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 frequently identify the histologic type. Currently, there are clinical trials being conducted to determine whether these biomarkers can be used to identify multiple primaries. Follow the Multiple Primary Rules; do not code multiple primaries based on biomarkers.

Changes from 2007 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 (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).”
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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.

### 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
- Majority; major; predominantly; greater than 50%
- 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
Terms that are NOT Equivalent or Equal

This is a term that is 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

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

Table begins on next page
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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>8041</strong></td>
<td>Carcinoid [OBS] Small cell neuroendocrine tumor/carcinoma</td>
<td>Large cell neuroendocrine carcinoma/tumor <strong>8013</strong> Well-differentiated neuroendocrine tumor <strong>8240</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 was not implemented in the 2018 ICD-O update. 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> <strong>Note:</strong> Hereditary leiomyomatosis and renal cell carcinoma-associated renal cell carcinoma and MiT family translocation 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. Mucinous tubular and spindle cell carcinoma <strong>8480</strong> Papillary renal cell carcinoma (PRCC) <strong>8260</strong> Renal medullary carcinoma <strong>8510</strong> <strong>Note:</strong> This is a new term (previously called renal spindle cell carcinoma).</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.”

Jump to [Multiple Primary Rules](#)  
Jump to [Histology Coding Rules](#)
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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>Sarcoma 8800/3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Rhabdomyosarcoma is a NOS with the following subtype/variants:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alveolar rhabdomyosarcoma 8920</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Embryonal rhabdomyosarcoma 8910</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pleomorphic rhabdomyosarcoma 8901</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spindle cell/sclerosing rhabdomyosarcoma 8912</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Angiosarcoma 9120/3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clear cell sarcoma/bone-metastasizing renal tumor of childhood 8964/3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Leiomyosarcoma/renal vein leiomyosarcoma 8890/3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Osteosarcoma 9180/3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Primitive/peripheral neuroectodermal tumor (pNET)/Ewing sarcoma 9364/3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rhabdomyosarcoma 8900/3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alveolar rhabdomyosarcoma 8920/3</td>
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<tr>
<td></td>
<td></td>
<td>Spindle cell/sclerosing rhabdomyosarcoma 8912/3</td>
</tr>
<tr>
<td></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

**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 as listed in column 1.

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

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

Kidney Anatomy (Includes Renal Pelvis)

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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
- Distant lymph nodes as identified in Summary Staging Manual
- Liver
- Lung
- Regional lymph nodes as identified in Summary Staging Manual

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\(^1\) when it is not possible to determine if there is a single tumor or multiple tumors.

Note 1: Use this rule only after all information sources have been exhausted.

Note 2: Examples of cases with minimal information include
- Death certificate only (DCO)
- Cases for which information is limited to pathology report only
  - Outpatient biopsy with no follow-up information available
  - Multiple pathology reports which do not specify whether a single tumor or multiple tumors have been biopsied and/or resected

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

\(^1\) Prepare one abstract. Use the histology rules to assign the appropriate histology code.
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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 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.

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 when multiple tumors are present in sites with ICD-O site codes that differ at the second (CXX), third (CXXX) and/or fourth characters (CXXX).

Note: When codes differ at the second, third, or fourth characters, the tumors are in different primary sites.

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

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 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

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

Note 2: ONLY abstract a single primary when pathology proves the tumor(s) in one kidney is/are metastatic from the other kidney.
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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. Tumors must be in same kidney.

Note: 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.

Rule M8  Abstract a single primary 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 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)
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Rule M9     Abstract multiple primaries\(^2\) when separate/non-contiguous tumors are on different rows in Table 1 in the Equivalent Terms and Definitions. Tumors must be in the same kidney.
Note: Each row in the table is a distinctly different histology.

Rule M10     Abstract a single primary\(^3\) 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\(^4\) (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.

Rule M12     Abstract multiple primaries\(^5\) when an invasive tumor occurs more than 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: 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.
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Rule M13  Abstract a **single primary**\(^1\) 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.

This is the end of instructions for Multiple Tumors.

\(^1\) 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.
**Priority Order for Using Documents to Identify Histology**

**IMPORTANT NOTES**

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

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. Biomarkers
2. Tissue or **pathology report from primary site** (in priority order)
   A. Addendum(s) and/or comment(s)
   B. Final diagnosis
   C. CAP protocol
      - *Note 1:* Addendums and comments on the pathology report are given a high priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.
      - *Note 2:* The pathologist’s diagnosis from the pathology report is always reliable, so the final diagnosis is the second priority.
      - *Note 3:* The CAP protocol is a checklist which:
        - Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care
        - Allows physicians to check multiple histologies
      *Note:* The CAP protocol must be documented in one location. Most frequently, in the:
        - Pathology final diagnosis
        - Addendum to the path report
3. **Cytology** (urine)
4. Tissue/pathology from a **metastatic** site
   - **Note 1:** Code the behavior /3.
   - **Note 2:** The **tissue** from a **metastatic** site often shows **variations** from the primary tumor. When it is the only tissue available, it is **more accurate** than a **scan**.
5. **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
6. Code the histology **documented** by the physician when none of the above are available. Use the documentation in the following priority order
   A. Documentation from Tumor Board
   B. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
   C. Physician’s **reference to** type of cancer (**histology**) in the medical record
   - **Note 1:** Code the specific histology when documented.
   - **Note 2:** Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.
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**Note:** Only code differentiation or features when there is a specific code for the NOS with differentiation or the NOS with features in Table 1 or the ICD-O and all updates. This instruction applies to single and multiple histologies.

### Coding Multiple Histologies

The priority is to code the most specific histology. **DO NOT USE BREAST HISTOLOGY CODING RULES FOR THIS SITE.**

1. **DO CODE** the most specific histology when any one of the following criteria are met:
   
   A. Code the histology when the **exact term** is documented.
   
   B. Code the histology when described as:
      - Subtype
      - Type
      - Variant

   **Note:** The most specific histology may be described as component, majority/majority of, or predominantly.

   C. 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.

   D. Code the histology described by **ambiguous terminology** (list follows) **ONLY** when:
      - Histology is clinically confirmed by a physician (attending, pathologist, oncologist, etc.)
      - Patient is receiving treatment based on the histology described by an ambiguous term
      - Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documentated
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List of Ambiguous Terminology

<table>
<thead>
<tr>
<th>Apparently</th>
<th>Most likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appears</td>
<td>Presumed</td>
</tr>
<tr>
<td>Comparable with</td>
<td>Probable</td>
</tr>
<tr>
<td>Compatible with</td>
<td>suspect(ed)</td>
</tr>
<tr>
<td>Consistent with</td>
<td>Suspicious (for)</td>
</tr>
<tr>
<td>Favor(s)</td>
<td>Typical (of)</td>
</tr>
<tr>
<td>Malignant appearing</td>
<td></td>
</tr>
</tbody>
</table>

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.

Example 3: 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 bullet 3.

Note: If the histology described by ambiguous terminology does not meet any of the criteria in bullets 1, 2, or 3, DO NOT CODE the histology.

2. **Do not code** histology when described as:
   - Architecture
   - Foci; focus; focal
   - Pattern
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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 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.

Code the histology according to the rule that fits the case