

Lung Equivalent Terms and Definitions
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Introduction

Note 1: 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 2: Cancers **from many primary sites metastasize** to the **lung**. It is important to **rule out metastases** from another organ/site before abstracting a lung primary.

Note 3: 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 4: Multifocal/multiple discrete foci tumors are often present in lepidic adenocarcinoma, minimally invasive adenocarcinoma, and adenocarcinoma in situ; these multiple foci may be referred to as ground-glass/lepidic.

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 MPH Rules

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

Note 1: Changes are **implemented slowly** over time, so it is not unusual for a pathology report to use an obsolete term. **Obsolete** terms and codes **can be used** when they are the **only information** available.

Note 2: WHO 4th Ed Tumors of Lung 2015 has a new classification of adenocarcinoma which is a significant change from the 2004 WHO classification. One of the major changes is discontinuing usage of the term **bronchioloalveolar carcinoma (BAC)** beginning with cases diagnosed 1/1/2018 and forward. The preferred term for BAC is now mucinous adenocarcinoma **8253**.

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** and **changed** ICD-O histology codes have been added to [Table 3](#) and are identified by an asterisk. Some of those changes include:
 - A. **In situ** and **minimally invasive terms** and codes
 - B. **Terms** assigned a **new histology** code
 - C. **Histology codes** assigned a **different preferred term** (18 codes with new preferred terms)
3. The following new terms and codes have been added. The new terms and codes are **for lung only**. See [notes](#) in Table 3.
 - A. Mucinous carcinoma/adenocarcinoma
 - **8253/3** when
 - Behavior unknown/not documented (use staging form to determine behavior when available)
 - Invasive
 - **8257/3** when
 - Microinvasive
 - Minimally invasive
 - **8253/2** when
 - Preinvasive
 - In situ

Note: Previously, only **invasive /3** codes were available for mucinous adenocarcinoma of the lung. It has been recognized that not all lung cancers are invasive /3 so new codes were implemented.
 - B. Non-mucinous carcinoma/adenocarcinoma
 - **8256/3** when
 - Microinvasive
 - Minimally invasive
 - **8250/2** when
 - Preinvasive
 - In situ

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Equivalent or Equal Terms

These terms can be used interchangeably:

- Adenocarcinoma, carcinoma
- And; with
Note: “And” and “with” are used as synonyms when **describing multiple histologies** within a **single tumor**.
- Carcinoma; adenocarcinoma
- Majority; major; predominantly; greater than 50%
- Non-small cell carcinoma **8046**; a broad category which includes all histologies in Table 3 **except** for small cell carcinoma/neuroendocrine tumors (NET Tumors) **8041** and all subtypes
- Simultaneous; existing at the same time; concurrent; prior to first course treatment
- Site; topography
- Squamous cell carcinoma, SCC, epidermoid carcinoma
- Tumor, mass, tumor mass, lesion, neoplasm, nodule
 - 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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Terms that are NOT Equivalent or Equal

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

- **Bilateral** is **NOT** equivalent to either single primary or multiple primaries. See Multiple Primary rules for instructions.
- **Bronchus** is **not** always equivalent to mainstem bronchus. The mainstem bronchus only extends a few centimeters into the lung.
 - Code to mainstem bronchus C340 when it is specifically stated in the operative report and/or documented by a physician
 - When only called bronchus, code to the lobe in which the bronchial tumor is located
- **Component** is not equivalent to subtype/variant
Note: Component is **only** coded when the pathologist specifies the component as a second **carcinoma**.
- Mucinous; colloid (**for lung only**)
Note: The **new codes** for mucinous adenocarcinoma were implemented so **mucinous** carcinoma and **colloid** carcinoma could be **analyzed separately**.
- **Mucin-producing/mucin-secreting** carcinoma **8481** is **not** equivalent to mucinous carcinoma **8253** (new code for lung primaries only)
 - Mucin-producing/secreting tumors produce mucin, but **not enough** to be classified as mucinous carcinoma
 - The terms mucin-producing and mucin-secreting are still **reportable**. This bullet simply states they are **not equivalent** or equal to mucinous carcinoma
- **Multilocular** is **not** equivalent to **multinodular** (see glossary for further information. The electronic glossary will be available in 2019)

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Table 1: Coding Primary Site

1. The mainstem bronchus **starts** at the **trachea** and extends only a few centimeters into the lung where it connects with the secondary bronchus and divides into **secondary bronchi**.
 - A. Each lobe of the lung has **secondary bronchi**
 - i. The **right** lung has **3 secondary bronchi**, one in each of the three lobes: upper; middle, and lower
 - ii. The **left** lung has **2 secondary bronchi**, one in each of the two lobes: upper and lower
 - B. Code to **mainstem bronchus** C340 when it is **specifically stated** in the operative report and/or documented by a physician.
 - C. When **only called bronchus**, code to the lobe in which the bronchial tumor is **located**
2. See the graphic in this document with the endnote “End of Mainstem Bronchus; Start of Terminal/Secondary Bronchus”
3. Refer to the **SEER Manual** and **COC Manual** for a **priority list** for using documents such as radiographic reports, operative reports, and pathology reports to determine the tumor location.

Table 1 contains terms used in **physicians’ documentation** and on **scans** to describe the location of a tumor.

This table has terms and anatomical descriptions which are not in the ICD-O.

Use this table to determine the **correct site** code. **Do not** use for other fields such as laterality.

Column 1 contains the **terminology used** by **physicians** or on **scans** to **describe lung “masses”** (not lymph nodes).

Column 2 indicates whether the **term** is **used only** for the **right** lung, or only for the **left** lung, or if it is used for **both** the right or left lung.

Column 3 contains the **ICD-O term** and **site code**.

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Terminology	Laterality	Site Term and Code
Bronchus intermedius Carina Hilus of lung Perihilar	Bilateral	Mainstem bronchus C340 <i>Note: Bronchus intermedius</i> is the portion of the right mainstem bronchus between the upper lobar bronchus and the origin of the middle and lower lobar bronchi
Lingula of lung	Left	Upper lobe C341
Apex Apex of lung Lung apex Pancoast tumor Superior lobar bronchus Upper lobe bronchi	Bilateral	Upper lobe C341
Middle lobe Middle lobe bronchi	Right	Middle lobe C342
Base of lung Lower lobar bronchus Lower lobe Lower lobe bronchi Lower lobe segmental bronchi	Bilateral	Lower lobe C343
Overlapping lesion of lung	Bilateral	Overlapping lesion of lung C348 <i>Note: One</i> lesion/tumor which overlaps two or more lobes

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Terminology	Laterality	Site Term and Code
Bronchus NOS Bronchogenic Extending up to the hilum Extending down to the hilar region Lung NOS Pulmonary NOS Suprahilar NOS	Bilateral	Lung NOS C349 <i>Note:</i> Includes <ul style="list-style-type: none"> • Multiple tumors in different lobes of ipsilateral lung OR • Multiple tumors in ipsilateral lung; unknown if same lobe or different lobe OR • Tumor in bronchus, unknown if mainstem or lobar bronchus OR • Tumor present, unknown which lobe
Lobar bronchi NOS Lobar bronchus NOS	Bilateral	Code the lobe in which the lobar bronchus tumor is present C34__ <i>Note:</i> When lobe of origin is not documented/unknown , code to lung NOS C349

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Table 2: Combination/Mixed Histology Codes

Instructions:

1. Compare the **terms** in the **diagnosis** (pathology, cytology, radiographic, clinical) to the terms in **Column 1**.
2. When the terms **match**, use the **combination code** listed in **Column 2**.
3. The **last row** in the table is a “**last resort**” code: adenocarcinoma mixed subtypes 8255.

Note 1: **Do not** use Table 2 in the following situations:

- For tumors with both **invasive** and **in situ** behavior. The [Histology Rules](#) instruct to code the invasive histology.
- When one of the histologies is described as **differentiation or features**
- When the terms are a **NOS** and a **subtype/variant** of that NOS. See the [Histology Rules](#) for instructions on coding a NOS and a subtype/variant in a single tumor or multiple tumors abstracted as a single primary.

Note 2: Some combinations can be either in situ or invasive; others are limited to a /2 or /3 behavior code.

- When a code is **limited to in situ**, /2 will be **added** to the code (both components are in situ)
- When a code is **limited to invasive**, /3 will be **added** to the code (both components are invasive)

Note 3: This table is not a complete listing of histology combinations.

Column 1 lists the **required terms** for the **combination code**.

Column 2 lists the **combination term** and **code** for histologies in **Column 1**.

Table begins on next page.

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Required Terms	Combination Histologies and Code
Adenocarcinoma NOS <p style="text-align: center;">AND</p> Squamous cell carcinoma NOS <i>Note:</i> Diagnosis must be adenocarcinoma NOS and squamous cell carcinoma NOS, NOT any of the subtypes/variants of adenocarcinoma or squamous cell carcinoma	Adenosquamous carcinoma 8560
Giant cell carcinoma <p style="text-align: center;">AND</p> Spindle cell carcinoma <i>Note:</i> Sarcomatoid carcinoma is not in the histology table because sarcomatoid tumors primarily originate in the mediastinum. The combination code is added for the rare occasion when a tumor occurs within the lung.	Sarcomatoid carcinoma 8033 <i>Note:</i> Both giant cell carcinoma and spindle cell carcinoma are components of sarcomatoid carcinoma. The most accurate code for a combination of giant cell and spindle cell carcinoma is sarcomatoid carcinoma
Epithelial carcinoma <p style="text-align: center;">AND</p> Myoepithelial carcinoma	Epithelial-myoepithelial carcinoma 8562
Mucinous carcinoma, invasive <p style="text-align: center;">AND</p> Non-mucinous carcinoma, invasive	Mixed invasive mucinous and non-mucinous carcinoma 8254/3*

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Required Terms	Combination Histologies and Code
<p>Small cell carcinoma/neuroendocrine tumor (NET) <i>Note: Includes subtypes/variants</i> of small cell/neuroendocrine tumor. See Table 3 for subtypes/variants.</p> <p style="text-align: center;">AND</p> <p>At least one of the following:</p> <ul style="list-style-type: none"> • Adenocarcinoma and any subtype/variant of adenocarcinoma • Adenosquamous carcinoma • Large cell carcinoma and any subtype/variant of large cell carcinoma • Squamous cell carcinoma and any subtype/variant of squamous cell carcinoma • Non-small cell carcinoma 	<p>Combined small cell carcinoma 8045</p>
<p>Squamous cell carcinoma (epidermoid carcinoma)</p> <p style="text-align: center;">AND</p> <p>Large cell non-keratinizing squamous cell carcinoma</p> <p><i>Note: Squamous cell carcinoma and epidermoid carcinoma are synonyms</i></p>	<p>Squamous cell carcinoma, large cell, nonkeratinizing 8072</p>
<p>Squamous cell carcinoma (epidermoid carcinoma)</p> <p style="text-align: center;">AND</p> <p>Small cell nonkeratinizing carcinoma</p> <p><i>Note: Squamous cell carcinoma and epidermoid carcinoma are synonyms</i></p>	<p>Squamous cell carcinoma, small cell, nonkeratinizing 8073</p>

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Required Terms	Combination Histologies and Code
<p>Squamous cell (epidermoid) carcinoma</p> <p style="text-align: center;">AND</p> <p>One or both of the following:</p> <ul style="list-style-type: none"> • Sarcomatoid carcinoma • Spindle cell carcinoma <p><i>Note 1:</i> Does not include subtypes/variants of squamous cell. See Table 3 for subtypes/variants.</p> <p><i>Note 2:</i> Squamous cell carcinoma and epidermoid carcinoma are synonyms.</p>	<p>Squamous cell carcinoma, sarcomatoid 8074</p> <p>Squamous cell carcinoma, spindle cell 8074</p>
<p>Diagnosis must be a single tumor which meets one of the following two criteria:</p> <p>1. <u>At least two</u> of the subtypes/variants of adenocarcinoma</p> <ul style="list-style-type: none"> • Acinar adenocarcinoma • Clear cell adenocarcinoma • Lepidic adenocarcinoma <p><i>Note:</i> Lepidic adenocarcinoma may or may not have mucinous components.</p> <ul style="list-style-type: none"> • Micropapillary adenocarcinoma • Papillary adenocarcinoma • Solid adenocarcinoma • Well-differentiated fetal adenocarcinoma <p><i>Note:</i> This includes a diagnosis of adenocarcinoma AND at least two subtypes/variants of adenocarcinoma.</p> <p>2. A combination of histologies not listed on previous rows of this table.</p>	<p>Adenocarcinoma with mixed subtypes 8255/3</p> <p><i>Note 1:</i> 8255 is a “last resort” code.</p> <p><i>Note 2:</i> See the Histology Rules to determine when it is appropriate to use this code for combination histologies other than adenocarcinoma subtypes/variants.</p>

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Table 3: Specific Histologies, NOS, and Subtype/Variants

Use Table 3 as directed by the [Histology Rules](#) to assign the more common histology codes for lung tumors.

Note 1: Rare histologies may not be listed in the table. When a histology term is not found, reference ICD-O and all updates.

Note 2: Submit a question to [Ask a SEER Registrar](#) when the histology code is not found in Table 3, ICD-O or ICD-O updates.

Note 3: Behavior codes are listed when the term has only one possible behavior (either a /2 or /3). For histologies which may be either /2 or /3, a behavior code is not listed. Code behavior as documented in the pathology report.

Note 4: Only use the histology code from the table when the diagnosis is **EXACTLY** the term listed.

Note 5: Sarcomatoid carcinoma is most frequently a tumor of the mediastinum, so it is not listed in this table.

IMPORTANT: Non-small cell lung carcinoma (NSCLC) is a broad group of cancers which includes all **carcinoma types** in Table 3 with the **exception** of:

- Small cell carcinoma/neuroendocrine tumors (NET Tumors) 8041 **AND**
 - All subtypes of small cell carcinoma **AND**
- Sarcoma NOS 8800 (not a carcinoma) **AND**
 - All subtypes of sarcoma NOS

NSCLC is usually adenocarcinoma, squamous cell carcinoma, or large-cell carcinoma. See the instructions for coding histology when NSCLC is the diagnosis.

Column 1 contains specific and NOS histology terms.

- **Specific** histology terms **do not** have **subtypes/variants**
- **NOS** histology terms **do** have **subtypes/variants**

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

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

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Specific or NOS Histology Term and Code	Synonym of Specific or NOS	Subtype/variant of NOS and Code
<p>Adenocarcinoma 8140</p> <p>Note 1: Mucinous adenocarcinoma for lung only is coded as follows:</p> <ul style="list-style-type: none"> • 8253/3* when <ul style="list-style-type: none"> ○ Behavior unknown/not documented (use staging form to determine behavior when available) ○ Invasive • 8257/3* when <ul style="list-style-type: none"> ○ Microinvasive ○ Minimally invasive • 8253/2* when <ul style="list-style-type: none"> ○ Preinvasive ○ In situ <p>Note 2: Non-mucinous adenocarcinoma for lung only is coded as follows:</p> <ul style="list-style-type: none"> • 8256/3* when <ul style="list-style-type: none"> ○ Microinvasive ○ Minimally invasive • 8250/2* when <ul style="list-style-type: none"> ○ Preinvasive ○ In situ 	<p>Adenocarcinoma NOS</p> <p>Adenocarcinoma in situ 8140/2</p> <p>Adenocarcinoma invasive 8140/3</p>	<p>Acinar adenocarcinoma/adenocarcinoma, acinar predominant (for lung only) 8551*</p> <p>Adenoid cystic/adenocystic carcinoma 8200</p> <p>Colloid adenocarcinoma 8480</p> <p>Fetal adenocarcinoma 8333</p> <p>Lepidic adenocarcinoma/adenocarcinoma, lepidic predominant 8250/3*</p> <p>Mucinous carcinoma/adenocarcinoma (for lung only)</p> <ul style="list-style-type: none"> in situ 8253/2* invasive 8253/3* minimally invasive 8257/3* microinvasive 8257/3* preinvasive 8253/2* <p>Micropapillary adenocarcinoma/adenocarcinoma, micropapillary predominant 8265</p> <p>Mixed invasive mucinous and non-mucinous adenocarcinoma 8254*</p> <p>Non-mucinous adenocarcinoma (for lung only)</p> <ul style="list-style-type: none"> in situ 8250/2* microinvasive 8256/3* minimally invasive 8256/3* preinvasive 8250/2* <p>Papillary adenocarcinoma/adenocarcinoma, papillary predominant 8260</p> <p>Pulmonary intestinal-type adenocarcinoma/enteric adenocarcinoma 8144</p> <p>Solid adenocarcinoma/adenocarcinoma, solid predominant 8230</p>

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Specific or NOS Histology Term and Code	Synonym of Specific or NOS	Subtype/variant of NOS and Code
Adenosquamous carcinoma 8560		
Epithelial-myoepithelial carcinoma 8562 <i>Note:</i> Adenomyoepithelioma, epithelial/myoepithelial tumor of unproven malignant potential were thought to be adenomas (not reportable) prior to 2018. These histologies are now designated as low-grade carcinomas based on lymph node metastasis, local invasion, and aggressiveness	Adenomyoepithelioma* Epimyoeplithelial carcinoma Epithelial-myoepithelial tumor of unproven malignant potential* Malignant mixed tumor comprising epithelial and myoepithelial cells Pneumocytic adenomyoepithelioma*	
Epithelioid hemangioepithelioma 9133		
Giant cell carcinoma 8031		
Intrapulmonary thymoma (arising within lung) 8580/3 <i>Note:</i> <u>Intrapulmonary</u> thymoma is always malignant /3 .		

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Specific or NOS Histology Term and Code	Synonym of Specific or NOS	Subtype/variant of NOS and Code
<p>Large cell carcinoma 8012</p> <p><i>Note 1:</i> A diagnosis of large cell carcinoma is usually followed by further diagnostic testing to identify the subtype/variant.</p> <p><i>Note 2:</i> The diagnosis of large cell carcinoma usually happens when there is a small amount of tissue (FNA), cytology, or when the tumor is highly differentiated. Large cell carcinoma lacks the features of small cell carcinoma, adenocarcinoma, or squamous carcinoma.</p> <p><i>Note 3:</i> Large cell carcinoma with neuroendocrine (NE) differentiation lacks NE morphology and is coded as large cell carcinoma, <u>not</u> large cell neuroendocrine carcinoma.</p>	<p>Large cell anaplastic carcinoma</p> <p>Large cell carcinoma NOS</p> <p>Large cell carcinoma with no additional stains (subtype/variant – no ICD-O code)</p> <p>Large cell carcinoma with null immunohistochemical features (subtype/variant – no ICD-O code)</p> <p>Large cell carcinoma with unclear immunohistochemical features (subtype/variant – no ICD-O code)</p> <p>Large cell undifferentiated carcinoma</p>	
Lymphoepithelioma-like carcinoma 8082		
Melanoma 8720		
<p>Mucoepidermoid carcinoma 8430</p> <p><i>Note:</i> Mucoepidermoid tumor is listed as a synonym of mucoepidermoid carcinoma in WHO</p>	Mucoepidermoid tumor	
Myoepithelial carcinoma 8982		

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Specific or NOS Histology Term and Code	Synonym of Specific or NOS	Subtype/variant of NOS and Code
<p>Neuroendocrine tumors (NET) 8041</p> <p><i>Note:</i> Large cell carcinoma with neuroendocrine differentiation lacks NE morphology and is coded as large cell carcinoma, not large cell neuroendocrine carcinoma</p>	<p>Reserve cell carcinoma Round cell carcinoma SCLC Small cell carcinoma NOS (no longer preferred term) Small cell neuroendocrine carcinoma</p>	<p>Atypical carcinoid 8249 Combined small cell carcinoma 8045 Large cell neuroendocrine carcinoma/combined large cell neuroendocrine carcinoma 8013 Typical carcinoid 8240</p>
<p>NUT carcinoma 8023/3* NUT: nuclear protein in tests NUT/M1 gene rearrangement</p>	<p>Aggressive t(15:19) positive carcinoma BET-rearranged carcinoma Carcinoma with t(15:19) translocation Midline carcinoma of children and young adults with NUT rearrangement Midline lethal carcinoma NUT midline carcinoma</p>	
<p>PEComa malignant 8714/3</p> <p><i>Note:</i> Tumor displays perivascular epithelioid (PEC) differentiation</p>		

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<p>Pleomorphic carcinoma 8022</p> <p><i>Note 1:</i> The definition of pleomorphic carcinoma is that it is a subtype of sarcomatoid carcinoma. It has at least 10% spindle or giant cells</p> <p><i>Note 2:</i> Pleomorphic carcinoma has components of adenocarcinoma and/or large cell carcinoma, also squamous carcinoma</p>		
<p>Sarcoma NOS 8800/3</p>		<p>Biphasic synovial sarcoma 9043/3 Epithelioid cell synovial sarcoma 9042/3 Pulmonary artery intimal sarcoma/low-grade malignant myxoid endobronchial tumor 9173/3 Pulmonary myxoid sarcoma with EWSR1 - CREB1 translocation 8842/3 Spindle cell synovial sarcoma 9041/3 Synovial sarcoma 9040/3</p>
<p>Spindle cell carcinoma 8032</p>		
<p>Squamous cell carcinoma 8070</p>	<p>Epidermoid carcinoma Epidermoid carcinoma NOS Squamous carcinoma Squamous cell carcinoma NOS Squamous cell epithelioma Squamous cell carcinoma in situ 8070/2</p>	<p>Basaloid carcinoma/basaloid squamous cell carcinoma 8083 Keratinizing squamous cell carcinoma 8071 Non-keratinizing carcinoma 8072</p>

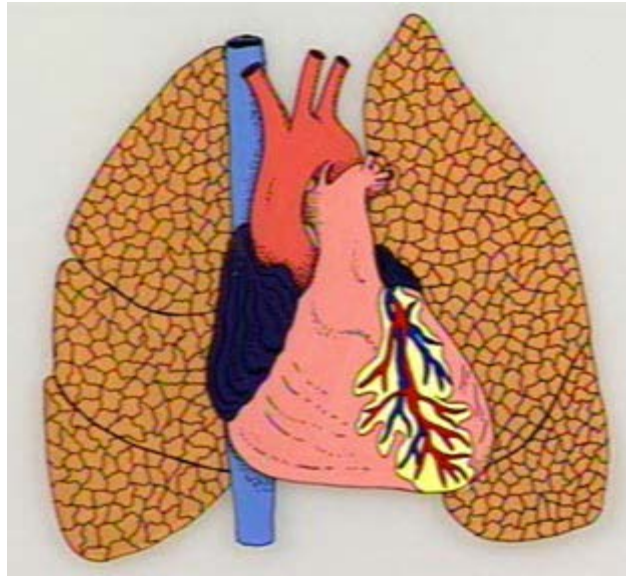
*New codes/terms approved by IARC/WHO Committee for ICD-O.

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Illustrations



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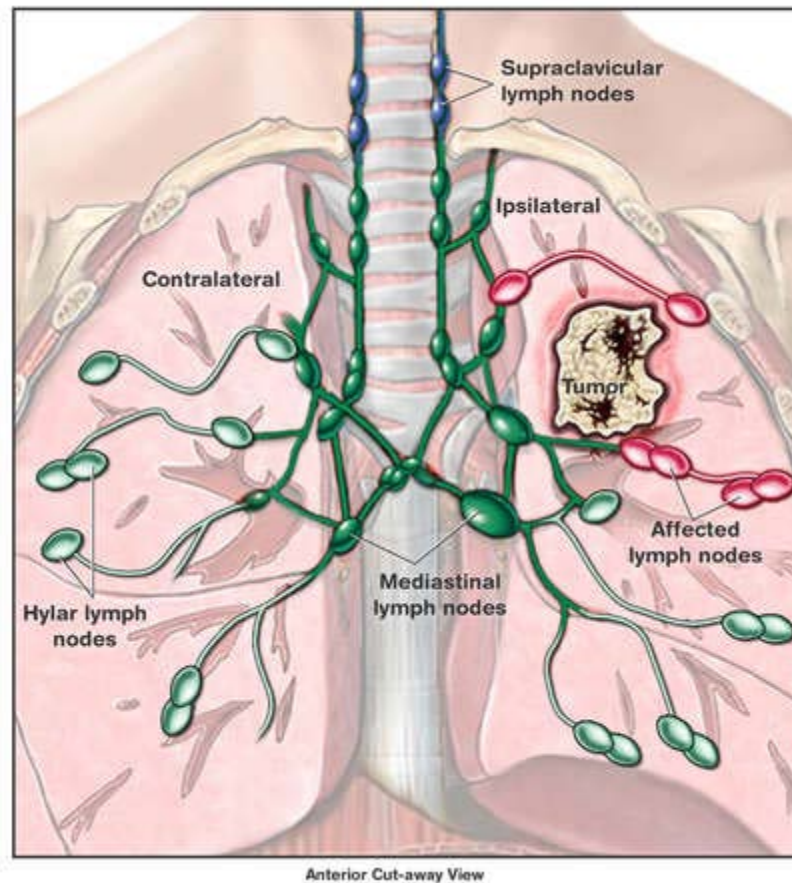
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Mediastinum

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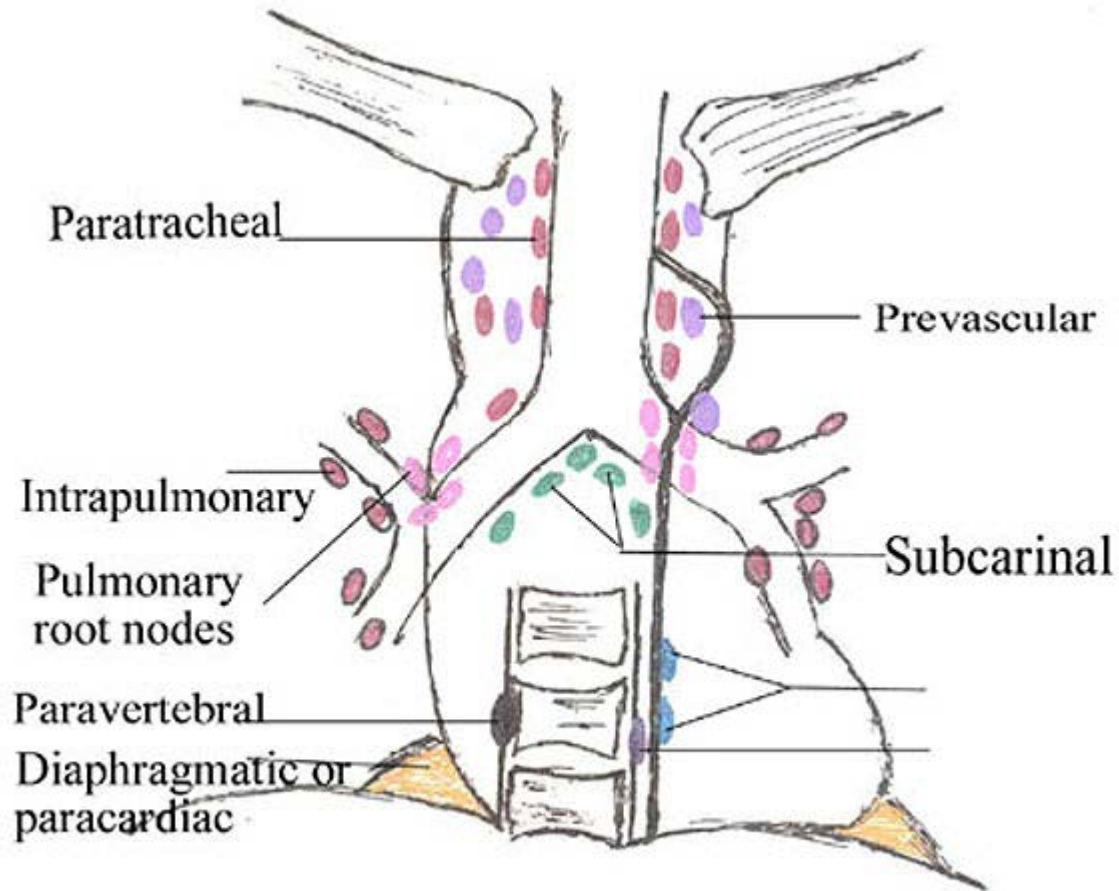
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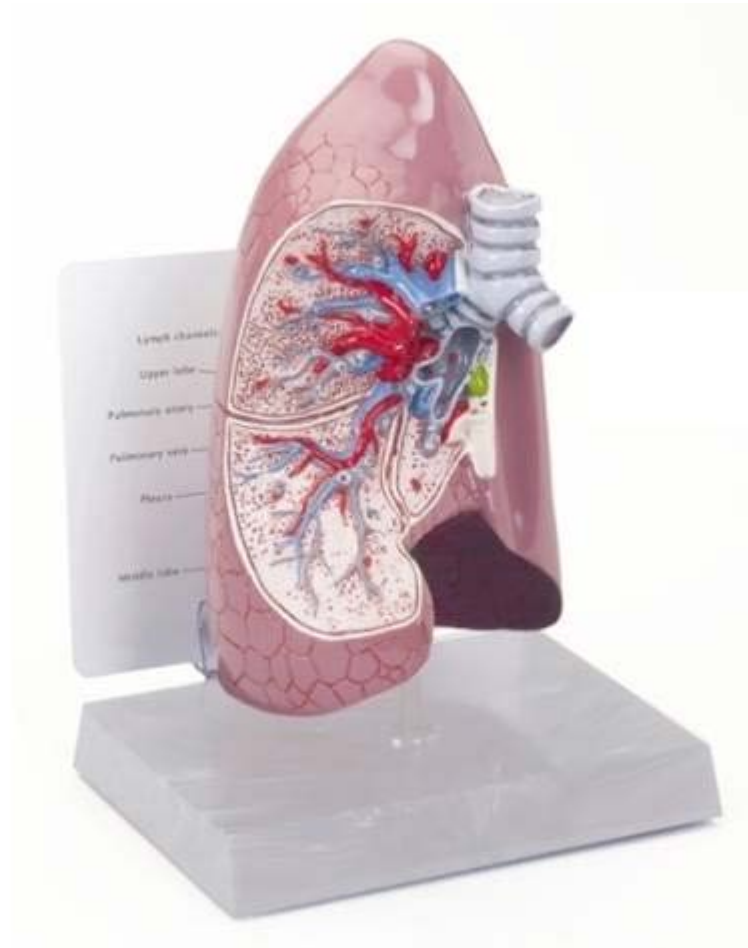
Lymph Nodes Lung

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Inside the Lung
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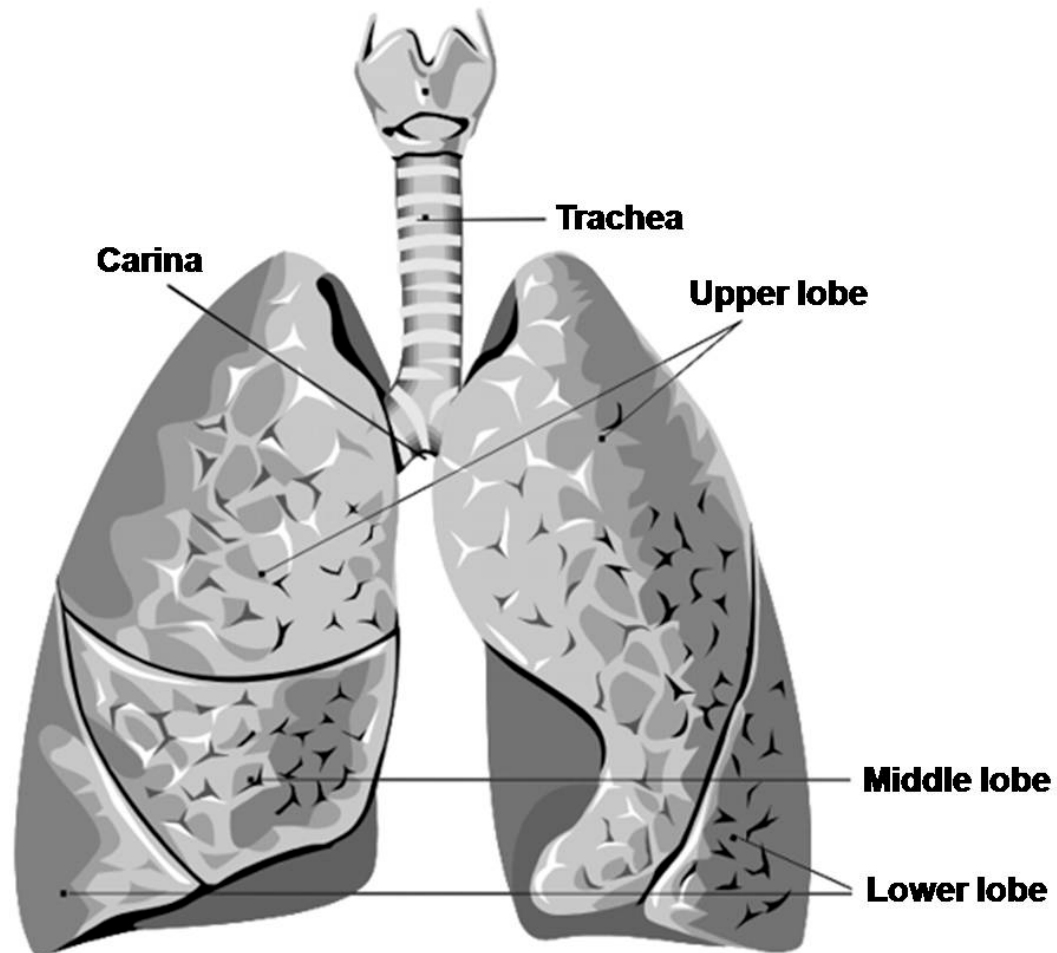


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Gross Anatomy of Lung
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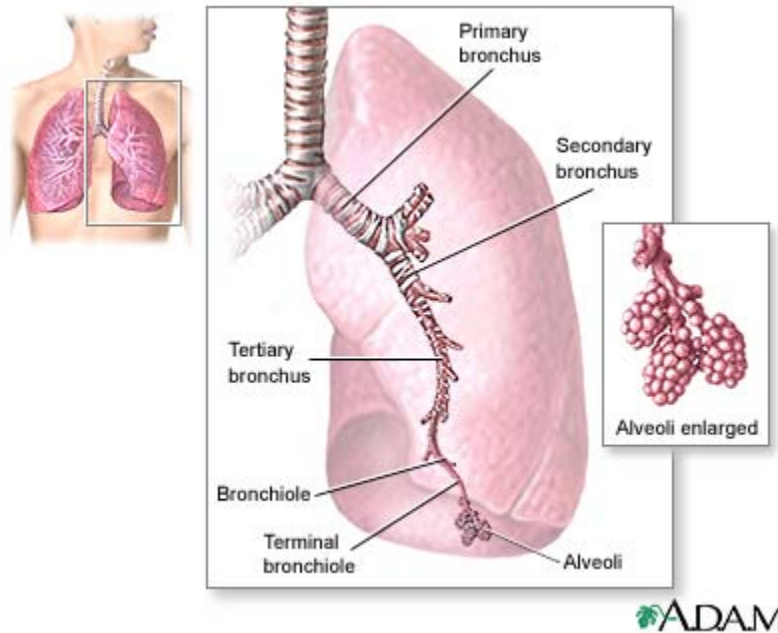
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End of Mainstem Bronchus; Start of Terminal/Secondary Bronchus

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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 glands
- Bone
- Brain
- Discontinuous lesions in adjacent/contiguous organs
- Discontinuous lesions in chest wall
- Discontinuous lesions/nodules in soft tissue adjacent to primary site
- Distant lymph nodes as identified in Summary Staging Manual
- Esophagus
- Heart
- Liver
- Regional lymph nodes as identified in Summary Staging Manual
- Trachea

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**ⁱ when it is not possible to determine if there is a **single** tumor or **multiple** tumors.

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

Note 2: Examples of cases with minimal information include

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

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

ⁱ Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

Jump to [Equivalent Terms and Definitions](#)

Jump to [Histology Coding Rules](#)

Lung Solid Tumor Rules 2018

January 2019 Update

Lung Multiple Primary Rules
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Single Tumor

Rule M2 Abstract a **single primary**ⁱ when there is a **single tumor**.

Note 1: A single tumor is always a single primary.

Note 2: The tumor may overlap onto or extend into adjacent/contiguous site or subsites.

Note 3: The tumor may have in situ and invasive components.

Note 4: The tumor may have two or more histologic components.

This is the end of instructions for Single Tumor

ⁱ Prepare one abstract. Use the histology coding 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**ⁱⁱ when there are **separate, non-contiguous** tumors in sites with ICD-O site codes that differ at the second CXxx and/or third character CxXx.

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

Rule M4 Abstract **multiple primaries**ⁱⁱ 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 in the same lung on follow-up.

- Scans are NED
- Tumor biomarkers are 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, use **date of diagnosis** to compute the time interval.

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

Jump to [Equivalent Terms and Definitions](#)

Jump to [Histology Coding Rules](#)

Lung Solid Tumor Rules 2018

January 2019 Update

Lung Multiple Primary Rules
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Rule M5 Abstract **multiple primaries**ⁱⁱ when there is **at least one** tumor that is **small cell carcinoma 8041** or any small cell subtypes/variants and another tumor that is **non-small cell carcinoma 8046** or any non-small cell carcinoma subtypes/variants.

Note 1: Small cell carcinoma and non-small cell carcinoma are the two major classifications/divisions for lung cancer.

- See [Table 3](#) in Equivalent Terms and Definitions for terms and codes for small cell carcinoma and all of the subtypes/variants
- With the exception of small cell/neuroendocrine carcinoma, **all other histologies** listed in [Table 3](#) in Equivalent Terms and Definitions are **non-small cell carcinoma**

Note 2: It is **irrelevant** whether the tumors are in the **ipsilateral** (same) lung or are **bilateral** (both lungs).

Rule M6 Abstract **multiple primaries**ⁱⁱ when separate/non-contiguous tumors are two or more **different subtypes/variants** in Column 3, [Table 3](#) in the Equivalent Terms and Definitions. Timing is irrelevant.

Note: The tumors may be subtypes/variants of the **same** or **different** NOS histologies.

- **Same NOS:** Colloid adenocarcinoma 8480/3 and lepidic adenocarcinoma 8250/3 are both subtypes of adenocarcinoma NOS 8140/3 but are distinctly different histologies. Abstract multiple primaries.
- **Different NOS:** Keratinizing squamous cell carcinoma 8071/3 is a subtype of squamous cell carcinoma NOS 8070; Lepidic adenocarcinoma 8520/3 is a subtype of adenocarcinoma 8140/3. They are distinctly different histologies. Abstract multiple primaries.

Rule M7 Abstract a **single primary**ⁱ when synchronous, separate/non-contiguous tumors **in the same lung** are on **the same row** in [Table 3](#) in the Equivalent Terms and Definitions.

Note 1: Tumors must be **in the same lung**.

Note 2: The tumors **must be the same behavior**. When one tumor is in situ and the other invasive, continue through the rules.

Note 3: The same row means the tumors are:

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

Rule M8 Abstract **multiple primaries**ⁱⁱ when separate/non-contiguous tumors are on **different rows** in [Table 3](#) in the Equivalent Terms and Definitions. Timing is irrelevant.

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

Lung Multiple Primary Rules
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Rule M9 Abstract a **single primary**ⁱ when there are **simultaneous multiple** tumors:

- In **both** lungs (multiple in right and multiple in left) **OR**
- In the **same** lung **OR**
- **Single** tumor in one lung; **multiple** tumors in **contralateral** lung

Note 1: Tumors may be combinations of:

- In situ and invasive **OR**
- NOS and subtype/variant (See [Table 3](#) in the Equivalent Terms and Definitions)

Note 2: Examples of NOS and subtypes/variants include:

- Adenocarcinoma **8140** and a subtype/variant of adenocarcinoma
- Squamous cell carcinoma **8070** and a subtype/variant of squamous cell carcinoma
- NSCLC **8046** and a subtype/variant of NSCLC

Note 3: Code multiple primaries only when there is **proof** that one of the tumors is a different histology. Proof is any one of the following:

- Pathology from a biopsy or resection proves tumors are different histologies
- Attending, oncologist, or pulmonologist state unequivocally that the tumors are different primaries
 - o **Unequivocal** means that **no words** such as “**probable**” are used in the statement. Terms which are on the “ambiguous terms” list such as “probable” cannot be used to prove different primaries.

Note 4: When there are multiple tumors in one or both lungs, the physician usually biopsies only one mass/tumor. They treat the patient based on that single biopsy, assuming all of the masses/tumors are the same histology.

Rule M10 Abstract a **single primary**ⁱ when an **in situ** tumor is diagnosed **after** an **invasive** tumor **AND** tumors occur in the same lung.

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 3](#) in the Equivalent Terms and Definitions for listings of NOS and subtype/variants.

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

Lung Multiple Primary Rules
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Rule M11 Abstract **multiple primaries**ⁱⁱ when there is a **single tumor in each lung** (one tumor in the right lung and one tumor in the left lung).

Note 1: The only **exception** is when there is **proof** that one tumor is **metastatic**. Proof is any one of the following:

- Tissue from both tumors is compared and the pathologic diagnoses definitively says one tumor is metastatic
- Attending physician, oncologist, or pulmonologist state unequivocally that the tumor in the contralateral lung is metastatic
 - o Unequivocal means that no words such as “probably possibly, most likely, etc.” are used in the statement. Terms which are on the “ambiguous terms” list make the statement equivocal (cannot be used to prove metastases)

Note 2: Lung **metastases usually** present as multiple tumors/masses. A single tumor in each lung is unlikely to be a single primary (e.g. metastatic to the contralateral lung).

Note 3: The term “**bilateral**” is **not** a synonym for a **single primary**. It is simply a statement that there are tumors in both lungs.

Note 4: This rule is based on **long-term epidemiologic studies** of multiple primaries. The specialty medical experts (SME) and the CoC site physician teams reviewed and approved these rules. Many of the CoC site team physicians were also authors, co-authors, or editors of the AJCC Staging Manual.

Note 5: Lymph node involvement is recorded in staging criteria.

Rule M12 Abstract a **single primary**ⁱ (the invasive) when an **invasive tumor is diagnosed less than or equal to 60 days after an in situ tumor in the same lung**.

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.

Lung Multiple Primary Rules
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Rule M13 Abstract **multiple primaries**ⁱⁱ when an **invasive** tumor occurs **more than 60** days after an **in situ** tumor in the same lung.

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

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

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

Note 4: This rule is based on long-term epidemiologic studies of recurrence intervals. The specialty medical experts (SMEs) reviewed and approved these rules. Many of the SMEs were also authors, co-authors, or editors of the AJCC Staging Manual.

Rule M14 Abstract a **single primary**ⁱ when none of the previous rules apply.

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

This is the end of instructions for Multiple Tumors

ⁱPrepare 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.

ⁱⁱPrepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

Lung Histology Rules C340-C343, C348, C349

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

Note: WHO 4th Ed Tumors of Lung: in 2011 has a new classification of adenocarcinoma which is a significant changes from the 2004 WHO classification. One of the major changes is discontinuing usage of the term bronchioloalveolar carcinoma (BAC) beginning with cases diagnosed 1/1/2018 and forward. The preferred term for BAC is now mucinous adenocarcinoma **8253**.

Priority Order for Using Documents to Identify Histology

IMPORTANT NOTES

1. Code the histology diagnosed prior to neoadjuvant treatment.
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 stage.

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** histology 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.

Jump to [Equivalent Terms and Definitions](#)

Jump to [Multiple Primary Rules](#)

Lung Solid Tumor Rules 2018

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- 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** (Fine needle biopsy, pleural fluid) from primary site

Example: Fine needle aspiration shows squamous cell carcinoma and the resection pathology shows invasive adenocarcinoma. Code adenocarcinoma 8140/3.

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 **in priority** order.

- A. CT
- B. PET
- C. MRI
- D. Chest X-ray

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.

Lung Histology Rules
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(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Note: Only code **differentiation** or **features** when there is a **specific code** for the NOS with differentiation or the NOS with features in [Table 2](#) or [Table 3](#), or the ICD-O and all updates. This instruction applies to single and multiple histologies.

Coding Multiple Histologies

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

Note 2: Predominantly describes the greater amount of tumor. Predominant and majority are synonyms. Per the CAP protocol, the term predominant is acceptable for the following specific subtypes of adenocarcinoma. For these subtypes only, the word predominant is used to describe both the subtype and the grade of the tumor. See Table 3 for coding instructions.

- Adenocarcinoma, acinar predominant (lung only) **8551**
- Adenocarcinoma, lepidic predominant **8250**
- Adenocarcinoma, micropapillary predominant **8265**
- Adenocarcinoma, papillary predominant **8260**
- Adenocarcinoma, solid predominant **8230**

Note 3: For histologies other than those in Note 2, see Note 1. The terms majority and predominant are used to determine histology for breast cancers only.

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.

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

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

- Histology is clinically confirmed by a physician (attending, pathologist, oncologist, pulmonologist, 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/documented

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	

Example 1: The pathology diagnosis is NSCLC consistent with adenocarcinoma. The oncology consult says the patient has adenocarcinoma of the right lung. This is clinical confirmation of the diagnosis, code adenocarcinoma. The case meets the criteria in **bullet 1**.

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

Example 3: Outpatient biopsy says probably squamous 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 squamous 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.

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2. **Do not code** histology when described as:

- Architecture
- Foci; focus; focal
- Pattern

Single Tumor

Rule H1 Code **mucinous** adenocarcinoma as follows (for lung only):

- **8253/3** when
 - Behavior unknown/not documented (use staging form to determine behavior when available)
 - Invasive
- **8257/3** when
 - Microinvasive
 - Minimally invasive
- **8253/2** when
 - Preinvasive
 - In situ

Note 1: These **new codes and terms** will allow mucinous adenocarcinoma to be analyzed separately from colloid carcinoma.

Note 2: Changes take place over time. **Pathologists may not use** terms “minimally invasive” and “pre-invasive” **immediately**. Code the pathology diagnosis.

Rule H2 Code **non-mucinous** adenocarcinoma as follows:

- **8256/3** when
 - Microinvasive
 - Minimally invasive
- **8250/2** when
 - Preinvasive
 - In situ

Note 1: These are new codes and terms.

Note 2: Pathologists may not use the terms “minimally invasive” and “pre-invasive” immediately. Code the pathology diagnosis.

Jump to [Equivalent Terms and Definitions](#)

Jump to [Multiple Primary Rules](#)

Lung Solid Tumor Rules 2018

January 2019 Update

**Lung Histology Rules
C340-C343, C348, C349**

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

- Rule H3** Code the specific histology when the diagnosis is **non-small cell lung carcinoma (NSCLC) consistent with** (or any other ambiguous term) **a specific carcinoma** (such as adenocarcinoma, squamous cell carcinoma, etc.) when:
- The histology is clinically confirmed by a physician (attending, pathologist, oncologist, pulmonologist, etc.)
 - The patient is treated for the histology described by an ambiguous term
 - The case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documentated

Example 1: The pathology diagnosis is NSCLC consistent with adenocarcinoma. The oncology consult says the patient has adenocarcinoma of the right lung. This is clinical confirmation of the diagnosis, code adenocarcinoma. The case meets the criteria in bullet 1.

Example 2: The pathology diagnosis is NSCLC consistent with squamous cell carcinoma. The treatment plan says the patient will receive the following treatment for squamous cell carcinoma. Treatment plan confirms squamous cell carcinoma; code squamous cell carcinoma. The case meets the criteria in bullet 2.

Example 3: Outpatient biopsy says probably squamous 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 squamous cell carcinoma. The case meets the criteria in bullet 3.

- Rule H4** Code the histology when only **one histology** is present.

Note 1: Use [Table 3](#) to code histology. New codes, terms, and synonyms are included in **Table 3** and coding errors may occur if the table is not used.

Note 2: When the histology is **not listed** in **Table 3**, use the **ICD-O** and all **updates**.

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

Note 4: This includes coding non-small cell carcinoma when it is the only diagnosis available.

- Rule H5** Code the **invasive** histology **when in situ** and **invasive** histologies are present.

Note 1: Histologies may be **NOS** and a **subtype/variant**.

Note 2: When the NOS is invasive and the subtype/variant is situ, code the NOS (invasive).

Example: The histologies are mucinous adenocarcinoma in situ **8253/2** and invasive adenocarcinoma NOS **8140/3**. Code the invasive histology: adenocarcinoma **8140/3**.

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

Rule H6 Code the **subtype/variant** when there is a **NOS** and a **single subtype/variant** of that NOS, such as the following:

- Adenocarcinoma **8140** and a subtype/variant of adenocarcinoma
- Mucinous adenocarcinoma and a subtype/variant of mucinous adenocarcinoma
- Non-small cell carcinoma **8046** and a subtype/variant of non-small cell carcinoma
- Sarcoma **8800** and a subtype/variant of sarcoma
- Small cell neuroendocrine tumors/NET **8041** and a subtype/variant of small cell neuroendocrine tumor/NET
- Squamous cell carcinoma **8070** and a subtype/variant of squamous cell carcinoma

Note: See [Table 3](#) in the Equivalent Terms and Definitions to find NOS and subtypes/variants.

Rule H7 Code a **combination** code when there are multiple histologies **AND**

- The combination is listed in [Table 2](#) in Equivalent Terms and Definitions, the ICD-O and all updates, **OR**
- You received a combination code from [Ask a SEER Registrar](#).

Note: The rules are **hierarchical**. Use this rule only when previous rules do not **apply**.

Rule H8 Code adenocarcinoma with mixed subtypes **8255** for

- Multiple adenocarcinoma subtypes **OR**
- Any combination of histologies which are not listed in Table 2 in the Equivalent Terms and Definitions.

This is the end of instructions for Single Tumor

Code the histology using the rule that fits the case.

Lung Histology Rules
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9992 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 H9 Code **mucinous** adenocarcinoma (for lung only) when all tumors consist of:

- **8253/3** when
 - Behavior unknown/not documented (use staging form to determine behavior when available)
 - Invasive
- **8257/3** when
 - Microinvasive
 - Minimally invasive
- **8253/2** when
 - Preinvasive
 - In situ

Note 1: These are **new codes and terms** which will allow mucinous adenocarcinoma/carcinoma to be analyzed separately from colloid carcinoma.

Note 2: Changes take place over time. **Pathologists may not use** terms “minimally invasive” and “pre-invasive” **immediately**. Code the **pathology diagnosis**.

Rule H10 Code **non-mucinous** adenocarcinoma (for lung only) when all tumors consist of:

- **8256/3** when
 - Microinvasive
 - Minimally invasive
- **8250/2** when
 - Preinvasive
 - In situ

Note: These are new codes and terms.

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

Rule H11 Code the specific histology when the diagnosis for the tumor which is biopsied is **non-small cell lung carcinoma** (NSCLC) **consistent with** (or any other ambiguous term) **a specific carcinoma** (such as adenocarcinoma, squamous cell carcinoma, etc.) when:

- The histology is clinically confirmed by a physician (attending, pathologist, oncologist, pulmonologist, etc.)
- The patient is treated for the histology described by an ambiguous term
- The case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

Example 1: Only one tumor is biopsied. The pathology diagnosis is NSCLC consistent with adenocarcinoma. The oncology consult says the patient has adenocarcinoma of the right lung. This is clinical confirmation of the diagnosis, code adenocarcinoma. The case meets the criteria in bullet 1.

Example 2: Only one tumor is biopsied. The pathology diagnosis is NSCLC consistent with squamous cell carcinoma. The treatment plan says the patient will receive the following treatment for squamous cell carcinoma. Treatment plan confirms squamous cell carcinoma; code squamous cell carcinoma. The case meets the criteria in bullet 2.

Example 3: Only one tumor is biopsied. Outpatient biopsy says probably squamous 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 squamous cell carcinoma. The case meets the criteria in bullet 3.

Rule H12 Code the histology when only **one** histology is present in **all** tumors.

Note 1: Use [Table 3](#) to code histology. New codes, terms, and synonyms are included in **Table 3** and coding errors may occur if the table is not used.

Note 2: When the histology is **not listed** in **Table 3**, use the **ICD-O** and all **updates**.

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

Rule H13 Code the **invasive** histology when all tumors have both invasive and in situ elements.

Note 1: All tumors may be **mixed** in situ and invasive **OR** one tumor may be in situ and the other invasive.

Note 2: Tumors may be **NOS** and a **subtype/variant**.

Note 3: When the NOS is invasive and the subtype/variant is situ, code the NOS (invasive).

Note 4: Multiple Primary Rules must be applied to be certain all tumors are a single primary.

Jump to [Equivalent Terms and Definitions](#)

Jump to [Multiple Primary Rules](#)

Lung Solid Tumor Rules 2018

January 2019 Update

**Lung Histology Rules
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(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

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

- Adenocarcinoma **8140** and a subtype/variant of adenocarcinoma
- Mucinous adenocarcinoma and a subtype/variant of mucinous adenocarcinoma
- Non-small cell carcinoma **8046** and a subtype/variant of non-small cell carcinoma
- Sarcoma **8800** and a subtype/variant of sarcoma
- Small cell neuroendocrine tumors/NET **8041** and a subtype/variant of small cell neuroendocrine tumor/NET
- Squamous cell carcinoma **8070** and a subtype/variant of squamous cell carcinoma

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

Note 2: See [Table 3](#) in the Equivalent Terms and Definitions to find NOS and subtypes/variants.

Rule H15 Code the appropriate **combination code** when all tumors have multiple histologies **AND**

- The combination is listed in [Table 2](#) in Equivalent Terms and Definitions, the ICD-O and all updates, **OR**
- You received a combination code from [Ask a SEER Registrar](#).

Note: The rules are hierarchical. Use this rule **only** when previous rules do not 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.
