2018 SEER Solid Tumor Manual

2018 KCR SPRING TRAINING

Eight Groups are Revised for 2018

Head & Neck

Colon (includes rectosigmoid and rectum for cases diagnosed 1/1/2018 forward)

Lung (2018 Draft not yet available)

Breast

Kidney

Urinary Sites (2018 Draft not yet available)

Non-malignant CNS (2018 Draft not yet available)

Malignant CNS and Peripheral Nerves (2018 Draft not yet available)

2019 Changes for other two Groups

Cutaneous melanoma (minor revisions and draft available now)

- Cutaneous melanoma site rules will be revised for 2019 implementation to incorporate information from the new WHO 4th Ed Tumors of Skin scheduled to be released in 2018.

Other sites (minor revisions and draft available now)

- Primary sites excluded are:
  - Rectosigmoid and rectum which are included in 2018 Colon rules.
  - Peripheral nerves which are included in 2018 Malignant Brain rules.
- Other sites rules will be revised for 2019 implementation. The Solid Tumor Task Force has identified the need to expand the rules to include GYN, soft tissue, thyroid and other site-specific solid tumors.

Solid Tumor Rules

What we will cover:

- Overview of General rules
- New Head and Neck rules
- New Colorectal rules
- New Breast rules
- New Kidney rules

Remember: These are currently in draft form and may change slightly in the final version!

General Instructions

The 2018 solid tumor rules replace all previous MP/H rules, but they are effective for diagnoses on or after 1/1/2018. Do not use these rules for cases diagnosed prior to 1/1/2018.

The 2018 Solid Tumor rules are available in text format only, and each site grouping contains the general instructions and terms and definitions from the 2007 MP/H rules.

Do not use a physician's statement to decide whether a patient has a recurrence pf a previous cancer or a new primary. Use the multiple primary rules, as written, unless a pathologist compares the present tumor to the original tumor and states that the new tumor is a recurrence.

NEW! Code subtypes/variants when definitively described (with no modifiers)

Example: Well -differentiated neuroendocrine tumor 8240.

Do not code a histology (*including subtypes or variants) when described as below:

Differentiation	Favor(s)
Features	Malignant appearing
Terms modified by ambiguous terminology	Most likely
Apparently	Presumed
Appears	Probable
Comparable with	Suspect(ed)
Compatible with	Suspicious (for)
Consistent with	Typical (of)

Ambiguous terminology is used to determine reportability, not to determine histology.

Using the MP Rules

These steps are the same as the 2007 MP/H rules:

1. Use the MP rules to decide on the number of primary malignancies to be reported.
2. Use the site specific rules where they exist.
3. Use the Other Sites rules when there are no site specific rules.
4. Each module has separate rules for Single Tumor, Multiple Tumors, and Unknown Number
5. Choose the appropriate module based on the number of tumors.
6. Single primary – one abstract; Multiple primaries – two or more abstracts
7. Rules are hierarchical; use the first rule that applies and then STOP

Using the Histology coding rules

Use the ICD-O-3 Histology Code and Behavior update for 2018, along with the ICD-O-3 publication by WHO, to accurately code histology.

The Priority of documents to be used for coding Histology vary by site:

- Use tissue/pathology for CNS tumors, benign or malignant, if available. For all other sites, use the most specific pathology from either the resection or the biopsy. *change from 2007*

- Radiology reports are prioritized by site: Breast – use mammogram first; for all other sites, the order to use US, CT, or MRI may differ – use the site specific priority order listed for that site

- Clinical documents for diagnoses also differ in their priority by site. Use the site specific priority listed

Head and Neck: 2018 Solid Tumor Rules

HEAD and NECK Solid Tumor Rules

Separate sections for:

Equivalent Terms

Terms that are NOT Equivalent

Instructions for Coding Primary Site

Table 1: Contiguous sites

Tables 2-10: Histologies for specific H&N sites

Table 11: Paired sites, which must have Laterality coded

Illustrations

Multiple Primary Rules

Histology Coding Rules

Head and Neck

Priority Rules for Identifying Primary Site with #1 having the highest priority

1. Tumor Board
2. Physician staging
3. Tumor resection:
   - a. Op report b. Addendum on path c. Final diagnosis on path d. CAP synoptic report
4. Biopsy
   - a. Op report b. Addendum on path c. Final diagnosis on path d. CAP synoptic report
5. Scans
   - A. CT b. MRI c. PET
6. Physician documentation which refers to primary site

Head and Neck

New Tables for coding primary site:

Table 1. Contiguous sites

Tables 2 - 10. Histologies that occur in specific sites

Table 11. Paired sites

Instructions

1. Verify site/histology combinations in Tables
2. Find the specific ICD-O-3 code
3. Identify subtypes or variants of an NOS code when instructed to by the Histology rules
4. Determine the primary site when lesions involve multiple sites
   - Use Table 1 for Contiguous sites, then Tables 2-10 for specific sites, then C__.8 overlapping site.

Head and Neck Site/Histology Tables

C000-C148, C300-C329, C339, C410, C411, C44.2

1	Contiguous sites
2	Nasal cavity, Paranasal sinuses, and Skull base
3	Nasopharynx
4	Hypopharynx, Larynx, Trachea, and Parapharyngeal space
5	Oral cavity and Mobile Tongue
6	Oropharynx, Base of Tongue, Tonsils, and Adenoids
7	Salivary glands
8	Odontogenic and Maxillofacial Bones
9	Ear and External auditory canal
10	Paraganglioma of Carotid body. Larynx, and Middle ear
11	Paired sites

Example from Table 1. Contiguous sites

Site Group	ICD-O-3 code range	ICD-O-3 code	ICD-O-3 Term	Contiguous sites
Base of Tongue	C019	C019	Base of tongue, NOS	C100 Vallecula C020 Dorsal surface of tongue NOS; anterior 2/3 of tongue; midline of tongue; dorsal surface of anterior tongue NOS C021 Border of tongue; tip of tongue C062 Retromolar area; retromolar trigone C091 Tonsillar pillar; faucial pillar; glossopalantine fold

Example: Table 2: Histologies of the Nasal cavity, Paranasal sinuses, and Skull base

Histology Term and Code (may be specific term or NOS term)	Synonyms for Histology Term	Subtypes/ variants and Histology code
Rhabdomyosarcoma 8900/3	Malignant rhabdomyosarcoma Myosarcoma Rhabdomyoblastoma	Alveolar rhabdomyosarcoma 8920/3 Embryonal rhabdomyosarcoma 8910/3 Pleomorphic rhabdomyosarcoma, adult type 8901/3 Spindle cell rhabdomyosarcoma 8912/3

Head and Neck – MP Rules

M1. Unknown if Single or Multiple Tumors – Abstract as Single Primary

M2. Single Tumor – A single tumor is always a Single Primary

Multiple Tumors –

- M3. Multiple primary if upper lip and lower lip; upper gum and lower gum; nasal cavity and middle ear
- M4. Multiple primaries if diagnosed more than 5 years apart
  - **NOTE: The time frame means clinically disease free for more than 5 years. If a patient has a recurrence within the 5 years, the 'clock' starts over, and the 5 year interval is computed from the date of last known recurrence. If recurrence is unknown, compute time from date of diagnosis.**
- M5. Multiple primary if separate tumors are in topography codes that differ at the second or third character (example: C07.9 and C08.9)

Head and Neck – MP Rules

Multiple Tumors – (cont.)

- M6. Multiple primary if multiple tumors are in the right and left side of a paired site
- M7. Single primary if multiple tumors and one is an NOS histology and the other is a subtype or variant of that histology
- M8. Single primary if the patient has an invasive tumor followed by an in situ tumor of the same histology, or of a subtype or variant of that histology
- M9. Single tumor when an invasive tumor of the same histology occurs within 60 days of an in situ tumor in the same site
- M10. Multiple primaries when an invasive tumor occurs more than 60 days after an in situ tumor of the same histology
- M11. Multiple primaries when there are multiple tumors with histology codes that differ at the first, second, or third digit (example: 8050 and 8070)

Head and Neck – Histology Rules

Priority list for using documentation to code histology

1. Use the most specific tissue diagnosis; may be from biopsy or resection *change*
   - The most specific is the subtype or variant term that may used for histology coding
   - Use tissue reports in this order: Addenda, Comments, Final diagnosis, CAP report
2. Cytology report from primary site
3. Tissue or cytology from a metastatic site
4. Physician documentation
5. Radiology – a) CT b) PET c) MRI

Head and Neck – Histology Rules

Terminology to determine subtypes and variants: DO USE:

- Majority
- Predominantly
- Subtype
- Type
- Variant

DO NOT USE:

- Architecture
- Differentiation
- Features of
- Foci, focus, focal
- Pattern
- Any subtype or variant modified by an ambiguous term

Head and Neck – Histology Rules

Single tumor –

H1. Code the histology using Tables 2-10 when only 1 histologic type is identified

H2. Code the invasive histology when both invasive and in situ elements are present

H3. Code the subtype or variant when both a subtype and an NOS histology are identified

H4. Code the histology with the numerically higher code

Head and Neck – Histology Rules

Multiple tumors abstracted as one primary –

H5. Code the histology using Tables 2-10 when only 1 histologic type is identified

H6. Code the invasive histology when both invasive and in situ elements or tumors are present

H7. Code the subtype or variant when both a subtype and an NOS histology are identified

H8. Code the histology with the numerically higher code

Colon and Rectum: 2018 Solid Tumor Rules

Colon and Rectum Solid Tumor Rules

Separate sections for:

Introduction
Changes from 2007 MP/H rules
Equivalent Terms
Terms that are NOT Equivalent
Solid Tumor Rules DO NOT Apply to Tumors described as Metastatic
Table 1: Colon, Rectum, and Appendix; NOS and Variants and Subtypes
Tables 2: Histologies NOT Reportable for Colon, Rectum, and Appendix
Illustrations
Multiple Primary Rules
Histology Coding Rules

Colon and Rectum Solid Tumor Rules

Introduction

98% of colon cancers are adenocarcinoma or adenocarcinoma subtypes

Mixed histologies or subtypes other than mucinous/colloid or signet ring cell are **rare**

A less common combination of mixed adenoneuroendocrine carcinoma (MANEC) is 8244

Frequently seen terms:

- **NET Neuroendocrine tumor**
- **NEC Neuroendocrine carcinoma**
- **GIST Gastrointestinal stromal tumor**

Colon and Rectum Major Changes in 2018

Pseudomyxoma peritonei is now classified as either high grade or low grade

- High grade is malignant
- Low grade is not malignant

Dysplasias which have an in situ (/2) behavior code in the WHO ICD-O-3 Addendum are not reportable in the U.S.

- Code this as CIS only if the pathologist states it as carcinoma in situ,
- or states intraepithilelial neoplasia Grade III,
- or when the registry includes in their Policies and Procedures a pathologist's statement that high grade dysplasia is equivalent to carcinoma in situ

Polyps are disregarded when coding histology.

Clarifications

Equivalent terms – nothing new for 2018

Terms that are NOT equivalent

- 'exophytic' and 'polypoid' are NOT synonymous with an adenomatous polyp
- Mucin-producing and mucin-secreting adenocarcinoma (8481) are NOT synonymous with mucinous adenocarcinoma (8480)
- Polypoid adenocarcinoma is NOT equivalent to adenocarcinoma in a polyp

Solid Tumor rules DO NOT APPLY to metastatic tumors, such as

- Discontinuous local metastases and local recurrence at an anastomotic site
- Regional metastases in contiguous organs or regional lymph nodes
- Distant metastases in other sites or distant lymph nodes

Table 1. Colorectal Histologies

CAN BE USED TO IDENTIFY SUBTYPES	CANNOT BE USED TO IDENTIFY SUBTYPES
1. Majority	1. Architecture
2. Predominantly	2. Component
3. Subtype	3. Differentiation
4. Type	4. Features
5. Variant	5. Foci, focus, focal
	6. Pattern

Example: Table 1: Histologies of the Colon, Rectum and Appendix

Histology Term and Code (may be specific term or NOS term)	Synonyms for Histology Term	Subtypes/ variants and Histology code
Neuroendocrine tumor Grade 1 8240	Carcinoid NOS Low-grade neuroendocrine tumor NET G1 NET Grade 1 Well differentiated neuroendocrine tumor	EC cell serotonin-producing NET 8241 Enterochromaffin cell carcinoid 8241 NET G2 8249 NET Grade 2 8249 Neuroendocrine tumor Grade 2 8249 Somatostatin-producing NET 8156

Table 2. Histologies NOT Reportable for the Colon, Rectum, and Appendix (examples)

Histology and Code	Synonyms	Subtypes/Variants	Reason not reportable
Adenoma 8140/0	Adenoma, NOS	Tubular adenoma 8211/0 Tubulovillous adenoma 8263/0 Villous adenoma 8261/0	Non-malignant
Cowden associated polyp	Cowden disease Cowden syndrome Multiple hamartoma syndrome		Non-malignant

Colon and Rectum – MP Rules

M1. Unknown if Single or Multiple Tumors – Abstract as Single Primary

M2. Single Tumor – A single tumor is always a Single Primary

NOTE: Collision tumors are treated as two separate tumors. Use the Multiple Tumors Module

Multiple Tumors –

- M3. Single primary if diagnosis is adenomatous polyposis coli (FAP), **OR** >100 polyps are identified and adenocarcinoma is present (/2 or /3) in at least 1 polyp
- M4. Multiple primaries if diagnosed more than 1 year apart
  - **NOTE: The time frame means clinically disease free for more than 1 year. If a patient has a recurrence within the 1 year, the 'clock' starts over, and the 1 year interval is computed from the date of last known recurrence. If recurrence is unknown, compute time from date of diagnosis.**
- M5. Multiple primaries if a subsequent tumor of a different histology arises at the anastomotic site, even if the original tumor was an NOS and the second tumor is a subtype of that NOS term

Colon and Rectum – MP Rules

Multiple Tumors –

- M6. Single primary if subsequent tumor at anastomotic site arises in colon wall or surrounding tissue and there is no involvement of mucosa OR physician documents it as anastomotic recurrence
- M7. Multiple primaries if a subsequent tumor arises at the anastomotic site, AND arises in the mucosa AND there is no documentation of anastomotic recurrence
- M8. Multiple primaries when there are multiple tumors present in topography codes that differ at the second, third, or fourth digit
- M9. Single primary when
  - there is a frank carcinoma and a carcinoma in a polyp, OR
  - an NOS term and a subtype or variant of that NOS, OR
  - Adenocarcinoma in multiple polyps, OR
  - An in situ and an invasive tumor, OR
  - The same adenocarcinoma subtype/variant in multiple polyps

Colon and Rectum – MP Rules

Multiple Tumors – (cont.)

- M10. Single primary when an invasive tumor of the same histology occurs within 60 days of an in situ tumor in the same site
- M11. Multiple primaries when an invasive tumor occurs more than 60 days after an in situ tumor of the same histology, AND the patient had a resection of the in situ tumor
- M12. Multiple primaries when there are multiple tumors with histology codes that differ at the first, second, or third digit
- M13. Multiple primaries when
  - There is a collision tumor
  - There is an in situ and an invasive tumor and rules M8, M9, and M12 do not apply
  - There is a de novo tumor and a tumor in a polyp and rules M8, M9, and M12 do not apply
  - Multiple de novo tumors and rules M8, M9, and M12 do not apply
- M14. Single primary when rules M1-M13 do not apply.

Colon and Rectum – Histology Rules

Priority list for using documentation to code histology

1. Use the most specific tissue diagnosis; may be from biopsy or resection *change*
   - The most specific is the subtype or variant term that may used for histology coding
   - Use tissue reports in this order: Addenda, Comments, Final diagnosis, CAP report
2. Cytology report from primary site
3. Tissue or cytology from a metastatic site
4. Physician documentation
5. Radiology – a) CT b) PET c) MRI

Colon and Rectum – Histology Rules

General rules

- Use the histology terminology from Table 1 of the Colon and Rectum Solid Tumor rules
- If not found there, use the ICD-O- reference book
- Ignore 'cribriform' and comedo' when coding histologies
- Collision tumors are treated as two separate tumors
- Subtypes and variants are used when definitively described in the diagnosis; ambiguous terminology should NOT be used to code histology

Colon and Rectum – Histology Rules

Single tumor –

H1. Code the histology using Table 1 (or ICD-O-3) when only 1 histologic type is identified

H2. Code 8574 when the diagnosis is exactly 'adenocarcinoma with neuroendocrine differentiation'. Do NOT use this code if the diagnosis is a subtype or variant of adenocarcinoma with neuroendocrine differentiation.

H3. Code adenocarcinoma, NOS (8140) the diagnosis is exactly 'adenocarcinoma' OR 'adenocarcinoma in a polyp' OR 'adenocarcinoma, intestinal type'

H4. Code the histology when carcinoma originates in a polyp *change*

H5. Code 8045 (combined small cell carcinoma) when the diagnosis is small cell carcinoma AND

- Adenocarcinoma
- Neuroendocrine carcinoma
- An other carcinoma

Colon and Rectum – Histology Rules

Single tumor – (cont.)

H6. Code 8480 when the diagnosis is exactly 'mucinous carcinoma' (no modifiers) OR

high grade, invasive, or malignant pseudomyxoma peritonei .

H7. Code the invasive histology when both invasive and in situ are present in a single tumor

H8. Code the subtype or variant when both a subtype and an NOS histology are identified

H9. Code the majority histology when multiple histologies are present in a single tumor

H10. Code 8255 (adenocarcinoma with mixed subtypes) when the majority histology is not identified, or when the diagnosis is mucinous/colloid and signet ring cell carcinoma

H11. Code the histology with the numerically higher code

Colon and Rectum – Histology Rules

Multiple tumors –

H12. Code 8220 when the diagnosis is familial adenomatous polyposis (FAP) OR there are >100 polyps and the path report says adenocarcinoma.

H13. Code 8221 when the diagnosis is adenocarcinoma in multiple adenomatous polyps AND FAP is not mentioned, but there are 2-100 polyps and the path report says adenocarcinoma.

H14. Code the invasive histology when both invasive and in situ are present in a single tumor

H15. Code the most invasive tumor when there are multiple invasive tumors

H16. Code the histology when only 1 histologic type is identified for all tumors

H17. Code the subtype or variant when both a subtype and an NOS histology are identified

H18. Code the histology with the numerically higher code

Kidney: 2018 Solid Tumor Rules

Kidney Solid Tumor Rules

Separate sections for:

Introduction

Major Changes from 2007 MP/H rules

Equivalent Terms

Table 1: Kidney histologies, NOS Terms and Variants and Subtypes

Table 2: Reportable Histologies that DO NOT have ICD-O-3 codes

Table 3. Neoplasms which are NOT reportable

Illustrations

Multiple Primary Rules

Histology Coding Rules

Kidney Solid Tumor Rules

Introduction
- Renal cell carcinoma (8312) is a group term; ~85% of all kidney malignancies are RCC or a subtype
- Transitional cell carcinoma usually arises in the renal pelvis; it very rarely arises in the kidney

Major Changes from 2007 MP/H rules
- There are new histology codes for hereditary leiomyomatosis and RCC syndrome (8311)
- There are new histology codes for genetic anomalies

Table 1. Kidney histologies, NOS terms, Subtypes and Variants
- Similar to Histology tables in Head and Neck, Colon, Breast, etc., but specific to kidney

Kidney Table 2. Reportable but NO ICD-O-3 code

Histology	Use ICD-O-3 code	Notes
Clear cell carcinoma with sarcomatoid change	Sarcomatoid RCC 8318	
Cystic papillary renal cell	Papillary RCC 8260	
Malignant PECOMA (pigmented perivascular epithelioid tumor	Angiolipoma, malignant 8861	PECOMA is seldom malignant; benign PECOMA is not reportable
Oncocytic variant of clear renal cell carcinoma	Clear cell RCC 8310	
Renal cell carcinoma with rhabdoid differentiation	RCC, NOS 8312	

Kidney Table 3. Neoplasms NOT Reportable

Histology	Synonyms
Adult cystic teratoma 8959/0	Mixed epithelial and stromal tumor Renal epithelial stromal tumor
Angiomyolipoma 8860/0	
Clear cell papillary renal cell carcinoma 8323/1	Clear cell tubulopapillary renal cell carcinoma
Hemangioblastoma 9691/1	
Multilocular cystic renal neoplasm of low malignant potential 8361/1	

Kidney – MP Rules

M1. Unknown if Single or Multiple Tumors – Abstract as Single Primary

M2. Single Tumor – A single tumor is always a Single Primary

Multiple tumors

M3. Multiple primaries when there are multiple tumors present in topography codes that differ at the second, third, or fourth digit (anything other than C64.9)

M4. Single primary when there are bilateral nephroblastomas (Wilms tumors)

M5. Multiple primaries when there are tumors in both the left and the right kidney

M6. Single primary when there is an NOS term and a subtype or variant of that NOS

Kidney – MP Rules

Multiple tumors – (cont.)

M7. Multiple primaries when there are multiple tumors present and histology codes differ at the first, second, or third digit

M8. Single primary when there are multiple tumors diagnosed less than or equal to 3 years apart

M9. Multiple primaries when there are tumors diagnosed more than 3 years apart

- **NOTE: The time frame means clinically disease free for more than 3 years. If a patient has a recurrence within the 3 years, the 'clock' starts over, and the 3 year interval is computed from the date of last known recurrence. If recurrence is unknown, compute time from date of diagnosis.**

M10. Single primary when there are multiple tumors that do not meet any of the criteria in rules M3-9.

Kidney– Histology Rules

Priority list for using documentation to code histology

1. Use the most specific tissue diagnosis; may be from biopsy or resection *change*
   - The most specific is the subtype or variant term that may used for histology coding
   - Use tissue reports in this order: Addenda, Comments, Final diagnosis, CAP report
2. Cytology report from primary site
3. Tissue or cytology from a metastatic site
4. Radiology – a) MRI b) CT c) PET
5. Physician documentation

Kidney – Histology Rules

Coding Subtypes/Variants

- Do NOT code histologies described as differentiation or features
- Do NOT code histologies modified by ambiguous terminology

Kidney – Histology Rules

Single tumor –

H1. Code the histology using Table 1 (or ICD-O-3) when only 1 histologic type is identified

H2. Code the NOS term when two or more variants are present in a tumor

- Example 1: a tumor contains RCC (8312), papillary renal cell carcinoma (8260), and mucinous tubular and spindle cell carcinoma (8480). Code to the NOS: RCC 8312/3.
- Example 2: a tumor contains spindle cell rhabdomyosarcoma (8912) and alveolar rhabdomyosarcoma (8920). Both are subtypes of rhabdomyosarcoma (8900) – code 8900.

H3. Code the subtype/variant when a single subtype/variant is present

H4. Code the histology of the numerically higher code

Kidney – Histology Rules

Multiple tumors –

H5. Code the histology using Table 1 (or ICD-O-3) when only 1 histologic type is identified

H6. Code the NOS term when two or more variants are present in a tumor

H7. Code the subtype/variant when a single subtype/variant is present

H8. Code the histology of the numerically higher code

Breast: 2018 Solid Tumor Rules

Breast Solid Tumor Rules

Separate sections for:

Changes from 2007 MP/H rules

Equivalent Terms

Table 1: Breast Primary site codes

Table 2. Breast Histology Combination codes

Table 3: Breast Histologies, NOS or NST and Subtypes/Variants

Illustrations

Multiple Primary Rules

Histology Coding Rules

Major Changes for 2018

Carcinoma, NST **(no special type)** and mammary carcinoma, NST, are new terms for ductal carcinoma.

DCIS/Carcinoma, NST in situ – Code grade as designated by the current AJCC Manual.

It is **very important to code grade for DCIS**

Breast – Histology Rules Changes

Terminology to determine subtypes and variants: DO USE:	**DO NOT USE:**
Majority	Component
Predominantly	Differentiation
Subtype	Features of
Type	Foci, focus, focal
Variant	Pattern
	Any subtype or variant modified by an ambiguous term

Tables for Breast Site and Histology

Table 1. Primary Site Codes – Column 1 shows descriptive terms for parts of the breast

Column 2 shows the preferred topography term and code

Table 2. Histology Combination Codes

- Use only when coding a single tumor or multiple tumors abstracted as a single primary
- Do not use if one tumor is invasive and one tumor is in situ; code the invasive term
- Do not code terms described as differentiation or features

Table 3. Carcinoma, NOS or NST and Subtypes/Variants

Table 3: Histologies of the Breast - Example

Histology , Specific term or NOS term and Code	Synonyms for Histology Term	Subtypes/ variants and Histology code
Lobular carcinoma 8520	Alveolar lobular carcinoma Mixed lobular carcinoma Pleomorphic lobular carcinoma Solid lobular carcinoma Tubulolobular carcinoma NOTE: These variants have no ICD-O code so they are coded to lobular carcinoma, NOS 8520	Pleomorphic lobular carcinoma in situ 8519/2 NOTE: 8519/2 is a new code for in situ tumors only.

Breast – MP Rules

M1. Unknown if Single or Multiple Tumors – Abstract as Single Primary

M2. Single primary when the diagnosis is inflammatory carcinoma, even if bilateral

M3. Single Tumor – A single tumor is always a Single Primary

Multiple tumors

M4. Single primary when the diagnosis is inflammatory carcinoma, even if bilateral

M5. Multiple primaries when there are multiple tumors present in topography codes that differ at the second, or third digit

M6. Multiple primaries when there are bilateral breast cancers

Breast – MP Rules

M7. Single primary when there is synchronous Paget disease and an underlying breast cancer

M8. Multiple primaries if diagnosed more than 5 years apart

- **NOTE: The time frame means clinically disease free for more than 5 years. If a patient has a recurrence within the 5 years, the 'clock' starts over, and the 5 year interval is computed from the date of last known recurrence. If recurrence is unknown, compute time from date of diagnosis.**

M9. Single tumor when an invasive tumor of the same histology occurs within 60 days of an in situ tumor in the same site

M10. Multiple primaries when an invasive tumor occurs more than 60 days after an in situ tumor of the same histology

M11. same as M7

Breast – MP Rules

Multiple Tumors – (cont.)

- M12. Single primary if multiple tumors and one is an NOS or NST or duct histology and the other is a lobular carcinoma
- M13. Single primary if the patient has multiple tumors with the same histology code, or an NOS and a subtype or variant of that histology
- M14. Multiple primaries when there are multiple tumors with histology codes that differ at the first, second, or third digit
- M15. Single primary when multiple tumors do not meet any of the criteria in M1-M14

Breast – Histology Rules

Priority list for using documentation to code histology

1. Use the most specific tissue diagnosis; may be from biopsy or resection *change*
   - The most specific is the subtype or variant term that may used for histology coding
   - Use tissue reports in this order: Addenda, Comments, Final diagnosis, CAP report
2. Cytology report from primary site
3. Tissue or cytology from a metastatic site
4. Physician documentation
5. Radiology – a) Mammogram b) US c) CT

NOTE: Code the histology diagnosis prior to neoadjuvant therapy

Breast – Histology Rules

Single tumor, in situ only–

H1. Code the histology when only 1 histologic type is identified

H2. Code the histology as specified:

- Code 8201/2 when the diagnosis is specifically cribriform carcinoma in situ
- Code duct carcinoma 8500/2 the diagnosis is carcinoma in situ with no modifiers, or the modifiers are described as differentiation or features.
- Code lobular carcinoma 8520/2 when any of the following terms are used: lobular carcinoma, alveolar lobular, classic lobular, solid lobular, tubulolobular, lobular and any subtypes
- Code Paget disease in situ when the diagnosis is specifically Paget disease in situ

H3. Code the subtype/variant when a the diagnosis is NOS or NST and a single subtype/variant is present

Breast – Histology Rules

Single tumor, in situ only– (cont.)

H4. Code comedocarcinoma in situ 8501/2 when the diagnosis is in situ comedocarcinoma and any other in situ carcinoma

H5. Code the combination code using Table 2.

H6. Code the histology with the numerically higher code.

Single tumor – in situ and invasive components

H7. Code the invasive histology. *This is a change.* Using this rule, an invasive duct carcinoma or NST and an in situ lobular carcinoma is coded 8500/3 instead of 8522/3.

Breast – Histology Rules

Single tumor, invasive only–

H8. Code the histology when only 1 histologic type is identified

H9. Code inflammatory carcinoma 8530/3 only when the path diagnosis is inflammatory

H10. Code the histology as specified:

- Code metaplastic carcinoma 8575/3 when the diagnosis is specifically metaplastic carcinoma and all modifiers are described as differentiation or components
- Code cribriform carcinoma 8201/3 when cribriform is specified with no modifiers, or is >90% of the tumor, or along with tubular is >90% of the tumor
- Code duct carcinoma 8500/3 the diagnosis is carcinoma NST with no modifiers, or the modifiers are described as differentiation or features.
- Code lobular carcinoma 8520/2 when any of the following terms are used: lobular carcinoma, alveolar lobular, classic lobular, solid lobular, tubulolobular, lobular and any subtypes
- Code Paget disease in situ when the diagnosis is specifically Paget disease in situ

Breast – Histology Rules

Single tumor, invasive only–

H10. Code the histology as specified:

- Code tubular carcinoma 8211/3 when the diagnosis is tubular with no modifiers, or tubular is >90% of the tumor
- Code lobular carcinoma 8520/3 when any of the following terms are used: lobular carcinoma, alveolar lobular, classic lobular, solid lobular, tubulolobular, lobular and any subtypes
- Code Paget disease 8540/3 when the diagnosis is Paget disease

H11. Code the subtype/variant using Table 3 when an NOS/NST and a subtype is named

H12. Code the combination code from Table 2 when two histologies are in a single tumor; if there are more than 2 histologies, code 8255/3

H13. Code the histology with the numerically higher code, when rules H8-H12 do not apply.

Breast – Histology Rules

Multiple tumors abstracted as a single primary

H14. Code the histology when only 1 histologic type is identified

H15. Code inflammatory when there is a clinical diagnosis of inflammatory carcinoma and a pathologic diagnosis of inflammatory or duct carcinoma NST

H16. Code subtypes/ variants using Table 3

H17. Code multiple histologies in separate tumors using Table 2

H18. Code the histology with the higher numeric code when rules H14-H17 do not apply

Solid Tumor Rules still to come

These site groupings are being revised for 2018, but no drafts are available at this time:

- Lung
- Ureter/Renal pelvis/Bladder
- Malignant Meninges, Brain, Spinal Cord, Cranial nerves, Pituitary gland, Craniopharyngeal duct, and Pineal gland
- Benign and Borderline Intracranial and CNS tumors

These site groupings have been slightly revised for 2018 with more to come in 2019:

(Drafts of the minor revisions for 2018 are available)

- Cutaneous melanoma
- Other sites

THE END of the beginning…

There is no real end to change!