Solid Tumor Rules

Effective with Cases Diagnosed 1/1/2018 and Forward

2026 Update

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NCI SEER gratefully acknowledges the dedicated work of Lois Dickie, ODS-C, Dr. Charles Platz and Carol Johnson, BS, CTR, who were all involved with the project since the inception of the 2007 Multiple Primary and Histology Coding Rules. We appreciate the support they provided for the Solid Tumor Rules. The quality of the Solid Tumor Rules directly relates to their commitment.

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The Solid Tumor Rules

Preface

The *Solid Tumor Rules* (along with its predecessor, the *2007 Multiple Primary and Histology Rules*) were developed to promote consistent and standardized coding by cancer registrars. The primary reference for both the 2007 MPH rules and Solid Tumor Rules are the WHO Classification of Tumors books (blue books). Since 2007, WHO has continued publishing updates to the WHO Classification of Tumors series. As part of each new edition, subject matter experts review current literature and make recommendations regarding current practices in histology terminology and diagnosis. The Solid Tumors Rules are continually revised to reflect current CAP and WHO practices.

Beginning 2024, the Solid Tumor Editorial Board replaces the Solid Tumor Work Group and is comprised of the Solid Tumor editors, expert Oncology Data Specialists, and expert pathologists, oncologists, surgeons, and clinicians. As part of ongoing revisions to the rules, the editors and Solid Tumor Editorial Board review issues and questions NCI SEER received from the registrar community. These questions provided valuable information as to what clarifications were needed in the form of additional rules, tables, examples, and notes.

Physician guidance by specialty pathologists and clinicians is integral to the review and revision process. Regular consultation with the editors of the WHO Classification of Tumors series and AJCC physicians ensures that the rules accurately reflect the editors' intent and purpose.

Diagnosis Years for Which the Solid Tumor Rules Should be Used

The Solid Tumor Rules are revised annually to reflect new terminology, ICD-O codes, and other changes needed to keep in step with current clinical practice. The most recent Solid Tumor Rules manual should be used as soon as it is released. Each update contains start years for when new codes become valid and when new instructions become active (theoretical examples– "this code should be used for 2021+" or "do not use this code before 2022"). If there is no date associated with a newly-added code or instruction, then it can be applied back to 2018 (or 2021 or 2023 for Melanoma and Other Sites, respectively).

Previous versions of the Solid Tumor Rules should not be used for abstracting. The manual uses the term “ICD-O” rather than “ICD-O-3” to allow for updates. Use the currently approved version of ICD-O.

The table below indicates the diagnosis years for which each site-group should be used. The table also indicates the years for which the MP/H Rules should be used. To determine the number of primaries for cases diagnosed prior to 2007, use the standard setter manuals. Use the diagnosis year of the later tumor to determine what set of rules to use.

Table 1. Solid Tumor Rules Site-groups by Diagnosis Year

Site-group	Solid Tumor Rules	MP/H Rules
Head and Neck*	2018-Current	2007-2017
Colon**	2018-Current	2007-2017
Lung	2018-Current	2007-2017
Breast	2018-Current	2007-2017
Kidney	2018-Current	2007-2017
Urinary Sites	2018-Current	2007-2017
Non-Malignant CNS*	2018-Current	2007-2017
Malignant CNS and Peripheral Nerves *	2018-Current	2007-2017
Cutaneous Melanoma	2021-Current	2007-2020
Other Sites	2023-Current	2007-2022*, **

Example: A patient presents with a newly diagnosed invasive lobular carcinoma (8520/3) of the breast in 2025. The patient has a history of ductal carcinoma in situ (8500/2) diagnosed in 2017. Apply the rules that are in effect at the time the most recent tumor was diagnosed to determine if the invasive lobular carcinoma is a subsequent primary.

*Peripheral nerves were moved from the MP/H Other Sites to the Solid Tumor Head and Neck, Non-Malignant CNS, and Malignant CNS site-groups beginning with cases diagnosed 2018. Paraganglioma histologies 8680/3, 8690/3, 8692/3, and 9693/3 for primary sites C479, C754 and C755 ONLY are in Head and Neck (Table 9) for cases diagnosed 1/1/2019 forward.
*Trachea was moved from MP/H Other Sites to Solid Tumor Head and Neck beginning with cases diagnosed 2018.
**Rectosigmoid and rectum were moved from MP/H Other Sites to Solid Tumor Colon beginning with cases diagnosed 2018.

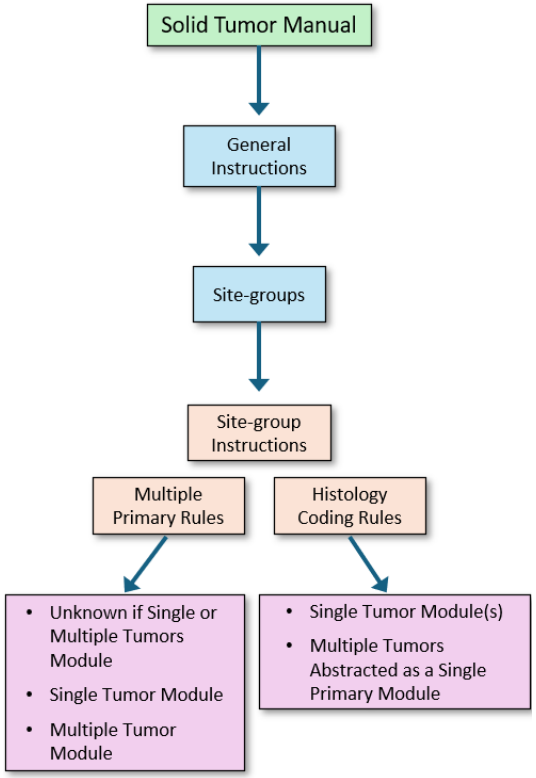
Purpose and Structure of the Solid Tumor Rules

The purpose of these rules is to determine multiple primaries and to code histology ONLY. The Solid Tumor Rules are not used to determine case reportability, casefinding, stage, or tumor grade.

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). The multiple primary rules guide and standardize the process of determining the number of primaries.

Structure of this document

The Solid Tumor Rules consist of 10 site-groups that cover a specific primary site (i.e. Kidney) or primary site group (i.e. Head and Neck) and contain site-specific instructions that may take precedence over the General Instructions. Each site-group contains 3 sections: Site-group Instructions, Multiple Primary Rules, Histology Rules. The site-groups also contain histology tables, as well as modules for determining the number of primaries and histology. There may be additional tables in each site-group. See the graphic to the right and the outline below.



General Instructions

The General Instructions contain information that may not appear in the site-groups. It is important to be familiar with the General Instructions and to use them in tandem with the site-groups.

Site-group Sections

1. Site-group Instructions
   a. Major changes and clarifications
   b. Equivalent and equal terms

   c. Terms that are not equivalent or equal
   d. Tables for coding may include:
      i. Primary site codes
      ii. Combination histologies
      iii. Reportable histologies and subtypes/variants
      iv. Not reportable histologies
      v. Paired sites
   e. Illustrations
2. Multiple Primary Rules
   a. Unknown if Single or Multiple Tumors Module
   b. Single Tumor Module
   c. Multiple Tumor Module
3. Histology Rules
   a. Priority Order for Using Documentation to Identify Histology
   b. Coding Histology
   c. Single Tumor Module[1]
   d. Multiple Tumors Abstracted as Single Primary Module

[1] There may be additional single tumor modules depending on behavior.

How to Use the Multiple Primary Rules

1. Determine which site-group applies (i.e., Colon, Lung, Other Sites, etc.)
   a. The correct site-group is based on the site from which the disease arose. If a tumor is found to be metastasis, the site-group used would be based on the site of origin.
      - ***Example:*** A patient presents with a lung nodule that is found to be metastatic from a kidney primary. The Kidney site-group would be used to determine the number of primaries and the correct histology.

2. Use the Multiple Primary Rules to determine if the patient has a single primary or multiple primaries.
   a. Unless the rules in the site-group state otherwise, the multiple primary rules only apply to tumor(s) arising in the organ of origin. Metastatic tumors are not included when determining how many tumors are present.
      - ***Example***: A patient has a single tumor in the right breast and 3 metastatic lesions in the brain. Do not count the 3 metastatic lesions in the brain when determining how many tumors are present.
   b. Tumor(s) may be synchronous (present at the same time) or metachronous (arising at different times).
      i. When there are multiple tumors present, assign a provisional histology to each tumor prior to applying the multiple primary rules.
      ii. If the tumors are metachronous, apply the multiple primary rules to the most recently diagnosed tumor to decide if it is the same primary or a new primary.

3. Begin with the first rule within the Multiple Primary Rules **MODULE** that applies. Follow the rules in order. Once a rule applies and it can be determined if the patient has a single primary or multiple primaries, **STOP.**
   a. If a patient presents with a single tumor, go to the Single Tumor Module.
   b. If a patient has multiple tumors (either synchronous or metachronous), go to the Multiple Tumors Module.
   c. If it cannot be determined if a patient has a single or multiple tumors, use the Unknown if Single or Multiple Tumors Module.
      - ***Example:*** A patient presents with unifocal breast cancer diagnosed at a different institution. The physician refers to the patient's "history of cancer in her left breast". The registrar is not certain if the physician is referring to the

current single tumor or if the patient has a history of a different malignancy in her left breast. The Unknown if Single or Multiple Tumors Module should be used.

4. If a patient is found to have a single primary, prepare a single abstract.

5. If a patient is found to have multiple primaries, prepare an abstract for each primary.

6. If a new tumor is found to be a recurrence, do not make changes to the original abstract unless instructed to by the rules.
    - ***Example*:** Patient has a previously abstracted invasive urothelial carcinoma (8120/3) of the bladder. The patient presents with new invasive papillary urothelial carcinoma (8130/3) of the bladder. Per the multiple primary rules, this is not a new primary.

Timing Rules for Metachronous Tumors Arising in the Same Site

The time between the diagnosis of metachronous (arising at different times) tumors may determine if the new tumor is a new primary. The length of time between the diagnosis of the tumors varies among site-groups. With the exception of *Malignant CNS and Peripheral Nerves* and *Non-Malignant CNS*, all site-groups have timing rules. If the patient has a recurrence or develops metastasis from the original primary, the time-period must start over.

One year = One calendar year

- ***Example:*** A tumor diagnosed 1/1/2018 and second tumor diagnosed 1/1/2019 occur exactly one year apart. Less than one year = Less than one calendar year

More than one year = More than one calendar year

- ***Example****:* A tumor diagnosed 1/1/2018 and second tumor diagnosed 1/2/2019 occur more than one year apart.

1. **Clinically disease-free** means that there was **no evidence** of recurrence on follow-up.
2. When there is a recurrence less than or equal to X years of diagnosis, continue through the rules. The patient must have been disease-free for greater than X years from the date of the last recurrence.
3. When it is **unknown/not documented** whether the patient had a recurrence, default to **date of diagnosis** to compute the time interval.
4. Use the Multiple Primary Rules as written to determine whether a subsequent tumor is a new primary or a recurrence. The **ONLY exception** is when a **pathologist compares slides** from the subsequent tumor to the "original" tumor and documents the subsequent tumor is a recurrence of the previous primary. **Never abstract multiple primaries based only on a physician's statement of "recurrence" or "recurrent" unless instructed to do so by a specific rule.**

How to Use the Histology Rules

Use the Histology Rules to assign a histology code for each primary.

1. Use the appropriate module for
   a. Single Tumor
      Note: Some site-groups may have more than one Single Tumor module
   b. Multiple Tumors Abstracted as a Single Primary

2. Apply the rules in order and stop at the first rule that can be used to assign a histology.
   Note 1: Do not use these rules to determine case reportability.
   Note 2: Code the histology prior to neoadjuvant therapy, when available. Refer to individual site-groups for exceptions.
      - Neoadjuvant therapy can change the histological profile of the tumor.
   Note 3: For each site-group, priorities include tissue/histology, cytology, radiography/scans, physician diagnoses, and biomarkers. **Use the priority order that precedes the histology rules for each site.**

- Priority order will differ by site. Tissue pathology (and/or biomarkers, if applicable) always takes precedence.
- The specific types of radiography/scans also differ by site.

Discrepancies between the final diagnosis, synoptic report, or CAP protocol:

Use the document that provides the more specific histology when there are discrepancies between the final diagnosis and synoptic report. This will likely be found in the synoptic report.

The CAP Protocol should be used only when a final diagnosis or synoptic report is not available. Definitions for CAP Protocol, final diagnosis, and synoptic report can be found in the **Definitions** section.

How to Use Ambiguous Terms to Code Histology

Note: *The following instructions apply to coding histology. These instructions should not be used when determining reportability or when assigning stage.*

1. Within each site-group, the Coding Histology section will contain instructions for using ambiguous terms to assign a more specific histology. The table below includes the ambiguous terms for which the histology coding instructions apply.

List of Ambiguous Terminology	
Appears	Presumed
Cannot rule out	Suspicious (for)
Likely	Suggestive of
Favor(s)	

2. The table below includes terms previously included in the list of ambiguous terms. These terms should be treated as supporting a definitive diagnosis of a histologic subtype. A definitive term does not require clinical verification of the subtype/variant.
   The terms in the table below were re-classified as definitive terminology based on the recommendation of a panel of pathologists and subject matter experts.

   IMPORTANT: This change applies to any diagnosis year covered by the Solid Tumor Rules. Previously abstracted cases do not need to be reviewed or updated.

List of Definitive Terminology	
Comparable with	Most likely
Compatible with	Probable
Consistent with	Typical (of)

Instructions for Coding Histology Described by Ambiguous Terminology

Code the specific histology described by ambiguous terminology ONLY when A or B is true:

a. The only diagnosis available is one histology term described by ambiguous terminology
   - CoC and SEER require reporting of cases diagnosed only by ambiguous terminology
   - The final pathology diagnosis is an ambiguous term followed by a histology type
   - Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

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

   If the specific histology does not meet this criteria, then code the NOS histology.

Examples

Example 1: A biopsy is taken of a lung mass. The final diagnosis on the pathology report states "carcinoma, likely small cell carcinoma". The patient's oncologist later refers to the patient's "small cell carcinoma".

The Coding Histology section for Lung instructs to code the specific histology described by ambiguous terminology when there is a NOS histology and a more specific histology (subtype or variant) described by ambiguous terminology as long as one of two conditions are met: a physician clinically confirms the more specific histology OR the patient is receiving treatment that specifically targets the more specific histology.

The patient's oncologist confirmed the patient had small cell carcinoma. Assign 8041/3 small cell carcinoma NOS.

Example 2: A biopsy is taken of a laryngeal mass. The final diagnosis from the pathology reports states "squamous cell carcinoma, suggestive of verrucous carcinoma". Due to her comorbid conditions, the patient is placed in hospice. There are no further references to her laryngeal cancer.

The Coding Histology section for Head and Neck instructs to code the specific histology described by ambiguous terminology when there is a NOS code and a more specific histology (subtype or variant) described by ambiguous terminology as long as one of two conditions are met: a physician clinically confirms the more specific histology OR the patient is receiving treatment that specifically targets the more specific histology.

The patient's physician did not clinically confirm the subtype, and she did not have treatment specifically targeting the subtype. Assign squamous cell carcinoma NOS 8070/3.

Example 3: A biopsy is taken of a thyroid mass. The final diagnosis on the pathology report states, "papillary thyroid carcinoma, possibly an oncocytic variant of papillary thyroid carcinoma". The patient's oncologist later refers to the patient's "papillary thyroid carcinoma". The patient received the standard treatment for patients with her stage of papillary thyroid carcinoma.

The term "possibly" is not included in the list of ambiguous terms or on the list of definitive diagnosis terms. A statement of possibly cannot be used to assign a subtype or variant.

Assign 8260/3 papillary thyroid carcinoma, NOS.

Example 4: A patient with a kidney mass had a partial nephrectomy. The final diagnosis from the pathology report shows renal cell carcinoma consistent with clear cell carcinoma. The patient goes elsewhere for additional work-up and treatment. No further information is available concerning the patient's histology or treatment.

"Consistent with" is included in the list of Definitive Terminology. Further clinical correlation or treatment information is not required. Assign 8310/3 clear cell carcinoma.

Example 5: A patient has imaging that shows a mass in the left upper lobe of the lung suspicious for adenocarcinoma. The patient refuses any further work-up or treatment.

Based on the rules for reportability, "suspicious for adenocarcinoma" is a reportable diagnostic statement. In this situation, the only histology we have available is "adenocarcinoma". Since adenocarcinoma is the only histologic term provided, we assign the histology to 8140/3.

General Equivalent or Equal Terms

These are general equivalent terms that apply to all site-groups. Each set of site-groups may have additional terms.

1. The following equivalent terms are primarily used when determining histology
   a. And; with

      Note: "And" and "with" are used as synonyms when **describing multiple histologies** within a **single tumor**
   b. De novo; new tumor; frank (obsolete term)
   c. Multicentric; multifocal
   d. Type; subtype; variant

2. The following equivalent terms are primarily used when determining multiple primaries
   a. Clinically disease free; WNL
   b. Simultaneous; synchronous; at the same time; prior to first course treatment
   c. Topography; site code
   d. Tumor; mass; tumor mass; lesion; neoplasm; nodule
      i. These terms 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.**
      ii. These terms are used **ONLY** to determine multiple primaries
      iii. **Do not** use these terms for casefinding or determining reportability
   e. Type; subtype; variant

Definitions

Note 1: Use these definitions for all reportable tumors except hematolymphoid morphologies (M9590-9993).

Note 2: Additional terms can be found in the SEER Glossary for registrars at: **https://seer.cancer.gov/seertools/glossary**

STR Module: See **STR structure**

STR Section: See **STR structure**

STR Site-group: See **STR structure**

Matrix Rule: The Matrix Rule allows a behavior code to be assigned to a histology code even when that specific histology/behavior combination is **not listed** in the ICD-O manual. See the **ICD O 3.1** manual section 4.3.3 Rule F. for further explanation of the matrix concept.

Example: Pathology report shows nodular melanoma, in situ. In ICD-O, nodular melanoma is coded as 8721/3 (malignant). The histology code 8721 is not listed with a behavior of /2 (in situ). The Matrix Rule permits the registrar to assign 8721/2.

Pathology report:

- **CAP Protocol:** The CAP Cancer Reporting Protocols provide guidelines for collecting the essential data elements for complete reporting of malignant tumors and ensuring optimal patient care. The protocol is a check list which allows the pathologist to note their observations while reviewing the slides and/or gross specimen. CAP Protocols include all relevant data elements including site, surgical procedure, tumor size, histology, grade, margins, lymph node status, and staging along with other site-specific elements. The protocols are multiple pages.
- Synoptic reporting using the **CAP eleODS-Conic Cancer Protocols (eCP)** also helps laboratories and hospitals comply with requirements for organizations like the American College of Surgeons Commission on Cancer, the CAP Laboratory Accreditation Program, and more.

- **Final Diagnosis:** The final diagnosis is found in the pathology report. The findings from the CAP Protocol are consolidated into paragraph format.
- **Synoptic report:** All core and conditionally required data elements outlined on the surgical case summary from the cancer protocol must be displayed in synoptic report format. Synoptic format is defined as:
  1. Data element: followed by its answer (response).
  2. The data element should be represented in the report as it is listed in the case summary. The response for any data element may be modified from those listed in the case summary, including "Cannot be determined" if appropriate.
  3. Each diagnostic parameter pair (Data element: Response) is listed on a separate line or in a tabular format to achieve visual separation. The following exceptions are allowed to be listed on one line:
     - Anatomic site or specimen, laterality, and procedure
     - Pathologic Stage Classification (pTNM) elements
     - Negative margins, as long as all negative margins are specifically enumerated where applicable
  4. The synoptic portion of the report can appear in the diagnosis section of the pathology report, at the end of the report or in a separate section, but all Data element: Response pair must be listed together in one location

Timing:

- **Metachronous:** A term used to describe a subsequent reportable tumor that develops months or years after a previously diagnosed reportable tumor. The tumor may develop either in the same organ or in a different organ.
- **Simultaneous:** This term is used in the Solid Tumor Rules to describe reportable tumors diagnosed at the same time or during the initial workup (prior to first course of therapy).
- **Synchronous:** See "Simultaneous".

Tumor description:

- **Overlapping tumor:** A single tumor that overlaps the boundaries of two or more sites or subsites and its point of origin cannot be determined.
- **Non-contiguous tumors:** Separate tumors that are not in contact and arise independently from each other.

Recurrence:

This term has two meanings:

1. The reappearance of disease that was thought to be cured or inactive (in remission). Recurrent cancer starts from cancer cells that were not removed or destroyed by the original therapy.
2. A new occurrence of cancer in the same primary site such as a previous adenocarcinoma of the right lung and a subsequent squamous cell carcinoma of the left lung called a "recurrence" of lung cancer (the patient had lung cancer before, now has another lung cancer). This type of recurrence arises from cells that have nothing to do with the earlier (first) cancer. A new or another occurrence, incidence, episode, or report of the same disease (cancer) in a general sense – a new occurrence of cancer.

   Note: Do not use a physician statement of *recurrence* unless directed to do so within the multiple primary rules.

WHO/IARC: The International Agency for Research on Cancer (IARC) is a specialized cancer agency at the World Health Organization (WHO). WHO's primary role is to direct international health within the United Nations system and to lead partners in global health responses. IARC is responsible for the WHO Classification of Tumours, also known as the Blue Books.

Histologic Type ICD-O-3

The data item Histologic Type ICD-O-3 describes the microscopic composition of cells and/or tissue for a specific primary. The tumor type or histology is a basis for staging and affects treatment decisions, prognosis and course of the disease.

The International Classification of Diseases for Oncology, Third Edition (ICD-O-3) is the standard reference for histology codes for tumors diagnosed 2001 and later. Do not record the 'M' that precedes the histology code. See sections *Coding Guidelines for Topography and Morphology and Summary of Principal Rules* for Using the ICD-O, Third Edition, First Revision for guidance in using the ICD-O-3. **International Classification of Diseases for Oncology, Third Edition, First Revision (ICD-O-3.1)**

Important Information for Coding Histologic Type for Cases Diagnosed 1/1/2018 Forward

The North American Association of Central Registries (NAACCR) releases **updates** that contain new ICD-O codes, changes in behaviors for existing ICD-O codes, and new preferred terminology. The updates are included with each update to the Solid Tumor Rules and are listed below in chronological order:

1. 2018 Guidelines for ICD-O-3 Histology Code and Behavior Update effective for cases diagnosed 1/1/2018 forward
2. 2021 Guidelines for ICD-O-3 Histology Code and Behavior Update, effective for cases diagnosed 1/1/2021 forward
3. 2022 Guidelines for ICD-O-3.2 Histology Code and Behavior Update, effective for cases diagnosed 1/1/2022 forward
4. 2023 Guidelines for ICD-O-3.2 Histology Code and Behavior Update, effective for cases diagnosed 1/1/2023 forward
5. 2024 Guidelines for ICD-O-3.2 Histology Code and Behavior Update, effective for cases diagnosed 1/1/2024 forward
6. 2026 Guidelines for ICD-O-3.2 Histology Code and Behavior Update, effective for cases diagnosed 1/1/2026 forward

The Solid Tumor Editors recommend coding histology using:

1. The Solid Tumor Rules
2. **ICD-O-3 Update Tables** (Terms, codes, and behaviors not included in ICD-O-3.2)
3. **WHO IARC ICD-O-3.2 Excel Table** (Morphology list)

When a histology code cannot be identified using the above recommendations, submit a question to **Ask a SEER Registrar**.

Cancer PathCHART Site-Morphology Combination Standards

About Cancer PathCHART

The Cancer Pathology Coding Histology and Registration Terminology (Cancer PathCHART) initiative is a ground-breaking collaboration of North American and global registrar, registry, pathology, and clinical organizations. The main goal of Cancer PathCHART is to improve cancer surveillance data quality by updating standards for tumor site, histology, and behavior code combinations and associated terminology. This initiative involves a substantial, multi-faceted review process of histology and behavior codes (and associated terminology) by tumor site that includes expert pathologists and tumor registrars. The results of these in-depth reviews are incorporated into the Cancer PathCHART database, which serves as the single source of truth standards for tumor site, histology, and behavior coding across all standard setters. See the Cancer PathCHART website for further information: **https://seer.cancer.gov/cancerpathchart/**

Cancer PathCHART Search Tool (CPC*Search Tool)

A webtool is now available on the Cancer PathCHART website that will allow searches for tumor topography, histology, and behavior codes and terms. The search tool will also indicate if the tumor topography and histology combination are biologically valid, unlikely, or impossible.

Cancer PathCHART and the Solid Tumor Rules

1. The CPC*Search Tool does not replace the Solid Tumor Rules when determining histology coding. The search tool is an additional resource primarily to determine if a site/histology combination is biologically valid, unlikely, or impossible.

2. Many histology tables in the Solid Tumor Rules include more than one site or site-group. The tables are based on current WHO Classification of Tumors books. The Cancer PathCHART review determined that some histologies are valid for specific sites and not for all sites within a site-group. The valid C-code will be denoted in bold next to the histology or histologies in applicable tables, including combination/mixed histology code tables. Coding these histologies to a site other than the one(s) noted in the tables has been determined to be biologically impossible and will not pass edits.

Submitting Questions

Submit technical questions and suggestions related to this manual to Ask a SEER Registrar on the SEER website. SEER regions may also submit technical questions to NCI SEER inquiry system using the web-based SINQ system. When submitting questions to Ask A SEER Registrar, make sure you select the correct category (2007 MPH rules or Solid Tumor Rules) AND always include primary site and diagnosis year.

IMPORTANT INFORMATION: When needed, we will consult with experts to provide guidance and clarifications when answering difficult or unusual questions. Our specialty matter experts (SMEs) are authors of WHO Classification of Tumors books, CAP pathologists, and recognized experts in their fields of interest.

Breast Site-group Instructions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Introduction

Note 1: Breast includes Nipple C500; Central portion of breast C501; Upper-inner quadrant C502; Lower-inner quadrant C503; Upper-outer quadrant of breast C504; Lower-outer quadrant C505; Axillary tail C506; Overlapping lesion of breast C508; Breast NOS C509.

Note 2: **NST (N**o **S**pecial **T**ype**), mammary carcinoma NST, and carcinoma NST** are new terms for duct or ductal carcinoma for diagnosis years 2018 forward. Previously, it was thought that carcinoma originated in the ducts or lobules of the breast, hence the names duct carcinoma and lobular carcinoma. Current thinking is that carcinoma originates in the "terminal duct lobular unit" therefore the preferred term is NST or carcinoma NST.

Note 3: **Mammary carcinoma** is a synonym for carcinoma no special type (NST)/duct carcinoma not otherwise specified (NOS) **8500.** For diagnosis year 2018 forward, it is **no longe**r coded as carcinoma NOS **8010.**

Note 4: **DCIS/Carcinoma NST in situ** has a major classification change for diagnosis year 2018 forward.

A. Architecture, pattern, and features **ARE NOT CODED**. The majority of in situ tumors will be coded to DCIS **8500/2.**
B. It is very important to code the grade of all DCIS.
C. Code the grade per the instructions in the Grade Manual.
    i. The current breast **WHO** edition emphasizes coding the **grade** of tumor rather than the **subtype/variant**.
    ii. The WHO editions are used internationally by pathologists to keep their nomenclature and histology identification current.
    iii. Over time, **subtypes/variants** will be diagnosed **less frequently.**

Note 5: The invasive subtype/variant is coded **ONLY** when it comprises **greater than 90%** of the tumor. This change has been implemented in both the WHO and in the CAP protocols.

Note 6: Excerpt from the CAP Invasive Breast Protocol (page 17): "A modified list is presented in the protocol based on the most frequent types of invasive carcinomas and terminology that is in widespread usage. The modified list is intended to capture the majority of tumors and reduce the classification of tumors being reported as 'other.' The WHO classification is presented for completeness".

Equivalent or Equal Terms

These terms can be used interchangeably:

- And; with; (duct **and** lobular is equivalent to duct **with** lobular)
  Note: "And" and "with" are used as synonyms when **describing multiple histologies** within a **single tumor**.
- Behavior code /2; DCIS; intraductal; noninfiltrating; noninvasive; carcinoma in situ
- De novo; new tumor; frank (obsolete term)
- Mammary; breast
- Simultaneous; synchronous; 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

Terms That Are NOT Equivalent or Equal

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

- **Phenotype** is not equivalent to **subtype/type/variant**
- **Invasive carcinoma, NST with lobular features** is not equivalent to **invasive carcinoma with ductal and lobular features**

Breast Site-group Instructions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Table 1: Primary Site Codes

Table 1 contains terms used in **mammograms, clinical diagnosis,** and less frequently the **operative and pathology reports** to describe the **location** of the tumor. Find the **term** in Column 1 and use the **site code** in Column 2.

Note: See the **"clock" diagram** at the end of the Site-group Instructions for a graphic of the o'clock designations and corresponding **quadrants/subsites** of the breast.

Refer to the **SEER Manual** and **COC Manual** for a **priority list** for using documents such as mammograms, operative reports, and pathology reports to determine the tumor location.

Column 1 includes terms used to describe the **location/site** of the tumor.
Column 2 contains the **site term and code.**

Terms and Descriptive Language	Site Term and Code
Areolar Nipple Paget disease **without** underlying tumor [1]	Nipple **C500**

[1] Paget with underlying tumor is coded to the quadrant of breast in which the underlying tumor is located.

Table 1: Primary Site Codes

Terms and Descriptive Language	Site Term and Code
Above nipple Area extending 1 cm around areolar complex Behind the nipple Below the nipple Beneath the nipple Central portion of breast Cephalad to nipple Infra-areolar Lower central Next to areola NOS Next to nipple Retroareolar Subareolar Under the nipple Underneath the nipple	Central portion of breast **C501**
Superior inner Superior medial Upper inner quadrant (UIQ) Upper medial	Upper inner quadrant of breast **C502**
Inferior inner Inferior medial Lower inner quadrant (LIQ) Lower medial	Lower inner quadrant of breast **C503**

Table 1: Primary Site Codes

Terms and Descriptive Language	Site Term and Code
Superior lateral Superior outer Upper lateral Upper outer quadrant (UOQ)	Upper outer quadrant of breast **C504**
Inferior lateral Inferior outer Lower lateral Lower outer quadrant (LOQ)	Lower outer quadrant of breast **C505**
Axillary tail of breast Tail of breast NOS Tail of Spence **Table continued on next page**	Axillary tail of breast **C506**

Breast Site-group Instructions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Table 1: Primary Site Codes

Terms and Descriptive Language	Site Term and Code
12:00 o'clock 3:00 o'clock 6:00 o'clock 9:00 o'clock Inferior breast NOS Inner breast NOS Lateral breast NOS Lower breast NOS Medial breast NOS Midline breast NOS Outer breast NOS Overlapping lesion of breast Superior breast NOS Upper breast NOS	Overlapping lesion of breast **C508** [2]
¾ or more of breast involved with tumor Diffuse (tumor size 998) Entire breast Inflammatory without palpable mass Multiple tumors in different subsites (quadrants) within the same breast	Breast NOS **C509** [3]

[2] C508 is for a single tumor. See the SEER Manual breast coding guidelines for instructions on when to use C508.
[3] See the SEER Manual breast coding guidelines for instructions on when to use C509.

Breast Site-group Instructions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Table 2: Histology Combination Codes

Instructions:

1. Use Table 2 when instructed to by the Multiple Primary and Histology Rules.
2. Compare the **terms** in the **diagnosis** (pathology, cytology, radiographic, clinical) to the terms in **Column 1.**
3. When the terms **match**, use the **combination code** listed in **Column 2.**
4. The **last row** in the table is a **"last resort"** code: adenocarcinoma mixed subtypes **8255**.
5. Use the combination codes only when the histologies are in a **single** tumor **OR multiple tumors** abstracted as a single primary.
6. Mixed histologies may be described as follows:
   A. A "**combination** of"
   B. Histology 1 **AND** histology 2
   C. Histology 1 **WITH** histology 2
   D. **Mixed** histology 1 and histology 2

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 histologies can be in situ or invasive; others are limited to either /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.

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

Column 1 contains the required ICD-O histology terms.
Column 2 contains the histology **combination term** and **code.**

Table 2: Histology Combination Codes

Required Histology Terms	Histology Combination Term and Code
DCIS/duct carcinoma/carcinoma NST **8500 OR** any subtype/variant of carcinoma NST (see **Table 3**) **AND** LCIS/lobular carcinoma (**8520**) **OR** pleomorphic lobular carcinoma in situ **8519/2**	Duct and lobular **8522** [1] [2] • Invasive duct and in situ lobular **(/3)** [3] • DCIS and invasive lobular **(/3)** • Invasive duct and invasive lobular **(/3)** • Invasive carcinoma with ductal and lobular features ("mixed type carcinoma") **(/3)** [4] • DCIS and LCIS **(/2)** [3]
DCIS/duct carcinoma/carcinoma NST **OR** any ONE subtype/variant of carcinoma NST (see **Table 3**) **AND** [5] **Any** histology in **Table 3 with exception** of • Lobular carcinoma **8520** and pleomorphic lobular carcinoma in situ **8519 (/2)** • Paget disease **8540**	Invasive carcinoma NST/duct mixed with other types of invasive carcinoma **8523 (/3)** DCIS mixed with other in situ carcinoma **8500 (/2)** [6]

[1] 8522 is used when:
- Duct and lobular carcinoma are present in a single tumor **OR**
- All tumors in the same breast are mixed duct and lobular

[2] **Do not** use when the diagnosis is carcinoma NST/duct carcinoma with lobular **differentiation.**

[3] Includes pleomorphic LCIS

[4] CAP uses the term Invasive carcinoma with ductal and lobular features ("mixed type carcinoma") to indicate both duct and lobular are present. This is an exception to the instruction that features are not coded.

[5] Both histologies **must have** the **same behavior** code.

[6] Prior to 2018, DCIS and other in situ was coded 8523/2.

Table 2: Histology Combination Codes

Required Histology Terms	Histology Combination Term and Code
Lobular carcinoma **AND** [7] **Any** histology in **Table 3 with the exception** of • Duct carcinoma/carcinoma NST/DCIS (including subtypes/variants- see **Table 3**) **8500** • Paget disease, in situ and invasive	Infiltrating lobular mixed with other types of carcinoma **8524 (/3)** In situ lobular mixed with other types of in situ carcinoma **8524 (/2)** [8]
Metaplastic carcinoma **OR** any ONE subtype/variant of metaplastic carcinoma **AND** [9] **Duct** carcinoma/carcinoma NST **OR** Lobular carcinoma	Code metaplastic carcinoma **8575** **OR** Subtype/variant of metaplastic carcinoma (see **Table 3**)
Paget disease **AND** [10] **Underlying DCIS**	Paget disease (invasive or behavior not specified) and DCIS/intraductal carcinoma **8543 (/3)** Paget disease (specified as in situ) and DCIS/intraductal carcinoma **8543 (/2)**

[7] This code does not include lobular and Paget disease. See Multiple Primary Rules. Lobular carcinoma and Paget are separate primaries.
[8] Beginning with cases diagnosed 1/1/2024 forward, in situ lobular carcinoma with other types of in situ carcinoma 8524/2 has been deemed biologically impossible based on expert pathologist review for the Cancer PathCHART project. See H Rules for coding instructions. Use 8524/2 for **Cases diagnosed prior to 1/1/2024 only.**
[9] Metaplastic carcinoma NOS and subtypes are almost always mixed with invasive mammary carcinoma, NST and at times lobular carcinoma. These tumors should be coded to metaplastic regardless of percent invasive mammary carcinoma or lobular carcinoma present.
[10] Paget disease is classified as malignant /3 in the ICD-O. Paget disease is coded as in situ /2 **ONLY** when the pathology states the Paget disease is in situ.

Table 2: Histology Combination Codes

Required Histology Terms	Histology Combination Term and Code
Paget disease **AND** **Underlying infiltrating duct** carcinoma/carcinoma NST or any **invasive subtype/variant** of carcinoma NST **(must be /3)** (see **Table 3**)	Paget disease and infiltrating duct carcinoma **8541 (/3)**
Any two invasive carcinoma NST subtypes/variants (percentage not stated) abstracted as a single primary [11]	Adenocarcinoma with mixed subtypes **8255 (/3)**

[11] The pathologist may mention the presence of duct/carcinoma NST. Ignore the mention of carcinoma NST. See **Table 3** for subtypes/variants of duct.

Table 3: Specific Histologies, NOS/NST, and Subtypes/Variants

Use Table 3 as directed by the **Histology Rules** to assign the more common histology codes for breast 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 is not found in Table 3, ICD-O or all updates.
Note 3: Behavior codes are listed when the term has only one possible behavior (either a /2 or /3).
Note 4: Column 2 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 2). Rhabdomyosarcoma is also a NOS because it has subtypes/variants. The subtypes/variants are indented under the NOS (rhabdomyosarcoma) in column 2.

Column 1 contains specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3).**

.

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2.
- Synonyms do not have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**.
- Subtypes or variants of the NOS histologies in column 2 will be indented under the NOS histology and have a full 4-digit histology code (see Note 4). The behavior code (/2 or /3) is included with the 4-digit histology code if the term has only one possible behavior.

Table begins on next page

Table 3: Specific Histologies, NOS/NST, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Acinic cell carcinoma 8550 • Acinar adenocarcinoma • Acinar carcinoma	
Adenoid cystic carcinoma 8200 • Adenocystic basal cell carcinoma • Carcinoma adenoides cysticum • Cylindromatous carcinoma	
Adenomyoepithelioma with carcinoma 8983 • AME • Malignant AME	Epithelial-myoepithelial carcinoma **8562**
Apocrine carcinoma 8401 [1]	
Carcinoma NST 8500 • Carcinoma NOS • Carcinoma of no special type • Carcinoma NST with choriocarcinomatous features • Carcinoma NST with cribriform features • Carcinoma NST with melanotic features • Carcinoma NST with neuroendocrine features • Carcinoma/Carcinoma NST with signet ring cell differentiation • Ductal carcinoma	Carcinoma with osteoclastic-like stromal giant cells **8035** Cribriform carcinoma **8201 (/3)** • Ductal carcinoma, cribriform type **(/3)** • Cribriform carcinoma in situ **(/2)** Pleomorphic carcinoma **8022 (/3)** Solid carcinoma **8230 (/3)** [2] • Solid adenocarcinoma **(/3)** • Ductal carcinoma in situ, solid type **(/2)** • Intraductal carcinoma, solid type **(/2)**

[1] This is a diagnosis that is **EXACTLY** apocrine carcinoma, **not** a carcinoma NST with apocrine **features**, **differentiation**, or **type**.
[2] Invasive solid carcinoma is coded 8500/3 for cases diagnosed 1/1/2024 forward. Use code 8230 for diagnoses prior to 1/1/2024.

Table 3: Specific Histologies, NOS/NST, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Carcinoma NST 8500 (continued) • Ductal carcinoma NST (no special type) • Ductal carcinoma with apocrine features • Ductal carcinoma with apocrine metaplasia • Ductal carcinoma with lobular features • Ductal carcinoma with micropapillary features • Ductal carcinoma with mucin production • Duct/ductal carcinoma with neuroendocrine features • Ductal carcinoma with squamous metaplasia • Mammary carcinoma/cancer • Infiltrating ductal carcinoma **(/3)** • Invasive carcinoma with medullary features **(/3)** • Invasive carcinoma with micropapillary features **(/3)** • Invasive carcinoma with neuroendocrine features **(/3)** • Invasive carcinoma not otherwise specified (Invasive carcinoma NOS) **(/3)** • Invasive carcinoma NST with metaplastic features **(/3)** • Invasive carcinoma NST with medullary features **(/3)** • Invasive carcinoma, with signet-ring cell features **(/3)** • Invasive carcinoma of no special type (NST) **(/3)** • Invasive carcinoma with clear cell (glycogen rich) features **(/3)** • Invasive carcinoma, NST **(/3)** • Invasive carcinoma, type cannot be determined **(/3)** • Invasive ductal with medullary features **(/3)** • Invasive mammary carcinoma **(/3)**	

Table 3: Specific Histologies, NOS/NST, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Carcinoma NST 8500 (continued) • Invasive mammary carcinoma associated with encysted papillary carcinoma **(/3)** • Invasive mammary carcinoma NST with lobular features **(/3)** • Invasive mammary carcinoma NST with medullary features **(/3)** • Invasive mammary carcinoma NST with mucinous features **(/3)** • Invasive mammary carcinoma NST with neuroendocrine features **(/3)** • Invasive mammary carcinoma NST with tubulo-lobular variant **(/3)** • Invasive mammary carcinoma with apocrine features **(/3)** • Invasive mammary carcinoma with cribriform features **(/3)** • Invasive mammary carcinoma with tubular features **(/3)** • Invasive solid adenocarcinoma **(/3)** Error! Bookmark not defined. • DCIS **(/2)** • DCIS of high nuclear grade **(/2)** • DCIS of intermediate nuclear grade **(/2)** • DCIS of low nuclear grade **(/2)** • Ductal carcinoma in situ **(/2)** • Intraductal carcinoma **(/2)** • Mammary carcinoma in situ **(/2)** • Non-invasive mammary carcinoma **(/2)**	

Table 3: Specific Histologies, NOS/NST, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Glycogen-rich clear cell carcinoma 8315 • Glycogen-rich carcinoma	Clear cell carcinoma **8310**
Inflammatory carcinoma 8530	
Lipid-rich carcinoma 8314 • Lipid-secreting carcinoma	
Lobular carcinoma 8520 • Alveolar lobular carcinoma • Classic lobular carcinoma • Lobular carcinoma with cribriform features • Mixed lobular carcinoma (lobular carcinoma NOS and one or more variants of lobular carcinoma) • Solid lobular carcinoma • Tubulolobular carcinoma • Invasive lobular carcinoma, alveolar type/variant **(/3)** • Invasive lobular carcinoma, solid type **(/3)** • Invasive pleomorphic lobular carcinoma **(/3)** • Florid lobular carcinoma **(/2)** • Intraductal papilloma with lobular carcinoma in situ **(/2)** • Lobular carcinoma in situ **(/2)**	Pleomorphic lobular carcinoma in situ **8519 (/2)**
Medullary carcinoma 8510 • MC	Atypical medullary carcinoma **8513** • AMC

Table 3: Specific Histologies, NOS/NST, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Metaplastic carcinoma NOS or of no special type (NST) 8575 [3] • Invasive mammary carcinoma with matrix production • Metaplastic carcinoma, mixed epithelial and mesenchymal type • Metaplastic carcinoma with mesenchymal differentiation • Metaplastic carcinoma with squamous features • Metaplastic carcinoma with other types of mesenchymal differentiation • Mixed metaplastic carcinoma • Metaplastic carcinoma spindle-cell type [4] • Spindle cell carcinoma [4]	Carcinosarcoma **8980 (/3)** Fibromatosis-like metaplastic carcinoma **8572** Low grade adenosquamous carcinoma **8570** Metaplastic carcinoma spindle-cell type **8032** • Spindle cell carcinoma [4] Metaplastic carcinoma with _____ **8571** [5] • chondroid differentiation • osseous differentiation Myoepithelial carcinoma **8982** Squamous cell carcinoma **8070** [6]

[3] Metaplastic carcinoma, NOS and subtypes are almost always mixed with invasive mammary carcinoma, NST and at times lobular carcinoma. These tumors should be coded to metaplastic regardless of percent invasive mammary carcinoma or lobular carcinoma present.
[4] Metaplastic carcinoma spindle-cell type and Spindle cell carcinoma are coded 8575 for 1/1/2024+ diagnoses. Use code 8032 for cases diagnosed prior to 1/1/2024 ONLY.
[5] Metaplastic carcinoma with chondroid differentiation and metaplastic carcinoma with osseous differentiation are related terms, both of which are coded to 8571. Do not treat them as different subtypes/variants. The blank line may **ONLY** be filled with *chondroid* or *osseous*. Do NOT insert other terms there. **Example**: Metaplastic carcinoma with osseous differentiation.
[6] Squamous cell carcinoma of the breast is **extremely rare**. Carefully check the **pathology report** to verify the squamous cell originated in the breast parenchyma, rather than the skin of the breast.

Table 3: Specific Histologies, NOS/NST, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Mucinous carcinoma 8480 [7] [8] • Colloid carcinoma • Mucinous adenocarcinoma • Mucoid carcinoma	
Mucinous cystadenocarcinoma 8470 • Mucinous cystic neoplasm with associated invasive carcinoma **(/3)**	
Mucoepidermoid carcinoma 8430	
Neuroendocrine carcinoma NOS 8246 (/3)	Carcinoma with neuroendocrine differentiation **8574 (/3)** Large cell neuroendocrine carcinoma **8013 (/3)** Small cell neuroendocrine carcinoma **8041 (/3)** • Small cell carcinoma **(/3)**
Neuroendocrine tumor NOS 8240 (/3) • Neuroendocrine tumor, grade 1 **(/3)**	Neuroendocrine tumor, grade 2 **8249 (/3)**
Oncocytic carcinoma 8290	
Paget disease of the nipple with no underlying tumor 8540	

[7] The term mucinous carcinoma applies when the diagnosis is EXACTLY "mucinous carcinoma," "mucinous duct carcinoma," "mucinous DCIS" OR "greater than 90% mucinous." See **Histology Rules**.

[8] Mucinous duct carcinoma is listed on the CAP protocol. It is not recognized by WHO or IARC. Mucinous carcinoma is not a subtype/variant of Carcinoma NST/duct carcinoma.

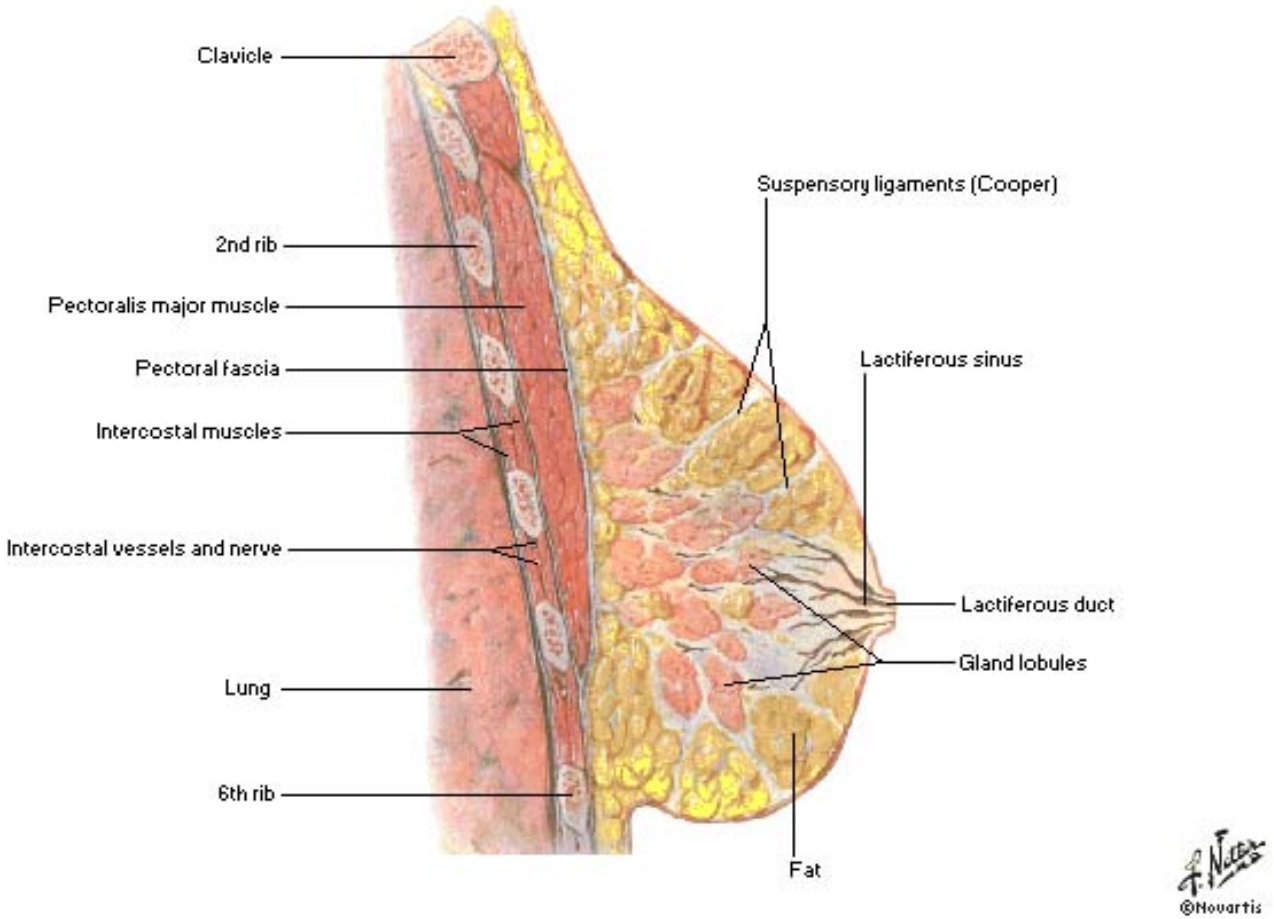
Table 3: Specific Histologies, NOS/NST, and Subtypes/Variants

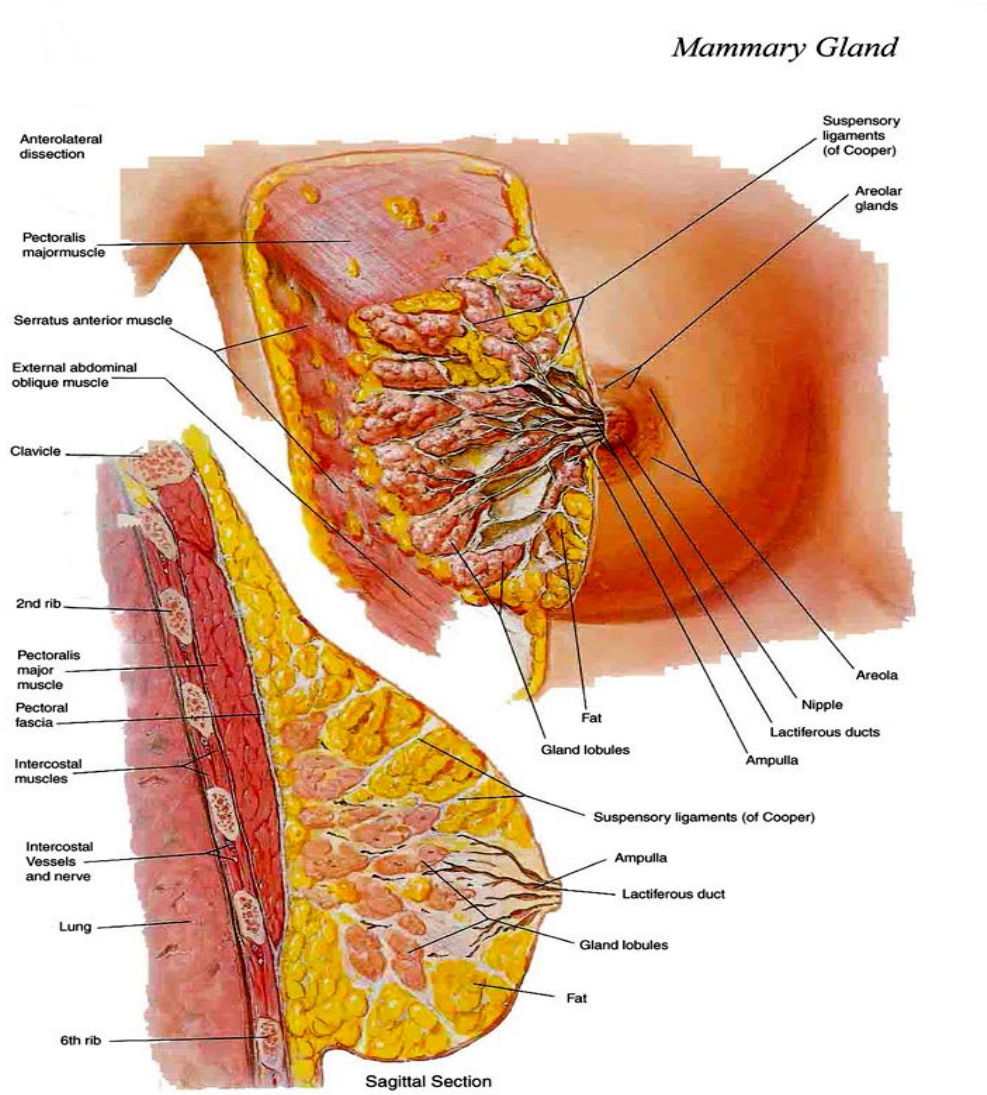
Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Papillary carcinoma 8503 • Invasive ductal papillary carcinoma **(/3)** • Invasive papillary carcinoma **(/3)** • Papillary carcinoma of breast, NOS **(/3)** • Intraductal papillary carcinoma **(/2)** • Intraductal papillary carcinoma with DCIS **(/2)** • Intraductal papilloma with ductal carcinoma in situ **(/2)** • Papillary carcinoma non-invasive **(/2)** • Papillary ductal carcinoma in situ **(/2)**	Encapsulated papillary carcinoma with invasive carcinoma, NST **8504 (/3)** • Encapsulated papillary carcinoma with invasion **(/3)** • Encapsulated papillary carcinoma with invasive duct carcinoma **(/3)** • Encapsulated papillary carcinoma, NOS **(/2)** • Intracystic papillary carcinoma **(/2)** • Non-infiltrating papillary carcinoma **(/2)** Micropapillary carcinoma **8507** Tall cell carcinoma with reverse polarity **8509 (/3)** • Solid papillary carcinoma with invasion **(/3)** • Solid papillary carcinoma in situ **(/2)**
Phyllodes tumor, malignant 9020 (/3) • Cystosarcoma phyllodes, malignant • Periductal stromal tumor, low grade	
Polymorphous carcinoma 8525	

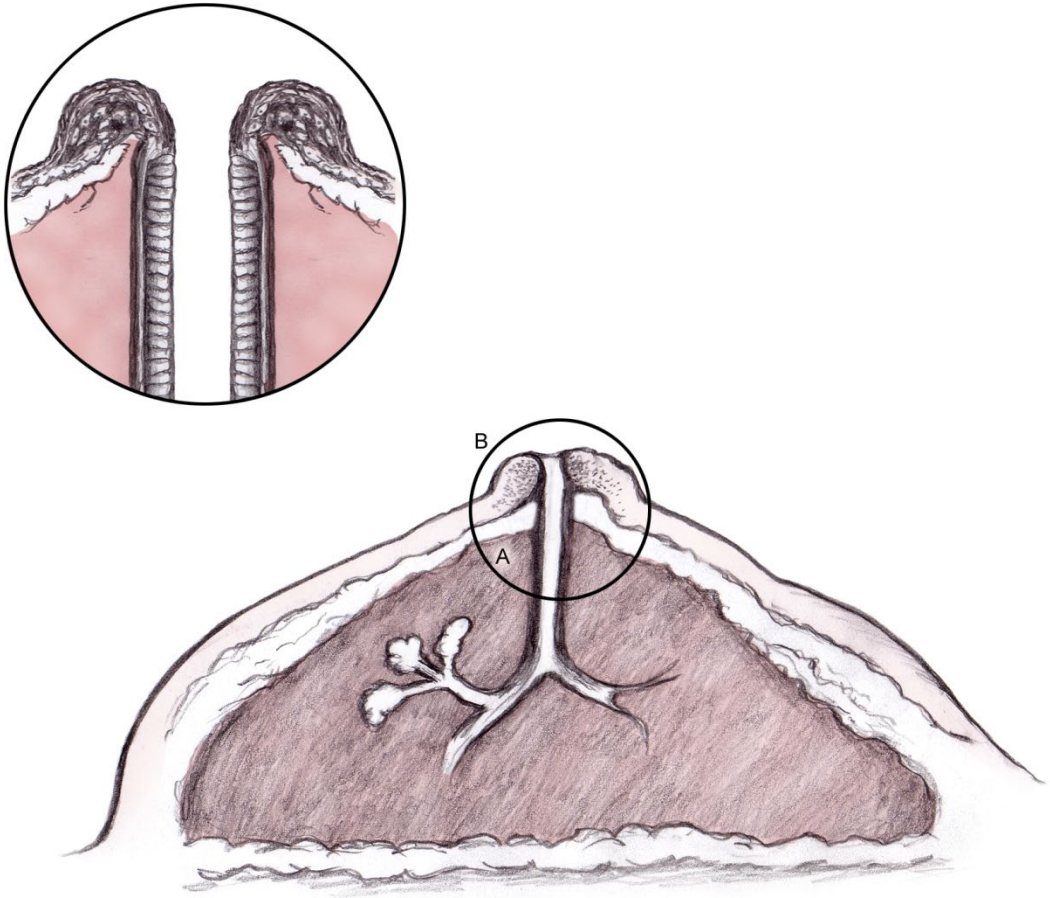
Table 3: Specific Histologies, NOS/NST, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Sarcoma NOS 8800 (/3)	Angiosarcoma **9120 (/3)** • Epithelioid angiosarcoma **(/3)** • Hemangiosarcoma **(/3)** • Post radiation angiosarcoma of breast **(/3)** • Lymphangiosarcoma **9170 (/3)** • Malignant hemangioendothelioma **9130 (/3)** Liposarcoma **8850 (/3)** Leiomyosarcoma **8890 (/3)** Osteosarcoma **9180 (/3)** Rhabdomyosarcoma **8900 (/3)** • Alveolar type **8920 (/3)** • Embryonal type **8910 (/3)** • Pleomorphic **8901 (/3)**
Sebaceous carcinoma 8410	
Secretory carcinoma 8502 • Juvenile breast carcinoma	
Signet ring carcinoma 8490	
Tubular carcinoma 8211	

Illustrations

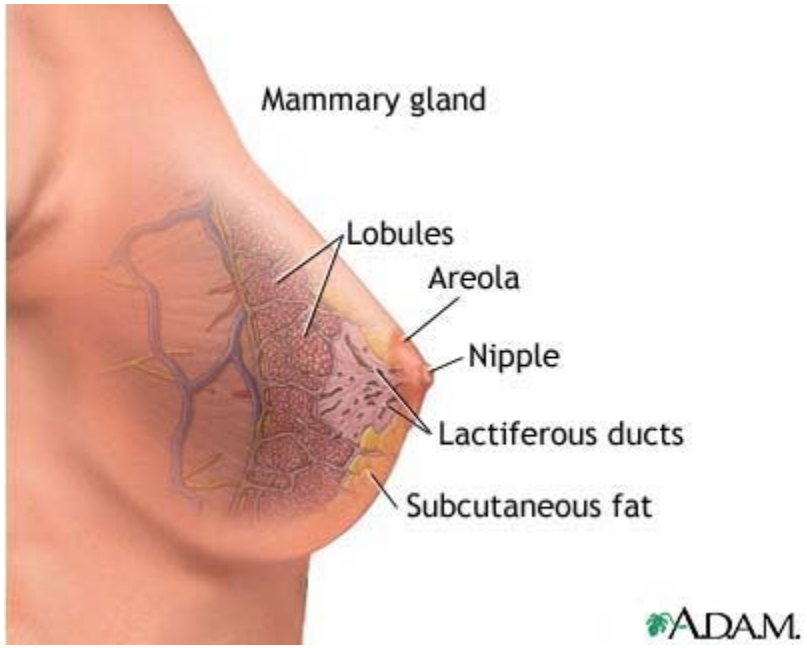



Mammary Gland
Anterolateral dissection
Pectoralis majormuscle
Serratus anterior muscle
External abdominal oblique muscle
Clavicle
2nd rib
Pectoralis major muscle
Pectoral fascia
Intercostal muscles
Intercostal Vessels and nerve
Lung
6th rib
Suspensory ligaments (of Cooper)
Areolar glands
Areola
Nipple
Lactiferous ducts
Ampulla
Fat
Gland lobules
Suspensory ligaments (of Cooper)
Ampulla
Lactiferous duct
Gland lobules
Fat
Sagittal Section
Atlas of Human Anatomy -- Frank H. Netter



Paget Disease of the nipple. Shows growth pattern of Paget on the pigmented portion of nipple and inside the milk duct opening

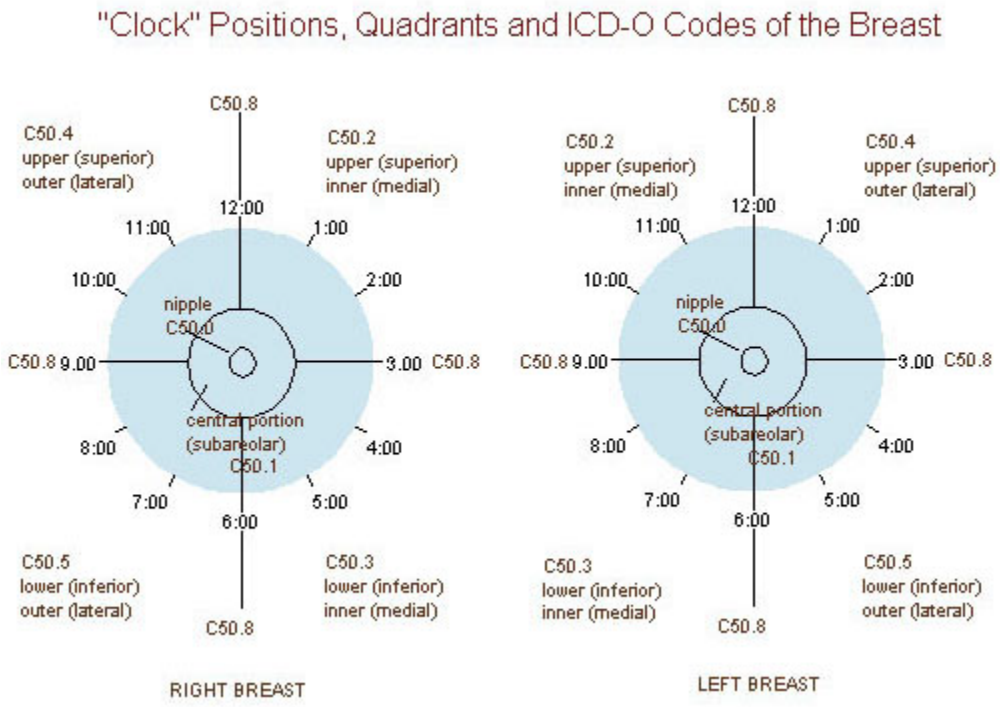
Source:
*"Image reprinted with permission from eMedicine.com, 2010. Available at: **http://emedicine.medscape.com/article/1101235-overview***


Mammary gland
Lobules
Areola
Nipple
Lactiferous ducts
Subcutaneous fat
A.D.A.M.

Breast Site-group Instructions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

The position of the tumor in the breast may be described as the positions on a clock

The two circles in the graphic are
Innermost circle: Retroareolar (under/behind areola)
Outer circle: Central portion of breast



Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Note: Metastatic tumors are not included when determining how many tumors are present. Metastatic tumors include but are not limited to:

- Axillary lymph nodes
- Bone
- Brain
- Chest wall
- Discontinuous involvement of skin of breast
- Distant lymph nodes as identified in Summary Staging Manual
- Liver
- Lung

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

Use the histology rules to assign the appropriate histology code.

Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Single Tumor

IMPORTANT: If the current tumor was **preceded** by a tumor in the same breast or contralateral breast, go to the **Multiple Tumors module.**

Rule M2 Abstract a **single primary** when the diagnosis is **inflammatory carcinoma** in:

- Multiple quadrants of same breast **OR**
- Bilateral breasts

Rule M3 Abstract a **single primary** when there is a **single tumor**.

Note 1: A single tumor is always a single primary.
Note 2: The tumor may overlap onto or extend into adjacent/contiguous site or subsites/quadrants.
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

Use the histology rules to assign the appropriate histology code.

Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Multiple Tumors

Note 1: Multiple tumors may be single primary or multiple primaries**.**
***Note 2*:** ER, PR, and/or HER2 are not used to determine multiple primaries.
Note 3: A subsequent tumor in the chest wall or surgical scar **without** evidence of residual breast tissue is regional metastasis.
Note 4: For those sites which have recognized biomarkers, the biomarkers are most frequently used to target treatment. Follow the rules; do not code multiple primaries or histology based on biomarkers.

Rule M4 Abstract **multiple primaries** when there are **separate**, **non-contiguous** tumors in sites with ICD-O site codes that **differ** at the second (C**X**xx) and/or third characters (Cx**X**x).

Note 1: Tumors with site codes that differ at the second or third character are in **different primary sites;** for example, a breast tumor C**50x** and a colon tumor C**18x** differ at the second and third character.

Note 2: This rule **does not** include metastases. Metastatic tumors are not used to determine multiple primaries; for example, liver metastases from the breast cancer would not be counted as a second primary.

Rule M5 Abstract **multiple primaries** when the patient has a subsequent tumor after being **clinically disease-free** for **greater than five years** after the original diagnosis or last recurrence.

Note 1: The rules are hierarchical. This rule **only** applies when there is a **subsequent tumor in the same breast**. In other words, a primary in the contralateral breast does not start the "clock" over.

Note 2: **Clinically** disease-free means that there was **no evidence** of recurrence on follow-up.

- Mammograms are WNL
- Scans are WNL

Note 3: When there is a recurrence less than or equal to five 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 five years from the date of the last recurrence.

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

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

Note 6: When a breast resection was done and a subsequent tumor is identified in the remaining chest wall, muscle, or skin **AND** there was no residual breast tissue identified in the resected specimen, this is a recurrence and not a new primary.

Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M6 Abstract a **single primary** when there is inflammatory carcinoma in:

- Multiple quadrants of same breast **OR**
- Bilateral breasts

Rule M7 Abstract **multiple primaries** when there is **bilateral** breast cancer (both right and left breast).

Note 1: Physician statement of "bilateral breast cancer" should not be interpreted as meaning a single primary. The term is not used consistently. The literal definition of bilateral is "cancer in both breasts".

Note 2: The histologies within each breast may be the same or different.

Rule M8 Abstract a **single primary** when the diagnosis is **Paget disease with synchronous underlying** in situ or invasive carcinoma NST (duct/ductal) or subtypes of duct.

Note: If the underlying tumor is any histology **other than** duct or subtypes of duct, continue through the rules.

Rule M9 Abstract **multiple primaries** when the diagnosis is **Paget disease with underlying** tumor which is NOT duct.

Example: Paget disease of the nipple with underlying lobular carcinoma are multiple primaries.

Rule M10 Abstract a **single primary** when a **ductal** carcinoma occurs **after a combination code** in the same breast. See the following list:

- **DCIS** following a diagnosis of:
  - DCIS + lobular carcinoma in situ **8522/2 OR**
  - DCIS + in situ Paget **8543/2 OR**
  - DCIS + Invasive Paget **8543/3 OR**
  - DCIS mixed with other in situ **8523/2** (code used for cases diagnosed prior to 1/1/2018)
- **Invasive carcinoma NST/duct following a diagnosis of:**
  - Invasive duct + invasive lobular **8522/3 OR**
  - Invasive duct + invasive Paget **8541/3 OR**
  - Invasive duct + other invasive carcinoma **8523/3**

Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M11 Abstract **multiple primaries** when separate/non-contiguous tumors are two or more **different subtypes/variants** in Column 2 of **Table 3** in the Site-group Instructions. Timing is irrelevant.

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

- **Same NOS:** Encapsulated papillary carcinoma with invasion 8504/3 and solid papillary carcinoma with invasion 8509/3 are both subtypes of invasive papillary carcinoma 8503/3 but are distinctly different histologies. Abstract multiple primaries.
- **Different NOS:** Encapsulated papillary carcinoma 8504/2 is a subtype/variant of in situ papillary carcinoma 8503/2. Pleomorphic lobular carcinoma in situ 8519/2 is a subtype/variant of lobular carcinoma in situ 8520/2. They are distinctly different histologies. Abstract multiple primaries.

Rule M12 Abstract a **single primary** when **synchronous**, separate/non-contiguous tumors are on the **same row** in **Table 3** in the Site-group Instructions.

Note: 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 (indented under the preferred term in column 1) **OR**
- A NOS (column 1) and the other is a subtype/variant of that NOS (column 2) **OR**
- A NOS histology in column 2 with an indented subtype/variant

Rule M13 Abstract **multiple primaries** when separate/non-contiguous tumors are:

- On **different rows** in **Table 3** in the Site-group Instructions
- A combination code in **Table 2** and a code from **Table 3**

Note 1: Timing is irrelevant. Tumors may be synchronous or non-synchronous.

Note 2: Each row in the table is a distinctly different histology.

Example 1: Paget disease of the nipple with underlying lobular are multiple primaries. Paget and lobular are on different rows in Table 3.

Example 2: Two tumors right breast. One tumor is invasive mixed duct and lobular 8522/3 (combination code from Table 2) and the second tumor is tubular 8211/3 (histology from Table 3). Abstract two primaries: 8522/3 and 8211/3.

Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M14 Abstract a **single primary** (the invasive) when an **in situ** tumor is diagnosed **after** an **invasive** tumor in the same breast.

Note 1: Once the patient has an invasive tumor, the **in situ** is recorded as a recurrence for those registrars who collect recurrence data.

Note 2: The rules are **hierarchical**. Only use this rule when none of the previous rules apply.

Note 3: The tumors may be a **NOS** and a **subtype/variant** of that NOS.

Rule M15 Abstract a **single primary** (the invasive) when an **invasive** tumor is diagnosed **less than or equal to 60** days **after** an **in situ** tumor in the same breast.

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

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

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

Note 4: Do **not** change **date of diagnosis**.

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

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

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

Rule M16 Abstract **multiple primaries** when an **invasive** tumor occurs **more than 60** days after an **in situ** tumor in the same breast.

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.

Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M17 Abstract a **single primary** 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.

Example: The first tumor is invasive carcinoma NST/ductal 8500/3 treated with lumpectomy and radiation. A year later, the patient is diagnosed with a new invasive carcinoma NST/ductal. Abstract a single primary: invasive carcinoma NST/ductal 8500/3.

This is the end of instructions for Multiple Tumors.

Use the histology rules to assign the appropriate histology code.

Breast Histology Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Priority Order for Using Documentation to Identify Histology

IMPORTANT NOTES

1. Code the histology diagnosed **prior to neoadjuvant treatment.**
   Note 1: Histology changes do occur following immunotherapy, chemotherapy, hormone, and radiation therapy.
   Note 2: Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.

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

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

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

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

   Note 1: Addendums and comments on the pathology report are given 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. The final diagnosis is often the synoptic CAP report.
   Note 3: The CAP protocol is a checklist which:
   - Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care.
   - Allows physicians to check multiple histologies

2. **Cytology** (nipple discharge or fine needle aspirate (FNA) of primary site)

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

4. **Radiography:** The following list is **not in priority** order because they are not a reliable method for **identifying** specific **histology**(ies). They are, however, valuable in diagnosing a malignancy.
   A. Mammography
   B. Ultrasound
   C. CT
   D. MRI

5. Code the histology **documented** by the physician when none of the above are available. Use the documentation in the following **priority order:**
   A. Treatment Plan
   B. Documentation from Tumor Board
   C. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
   D. Physician's **reference** to type of cancer (histology) in the medical record
   Note 1: Code the specific histology when documented.
   Note 2: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.

Breast Histology Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 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.

Example: **Do not** code **apocrine carcinoma** when the diagnosis specifies apocrine differentiation or features. **Apocrine differentiation** is frequently present in:

- Carcinoma NST/duct carcinoma
  - Subtypes/variants of carcinoma NST/duct carcinoma
- Lobular carcinoma NOS
  - Pleomorphic lobular carcinoma in situ

Coding Histology

Note 1: The rules for coding breast histology are different from the histology coding rules for all other sites. **DO NOT USE THESE RULES FOR ANY SITE OTHER THAN BREAST.**

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

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

Two INVASIVE histologies

Two histologies within a single tumor will be either:

- A NOS and a subtype/variant **OR**
- Different histologies (different rows in Table 3 **OR** different subtypes in Table 3 Column 2 **OR** a combination code from Table 2 and a code from Table 3)

The following instructions are in priority order:

1. **NOS and a subtype/variant**
   A. Code the **subtype/variant** (specific histology) **ONLY** when documented to be **greater than 90%** of the tumor.
      Note: When a histology is listed as “minimal”, “focus/foci/focal”, “microscopic”, you can assume the other histological portion comprises greater than 90% of the tumor.

Example: Patient had an excisional biopsy with a pathologic diagnosis of invasive cribriform carcinoma 8201/3. There was microscopic involvement of one margin. The patient chose to have a total mastectomy. Pathology from the total mastectomy showed minimal residual invasive carcinoma NST 8500/3. Because the invasive carcinoma NST was minimal, the subtype/variant invasive cribriform carcinoma 8201/3 is assumed to be greater than 90% of the tumor.

B. Code the **NOS/NST** when the subtype/variant is documented to be **less than or equal to 90%** of the tumor **OR** the percentage of subtype/variant is **unknown/not documented**.

2. Different histologies

A. Code the histology which comprises the majority of tumor.

Note 1: This instruction **does not apply** to:

- Invasive carcinoma NST/ductal and lobular carcinoma (use the combination code 8522/3).
- Mucinous carcinoma and a different histology (see Histology Rules)
- Metaplastic carcinoma, NOS and subtypes/variants and invasive carcinoma, NST (see Histology Rules)

Note 2: The following terms do not describe the majority of tumor.

Architecture	Pattern(s)
Component	Subtype
Differentiation	Type
Features (of)	Variant
Foci; focus, focal	

B. Code a combination code using **Table 2** in the Site-group Instructions when the majority is unknown/not documented.

Ambiguous Terminology

3. Code the specific histology described by **ambiguous terminology** (list follows) **ONLY** when A or B is true:
   A. The only diagnosis available is **one histology** term described by ambiguous terminology
      - CoC and SEER require reporting of cases diagnosed only by ambiguous terminology
      - Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

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

      If the specific histology does not meet the criteria in #3B, then code the NOS histology.

See the **Ambiguous Terminology** section of the General Instructions for instructions and examples on when ambiguous terms and definitive terms may be used to assign histology.

Ambiguous Terms list on the next page

Table 4: List of Ambiguous Terminology

Ambiguous Terminology	
Appears	Presumed
Cannot rule out	Suspicious (for)
Likely	Suggestive of
Favor(s)	

Note 1: Table 5 below includes terms **previously** included in the table of ambiguous terms. These terms should be treated as supporting a definitive diagnosis of a histologic subtype. A definitive term does not require clinical verification of the subtype or variant.

Note 2: The terms in Table 5 were removed from the list of ambiguous terms and added to a list of definitive terminology based on the recommendation of a panel of pathologists and subject matter experts.

Table 5: List of Definitive Terminology

Definitive Terminology	
Comparable with	Most likely
Compatible with	Probable
Consistent with	Typical (of)

Single Tumor: In Situ Only

Note 1: DCIS is often multifocal/multicentric; use this module.
Note 2: Architecture, pattern, and features **ARE NOT CODED**. The majority of in situ tumors will be coded to DCIS 8500/2.
Note 3: The terms type, subtype or variant may be included in the WHO preferred term. See **Table 3** for histologies with these terms included.

Rule H1 Code Paget disease in situ **8540/2** when the diagnosis is **exactly** Paget disease in situ.
Note 1: This is a **de novo** primary of the **nipple** (new tumor) with **no underlying** tumor.
Note 2: Paget is coded as in situ /2 **only** when **pathology** documents in situ behavior.

Rule H2 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: The terms type, subtype or variant may be included in the WHO preferred term. See Table 3 for histologies with these terms included.
Example: Ductal carcinoma in situ, solid type has an ICD-O code of 8230/2.
Note 3: When the histology is **not listed** in Table 3, use the **ICD-O** and all **updates**.
Note 4: Submit a question to **Ask a SEER Registrar** when the histology code is not found in Table 3, ICD-O or all updates.

Rule H3 Code DCIS and in situ lobular carcinoma **8522/2** when DCIS and in situ lobular carcinoma are present.
Note 1: Although the notes preceding the in situ section say most tumors will be coded to DCIS, 8522/2 identifies both DCIS and lobular carcinoma in situ.
Note 2: 8522/2 is the most accurate description of DCIS and lobular carcinoma in situ.
Note 3: 8522/2 includes DCIS and pleomorphic lobular carcinoma in situ.

Rule H4 Code DCIS and in situ Paget **8543/2.**
Note 1: Although the notes preceding the in situ section say most tumors will be coded to DCIS, 8543/2 identifies both DCIS and in situ Paget.
Note 2: 8543/2 is the most accurate description of DCIS and in situ Paget.

Rule H5 Code DCIS **8500/2** when there is a combination of DCIS and any other carcinoma in situ. See **Table 2**.

Rule H6 Code pleomorphic lobular carcinoma in situ **8519/2** when there is a combination of lobular carcinoma in situ and pleomorphic lobular carcinoma in situ.

Rule H7 Code in situ lobular carcinoma **8520/2** when there is a combination of lobular carcinoma in situ and one histology other than DCIS **AND**

- The percentage of lobular in situ comprises greater than 50% of the tumor **OR**
- Percentage of lobular in situ is unknown/not documented

Note: This is a new rule and applies to cases diagnosed 1/1/2024 forward. See H9 for cases diagnosed prior to 1/1/2024.

Rule H8 Code the histology that comprises greater than 50% of the tumor when two histologies are in situ lobular AND any histology other than DCIS.

Note: This is a new rule and applies to cases diagnosed 1/1/2024 forward. See H9 for cases diagnosed prior to 1/1/2024.

Rule H9 Code the histology using **Table 2** when there are multiple in situ histologies (2 or more) within a single tumor.

- Lobular and any histology other than DCIS **8524/2**
- Two or more histologies other than lobular and DCIS **8255/2**

Note: This rule does not include DCIS. See previous rules.

This is the end of instructions for a Single Tumor: In Situ Only

Code the histology according to the rule that fits the case

Single Tumor: Invasive and In Situ Components

Rule H10 Code the **invasive** histology when both invasive and in situ components are present (see Notes 2 and 3).

Note 1: Ignore the in situ term.
- This is consistent with the 2007 MPH Rules.

Note 2: When a single tumor has one of the histologies listed, see Table 3. These are specific histology terms that capture both invasive and in situ components.
- Encapsulated papillary carcinoma with invasion/with invasive carcinoma, NST/invasive duct carcinoma
- Solid papillary carcinoma with invasion

Note 3: When a single tumor has carcinoma NST/duct and lobular with different behaviors, continue through the rules.

Rule H11 Code duct and lobular **8522/3** when the final diagnosis is any of the following:
- Intraductal and invasive lobular carcinoma (includes invasive pleomorphic lobular carcinoma)
- Infiltrating duct and lobular carcinoma in situ (LCIS)
- Infiltrating duct and pleomorphic lobular carcinoma in situ
- Infiltrating lobular carcinoma and ductal carcinoma in situ (DCIS)
- Infiltrating pleomorphic lobular carcinoma and ductal carcinoma in situ (DCIS)

Note 1: Assign behavior code /3 even when an in situ histology is mixed with an invasive. This aligns with ICD-O-3.2 and was vetted with specialty matter experts.

Note 2: CAP uses the term Invasive carcinoma with ductal and lobular features ("mixed type carcinoma") as a synonym for duct carcinoma/carcinoma NST AND lobular carcinoma 8522/3.

Note 3: Although the instructions in the "Coding Multiple Histologies in a Single Tumor" section state, "Code the histology that comprises the majority of tumor", 8522/3 identifies both invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma and is the most accurate description.

This is the end of instructions for a Single Tumor: Invasive and In Situ Components

Code the histology according to the rule that fits the case

Single Tumor: Invasive Only

Rule H12 Code Paget disease **8540/3** when the diagnosis is **exactly** Paget disease.

Note 1: This is a **de novo** primary of the **nipple** (new tumor) with **no underlying** tumor.

Note 2: Paget is coded /3 when:

- Pathology documents invasive behavior **OR**
- Behavior is not documented/unknown

Rule H13 Code the **underlying tumor** when there is a diagnosis of **inflammatory carcinoma**.[1]

Example: The patient has a clinical diagnosis of inflammatory breast carcinoma. Pathology shows carcinoma NST with dermal invasion as well as erythema. Code the underlying tumor: carcinoma NST 8500/3.

Informational item: The **clinical symptoms** of inflammatory breast cancer include rapid breast enlargement and skin changes (redness, edema peau d'orange) involving more than a third of the breast. Usually there is a diffuse firmness of the breast and there is no palpable underlying mass.

Note 1: Record the inflammatory carcinoma in **staging** fields.

Note 2: **Code inflammatory** carcinoma 8530/3 when it is the **only diagnosis** available (DCO, outpatient only, no follow-up).

Rule H14 Code mucinous carcinoma/adenocarcinoma **8480 ONLY** when:

- The diagnosis is **exactly** mucinous carcinoma or mucinous duct carcinoma **OR**
- Multiple histologies are present and mucinous carcinoma is documented as **greater than 90%** of the tumor

Note 1: The pure mucinous carcinoma category includes only cases which are diagnosed as exactly mucinous or documented to be greater than 90% of the tumor.

Note 2: This is a change from the 2007 MPH Rules.

Note 3: When a tumor has both mucinous carcinoma and a different histology, and mucinous is less than or equal to 90% of the tumor (or the percentage is not documented), code the other histology.

[1] American College of Pathologists: Protocol for the Examination of Specimens From Patients With Invasive Carcinoma of the Breast: "Inflammatory carcinoma requires the presence of clinical findings of erythema and edema involving at least one-third or more of the skin of the breast"

Rule H15 Code the **primary invasive histology** when there is a carcinoma with **signet ring cells OR signet ring cell differentiation**.

Example: Resection pathology diagnosis is invasive lobular carcinoma with signet ring cell differentiation. Code the invasive lobular carcinoma **8520/3.**

Rule H16 Code **metaplastic carcinoma**, NOS, or subtype/variant of metaplastic carcinoma, NOS when **invasive carcinoma, NST OR invasive lobular carcinoma** is present along with the metaplastic carcinoma.

Example: Resection pathology diagnosis is invasive mammary carcinoma, NST with extensive metaplastic carcinoma present. Code metaplastic carcinoma **8575/3**.

Rule H17 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: The terms type, subtype or variant may be included in the WHO preferred term. See Table 3 for histologies with these terms included.

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

Note 4: Submit a question to **Ask a SEER Registrar** when the histology code is not found in Table 3, ICD-O or all updates.

Rule H18 Code duct carcinoma and lobular carcinoma **8522/3** when the final diagnosis is invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma (includes invasive pleomorphic lobular carcinoma)

Note 1: CAP uses the term **Invasive carcinoma with ductal and lobular features** ("mixed type carcinoma") as a synonym for duct carcinoma/carcinoma NST AND lobular carcinoma 8522/3.

Note 2: Although the instructions in the "Coding Multiple Histologies in a Single Tumor" section state, "Code the histology that comprises the majority of tumor", 8522/3 identifies both invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma and is the most accurate description.

Rule H19 Code the **subtype/variant** (specific histology) **ONLY** when there is a NOS/NST and a subtype/variant **AND** the subtype/variant is documented to be **greater than 90%** of the tumor.

Note 1: When a histology is listed as "minimal", "focus/foci/focal", "microscopic", you can assume the other histological portion comprises greater than 90% of the tumor.

Note 2: Use **Table 3** to identify NOS/NST and subtypes/variants. Examples include the following:

- Carcinoma NST **8500** and a subtype/variant of carcinoma NST
- Glycogen-rich clear cell carcinoma **8315** and a subtype/variant of glycogen-rich clear cell carcinoma
- Lobular carcinoma **8520** and a subtype/variant of lobular carcinoma
- Medullary carcinoma **8510** and a subtype/variant of medullary carcinoma
- Metaplastic carcinoma **8575** and a subtype/variant of metaplastic carcinoma
- Neuroendocrine carcinoma (NEC) **8246** and a subtype/variant of NEC
- Neuroendocrine tumor NOS (NET) **8240** and a subtype/variant of NET
- Papillary carcinoma **8503** and a subtype/variant of papillary carcinoma
- Sarcoma **8800** and a subtype/variant of sarcoma

Note 3: **Do not** code any histology described as **features or differentiation** unless it is part of the preferred term.

Example 1: Pathology from excision shows a 1.4 cm tumor and a diagnosis of clear cell carcinoma 8310/3 with a focus of glycogen-rich clear cell carcinoma NOS 8315/3. Because the glycogen-rich clear cell carcinoma NOS is just a focus, more than 90% of the tumor is clear cell carcinoma. Code the subtype/variant: clear cell carcinoma 8310/3.

Example 2: Pathology from an excised tumor says tumor is 95% metaplastic carcinoma squamous cell carcinoma 8070/3 and the remainder is metaplastic carcinoma NOS 8575/3. Code the subtype/variant: squamous cell carcinoma 8070/3.

Rule H20 Code the **NOS/NST** when there is a NOS/NST and a subtype/variant **AND**

- The subtype/variant is designated as **less than or equal to 90%** of tumor **OR**
- The percentage of each is **unknown/not documented**

Example 1: Pathology diagnosis is carcinoma NST 8500/3 and pleomorphic carcinoma 8022/3. The percentage of subtype/variant is unknown. Code the NOS: carcinoma NST 8500/3.

Example 2: Pathology says the majority of tumor is metaplastic carcinoma with chondroid differentiation 8571/3 and the remainder is metaplastic carcinoma NOS 8575/3. Majority simply means greater than 50%, so it is unknown whether or not the subtype/variant is greater than 90% of the tumor. Code metaplastic carcinoma NOS 8575/3.

Rule H21 Code the histology that comprises **greater than 50%** of tumor when **two histologies** are:

- On **different rows** in **Table 3** in the Site-group Instructions **OR**
- **Different subtypes** of the same NOS **OR**
- A **combination code** from **Table 2** and a code from **Table 3**

Note 1: This rule does not apply to mucinous. See previous rules.

Note 2: The rules are hierarchical, so the tumors are **NOT** a NOS/NST and subtype/variant.

Note 3: If the majority histology is unknown/not documented, continue through the rules.

Example: Pathology reads the tumor is predominantly carcinoma NST 8500/3 with areas of tubular carcinoma 8211/3. Code the predominant histology: carcinoma NST 8500/3. Carcinoma NST and tubular carcinoma are on different rows in Table 3, so they are distinctly different histologies.

Rule H22 Code a **combination code** when there are **two histologies** (two components) within a single tumor and the majority histology is unknown/not documented.

Note 1: Use **Table 2** in the Site-group Instructions to identify valid combination codes.

Note 2: The rules are hierarchical, so the tumors are **NOT** a NOS/NST and a single subtype/variant.

Note 3: The diagnosis may be two subtypes/variants and the pathologist may mention the presence of duct/carcinoma NST. Ignore the mention of carcinoma NST.

Note 4: **Do not** use a combination code when the second histology is described as **features** or **differentiation** unless it is part of the preferred term.

Note 5: The histologies may be identified as:

- Mixed histologies
- Combination histologies
- Histology 1 **AND** histology 2
- Histology 1 **WITH** histology 2

This is the end of instructions for a Single Tumor: Invasive Only

Code the histology according to the rule that fits the case

Multiple Tumors Abstracted as a Single Primary

Note 1: DCIS is often multifocal/multicentric; use the Single Tumor: In Situ module.
Note 2: First use the multiple primary rules to ensure that the multiple tumors are to be abstracted as a single primary.

Rule H23 Code the **underlying tumor** when there is a diagnosis of inflammatory carcinoma:

Example: The patient has a clinical diagnosis of inflammatory breast carcinoma. Pathology shows carcinoma NST with dermal invasion as well as erythema. Code the underlying tumor: carcinoma NST 8500/3.

Informational item: The **clinical symptoms** of inflammatory breast cancer include rapid breast enlargement and skin changes (redness, edema peau d'orange) involving more than a third of the breast. Usually there is a diffuse firmness of the breast and there is no palpable underlying mass.

Note 1: Record the inflammatory carcinoma in **staging** fields.
Note 2: Code inflammatory carcinoma 8530/3 when it is the only diagnosis available (DCO, outpatient only, no follow-up).

Rule H24 Code **Paget disease** and **ductal carcinoma** as follows when:

- Pathology specifies Paget disease as **invasive** /3 **OR** behavior not documented **AND**
- Underlying tumor is:
  - Invasive carcinoma NST/duct carcinoma **8541/3**
  - DCIS **8543/3**

Note: Ignore the presence of lobular carcinoma in situ (LCIS).

Rule H25 Code Paget disease and DCIS **8543/2** when there is Paget disease (specified as **in situ**) with underlying **DCIS**.

Rule H26 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: The terms type, subtype or variant may be included in the WHO preferred term. See Table 3 for histologies with these terms included.
Note 3: When the histology is not listed in Table 3, use the ICD-O and all updates.
Note 4: Submit a question to Ask a SEER Registrar when the histology code is not found in Table 3, ICD-O or all updates.

Rule H27 Code the **invasive** histology when there are both invasive and in situ histologies.

Rule H28 Code the **NOS/NST** when there is a NOS/NST and a subtype/variant:

- Mixed in all of the tumors **OR**
- Separate tumors with different histologies

Note: It is very difficult to determine whether the subtype/variant is greater than 90% of the tumor mass when there are multiple tumors.

Rule H29 Code a **combination code** when there are **two histologies** (two components) within all tumors.

Note 1: Use **Table 2** in the Site-group Instructions to identify valid combination codes.

Note 2: **Do not** use a combination code when the second histology is described as **differentiation** or **features**, unless it is part of the preferred term.

Note 3: The histologies may be identified as:

- Mixed histologies
- Combination histology
- Histology 1 **AND** histology 2
- Histology 1 **WITH** histology 2

Note 4: Table 2 is used for **two** histologies. When there are **greater than two** histologies, use the "last resort" code **8255** because none of the other combinations include greater than two histologies.

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

Code the histology according to the rule that fits the case

Colon, Rectosigmoid, and Rectum Site-group Instructions
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Introduction

Note 1: New terms and codes in these rules are based on the WHO Classification of Tumors of the Digestive System 5th edition.

Note 2: Ninety-eight percent of colon cancers are **adenocarcinoma** and **adenocarcinoma subtypes**.

Note 3: **Mixed** histologies and specific **variants or subtypes of adenocarcinoma** other than mucinous/colloid or signet ring cell are **rare**. A less common combination is **mixed adenoneuroendocrine carcinoma (MANEC) 8244** (previously called adenocarcinoma and carcinoid). The new terminology was originally proposed for tumors arising from goblet cell carcinoid but with more aggressive adenocarcinoma histology. It was also proposed because **carcinoids** are a subgroup of neuroendocrine carcinoma. Pathologists **may still diagnose** adenocarcinoma and carcinoid, adenocarcinoid, or adenocarcinoma and a specific neuroendocrine tumor or adenocarcinoma arising from/with a NET (including specific types of **NET-like goblet cell** carcinoid). Over time, the histologic diagnoses will change to MANEC.

Note 4: **De novo** (previously called frank) adenocarcinoma arises in the **mucosa** of the bowel, not in a polyp.

Note 5: **Terms Seen More Frequently: NET, NEC, GIST**

- **NET** (neuroendocrine tumor): The term NET is gradually replacing **carcinoid**; however, some pathologists still use the term carcinoid
- **NEC** (neuroendocrine carcinoma): The term NEC includes **small cell neuroendocrine** carcinoma, **large cell neuroendocrine** carcinoma, and **poorly differentiated neuroendocrine** carcinoma
- **GIST** (gastrointestinal stromal tumor):
  - GIST NOS is **reportable** beginning with cases diagnosed 1/1/2021 forward

Note 6: **Pseudomyxoma peritonei** (accumulation of mucin-secreting tumor cells in the abdominal or pelvic cavity) now has a **two-tiered** system that classifies pseudomyxoma peritonei as either **high-grade** or **low-grade** (see below). Pseudomyxoma peritonei is usually associated with mucinous tumors of the appendix and is rarely associated with ovarian mucinous tumors.

- **High**-grade pseudomyxoma peritonei is **malignant** /3
- **Low**-grade pseudomyxoma peritonei is **not malignant** /1
- See **Histology Rules** for coding instructions

Note 7: There are dysplasias which have been assigned an in situ behavior code (/2) in WHO and in the ICD-O Update. Despite becoming a (/2), "they are not reportable in the US. They are reportable in Canada.

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**.
- Carcinoma; adenocarcinoma
  - A histology type must be stated for these terms to be equal
  - **Example of equivalent or equal**: Mucinous carcinoma and mucinous adenocarcinoma are both coded 8480
  - **Example of NOT equivalent or equal**: Carcinoma NOS 8010 and adenocarcinoma NOS 8140
- Familial polyposis; familial adenomatous polyposis (FAP) **8220**
- Polyp; adenoma; polyp NOS; adenomatous polyp
- Simultaneous; synchronous; existing at the same time; concurrent; prior to first course treatment
- Site; topography
- Tumor; mass; tumor mass; lesion; neoplasm
  - The terms tumor, mass, tumor mass, lesion, 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

Terms That Are NOT Equivalent or Equal

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

- **Carcinoma**, NOS 8010 is not equivalent to **adenocarcinoma**, NOS 8140
    - Carcinoma NOS 8010 and adenocarcinoma NOS 8140 are not interchangeable unless they include a histology type
- **Component** is not equivalent to **subtype/type/variant**
- **Exophytic** and **polypoid** are not equivalent to either an **adenoma** or an **adenomatous polyp**.
- **Phenotype** is not equivalent to **subtype/type/variant**
- **Polypoid adenocarcinoma** is not equivalent to **adenocarcinoma in a polyp**

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Table 1: Specific Histologies, NOS, and Subtypes/Variants

Use Table 1 as directed by the Histology Rules to assign the more common histology codes for malignancies found in the colon, rectosigmoid and rectum.

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 1, ICD-O or all updates.
Note 3: Behavior codes are listed when the term has only one possible behavior (either a /2 or /3).

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3).**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2.
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3).**

Table begins on next page

Table 1: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)

Adenocarcinoma 8140 [1]
• Adenocarcinoma NOS
• Adenocarcinoma and cribriform carcinoma percentage of cribriform documented as less than 50% of tumor
• Adenocarcinoma and cribriform carcinoma, percentage of cribriform unknown
• Adenocarcinoma and cribriform carcinoma, percentage of cribriform not documented
• Adenocarcinoma and mucinous carcinoma, mucinous documented as less than 50% of tumor
• Adenocarcinoma and mucinous carcinoma, percentage of mucinous unknown/not documented
• Adenocarcinoma and signet ring cell carcinoma, percentage of signet ring cell carcinoma documented as less than 50% of tumor
• Adenocarcinoma and signet ring cell carcinoma, percentage of signet ring cell carcinoma not documented
• Adenocarcinoma and signet ring cell carcinoma, percentage of signet ring cell carcinoma unknown
 	
Row continues on next page
	Adenoid cystic carcinoma **8200**
	Cribriform comedo-type carcinoma **8201**
	• Adenocarcinoma, cribriform comedo-type
	Diffuse adenocarcinoma **8145**
	• Diffuse carcinoma
	Linitis plastica **8142 (/3)**
	Medullary adenocarcinoma **8510**
	• Medullary carcinoma
	Micropapillary carcinoma **8265**
	Mucinous adenocarcinoma **8480**
	• Colloid adenocarcinoma
	  ○ Colloid carcinoma
	• High grade appendiceal mucinous neoplasm
	  ○ HAMN
	• Low grade appendiceal mucinous neoplasm
	  ○ LAMN
	• Mucinous carcinoma
	Mucoepidermoid carcinoma **8430**
	
	Subtypes continue on next page (same row)

[1] See **Histology Rules** for instructions on coding adenocarcinoma subtypes/variants arising in a polyp.

Table 1: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)

Adenocarcinoma 8140 (continued) [1]
• Adenocarcinoma in adenomatous polyp
  ○ Carcinoma in adenomatous polyp
• Adenocarcinoma in any type of polyp
• Adenocarcinoma in polyp, NOS
  ○ Carcinoma in a polyp, NOS
• Adenocarcinoma in polypoid adenoma
  ○ Carcinoma in polypoid adenoma
• Adenocarcinoma in serrated adenoma
  ○ Carcinoma in serrated adenoma
• Adenocarcinoma in tubular polyp
  ○ Carcinoma in tubular polyp
• Adenocarcinoma in tubulovillous polyp
  ○ Carcinoma in tubulovillous polyp
• Adenocarcinoma in villous adenoma
  ○ Carcinoma in villous adenoma
• Adenocarcinoma, intestinal type
• Adenocarcinoma with mucinous and signet ring cell features
• Comedocarcinoma
• Intestinal adenocarcinoma [2]
	Serrated adenocarcinoma **8213**
	Signet ring cell adenocarcinoma **8490**
	• Poorly cohesive adenocarcinoma
	• Poorly cohesive carcinoma
	• Signet ring cell carcinoma
	Superficial spreading adenocarcinoma **8143**
	Tubulopapillary carcinoma **8263**
	Undifferentiated adenocarcinoma **8020**
	• Undifferentiated carcinoma

[2] When the term **intestinal adenocarcinoma is** used to describe a colon primary, it simply means the **appearance** is similar to adenocarcinoma seen in the stomach and is coded to adenocarcinoma NOS 8140.

Table 1: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenosquamous carcinoma 8560 [3] • Mixed adenocarcinoma NOS and epidermoid carcinoma • Mixed adenocarcinoma NOS and squamous cell carcinoma	
Combined small cell carcinoma 8045 • Small cell carcinoma mixed with adenocarcinoma • Small cell carcinoma mixed with any other type of adenocarcinoma • Small cell carcinoma mixed with any other type of carcinoma • Small cell carcinoma mixed with neuroendocrine carcinoma	
Gastrinoma 8153	

[3] This code **cannot** be used for **adenocarcinoma subtypes/variants** with **squamous cell/epidermoid carcinoma.**

Table 1: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Gastrointestinal stromal tumor 8936 (/3) [4] • GANT • Gastrointestinal autonomic nerve tumor • Gastrointestinal pacemaker cell tumor • Gastrointestinal stromal tumor • GIST, malignant • GIST NOS • GIST, spindle cell type • Gastrointestinal stromal sarcoma • Succinate dehydrogenase-deficient gastrointestinal stromal tumor	
Mixed adenoneuroendocrine carcinoma 8244 • Adenocarcinoma ex-goblet cell • Adenocarcinoma mixed with high-grade large cell neuroendocrine carcinoma • Adenocarcinoma mixed with high-grade small cell neuroendocrine carcinoma • MANEC • Mixed neuroendocrine carcinoma	Goblet cell adenocarcinoma **8243** • Goblet cell carcinoid
Mixed neuroendocrine non-neuroendocrine neoplasm 8154 • MiNEN	

[4] Beginning with cases diagnosed 1/1/2021 forward, the word malignant is no longer required in order to be reportable.

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Table 1: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Neuroendocrine carcinoma 8246 • NEC	Large cell neuroendocrine carcinoma **8013** Small cell neuroendocrine carcinoma **8041**
Neuroendocrine tumor Grade 1 8240 • Carcinoid NOS [5] • Low-grade neuroendocrine tumor • NET Grade 1 • Neuroendocrine tumor Grade 1 • Well-differentiated neuroendocrine tumor	EC cell serotonin-producing neuroendocrine tumor **8241** • Enterochromaffin cell carcinoid Neuroendocrine tumor Grade 2 **8249** • NET Grade 2 Somatostatin-producing neuroendocrine tumor Grade 2 **8156**
Sarcoma NOS 8800 (/3)	Angiosarcoma **9120 (/3)** • Hemangiosarcoma Leiomyosarcoma **8890 (/3)**
Spindle cell carcinoma 8032	
Squamous cell carcinoma 8070 • Epidermoid carcinoma NOS • Squamous cell carcinoma NOS • Squamous cell epithelioma	

[5] When the diagnosis is **exactly** "**carcinoid**" it may be a Grade 1 or Grade 2 NET. Default is coding NET Grade 1 8240.

Table 2: Histologies Not Reportable for Colon, Rectosigmoid and Rectum

Column 1 lists the **non-reportable** histology term and code for NOS or specific. Under the NOS code synonyms and subtypes/variants are listed. Synonyms do not include a histology code (histology code is same as NOS code). The synonyms include a histology and behavior code.
Column 2 lists the **reason** these histologies are **not reportable**

Specific or NOS Term and Code, Synonym(s), and Subtype(s)/Variant(s)	Reason not reportable
Adenoma 8140 (/0) [1] • Adenoma NOS • Tubular adenoma **8211 (/0)** • Tubulovillous adenoma **8263 (/0)** • Villous adenoma **8261 (/0)**	Non-malignant
Adenomatous polyp, high grade dysplasia 8210 (/2)	Non-reportable terminology
Cowden-associated polyp No code [1] • Cowden disease • Cowden syndrome • Multiple hamartoma syndrome	Non-malignant/no code
Dysplasia, high grade 8148 (/2) [2] • High-grade dysplasia • Intraepithelial neoplasia, high grade	**CURRENTLY NOT REPORTABLE**

[1] With no malignancy in polyps
[2] Colorectal primaries only (C180-C189, C199 and C209)

Table 2: Histologies Not Reportable for Colon, Rectosigmoid and Rectum

Specific or NOS Term and Code, Synonym(s), and Subtype(s)/Variant(s)	Reason not reportable
Dysplasia, low grade 8148 (/0) • Intraepithelial neoplasia, low grade	Non-malignant
Familial adenomatous polyposis (FAP) No code • Adenomatous polyposis coli • Bussey-Garder polyposis • Familial multiple polyposis • Familiar polyposis coli • Familial polyposis of the colon and rectum • Familial polyposis of the gastrointestinal tract • Gardner syndrome • Multiple adenomatosis	Reportable only when there is cancer in a polyp
Gangliocytic paraganglioma 8683 (/0)	Non-malignant
Gastrointestinal stromal tumor stated as benign, borderline, or non-malignant 8936 (/1) • GIST NOS [3] • GIST, behavior not specified	Non-malignant
Hyperplastic polyp No code	Non-malignant/no code
Inflammatory or pseudopolyp No code	Reactive lesions; mimic carcinoma
Intestinal-type adenoma, high grade 8144 (/2)	Non-reportable terminology

[3] Gastrointestinal stromal tumor, NOS or behavior not specified is not reportable for cases diagnosed prior to 1/1/2021. Cases diagnosed 1/1/2021 forward are reportable

Table 2: Histologies Not Reportable for Colon, Rectosigmoid and Rectum

Specific or NOS Term and Code, Synonym(s), and Subtype(s)/Variant(s)	Reason not reportable
Juvenile polyp No code • Combined juvenile polyposis • Hereditary hemorrhagic telangiectasis • Osler-Webec-Rendu syndrome • Familial juvenile polyposis • Generalized juvenile polyposis • Hamartomatous gastrointestinal polyposis • Juvenile polyposis • Juvenile polyposis coli • Juvenile polyposis of infancy	Non-malignant/no code
L cell glucagon-like peptide and PP/PYY-producing NETs 8152 (/1)	Non-malignant
Leiomyoma 8890 (/0)	Non-malignant
Lipoma 8850 (/0)	Benign accumulation of fat cells that are circumscribed or encapsulated
Low-grade appendiceal mucinous neoplasm 8480 (/1) [4] [5] • LAMN	Non-malignant
Lynch syndrome No code	Non-malignant/no code

[4] May have low-grade, non-invasive pseudomyxoma peritonei, mucinous implants in peritoneum or beyond.
[5] LAMN is non-reportable for cases diagnosed prior to 1/1/2022. Beginning 1/1/2022, LAMN becomes a reportable neoplasm. See Table 1.

Table 2: Histologies Not Reportable for Colon, Rectosigmoid and Rectum

Specific or NOS Term and Code, Synonym(s), and Subtype(s)/Variant(s)	Reason not reportable
Mesenchymal tumors • Granular cell tumor **9580 (/0)** • Hemangioma **9120 (/0)**	Non-malignant
Peutz-Jeghers polyp No code • Intraepithelial neoplasia in Peutz-Jeghers polyp(s) • Periorificial lentiginosis • Peutz-Jeghers polyposis • Polyps-and-spots syndrome	Non-malignant/no code
Pseudomyxoma peritonei 8480 (/1) [6]	Non-malignant. When both implants and site of origin are benign, the case is not reportable.
Serrated dysplasia, high grade 8213 (/2)	Non-reportable terminology
Sessile serrated adenoma/polyp 8213 (/0) [7] • Serrated polyposis • Sporadic serrated polyps • Traditional serrated adenoma	Non-malignant
Tubular adenoma, high grade 8211 (/2)	Non-reportable terminology
Tubular carcinoid, no malignancy 8245 (/1)	Non-malignant

[6] When pathologist does not designate as malignant OR implants are benign
[7] With no malignancy in polyps

Table 2: Histologies Not Reportable for Colon, Rectosigmoid and Rectum

Specific or NOS Term and Code, Synonym(s), and Subtype(s)/Variant(s)	Reason not reportable
Tubulovillous adenoma, high grade 8263 (/2)	Non-reportable terminology
Villous adenoma, high grade 8261 (/2)	Non-reportable terminology

Table 3: Primary Site Codes

Column 1 includes the primary site code and term for colon and rectum sites.
Column 2 includes additional terms associated with the term.

Site Code and Term	Associated Terminology
C180 Cecum	Ileocecal valve Ileocecal junction
C181 Appendix	
C182 Ascending colon	Right colon
C183 Hepatic flexure	
C184 Transverse colon	
C185 Splenic flexure of colon	
C186 Descending colon	Left colon
C187 Sigmoid colon	Sigmoid, NOS Sigmoid flexure of colon Pelvic colon
C188 Overlapping lesion of colon	Left colon
C189 Colon, NOS	Large intestine (Excludes rectum, NOS C20.9 and rectosigmoid junction C19.9) Large bowel, NOS

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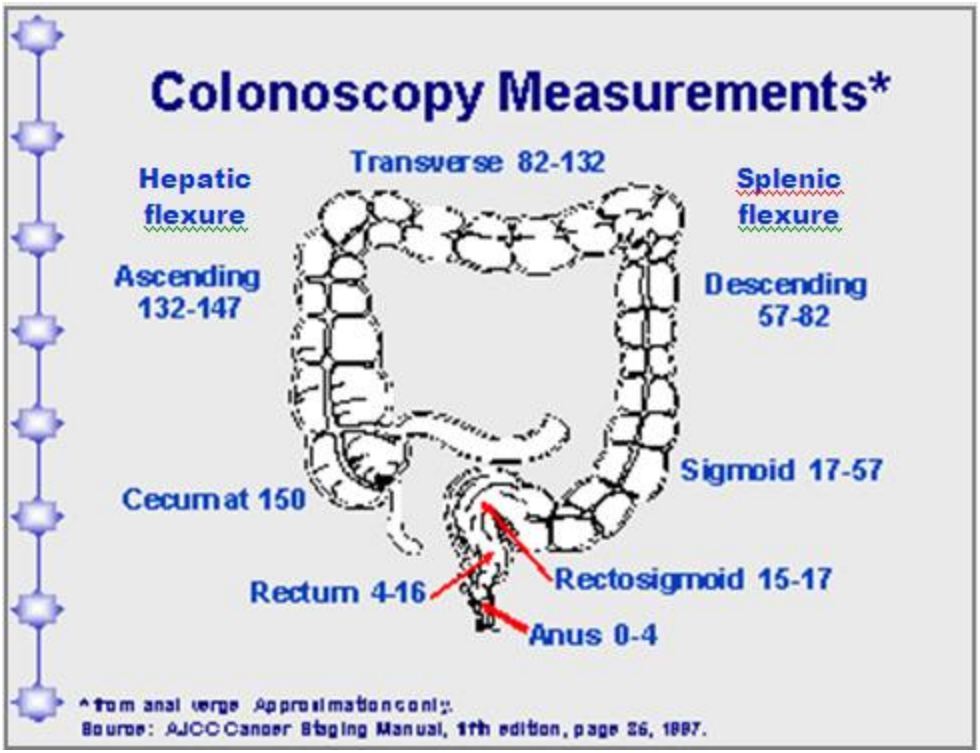
Table 3: Primary Site Codes

Site Code and Term	Associated Terminology
C199 Rectosigmoid junction	Rectosigmoid, NOS Rectosigmoid colon Colon and Rectum Pelvirectal junction
C209 Rectum, NOS	Rectal ampulla

Illustrations

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



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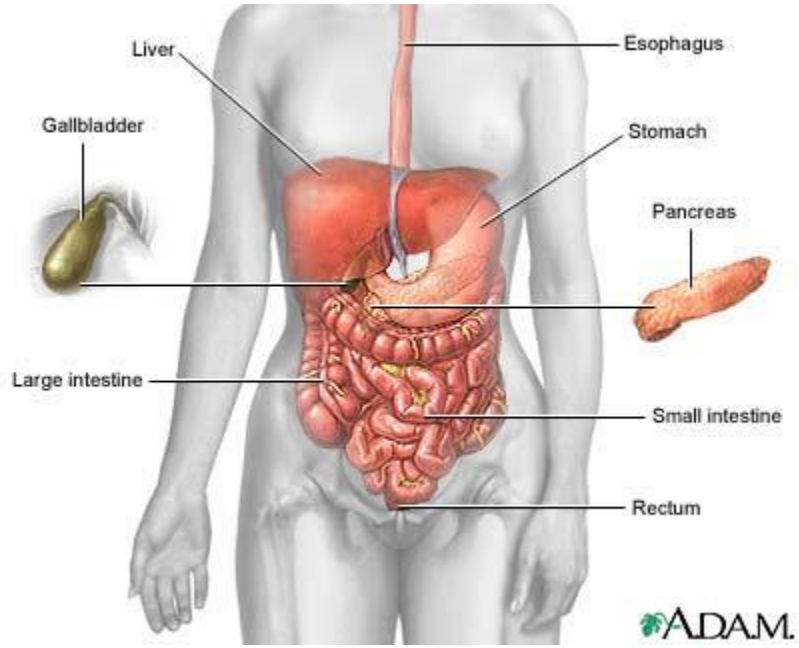
GI System



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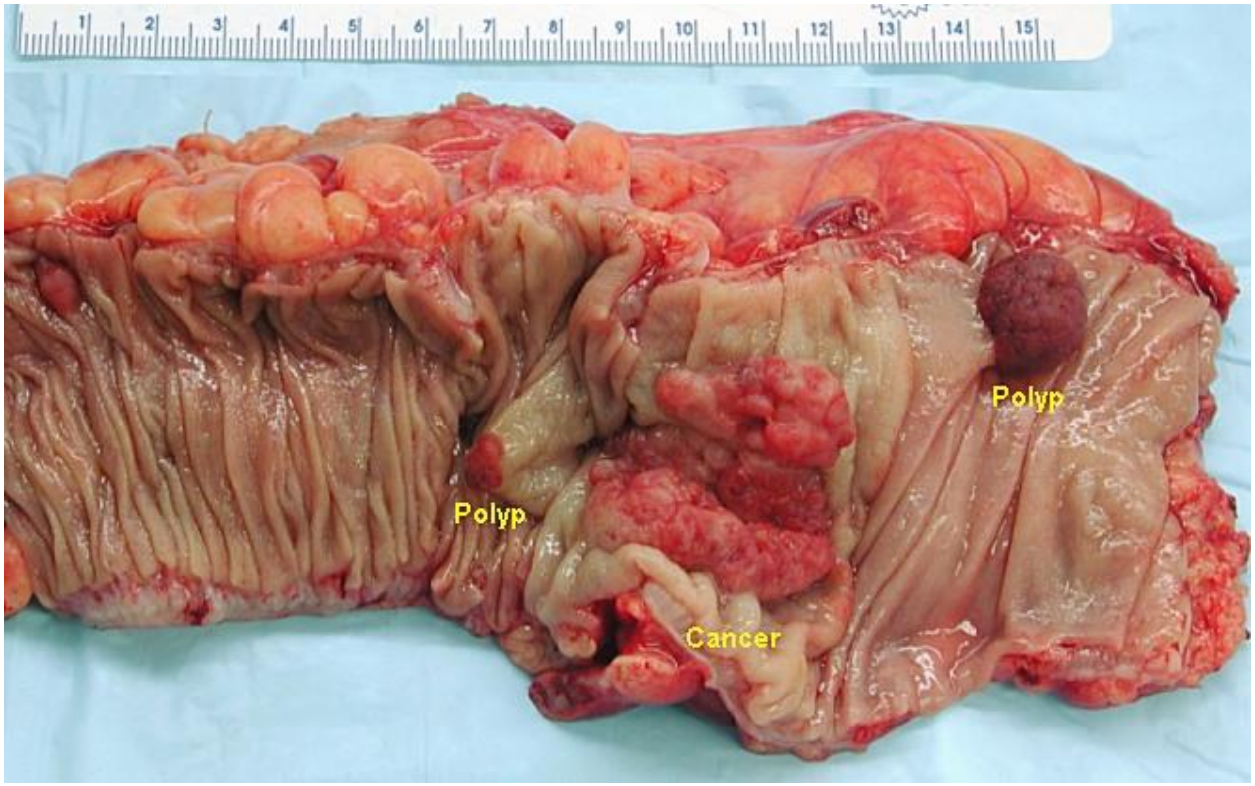
Polyps and de novo or "frank" adenocarcinoma in colon



Source: http://upload.wikimedia.org/wikipedia/commons/4/44/Colon_cancer.jpg

Colon, Rectosigmoid, and Rectum Site-group Instructions
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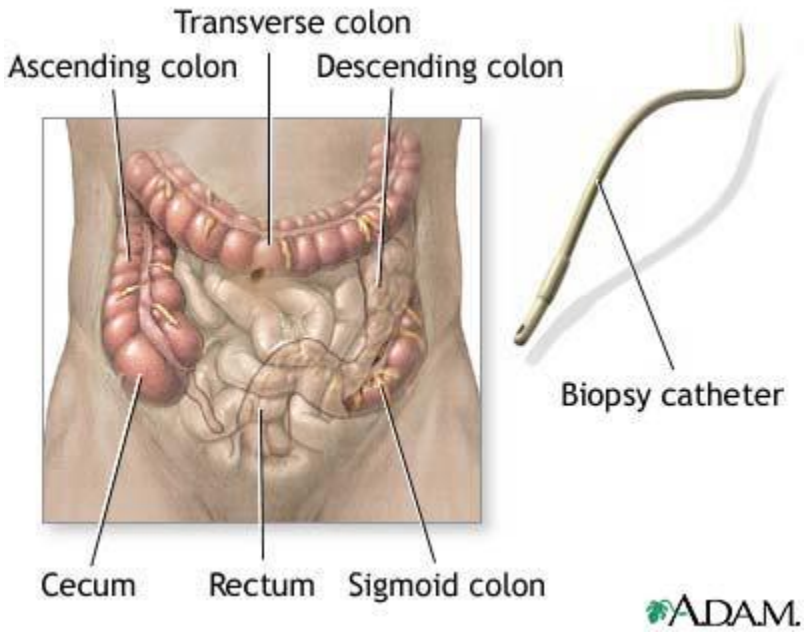
Large intestine; snare instrument to remove polyps



Colon, Rectosigmoid, and Rectum Site-group Instructions
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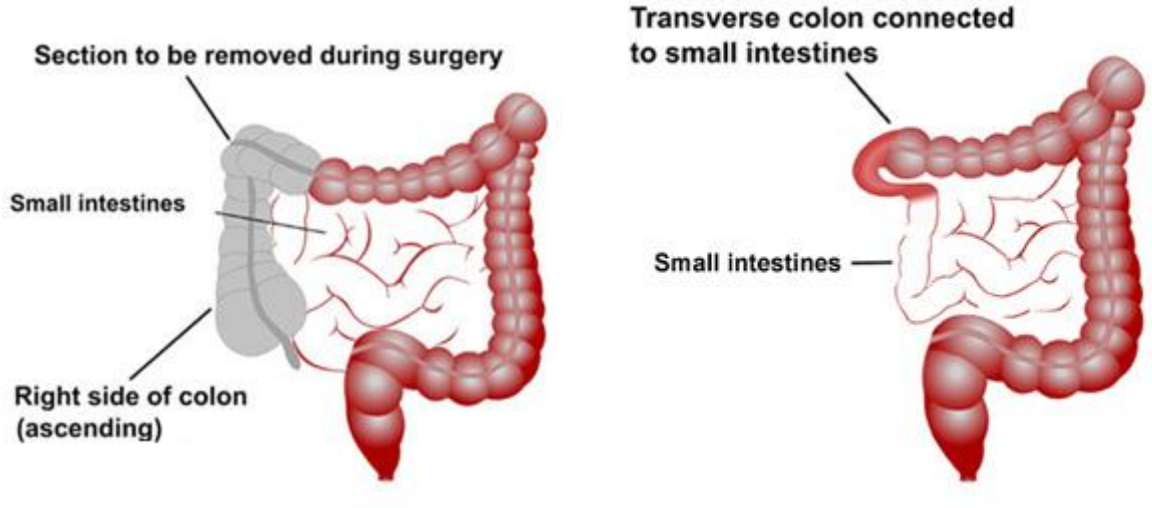
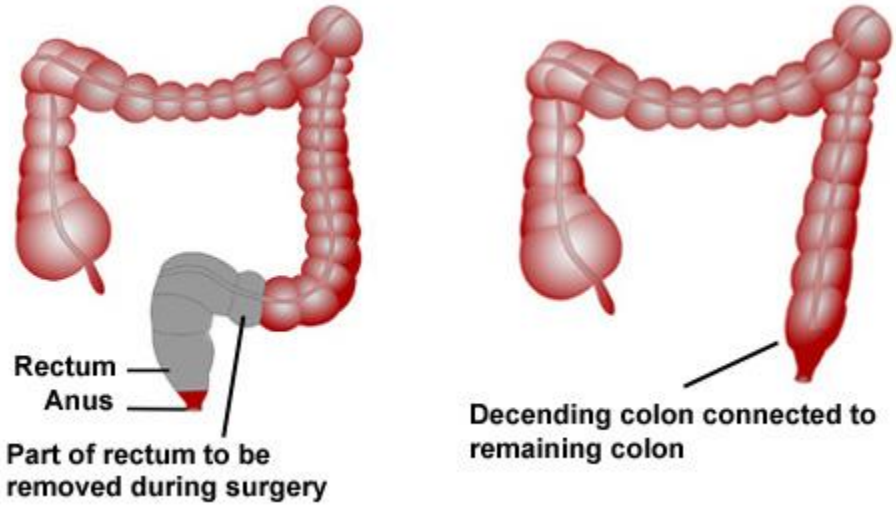
Colon Surgery: Hemicolectomy

The primary treatment for colon cancer is surgery. Part of the large bowel and the surrounding lymph nodes are removed. The remaining bowel is then joined together (anastomosis).



http://www.cedars-sinai.edu/Patients/Programs-and-Services/Colorectal-Cancer-Center/Services-and-Treatments/Rectal-Cancer.aspx

Rectal Surgery



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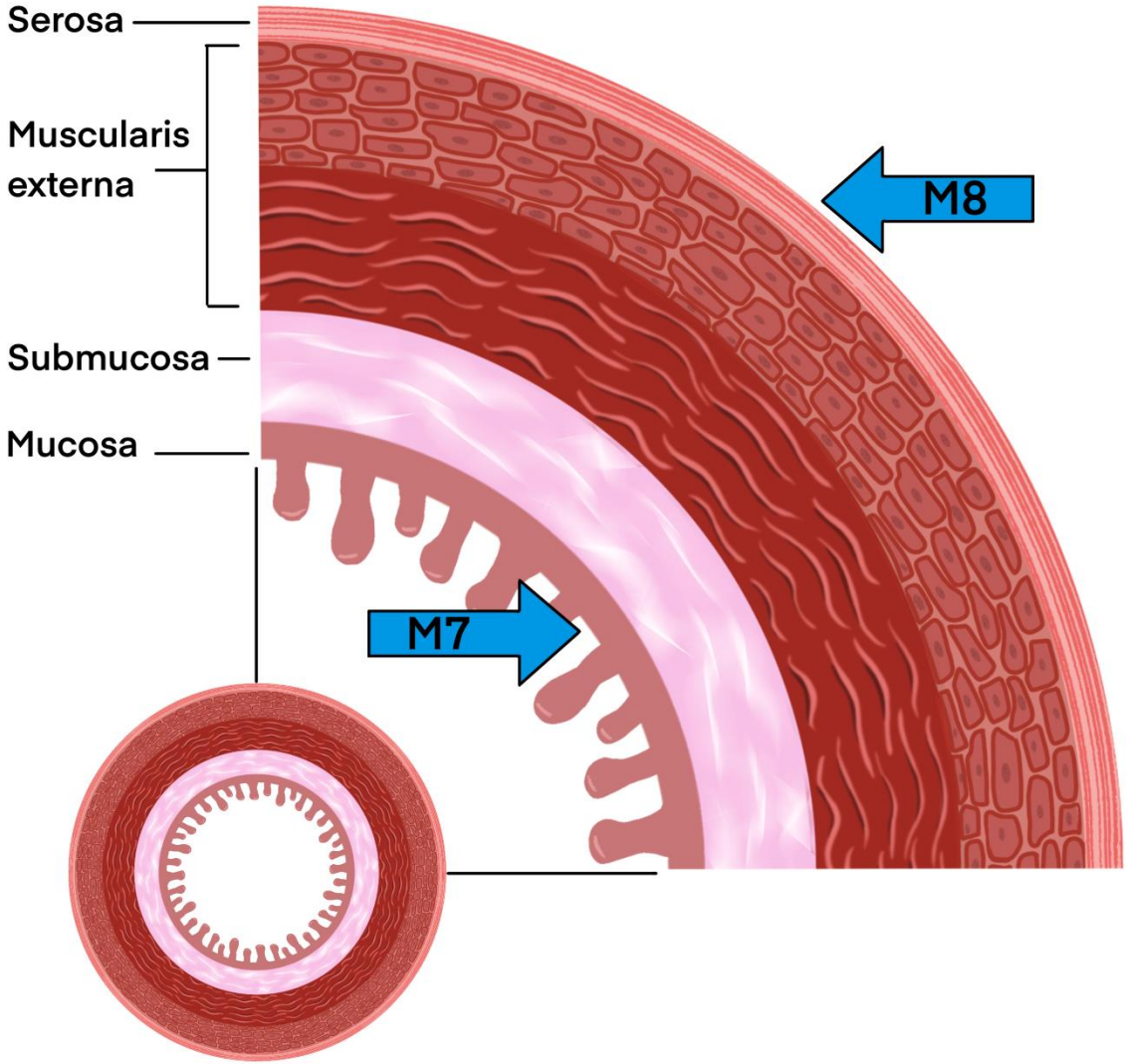

Colon, Rectosigmoid, and Rectum Multiple Primary Rules
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Note: Metastatic tumors are not included when determining how many tumors are present. Metastatic tumors include but are not limited to:

- Discontinuous lesions in soft tissue adjacent to primary site
- Regional or distant lymph nodes for the primary site being abstracted as identified in Summary Staging Manual
- Brain
- Liver
- Lung
- Peritoneum
- Spinal cord (not frequent)

Unknown if Single or Multiple Tumors

Note: **Collision tumors** are counted as **two individual** tumors for the purpose of determining multiple primaries. Collision tumors were originally two **separate** tumors that arose in close proximity. As the tumors increased in size, they merged or overlapped each other. Use the Multiple Tumors module.

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

Use the histology rules to assign the appropriate histology code.

Colon, Rectosigmoid, and Rectum Multiple Primary Rules
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Single Tumor

Note 1: **Collision tumors** are counted as **two individual** tumors for the purpose of determining multiple primaries. Collision tumors were originally two **separate** tumors that arose in close proximity. As the tumors increased in size, they merged or overlapped each other. Use the Multiple Tumors module.

Note 2: For those sites which have recognized biomarkers, the biomarkers are most frequently used to target treatment. Follow the rules; do not code multiple primaries or histology based on biomarkers.

Rule M2 Abstract a **single primary** when there is a **single tumor.**
Note 1: A single tumor is always a single primary.
Note 2: The tumor may overlap onto or extend into adjacent/contiguous site or subsites.
Note 3: The tumor may have in situ and invasive components.
Note 4: The tumor may have two or more histologic components.

This is the end of instructions for Single Tumor

Use the histology rules to assign the appropriate histology code.

Colon, Rectosigmoid, and Rectum Multiple Primary Rules
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(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Multiple Tumors

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

Note 2: **Collision tumors** are counted as **two individual** tumors for the purpose of determining multiple primaries. Collision tumors were originally two **separate** tumors that arose in close proximity. As the tumors increased in size, they merged or overlapped each other. Use the Multiple Tumors module to determine if they are a single primary or multiple primaries.

Rule M3 Abstract a **single primary** when there is adenocarcinoma in situ and/or invasive in at least one polyp **AND**

- There is a clinical diagnosis of familial adenomatous polyposis (FAP) **OR**
- Greater than 100 polyps are documented (no diagnosis of FAP) **OR**
- Referred to as polyps carpeting the bowel, small bowel, intestines, etc.

Note 1: A diagnosis of familial adenomatous polyposis (FAP) is made when the patient has **greater than 100** adenomatous polyps. Polyps with adenocarcinoma and benign polyps will be present. Because there are many polyps, the pathologist does not examine every polyp.

Note 2: **In situ /2** and **malignant /3** adenocarcinoma in polyps, malignancies with remnants of a polyp, as well as de novo (previously called frank) malignancies may be present in **multiple segments** of the colon or in both the **colon** and **rectum**. Polyposis **may** be present in other GI sites such as stomach (a de novo does not have to be present; all adenocarcinoma may be in polyps).

Note 3: FAP is a **genetic** disease. The characteristics of FAP are **numerous precancerous polyps** in the colon and rectum when the patient reaches puberty. If not treated, the polyps typically become malignant. Patients often have **total colectomies.**

Note 4: **Multiple polyps** in the colorectum is **not equivalent** to FAP.

Note 5: Code **primary site** as follows:

- Present in more than one segment of colon: **C189** colon, NOS
- Present in colon and rectosigmoid **OR** colon and rectum: **C199** rectosigmoid junction
- Present in colon and small intestine: **C260** intestinal tract, NOS (there is no code for large and small bowel)

  Note: In addition to the colon and small intestine, FAP may also be present in the:
  - Stomach **AND/OR**
  - Rectosigmoid **AND/OR**
  - Rectum

Example: The patient has a diagnosis of FAP. The operative report and physician's documentation say that polyps with adenocarcinoma were present in specimens removed from the ascending colon and the sigmoid colon. The ascending and sigmoid colon are part of the large bowel. Code the primary site **C189** colon NOS.

Rule M4 Abstract **multiple primaries** when there are separate, non-contiguous tumors in sites with ICD-O site codes that **differ** at the second C**X**xx and/or third Cx**X**x character.

Note 1: Definition of separate/non-contiguous tumors: at least two malignancies which **do not** overlap/merge.

Note 2: **Differences** at either the **second** or **third** characters are different primary sites/multiple primaries.

Example 1: Breast C**50**x and colon C**18**x

Example 2: Colon C**18**x and rectum C**20**9 (This does not include FAP- see earlier rules)

Note: This rule **does not** apply to a single **overlapping** malignancy of colon and rectum.

Rule M5 Abstract **multiple primaries** when separate/non-contiguous tumors are two or more different **subtypes/variants** in Column 2 of **Table 1** in the Site-group Instructions. Timing is irrelevant.

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

- **Same NOS**: Medullary carcinoma NOS 8510/3 and tubulopapillary adenocarcinoma 8263/3 are both subtypes of adenocarcinoma NOS 8140/3 but are distinctly different histologies. Abstract multiple primaries.
- **Different NOS**: Goblet cell carcinoid 8243/3 is a subtype of mixed adenoneuroendocrine carcinoma 8244/3; somatostatin-producing NET 8156/3 is a subtype of neuroendocrine tumor Grade 1 (G1) 8240/3. They are distinctly different histologies. Abstract multiple primaries.

Rule M6 Abstract **multiple primaries** when separate/non-contiguous tumors are on **different rows in Table 1** in the Site-group Instructions. Timing is irrelevant.

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

Colon, Rectosigmoid, and Rectum Multiple Primary Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M7 Abstract **multiple primaries** when a subsequent tumor arises at the **anastomotic** site **AND:**

- One tumor is a **NOS** and the other is a **subtype/variant** of that NOS **OR**
- The subsequent tumor occurs **greater than 36 months** after original tumor resection **OR**
  Note: For cases diagnosed prior to 1/1/2022, the time interval is greater than 24 months.
- The **subsequent** tumor arises in the **mucosa** (see **illustration**)
  Note: Bullet three does not apply to GIST. GISTs only start in the wall; never in the mucosa.

Example: (For bullet 1: NOS and subtype/variant) The original tumor was adenocarcinoma NOS **8140**. The patient had a hemicolectomy. There was a recurrence at the **anastomotic** site diagnosed exactly as **mucinous** adenocarcinoma **8480.** Mucinous adenocarcinoma is a subtype/variant of the NOS adenocarcinoma, but they are two different histologies. **Code two primaries,** one for the original adenocarcinoma NOS and another for the subsequent anastomotic site mucinous adenocarcinoma.

Note 1: There may or may not be **physician documentation** of anastomotic recurrence. Follow the rules.

Note 2: When the original tumor was diagnosed prior to 1/1/2018 and was coded to adenocarcinoma in a polyp, and the anastomotic site tumor is adenocarcinoma per 2018 rules, the tumors are the same histology. ICD-O codes differ because of changes in histology coding rules.

Note 3: The tumor may or may not invade into the colon wall or adjacent tissue.

Note 4: A "rectal stump" is an anastomotic site.

Note 5: These rules are hierarchical. Only use this rule when previous rules do not apply.

Rule M8 Abstract a **single primary** when a subsequent tumor arises at the **anastomotic** site **AND:**

- The subsequent tumor occurs **less than or equal to 36 months** after original tumor resection **OR**
  Note: For cases diagnosed prior to 1/1/2022, timing is less than or equal to 24 months
- The tumor arises in **colon/rectal wall** and/or surrounding tissue; there is **no involvement** of the **mucosa** (see **illustration**) **OR**
- The pathologist or clinician documents an **anastomotic recurrence**

Note 1: Bullet two does not apply to GIST. GISTs only start in the wall; never in the mucosa.

Note 2: The physician may stage the subsequent tumor because the depth of invasion determines the second course of treatment.

Note 3: These tumors are a single primary/recurrence. Registrars that collect recurrence information should record the information in the recurrence fields.

Note 4: A "rectal stump" is an anastomotic site.

Colon, Rectosigmoid, and Rectum Multiple Primary Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M9 Abstract **multiple primaries** when there are separate, non-contiguous tumors in sites with ICD-O site codes that **differ** at the fourth characters C18**X**. See **Table 3** for a list of ICD-O site codes for colon and rectum.

Note: Differences at the fourth character include different segments of the colon. Abstract a primary for each separate non-contiguous tumor in a different segment of the colon. This rule is not used for colon NOS C189. C189 is rarely used other than DCO.

Example: The patient has adenocarcinoma in situ in a **sigmoid** polyp and mucinous adenocarcinoma in a polyp in the **descending** colon, the site code differs at the fourth character (sigmoid C18**7** and descending C18**6**). **Code two primaries**, one for the sigmoid and another for the descending colon.

Rule M10 Abstract **multiple primaries** when the patient has a subsequent tumor after being **clinically disease-free** for **greater than one year** after the original diagnosis or last recurrence.

Note 1: Clinically disease-free means that there was **no evidence** of recurrence on follow-up.
- Colonoscopies are WNL
- Scans are WNL

Note 2: When there is a recurrence less than or equal to one year 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 one year** from the date of the last recurrence.

Note 3: When the first course of treatment was a **polypectomy** only, this rule means there were **no recurrences** for greater than one year.

Note 4: When the first course of treatment was a **colectomy or A&P resection**, there were no **anastomotic recurrences** for greater than one year.

Note 5: When it is **unknown/not documented** whether the patient had a recurrence, default to **date of diagnosis** to compute the time interval.

Note 6: The physician may state this is a **recurrence**, meaning the patient had a previous colon tumor and now has another colon tumor. **Follow the rules;** do not attempt to interpret the physician's statement.

Colon, Rectosigmoid, and Rectum Multiple Primary Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M11 Abstract a **single primary** when synchronous, separate/non-contiguous tumors are on **the same row in Table 1** in the Site-group Instructions.

Note: 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 (indented under the preferred term in column 1) OR
- A NOS (column 1) and the other is a subtype/variant of that NOS (column 2) OR
- A NOS histology in column 2 with an indented subtype/variant

Rule M12 Abstract a **single primary** (the invasive) when an **in situ** tumor is diagnosed **after** an **invasive** tumor.

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

Note 2: The tumors **may** be a **NOS** and a **subtype/variant** of that NOS. See **Table 1** in the Site-group Instructions for listings of NOS and subtype/variants.

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

Rule M13 Abstract a **single primary** (the invasive) when an invasive tumor is diagnosed **less than or equal to 60 days** after an **in situ** tumor.

Note 1: The rules are hierarchical. Only use this rule when previous rules do not apply.

Note 2: **Change behavior** code on original abstract from /2 to /3. **Do not** change **date of diagnosis.**

Note 3: If the case has already been submitted to the central registry, **report** all changes.

Note 4: 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 5: See the **COC** and **SEER manuals** for instructions on **coding data items** such as Date of Diagnosis, Accession Year and Sequence Number.

Rule M14 Abstract multiple primaries when an invasive tumor occurs more than 60 days after an in situ tumor.

Note 1: Abstract both the invasive and in situ tumors.

Note 2: Abstract as multiple primaries even if physician states the invasive tumor is disease recurrence or progression. 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 authors, co-authors, or editors of the AJCC Staging Manual.

Rule M15 Abstract a **single primary** when tumors do not meet any of the above criteria.

Note: Use caution when applying this default rule. Please confirm that you have not overlooked an applicable rule.

Example: The pathology states adenocarcinoma in situ 8140/2 and a second non-contiguous invasive adenocarcinoma 8140/3 in the sigmoid colon C187. Multiple tumors that are the same histology in the same primary site (same four characters of ICD-O topography code) are a single primary.

This is the end of instructions for Multiple Tumors.

Use the histology rules to assign the appropriate histology code.

Colon, Rectosigmoid, and Rectum Histology Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Priority Order for Using Documentation to Identify Histology

IMPORTANT NOTES

1. Code the histology diagnosed ***prior*** to **neoadjuvant treatment.**
   Note 1: Histology changes may occur following immunotherapy, chemotherapy, targeted therapy, and radiation therapy.
   Note 2: Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.

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

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

The priority list is used for **single primaries** (including multiple tumors abstracted as a single primary).

This is a hierarchical list of source documentation.
Code the **most specific** pathology/tissue from either **resection** or **biopsy**.

Note 1: The term "most specific" usually refers to a subtype/variant.
Note 2: The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor.
Note 3: When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).

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

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

2. 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.

3. **Scan:** The following list is in **priority order**.
   A. CT
   B. PET
   C. MRI

4. Code the histology **documented** by the physician when none of the above are available. Use the documentation in the following **priority order:**
   A. Treatment plan
   B. Documentation from Tumor Board
   C. Documentation in the medical record that **refers to original pathology, cytology, or scan(s)**
   D. Physician's **reference** to type of cancer (**histology**) in the medical record
   Note 1: Code the specific histology when documented.
   Note 2: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.

5. **Cytology** (seldom used for colon, rectosigmoid and rectum)

Colon, Rectosigmoid, and Rectum Histology Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Coding Histology

Note 1: The priority is to code the most specific histology. **DO NOT USE BREAST HISTOLOGY CODING RULES FOR THIS SITE.**
Note 2: Only use this section for one or more histologies within a single tumor.
Note 3: Do not use this section in place of the Histology Rules.

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

   Note 1: Mucinous and signet ring cell carcinoma must meet a percentage requirement in order to be coded. Refer to the Histology Rules if mucinous and/or signet ring cell carcinoma is present.

   Note 2: The terms above (A, B, C) must describe a **carcinoma** or **sarcoma** in order to code a histology described by those terms.
   Example: When the diagnosis is adenocarcinoma with a component of medullary **carcinoma**, code medullary carcinoma 8510.
   Negative Example: When the diagnosis is simply adenocarcinoma with a medullary component, code adenocarcinoma NOS 8140. Do not assume this is a medullary carcinoma. This could be medullary differentiation or features.

   Note 3: When the most specific histology is described as differentiation or features, see #2.

   Example 1: Diagnosis for a single tumor is adenocarcinoma 8140 with the majority or predominant part of tumor being medullary adenocarcinoma 8510. Code the subtype/variant: medullary adenocarcinoma 8510.

   Example 2: Diagnosis for a single tumor is mixed neuroendocrine carcinoma 8244 with minority of tumor being goblet cell carcinoid 8243. Code the subtype/variant: goblet cell carcinoid 8243.

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

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

Note: Do not code differentiation or features when there is no specific ICD-O code.

3. Code the specific histology described by **ambiguous terminology** (list follows) **ONLY** when A or B is true:
   A. The only diagnosis available is **one histology** term described by ambiguous terminology
      - CoC and SEER require reporting of cases diagnosed only by ambiguous terminology
      - Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

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

   See the **Ambiguous Terminology** section of the General Instructions for instructions and examples on when ambiguous terms and definitive terms may be used to assign histology.

If the specific histology does not meet the criteria in #3B, then code the NOS histology.

Table 4: List of Ambiguous Terminology

Ambiguous Terminology	
Appears	Presumed
Cannot rule out	Suspicious (for)
Likely	Suggestive of
Favor(s)	

Note 1: Table 5 below includes terms **previously** included in the list of ambiguous terms. These terms should be treated as supporting a **definitive diagnosis** of a histologic subtype. A definitive term does not require clinical verification of the subtype or variant.

Note 2: The terms in Table 5 were removed from the list of ambiguous terms and added to a list of **definitive terminology** based on the recommendation of a panel of pathologists and subject matter experts.

Table 5: List of Definitive Terminology

Definitive Terminology	
Comparable with	Most likely
Compatible with	Probable
Consistent with	Typical (of)

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

   - Architecture
   - Foci; focus; focal
   - Pattern
   - Phenotype

Colon, Rectosigmoid, and Rectum Histology Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Single Tumor

Rule H1 Code adenocarcinoma with neuroendocrine differentiation **8574** when the final diagnosis is **exactly** "adenocarcinoma with neuroendocrine differentiation".

Note: **Do not** use this code when:

- The diagnosis is any subtype/variant of adenocarcinoma with neuroendocrine differentiation
- Any modifier other than differentiation is used, i.e., adenocarcinoma with neuroendocrine features

Rule H2 Code the histology and ignore the polyp when a carcinoma originates in a polyp.

Note 1: This is a **change** from the **2007** MPH rules which instructed registrars to use the codes for malignancies in a polyp, such as adenocarcinoma in a polyp **8210.**

Note 2: Sufficient data has been collected to:

- Determine the frequency with which carcinomas arise within polyps
- Establish patient care guidelines for individuals with colon polyps

Example: Colonoscopy with polypectomy finds mucinous adenocarcinoma in the polyp. Code mucinous adenocarcinoma **8480.**

Rule H3 Code combined small cell carcinoma **8045** when the final diagnosis is **small cell** carcinoma **AND any other carcinoma.**

Examples:

- Small cell carcinoma **8041** and adenocarcinoma **8140**
- Small cell carcinoma **8041** and neuroendocrine carcinoma **8246**

Rule H4 Code mixed mucinous and signet ring cell as follows:

- Adenocarcinoma with mucinous and signet ring features – code adenocarcinoma **8140**
- Mucinous carcinoma and signet ring cell carcinoma:
  - Mucinous carcinoma documented as **greater than 50%** – code mucinous carcinoma **8480**
  - Signet ring cell carcinoma documented as **greater than 50%** – code signet ring cell carcinoma **8490**
  - Percentage of mucinous carcinoma and signet ring cell carcinoma **unknown/not designated**- code adenocarcinoma mixed subtypes **8255**

Note: This rule is for mucinous carcinoma and signet ring cell carcinoma in a single tumor. For mucinous adenocarcinoma mixed with another histology OR signet ring cell carcinoma mixed with another histology, proceed through the rules.

Rule H5 Code **low grade appendiceal mucinous neoplasm (LAMN)** and **high grade appendiceal mucinous neoplasm (HAMN) 8480/2** when:

- Diagnosis date is 1/1/2022 forward **AND**
- Behavior is stated to be in situ/non-invasive **OR**
- Behavior is not indicated

Note 1: ICD-O-3.2 lists LAMN with behavior of /1. WHO 5th Ed Digestive Systems Tumors indicates this neoplasm is considered in situ. After consulting with WHO Digestive System editors, College of American pathologists, and AJCC GI chapter experts, the standard setting organizations have agreed LAMN should be collected and should be assigned a behavior code of /2 beginning with cases diagnosed 1/1/2022 forward.

Note 2: A diagnosis of LAMN or HAMN does not require the tumor be comprised of greater than 50% mucinous in order to be coded 8480.

Note 3: If the pathologist indicates LAMN or HAMN is invasive or has a malignant behavior, continue through the rules.

Note 4: If the pathologist stages the LAMN as T3 or T4, continue through the rules.

Rule H6 Code invasive **mucinous** adenocarcinoma **8480** when the diagnosis is any of the following:

- **Exactly** "**mucinous** adenocarcinoma" (no modifiers)
- Colloid adenocarcinoma
- High grade appendiceal mucinous neoplasm (HAMN) stated to be invasive (DX 1/1/2022 forward)
- **High-grade** pseudomyxoma peritonei
- **Invasive** pseudomyxoma peritonei
- Low grade appendiceal mucinous neoplasm (LAMN) stated to be invasive (DX 1/1/2022 forward)
- **Malignant** pseudomyxoma peritonei
- Two histologies and mucinous is documented to be **greater than 50%** of the tumor
  - Mucinous carcinoma must meet a percentage requirement in order to be coded. Do not use majority of tumor, predominantly, or predominant part of the tumor to code mucinous 8480.

Note 1: Be very **careful** when **determining primary** site; almost all pseudomyxoma peritonei originate in the appendix C181. However, it **can be metastatic** disease from sites such as bowel, ovary, or bladder. Code the primary site as designated by a physician. When the primary site is not designated, code unknown primary **C809** and the histology as mucinous carcinoma **8480.**

Note 2: Report the appendiceal mucinous neoplasm as malignant /3 using the ICD-O matrix principle and the SEER and COC Manuals when the **pathology** from the appendix is **low-grade mucinous** neoplasm (not reportable prior to 1/1/2022) **AND**

- The pseudomyxoma peritonei are **high-grade**/invasive/malignant **OR**
- Patient is **treated** for malignant pseudomyxoma peritonei OR
- The diagnosis is low grade appendiceal mucinous neoplasm (LAMN) and the physician states it is malignant OR
- The diagnosis is high grade appendiceal mucinous neoplasm (HAMN) and the physician states it is malignant
- The pathologist has staged the LAMN as T3 or T4

Note 3: The following are **non-reportable for cases diagnosed prior to 1/1/2022:**

- Appendiceal neoplasm with **low-grade** pseudomyxoma peritonei **AND no treatment**
- **No designation** of high- or low-grade for the appendiceal neoplasm **AND no treatment** for the pseudomyxoma peritonei

Rule H7 Code invasive **signet ring cell adenocarcinoma 8490** when the diagnosis is any of the following:

- Exactly **signet ring cell carcinoma** (no modifiers)
- **Adenocarcinoma and signet ring cell carcinoma**, where signet ring cell is documented to be **greater than 50%** of the tumor
  - Signet ring cell adenocarcinoma must meet a percentage requirement in order to be coded. Do not use majority of tumor, predominantly, or predominant part of tumor to code signet ring cell 8490.

Rule H8 Code adenocarcinoma NOS **8140** when the final diagnosis is:

- Two histologies:
  - Adenocarcinoma and mucinous carcinoma
    - Percentage of mucinous **unknown/not documented**
    - Mucinous documented as less than or equal to 50% of tumor
  - Adenocarcinoma and signet ring cell carcinoma
    - Percentage of signet ring **unknown/not documented**
    - Signet ring cell documented as less than or equal to 50% of tumor
- **Exactly** adenocarcinoma **OR**
- **Intestinal** type adenocarcinoma **OR** adenocarcinoma intestinal type (no modifiers or additional histologic terms).

Note 1: Code **8140** adenocarcinoma NOS even if pathology says **intestinal type adenocarcinoma**.

Note 2: Do not use code **8144** adenocarcinoma intestinal type for **colorectal** primaries. Intestinal type adenocarcinoma 8144 is used for tumors which occur in the stomach, head and neck, and specific GYN sites. It is called intestinal because it resembles carcinoma which occurs in the colon, rectosigmoid or rectum.

Note 3: When a diagnosis of intestinal type adenocarcinoma is further described by a **specific term** (such as mucinous intestinal type adenocarcinoma or signet ring cell intestinal type adenocarcinoma), it would be treated as an adenocarcinoma with a **subtype/variant**.

Rule H9 Code the histology when only **one histology** is present.

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

Note 2: Use the ICD-O and all updates when the histology is not listed in Table 1.

Note 3: Submit a question to **Ask a SEER Registrar** when the histology code is not found in Table 1, ICD-O or all updates.

Rule H10 Code the **invasive** histology **when in situ** and **invasive** histologies are present in the **same tumo**r.

Rule H11 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
- Mixed adenoneuroendocrine carcinoma **8244** and a subtype/variant of mixed adenoneuroendocrine carcinoma
- Neuroendocrine carcinoma **8246** and a subtype/variant of neuroendocrine carcinoma
- Neuroendocrine tumor Grade 1 (G1) **8240** and a subtype/variant of neuroendocrine tumor Grade 1 (G1)
- Sarcoma **8800** and a subtype/variant of sarcoma

Note 1: See **Table 1** in the Site-group Instructions to find NOS and subtypes/variants.

Note 2: Only code subtypes/variant when pathology gives an **exact diagnosis**. **Do not** code the subtype/variant when **modified** by terms such as **differentiation, features of, etc., unless** there is a specific code for the histology term with the modifier.

This is the end of instructions for Single Tumor.

Code the histology using the rule that fits the case.

Colon, Rectosigmoid, and Rectum Histology Rules
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Multiple Tumors Abstracted as a Single Primary

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

Rule H12 Code adenocarcinoma in familial adenomatous polyposis (**FAP**) **8220** when **clinical** history says the patient has **familial adenomatous polyposis AND**

- The final diagnosis on the **pathology report** from resection is **adenocarcinoma in FAP OR**
- There are **greater than 100 polyps** identified in the resected specimen

Note 1: Use this rule **only** when there are **multiple polyps**. **Do not** use for a single polyp (adenoma) or for a de novo (frank) malignancy and a malignancy in a single polyp.
Note 2: Use this rule **ONLY** for adenocarcinoma in **FAP.**
Note 3: The disease process, treatment, and prognosis for FAP is not as favorable as a single polyp with adenocarcinoma.

Rule H13 Code adenocarcinoma in multiple adenomatous polyps **8221** when FAP is not mentioned **AND**

- There are at least 2 polyps with adenocarcinoma /2 or /3 **AND**
  - Less than or equal to 100 polyps are identified **OR**
  - The exact number of polyps is unknown/not documented

Note 1: **Do not use** this code for a malignancy in **a single polyp** (adenoma) or for a de novo (frank) malignancy.
Note 2: Use this rule **ONLY** for **adenocarcinoma NOS** in multiple polyps**.**

Rule H14 Code the histology of the **invasive** tumor when there are **in situ** /2 and **invasive** /3 tumors.

- One tumor is in situ and the other is invasive
- All tumors are a **mixture** of **in situ** and **invasive** histology

Rule H15 Code the histology when only **one** histology is present in **all** tumors.

Note 1: Use **Table 1** to code histology. New codes, terms, and synonyms are included in **Table 1** and coding errors may occur if the table is not used.
Note 2: When the histology is **not listed** in **Table 1,** use the **ICD-O** and all **updates**.
Note 3: Submit a question to **Ask a SEER Registrar** when the histology code is not found in Table 1, ICD-O or all updates.

Rule H16 Code the **subtype/variant** when the diagnosis is a **NOS** and a **single subtype/variant** of that NOS such as the following:

- Adenocarcinoma **8140** and a subtype/variant of adenocarcinoma
- Mixed adenoneuroendocrine carcinoma **8244** and a subtype/variant of mixed adenoneuroendocrine carcinoma
- Neuroendocrine carcinoma **8246** and a subtype/variant of neuroendocrine carcinoma
- Neuroendocrine tumor Grade 1 (G1) **8240** and a subtype/variant of neuroendocrine tumor Grade 1 (G1)
- Sarcoma **8800** and a subtype/variant of sarcoma

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 1** in the Site-group Instructions to find NOS and subtypes/variants.

Note 3: Check the **Multiple Primary Rules** to confirm that the tumors are a single primary.

Note 4: Only code subtypes/variant when pathology gives an **exact diagnosis**. **Do not** code the subtype/variant when **modified** by terms such as **differentiation, features of, etc., unless** there is a specific code for the histology term with the modifier.

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

Code the histology using the rule that fits the case.

Equivalent or Equal Terms

These terms can be used interchangeably:

- Adenocarcinoma; carcinoma
  - A histology type must be stated for these terms to be equal
    - **Example of equivalent or equal**: Acinic cell carcinoma and acinic cell adenocarcinoma are both coded 8550
    - **Example of NOT equivalent or equal**: Carcinoma NOS 8010 and adenocarcinoma NOS 8140
- And; with
  Note: "And" and "with" are used as synonyms when **describing multiple histologies** within a **single tumor**
- Contiguous; continuous
- Hypopharynx; laryngopharynx
- In situ; noninvasive; intraepithelial
- Malignant tumor; malignant mass; malignant lesion; malignant neoplasm
- Simultaneous; synchronous; existing at the same time; concurrent; prior to first course treatment
- Site; topography
- Squamous cell carcinoma with verrucous **growth** pattern; squamous cell carcinoma
  - Growth pattern is not a histological type
- 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

Terms That Are NOT Equivalent or Equal

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

- **Component** is not equivalent to **subtype/type/variant**
  Note: Component is **only** coded when the pathologist specifies the component as a second **carcinoma**
- **p16 positive** is not equivalent to **HPV positive (pre-2022)**
- **p16 negative** is not equivalent to **HPV negative (pre-2022)**
- **Phenotype** is not equivalent to **subtype/type/variant**
- **Squamous cell carcinoma with prominent keratinization 8070** is not equivalent to **keratinizing squamous cell carcinoma 8071**
- Salivary **gland** adenocarcinoma **8140** is not equivalent to salivary **duct** carcinoma **8500**

Coding Primary Site When There is Conflicting Information

Identifying the primary site is **difficult** because:

- Workups (PE scans, endoscopies, biopsies) each provide a unique view of the tumor, therefore the medical record often contains conflicting documentation on the primary site.
- The sites/organs are small and right next to each other. Tumors frequently extend into adjacent anatomic sites or overlap multiple contiguous sites.

Priority Order for Identifying Primary Site When There is Conflicting Information

Note: Record primary site based on the most definitive indication of primary site in the medical documentation and use the priority order when there is conflicting info without a definitive statement.

1. **Tumor Board**
   A. Specialty
   B. General
2. **Tissue/pathology** from tumor resection or biopsy
   A. Operative report
   B. Addendum and/or comments on tissue/pathology report
   C. Final diagnosis on issue/pathology report
   D. CAP protocol/summary
3. **Scans**
   A. CT
   B. MRI
   C. PET
4. **Physician documentation**. Use the documentation in the following priority order:
   A. Physician's **reference** in medical record to primary site from **original pathology, cytology, or scan(s), any other documentation**
   B. Physician's **reference** to primary site in the medical record

5. Use **Tables 1-9** to assist in assigning primary site when a **SINGLE** lesion overlaps two or more sites.
   A. Go to the appropriate table for each involved site (use the hyperlinked index below).
   B. Compare the histology diagnosis to the histologies in the table for each of the involved sites.
   C. When the histology diagnosis is listed for only one primary site (only listed in one table), code that primary site.

6. When the primary site cannot be determined using previous instructions, code as follows for an overlapping lesion:
   A. **C028** Overlapping lesion of tongue (See **Table 4** for subsites of the tongue)
   B. **C058** Overlapping lesion of palate, junction of hard and soft palate (See **Table 4** for subsites of the palate)
   C. **C088** Overlapping lesion of major salivary glands (See **Table 6** for specific salivary glands)
   D. **C148** Overlapping lesion of lip, oral cavity and pharynx
      Note: Codes and terms for overlapping lesions C__.8 are **not** included in the **tables**

7. Code to the NOS region
   A. **C069** Mouth NOS (See **Table 4** for mouth subsites)
   B. **C089** Major Salivary Gland NOS (See **Table 6** for specific salivary glands)
   C. **C099** Tonsil NOS (See **Table 5** for tonsil subsites)
   D. **C109** Oropharynx NOS (See **Table 5** for oropharynx subsites)
   E. **C119** Nasopharynx NOS (See **Table 2** for nasopharynx subsites)
   F. **C139** Hypopharynx NOS (See **Table 3** for hypopharynx subsites)
   G. **C140** Pharynx NOS
      Note: Pharynx NOS includes the oropharynx, nasopharynx, and hypopharynx.
   H. **C760** Head, face, or neck NOS (organs involved unknown/not documented)
      Note: This code is used in circumstances such as biopsy of lymph node and no information about primary site
      - Patient lost to follow-up; no further information available
      - Patient/family declined further work-up or treatment

Head and Neck Site-group Instructions
C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Table Index

Table 1: Tumors of Nasal Cavity, Paranasal Sinuses and Skull base

Table 1 lists the more common histologies for the following head and neck subsites:

- **C300** Nasal cavity; naris; nasal cartilage; nasal mucosa; nasal septum NOS; nasal turbinate; nostril; vestibule of nose
- **C310** Maxillary sinus; maxillary antrum; antrum NOS
- **C311** Ethmoid sinus
- **C312** Frontal sinus
- **C313** Sphenoid sinus
- **C318** Overlapping lesion of accessory sinuses
- **C319** Accessory sinus NOS; accessory nasal sinus; paranasal sinus

For hematopoietic neoplasms such as lymphomas, myelomas, etc., see the **Hematopoietic Database**.
Note: Hematopoietic tumors are common in the nasal cavity and paranasal sinuses.

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**
- Subtypes or variants of the NOS histologies in column 2 are also indented under the NOS histology and have a full 4-digit histology code (see Note 4). The behavior code (/2 or /3) is included with the 4-digit histology code if the term has only one possible behavior.

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 is not found in Table 3, ICD-O or all updates.
Note 3: Behavior codes are listed when the term has only one possible behavior (either a /2 or /3).

Table 1: Tumors of Nasal Cavity, Paranasal Sinuses and Skull base

Note 4: Column 2 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 2). Rhabdomyosarcoma is also a NOS because it has subtypes/variants. The subtypes/variants are indented under the NOS (rhabdomyosarcoma) in column 2.

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenocarcinoma 8140 • Adenocarcinoma non-intestinal type • Low-grade adenocarcinoma • Renal cell-like carcinoma • Renal cell-like sinonasal adenocarcinoma [1] • Seromucinous adenocarcinoma • TAC • Terminal tubulous adenocarcinoma • Tubulopapillary low-grade adenocarcinoma	Adenocarcinoma intestinal type **8144** [2] • Colloid-type adenocarcinoma • Colonic-type adenocarcinoma • Enteric-type adenocarcinoma • ITAC HPV-related multiphenotypic sinonasal carcinoma **8483 (/3)** [1]
Lymphoepithelial carcinoma 8082 • LEC • Lymphoepithelioma-like carcinoma • Sinonasal lymphoepithelial carcinoma [1]	
Malignant peripheral nerve sheath tumor 9540 (/3) [3] • MPNST • Neurofibrosarcoma	

[1] This term may be used for cases diagnosed 2026 and later.
[2] Adenocarcinoma intestinal-type of the sinonasal tract is morphologically similar to adenocarcinomas of the intestines.
[3] The terms malignant schwannoma/malignant neurilemoma are obsolete. Code to 9540/3.

Table 1: Tumors of Nasal Cavity, Paranasal Sinuses and Skull base

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Mucoepidermoid carcinoma 8430 • Salivary gland-type mucoepidermoid carcinoma	
Mucosal melanoma 8720 [4]	Desmoplastic mucosal melanoma **8745 (/3)** Mucosal lentiginous melanoma **8746 (/3)** Nodular melanoma **8721 (/3)**
Myoepithelial carcinoma 8982 • Myoepithelioma, malignant	
NUT carcinoma 8023 • Midline carcinoma of children and young adults with NUT rearrangement • NUT midline carcinoma	
Olfactory neuroblastoma 9522 (/3) • Esthesioneuroblastoma • Esthesioneurocytoma • Esthesioneuroepithelioma • Olfactory placode tumor	
Primitive neuroectodermal tumor 9364 • Adult neuroblastoma • Ewings sarcoma • Peripheral neuroblastoma • Peripheral neuroectodermal tumor • Peripheral neuroepithelioma	

[4] Mucosal melanomas are primarily seen in C300 and C310.

Table 1: Tumors of Nasal Cavity, Paranasal Sinuses and Skull base

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Sarcoma 8800 (/3)	Angiosarcoma **9120 (/3)** [5] • Hemangiosarcoma Biphenotypic sinonasal sarcoma **9045 (/3)** • BSNS • Low grade sinonasal sarcoma with neural and myogenic features Epithelioid hemangioendothelioma **9133 (/3)** Fibrosarcoma **8810 (/3)** • Adult type fibrosarcoma Leiomyosarcoma **8890 (/3)** Malignant hemangioendothelioma **9130 (/3)** Rhabdomyosarcoma **8900 (/3)** • Alveolar rhabdomyosarcoma **8920 (/3)** • Embryonal rhabdomyosarcoma **8910 (/3)** • Pleomorphic rhabdomyosarcoma, adult type **8901 (/3)** • Spindle cell rhabdomyosarcoma **8912 (/3)** Synovial sarcoma **9040 (/3)** • Synovial cell sarcoma Undifferentiated pleomorphic sarcoma **8802 (/3)** • Malignant fibrous histiocytoma

[5] Angiosarcomas are coded to the organ in which they occur. The prognosis and disease process of angiosarcomas differ between sites. Contiguous organs, blood vessels, and lymph nodes are not the same for every organ.

Table 1: Tumors of Nasal Cavity, Paranasal Sinuses and Skull base

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Sinonasal undifferentiated carcinoma 8020 [6] • Sinonasal carcinoma, undifferentiated • SNUC	
Small cell carcinoma, intermediate 8044 • SMARCA4-deficient carcinoma • SMARCA4-deficent sinonasal carcinoma [7] • SMARCB1-deficient adenocarcinoma • SMARCB1-deficient sinonasal carcinoma [7] • SMARCB1-deficient sinonasal adenocarcinoma [7] **Table continues on next page**	

[6] This is an undifferentiated carcinoma of the sinonasal tract.
[7] This term may be used for cases diagnosed 2026 and later.

Table 1: Tumors of Nasal Cavity, Paranasal Sinuses and Skull base

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Squamous cell carcinoma 8070 [8] • Epidermoid carcinoma NOS **(/3)** • Squamous carcinoma **(/3)** • Squamous cell carcinoma, usual type **(/3)** • Squamous cell epithelioma **(/3)** • Epidermoid carcinoma in situ NOS **(/2)** • Intraepithelial squamous cell carcinoma **(/2)** • Squamous cell carcinoma in situ NOS **(/2)**	Basaloid squamous cell carcinoma **8083** HPV-associated squamous cell carcinoma **8085** [9] • Squamous cell carcinoma, HPV-mediated (p16+) • Squamous cell carcinoma, HPV-positive • Squamous cell carcinoma, HPV-related HPV-independent squamous cell carcinoma **8086** [9] • Squamous cell carcinoma, HPV-negative Keratinizing squamous cell carcinoma **8071** • Conventional squamous cell carcinoma NOS • Epidermoid carcinoma, keratinizing • KSCC • Squamous cell carcinoma, large cell, keratinizing Papillary squamous cell carcinoma **8052** Squamous cell carcinoma, large cell, nonkeratinizing **8072** • DEK-AFF2 SCC [9] • DEK::AFF2 squamous cell carcinoma [9] • Squamous cell carcinoma, nonkeratinizing NOS Schneiderian carcinoma **8121** • Cylindrical cell carcinoma Sarcomatoid squamous cell carcinoma **8074** • Spindle cell squamous cell carcinoma ○ SC SCC Verrucous carcinoma **8051** • Carcinoma cuniculatum [9]

[8] Sinonasal squamous cell tumors account for about 3% of head and neck malignancies.
[9] This term may be used for cases diagnosed 2026 and later.

Table 1: Tumors of Nasal Cavity, Paranasal Sinuses and Skull base

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Teratocarcinosarcoma 9081 • Blastoma • Malignant teratoma • Teratocarcinoma • Teratoid carcinosarcoma	

Table 2: Tumors of Nasopharynx

Table 2 lists the more common histologies for the following head and neck subsites:

- **C110** Superior wall of nasopharynx; roof of nasopharynx
- **C111** Posterior wall of nasopharynx only (does not include adenoid/pharyngeal tonsil)
- **C112** Lateral wall of nasopharynx; fossa of Rosenmuller
- **C113** Anterior wall of nasopharynx; nasopharyngeal surface of soft palate; pharyngeal fornix; choana; posterior margin of nasal septum
- **C118** Overlapping lesion of nasopharynx. Use only when a **single lesion** overlaps **subsites** of the nasopharynx.
  Example: A single tumor overlaps C110 superior wall of nasopharynx and C111 posterior wall of the nasopharynx.
- **C119** Nasopharynx NOS; nasopharyngeal wall; use when a specific subsite cannot be identified.
  Example: The primary site is designated as pharyngeal wall. It is unknown whether it is the superior, posterior lateral, or anterior wall.

Note 1: The **nasopharynx** is the upper part of the pharynx. It is above the soft palate and extends to the nasal passages.
Note 2: Nasopharyngeal tumors are usually assigned to the subsite in which they occur.

For hematopoietic neoplasms such as lymphomas, myelomas, etc., see the **Hematopoietic Database**.
Note: Hematopoietic tumors are common in the nasopharynx.

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Note 3: Rare histologies may not be listed in the table. When a histology term is not found, reference ICD-O and all updates.
Note 4: Submit a question to Ask a SEER Registrar when the histology is not found in Table 3, ICD-O or all updates.
Note 5: Behavior codes are listed when the term has only one possible behavior (either a /2 or /3).

Table 2: Tumors of Nasopharynx

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenoid cystic carcinoma 8200	
Chordoma 9370	
Nasopharyngeal papillary adenocarcinoma 8260 • Low-grade nasopharyngeal papillary adenocarcinoma • Thyroid-like low-grade nasopharyngeal papillary adenocarcinoma	
Squamous cell carcinoma NOS 8070 • Epidermoid carcinoma • Nasopharyngeal carcinoma [1] • Squamous carcinoma • Squamous cell carcinoma • Squamous cell epithelioma	Basaloid squamous cell carcinoma **8083** Keratinizing squamous cell carcinoma **8071** Non-keratinizing squamous cell carcinoma **8072** Lymphoepithelial carcinoma **8082** Undifferentiated carcinoma **8020** • Undifferentiated carcinoma with lymphoid stroma

[1] This term may be used for cases diagnosed 2026 and later.

Table 3: Tumors of Pyriform Sinus, Hypopharynx, Larynx, Trachea, and Parapharyngeal Space

Table 3 lists the more common histologies for the following head and neck subsites:

- **C129** Pyriform sinus
- **C130** Postcricoid region; cricopharynx cricoid NOS
- **C131** Hypopharyngeal aspect of aryepiglottic fold; aryepiglottic fold NOS; arytenoid fold
- **C132** Posterior wall of hypopharynx
- **C138** Overlapping lesion of hypopharynx. Use only when a **single lesion overlaps subsites** of the hypopharynx.
  Example: A single tumor overlaps C130 postcricoid region and C131 aryepiglottic fold.
- **C139** Hypopharynx NOS and parapharyngeal space. Use only when the subsite/site is unknown
- **C320** Glottis; intrinsic larynx; laryngeal commissure; vocal cord NOS; true vocal cord; true cord
- **C321** Supraglottis; epiglottis NOS (excludes anterior surface of epiglottis); extrinsic larynx; laryngeal aspect of aryepiglottic fold; posterior surface of epiglottis; ventricular band of larynx; false vocal cord; false cord
- **C322** Subglottis
- **C323** Laryngeal cartilage; arytenoid cartilage; cricoid cartilage; cuneiform cartilage; thyroid cartilage
- **C328** Overlapping lesion of larynx
- **C329** Larynx NOS
- **C339** Trachea

Note 1: The **hypopharynx** is in the inferior position of the three segments of pharynx. The hypopharynx links the oropharynx to the esophagus, lower part of the pharynx. The pyriform sinus is located in the hypopharynx.

Note 2: The **larynx** is only 1 1/2 inches. It is inferior to the hyoid bone and tongue. It is anterior to the esophagus.

Note 3: The **trachea** starts where larynx ends and continues down the middle of the neck anterior to the esophagus.

Note 4: The **parapharyngeal space** is an equivalent of the lateral pharyngeal space which includes the soft tissue, vessels and skeletal muscles supporting the mechanics of the pharynx. Code the specific site when the soft tissue, vessel, or skeletal muscle is documented. When specific information is not available/not documented, code hypopharynx NOS, C139.

Note 5: These primary sites are mostly composed of muscle and cartilage, but the most common tumors arise from the epithelial lining of the structures (squamous cell carcinoma, for example).

Head and Neck Site-group Instructions
C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Table 3: Tumors of Pyriform Sinus, Hypopharynx, Larynx, Trachea, and Parapharyngeal Space

For hematopoietic neoplasms such as lymphomas, myelomas, etc., see the **Hematopoietic Database**.
Note: Hematopoietic tumors are common in the hypopharynx, larynx and trachea.

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Note 6: Rare histologies may not be listed in the table. When a histology term is not found, reference ICD-O and all updates.
Note 7: Submit a question to Ask a SEER Registrar when the histology is not found in Table 3, ICD-O or all updates.
Note 8: Behavior codes are listed when the term has only one possible behavior (either a /2 or /3).

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenoid cystic carcinoma 8200 • ACC (rare)	
Chondrosarcoma 9220 (/3) • Chondrosarcoma grade 2/3 • Chondrosarcoma NOS	Chondrosarcoma, grade 1 **9222 (/3)** [1] Clear cell chondrosarcoma **9242 (/3)** Dedifferentiated chondrosarcoma **9243 (/3)**
Liposarcoma 8850 (/3)	Liposarcoma, well differentiated **8851 (/3)**

[1] Reportable for cases diagnosed 1/1/2022 forward. Pre-2022 the behavior is /1.

Table 3: Tumors of Pyriform Sinus, Hypopharynx, Larynx, Trachea, and Parapharyngeal Space

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Neuroendocrine carcinoma 8246 (/3)	Large cell neuroendocrine carcinoma **8013 (/3)** Small cell neuroendocrine carcinoma **8041 (/3)** • Small cell carcinoma
Neuroendocrine tumor NOS 8240 (/3) • Carcinoid • Neuroendocrine tumor grade 1	Neuroendocrine tumor grade 2 **8249 (/3)** • Atypical carcinoid • Neuroendocrine tumor grade 3 [2]
Squamous cell carcinoma 8070 • Epidermoid carcinoma • Hybrid verrucous carcinoma [3] • SCC • Squamous carcinoma • Squamous cell epithelioma	Adenosquamous carcinoma **8560** Basaloid squamous cell carcinoma **8083** Lymphoepithelial carcinoma **8082** • Lymphoepithelioma-like carcinoma Keratinizing squamous cell carcinoma **8071** • Conventional squamous cell carcinoma NOS Non-keratinizing squamous cell carcinoma **8072** [4] Papillary squamous cell carcinoma **8052** Spindle cell squamous cell carcinoma **8074** Verrucous squamous cell carcinoma **8051**

[2] This term may be used for cases diagnosed 2024 and later.
[3] This term may be used for cases diagnosed 2026 and later.
[4] 2026+ cases: Per Cancer PathCHART, non-keratinizing squamous cell carcinoma 8072 is valid only for trachea. For the remaining sites in Table 3, use 8070/3.

Table 4: Tumors of Oral Cavity and Mobile Tongue

Table 4 lists the more common histologies for the following head and neck subsites:

The **oral cavity category** includes the following:

Lip:
- **C000** External upper lip
- **C001** External lower lip
- **C002** External lip, NOS
- **C003** Mucosa of upper lip
- **C004** Mucosa of lower lip
- **C005** Mucosa of lip, NOS
- **C006** Commissure of lip
- **C008** Overlapping lesion of lip
- **C009** Lip, NOS

Mobile Tongue:
- **C020** Dorsal surface of tongue NOS
- **C021** Border of tongue
- **C022** Ventral surface of tongue NOS
- **C023** Anterior 2/3 of tongue NOS
- **C028** Overlapping lesion of tongue
- **C029** Tongue NOS

Gum:
- **C030** Upper gum, maxillary gingiva, upper alveolar mucosa, upper alveolar ridge mucosa, upper alveolus, upper gingiva
- **C031** Lower gum mandibular gingiva, lower alveolar mucosa, lower alveolar ridge mucosa, lower alveolus, lower gingiva
- **C039** Gum NOS, gingiva NOS, alveolar mucosa NOS, alveolar ridge mucosa NOS, alveolar NOS periodontal tissue, tooth socket

Floor of Mouth:
- **C040** Anterior floor of mouth
- **C041** Lateral floor of mouth
- **C048** Overlapping lesion floor of mouth
- **C049** Floor of mouth NOS

Table 4: Tumors of Oral Cavity and Mobile Tongue

Palate:
C050 Hard palate
C058 Overlapping lesion of palate, junction of hard and soft palate
C059 Palate NOS, roof of mouth

Other and unspecified parts of Mouth:
C060 Cheek mucosa, buccal mucosa, internal cheek
C061 Vestibule of mouth, alveolar sulcus, buccal sulcus, labial sulcus
C062 Retromolar area, retromolar triangle, retromolar trigone
C068 Overlapping lesion of other and unspecified parts of mouth
C069 Mouth NOS, buccal cavity, oral cavity, oral mucosa, minor salivary gland NOS

Note: There is no ICD-O site code for minor salivary glands. Many minor salivary glands are located in the lips, inner cheek (buccal mucosa) and there are extensive minor salivary glands in the linings of the mouth and throat. Code to the site in which the salivary gland is located. Use Table 6 Tumors of the Salivary Glands to assign histology.

For hematopoietic neoplasms such as lymphomas, myelomas, etc., see the **Hematopoietic Database**.
Note: Hematopoietic tumors are common in the oral cavity.

Column 1 contains Specific and NOS histology terms.
- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3).**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.
- Synonyms are indented under NOS terms in column 2.
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**.

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 is not found in Table 3, ICD-O or all updates.
Note 3: Behavior codes are listed when the term has only one possible behavior (either a /2 or /3).

Table 4: Tumors of Oral Cavity and Mobile Tongue

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Granular cell tumor 9580	
Mucoepidermoid carcinoma 8430 • Mucoepidermoid tumor	
Mucosal melanoma 8720 [1] • Oral mucosal melanoma	Desmoplastic mucosal melanoma **8745 (/3)** Mucosal lentiginous melanoma **8746 (/3)** Nodular melanoma **8721 (/3)**
Myofibroblastic sarcoma 8825 • Myofibrosarcoma	
Squamous cell carcinoma 8070 • Epidermoid carcinoma • Squamous carcinoma • Squamous cell carcinoma NOS • Squamous cell epithelioma • High-grade intraepithelial squamous lesions **(/2)**	Acantholytic squamous cell carcinoma **8075** Adenosquamous carcinoma **8560** Basaloid squamous cell carcinoma **8083** HPV-associated oral epithelial dysplasia, high grade **8085 (/2)** [2] Lymphoepithelial carcinoma **8082** Keratinizing squamous cell carcinoma **8071** • Conventional squamous cell carcinoma NOS Non-keratinizing squamous cell carcinoma **8072** Papillary squamous cell carcinoma **8052** Spindle cell squamous cell carcinoma **8074** Verrucous squamous cell carcinoma **8051** • Carcinoma cuniculatum [2]

[1] Mucosal melanomas are primarily seen in C03. _ and C05._
[2] This term may be used for cases diagnosed 2026 and later.

Table 5: Tumors of the Oropharynx, Base of Tongue, Tonsils, Adenoids

Table 5 lists the more common histologies for the following head and neck subsites:

Oropharynx:

- **C051** Soft palate
- **C052** Uvula
- **C100** Vallecula
- **C101** Anterior surface of epiglottis
- **C102** Lateral wall of oropharynx; lateral wall of nasopharynx; lateral wall of mesopharynx
- **C103** Posterior wall of oropharynx; posterior wall of nasopharynx; posterior wall of mesopharynx
- **C104** Branchial cleft
- **C108** Overlapping lesion of oropharynx; junctional region of oropharynx
- **C109** Oropharynx NOS; mesopharynx NOS; fauces NOS. Use this code only when a subsite has not been identified as the origin of the lesion.
  - ***Note:*** Code **C108** when a single tumor overlaps subsites of the oropharynx. For example, a single lesion which overlaps the vallecular and the anterior surface of the epiglottis.

C019 Base of tongue

C024 Lingual tonsil

Tonsils:

- **C090** Tonsillar fossa
- **C091** Tonsillar pillar
- **C098** Overlapping lesion of tonsil
- **C099** Tonsil NOS
- **C111** Adenoids/pharyngeal tonsil (does not include posterior wall of nasopharynx)

Cases diagnosed 1/1/2018 to 12/31/2021:

Squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086) are coded only when HPV status is determined by tests based on ISH, PCR, RT-PCR technologies to detect viral DNA or RNA. p16 is not a valid test to assign these codes.

Head and Neck Site-group Instructions
C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Table 5: Tumors of the Oropharynx, Base of Tongue, Tonsils, Adenoids

Cases diagnosed 1/1/2022 forward:
Beginning with cases diagnosed 1/1/2022 forward, p16 test results can be used to code squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086).

Cases diagnosed 1/1/2023 forward:
When the diagnosis is a subtype/variant of squamous cell carcinoma and HPV status is also noted, code the subtype/variant.
EXCEPTION: Keratinizing SCC (see **Footnotes** in Table 5, Squamous Cell Carcinoma row)
Example 1: Basaloid squamous cell carcinoma, HPV positive. Code basaloid SCC, 8083/3.
Example 2: Keratinizing SCC, HPV-associated is coded to SCC HPV-associated 8085/3.

Column 1 contains Specific and NOS histology terms.
- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.
- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

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 is not found in Table 3, ICD-O or all updates.

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenoid cystic carcinoma 8200	
Polymorphous adenocarcinoma 8525 • Cribriform adenocarcinoma • Polymorphous low-grade adenocarcinoma • Terminal duct carcinoma	

Table 5: Tumors of the Oropharynx, Base of Tongue, Tonsils, Adenoids

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Squamous cell carcinoma 8070 • Epidermoid carcinoma • Squamous carcinoma • Squamous cell carcinoma • Squamous cell epithelioma	Basaloid squamous cell carcinoma **8083** Keratinizing squamous cell carcinoma NOS **8071** [1] • Conventional squamous cell carcinoma NOS Lymphoepithelial carcinoma **8082** Non-keratinizing squamous cell carcinoma NOS **8072** [2] Papillary squamous cell carcinoma **8052** Squamous cell carcinoma HPV-negative **8086** [1] [3] [4] • HPV-independent squamous cell carcinoma • Non-keratinizing squamous cell carcinoma, HPV-negative Squamous cell carcinoma HPV-positive **8085** [3] [5] • HPV-associated squamous cell carcinoma • Keratinizing squamous cell carcinoma, HPV-positive • Squamous cell carcinoma, HPV-mediated (p16+) • Squamous cell carcinoma, HPV-related Squamous cell carcinoma, spindle cell **8074** Verrucous carcinoma **8051** • Carcinoma cuniculatum [6]

[1] **2022+:** Keratinizing SCC, HPV negative is coded 8086 for sites listed in Table 5 only. A diagnosis of keratinizing SCC NOS is coded 8071.

[2] **2022+:** Non-keratinizing SCC, HPV positive is coded 8085 for sites listed in Table 5 only. A diagnosis of non-keratinizing SCC NOS is coded 8072.

[3] **Pre-2022:** Per the 2018 SEER Manual, HPV-type 16 refers to virus type and is different from p16 overexpression (p16+). HPV status is determined by tests (ISH, PCR, RT-PCR technologies) designed to detect viral DNA or RNA, whereas the test for p16 expression (a surrogate marker for HPV) is IHC. HPV testing must be negative by viral detection to code 8086; and positive by viral detection to code 8085.

[4] **2022+:** p16- test results can be used to assign code 8086.

[5] **2022+:** p16+ test results can be used to assign code 8085.

[6] This term may be used for cases diagnosed 2026 and later.

Table 6: Tumors of Salivary Glands

Table 6 lists the more common histologies for the following head and neck subsites:

- **C079** Parotid gland, parotid NOS Stensen duct, parotid gland duct
- **C080** Submandibular gland, submaxillary gland, Wharton duct, submaxillary gland duct
- **C081** Sublingual gland; sublingual gland duct
- **C088** Overlapping lesion of major salivary glands
- **C089** Major salivary gland NOS; salivary gland NOS

For hematopoietic neoplasms such as lymphomas, myelomas, etc., see the **Hematopoietic Database**.
Note: Hematopoietic neoplasms are common in the major salivary glands.

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

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 is not found in Table 3, ICD-O or all updates.

Note 1: **Salivary duct carcinoma** was **assigned** code **8500** because it resembles high-grade duct carcinoma as found in the breast. These tumors are very aggressive. Code **8500 only** when the diagnosis is **exactly salivary duct carcinoma.**
Note 2: Assign code **8140** when the diagnosis is **salivary gland adenocarcinoma**.

Table begins on next page

Table 6: Tumors of Salivary Glands

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Acinic cell carcinoma 8550 • Acinar cell carcinoma • Acinic cell adenocarcinoma	
Adenocarcinoma 8140 • Adenocarcinoma NOS • Salivary gland adenocarcinoma NOS • Unclassified adenocarcinoma	Basal cell adenocarcinoma **8147** • Basal cell adenocarcinoma ex-monomorphic adenoma Carcinoma ex-pleomorphic adenoma **8941 (/3)** • Intracapsular carcinoma ex-pleomorphic adenoma **(/2)** Clear cell carcinoma **8310** • CCC • Hyalinizing clear cell carcinoma Intestinal-type adenocarcinoma **8144** Mucinous adenocarcinoma **8480** Mucoepidermoid carcinoma **8430** • Malignant mucoepidermoid tumor • MEC Sclerosing microcystic adenocarcinoma **8407** [1]
Adenoid cystic carcinoma 8200 • ACC	
Carcinosarcoma 8980 • Carcinosarcoma NOS • True malignant mixed tumor	

[1] This term may be used for cases diagnosed 2026 and later.

Table 6: Tumors of Salivary Glands

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Cystadenocarcinoma 8440	
Epithelial-myoepithelial carcinoma 8562 • Adenomyoepithelioma	
Lymphoepithelial carcinoma 8082 • LEC • Lymphoepithelioma-like carcinoma • Malignant lymphoepithelial lesion • Undifferentiated carcinoma with lymphoid stroma	
Myoepithelial carcinoma 8982 • Malignant myoepithelioma	
Neuroendocrine carcinoma 8246 • Neuroendocrine carcinoma NOS	Large-cell neuroendocrine carcinoma **8013** Small cell carcinoma NOS **8041** • Small cell neuroendocrine carcinoma
Polymorphous adenocarcinoma 8525 • Cribriform adenocarcinoma of the salivary glands [2] • Cribriform polymorphous adenocarcinoma [2] • PAC • Polymorphous adenocarcinoma, conventional subtype [2] • Polymorphous adenocarcinoma, cribriform subtype • Polymorphous low-grade adenocarcinoma • Terminal duct carcinoma	

[2] This term may be used for cases diagnosed 2026 and later.

Table 6: Tumors of Salivary Glands

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Salivary duct carcinoma 8500 • Basal-like salivary duct carcinoma **(/3)** [3] • Ductal carcinoma/adenocarcinoma **(/3)** • High grade ductal carcinoma **(/3)** • Apocrine intraductal carcinoma **(/2)** [3] • Cribriform cystadenocarcinoma low-grade **(/2)** • Intercalated duct intraductal carcinoma **(/2)** [3] • Intraductal low grade carcinoma **(/2)** • Mixed intraductal carcinoma **(/2)** [3] • Oncocytic intraductal carcinoma **(/2)** [3]	Micropapillary salivary duct carcinoma **8265 (/3)** [3] Mucin-rich salivary duct carcinoma **8481 (/3)** [3] Oncocytic salivary duct carcinoma **8290 (/3)** [3] • Malignant oncocytoma • Oncocytic carcinoma • Oncocytic adenocarcinoma Sarcomatoid salivary gland carcinoma **8033 (/3)** • Sarcomatoid salivary duct carcinoma [3]
Sebaceous adenocarcinoma 8410 • Sebaceous carcinoma NOS	
Secretory carcinoma 8502 • Mammary analog secretory carcinoma • Microsecretory adenocarcinoma	
Squamous cell carcinoma NOS 8070 • Epidermoid carcinoma • Squamous carcinoma • Squamous cell carcinoma • Squamous cell epithelioma	
Undifferentiated carcinoma 8020 (/3)	

[3] This term may be used for cases diagnosed 2026 and later.

Table 7: Tumors of Odontogenic and Maxillofacial Bone (Mandible, Maxilla)

Table 7 lists the more common histologies for the following head and neck subsites:

C410 Bones of skull and face and associated joints; maxilla
C411 Mandible; jaw bone NOS; lower jaw bone; temporomandibular joint

Note: The term odontogenic means originating in tooth forming tissue and bone. Code the primary site listed on the pathology report. The common primary sites include the maxillofacial skeleton (**C410** maxilla and **C411** mandible)

There are no hematopoietic neoplasms common to odontogenic bone or tissue. If a hematopoietic neoplasm such as lymphomas, myelomas, plasmacytoma etc., is diagnosed, verify the primary site. If the primary site is correct, see the **Hematopoietic Database**.

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**
- Subtypes or variants of the NOS histologies in column 2 are also indented under the NOS histology and have a full 4-digit histology code (see Note 1). The behavior code (/2 or /3) is included with the 4-digit histology code if the term has only one possible behavior.

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 is not found in Table 3, ICD-O or all updates.
Note 3: Column 2 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 osteosarcoma 9180/3 (column 2). Osteosarcoma is also a NOS because it has subtypes/variants. The subtypes/variants are indented under the NOS (osteosarcoma) in column 2.

Table 7: Tumors of Odontogenic and Maxillofacial Bone (Mandible, Maxilla)

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)

Ameloblastic carcinoma-primary type 9270 (/3)
• Ameloblastic carcinoma
• Ameloblastic carcinoma, dedifferentiated
• Ameloblastic carcinoma, secondary type
• Central intraosseous mucoepidermoid carcinoma
• Primary intraosseous carcinoma NOS
  ○ PIOC
• Sclerosing odontogenic carcinoma
  ○ SOC
	Metastasizing ameloblastoma **9310 (/3)** [1]

Clear cell odontogenic carcinoma 9341 [2] • CCOC	
Ghost cell odontogenic carcinoma 9302 • Aggressive epithelial ghost cell odontogenic tumor • Calcifying ghost cell odontogenic carcinoma • Carcinoma arising in calcifying odontogenic cyst • Malignant calcifying ghost cell odontogenic tumor • Malignant calcifying odontogenic cyst • Malignant epithelial odontogenic ghost cell tumor	
Odontogenic carcinosarcoma 9342 (/3) • Ameloblastic carcinosarcoma • Malignant odontogenic mixed tumor • Mixed odontogenic carcinoma	

[1] This is an ameloblastoma which has a benign appearance but metastasizes.
[2] Clear cell odontogenic tumors were classified as benign prior to the 2005 edition of WHO Pathology & Genetics Head and Neck Tumors.

Table 7: Tumors of Odontogenic and Maxillofacial Bone (Mandible, Maxilla)

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Sarcoma NOS 8800 (/3)	Ameloblastic fibrosarcoma **9330 (/3)** • Ameloblastic fibrodentinosarcoma [3] • Ameloblastic fibro-odontosarcoma [3] Chondrosarcoma, grade 1 **9222 (/3)** Chondrosarcoma grade 2/3 **9220 (/3)** • Mesenchymal chondrosarcoma **9240 (/3)** Chondrosarcoma, periosteal **9221 (/3)** Clear cell chondrosarcoma **9242 (/3)** Dedifferentiated chondrosarcoma **9243 (/3)** Osteosarcoma **9180 (/3)** • Osteogenic sarcoma • Chondroblastic osteosarcoma **9181 (/3)** • Conventional osteosarcoma **9186 (/3)** • High-grade surface osteosarcoma **9194 (/3)** • Intraosseous well-differentiated osteosarcoma **9187 (/3)** ○ Low grade central osteosarcoma • Parosteal osteosarcoma **9192 (/3)** • Periosteal osteosarcoma **9193 (/3)** • Radiation-induced osteosarcoma **9184 (/3)** [3] • Small cell osteosarcoma **9185 (/3)** • Telangiectatic osteosarcoma **9183 (/3)** Rhabdomyosarcoma with TFCP2 rearrangement **8900 (/3)** [3]

[3] This term may be used for cases diagnosed 2026 and later.

Table 8: Tumors of Ear

Table 8 lists the more common histologies for the following head and neck subsites:

- **C301** Middle ear; inner ear; auditory tube; eustachian tube; mastoid antrum; tympanic cavity

For hematopoietic neoplasms such as lymphomas, myelomas, etc., see the **Hematopoietic Database**.

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

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 is not found in Table 3, ICD-O or all updates.
Note 3: Behavior codes are listed when the term has only one possible behavior (either a /2 or /3).

Table 8: Tumors of Ear

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Endolymphatic sac tumor 8140 [1] • Adenocarcinoma • Heftner tumor • Low-grade papillary adenocarcinoma of endolymphatic sac origin • Middle ear adenocarcinoma	
Ceruminous adenocarcinoma 8420 (/3) • Ceruminous adenoid cystic carcinoma [2] • Ceruminous mucoepidermoid carcinoma	
Middle ear neuroendocrine tumor 8240 (/3) [2]	
Squamous cell carcinoma of the middle ear 8070 [3] • Epidermoid carcinoma • SCC • Squamous carcinoma • Squamous cell carcinoma • Squamous cell carcinoma NOS • Squamous cell epithelioma	Squamous cell carcinoma, keratinizing type NOS **8071 (/3)**

[1] The endolymphatic sac is located within the inner ear C301.
[2] This term may be used for cases diagnosed 2026 and later.
[3] This neoplasm **arises** in the squamous epithelium within the middle ear C301.

Table 9: Paraganglioma of Carotid Body, Extra-adrenal, Larynx, Middle Ear, Vagal Nerve

Table 9 lists codes for paragangliomas diagnosed prior to 1/1/2021 and new codes for cases diagnosed 1/1/2021 forward. Table 9 does not list all paragangliomas, only those common to head and neck sites.

Cases diagnosed prior to 1/1/2021:
Only report these neoplasms when the pathology/tissue specifies malignant (/3) behavior. Change the behavior using ICD-O-3 Rule F Matrix Concept.

Cases diagnosed 1/1/2021 forward:
The term "malignant" is no longer required to assign malignant (/3) behavior. Paragangliomas diagnosed 1/1/2021 or after are malignant unless otherwise stated by the pathologist.

Coding Primary Site:
Paragangliomas have a separate chapter in the WHO Classification of Head and Neck Tumors which is why they are included in the Head and Neck Solid Tumor Rules. Some variants of paraganglioma are specific to certain sites but may occur in sites other than the nervous system. Variants that have specific sites are noted with the appropriate C-code in Table 9. Always code the site noted by the physician. If site is not stated or unclear and histology term does not have a specific site noted in Table 9, code to autonomic nervous system **C479**.

Definitions

- **Ganglion:** A group of nerve cell bodies located outside the central nervous system.
- **Sympathetic nervous system:** It is a part of the autonomic nervous system and contains adrenergic fibers which depress secretion, decrease tone and contractility of smooth muscle and increase heart rate.

Column 1 contains Specific and NOS histology terms. ICD-O histology term or NOS term and C-code if appropriate are listed.

- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 lists **ICD-O code** for cases **diagnosed prior to 1/1/2021** and stated to be malignant (/3)
Column 3 lists **ICD-O code** for cases **diagnosed 1/1/2021 forward**

Table 9: Paraganglioma of Carotid Body, Extra-adrenal, Larynx, Middle Ear, Vagal Nerve

Specific or NOS Term, Code, and Synonym(s)	ICD-O Code (Dx prior to 2021) [1]	ICD-O Code (Dx 2021+) [1]
Aortic body paraganglioma (C75.5) 8691 (/3) • Aortic body tumor • Aorticopulmonary paraganglioma	8691 **(/3)**	8691 **(/3)**
Carotid body paraganglioma (C75.4) 8692 (/3) • Carotid body tumor	8692 **(/3)**	8692 **(/3)**
Extra-Adrenal paraganglioma, NOS 8693 (/3) • Chemodectoma • Composite paraganglioma • Nonchromaffin paraganglioma NOS	8693 **(/3)**	8693 **(/3)**
Laryngeal paraganglioma	8690 **(/3)**	8693 **(/3)**
Middle ear paraganglioma (C75.5) 8690 (/3) • Glomus jugulare tumor • Jugular • Jugulotympanic paraganglioma	8690 **(/3)**	8690 **(/3)**
Paraganglioma NOS 8680 (/3)	8680 **(/3)**	8680 **(/3)**
Parasympathetic paraganglioma 8682 (/3)	8682 **(/3)**	8682 **(/3)**
Sympathetic paraganglioma 8681 (/3)	8681 **(/3)**	8681 **(/3)**
Vagal paraganglioma	8690 **(/3)**	8693 **(/3)**

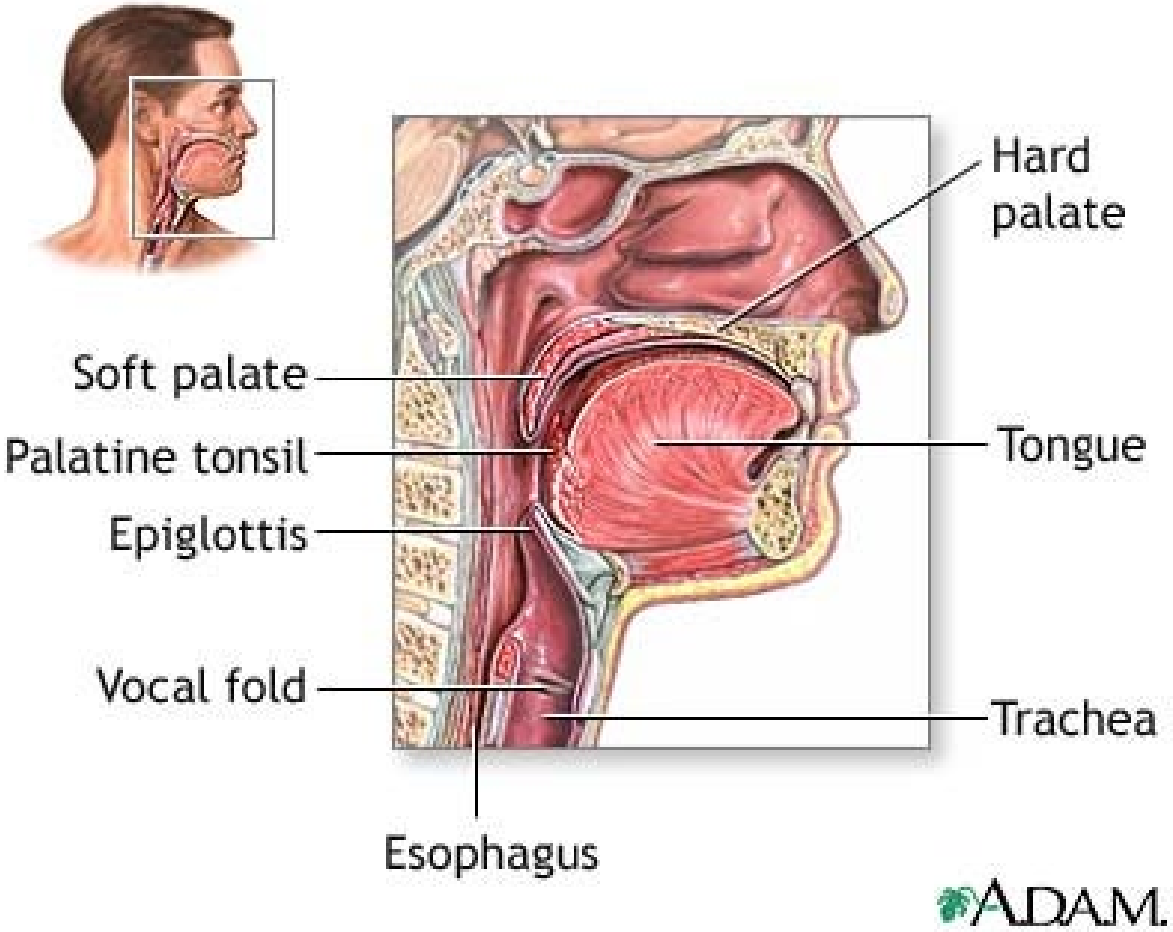
[1] Prior to 1/1/2021: must be stated to be malignant. 1/1/2021 forward: "Malignant" is no longer required to assign /3.

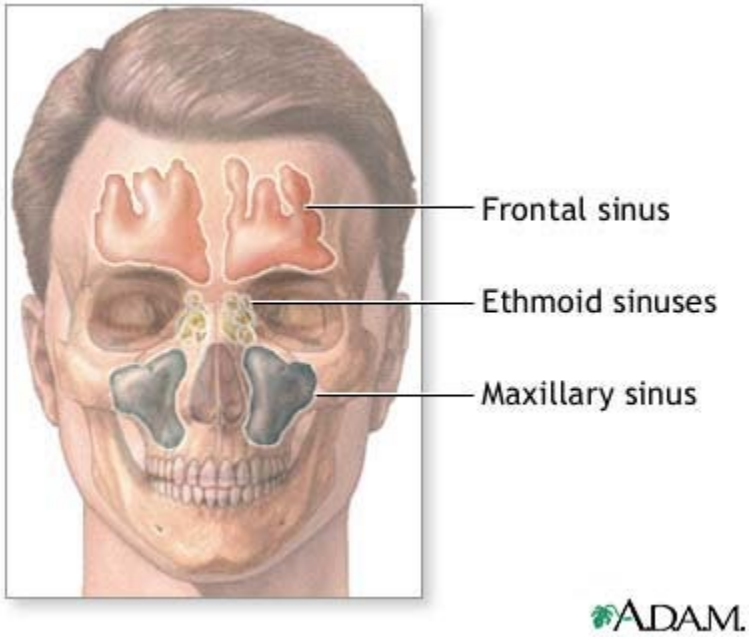
Table 10: Paired Sites

Laterality **must be coded** for all of the following sites. SEER does allow coding laterality for sites not listed in **Table 10.**

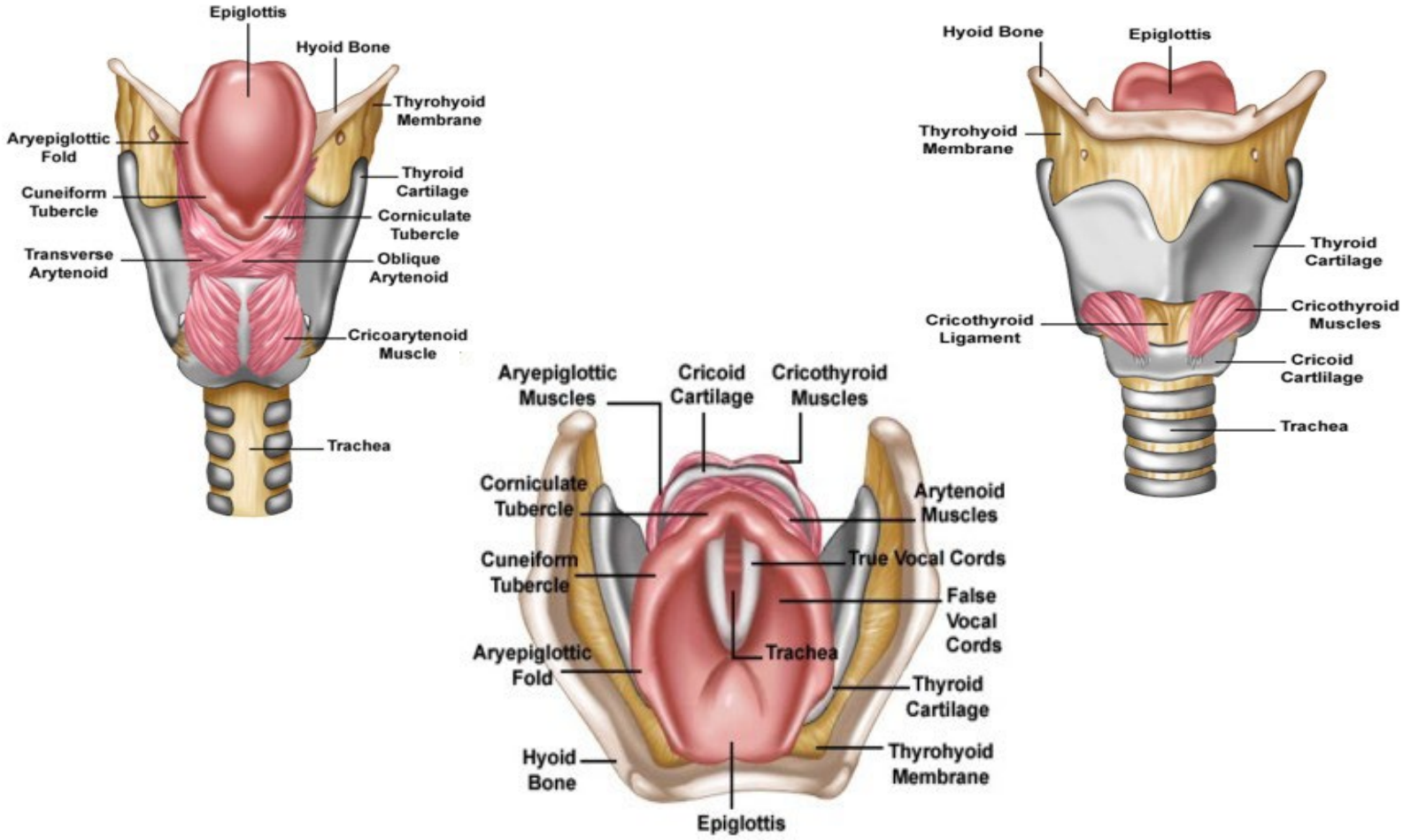
Paired Sites	Site Code
Carotid body	C754
Frontal sinus	C312
Maxillary sinus	C310
Middle ear	C301
Tonsil	C098, C099
Parotid gland	C079
Sublingual gland	C081
Submandibular gland	C080

Illustrations





Nasal Sinuses



Larynx

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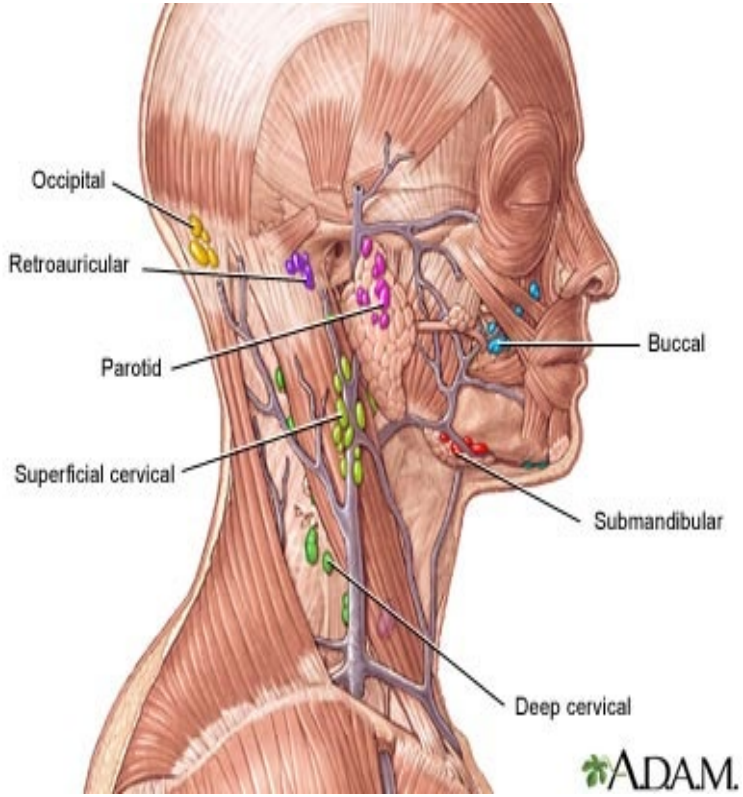
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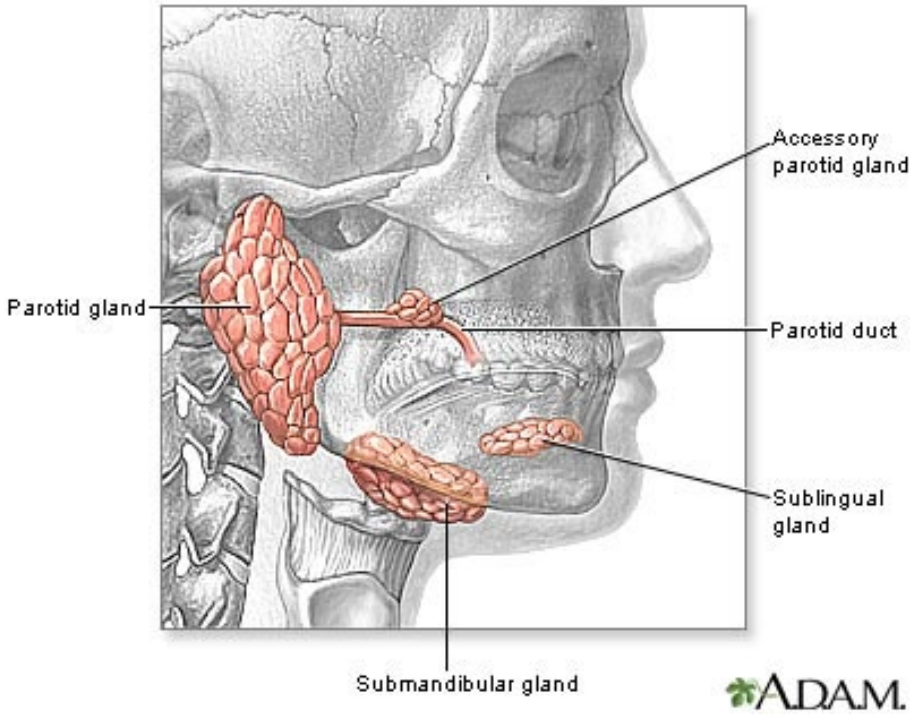
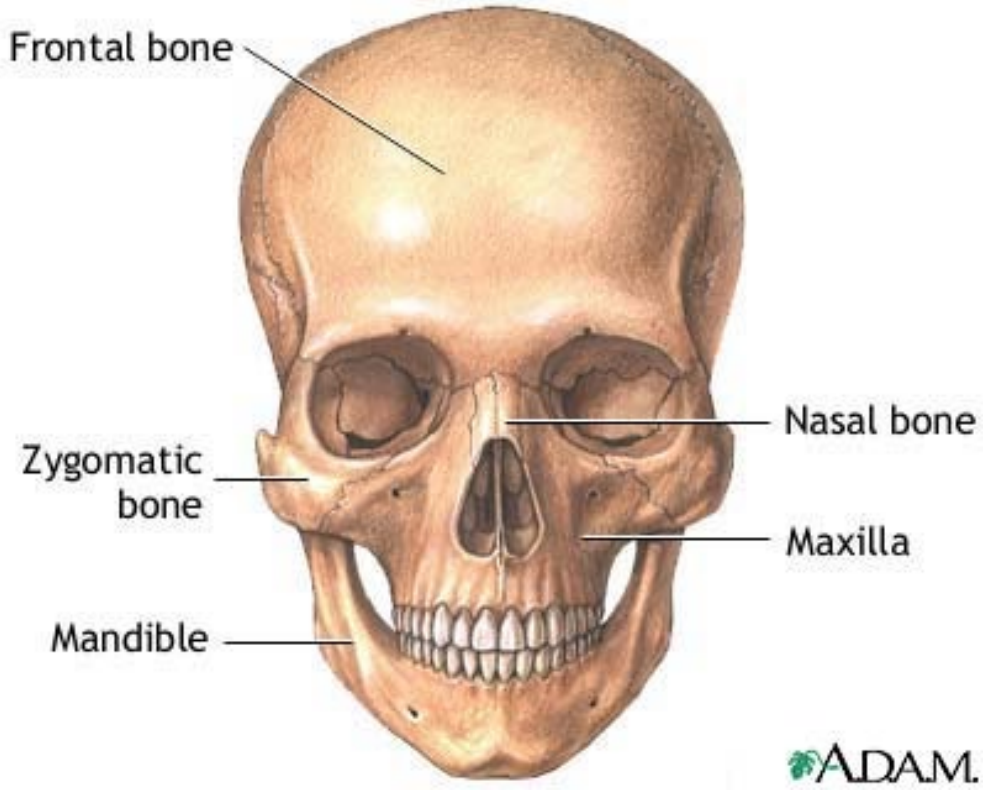
Parotid
Superficial cervical
Buccal
Submandibular
Deep cervical
A.D.A.M.


Accessory parotid gland
Parotid gland
Parotid duct
Sublingual gland
Submandibular gland
A.D.A.M.


Frontal bone
Nasal bone
Zygomatic bone
Maxilla
Mandible
A.D.A.M.

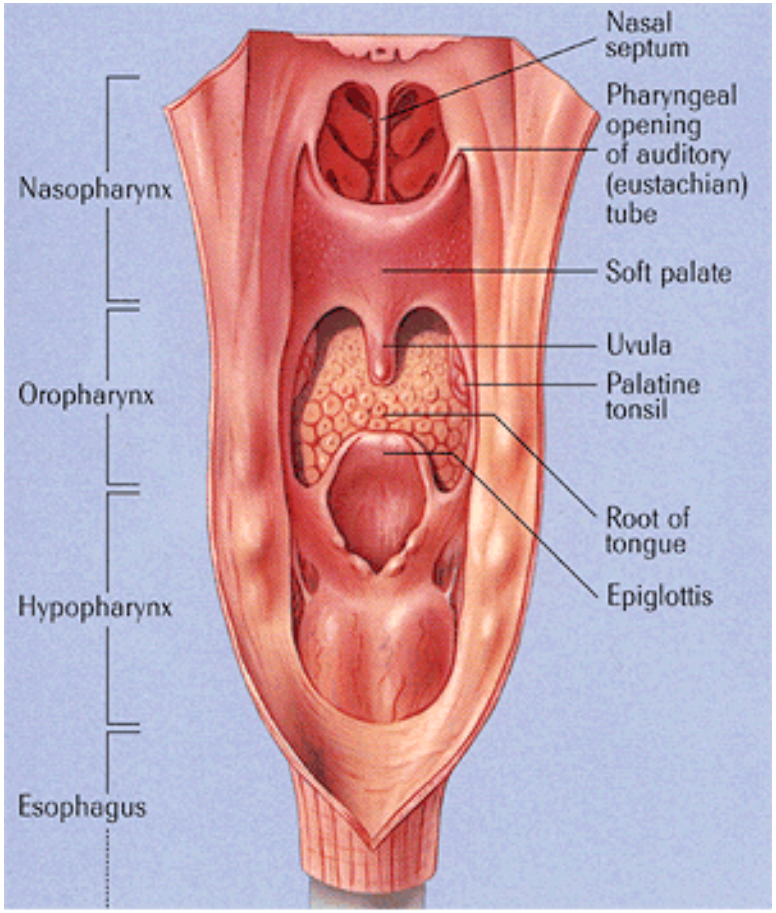


Image made available by a generous grant from Bristol-Myers Squibb

Head and Neck Multiple Primary Rules
C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Note: Metastatic tumors are not included when determining how many tumors are present. Metastatic tumors include but are not limited to:

- Bone marrow
- Discontinuous lesions/nodules in soft tissue adjacent to primary site
- Regional and distant lymph nodes for the primary site being abstracted as identified in Summary Staging Manual
- Liver
- Lung
- Skin

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
  - Pathology reports which do not specify whether a single tumor or multiple tumors were biopsied and/or resected

Example 1: History and physical exam states large tumor in nasopharynx. Biopsy base of tongue shows squamous cell carcinoma. No further information available. Abstract a single primary.

Example 2: Hospital A reports a biopsy of the upper lip mucosa. Hospital B reports a biopsy of the commissure of the lip. There is no information on whether this is a single tumor or whether there are separate tumors. Code a single primary.

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

Use the histology rules to assign the appropriate histology code.

Head and Neck Multiple Primary Rules
C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Single Tumor

IMPORTANT: If the current tumor was **preceded** by a tumor in the same primary site, go to the **Multiple Tumors module.**

Rule M2 Abstract a **single primary** when there is a **single tumor**.
Note 1: A single tumor is always a single primary.
Note 2: The tumor may overlap onto or extend into adjacent/contiguous site or subsites.
Note 3: The tumor may have in situ and invasive components.
Note 4: The tumor may have two or more histologic components.

This is the end of instructions for Single Tumor.

Use the histology rules to assign the appropriate histology code.

Head and Neck Multiple Primary Rules
C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Multiple Tumors

Note 1: Multiple tumors may be a single primary or multiple primaries.
Note 2: For those sites which have recognized biomarkers, the biomarkers are most frequently used to target treatment. Follow the rules; do not code multiple primaries or histology based on biomarkers.

Rule M3 Abstract **multiple primaries** when there are separate/non-contiguous tumors in any two of the following sites:

- Aortic body **C755 AND** carotid body **C754**
- Glottis **C320 AND/OR** supraglottis **C321 AND/OR** subglottis **C322** A**ND/OR** laryngeal cartilage **C323**
- Hard palate **C050 AND/OR** soft palate **C051 AND/OR** uvula **C052**
- Maxilla **C410 AND** Mandible **C411**
- Maxillary sinus **C310 AND/OR** ethmoid sinus **C311 AND/OR** frontal sinus **C312 AND/OR** sphenoid sinus **C313**
- Nasal cavity **C300 AND** middle ear **C301**
- Postcricoid **C130 AND/OR** hypopharyngeal aspect of aryepiglottic fold **C131 AND/OR** posterior wall of hypopharynx **C132**
- Submandibular gland **C080 AND** sublingual gland **C081**
- Upper gum **C030 AND** lower gum **C031**
- Upper lip **C000** or **C003 AND** lower lip **C001** or **C004**

Note 1: Use this rule only for **multiple tumors.**
Note 2: Timing is irrelevant.
Note 3: Histology is irrelevant.
Note 4: These primary sites differ at the fourth character of the site code Cxx**X**. Use this rule **ONLY** for the primary sites listed.

Rule M4 Abstract **multiple primaries** when separate/non-contiguous tumors are present in sites with ICD-O **site** codes that **differ** at the second C**X**xx, and/or third characters Cx**X**x.
Note 1: Use this rule only for **multiple tumors.**
Note 2: Timing is irrelevant.
Note 3: Histology is irrelevant.

Rule M5 Abstract **multiple primaries** when there are separate/non-contiguous tumors on both the **right** side and the **left** side of a paired site.

Note 1: See **Table 10** for a list of **paired sites.**

Note 2: Use this rule only for **multiple tumors.**

Note 3: Timing is irrelevant.

Note 4: Histology is irrelevant.

Rule M6 Abstract **multiple primaries** when the patient has a subsequent tumor after being **clinically disease-free** for **greater than five years** after the original diagnosis or last recurrence.

Note 1: **Clinically** disease-free means that there was **no evidence** of recurrence on follow-up.

- Scopes are WNL
- Scans are WNL

Note 2: When there is a recurrence less than or equal to five 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 five 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: When the patient has more than one Head & Neck primary, it is often difficult to determine which primary recurred. Use the last date of recurrence for any tumor to calculate the time interval.

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

Rule M7 Abstract **multiple primaries** when separate/non-contiguous tumors are two or more **different subtypes/variants** in Column 2 of the appropriate site table **(Tables 1-8)** in the Site-group Instructions. Timing is irrelevant.

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

- **Same NOS**: Alveolar rhabdomyosarcoma 8920/3 and embryonal rhabdomyosarcoma 8910/3 are both subtypes of rhabdomyosarcoma 8900/3 but are distinctly different histologies. Abstract multiple primaries.
- **Different NOS**: Colloid-type adenocarcinoma 8144 is a subtype of adenocarcinoma NOS 8140; Spindle cell squamous cell carcinoma 8074 is a subtype of squamous cell carcinoma 8070. They are distinctly different histologies. Abstract multiple primaries.

Rule M8 Abstract **multiple primaries** when separate/non-contiguous tumors are on **different rows** in the appropriate site table **(Tables 1-9)** in the Site-group Instructions. Timing is irrelevant.
Note: Each row in the table is a **distinctly different** histology.

Rule M9 Abstract a **single primary** (the invasive) when an **in situ** tumor is diagnosed **after** an **invasive** tumor **in the same primary site**.
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 **Tables 1-8** in the Site-group Instructions for listings of NOS and subtype/variants.
Note 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.

Rule M10 Abstract a **single primary** (the invasive) when an **invasive** tumor is diagnosed **less than or equal to 60** days **after** an **in situ** tumor **in the same primary site**.

Note 1: The rules are **hierarchical.** Only use this rule when 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.

Rule M11 Abstract **multiple primaries** when an **invasive** tumor occurs **more than 60** days after an **in situ** tumor.

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

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

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

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 M12 Abstract a **single primary** when separate/non-contiguous tumors **in the same primary site** are on **the same row** in the appropriate site table **(Tables 1-9)** in the Site-group Instructions. Timing is irrelevant.

Note: The same row means the tumors are:

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

Rule M13 Abstract a **single primary** 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.

Use the histology rules to assign the appropriate histology code.

Head and Neck Histology Rules
C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Priority Order for Using Documentation to Identify Histology

IMPORTANT NOTES

1. Code the histology diagnosed ***prior*** to **neoadjuvant treatment.**
   Note 1: Histology changes may occur following immunotherapy, chemotherapy, targeted therapy, and radiation therapy.
   Note 2: Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.

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

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

The priority list is used for single primaries (including multiple tumors abstracted as a single primary).

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).

This is a hierarchical list of source documentation.

1. **Tissue or pathology report from biopsy or resection of primary site** (in priority order)
   A. Addendum(s) and/or comment(s)
   B. Final diagnosis / synoptic report as required by CAP
   C. CAP protocol
   Note 1: Addendums and comments on the pathology report are given 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

2. Cytology of primary site (fine needle aspirate (FNA))

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

4. **Scan:** The following list is in **priority** order.
   A. **CT**
   B. **MRI**
   C. **PET**

5. Code the histology **documented** by the physician when none of the above are available. Use the **documentation** in the following **priority order:**
   A. Treatment plan
   B. Tumor Board
   C. Documentation in the medical record that **refers to original pathology, cytology, or scan(s)**
   D. Physician's **reference to** type of cancer (**histology**) in the medical record
   Note 1: Code the specific histology when documented.
   Note 2: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.

Head and Neck Histology Rules
C000-C148, C300-C339, C410, C411, C479, C754, C755
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Coding Histology

Note 1: The priority is to code the most specific histology. **DO NOT USE BREAST HISTOLOGY CODING RULES FOR THIS SITE.**
Note 2: Only use this section for one or more histologies within a single tumor.
Note 3: Do not use this section in place of the Histology Rules.

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

   Example 1: Diagnosis for a single tumor is adenocarcinoma 8140 with the majority or predominant part of tumor being enteric-type adenocarcinoma 8144. Code the subtype/variant: enteric-type adenocarcinoma 8144.

   Example 2: Diagnosis for a single tumor is squamous cell carcinoma 8070 with minority of tumor being spindle cell squamous cell carcinoma 8074. Code the subtype/variant: spindle cell squamous cell carcinoma 8074.

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

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

   Example: When the diagnosis is adenocarcinoma with an enteric-type **adenocarcinoma** component, code enteric-type adenocarcinoma 8144.

   Negative Example: When the diagnosis is simply adenocarcinoma with an enteric-type component, code adenocarcinoma NOS 8140. Do not assume this is enteric-type adenocarcinoma. This could be enteric-type differentiation or features.

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

2. Code the histology described as **differentiation** or **features/features of ONLY** when there is a specific ICD-O code for the "NOS with ____ features" or "NOS with ____ differentiation".
   ***Note*:** Do not code differentiation or features when there is no specific ICD-O code.

3. Code the specific histology described by **ambiguous terminology** (list follows) **ONLY** when A or B is true:
   A. The only diagnosis available is **one histology** term described by ambiguous terminology
      - CoC and SEER require reporting of cases diagnosed only by ambiguous terminology
      - Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

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

   If the specific histology does not meet the criteria in #3B, then code the NOS histology.

See the Ambiguous Terminology section of the General Instructions for instructions and examples on when ambiguous terms and definitive terms may be used to assign histology.

Table 11: List of Ambiguous Terminology

Ambiguous Terminology	
Appears	Presumed
Cannot rule out	Suspicious (for)
Likely	Suggestive of
Favor(s)	

Note 1: Table 12 below includes terms **previously** included in the list of ambiguous terms. These terms should be treated as supporting a **definitive diagnosis** of a histologic subtype.

Note 2: The terms in Table 12 were removed from the list of ambiguous terms and added to a list of **definitive terminology** based on the recommendation of a panel of pathologists and subject matter experts.

Table 12: List of Definitive Terminology

Definitive Terminology	
Comparable with	Most likely
Compatible with	Probable
Consistent with	Typical (of)

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

   - Architecture
   - Foci; focus; focal
   - Pattern

Single Tumor

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

Note 1: Use **Tables 1-9** to code histology. New codes, terms, and synonyms are included in **Tables 1-9** and coding errors may occur if the table is not used.

Note 2: When the histology is **not listed** in **Tables 1-9,** 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 Tables 1-9, ICD-O or all updates.

Note 4: **Cases diagnosed prior to 1/1/2022:** Squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086) are coded only when HPV status is determined by tests based on ISH, PCR, RT-PCR technologies to detect the viral DNA or RNA. p16 is not a valid test to assign these histology codes.
Cases diagnosed 1/1/2022 forward: p16 test results can be used to code squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086).

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

***Example*:** The tissue/pathologic diagnosis is invasive squamous cell carcinoma **8070/3** and keratinizing squamous cell carcinoma in situ **8071/2**. Code the invasive histology, SCC **8070/3,** even though it is not the most specific histology.

Rule H3 Code the subtype/variant when there is a **NOS** and a **single subtype/variant** of that NOS such as the following (not exhaustive):

- Adenocarcinoma/endolymphatic sac tumor **8140** and a subtype/variant of adenocarcinoma
- Ameloblastic carcinoma-primary type **9270** and a subtype variant of ameloblastic carcinoma-primary type
- Chondrosarcoma grade 2/3 **9220** and a subtype/variant of chondrosarcoma grade 2/3
- Neuroendocrine carcinoma **8246** and a subtype/variant of neuroendocrine carcinoma
- Neuroendocrine tumor **8240** and a subtype/variant of neuroendocrine tumor
- Sarcoma **8800/3** and a subtype/variant of sarcoma
- Squamous cell carcinoma **8070** and subtype/variant of squamous carcinoma

Note: See **Tables 1-8** in the Site-group Instructions to find NOS and subtypes/variants.

Rule H4 When the diagnosis is carcinoma ex pleomorphic adenoma **AND** the histologic type of the malignant component is provided, code the malignant component.

Note 1: Carcinoma ex pleomorphic adenoma primarily occurs in the parotid gland, submandibular gland, and salivary gland. Use Table 6 to code histology.

Note 2: When the diagnosis is carcinoma ex pleomorphic adenoma, NOS and no other histologic type provided, code 8941.

Example 1: The pathology diagnosis is salivary duct carcinoma ex pleomorphic adenoma. Code salivary duct adenocarcinoma 8500.

Example 2: The pathology is carcinoma ex pleomorphic adenoma, myoepithelial carcinoma type. Code myoepithelial carcinoma 8982.

This is the end of instructions for Single Tumor

Code the histology according to the rule that fits the case

Multiple Tumors Abstracted as a Single Primary

Rule H5 Code the **histology** when only **one** histologic type is identified for **all tumors.**

Note 1: Use **Tables 1-9** to code histology. New codes, terms, and synonyms are included in **Tables 1-9** and coding errors may occur if the table is not used.

Note 2: When the histology is **not listed** in **Tables 1-9,** 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 Tables 1-9, ICD-O or all updates.

Rule H6 Code the **invasive** histology when one of the following criteria are met:

- All **tumors** have both **invasive and in situ** elements **OR**
- **One** or more tumors are **invasive** and **one** or more tumors are **in situ**

Note 1: **Multiple Primary Rules must be applied** to be certain all tumors are a single primary.

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

Rule H7 Code the **subtype/variant** when **all** tumors are a **NOS** and a **single subtype/variant** of that NOS such as the following (not exhaustive):

- Adenocarcinoma/endolymphatic sac tumor **8140** and a subtype/variant of adenocarcinoma
- Ameloblastic carcinoma primary-type **9270** and a subtype variant of ameloblastic carcinoma-primary type
- Chondrosarcoma grade 2/3 **9220** and a subtype/variant of chondrosarcoma grade 2/3
- Neuroendocrine carcinoma **8246** and a subtype/variant of neuroendocrine carcinoma
- Neuroendocrine tumor **8240** and a subtype/variant of neuroendocrine tumor
- Sarcoma **8800/3** and a subtype/variant of sarcoma
- Squamous cell carcinoma **8070** and subtype/variant of squamous carcinoma

Note: See **Tables 1-8** in the Site-group Instructions to find NOS and subtypes/variants.

Rule H8 When the diagnosis is carcinoma ex pleomorphic adenoma **AND** the histologic type of the malignant component is provided, code the malignant component.

Note 1: Carcinoma ex pleomorphic adenoma primarily occurs in the parotid gland, submandibular gland, and salivary gland. Use Table 6 to code histology

Note 2: When the diagnosis is carcinoma ex pleomorphic adenoma, NOS and no other histologic type provided, code 8941

Example 1: The pathology diagnosis is salivary duct carcinoma ex pleomorphic adenoma. Code salivary duct adenocarcinoma 8500.

Example 2: The pathology is carcinoma ex pleomorphic adenoma, myoepithelial carcinoma type. Code myoepithelial carcinoma 8982.

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

Code the histology according to the rule that fits the case

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Introduction

Note 1: **Renal cell carcinoma** (RCC) **8312** is a **group** term for glandular (adeno) carcinoma of the kidney. Approximately 85% of all malignancies of the kidney C649 are RCC or subtypes/variants of RCC.

- See **Table 1** for renal cell carcinoma subtypes/variants.
- Clear cell renal cell carcinoma (ccRCC) 8310 is the most common subtype/variant of RCC.

Note 2: Urothelial carcinoma of the upper urinary system usually arises in the renal pelvis C659 and not in the kidney. Per Cancer PathCHART review, **urothelial carcinoma 8120** and **papillary urothelial carcinoma 8130** are biologically **impossible** in the kidney.

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.
- Adenocarcinoma; carcinoma
  - A histology type must be stated for these terms to be equal
    - ***Example of equivalent or equal:*** Renal cell carcinoma and renal cell adenocarcinoma are both coded 8312
    - ***Example of NOT equivalent or equal:*** Carcinoma NOS 8010 and adenocarcinoma NOS 8140
- Multifocal; multicentric
- Simultaneous; synchronous; existing at the same time; concurrent; prior to first course treatment
- Site; topography
- Tumor; mass; tumor mass; lesion, neoplasm
  - The terms tumor, mass, tumor mass, lesion, neoplasm and nodule are not used in a standard manner in clinical diagnoses, scans, or consults. Disregard the terms unless there is a physician's statement that the term is malignant/cancer
  - These terms are used ONLY to determine multiple primaries
  - Do not use these terms for casefinding or determining reportability
- Type; subtype; variant

Terms That Are NOT Equivalent or Equal

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

- **Carcinoma**, NOS 8010 is not equivalent to **adenocarcinoma**, NOS 8140
- **Component** is not equivalent to **subtype/type/variant**
  Note 1: Component is only coded when the pathologist specifies the component as a second carcinoma.
  Note 2: See examples provided in H rules **Coding Histology** section
- **Phenotype** is not equivalent to **subtype/type/variant**

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Table 1: Specific Histologies, NOS, and Subtypes/Variants

Use Table 1 as directed by the **Histology Rules** to assign the more common histology codes for kidney tumors.

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 is not found in Table 3, ICD-O or all updates.
Note 3: Behavior codes are listed when the term has only one possible behavior (either a /2 or /3).
Note 4: Column 2 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 2). Rhabdomyosarcoma is also a NOS because it has subtypes/variants. The subtypes/variants are indented under the NOS (rhabdomyosarcoma) in column 2.

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do not have behavior codes listed next to the term unless the term has only one possible behavior (/2 or /3)

Column 2 contains subtypes or variants of the NOS histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do not have behavior codes next to the term unless the term has only one possible behavior (/2 or /3)
- Subtypes or variants of the NOS histologies in column 2 are also indented under the NOS histology and have a full 4-digit histology code. The behavior code (/2 or /3) is included with the 4-digit histology code if the term has only one possible behavior.

Table begins on next page

Table 1: Specific Histologies, NOS, and Subtypes/Variants

NOS or Specific Histology Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Medullary carcinoma 8510 • Medullary adenocarcinoma • Renal medullary carcinoma • SMARCB1-deficient medullary-like RCC • SMARCB1-deficient undifferentiated RCC NOS • SMARCB1-deficent dedifferentiated RCC of other specific subtypes	
Nephroblastoma 8960 • Wilms tumor	
Neuroendocrine carcinoma 8246 (/3)	Large cell neuroendocrine carcinoma **8013 (/3)** • Large cell neuroendocrine tumor Small cell neuroendocrine carcinoma **8041 (/3)**
Neuroendocrine tumor 8240 (/3) • Carcinoid [OBS] • NET • Neuroendocrine tumor, grade 1 • Well-differentiated neuroendocrine tumor	Neuroendocrine tumor, grade 2 **8249 (/3)**
Paraganglioma 8693 (/3) [1] • Extra-adrenal paraganglioma • Parasympathetic paraganglioma • Sympathetic paraganglioma	

[1] Reportable for kidney C64.9 beginning 1/1/2024.

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Table 1: Specific Histologies, NOS, and Subtypes/Variants

NOS or Specific Histology Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Renal cell carcinoma NOS 8312 • Eosinophilic renal cell carcinoma • Oncocytic renal cell carcinoma [2] • RCC • Renal cell spindle cell carcinoma • Sarcomatoid carcinoma [3] [4] • Sarcomatoid renal cell carcinoma [5] • Succinate dehydrogenase-deficient renal cell carcinoma [6] ○ SDHD • Unclassified renal cell carcinoma **Continued on next page (same row)**	Acquired cystic disease-associated renal cell carcinoma **8316** • Tubulocystic renal cell carcinoma Chromophobe renal cell carcinoma **8317** • ChRCC • Hybrid oncocytic chromophobe tumor Clear cell papillary renal cell carcinoma **8323 (/3)** [7] Clear cell renal cell carcinoma **8310** • ccRCC Collecting duct carcinoma **8319** **Subtypes/variants continue on next page (same row)**

[2] "Oncocytic" is not a histologic type unless listed in column 2.
[3] WHO, IARC, and CAP agree that sarcomatoid carcinoma is a pattern of differentiation, not a specific subtype, of renal cell carcinoma.
[4] Sarcomatoid is listed in the CAP Kidney protocol under the header "features."
[5] Continue coding sarcomatoid renal cell carcinoma as 8312 until otherwise indicated.
[6] SDHD is coded 8312 for pre-2022 cases. For 2022+, code 8311.
[7] The 2016 WHO 4th Ed reclassified this histology as /1. This change has **NOT** yet been implemented and it **remains reportable.**

Table 1: Specific Histologies, NOS, and Subtypes/Variants

NOS or Specific Histology Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Renal cell carcinoma NOS 8312 (continued)	ELOC (formerly TCEB1) mutated RCC **8311** [8] Eosinophilic solid and cystic RCC **8311** [8] Fumarate hydratase-deficient RCC ALK-rearranged RCC **8311** [8] Hereditary leiomyomatosis and renal cell carcinoma-associated renal cell carcinoma **8311** [8] MiT family translocation renal cell carcinomas **8311** [8] Succinate dehydrogenase-deficient renal cell carcinoma **8311** [6 8] • SDHD T(6;11) RCC **8311** [8] TFE3-rearranged RCC **8311** [8] TFEB-altered RCC **8311** [8] Xp11 translocation RCC **8311** [8] Mucinous tubular and spindle cell carcinoma **8480** Papillary renal cell carcinoma **8260** • PRCC

[8] The 8311 terms listed here have the same ICD-O code but are distinctly different histologies. Because they are different, they are on different lines in column 2 (see M rules).

Table 1: Specific Histologies, NOS, and Subtypes/Variants

NOS or Specific Histology Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Sarcoma 8800 (/3)	Angiosarcoma **9120 (/3)** Clear cell sarcoma **8964 (/3)** • Bone-metastasizing renal tumor of childhood Leiomyosarcoma **8890 (/3)** • Renal vein leiomyosarcoma Osteosarcoma **9180 (/3)** Peripheral neuroectodermal tumor **9364 (/3)** • Ewing sarcoma • Neuroectodermal tumor NOS • pNET • pPNET • Primitive neuroectodermal tumor • Primitive peripheral neuroectodermal tumor • Rhabdomyosarcoma **8900 (/3)** ○ Embryonal rhabdomyosarcoma **8910 (/3)** ○ Pleomorphic rhabdomyosarcoma **8901 (/3)** ○ Spindle cell rhabdomyosarcoma **8912 (/3)** ▪ Sclerosing rhabdomyosarcoma Synovial sarcoma **9040 (/3)**

Table 2: Neoplasms which are Not Reportable

Table 2 lists the non -reportable histology **term** and **code**. Not all of the non-reportable neoplasms have codes. **Synonyms** are indented under the preferred term. Synonyms have the same histology code (if applicable) as the preferred term under which they are indented.

Non-Reportable Histology Term and Code
Adult cystic teratoma 8959 (/0) • Mixed epithelial and stromal tumor • Pediatric cystic nephroma • Renal epithelial stromal tumor
Angiomyolipoma 8860 (/0) • Angiomyolipoma with epithelial cysts • Oncocytic angiomyolipoma
Congenital mesoblastic nephroma 8960 (/1) • CMN • Cellular congenital mesoblastic nephroma • Classic congenital mesoblastic nephroma • Mesoblastic nephroma • Mixed congenital mesoblastic nephroma
Cystic partially-differentiated nephroblastoma 8959 (/1)
Epithelioid angiolipoma 8860 (/1)
Hemangioblastoma 9161 (/1)

Table 2: Neoplasms which are Not Reportable

Non-Reportable Histology Term and Code
Hemangioma 9120 (/0)
Juxtaglomerular cell tumor 8361 (/0) • Functioning juxtaglomerular cell tumor • Non-functioning juxtaglomerular cell tumor
Leiomyoma 8890 (/0)
Lymphangioma 9170 (/0)
Metanephric adenofibroma 9013 (/0) • Nephrogenic adenofibroma
Metanephric adenoma 8325 (/0)
Metanephric stromal tumor 8935 (/1)
Multilocular cystic renal neoplasm of low malignant potential 8316 (/1)
Nephrogenic rests (no code)
Oncocytic tumor NOS (no code) • Oncocytic tumor, low grade
Oncocytoma 8290 (/0)
Ossifying renal tumor of infancy 8967 (/0)

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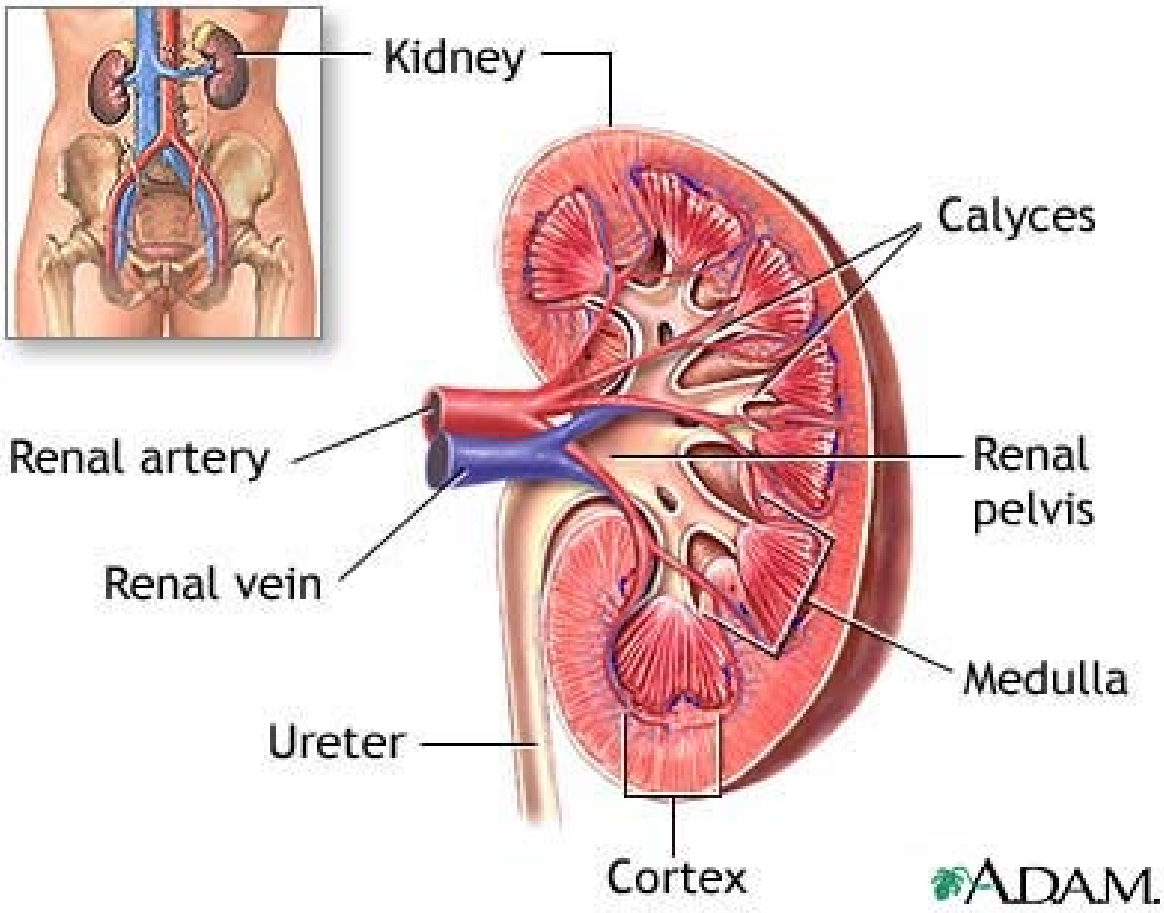
Table 2: Neoplasms which are Not Reportable

Non-Reportable Histology Term and Code
Papillary adenoma 8260/0 • Tubulopapillary adenoma
Paraganglioma 8700 (/0) [1] • Extra-adrenal pheochromocytoma
Pediatric cystic nephroma 8959 (/0)
Renomedullary interstitial cell tumor 8966 (/0) • Medullary fibroma
Schwannoma 9560 (/0)
Solitary fibrous tumor 8815 (/1)

[1] Non-reportable through 12/31/2023. See Table 1.

Illustrations

Kidney Anatomy (Includes Renal Pelvis)



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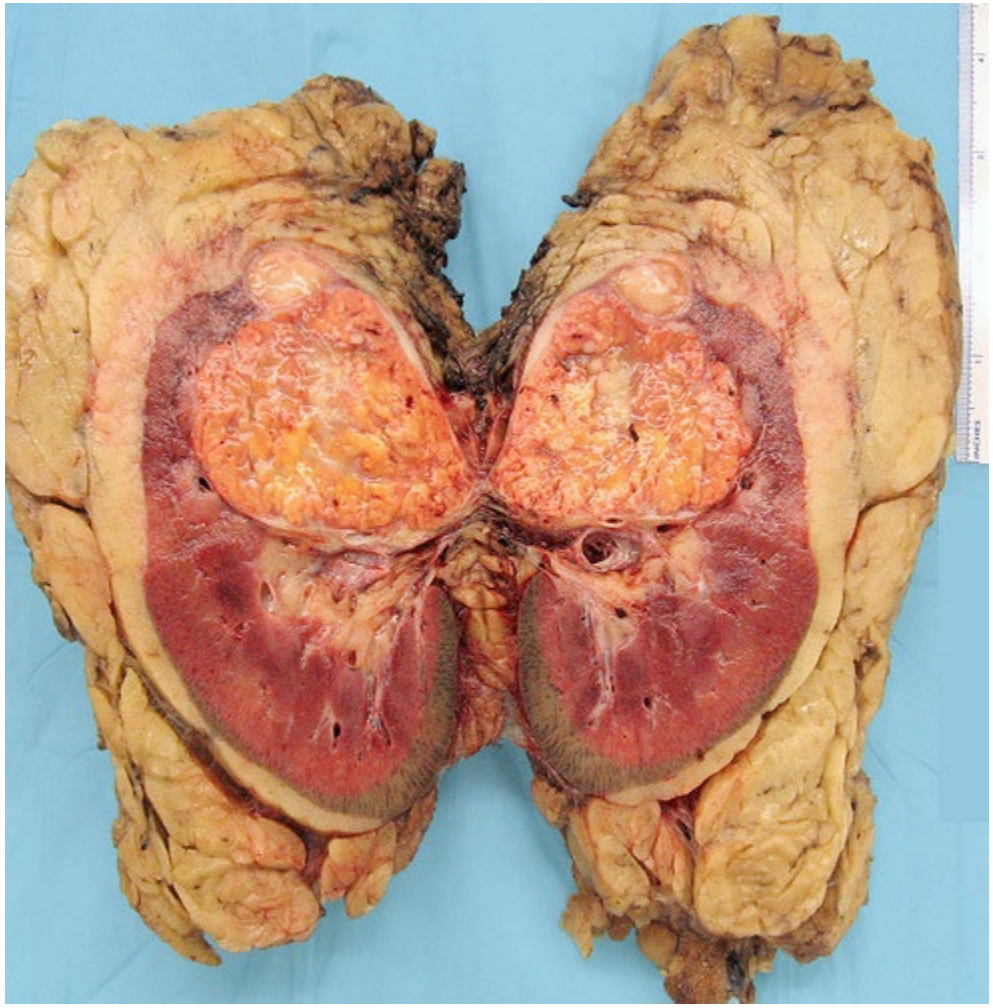
Pathology Specimen Kidneys



Kidney Site-group Instructions
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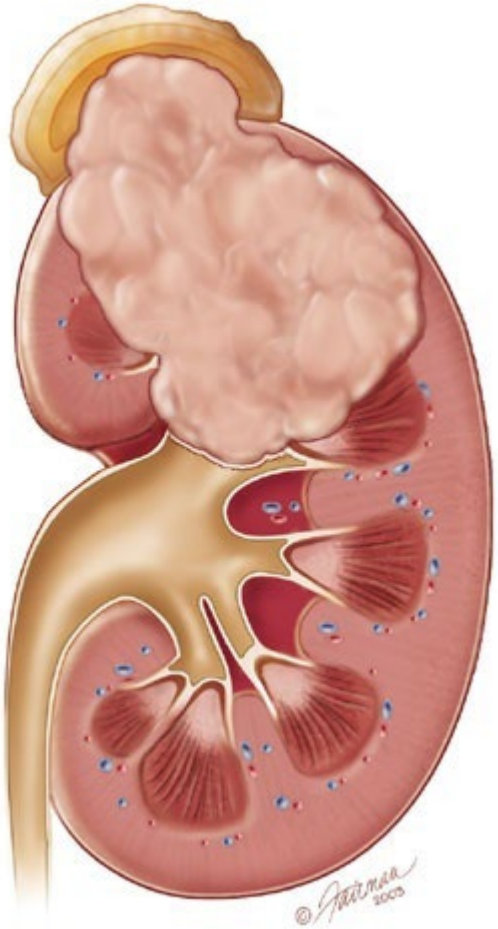
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Kidney Cancer



Kidney Multiple Primary Rules
C649
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Note 1: Metastatic tumors are not included when determining how many tumors are present. Metastatic tumors include but are not limited to:

- Adrenal gland
- Bones
- Bowel
- Brain
- Discontinuous nodules in surrounding tissue
- Regional and distant lymph nodes as identified in Summary Staging Manual
- Liver
- Lung

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.

Use the histology coding rules to assign the appropriate histology code

Kidney Multiple Primary Rules
C649
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Single Tumor

Rule M2 Abstract a **single primary** when there is a **single tumor**.
Note 1: A single tumor is always a single primary.
Note 2: The tumor may overlap onto or extend into adjacent/contiguous site or subsites.
Note 3: The tumor may have in situ and invasive components.
Note 4: The tumor may have two or more histologic components.

This is the end of instructions for Single Tumor.

Use the histology coding rules to assign the appropriate histology code

Multiple Tumors

Note 1: Multiple tumors may be a **single** primary **OR multiple** primaries.
Note 2: For those sites which have recognized biomarkers, the biomarkers are most frequently used to target treatment. Follow the rules; do not code multiple primaries or histology based on biomarkers.

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

Rule M4 Abstract a **single primary** when there are **bilateral nephroblastomas** (previously called Wilms tumors).
Note: Timing is irrelevant; the tumors may occur simultaneously OR the contralateral tumor may be diagnosed later (no time limit).

Kidney Multiple Primary Rules
C649
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M5 Abstract **multiple primaries** when there are tumors in **both** the **right kidney** and in the **left kidney**. There may be:

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

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

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

Rule M6 Abstract **multiple primaries** when the patient has a subsequent tumor after being clinically disease-free for greater than **three years** after the original diagnosis or last recurrence.

Note 1: Clinically disease-free means that there was **no <u>evidence</u>** of recurrence on follow-up.

- Scans are WNL
- Urine cytology is negative
- All other work-up is WNL

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

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

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

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

Kidney Multiple Primary Rules
C649
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M7 Abstract **multiple primaries** when separate/non-contiguous tumors are two or more **different subtypes/variants** in Column 2, **Table 1** in the Site-group Instructions.

Note 1: The tumors may be subtypes/variants of the **same** or **different** NOS histologies.

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

Note 2: Abstract multiple primaries when you have any of the following combinations (all coded 8311):

- ELOC (formerly TCEB1) mutated RCC
- Eosinophilic solid and cystic RCC
- Fumarate hydratase-deficient RCC ALK-rearranged RCC
- Hereditary leiomyomatosis and renal cell carcinoma-associated renal cell carcinoma (HLRCC)
- MiT family translocation renal cell carcinoma
- Succinate dehydrogenase-deficient renal cell carcinoma (SDHD)
- t(6;11) RCC
- TFE3-rearranged RCC
- TFEB-altered RCC
- Xp11 translocation RCC

Rule M8 Abstract a **single primary** when synchronous, separate/non-contiguous tumors are on the **same row** in **Table 1** in the Site-group Instructions. Tumors must be in the same kidney.

Note: The same row means the tumors are:

- The same histology (same four-digit ICD-O code; see exception for 8311) **OR**
- One is the preferred term (column 1) and the other is a synonym for the preferred term (indented under the preferred term in column 1) **OR**
- A NOS (column 1) and the other is a subtype/variant of that NOS (column 2) **OR**
- A NOS histology in column 2 with an indented subtype/variant

Kidney Multiple Primary Rules
C649
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M9 Abstract **multiple primaries** when separate/non-contiguous tumors are on **different rows** in **Table 1** in the Site-group Instructions.
Note: Each row in the table is a **distinctly different** histology.

Rule M10 Abstract a **single primary** when an **in situ** tumor is diagnosed **after** an **invasive** tumor **AND** tumors occur in the same kidney.
Note 1: The rules are **hierarchical**. Only use this rule when none of the previous rules apply.
Note 2: The tumors **may** be a **NOS** and a **subtype/variant** of that NOS. See **Table 1** in the Site-group Instructions for listings of NOS and subtype/variants.
Note 3: Once the patient has an invasive tumor, the **in situ** is recorded as a **recurrence** for those registrars who collect recurrence data.

Rule M11 Abstract a **single primary** (the invasive) when an invasive tumor is diagnosed less than or equal to 60 days after an in situ tumor in the same kidney.
Note 1: The rules are **hierarchical.** Only use this rule when none of the previous rules apply.
Note 2: The tumors may be a **NOS** and a **subtype/variant** of that NOS.
Note 3: When the case has been abstracted, **change behavior** code on original abstract from /2 to /3.
Note 4: Do **not** change **date of diagnosis**.
Note 5: If the case has already been submitted to the central registry, **report** all changes.
Note 6: The physician may **stage both** tumors because staging and determining multiple primaries are done for different reasons. Staging determines which treatment would be most effective. Determining multiple primaries is done to stabilize the data for the study of epidemiology (long-term studies done on incidence, mortality, and causation of a disease with the goal of reducing or eliminating that disease).
Note 7: See the **COC** and **SEER** manuals for **instructions** on coding **other data items** such as Date of Diagnosis, Accession Year and Sequence Number.

Rule M12 Abstract **multiple primaries** when an **invasive** tumor occurs **more than 60** days after an **in situ** tumor.
Note 1: The rules are **hierarchical**. Only use this rule when none of the previous rules apply.
Note 2: Abstract **both** the invasive and in situ tumors.
Note 3: Abstract as multiple primaries even if **physician states** the invasive tumor is disease **recurrence** or **progression.**

Kidney Multiple Primary Rules
C649
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M13 Abstract a **single primary** when there are multiple tumors that **do not meet any** of the **above criteria.**

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

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

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

This is the end of instructions for Multiple Tumors.

Use the histology coding rules to assign the appropriate histology code

Kidney Histology Rules
C649
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Priority Order for Using Documents to Identify Histology

IMPORTANT NOTES

1. Code the histology diagnosed ***prior*** to **neoadjuvant treatment.**
   Note 1: Histology changes may occur following immunotherapy, chemotherapy, targeted therapy, and radiation therapy.
   Note 2: Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.

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

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

The priority list is used for **single primaries** (including multiple tumors abstracted as a single primary).

This is a hierarchical list of source documentation.
Code the **most specific** pathology/tissue from either **resection** or **biopsy**.
Note 1: The term "most specific" usually refers to a subtype/variant.
Note 2: The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor.
Note 3: When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).

1. Tissue or pathology report from primary site (in priority order)
   A. Addendum(s) and/or comment(s)
   B. Final diagnosis / synoptic report as required by CAP
   C. CAP protocol
      Note 1: Addendums and comments on the pathology report are given the highest priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.
      Note 2: The pathologist's diagnosis from the pathology report is always reliable, so the final diagnosis is the second priority.

Note 3: The CAP protocol is a checklist which:

- Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care
- Allows physicians to check multiple histologies

2. **Cytology** (urine)

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

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

5. Code the histology **documented** by the physician when none of the above are available. Use the documentation in the following priority order:
   A. Treatment plan
   B. Documentation from Tumor Board
   C. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
   D. Physician's **reference to** type of cancer (**histology**) in the medical record
   Note 1: Code the specific histology when documented.
   Note 2: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.

Kidney Histology Rules
C649
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Coding Histology

Note 1: The priority is to code the most specific histology. **DO NOT USE BREAST HISTOLOGY CODING RULES FOR THIS SITE.**
Note 2: Only use this section for one or more histologies within a single tumor.
Note 3: Do not use this section in place of the Histology Rules.
Note 4: Code the most specific histology from the biopsy or resection. When there is a discrepancy between the biopsy and resection (two distinctly different histologies), code the histology from the most representative specimen (the greatest amount of tumor).

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

   Example 1: Diagnosis for a single tumor is renal cell carcinoma 8312 with the majority or predominant part of tumor being clear cell renal cell carcinoma 8310. Code the subtype/variant: clear cell renal cell carcinoma 8310.
   Example 2: Diagnosis for a single tumor is neuroendocrine tumor 8041 with minority of tumor being large cell neuroendocrine tumor 8013. Code the subtype/variant: large cell neuroendocrine tumor 8013.
   Example 3: Diagnosis for a single tumor is sarcoma NOS 8800/3 with a component of leiomyosarcoma 8890/3. Code the subtype/variant: leiomyosarcoma 8890/3.

   Note 1: The terms above (A, B, C) must describe a **carcinoma** or **sarcoma** in order to code a histology described by those terms.
   Example: When the diagnosis is adenocarcinoma with a clear cell **carcinoma** component, code clear cell carcinoma 8310.
   Negative Example: When the diagnosis is simply adenocarcinoma with a clear cell component, code adenocarcinoma NOS 8140. Do not assume this is a clear cell carcinoma. This could be clear cell differentiation or features.

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

2. Code the histology described as **differentiation** or **features/features of ONLY** when there is a specific ICD-O code for the "NOS with ____ features" or "NOS with ____ differentiation".
   Note: Do not code differentiation or features when there is no specific ICD-O code.

3. Code the specific histology described by **ambiguous terminology** (list follows) **ONLY** when A or B is true:
   A. The only diagnosis available is **one histology** term described by ambiguous terminology
      - CoC and SEER require reporting of cases diagnosed only by ambiguous terminology
      - Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

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

If the specific histology does not meet the criteria in #3B, then code the NOS histology.

See the **Ambiguous Terminology** section of the General Instructions for instructions and examples on when ambiguous terms and definitive terms may be used to assign histology.

Table 3: List of Ambiguous Terminology

Ambiguous Terminology	
Appears	Presumed
Cannot rule out	Suspicious (for)
Likely	Suggestive of
Favor(s)	

Note 1: Table 4 below includes terms **previously** included in the list of ambiguous terms. These terms should be treated as supporting a **definitive diagnosis** of a histologic subtype. A definitive term does not require clinical verification of the subtype or variant.

Note 2: The terms in Table 4 were removed from the list of ambiguous terms and added to a list of **definitive terminology** based on the recommendation of a panel of pathologists and subject matter experts.

Table 4: List of Definitive Terminology

Definitive Terminology	
Comparable with	Most likely
Compatible with	Probable
Consistent with	Typical (of)

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

Kidney Histology Rules
C649
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Single Tumor

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

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

Note 2: When the histology is **not listed** in **Table 1** use the **ICD-O** and all **updates**.

Note 3: Submit a question to **Ask a SEER Registrar** when the histology code is not found in Table 1, ICD-O or all updates.

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

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

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

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

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

Note: Use **Table 1** in the Site-group Instructions to determine NOS and subtype/variant.

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

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

Note: Use **Table 1** in the Site-group Instructions to determine NOS and subtype/variant.

This is the end of instructions for Single Tumor.

Code the histology according to the rule that fits the case.

Kidney Histology Rules
C649
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Multiple Tumors Abstracted as a Single Primary

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

Rule H4 Code the histology when only **one** histology is present in **all** tumors.

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

Note 2: When the histology is **not listed** in **Table 1** use the **ICD-O** and all **updates**.

Note 3: Submit a question to **Ask a SEER Registrar** when the histology code is not found in Table 1, ICD-O or all updates.

Rule H5 Code the NOS when there are:

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

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

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

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

Note: Use **Table 1** in the Site-group Instructions to determine NOS and subtype/variant.

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

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

Note: Use **Table 1** in the Site-group Instructions to determine NOS and subtype/variant.

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

Code the histology according to the rule that fits the case

Lung Site-group Instructions
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Introduction

Note 1: 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 2: 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.

Equivalent or Equal Terms

These terms can be used interchangeably:

- Adenocarcinoma; carcinoma
    - A histology type must be stated for these terms to be equal
        - ***Example of equivalent or equal:*** Acinar carcinoma and acinar adenocarcinoma are both coded 8551
        - ***Example of NOT equivalent or equal:*** Carcinoma NOS 8010 and adenocarcinoma NOS 8140
- And; with
  Note: "And" and "with" are used as synonyms when **describing multiple histologies** within a **single tumor**.
- Simultaneous; synchronous; existing at the same time; concurrent; prior to first course treatment
- Site; topography
- 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

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 **type/subtype/variant**
  Note: Component is **only** coded when the pathologist specifies the component as a second **carcinoma.**
- **Lung only: Mucinous** is not equivalent to **colloid**
  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** (a 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 to mucinous carcinoma
- **Multilocular** is not equivalent to **multinodular**
- **Phenotype** is not equivalent to **subtype/type/variant**

Table 1: Coding Primary Site

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**.

Terminology	Laterality	Site Term and Code
Bronchus intermedius **Carina** **Hilus of lung** **Perihilar**	Bilateral	Mainstem bronchus **C340** [1] [2] [3]
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**

[1] Mainstem bronchus starts at the trachea and extends only a few centimeters into the lung where it divides into secondary bronchi at the carina.
[2] Bronchus intermedius is the portion of the right mainstem bronchus between the upper lobar bronchus and the origin of the middle and lower lobar bronchi.
[3] Code to mainstem bronchus C340 when it is specifically stated in the operative report and/or documented by a physician.

Table 1: Coding Primary Site

Terminology	Laterality	Site Term and Code
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** [4]
Bronchus NOS **Bronchogenic** **Extending up to the hilum** **Extending down to the hilar region** **Infrahilar NOS** **Lung NOS** **Pulmonary NOS** **Suprahilar NOS**	Bilateral	Lung NOS **C349** [5]

[4] One lesion/tumor which overlaps two or more lobes

[5] C349 includes

- Multiple tumors in ipsilateral lobe, different lobes **OR** unknown if same/different lobe
- Tumor in bronchus, unknown if mainstem or lobar bronchus
- Tumor present, unknown which lobe
- Multiple tumors abstracted as a single primary

Table 1: Coding Primary Site

Terminology	Laterality	Site Term and Code
Lobar bronchi NOS **Lobar bronchus NOS**	Bilateral	Code the lobe in which the lobar bronchus tumor is present **C34__**[5]

Lung Site-group Instructions
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

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.** A histology with differentiation or features is a single histology.
- 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

Table 2: Combination/Mixed Histology Codes

Required Terms	Combination Histologies and Code
Adenocarcinoma NOS **AND** [1] Squamous cell carcinoma NOS	Adenosquamous carcinoma **8560**
Giant cell carcinoma **AND** Spindle cell carcinoma [2]	Sarcomatoid carcinoma **8033** [3]
Epithelial carcinoma **AND** Myoepithelial carcinoma	Epithelial-myoepithelial carcinoma **8562**
Large cell neuroendocrine carcinoma **AND** • Adenocarcinoma (includes subtypes/variants) **OR** • Squamous cell carcinoma (includes subtypes/variants **OR** • Spindle cell carcinoma **OR** • Giant cell carcinoma	Combined large cell neuroendocrine carcinoma **8013**

[1] **Cases dx'd prior to 1/1/2023:** Dx must be adenocarcinoma NOS and squamous cell carcinoma NOS, NOT any of the subtypes/variants. **Cases dx'd 1/1/2023+:** Subtypes/variants of adenocarcinoma NOS and keratinizing, non-keratinizing, and/or basaloid variants of SCC NOS can be coded to adenosquamous carcinoma.
[2] 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.
[3] 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.

Table 2: Combination/Mixed Histology Codes

Required Terms	Combination Histologies and Code
Mucinous carcinoma, invasive **AND** Non-mucinous carcinoma, invasive	Mixed invasive mucinous and non-mucinous carcinoma **8254 (/3)**
Small cell carcinoma **AND** **At least one** of the following: • Adenocarcinoma and any subtype/variant of adenocarcinoma • Adenosquamous carcinoma • Large cell carcinoma and any subtype/variant of large cell carcinoma (includes large cell neuroendocrine carcinoma) • Squamous cell carcinoma and any subtype/variant of squamous cell carcinoma • Non-small cell carcinoma	Combined small cell carcinoma **8045**
Squamous cell carcinoma (epidermoid carcinoma) [4] **AND** Large cell non-keratinizing squamous cell carcinoma	Squamous cell carcinoma, large cell, nonkeratinizing **8072**
Squamous cell carcinoma (epidermoid carcinoma) [4] **AND** Small cell nonkeratinizing squamous cell carcinoma	Squamous cell carcinoma, small cell, nonkeratinizing **8073**

[4] Squamous cell carcinoma and epidermoid carcinoma are synonyms.

Table 2: Combination/Mixed Histology Codes

Required Terms	Combination Histologies and Code
Squamous cell carcinoma, keratinizing **AND** Squamous cell carcinoma, non-keratinizing	Squamous cell carcinoma NOS **8070**
Squamous cell (epidermoid) carcinoma [4] [5] **AND** **One or both** of the following: • Sarcomatoid carcinoma • Spindle cell carcinoma	Squamous cell carcinoma, sarcomatoid **8074** • Squamous cell carcinoma, spindle cell

[5] Does **not** include subtypes/variants of SCC.

Table 2: Combination/Mixed Histology Codes

Required Terms	Combination Histologies and Code
Diagnosis must be a single tumor which meets one of the following two criteria: 1. At least two of the below subtypes/variants of adenocarcinoma [6] **AND** percentages of each type are unknown/not stated **OR** they are equal percentages • Acinar adenocarcinoma • Clear cell adenocarcinoma • Lepidic adenocarcinoma [7] • Micropapillary adenocarcinoma • Papillary adenocarcinoma • Solid adenocarcinoma • Well-differentiated fetal adenocarcinoma 2. A combination of histologies **not listed on previous rows** of this table.	Adenocarcinoma with mixed subtypes **8255 (/3)** [8] [9] [10]

[6] Adenocarcinoma NOS may be present in addition to at least two subtypes/variants of adenocarcinoma.
[7] Lepidic adenocarcinoma may or may not have mucinous components.
[8] 8255 is a "last resort" code and does not apply to squamous cell carcinoma NOS and/or subtype/variants of SCC. See the Histology Rules to determine when it is appropriate to use this code for combination histologies other than adenocarcinoma subtypes/variants.
[9] Cancer PathCHART has determined that 8255 is an "unlikely" histology for lung. If 8255 is the correct code per the histology rules, override inter-field edit 25.
[10] The histology terms may be identified as pattern or predominantly.

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).
Note 4: Sarcomatoid carcinoma is most frequently a tumor of the mediastinum, so it is not listed in this table.

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

- Neuroendocrine tumors (NET), Neuroendocrine carcinoma (NEC)
- Large cell neuroendocrine carcinoma/combined large cell neuroendocrine carcinoma
- 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 or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

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

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenocarcinoma 8140 • Minimally invasive adenocarcinoma NOS **(/3)** • Invasive non-mucinous adenocarcinoma **(/3)**	Acinar adenocarcinoma **(for lung only) 8551** • Adenocarcinoma, acinar predominant **(for lung only)** Adenoid cystic **8200** • Adenocystic carcinoma Colloid adenocarcinoma **8480** Enteric adenocarcinoma **8144** • Pulmonary intestinal type adenocarcinoma Fetal adenocarcinoma **8333** Lepidic adenocarcinoma **8250 (/3)** • Adenocarcinoma, lepidic predominant **(/3)** • Non-mucinous adenocarcinoma preinvasive **(/2)** • Non-mucinous adenocarcinoma in situ **(/2)** Micropapillary adenocarcinoma **8265** • Adenocarcinoma micropapillary predominant Mixed invasive mucinous and non-mucinous adenocarcinoma **8254** Mucinous adenocarcinoma **8253 (/3)** • Mucinous adenocarcinoma, in situ **(/2)** • Mucinous adenocarcinoma, preinvasive **(/2)** Mucinous adenocarcinoma, minimally invasive **8257 (/3)** [1] Non-mucinous adenocarcinoma, minimally invasive **8256 (/3)** [2] Papillary adenocarcinoma **8260** • Adenocarcinoma, papillary predominant Solid adenocarcinoma **8230** • Adenocarcinoma, solid predominant

[1] "Mucinous adenocarcinoma, microinvasive" is a non-preferred term. It should be coded to 8257.
[2] "Non-mucinous adenocarcinoma, microinvasive" is a non-preferred term. It should be coded to 8256.

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

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenosquamous carcinoma 8560	
Carcinosarcoma 8980 (/3)	
Diffuse pulmonary lymphangiomatosis 9170 [3]	
Epithelial-myoepithelial carcinoma 8562 [4] • Adenomyoepithelioma • Epimyoepithelial carcinoma • Epithelial-myoepithelial tumor of unproven malignant potential • Malignant mixed tumor comprising epithelial and myoepithelial cells • Pneumocytic adenomyoepithelioma	
Epithelioid hemangioendothelioma 9133	
Giant cell carcinoma 8031	
Hyalinizing clear cell carcinoma 8310	
Intrapulmonary thymoma (arising within lung) 8580 (/3)	

[3] Diffuse pulmonary lymphangiomatosis is a diffuse proliferation of lymphatic channels and smooth muscle along otherwise normal lymphatic vessels of lungs, pleura, and mediastinum. Primarily occurs in infants and children.
[4] 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.

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

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Large cell carcinoma 8012 [5] [6] • Large cell anaplastic carcinoma • Large cell carcinoma NOS • Large cell carcinoma with no additional stains • Large cell carcinoma with null immunohistochemical features • Large cell carcinoma with unclear immunohistochemical features • Large cell undifferentiated carcinoma	
Large cell neuroendocrine carcinoma 8013 [7] • Combined large cell neuroendocrine carcinoma	
Lymphangioleiomyomatosis 9174 (/3) [8]	
Lymphoepithelioma-like carcinoma 8082	
Melanoma 8720	
Mucoepidermoid carcinoma 8430 [9]	
Myoepithelial carcinoma 8982	

[5] 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. A dx of large cell carcinoma is usually followed by further diagnostic testing to identify the subtype/variant.

[6] Large cell carcinoma with neuroendocrine (NE) differentiation lacks NE morphology and should be coded as large cell carcinoma, not large cell neuroendocrine carcinoma.

[7] Per WHO, both large cell neuroendocrine carcinoma NOS and combined large cell neuroendocrine carcinoma are coded 8013. See Table 2 for histologies included in combined large cell neuroendocrine carcinoma.

[8] Locally destructive mesenchymal neoplasm.

[9] As of 1/1/2023, mucoepidermoid tumor is no longer a synonym of mucoepidermoid carcinoma in WHO.

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

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Neuroendocrine carcinoma 8246 • NEC	Combined small cell carcinoma **8045** Small cell carcinoma **8041** • Small cell neuroendocrine carcinoma
Neuroendocrine tumor, NOS 8240 • Bronchial adenoma, carcinoid • Carcinoid NOS • Carcinoid tumor NOS • NET • Neuroendocrine tumor, grade 1 • Neuroendocrine tumor, low grade • Neuroendocrine carcinoma, well differentiated • Typical carcinoid	Atypical carcinoid **8249** • Neuroendocrine tumor, grade 2 • Neuroendocrine tumor, grade 3 • Neuroendocrine carcinoma, moderately differentiated
NUT carcinoma 8023 [10] • 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	

[10] NUT carcinoma is a poorly differentiated carcinoma (often with evidence of squamous differentiation) defined by the presence of nuclear protein in testis (NUT) gene (NUTM1) rearrangement.

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

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
PEComa malignant 8714 (/3) [11] • PEComa of the lung • PEComa, malignant	
Pleomorphic carcinoma 8022 [12]	
Pleuropulmonary blastoma 8973 [13]	
Pulmonary blastoma 8972 (/3) [14]	
Sarcoma NOS 8800 (/3)	Biphasic synovial sarcoma **9043 (/3)** Epithelioid cell synovial sarcoma **9042 (/3)** Pulmonary artery intimal sarcoma **9137 (/3)** • Low grade malignant myxoid endobronchial tumor Pulmonary myxoid sarcoma with EWSR1-CREB1 translocation **8842 (/3)** Spindle cell synovial sarcoma **9041 (/3)** Synovial sarcoma **9040 (/3)**
Spindle cell carcinoma 8032	

[11] Tumor displays perivascular epithelioid (PEC) differentiation.

[12] Pleomorphic carcinoma a subtype of sarcomatoid carcinoma with at least 10% spindle or giant cells, and also has components of adenocarcinoma and/or large cell carcinoma, and squamous carcinoma.

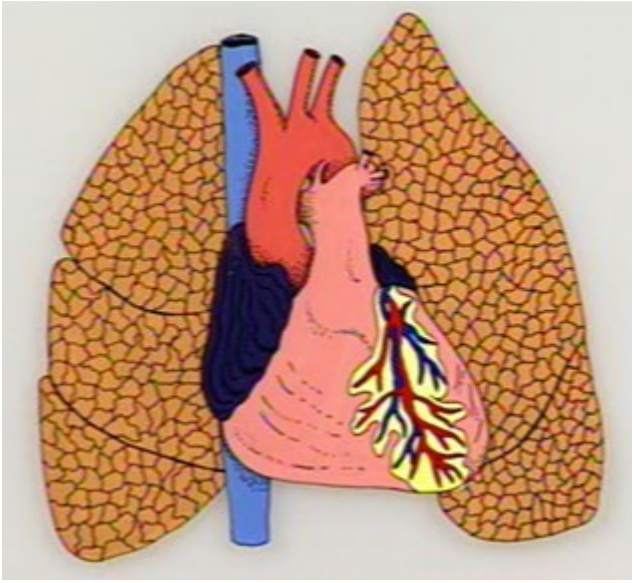
[13] Pleuropulmonary blastoma is an embroynal tumor and differs from pulmonary blastoma.

[14] Pulmonary blastoma is a biphasic tumor that consists of low-grade/WD fetal adenocarcinoma and primitive mesenchymal differentiation (osteosarcoma, chondrosarcoma, or rhabdomyosarcoma).

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

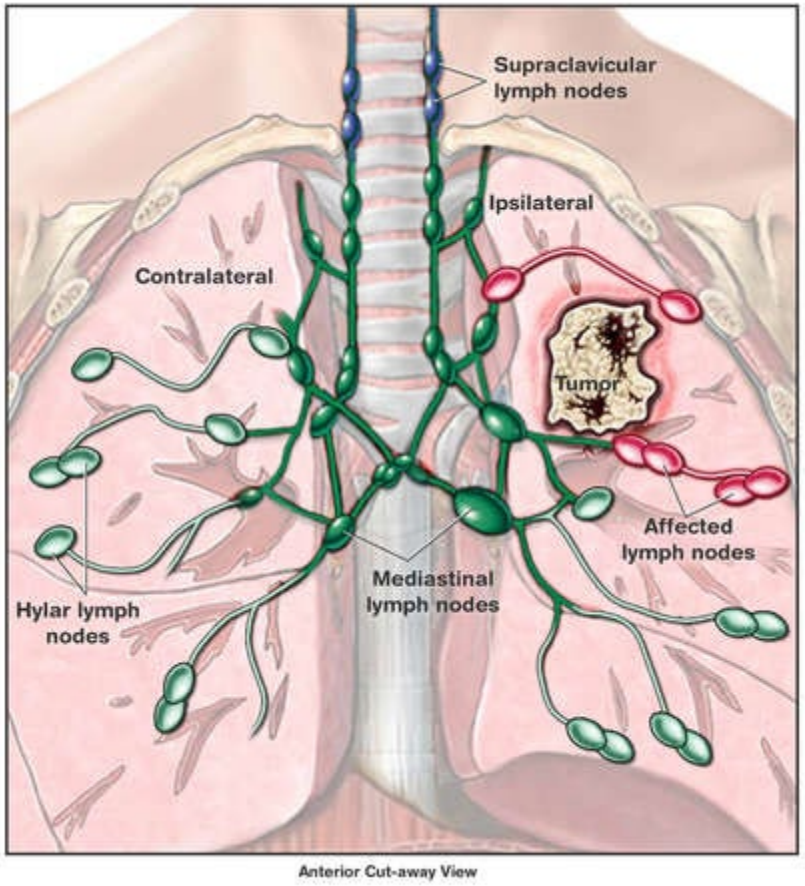
Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Squamous cell carcinoma 8070 • Epidermoid carcinoma • Squamous carcinoma • Squamous cell epithelioma	Basaloid carcinoma **8083** • Basaloid squamous cell carcinoma Keratinizing squamous cell carcinoma **8071** Non-keratinizing carcinoma **8072**
Thoracic SMARCA4-deficient undifferentiated tumor 8044 (/3)	

Illustrations

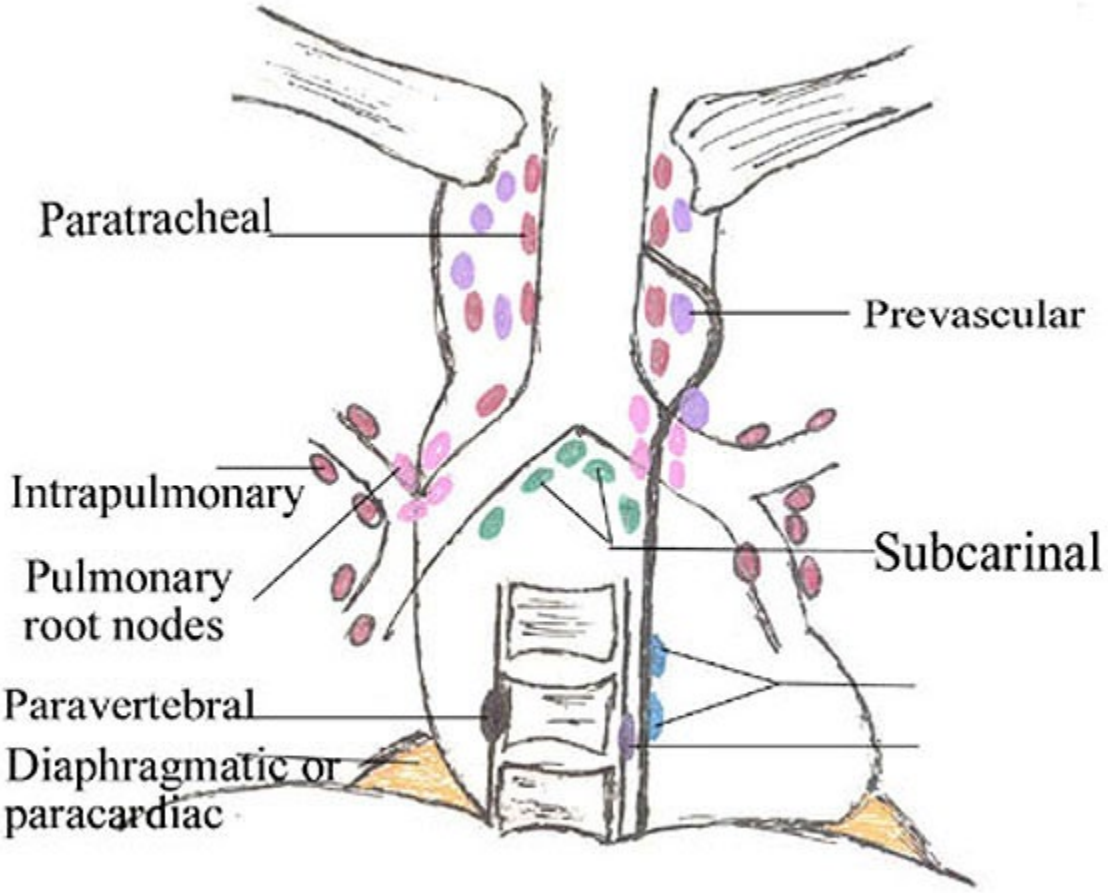


Used with permission

Mediastinum
Used with permission

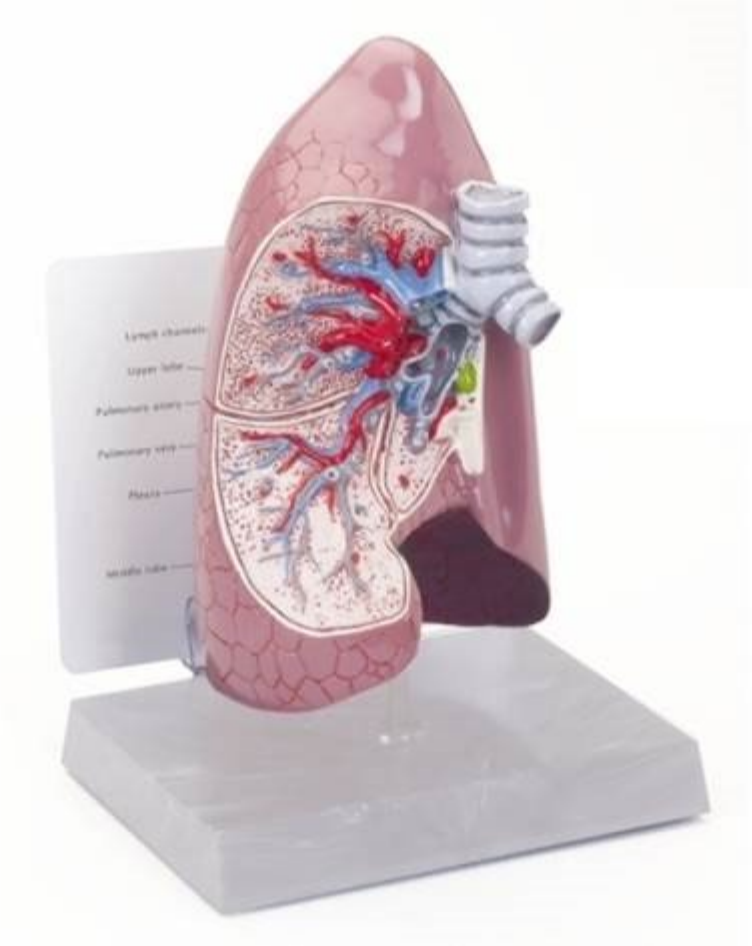


Lymph Nodes Lung
Used with permission

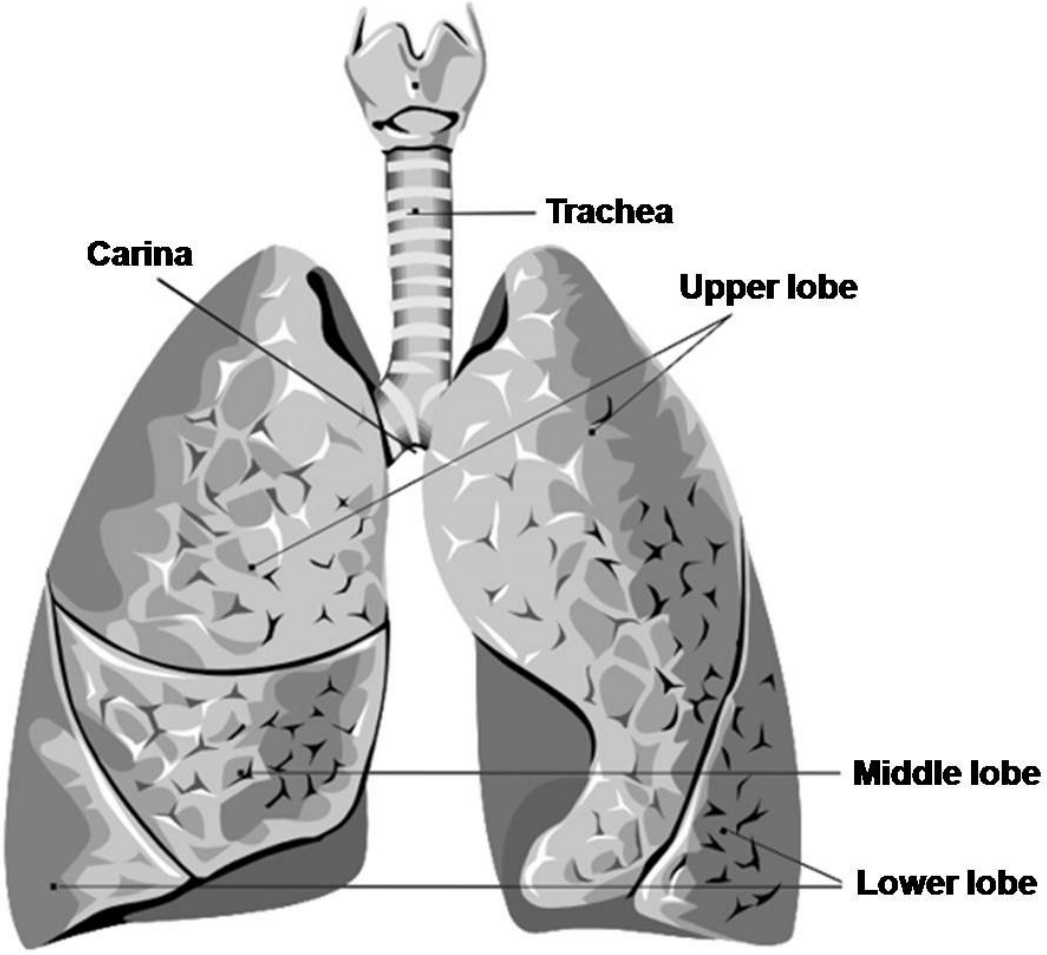


Lung Site-group Instructions
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Inside the Lung
Used with permission



Gross Anatomy of Lung
Used with permission



Lung Site-group Instructions
C340-C343, C348, C349
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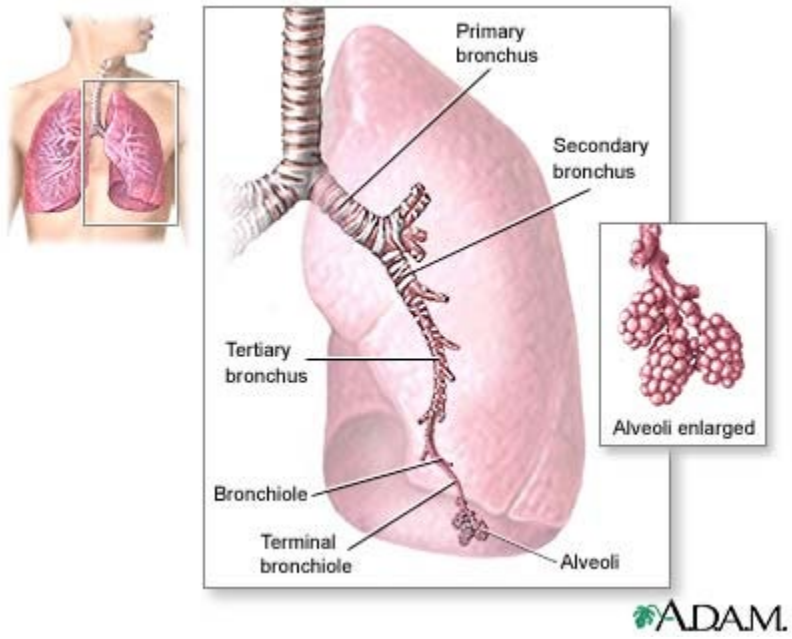
End of Mainstem Bronchus; Start of Terminal/Secondary Bronchus
Used with permission



Lung Multiple Primary Rules
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Note: Metastatic tumors are not included when determining how many tumors are present. Some of the more common sites of metastasis from lung primaries include:

- 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
- Regional or distant lymph nodes as identified in Summary Staging Manual
- Esophagus
- Heart
- Liver
- Trachea

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

Use the histology rules to assign the appropriate histology code.

Lung Multiple Primary Rules
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Single Tumor

Rule M2 Abstract a **single primary** when there is a **single tumor**.
Note 1: A single tumor is always a single primary.
Note 2: The tumor may overlap onto or extend into adjacent/contiguous site or subsites.
Note 3: The tumor may have in situ and invasive components.
Note 4: The tumor may have two or more histologic components.

This is the end of instructions for Single Tumor

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: For those sites which have recognized biomarkers, the biomarkers are most frequently used to target treatment. Follow the rules; do not code multiple primaries or histology based on biomarkers.

Rule M3 Abstract **multiple primaries** when there are **separate, non-contiguous** tumors in sites with ICD-O **site** codes that differ at the second C**X**xx and/or third character Cx**X**x.
Note: When **codes differ** at the second or third characters, the tumors are in **different** primary **sites.**

Rule M4 Abstract **multiple primaries** when the patient has a subsequent tumor after being **clinically disease-free** for greater than **three years** after the original diagnosis or last recurrence.

Note 1: **Clinically** disease-free means that there was **no evidence** of recurrence in the same lung on follow-up.
- Scans are WNL

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.

Rule M5 Abstract **multiple primaries** when there is:
- At least one tumor with:
  - **neuroendocrine carcinoma** or subtype/variant of neuroendocrine carcinoma **OR**
  - **neuroendocrine tumor** or subtype/variant of neuroendocrine tumor
- **AND** there is another tumor with **non-small cell carcinoma** subtypes/variant

Note 1: See note before **Table 3** for the definition of 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** when separate/non-contiguous tumors are two or more **different subtypes/variants** in Column 2, **Table 3** in the Site-group Instructions. Timing is irrelevant.

Note 1: 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 8250/3 is a subtype of adenocarcinoma 8140/3. They are distinctly different histologies. Abstract multiple primaries.

Note 2: The tumors may be different **behaviors:** Acinar adenocarcinoma 8551/3 and mucinous carcinoma, in situ 8253/2 are both subtypes of adenocarcinoma NOS 8140/3 but are distinctly different histologies. Abstract multiple primaries.

Lung Multiple Primary Rules
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M7 Abstract a **single primary** when synchronous, separate/non-contiguous tumors **in the same lung** are on the **same row** in Table 3 in the Site-group Instructions.

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

Note 2: The same row means the tumors are:

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

Rule M8 Abstract **multiple primaries** when separate/non-contiguous tumors are:

- On different rows in Table 3 in the Site-group Instructions
- A combination code in Table 2 and a code from Table 3

Note 1: Timing is irrelevant. Tumors may be synchronous or non-synchronous.

Note 2: Each row in the table is a distinctly different histology.

Example 1: In 2018, the patient has non-mucinous adenocarcinoma **8140/3**. Patient returns in 2019 with large cell carcinoma **8012/3**. These histologies are on different rows in Table 3. Abstract two primaries.

Example 2: In 2017, patient had epithelial-myoepithelial carcinoma **8562** (combination code from Table 2). In 2020, the patient returned with a myoepithelial carcinoma **8982** in the same lung (histology from Table 3). Abstract two primaries.

Rule M9 Abstract a **single primary** 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

EXCEPTION: Do not apply this rule if:

- Pathology from a biopsy or resection proves tumors are different histologies (see previous rule)
- Attending, oncologist, or pulmonologist state unequivocally that the tumors are different primaries. 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 1: Tumors may be combinations of:

- In situ and invasive OR
- NOS and subtype/variant (See Table 3 in the Site-group Instructions)
- Cancer NOS **8000** or carcinoma NOS **8010** and any other histology

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
- Carcinoma NOS **8010** and adenocarcinoma

Note 3: 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.

Note 4: Multiple tumors in the same lung, or both lungs, or single tumor in one lung and multiple tumors in the contralateral lung must be diagnosed **simultaneously (same time) to apply this rule.**

Rule M10 Abstract a **single primary** 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 Site-group Instructions for listings of NOS and subtype/variants.

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

Rule M11 Abstract **multiple primaries** 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
  - 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.

Note 6: Tumors do **not** need to be diagnosed at the same time (do not need to be simultaneous or synchronous).

Rule M12 Abstract a **single primary** (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.

Rule M13 Abstract **multiple primaries** 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** 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

Use the histology rules to assign the appropriate histology code.

Lung Histology Coding Rules
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Priority Order for Using Documents to Identify Histology

IMPORTANT NOTES

1. Code the histology diagnosed ***prior*** to **neoadjuvant treatment.**
   Note 1: Histology changes may occur following immunotherapy, targeted therapy, and radiation therapy.
   Note 2: Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.

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

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

The priority list is used for **single primaries (including multiple tumors abstracted as a single primary)**

Code the **most specific** pathology/tissue from either the 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).

This is a hierarchical list of source documentation.

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

Note 1: Addendums and comments on the pathology report are given highest priority because they often contain additional 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

2. **Cytology** (Fine needle biopsy from primary site, pleural fluid or pericardial fluid)
   Example: Fine needle aspiration shows squamous cell carcinoma and the resection pathology shows invasive adenocarcinoma. Code adenocarcinoma 8140/3.

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

4. **Scan:** The following list is **in priority** order.
   A. CT
   B. PET
   C. MRI
   D. Chest X-ray

5. Code the histology **documented** by the physician when none of the above are available. Use the **documentation** in the following **priority order:**
   A. Treatment Plan
   B. Documentation from Tumor Board
   C. Documentation in the medical record that **refers to original pathology, cytology, or scan(s)**
   D. Physician's **reference to** type of cancer (**histology**) in the medical record
      Note 1: Code the specific histology when documented.
      Note 2: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.

Lung Histology Coding Rules
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Coding Histology

Note 1: The priority is to code the most specific histology. **DO NOT USE BREAST HISTOLOGY CODING RULES FOR THIS SITE.**
Note 2: Only use this section for one or more histologies within a single tumor.
Note 3: Do not use this section in place of the Histology Rules.

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

   Example 1: Diagnosis for a single tumor is adenocarcinoma 8140 with the majority or predominant part of tumor being acinar adenocarcinoma 8551. Code the subtype/variant: acinar adenocarcinoma 8551.

   Example 2: Diagnosis for a single tumor is squamous cell carcinoma 8070 with minority of tumor being keratinizing squamous cell carcinoma 8071. Code the subtype/variant: keratinizing squamous cell carcinoma 8071.

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

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

   Example: When the diagnosis is adenocarcinoma with a component of medullary **carcinoma**, code medullary carcinoma 8510.

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

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

2. **Code** the histology described as **differentiation** or **features/features of ONLY** when there is a specific ICD-O code for the "NOS with ____ features" or "NOS with ____ differentiation".
   Note: Do not code differentiation or features when there is no specific ICD-O code.

3. Code the specific histology described by **ambiguous terminology** (list follows) **ONLY** when A or B is true:
   A. The only diagnosis available is **one histology** term described by ambiguous terminology
      - CoC and SEER require reporting of cases diagnosed only by ambiguous terminology
      - Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

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

   If the specific histology does not meet the criteria in #3B, then code the NOS histology.

See the **Ambiguous Terminology** section of the General Instructions for instructions and examples on when ambiguous terms and definitive terms may be used to assign histology.

Table 24: List of Ambiguous Terminology

Ambiguous Terminology	
Appears	Presumed
Cannot rule out	Suspicious (for)
Likely	Suggestive of
Favor(s)	

Note 1: Table 25 below includes terms previously included in the list of ambiguous terms. These terms should be treated as supporting a definitive diagnosis of a histologic subtype. A definitive term does not require clinical verification of the subtype or variant.

Note 2: The terms in Table 25 were removed from the list of ambiguous terms and added to a list of definitive terminology based on the recommendation of a panel of pathologists and subject matter experts.

Table 25: List of Definitive Terminology

Definitive Terminology	
Comparable with	Most likely
Compatible with	Probable
Consistent with	Typical (of)

4. **DO NOT CODE** histology described as:
    - Architecture
    - Foci; focus; focal
    - Pattern (**Exceptions** below)
        - Acinar pattern: Adenocarcinoma, acinar predominant **8551**
        - Lepidic (growth) pattern: Adenocarcinoma, lepidic predominant **8250**
        - Micropapillary pattern: Adenocarcinoma, micropapillary predominant **8265**
        - Papillary pattern: Adenocarcinoma, papillary predominant **8260**
        - Solid pattern: Adenocarcinoma, solid predominant **8230**

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: When mucinous carcinoma is mixed with another histology, such as adenocarcinoma and mucinous carcinoma, code mucinous **ONLY** when mucinous is **documented** to be **greater than 50%** of the tumor.

Note 2: These **new codes and terms** will allow mucinous adenocarcinoma to be analyzed separately from colloid carcinoma.

Note 3: 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.

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

Note 1: If the case does not meet the criteria in the first two bullets, code non-small cell lung cancer (NSCLC) 8046.

Note 2: If the case is accessioned (added to your database) based on a **single histology** described by ambiguous terminology and no other histology information is available/documented, then code that histology.

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 **Note 2**.

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.

Note 5: Single histologies identified as pattern should be coded. This applies to the following histologies only: acinar adenocarcinoma, lepidic adenocarcinoma, micropapillary adenocarcinoma, papillary carcinoma, and solid adenocarcinoma.

Note 6: When the histology is carcinoma in situ NOS, code histology to 8010/3. Cancer PathCHART has determined that carcinoma in situ 8010/2 is biologically impossible and will not pass edits.

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**.

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
- Neuroendocrine carcinoma (NEC) **8246** and a subtype/variant of NEC
- Neuroendocrine tumor (NET) **8240** and a subtype/variant of NET
- Squamous cell carcinoma **8070** and a subtype/variant of squamous cell carcinoma

Note: See **Table 3** in the Site-group Instructions to find NOS and subtypes/variants.

Rule H7 Code the histology that comprises the **greatest percentage** of tumor when two or more of the following histologies are present:

- Acinar adenocarcinoma / Adenocarcinoma, acinar predominant **8551**
- Lepidic adenocarcinoma / Adenocarcinoma, lepidic predominant **8250**
- Micropapillary adenocarcinoma / Adenocarcinoma, micropapillary predominant **8265**
- Papillary adenocarcinoma / Adenocarcinoma, papillary predominant **8260**
- Solid adenocarcinoma / Adenocarcinoma, solid predominant **8230**

Note 1: The rules are hierarchical, so the tumors are **NOT** a NOS and subtype/variant.

Note 2: If the percentages are unknown/not documented, or are equal percentages, continue through the rules.

Note 3: CAP Lung Protocol now allows pathologists to identify the bulleted histologies as **pattern** along with percentages. The histology pattern with the greatest percentage can be coded. This is an **exception** to the histology coding instruction to not code pattern.

Example 1: Pathology reads the tumor is adenocarcinoma, acinar predominant (acinar 60%, solid predominant 20%, lepidic predominant 20%). Code the histology with the highest percentage: acinar adenocarcinoma 8551/3.

Example 2: Pathology reads the tumor is adenocarcinoma, solid predominant (with acinar, lepidic, and papillary subtypes). Code the predominant histology: solid adenocarcinoma 8230/3.

Example 3: Pathology reads the tumor is adenocarcinoma, lepidic prominent 80%, solid predominant 20% and the synoptic report states lepidic pattern 80%, solid pattern 20%. Code the histology with the higher pattern percentage: lepidic adenocarcinoma 8250/3.

Rule H8 Code a **combination** code when there are multiple histologies **AND**

- The combination is listed in **Table 2** in Site-group Instructions, 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 H9 Code adenocarcinoma with mixed subtypes **8255** for

- Multiple adenocarcinoma subtypes **OR**
- Any combination of histologies which are not listed in Table 2 in the Site-group Instructions.

Note 1: Any combination of histologies listed in H7 with equal percentages is coded 8255.

Note 3: Adenocarcinoma with mixed subtypes 8255 does not apply to squamous cell carcinoma.

Note 2: Cancer PathCHART has determined that 8255 is an "unlikely" histology for lung primary sites. If 8255 is the appropriate code per the histology rules, override the inter-field edit 25 (IF25).

This is the end of instructions for Single Tumor

Code the histology using the rule that fits the case.

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 H10 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 H11 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.

Rule H12 Code the specific histology when the diagnosis for the tumor 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 a single histology described by ambiguous terminology and no other histology information is available/documented
  Note: If the case does not meet the criteria in the first two bullets, code non-small cell lung cancer (NSCLC) **8046**.

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 H13 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.

Note 4: When the histology is **carcinoma in situ NOS**, code histology to 8010/3. Cancer PathCHART review has determined carcinoma in situ 8010/2 is biologically impossible and will not pass edits.

Rule H14 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.

Rule H15 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
- Neuroendocrine carcinoma (NEC) **8246** and a subtype/variant of NEC
- Neuroendocrine tumor (NET) **8240** and a subtype/variant of 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 Site-group Instructions to find NOS and subtypes/variants.

Rule H16 Code the appropriate **combination code** when all tumors have multiple histologies **AND**

- The combination is listed in **Table 2** in Site-group Instructions, the ICD-O and all updates, **OR**
- You received a combination code from **Ask a SEER Registrar**.

Note 1: The rules are hierarchical. Use this rule **only** when previous rules do not apply.

Note 2: Cancer PathCHART has determined that 8255 is an "unlikely" histology for lung primary sites. If 8255 is the appropriate code per the histology rules, override the inter-field edit 25 (IF25).

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

Code the histology using the rule that fits the case.

Malignant CNS and Peripheral Nerves Site-group Instructions
C470-C479, C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Introduction

Note 1: This site group includes the following **primary sites**: Peripheral nerves C470-C479; cerebral meninges C700; spinal meninges C701; meninges NOS C709; brain C710-C719; spinal cord C720; cauda equina C721; olfactory nerve C722; optic nerve C723; acoustic nerve C724; cranial nerve NOS C725; overlapping lesion of brain and central nervous system C728; nervous system NOS C729; pituitary gland C751; craniopharyngeal duct C752; pineal gland C753.

Note 2: Non-malignant intracranial and CNS tumors have a separate set of rules.

Note 3: There **must be** a histologic, cytologic, radiographic, or clinical **diagnosis** of a **malignant** neoplasm /3.

Note 4: Tumors from a number of primary sites metastasize to the brain. Do not use these rules for tumors described as metastases; report metastatic tumors using the rules for that primary site.

Note 5: **Pilocytic astrocytoma/juvenile pilocytic astrocytoma** is reportable in North America as a **malignant** neoplasm 9421/3.

- See the Non-malignant CNS Rules when the primary site is optic nerve and the diagnosis is either optic glioma or pilocytic astrocytoma. The behavior for these tumors is non-malignant and coded 9421/1.
- **IMPORTANT FOR 2023 FORWARD: Beginning 1/1/2023, all cases diagnosed with pilocytic astrocytoma/juvenile pilocytic astrocytoma and new related terminology are to be reported with behavior /1. They will no longer be collected with malignant behavior (/3). See the Non-malignant CNS Rules.**

Note 6: Do not use this site group for coding paragangliomas.

Note 7: Use this site group for histologies other than paraganglioma arising in C47_.

Notes continued on next page

Note 8: Diffuse gliomas, medulloblastomas and other embryonal tumors underwent major restructuring in the 2016 CNS WHO blue book. New entities were incorporated that are defined by both histology and molecular features, including glioblastoma, IDH-wildtype and glioblastoma, IDH-mutant; diffuse midline glioma, H3 K27M-mutant, RELA fusion-positive ependymoma, medulloblastoma, WNT-activated and medulloblastoma, SHH-activated, and embryonal tumor with multilayered rosettes, C19MC-altered. The 2016 edition added newly recognized neoplasms and referred to some entities, variants and patterns as "not recommended" (previously called obsolete).

- It has been determined that these "not recommended" terms no longer have diagnostic and/or biological relevance. For example, gliomatosis cerebri is a term which is no longer recommended. Gliomatosis cerebri is now termed a "growth pattern" rather than a histologic type.
- Terms which are not recommended are not included in the tables. When one of these terms are used, refer to the ICD-O and all updates for the correct histology code. For example, glioma NOS is an umbrella term for all gliomas and astrocytomas. Glioma NOS is not recommended because diagnostic methodology is able to determine a more specific diagnosis.

Note 9: Beginning with cases diagnosed 1/1/2023, pilocytic astrocytoma/juvenile pilocytic astrocytoma are **no longer reported as malignant (/3)**. These neoplasms will continue to be reportable with a behavior of /1. Historically, pilocytic astrocytomas were coded as 9421/3 from 1976-2000. Beginning in 2001 with the release of ICD-O-3, WHO changed the behavior to /1; however, the standard setters opted to continue collecting these cases using malignant /3 behavior through 12/31/2022.

Note 10: WHO 5th Ed CNS Tumors has assigned a new histology to 9421/3. Beginning with cases diagnosed 1/1/2023, for surveillance purposes, code **9421/3** will be valid for the following histology ***only:***

- High Grade astrocytoma with piloid features (HGAP)

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**.
- Cerebrospinal fluid; CSF
- Dura; meninges
- Extradural; not within the meninges; within the cranium; within the skull but not within the cerebral meninges
- Extramedullary; outside medulla oblongata C700
- Infratentorial; below the tentorium cerebelli; either cerebellum or brainstem
- Intracranial; within the skull, within the cranium
- Intradural; between layers of the cerebral meninges; C700
- Intradural-extramedullary; within the spinal canal but outside of the nerves
- Intraspinal; occurring within the spinal column especially the vertebral canal; spinal nerve roots
- Site; topography
- Supratentorial; above the tentorium cerebelli; cerebrum
  - Cerebrum contains frontal lobe, parietal lobe, occipital lobe, and temporal lobe
- Tentorium cerebelli; cerebellar tentorium
- Tumor; mass; lesion; neoplasm when
  - These terms are used ONLY to determine multiple primaries
  - Do not use these terms for casefinding or determining reportability
- Type; subtype; variant
- WHO Grade 3 and WHO Grade 4; malignant; invasive; /3

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Terms That Are NOT Equivalent or Equal

- **Component** is not equivalent to **subtype/type/variant**
  Note: Component is only coded when the pathologist specifies the component as a second **malignancy**.
- **Phenotype** is not equivalent to **subtype/type/variant**
- **WHO Grade** is not equivalent to **tumor grade**

Reportability Criteria

CNS neoplasms must meet **ALL three of the conditions below** to be **reported as malignant /3**:

1. The **behavior** must be malignant /3. See **Behavior Code** section.
   Note: **Never report** a **malignant** /3 behavior code for a meningioma **based on tumor extension** to brain, skin of scalp, or other regional organs/tissue. Non-malignant CNS tumors can extend to the regional tissue and bone.
2. The **primary site** must be reportable (See **Section 1**: **Table 1**)
3. The **histology** must be reportable (See **Section 1**: **Table 2**)

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Behavior Code

Note: Behavior determines which set of CNS rules should be used: malignant or non-malignant.

Instructions for using source **documentation** to determine behavior are in **priority order.** Start with Instruction 1 and **STOP** when you reach the instruction that applies to the case being abstracted. For example, when the **resection pathology** specifies behavior, use Instruction 1. There is no need to move on to Instructions 2-5.

Priority Order for Using Documentation to Assign Behavior

1. Pathology: Tissue from **resection**
   A. Use the pathologist's **description** of **malignant/invasive** behavior
   B. Cases are reportable as malignant when pathology states a WHO Grade 3 or 4
      i. WHO Grade 2 may be either non-malignant or malignant. Use the pathologist's description of behavior first. When the pathologist's description of behavior is not available and the CNS tumor is stated to be WHO Grade 2, code the corresponding ICD-O histology code and behavior listed in ICD-O, ICD-O updates, or solid tumor rules. Code the WHO Grade in the appropriate SSDI data field.
      Example: Astrocytoma, IDH-mutant NOS, Grade 2 - code 9400/3
   C. **Never change behavior** described by pathologist
2. Pathology: Tissue from **biopsy**
   A. See A and B above.
3. Cytology (usually cerebrospinal fluid)
   A. See A and B above.
4. Physician's documentation (no pathology report) in the following priority order:
   A. Tumor Board
   B. Documentation of original pathologic diagnosis and behavior
      Example: Pathology report is not in the medical record. Oncology consult states biopsy was done in a different facility and cites the **original pathology** diagnosis including the **behavior**.
   C. Documentation of behavior, no mention of original diagnosis
      Example: Pathology report is not in the medical record. **Physician documents** the **behavior** as malignant, or WHO Grade 3 or 4, but **does not cite/mention original** pathology report as source of behavior classification.

5. **Scans**, in the following **priority order**:
   A. MRI
   B. CT
   C. PET
   D. Angiogram
6. When instructions **1-5 do not apply**, use **CNS CAP Protocol** to determine behavior. See **WHO Grades for Select CNS Neoplasms**.

   Example 1: Biopsy of tumor shows Meningioma, WHO Grade 3. Assign behavior to /3 based on WHO Grade 3.

   Example 2: CT shows a meningioma located over the temporal lobe. No further work-up or treatment. Assign behavior as /1 since meningioma is listed with behavior /1 in the ICD O 3.2.

WHO Grades for Select CNS Neoplasms

Note 1: CNS WHO classifications use a grading scheme that is a "malignancy scale" ranging across a wide variety of neoplasms rather than a strict histologic grading system that can be applied equally to all tumor types.

Note 2: See the SEER and COC Manuals for instructions on coding grade for CNS tumors.

Note 3: WHO does not provide Grades for all CNS and peripheral nerve neoplasms.

Note 4: Refer to the **CNS CAP Protocol** to code behavior based on WHO grade for specific histologies when grade is not available. The table in the CAP protocol for CNS tumors should only be used for histologies listed in the table. If a histology is listed with a single WHO Grade, the Grade listed may be used to assign grade.

Example 1: Choroid plexus carcinoma, listed as WHO Grade 3 in the table, code behavior to malignant (/3).
Example 2: Papillary meningioma can have a WHO Grade of 1, 2, or 3. The CNS CAP Protocol Table should not be used to determine grade for this histology.

WHO Grade Definitions

WHO Grade	Definition
WHO Grade 1	Non-malignant (/0 or /1) (See **Non-malignant CNS** site-group)
WHO Grade 2	Malignant or Non-malignant
WHO Grade 3	Malignant (/3)
WHO Grade 4	Malignant (/3)

Refer to the most current version of the **CNS CAP Protocol** for WHO grading of some of the more common CNS tumors.

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Directory of Sections and Tables

Information is presented in the general order in which a case is abstracted.

Malignant CNS and Peripheral Nerves Site-group Instructions
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Section 1: Reportable Primary Sites and Histologies

After determining behavior code, the next step is to confirm both the primary site and the histology are reportable.

Note 1: **Peripheral nerves** are included in the Malignant CNS and Peripheral Nerve rules because:

- **All malignant** tumors are reportable, including peripheral nerve tumors **AND**
- The Malignant CNS and Peripheral Nerve **rules** contain the **correct histologies** and coding **rules** for tumors of **peripheral nerves and meninges/dura.**

Note 2: **Peripheral nerves** are:

- **Extracranial**/outside the cranium **OR**
- **Extradural**/outside the spinal dura

Note 3: The following **malignant meningiomas** are reportable:

- **Intraosseous**
  Note: The **dura** layer of the meninges **contacts** the **endosteum** of the bones of the skull. The primary site for intraosseous meningioma is cranial meninges C700.
- **Sphenoid wing**
  Note 1: Sphenoid wing meningiomas arise in the **cranial meninges** C700 which covers the bony structure called the sphenoid wing.
  Note 2: The term "sphenoid wing meningioma" is used to identify the **location** of the meningioma because sphenoid wing meningiomas may be very **invasive**, spreading to the dura of the frontal, temporal and orbital regions.
- **Cavernous sinus**
  Note 1: Cavernous sinus is located between the endosteal and meningeal layers of the dura.
  Note 2: There is **no ICD-O site** code for cavernous sinus because tumors do not arise in the sinus itself; the primary sites are:
  - The **cranial nerves** passing through the sinus (trochlear, abducent **C725**) **OR**
  - The cerebral **meninges/dura C700** covering the cranial nerve

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(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Priorities for Coding Primary Site

Note 1: **Always** check the **operative report(s)** which will have **information** on whether the surgery or biopsy was **intracranial** (inside the cranium/skull) or **intraspinal** (within the dura/meninges covering the spinal cord).

Note 2: Code **the specific primary site**. Use an **NOS** site code **only** when a specific site is not known.

Use the list in **hierarchical order**:

1. **Resection**
   A. Operative report(s)
   B. Pathology report(s)
2. **Biopsy**
   A. Operative report(s)
   B. Pathology report(s)
3. Resection and/or biopsy performed, but operative report(s) and pathology are not available (minimal information)
   A. Tumor Board
   B. Code from physician's documentation of **original diagnosis** from operative or pathology report OR
   C. Physician's **documentation of primary site** in the medical record

   Example: The patient had a **biopsy** done at **another facility**. The operative and pathology reports are not in the medical record. The **attending documents** that the patient had a biopsy of a **cerebral meningioma** at a different facility. Code the primary site cerebral meninges C700.
4. For cases diagnosed by imaging (**no pathology/resection or biopsy**) use information from scans in the following priority order:
   A. MRI
   B. CT
   C. PET
   D. Angiogram
5. See **Table 1**: **Reportable Primary Sites** to confirm the primary site is reportable.
6. When the primary site is cranial nerve **OR** peripheral nerve, see **Table 3**: **Coding Primary Site for Malignant Tumors of Cranial and Peripheral Nerves** to determine whether the portion of the nerve is cranial or peripheral (different site codes).

Reportable Primary Site Groups

The three major groups of reportable sites are:

1. **Intracranial** (within the skull/cranium) **AND**
2. **Spinal sites** (spinal meninges and sites within the spinal meninges)
3. **Peripheral nerves** (extracranial or extraspinal nerves)**.**

Terms and sites for these broad categories are:

Reportable Primary Sites and their ICD-O Codes

1. Intracranial (intra means inside or within; intracranial is inside the skull).
   A. **Cerebral/cranial dura/meninges** C700. The cerebral meninges has three layers:
      i. **Dura** mater is the **superficial** layer of meninges
         - Tightly adherent to skull
         - Contains folds and **sinuses**
         - Contacts **endosteum** which lines the bones of the skull
      ii. **Arachnoid** mater forms the middle of the three layers of meninges
      iii. **Pia** mater is the delicate vascular fibrous membrane which is adherent to the brain.
   B. **Brain** C710-C719
   C. **Cranial nerves** C722-C729. See **Table 3: Coding Primary Site for Malignant Tumors of Cranial and Peripheral Nerves**
   D. **Intracranial glands C751-C753**
      i. Craniopharyngeal duct C752
      ii. Pineal gland C753
      iii. Pituitary gland C751

Continued on next page

2. **Spinal** sites: includes the **spinal meninges** and **all** structures **within** the meninges (Intradural, within/in the spinal meninges).
   A. **Spinal cord C720**
   B. **Spinal meninges C701** covers/encloses the spinal nerve roots and the spinal cord.
   C. Spinal nerve roots:
      i. **Cervical** nerve, 8 pair, occipital nerve. Code to peripheral nerve of head, face, and neck C470
      ii. **Coccygeal** nerve, 1 pair. Code to cauda equina C721
      iii. **Lumbar** nerve, 5 pair. Code to cauda equina C721
      iv. **Sacral** nerve, 5 pair. Code to cauda equina C721
      v. **Thoracic** nerve, 12 pair. Code to peripheral nerves of thorax C473

3. **Peripheral nerves**
      i. **Cervical** nerve, 8 pair, occipital nerve. Code to peripheral nerve of head, face, and neck C470
      ii. **Thoracic** nerve, 12 pair. Code to peripheral nerves of thorax C473
      iii. **Lumbar** nerve, 5 pair. Code to cauda equina C721
      iv. **Sacral** nerve, 5 pair. Code to cauda equina C721
      v. **Coccygeal** nerve, 1 pair. Code to cauda equina C721

Table 1: Reportable Primary Sites

Use Table 1 to **determine** whether a primary site is **reportable.**

Site Group	Reportable Subsite Terms and Code
Brain	Brain NOS **C719** Brain stem **C717** Cerebellum NOS **C716** Cerebrum **C710** Frontal lobe **C711** Occipital lobe **C714** Overlapping lesion of brain **C718** Parietal lobe **C713** Temporal lobe **C712** Ventricle NOS **C715**
Cranial Nerves **Row continues on next page**	Abducent (cranial nerve VI) **C725** Accessory (cranial nerve XI) **C725** Acoustic (cranial nerve VIII) **C724** Cranial nerve NOS **C725** Facial (cranial nerve VII) **C725** Glossopharyngeal (cranial nerve IX) **C725** Hypoglossal (cranial nerve XII) **C725** Oculomotor (cranial nerve III) **C725** **Row continues on next page**

Table 1: Reportable Primary Sites

Site Group	Reportable Subsite Terms and Code
Cranial Nerves **(continued)**	Olfactory (cranial nerve I) **C722** Optic (cranial nerve II) **C723** Trigeminal (cranial nerve V) **C725** Trochlear (cranial nerve IV) **C725** Vagus (cranial nerve X) **C725**
Ill-Defined Sites Central Nervous System	Nervous system NOS **C729** Overlapping lesion of brain and central nervous system **C728**
Intracranial Duct and Glands	Craniopharyngeal duct **C752** Pineal gland **C753** Pituitary gland **C751**
Meninges	Cerebral meninges **C700** Meninges NOS **C709** Spinal meninges **C701**

Malignant CNS and Peripheral Nerves Site-group Instructions
C470-C479, C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Table 1: Reportable Primary Sites

Site Group	Reportable Subsite Terms and Code
Peripheral Nerve and Autonomic Nervous System	Abdomen **C474** Autonomic nervous system NOS **C479** Head, face and neck **C470** Lower limb and hip **C472** Nerves of pelvis **C475** Overlapping lesion of peripheral nerves and autonomic nervous system **C478** Thorax **C473** Trunk NOS **C476** Upper limbs and shoulder **C471** Spinal Nerve NOS **C479**
Spinal Sites	Cauda equina **C721** Conus medullaris/filum terminale **C720** Meninges NOS **C709** Spinal cord **C720** Spinal meninges **C701**

Table 2: Specific Histologies, NOS, and Subtypes/Variants

Table 2 lists the more common histologies for CNS and Peripheral Nerves. For hematopoietic neoplasms such as lymphomas, myelomas, etc., see the **Hematopoietic Database.**

Note: Behavior codes are not listed because all histologies are **malignant /3.**

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do not have behavior codes next to the term unless the term has only one possible behavior (/3)
- Subtypes or variants of the NOS histologies in column 2 are also indented under the NOS histology and have a full 4-digit histology code (see Note 3). The behavior code (/1 or /3) is included with the 4-digit histology code if the term has only one possible behavior.

Note 1: Rare histologies may not be listed in the table. When a histology term is not found, reference ICD-O and all updates. All histologies are malignant/invasive (/3).

Note 2: Submit a question to **Ask a SEER Registrar** when the histology is not found in Table 3, ICD-O or all updates.

Note 3: Column 2 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 leiomyosarcoma 8890/3 (column 2). Leiomyosarcoma is also a NOS because it has subtypes/variants. The subtypes/variants are indented under the NOS (rhabdomyosarcoma) in column 2.

Table 2: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Anaplastic ganglioglioma 9505	
Astroblastoma 9430 • Astroblastoma, MN1-altered	
Astrocytoma NOS 9400 [1] • Astrocytoma, IDH-mutant, grade 2 • Diffuse astrocytoma IDH-mutant • Diffuse astrocytoma IDH-wildtype • Diffuse astrocytoma NOS	Anaplastic astrocytoma IDH-mutant **9401** • Anaplastic astrocytoma IDH-wildtype • Anaplastic astrocytoma NOS Astrocytoma, IDH-mutant, grade 3 **9401** Astrocytoma, IDH-mutant, grade 4 **9445** Gemistocytic astrocytoma IDH-mutant **9411** Pleomorphic xanthroastrocytoma **9424** • Anaplastic pleomorphic xanthroastrocytoma
Cauda equina neuroendocrine tumor 8693 (/3) [2]	
Choriocarcinoma 9100	
Choroid plexus carcinoma 9390	
CNS embryonal tumor with rhabdoid features 9508 • Atypical teratoid/rhabdoid tumor • Embryonal tumor with rhabdoid features	

[1] Pathologists may use the terms glioma and astrocytoma interchangeably. These terms are equal/equivalent only when they are used to describe a synonym of astrocytoma or subtype/variant of astrocytoma. The terms glioma NOS and astrocytoma NOS are not equal/equivalent terms.

[2] This neoplasm is coded with /3 behavior even though it is a WHO Grade 1.

Table 2: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
CNS ganglioneuroblastoma 9490	CNS embryonal tumor NEC **9473** • CNS embryonal tumor NOS
CNS neuroblastoma 9500 • CNS neuroblastoma, FOXR2-activated • CNS Tumor with BCOR internal tandem duplication	
Diffuse leptomeningeal glioneuronal tumor 9509 [3] • DLGNT	
Diffuse midline glioma H3 K27M mutant 9385 • Diffuse hemispheric glioma, H3 G34-mutant • Diffuse intrinsic pontine glioma • Diffuse pediatric-type high grade glioma, H3-wildtype and IDH-wildtype • DIPG • Infant-type hemispheric glioma	
Embryonal carcinoma 9070	Yolk sac tumor **9071**
Embryonal tumor with multilayered rosettes C19MC-altered 9478 • Embryonal tumor with multilayered rosettes NOS • ETMR	

[3] Cases diagnosed prior to 1/1/2023 are coded 9509/1. See the non-malignant CNS rules. Cases diagnosed 1/1/2023 forward are coded 9509/3.

Table 2: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Ependymoma 9391 • Clear cell ependymoma • Posterior fossa ependymoma NOS • Spinal ependymoma, NOS • Supratentorial ependymoma NOS • Tanycytic ependymoma	Anaplastic ependymoma **9392** Ependymoma, RELA fusion-positive **9396** • Posterior fossa group A (PFA) ependymoma • Posterior fossa group B (PFB) ependymoma • Spinal ependymoma, MYCN-amplified • Supratentorial ependymoma, YAP1 fusion-positive • Supratentorial ependymoma, ZFTA fusion-positive Papillary ependymoma **9393**
Epithelioid hemangioendothelioma 9133	
Germinoma 9064	
Glioblastoma NOS 9440 • GBM • Glioblastoma multiforme • Glioblastoma, IDH wild-type • Epithelioid glioblastoma	Giant cell glioblastoma **9441** Glioblastoma IDH-mutant **9445** Gliosarcoma **9442**
Glioma NOS 9380 [4] [5] [6]	

[4] Glioma NOS is considered an umbrella term. Additional testing should be performed to identify mutations and biomarkers that would provide a definitive type. A diagnosis of glioma NOS is not recommended and may be used only when additional test were inconclusive.

[5] Cancer PathCHART expert review determined site/histology combination of glioma and CNS is unlikely and if coded, will trigger the IF25 edit. If review of the case confirms glioma, override the edit.

[6] IMPORTANT: See M rules to determine multiple primaries.

Table 2: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
High-grade astrocytoma with piloid features 9421 (/3) [7] • HGAP	
Immature teratoma 9080	Mixed germ cell tumor **9085** Teratoma with malignant transformation **9084**
Malignant meningioma 9530 • Anaplastic meningioma	Papillary meningioma **9538** • Rhabdoid meningioma
Malignant peripheral nerve sheath tumor 9540 • Malignant melanotic nerve sheath tumor • Malignant perineurioma • MPNST • MPNST with perineural differentiation	Epithelioid malignant peripheral nerve sheath tumor **9542**

[7] This term is reportable for cases diagnosed 1/1/2023 forward.

Table 2: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Medulloblastoma NOS 9470 • Classic medulloblastoma • Medulloblastoma, histologically defined	Anaplastic medulloblastoma **9474** • Large cell medulloblastoma Medulloblastoma described as one of the following **9471** • Desmoplastic nodular medulloblastoma • Medulloblastoma with extensive nodularity • Medulloblastoma, SHH-activated and TP53- wildtype Medulloblastoma non-WNT/non-SHH **9477** • Medulloblastoma group 3 • Medulloblastoma group 4 Medulloblastoma SHH-activated and TP53-mutant **9476** Medulloblastoma WNT-activated **9475**
Medulloepithelioma 9501	
Meningeal melanoma 8720	
Neuroepithelial tumor, malignant 8000 (/3) [8]	
Oligoastrocytoma NOS 9382 • Anaplastic oligoastrocytoma NOS	

[8] Neuroepithelial tumor is a rare tumor specific to children. These neoplasms have numerous subtypes which are not easily identified so a specific type may not be identified on the pathology report. WHO has not proposed an ICD-O code for this entity. The current option is to assign code 8000. Because these tumors are different, they are on a separate row.

Table 2: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Oligodendroglioma NOS 9450 [9] • Oligodendroglioma 1p/19q-codeleted • Oligodendroglioma IDH-mutant • Oligodendroglioma IDH-mutant and 1p/19q-codeleted, grade 2	Anaplastic oligodendroglioma NOS **9451** • Anaplastic oligodendroglioma, IDH-mutant 1p/19q-codeleted • Anaplastic oligodendroglioma, IDH-mutant and 1p/19q-codeleted • Oligodendroglioma, IDH-mutant and 1p/19q-codeleted, grade 3
Peripheral primitive neuroectodermal tumor 9364 • Ewing sarcoma • pPNET	
Pilocytic astrocytoma 9421[10] [11]	Pilomyxoid astrocytoma **9425**
Pineal parenchymal tumor of intermediate differentiation 9362 • Pineoblastoma	Papillary tumor of the pineal region **9395**
Pituitary adenoma/pituitary neuroendocrine tumor 8272 (/3) [12] • PitNET • Pituitary adenoma/PitNET	

[9] Oligodendroglioma NOS is used when molecular markers cannot fully be determined.
[10] ICD-O-3 lists a behavior code of /1. It is collected as /3 in North America for cases diagnosed prior to 1/1/2023.
[11] Beginning with cases diagnosed 1/1/2023 forward, pilocytic astrocytoma will no longer be reported with /3 behavior. Pilocytic astrocytoma and the related terms listed below are to be reported as a /1
- Diffuse astrocytoma, MTB- or MYBL1-altered
- Diffuse low-grade glioma, MAPK pathway- altered+

[12] A diagnosis of pituitary adenoma NOS is coded 8272/0. A diagnosis of pituitary adenoma/PitNET (this is a single term) or PitNET is coded 8272/3.

Table 2: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Sarcoma NOS 8800	Angiosarcoma **9120** Chondrosarcoma **9220** [13] • Mesenchymal chondrosarcoma **9240** Leiomyosarcoma **8890** • Granular cell leiomyosarcoma • Inflammatory leiomyosarcoma • Epithelioid leiomyosarcoma **8891** • Myxoid leiomyosarcoma **8896** Myxoid pleomorphic liposarcoma **8859** Osteosarcoma **9180** Primary intracranial sarcoma, DICER1-mutant **9480** Round cell sarcoma with EWSR1-non-ETS fusion **9366** Sarcoma with BCOR genetic alterations **9268** Undifferentiated pleomorphic sarcoma **8802** • Malignant fibrous histiocytoma
Solitary fibrous tumor grade 3 8815 (/3) • Hemangiopericytoma grade 3 • Solitary fibrous tumor/Hemangiopericytoma grade 3 (CNS)	

[13] Chondrosarcoma is no longer valid for Malignant CNS beginning with cases diagnosed 1/1/2025 forward.

Table 3: Coding Primary Site for Malignant Tumors of Cranial and Peripheral Nerves

Note 1: Neoplasms arising in a **cranial** or **spinal** nerve are coded to the specific nerve in which it arises.
Note 2: Neoplasms, commonly meningiomas, arising in the **dura/meninges** of an **intracranial** nerve (cranial nerve within the skull) are coded to **cerebral meninges** C700.
Note 3: Neoplasms, commonly meningiomas, arising in the **dura/meninges** of the **spinal nerve roots** are coded to the ICD-O site code **spinal meninges** C701.
Note 4: It is important to **check** the **operative report** to determine whether the surgery is **intracranial** or **intradural.**

Use **Table 3** to **determine** whether a malignant cranial nerve tumor should be coded to a cranial nerve or to a peripheral nerve. The anatomic location of the tumor determines whether the primary site is a peripheral or a cranial nerve.

Column 1: The **proper name** for the cranial nerve (CN) and the **cranial nerve number**
Column 2: The point at which the nerve exits the cranium
Column 3: Portions of the nerve coded to cranial nerve
Column 4: Portions of nerve coded to peripheral nerve

Name and CN #	Exits Cranium Through	Site Code: Cranial Nerve	Site Code: Peripheral Nerve
Cranial nerve NOS		**Within cranium**, unknown which nerve **C725**	
Olfactory CN 1	Cribriform plate	Surface of the **brain C722**	Originates on the olfactory mucosa of nasal cavity, then travels through the cribriform plate of the ethmoid bone **C470**
Optic CN 2	Optic canal	All portions are covered by meninges/dura so are **reportable** as **C723**	

Table 3: Coding Primary Site for Malignant Tumors of Cranial and Peripheral Nerves

Name and CN #	Exits Cranium Through	Site Code: Cranial Nerve	Site Code: Peripheral Nerve
Oculomotor CN 3	Superior orbital fissure	Originates in the **midbrain C725**	After exiting the superior orbital fissure, the nerve enters the **orbit C470**
Trochlear CN 4	Superior orbital fissure	Arises from the **dorsal brain stem**, loops around the brainstem and passes anteriorly within the **subarachnoid space**. It travels between the **superior cerebellar and posterior cerebral arteries** and through the **dura,** enters **cavernous sinus C725**	Enters the orbital fissure **C470**

Table continued on next page

Table 3: Coding Primary Site for Malignant Tumors of Cranial and Peripheral Nerves

Name and CN #	Exits Cranium Through	Site Code: Cranial Nerve	Site Code: Peripheral Nerve
Trigeminal CN 5 [1]	The ophthalmic, maxillary and mandibular branches leave the skull through three separate foramina Superior orbital fissure The foramen rotundum The foramen ovale	CN5 originates in the **pons**. Upon leaving the pons it enters a **small fossa** posterior and inferolateral to the cavernous sinus called **Meckel's (trigeminal) cave C725**	• **Ophthalmic nerve branch** crosses the **pterygopalatine fossa**, inclines laterally on the back of the **maxilla**, and enters the **orbit** through the inferior orbital fissure where it is called the **infraorbital** nerve. It ends beneath the **quadatus labii superius**, and divides into multiple branches that spread to the side of the **nose**, the lower **eyelid**, and the upper **lip C470** • **Maxillary** nerve leaves foramen rotundum and traverses the **infraorbital groove** and **canal** in the floor of the **orbit**, and appears on the face at the infraorbital foramen **C470** • **Mandibular** nerve leaves via the foramen ovale travels along the **mandibular** groove **C470**
Abducent CN 6	Cranial meninges	Exits brainstem at junction of **pons** and the **medulla**, enters the **subarachnoid** space and runs upward between the pons and the **clivus** entering the **cavernous sinus C725**	**Dorello's canal** and travels to the tip of the **temporal bone**. Enters **orbit C470**

[1] Trigeminal is derived from Latin trigeminus which means born in threes (tri) and born at the same time (germinal). As the name implies, the nerve separates into three branches; ophthalmic, maxillary, and mandibular

Table 3: Coding Primary Site for Malignant Tumors of Cranial and Peripheral Nerves

Name and CN #	Exits Cranium Through	Site Code: Cranial Nerve	Site Code: Peripheral Nerve
Facial CN 7	Internal acoustic meatus	**CN7** originates in the **pons,** along the posterior cranial fossa (**posterior cranial fossa** (the posterior cranial fossa is part of the intracranial cavity) **C725**	Enters the temple through the internal auditory meatus and runs through the facial canal. **C470**
Acoustic or vestibulocochlear CN 8	Internal acoustic meatus	Originates in the **brain stem** (**medulla oblongata**) **between** the base of the brain (**pons**) and the **spinal cord C724** Both the **vestibular** branch and the **cochlear** branch are located in the **inner ear**	
Glossopharyngeal CN 9	Jugular foramina	**Originates** in the anterior portion of the **medulla oblongata C725**	Jugular foramen Between the **internal jugular vein** and **internal carotid artery** Lies on the **stylopharyngeus** and middle **pharyngeal** constrictor muscle Passes under the **hypoglossus** muscle Palatine tonsil Extends to mucous **glands** of the **mouth**, and **base** of the **tongue C470**

Table 3: Coding Primary Site for Malignant Tumors of Cranial and Peripheral Nerves

Name and CN #	Exits Cranium Through	Site Code: Cranial Nerve	Site Code: Peripheral Nerve
Vagus CN 10	Jugular foramen	The vagus nerve originates from the **medulla** of the **brainstem C725**	CN10 descends within the **carotid sheath** medial to the internal jugular vein at the root of the **neck C470** The right vagus crosses in front of the subclavian artery and travels into the **fat behind** the blood **vessels**, reaching the **thorax**. It then inclines **behind** the **hilum** of the **right lung** and moves toward the esophagus. The nerve splits into the **right** and **left** vagus at the **esophageal plexus C473** Forms the anterior and posterior **gastric** nerves **C475**
Accessory CN 11	Jugular foramen	The spinal accessory nerve **originates** in the neurons of the upper spinal cord, specifically **C1-C5/C6** spinal **nerve roots**. The nerve enters the foramen magnum or lateral aspect of the **medulla oblongata.** The fibers of the spinal accessory nerve coalesce to **form spinal rootlets, roots**, and finally the **spinal accessory nerv**e itself **C725**	The nerve **exits** the skull through the jugular foramen. It then runs along the internal **carotid** artery within the **neck C470** Reaches the sternocleidomastoid muscle and the trapezius **C476**
Hypoglossal CN 12	Hypoglossal canal	**CN12** starts in the **hypoglossal** nucleus of the **brainstem**, **C725**	**CN12** exits the hypoglossal canal, traveling **between** the **carotid** artery and **jugular** vein, ending under the **tongue C470**

Section 2: Additional Information to Complete the Abstract

Conflicting Information on Pathology Report(s)

The **classification** of brain tumors is a **subjective** matter because definitive criteria have not been established/accepted. Pathologists may **disagree** on the **histology** or **behavior**.

Follow the steps below for coding the histology and/or behavior of tumor when there are discrepancies:

- When possible, get advice from the **pathologist**
- When possible, contact **attending** physician
- When possible, consult with **registry advisor**
- If none of those **options** are **available**, code the histology and behavior from **the most dependable source** (see **Priority Order for Using Documentation to Identify Histology**).

The following are examples of how conflicting information occurs in single and in multiple pathology reports:

- **Single pathology report:**
  - **Multiple pathologists** within the institution review the slides
  - Slides are sent for **outside review** and the information from the **consulting** lab **conflicts** with the **original** pathology report
- **Multiple pathology reports:** The **first report** is from a biopsy and the **second report** is from a resection. Code the histology and/or behavior from the resection.

Table 5: Non-malignant CNS Tumors with the Potential of Transforming to Malignant Behavior

Table 4: Paired Sites

Use **Table 4** to identify sites for which laterality **must** be coded. Do **not** use this table to determine multiple primaries.

Paired Sites and Codes
Acoustic nerve **C724**
Cerebral meninges **C700**
Cerebrum **C710**
Cranial nerves **C725**
Frontal lobe **C711**
Occipital lobe **C714**
Olfactory nerve **C722**
Optic nerve **C723**
Parietal lobe **C713**
Temporal lobe **C712**

Note 1: Midline tumors are common for glioblastoma multiform and meningiomas.
Note 2: SEER allows laterality to be coded for sites other than those in the table.

Table 5: Non-malignant CNS Tumors with the Potential of Transforming to Malignant Behavior

The word "**transformation**" as used in this table means that:

- Residual tumor becomes more aggressive /3 **OR**
- The tumor **recurs** as a **more aggressive /3 histology**

The table identifies non-malignant tumors that have the **potential** of **transforming to** a malignant tumor (**new primary**).

Use **Table 5** when directed to by the Multiple Primary Rules.

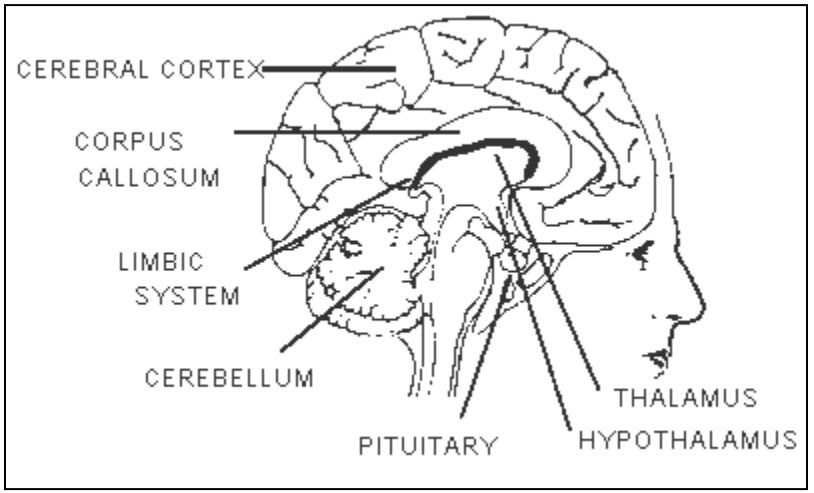
Column 1 is the **non-malignant** ICD-O histology term and code.
Column 2 is the **malignant** /3 ICD-O histology term and code to which the non-malignant tumor can transform.

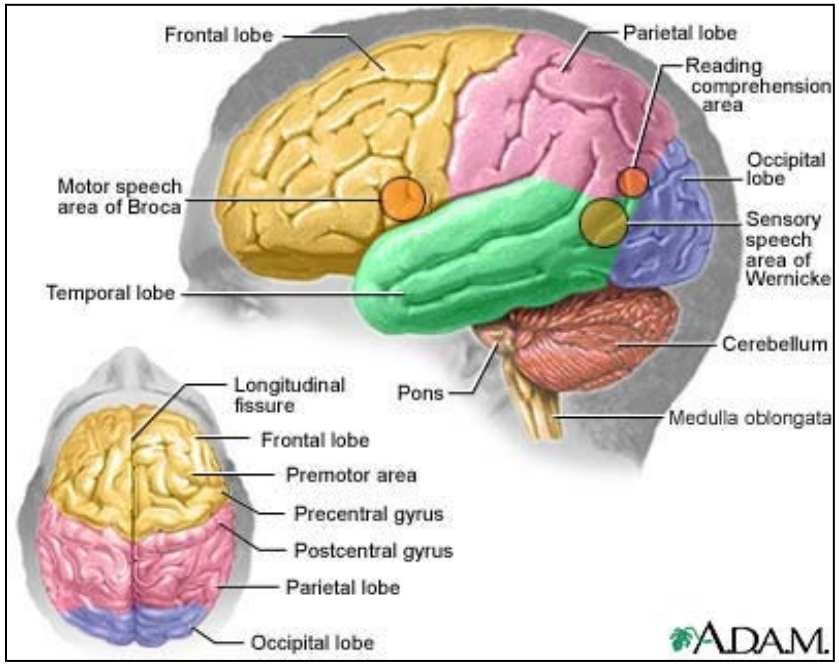
Original Histology and Code	Transformed Histology and Code
Chondroma **9220 (/0)**	Chondrosarcoma **9220 (/3)**
Ganglioglioma **9505 (/1)**	Anaplastic ganglioglioma **9505 (/3)**
Hemangioma **9120 (/0)**	Angiosarcoma **9120 (/3)**
Hemangiopericytoma **9150 (/1)**	Anaplastic hemangiopericytoma **9150 (/3)**
Leiomyoma **8890 (/0)**	Leiomyosarcoma **8890 (/3)**
Lipoma **8850 (/0)**	Liposarcoma **8850 (/3)**
Osteoma **9180 (/0)**	Osteosarcoma **9180 (/3)**
Perineurioma **9571 (/0)**	Malignant perineurioma **9571 (/3)**

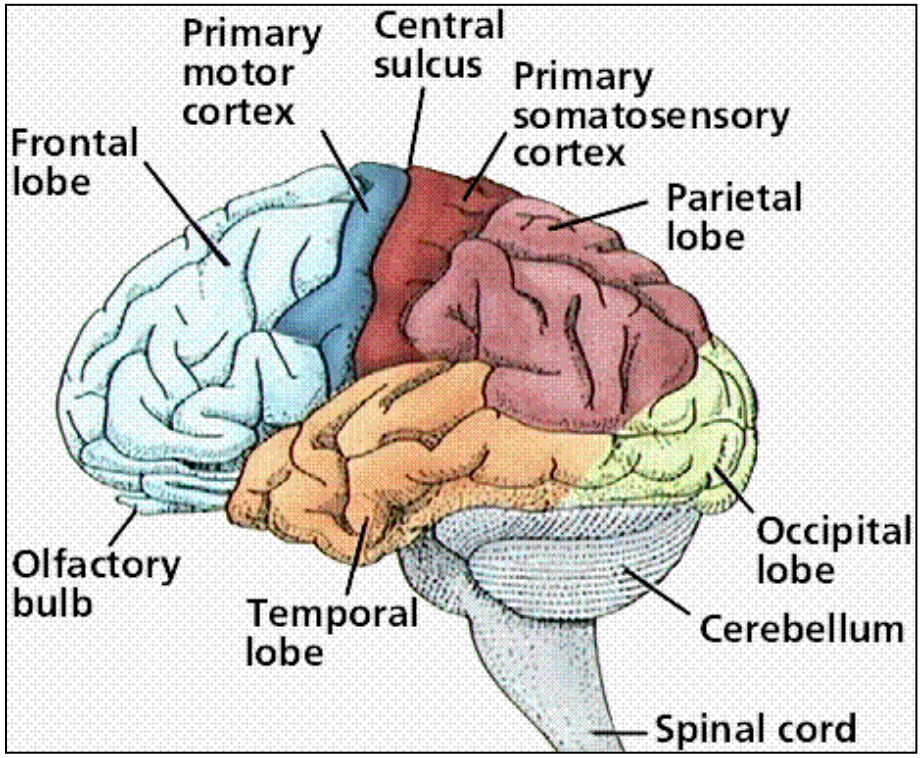
Table 5: Non-malignant CNS Tumors with the Potential of Transforming to Malignant Behavior

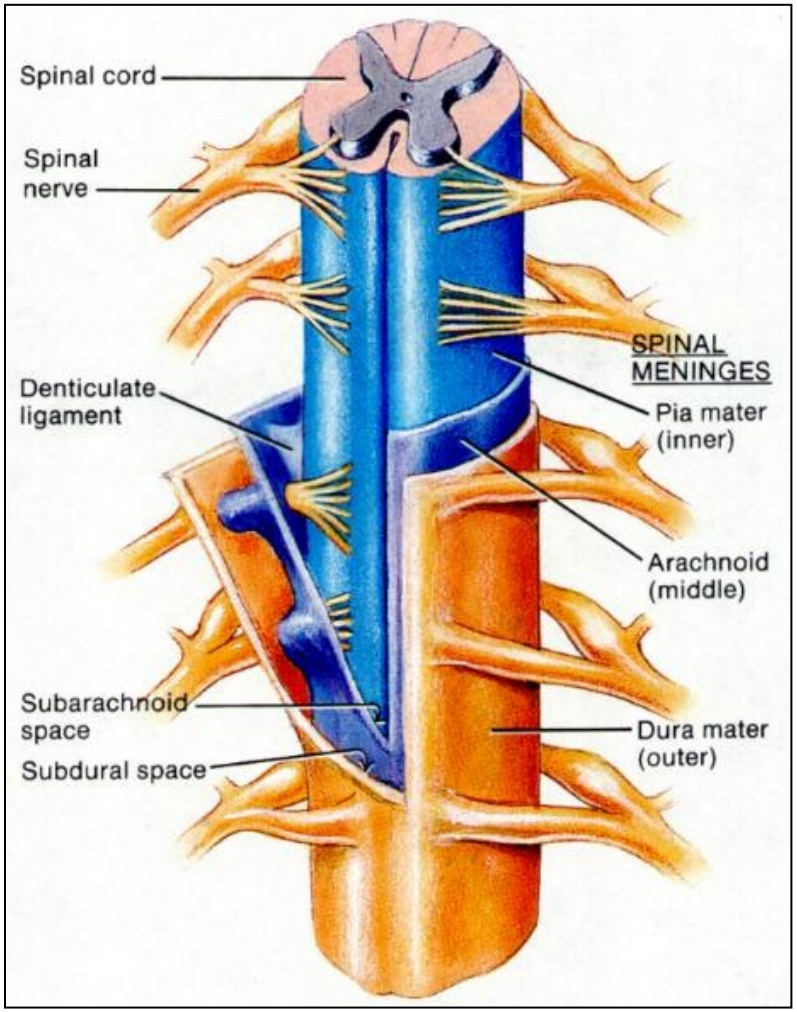
Original Histology and Code	Transformed Histology and Code
Rhabdomyoma **8900 (/0)**	Rhabdomyosarcoma **8900 (/3)**
Teratoma **9080 (/1)**	Immature teratoma **9080 (/3)**
Teratoma, mature **9080 (/0)**	Immature teratoma **9080 (/3)**

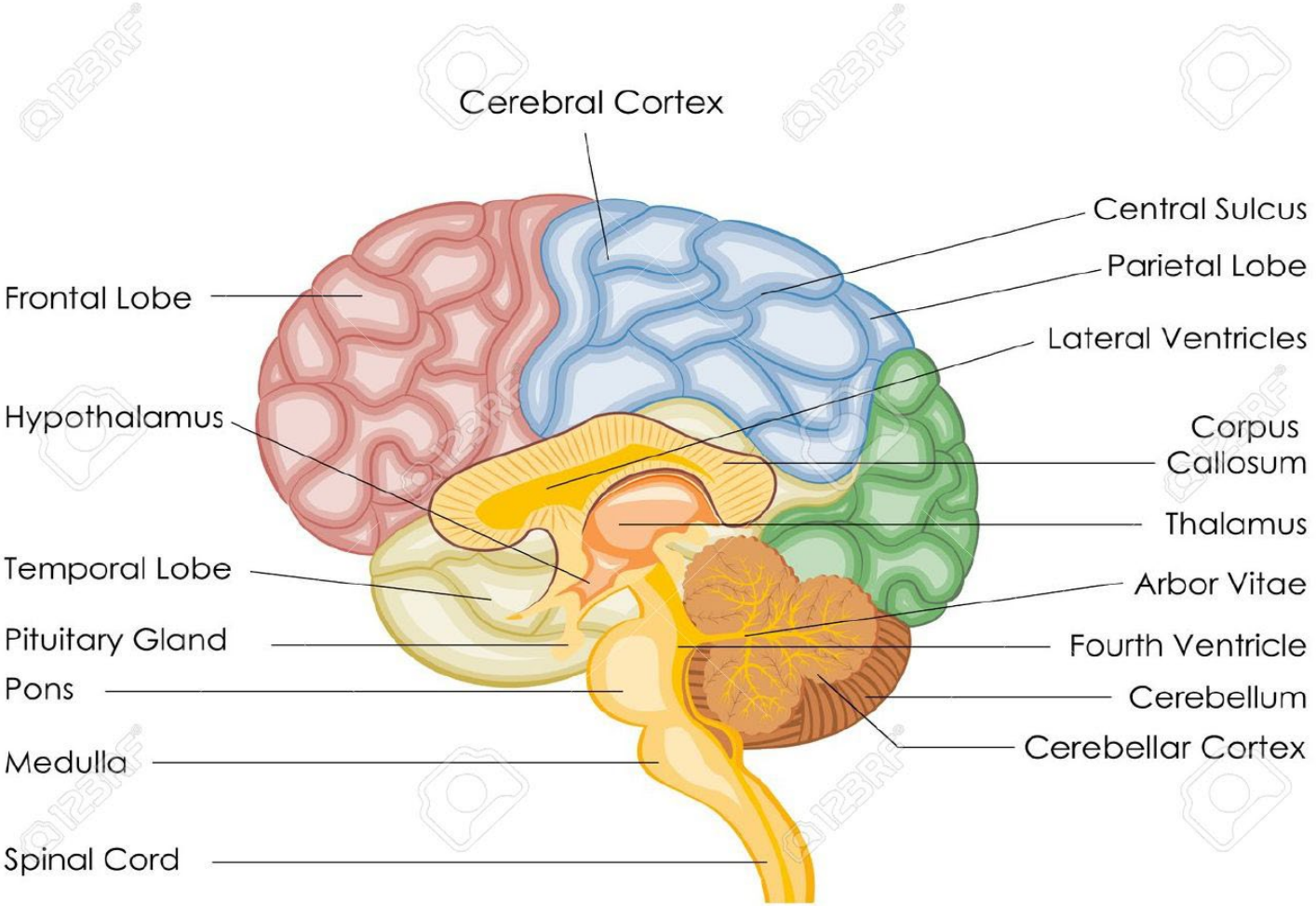
Illustrations

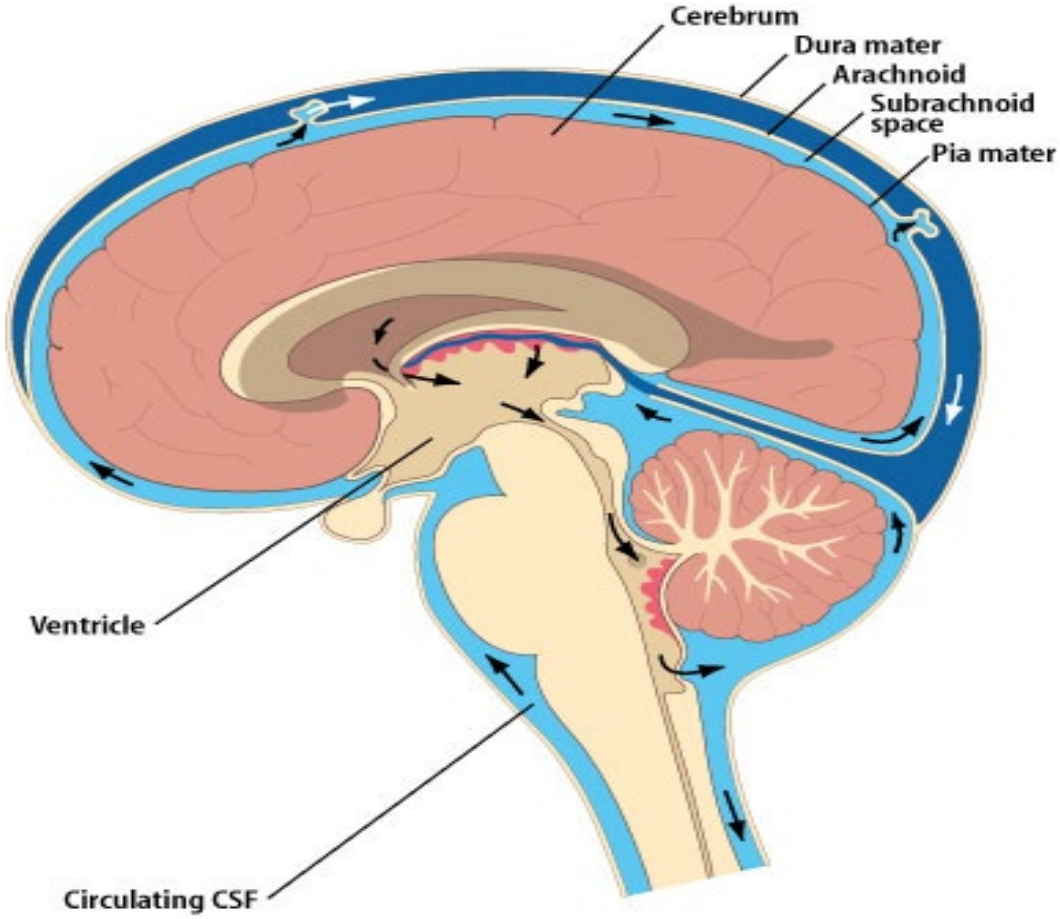







Spinal cord
Spinal nerve
SPINAL MENINGES
Denticulate ligament
Pia mater (inner)
Arachnoid (middle)
Subarachnoid space
Dura mater (outer)
Subdural space


Cerebral Cortex
Central Sulcus
Parietal Lobe
Frontal Lobe
Lateral Ventricles
Hypothalamus
Corpus Callosum
Thalamus
Temporal Lobe
Arbor Vitae
Pituitary Gland
Fourth Ventricle
Pons
Cerebellum
Medulla
Cerebellar Cortex
Spinal Cord


Cerebrum
Dura mater
Arachnoid
Subrachnoid space
Pia mater
Ventricle
Circulating CSF

Malignant CNS and Peripheral Nerves Multiple Primary Rules
C470-C479, C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Note 1: Non-malignant intracranial and CNS tumors have a separate set of rules.
Note 2: Laterality **is not** used to determine multiple primaries for malignant CNS tumors.
Note 3: Timing **is not** used to determine multiple primaries for malignant CNS tumors.
Note 4: Separate GBM following an astrocytic or glial tumor is a multiple primary.
Note 5: These rules are **NOT** used for tumor(s) described as metastases.

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.

Use the histology coding rules to assign the appropriate histology code

Malignant CNS and Peripheral Nerves Multiple Primary Rules
C470-C479, C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Single Tumor

IMPORTANT: The **major difference** between **M5** and **M6** is:
M5: No resection as first course of treatment **AND** when the same tumor is subsequently **resected**, **pathology proves malignant** behavior
M6: Tumor resected as first course of treatment. Subsequent tumor (**recurrence** or **de novo**) is **malignant**

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

Note 1: A single tumor is always a single primary.
Note 2: The tumor **may overlap onto** or **extend** into **adjacent**/contiguous site or subsites.
Note 3: The tumor may have two or more histologic components.
Note 4: A glioblastoma multiforme 9440 (GBM) diagnosed in residual tumor, regardless of timing, is not a new primary

Rule M3 Abstract a **single primary** when a neoplasm is **originally diagnosed** as an **oligodendroglioma** and subsequently **recurs** in residual tumor tissue with **different features** such as a densely cellular tumor with pseudo palisading necrosis.

Note 1: The pathology may state that the recurrence "looks like" or "has the appearance of" a glioblastoma multiforme (GBM). This is not a true GBM.
Note 2: Record as a recurrence for those registrars who collect recurrence data.

Rule M4 Abstract a **single primary** when a neoplasm is originally diagnosed as **Glioma, NOS** and subsequently recurs in residual tumor with a more specific histology.

Note 1: Glioma, NOS is considered an umbrella term. Additional testing should be performed to identify mutations and biomarkers that would provide a definitive histology type. A diagnosis of glioma, NOS is not recommended and may be used only when additional tests were inconclusive.
Note 2: If a specific histology is diagnosed in residual tumor or additional testing provides a definitive histology, edit the original abstract as follows:
- Do not change the date of diagnosis
- For cases that have been abstracted, update the ICD-O code based on the new findings
- Report all data changes for cases which have been submitted to the central registry

Note 3: There is no time requirement.

Rule M5 Abstract a **single primary** (the malignant) when a single tumor meets the following two criteria:

1. The original diagnosis was non-malignant /0 or /1 **AND**
   - First course treatment was active surveillance (no tumor resection). Diagnosis was:
     - Clinical
     - Radiographic
     - Stereotactic biopsy
2. Subsequent resection pathology is malignant /3

Note 1: This rule **clarifies** that a single tumor is **always** a single primary and the malignant behavior is reported.

Note 2: The **resection pathology** is **more accurate** than clinical, radiographic or stereotactic biopsy information. While stereotactic **biopsy provides** a **pathologic** specimen, it is small and **may not** include the **malignant** portion of tumor.

Note 3: There is **no time requirement** from initial diagnosis to resection.

Note 4: Edit the original abstract as follows:

- Do **not** change **date of diagnosis**.
- For cases which have been abstracted, **change behavior** code on original abstract from /0 or /1 to /3.
- **Report** all data changes for cases which have been submitted to the central registry.
- See the **COC** and **SEER manuals** for **instructions** on coding **other data items** such as Accession Year, Treatment and Sequence Number.

Note 5: The physician may stage the non-malignant tumor at the time of original diagnosis. The physician will also stage the malignant tumor. 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 research.

Example 1: A patient is diagnosed by **MRI** with **ganglioglioma 9505/1** in July 2018. After months of active surveillance (watchful waiting), the **patient** becomes **symptomatic**. A **resection** is done in April 2019; the **resection** pathology is **anaplastic ganglioglioma 9505/3**. **Change behavior code** on the **original abstrac**t from /1 to /3. Do not **change date of diagnosis.**

Example 2: A November 15, 2017 **MRI** and **subsequent** stereotactic **biopsy** of lateral ventricle of brain show a **mature teratoma 9080/1**. The patient becomes symptomatic in 2018 and the neoplasm is resected on October 31, 2018. The **resection pathology** diagnoses **immature teratoma 9080/3. Change behavior code** on the **original abstract. Do not change date of diagnosis.**

This is the end of instructions for Single Tumor.

Use the histology coding rules to assign the appropriate histology code

Malignant CNS and Peripheral Nerves Multiple Primary Rules
C470-C479, C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

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 CNS (see **Table 1**) AND in a site other than the CNS
  Example: Patient has a malignant nerve sheath tumor of the right arm C471 and non-metastatic adenocarcinoma of the lung. The lung is not a CNS site. Abstract two primaries.
- In different CNS sites (see Rule M9)

Note 3: For those sites which have recognized biomarkers, the biomarkers are most frequently used to target treatment. Follow the rules; do not code multiple primaries or histology based on biomarkers.

IMPORTANT: The **major difference** between **M5** and **M6** is:
M5: No resection as first course of treatment **AND** when the same tumor is subsequently **resected**, **pathology proves malignant** behavior
M6: Tumor resected as first course of treatment. Subsequent tumor (**recurrence** or **de novo)** is **malignant**

Rule M6 Abstract **multiple primaries** when there are multiple CNS tumors, one of which is malignant /3 and the other is non-malignant /0 or /1.

- Original non-malignant tumor followed by malignant tumor
  - Patient had a resection of the non-malignant tumor (not the same tumor) **OR**
  - It is unknown/not documented if the patient had a resection
- Simultaneous non-malignant and malignant tumors
  - Abstract both the malignant and the non-malignant tumors

Note 1: The rules are hierarchical. Only use when previous rules do not apply.

Note 2: See **Table 1** in the Site-Group Instructions for a listing of CNS sites.

Note 3: A non-malignant CNS tumor and a malignant CNS tumor are **always multiple** primaries (timing and primary sites are irrelevant). Prepare two abstracts; one for the non-malignant and another for the malignant tumor.

Rule M7 Abstract **multiple primaries** when a patient has a glial tumor and is subsequently diagnosed with a **glioblastoma multiforme 9440** (GBM).

Note 1: Definition of a glial tumor: Any tumor arising from the CNS glial cells. The following is simply a list of all tumors which would be classified as glial.

- Astroblastoma **9430**
- Astrocytomas **9400** and all subtypes
  - Anaplastic astrocytoma IDH-mutant/wildtype; anaplastic astrocytoma NOS **9401**
  - Gemistocytic astrocytoma IDH-mutant **9411**
- Diffuse midline glioma H3 K27M Mutant **9385**
- Ependymoma **9391** and all subtypes
  - Anaplastic ependymoma **9392**
  - Ependymoma, RELA fusion-positive **9396**
  - Papillary ependymoma **9393**
- Glioblastoma **9440** and all subtypes **(this is a glial tumor; however do not apply this rule to a GBM followed by a GBM)**
  - Giant cell glioblastoma **9441**
  - Glioblastoma IDH-mutant **9445**
  - Gliosarcoma **9442**
- Glioma NOS **9380**
- Oligodendroglioma and all subtypes **9450**
  - Anaplastic oligodendroglioma; IDH-mutant; 1p/19q-codeleted; IDH-mutant and 1p/19q-codeleted **9451**
- Pleomorphic xanthroastrocytoma **9424**

Note 2: This is a change from the 2007 Rules.

Note 3: Abstracting GBM as a new primary will allow analysis of:

- The number of tumors that recur as a more aggressive histology (GBM)
- The time interval between occurrence of the glial or astrocytic tumors and a GBM
- Which histologies are more likely to recur as a GBM

Note 4: This rule applies to multiple tumors. A glioblastoma multiforme (GBM) that is subsequently diagnosed in residual tumor from a glial tumor is a single primary. See previous rules.

Rule M8 Abstract a **single primary** when there are separate, non-contiguous tumors in the brain (multicentric/multifocal) with the **same histology XXXX**. Tumors may be any of the following combinations:

- In the same lobe; for example, two tumors in right temporal lobe **C712** (same site code)
- Different lateralities of the same lobe; for example, left and right frontal lobes **C711** (same site code)
- In different lobes; for example, parietal lobe **C713** and occipital lobe **C714** (different site codes)

Example: The patient had a resection of an anaplastic astrocytoma 9401 in the right parietal lobe. Three months later the patient is diagnosed with a de novo anaplastic astrocytoma in the left parietal lobe. This is one primary because neither laterality nor timing are used to determine multiple primary status.

Note 1: **Multiple sites/subsites** and/or different **lateralities imply** either **metastatic** or **multifocal/multicentric** disease. Glioblastoma multiforme commonly exhibits multiple tumors which are described as **multifocal**/**multicentric**.

Note 2: Metastases are never used to determine multiple primaries. **Seeding metastasis** is often noted for the following tumors:

- Glioblastoma multiforme
- pNET-medulloblastoma
- Oligodendroglioma

Note 3: **Hereditary** syndromes frequently exhibit multiple tumors including the following:

- Neurofibromatosis type 1 (NF1)
  - Malignant peripheral nerve sheath tumors (MPNST)
- Neurofibromatosis type 2 (NF2)
  - Anaplastic ependymomas
  - Meningiomas

Note 4: Most malignant neoplasms are **single tumors** with the exception of those listed in this rule.

Note 5: This is a **change** from/**clarification** to previous rules.

Malignant CNS and Peripheral Nerves Multiple Primary Rules
C470-C479, C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M9 Abstract **multiple primaries** when multiple tumors are present in any of the following **sites** or **subsites**:

- Any lobe of the brain **C710-C719 AND** any other part of CNS
- Cauda equina **C721 AND** any other part of CNS
- Cerebral meninges **C700 AND** spinal meninges **C701**
- Cerebral meninges **C700 AND** any other part of CNS
- Any one of the cranial nerves **C722-C725 AND** any other part of the CNS
- Any two or more of the cranial nerves
  - **C722** Olfactory, **C723** Optic, **C724** Acoustic, **C725** Cranial nerves NOS
- Meninges of cranial or peripheral nerves **C709 AND** any other part of the CNS
- Spinal cord **C720 AND** any other part of CNS
- Spinal meninges **C701 AND** any other part of CNS

Rule M10 Abstract **multiple primaries** when separate, non-contiguous tumors are two or more **different subtypes/variants** in Column 2, **Table 2** in the Site-Group Instructions. Timing is irrelevant.

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

- **Same NOS**: Anaplastic astrocytoma IDH-mutant 9401 and gemistocytic astrocytoma IDH-mutant 9411 are both subtypes of astrocytoma NOS 9400/3 but are distinctly different histologies. Abstract multiple primaries.
- **Different NOS**: Papillary ependymoma 9393 is a subtype of ependymoma NOS 9391; gliosarcoma 9442 is a subtype of glioblastoma NOS 9440. They are distinctly different histologies. Abstract multiple primaries.

Rule M11 Abstract a **single primary** when separate, non-contiguous tumors are Glioma NOS and a subtype/variant of Glioma NOS.

Note 1: Glioma, NOS is considered an umbrella term. Additional testing should be performed to identify mutations and biomarkers that would provide a definitive type. A diagnosis of glioma, NOS is not recommended and may be used only when additional test were inconclusive.

Note 2: The following is a list of all tumors which would be classified as subtypes/variants of glioma NOS.

- Astroblastoma **9430**
- Astrocytomas **9400** and all subtypes
  - Anaplastic astrocytoma IDH-mutant/wildtype; anaplastic astrocytoma NOS **9401**
  - Gemistocytic astrocytoma IDH-mutant **9411**
- Diffuse midline glioma H3 K27M Mutant **9385**
- Ependymoma **9391** and all subtypes

- Anaplastic ependymoma **9392**
- Ependymoma, RELA fusion-positive **9396**
- Papillary ependymoma **9393**

- Glioblastoma **9440** and all subtypes **(this is a glial tumor; however do not apply this rule to a glial tumor followed by a GBM)**
  - Giant cell glioblastoma **9441**
  - Glioblastoma IDH-mutant **9445**
  - Gliosarcoma **9442**
- Oligodendroglioma and all subtypes **9450**
  - Anaplastic oligodendroglioma; IDH-mutant; 1p/19q-codeleted; IDH-mutant and 1p/19q-codeleted **9451**
- Pleomorphic xanthroastrocytoma **9424**

Rule M12 Abstract a **single primary** when separate, non-contiguous tumors are on **the same row** in Table 2 in the Site-Group Instructions. Timing is irrelevant.

Note: The same row means the tumors are:

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

Rule M13 Abstract **multiple primaries** when separate, non-contiguous tumors are on **different rows** in Table 2 in the Site-Group Instructions. Timing is irrelevant.

Note 1: Each row in the table is a **distinctly different** histology.

Note 2: 8000 is considered a different row ONLY when the diagnosis is neuroepithelial tumor. If the diagnosis is cancer, NOS, do not consider 8000 to be a separate row from other histologies for the purpose of the table rules.

- ***Example 1:*** A tumor is diagnosed as 8000/3 Neuroepithelial tumor, NOS. Later, a separate tumor is diagnosed as Ependymoma 9391/3. These are considered separate rows.
- ***Example 2:*** A tumor has a provisional diagnosis of 8000/0 and further diagnosis is done. A subsequent tumor in another lobe of the brain is diagnosed as Germinoma 9064/3. These are not considered separate rows.

Rule M14 Abstract a **single primary** when multiple 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.

This is the end of instructions for Multiple Tumors.

Use the histology coding rules to assign the appropriate histology code

Malignant CNS and Peripheral Nerves Histology Rules
C470-C479, C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Note: Non-malignant CNS tumors have a separate set of rules.

Priority Order for Using Documentation to Identify Histology

IMPORTANT NOTES

1. Code the histology diagnosed ***prior*** to **neoadjuvant treatment.**
   Note 1: Histology changes may occur following immunotherapy, chemotherapy, targeted therapy, and radiation therapy.
   Note 2: Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.

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

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

The priority list is used for single primaries (including multiple tumors abstracted as a single primary)

This is a hierarchical list of source documentation.

1. Pathology/tissue from **resection** of primary tumor
   A. Biomarkers
      Note 1: Biomarkers are emerging as an important part of cancer diagnosis and treatment. Some biomarkers are used to determine treatment rather than histologic type. The efficacy of identification of histologic type using biomarkers differs from primary site to primary site. When a histologic type is identified using a biomarker, code the identified histology. Biomarkers do not identify all histologic types.
      Note 2: Biomarkers are not listed because they change rapidly.
      Example: Biomarkers are required to diagnose medulloblastoma SHH-activated and TP53-wildtype. Biomarkers include genetic testing, FISH, MYCN.
   B. The addendum(s) and/or comment(s)
   C. Final diagnosis / synoptic report as required by CAP
   D. CAP protocol

2. Pathology/tissue from **biopsy** of primary tumor
   A. **Biomarkers**
      Note 1: Biomarkers are emerging as an important part of cancer diagnosis and treatment. Some biomarkers are used to determine treatment rather than histologic type. The efficacy of identification of histologic type using biomarkers differs from primary site to primary site. When a histologic type is identified using a biomarker, code the identified histology. Biomarkers do not identify all histologic types.
      Note 2: Biomarkers are not listed because they change rapidly.
      Example: Biomarkers are required to diagnose medulloblastoma SHH-activated and TP53-wildtype. Biomarkers include genetic testing, FISH, MYCN.
   B. The addendum and/or comments
   C. Final diagnosis / synoptic report as required by CAP
   D. CAP protocol

   Note 1: Addendums and comments are given the second 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 is always the most reliable, so the final diagnosis is the third priority.
   Note 3: **Do not** use the microscopic or gross section of the pathology report for coding.
   Note 4: The CAP protocol is a checklist which
   - Provides guidelines for collecting the essential data elements for complete reporting of tumors and optimal patient care.
   - Allows physicians to check multiple histologies

3. **Cytology** (most frequently cerebrospinal fluid)

4. Tissue/pathology from a metastatic site
   Note 1: Code the behavior /3
   Note 2: The tissue from a **metastatic s**ite 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. MRI
   B. CT
   C. PET
   D. Angiogram

6. Code the histology **documented** by the physician when none of the above are available. Use the **documentation** in the following **priority order**
   A. Treatment plan
   B. Documentation from Tumor Board
   C. Documentation in the medical record that **refers to original pathology, cytology, or scan(s)**
   D. Physician's **reference to** type of cancer (**histology**) in the medical record

   Note 1: Code the specific histology when documented.

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

Coding Histology

Note 1: The priority is to code the most specific histology. **DO NOT USE BREAST HISTOLOGY CODING RULES FOR THIS SITE.**
Note 2: Only use this section for one or more histologies within a single tumor.
Note 3: Do not use this section in place of the Histology Rules.

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

   Example 1: Diagnosis for a single tumor is astrocytoma 9400 with the majority or predominant part of tumor being anaplastic astrocytoma IDH-mutant 9401. Code the subtype/variant: anaplastic astrocytoma IDH-mutant 9401.

   Example 2: Diagnosis for a single tumor is CNS ganglioneuroblastoma 9490 with minority of tumor being CNS embryonal tumor 9473. Code the subtype/variant: CNS embryonal tumor 9473.

   Example 3: Diagnosis for a single tumor is ependymoma 9391 with a component of anaplastic ependymoma 9392. Code the subtype/variant: anaplastic ependymoma 9392.

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

2. Code the histology described as **differentiation** or **features/features of <u>ONLY</u>** when there is a specific ICD-O code for the "NOS with ____ features" or "NOS with ____ differentiation".
   Note: Do not code differentiation or features when there is no specific ICD-O code.

3. Code the specific histology described by ambiguous terminology (list follows) ONLY when A or B is true:
   A. The only diagnosis available is one histology term described by ambiguous terminology
      - CoC and SEER require reporting of cases diagnosed only by ambiguous terminology
      - Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

   Example: Outpatient biopsy says probably desmoplastic medulloblastoma. The case is accessioned (entered into the database) as required by both SEER and COC. No further information is available. Code the histology desmoplastic medulloblastoma. The case meets the criteria in **#3A.**

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

If the specific histology does not meet the criteria in #3B, then code the NOS histology.

See the **Ambiguous Terminology** section of the General Instructions for instructions and examples on when ambiguous terms and definitive terms may be used to assign histology.

Table 6: List of Ambiguous Terminology

Ambiguous Terminology	
Appears	Presumed
Cannot rule out	Suspicious (for)
Likely	Suggestive of
Favor(s)	

Note 1: Table 7 below includes terms **previously** included in the list of ambiguous terms. These terms should be treated as supporting a **definitive diagnosis** of a histologic subtype. A definitive term does not require clinical verification of the subtype or variant.

Note 2: The terms in Table 7 were removed from the list of ambiguous terms and added to a list of **definitive terminology** based on the recommendation of a panel of pathologists and subject matter experts.

Table 7: List of Definitive Terminology

Definitive Terminology	
Comparable with	Most likely
Compatible with	Probable
Consistent with	Typical (of)

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

Malignant CNS and Peripheral Nerves Histology Rules
C470-C479, C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Single Tumor

Rule H1 Code the **reportable CNS tumor** (Table 2 in the Site-Group Instructions) when a patient has any of the following:

- Neurofibromatosis type 1 (**NF1**)
- Neurofibromatosis type 2 (**NF2**)
- **Schwannomatosis**

Note 1: **Do not code** NF1 or NF2 as neurofibromatosis. NF1, NF2, and schwannomatosis are genetic syndromes which have a high risk of developing reportable and non-reportable tumors. **ONLY** abstract **reportable tumors** such as malignant peripheral nerve sheath tumors.

Note 2: Tumors are reportable when they meet the behavior (/3) and histology requirements (see **Reportability Criteria**).

Note 3: Schwannomatosis is a newer term for a distinct subtype/variant of the genetic diseases NF1 and NF2.

Example: Patient presents with vestibular schwannoma (acoustic neuroma). Genetic testing proves the patient has NF2. Report the acoustic nerve neuroma.

Rule H2 Code malignant meningioma **9530** when the diagnosis specifically states malignant/invasive.

Note: Code the behavior designated in the pathology report. Do not code malignant /3 based on invasion of brain or skull. Atypical meningioma (non-malignant) may invade contiguous structures.

Rule H3 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.

Rule H4 Code the **subtype/variant** when there is a **NOS** and a **single subtype/variant** of that NOS such as the following:

- Astrocytoma **9400** and a subtype/variant of astrocytoma
- CNS ganglioneuroblastoma **9490** and a subtype/variant of CNS ganglioneuroblastoma
- Embryonal carcinoma **9070** and a subtype/variant of embryonal carcinoma
- Ependymoma **9391** and a subtype/variant of ependymoma
- Glioblastoma **9440** and a subtype/variant of glioblastoma
- Immature teratoma **9080** and a subtype/variant of immature teratoma
- Malignant meningioma **9530** and a subtype/variant of malignant meningioma
- Malignant peripheral nerve sheath tumor **9540** and a subtype/variant of malignant peripheral nerve sheath tumor
- Medulloblastoma **9470** and a subtype/variant of medulloblastoma
- Meningeal melanoma **8720** and a subtype/variant of meningeal melanoma
- Oligodendroglioma **9450** and a subtype/variant of oligodendroglioma
- Pilocytic astrocytoma **9421** and a subtype/variant of pilocytic astrocytoma
- Pineal parenchymal tumor of intermediate differentiation **9362** and a subtype/variant of pineal parenchymal tumor of intermediate differentiation
- Sarcoma **8800** and a subtype/variant of sarcoma

Note 1: All tumors are malignant/invasive /3.
Note 2: See **Table 2** in the Site-Group Instructions to find NOS and subtypes/variants.

This is the end of instructions for Single Tumor

Code the histology using the rule that fits the case.

Multiple Tumors Abstracted as a Single Primary

Rule H5 Code malignant meningioma **9530** when the diagnosis specifically states malignant/invasive.

Note: Code the behavior designated in the pathology report. Do not code malignant /3 based on invasion of brain or skull. Atypical meningioma (non-malignant) may invade contiguous structures.

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

Note 2: Submit a question to **Ask a SEER Registrar** when the histology code is not found in Table 2, ICD-O or all updates.

Rule H7 Code the **subtype/variant** when **all tumors** are a **NOS** and **a single subtype/variant** of that NOS such as the following:

Note: See **Table 2** in the Site-Group Instructions to find NOS and subtypes/variants.

- Astrocytoma **9400** and a subtype/variant of astrocytoma
- CNS ganglioneuroblastoma **9490** and a subtype/variant of CNS ganglioneuroblastoma
- Embryonal carcinoma **9070** and a subtype/variant of embryonal carcinoma
- Ependymoma **9391** and a subtype/variant of ependymoma
- Glioblastoma **9440** and a subtype/variant of glioblastoma
- Immature teratoma **9080** and a subtype/variant of immature teratoma
- Malignant meningioma **9530** and a subtype/variant of malignant meningioma
- Malignant peripheral nerve sheath tumor **9540** and a subtype/variant of malignant peripheral nerve sheath tumor
- Medulloblastoma **9470** and a subtype/variant of medulloblastoma
- Meningeal melanoma **8720** and a subtype/variant of meningeal melanoma
- Oligodendroglioma **9450** and a subtype/variant of oligodendroglioma
- Pilocytic astrocytoma **9421** and a subtype/variant of pilocytic astrocytoma
- Pineal parenchymal tumor of intermediate differentiation **9362** and a subtype/variant of pineal parenchymal tumor of intermediate differentiation
- Sarcoma **8800** and a subtype/variant of sarcoma

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

Code the histology using the rule that fits the case.

Non-Malignant CNS Site-group Instructions
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Introduction

Note 1: This site group **includes** the following **primary sites**: Cerebral meninges C700; spinal meninges C701; meninges NOS C709; brain C710-C719; spinal cord C720; cauda equina C721; olfactory nerve C722; optic nerve C723; acoustic nerve C724; cranial nerve NOS C725; overlapping lesion of brain and central nervous system C728; nervous system NOS C729; pituitary gland C751; craniopharyngeal duct C752; pineal gland C753.

Note 2: Malignant CNS neoplasms have a separate set of rules.

Note 3: Non-malignant central nervous system (CNS) neoplasms (previously called benign and borderline) are **reportable** for cases **diagnosed 1/1/2004** and later.

Note 4: **Pilocytic astrocytoma/juvenile pilocytic astrocytoma:**

- For cases diagnosed prior to 1/1/2023, these neoplasms are reportable in North American as malignant 9421/3 for all CNS sites with the exception of the optic nerve:
  - WHO Classification Tumors of the Central Nervous System and IARC designate pilocytic astrocytoma as a synonym for optic glioma
  - When the primary site is optic nerve and the diagnosis is either optic glioma or pilocytic astrocytoma, the behavior is non-malignant and coded 9421/1
  - Beginning with cases diagnosed 1/1/2023 forward, pilocytic astrocytoma/juvenile pilocytic astrocytoma are to be reported as 9421/1 for ***all*** CNS sites.

Note 5: Neurofibromatosis NOS, Neurofibromatosis 1 (NF1), Neurofibromatosis 2 (NF2), and schwannomatosis are familial tumor syndromes and are not reportable conditions. People with NF1 and NF2 have a high risk of developing reportable and non-reportable tumors. Tumors associated with NF1 and NF2 are reportable when they meet the behavior (/0 or /1), site (within the CNS), and histology reportability requirements (see Reportability Criteria).

Note 6: Beginning with cases diagnosed 1/1/2023, pilocytic astrocytoma/juvenile pilocytic astrocytoma are no longer reported as malignant (9421/3). These neoplasms will continue to be reportable as a benign CNS tumor with a behavior of /1. Historically, pilocytic astrocytomas were coded as 9421/3 from 1976-2000. Beginning in 2001 with the release of ICD-O-3, WHO changed the behavior to /1, however, the standard setters opted to continue collecting these cases using malignant /3 behavior. This practice will continue through 12/31/2022.

Note 7: Do not use this site group for coding paragangliomas.

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**.
- Atypical; uncertain behavior /1
- Cerebrospinal fluid; CSF
- Dermoid; dermoid cyst
- Dura; meninges
- Extradural; not within the meninges; within the cranium; within the skull but not within the cerebral meninges
- Extramedullary; outside medulla oblongata C700
- Intracranial; within the skull; within the cranium
- Intradural; between layers of the cerebral meninges; C700
- Intradural-extramedullary; within the spinal canal but outside of the nerves
- Intraspinal; occurring within the spinal column especially the vertebral canal
- Non-malignant is synonymous with:
  - /0 Benign
  - /1 Uncertain whether benign or malignant; borderline malignancy; low malignant potential; uncertain malignant potential
  - WHO Grade 1
- Site; topography
- Subarachnoid space; between the arachnoid mater and the pia mater of spinal meninges
- 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 a non-malignant tumor/neoplasm
  - These terms are used **ONLY** for determining multiple primaries
  - **DO NOT USE** these terms for **casefinding** or **determining reportability**
- Type; subtype; variant

Terms That Are NOT Equivalent or Equal

- **Component** is not equivalent to **subtype/type/variant**
  Note: Component is only coded when the pathologist specifies the component as a second **non-malignancy**.
- **Phenotype** is not equivalent to **subtype/type/variant**
- **WHO Grade** is not equivalent to **tumor grade**

Reportability Criteria for Non-Malignant CNS Neoplasms

CNS neoplasms must meet **all three** conditions below to be reported as **non-malignant**:

1. The **behavior** must non-malignant /0 or /1. See **Behavior Code** section.
   Note: **Never report** a **malignant** /3 behavior code for a **meningioma** based on **tumor extension** to brain, skin of scalp, or other regional organs/tissue. Non-malignant CNS tumors can extend to the regional tissue and bone. Tumor extension is usually equivalent to atypical meningioma 9539/1.
2. The **primary site** must be reportable (See **Section 1: Table 1** and **Table 2**).
3. The **histology** must be reportable (See **Section 1: Table 4** and **Table 5**).

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Behavior Code

Note: Behavior determines which set of CNS rules should be used: malignant or non-malignant.

Instructions for using source **documentation** to determine behavior are in **priority order.** Start with Instruction 1 and **STOP** when you reach the instruction that applies to the case being abstracted. For example, when the **resection pathology** specifies behavior, use Instruction 1. There is no need to move on to Instructions 2-5.

Priority Order for Using Documentation to Assign Behavior

1. Pathology: Tissue from **resection** in the following priority order:
   A. Use the pathologist's description of behavior
      Note: **Never change behavior** described by pathologist
   B. Cases are reportable as non-malignant when pathology states a WHO Grade 1
      i. WHO Grade 2 may be either non-malignant or malignant. Use the pathologist's description of behavior (first). When the pathologist's description of behavior is not available and the CNS tumor is stated to be WHO Grade 2, code the corresponding ICD-O histology code and behavior listed in ICD-O, ICD-O updates, or solid tumor rules. Code the WHO Grade in the appropriate SSDI data field.
      Example: Chordoid glioma of the third ventricle, grade 2 - code 9444/1.
2. Pathology: Tissue from **biopsy**
   A. See A and B above.
3. Cytology (usually cerebrospinal fluid)
   A. See A and B above.
4. Physician's documentation (no pathology report) in the following priority order:
   A. Tumor Board
   B. Documentation of original diagnosis/tumor behavior
      Example: **Biopsy or resection** was done at a **different institution**; pathology report is not in the medical record**. Oncology consult** states **biopsy was done** in a different facility and **cites pathology from biopsy** including the **behavior** as benign, borderline, non-malignant or WHO Grade 1.
   C. Documentation of behavior, no mention of original diagnosis

Example: **Biopsy or resection** was done at a **different institution**; pathology report is not in the medical record. **Physician documents** the **behavior** as benign, borderline, non-malignant, or WHO Grade 1, but **does not cite/mention original** pathology report as source of behavior classification.

5. **Scans:** Use behavior information from imaging in the following **priority order**:
   A. MRI
   B. CT
   C. PET
   D. Angiogram
6. When above instructions **do not apply**, use **CNS CAP Protocol** to determine behavior. See **WHO Grades for Select CNS Neoplasms**.

   Example 1: Biopsy of tumor shows Meningioma, WHO Grade 3. Assign behavior to /3 based on WHO Grade 3.

   Example 2: CT shows a meningioma located over the temporal lobe. No further work-up or treatment. Assign behavior as /1 since meningioma is listed with behavior /1 in the ICD O 3.2.

WHO Grades of Select CNS Neoplasms

Note 1: CNS WHO classifications use a grading scheme that is a "malignancy scale" ranging across a wide variety of neoplasms rather than a strict histologic grading system that can be applied equally to all tumor types.

Note 2: See the SEER and CoC Manuals for instructions on coding grade for CNS tumors.

Note 3: WHO does not provide Grades for all CNS and peripheral nerve neoplasms.

Note 4: Refer to the **CNS CAP Protocol** to code behavior based on WHO grade for specific histologies when grade is not available. The table in the CAP protocol for CNS tumors should only be used for histologies listed in the table. If a histology is listed with a single WHO Grade, the Grade listed may be used to assign grade.

Example 1: Choroid plexus carcinoma, listed as WHO Grade 3 in the table, code behavior to malignant (/3).
Example 2: Papillary meningioma can have a WHO Grade of 1, 2, or 3. The CNS CAP Protocol Table should not be used to determine grade for this histology.

WHO Grade Definitions

WHO Grade	Definition
WHO Grade I	Non-malignant (/0 or /1)
WHO Grade II	Malignant or Non-malignant
WHO Grade III	Malignant (/3) (See **Malignant CNS** site-group)
WHO Grade IV	Malignant (/3) (See **Malignant CNS** site-group)

Refer to the most current version of the **CNS CAP Protocol** for WHO grading of some of the more common CNS tumors.

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Directory of Sections and Tables

Information is presented in the general order in which a case is abstracted.

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Section 1: Reportable Primary Sites and Histologies

After determining behavior code, the next step is to confirm both the primary site and the histology are reportable.

Note 1: The following non-malignant meningiomas are reportable:

- **Intraosseous**
  Note: The **dura** layer of the meninges **contacts** the **endosteum** of the bones of the skull. The primary site for intraosseous meningioma is cranial meninges C700.
- **Sphenoid wing**
  Note 1: Sphenoid wing meningiomas arise in the **cranial meninges** C700 which **covers** the bony structure called the sphenoid wing.
  Note 2: The term "sphenoid wing meningioma" is used to identify the **location** of the meningioma because sphenoid wing meningiomas may be very **invasive**, spreading to the dura of the frontal, temporal and orbital regions.
- **Cavernous sinus**
  Note 1: Cavernous sinus is located between the endosteal and meningeal layers of the dura.
  Note 2: There is **no ICD-O site** code for cavernous sinus because tumors do not arise in the sinus itself; the primary sites are:
  - The **cranial nerves** passing through the sinus (trochlear, abducent **C725**) **OR**
  - The cerebral **meninges/dura C700** covering the cranial nerve

Note 2: Cavernous sinus hemangiomas are reportable. Code primary site cerebral meninges C700.

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Priorities for Coding Primary Site

Note 1: **Always** check the **operative report(s)** which will have information on whether the surgery or biopsy was **intracranial** (inside the cranium/skull) or **intraspinal** (within the dura/meninges covering the spinal cord)
Note 2: Code **the specific primary site**. Use an **NOS** site code **only** when a specific site is not known.
Note 3: See **Table 1**: **Reportable Primary Sites** to confirm the primary site is reportable.
Note 4: When the primary site is cranial nerve **OR** cranial nerve meninges, see **Table 2: Reportability of Non-Malignant Cranial Nerve (CN) Tumors** to confirm the site of the tumor is intracranial (reportable) or extracranial (not reportable)
Note 5: See **Table 3**: **Non-Reportable Neoplasms** for site/histology combinations and histologies that are not reportable.
Note 6: When the primary site is brain or intracranial glands, see **Table 4**: **Histologic Types of Non-Malignant Intracranial (Brain and Gland) Tumors** to confirm site/histology combinations.

Use the list below in **hierarchical order**:

1. **Resection**
   A. Operative report(s)
   B. Pathology report(s)
2. **Biopsy**
   A. Operative report(s)
   B. Pathology report(s)
3. Resection and/or biopsy performed, but operative report(s) and pathology are not available (minimal information):
   A. Tumor Board
   B. Code from physician's documentation of **original diagnosis** from operative or pathology report
   C. Physician's **documentation of primary site** in the medical record
   Example: The operative and pathology reports are not in the medical record. The **attending documents** that the patient had a biopsy of a **cerebral meningioma** at a different facility. Code the primary site cerebral meninges C700.
4. For cases diagnosed by imaging (**no pathology/resection or biopsy**) use information from scans in the following priority order:
   A. MRI
   B. CT
   C. PET
   D. Angiogram

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Reportable Primary Site Groups

The two major groups of reportable sites are:

1. **Intracranial** (within the skull/cranium)
2. **Spinal sites** (spinal meninges and sites within the spinal meninges)

Reportable Primary Sites and their ICD-O Codes

1. Intracranial (intra means inside or within; intracranial is inside the skull).
   A. **Cerebral/cranial dura/meninges** C700. The cerebral meninges has three layers:
      i. **Dura** mater is the **superficial** layer of meninges
         - Tightly adherent to skull
         - Contains folds and **sinuses**
         - Contacts **endosteum** which lines the bones of the skull
      ii. **Arachnoid** mater forms the middle of the three layers of meninges
      iii. **Pia** mater is the delicate vascular fibrous membrane which is adherent to the brain.
   B. **Brain** C710-C719
   C. **Cranial nerves** C722-C729. See **Table 2:** **Reportability of Non-Malignant Cranial Nerve (CN) Tumors**
   D. **Intracranial glands C751-C753**
      i. Craniopharyngeal duct C752
      ii. Pineal gland C753
      iii. Pituitary gland C751
2. **Spinal** sites: includes the **spinal meninges** and **all** structures **within** the meninges (Intradural, within/in the spinal meninges).
   A. Spinal cord **C720**
   B. The spinal meninges **C701** covers/encloses the spinal cord.

Table 1: Reportable Primary Sites

Column 1 lists the reportable primary site term.
Column 2 lists the site code for the reportable primary site.

Site Group	Reportable Subsite Terms and Code
Brain	Brain NOS **C719** Brain stem **C717** Cerebellum NOS **C716** Cerebrum **C710** Frontal lobe **C711** Occipital lobe **C714** Overlapping lesion of brain **C718** Parietal lobe **C713** Temporal lobe **C712** Ventricle NOS **C715**
Cranial Nerves **Row continues on next page**	Abducent (cranial nerve VI) **C725** Accessory (cranial nerve XI) **C725** Acoustic (cranial nerve VIII) **C724** Cranial nerve NOS **C725** Facial (cranial nerve VII) **C725** Glossopharyngeal (cranial nerve IX) **C725** Hypoglossal (cranial nerve XII) **C725** Oculomotor (cranial nerve III) **C725** **Row continues on next page**

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(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Table 1: Reportable Primary Sites

Site Group	Reportable Subsite Terms and Code
Cranial Nerves **(continued)**	Olfactory (cranial nerve I) **C722** Optic (cranial nerve II) **C723** Trigeminal (cranial nerve V) **C725** Trochlear (cranial nerve IV) **C725** Vagus (cranial nerve X) **C725**
Ill-Defined Sites Central Nervous System	Nervous system NOS **C729** Overlapping lesion of brain and central nervous system **C728**
Intracranial Duct and Glands	Craniopharyngeal duct **C752** Pineal gland **C753** Pituitary gland **C751**
Meninges	Cerebral meninges **C700** Meninges NOS **C709** Spinal meninges **C701**
Spinal Sites	Cauda equina **C721** Conus medullaris/filum terminale **C720** Meninges NOS **C709** Spinal cord **C720** Spinal meninges **C701**

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Table 2: Reportability of Non-Malignant Cranial Nerve (CN) Tumors

This table is used to determine whether non-malignant cranial nerve tumors and cranial nerve meningiomas are **reportable**. When cranial nerves **exit** the **intracranial** space, they become **peripheral nerves (non-reportable)**.

Note 1: A neoplasm arising in a **cranial** nerve is coded to the **specific nerve** in which it **arises**.
Note 2: Neoplasms, commonly meningiomas, **arising** in the **dura/meninges** of an **intracranial** nerve are coded to **cerebral meninges** C700.
Note 3: It is important to check the **operative report** to determine whether the surgery is **intracranial** or **intradural.**
Note 4: This table is used for **non-malignant** neoplasms **ONLY.**

Column 1: The **proper name** for the cranial nerve (CN) and the **cranial nerve number**
Column 2: The point at which the nerve exits the cranium
Column 3: **Reportable** portions of the cranial nerve. Of note, malignant neoplasms are reportable for all parts of the cranial nerves
Column 4: **Non-reportable** portions of the cranial nerve

Name and CN #	Exits Cranium Through	Reportable Portions of CN	Non-Reportable Portions of CN
Cranial nerve NOS **C725**		**Within cranium**, unknown which nerve	
Olfactory CN 1 **C722**	Cribriform plate	Surface of the **brain**	Originates on the **olfactory mucosa** of **nasal cavity**, then travels through the **cribriform plate** of the **ethmoid bone**
Optic CN 2 **C723**	Optic canal	**Always reportable:** CN2 is unique because it is intradural, covered with the meninges/dura and **all portions** are **reportable**.	

Table 2: Reportability of Non-Malignant Cranial Nerve (CN) Tumors

Name and CN #	Exits Cranium Through	Reportable Portions of CN	Non-Reportable Portions of CN
Oculomotor CN 3 **C725**	Superior orbital fissure	Originates in the **midbrain**	After exiting the superior orbital fissure, the nerve enters the **orbit**.
Trochlear CN 4 **C725**	Superior orbital fissure	Arises from the **dorsal brain stem**, loops around the brainstem and passes anteriorly within the **subarachnoid space**. It travels between the **superior cerebellar and posterior cerebral arteries** and through the **dura,** enters **cavernous sinus.**	Enters the **orbital fissure**.

Table 2: Reportability of Non-Malignant Cranial Nerve (CN) Tumors

Name and CN #	Exits Cranium Through	Reportable Portions of CN	Non-Reportable Portions of CN
Trigeminal CN 5 [1] **C725**	The ophthalmic, maxillary and mandibular branches leave the skull through three separate foramina, the superior orbital fissure, the foramen rotundum and the foramen ovale.	CN5 originates in the **pons**. Upon leaving the pons it enters a **small fossa** posterior and inferolateral to the cavernous sinus called **Meckel's (trigeminal) cave**.	• **Ophthalmic nerve branch** crosses the **pterygopalatine fossa**, inclines laterally on the back of the **maxilla**, and enters the **orbit** through the inferior orbital fissure where it is called the **infraorbital** nerve. It ends beneath the **quadatus labii superius**, and divides into multiple branches that spread to the side of the **nose**, the lower **eyelid**, and the upper **lip** • **Maxillary** nerve leaves foramen rotundum and traverses the **infraorbital groove** and **canal** in the floor of the **orbit**, and appears on the face at the infraorbital foramen. • **Mandibular** nerve leaves via the foremen ovale travels along the **mandibular** groove
Abducent CN 6 **C725**	Cranial meninges	Exits brainstem at junction of **pons** and the **medulla**, enters the **subarachnoid** space and runs upward between the pons and the **clivus** entering the **cavernous sinus.**	**Dorello's canal** and travels to the tip of the **temporal bone**. Enters **orbit**
Facial CN 7 **C725**	Internal acoustic meatus	**CN7** originates in the **pons,** along the posterior cranial fossa (the posterior cranial fossa is part of the intracranial cavity).	Enters the **temple** through the **internal auditory meatus** and runs through the **facial canal**.

[1] Trigeminal is derived from Latin trigeminus which means born in threes (tri) and born at the same time (germinal). As the name implies, the nerve separates into three branches; ophthalmic, maxillary, and mandibular

Table 2: Reportability of Non-Malignant Cranial Nerve (CN) Tumors

Name and CN #	Exits Cranium Through	Reportable Portions of CN	Non-Reportable Portions of CN
Acoustic or vestibulocochlear CN 8 **C724**	Internal acoustic meatus	Originates in the **brain stem** (**medulla oblongata**) **between** the base of the brain (**pons**) and the **spinal cord.** Both the **vestibular** branch and the **cochlear** branch are located in the **inner ear.**	
Glossopharyngeal CN 9 **C725**	Jugular foramen	**Originates** in the anterior portion of the **medulla oblongata.**	**Jugular foramen** Between the i**nternal jugular** vein and **internal carotid artery** Lies on the **stylopharyngeus** and **middle pharyngeal constrictor muscle** Passes under the **hypoglossus muscle** **Palatine tonsil** Extends to **mucous glands** of the **mouth**, and **base** of the **tongue**
Vagus CN 10 **C725**	Jugular foramen	The vagus nerve originates from the **medulla** of the **brainstem**.	CN10 descends within the **carotid sheath** medial to the internal jugular vein at the root of the **neck**. The right vagus crosses in front of the subclavian artery and travels into the **fat behind the blood vessels**, reaching the **thorax**. It then inclines **behind** the **hilum** of the **right lung** and moves toward the esophagus. The nerve splits into the **right** and **left** vagus at the **esophageal plexus** forming the anterior and posterior **gastric** nerves.

Table 2: Reportability of Non-Malignant Cranial Nerve (CN) Tumors

Name and CN #	Exits Cranium Through	Reportable Portions of CN	Non-Reportable Portions of CN
Accessory CN 11 **C725**	Jugular foramen	The nerve enters the foramen magnum or lateral aspect of the **medulla oblongata.**	The spinal accessory nerve **originates** in the neurons of the upper spinal cord, specifically **C1-C5/C6 spinal nerve roots**. The fibers of the spinal accessory nerve coalesce to **form spinal rootlets, roots**, and finally the **spinal accessory nerv**e itself. The nerve **exits** the skull through the jugular foramen. It then runs along the internal **carotid artery** within the **neck** and reaches the **sternocleidomastoid** muscle and the **trapezius.**
Hypoglossal CN 12 **C725**	Hypoglossal canal	**CN12** starts in the **hypoglossal** nucleus of the **brainstem**.	**CN12** exits the hypoglossal canal, traveling **between** the **carotid** artery and **jugular** vein, ending under the **tongue.**

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Table 3: Non-Reportable Neoplasms

Use **Table 3** for **non-malignant neoplasms ONLY**. The table identifies **histology/site** combinations which are **not reportable.** This table was created from WHO with the cooperation of the Central Brain Tumor Registry of the United States (CBTRUS).

Non-reportable Histology Term	Non-reportable Histology Code	Definitions and Sites
Carcinomas	**8010-8060, 8071-8671, 8940-8941**	Brain C710-C719 **Site/histology edit carcinomas/brain**
Carcinomas	**8010-8671, 8940-8941**	Cerebral meninges, spinal meninges, meninges NOS C700-C709 **Site/histology edit carcinomas/meninges**
Carcinomas	**8010-8671, 8940-8941**	C721-C729 (Other central nervous system) **Site/histology edit carcinomas/other CNS**
Colloid cyst	**No code**	
Epidermoid tumor/cyst	**No code**	
Glomus tympanicum, glomus jugulare	**8690/1**	These tumors occur in the inner ear, the aortic body and other paraganglia respectively; these sites are **not reportable** as non-malignant. See Head and Neck Table 9 for malignant glomus jugular tumors.
Hygroma	**9173/0**	
Hypothalamic hamartoma	**No code**	Occurs in hypothalamus

Table 3: Non-Reportable Neoplasms

Non-reportable Histology Term	Non-reportable Histology Code	Definitions and Sites
Neurofibromatosis, NOS [1]	**9540/1**	Genetic disease that produces non-malignant tumors in the skin, brain, CNS, and other sites. The brain and CNS tumors spawned by NF, NOS are reportable, the genetic disease is not.
Neurofibromatosis, type 1 (NF1) [1]	**No code**	Genetic disease that produces non-malignant tumors in the skin, brain, CNS, and other sites. The brain and CNS tumors spawned by NF1 are reportable, the genetic disease is not.
Neurofibromatosis, type 2 (NF2) [1]	**No code**	Genetic disease that produces non-malignant tumors in the skin, brain, CNS, and other sites. The brain and CNS tumors produced by NF2 are reportable, the genetic disease is not.
Neuroglial cyst	**No code**	Ventricles
Osteochondroma	**9210/0**	Originates in the cartilage around bone, site not reportable for non-malignant neoplasms
Rathke cleft cyst	**No code**	Sella turcica C751. This is a Rathke cleft CYST, not a Rathke cleft tumor.
Schwannomatosis [1]	**No code**	A form of neurofibromatosis newly named/discovered

[1] The code which is currently in ICD-O-3 for neurofibromatosis will not be used in ICD-O updates or in future ICD-O editions.

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(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Table 4: Histologic Types of Non-Malignant Intracranial (Brain and Glands) Tumors

Because non-malignant brain and gland tumors are **less common,** this table identifies histologies which occur in the brain C710-C719 and the glands within the cranium C751-C753. These histologies also appear in Table 5.

IMPORTANT: This table does not list ALL PRIMARY SITES that are possible for a histology. It only includes sites where the histology can occur INTRACRANIALLY.

Use **Table 4** to:

- **Code primary site** when the instructions in **Section 1**: **Reportable Primary Sites and Histologies** do not apply
- **Confirm** that a **histology** can/should be coded to brain or intracranial glands

Column 1 contains **histology terms and codes** that occur in the **brain**, **ventricles** of the brain, and **intracranial glands**
Column 2 contains the **site code** for the most common **intracranial** primary site(s) for that specific histology

Histology Term and Code	Most Common Intracranial Primary Site
Angiocentric glioma 9431 (/1)	Cerebrum **C710**
Choroid plexus papilloma 9390 (/0)	Intraventricular site (lateral/third ventricle **C715** and IV ventricle **C717**)
(Capillary) hemangioblastoma 9161 (/1)	Cerebellum **C716**, cerebrum (rare) **C710**
Craniopharyngioma 9350 (/1)	Craniopharyngeal duct **C752,** pituitary gland, sella turcica **C751**
Dermoid cyst 9084 (/0)	Pineal gland **C753**, suprasellar **C719**
Desmoplastic infantile astrocytoma and ganglioglioma 9412 (/1)	Cerebrum/supratentorial brain NOS **C710**

Table 4: Histologic Types of Non-Malignant Intracranial (Brain and Glands) Tumors

Histology Term and Code	Most Common Intracranial Primary Site
Dysembryoplastic neuroepithelial tumor (DNT) 9413 (/0)	Cerebrum **C710**, temporal lobe **C712**
Dysplastic gangliocytoma 9493 (/0)	Cerebellum **C716**
Juvenile xanthogranuloma 9749 (/1)	Intraventricular **C715**
Meningioma (rare) 9530 (/0)	Intraventricular **C715**
Myxopapillary ependymoma 9394 (/1)	4th ventricle **C717**
Pilocytic astrocytoma/juvenile pilocytic astrocytoma 9421 (/1)	Optic nerve **C723**
Pineocytoma 9361 (/1)	Pineal gland **C753**
Pituicytoma 9432 (/1)	Pituitary gland **C751**, sella turcica **C751,** suprasellar **C719**
Pituitary adenoma 8272 (/0)	Pituitary gland **C751**
Prolactinoma 8271 (/0)	Pituitary gland **C751**
Subependymal giant cell tumor (SEGA) 9384 (/1)	Lateral ventricles **C715**
Subependymoma 9383 (/1)	Intraventricular site (lateral/third ventricle, rare **C715** and IV ventricle **C717**)

Table 5: Specific Histologies, NOS, and Subtypes/Variants

Use this table to identify **reportable** histologies, **including specific, NOS,** and the **subtype/variant** of that NO**S** when referenced in the Multiple Primary and Histology coding rules**.**

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 is not found in Table 3, ICD-O or all updates.

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/0 or /1)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/0 or /1)**

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Benign fibrous histiocytoma 8830 (/0)	
Chondroma 9220 (/0)	
Chordoid glioma of the third ventricle 9444 (/1)	
Choroid plexus papilloma 9390 (/0)	Atypical choroid plexus papilloma **9390 (/1)**

Table 5: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Craniopharyngioma 9350 (/1)	Adamantinomatous craniopharyngioma **9351 (/1)** Papillary craniopharyngioma **9352 (/1)**
Desmoplastic infantile astrocytoma and ganglioglioma 9412 (/1) • DIAG	
Diffuse astrocytoma, MYB- or MYBL1 altered 9421 (/1) [1] • Diffuse low-grade glioma, MAPK pathway-altered • Juvenile pilocytic astrocytoma • Pilocytic astrocytoma [2]	Angiocentric glioma **9431 (/1)** • Angiocentric neuroepithelial tumor • Monomorphous angiocentric glioma
Dysembryoplastic neuroepithelial tumor 9413 (/0) [3] • DNET	
Gangliocytoma 9492 (/0)	Dysplastic cerebellar gangliocytoma **9493 (/0)** • Lhermitte-Duclos disease
Ganglioglioma 9505 (/1)	
Granular cell tumor of the sellar region 9582 (/0)	
Hemangioblastoma 9161 (/1) • Capillary hemangioblastoma	

[1] Beginning 1/1/2023, diffuse astrocytoma, MYB- or MYBL1 altered is the preferred term for 9421/1.
[2] Beginning 1/1/2023, pilocytic astrocytoma/juvenile pilocytic astrocytoma are coded 9421/1. Cases diagnosed prior to 1/1/2023 are coded 9421/3.
[3] DNET and PLNTY have the same ICD-O code but are distinctly different histologies. Because they are different, they are on separate rows in column 1.

Table 5: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Hemangioma 9120 (/0) • Cavernoma • Cavernous angioma	Cavernous hemangioma **9121 (/0)** Venous hemangioma **9122 (/0)**
Juvenile xanthogranuloma 9749 (/1)	
Leiomyoma 8890 (/0)	
Lipoma 8850 (/0)	Hibernoma **8880 (/0)**
Low-grade glioma 9380 (/1) [4] [5]	
Meningeal melanocytosis 8728 (/0)	Meningeal melanocytoma **8728 (/1)**
Meningioma 9530 (/0) • Lymphoplasmacyte-rich meningioma • Metaplastic meningioma • Microcystic meningioma • Secretory meningioma	Angiomatous meningioma **9534 (/0)** Atypical meningioma **9539 (/1)** Clear cell meningioma **9538 (/1)** • Chordoid meningioma Fibrous meningioma **9532 (/0)** Meningothelial meningioma **9531 (/0)** Psammomatous meningioma **9533 (/0)** Transitional meningioma **9537 (/0)**

[4] Low grade glioma is an umbrella term or non-specific diagnosis, primarily seen on radiologic reports such as CT scans and MRIs. Often, the patient is actively followed with scans and surgical intervention delayed or not recommended.

[5] Cancer PathCHART expert review determined site/histology combination of glioma and CNS is unlikely and if coded, will trigger the IF25 edit. If review of the case confirms glioma, override the edit.

Table 5: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Multinodular and vacuolating neuronal tumor 9509 (/0) [6] • MVNT	
Myofibroblastoma 8825 (/0)	Inflammatory myofibroblastic tumor **8825 (/1)**
Myxopapillary ependymoma 9394 (/1)	
Neurocytoma 9506 (/1) • Central neurocytoma • Cerebellar liponeurocytoma • Extraventriculare neurocytoma • Lipomatous medulloblastoma • Medullocytoma • Neurolipocytoma	
Neuroepithelial tumor, benign 8000 (/0) [7] • Neuroepithelial tumor NOS **(/1)**	
Neurofibroma 9540 (/0) • Atypical neurofibroma	Plexiform neurofibroma **9550 (/0)**

[6] MVNT and papillary glioneuronal tumor have the same ICD-O code but are distinctly different histologies based on behavior codes. Because they are different, they are on separate rows in column 1.

[7] Neuroepithelial tumor is a rare tumor specific to children. These neoplasms have numerous subtypes which are not easily identified so a specific type may not be provided in the pathology report. WHO has not proposed an ICD-O code for this entity. The current option is to assign code 8000. Because these tumors are different, they are on a separate row.

Table 5: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Optic glioma 9421 (/1) • Pilocytic astrocytoma	
Papillary glioneuronal tumor 9509 (/1) [8] • Diffuse leptomeningeal glioneuronal tumor [9] • Rosette-forming glioneuronal tumor	
Paraganglioma 8693 (/1) [10]	
Perineurioma 9571 (/0)	
Pineocytoma 9361 (/1)	
Pituicytoma 9432 (/1)	
Pituitary adenoma NOS 8272 (/0) [11] • Corticotroph • Gonadotroph adenoma • Null cell adenoma • Plurihormonal and double adenomas • Somatotroph adenoma • Thyrotroph adenoma	

[8] MVNT and papillary glioneuronal tumor have the same ICD-O code but are distinctly different histologies based on behavior codes. Because they are different, they are on rows in column 1.
[9] Beginning with cases diagnosed 1/1/2023 forward, diffuse leptomeningeal glioneuronal tumor is coded 9509/3. See the Malignant CNS rules.
[10] Paraganglioma must be staged as benign to assign /1.
[11] A diagnosis of pituitary adenoma NOS is coded 8272/0. A diagnosis of pituitary adenoma/PitNET (this is a single term) or PitNET is coded 8272/3.

Table 5: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Polymorphous low-grade neuroepithelial tumor of the young 9413 (/0) [12] • PLNTY	
Prolactinoma 8271 (/0)	
Rhabdomyoma 8900 (/0)	
Schwannoma 9560 (/0) • Acoustic neuroma • Cellular schwannoma • Neurilemoma • Neurinoma • Plexiform schwannoma	Melanotic schwannoma **9560 (/1)**
Solitary fibrous tumor Grade 1 8815 (/1) [13] • Hemangiopericytoma Grade 1 • Hemangiopericytoma Grade 2 • Solitary fibrous tumor	
Spindle cell oncocytoma 8290 (/0)	
Subependymal giant cell astrocytoma 9384 (/1)	

[12] DNET and PLNTY have the same ICD-O code but are distinctly different histologies. Because they are different, they are on separate rows in column 1.
[13] Behavior for solitary fibrous tumor, grade I changed from /0 to /1 effective with cases diagnosed 1/1/2025 forward. The change is per Cancer PathCHART expert neuropathologist review.

Table 5: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Subependymoma 9383 (/1)	
Teratoma 9080 (/1)	

Section 2: Additional Information to Complete Abstract

Conflicting Information on Pathology Report(s)

The **classification** of brain tumors is a **subjective** matter because definitive criteria have not been established/accepted. Pathologists may **disagree** on the histology or behavior.

Follow the steps below for coding the histology and/or behavior of tumor when there are discrepancies:

- When possible, get advice from the **pathologist**
- When possible, contact **attending** physician
- When possible, consult with **registry advisor**
- If none of those **options** are **available**, code the histology and grade from **the most dependable source** (see **Priority Order for Using Documentation to Identify Histology**).

The following are examples of how conflicting information occurs in single and in multiple pathology reports

- **Single pathology report:**
  - **Multiple pathologists** within the institution review the slides
  - Slides are sent for **outside review** and the information from the **consulting** lab **conflicts** with the **original** pathology report
- **Multiple pathology reports:** The **first report** is from a biopsy and the **second report** is from a resection. Code the histology and/or behavior from the resection.

Table 6: Paired Sites

Use **Table 6** to identify sites for which laterality **must** be coded. Do **not** use this table to determine multiple primaries.

Paired Sites and Codes
Acoustic nerve **C724**
Cerebral meninges **C700**
Cerebrum **C710**
Cranial nerves **C725**
Frontal lobe **C711**
Occipital lobe **C714**
Olfactory nerve **C722**
Optic nerve **C723**
Parietal lobe **C713**
Temporal lobe **C712**

Note 1: Midline tumors are most common for the following histologies: glioblastoma multiforme, meningiomas, lymphomas (usually located near the midline), and epidermoid cysts (which can cross the midline via the subarachnoid space).

Note 2: SEER allows laterality to be coded for sites other than those in the table.

Table 7: Non-Malignant CNS Tumors with the Potential of Transforming to Malignant Behavior

The word "**transformation**" as used in this table means that:

- Residual tumor becomes **more aggressive /3 OR**
- The tumor **recurs** as a **more aggressive /3 histology**

The table identifies non-malignant tumors that have the **potential** of **transforming to** a malignant tumor (**new primary**).

Column 1 is the **non-malignant** ICD-O histology term and code.
Column 2 is the **malignant** /3 ICD-O histology term and code to which the non-malignant tumor can transform.

Original Histology and Code	Transformed Histology and Code
Chondroma **9220 (/0)**	Chondrosarcoma **9220 (/3)**
Ganglioglioma **9505 (/1)**	Anaplastic ganglioglioma **9505 (/3)**
Hemangioma **9120 (/0)**	Angiosarcoma **9120 (/3)**
Hemangiopericytoma **9150(/1)**	Anaplastic hemangiopericytoma **9150 (/3)**
Leiomyoma **8890 (/0)**	Leiomyosarcoma **8890 (/3)**
Lipoma **8850 (/0)**	Liposarcoma **8850 (/3)**
Osteoma **9180 (/0)**	Osteosarcoma **9180 (/3)**
Perineurioma **9571 (/0)**	Malignant perineurioma **9571 (/3)**
Rhabdomyoma **8900 (/0)**	Rhabdomyosarcoma **8900 (/3)**

Table 7: Non-Malignant CNS Tumors with the Potential of Transforming to Malignant Behavior

Original Histology and Code	Transformed Histology and Code
Teratoma **9080(/1)**	Immature teratoma **9080 (/3)**
Teratoma, mature **9080 (/0)**	Immature teratoma **9080 (/3)**

Illustrations

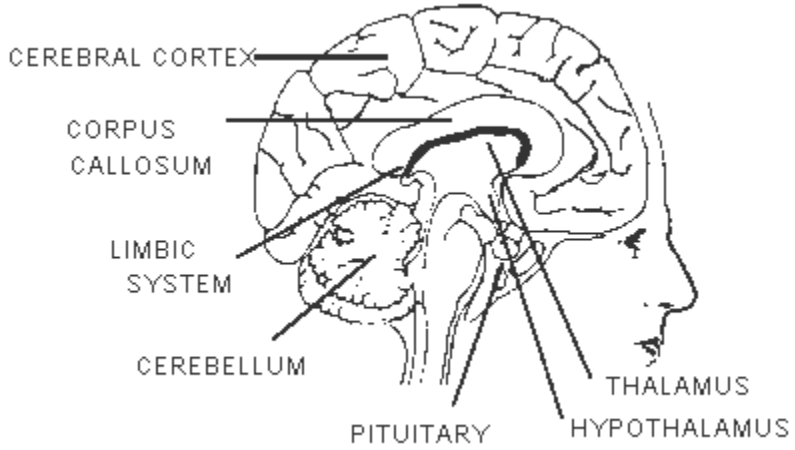


Table 7: Non-Malignant CNS Tumors with the Potential of Transforming to Malignant Behavior

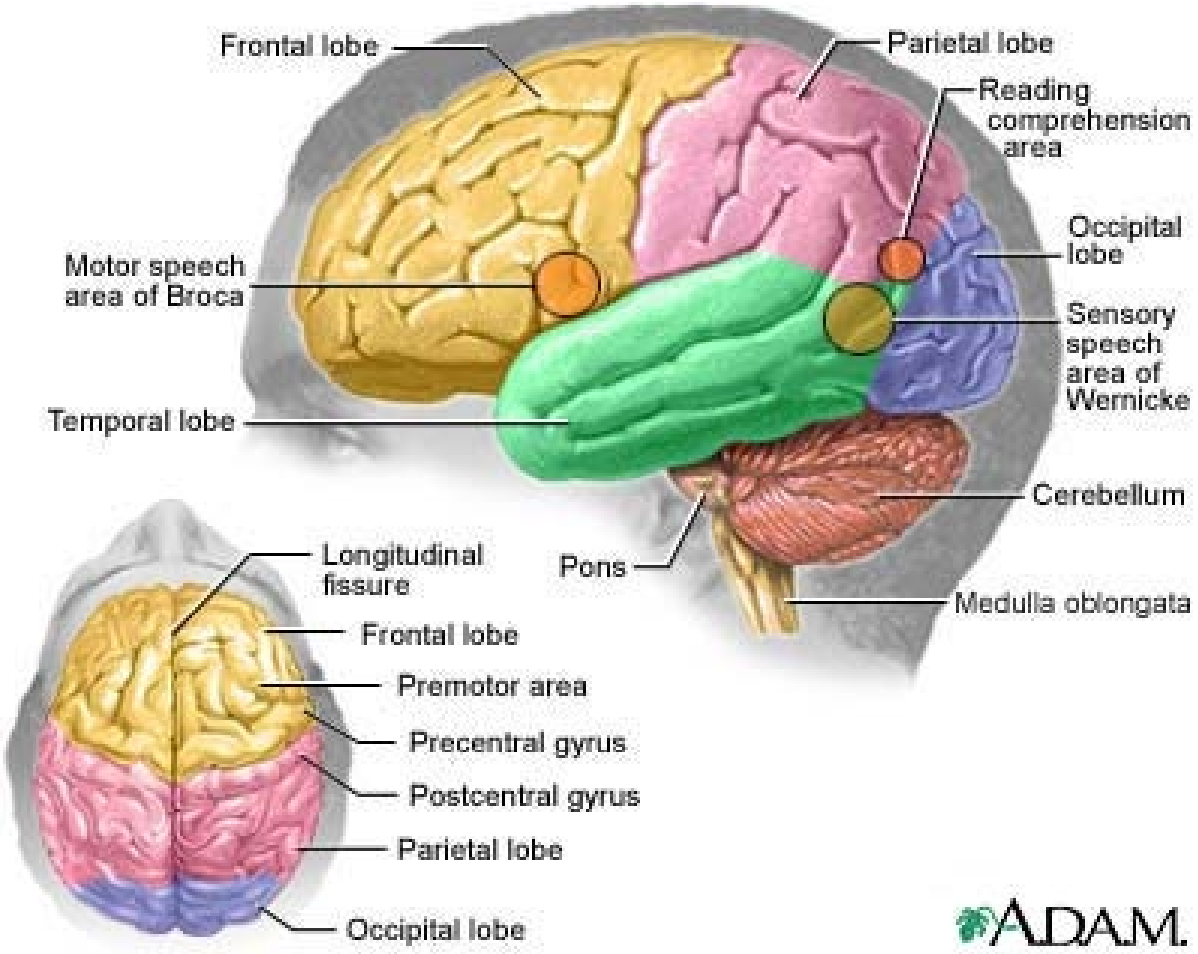


Table 7: Non-Malignant CNS Tumors with the Potential of Transforming to Malignant Behavior

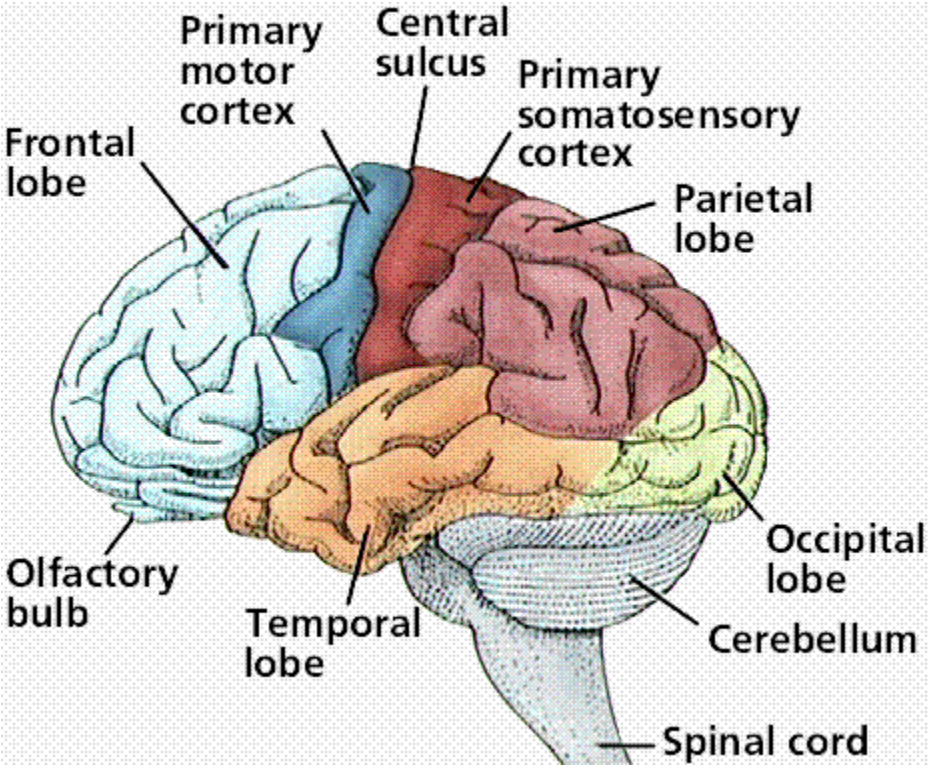


Table 7: Non-Malignant CNS Tumors with the Potential of Transforming to Malignant Behavior

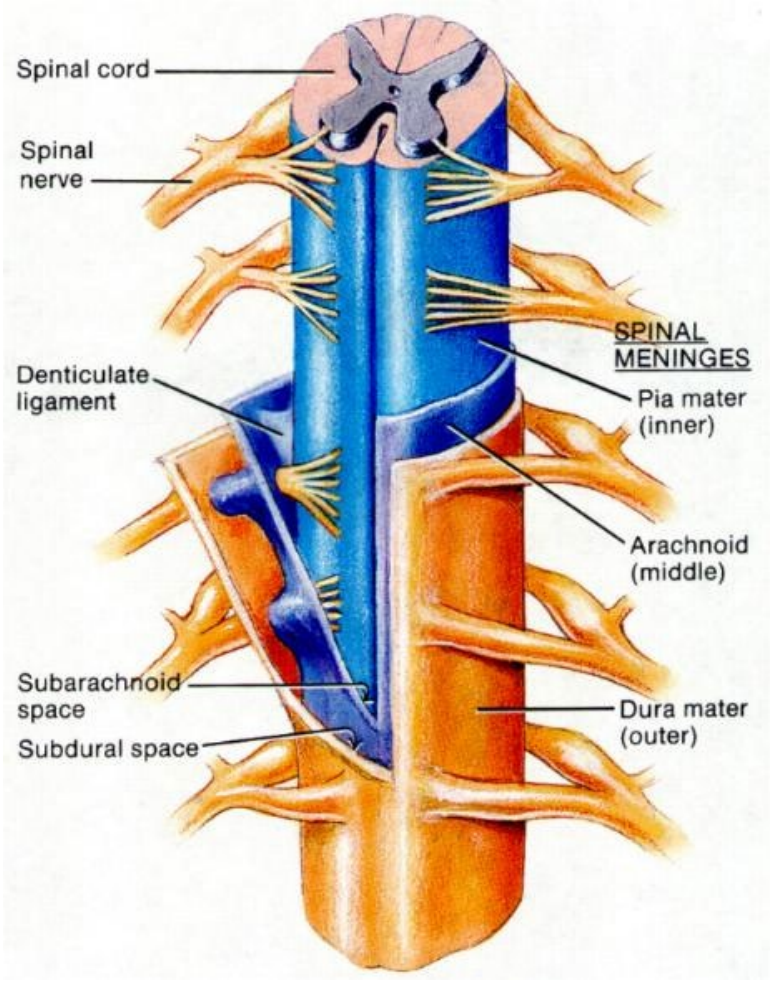


Table 7: Non-Malignant CNS Tumors with the Potential of Transforming to Malignant Behavior

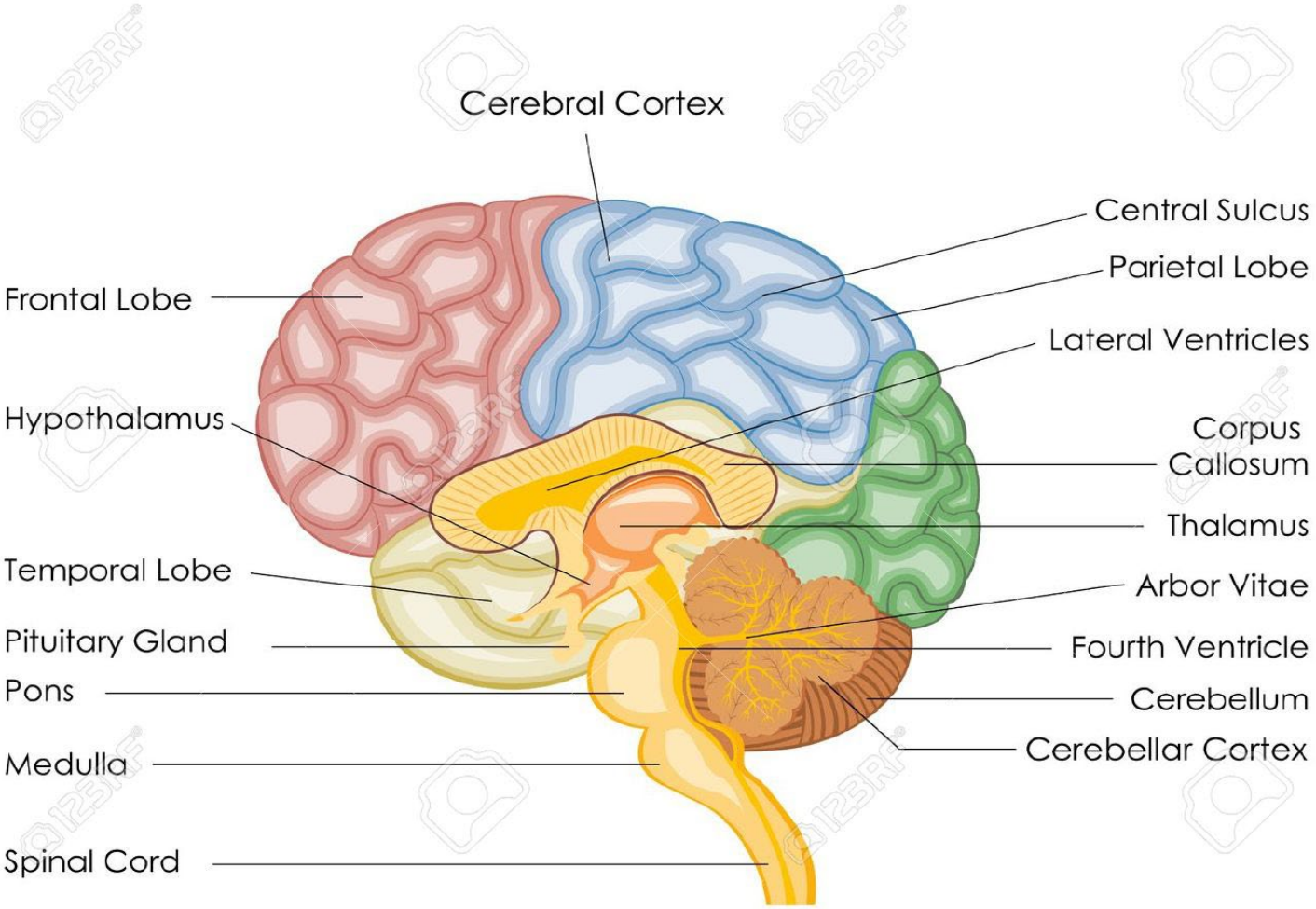
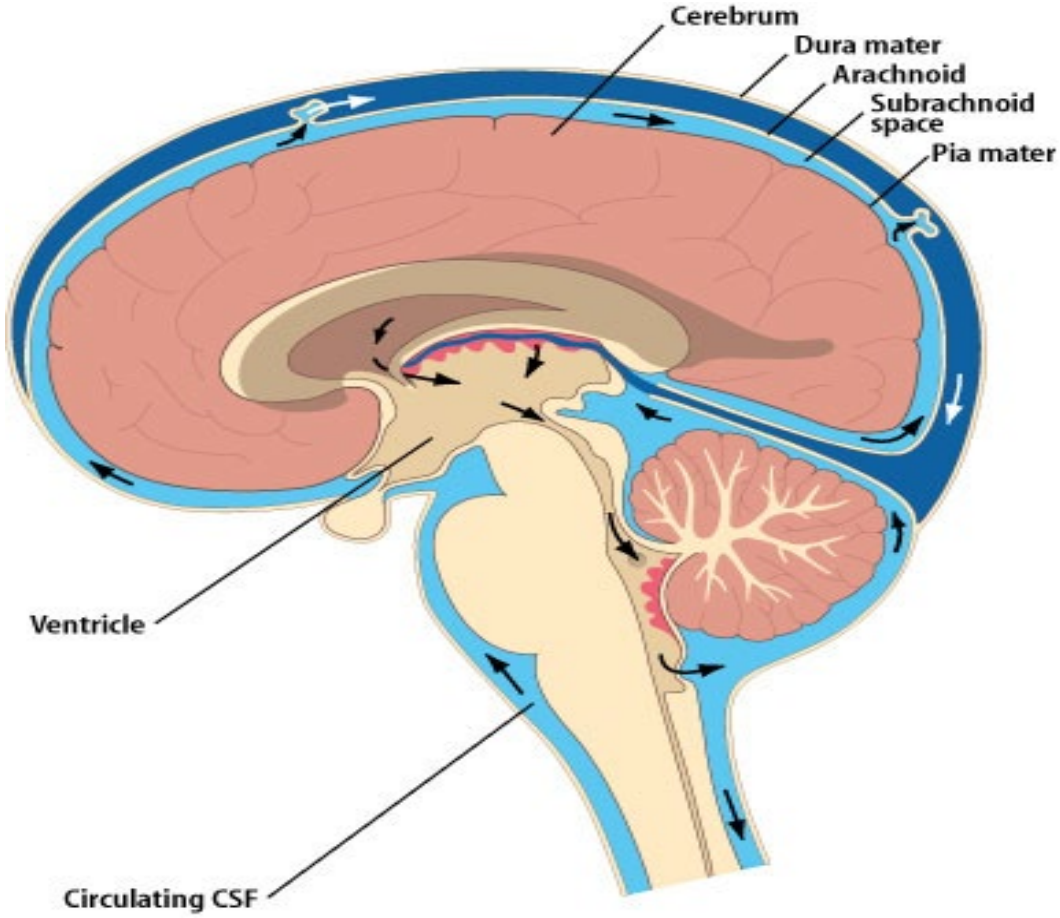


Table 7: Non-Malignant CNS Tumors with the Potential of Transforming to Malignant Behavior



Non-Malignant CNS Multiple Primary Rules
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Note 1: Timing is not used to determine multiple primaries.
Note 2: Laterality is not used to determine multiple primaries.
Note 3: Malignant central nervous system (CNS) tumors have a separate set of 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.

Use the histology coding rules to assign the appropriate histology code

Non-Malignant CNS Multiple Primary Rules
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Single Tumor

IMPORTANT: The **major difference** between **M3** and **M6** is:
M3: No resection as first course of treatment **AND** when the same tumor is subsequently **resected**, **pathology proves malignant** behavior
M6: Tumor resected as first course of treatment. Subsequent tumor (**recurrence** or **de novo)** is **malignant**

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

Note 1: A single tumor is **always** a single primary.
Note 2: The tumor may overlap onto or extend into an adjacent/contiguous site or subsite.
Note 3: The tumor may have multiple histologic components.
Note 4: The tumor may be diagnosed as borderline /1 on scans and subsequent pathology proves a benign /0 tumor.
Example: Patient has an MRI with a diagnosis of a benign /0 tumor. The pathology report from the subsequent surgery shows a borderline /1 tumor. This is a single tumor and **a single primary**. (It is the same tumor as seen on the MRI; better information is provided by the pathology report.)

Rule M3 Abstract a **single primary** (the malignant) when a single tumor meets the following two criteria:

1. The original diagnosis was non-malignant /0 or /1 **AND**
   - First course treatment was active surveillance (no tumor resection). Diagnosis was:
     - Clinical
     - Radiographic
     - Stereotactic biopsy
2. Subsequent resection pathology is malignant /3

Note 1: This is a **new rule** which **clarifies** that a single tumor is **always** a single primary and the malignant behavior is reported.
Note 2: Use the Malignant CNS and Peripheral Nerves Rules to code histology.
Note 3: The **resection pathology** is **more accurate** than clinical, radiographic or stereotactic biopsy information. While stereotactic biopsy provides a pathologic specimen, it is small and may not have included the malignant portion of tumor.
Note 4: There is **no time requirement** from initial diagnosis to resection.
Note 5: Edit the original abstract as follows:
- Do **not** change **date of diagnosis**.
- For cases which have been abstracted, **change behavior** code on original abstract from /0 or /1 to /3.

- **Report** all data changes for cases which have been submitted to the central registry.
- See the **COC** and **SEER manuals** for **instructions** on coding **other data items** such as Accession Year, Tx and Seq Num.

Note 6: The physician may have staged the non-malignant tumor at the time of original diagnosis (benign). The physician will also stage the malignant tumor. 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).

Example 1: A patient is diagnosed by **MRI** with **ganglioglioma 9505/1** in July 2009. After months of active surveillance (watchful waiting), the **patient** becomes **symptomatic**. A **resection** is done in April 2010; the **resection** pathology is **anaplastic ganglioglioma 9505/3**. **Change behavior code** on the **original abstrac**t from /1 to /3. Do not **change date of diagnosis.**

Example 2: A November 15, 2016 **MRI** and **subsequent** stereotactic **biopsy** of lateral ventricle of brain show a **mature teratoma 9080/1**. The patient becomes symptomatic in 2017 and the neoplasm is resected on October 31, 2017. The **resection pathology** diagnoses **immature teratoma 9080/3. Change behavior code** on the **original abstract. Do not change date of diagnosis.**

Rule M4 Abstract a **single primary** when a single **benign** tumor /0 **transforms** to an **uncertain/borderline** tumor /1. Timing is irrelevant. The tumors are:

- The **same histology OR**
- A **NOS** and a **subtype/variant** of that NOS

Note 1: **Do not change** the date of diagnosis **OR** the behavior code on the original abstract.

Note 2: This is a single tumor; single primary

Note 3: Both behaviors /0 and /1 are non-malignant; it is not necessary to change the original abstract.

Note 4: The physician may stage both tumors. 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 5: For registries that collect recurrence data, document the transformed tumor as a recurrence.

Example 1: A choroid plexus papilloma NOS **9390/0 transforms** to an atypical choroid plexus papilloma **9390/1**. This is a **single primary.**

Example 2: A meningioma **9530/0 transforms** to an atypical meningioma **9539/1.**

Rule M5 Abstract a **single primary** when a neoplasm is originally diagnosed as low-grade glioma and subsequently recurs in residual tumor with a more specific histology.

Note 1: Low-grade glioma is considered an umbrella term or non-specific diagnosis, primarily seen on radiographic reports such as CT scans and MRIs. Often the patient is actively followed with scans and surgical intervention delayed or not recommended that would provide a definitive histology type. A diagnosis of low-grade glioma is not recommended and may be used when the diagnosis is based on imaging and/or additional tests were inconclusive.

Note 2: If a specific histology is diagnosed in residual tumor or additional testing provides a definitive histology, edit the original abstract as follows:

- Do not change the date of diagnosis
- For cases that have been abstracted, update the ICD-O code based on the new findings
- Report all data changes for cases which have been submitted to the central registry

Note 3: Timing is irrelevant.

This is the end of instructions for Single Tumor.

Use the histology coding 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 CNS (see Table 1) **AND** in a site other than the CNS
  Example: Patient has a non-malignant meningioma of the cerebral meninges and adenocarcinoma of the lung. The lung is not a CNS site. Abstract two primaries.
- In different CNS sites (see Rule M8)

Note 3: For those sites which have recognized biomarkers, the biomarkers are most frequently used to target treatment. Follow the rules; do not code multiple primaries or histology based on biomarkers.

IMPORTANT: The **major difference** between **M3** and **M6** is:
M3: No resection as first course of treatment **AND** when the same tumor is subsequently **resected**, **pathology proves malignant** behavior
M6: Tumor resected as first course of treatment. Subsequent tumor (**recurrence** or **de novo)** is **malignant**

Rule M6 Abstract **multiple primaries** when a **malignant** tumor /3 occurs **after** a **non-malignant** tumor /0 or /1 **AND:**

- The patient had a **resection** of the non-malignant tumor **OR**
- It is **unknown/not documented** whether a resection was done

Note: Abstract the second tumor (malignant) using the Malignant CNS rules.

Rule M7 Abstract a **single primary** when the patient has **bilateral**:

- **Acoustic neuromas/ vestibular schwannomas 9560/0**
- **Optic gliomas/pilocytic astrocytomas 9421/1**

Note 1: The bilateral tumors may appear simultaneously (at the same time) **OR** the contralateral tumor may be diagnosed at any time following the original diagnosis.

Note 2: WHO and IARC designate pilocytic astrocytoma as a synonym for optic glioma. When the primary site is optic nerve, the behavior is non-malignant.

Note 3: When the bilateral tumors are diagnosed at different times**,** the physician **may stage each tumor** because staging and determining multiple primaries are done for different reasons. Staging determines which course of 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).

Non-Malignant CNS Multiple Primary Rules
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M8 Abstract **multiple primaries** when multiple tumors are present in any of the following **sites**:

- Any lobe(s) of the brain **C710-C719 AND** any other part of CNS
- Cauda equina **C721** AND any other part of CNS
- Cerebral meninges **C700 AND** spinal meninges **C701**
- Cerebral meninges **C700 AND** any other part of CNS
- Any cranial nerve(s) **C722-C725 AND** any other part of the CNS
- Meninges of cranial nerves **C700 AND** any other part of the CNS
- Spinal cord **C720 AND** any other part of CNS
- Spinal meninges **C701 AND** any other part of CNS

Rule M9 Abstract **multiple primaries** when separate, non-contiguous tumors are **two** or more different **subtypes/variants** in Column 2, **Table 5** in the Site-group Instructions. Timing is irrelevant.

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

- **Same NOS**: Atypical meningioma 9539/1 and fibrous meningioma 9532/0 are both subtypes of meningioma NOS 9530 but are distinctly different histologies. Abstract multiple primaries.
- **Different NOS**: Melanotic schwannoma 9560/1 is a subtype of schwannoma NOS 9560/0; papillary craniopharyngioma 9352/1 is a subtype of craniopharyngioma 9350/1. They are distinctly different histologies. Abstract multiple primaries.

Rule M10 Abstract a **single primary** when two or more separate/non-contiguous **meningiomas** arise in the cranial meninges. Laterality is irrelevant and may be any of the following combinations:

- The same laterality (left or right) of the cranial meninges
- Bilateral (both left and right) cranial meninges
- The midline **AND** in either the right or left cranial meninges

Note: This rule applies **ONLY** to **meningiomas** that are either a **NOS** and **subtype/variant**, OR they are the **same histology**.

Non-Malignant CNS Multiple Primary Rules
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M11 Abstract a **single primary** when there are separate/non-contiguous tumors in the brain (multicentric/multifocal) with the **same histology XXXX***. Tumors may be in any of the following locations and/or lateralities:

- Same laterality: In the same lobe; for example, two tumors in right temporal lobe **C712** (same site code)
- Different lateralities of the same lobe; for example, left and right frontal lobes **C711** (same site code)
- Different lobes; for example, parietal lobe **C713** and occipital lobe **C714** (different site codes)

***Exception 1:** MVNT and papillary glioneuronal tumor have the same ICD-O code but are distinctly different histologies based on behavior codes. Because they are different, they are in separate rows in Table 5.

***Exception 2:** DNET and PLNTY have the same ICD-O code but are distinctly different histologies. Because they are different, they are on separate rows in Table 5.

Note 1: Metastases are never used to determine multiple primaries. Seeding metastasis is often noted in ependymomas.
Note 2: This is a **change** from/**clarification** to **previous** rules.
Note 3: These rules are hierarchical. Use this rule ONLY when the previous rules do not apply.
Note 4: An example of a non-malignant brain tumor that may be multi-focal/multi-centric is hemangioblastoma **9161/1**.
Note 5: The physician may **stage each tumor** because staging and determining multiple primaries are done for different reasons. Staging determines which course of 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).

Rule M12 Abstract a **single primary** when separate/non-contiguous tumors are on the **same row** in **Table 5** in the Site-group Instructions. Timing is irrelevant.

Note: The same row means the tumors are:

- The same histology* (same four-digit ICD-O code) **OR**
- One is the preferred term and the other is a synonym for the preferred term indented below (column 1) **OR**
- A NOS (column 1) and the other is a subtype/variant of that NOS (column 2). NOS and subtype/variants are:
  - Choroid plexus papilloma **9390/0** and a subtype/variant of choroid plexus papilloma
  - Craniopharyngioma **9350/1** and a subtype/variant of craniopharyngioma
  - Gangliocytoma **9492/0** and a subtype/variant of gangliocytoma
  - Lipoma **8850/0** and a subtype/variant of lipoma
  - Meningeal melanocytosis **8728/0** and a subtype/variant of meningeal melanocytosis
  - Meningioma **9530/0** and a subtype/variant of meningioma

- Myofibroblastoma **8825/0** and a subtype/variant of myofibroblastoma
- Neurofibroma **9540/0** and a subtype/variant of neurofibroma
- Schwannoma **9560/0** and a subtype/variant of schwannoma
- Solitary fibrous tumor WHO Grade 1 **8815/0** and a subtype/variant of solitary fibrous tumor WHO Grade 1

***Exception 1:** MVNT and papillary glioneuronal tumor have the same ICD-O code but are distinctly different histologies based on behavior codes. Because they are different, they are on separate rows in Table 5.

***Exception 2:** DNET and PLNTY have the same ICD-O code but are distinctly different histologies. Because they are different, they are on separate rows in Table 5.

Rule M13 Abstract a **single primary** when separate, non-contiguous tumors are Glioma NOS and a subtype/variant of Glioma NOS.

Note: Low-grade glioma is considered an umbrella term or non-specific diagnosis, primarily seen on radiographic reports such as CT scans and MRIs. Often the patient is actively followed with scans and surgical intervention delayed or not recommended that would provide a definitive histology type. A diagnosis of low-grade glioma is not recommended and may be used when the diagnosis is based on imaging and/or additional tests were inconclusive.

Rule M14 Abstract **multiple primaries** when separate/non-contiguous tumors are on **different rows** in **Table 5** in the Site-group Instructions. Timing is irrelevant.

Note 1: Each row in the table is a **distinctly different** histology.

Note 2: MVNT and papillary glioneuronal tumor have the same ICD-O code but are distinctly different histologies based on behavior codes. Because they are different, they are on different rows in Table 5.

Note 3: DNET and PLNTY have the same ICD-O code but are distinctly different histologies. Because they are different, they are on separate rows in Table 5.

Note 4: 8000 is considered a different row ONLY when the diagnosis is neuroepithelial tumor. If the diagnosis is cancer, NOS, do not consider 8000 to be a separate row from other histologies for the purpose of the table rules.

Example 1: A tumor is diagnosed as 8000/1 Neuroepithelial tumor, NOS. Later, a separate tumor is diagnosed as Hemangioma 9120/0. These are considered separate rows.

Example 2: A tumor has a provisional diagnosis of 8000/0 and further diagnosis is done. A subsequent tumor in another lobe of the brain is diagnosed as myofibroblastoma 8825/0. These are not considered separate rows.

Non-Malignant CNS Multiple Primary Rules
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M15 Abstract a **single primary** when the tumors do not meet any of the above criteria.
Note: These rules are hierarchical. Use this rule **ONLY** when the previous rules do not apply.

This is the end of instructions for Multiple Tumors

Use the histology coding rules to assign the appropriate histology code

Non-Malignant CNS Histology Rules
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Note 1: Non-malignant central nervous system (CNS) neoplasms (previously called benign and borderline) are **reportable** for cases **diagnosed 1/1/2004** and later.
Note 2: **Malignant** central nervous system **(CNS)** tumors have a **separate** set of **rules.**
Note 3: These rules are **not used** for tumor(s) or neoplasm(s) described as **metastatic/metastasis.**
Note 4: For rules specifying a **NOS** and a **subtype/variant** of the NOS, the NOS may be the preferred/most common term **OR** any of the **synonyms** for the **NOS.**

Priority Order for Using Documentation to Identify Histology

IMPORTANT NOTES

1. Code the histology diagnosed ***prior*** to **neoadjuvant treatment.**
   Note 1: Histology changes may occur following immunotherapy, chemotherapy, targeted therapy, and radiation therapy.
   Note 2: Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.

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

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

The priority list is used for single primaries (including multiple tumors abstracted as a single primary).

This is a hierarchical list of source documentation:

1. **Pathology/tissue** from **resection**
   A. The addendum and/or comments
   B. Final diagnosis / synoptic report as required by CAP
   C. CAP protocol
   D. Biomarkers
      - Biomarkers do not identify all histologic types.

- Biomarkers are not listed because they change rapidly.

Example: BRAF will help determine whether a tumor is a pilocytic astrocytoma or a non-pilocytic astrocytoma.

Note 1: Addendums and comments on the pathology report are given the highest priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.

Note 2: The pathologist's diagnosis is always the most reliable, so the final diagnosis is the second priority.

Note 3: **Do not** use the microscopic or gross section of the pathology report for coding.

Note 4: The CAP protocol is a checklist which

- Provides guidelines for collecting the essential data elements for complete reporting of tumors and optimal patient care.
- Allows physicians to check multiple histologies

2. Pathology/tissue from **biopsy**
   A. The addendum and/or comments
   B. Final diagnosis / synoptic report as required by CAP
   C. CAP protocol
   D. Biomarkers
      - Biomarkers do not identify all histologic types.
      - Biomarkers are not listed because they change rapidly.

      Example: BRAF will help determine whether a tumor is a pilocytic astrocytoma or a non-pilocytic astrocytoma.

   Note 1: Addendums and comments on the pathology report are given the highest priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.

   Note 2: The pathologist's diagnosis is always the most reliable, so the final diagnosis is the second priority.

   Note 3: **Do not** use the microscopic or gross section of the pathology report for coding.

   Note 4: The CAP protocol is a checklist which

      - Provides guidelines for collecting the essential data elements for complete reporting of tumors and optimal patient care.
      - Allows physicians to check multiple histologies

3. **Cytology** (most frequently spinal fluid)

4. **Radiography:** The following list is in priority order.
   A. MRI
   B. CT
   C. PET
   D. Angiogram

5. **Clinical Diagnosis:** Code the histology documented by the physician when none of the above are **available**. **Priority** for using documentation:
   A. Treatment plan
   B. Documentation from Tumor Board
   C. References to pathology diagnosis
   D. Physician's reference to type of cancer (histology) in the medical record

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

Non-Malignant CNS Histology Rules
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Coding Histology

Note 1: The priority is to code the most specific histology. **DO NOT USE BREAST HISTOLOGY CODING RULES FOR THIS SITE.**
Note 2: Only use this section for one or more histologies within a single tumor.
Note 3: Do not use this section in place of the Histology Rules.

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

   Example 1: Diagnosis for a single tumor is choroid plexus papilloma 9390/0 with the majority or predominant part of tumor being atypical choroid plexus papilloma 9390/1. Code the subtype/variant: atypical choroid plexus papilloma 9390/1.

   Example 2: Diagnosis for a single tumor is meningioma 9530/0 with minority of tumor being atypical meningioma 9539/1. Code the subtype/variant: atypical meningioma 9539/1.

   Example 3: Diagnosis for a single tumor is schwannoma 9560/0 with a component of melanotic schwannoma 9560/1. Code the subtype/variant: melanotic schwannoma 9560/1.

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

2. Code the histology described as **differentiation** or **features/features of <u>ONLY</u>** when there is a specific ICD-O code for the "NOS with ____ features" or "NOS with ____ differentiation".
   Note: Do not code differentiation or features when there is no specific ICD-O code.

3. Code the specific histology described by ambiguous terminology (list follows) <u>ONLY</u> when A or B is true:
   A. The only diagnosis available is **one histology** term described by ambiguous terminology
      - CoC and SEER require reporting of cases diagnosed only by ambiguous terminology
      - Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

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

If the specific histology does not meet the criteria in #3B, then code the NOS histology.

See the **Ambiguous Terminology** section of the General Instructions for instructions and examples on when ambiguous terms and definitive terms may be used to assign histology.

Table 9: List of Ambiguous Terminology

Ambiguous Terminology	
Appears	Presumed
Cannot rule out	Suspicious (for)
Likely	Suggestive of
Favor(s)	

Note 1: Table 10 below includes terms **previously** included in the list of ambiguous terms. These terms should be treated as supporting a **definitive diagnosis** of a histologic subtype. A definitive term does not require clinical verification of the subtype or variant.

Note 2: The terms in Table 10 were removed from the list of ambiguous terms and added to a list of **definitive terminology** based on the recommendation of a panel of pathologists and subject matter experts.

Table 10: List of Definitive Terminology

Definitive Terminology	
Comparable with	Most likely
Compatible with	Probable
Consistent with	Typical (of)

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

   - Architecture
   - Foci; focus; focal
   - Pattern

Non-Malignant CNS Histology Rules
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Single Tumor

Rule H1 Code meningioma **9530/0** when the diagnosis is any of the following:

- Benign meningioma
- Lymphoplasmacyte-rich meningioma
- Meningioma with no mention of behavior
- Metaplastic meningioma
- Microcystic meningioma
- Secretory meningioma
- Two meningioma subtypes (See **Table 5**)

Note: **Do not report** a **malignant** /3 meningioma based on:

- **Invasion** of the **skull** bone
- Tumor **extension through the foramina at the base of the skull**
- Do not report a malignant /3 meningioma based on tumor extension to brain

Rule H2 Code the **reportable CNS tumor (Table 5** in the Site-group Instructions) when a patient has any of the following:

- Neurofibromatosis type 1 (NF1)
- Neurofibromatosis type 2 (NF2)
- Schw**annomatosis**

Note 1: **Do not code** NF1 or NF2 as neurofibromatosis. NF1, NF2, and schwannomatosis are genetic syndromes which have a high risk of developing reportable and non-reportable tumors. **ONLY** abstract **reportable tumors** such as:

- Plexiform neurofibroma (usually NF1)
- Tumors of brain and spinal cord, meningiomas of cranial or spinal dura, glioma (usually NF2)

Note 2: Tumors are reportable when they meet the behavior (/0 or /1), site (within the CNS), and histology reportability requirements (see **Reportability Criteria**).

Note 3: Schwannomatosis is a newer term for a distinct subtype/variant of the genetic diseases NF1 and NF2.

Example: Patient presents with vestibular schwannoma (acoustic neuroma). Genetic testing proves the patient has NF2. Report the acoustic nerve neuroma.

Rule H3 Code the histology when only **one histology** is present.

Note 1: Use **Table 5** to code histology. New codes, terms, and synonyms are included in **Table 5** and coding errors may occur if the table is not used.

Note 2: When the histology is **not listed** in **Table 5** 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 5, ICD-O or all updates.

Rule H4 Code the **subtype/variant** when there is a **NOS** and a **single subtype/variant** of that NOS, such as the following:

- Choroid plexus papilloma **9390/0** and a subtype/variant of choroid plexus papilloma
- Craniopharyngioma **9350/1** and a subtype/variant of craniopharyngioma
- Gangliocytoma **9492/0** and a subtype/variant of gangliocytoma
- Lipoma **8850/0** and a subtype/variant of lipoma
- Meningeal melanocytosis **8728/0** and a subtype/variant of meningeal melanocytosis
- Meningioma **9530/0** and a subtype/variant of meningioma
- Myofibroblastoma **8825/0** and a subtype/variant of myofibroblastoma
- Neurofibroma **9540/0** and a subtype/variant of neurofibroma
- Schwannoma **9560/0** and a subtype/variant of schwannoma
- Solitary fibrous tumor WHO Grade 1 **8815/0** and a subtype/variant of solitary fibrous tumor WHO Grade 1

Note: Use **Table 5** in the Site-group Instructions to identify the NOS and subtypes/variants of the NOS.

This is the end of instructions for Single Tumor.

Code the histology according to the rule that fits the case.

Multiple Tumors Abstracted as a Single Primary

Rule H5 Code meningioma **9530/0** when there are multiple meningiomas with the following diagnosis:

- Benign meningioma
- Lymphoplasmacyte-rich meningioma
- Meningioma with no mention of behavior
- Metaplastic meningioma
- Microcystic meningioma
- Secretory meningioma

Note: **Do not report** a **malignant** /3 meningioma based on tumor extension/tumor expansion such as:

- **Invasion** of the **skull** bone
- Tumor **extension through the foramina at the base of the skull**
- Tumor **extension to brain**

Rule H6 Code meningioma **9530/1** when there are multiple meningiomas of uncertain behavior.

Note 1: This is a rare condition that is usually associated with neurofibromatosis type 2 (NF2) and other genetic disorders.

Note 2: Use this code only for meningiomas with uncertain behavior; **do not use** this code for **multiple benign or malignant** meningiomas.

Note 3: It is **not necessary** for **all tumors** to be **biopsied** to use this code.

Rule H7 Code the **reportable CNS tumor (Table 5** in the Site-group Instructions) when a patient has any of the following:

- Neurofibromatosis type 1 (NF1)
- Neurofibromatosis type 2 (NF2)
- Schwannomatosis

Note 1: Only report tumors such as:

- Plexiform neurofibroma (usually NF1)
- Tumors of brain and spinal cord, meningiomas of cranial or spinal dura, glioma (usually NF2)

Note 2: Tumors are reportable when they meet the behavior code, site, and histology reportability requirements (see **Reportability Criteria**). Do not code neurofibromatosis.

Note 3: NF1 is a genetic disorder causing lesions in the skin, nervous system and skeleton.

Note 4: NF2 is a central form of the genetic disease and produces CNS tumors such as vestibular tumors, meningiomas, and ependymomas. When tumors meet the behavior code, site, and histology reportability requirements (see **Reportability Criteria**) those tumors are reportable.

Note 5: Schwannomatosis is a newer term for a distinct subtype/variant of the genetic diseases NF1 and NF2.

Example: Patient presents with bilateral vestibular schwannoma (acoustic neuroma). Genetic testing proves the patient has NF2. Report the acoustic nerve neuromas 9560/0.

Rule H8 Code the histology when only **one histology** is present in all tumors.

Note 1: Use **Table 5** to code histology. New codes, terms, and synonyms are included in **Table 5** and coding errors may occur if the table is not used.

Note 2: When the histology is **not listed** in **Table 5**, 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 5, ICD-O or all updates.

Rule H9 Code the **subtype/variant** when there is a **NOS** and a **single subtype/variant** of that NOS present in all tumors, such as the following:

- Choroid plexus papilloma **9390/0** and a subtype/variant of choroid plexus papilloma
- Craniopharyngioma **9350/1** and a subtype/variant of craniopharyngioma
- Gangliocytoma **9492/0** and a subtype/variant of gangliocytoma
- Lipoma **8850/0** and a subtype/variant of lipoma
- Meningeal melanocytosis **8728/0** and a subtype/variant of meningeal melanocytosis
- Meningioma **9530/0** and a subtype/variant of meningioma
- Myofibroblastoma **8825/0** and a subtype/variant of myofibroblastoma
- Neurofibroma **9540/0** and a subtype/variant of neurofibroma
- Schwannoma **9560/0** and a subtype/variant of schwannoma
- Solitary fibrous tumor WHO Grade 1 **8815/0** and a subtype/variant of solitary fibrous tumor WHO Grade 1

Note: Use **Table 5** in the Site-group Instructions to identify the NOS and subtypes/variants.

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

Code the histology according to the rule that fits the case.

Renal Pelvis, Ureter, Bladder, and Other Urinary Site-group Instructions
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Introduction

Note 1: This site group includes: 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: **In US, 90% of bladder tumors are urothelial carcinoma; less than 5% are pure squamous cell carcinoma or pure adenocarcinoma.**

Note 3: 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 4: Both urothelial carcinoma and papillary urothelial carcinoma can be in situ /2 or invasive /3. Code the behavior specified in the pathology report. See the SEER Coding Manual Appendix C, Bladder Coding Guidelines for information on coding behavior for bladder tumors.

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.

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

The rules attempt to reconcile these observations in order to provide **incidence** data that are consistent and reproducible.

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".
- Flat transitional cell carcinoma; flat urothelial carcinoma; urothelial carcinoma in situ; noninvasive flat carcinoma; in situ transitional cell carcinoma
- Multifocal; multicentric
- Noninvasive may describe either in situ papillary carcinoma or flat urothelial cell carcinoma
- Papillary transitional cell carcinoma; papillary urothelial carcinoma
- Simultaneous; synchronous; 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 for determining reportability
- Type; subtype; variant
- Urothelial carcinoma; transitional cell carcinoma
- Urothelium; epithelium; transitional epithelium

Terms That Are Not Equivalent or Equal

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

- **Carcinoma**, NOS (8010) and **adenocarcinoma**, NOS (8140) are not equivalent
- **Phenotype** is not equivalent to **subtype/type/variant**
- **Noninvasive, papillary urothelial carcinoma, flat urothelial carcinoma** are not equivalent
  Note: Noninvasive is **not equivalent** to either **papillary** urothelial or **flat** urothelial carcinoma. **Both Ta** and **Tis** tumors are technically noninvasive. Code the histology specified by the **pathologist.**
- **Papillary growth pattern** is not equivalent to **papillary urothelial carcinoma**

Instructions for Coding Primary Site

The following instructions are in priority order.

1. Code overlapping lesion of urinary bladder **C678** when:
   A. A single tumor of any histology overlaps subsites of the bladder
   B. A single tumor or non-contiguous tumors which are:
      - **Urothelial carcinoma in situ 8120/2 AND**
      - Involves only bladder and one or both ureters (no other urinary sites involved)

   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. Code bladder NOS **C679** when there are **multiple non-contiguous tumors** within the **bladder AND** the subsite/origin is unknown/not documented.

3. Code overlapping lesion of urinary organs **C688** when a single tumor overlaps two urinary sites and the origin is unknown/not documented.
   Note: See the following examples of contiguous urinary sites where overlapping tumor could occur:
   - Renal pelvis and ureter
   - Bladder and urethra
   - Bladder and ureter (for all histologies other than in situ urothelial cell)

4. Code Urinary System NOS **C689** when there are **multiple non-contiguous 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.

Site Term and code	Synonyms
Bladder, anterior wall **C673**	-
Bladder, dome **C671**	Roof Vault Vertex
Bladder, lateral wall **C672**	Lateral to ureteral orifice Left wall Right wall Sidewall
Bladder neck **C675**	Internal urethral orifice Vesical neck
Bladder NOS **C679**	Lateral posterior wall (**no hyphen**)
Bladder, overlapping lesion **C678**	Fundus Lateral-posterior wall (**hyphen**)
Bladder, posterior wall **C674**	-

Renal Pelvis, Ureter, Bladder, and Other Urinary Site-group Instructions
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Table 1: ICD-O Primary Site Codes

Site Term and code	Synonyms
Bladder, trigone **C670**	Base of bladder Below interureteric crest Below interureteric field Below interureteric ridge Floor of bladder
Bladder, urachus **C677**	Mid umbilical ligament Urachal remnant
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 Littre glands Prostatic utricle Urethral gland
Urinary system NOS **C689**	-

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.

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 is not found in Table 3, ICD-O or all updates.

Note 3: Behavior codes are listed when the term has only one possible behavior (either a /2 or /3).

Note 4: Column 2 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 2). Rhabdomyosarcoma is also a NOS because it has a subtype/variant. The subtype/variant is indented under the NOS (rhabdomyosarcoma) in column 2. There is also a footnote in column 2 which calls attention to the fact that rhabdomyosarcoma has a subtype/variant.

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

.

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**
- Subtypes or variants of the NOS histologies in column 2 are also indented under the NOS histology and have a full 4-digit histology code (see Note 1). The behavior code (/2 or /3) is included with the 4-digit histology code if the term has only one possible behavior.

Table 2: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenocarcinoma NOS 8140 • Carcinoma of Cowper glands • Carcinoma of Skene glands • Littre gland adenocarcinoma • Urachal adenocarcinoma [1]	Clear cell carcinoma **8310** Endometrioid carcinoma **8380** Enteric adenocarcinoma **8144** Mucinous adenocarcinoma **8480**
Malignant melanoma 8720 (/3) • Mucosal melanoma	Mucosal lentiginous melanoma **8746 (/3)** Nodular melanoma **8721 (/3)**
Malignant perivascular epithelioid cell tumor 8714 (/3) • Malignant PEComa	
Mixed adenocarcinoma 8323 (/3)	
Mixed neuroendocrine-non-neuroendocrine carcinoma 8154 (/3)	
Neuroendocrine carcinoma NOS 8246 (/3)	Large cell neuroendocrine tumor **8013 (/3)** • Combined large cell neuroendocrine carcinoma Small cell neuroendocrine carcinoma **8041 (/3)**
Neuroendocrine tumor NOS 8240 (/3) • Neuroendocrine tumor, grade 1	Neuroendocrine tumor, grade 2 **8249 (/3)**
Paraganglioma 8693 (/3) • Extra-adrenal paraganglioma [2]	

[1] Urachal carcinoma NOS is coded 8010/3. Urachal adenocarcinoma is coded 8140/3.
[2] Reportable for cases diagnosed 1/1/2021 forward.

Table 2: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Sarcoma NOS 8800 (/3)	Angiosarcoma **9120 (/3)** Chondrosarcoma **9220 (/3)** Leiomyosarcoma **8890 (/3)** Liposarcoma **8850 (/3)** Malignant peripheral nerve sheath tumor **9540 (/3)** • MPNST Pleomorphic sarcoma **8802 (/3)** Rhabdomyosarcoma **8900 (/3)** • Embryonal rhabdomyosarcoma **8910 (/3)** ○ Sarcoma botryoides **(/3)**
Squamous cell carcinoma 8070 • Pure squamous carcinoma of urothelial tract • Pure squamous cell carcinoma • SCC **Table continued on next page**	Verrucous carcinoma **8051**

Table 2: Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)

Urothelial carcinoma 8120 [3]
• Clear cell (glycogen-rich) urothelial carcinoma **(/3)**
• Conventional urothelial carcinoma **(/3)**
• Diverticular carcinoma **(/3)**
• Infiltrating urothelial carcinoma **(/3)**
  ○ Infiltrating urothelial carcinoma with divergent differentiation **(/3)**
  ○ Infiltrating urothelial carcinoma with endodermal sinus lines **(/3)**
  ○ Infiltrating urothelial carcinoma with glandular differentiation **(/3)**
  ○ Infiltrating urothelial carcinoma with squamous differentiation **(/3)**
  ○ Infiltrating urothelial carcinoma with trophoblastic differentiation **(/3)**
• Large nested urothelial carcinoma **(/3)**
• Lipid-rich urothelial carcinoma **(/3)**
• Microcystic urothelial carcinoma **(/3)**
• Nested urothelial carcinoma **(/3)**
• Plasmacytoid urothelial carcinoma **(/3)** [4]
• Tubular and microcystic urothelial carcinoma **(/3)**
• Urothelial carcinoma in situ **(/2)**
	Giant cell urothelial carcinoma **8031 (/3)**
	Lymphoepithelioma-like urothelial carcinoma **8082 (/3)**
	• Plasmacytoid/signet ring cell/diffuse variant [5]
	Papillary urothelial (transitional cell) carcinoma **8130**
	• invasive **(/3)**
	• in situ **(/2)**
	  ○ low-grade papillary urothelial carcinoma with inverted growth pattern **(/2)**
	  ○ non-invasive papillary urothelial carcinoma, high-grade **(/2)**
	  ○ non-invasive papillary urothelial carcinoma, low-grade **(/2)**
	• Micropapillary urothelial carcinoma **8131 (/3)** [6]
	Plasmacytoid urothelial carcinoma **8122 (/3)** [4]
	• Sarcomatoid urothelial carcinoma **(/3)**
	Poorly differentiated urothelial carcinoma **8020 (/3)**
	• Poorly differentiated urachal carcinoma

[3] Previously called transitional cell carcinoma, a term that is no longer recommended.
[4] Plasmacytoid urothelial carcinoma is coded 8120 for pre-2024 dx and 8122 for 2024+.
[5] This is the exact histology term. All three terms are used together to indicate a specific variant (coded 8082/3).
[6] Micropapillary **8131** is a subtype/variant of papillary urothelial carcinoma **8130**. It is an invasive /3 neoplasm with aggressive behavior.

Table 3: Non-Reportable Urinary Tumors

Table 3 contains the terms and codes (if applicable) for the non-reportable histology.
Synonyms are indented under the preferred term. Synonyms have the same histology code (if applicable) as the preferred term under which they are indented.

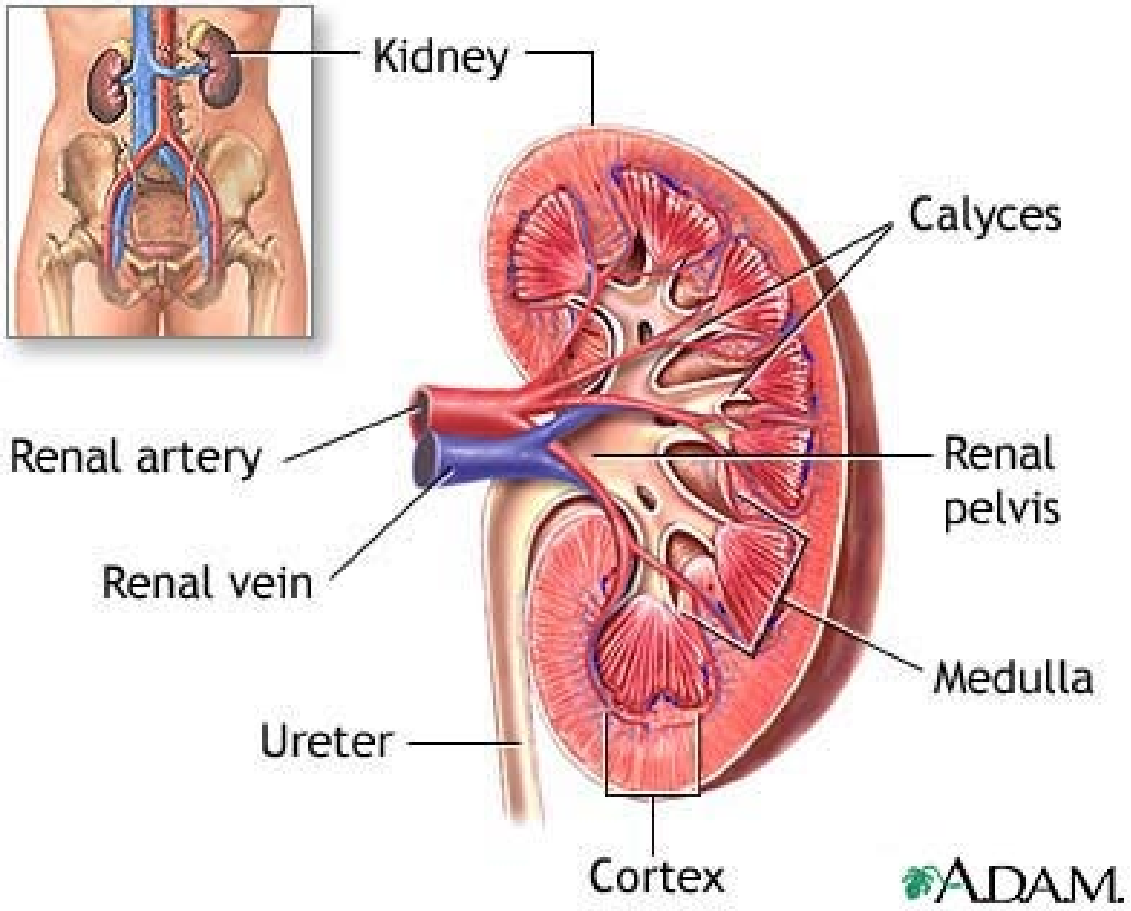
Histology Term and Code
Benign perivascular epithelioid cell tumor **8714 (/0)** • Benign PEComa
Granular cell tumor **9580 (/0)**
Hemangioma **9120 (/0)**
Inflammatory myofibroblastic tumor **8825 (/1)**
Inverted urothelial papilloma **8121 (/0)**
Leiomyoma 8890 (/0)
Melanosis No code
Neurofibroma 9540 (/0)
Nevus 8720 (/0)
Papillary urothelial neoplasm of low-malignant potential **8130 (/1)**

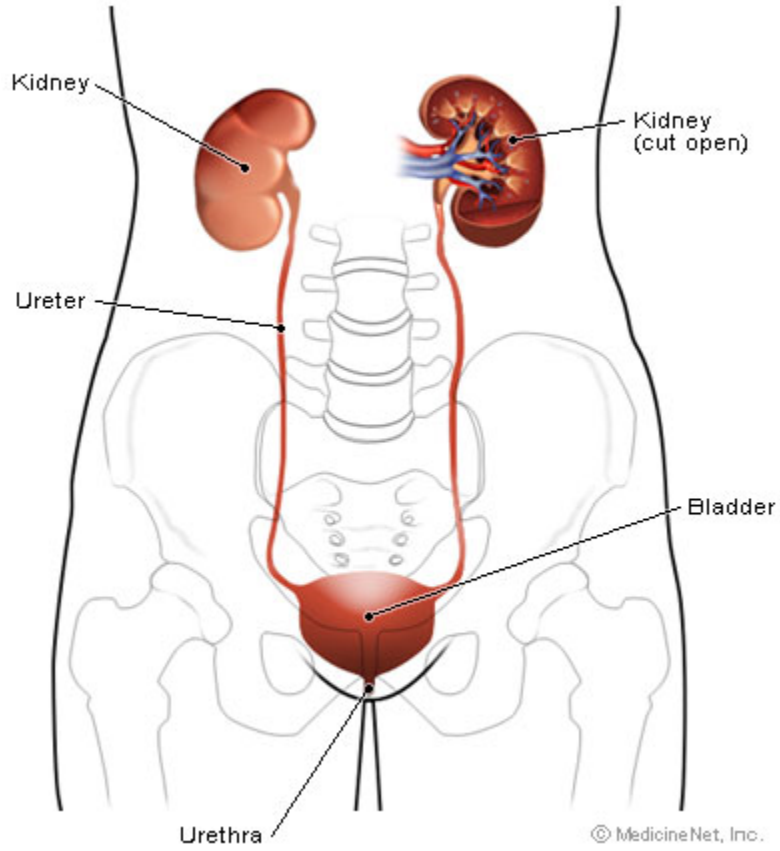
Table 3: Non-Reportable Urinary Tumors

Histology Term and Code
Paraganglioma **8693 (/1)** [1] • Extra-adrenal pheochromocytoma
Solitary fibrous tumor **8815 (/1)**
Squamous cell papilloma **8052 (/0)** • Keratotic papilloma
Urothelial dysplasia **No code**
Urothelial papilloma **8120 (/0)**
Villous adenoma **8261 (/0)**

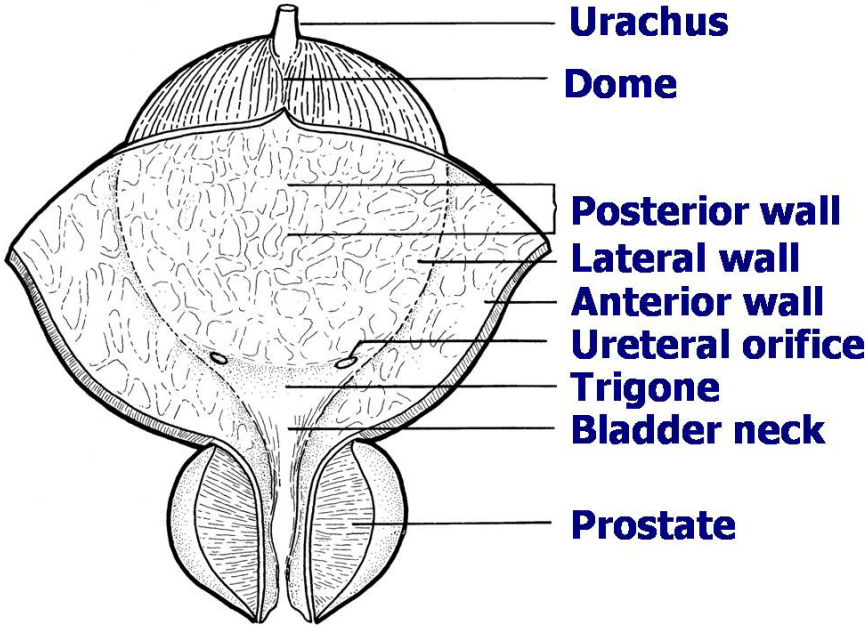
[1] Not reportable for cases diagnosed prior to 1/1/2021

Illustrations

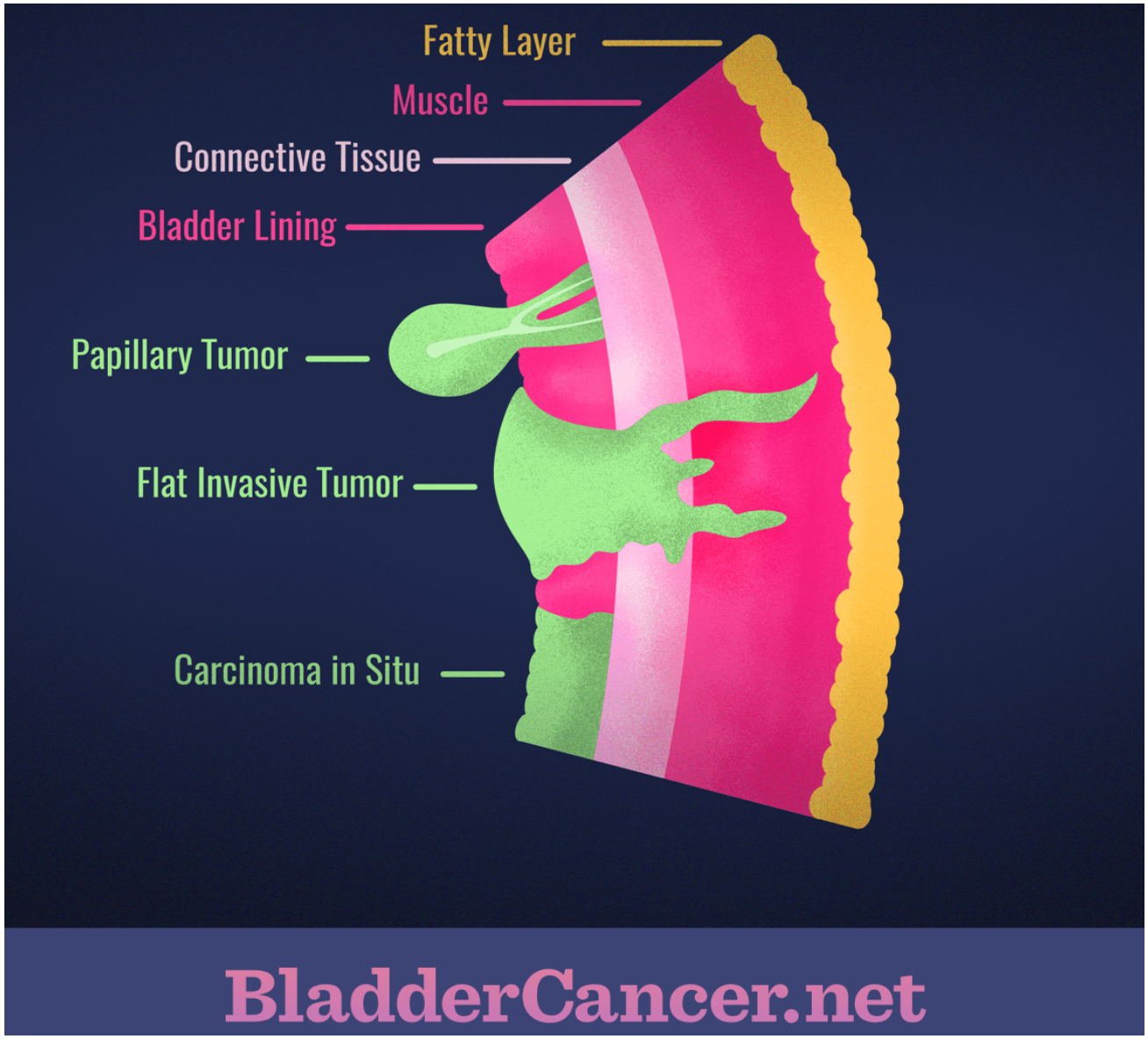


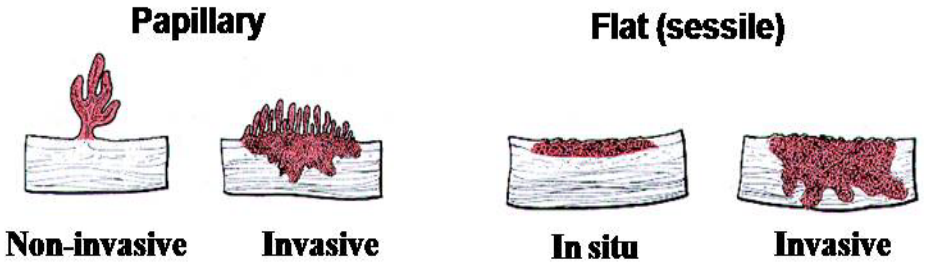


www.MedicineNet.com

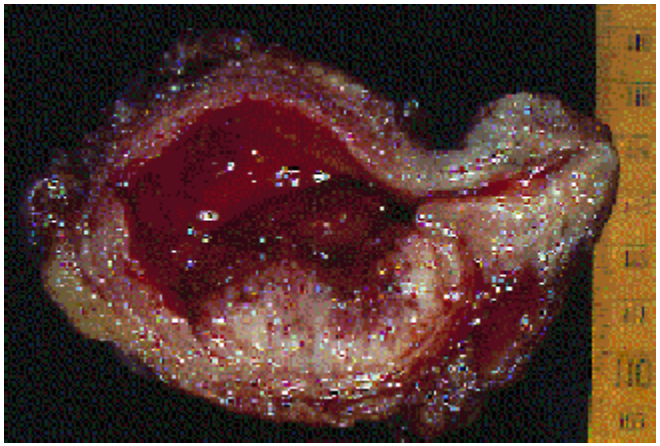


Source: TNM Atlas, 3rd edition, 2nd revision


Fatty Layer
Muscle
Connective Tissue
Bladder Lining
Papillary Tumor
Flat Invasive Tumor
Carcinoma in Situ
BladderCancer.net

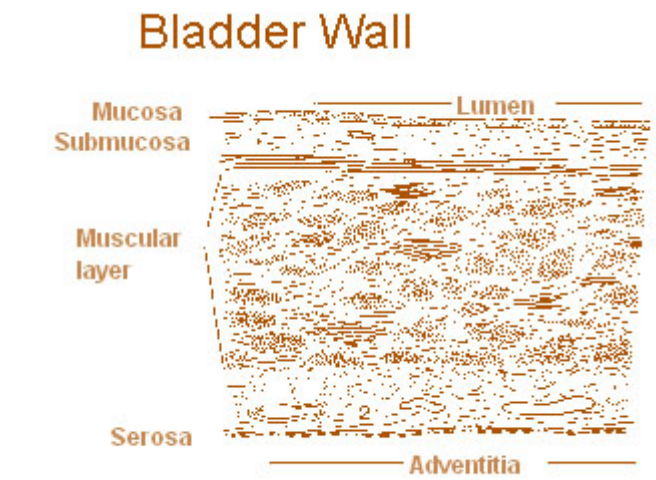

Papillary
Flat (sessile)
Non-invasive
Invasive
In situ
Invasive

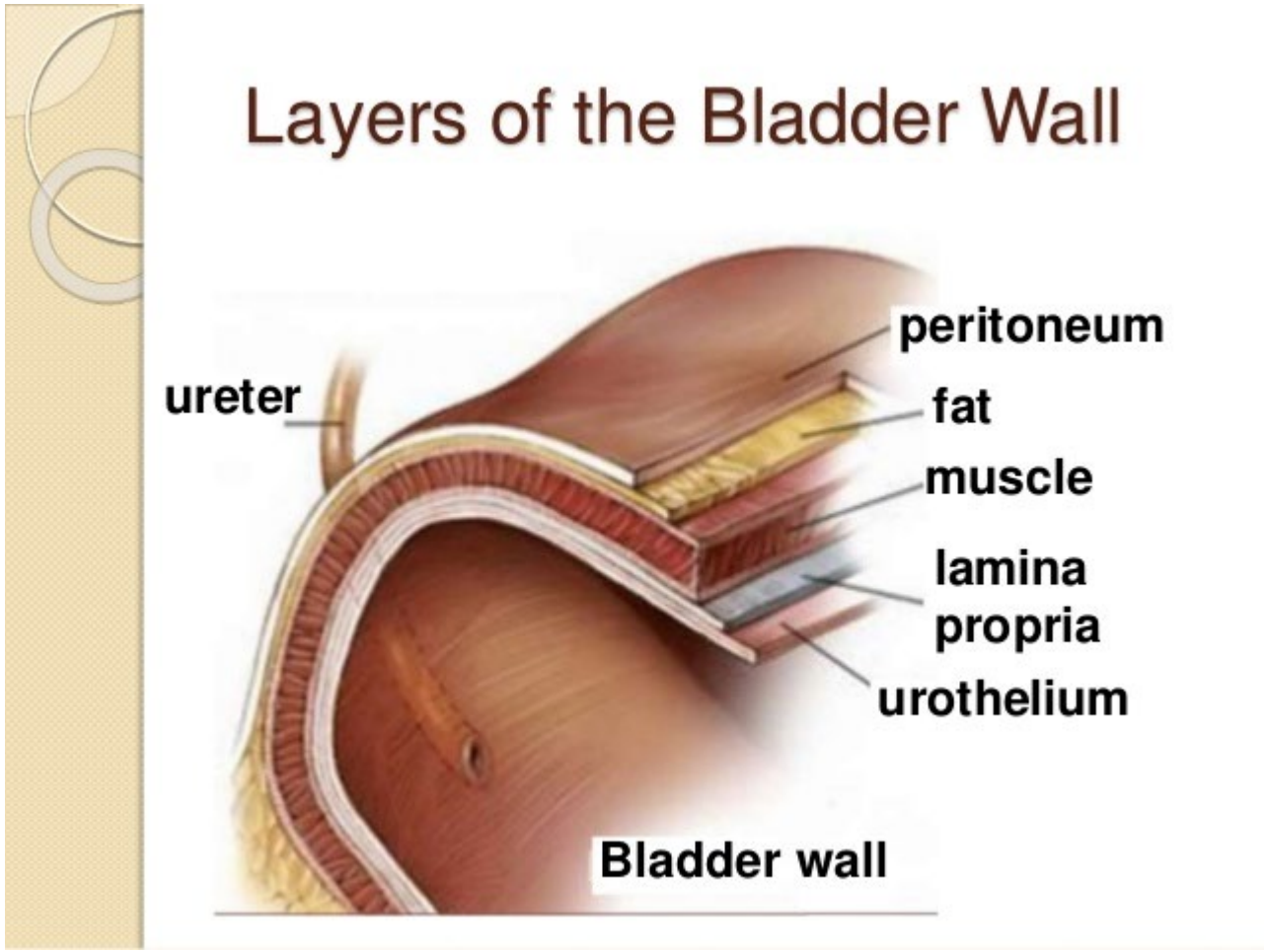
Bladder Tumor



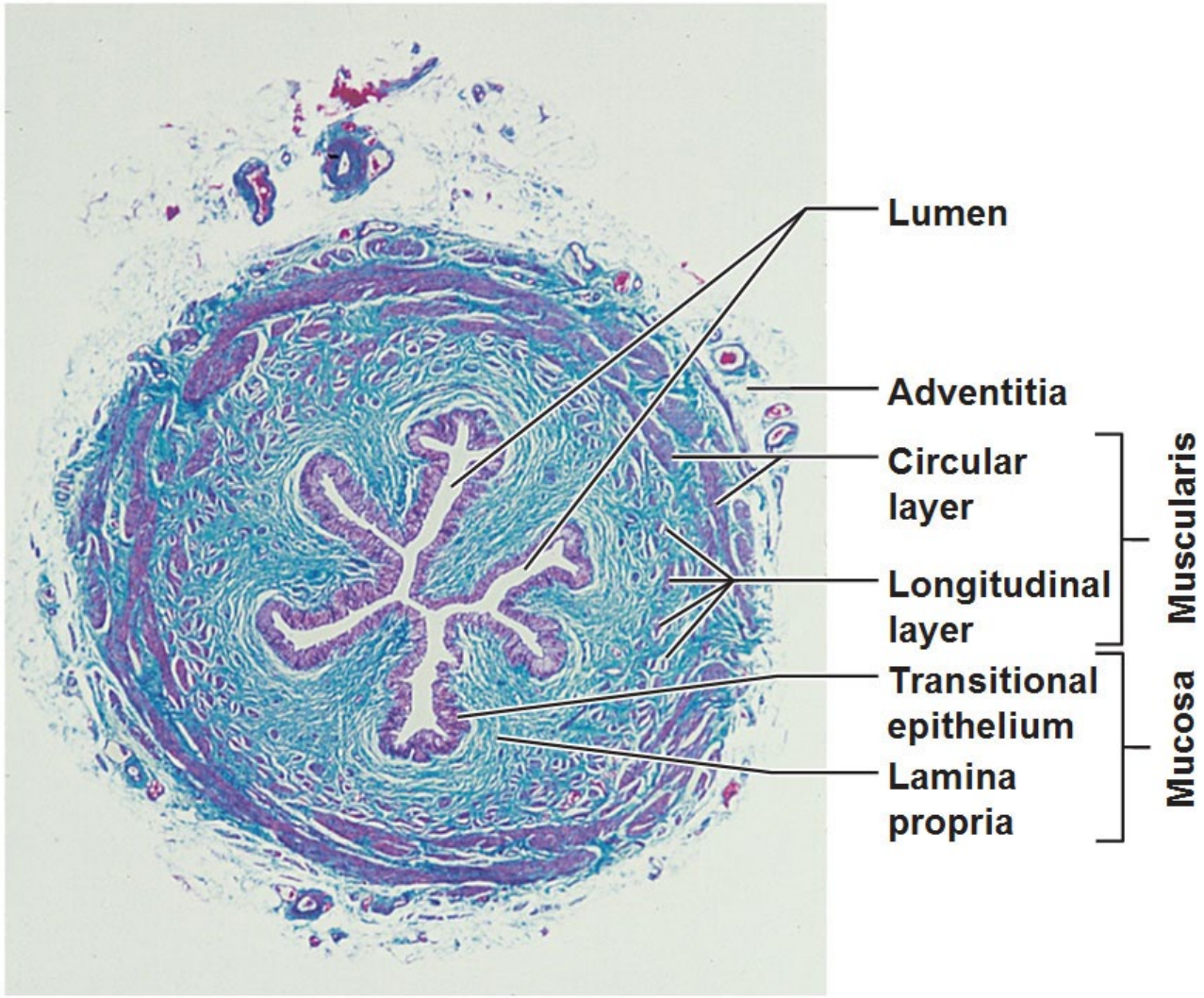
Courtesy Jean-Loup Huret reprinted from Atlas Genet Cytogenet Oncol Haematol. October 2003. van Tilborg A

A, van Rhijn BW. Bladder: Urothelial carcinomas. URL: **http://atlasgeneticsoncology.org/Tumors/bladID5001.html**, by permission of the Atlas.


Bladder Wall
Mucosa
Submucosa
Muscular layer
Serosa
Lumen
Adventitia
Source: Feneis, Pocket Atlas of Human Anatomy, 2nd ed.


Layers of the Bladder Wall
peritoneum
ureter
fat
muscle
lamina
propria
urothelium
Bladder wall

Microscopic Structure of the Ureter



Renal Pelvis, Ureter, Bladder, and Other Urinary Multiple Primary Rules
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Note: Metastatic tumors are not included when determining how many tumors are present. Metastatic tumors include but are not limited to:

- Bones
- Brain
- Regional and distant lymph nodes for the primary site being abstracted as identified in Summary Staging Manual
- Involvement of the pelvic or abdominal wall
- Liver
- Lung

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.

Single Tumor

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

Note 1: A single tumor is always a single primary.
Note 2: The tumor may overlap onto or extend into adjacent/contiguous site or subsites.
Note 3: The tumor may have in situ and invasive components.
Note 4: The tumor may have two or more histologic components.

This is the end of instructions for Single Tumor.

Renal Pelvis, Ureter, Bladder, and Other Urinary Multiple Primary Rules
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

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 other than urothelial carcinoma and urothelial carcinoma subtypes in multiple urinary sites (see Rule M14)

Rule M3 Abstract **multiple primaries** 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.

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** tumors are **noninvasive in situ /2** 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 **multiple primaries** when an **invasive** tumor occurs **more than 60** days after an **in situ** tumor.

Note 1: Abstract both the invasive and in situ tumors.

Note 2: Abstract as multiple primaries even if physician states the invasive tumor is disease recurrence or progression.

Note 3: 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 M7 Abstract a **single primary** when the patient has multiple occurrences of /2 urothelial carcinoma in the **bladder**. Tumors may be any combination of:

- In situ urothelial carcinoma **8120/2 AND/OR**
- Papillary urothelial carcinoma noninvasive **8130/2** (does **not** include micropapillary subtype)

Note 1: Timing is irrelevant. Tumors may be synchronous or non-synchronous.

Note 2: Abstract only one /2 urothelial bladder primary per the patient's lifetime.

Note 3: There are no /2 subtypes for urothelial carcinoma with the exception of papillary urothelial carcinoma.

Example: On 1/3/2018, the patient had a TURB with a diagnosis of in situ urothelial carcinoma 8120/2. On 5/8/2019, pathology from TURB is papillary urothelial carcinoma non-invasive 8130/2. This is a single primary; the papillary urothelial carcinoma is recorded as a recurrence for those registrars who collect recurrence data.

Rule M8 Abstract **multiple primaries** when the patient has **micropapillary** urothelial carcinoma **8131/3 AND** a urothelial carcinoma **8120** (including papillary **8130**). Tumors may be in the same urinary site OR in any combination of urinary sites (C67._. C65.9, C66.9, C68_).

Note: Micropapillary urothelial cell carcinoma is an extremely aggressive neoplasm. It is important to abstract a new primary to capture the incidence of micropapillary urothelial carcinoma. Micropapillary is excluded from the typical "NOS and subtype/variant" rule (same row in Table 2).

Rule M9 Abstract a **single primary** when the patient has multiple **invasive** urothelial cell carcinomas in the **bladder**.

- All tumors are multiple occurrences of urothelial or urothelial subtypes (with exception of micropapillary) **OR**
- All tumors are multiple occurrences of micropapillary

Note 1: Timing is irrelevant. Tumors may be synchronous or non-synchronous.

Note 2: Abstract only one /3 invasive urothelial bladder primary **AND** only one micropapillary urothelial 8131/3 bladder primary per the patient's lifetime.

- An occurrence of micropapillary and an occurrence of urothelial carcinoma would be multiple primaries (see previous rules).

Rule M10 Abstract **multiple primaries** when the patient has a subsequent tumor after being **clinically disease-free** for **greater** than **three years** after the original diagnosis or last recurrence.

Note 1: This rule **does not apply** when both/all tumors are urothelial carcinoma of the bladder (all subtypes/variants of 8120 except for 8131).

Note 2: **Clinically** disease-free means that there was **no evidence** of recurrence on follow-up.

- Scans are WNL
- Urine cytology is WNL
- Scopes are WNL

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.

Rule M11 Abstract a **single primary** when there are urothelial carcinomas in multiple urinary organs.

- All tumors are urothelial or urothelial subtypes (with exception of micropapillary) OR
- All tumors are micropapillary

Note 1: This rule does not apply to any other carcinomas or sarcomas.
Note 2: This rule applies to multiple tumors that occur less than 3 years apart.
Note 3: Behavior is irrelevant.
Note 4: This rule applies to multifocal/multicentric carcinoma which involves two or more of the following urinary sites:

- Renal pelvis
- Ureter
- Bladder
- Urethra

Rule M12 Abstract **multiple primaries** when separate/non-contiguous tumors are two or more **different subtypes/variants** in Column 3 of **Table 2** in the Site-group Instructions. Timing is irrelevant.
Note 1: 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.

Note 2: This rule does not apply to urothelial subtypes in the bladder (see previous rules).

Rule M13 Abstract **multiple primaries** when separate/non-contiguous tumors are on **different rows** in **Table 2** in the Site-group Instructions. 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 M14 Abstract **multiple primaries** when the ICD-O **site** code differs at the **second** (C**X**xx) and/or **third** (Cx**X**x) character.

Rule M15 Abstract a **single primary** when **synchronous**, separate/non-contiguous tumors are on the **same row** in **Table 2** in the Site-group Instructions.

Note: 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 indented under the preferred term in column 1 **OR**
- A NOS (column 1) and the other is a subtype/variant of that NOS (column 2) **OR**
- A NOS histology in column 2 with an indented subtype/variant

Example: TURBT shows invasive papillary urothelial carcinoma 8130/3 and CIS/in situ urothelial carcinoma 8120/2. Abstract a single primary. Papillary urothelial carcinoma and urothelial carcinoma are on the same row in Table 2.

Rule M16 Abstract a **single primary** (the invasive) when an **in situ** tumor is diagnosed **after** an **invasive** tumor **AND** tumors occur in the **same** urinary site.

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 Site-group Instructions 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 M17 Abstract a **single primary** (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.

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.

Rule M18 Abstract a **single primary** 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.

This is the end of instructions for Multiple Tumors.

Renal Pelvis, Ureter, Bladder, and Other Urinary Histology Rules
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Priority Order for Using Documentation to Identify Histology

IMPORTANT NOTES

1. Code the histology diagnosed **prior to neoadjuvant treatment.**
   Note 1*:* Histology changes do occur following immunotherapy, chemotherapy, hormone, and radiation therapy.
   Note 2*:* Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.

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

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

The priority list is used for **single primaries** (including multiple tumors abstracted as a single primary)

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).

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

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

Note 1: Addendums and comments on the pathology report are given 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. The final diagnosis is often the synoptic CAP report.

Note 3: The CAP protocol is a checklist which:

- Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care
- Allows physicians to check multiple histologies

2. **Cytology** (usually urine)

3. Tissue/pathology from a metastatic site

   Note 1: Code the behavior /3.

   Note 2: The **tissue** from a **metastatic** site often shows **variations** from the primary tumor. When it is the only tissue available, it is **more accurate** than a **scan and only physician documentation**.

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

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

   Note 1: Code the specific histology when documented.

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

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

Renal Pelvis, Ureter, Bladder, and Other Urinary Histology Rules
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590 – M9993 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 the **ICD-O and all updates. This instruction applies to single and multiple histologies.**

Coding Histology

Note 1: The priority is to code the most specific histology. **DO NOT USE BREAST HISTOLOGY CODING RULES FOR THIS SITE.**
Note 2: Only use this section for one or more histologies within a single tumor.
Note 3: Do not use this section in place of the Histology Rules.

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

   Example 1: Diagnosis for a single tumor is adenocarcinoma 8140 with the majority or predominant part of tumor being endometrioid carcinoma 8380. Code the subtype/variant: endometrioid carcinoma 8380.

   Example 2: Diagnosis for a single tumor is sarcoma NOS 8800/3 with a component of leiomyosarcoma 8890/3. Code the subtype/variant: leiomyosarcoma 8890/3.

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

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

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

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

2. **Code** the histology described as **differentiation** or **features/features of ONLY** when there is a specific ICD-O code for the "NOS with ____ features" or "NOS with ____ differentiation".
   Note: Do not code differentiation or features when there is no specific ICD-O code.

3. Code the specific histology described by **ambiguous terminology** (list follows) **ONLY** when A or B is true:
   A. The only diagnosis available is **one histology** term described by ambiguous terminology
      - CoC and SEER require reporting of cases diagnosed only by ambiguous terminology
      - Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

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

   If the specific histology does not meet the criteria in #3B, then code the NOS histology.

   See the **Ambiguous Terminology** section of the General Instructions for instructions and examples on when ambiguous terms and definitive terms may be used to assign histology.

Table 4: List of Ambiguous Terminology

Ambiguous Terminology	
Appears	Presumed
Cannot rule out	Suspicious (for)
Likely	Suggestive of
Favor(s)	

Note 1: Table 5 below includes terms **previously** included in the list of ambiguous terms. These terms should be treated as supporting a **definitive diagnosis** of a histologic subtype. A definitive term does not require clinical verification of the subtype or variant.

Note 2: The terms in Table 5 were removed from the list of ambiguous terms and added to a list of **definitive terminology** based on the recommendation of a panel of pathologists and subject matter experts.

Table 5: List of Definitive Terminology

Definitive Terminology	
Comparable with	Most likely
Compatible with	Probable
Consistent with	Typical (of)

4. **DO NOT CODE** histology when described as:

    - Architecture
    - Foci; focus; focal
    - Growth pattern
    - Pattern

Renal Pelvis, Ureter, Bladder, and Other Urinary Histology Rules
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

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 tumo**r.

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
- Neuroendocrine carcinoma (NEC) **8246** and a subtype/variant of neuroendocrine carcinoma
- Neuroendocrine tumor (NET) **8240** and a subtype/variant of neuroendocrine tumor
- Rhabdomyosarcoma **8900** and a subtype/variant of rhabdomyosarcoma
- Sarcoma **8800** and a subtype/variant of sarcoma
- 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 small cell neuroendocrine carcinoma mixed with any other type of carcinoma (does not apply to sarcoma).

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

Rule H5 Code combined large cell carcinoma **8013** when the final diagnosis is large cell neuroendocrine carcinoma and any other type of carcinoma (does not apply to sarcoma).

Example: Diagnosis from TURB is urothelial carcinoma and large cell neuroendocrine carcinoma. Code combined large cell carcinoma 8013.

Rule H6 Code mixed urothelial carcinoma as follows:

- Code **8120** when urothelial is mixed with:
  - Adenocarcinoma or adenocarcinoma subtypes
  - Squamous cell carcinoma or squamous cell carcinoma subtypes
- Code **8130** when papillary urothelial is mixed with:
  - Adenocarcinoma or adenocarcinoma subtypes
  - Squamous cell carcinoma or squamous cell carcinoma subtypes
- Code **8131/3** when micropapillary urothelial is mixed with:
  - Adenocarcinoma or adenocarcinoma subtypes
  - Squamous cell carcinoma or squamous cell carcinoma subtypes

Note: Adenocarcinoma and subtypes/variants as well as squamous cell carcinoma and subtypes/variants 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.

Multiple Tumors Abstracted as a Single Primary

Rule H7 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 H8 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 H9 Code the **subtype/variant** when **all 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
- Neuroendocrine carcinoma (NEC) **8246** and a subtype/variant of neuroendocrine carcinoma
- Neuroendocrine tumor (NET) **8240** and a subtype of neuroendocrine tumor
- Rhabdomyosarcoma **8900** and a subtype/variant of rhabdomyosarcoma
- Sarcoma **8800** and a subtype/variant of sarcoma
- 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.

Rule H10 Code mixed small cell carcinoma **8045** when the final diagnosis **for all tumors** is small cell neuroendocrine mixed with any other type of carcinoma (does not apply to sarcoma).

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

Rule H11 Code combined large cell carcinoma **8013** when the final diagnosis for all tumors is large cell neuroendocrine carcinoma and any other type of carcinoma (does not apply to sarcoma).

Example: Diagnosis from TURB is urothelial carcinoma **and** large cell neuroendocrine carcinoma. Code combined large cell carcinoma 8013.

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

Code the histology using the rule that fits the case.

Cutaneous Melanoma Site-group Instructions
C440-C449 with Histology 8720 – 8780 (Excludes melanoma of any other site)
Rules Apply to Cases Diagnosed 1/1/2021 forward

Introduction

Note 1: Melanoma can also start in the mucous membranes of the mouth, anus, vagina, vulva, and in the eye or other places in the body where melanocytes are found. This scheme is used ***only*** for melanomas that ***occur on the skin***.

Note 2: The WHO Classification of Skin Tumors 4th Ed does not include ICD-O codes for tumors with mixed melanoma subtypes/variants.

Note 3: Cutaneous melanoma starts in the melanocytes of the skin. Melanocytes lie in the epidermis, the outermost layer of the skin. Melanocytes often cluster together and form moles (nevi). Most moles are benign, but some may become malignant melanomas. Melanomas are divided into 5 main types, depending on their location, shape, and whether they grow outward or downward into the dermis:

- Acral melanoma: occurs on the palms of the hand, soles of the feet, or nail beds
- Desmoplastic melanoma: is a rare malignant melanoma marked by non-pigmented lesions on sun exposed areas of the body
- Lentigo maligna: usually occur on the faces of elderly people
- Superficial spreading or flat melanoma: grows outwards at first to form an irregular pattern on the skin with an uneven color
- Nodular melanoma: are lumpy and often blue-black in color and may grow faster and spread downwards

Note 4: Effective with cases diagnosed 1/1/2021 and later, melanocytic tumors are classified into two groups, per WHO 4th Ed Classification of Skin Tumors:

- Melanomas arising in sun-exposed skin
- Melanomas arising at sun-shielded sites or without known etiological association with UV radiation exposure

Cutaneous Melanoma Site-group Instructions
C440-C449 with Histology 8720 – 8780 (Excludes melanoma of any other site)
Rules Apply to Cases Diagnosed 1/1/2021 forward

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.
- Giant pigmented nevus; giant congenital nevus
- Mixed epithelioid and spindle cell melanoma (8770); Epithelioid melanoma and spindle cell melanoma
- Mole; Nevus
- Simultaneous; synchronous; existing at the same time; concurrent; prior to first course treatment
- Site; topography
- Tumor; mass; tumor mass; lesion; neoplasm
  - The terms tumor, mass, tumor mass, lesion, 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/melanoma**
  - These terms are used **ONLY** to determine multiple primaries
  - **Do not** use these terms for casefinding or determining reportability
- Type; subtype; variant

Terms That Are not Equivalent or Equal

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

- Component is not equivalent to subtype/type/variant
  Note 1: Component is only coded when the pathologist specifies the component as a second ***melanoma***
  Note 2: Examples provided in H rules **Coding Histology** section
- Phenotype is not equivalent to subtype/type/variant

Synonyms for In Situ

- Behavior code 2
- Clark level 1 (limited to the epithelium)
- Hutchinson freckle (See Synonyms for Hutchinson Freckle below)
- Intraepidermal, NOS
- Intraepithelial, NOS
- Lentigo maligna
- Noninvasive
- Precancerous melanoma of Dubreuilh
- Precancerous melanosis (C44_)
- Stage 0
- Tis

Synonyms for Hutchinson Freckle

- Circumscribed precancerous melanosis
- Intraepidermal malignant melanoma
- Lentigo maligna
- Precancerous melanosis of Dubreuilh

Anatomical Dermatology Terms

Term	Definition
Cutaneous	Pertaining to skin
Dermal	Pertaining to skin
Epidermal	Pertaining to upon the skin
Hypodermic	Pertaining to below the skin
Intradermal	Pertaining to within the skin
Subcutaneous	Pertaining to under the skin
Ungual	Pertaining to the nail

Cutaneous Melanoma Site-group Instructions
C440-C449 with Histology 8720 – 8780 (Excludes melanoma of any other site)
Rules Apply to Cases Diagnosed 1/1/2021 forward

Table 1: Primary Sites and Laterality

Table 1 contains terms used in **clinical diagnosis,** and less frequently the **operative and pathology reports** to describe the **location** of the skin lesion. Find the **term** in Column 1 and use the **site code** in Column 2. Column 3 notes whether the site requires **laterality** to be coded.

Note: Excludes melanoma of non-skin sites (excludes any sites other than C44_)

Terminology	Site Term and Code	Laterality Required
Skin of lip, NOS Skin of lower lip Skin of upper lip	Skin of lip, NOS **C440**	**No**
Eyelid Lid, NOS Palpebra Horizontal palpebra fissure Canthus Inner canthus Lateral canthus Lower lid Medial canthus Meibomian gland Outer canthus Pretarsal space Supratarsel crease Upper lid	Eyelid **C441**	**Yes**

Cutaneous Melanoma Site-group Instructions
C440-C449 with Histology 8720 – 8780 (Excludes melanoma of any other site)
Rules Apply to Cases Diagnosed 1/1/2021 forward

Table 1: Primary Sites and Laterality

Terminology	Site Term and Code	Laterality Required
External ear Auricle, NOS Pinna Ceruminal gland Concha Ear, NOS Ear lobule Earlobe External auditory canal Auditory canal, NOS Auricular canal, NOS External auricular canal Ear canal External auditory meatus Helix Skin of auricle Skin of ear, NOS Tragus	External ear **C442**	**Yes**

Table 1: Primary Sites and Laterality

Terminology	Site Term and Code	Laterality Required
Skin of other & unspecified parts of face Skin of: Cheek Chin Face Forehead Jaw Nose Temple Ala nasi Chin, NOS Columnella Eyebrow Brow External cheek External nose Forehead, NOS Lid-cheek junction Nasaljugal groove Temple, NOS	Skin of other and unspecified parts of face **C443**	**Yes**
Skin of scalp and neck Skin of head, NOS Skin of neck Skin of scalp Scalp, NOS Skin of cervical region	Skin of scalp and neck **C444**	**Yes**

Cutaneous Melanoma Site-group Instructions
C440-C449 with Histology 8720 – 8780 (Excludes melanoma of any other site)
Rules Apply to Cases Diagnosed 1/1/2021 forward

Table 1: Primary Sites and Laterality

Terminology	Site Term and Code	Laterality Required
Skin of trunk Skin of: Abdomen Abdominal wall Anus Axilla Back Breast Buttock Chest Chest wall Flank Groin Perineum Thoracic wall Thorax Trunk Umbilicus Gluteal region Infraclavicular region Inguinal region Sacrococcygeal region Scapular region Perianal skin Umbilicus, NOS	Skin of trunk **C445**	**Yes**

Table 1: Primary Sites and Laterality

Terminology	Site Term and Code	Laterality Required
Skin of upper limb and shoulder Skin of: Antecubital space Arm Elbow Finger Forearm Hand Palm Shoulder Thumb Upper limb Wrist Fingernail Nail Bed Palmar skin **Table continued on next page**	Skin of upper limb and shoulder **C446**	**Yes**

Cutaneous Melanoma Site-group Instructions
C440-C449 with Histology 8720 – 8780 (Excludes melanoma of any other site)
Rules Apply to Cases Diagnosed 1/1/2021 forward

Table 1: Primary Sites and Laterality

Terminology	Site Term and Code	Laterality Required
Skin of lower limb and hip Skin of: Ankle Calf Foot Heel Hip Knee Leg Lower limb Popliteal space Thigh Toe Plantar skin Sole of foot Toenail	Skin of lower limb and hip **C447**	**Yes**
Overlapping lesion of skin	Overlapping lesion of skin **C448** [1]	**No**
Skin, NOS	Skin, NOS **C449** [2]	**No**

[1] For Skin of Head and Neck: **Do not** use C448 for overlapping lesions of the Head & Neck. Assign the primary site code for the site where the bulk of the tumor is or where the epicenter is; do not use code C448.
[2] Code to Skin, NOS (C44.9) if a patient is diagnosed with metastatic melanoma and the primary site is not identified.

Cutaneous Melanoma Site-group Instructions
C440-C449 with Histology 8720 – 8780 (Excludes melanoma of any other site)
Rules Apply to Cases Diagnosed 1/1/2021 forward

Table 2: Specific Histologies, NOS, and Subtype/Variants

Use Table 2 as directed by the **Histology Rules** to assign the more common histology codes for melanotic skin 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 2, 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).

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

.

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Table begins on the next page

Table 2: Specific Histologies, NOS, and Subtype/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)

Melanoma NOS 8720
• Nevoid melanoma
• Early invasive melanoma **(/3)** [1]
  ○ Evolving invasive melanoma
• Melanoma in situ **(/2)**
• Early melanoma in situ **(/2)** [1]
  ○ Evolving melanoma in situ
	Acral melanoma **8744**
	• Acral lentiginous melanoma
	Amelanotic melanoma **8730**
	Balloon cell melanoma **8722**
	Desmoplastic melanoma **8745**
	• Desmoplastic melanoma, amelanotic
	• Neurotropic melanoma, malignant
	Epithelioid cell melanoma **8771**
	Lentigo maligna melanoma **8742 (/3)**
	• Melanoma in Hutchinson melanotic freckle **(/3)**
	• Lentigo maligna **(/2)**
	• Hutchinson melanotic freckle **(/2)**
	Low cumulative sun damage melanoma **8743**
	• Superficial spreading melanoma
	Melanoma arising in a blue nevus **8780**
	Malignant melanoma arising in giant congenital nevus **8761**
	• Malignant melanoma in giant pigmented nevus
	Malignant melanoma in a precancerous melanosis **8741**
	Malignant melanoma, regressing **8723**
	Malignant Spitz tumor **8770**
	• Mixed epithelioid and spindle cell melanoma

Row continues on next page

[1] Early/evolving melanoma in situ and early/evolving melanoma invasive are reportable for cases diagnosed 1/1/2021 forward. These terms are approved by standard setters, but are not listed in WHO or ICD-O.

Table 2: Specific Histologies, NOS, and Subtype/Variants

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Melanoma NOS 8720 (continued)	Nodular melanoma **8721** Spindle cell melanoma **8772 (/3)** • Sarcomatoid melanoma [2] Spindle cell melanoma, type A **8773** Spindle cell melanoma, type B **8774**

[2] Sarcomatoid melanoma is a rare subtype of melanoma characterized by almost complete loss of melanocytic differentiation both morphologically and phenotypically, with the bulk of the tumor being replaced by a spindle cell, sarcomatoid component. Use code 8772/3, spindle cell melanoma.

Table 3: Non-Reportable Terms and Codes

Table 3 lists non-reportable terms and codes used in the diagnosis of cutaneous melanotic neoplasms. ***This table is intended to be a reference only and may not be complete***. Please refer to your standard setter program manual for additional information on reportable neoplasms.

Non-Reportable Histology Term	Non-Reportable Histology Code
Pigmented nevus, NOS Nevus, NOS Melanocytic nevus Hairy nevus Nevus spilus Meyerson nevus Deep penetrating nevus Combined nevus Genital nevus Conjunctival nevus	**8720 (/0)**
Balloon cell nevus	**8722 (/0)**
Halo nevus Regressing nevus	**8723 (/0)**
Neuronevus	**8725 (/0)**
Magnocellular nevus Melanocytoma, NOS	**8726 (/0)**
Dysplastic nevus	**8727 (/0)**

Table 3: Non-Reportable Neoplasms

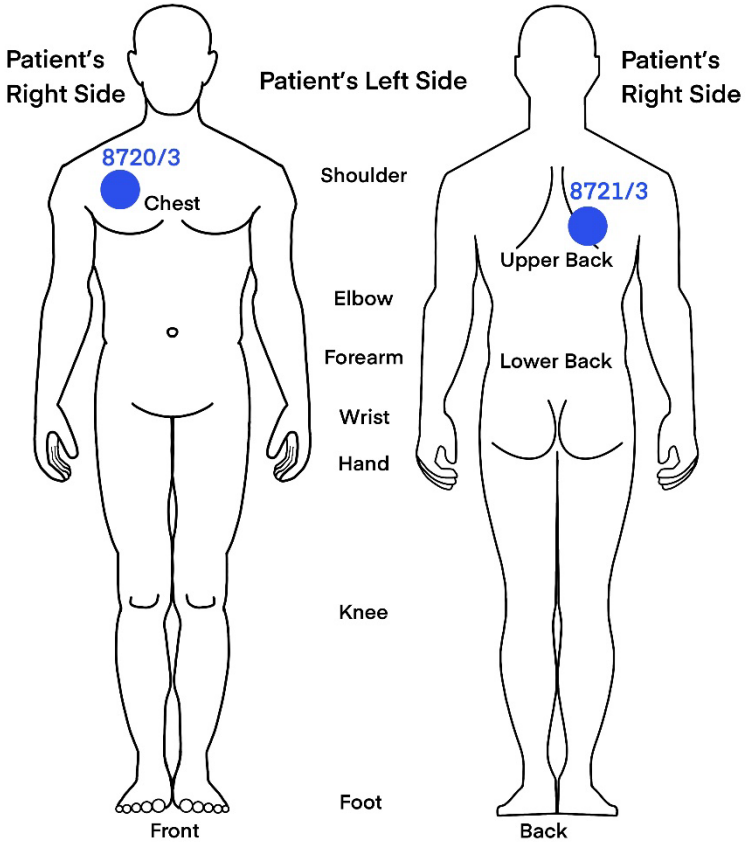
Non-Reportable Histology Term	Non-Reportable Histology Code
Nonpigmented nevus Achromic nevus	**8730 (/0)**
Junctional nevus, NOS Intraepidermal nevus Junction nevus	**8740 (/0)**
Lentiginous melanocytic nevus Simple lentigo Lentigo simplex	**8742 (/0)**
Acral nevus	**8744 (/0)**
Dermal nevus Intradermal nevus Stromal nevus	**8750 (/0)**
Compound nevus Dermal and epidermal nevus	**8760 (/0)**
Congenital melanocytic nevus, NOS Giant pigmented nevus, NOS Intermediate and giant congenital nevus	**8761 (/0)** **8761 (/0)** **8761 (/1)**
Proliferative dermal lesion in congenital nevus Proliferative nodule in congenital melanocytic nevus	**8762 (/1)**

Table 3: Non-Reportable Neoplasms

Non-Reportable Histology Term	Non-Reportable Histology Code
Epithelioid and spindle cell nevus Juvenile melanoma Juvenile nevus Spitz nevus Spitz nevus, atypical Pigmented spindle cell nevus of Reed Pigmented spindle cell Spitz nevus	**8770 (/0)**
Epithelioid cell nevus	**8771 (/0)**
Spindle cell nevus, NOS	**8772 (/0)**
Blue nevus, NOS Jadassohn blue nevus Pigmented epithelioid melanocytoma Blue nevus, epithelioid	**8780 (/0)** **8780 (/0)** **8780 (/1)** **8780 (/1)**
Cellular blue nevus	**8790 (/0)**
Intermediate lesion Melanocytic neoplasm of low malignant potential Melanocytic tumor of uncertain malignant potential (MELTUMP) Superficial atypical melanocytic proliferation of uncertain significance (SAMPUS) Primary acquired melanosis	**No ICD-O code**

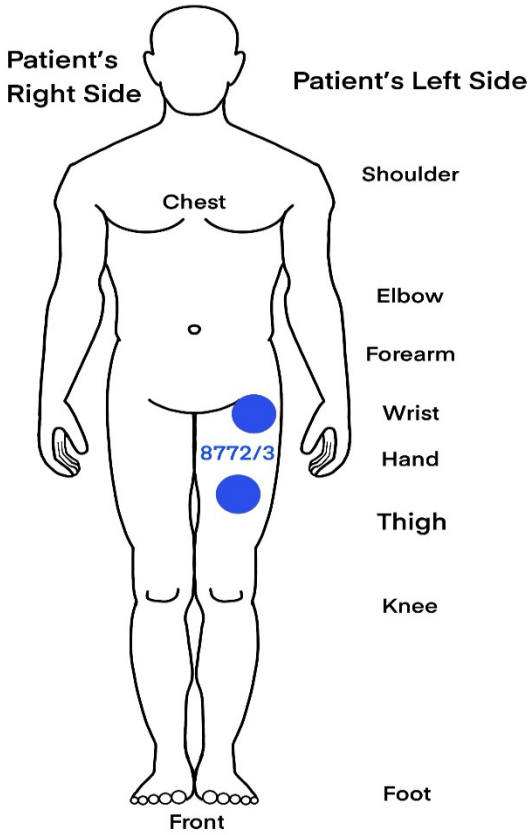
Illustrations

Explanatory illustrations for Multiple Primary Rule M6



Example 1: Both lesions are located on the right side of the body and sites are chest C445 and back C445. Histology for the chest lesion is melanoma, NOS (8720/3) and the back lesion is nodular melanoma (8721/3). Abstract a single primary.

Explanatory illustrations for Multiple Primary Rule M6



Example 2: Both lesions are located on the left leg. One lesion is spindle cell melanoma (8772/3) located on the front of the left hip C447. The other lesion is spindle cell melanoma (8772/3) located on the front of the left thigh C447.

Cutaneous Melanoma Multiple Primary Rules
C440-C449 with Histology 8720 – 8780 (Excludes melanoma of any other site)
Rules Apply to Cases Diagnosed 1/1/2021 forward

Note: Metastatic tumors are not included when determining how many tumors are present. Metastatic tumors include but are not limited to:

- Distant metastasis in skin, subcutaneous tissue including muscle
- Bone
- Brain
- Regional lymph nodes as identified in Summary Stage Manual
- Distant lymph nodes as identified in Summary Stage Manual
- Liver
- Lung
- In-transit metastases – metastases which occur along the lymph pathways between the primary tumor > 2 cm from the scar and the regional lymph nodes
- Satellites – new tumor within a radius of 2 cm from the scar after removal of primary tumor. Satellites may be caused by remains of the primary tumor.

Unknown if Single or Multiple Melanomas

Rule M1 Abstract a **single primary** when it is not possible to determine if there is a **single** melanoma or **multiple** melanomas.

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 Melanoma

Use the histology rules to assign the appropriate histology code.

Cutaneous Melanoma Multiple Primary Rules
C440-C449 with Histology 8720 – 8780 (Excludes melanoma of any other site)
Rules Apply to Cases Diagnosed 1/1/2021 forward

Single Melanoma

Note 1: Do not use the rules for melanoma described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 Abstract a **single primary** when there is a **single melanoma.**
Note 1: A single melanoma 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 Melanoma.

Use the histology rules to assign the appropriate histology code.

Multiple Melanomas

Note 1: Multiple melanomas may be a single primary or multiple primaries
Note 2: Do not use the rules for melanoma described as metastasis
Note 3: Includes combinations of in situ and invasive
Note 4: For those sites which have biomarkers, the biomarkers are most frequently used to target treatment. Follow the rules, do not code multiple primaries or histology based on biomarkers.

Rule M3 Abstract **multiple primaries** when there are separate, non-contiguous melanomas in sites with ICD-O site codes that **differ** at the second (C**X**xx), third (Cx**X**x) or fourth (C44**X**) character.
Note: This applies to a melanoma of unknown primary and a known cutaneous melanoma primary

Cutaneous Melanoma Multiple Primary Rules
C440-C449 with Histology 8720 – 8780 (Excludes melanoma of any other site)
Rules Apply to Cases Diagnosed 1/1/2021 forward

Rule M4 Abstract **multiple primaries** when there are separate, non-contiguous melanomas with **different lateralities**.

Note 1: A midline melanoma is a different laterality than right or left.

Note 2: If the laterality of one or both melanomas is unknown, then continue through the rules

Note 3: If one or more of the sites does not require laterality to be coded (laterality required = no in **Table 1**), then continue through the rules.

Example 1: Melanoma of the right side of the chest and melanoma at midline of the chest are different lateralities and are multiple primaries.

Example 2: A melanoma of the right side of the chest and a melanoma of the left side of the chest are multiple primaries.

Rule M5 Abstract **multiple primaries** when separate/non-contiguous tumors are two or more different subtypes/variants in Column 2, **Table 2** in the Site-group Instructions. Timing is irrelevant.

Example: Epithelioid cell melanoma 8771/3 and nodular melanoma 8721/3 are both subtypes/variants of melanoma NOS 8720/3.

Rule M6 Abstract a **single primary** when synchronous, separate/non-contiguous tumors are on **the same row in Table 2** in the Site-group Instructions. Tumors must have the same site code.

Note: The same row means the tumors are:

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

Example 1: Both lesions are located on the right side of the body and sites are chest C445 and back C445. Histology for the chest lesion is melanoma, NOS (8720/3) and the back lesion is nodular melanoma (8721/3). Abstract a single primary. Refer to **illustration**.

Example 2: Both lesions are located on the left leg. One lesion is spindle cell melanoma (8772/3) located on the front of the left hip C447. The other lesion is spindle cell melanoma (8772/3) located on the front of the left thigh C447. Refer to **illustration**.

Cutaneous Melanoma Multiple Primary Rules
C440-C449 with Histology 8720 – 8780 (Excludes melanoma of any other site)
Rules Apply to Cases Diagnosed 1/1/2021 forward

Rule M7 Abstract **multiple primaries** when melanomas are diagnosed more than 60 days apart.
Example 1: An **in situ** melanoma that occurs **more than 60 days** after an **invasive** melanoma is a **new** primary**.**
Example 2: An **invasive** melanoma that occurs **more than 60 days** after an **in situ** melanoma is a **new** primary.
Example 3: An **in situ** melanoma that occurs **more than 60 days** after an **in situ** melanoma is a **new** primary.
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M8 Abstract a **single primary** when melanomas do not meet any of the above criteria.
Note: Use caution when applying this default rule. Please confirm that you have not overlooked an applicable rule.

This is the end of instructions for Multiple Melanomas

Use the histology rules to assign the appropriate histology code.

Cutaneous Melanoma Histology Rules
C440-C449 with Histology 8720 – 8780 (Excludes melanoma of any other site)
Rules Apply to Cases Diagnosed 1/1/2021 forward

Priority Order for Using Documents to Identify Histology

IMPORTANT NOTES

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

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

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

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

The priority list is used for **single primaries** (including multiple tumors abstracted as a single primary).

This is a hierarchical list of source documentation.

Code the **most specific** pathology/tissue from either **resection** or **biopsy**.

Note 1: The term "most specific" usually refers to a subtype/variant.
Note 2: The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor.
Note 3: When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).

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

Note 1: Addendums and comments on the pathology report are given the highest priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.

Note 2: The pathologist's diagnosis from the pathology report is always reliable, so the final diagnosis is the second priority.

Note 3: The CAP protocol is a checklist which:

- Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care
- Allows physicians to check multiple histologies

2. Tissue/pathology from a **metastatic** site

   Note 1: Code the behavior /3.

   Note 2: The tissue from a **metastatic s**ite often shows **variations** from the primary tumor. When it is the only tissue available, it is **more accurate** than a scan.

3. **Scans: MRI, CT, PET. There is no priority** order because scans are not a reliable method for **identifying** specific **histology**(ies).

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

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

   Note 1: Code the specific histology when documented.

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

Cutaneous Melanoma Histology Rules
C440-C449 with Histology 8720 – 8780 (Excludes melanoma of any other site)
Rules Apply to Cases Diagnosed 1/1/2021 forward

Coding Histology

Note 1: The priority is to code the most specific histology. DO NOT USE BREAST HISTOLOGY CODING RULES FOR THIS SITE.
Note 2: Only use this section for one or more histologies within a single tumor.
Note 3: Do not use this section in place of the Histology Rules.
Note 4: Code the most specific histology from the biopsy or resection. When there is a discrepancy between the biopsy and resection (two distinctly different histologies), code the histology from the most representative specimen (the greatest amount of tumor). This applies to cases diagnosed 1/1/2021 forward.

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

   Example 1: Diagnosis for a single melanoma is melanoma, NOS 8720 with the majority or predominant part of tumor being nodular melanoma 8721. Code the subtype/variant: nodular melanoma 8721.
   Example 2: Diagnosis for a single melanoma is melanoma, NOS 8720 with the minority of tumor being amelanotic melanoma 8730. Code the subtype/variant: amelanotic melanoma 8730.
   Example 3: Diagnosis for a single tumor is melanoma, NOS 8720 with a component of malignant desmoplastic melanoma 8745. Code the subtype/variant: malignant desmoplastic melanoma 8745.

   Note 1: The terms above (A, B, C) must describe a **melanoma** in order to code a histology described by those terms.
   Example: When the diagnosis is melanoma with a nodular melanoma component, code nodular melanoma 8721.
   Negative Example: When the diagnosis is simply melanoma with a nodular component, code melanoma, NOS 8720. Do not assume this is a nodular melanoma.
   Note 2: When the most specific histology is described as differentiation or features, see #2.

2. Code the histology described as **differentiation** or **features/features of ONLY** when there is a specific ICD-O code for the "NOS with ____ features" or "NOS with ____ differentiation".
   Note: Do not code differentiation or features when there is no specific ICD-O code.

3. Code the specific histology described by **ambiguous terminology** (list follows) **ONLY** when A or B is true:
   A. The only diagnosis available is **one histology** term described by ambiguous terminology
      - CoC and SEER require reporting of cases diagnosed only by ambiguous terminology
      - Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

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

      If the specific histology does not meet the criteria in #3B, then code the NOS histology.

   See the **Ambiguous Terminology** section of the General Instructions for instructions and examples on when ambiguous terms and definitive terms may be used to assign histology.

Table 4: List of Ambiguous Terminology

Ambiguous Terminology	
Appears	Presumed
Cannot rule out	Suspicious (for)
Likely	Suggestive of
Favor(s)	

Note 1: Table 5 below includes terms **previously** included in the list of ambiguous terms. These terms should be treated as supporting a **definitive diagnosis** of a histologic subtype. A definitive term does not require clinical verification of the subtype or variant.

Note 2: The terms in Table 5 were removed from the list of ambiguous terms and added to a list of **definitive terminology** based on the recommendation of a panel of pathologists and subject matter experts.

Table 5: List of Definitive Terminology

Definitive Terminology	
Comparable with	Most likely
Compatible with	Probable
Consistent with	Typical (of)

4. **DO NOT CODE** histology when described as:
   - Architecture
   - Foci; focus; focal
   - Pattern

Single Melanoma or Multiple Melanomas Abstracted as a Single Primary

Rule H1 Code the histology when only **one histologic type** is identified.

Note 1: Use **Table 2** to code histology. New 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: When the histology includes the term regressing or regression, continue through the rules.

Note 4: When the histology includes the term lentigo maligna melanoma, continue through the rules.

Note 5: Submit a question to **Ask a SEER Registrar** when the histology code is not found in Table 2, ICD-O, or all updates.

Rule H2 Code the invasive histology when there are **invasive** and **in situ** components.

Rule H3 Code the **histologic type** when the diagnosis is **regressing** melanoma **and** a **histologic type**.

Example: The lesion has evidence of regressing melanoma, nodular melanoma type. Code 8721/3 (Nodular melanoma).

Rule H4 Code **8723/3** (Malignant melanoma, regressing) when the diagnosis is **regressing melanoma**.

Example 1: Malignant melanoma with regression. Code 8723 malignant melanoma, regressing.

Example 2: Malignant melanoma with features of regression. Code 8720/3 melanoma NOS.

Rule H5 Code the **histologic type** when the diagnosis is **lentigo maligna** melanoma **and** a **histologic type**.

***Example*:** The diagnosis is lentigo maligna melanoma with desmoplastic melanoma, right arm. Code desmoplastic melanoma, 8745/3.

Rule H6 Code **8742/3** (Lentigo maligna melanoma) when the diagnosis is **lentigo maligna** melanoma with **no** other histologic types.

Rule H7 Code the **subtype/variant** when there is a **NOS** and a **single subtype/variant** of that NOS.

- Melanoma NOS 8720 and a subtype/variant of melanoma

Note: Use **Table 2** in the Site-group Instructions to determine NOS and subtype/variant.

Rule H8 Code single tumors with **two variants** as follows:

- Code **8721/3** when Nodular melanoma is mixed with:
  - Amelanotic melanoma **OR**
  - Desmoplastic melanoma **OR**
  - Epithelial cell melanoma
- Code **8730/3** when amelanotic melanoma is mixed with:
  - Spindle cell melanoma, NOS
- Code **8743/3** when Low cumulative sun damaged melanoma/superficial spreading melanoma is mixed with:
  - Desmoplastic melanoma **OR**
  - Nodular melanoma **OR**
  - Spindle cell melanoma
- Code **8744/3** when Acral melanoma/acral lentiginous melanoma, malignant is mixed with:
  - All other melanoma subtype/variants listed in **Table 2**
- Code **8745/3** when desmoplastic melanoma is mixed with:
  - Spindle cell melanoma, NOS

Note 1: Percentage of a subtype/variant is not used to determine histology for mixed melanomas
Note 2: If the mixed subtypes/variants are not included in this rule, continue to the next rule

Rule H9 When two or more melanoma subtype/variants are present in a single tumor and are not listed in the previous rule, submit a question to **Ask A SEER Registrar** for coding instructions.
Note 1: Two or more melanoma subtype/variants identified in a single tumor is infrequent.
Note 2: The WHO Classification of Skin Tumors 4th Ed does not include ICD-O codes for tumors with mixed melanoma subtype/variants.

This is the end of instructions for Single Melanoma or Multiple Melanomas Abstracted as a Single Primary.

Other Sites Site-group Instructions
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Introduction

Note 1: De novo (previously called frank) adenocarcinoma arises in the mucosa of the small bowel/intestines, not in a polyp.

Note 2: Polyp-specific ICD-O codes remain valid for small bowel/intestine sites.

Note 3: Rectum and Rectosigmoid were moved to the Colon Rules beginning with cases diagnosed 1/1/2018.

Note 4: Bilateral epithelial ovarian tumors must be the same histology or be an NOS and subtype/variant in order to be coded as a single primary beginning with cases diagnosed 1/1/2023.

Equivalent or Equal Terms

These terms can be used interchangeably:

- Adenocarcinoma; carcinoma
  - A histology type must be stated for these terms to be equal
  - Example of equivalent or equal: Serous carcinoma and serous adenocarcinoma are both coded 8441
  - Example of **NOT** equivalent or equal: Carcinoma NOS 8010 and adenocarcinoma NOS 8140
- And; with; (duct **and** lobular is equivalent to duct **with** lobular)
  Note: "And" and "with" are used as synonyms when **describing multiple histologies** within a **single tumor**.
- Contiguous; continuous
- In situ; noninvasive; intraepithelial
- Mucinous; mucoid; mucous; colloid
- Multicentric; multifocal
- Polyp; adenoma; polyp NOS; adenomatous polyp
- Serosa; visceral peritoneum
- Simultaneous; synchronous; existing at the same time; concurrent; prior to first course treatment
- Site; topography

- Tumor; mass; tumor mass; lesion; neoplasm
  - The terms tumor, mass, tumor mass, lesion, 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

Terms That Are NOT Equivalent or Equal

These terms 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.
- **Carcinoma NOS 8010** is not equivalent to **adenocarcinoma NOS 8140**
- **Component** is not equivalent to **subtype/type/variant**
  - **Note:** Component is only coded when the pathologist specifies the component as a second carcinoma/sarcoma
- **Phenotype** is not equivalent to **subtype/type/variant**

Other Sites Site-group Instructions
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Site or Site-Group Histology-Specific Tables

Twenty-one site-specific histology tables are included in Solid Tumor Other Sites. Each table applies to a site or site group and lists histologies that commonly occur in those sites. These tables are based on the most recent WHO Classification of Tumors Books and/or College of American Pathologist (C.A.P.) protocols and do not list all possible histologies that may arise in that site.

In place of adding numerous site-based histology rules to the Other Sites group, the histology tables will include additional coding instructions and notes to assign the correct ICD-O code when appropriate.

Coding instructions are located above the tables and histology-specific coding information are found in footnotes.

The notes below apply to all tables.

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 the histology tables, 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).

IMPORTANT: It is important to refer to these tables when determining a histology code as the notes may provide coding guidance.

Other Sites Site-group Instructions
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Table Index

Jump to **Multiple Primary Rules**
Jump to **Histology Coding Rules**

Table 1: Paired Organs and Sites with Laterality

Laterality must be coded for all of the following sites. SEER does allow coding laterality for sites not listed in Table 1.

Site Code	Site or Subsite
C384	Pleura
C400	Long bones of upper limb, scapula, and associated joints
C401	Short bones of upper limb and associated joints
C402	Long bones of lower limb and associated joints
C403	Short bones of lower limb and associated joints
C441	Skin of the eyelid
C442	Skin of the external ear
C443	Skin of other and unspecific parts of the face (if midline, assign code 5)
C444	Skin of scalp and neck
C445	Skin of the trunk (if midline, assign code 5)
C446	Skin of upper limb and shoulder
C447	Skin of the lower limb and hip
C471	Peripheral nerves and autonomic nervous system of upper limb and shoulder

Other Sites Site-group Instructions
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Table 1: Paired Organs and Sites with Laterality

Site Code	Site or Subsite
C472	Peripheral nerves and autonomic nervous system of the lower limb and hip
C491	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C492	Connective, subcutaneous, and other soft tissues of the lower limb and hip
C569	Ovary
C570	Fallopian tube
C620-C629	Testis
C630	Epididymis
C631	Spermatic cord
C690-C699	Eye and adnexa
C740-C749	Adrenal gland

Other Sites Site-group Instructions
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Table 2: Mixed and Combination 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. Adenocarcinoma mixed subtypes 8255 is a "last resort" code.
4. Do not use this table unless instructed to by the Histology Rules.

IMPORTANT NOTE: Histology Tables 3-23 may include additional coding instructions for "mixed" histologies.

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

- For tumors with both **invasive** and **in situ** behavior.
- When one of the histologies is described as **differentiation or features.** A histology with differentiation or features is a single histology.
- 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.

Table 2: Mixed and Combination Codes

Required Histology Terms	Histology Combination Term and Code
Small cell carcinoma/neuroendocrine tumor (NET) **AND** **At least one** of the following: • Adenocarcinoma and any subtype/variant of adenocarcinoma • Adenosquamous carcinoma • Large cell carcinoma and any subtype/variant of large cell carcinoma (includes large cell neuroendocrine carcinoma) • Non-small cell carcinoma • Squamous cell carcinoma and any subtype/variant of squamous cell carcinoma	Combined small cell carcinoma **8045**
Large cell neuroendocrine carcinoma **AND** • Adenocarcinoma NOS **OR** • Giant cell carcinoma **OR** • Spindle cell carcinoma **OR** • Squamous cell carcinoma NOS	Combined large cell neuroendocrine carcinoma **8013**

Table 2: Mixed and Combination Codes

Required Histology Terms	Histology Combination Term and Code
Squamous carcinoma **AND** Basal cell carcinoma	Basosquamous carcinoma **8094**
Islet cell **AND** Exocrine carcinoma	Mixed islet cell and exocrine adenocarcinoma **8154**
Acinar **AND** Endocrine/neuroendocrine	Mixed acinar-endocrine **8154** • Neuroendocrine carcinoma
Acinar **AND** **Both of the following**: • Ductal • Endocrine	Mixed acinar-endocrine-ductal carcinoma **8154**

Table 2: Mixed and Combination Codes

Required Histology Terms	Histology Combination Term and Code
Ductal **AND** Acinar (includes acinar adenocarcinoma of prostate)	Mixed acinar-ductal carcinoma **8552** [1]
Ductal **AND** Endocrine/neuroendocrine	Mixed ductal-endocrine carcinoma **8154** • Mixed ductal-neuroendocrine carcinoma
Endocrine **AND** Exocrine	Mixed endocrine and exocrine adenocarcinoma **8154**
Hepatocellular carcinoma **AND** Cholangiocarcinoma	Combined hepatocellular carcinoma and cholangiocarcinoma **8180 (C221)**

[1] For prostate, assign code 8552 when the ductal component is not stated or is less than 50% of the tumor.

Other Sites Site-group Instructions
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Table 2: Mixed and Combination Codes

Required Histology Terms	Histology Combination Term and Code
Adenocarcinoma **AND** • Carcinoid/neuroendocrine carcinoma (NEC) **OR** • Neuroendocrine tumor (NET)	Mixed adenoneuroendocrine carcinoma **8244** • Combined carcinoid and adenocarcinoma
Adenocarcinoma **AND** **At least two** of the following: • Acinar • Clear cell • Mucinous/colloid • Papillary • Signet ring	Adenocarcinoma with mixed subtypes **8255** [2] [3] • Adenocarcinoma combined with other types of carcinoma

[2] Code 8255 does not apply to GYN primaries. Continue through the table to determine correct mixed histology code for GYN neoplasms.
[3] Gastric/stomach tumors with more than one adenocarcinoma subtype/variant should be coded 8255

Table 2: Mixed and Combination Codes

Required Histology Terms	Histology Combination Term and Code
Gyn malignancies with **two or more** of the following: • Clear cell • Endometrioid • Mucinous • Papillary • Serous • Squamous	Mixed cell adenocarcinoma **8323** [4]
Papillary thyroid carcinoma (includes subtype/variants) **AND** Follicular (includes subtype/variants)	Papillary carcinoma, follicular variant **8340** [5] • Infiltrative follicular variant of papillary carcinoma • Widely invasive follicular variant of papillary carcinoma
Medullary **AND** Follicular (includes subtype/variants)	Mixed medullary-follicular carcinoma **8346**

[4] First refer to ICD-O-3.2 and ICD-O updates to confirm if the mixed histology has a specific code. Example: Serous papillary adenocarcinoma is coded 8441 per ICD-O-3.2.

[5] First refer to ICD-O-3.2 and ICD-O updates to confirm if the mixed histology has a specific code.

Table 2: Mixed and Combination Codes

Required Histology Terms	Histology Combination Term and Code
Medullary **AND** Papillary (includes subtype/variants)	Mixed medullary-papillary carcinoma **8347**
Medullary **AND** • Anaplastic carcinoma **OR** • Oncocytic carcinoma **OR** • Poorly differentiated carcinoma	Mixed medullary and poorly differentiated carcinoma **8346** • Mixed medullary and anaplastic carcinoma • Mixed medullary and oncocytic carcinoma
Squamous carcinoma **AND** Adenocarcinoma	Adenosquamous carcinoma **8560**
Any combination of the following sarcomas: • Myxoid • Pleomorphic • Round cell	Liposarcoma NOS **8850**

Table 2: Mixed and Combination Codes

Required Histology Terms	Histology Combination Term and Code
Embryonal rhabdomyosarcoma **AND** Alveolar rhabdomyosarcoma	Mixed type rhabdomyosarcoma **8902**
Any combination of the following: • Embryonal carcinoma • Seminoma • Teratoma • Yolk sac tumor	Mixed germ cell tumor **9085**
Choriocarcinoma **AND** **Any of the following:** • Embryonal • Seminoma • Teratoma	Choriocarcinoma combined with other germ cell elements **9101**

Table 3: Prostate Histologies

Table 3 lists the more common histologies for prostate.
C619 Prostate gland; prostate, NOS
Note: Column 2 may contain NOS histologies which are part of a bigger histologic group.

- For example, acinar adenocarcinoma NOS 8140 (column 1) is a generic term which encompasses a number of adenocarcinomas, including ductal/intraductal adenocarcinoma 8500 (column 2). Ductal/intraductal is also a NOS because it has subtypes/variants. The subtypes/variants are indented under the NOS (ductal/intraductal) in column 2. There are also footnotes in column 2 which call attention to the fact that ductal/intraductal has subtypes/variants.

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**
- Subtypes or variants of the NOS histologies in column 2 are also indented under the NOS histology and have a full 4-digit histology code (see note above). The behavior code (/2 or /3) is included with the 4-digit histology code if the term has only one possible behavior.

Continued on next page

Table 3: Prostate Histologies

Coding notes for acinar adenocarcinoma subtype/variants:

- **Ductal adenocarcinoma 8500/3:** In order to code ductal adenocarcinoma 8500/3, a radical prostatectomy must be performed, and the ductal component must comprise >50% of the tumor. In prostate biopsies, the term "adenocarcinoma of prostate with ductal features" should be coded 8140/3.
- **Mucinous adenocarcinoma 8480/3:** In order to code 8480/3, the mucinous adenocarcinoma component must comprise >25% of the tumor, so the diagnosis must be made only in excision specimens.
- **Sarcomatoid carcinoma 8572/3:** Exceedingly rare and most commonly occurs during the development of high-grade adenocarcinoma, especially after irradiation.
- **Signet ring cell-like adenocarcinoma 8490/3:** In order to code 8490/3, the signet-ring-like cells must comprise >25% of tumor, so the diagnosis must be made only in excision specimens.

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Acinar adenocarcinoma 8140 • Acinar carcinoma • Adenocarcinoma NOS **(/3)** • Adenocarcinoma with ductal features **(/3)** • Atrophic adenocarcinoma **(/3)** • Foamy gland adenocarcinoma **(/3)** • Microcystic adenocarcinoma **(/3)** • Pleomorphic giant cell acinar carcinoma **(/3)** • Prostatic intraepithelial-like carcinoma **(/3)** • Pseudohyperplastic adenocarcinoma **(/3)** • Adenocarcinoma in situ **(/2)**	Acinar adenocarcinoma, sarcomatoid variant **8572** Ductal adenocarcinoma **8500** [1] • Intraductal adenocarcinoma • Cribriform adenocarcinoma **8201** • Papillary adenocarcinoma **8260** • Solid adenocarcinoma **8230** Mucinous adenocarcinoma **8480** • Colloid adenocarcinoma Signet ring-like cell adenocarcinoma **8490**

[1] Ductal/intraductal adenocarcinoma is NOS with subtype/variants.

Jump to **Multiple Primary Rules**
Jump to **Histology Coding Rules**

Table 3: Prostate Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenocarcinoma with neuroendocrine differentiation 8574 (/3) [2]	
Adenosquamous carcinoma 8560 • Prostatic carcinoma with adenosquamous differentiation	
Basal cell adenocarcinoma 8147 • Adenoid cystic basal cell carcinoma • Adenoid cystic carcinoma • Adenoid cystic carcinoma (solid pattern) • Basal cell carcinoma of prostate	
Mixed acinar-ductal adenocarcinoma 8552 [3]	
Mixed neuroendocrine–non-neuroendocrine neoplasm 8154 (/3)	
Neuroendocrine carcinoma 8246 (/3)	Combined small cell neuroendocrine carcinoma **8045 (/3)** Large cell neuroendocrine carcinoma **8013 (/3)** • Combined large cell neuroendocrine carcinoma Small cell neuroendocrine carcinoma **8041 (/3)** [4]
Neuroendocrine tumor 8240 (/3) • Neuroendocrine tumor, grade 1	Neuroendocrine tumor, grade 2 **8249 (/3)**

[2] Code 8574/3 only when there is no history of previous prostate adenocarcinoma treated with androgen deprivation therapy and/or radiation therapy.
[3] Assign code 8552 when the ductal component is not stated or is less than 50% of the tumor.
[4] 50% of SmCC of prostate cases present as a de novo malignancy. SmCC of the prostate often occurs following androgen deprivation treatment for acinar adenocarcinoma

Table 3: Prostate Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Sarcoma NOS 8800 (/3) • Mesenchymal tumor, malignant	Angiosarcoma **9120 (/3)** Leiomyosarcoma **8890 (/3)** Osteosarcoma **9180 (/3)** Rhabdomyosarcoma **8900 (/3)** Solitary fibrous tumor, malignant **8815 (/3)** Stromal sarcoma **8935 (/3)** Synovial sarcoma **9040 (/3)** Undifferentiated pleomorphic sarcoma **8802 (/3)**
Squamous cell carcinoma 8070 [5] • SCC NOS	
Urothelial carcinoma 8120 [6] [7]	

[5] If a patient has a known history of acinar adenocarcinoma of prostate treated with hormone and/or radiation and subsequent findings of squamous cell carcinoma, this is recurrence and not a new primary. Code 8070/3 only when there is no history of the patient receiving radiation and/or androgen-deprivation therapy for previously-diagnosed prostate adenocarcinoma. See M Rules.

[6] Primary urothelial carcinoma of the prostate can rarely occur in the absence of a bladder tumor.

[7] Urothelial carcinomas of the prostate are almost always found in the prostatic urethra.

Table 4: Testis Histologies

Table 4 lists the more common histologies for testis as stated in the College of American Pathologists (C.A.P.) testis protocol
C620 Undescended testis
C621 Descended testis
C629 Testis, NOS

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

.
Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do not have behavior codes next to the term unless the term has only one possible behavior (/2 or /3)

Table begins on next page

Table 4: Testis Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Germ cell tumor NOS 9064 • Germ cell neoplasia in situ **(/2)** • Intratubular germ cell neoplasia **(/2)** • Intratubular malignant germ cells **(/2)**	Choriocarcinoma **9100** Embryonal carcinoma **9070** Spermatocytic seminoma **9063** • Spermatocytic tumor NOS • Spermatocytic tumor with sarcomatous differentiation Teratoma with malignant transformation **9084** [1] • Teratoma with somatic type malignancy Yolk sac tumor **9071** • Alveolar pattern • Endodermal sinus/perivasvular pattern • Glandular pattern • Hepatoid pattern • Macrocystic pattern • Microcystic pattern • Myxoid pattern • Papillary pattern • Parietal pattern • Perivascular pattern • Polyvesicular vitelline pattern • Reticular pattern • Sarcomatoid pattern • Solid pattern • Spindle cell pattern • Yolk sac tumor, prepubertal

[1] The following teratomas are **not reportable:** Teratoma, prepubertal type and Teratoma mature prepubertal type, 9084/0

Table 4: Testis Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Leydig cell tumor, malignant 8650 (/3)	
Seminoma NOS 9061 • Seminoma with syncytiotrophoblastic cells	
Sertoli cell carcinoma 8640 (/3) • Sertoli cell tumor, malignant	

Table 5: Esophagus Histologies

Table 5 list the more common histologies for the following esophagus subsites:
C150 Cervical esophagus
C151 Thoracic esophagus
C152 Abdominal esophagus
C153 Upper third of esophagus (proximal third of esophagus)
C154 Middle third of esophagus
C155 Lower third of esophagus (Distal third of esophagus)
C158 Overlapping lesion of esophagus
C159 Esophagus, NOS

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Table begins on next page

Table 5: Esophagus Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenocarcinoma NOS 8140 • Adenocarcinoma in situ **(/2)**	
Adenoid cystic carcinoma 8200	
Adenosquamous carcinoma 8560	
Gastrointestinal stromal tumor 8936 • GANT • Gastrointestinal pacemaker cell tumor • Gastrointestinal stromal sarcoma • Gastrointestinal stromal tumor • GIST, malignant • GIST NOS • Succinate dehydrogenase-deficient gastrointestinal stromal tumor	
Mixed neuroendocrine-non-endocrine neoplasm 8154 (/3) [1] • MiNEN	
Mucoepidermoid carcinoma 8430	
Mucosal melanoma 8720 (/3)	

[1] Esophageal MiNENs usually consist of poorly differentiated NEC and either squamous cell carcinoma or adenocarcinoma

Table 5: Esophagus Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Neuroendocrine carcinoma 8246 (/3)	Large cell neuroendocrine carcinoma **8013 (/3)** Small cell neuroendocrine carcinoma **8041 (/3)**
Neuroendocrine tumor 8240 (/3) • NET • Neuroendocrine tumor, grade 1	Neuroendocrine tumor, grade 2 **8249 (/3)** • Neuroendocrine tumor, grade 3
Squamous cell carcinoma 8070 • Squamous carcinoma • Squamous cell carcinoma, usual type • Squamous cell carcinoma in situ **(/2)**	Basaloid squamous cell carcinoma **8083** Squamous cell carcinoma, spindle cell **8074** • Squamous cell carcinoma, sarcomatoid Verrucous squamous cell carcinoma **8051**
Undifferentiated carcinoma 8020 (/3)	

Table 6: Stomach Histologies

Table 6 list the more common histologies for the following stomach subsites:
C160 Cardia, NOS; gastric cardia; cardioesophageal junction; esophagogastric junction; gastroesophageal junction
C161 Fundus of stomach; gastric fundus
C162 Body of stomach; corpus of stomach; gastric corpus
C163 Gastric antrum; antrum of stomach; pyloric antrum
C164 Pylorus; pyloric canal; prepylorus
C165 Lesser curvature of stomach, NOS
C166 Greater curvature of stomach, NOS
C168 Overlapping lesion of stomach
C169 Stomach NOS; gastric, NOS

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Coding notes for Stomach:

- When both Lauren and WHO histologies are stated, code the WHO diagnosis.
  - Exception: If WHO diagnosis is adenocarcinoma NOS and Lauren indicates a more specific type, code the specific histology.
- When multiple subtype/variants of adenocarcinoma are identified, code adenocarcinoma, mixed subtypes 8255.

Table 6: Stomach Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenocarcinoma NOS 8140 • Adenocarcinoma of fundic gland type • Paneth cell carcinoma [1] • Adenocarcinoma in situ **(/2)**	Adenocarcinoma, diffuse type **8145 (/3)** Adenocarcinoma, intestinal type **8144 (/3)** • Intestinal type adenoma, high grade **(/2)** Hepatoid adenocarcinoma **8576** Medullary carcinoma with lymphoid stroma **8512** Micropapillary carcinoma **8265** Mucinous adenocarcinoma **8480** [2] Mucoepidermoid carcinoma **8430** Papillary adenocarcinoma **8260** Parietal cell carcinoma **8214** Signet ring cell carcinoma **8490** [2] • Poorly cohesive carcinoma Tubular adenocarcinoma **8211**
Adenomatous polyp, high grade 8210 (/2) • Adenocarcinoma in situ in adenomatous polyp • Adenomatous polyp, high grade dysplasia	
Adenosquamous carcinoma 8560	
Gastroblastoma 8976 (/3)	

[1] Paneth cell carcinoma is a rare subtype of adenocarcinoma. A specific ICD-O code has not been proposed by WHO. Code as 8140.
[2] For stomach sites, code mucinous carcinoma (8480) or signet-ring cell carcinoma (8490) regardless of percentage.

Table 6: Stomach Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Gastrointestinal stromal tumor 8936 • GANT • Gastrointestinal pacemaker cell tumor • Gastrointestinal stromal sarcoma • Gastrointestinal stromal tumor • GIST NOS • GIST, malignant • Succinate dehydrogenase-deficient gastrointestinal stromal tumor	
Glandular intraepithelial neoplasia, high grade 8148 (/2) • Glandular intraepithelial neoplasia, grade III	
Mixed adenoneuroendocrine carcinoma 8244 (/3) • Combined carcinoid and adenocarcinoma • Composite carcinoid • MANEC • Mixed carcinoid and adenocarcinoma	
Mixed neuroendocrine-non-neuroendocrine neoplasm 8154 (/3) • MiNEN	
Neuroendocrine carcinoma 8246 (/3) • NEC	Large cell neuroendocrine carcinoma **8013 (/3)** Small cell neuroendocrine carcinoma **8041 (/3)**

Table 6: Stomach Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Neuroendocrine tumor NOS 8240 (/3) • Carcinoid • Neuroendocrine tumor, grade 1 • Well-differentiated endocrine tumor	Enterochromaffin-like cell tumor **8242 (/3)** Neuroendocrine tumor, EC-cell, serotonin-producing **8241 (/3)** Neuroendocrine tumor, gastrin-producing **8153 (/3)** • Gastrinoma Neuroendocrine tumor, grade 2 **8249 (/3)** • Neuroendocrine tumor, grade 3
Serrated dysplasia, high grade 8213 (/2)	
Squamous cell carcinoma 8070	
Undifferentiated carcinoma 8020 (/3)	Carcinoma with osteoclast-like giant cells **8035 (/3)** Large cell carcinoma with rhabdoid phenotype **8014 (/3)** Pleomorphic carcinoma **8022 (/3)** Sarcomatoid carcinoma **8033 (/3)**

Table 7: Small Intestine and Ampulla of Vater Histologies

Table 7 list the more common histologies for the following small intestine subsites:
C170 Duodenum
C171 Jejunum
C172 Ileum (excludes ileocecal valve C180)
C173 Meckel diverticulum
C178 Overlapping lesion of small intestine
C179 Small intestine, NOS; small bowel, NOS
C241 Ampulla of Vater; periampullary

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Table begins on next page

Table 7: Small Intestine and Ampulla of Vater Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenocarcinoma 8140 • Ampullary carcinoma	Adenocarcinoma, intestinal type **8144 (/3)** • Intestinal type adenoma, high grade **8144 (/2)** Medullary adenocarcinoma **8510** Mucinous adenocarcinoma **8480** Pancreatobiliary-type carcinoma **8163 (/3)** • Non-invasive pancreatobiliary papillary neoplasm with high grade dysplasia **(/2)** Poorly cohesive carcinoma **8490** • Signet ring cell carcinoma Tubular adenocarcinoma **8211**
Adenomatous polyp, high grade 8210 (/2) • Adenocarcinoma in situ in adenomatous polyp • Adenomatous polyp, high grade dysplasia	
Gastrointestinal stromal tumor 8936 • GANT • Gastrointestinal pacemaker cell tumor • Gastrointestinal stromal sarcoma • Gastrointestinal stromal tumor • GIST NOS • GIST, malignant • Succinate dehydrogenase-deficient gastrointestinal stromal tumor	

Table 7: Small Intestine and Ampulla of Vater Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Mixed neuroendocrine-non-neuroendocrine neoplasm 8154 (/3) • MiNEN	
Neuroendocrine carcinoma 8246 (/3)	Large cell neuroendocrine carcinoma **8013 (/3)** Small cell neuroendocrine carcinoma **8041 (/3)**
Neuroendocrine tumor 8240 (/3) • Neuroendocrine tumor, grade 1	Neuroendocrine tumor, grade 2 **8249 (/3)** • Neuroendocrine tumor, grade 3
Serrated dysplasia, high grade 8213 (/2)	

Other Sites Site-group Instructions
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Table 8: Anus Histologies

Table 8 list the more common histologies for the following anal subsites:
C210 Anus, NOS
C211 Anal canal; anal sphincter
C212 Cloacogenic zone
C218 Overlapping lesion of rectum, anus, and anal canal

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Coding Notes for Anus:

- p16 test results can be used to code squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086).
- When the diagnosis is a subtype/variant of squamous cell carcinoma and HPV status is also noted, ignore the HPV status and code the subtype/variant. EXCEPTION: When keratinizing or non-keratinizing SCC are included in the diagnosis with HPV status, code the appropriate HPV histology: 8085 or 8086.

Table begins on next page

Table 8: Anus Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenocarcinoma 8140	
Mixed neuroendocrine-non-neuroendocrine neoplasm 8154 (/3) • MiNEN	
Mucosal melanoma 8720 (/3)	
Neuroendocrine carcinoma 8246 (/3)	Large cell neuroendocrine carcinoma **8013 (/3)** Small cell neuroendocrine carcinoma **8041 (/3)**
Neuroendocrine tumor 8240 (/3) • Neuroendocrine tumor, grade 1	Neuroendocrine tumor, grade 2 **8249 (/3)** • Neuroendocrine tumor, grade 3
Squamous cell carcinoma 8070 • Squamous cell carcinoma, usual type	Squamous cell carcinoma, HPV negative **8086** Squamous cell carcinoma, HPV positive **8085** Verrucous squamous cell carcinoma **8051**
Squamous intraepithelial neoplasia, high grade 8077 (/2) • AIN, grade II • AIN, grade III • Anal intraepithelial neoplasia, grade II • Anal intraepithelial neoplasia, grade III • HSIL • Squamous intraepithelial neoplasia, grade II • Squamous intraepithelial neoplasia, grade III	

Table 9: Liver and Intrahepatic Bile Duct Histologies

Table 9 list the more common histologies for the following liver and intrahepatic bile duct subsites:
C220 Liver; hepatic, NOS
C221 Intrahepatic bile duct; biliary canaliculus; cholangiole

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Coding notes for Cholangiocarcinoma:

Cases diagnosed *before* 1/1/2023: Intrahepatic cholangiocarcinomas are almost exclusively adenocarcinomas and often diagnosed by cytology. Additional diagnostic molecular tests and clinical collaboration are needed to define a diagnosis of cholangiocarcinoma. Clinicians often indicate a clinical diagnosis of cholangiocarcinoma without pathologic confirmation. Per histology coding rules, pathology and cytology have priority over clinical/physician diagnosis. If the diagnosis of cholangiocarcinoma is made on a resected specimen, then code this histology.

Cases diagnosed 1/1/2023 forward: See Table 9a for coding instructions on liver and intrahepatic bile duct primaries.

Table 9: Liver and Intrahepatic Bile Duct Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Carcinoma, undifferentiated 8020 (/3)	
Cholangiocarcinoma 8160 (/3) (C221) • Bile duct adenocarcinoma • Bile duct carcinoma • Intrahepatic cholangiocarcinoma (iCCA) • Large duct intrahepatic cholangiocarcinoma • Small duct intrahepatic cholangiocarcinoma	
Combined hepatocellular carcinoma and cholangiocarcinoma 8180 (/3) (C221) • Hepatocholangiocarcinoma • Mixed hepatobiliary carcinoma • Mixed hepatocellular-cholangiocarcinoma	
Hepatoblastoma 8970 (/3)	
Hepatocellular carcinoma 8170 (/3) (C220) • Hepatocarcinoma • Hepatoma, malignant • Hepatoma NOS	Hepatocellular carcinoma, fibrolamellar **8171** Hepatocellular carcinoma, scirrhous **8172** • Sclerosing hepatic carcinoma Hepatocellular carcinoma (HCC), clear cell **8174** • HCC, chromophobe • HCC, lymphocytic-rich • HCC, macrotrabecular massive • HCC, neutrophile-rich • HCC, steatohepatitic

Table 9: Liver and Intrahepatic Bile Duct Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Intraductal papillary neoplasm 8503 • Intraductal papillary neoplasm with associated invasive carcinoma **(/3)** • Intraductal papillary neoplasm with high grade intraepithelial neoplasia **(/2)**	
Mixed neuroendocrine-non-neuroendocrine neoplasm 8154 (/3) [1] • MiNEN	
Mucinous cystic neoplasm 8470 • Mucinous cystic neoplasm with associated invasive carcinoma **(/3)** • Mucinous cystic neoplasm with high grade intraepithelial neoplasia **(/2)**	
Neuroendocrine carcinoma 8246 (/3)	Large cell neuroendocrine carcinoma **8013 (/3)** Small cell neuroendocrine carcinoma **8041 (/3)**
Neuroendocrine tumor 8240 (/3) • Neuroendocrine tumor, grade 1	Neuroendocrine tumor, grade 2 **8249 (/3)** • Neuroendocrine tumor, grade 3

[1] The non-neuroendocrine neoplasm is most often hepatocellular carcinoma or cholangiocarcinoma.

Table 9a: Guidelines for Assigning Primary Site for Liver and Intrahepatic Bile Duct

C220 Liver; hepatic, NOS
C221 Intrahepatic bile duct; biliary canaliculus; cholangiole

Guidelines for assigning primary sites for liver and intrahepatic bile duct neoplasms based on histology and other criteria are included in the newly added Table 9a. The criteria for coding liver (C220) versus intrahepatic bile duct (C221) is based on Cancer PathCHART Specialty Matter Expert review. The experts have determined adenocarcinoma and subtypes of adenocarcinoma cannot be primary to liver and therefore are biologically impossible. This table may be applied to cases diagnosed 2023 forward. Registrars are not required to review and re-code cases abstracted prior to 1/1/2024.

Column 1 contains the site of the biopsy specimen and/or cytology specimen
Column 2 contains the histology diagnosis as stated by the pathologist
Column 3 contains the criteria required to assign primary site based on Cancer PathCHART Specialty Matter Expert review
Column 4 contains the primary site and histology to be assigned

Table begins on next page

Table 9a: Guidelines for Assigning Primary Site for Liver and Intrahepatic Bile Duct

Site of biopsy or cytology	Pathology or cytology diagnosis	Criteria	Primary Site/ Histology
Liver C220	Adenocarcinoma Adenocarcinoma subtypes/variants	Supporting documentation such as scans, lab tests, or definitive clinical diagnosis of intrahepatic bile duct primary and/or definitive diagnosis of cholangiocarcinoma	**C221** **8160 (/3)**
Liver C220	Adenocarcinoma Adenocarcinoma, subtypes/variants	No documentation supporting the primary site of intrahepatic bile duct is available in the medical record. This includes scans, lab tests or definitive clinical diagnosis. Liver is a common metastatic site for other neoplasms such as breast, lung, and colon. Code unknown primary site C809 when a primary site is not indicated in the pathology report or medical record.	**C809** **8140 (/3)**
Liver C220 or **Intrahepatic bile ducts C221**	Hepatocellular carcinoma	Cancer PathCHART review has determined hepatocellular carcinoma is valid for liver C220 only. Code C220 regardless of biopsy/cytology site.	**C220** **8170 (/3)**
Liver C220	Combined hepatocellular carcinoma and cholangiocarcinoma	Cancer PathCHART review has determined combined hepatocellular carcinoma and cholangiocarcinoma is valid for intrahepatic bile ducts C221 only. Code C221 regardless of biopsy/cytology site	**C221** **8180 (/3)**

Table 10: Gallbladder and Extrahepatic Bile Duct Histologies

Table 10 list the more common histologies for the following gallbladder and extrahepatic bile duct subsites:
C239 Gallbladder
C240 Extrahepatic bile duct; bile duct, NOS; biliary duct, NOS; choledochal duct; common bile duct; common duct; cystic bile duct; cystic duct; hepatic bile duct; hepatic duct; sphincter of Oddi
C248 Overlapping lesion of biliary tract
C249 Biliary tract, NOS

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Table begins on next page

Table 10: Gallbladder and Extrahepatic Bile Duct Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenocarcinoma 8140 • Biliary-type adenocarcinoma	Adenocarcinoma, intestinal type **8144** Clear cell adenocarcinoma **8310** Mucinous adenocarcinoma **8480** Pancreatobiliary-type carcinoma **8163** Poorly cohesive carcinoma **8490** • Signet ring cell carcinoma
Adenosquamous carcinoma 8560	
Bile duct carcinoma 8160 (C240) • Adenocarcinoma, biliary type • Cholangiocarcinoma • Extrahepatic cholangiocarcinoma	Bile duct cystadenocarcinoma **8161** Perihilar cholangiocarcinoma **8162** • Klatskin tumor
Biliary intraepithelial neoplasia, high grade 8148 (/2)	
Carcinoma NOS 8010 **Table continues on next page**	Undifferentiated carcinoma **8020**

Table 10: Gallbladder and Extrahepatic Bile Duct Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Intracystic papillary neoplasm 8503 • Intracystic papillary neoplasm with associated invasive carcinoma **(/3)** • Intraductal papillary neoplasm with associated invasive carcinoma **(/3)** • Intracystic papillary neoplasm with high grade intraepithelial neoplasia **(/2)** • Intracystic papillary tumor with high grade dysplasia **(/2)** • Intraductal papillary neoplasm with high grade dysplasia **(/2)** • Intraductal papillary neoplasm with high grade intraepithelial neoplasia **(/2)**	
Mixed neuroendocrine-non-neuroendocrine neoplasm 8154 (/3) • MiNEN	
Mucinous cystic neoplasm with invasive carcinoma 8470 (/3)	
Neuroendocrine carcinoma 8246 (/3)	Large cell neuroendocrine carcinoma **8013 (/3)** Small cell neuroendocrine carcinoma **8041 (/3)**
Neuroendocrine tumor 8240 (/3) • Neuroendocrine tumor, grade 1	Neuroendocrine tumor, grade 2 **8249 (/3)** • Neuroendocrine tumor, grade 3
Squamous cell carcinoma 8070	

Table 11: Pancreas Histologies

Table 11 list the more common histologies for the following pancreas subsites:
C250 Head of pancreas
C251 Body of pancreas
C252 Tail of pancreas
C253 Pancreatic duct; duct of Santorini; duct of Wirsung
C254 Islet of Langerhans; islands of Langerhans; endocrine pancreas
C257 Other specified parts of pancreas; neck of pancreas
C258 Overlapping lesion of pancreas
C259 Pancreas, NOS

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Table begins on next page

Table 11: Pancreas Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenocarcinoma NOS 8140	Acinar cell carcinoma **8550** Colloid carcinoma **8480** • Mucinous carcinoma Ductal adenocarcinoma **8500** • Pancreatic ductal adenocarcinoma Hepatoid carcinoma **8576** Invasive micropapillary carcinoma **8265** Medullary carcinoma **8510** Mixed acinar-ductal carcinoma **8552** Mixed acinar neuroendocrine carcinoma **8154 (/3)** • Mixed acinar ductal neuroendocrine carcinoma Signet-ring cell carcinoma **8490** • Poorly cohesive carcinoma
Adenosquamous carcinoma 8560	
Glandular intraepithelial neoplasia, high grade 8148 (/2) • Intestinal pancreatic intraepithelial neoplasia • Oncocytic pancreatic intraepithelial neoplasia • Pancreatic intraepithelial neoplasia ○ PanIN	

Table 11: Pancreas Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Intraductal oncocytic papillary neoplasm 8455 (/2) • Intraductal oncocytic papillary neoplasm with associated invasive carcinoma **(/3)** • Intraductal oncocytic papillary neoplasm NOS **(/2)**	
Intraductal papillary mucinous neoplasm 8453 [1] • Intraductal papillary mucinous carcinoma, invasive **(/3)** • Intraductal papillary mucinous neoplasm with associated invasive carcinoma **(/3)** • High-grade IPMN **(/2)** • Intraductal papillary mucinous carcinoma, non-invasive **(/2)** • Intraductal papillary mucinous neoplasm with high grade-dysplasia **(/2)**	
Intraductal tubulopapillary neoplasm 8503 • Intraductal tubulopapillary neoplasm with associated invasive carcinoma **(/3)** • Intraductal tubulopapillary neoplasm **(/2)**	

[1] Intraductal papillary mucinous neoplasm is an umbrella term and must include one of the synonym terms to report.

Table 11: Pancreas Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Mixed neuroendocrine non-neuroendocrine neoplasm 8154 • MiNEN • Mixed acinar-endocrine carcinoma • Mixed acinar-endocrine-ductal carcinoma • Mixed acinar-neuroendocrine carcinoma	
Mucinous cystic neoplasm 8470 [2] • Mucinous cystic neoplasm with an associated invasive carcinoma **(/3)** • Mucinous cystadenocarcinoma, non-invasive **(/2)** • Mucinous cystic neoplasm with high grade intraepithelial neoplasia **(/2)** • Mucinous cystic neoplasm with high-grade dysplasia **(/2)** • Mucinous cystic tumor with high grade dysplasia **(/2)**	
Neuroendocrine carcinoma NOS 8246 • PanNEC	Large cell neuroendocrine carcinoma **8013** Small cell neuroendocrine carcinoma **8041**

[2] Mucinous cystic neoplasm is an umbrella term and must include one of the terms in the synonym column to report.

Table 11: Pancreas Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Neuroendocrine tumor NOS 8240 • Islet cell tumor • Neuroendocrine tumor, grade 1 • PanNET	ACTH-producing neuroendocrine tumor **8158** • ACTH-producing tumor • Ectopic ACTH-producing pancreatic neuroendocrine tumor Serotonin-producing neuroendocrine tumor **8241** • Enterochromaffin cell carcinoid • Serotonin-producing tumor Gastrinoma **8153** Glucagonoma **8152** Insulinoma **8151** Neuroendocrine tumor, grade 2 **8249** • Neuroendocrine tumor, grade 3 Pancreatic neuroendocrine tumor, non-functioning **8150** • Clear cell neuroendocrine tumor, non-functioning pancreatic • Cystic neuroendocrine tumor, non-functioning pancreatic • Oncocytic neuroendocrine tumor, non-functioning pancreatic • Pancreatic endocrine tumor, non-functioning pancreatic • Pleomorphic neuroendocrine tumor, non-functioning pancreatic Somatostatinoma **8156** VIPoma **8155**
Pancreatoblastoma 8971 (/3)	

Table 11: Pancreas Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Solid pseudopapillary neoplasm of pancreas 8452 • Solid pseudopapillary carcinoma • Solid pseudopapillary neoplasm with high-grade carcinoma **(/3)**	
Squamous cell carcinoma 8070	
Undifferentiated carcinoma 8020 (/3)	Undifferentiated carcinoma with osteoclast-like giant cells **8035 (/3)** Undifferentiated carcinoma with rhabdoid cells **8014 (/3)**

Table 12: Thyroid Histologies

Table 12 lists the more common histologies for thyroid:
C739 Thyroid gland; thyroid, NOS; thyroglossal duct

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Coding Notes for Thyroid

- Papillary carcinoma, follicular variant, encapsulated/well demarcated, non-invasive is not reportable.
- **Multiple primary note:** Subsequent/new disease in thyroid bed following total thyroidectomy is a recurrence and not a new primary regardless of timing between occurrences.

Table begins on next page.

Table 12: Thyroid Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Carcinoma, anaplastic 8021 (/3)	Carcinoma, undifferentiated **8020 (/3)**
Follicular thyroid carcinoma NOS 8330 • Follicular adenocarcinoma • Follicular carcinoma • Follicular carcinoma, widely invasive **(/3)** • Infiltrative follicular carcinoma **(/3)**	Follicular carcinoma, encapsulated angioinvasive **8339 (/3)** Follicular thyroid carcinoma, minimally invasive **8335 (/3)** Well differentiated follicular adenocarcinoma **8331** Moderately differentiated follicular adenocarcinoma **8332** • Trabecular follicular carcinoma
Invasive encapsulated follicular variant of papillary thyroid carcinoma 8340 (/3) [1] • Encapsulated angioinvasive follicular variant of papillary carcinoma • IEFVPTC • Minimally invasive encapsulated follicular variant of papillary carcinoma (capsular invasion only) • Widely invasive follicular variant of papillary carcinoma	

[1] IEFVPTC and Infiltrative follicular variant of papillary thyroid carcinoma (a PTC subtype) share a histology code, but they are distinctly different histologies. They are on different rows of the table and are different primaries.

Table 12: Thyroid Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Medullary thyroid carcinoma 8345 • C cell carcinoma • Medullary carcinoma with amyloid stroma • Medullary microcarcinoma • Parafollicular cell carcinoma	
Oxyphilic adenocarcinoma 8290 • Encapsulated angioinvasive oncocytic carcinoma of the thyroid • Follicular carcinoma, oxyphilic cell • Hurthle cell adenocarcinoma • Hurthle cell carcinoma • Minimally invasive oncocytic carcinoma of the thyroid • Oncocytic adenocarcinoma • Oncocytic carcinoma • Widely invasive oncocytic carcinoma of the thyroid	

Table 12: Thyroid Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Papillary thyroid carcinoma NOS 8260 • Classical papillary carcinoma • Clear cell papillary thyroid carcinoma • Cribriform-morular variant of PTC • Hobnail variant of PTC • Micropapillary thyroid carcinoma [2] • Papillary microcarcinoma [2] • Papillary thyroid carcinoma with fasciitis-like stroma • Papillary thyroid carcinoma with fibromatosis • PTC • Solid variant of PTC • Spindle cell papillary thyroid carcinoma • Trabecular variant of PTC • Usual papillary carcinoma • Warthin-like papillary thyroid carcinoma	Columnar cell variant of PTC **8344** • Tall cell PTC Diffuse sclerosing PTC **8350** Encapsulated variant of PTC **8343 (/3)** Follicular variant of papillary thyroid carcinoma **8340** [3] Oncocytic variant of PTC **8342**
Poorly differentiated thyroid carcinoma 8337 (/3) • Differentiated high-grade thyroid carcinoma • Insular carcinoma	

[2] For thyroid cancer only, the terms micropapillary and papillary microcarcinoma do not refer to a specific histologic type. It means that the papillary portion of the tumor is minimal or occult.
[3] IEFVPTC and Infiltrative follicular variant of papillary thyroid carcinoma (a PTC subtype) share a histology code, but they are distinctly different histologies. They are on different rows of the table and are different primaries.

Table 13: Ovary Histologies

Table 13 list the more common histologies for ovary: **includes reportable neoplasms only**
C569 Ovary

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Coding Notes for Ovary: For ovarian primaries, code **9084/3 Teratoma with malignant transformation** when a malignant (/3) histology arises in a benign teratoma.

Table 13: Ovary Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenocarcinoma NOS 8140	Clear cell adenocarcinoma **8310** Endometrioid adenocarcinoma **8380** Mucinous adenocarcinoma NOS **8480**
Adenocarcinoma of rete ovarii 9110 (/3)	
Adenosarcoma 8933 (/3)	
Adult granulosa cell tumor 8620 (/3)	
Carcinosarcoma NOS 8980 (/3) • Malignant Mixed Mullerian Tumor • MMMT	
Choriocarcinoma NOS 9100	
Germ cell tumor NOS 9064 • Germinoma	Dysgerminoma **9060** Embryonal carcinoma **9070** Immature teratoma **9080** Mixed germ cell tumor **9085** • Mixed teratoma-yolk sac tumor Yolk sac tumor NOS **9071 (/3)**
Malignant Brenner tumor 9000 (/3)	
Mesonephric-like adenocarcinoma 9111 (/3)	

Table 13: Ovary Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Mixed cell adenocarcinoma 8323 [1]	
Sarcoma NOS 8800 (/3)	Endometrioid stromal sarcoma, high grade **8930 (/3)** Endometrioid stromal sarcoma, low grade **8931 (/3)** Leiomyosarcoma NOS **8890 (/3)** Fibrosarcoma NOS **8810 (/3)**
Serous carcinoma NOS 8441 • Papillary serous adenocarcinoma **(/3)** • Serous adenocarcinoma **(/3)** • Serous cystadenocarcinoma NOS **(/3)** • Serous papillary adenocarcinoma NOS **(/3)** • Serous surface papillary carcinoma **(/3)** • Serous intraepithelial carcinoma **(/2)**	High-grade serous carcinoma **8461 (/3)** Low-grade serous carcinoma **8460 (/3)** • Serous carcinoma, non-invasive, low grade **(/2)**
Small cell carcinoma hypercalcemic type 8044 (/3)	
Steroid cell tumor, malignant 8670 (/3)	
Struma ovarii, malignant 9090 (/3)	
Teratoma with malignant transformation 9084 (/3)	

[1] At least two histologic types must be recognized in the tumor. Percentages may be stated but do not affect histology coding. The most common mixed tumor is comprised of endometrial and clear cell carcinomas.

Table 13: Ovary Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Undifferentiated carcinoma 8020 (/3) • Dedifferentiated carcinoma	

Table 14: Peritoneum Histologies

Table 14 list the more common histologies for peritoneum as noted in the 5th Ed WHO Female Genital Tumors ***only***
C481 Specified parts of peritoneum
C482 Peritoneum, NOS; peritoneal cavity
C488 Overlapping lesion of retroperitoneum and peritoneum

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Gastrointestinal stromal tumor 8936 (/3) • GIST	
High-grade serous carcinoma 8461 (/3) • Peritoneal serous carcinoma, high grade	
Low-grade serous carcinoma 8460 (/3)	

Table 14: Peritoneum Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Mesothelioma, Malignant 9050 (/3) • Mesothelioma NOS	Epithelioid mesothelioma, malignant **9052 (/3)** Mesothelioma, biphasic **9053 (/3)** Sarcomatoid mesothelioma **9051 (/3)**
Sarcoma NOS 8800 (/3)	Desmoplastic small round cell tumor **8806 (/3)** Endometrioid stromal sarcoma, high-grade **8930 (/3)** Endometrioid stromal sarcoma, low-grade **8931 (/3)**
Solitary fibrous tumor, malignant 8815 (/3)	

Table 15: Fallopian Tube Histologies

Table 15 list the more common histologies for fallopian tube
C570 Fallopian tube; uterine tube

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
  Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenosarcoma 8933 (/3) • Mesodermal adenosarcoma	
Carcinosarcoma 8980 (/3) [1] • Malignant mixed Mullerian tumor	
Endometrioid adenocarcinoma NOS 8380 (/3)	

[1] This pathology diagnosis may provide subtypes/variants of the carcinoma/adenocarcinoma component and/or sarcoma subtype/variant component.

Table 15: Fallopian Tube Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Serous carcinoma NOS 8441 • Serous tubal intraepithelial carcinoma **(/2)** • STIC **(/2)**	High-grade serous carcinoma **8461 (/3)** Low-grade serous carcinoma **8460 (/3)**
Teratoma, malignant 9080 (/3) • Immature teratoma	

Table 16: Uterine Corpus Histologies

Table 16 list the more common histologies for uterine corpus
C540 Isthmus uteri; lower uterine segment
C541 Endometrium; endometrial gland; endometrial stroma
C542 Myometrium
C543 Fundus uteri
C548 Overlapping lesion of corpus uteri
C549 Corpus uteri; body of uterus
C559 Uterus, NOS

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Table 16: Uterine Corpus Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenosarcoma 8933 (/3) • Adenocarcinoma with sarcomatous overgrowth • Mullerian adenosarcoma	
Carcinoma, undifferentiated NOS 8020 (/3) [1] • Carcinoma, poorly differentiated • Dedifferentiated carcinoma	
Carcinosarcoma NOS 8980 (/3) [2] • Malignant mixed Mullerian tumor	
Clear cell adenocarcinoma 8310	
Endometrioid adenocarcinoma NOS 8380 [1] • Endometrial adenocarcinoma • Endometrial carcinoma • Mismatch repair-deficient endometrioid carcinoma **(/3)** • No specific molecular profile (NSMP) endometrioid carcinoma **(/3)** • P53-mutant endometrioid carcinoma **(/3)** • POLE-ultramutated endometrioid carcinoma **(/3)** • Endometrial atypical hyperplasia **(/2)** • Endometrioid intraepithelial neoplasia **(/2)**	Endometrioid carcinoma with squamous differentiation **8570 (/3)**

[1] This histology has been designated biologically impossible for **Myometrium (C542)** per Cancer PathCHART review.
[2] The most common carcinomas present in carcinosarcoma are endometrioid and/or serous.

Table 16: Uterine Corpus Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Mesonephric adenocarcinoma 9110 (/3)	Mesonephric-like adenocarcinoma **9111 (/3)**
Mixed cell adenocarcinoma 8323 [1] [3]	
Mixed neuroendocrine non-neuroendocrine carcinoma **8154 (/3)** • MiNEN	
Mucinous carcinoma NOS 8480 [1]	Mucinous carcinoma, intestinal type **8144** [1]
Neuroendocrine carcinoma NOS 8246 (/3) [1]	Large cell neuroendocrine carcinoma **8013 (/3)** Small cell neuroendocrine carcinoma **8041 (/3)**
Neuroendocrine tumor NOS 8240 (/3) • Neuroendocrine tumor, grade 1	Neuroendocrine tumor, grade 2 **8249 (/3)**
Perivascular epithelioid tumor, malignant 8714 (/3) • PEComa, malignant	
Primitive neuroendocrine tumor 9473 (/3) • PNET	

[3] Mixed cell adenocarcinoma is comprised of endometrial carcinoma with two distinct histological types, in which one component is either serous or clear cell. Excludes dedifferentiated carcinoma and carcinosarcoma.

Table 16: Uterine Corpus Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Sarcoma NOS 8800 (/3)	Endometrial stromal sarcoma, high grade **8930 (/3)** Endometrial stromal sarcoma, low grade **8931 (/3)** Epithelioid leiomyosarcoma **8891 (/3)** Leiomyosarcoma NOS **8890 (/3)** • Spindle leiomyosarcoma Myxoid leiomyosarcoma **8896 (/3)** Undifferentiated sarcoma **8805 (/3)**
Serous carcinoma NOS 8441 • Endometrial intraepithelial carcinoma **(/2)** ○ EIC • Serous endometrial intraepithelial carcinoma **(/2)** [4] ○ SEIC	
Squamous cell carcinoma 8070	

[4] The histology term Serous endometrial intraepithelial carcinoma is obsolete. It should be coded to 8441/2.

Table 17: Uterine Cervix Histologies

Table 17 list the more common histologies for uterine cervix
C530 Endocervix; internal os; cervical canal; endocervical canal; endocervical gland; Nabothian gland
C531 Exocervix; external os
C538 Overlapping lesion of cervix uteri; cervical stump; squamocolumnar junction of cervix
C539 Cervix uteri; cervix, NOS; uterine cervix

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Uterine Cervix Coding Notes

- In situ carcinoma of cervix (/2), any histology, is not reportable
- p16 is a valid test to determine HPV status and can be used to code HPV associated and HPV independent histologies
- When the diagnosis is a subtype/variant of squamous cell carcinoma and HPV status is also noted, ignore the HPV status and code the subtype/variant. EXCEPTION: When keratinizing or non-keratinizing SCC are included in the diagnosis with HPV status, code the appropriate HPV histology: 8085 or 8086.

Table begins on next page

Table 17: Uterine Cervix Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenocarcinoma NOS 8140 (/3)	Adenocarcinoma, HPV-associated **8483 (/3)** Adenocarcinoma, HPV-independent **8484 (/3)** Adenocarcinoma, HPV-independent, clear cell type **8310 (/3)** Adenocarcinoma, HPV-independent, gastric type **8482 (/3)** Adenocarcinoma, HPV-independent, mesonephric type **9110 (/3)**
Adenoid basal carcinoma 8098 (/3)	
Adenosarcoma 8933 (/3) • Adenocarcinoma with sarcomatous overgrowth	
Adenosquamous carcinoma 8560 (/3)	
Carcinosarcoma 8980 (/3) [1]	
Endometrioid adenocarcinoma NOS 8380 (/3) • Endometrial adenocarcinoma • Endometrial carcinoma	
Germ cell tumor NOS 9064 (/3)	Choriocarcinoma NOS **9100 (/3)** Endodermal sinus tumor **9071 (/3)** • Yolk sac tumor
Mixed neuroendocrine non-neuroendocrine carcinoma **8154 (/3)** • MiNEN	

[1] This pathology diagnosis may provide subtypes/variants of the carcinoma/adenocarcinoma component and/or sarcoma component.

Table 17: Uterine Cervix Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Mucoepidermoid carcinoma 8430 (/3)	
Neuroendocrine carcinoma NOS 8246 (/3)	Large cell neuroendocrine carcinoma **8013 (/3)** Small cell neuroendocrine carcinoma **8041 (/3)**
Neuroendocrine tumor NOS 8240 (/3) • Neuroendocrine tumor, grade 1	Neuroendocrine tumor, grade 2 **8249 (/3)**
Perivascular epithelioid tumor, malignant 8714 (/3) • PEComa, malignant	
Sarcoma NOS 8800 (/3)	Endometrial stromal sarcoma, high grade **8930 (/3)** Endometrial stromal sarcoma, low grade **8931 (/3)** Epithelioid leiomyosarcoma **8891 (/3)** Leiomyosarcoma NOS **8890 (/3)** • Spindle leiomyosarcoma Myxoid leiomyosarcoma **8896 (/3)** Rhabdomyosarcoma **8900 (/3)** Undifferentiated sarcoma **8805 (/3)**
Squamous cell carcinoma NOS 8070 (/3) • SCC NOS	Squamous cell carcinoma, HPV-associated **8085 (/3)** Squamous cell carcinoma, HPV-independent **8086 (/3)**

Table 18: Vagina Histologies

Table 18 list the more common histologies for vagina
C529 Vagina NOS; vaginal vault; fornix of vagina; Gartner duct; hymen

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Vagina Coding Notes:

- p16 is a valid test to determine HPV status and can be used to code HPV associated and HPV independent histologies.
- When the diagnosis is a subtype/variant of squamous cell carcinoma and HPV status is also noted, ignore the HPV status and code the subtype/variant. **EXCEPTION**: When keratinizing or non-keratinizing SCC is included in the diagnosis with HPV status, code the appropriate HPV histology: 8085 or 8086.

Table begins on next page

Table 18: Vagina Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenocarcinoma NOS 8140 • Adenocarcinoma, Skene, Cowper and Littre gland origin • Periurethral gland adenocarcinoma • Skene adenocarcinoma	Adenocarcinoma, HPV-associated **8483**
Adenoid basal carcinoma 8098	
Adenosarcoma 8933 (/3) • Adenocarcinoma with sarcomatous overgrowth • Mullerian adenosarcoma	
Adenosquamous carcinoma 8560	
Carcinosarcoma 8980 (/3) [1] • Malignant mixed Mullerian tumor	
Clear cell carcinoma 8310	
Endometrioid carcinoma 8380 • Endometrial adenocarcinoma • Endometrial carcinoma	
Germ cell tumor 9064 (/3)	Yolk sac tumor **9071 (/3)**
Mesonephric adenocarcinoma 9110 (/3)	

[1] This pathology diagnosis may provide subtypes/variants of the carcinoma/adenocarcinoma component and/or sarcoma component.

Table 18: Vagina Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Mucinous carcinoma NOS 8480	Mucinous carcinoma, gastric type **8482** Mucinous carcinoma, intestinal type **8144**
Mucosal melanoma 8720 (/3)	
Neuroendocrine carcinoma NOS 8246 (/3)	Combined small cell neuroendocrine carcinoma **8045 (/3)** Large cell neuroendocrine carcinoma **8013 (/3)** • Combined large cell neuroendocrine carcinoma Small cell neuroendocrine carcinoma **8041 (/3)**
Neuroendocrine tumor NOS 8240 (/3)	
Squamous cell carcinoma NOS 8070 • SCC NOS • Squamous cell carcinoma in-situ **(/2)**	High-grade squamous intraepithelial lesion **8077 (/2)** • Vaginal intraepithelial neoplasia, grade 2 • Vaginal intraepithelial neoplasia, grade 3 Squamous cell carcinoma, HPV-associated **8085** Squamous cell carcinoma, HPV-independent **8086**
Undifferentiated carcinoma 8020 (/3)	

Table 19: Vulva Histologies

Table 19 list the more common histologies for vulva
C510 Labium majus; labia majora, NOS; Bartholin gland; Skin of labia majora
C511 Labium minus; labia minora
C512 Clitoris
C518 Overlapping lesion of vulva
C519 Vulva, NOS; external female genitalia; fourchette; labia, NOS; labium, NOS; mons pubis; mons veneris; pudendum; skin of vulva

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Vulva Coding Notes:

- p16 is a valid test to determine HPV status and can be used to code HPV associated and HPV independent histologies.
- When the diagnosis is a subtype/variant of squamous cell carcinoma and HPV status is also noted, ignore the HPV status and code the subtype/variant. **EXCEPTION**: When keratinizing or non-keratinizing SCC is included in the diagnosis with HPV status, code the appropriate HPV histology: 8085 or 8086.

Table begins on next page

Table 19: Vulva Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenocarcinoma 8140 • Adenocarcinoma of anogenital mammary-like glands **(/3)**	Adenocarcinoma, intestinal type **8144**
Adenosquamous carcinoma 8560	
Basal cell carcinoma 8090 (/3)	
Carcinoma, poorly differentiated 8020 (/3)	
Epithelial-myoepithelial carcinoma 8562 (/3)	
Germ cell tumor 9064 (/3)	Yolk sac tumor NOS **9071 (/3)**
Mucosal melanoma 8720 (/3)	
Myoepithelial carcinoma 8982 (/3)	
Neuroendocrine carcinoma NOS 8246 (/3)	Combined small cell neuroendocrine carcinoma **8045 (/3)** Large cell neuroendocrine carcinoma **8013 (/3)** • Combined large cell neuroendocrine carcinoma Small cell neuroendocrine carcinoma **8041 (/3)**
Neuroendocrine tumor NOS 8240 (/3) • Neuroendocrine tumor, grade 1	Neuroendocrine tumor, grade 2 **8249 (/3)**
Paget disease, extramammary 8542 (/3)	

Table 19: Vulva Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Phyllodes tumor, malignant 9020 (/3)	
Squamous cell carcinoma NOS 8070	Squamous cell carcinoma, HPV-associated **8085** Squamous cell carcinoma, HPV-independent **8086** Squamous cell carcinoma keratinizing **8071 (/3)** • Differentiated vulvar intraepithelial neoplasm **8071 (/2)** Squamous cell carcinoma, non-keratinizing **8072** Vulvar intraepithelial neoplasm grade 2 **8077 (/2)** • Vulvar intraepithelial neoplasm grade 3
Sweat gland adenocarcinoma 8400	Adenoid cystic carcinoma **8200** [1] Apocrine adenocarcinoma **8401** Eccrine adenocarcinoma **8413** Porocarcinoma NOS **8409**

[1] ACC of sweat glands of the vulva is a distinctly different histology from ACC of Bartholin-gland (C510). Do not consider as the same histology when using the M Rules.

Table 20: Soft Tissue Histologies

Table 20 list the more common histologies for soft tissue as stated in the College of American Pathologists (C.A.P.) soft tissue protocol
C490* Connective, subcutaneous and other soft tissues of head, face and neck
C491* Connective, subcutaneous and other soft tissues of upper limb and shoulder
C492* Connective, subcutaneous and other soft tissues of lower limb and leg
C493* Connective, subcutaneous and other soft tissues of thorax
C494* Connective, subcutaneous and other soft tissues of abdomen
C495* Connective, subcutaneous and other soft tissues of pelvis
C496* Connective, subcutaneous and other soft tissues of trunk
C498 Overlapping lesion of connective, subcutaneous and other soft tissues
C499* Connective, subcutaneous and other soft tissues, NOS
**For specific sites and C-codes, please refer to ICD-O-3 or ICD-O-3.1 topography lists*

Note 1: Table 20 lists sarcomas arising in the soft tissue sites listed below only. Soft tissue neoplasms can arise in other organs. See the specific Solid Tumor Site Groups.

Note 2: Column 2 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 synovial sarcoma 9040/3 (column 2). Synovial sarcoma is also a NOS because it has subtypes/variants. The subtypes/variants are indented under the NOS (synovial sarcoma) in column 2. There are also footnotes in column 2 which call attention to the fact that synovial sarcoma has subtypes/variants.

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2

Table 20: Soft Tissue Histologies

- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**
- Subtypes or variants of the NOS histologies in column 2 are also indented under the NOS histology and have a full 4-digit histology code (see Note 2). The behavior code (/2 or /3) is included with the 4-digit histology code if the term has only one possible behavior.

Soft Tissue Coding Notes

- This is not an exhaustive list of all malignant soft tissue tumors. If a histology is not listed, refer to the current ICD-O versions and ICD-O updates. If the term is not listed, submit your question to **Ask A SEER Registrar**.
- Soft tissue terminology used in clinical practice may differ from the terms listed in the table, ICD-O, and C.A.P. protocol. Many soft tissue histologies are compound terms and the word roots may be inverted. It is not possible to list all combinations and permutations of such compound terms. Check various permutations of the word roots in a compound term if the version is not listed in ICD-O.
  Example: Myxofibrosarcoma and fibromyxosarcoma are the same and both coded 8811/3. The word roots have been inverted.

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Angiosarcoma 9120 (/3)	
Epithelioid hemangioendothelioma 9133 (/3) • Epithelioid hemangioendothelioma with WWTR1-CAMTA1 fusion • Epithelioid hemangioendothelioma with YAP1-TFE3 fusion	

Table 20: Soft Tissue Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Fibrosarcoma NOS 8810 (/3) • Adult fibrosarcoma	Infantile fibrosarcoma **8814 (/3)** Low-grade fibromyxoid sarcoma **8840 (/3)** • Sclerosing epithelioid fibrosarcoma Myofibroblastic sarcoma **8825 (/3)** • Myofibrosarcoma Myxofibrosarcoma **8811 (/3)** Solitary fibrous tumor, malignant **8815 (/3)**
Leiomyosarcoma 8890 (/3)	
Liposarcoma NOS 8850 (/3)	Dedifferentiated liposarcoma **8858 (/3)** Pleomorphic liposarcoma **8854 (/3)** • Epithelioid liposarcoma Myxoid liposarcoma **8852 (/3)** Myxoid pleomorphic liposarcoma **8859 (/3)** Well differentiated liposarcoma **8851 (/3)**
Osteosarcoma NOS 9180 (/3) • Osteosarcoma, extraskeletal	

Table 20: Soft Tissue Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Rhabdomyosarcoma NOS 8900 (/3)	Alveolar rhabdomyosarcoma **8920 (/3)** Ectomesenchymoma **8921 (/3)** Embryonal rhabdomyosarcoma **8910 (/3)** Pleomorphic rhabdomyosarcoma **8901 (/3)** Spindle cell rhabdomyosarcoma **8912 (/3)** • Congenital spindle cell rhabdomyosarcoma with VGLL2/NCOA2/CITED2 rearrangements • Intraosseous spindle cell rhabdomyosarcoma (with TFCP2/NCOA2 rearrangements) • MYOD1-mutant spindle cell • Sclerosing rhabdomyosarcoma

Table 20: Soft Tissue Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Sarcoma NOS 8800 (/3)	CIC-rearranged sarcoma **9367 (/3)** Clear cell sarcoma of soft tissue **9044 (/3)** Epithelioid sarcoma NOS **8804 (/3)** • Epithelioid sarcoma classical type • Epithelioid sarcoma proximal or large cell type Extraskeletal Ewing sarcoma **9364 (/3)** Extraskeletal myxoid chondrosarcoma **9231 (/3)** Mixed tumor, malignant **8940 (/3)** Myoepithelioma NOS **8982 (/3)** • Myoepithelial carcinoma Ossifying fibromyxoid tumor, malignant **8842 (/3)** Phosphaturic mesenchymal tumor, malignant **8990 (/3)** Round cell sarcoma with EWSR1-non ETS fusions **9366 (/3)** Sarcoma with BCOR genetic alterations **9368 (/3)** Synovial sarcoma NOS **9040 (/3)** • Synovial sarcoma, biphasic **9043 (/3)** ○ Synovial sarcoma, poorly differentiated
Undifferentiated sarcoma 8805 (/3)	Undifferentiated pleomorphic sarcoma **8802 (/3)** Undifferentiated round cell sarcoma **8803 (/3)** Undifferentiated spindle cell sarcoma **8801 (/3)**

Table 21: Bone Histologies

Table 21 list the more common histologies for bone as stated in the College of American Pathologists (C.A.P.) bone protocol
C400* Long bones of upper limbs, scapula and associated joints
C401* Short bones of upper limb and associated joints
C402* Long bones of lower limb and associated limbs
C403* Short bones of lower limb and associated joints
C408 Overlapping lesion of bones, joints and articular cartilage of limbs
C409* Bone of limb, NOS
C412* Vertebral column
C413* Rib, sternum, clavicle, and associated joints
C414* Pelvic bones, sacrum, coccyx, and associated joints
C418* Overlapping lesions of bones, joints and articular cartilage
C419* Bone, NOS

**For specific sites and C-codes, please refer to ICD-O-3 or ICD-O-3.1 topography lists*

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Bone Coding Note: This is not an exhaustive list of all malignant bone tumors. If a histology is not listed, refer to the current ICD-O versions and ICD-O updates. If the term is not listed, submit your question to **Ask A SEER Registrar**.

Table 21: Bone Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adamantinoma 9261 (/3) • Dedifferentiated adamantinoma	
Angiosarcoma 9120 (/3)	
Chondrosarcoma NOS 9220 (/3) • Chondrosarcoma, grade 2 • Chondrosarcoma, grade 3 • Fibrochondrosarcoma	Chondrosarcoma, grade 1 **9222 (/3)** Clear cell chondrosarcoma **9242 (/3)** Dedifferentiated chondrosarcoma **9243 (/3)** Mesenchymal chondrosarcoma **9240 (/3)** Periosteal chondrosarcoma **9221 (/3)**
Chordoma NOS 9370 (/3) • Poorly differentiated chordoma	Chondroid chordoma **9371 (/3)** Dedifferentiated chordoma **9372 (/3)**
Epithelioid hemangioendothelioma NOS 9133 (/3)	
Fibrosarcoma NOS 8810 (/3)	
Giant cell tumor of bone, malignant 9250 (/3)	
Leiomyosarcoma NOS 8890 (/3)	

Table 21: Bone Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Osteosarcoma NOS 9180 (/3) • Conventional osteosarcoma • Osteoblastic sarcoma • Osteochondrosarcoma • Osteogenic sarcoma NOS • Osteosarcoma, extraskeletal • Small cell osteosarcoma • Telangiectatic osteosarcoma	High grade surface osteosarcoma **9194 (/3)** Parosteal osteosarcoma **9192 (/3)** Periosteal osteosarcoma **9193 (/3)** Secondary osteosarcoma **9184 (/3)**
Sarcoma NOS 8800 (/3)	CIC-rearranged sarcoma **9367 (/3)** Ewing sarcoma **9364 (/3)** Round cell sarcoma with EWSR1-non ETS fusions **9366 (/3)** Sarcoma with BCOR genetic alterations **9368 (/3)**
Undifferentiated high grade pleomorphic sarcoma of bone 8830 (/3)	
Undifferentiated pleomorphic sarcoma 8802 (/3)	

Table 22: Thymus Histologies

Table 22 lists the more common histologies for thymus
C379 Thymus

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Table begins on next page

Table 22: Thymus Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenocarcinoma NOS 8140	Adenocarcinoma, enteric-type **8144 (/3)** Low-grade papillary adenocarcinoma **8260 (/2)** Thymic carcinoma with adenoid cystic carcinoma-like features **8200 (/3)**
Adenosquamous carcinoma 8560 (/3) [1]	
Carcinosarcoma 8980 (/3) [1]	
Clear cell carcinoma 8310 (/3) [1]	
Mucoepidermoid carcinoma 8430 (/3) [1]	
Neuroendocrine carcinoma 8246 (/3)	Combined small cell carcinoma **8045 (/3)** Large cell neuroendocrine carcinoma **8013 (/3)** Small cell carcinoma **8041 (/3)**
Neuroendocrine tumor 8240 (/3) • Carcinoid tumor NOS • Neuroendocrine tumor, grade 1 • Typical carcinoid	Atypical carcinoid **8249 (/3)** • Neuroendocrine tumor, grade 2
NUT carcinoma 8023 (/3)	
Sarcomatoid carcinoma 8033 (/3) [1]	

[1] These histologies are salivary gland-like carcinomas.

Table 22: Thymus Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Squamous cell carcinoma NOS 8070	Basaloid carcinoma **8123 (/3)** Basaloid squamous cell carcinoma **8083 (/3)** Lymphoepithelial carcinoma **8082 (/3)**
Thymic carcinoma 8586 (/3) [1] • Thymoma, type C	
Thymoma NOS 8580 (/3) • Intrapulmonary thymoma • Metaplastic thymoma • Sclerosing thymoma	Thymoma, type A **8581 (/3)** • Thymoma, medullary • Thymoma, spindle cell Thymoma, type AB **8582 (/3)** • Thymoma, mixed type Thymoma, type B1 **8583 (/3)** • Thymoma, lymphocytic • Thymoma, lymphocyte-rich • Thymoma, organoid • Thymoma, predominantly cortical Thymoma, type B2 **8584 (/3)** • Thymoma, cortical Thymoma, type B3 **8585 (/3)** • Thymoma, atypical • Thymoma, epithelial • Well-differentiated thymic carcinoma
Undifferentiated carcinoma 8020 (/3)	

Table 23: Penis and Scrotum Histologies

Table 23 lists the more common histologies for penis
C600 Prepuce; foreskin
C601 Glans penis
C602 Body of penis; corpus cavernosum; corpus of penis
C608 Overlapping lesion of penis
C609 Penis, NOS; skin of penis
C630 Epididymis
C632 Scrotum, NOS; skin of scrotum

Column 1 contains Specific and NOS histology terms.

- Specific histology terms do not have subtypes or variants (column 2 is blank).
- NOS histology terms have subtypes or variants listed in column 2.
- Synonyms share the same histology code as the term under which they are indented.
- Synonyms do **not** have behavior codes listed next to the term **unless the term has only one possible behavior (/2 or /3)**

Column 2 contains **subtypes or variants** of the **NOS** histology listed in column 1.

- Synonyms are indented under NOS terms in column 2
- Synonyms do **not** have behavior codes next to the term **unless the term has only one possible behavior (/2 or /3)**

Coding Notes on next page

Other Sites Site-group Instructions
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Table 23: Penis and Scrotum Histologies

Penis Coding Notes

- Codes 8085 and 8086 are valid for C60. _ and C63.2 beginning with cases diagnosed 1/1/2024.
- P16 is a valid test to determine HPV status and can be used to code HPV-associated and HPV-independent histologies
- When the diagnosis is a subtype/variant of squamous cell carcinoma and HPV status is also noted, ignore the HPV status and code the subtype/variant.

  EXCEPTION: When keratinizing or non-keratinizing SCC are included in the diagnosis with HPV status, code the appropriate HPV histology: 8085 or 8086.

  Example 1: Basaloid SCC, HPV-associated is coded basaloid SCC 8083/3.
  Example 2: Keratinizing SCC, HPV-associated is coded to SCC HPV-associated 8085/3.
- Definition of HPV-associated SCC: invasive keratinizing carcinoma arising from penile mucosal or cutaneous compartments that is associated with HPV infection.
- Definition of HPV-independent SCC: invasive keratinizing carcinoma arising from penile mucosal or cutaneous compartments that is not associated with HPV infection.

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Adenocarcinoma NOS 8140	Adenosquamous carcinoma **8560** Mucoepidermoid carcinoma **8430**
Mucosal melanoma 8720 (/3)	
Paget disease, extramammary 8542 (/3)	

Table 23: Penis and Scrotum Histologies

Specific or NOS Term, Code, and Synonym(s)	Subtype(s)/Variant(s) and Synonym(s)
Squamous cell carcinoma NOS 8070 • SCC NOS • Squamous cell carcinoma, in-situ **(/2)**	Basaloid squamous cell carcinoma **8083** [1] Clear cell squamous cell carcinoma **8084** [1] Differentiated penile intraepithelial neoplasia **8071 (/2)** High-grade squamous intraepithelial lesion **8077 (/2)** Lymphoepithelial carcinoma **8082** [1] Papillary squamous cell carcinoma **8052** [2] Pseudoglandular squamous cell carcinoma **8075** [2] • Pseudohyperplastic SCC Sarcomatoid squamous cell carcinoma **8074** [2] • Spindle cell SCC Squamous cell carcinoma, HPV-associated **8085** [1] [3] Squamous cell carcinoma, HPV-independent **8086** [2] [3] • SCC, usual type Verrucous carcinoma **8051** • Carcinoma cuniculatum Warty-basaloid carcinoma **8054** (C60._ only) • Warty carcinoma (C60._ only)

[1] These histologies are HPV-associated neoplasms per WHO.
[2] These histologies are HPV-independent neoplasms per WHO.
[3] Codes 8085 and 8086 are valid for primary sites C60._ and C63.2 beginning with cases diagnosed 1/1/2024.

Other Sites Multiple Primary Rules
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Note: Metastatic tumors are not included when determining how many tumors are present.

Unknown if Single or Multiple Tumors

Rule M1 Abstract a **single primary** when it is not possible to determine if there are **single** 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.

Other Sites Multiple Primary Rules
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Single Tumor

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

Note 1: A single tumor is always a single primary

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

Note 3: The tumor may be comprised of both in situ and invasive histologies.

Note 4: The invasive malignancy may arise in or is in a background of in situ/non-invasive neoplasm.

This is the end of instructions for Single Tumors

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

Other Sites Multiple Primary Rules
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Multiple Tumors

Note 1: Multiple tumors may be single primary or multiple primaries.
Note 2: Includes combinations of in situ and invasive.
Note 3: For those sites which have recognized biomarkers, the biomarkers are most frequently used to target treatment. Follow the rules; do not code multiple primaries or histology based on biomarkers.

Important: Rules M3 through M9 apply to specific sites and histologies.

Rule M3 **Acinar Adenocarcinoma (8140)** of the **prostate** is always a **single primary**.
Note 1: Report only one acinar/adenocarcinoma of the prostate per patient lifetime.
Note 2: 95% of prostate malignancies are the common (acinar) adenocarcinoma histology (8140/3).
Note 3: If the patient has a previous acinar adenocarcinoma of the prostate in the database and is diagnosed with adenocarcinoma in 2023, it is a single primary.
Note 4: The rule applies to multiple occurrences of acinar adenocarcinoma of prostate and/or subtype variants of acinar adenocarcinoma of prostate listed in **Table 3**.

Rule M4 Abstract **multiple primaries** when the patient has a subsequent **small cell carcinoma** of the **prostate** more than 1 year following a diagnosis of **acinar adenocarcinoma** and/or subtype/variant of acinar adenocarcinoma of prostate (**Table 3**).
Note 1: Small cell carcinoma (SmCC) of the prostate is rare and accounts for less than 1% of prostate cancers.
Note 2: 50% of SmCC of the prostate cases present as a de novo malignancy
Note 3: SmCC of the prostate often occurs following androgen deprivation treatment (ADVT) and/or radiation therapy for acinar adenocarcinoma
Note 4: SmCC of the prostate is aggressive with poor clinical outcomes and survival.

Rule M5 **Retinoblastoma** is always a **single primary** (unilateral or bilateral).

Rule M6 **Kaposi sarcoma** (of any site(s)) is always a **single primary**.

Other Sites Multiple Primary Rules
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Rule M7 Abstract a **single primary** when **follicular** and **papillary** tumors in the **thyroid** are diagnosed **within 60 days** and tumors are:

- Papillary thyroid carcinoma NOS and follicular carcinoma NOS **OR**
- Papillary carcinoma, follicular variant and papillary thyroid carcinoma **OR**
- Papillary carcinoma, follicular variant and follicular carcinoma **OR**
- Any papillary thyroid carcinoma subtype/variant and any follicular subtype/variant listed in Column 2, **Table 12**.

Rule M8 Abstract **multiple primaries** when separate/non-contiguous tumors are **anaplastic carcinoma** and any other histologies in the **thyroid**.

Note: This rule does not apply to multiple tumors that are anaplastic carcinoma and undifferentiated carcinoma.

Rule M9 Bilateral epithelial tumors (8000-8799) of the **ovary within 60 days** are a **single primary**.

Note 1: Tumors must be **same histology** or be an **NOS and subtype/variant** (are on the **same row** in **Table 13**).

Note 2: 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 (indented under the preferred term in column 1) **OR**
- A NOS (column 1) and the other is a subtype/variant of that NOS (column 2)

Rule M10 Tumors on both sides (right and left) of a site listed in **Table 1** are **multiple primaries**.

Rule M11 Adenocarcinoma in **adenomatous polyposis coli** (familial polyposis) with one or more in situ or malignant polyps is a **single primary**.

Note: Tumors may be present in a single or multiple segments of small bowel, colon, rectosigmoid, rectum.

Other Sites Multiple Primary Rules
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Rule M12 Abstract **multiple primaries** when the patient has a subsequent tumor after being clinically disease-free for greater than **one year** after the original diagnosis or recurrence.

***Exception*:** A subsequent/new tumor in the thyroid bed following a total thyroidectomy is recurrence and not a new primary regardless of timing.

Note 1: Clinically disease-free means that there was no evidence of recurrence in the same site on follow-up.

- Scopes are WNL
- Scans are WNL
- All other work-up is WNL

Note 2: When there is a recurrence less than or equal to one year 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 one year 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 tumor and now has another tumor. **Follow the rules**; do not attempt to interpret the physician's statement.

Rule M13 Tumors with ICD-O-3 topography codes that are different at the second (C**X**xx) and/or third characters (Cx**X**x) are **multiple primaries**.

Example 1: A tumor in the penis C**6**09 and a tumor in the rectum C**2**09 have different second characters in their ICD-O-3 topography codes, so they are multiple primaries.

Example 2: A tumor in the cervix C5**3**9 and a tumor in the vulva C5**1**9 have different third characters in their ICD-O-3 topography codes, so they are multiple primaries.

Rule M14 Tumors with ICD-O-3 **topography** codes that **differ** only at the **fourth character** (Cxx**X**) and are in any **one** of the following primary sites are **multiple primaries**.

- Anus and anal canal (C21_)
- Bone, joints, and articular cartilage (C40_ to C41_)
- Connective subcutaneous and other soft tissues (C49_)
- Skin (C44_)

Rule M15 A de novo (frank) in situ or malignant adenocarcinoma and an in situ or malignant tumor in a **polyp** are a **single primary**.

Other Sites Multiple Primary Rules
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Rule M16 Multiple in situ and/or malignant polyps are a **single primary**.
Note: Includes all combinations of adenomatous, tubular, villous, and tubulovillous adenomas or polyps.

Rule M17 Abstract **multiple primaries** when separate/non-contiguous tumors are two or more **different subtypes/variants** in Column 2, **Table 3-23** in the Site-group Instructions.
Note: The tumors may be subtypes/variants of the same or different NOS histologies:
- **Same NOS**: Micropapillary carcinoma of stomach 8265/3 and mucinous adenocarcinoma of stomach 8480/3 are both subtypes of adenocarcinoma NOS of stomach but are distinctly different histologies. Abstract multiple primaries.
- **Different NOS**: Myxofibrosarcoma 8811/3 is a subtype/variant of fibrosarcoma NOS 8810/3; myxoid liposarcoma 8852/3 is a subtype liposarcoma NOS 8850/3. They are distinctly different histologies. Abstract multiple primaries.

Rule M18 Abstract a **single primary** when synchronous, separate/non-contiguous tumors are on **the same row in Table 3-23** in the Site-group Instructions.
Note 1: 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 (indented under the preferred term in column 1) **OR**
- A NOS (column 1) and the other is a subtype/variant of that NOS (column 2)

Note 2: Invasive encapsulated follicular variant of papillary thyroid carcinoma and Infiltrative follicular variant of papillary thyroid carcinoma share a histology code (8340) but are distinctly different entities. They are on separate rows of the table.

Rule M19 Abstract **multiple primaries** when separate/non-contiguous tumors are on **multiple rows** in **Table 2-23** in the Site-group Instructions. Timing is irrelevant
Note: Each row in the table is a **distinctly different** histology.

Rule M20 Abstract **multiple primaries** when an **invasive** tumor occurs **more than 60 days** after an **in situ** tumor.
Note 1: This rule applies to multiple tumors, one in situ and a separate malignant tumor.
Note 2: The purpose of this rule is to ensure the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 3: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Other Sites Multiple Primary Rules
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Rule M21 Abstract a **single primary** when there are multiple tumors that do not meet any of the above criteria.
Note 1: Use this rule as a last resort. Confirm that you have not overlooked an applicable rule.
Note 2: When an invasive tumor follows an in situ tumor within 60 days, abstract a single primary.

This is the end of instructions for Multiple Tumors

Other Sites Histology Rules
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Priority Order for Using Documents to Identify Histology

IMPORTANT NOTES

1. Code the histology diagnosed ***prior*** to **neoadjuvant treatment.**
   Note 1: Histology changes may occur following immunotherapy, targeted therapy, and radiation therapy.
   Note 2: Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.

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

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

The priority list is used for **single primaries (including multiple tumors abstracted as a single primary).**

This is a hierarchical list of source documentation.

Code the **most specific** pathology/tissue from either the resection or biopsy.
Note 1: The term "most specific" usually refers to a subtype/variant.
Note 2: The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor.
Note 3: When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).

1. **Tissue or pathology** report from primary site (in priority order)
   A. Addendum(s) and/or comment(s)
   B. Final diagnosis/synoptic report as required by CAP
   C. CAP protocol (this is not the same as the CAP synoptic report)

Note 1: Addendums and comments on the pathology report are given highest priority because they often contain additional 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

2. **Cytology** (Fine needle biopsy from primary site, retroperitoneal, peritoneal, abdominal cavity fluid, ascites)
   Example: Fine needle aspiration of ascites shows adenocarcinoma, and the resection pathology shows serous adenocarcinoma. Code serous adenocarcinoma 8441/3

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

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

5. Code the histology **documented** by the physician when none of the above are available. Use the documentation in the following
   A. Priority order:
   B. Treatment plan
   C. Documentation from Tumor Board
   D. Documentation from the medical record that refers to the original pathology, cytology, or scan(s)
   E. 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

Other Sites Histology Rules
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Coding Histology

Important Information for using Other Sites Histology Tables:

- Site-specific histology tables have been added to Other Sites Solid Tumor Rules.
- Not all site groups have individual histology tables and will require the use of ICD-O and updates.
- Site-specific histology tables are based on current WHO Classification of Tumors books and the current version of ICD-O. The tables may not include all histologies that could occur in that site.
- In place of adding numerous site-based histology rules to the 2023 revision, the histology tables in Other Sites Terms and Definitions include additional coding instructions and notes to assign the correct ICD-O code when appropriate.

Note 1: The priority is to code the most specific histology. **DO NOT USE BREAST HISTOLOGY CODING RULES FOR THIS SITE GROUP.**
Note 2: Only use this section for one or more histologies within a single tumor.
Note 3: Do not use this section in place of the Histology Rules.

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

   Note 1: Some site-specific histologies must meet a percentage requirement in order to be coded. Refer to the Histology Rules and the appropriate site group Histology Table for coding guidance.

   Note 2: The terms above (A, B, C) must describe a **carcinoma** or **sarcoma** in order to code a histology described by those terms.
   Example: When the diagnosis is adenocarcinoma with a component of papillary **carcinoma**, code papillary carcinoma 8260.
   Negative example: When the diagnosis is simply adenocarcinoma with a papillary component. Code adenocarcinoma 8140. Do not assume this is a papillary carcinoma. This could be papillary differentiation or features.

   Note 3: When the most specific histology is described as differentiation or features, see #2.

2. Code the histology described as **differentiation** or **features/features of ONLY** when there is a specific ICD-O code for the "NOS with ____ features" or "NOS with ____ differentiation".
   Example: Endometrioid carcinoma with squamous differentiation has an ICD-O code of 8570/3
   Note: Do not code differentiation or features when there is no specific ICD-O code.

3. Code the specific histology described by **ambiguous terminology** (list follows) **ONLY** when A or B is true:
   A. The only diagnosis available is **one histology** term described by ambiguous terminology
      - CoC and SEER require reporting of cases diagnosed only by ambiguous terminology
      - The final pathology diagnosis is an ambiguous term followed by a histology type
      - Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

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

   If the specific histology does not meet the criteria in #3B, then code the NOS histology.

See the **Ambiguous Terminology** section of the General Instructions for instructions and examples on when ambiguous terms and definitive terms may be used to assign histology.

Table 24: List of Ambiguous Terminology

Ambiguous Terminology	
Appears	Presumed
Cannot rule out	Suspicious (for)
Likely	Suggestive of
Favor(s)	

Note 1: Table 25 below includes terms previously included in the list of ambiguous terms. These terms should be treated as supporting a definitive diagnosis of a histologic subtype. A definitive term does not require clinical verification of the subtype or variant.

Note 2: The terms in Table 25 were removed from the list of ambiguous terms and added to a list of definitive terminology based on the recommendation of a panel of pathologists and subject matter experts.

Table 25: List of Definitive Terminology

Definitive Terminology	
Comparable with	Most likely
Compatible with	Probable
Consistent with	Typical (of)

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

Other Sites Histology Rules
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Single Tumor: In Situ Only
(All parts are in situ)

Rule H1 Code the histology documented by the physician when the **pathology/cytology** report is **not available.**

Note 1: Priority for using documents to code histology when pathology/cytology report is not available
- Documentation in the medical record that refers to the pathologic or cytologic findings
- Physician's reference to type of cancer in the medical record

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000/2 (cancer, in situ/non-invasive) or 8010/2 (carcinoma in situ NOS) as stated by the physician when nothing more specific is documented.

Rule H2 Code the histology when only **one histologic type** is identified.

Note 1: Do not code terms that do not appear in the histology description.

Note 2: Use **Tables 3-23** to code histology. New codes, terms, and synonyms are included in Tables 3-23 and coding errors may occur if the table is not used.

Note 3: For prostate cases, code ductal carcinoma in-situ/DCIS 8500/2 when that is the only histology noted.

Example: Do not code SCC non-keratinizing unless the words "non-keratinizing" actually appear in the final diagnosis.

Rule H3 Code **8077/2** (squamous intraepithelial neoplasia, high grade) for the following:
- AIN, grade II/Anal intraepithelial neoplasia, grade II
- AIN, grade III/Anal intraepithelial neoplasia, grade III
- CIN with severe dysplasia
- Conjunctival intraepithelial neoplasia grade III (CIN III)
- High-grade squamous dysplasia
- High-grade squamous intraepithelial neoplasia, grade II
- High-grade intraepithelial neoplasia, grade III
- High-grade squamous intraepithelial lesion (HSIL)
- Intraepithelial neoplasia grade II/III
- Squamous intraepithelial neoplasia, grade II
- Squamous intraepithelial neoplasia, grade III

- Vaginal intraepithelial neoplasia, grade III/VAIN III

Note 1: Code 8077 cannot be used for glandular intraepithelial neoplasia such as pancreatic intraepithelial neoplasia (PAIN).

Note 2: This list should not be used to determine reportability and may not include all reportable neoplasms for 8077/2. See your standard setter manuals (e.g., SEER Program Coding and Staging Manual or STORE manual) for reportable neoplasms.

Rule H4 Code **8148/2** (glandular intraepithelial neoplasia, grade III) for the following:

- Biliary intraepithelial neoplasm Grade 3/BiIN-3
- Esophageal intraepithelial neoplasm, high grade
- High-grade biliary intraepithelial neoplasms (BiIN III)
- High-grade glandular dysplasia
- Pancreatic intraepithelial neoplasia (PanIN III)

Note: This list should not be used to determine reportability and may not include all reportable neoplasms for 8148/2. See your standard setter manuals (e.g., SEER Program Coding and Staging Manual or STORE manual) for reportable neoplasms.

Rule H5 Code **8210** (adenocarcinoma in adenomatous polyp), **8261** (adenocarcinoma in villous adenoma), or **8263** (adenocarcinoma in tubulovillous adenoma) **only when**:

- The final diagnosis is **adenocarcinoma/carcinoma** in a polyp **OR**
- The final diagnosis is **adenocarcinoma/carcinoma**, and a residual polyp or polyp architecture is recorded in other parts of the pathology report **OR**
- The final diagnosis is **adenocarcinoma/carcinoma** and there is reference to residual or pre-existing polyp **OR**
- There is documentation that the patient had a **polypectomy**

Important note: For cases diagnosed 1/1/2023 forward: If the final diagnosis indicates a histology other than adenocarcinoma/carcinoma arising in a polyp, code the specific histology. This applies to all sites.

Example: Endometrial biopsy shows endometrioid adenocarcinoma in situ arising in a polyp. Code endometrioid adenocarcinoma, in situ.

Rule H6 Code the **subtype/variant** when a **NOS** and a **single subtype/variant** of that NOS are present.

- Adenocarcinoma in situ NOS (**8140**) and a specific in situ adenocarcinoma
- Carcinoma in situ NOS (**8010**) and a specific in situ carcinoma
- Melanoma in situ NOS (**8720**) and a specific in situ melanoma
- Sarcoma NOS (**8800**) and a specific sarcoma
- Squamous cell carcinoma NOS (**8070**) and a specific squamous cell carcinoma

Note 1: The specific type may be identified as type, subtype, variant or predominantly.
Note 2: Do not code architecture and pattern.
Note 3: Refer to **Tables 3-23** in Terms and Definitions for additional coding instructions. There may be exceptions to this rule.

Rule H7 Code a **combination code** when there are multiple specific in situ histologies or when there is an NOS with multiple specific in situ histologies **AND**

- The combination is listed in **Table 2** in Site-group Instructions, ICD-O and all updates **OR**
- You receive a combination code from **Ask A SEER Registrar**

Note 1: The rules are hierarchical. Use this rule when previous rules do not apply.
Note 2: Submit a question to Ask A SEER Registrar when a combination is not listed in Table 2 in Site-group Instructions, ICD-O, and all ICD-O updates.

This is the end of instructions for a Single Tumor: In Situ Components
Code the histology according to the rule that fits the case

Single tumor: Invasive and In Situ Components

Rule H8 Code the **invasive histology** when both invasive and in situ components are present.

Note 1: Use **Tables 3-23**, ICD-O, and all ICD-O updates to determine if the term containing both invasive and in situ histologies has a specific ICD-O code.

Example: Intraductal papillary mucinous neoplasm with associated carcinoma has both in situ (intraductal) and associated invasive carcinoma and has an ICD-O code of 8453/3

Note 2: When the term is not listed in **Tables 3-23**, ICD-O, and ICD-O updates, ignore the in situ term.

This is the end of instructions for a Single Tumor: Invasive and In Situ Components
Code the histology according to the rule that fits the case

Other Sites Histology Rules
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Single Tumor: Invasive Only

Rule H9 Code the histology documented by the physician when the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code histology when pathology/cytology report is not available

- Documentation in the medical record that refers to the pathologic or cytologic findings
- Physician's reference to type of cancer in the medical record
- CT, PET, or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000/3 (cancer, malignant neoplasm) or 8010/3 (carcinoma NOS) as stated by the physician when nothing more specific is documented.

Rule H10 Code the histology from a **metastatic site** when there is **no pathology/cytology** from the primary site.

Note: Code the behavior /3.

Rule H11 Code **8140** (adenocarcinoma NOS) for **prostate primaries** when the diagnosis is:

- Acinar adenocarcinoma/carcinoma **OR**
- Adenocarcinoma **OR**
- Adenocarcinoma with ductal features **OR**
- Atrophic adenocarcinoma **OR**
- Ductal adenocarcinoma when the percentage of duct is not stated or less than 50 percent of the tumor **OR**
- Foamy gland adenocarcinoma **OR**
- Microcystic adenocarcinoma **OR**
- Pseudohyperplastic adenocarcinoma **OR**
- Prostatic intraepithelial-like carcinoma

Note: Ductal adenocarcinoma cannot be coded from a TURP. A radical prostatectomy must be done with a diagnosis of ductal adenocarcinoma comprising more than 50% of the tumor to code 8500/3.

Rule H12 Code the histology when only **one histologic type** is identified.

Exceptions:

- If histology is papillary carcinoma of thyroid, continue through the rules.
- If the histology arises in an adenoma or polyp, continue through the rules.

Note 1: Do not code terms that do not appear in the histology description.

Example: Do not code squamous cell carcinoma non-keratinizing unless the words "non-keratinizing" actually appear in the diagnosis.

Note 2: Some histologies are compound terms meaning two or more histology types are combined into a single ICD-O code. Use **Tables 3-23**, ICD-O, and all ICD-O updates to determine if the term containing multiple histologies has a specific code.

***Example*:** Myxoid pleomorphic liposarcoma has more than one histology in the term and is coded 8854/3 per ICD-O.

Rule H13 Code **8210** (adenocarcinoma in adenomatous polyp), **8261** (adenocarcinoma in villous adenoma), or **8263** (adenocarcinoma in tubulovillous adenoma) **only when:**

- The final diagnosis is **adenocarcinoma/carcinoma** in a polyp **OR**
- The final diagnosis is **adenocarcinoma/carcinoma**, and a residual polyp or polyp architecture is recorded in other parts of the pathology report **OR**
- The final diagnosis is **adenocarcinoma/carcinoma** and there is reference to residual or pre-existing polyp **OR**
- There is documentation that the patient had a polypectomy

Important note for cases diagnosed 1/1/2023 forward: If the final diagnosis indicates a histology other than adenocarcinoma/carcinoma arising in a polyp, code the specific histology.

Example: Cervix biopsy shows endometrioid adenocarcinoma arising in multiple polyps. Code endometrioid adenocarcinoma.

Rule H14 Code the subtype/variant for pancreas primaries when the diagnosis is **ductal carcinoma/adenocarcinoma AND**

- Adenosquamous carcinoma **8560/3**
- Colloid/mucinous carcinoma/adenocarcinoma **8480/3**
- Hepatoid carcinoma **8576/3**
- Large cell carcinoma with rhabdoid phenotype **8014/3**
- Medullary carcinoma **8510/3**
- Signet-ring/poorly cohesive carcinoma/adenocarcinoma **8490/3**
- Undifferentiated carcinoma **8020/3**

- Undifferentiated carcinoma with osteo-clast-like giant cells **8035/3**

Rule H15 Code the **subtype/variant** when there is a **NOS** and a **single subtype/variant** of that NOS, such as the following:

- Cancer/malignant neoplasm NOS (**8000**) **AND** a subtype/variant of cancer
- Carcinoma NOS (**8010**) **AND** a subtype/variant of carcinoma
- Adenocarcinoma NOS (**8140**) **AND** a subtype/variant of adenocarcinoma
- Squamous cell carcinoma NOS (**8070**) **AND** a subtype/variant of squamous cell carcinoma
- Melanoma NOS (**8720**) **AND** a subtype/variant of melanoma
- Sarcoma NOS (**8800**) **AND** a subtype/variant of sarcoma

Note: See **Tables 3-23** to find NOS and subtype/variants. There may be exceptions to this rule.

Rule H16 Code anaplastic carcinoma of thyroid (**8021**) or undifferentiated carcinoma of thyroid (**8020**) when anaplastic or undifferentiated is mixed with other thyroid histologies in a single tumor.

- Treatment and prognosis will be largely determined by the anaplastic or undifferentiated component.
- This rule is new for 2023

Rule H17 Code **dedifferentiated carcinoma** (**8020**) when mixed with endometrioid carcinoma/adenocarcinoma.

- Dedifferentiated carcinoma is a distinct entity which has worse prognosis than endometrioid adenocarcinoma.

Rule H18 Code **papillary carcinoma/adenocarcinoma** of the **thyroid** to papillary adenocarcinoma NOS (**8260**).

Rule H19 Code **papillary microcarcinoma** of **thyroid** to papillary adenocarcinoma NOS (**8260**).

Note: For thyroid primaries only, the term micropapillary/papillary microcarcinoma does not refer to a specific histologic type. In North America, it means the papillary component of the tumor is minimal or occult.

Rule H20 Code **papillary carcinoma, follicular variant** of **thyroid (8340)** when there are multiple papillary and follicular carcinoma subtypes/variants:

- Papillary thyroid carcinoma NOS and follicular carcinoma NOS **OR**
- Papillary carcinoma, follicular variant and papillary thyroid carcinoma **OR**
- Papillary carcinoma, follicular variant and follicular carcinoma **OR**
- Any papillary thyroid carcinoma subtype/variant and any follicular subtype/variant listed in Column 2, **Table 12**

Note: Some thyroid histologies are compound terms meaning two or more histology types are combined into a single ICD-O code. Use **Table 12**, ICD-O, and all ICD-O updates to determine if the term containing multiple histologies has a specific code.

Rule H21 Code a combination code when there are multiple specific histologies or when there is an NOS with multiple specific histologies **AND**

- The combination is listed in **Table 2** in Site-group Instructions, ICD-O and all updates **OR**
- There are coding instructions for the combination in the applicable histology **Tables 3-23 OR**
- You receive a combination code from **Ask A SEER Registrar**

Note 1: The rules are hierarchical. Use this rule when previous rules do not apply.

Note 2: Submit a question to **Ask A SEER Registrar** when a combination is not listed in Table 2 in Site-group Instructions, ICD-O, and all ICD-O updates.

This is the end of instructions for a Single Tumor: Invasive Only
Code the histology according to the rule that fits the case

Multiple Tumors Abstracted as a Single Primary

Rule H22 Code the histology documented by the physician when the **pathology/cytology** report is **not available.**

Note 1: Priority for using documents to code histology when pathology/cytology report is not available

- Documentation in the medical record that refers to the pathologic or cytologic findings
- Physician's reference to type of cancer in the medical record
- CT, PET, or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000/3 (cancer, malignant neoplasm) or 8010/3 (carcinoma NOS) as stated by the physician when nothing more specific is documented.

Rule H23 Code the histology from a **metastatic site** when there is **no pathology/cytology** from the primary site.

Note: Code the behavior /3.

Rule H24 Code **8140** (adenocarcinoma NOS) for **prostate primaries** when the diagnosis is:

- Acinar adenocarcinoma/carcinoma **OR**
- Adenocarcinoma **OR**
- Adenocarcinoma with ductal features **OR**
- Atrophic adenocarcinoma **OR**
- Ductal adenocarcinoma when the percentage of duct is not stated or is less than 50 percent of the tumor **OR**
- Foamy gland adenocarcinoma **OR**
- Microcystic adenocarcinoma **OR**
- Pseudohyperplastic adenocarcinoma **OR**
- Prostatic intraepithelial-like carcinoma

Note: Ductal adenocarcinoma cannot be coded from a TURP. A radical prostatectomy must be done with a diagnosis of ductal adenocarcinoma comprising more than 50% of the tumor to code 8500/3.

Rule H25 Code **8077/2** (Squamous intraepithelial neoplasia, high grade) for the following:

- AIN, grade II/Anal intraepithelial neoplasia, grade II
- AIN, grade III/Anal intraepithelial neoplasia, grade III
- CIN with severe dysplasia
- Conjunctival intraepithelial neoplasia grade III (CIN III)
- High-grade intraepithelial neoplasia, grade III
- High-grade squamous dysplasia
- High-grade squamous intraepithelial lesion (HSIL)
- High-grade squamous intraepithelial neoplasia, grade II
- Intraepithelial neoplasia grade II/III
- Squamous intraepithelial neoplasia, grade II
- Squamous intraepithelial neoplasia, grade III
- Vaginal intraepithelial neoplasia, grade III/VAIN III

Note 1: Code 8077 cannot be used for glandular intraepithelial neoplasia such as pancreatic intraepithelial neoplasia (PAIN).

Note 2: This list should not be used to determine reportability and may not include all reportable neoplasms for 8077/2. See your standard setter manuals (e.g., SEER Program Coding and Staging Manual or STORE manual) for reportable neoplasms.

Rule H26 Code **8148/2** (Glandular intraepithelial neoplasia grade III) for the following:

- Biliary intraepithelial neoplasm Grade 3/BiIN-3
- Esophageal intraepithelial neoplasm, high grade
- High-grade biliary intraepithelial neoplasms (BiIN III)
- High-grade glandular dysplasia
- Pancreatic intraepithelial neoplasia (PanIN III)

Note: This list should not be used to determine reportability and may not include all reportable neoplasms for 8148/2. See your standard setter manuals (e.g., SEER Program Coding and Staging Manual or STORE manual) for reportable neoplasms.

Rule H27 Code the histology when only **one histologic type** is identified.

Note: Do not code terms that do not appear in the histology description.

Example: Do not code squamous cell carcinoma non-keratinizing unless the words “non-keratinizing” actually appear in the diagnosis

Rule H28 Code the histology of the underlying tumor when there is **extramammary Paget disease** and an underlying tumor of the **anus, perianal region, or vulva**.

Rule H29 Code **8210** (adenocarcinoma in adenomatous polyp), **8261** (adenocarcinoma in villous adenoma), or **8263** (adenocarcinoma in tubulovillous adenoma) **only when**:

- The final diagnosis is **adenocarcinoma/carcinoma** in a polyp **OR**
- The final diagnosis is **adenocarcinoma/carcinoma**, and a residual polyp or polyp architecture is recorded in other parts of the pathology report **OR**
- The final diagnosis is **adenocarcinoma/carcinoma** and there is reference to residual or pre-existing polyp **OR**
- There is documentation that the patient had a polypectomy

Important note for cases diagnosed 1/1/2023 forward: If the final diagnosis indicates a histology other than adenocarcinoma/carcinoma arising in a polyp, code the specific histology.

Example: Cervix biopsy shows endometrioid adenocarcinoma arising in multiple polyps. Code endometrioid adenocarcinoma.

Rule H30 Code **papillary carcinoma, follicular variant** of **thyroid** (**8340**) when there are multiple papillary and follicular carcinoma subtypes/variants:

- Papillary thyroid carcinoma NOS and follicular carcinoma NOS **OR**
- Papillary carcinoma, follicular variant and papillary thyroid carcinoma **OR**
- Papillary carcinoma, follicular variant and follicular carcinoma **OR**
- Any papillary thyroid carcinoma subtype/variant and any follicular subtype/variant listed in Column 2, **Table 12**

Rule H31 Code **papillary microcarcinoma** of thyroid to papillary carcinoma/adenocarcinoma of the **thyroid** to **8260.**

Note: For thyroid primaries only, the term micropapillary/papillary microcarcinoma does not refer to a specific histologic type. In North America, it means the papillary component of the tumor is minimal or occult.

Rule H32 Code the single **invasive** histology for **combinations of invasive and in situ**. Ignore the in situ terms.

Note: If the Multiple Primary Rules indicate an invasive tumor and separate in situ tumor are a single primary, code the invasive histology.

Rule H33 Code the subtype/variant for **pancreas** primaries when the diagnosis is **ductal carcinoma/adenocarcinoma AND**

- Adenosquamous carcinoma **8560/3**
- Colloid/mucinous carcinoma/adenocarcinoma **8480/3**
- Hepatoid carcinoma **8576/3**
- Large cell carcinoma with rhabdoid phenotype **8014/3**
- Medullary carcinoma **8510/3**
- Signet-ring/poorly cohesive carcinoma/adenocarcinoma **8490/3**
- Undifferentiated carcinoma **8020/3**
- Undifferentiated carcinoma with osteo-clast-like giant cells **8035/3**

Rule H34 Code the **subtype/variant** when there is a **NOS** and a **single subtype/variant** of that NOS, such as the following:

- Cancer/malignant neoplasm NOS (**8000**) **AND** a subtype/variant of cancer
- Carcinoma NOS (**8010**) **AND** a subtype/variant of carcinoma
- Adenocarcinoma NOS (**8140**) **AND** a subtype/variant of adenocarcinoma
- Squamous cell carcinoma NOS (**8070**) **AND** a subtype/variant of squamous cell carcinoma
- Melanoma NOS (**8720**) **AND** a subtype/variant of melanoma
- Sarcoma NOS (**8800**) **AND** a subtype/variant of sarcoma

Note: See **Tables 3-23** in to find NOS and subtype/variants. There may be exceptions to this rule.

Rule H35 Code a combination code when there are multiple specific histologies or when there is an NOS with multiple specific histologies **AND**

- The combination is listed in **Table 2** in Site-group Instructions, ICD-O and all updates OR
- There are coding instructions for the combination in the applicable histology **Tables 3-23** OR
- You receive a combination code from Ask A SEER Registrar

Note 1: The rules are hierarchical. Use this rule when previous rules do not apply.

Note 2: Submit a question to **Ask A SEER Registrar** when a combination is not listed in Table 2 in Site-group Instructions, ICD-O, and all ICD-O updates.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary
Code the histology according to the rule that fits the case