

SOLID TUMOR RULES



To determine the number of primaries, you must follow the Solid Tumor Rules!

- Do not use physician statements of multiple primary tumors to determine multiple primaries.
- Do not use AJCC staging classification of TNM to determine multiple primaries.
- Its important to remember the AJCC Manual is written for physicians to help in the classification of the extent of tumor spread to aid in treatment.
- The Solid Tumor Manual is written for you, the registrar!



History

SEER rules have been the de facto standard for determining the number of primary cancers in the U.S. for both central and hospital-based registries.

The 2018 Solid Tumor Rules replaced the 2007 Multiple Primary and Histology (MP/H) Rules for the following eight site groups:

- Head & Neck
- Colon (includes rectosigmoid and rectum for cases diagnosed 01/01/2018 and forward)
- Lung
- Breast
- Kidney
- Urinary Sites
- Non-malignant CNS
- Malignant CNS
- Peripheral Nerves

see <https://seer.cancer.gov/tools/solidtumor/>



Cutaneous Melanoma

- The cutaneous melanoma site rules will be revised for 2021 implementation to incorporate the *WHO Classification of Skin Tumours, 4th Edition*
 - Use for cases diagnosed 1/1/2021
- The 2007 Multiple Primary & Histology Rules for Cutaneous Melanoma
 - Use for Melanoma cases diagnosed prior to 1/1/2021

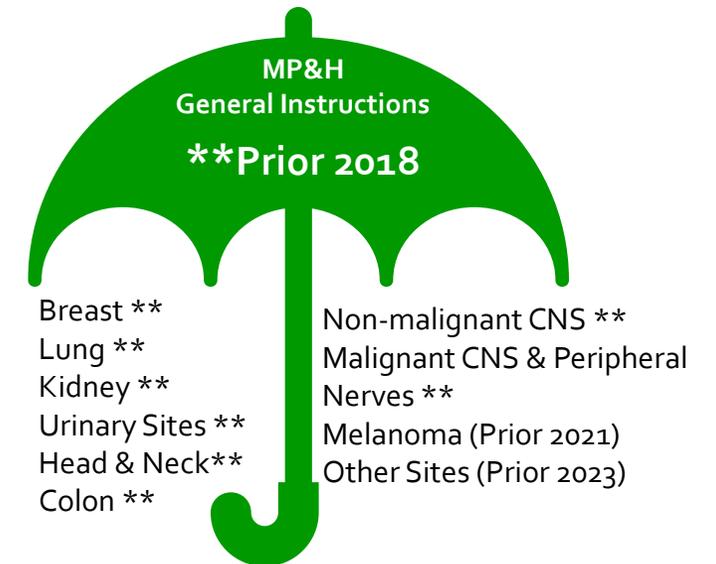
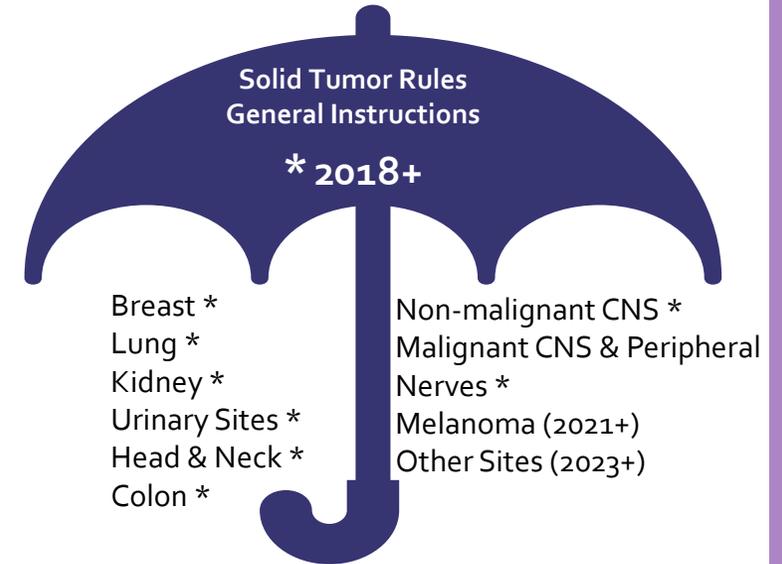
For all Sites not mentioned in the Solid Tumor Rules

- The 2007 Multiple Primary & Histology Rules remain in effect for the other sites not listed above effective cases diagnosed 01/01/2007 to 12/31/2022
- Other Sites was updated for 2023. The Solid Tumor General Instructions apply to sites covered in Other for cases diagnosed January 1, 2023 and forward.



General Instructions

- There are separate General Instructions for the Solid Tumor Rules and the Multiple Primary and Histology Rules
 - These rules are blanket/umbrella coding rules that all sites within each manual falls under
- Each Site module has its own coding rules and guidelines
 - These rules are site specific rules not covered in General Instructions
 - Also, there can be exceptions to the General Instructions listed
- It is important to review the general rules as well as the coding rules for each site



General Coding Instructions

- Solid Tumor Manual General Instructions (Pages 1-16)
- Multiple Primary & Histology General Instructions (Pages 1-16)

Both set of General Instructions Contain:

- General Equivalent Terms and Definitions
- General instructions on how to use the Multiple Primary Rules
- General Timing Rules
- General instructions on how to use the Histology Rules
- Important Definitions

Though the coding instructions between the 2 manuals are very similar
They do differ in respects to the use of Ambiguous Terminology

- Once you have reviewed the General Instructions, you will need to review the site-specific rules



Histology

- Use only the ambiguous terms listed when assigning histology
- Do not use Ambiguous phrases to assign a more specific histology
 - **Exception:** Case is accessioned (added to your database) based on a single histology described by an ambiguous phrase and no other histology information is available/documented
- The rules for the use of ambiguous terminology when coding histology differ between the Solid Tumor Rules Manual and the Multiple Primary and Histology Manual
- It is important to remember this coding difference when assigning a working histology
- The manual you use will be based on the date of diagnosis



The Solid Tumor Rules



Code a histology when described by ambiguous terminology **ONLY** when:

- Histology is clinically confirmed by a physician (attending, pathologist, oncologist, etc.)
- Patient is treated for the histology described by an ambiguous term
- Case is accessioned (added to your database) based on a single histology described by ambiguous terminology and no other histology information is available/documentated
- **Note:** If the histology described by ambiguous terminology does not meet any of the criteria in bullets 1, 2, or 3, **DO NOT CODE** the histology

If the diagnosis is an NOS histology and a more specific (subtype/variant) described by ambiguous terminology:

- If the criteria in bullets 1 and 2 are met, code the specific histology
- If the criteria in bullets 1 and 2 are **NOT** met, code the NOS histology



Multiple Primary and Histology Rules

- When any of the ambiguous terms on the list are used to describe a more specific histology, code the more specific histology
- No additional criteria needs to be met

IMPORTANT: This rule will not apply to cases diagnosed 2023 and forward



Ambiguous Terminology

Ambiguous Terminology

Apparently	Most likely
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect(ed)
Consistent with	Suspicious (for)
Favor(s)	Typical (of)
Malignant appearing	

The Solid Tumor Manual and the MP&H Manual have different rules for Ambiguous Terminology

Be sure to use the ambiguous terminology and coding instructions listed in the manual that contains the site and year you are abstracting!



The Manuals

Each individual Module contains:

- Changes from the 2007 Multiple Primary and Histology Rules*
- Equivalent and equal terms
- Terms that are not equivalent or equal
- Tables for coding
- Primary site codes
- Combination histologies
- Reportable histologies and subtypes/variants
- Not reportable histologies
- Paired sites
- Illustrations*

* Not found in the Multiple Primary & Histology Manual



The components that the Solid Tumor manual uses when determining single or multiple primaries

- Site
- Laterality
- Timing
- Behavior
- Number of tumors within the primary site
- Histology



Table 1

Terminology used by physicians or on scans to describe the location of lung "mass")

Indicates if the location is found only in the right or left lung or if can be found in both lungs (bilateral).

Contains the ICD-O term and site code for the terminology used

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



Table 2

Use Table 2 only when instructed to by the Multiple Primary and Histology Rules

Required Histology Terms	Histology Combination Term and Code
<p>DCIS/duct carcinoma/carcinoma NST 8500</p> <p style="text-align: center;">AND</p> <p>Lobular carcinoma 8520</p> <p><i>Note 1:</i> Both histologies, duct and lobular, must have the same behavior code.</p> <p><i>Note 2:</i> 8522 is used when:</p> <ul style="list-style-type: none"> • Duct AND lobular carcinoma are present in a single tumor OR • Duct is present in at least one tumor and lobular is present in at least one tumor in the same breast OR • One tumor is mixed duct and lobular; the other tumor in the same breast is either duct or lobular OR • All tumors in the same breast are mixed duct and lobular <p><i>Example:</i> One tumor with invasive duct CA in LOQ RT breast; second tumor with invasive lobular in UOQ RT breast</p> <p><i>Note 3:</i> Do not use 8522 when the diagnosis is carcinoma NST/duct carcinoma with lobular differentiation. See Histology Rules for instructions on coding differentiation.</p>	<p>Invasive carcinoma NST/duct carcinoma <u>and</u> invasive lobular carcinoma 8522/3</p> <p><i>Note 1:</i> CAP uses the term Invasive carcinoma with ductal and lobular features (“mixed type carcinoma”)</p> <p><i>Note 2:</i> This is the exception to the instruction that features are not coded.</p> <p><i>Note 3:</i> Carcinoma NST includes all subtypes/variants of carcinoma NST.</p> <p>DCIS and in situ lobular carcinoma 8522/2</p> <p><i>Note:</i> The lobular carcinoma includes pleomorphic lobular carcinoma in situ 8519/2.</p>



Table 3

Columns

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



Timing

- Each site has its own timing rules
 - One year – 365 days
 - Clinically disease free
 - Date of last recurrence
- Use the Multiple Primary Rules to determine if it is a new primary or recurrence
 - Do not base recurrence on the physician's statement
 - Exception: Pathologist compares the slides and states it is a recurrence of previous tumor



Timing By Site

- Breast: Greater than 5 years
- Colon: Greater than 3 year (Greater than 2 years Prior to 2022)
- Lung: Greater than 3 years
- Head and Neck: Greater than 5 years
- Melanoma: Greater than 60 days
- Kidney: Greater than 3 years
- Bladder: Greater than 3 years (unless urothelial or micropapillary urothelial, only 1 abstract per histology, per patient's lifetime)
- Other Urinary Sites: Greater than 3 years
- Sites covered under the "Other Rules (MP&H): Greater than 1 year



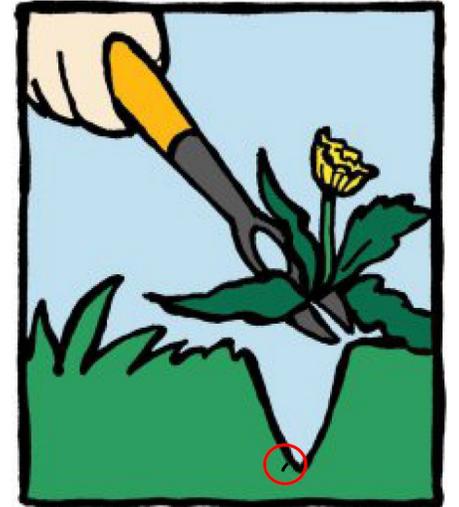
Remember:

Recurrence has 2 definitions.

- 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.
- The patient had cancer before, now has another cancer. This type of recurrence arises from cells that have nothing to do with the earlier (first) cancer. The patient has a new or another occurrence, incidence, episode, or report of cancer.

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 that the subsequent tumor is a recurrence of the previous primary.
- **Never** code multiple primaries based only on a physician’s statement of “recurrence” or “recurrent”!



FILM IDEA:
NOT MY
FIRST
RODEO:
A COWBOY
GOES ON HIS
SECOND
RODEO



General 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; glandular carcinoma; carcinoma
- De novo; new tumor; frank (obsolete term)
- Multicentric; multifocal
- Simultaneous; synchronous; at the same time; prior to first course treatment
- Topography; site code
- 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



Documentation Priority

For each site, priorities include tissue/histology, cytology, imaging/scans, and physician diagnoses, and biomarkers. You must 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 imaging/scans also differ by site.
- Which document to use when there is conflicting information between the final diagnosis, synoptic report, or CAP protocol:
- When there are discrepancies between the final diagnosis and synoptic report, use the document that provides the more specific histology. This will likely be found in the synoptic report. The CAP Protocol should be used only when a final diagnosis or synoptic report are not available. Definitions for CAP Protocol, final diagnosis, and synoptic report can be found in the Definitions section



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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



How to Use these Manuals

- Does not apply to hematopoietic primaries
- Determines multiple primary and histologies
- Not for case reportability, casefinding, stage or tumor grade
- Site-specific rules based on date of diagnosis
- Rules are hierarchical
 - Use the first rule that applies and STOP



How to Use Histology Rules

- Code prior to neoadjuvant therapy
- Terms and definitions within each site-specific module
- Behavior (invasive and/or insitu)
- Ambiguous terminology
 - Clinically confirmed by a physician
 - Treated for that histology
 - Case is accessioned based on that histology
- Priority order for using documentation



Tumor or Tumors

The Number Matters

Step 1

- Determine the number of separate tumor nodules within the primary tumor
 - Do not count metastatic lesions
 - Metastatic tumors are not included in the number of tumors within the primary site
 - If tumors(s) have separate microscopic foci ignore the microscopic foci



Step 2

- Use the Histology Rules to assign a “working” histology for each tumor

Step 3

- Use the Multiple Primary Rules to determine whether the tumors are a single primary or are multiple primaries
 - The M rules are separated into 3 modules
 - For a single tumor use the “Single Tumor” module
 - For multiple Tumors, use the “Multiple Tumors” module
 - If the number of tumors is unknown use the “Unknown if Single or Multiple Tumors” module
- When you come to the rule that matches your scenario, **STOP!**
 - **No need to go farther, you will only confuse yourself**



Step 4

- Now you will review the Histology Rules (H Rules)
- The H Rule Modules are divided by Single or Multiple Tumor(s)
 - Single Tumor is then divided into 3 modules based on behavior
 - Single Tumor Insitu only
 - Single Tumor Invasive & Insitu Components
 - Single Tumor Invasive only
 - Multiple Tumor only has one category
 - Multiple Tumors abstracted as a single Primary
- **If a single primary:**
 - Review the appropriate H Rule Module to assign the proper histology
- **If multiple tumors abstracted as a single primary:**
 - Review the Histology Rules for that module
- **Remember:** If you have multiple tumors that are being abstracted as multiple primaries
 - You must prepare an abstract for each primary
 - You will need to review the H Rules for each primary



Trouble finding the appropriate rule?

- If you are unable to find an M or H rule that fits your case
- Take a second trip through
- Review the rules again

**TAKE
A
SECOND
LOOK!**



When you have looked so much that your eyes are crossing!

Sometimes things are not as clear cut as they should be
Remember these rules are written for the majority of cases
Meaning that not every case is going to fit like Cinderella's slipper



So, when you are faced with a case that just “doesn't seem to fit”, there is help

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, make sure you select the correct category (2007 MPH rules or 2018 Solid Tumor Rules) **AND always include primary site and diagnosis year.**

It is best not to submit SEER questions to the Canswer Forum
The Canswer Forum is a CoC website and SEER questions will be directed to Asl a SEER Registrar



My Tip!

- I make a chart so that I can list the criteria that are used to help decide number of primaries and histology
- The information is readily available and prevents me from having to flip back and forth through the file looking for it

	Tumor 1	Tumor 2
Date of Dx		
Site		
Laterality		
Histology		
Behavior		



I will review additional Solid Tumor rules when I go over the specific sites later in the training!



QUESTIONS?
