Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms and Definitions
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Introduction

Note 1: The group name “urinary sites” include: Renal pelvis C659; ureter C669; trigone of bladder C670; dome of bladder C671; lateral wall of bladder C672; anterior wall of bladder C673; posterior wall of bladder C674; bladder neck C675; ureteric orifice C676; urachus C677; overlapping lesion of bladder C678; bladder NOS C679; urethra C680; paraurethral gland C681; overlapping lesion of urinary organs C688; and urinary system NOS C689.

Note 2: 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 3: 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 4: 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.

In US, 90% of bladder tumors are urothelial carcinoma, less than 5% are pure squamous cell carcinoma or pure adenocarcinoma.

Urothelial carcinoma originates in urothelial/transitional cells which line the urethra, bladder, ureters, and renal pelvis and has two major subdivisions: papillary and non-papillary.
- Papillary carcinoma: (commonly in bladder, ureter, or renal pelvis): A warty growth which projects from the wall on a stalk
  - Non-invasive papillary urothelial carcinoma (occasionally called in situ)
  - Invasive papillary urothelial carcinoma
- Non-papillary urothelial: originates within the mucosa and does not project from the wall
  - Non-invasive carcinoma in situ (CIS)
  - Invasive urothelial carcinoma

Note: Both papillary and non-papillary urothelial carcinoma can be in situ /2 or invasive /3. Code the behavior specified in the pathology report.
Multifocal/Multicentric Tumors of Urinary Sites

Multifocality of urothelial carcinoma is a common finding. The phenomenon of multiple tumors has been theorized as being a result of the field effect.

The field effect concept has two main theories:

1. **Monoclonal**: A single malignant cell spreads throughout the urothelium by:
   a. Intraluminal spread with secondary implantation in different sites within the urinary tract OR
   b. Intraepithelial migration
2. **Oligoclonal**: Multifocal/multicentric tumors develop secondary to a field effect precipitated by carcinogens. The carcinogens cause genetic alterations at different sites within the urinary tract.

Neither theory has been conclusively proven.

Flat/urothelial carcinoma in situ can have a wide spread effect as a result of direct spread of neoplastic cells within the epithelium.

The rules for coding histology and defining the number of primaries are attempt to reconcile these observations in order to provide incidence data are consistent and reproducible.

Changes from 2007 MPH Rules

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).”
2. There are no significant changes in histology terms or codes in the 2016 WHO edition.
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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. Urothelial carcinoma and small cell neuroendocrine carcinoma is equivalent to urothelial carcinoma with small cell neuroendocrine carcinoma.
- Carcinoma; adenocarcinoma
- Flat transitional cell carcinoma; flat urothelial carcinoma; urothelial carcinoma in situ; noninvasive flat carcinoma; in situ transitional cell carcinoma
- Majority; major; predominantly; greater than 50%
- Noninvasive papillary carcinoma; papillary transitional cell carcinoma; intramucosal papillary urothelial carcinoma
- Non-invasive; cancer that has not spread into muscle; anatomic term which may be used to describe both in situ papillary and non-invasive urothelial carcinoma
- Papillary transitional cell carcinoma; papillary urothelial carcinoma
- Simultaneous; existing at the same time; concurrent; prior to first course treatment
- Topography; site code
- Tumor; mass; tumor mass; lesion; neoplasm
  - The terms tumor, mass, tumor mass, lesion, and neoplasm are not used in a standard manner in clinical diagnoses, scans, or consults. Disregard the terms unless there is a physician’s statement that the term is malignant/cancer
  - These terms are used ONLY to determine multiple primaries
  - Do not use these terms for casefinding or determining reportability
- Type; subtype; variant
- Urothelial carcinoma; transitional cell carcinoma
- Urothelium; epithelium; transitional epithelium

Jump to Multiple Primary Rules
Jump to Histology Coding Rules

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Terms that are Not Equivalent or Equal

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

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

- Noninvasive; papillary urothelial carcinoma; flat urothelial carcinoma
  
  Note: Noninvasive is not equivalent to either papillary urothelial or flat urothelial carcinoma. Pathologists may use the term noninvasive to describe a tumor which does not invade beyond the subepithelial connective tissue. Both Ta and Tis tumors are technically noninvasive because invasion is limited to the subepithelial connective tissue. Code the histology specified by the pathologist.

Priority for Coding Primary Site

The following list is in priority order.

1. Code urinary bladder C678 when:
   A. The histology is non-invasive or in situ /2 urothelial carcinoma (may be called flat carcinoma, noninvasive flat carcinoma)
      AND
   B. ONLY bladder and one or both ureters are involved (no tumors in other urinary sites/organs)
      Note: Overlapping non-invasive tumors of the bladder and ureter almost always originate in the bladder. They extend/overlap into the ureter by spreading along the mucosa. It is important to code these primaries to bladder C678, NOT to overlapping lesion of urinary organs C688.

2. In situ /2 or invasive /3 any histology:
   A. Code overlapping tumor of bladder C678 when a single tumor
      i. Overlaps subsites of the bladder
      ii. Overlaps the bladder and ureter AND/OR urethra
   B. Code bladder NOS C679 when there are multiple tumors within the bladder and the subsite/origin is unknown/not documented.
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C. Code overlapping lesion of urinary organs C688 when a single tumor overlaps two urinary sites and the origin is unknown/not documented. Use for overlapping tumor involving any of the following sites:
   i. Renal pelvis and ureter
   ii. Bladder and urethra

D. Code Urinary System NOS C689 when there are tumors in multiple organs within the urinary system.

Note: The physician subject matter experts (SME) discussed the issue of coding primary site for multifocal/multicentric urinary tract carcinoma. Although the SMEs understood and acknowledged the importance of coding a specific primary site, there is no literature or criteria for determining the organ of origin for multiple tumors involving multiple urinary sites.

Table 1: ICD-O Primary Site Codes

Use the following table to determine the correct site code.

Column 1 contains the site term and ICD-O code.
Column 2 contains synonyms for the site code and term in column 1.

<table>
<thead>
<tr>
<th>Site Term and code</th>
<th>Synonyms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bladder, anterior wall C673</td>
<td>-</td>
</tr>
<tr>
<td>Bladder, dome C671</td>
<td>Roof, Vault, Vertex</td>
</tr>
<tr>
<td>Bladder, lateral wall C672</td>
<td>Lateral to ureteral orifice, Left wall, Right wall, Sidewall</td>
</tr>
<tr>
<td>Bladder neck C675</td>
<td>Internal urethral orifice, Vesical neck</td>
</tr>
<tr>
<td>Bladder NOS C679</td>
<td>Lateral posterior wall (no hyphen)</td>
</tr>
<tr>
<td>Bladder, overlapping lesion C678</td>
<td>Fundus, Lateral-posterior wall (hyphen)</td>
</tr>
</tbody>
</table>
### Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms and Definitions

<table>
<thead>
<tr>
<th>Site Term and code</th>
<th>Synonyms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bladder, posterior wall C674</td>
<td>-</td>
</tr>
</tbody>
</table>
| Bladder, trigone C670 | Base of bladder  
Below interureteric crest  
Below interureteric field  
Below interureteric ridge  
Floor of bladder |
| Bladder, urachus C677 | Mid umbilical ligament |
| Bladder, ureteric orifice C676 | Just above ureteric orifice |
| Overlapping lesion of urinary organs C688 | - |
| Paraurethral gland C681 | - |
| Renal pelvis C659 | Pelvis of kidney  
Pelviureteric junction  
Renal calyces  
Renal calyx |
| Ureter C669 | - |
| Urethra C680 | Cowper gland  
Prostatic utricle  
Urethral gland |
| Urinary system NOS C689 | - |

(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)
Table 2: Specific Histologies, NOS, and Subtypes/Variants

Use Table 2 as directed by the Histology Rules to assign the more common histology codes for urinary tract neoplasms.

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.

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 a subtype/variant 8910/3. The subtype/variant is 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 a subtype/variant.

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

Table begins on next page
## Specific and NOS Histology Codes

### Adenocarcinoma NOS 8140
- Mixed adenocarcinoma
- Urachal adenocarcinoma/carcinoma
- Clear cell carcinoma 8310
- Endometrioid carcinoma 8380
- Enteric adenocarcinoma 8144
- Mucinous adenocarcinoma 8480

### Malignant melanoma 8720/3

### Malignant perivascular epithelioid cell tumor 8714/3

### Sarcoma NOS 8800/3

- **Note:** Rhabdomyosarcoma 8900 is a NOS with a subtype/variant of embryonal rhabdomyosarcoma/sarcoma botryoides 8910/3.
  - Angiosarcoma 9120/3
  - Chondrosarcoma 9220/3
  - Leiomyosarcoma 8890/3
  - Liposarcoma 8850/3
  - Malignant peripheral nerve sheath tumor (MPNST) 9540/3
  - Pleomorphic sarcoma 8802/3
  - Rhabdomyosarcoma 8900/3
  - Embryonal rhabdomyosarcoma/sarcoma botryoides 8910/3

### Small cell neuroendocrine carcinoma 8041
- Neuroendocrine carcinoma
- SmCC
- Large cell neuroendocrine tumor 8013
- Well-differentiated neuroendocrine tumor 8240

### Squamous cell carcinoma 8070
- Pure squamous cell carcinoma
- SCC
- Verrucous carcinoma 8051

Table continues on next page
# Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms and Definitions

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<table>
<thead>
<tr>
<th>Specific and NOS Histology Codes</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urothelial carcinoma <strong>8120</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note 1:</strong> Previously called <em>transitional cell</em> carcinoma, a term that is no longer recommended.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note 2:</strong> Micropapillary <strong>8131</strong> is a subtype/variant of papillary urothelial carcinoma <strong>8130</strong>. It is an invasive /3 neoplasm with aggressive behavior.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear cell (glycogen-rich) urothelial carcinoma <strong>8120/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infiltrating urothelial carcinoma <strong>8120/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infiltrating urothelial carcinoma with divergent differentiation <strong>8120/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infiltrating urothelial carcinoma with endodermal sinus lines <strong>8120/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infiltrating urothelial carcinoma with glandular differentiation <strong>8120/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infiltrating urothelial carcinoma with squamous differentiation <strong>8120/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infiltrating urothelial carcinoma with trophoblastic differentiation <strong>8120/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lipid-rich urothelial carcinoma <strong>8120/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Microcystic urothelial carcinoma <strong>8120/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nested urothelial carcinoma <strong>8120/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plasmacytoid urothelial carcinoma <strong>8120/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urothelial carcinoma in situ <strong>8120/2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Giant cell urothelial carcinoma <strong>8031/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphoepithelioma-like urothelial carcinoma <strong>8082/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Papillary urothelial (transitional cell) carcinoma in situ <strong>8130/2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>invasive <strong>8130/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Microcystic urothelial carcinoma <strong>8131/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorly differentiated carcinoma <strong>8020/3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sarcomatoid urothelial carcinoma <strong>8122/3</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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Table 3: Non-Reportable Urinary Tumors

<table>
<thead>
<tr>
<th>Histology Term and Code</th>
<th>Synonyms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benign perivascular epithelioid cell tumor 8714/0</td>
<td>Benign PEComa</td>
</tr>
<tr>
<td>Granular cell tumor 9580/0</td>
<td></td>
</tr>
<tr>
<td>Hemangioma 9120/0</td>
<td></td>
</tr>
<tr>
<td>Inflammatory myofibroblastic tumor 8825/1</td>
<td></td>
</tr>
<tr>
<td>Inverted urothelial papilloma 8121/0</td>
<td></td>
</tr>
<tr>
<td>Leiomyoma 8890/0</td>
<td></td>
</tr>
<tr>
<td>Melanosis No code</td>
<td></td>
</tr>
<tr>
<td>Neurofibroma 9540/0</td>
<td></td>
</tr>
<tr>
<td>Nevus 8720/0</td>
<td></td>
</tr>
<tr>
<td>Papillary urothelial neoplasm of low-malignant potential 8130/1</td>
<td>Extra-adrenal pheochromocytoma</td>
</tr>
<tr>
<td>Paraganglioma 8693/1</td>
<td></td>
</tr>
<tr>
<td>Solitary fibrous tumor 8815/1</td>
<td></td>
</tr>
<tr>
<td>Squamous cell papilloma 8052/0</td>
<td>Keratotic papilloma</td>
</tr>
<tr>
<td>Urothelial dysplasia No code</td>
<td></td>
</tr>
<tr>
<td>Urothelial papilloma 8120/0</td>
<td></td>
</tr>
<tr>
<td>Villous adenoma 8261/0</td>
<td></td>
</tr>
</tbody>
</table>
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Source: TNM Atlas, 3rd edition, 2nd revision
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Bladder Tumor

Courtesy Jean-Loup Huret reprinted from Atlas Genet Cytogenet Oncol Haematol. October 2003. van Tilborg A
Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms and Definitions

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Bladder Wall

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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:
- Bones
- Brain
- Distant lymph nodes for the primary site being abstracted as identified in Summary Staging Manual
- Involvement of the pelvic or abdominal wall
- Liver
- Lung
- Regional lymph nodes for the primary site being abstracted 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 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\(^1\) 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.

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

Multiple Tumors

*Note 1:* Multiple tumors may be a single primary or multiple primaries.

*Note 2:* Separate, non-contiguous tumors are always multiple primaries when:

- In the urinary system (see Table 1) AND in a site other than the urinary system
  
  *Example:* Patient has urothelial carcinoma of the bladder and non-metastatic adenocarcinoma of the lung. The lung is not a urinary site. Abstract two primaries.

- Non-synchronous tumors in multiple urinary sites (see Rule M13)

Rule M3 Abstract multiple primaries\(^2\) when there are:

- Separate/non-contiguous tumors in both the right AND left renal pelvis AND

- No other urinary sites are involved with separate/non-contiguous tumors

*Note 1:* Only abstract a single primary when pathology confirms tumor(s) in the contralateral renal pelvis are metastatic.

*Note 2:* This rule is used only when there is no involvement by separate/non-contiguous tumors in the ureter(s), bladder, or urethra.

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Jump to Equivalent Terms and Definitions
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Rule M4  Abstract **multiple primaries** when there are:
- Separate/non-contiguous tumors in the right **AND** left **ureter** **AND**
- No other urinary sites are involved with separate/non-contiguous tumors
Note 1: Only abstract a single primary when pathology confirms tumor(s) in contralateral ureter are metastatic.
Note 2: This rule is used only when there is **no involvement** by separate/non-contiguous tumors in the renal pelvis, bladder, and urethra.

Rule M5  Abstract a **single primary** when synchronous or simultaneous tumors are **noninvasive in situ** urothelial carcinoma (flat tumor) **8120/2** in the following sites:
- **Bladder C67** **AND**
- One or both **ureter(s) C669**
Note 1: No other urinary organs are involved.
Note 2: Use this rule ONLY for noninvasive in situ urothelial carcinoma (may be called noninvasive urothelial carcinoma or noninvasive flat tumor). For other histologies, continue through the rules.
Note 3: Urothelial carcinoma in situ spreads by intramucosal extension and may involve large areas of mucosal surface. The default for these cases is coding a bladder primary.

Rule M6  Abstract a **single primary** when the patient has multiple occurrences of **noninvasive in situ** urothelial carcinoma (flat tumor) **8120/2** tumors in the **bladder**. Original tumor and subsequent tumor are **8120/2**.
Note 1: Timing is irrelevant.
Note 2: Abstract only one in situ urothelial bladder tumor per the patient’s lifetime.

Rule M7  Abstract a **single primary** when the patient has multiple occurrences of **invasive** tumors in the **bladder**. Original tumor and subsequent tumor are either:
- Papillary **urothelial** carcinoma and a recurrence of papillary urothelial carcinoma **8130/3** OR
- Urothelial carcinoma and a recurrence of urothelial carcinoma **8120/3**
Note 1: Timing is irrelevant.
Note 2: This rule does not include subtypes/variants of 8120/3 or 8130/3.
Note 3: Abstract only one invasive urothelial bladder tumor per the patient’s lifetime.
Note 4: The rules are **hierarchical**. Only use this rule when previous rules do not apply.
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Rule M8  Abstract a single primary\(^1\) when there are synchronous urothelial carcinomas in multiple urinary organs.

*Note 1:* This rule is ONLY for urothelial carcinoma 8120 and all subtypes/variants of urothelial carcinoma. This rule does not apply to any other carcinomas or sarcomas.

*Note 2:* The histology for all tumors must be identical. The behavior is irrelevant.

*Note 3:* This rule applies to multifocal/multicentric carcinoma which involves two or more of the following urinary sites:
- Renal pelvis
- Ureter
- Bladder
- Urethra

Rule M9  Abstract multiple primaries\(^2\) 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:* The rules are hierarchical. This rule does not apply to urothelial carcinoma of the bladder.

*Note 2:* Clinically disease-free means that there was no evidence of recurrence on follow-up.
- Scans are NED
- Urine cytology is NED
- Scopes are NED

*Note 3:* When there is a recurrence within three years of diagnosis, the “clock” starts over. The time interval is calculated from the date of last recurrence.

*Note 4:* When it is unknown/not documented whether the patient had a recurrence, default to date of diagnosis to compute the time interval.

*Note 5:* The physician may state this is a recurrence, meaning the patient had a previous urinary site tumor and now has another urinary site tumor. Follow the rules; do not attempt to interpret the physician’s statement.

*Example:* Patient is diagnosed with multifocal/multicentric urothelial carcinomas in the ureter and renal pelvis in January 2018. Both the kidney and ureter are surgically removed. In June 2022 the patient presents with tumor in the contralateral ureter. The physician states this is a recurrence of the original urothelial carcinoma. Code a new primary for the 2022 ureter carcinoma.
Renal Pelvis, Ureter, Bladder, and Other Urinary Multiple Primary Rules
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Rule M10  Abstract multiple primaries\textsuperscript{a} when separate/non-contiguous tumors are two or more different subtypes/variants in Column 3 of Table 2 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:** Leiomyosarcoma 8890/3 and liposarcoma 8850/3 are both subtypes of sarcoma NOS 8800/3 but are distinctly different histologies. Abstract multiple primaries.
- **Different NOS:** Verrucous carcinoma 8051 is a subtype of squamous cell carcinoma NOS 8070; giant cell urothelial carcinoma 8031 is a subtype of urothelial carcinoma 8120. They are distinctly different histologies. Abstract multiple primaries.

Rule M11  Abstract multiple primaries\textsuperscript{a} when separate/non-contiguous tumors are on different rows in Table 2 in the Equivalent Terms and Definitions. Timing is irrelevant.

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

*Example:* Small cell neuroendocrine carcinoma 8041 and urothelial carcinoma 8120 are on different rows of Table 2. Abstract two primaries, one for the small cell neuroendocrine carcinoma and a second for the urothelial carcinoma.

Rule M12  Abstract multiple primaries\textsuperscript{a} when the patient has non-synchronous tumors which are:

- Papillary urothelial/transitional cell NOS 8130/3 AND
- Micropapillary urothelial/transitional cell 8131/3

*Note 1:* This is a new rule for 2019.

*Note 2:* Micropapillary urothelial cell carcinoma is an extremely aggressive neoplasm. It is important to capture the incidence of micropapillary urothelial carcinoma, therefore it is excluded from the typical “NOS and subtype/variant” rule (same row in table 2).

*Note 3:* For synchronous tumors, continue through the rules. Code the most specific histology.
Rule M13  Abstract multiple primaries when the original tumor and subsequent tumor occur in different urinary sites.  

**Note 1:** These tumors are not synchronous. Treatment has been given for the first tumor prior to the occurrence of the second tumor.  

**Note 2:** Histology and behavior are irrelevant. These tumors are always multiple primaries.  

**Note 3:** The original tumor occurs in one of the following urinary sites; the second tumor occurs in a different urinary site:  
- Renal pelvis (original tumor was not in renal pelvis)  
- Ureter (original tumor was not in ureter)  
- Bladder (original tumor was not in bladder)  
- Urethra (original tumor was not in urethra)  

**Example:** The patient was diagnosed 1/1/2018 with squamous cell carcinoma of the renal pelvis 8070/3. Patient had a nephrectomy. On routine follow-up six months later, the patient was diagnosed with urothelial carcinoma of the bladder 8120/3. The patient has two non-synchronous tumors involving different urinary organs. Abstract multiple primaries.

Rule M14  Abstract a single primary when synchronous, separate/non-contiguous tumors are on the same row in Table 2 in the Equivalent Terms and Definitions.  

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

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

**Note 3:** The multiple tumors may:  
- Occur in the same urinary site OR  
- Be multifocal/multicentric occurring in at least two of the following urinary sites:  
  - Renal pelvis C659  
  - Ureter C669  
  - Bladder C670-C679  
  - Urethra/prostatic urethra C680  

**Note:** A previous rule specifically lists in situ urothelial carcinoma of bladder and ureter as a single primary.
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Rule M15  Abstract a single primary\(^1\) (the invasive) when an in situ tumor is diagnosed after an invasive tumor AND tumors:
- Occur in the same urinary site OR
- The original tumors are multifocal/multicentric and occur in multiple urinary sites; subsequent tumor(s) are in at least one of the previously involved urinary sites

Note 1: The rules are hierarchical. Only use this rule when previous rules do not apply.
Note 2: The tumors may be a NOS and a subtype/variant of that NOS. See Table 2 in the Equivalent Terms and Definitions for listings of NOS and subtype/variants.
Note 3: Once the patient has an invasive tumor, the subsequent in situ is recorded as a recurrence for those registrars who collect recurrence data.

Rule M16  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 AND tumors:
- Occur in the same urinary site OR
- Original tumor is multifocal/multicentric and involves multiple urinary sites; the subsequent invasive tumor(s) occur in at least one of the previously involved urinary sites

Note 1: The rules are hierarchical. Only use this rule if none of the previous rules apply.
Note 2: The tumors may be an 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. Do not change date of diagnosis.
Note 4: If the case has already been submitted to the central registry, report all changes.
Note 5: 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 6: 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 M17**  
Abstract multiple primaries[^1] when an invasive tumor occurs more than 60 days after an in situ tumor AND tumors:  
- Occur in the same urinary site OR  
- Are multifocal/multicentric tumors in multiple urinary sites  
**Example:** The first presentation was multifocal/multicentric in situ tumors in multiple urinary organs; the subsequent presentation was invasive tumor in at least one of the previously involved urinary organs.  
**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 M18**  
Abstract a single primary[^2] when tumors 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:** TURB shows invasive urothelial carcinoma 8120/3 and CIS/in situ urothelial carcinoma 8120/2. Abstract a single primary.

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.  
[^2]: Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.
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Priority Order for Using Documentation 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)

Use documentation in the following priority order to identify the histology type(s):

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 (usually urine)

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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 and only physician documentation.

5. Code the histology **documented** by the physician when none of the above are available. Use the documentation in the following **priority order:**

   A. Documentation from Tumor Board
   B. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
   C. Physician’s reference to type of cancer (histology) in the medical record

   **Note 1:** Code the specific histology when documented.

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

6. **Scans:** CT, MRI. There is **no priority** order because scans are not a very reliable method for identifying specific histology(ies) for these sites.
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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 2 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

- Apparently
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Malignant appearing

- Most likely
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- Typical (of)

**Example 1:** The pathology diagnosis is sarcoma NOS consistent with leiomyosarcoma. The oncology consult says the patient has leiomyosarcoma of the bladder. This is clinical confirmation of the diagnosis, code leiomyosarcoma. The case meets the criteria in **bullet 1**.

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

**Example 3:** Outpatient biopsy says probably papillary urothelial 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 urothelial 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

Jump to [Equivalent Terms and Definitions](#) Urinary Solid Tumor Rules 2018
Jump to [Multiple Primary Rules](#) January 2019 Update
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Single Tumor

Rule H1  Code the histology when only one histology is present.

*Note 1:* Use Table 2 to code histology. New codes, terms, and synonyms are included in Table 2 and coding errors may occur if the table is not used.

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

*Note 4:* Only code squamous cell carcinoma (8070) when there are no other histologies present (pure squamous cell carcinoma).

*Note 5:* Only code adenocarcinoma (8140) when there are no other histologies present (pure adenocarcinoma).

Rule H2  Code the invasive histology when in situ and invasive histologies are present in the same tumor.

Rule H3  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
- Papillary urothelial carcinoma 8130 and a subtype/variant of papillary urothelial carcinoma
- Rhabdomyosarcoma 8900 and a subtype/variant of rhabdomyosarcoma
- Sarcoma 8800 and a subtype/variant of sarcoma
- Small cell neuroendocrine carcinoma 8041 and a subtype/variant of small cell neuroendocrine carcinoma
- Squamous cell carcinoma 8070 and a subtype/variant of squamous cell carcinoma
- Urothelial carcinoma 8120 and a subtype/variant of urothelial carcinoma

*Note:* Use Table 2 to identify NOS histologies and subtypes/variants.

Rule H4  Code mixed small cell carcinoma 8045 when the final diagnosis is any of the following:
- Small cell neuroendocrine mixed with any other type of carcinoma (does not apply to sarcoma)
- Two or more subtypes/variants of small cell neuroendocrine carcinoma
- Subtype/variant of small cell neuroendocrine mixed with any other carcinoma (does not apply to sarcoma)

*Example:* Diagnosis from TURB is urothelial carcinoma and small cell neuroendocrine carcinoma. Code mixed small cell carcinoma 8045.
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Rule H5  Code as follows when there is a mixture of urothelial carcinoma OR one urothelial carcinoma subtype/variant AND or WITH:
- Adenocarcinoma – code 8120 (or urothelial subtype/variant code)
  - Clear cell carcinoma – code 8120 (or urothelial subtype/variant code)
  - Endometrioid carcinoma – code 8120 (or urothelial subtype/variant code)
  - Enteric adenocarcinoma – code 8120 (or urothelial subtype/variant code)
  - Mucinous adenocarcinoma – code 8120 (or urothelial subtype/variant code)
  
  Note: Adenocarcinoma and subtypes/variants are coded ONLY when pure (not mixed with any other histology).
- Squamous cell carcinoma – code 8120/3 (or urothelial subtype/variant code)
  - Verrucous carcinoma – code 8120/3 (or urothelial subtype/variant code)
  
  Note: Squamous cell and verrucous carcinoma are coded ONLY when pure (not mixed with any other histology).

Example: Pathology says majority of tumor is squamous cell carcinoma 8070/3 with a minority composed of papillary urothelial cell carcinoma 8130/3. Code the papillary urothelial cell carcinoma 8130/3. The squamous cell carcinoma is not pure and cannot be coded.

This is the end of instructions for Single Tumor.

Code the histology using the rule that fits the case.
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C659, C669, C670-C679, C680-C689  
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Multiple Tumors Abstracted as a Single Primary

Rule H6  Code the histology when only one histology is present in all tumors.

**Note 1:** Use Table 2 to code histology. New codes, terms, and synonyms are included in Table 2 and coding errors may occur if the table is not used.

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

**Note 4:** Only code squamous cell carcinoma (8070) when there are no other histologies present (pure squamous cell carcinoma).

**Note 5:** Only code adenocarcinoma (8140) when there are no other histologies present (pure adenocarcinoma).

Rule H7  Code the invasive histology when there are invasive and in situ histologies:

- Mixed in each of the tumors OR
- In separate tumors (one or more invasive and one or more in situ)

Rule H8  Code the subtype/variant when all synchronous multifocal/multicentric tumors are a NOS and a single subtype/variant of that NOS such as the following:

- Adenocarcinoma 8140 and a subtype/variant of adenocarcinoma
- Papillary urothelial carcinoma 8130 and a subtype/variant of papillary urothelial carcinoma
- Rhabdomyosarcoma 8900 and a subtype/variant of rhabdomyosarcoma
- Sarcoma 8800 and a subtype/variant of sarcoma
- Small cell neuroendocrine carcinoma 8041 and a subtype/variant of small cell neuroendocrine carcinoma
- Squamous cell carcinoma 8070 and a subtype/variant of squamous cell carcinoma
- Urothelial carcinoma 8120 and a subtype/variant of urothelial carcinoma

**Note 1:** Use Table 2 to identify NOS histologies and subtypes/variants.

**Note 2:** 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.
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(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Rule H9  Code mixed small cell carcinoma 8045 when the final diagnosis for all tumors is any of the following:
  • Small cell neuroendocrine mixed with any other type of carcinoma (does not apply to sarcoma)
  • Two or more subtypes/variants of small cell neuroendocrine carcinoma
  • Subtype/variant of small cell neuroendocrine mixed with any other carcinoma (does not apply to sarcoma)

Example: Diagnosis from TURB is urothelial carcinoma and small cell neuroendocrine carcinoma. Code mixed small cell carcinoma 8045.

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

Code the histology using the rule that fits the case.