Kidney Equivalent Terms and Definitions
C649
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Introduction

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.

Note 3: Renal cell carcinoma (RCC) 8312 is a group term for glandular (adeno) carcinoma of the kidney. Approximately 85% of all malignancies of the kidney C649 are RCC or subtypes/variants of RCC.
- See Table 1 for renal cell carcinoma subtypes/variants.
- Clear cell renal cell carcinoma (ccRCC) 8310 is the most common subtype/variant of RCC.

Note 4: Transitional cell carcinoma rarely arises in the kidney C649. Transitional cell carcinoma of the upper urinary system usually arises in the renal pelvis C659. Only code a transitional cell carcinoma for kidney in the rare instance when pathology confirms the tumor originated in the kidney.

Note 5: For those sites/histologies which have recognized biomarkers, the biomarkers are most frequently used to target treatment. Biomarkers may identify the histologic type. Currently, there are clinical trials being conducted to determine whether these biomarkers can be used to identify multiple primaries. Follow the Multiple Primary Rules; do not code multiple primaries based on biomarkers.

Changes from 2007 Rules

These changes are effective with cases diagnosed 1/1/2018 and later. WHO Classification of Tumors of the Urinary System and Male Genital Organs was published in 2016.

1. 2007 Rules instruct “Code the histology from the most representative specimen.” For all sites except breast and CNS, 2018 Rules instruct “Code the most specific histology from biopsy or resection. When there is a discrepancy between the biopsy and resection
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(two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).”

2. **New histology terms and codes were included** (identified by asterisks (*) in the histology table in the Terms and Definitions).
   A. Histologies with terms that indicate they are **hereditary** (hereditary leiomyomatosis and renal cell carcinoma syndrome–associated RCC 8311)
   B. Histologies with **genetic anomalies** (succinate dehydrogenase–deficient RCC)

3. Some histologies are rare and are not listed in the tables; refer to ICD-O and all updates.  
   **Note:** Renal cell spindle cell carcinoma 8318 is no longer a recommended term.

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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.
- Multifocal; multicentric
- Carcinoma; adenocarcinoma
- 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, neoplasm and nodule are **not** used in a **standard manner** in clinical diagnoses, scans, or consults. **Disregard** the terms **unless** there is a **physician’s statement** that the term is **malignant/cancer**
  - These terms are used **ONLY** to determine **multiple primaries**
  - **Do not** use these terms for **casefinding** or **determining reportability**
- Type; subtype; variant

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Jump to **Multiple Primary Rules**  
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Terms that are NOT Equivalent or Equal

These terms are **not equivalent**. There are no casefinding implications.

- **Component** is not equivalent to **subtype/type/variant**
  *Note*: Component is only coded when the pathologist specifies the component as a second carcinoma
- **Phenotype** is not equivalent to **subtype/type/variant**

### 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 kidney tumors.

**Column 1** contains specific and NOS ICD-O histology terms.
- **Specific** histology terms **do not** have **subtypes/variants**
- **NOS** histology terms **do** have **subtypes/variants**

**Column 2** contains **synonyms** for the specific or NOS term. Synonyms have the **same** histology code as the specific or NOS term.

**Column 3** contains **subtypes/variants** of the **NOS** histology. Subtypes/variants **do not** have the **same** histology code as the NOS term.

Column 3 may contain NOS histologies which are part of a bigger histologic group. For example, sarcoma NOS 8800/3 (column 1) is a generic term which encompasses a number of soft tissue tumors, including rhabdomyosarcoma 8900/3 (column 3). Rhabdomyosarcoma is also a NOS because it has subtypes/variants. The subtypes/variants are indented under the NOS (rhabdomyosarcoma) in column 3. There is also a note in column 1 which calls attention to the fact that rhabdomyosarcoma has subtypes/variants.

When subtypes/variants are indented under a NOS in Column 3, use coding rules for a NOS and a single subtype/variant. For example, rhabdomyosarcoma **8900/3** and alveolar type rhabdomyosarcoma **8920/3** are a NOS and a subtype/variant, **NOT** two different subtypes.

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<table>
<thead>
<tr>
<th>NOS/Specific Histology Term and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nephroblastoma <strong>8960</strong></td>
<td>Wilms tumor</td>
<td></td>
</tr>
<tr>
<td>Neuroendocrine tumor (NET) <strong>8240</strong></td>
<td>Carcinoid [OBS] Well-differentiated neuroendocrine tumor</td>
<td>Large cell neuroendocrine carcinoma/tumor <strong>8013</strong> Small cell neuroendocrine carcinoma <strong>8041</strong></td>
</tr>
<tr>
<td>Renal cell carcinoma NOS <strong>8312</strong></td>
<td>RCC Sarcomatoid carcinoma Sarcomatoid renal cell carcinoma Succinate dehydrogenase-deficient renal cell carcinoma (SDHD) Unclassified renal cell carcinoma</td>
<td>Acquired cystic disease-associated renal cell carcinoma/tubulocystic renal cell carcinoma <strong>8316</strong> Chromophobe renal cell carcinoma (ChRCC) <strong>8317</strong> Clear cell papillary renal cell carcinoma <strong>8323/3</strong> <strong>Note:</strong> The 2016 WHO 4th Edition Classification of Tumors of the Urinary System and Male Genital Organs has reclassified this histology as a /1 because it is low nuclear grade and is now thought to be a neoplasia. This change has <strong>NOT</strong> yet been implemented and it <strong>remains reportable.</strong> Clear cell renal cell carcinoma (ccRCC) <strong>8310</strong> Collecting duct carcinoma <strong>8319</strong> Hereditary leiomyomatosis and renal cell carcinoma-associated renal cell carcinoma <strong>8311</strong> MiT family translocation renal cell carcinomas <strong>8311</strong> Succinate dehydrogenase-deficient renal cell carcinoma (SDHS) <strong>8311</strong> (reportable beginning 1/1/2022) <strong>Note:</strong> Hereditary leiomyomatosis and renal cell carcinoma-associated renal cell carcinoma, MiT family translocation renal cell carcinomas, and succinate dehydrogenase-deficient renal cell carcinomas have the same ICD-O code but are distinctly different histologies. Because they are different, they are on different lines in column 3 (see M rules). Mucinous tubular and spindle cell carcinoma <strong>8480</strong> Papillary renal cell carcinoma (PRCC) <strong>8260</strong></td>
</tr>
</tbody>
</table>

**Note 1:** WHO, IARC, and CAP agree that sarcomatoid carcinoma is a pattern of differentiation, not a specific subtype, of renal cell carcinoma.

**Note 2:** Sarcomatoid is listed in the CAP Kidney protocol under the header “features.”

**Note 3:** Continue coding sarcomatoid renal cell carcinoma as 8312 until otherwise indicated.
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<table>
<thead>
<tr>
<th>NOS/Specific Histology Term and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kidney medullary carcinoma 8510</strong></td>
<td><strong>Note:</strong> This is a new term (previously called renal spindle cell carcinoma).</td>
<td></td>
</tr>
<tr>
<td><strong>Sarcoma 8800/3</strong></td>
<td></td>
<td>Angiosarcoma 9120/3 Clear cell sarcoma/bone-metastasizing renal tumor of childhood 8964/3 Leiomyosarcoma/renal vein leiomyosarcoma 8890/3 Osteosarcoma 9180/3 Primitive/peripheral neuroectodermal tumor (pNET)/Ewing sarcoma 9364/3 Rhabdomyosarcoma 8900/3 Alveolar rhabdomyosarcoma 8920/3 Embryonal rhabdomyosarcoma 8910/3 Pleomorphic rhabdomyosarcoma 8901/3 Spindle cell/sclerosing rhabdomyosarcoma 8912/3</td>
</tr>
<tr>
<td><strong>Synonyms</strong></td>
<td></td>
<td>Synovial sarcoma 9040/3</td>
</tr>
</tbody>
</table>

* These new codes were approved by the IARC/WHO Committee for ICD-O.
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**Table 2: Neoplasms which are Not Reportable**

<table>
<thead>
<tr>
<th>Not Reportable Histology Term and Code</th>
<th>Synonyms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult cystic teratoma 8959/0</td>
<td>Mixed epithelial and stromal tumor</td>
</tr>
<tr>
<td></td>
<td>Renal epithelial stromal tumor</td>
</tr>
<tr>
<td>Angiomyolipoma 8860/0</td>
<td></td>
</tr>
<tr>
<td>Congenital mesoblastic nephroma 8960/1</td>
<td></td>
</tr>
<tr>
<td>Cystic partially-differentiated nephroblastoma 8959/1</td>
<td></td>
</tr>
<tr>
<td>Epithelioid angiolipoma 8860/1*</td>
<td></td>
</tr>
<tr>
<td>Hemangioblastoma 9161/1</td>
<td></td>
</tr>
<tr>
<td>Hemangioma 9120/0</td>
<td></td>
</tr>
<tr>
<td>Juxtaglomerular cell tumor 8361/0</td>
<td></td>
</tr>
<tr>
<td>Leiomyoma 8890/0</td>
<td></td>
</tr>
<tr>
<td>Lymphangioma 9170/0</td>
<td></td>
</tr>
<tr>
<td>Metanephric adenofibroma 9013/0</td>
<td>Nephrogenic adenofibroma</td>
</tr>
<tr>
<td>Metanephric adenoma 8325/0</td>
<td></td>
</tr>
<tr>
<td>Metanephric stromal tumor 8935/1</td>
<td></td>
</tr>
<tr>
<td>Multilocular cystic renal neoplasm of low malignant potential 8316/1*</td>
<td></td>
</tr>
<tr>
<td>Nephrogenic rests (no code)</td>
<td></td>
</tr>
<tr>
<td>Oncocytoma 8290/0</td>
<td></td>
</tr>
<tr>
<td>Papillary adenoma 8260/0</td>
<td></td>
</tr>
<tr>
<td>Paraganglioma 8700/0</td>
<td>Extra-adrenal pheochromocytoma</td>
</tr>
<tr>
<td>Pediatric cystic nephroma 8959/0</td>
<td></td>
</tr>
<tr>
<td>Renomedullary interstitial cell tumor 8966/0</td>
<td>Medullary fibroma</td>
</tr>
<tr>
<td>Schwannoma 9560/0</td>
<td></td>
</tr>
<tr>
<td>Solitary fibrous tumor 8815/1</td>
<td></td>
</tr>
</tbody>
</table>

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

Column 1 lists the not reportable histology **term** and **code**. Not all of the non-reportable neoplasms have codes. Column 2 lists **synonyms** for the term in column 1. Synonyms have the same histology code (if applicable) as listed in column 1.

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Pathology Specimen Kidneys
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Kidney Cancer
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Note 1: These rules are NOT used for tumor(s) described as metastases. Metastatic tumors include but are not limited to:
- Adrenal gland
- Bones
- Bowel
- Brain
- Discontinuous nodules in surrounding tissue
- Regional and distant lymph nodes as identified in Summary Staging Manual
- Liver
- Lung

Note 2: 2007 MPH Rules and 2018 Solid Tumor Rules are used based on date of diagnosis.
- Tumors diagnosed 01/01/2007 through 12/31/2017: Use 2007 MPH Rules
- Tumors diagnosed 01/01/2018 and later: Use 2018 Solid Tumor Rules
- The original tumor diagnosed before 1/1/2018 and a subsequent tumor diagnosed 1/1/2018 or later in the same primary site: Use the 2018 Solid Tumor Rules.

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. 

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.

Prepare one abstract. Use the histology rules to assign the appropriate histology code.
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Single Tumor

Rule M2  Abstract a single primary\(^i\) when there is a single tumor.

\(\text{Note 1:}\) A single tumor is always a single primary.

\(\text{Note 2:}\) The tumor may overlap onto or extend into adjacent/contiguous site or subsites.

\(\text{Note 3:}\) The tumor may have in situ and invasive components.

\(\text{Note 4:}\) The tumor may have two or more histologic components.

This is the end of instructions for Single Tumor.

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

Multiple Tumors

Note: Multiple tumors may be a single primary OR multiple primaries.

Rule M3  Abstract multiple primaries\(^d\) when multiple tumors are present in sites with ICD-O site codes that differ at the second (C\(X\)xx), third (Cx\(X\)x) and/or fourth characters (Cxx\(X\)).

\(\text{Note:}\) When codes differ at the second, third, or fourth characters, the tumors are in different primary sites.

Rule M4  Abstract a single primary\(^i\) when there are bilateral nephroblastomas (previously called Wilms tumors).

\(\text{Note:}\) Timing is irrelevant; the tumors may occur simultaneously OR the contralateral tumor may be diagnosed later (no time limit).

Rule M5  Abstract multiple primaries\(^d\) when there are tumors in both the right kidney and in the left kidney. There may be:

- A single tumor in each kidney
- A single tumor in one kidney and multiple tumors in the contralateral kidney
- Multiple tumors in both kidneys

\(\text{Note 1:}\) The rules are hierarchical. Only use this rule when none of the previous rules apply.

\(\text{Note 2:}\) ONLY abstract a single primary when pathology proves the tumor(s) in one kidney is/are metastatic from the other kidney.
Rule M6  Abstract multiple primaries when the patient has a subsequent tumor after being clinically disease-free for greater than three years after the original diagnosis or last recurrence.

Note 1: Clinically disease-free means that there was no evidence of recurrence on follow-up.
   - Scans are NED
   - Urine cytology is negative
   - All other work-up is NED

Note 2: When there is a recurrence less than or equal to three years of diagnosis, the “clock” starts over. The time interval is calculated from the date of last recurrence. In other words, the patient must have been disease-free for greater than three years from the date of the last recurrence.

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

Note 4: The physician may state this is a recurrence, meaning the patient had a previous kidney tumor and now has another kidney tumor. Follow the rules; do not attempt to interpret the physician’s statement.

Note 5: The location and histology of the subsequent tumor is irrelevant. Kidney tumors that occur more than 3 years apart are always multiple primaries.

Rule M7  Abstract multiple primaries when separate/non-contiguous tumors are two or more different subtypes/variants in Column 3, Table 1 in the Equivalent Terms and Definitions.

Note 1: The tumors may be subtypes/variants of the same or different NOS histologies.
   - Same NOS: Clear cell renal cell carcinoma (ccRCC) 8310/3 and papillary renal cell carcinoma 8260/3 are both subtypes of renal cell carcinoma NOS 8312/3 but are distinctly different histologies. Abstract multiple primaries.
   - Different NOS: Pleomorphic rhabdomyosarcoma 8901/3 is a subtype/variant of rhabdomyosarcoma 8900/3; large cell neuroendocrine carcinoma 8013/3 is a subtype of small cell neuroendocrine tumor 8041/3. They are distinctly different histologies. Abstract multiple primaries.

Note 2: Abstract multiple primaries when you have any of the following combinations (all coded 8311):
   - MiT family translocation renal cell carcinoma and Hereditary leiomyomatosis
   - MiT family translocation renal cell carcinoma and Renal cell carcinoma-associated renal cell carcinoma
   - MiT family translocation renal cell carcinoma and Succinate dehydrogenase-deficient renal cell carcinoma (SDHS)
   - Hereditary leiomyomatosis and Succinate dehydrogenase-deficient renal cell carcinoma (SDHS)
   - Renal cell carcinoma-associated renal cell carcinoma and Succinate dehydrogenase-deficient renal cell carcinoma (SDHS)
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Rule M8 Abstract a single primary\(^1\) when synchronous, separate/non-contiguous tumors are on the same row in Table 1 in the Equivalent Terms and Definitions. Tumors must be in the same kidney.

Note: The same row means the tumors are:
- The same histology (same four-digit ICD-O code; see exception for 8311) 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) OR
- A NOS histology in column 3 with an indented subtype/variant

Rule M9 Abstract multiple primaries\(^2\) when separate/non-contiguous tumors are on different rows in Table 1 in the Equivalent Terms and Definitions.

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

Rule M10 Abstract a single primary\(^1\) when an in situ tumor is diagnosed after an invasive tumor AND tumors occur in the same kidney.

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

Rule M11 Abstract a single primary\(^1\) (the invasive) when an invasive tumor is diagnosed less than or equal to 60 days after an in situ tumor in the same kidney.

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

Note 2: The tumors may be a NOS and a subtype/variant of that NOS.

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

Note 4: Do not change date of diagnosis.

Note 5: If the case has already been submitted to the central registry, report all changes.

Note 6: The physician may stage both tumors because staging and determining multiple primaries are done for different reasons. Staging determines which treatment would be most effective. Determining multiple primaries is done to stabilize the data for the study of epidemiology (long-term studies done on incidence, mortality, and causation of a disease with the goal of reducing or eliminating that disease).

Note 7: See the COC and SEER manuals for instructions on coding other data items such as Date of Diagnosis, Accession Year and Sequence Number.

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Rule M12  Abstract multiple primaries\(^i\) when an invasive tumor occurs more than 60 days after an in situ tumor.

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

**Note 2:** Abstract both the invasive and in situ tumors.

**Note 3:** Abstract as multiple primaries even if physician states the invasive tumor is disease recurrence or progression.

Rule M13  Abstract a single primary\(^i\) when there are multiple tumors that do not meet any of the above criteria.

**Note:** Use this rule as a last resort. Please confirm that you have not overlooked an applicable rule.

**Example 1:** Patient presents in 2018 with renal cell carcinoma in the right kidney. Patient has a history of a previous renal cell carcinoma in the right kidney diagnosed in 2016. This is a single primary because it is the same primary site and the same histology.

**Example 2:** Patient presents in 2020 with a clear cell renal cell carcinoma 8310/3 in the left kidney. The patient was diagnosed with renal cell carcinoma 8312/3 in 2018. This is a single primary because it is the same primary site and a NOS and subtype/variant of that NOS.

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\(^i\) Prepare one abstract. Use the histology coding 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.

\(^i\) Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

This is the end of instructions for Multiple Tumors.
IMPORTANT NOTES
   
   Note 1: Histology changes may occur following immunotherapy, chemotherapy, targeted therapy, and radiation therapy.
   
   Note 2: Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.

   Exception: If the initial diagnosis is based on histology from FNA, smears, cytology, or from a regional or metastatic site, and neoadjuvant treatment is given and followed by resection of primary site which identifies a different or specific histology, code the histology from the primary site.

2. Code the histology using the following priority list and the Histology Rules. Do not change histology in order to make the case applicable to staging.

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 1: The term “most specific” usually refers to a subtype/variant.

   Note 2: The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor.

   Note 3: When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).

1. Tissue or pathology report from primary site (in priority order)
   A. Addendum(s) and/or comment(s)
   B. Final diagnosis / synoptic report as required by CAP
   C. CAP protocol

   Note 1: Addendums and comments on the pathology report are given the highest 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.
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**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

2. **Cytology** (urine)

3. **Tissue/pathology from a metastatic site**
   **Note 1:** Code the behavior /3.
   **Note 2:** The tissue from a metastatic site often shows variations from the primary tumor. When it is the only tissue available, it is more accurate than a scan.

4. **Scan:** The following list is **not in priority** order because they are not a reliable method for identifying specific histology(ies).
   A. MRI
   B. CT
   C. PET

5. Code the histology **documented** by the physician when none of the above are available. Use the documentation in the following priority order:
   A. Treatment plan
   B. Documentation from Tumor Board
   C. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
   D. Physician’s **reference to** type of cancer (histology) in the medical record
   **Note 1:** Code the specific histology when documented.
   **Note 2:** Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.
Note 1: The priority is to code the most specific histology. DO NOT USE BREAST HISTOLOGY CODING RULES FOR THIS SITE.

Note 2: Only use this section for one or more histologies within a single tumor.

Note 3: Do not use this section in place of the Histology Rules.

1. **Code** the most specific histology or **subtype/variant**, regardless of whether it is described as:
   A. The majority or predominant part of tumor
   B. The minority of tumor
   C. A component

   **Example 1:** Diagnosis for a single tumor is renal cell carcinoma 8312 with the majority or predominant part of tumor being clear cell renal cell carcinoma 8310. Code the subtype/variant: clear cell renal cell carcinoma 8310.

   **Example 2:** Diagnosis for a single tumor is neuroendocrine tumor 8041 with minority of tumor being large cell neuroendocrine tumor 8013. Code the subtype/variant: large cell neuroendocrine tumor 8013.

   **Example 3:** Diagnosis for a single tumor is sarcoma NOS 8800/3 with a component of leiomyosarcoma 8890/3. Code the subtype/variant: leiomyosarcoma 8890/3.

   **Note 1:** The terms above (A, B, C) must describe a **carcinoma** or **sarcoma** in order to code a histology described by those terms. 

   **Example:** When the diagnosis is adenocarcinoma with a clear cell carcinoma component, code clear cell carcinoma 8310.

   **Negative Example:** When the diagnosis is simply adenocarcinoma with a clear cell component, code adenocarcinoma NOS 8140. Do not assume this is a clear cell carcinoma. This could be clear cell differentiation or features.

   **Note 2:** When the most specific histology is described as differentiation or features, see #2.

2. **Code** the histology described as **differentiation** or **features/features of ONLY** when there is a specific ICD-O code for the “NOS with ____ features” or “NOS with ____ differentiation”.

   **Note:** Do not code differentiation or features when there is no specific ICD-O code.
3. Code the specific histology described by ambiguous terminology (list follows) ONLY when A or B is true:
   A. The only diagnosis available is one histology term described by ambiguous terminology
      • CoC and SEER require reporting of cases diagnosed only by ambiguous terminology
      • Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/document
      
      **Example:** Outpatient biopsy says probably papillary renal cell carcinoma. The case is accessioned (entered into the database) as required by both SEER and COC. No further information is available. Code the histology papillary renal cell carcinoma. The case meets the criteria in #3A.

   B. There is a NOS histology and a more specific (subtype/variant) described by ambiguous terminology
      • Specific histology is clinically confirmed by a physician (attending, pathologist, oncologist, etc.) OR
      • Patient is receiving treatment based on the specific histology described by ambiguous term

      **Example 1:** The pathology diagnosis is renal cell carcinoma consistent with chromophobe renal cell carcinoma. The oncology consult says the patient has chromophobe renal cell carcinoma of the right kidney. This is clinical confirmation of the diagnosis, code chromophobe renal cell carcinoma. The case meets the criteria in bullet 1.

      **Example 2:** The pathology diagnosis is neuroendocrine tumor consistent with large cell neuroendocrine tumor. The treatment plan says the patient will receive treatment for large cell neuroendocrine tumor. Treatment plan confirms large cell neuroendocrine tumor; code large cell neuroendocrine tumor. The case meets the criteria in bullet 2.

      **If the specific histology does not meet the criteria in #3B, then code the NOS histology.**
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List of Ambiguous Terminology

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

4. **Do not code** histology when described as:
   - Architecture
   - Foci; focus; focal
   - Pattern
### Single Tumor

**Rule H1** 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:* 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.

**Rule H2** Code the **NOS** histology when there are:

- A **NOS** and **two or more variants** of that **NOS** present in the tumor **OR**
- **Two or more variants** of a **NOS** present in the tumor

*Example 1:* The diagnosis is a single tumor with renal cell carcinoma (RCC) 8312, papillary renal cell carcinoma 8260, and mucinous tubular and spindle cell carcinoma 8480. Papillary renal cell carcinoma and mucinous tubular and spindle cell carcinoma are subtypes/variants of renal cell carcinoma. Code the histology to the **NOS**, RCC 8312.

*Example 2:* The diagnosis is spindle cell rhabdomyosarcoma 8912 and alveolar rhabdomyosarcoma 8920. Both are subtypes/variants of rhabdomyosarcoma 8900. Code the **NOS**, rhabdomyosarcoma.

*Informational Item:* WHO 4th edition Tumors of the Urinary System has proposed ICD-O code 8323/1 for clear cell papillary renal cell carcinoma. This has not been approved for implementation by the standard setters in 2018.

*Note:* Use [Table 1](#) in the Equivalent Terms and Definitions to determine NOS and subtype/variant.

**Rule H3** Code the **subtype/variant** when a **NOS** and a **single subtype/variant** of that **NOS** are present.

- Renal cell carcinoma **NOS** 8312 and a subtype/variant of RCC
- Rhabdomyosarcoma 8900 and a subtype/variant of rhabdomyosarcoma
- Well differentiated neuroendocrine tumor 8240 and subtype/variant of well differentiated neuroendocrine tumor

*Note:* Use [Table 1](#) in the Equivalent Terms and Definitions to determine NOS and subtype/variant.

This is the end of instructions for Single Tumor.

Code the histology according to the rule that fits the case.
Multiple Tumors Abstracted as a Single Primary

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

**Rule H4** 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.

**Rule H5** Code the NOS when there are:

- A NOS and two or more variants of that NOS present in the tumors OR
- Two or more variants of a NOS present in the tumors

*Example 1:* The diagnosis is a single tumor with renal cell carcinoma (RCC) 8312, papillary renal cell carcinoma 8260, and mucinous tubular and spindle cell carcinoma 8480. Papillary renal cell carcinoma and mucinous tubular and spindle cell carcinoma are subtypes/variants of renal cell carcinoma. Code the histology to the NOS: RCC 8312.

*Example 2:* The diagnosis is spindle cell rhabdomyosarcoma 8912 and alveolar rhabdomyosarcoma 8920. Both are subtypes/variants of rhabdomyosarcoma 8900. Code the NOS: rhabdomyosarcoma.

*Informational Item:* WHO 4th edition Tumors of the Urinary System has proposed ICD-O code 8323/1 for clear cell papillary renal cell carcinoma. This has not been approved for implementation by the standard setters in 2018.

*Note:* Use Table 1 in the Equivalent Terms and Definitions to determine NOS and subtype/variant.

**Rule H6** Code the subtype/variant when a NOS and a single subtype/variant of that NOS are present such as the following:

- Renal cell carcinoma 8312 and a subtype/variant of renal cell carcinoma
- Rhabdomyosarcoma 8900 and a subtype/variant of rhabdomyosarcoma
- Well differentiated neuroendocrine tumor 8240 and subtype/variant of well differentiated neuroendocrine tumor

*Note:* Use Table 1 in the Equivalent Terms and Definitions to determine NOS and subtype/variant.

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