multiple Primary Rules to determine that multiple tumors are a single primary.

Rule H12  Code 8220 adenocarcinoma in familial adenomatous polyposis coli (FAP) 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 >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 H13  Code 8221 adenocarcinoma in multiple adenomatous polyps when FAP is not mentioned AND
  - There are more than 1 but ≤100 polyps identified AND/OR
  - There are at least 2 polyps with adenocarcinoma (in situ /2 or invasive /3) but the exact number 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. For other histologies such as mucinous adenocarcinoma, signet cell carcinoma, etc. continue through the histology rules.

Rule H14  Code the histology of the invasive tumor when there are in situ (/2) and invasive (/3) neoplasms.

Rule H15  Code the histology of the most invasive tumor when there are multiple invasive neoplasms, such as:
  - A NOS and a subtype/variant of that NOS OR
  - Multiple invasive tumors abstracted as a single primary

Note 1: See the Equivalent Terms and Definitions for the definition of most invasive.

Note 2: If tumors are equally invasive, go to the next rule.
Colon, Rectosigmoid, and Rectum Histology Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590-M9992 and Kaposi sarcoma M9140)

Rule H16 Code the histology when only one histologic type is identified for all tumors.

Note: See Table 1 in Equivalent Terms and Definitions. When the histological term is not in Table 1, use the ICD-O. Rare terms may not be in Table 1.

Rule H17 Code the subtype/variant when the diagnosis for multiple tumors is an NOS and a subtype/variant of that NOS. See Table 1 in Equivalent Terms and Definitions for NOS and subtype/variant.

- Adenocarcinoma NOS (8140) and a subtype/variant of adenocarcinoma OR
- Cancer/malignant neoplasm NOS (8000) and a subtype/variant of cancer/malignant neoplasm OR
- Carcinoma NOS (8010) and a subtype/variant of carcinoma OR
- Neuroendocrine carcinoma NOS and a subtype/variant of neuroendocrine carcinoma OR
- Sarcoma NOS (8800) and a subtype/variant of sarcoma

Note 1: Check the Multiple Primary rules to confirm that the tumors are a single primary.

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 modifier.

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).

Rule H18 Code the histology with the numerically higher ICD-O code.

Note: The rules are hierarchical. Do not use this rule when rules H12-H17 apply.

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

Code the histology using the rule that fits the case.