EQUIVALENT OR EQUAL TERMS

Adenocarcinoma, glandular carcinoma
Multicentric, multifocal
Tumor, mass, lesion, neoplasm

DEFINITIONS

Note: Use these terms and definitions for all reportable cases except lymphoma and leukemia primaries (M9590-9989).

Bilateral: Relating to the right **and** left sides of the body or of a body structure; bilaterality is **not** an indication of single or multiple primaries.

Clinical Diagnosis: A diagnosis that is not microscopically confirmed. It may be based on information from diagnostic imaging or the clinician's expertise.

Contiguous tumor: A single tumor that involves, invades, or bridges adjacent or connecting sites or subsites.

Focal: An adjective meaning limited to one specific area. A focal cancer is limited to one specific area or organ. The area may be microscopic **or** macroscopic.

Foci: Plural of focus.

Focus: A term used by pathologists to describe a group of cells that can be **seen only by a microscope**. The cells are noticeably different from the surrounding tissue either by their appearance, chemical stain, or other testing.

Laterality: Indication of which side of a **paired organ/site** a tumor is located. (See Paired organ/site)

Most representative specimen: The pathologic specimen from the surgical procedure that removed the most **tumor** tissue.

Multiple primaries: More than one reportable case.

Overlapping tumor: The involved sites are adjacent (next to each other) and the tumor is contiguous.

Paired organ/site: There are two sides, one on the left side of the body and one on the right side of the body. (See Laterality)

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 arising 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.

Single primary: One reportable case.

Unilateral: Relating to one side of the body or one side of a body structure.

DETERMINING MULTIPLE PRIMARIES FOR SOLID MALIGNANT TUMORS

Note: The rules do not apply to hematopoietic primaries (lymphoma and leukemia) of any site or to the reportable benign or borderline intracranial or CNS tumors..

A. General Information

1. Use these rules to determine the number of reportable primaries. Do **not** use these rules to determine case reportablility, stage, or grade.
2. The 2007 multiple primary and histology coding rules **replace all previous** multiple primary and histology coding **rules**.
3. The rules are **effective** for cases **diagnosed January 1, 2007** and after. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.
4. Read the **General Instructions** and the **site-specific Equivalent Terms and Definitions** before using the multiple primary rules.
5. The multiple primary and histology coding rules are available in **three formats**: flowchart, text, and matrix. The **rules are identical**, only the formats differ. Use the rules in the format that is easiest for you to follow.
6. **Notes** and **examples** are included with some of the rules to **highlight key points** or to add **clarity** to the rules.
7. **Do not use** a physician's statement to decide whether the patient has a recurrence of 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 this tumor is a recurrence of cancer from the previous primary.
8. Use the Determining Multiple Primaries: Hematopoietic Primaries (Lymphoma and Leukemia) rules and table "Definitions of Single and Subsequent Primaries for Hematologic Malignancies" to determine single versus multiple primaries for lymphoma and leukemia cases.

B. How to Use the Multiple Primary Rules

1. **Use** the **Multiple Primary** rules to **make a decision on the number of primary malignancies** to be abstracted for reportable solid malignant tumors.
2. Use the **site-specific rules** for the following primary sites:
   - Brain, malignant (intracranial and CNS)
   - Breast

- Renal pelvis, ureter, bladder, and other urinary

7. Use the **Other Sites rules** for all solid malignant tumors that occur in primary sites **not included** in the site-specific rules.
8. Determine whether the patient has a single tumor or multiple tumors that will be abstracted as a single primary
    a. Do not count metastatic tumors
    b. When the tumor is described as multifocal or multicentric, use the Multiple Tumors module
    c. When there is a tumor or tumors with separate foci of tumor do not count the foci
    d. Only count the tumors that will be used to prepare that abstract. For example, when there are two tumors that will be abstracted as multiple primaries, you would use the Single Tumor modules to determine the histology code for each of the abstracts..
9. **Each section** (Single Tumor and Multiple Tumors Abstracted as a Single Primary) is an independent, **complete set of coding rules**. For example, if the patient has multiple tumors, that will be abstracted as a single primary start with the first rule under the heading Multiple Tumors Abstracted as a Single Primary. Do not use any of the rules under the header Single Tumor.
10. Use the first rule that applies and

STOP

Priority order for using Documents to Code Histology

Medical records frequently include multiple pathology reports and references to histologic diagnosis. Use the following instructions to identify which reports best represent the histology to be coded.

1. Pathology report:
    a. From the **most representative** tumor specimen examined
    b. From the **final diagnosis**
    Note 1: Use information from **addenda** and **comments** associated with the final diagnosis to code the histology.
    Note 2: A **revised/amended diagnosis** replaces the original final diagnosis. Code the histology from the revised/amended diagnosis.
    Note 3: The new rules **limit** the information **to the final diagnosis**. The old rules allowed coding from information in the microscopic description. You will only use information from the microscopic portion of the pathology report when instructed to do so in one of the site-specific rules.
2. Cytology report.
3. When you do not have either a pathology report or cytology report:
    a. Documentation in the medical record that references pathology or cytology findings
    b. From mention of type of cancer (histology) in the medical record

Ambiguous Terms Used to Code Histology

When any of the ambiguous terms are used to describe a more specific histology, code the more specific histology.

Ambiguous terms that are characteristic (used to code histology)

Apparent(ly)
Appears
Comparable with
Compatible with
Consistent with
Favor(s)
Most likely
Presumed
Probable
Suspect(ed)
Suspicious (for)
Typical (of)

Example: Non-small cell carcinoma, most likely adenocarcinoma. Code adenocarcinoma.

General Instructions Histology Coding Rules

When using rule (see note) that states "Code the histology documented by the physician when the pathology/cytology report is not available" code the histology from the document with the highest priority. Make a second pass through the histology rules to determine which histology code should be recorded. Start with the appropriate module, Single Tumor or Multiple Tumors, and continue through the rules until you reach the rule that fits the case you are coding.

Note: For most sites this will be rule H1 and the first rule in the Multiple Tumors module

When using rule (see note) that states "When the only histology is from a metastatic site" make a second pass through the histology rules to determine which histology code should be recorded. Start with the appropriate module, Single Tumor or Multiple Tumors, and continue through the rules until you reach the rule that fits the case you are coding.

Note: For most sites this will be rule H2 and the second rule in the Multiple Tumors module

When the patient has a previous or subsequent unknown primary site (80.9) or an ill-defined primary site, check carefully to see if this abstract or document should be consolidated into the previous abstract rather than making it a new primary.

Colon Equivalent Terms, Definitions and Illustrations
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Introduction

***Note 1*:** Rectum and rectosigmoid are covered by The Other Sites rules.
Note 2: For the purpose of these rules, the words "exophytic" and "polypoid" are not synonymous with a polyp.

Use these rules only for cases with primary colon cancer.

Ninety-eight percent of colon cancers are adenocarcinoma. Ten to fifteen percent of these cases produce enough mucin to be categorized as mucinous/colloid.* Mixed histologies and specific types other than mucinous/colloid or signet ring cell are rare.

**ACS Clinical Oncology*

Equivalent or Equal Terms

***Note*:** For the purpose of these rules, the words "exophytic" and "polypoid" are not synonymous with a polyp

- Familial polyposis, familial adenomatous polyposis, (FAP)
- Intramucosal, lateral extension
- Invasion through colon wall, extension through colon wall, transmural
- Low grade neuroendocrine carcinoma, carcinoid
- Most invasive, most extensive
- Mucin producing, mucin secreting
- Mucinous, colloid
- Polyp, adenoma
- Serosa, visceral peritoneum
- Tumor, mass, lesion, neoplasm
- Type, subtype, predominantly, with features of, major, or with ____differentiation.

Definitions

Adenocarcinoid (8245/3): A specific histology commonly found in the appendix.

Adenocarcinoma with mixed subtypes (8255): Rarely used for colon primaries (see introduction).

Adenocarcinoma, intestinal type (8144) is a form of stomach cancer. Do not use this code when the tumor arises in the colon.

Adenoma: A **benign** lesion composed of tubular or villous structures showing **intraepithelial neoplasia** (See definition of **intraepithelial neoplasia**).

Colon Equivalent Terms, Definitions and Illustrations
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Composite carcinoid (8244): One tumor which contains both carcinoid and adenocarcinoma.

Familial polyposis, familial adenomatous polyposis (FAP), adenocarcinoma in: a condition characterized by the development of many adenomatous polyps, often seen in several members of the same family.

Frank adenocarcinoma: Adenocarcinoma arising from the colon wall (no evidence of a polyp)

In Situ: Noninvasive; intraepithelial; (adeno)carcinoma in a polyp or adenoma, noninvasive.

Intestinal type adenocarcinoma (8144) is a gastric histology term and is not listed in the WHO Histological Classification of Tumors of the Colon and Rectum.

Intraepithelial neoplasia, high grade may be either severe dysplasia or carcinoma in situ. Report cases of carcinoma in situ only.

Intraepithelial neoplasia, low grade is not a reportable condition. A person with intraepithelial neoplasia is at risk for developing invasive cancer.

Intramucosal tumors may be noninvasive or invasive. The term intramucosal may refer to the surface epithelium, the basement membrane, or the lamina propria..

Invasive tumor: A tumor that penetrates the basement membrane and invades the lamina propria.

Most invasive: The tumor with the greatest continuous extension through the wall of the colon. The layers of the colon wall in order of least to greatest extension:

- Mucosa (surface epithelium, lamina propria, basement membrane)
- Submucosa
- Muscularis propria
- Subserosa (pericolic fat, subserosal fat)
- Retroperitoneal fat (pericolic fat)
- Mesenteric fat (pericolic fat)
- Serosa (visceral peritoneum).

Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

Introduction

Cutaneous melanoma starts in the melanocyte cells 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 go on to 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 melanomas:** are lumpy and often blue-black in color and may grow faster and spread downwards

These types account for the majority of melanomas occurring in the US population. For a more complete listing of histologic types of melanoma, see the *AJCC Cancer Staging Manual*, 6th Ed.

Melanoma can also start in the mucous membranes of the mouth, anus and vagina, 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.

Equivalent or Equal Terms

- Tumor, mass, lesion, neoplasm
- Type, subtype, predominantly, with features of, major, or with ____differentiation.
- Giant pigmented nevus, giant congenital nevus
- Mole, Nevus
- Mixed epithelioid and spindle cell melanoma (8770): Epithelioid melanoma and spindle cell melanoma

Synonyms for In Situ

Behavior code 2
Clark level 1 (limited to the epithelium)
Hutchinson freckle (See synonyms for Hutchinson freckle)
Intraepidermal, NOS
Intraepithelial, NOS
Lentigo maligna
Noninvasive
Precancerous melanoma of Dubreuilh
Stage 0
Tis

Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

Synonyms for Hutchinson freckle

Circumscribed precancerous melanosis
Intraepidermal malignant melanoma
Lentigo maligna
Precancerous melanosis of Dubreuilh

Definitions

Amelanotic melanoma: A non-pigmented malignant melanoma.

Atypical melanocytic hyperplasia (dysplasia): Tumor-like lesion or condition may represent precursor stage or stage in development of melanoma. Not reportable.

Different lateralities: The right side of the body, the left side of the body and the midline are separate lateralities in the melanoma coding rules.

Evolving melanoma (borderline evolving melanoma): Evolving melanoma are tumors of uncertain biologic behavior. Histological changes of borderline evolving melanoma are too subtle for a definitive diagnosis of melanoma in situ. The tumors may be described as "proliferation of atypical melanocytes confined to epidermal and adnexal epithelium," "atypical intraepidermal melanocytic proliferation, "atypical intraepidermal melanocytic hyperplasia"; or “severe melanocytic dysplasia.” Not reportable.

Familial Atypical Multiple Mole Melanoma Syndrome (FAMM, FAM-M): An inherited condition identified when:

- Melanoma has been diagnosed in a family member, including grandparents, aunts, uncles, and cousins
- Several family members have large numbers of moles (often more than 50) which may be abnormal or atypical moles.

Giant pigmented nevus: Diameter larger than 20 cm; frequently covers large areas of the body in a garment-like fashion. The trunk, head and neck are the most common sites.

Junctional nevus: Smooth, hairless, light to dark brown mole. Can be slightly elevated, usually multiple and can occur on any part of the body. Melanocytes are confined to the dermo-epidermal junction.

Hypodermis: A subcutaneous layer of loose connective tissue containing a varying number of fat cells.
Synonyms: subcutaneous fat; subcutis.

Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Table 1 – Intraductal(8500/2) and Specific Intraductal Carcinomas

***Note*:** These are the most common specific intraductal carcinomas**.** This is not intended to be a complete list of all possible intraductal types. If a histology appears only on table 1, it does not mean that it is impossible for that histology to occur with a malignant behavior (/3).

Column 1: Code	Column 2: Type
8201	Cribriform
8230	Solid
8401	Apocrine
8500	Intraductal, NOS
8501	Comedo
8503	Papillary
8504	Intracystic carcinoma
8507	Micropapillary/Clinging

Table 2 – Duct (8500/3) and Specific Duct Carcinomas

***Note*:** These are the most common specific duct carcinomas**.** This is not intended to be a complete list of all possible duct types. If a histology appears only on table 2, it does not mean that it is impossible for that histology to occur with an in situ behavior (/2).

Column 1: Code	Column 2: Type
8022	Pleomorphic carcinoma
8035	Carcinoma with osteoclast-like giant cells
8500	Duct, NOS
8501	Comedocarcinoma
8502	Secretory carcinoma of breast
8503	Intraductal papillary adenocarcinoma with invasion
8508	Cystic hypersecretory carcinoma

Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Table 3 – Combination Codes for Breast Cancers

Use this **two-page** table with rules H5, H6, H7, H8, H16, H17, H18, H19, H24, H25, H26 and H28 to select combination histology codes. Compare the terms in the diagnosis to the terms in Columns 1 and 2. If the terms match, code the case using the ICD-O-3 histology code in column 4. Use the combination codes listed in this table only when the histologies in the tumor match the histologies listed below.

Column 1: Required Histology	Column 2: Combined with Histology	Column 3: Combination Term	Column 4: Code
Any combination excluding lobular and duct histologies from Tables 1 and 2	Other than ductal and lobular	Adenocarcinoma with mixed subtypes*	8255/3*
Intraductal carcinoma and	Lobular carcinoma in situ	Intraductal carcinoma and lobular carcinoma in situ	8522/2
Infiltrating duct and	Infiltrating lobular carcinoma	Infiltrating duct and lobular carcinoma	8522/3
Intraductal and **two or more** of the histologies in Column 2 OR **two or more** of the histologies in Column 2	Cribriform	Intraductal mixed with other types of carcinoma	8523/2
	Solid		
	Apocrine		
	Papillary		
	Micropapillary		
	Clinging		
Infiltrating duct and **one or more** of the histologies in Column 2	Tubular	Infiltrating duct mixed with other types of carcinoma	8523/3
	Apocrine		
	Mucinous		
	Secretory carcinoma		
	Intraductal papillary adenocarcinoma with invasion		
	Intracystic carcinoma, NOS		
	Medullary		

Table 3 continues on the next page

Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Renal Pelvis, Ureter, Bladder, and Other Urinary

The renal pelvis, ureters, bladder and proximal portion of the urethra are lined by transitional epithelium, also known as urothelium. Tumors of the urothelium are more often multifocal compared to other sites. Two mechanisms have been proposed to explain this phenomenon: 1). a "field effect" and 2) tumor cell implantation.

1. The **field effect** theory suggests that the urothelium has undergone a widespread change, perhaps in response to a carcinogen, making it more sensitive to malignant transformations. As a result, multiple tumors arise more easily.
2. The **implantation** theory suggests that tumor cells in one location lose their attachments and float in the urine until they attach (implant) on another site. Transitional cell tumors commonly spread in a head-to-toe direction, for example from the renal pelvis to the ureter.

Molecular evidence has been found to support both of these theories, but neither has been proven to be the case for all tumors. Similarly, the widespread presence of flat carcinoma in situ may be a result of direct spread of neoplastic cells within the epithelium, direct extension, or due to implantation or field effect. The rules regarding histology and number of primaries are an attempt to reconcile these observations so that incidence data are consistent and reproducible.

Bladder

In the United States, transitional cell carcinomas account for more than 90% of all bladder cancers. Squamous cell carcinomas make up 3-8%, and adenocarcinomas make up about 1-2%. Pure squamous cell carcinoma of the bladder has a poor prognosis. See histology coding rules H5 and H13 for coding instructions.

Equivalent or Equal Terms

- **Flat transitional cell, flat urothelial**
- **In situ transitional cell carcinoma, in situ urothelial carcinoma**
- **Tumor, mass, lesion, neoplasm**
- **Urothelial** and **transitional**
- **Urothelium** and **transitional epithelium**
- **Intramucosal** and **in situ**
- **Papillary transitional cell carcinoma, papillary urothelial carcinoa**

Definitions

Contiguous Sites:

- Renal pelvis
- Ureter
- Bladder
- Urethra/prostatic urethra

Field effect: Widespread changes in normal or relatively normal tissue that predispose a person to cancer

Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations C659, C669, C670-C679, C680-C689 (Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Flat Tumor (bladder)/Noninvasive flat TCC: A flat tumor is a non-papillary bladder tumor that lies flat against the bladder tissue. Flat tumors usually have a poor prognosis. Noninvasive flat TCC (also called carcinoma in situ, or CIS) grows in the layer of cells closest to the inside of the bladder and appears as flat lesions on the inside surface of the bladder. Flat, invasive TCC may invade the deeper layers of the bladder, particularly the muscle layer.

Note 1: Flat tumors may have foci or focus of invasion. This definition is for those flat tumors described as being carcinoma in situ, CIS, or non-invasive.
Note 2: Flat tumors could be called in situ or non-invasive. If the term "non-invasive' is used to describe flat carcinoma, be aware that for staging this would be an in situ carcinoma.

In situ: A tumor confined to epithelium (intraepithelial) with no penetration below the basement membrane

Intraluminal (Ureter): Within the lumen of a tubular or hollow structure. Urinary tumors may spread intraluminally to adjacent urinary organs.

Intramucosal: Within the mucosal surface.

Invasive: A tumor that penetrates beyond the basement membrane.

Most invasive: The tumor with the greatest continuous local/regional extension (see focal and foci/focus definitions).

Bladder

The walls of the **bladder** in order from least to greatest extension are:

- Mucosa
- Lamina propria (some pathologists equate this to submucosa)
- Muscularis mucosae (this layer not always present, may not be mentioned)
- Submucosa
- Muscular layer (muscularis propria, detrusor muscle)
- Serosa, adventitia

Renal pelvis and ureter

The walls of the **renal pelvis** and **ureter** from least to greatest extension are:

- Epithelium
- Subepithelial connective tissue, submucosa
- Muscularis mucosa
- Adventitia, periureteric fat, peripelvic fat

Multicentric, multifocal, and polycentric are often used as synonyms. The tumor has multiple centers. The foci are not contiguous.

Non-invasive tumor: A tumor confined to epithelium (intraepithelial) with no penetration below the basement membrane.

Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland
Equivalent Terms, Definitions, Charts and Illustrations
C700, C701, C709, C710-C719, C720-725, C728, C729, C751-C753
(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

Note: Benign and borderline intracranial and CNS tumors have a separate set of rules.

There are two types of cells that make up the nervous system: *neurons* and *neuroglia* . Neurons send and receive nerve messages. Neuroglia, otherwise known as *glial cells* , often surround the neurons. Glial cells play a supportive role by nourishing, protecting and supporting neurons. There are six kinds of glial cells; oligodendrocytes, astrocytes, ependymal cells, Schwann cells, microglia, and satellite cells. http://www.braintumorfoundation.org/tumors/primer.htm.

It is important to know that any of the glial tumors (Chart 1) can recur as a glioblastoma or glioblastoma multiforme.

Equivalent or Equal Terms (Terms that can be used interchangeably)

- Tumor, mass, lesion, neoplasm
- Type, subtype, variant

Definitions

Anaplastic Ependymomas (9392) are ependymal tumors that do not look like normal cells and grow more quickly than well-differentiated ependymal tumors.

Astrocytoma: A tumor that begins in the brain or spinal cord in small, star-shaped cells called astrocytes. “Astrocytoma” is a term that applies to a group of neoplasms that can be divided into the following clinical-pathological components: Diffuse astrocytomas, anaplastic astrocytomas (grade III), and glioblastoma multiforme (grade IV).

Cerebellum: The part of the brain below the back of the cerebrum. It regulates balance, posture, movement, and muscle coordination.

Corpus Callosum: A large bundle of nerve fibers that connect the left and right cerebral hemispheres. In the lateral section, it looks a bit like a "C" on its side.

Ependymoblastoma (9302) is an embryonal tumor.

Ependymoma: A glioma derived from relatively undifferentiated ependymal cells, comprising approximately 1–3% of all intracranial neoplasms. Ependymomas occur in all age groups and may originate from the lining of any of the ventricles or, more commonly, from the central canal of the spinal cord. Histologically, the neoplastic cells tend to be arranged radially around blood vessels, to which they are attached by means of fibrillary processes.

Frontal Lobe of the Cerebrum: The top, front region of each of the cerebral hemispheres. Used for reasoning, emotions, judgment, and voluntary movement.

Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland Equivalent Terms, Definitions, Charts and Illustrations C700, C701, C709, C710-C719, C720-725, C728, C729, C751-C753 (Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

Glioblastoma: A malignant rapidly growing Astrocytoma of the central nervous system. These neoplasms grow rapidly, invade extensively, and occur most frequently in the cerebrum of adults. Any glial tumor can recur as a glioblastoma or a glioblastoma multiforme (see Chart 1)

Glioma: Any neoplasm derived from one of the various types of cells that form the interstitial tissue of the brain, spinal cord, pineal gland, posterior pituitary gland, and retina. About half of all primary brain tumors and one-fifth of all primary spinal cord tumors form from glial cells. Gliomas tend to grow in the cerebral hemispheres, but may also occur in the brain stem, optic nerves, spinal cord, and cerebellum.Gliomas are divided into subgroups depending on the origin of the glial cells. The most common type of glioma is an astrocytoma.

Infratentorial: Tumors located in the posterior fossa, cerebellum, or fourth ventricle.

Medulla Oblongata: The lowest section of the brainstem (at the top end of the spinal cord). It controls automatic functions including heartbeat, breathing, etc.

Medulloblastoma: A tumor consisting of neoplastic cells that resemble the undifferentiated cells of the primitive medullary tube; medulloblastomas are usually located in the vermis of the cerebellum, and may be implanted discretely or coalescently on the surfaces of the cerebellum, brainstem, and spinal cord. They comprise approximately 3% of all intracranial neoplasms, and occur most frequently in children. A type of primitive neuroectodermal tumor.

Mixed glioma: The presence of at least two of the following cells/differentiation in a single tumor: astrocytic; oligodendroglial; ependymal

Occipital Lobe of the Cerebrum - the region at the back of each cerebral hemisphere that contains the centers of vision and reading ability (located at the back of the head).

Oligodendroglioma: A relatively rare, relatively slowly growing glioma derived from oligodendrocytes that occurs most frequently in the cerebrum of adults

Parietal Lobe of the Cerebrum: The middle lobe of each cerebral hemisphere between the frontal and occipital lobes. It contains important sensory centers (located at the upper rear of the head).

Pituitary Gland: A gland attached to the base of the brain that secretes hormones. It is located between the Pons and the Corpus Callosum, above the Medulla Oblongata. Synonym: Hypophysis.

Table 2 – Mixed and Combination Codes

This table is used to determine mixed and combination codes ONLY

Apply the multiple primary rules FIRST. Combination codes are most often used when multiple histologies are present in a single tumor; they are rarely used for multiple tumors. Use a combination code for multiple tumors ONLY when the tumors meet the rules for a single primary.

Use this **two-page** table to select combination histology codes. Compare the terms in the diagnosis to the terms in Columns 1 and 2. If the terms match, code the case using the ICD-O-3 histology code in column 4. Use the combination codes listed in this table only when the histologies in the tumor match the histologies listed below.

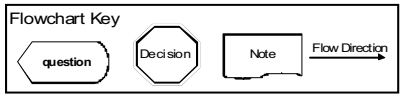
Column 1: Required Histology	**Column 2: Combined with Histology**	**Column 3: Combination Term**	**Column 4: Code**
Small cell carcinoma	Large cell carcinoma	Combined small cell carcinoma	8045
	Adenocarcinoma		
	Squamous cell carcinoma		
Squamous carcinoma	Basal cell carcinoma	Basosquamous carcinoma	8094
Islet cell	Exocrine	Mixed islet cell and exocrine adenocarcinoma (pancreas)	8154
Acinar	Endocrine		
Hepatocellular carcinoma	Cholangiocarcinoma	Combined hepatocellular carcinoma and cholangiocarcinoma	8180
Adenocarcinoma	Carcinoid	Composite carcinoid	8244
Adenocarcinoma and **two or more** of the histologies from column 2 OR **two or more** of the histologies from column 2	Papillary	Adenocarcinoma with mixed subtypes Adenocarcinoma combined with other types of carcinoma	8255
	Clear cell		
	Mucinous (colloid)		
	Signet ring		
	Acinar		
Table 2 continues on the next page			

Other Sites Equivalent Terms, Definitions and Tables
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

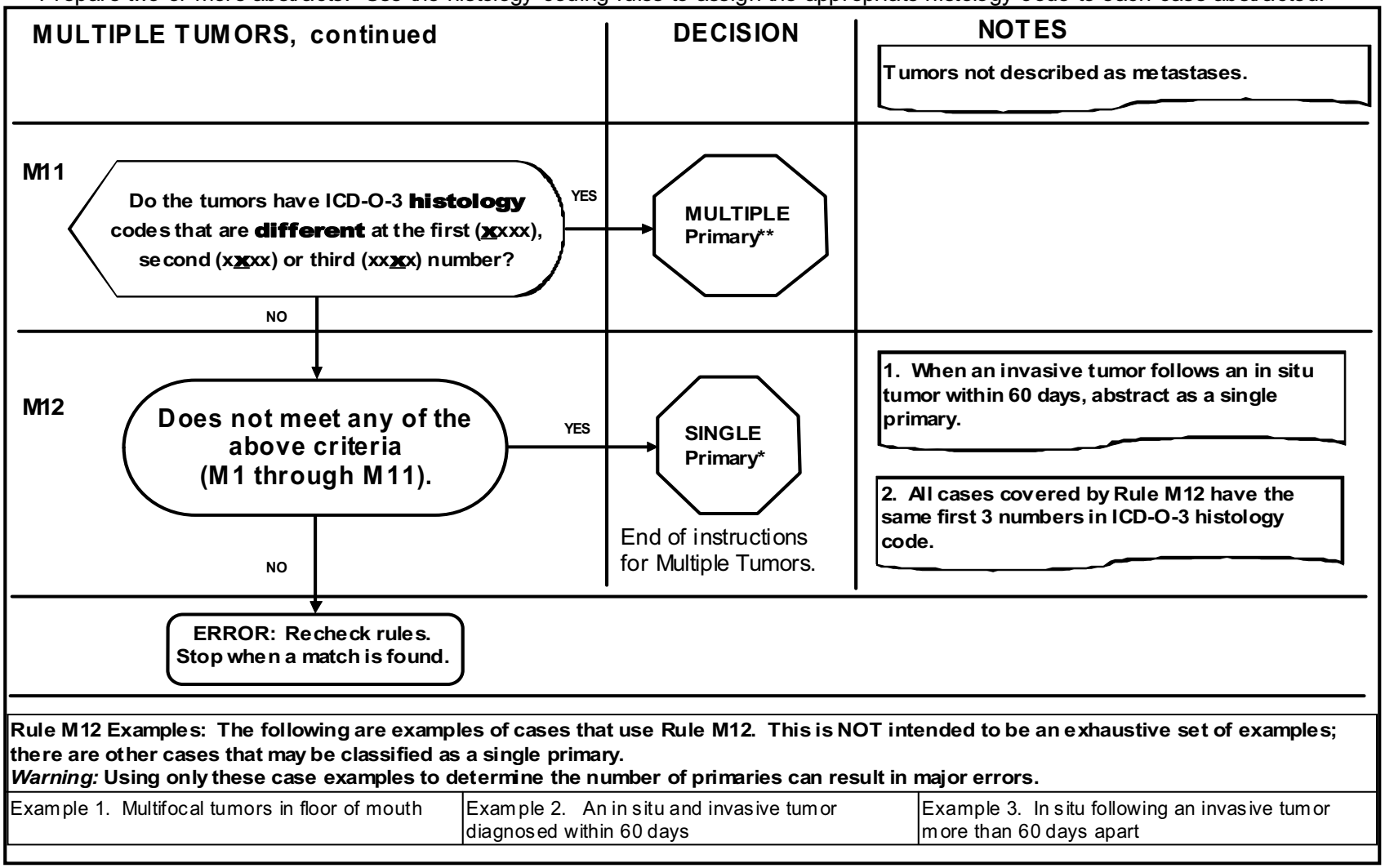
Column 1: Required Histology	Column 2: Combined with Histology	Column 3: Combination Term	Column 4: Code
Table 2 continued			
Gyn malignancies with two or more of the histologies in column 2	Clear cell Endometroid Mucinous Papillary Serous Squamous Transitional (Brenner)	Mixed cell adenocarcinoma	8323
Papillary and Follicular		Papillary carcinoma, follicular variant	8340
Medullary	Follicular	Mixed medullary-follicular carcinoma	8346
Medullary	Papillary	Mixed medullary-papillary carcinoma	8347
Squamous carcinoma and Adenocarcinoma		Adenosquamous carcinoma	8560
Any combination of histologies in Column 2	Myxoid Round cell Pleomorphic	Mixed liposarcoma	8855
Embryonal rhabdomyosarcoma	Alveolar rhabdomyosarcoma	Mixed type rhabdomyosarcoma	8902
Teratoma	Embryonal carcinoma	Teratocarcinoma	9081
Teratoma and one or more of the histologies in Column 2	Seminoma Yolk sac tumor	Mixed germ cell tumor	9085
Choriocarcinoma	Teratoma Seminoma Embryonal	Choriocarcinoma combined with other germ cell elements	9101

Head and Neck Multiple Primary Rules

(C000-C148, C300-C329)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.



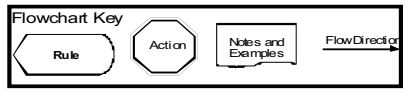
Rule M12 Examples: The following are examples of cases that use Rule M12. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary.
Warning: **Using only these case examples to determine the number of primaries can result in major errors.**

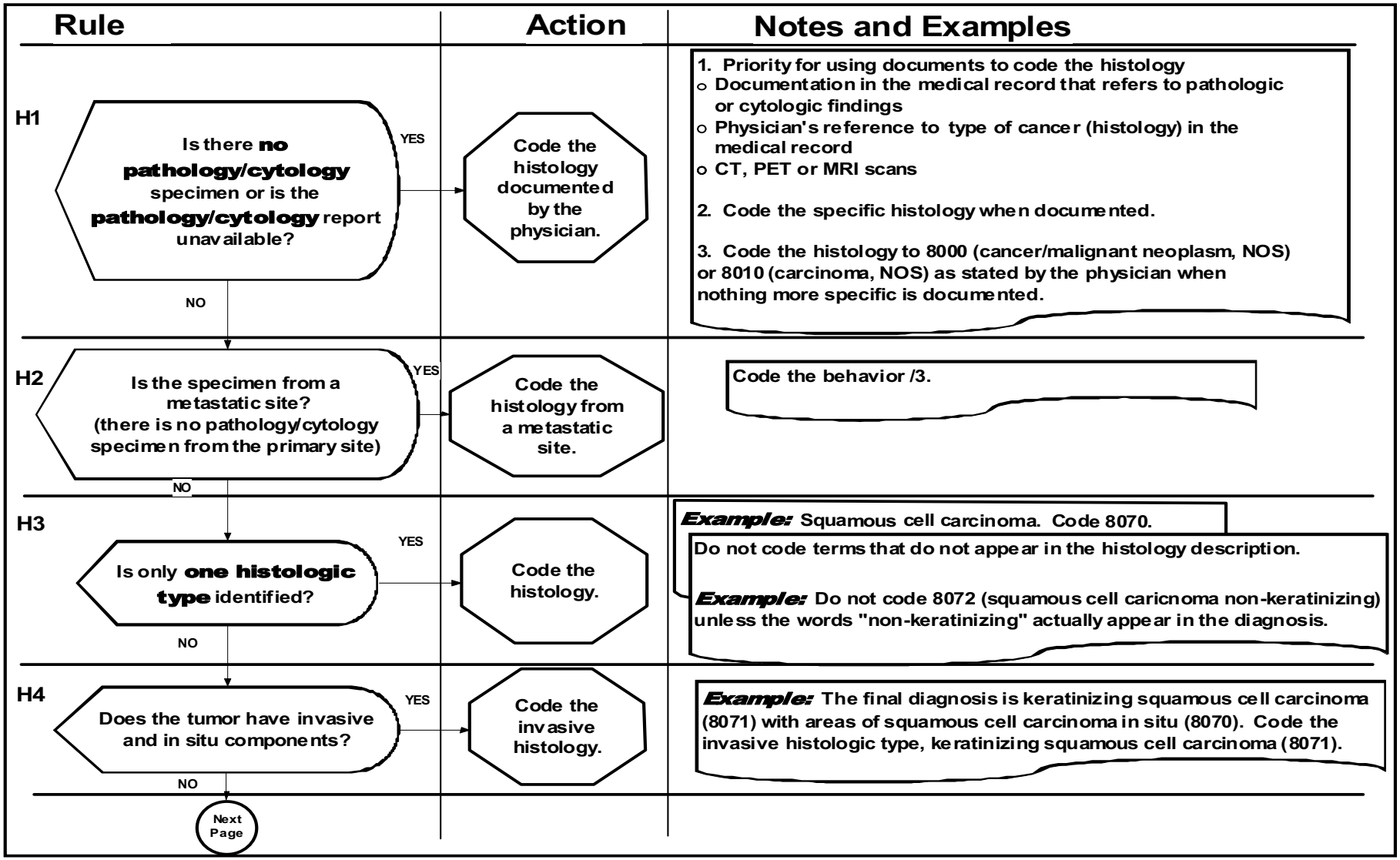
Example 1. Multifocal tumors in floor of mouth	Example 2. An in situ and invasive tumor diagnosed within 60 days	Example 3. In situ following an invasive tumor more than 60 days apart

Head and Neck Histology Coding Rules-Flowchart

(C000-C148, C300-C329)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR



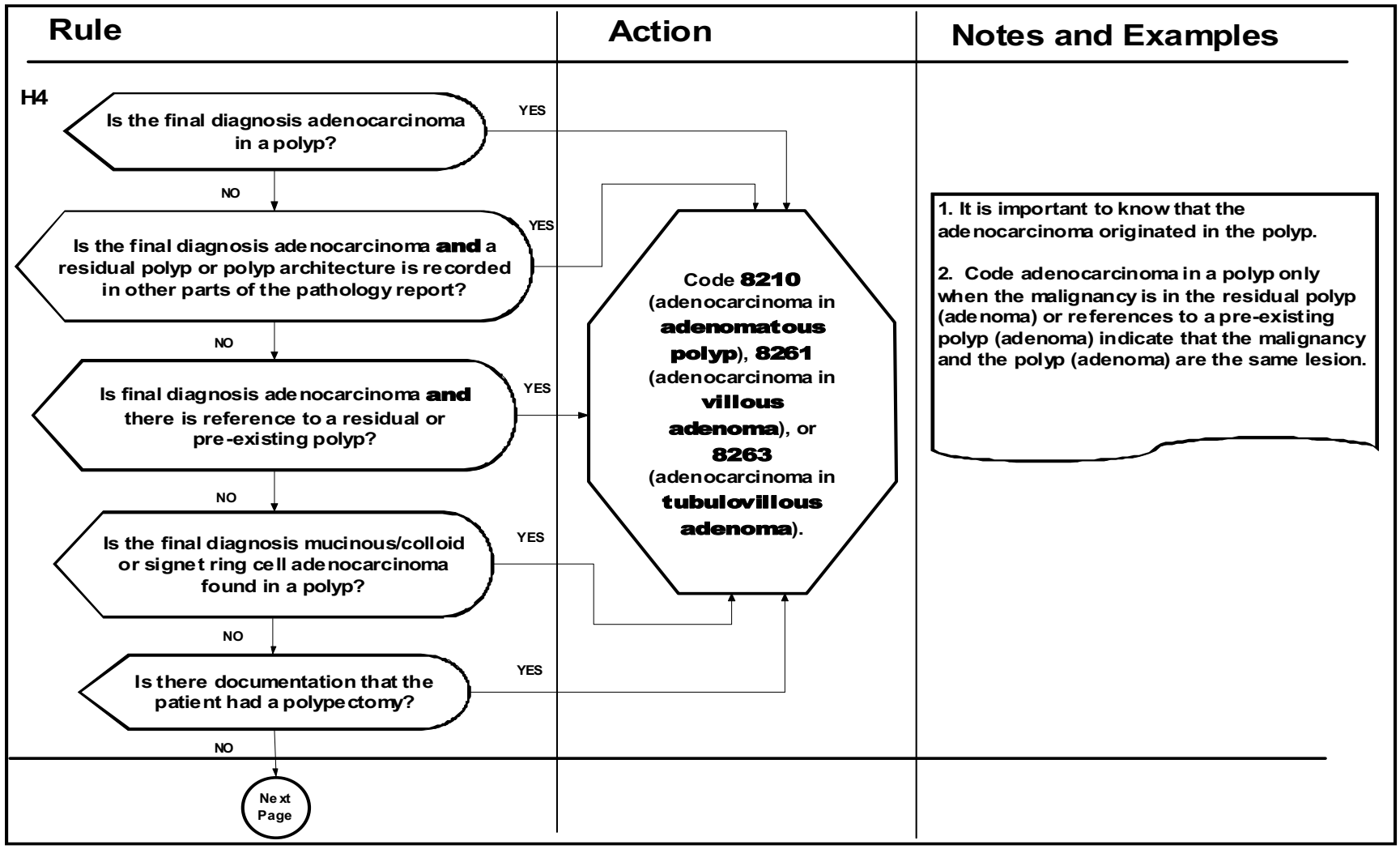


Colon Histology Coding Rules - Flowchart

(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR



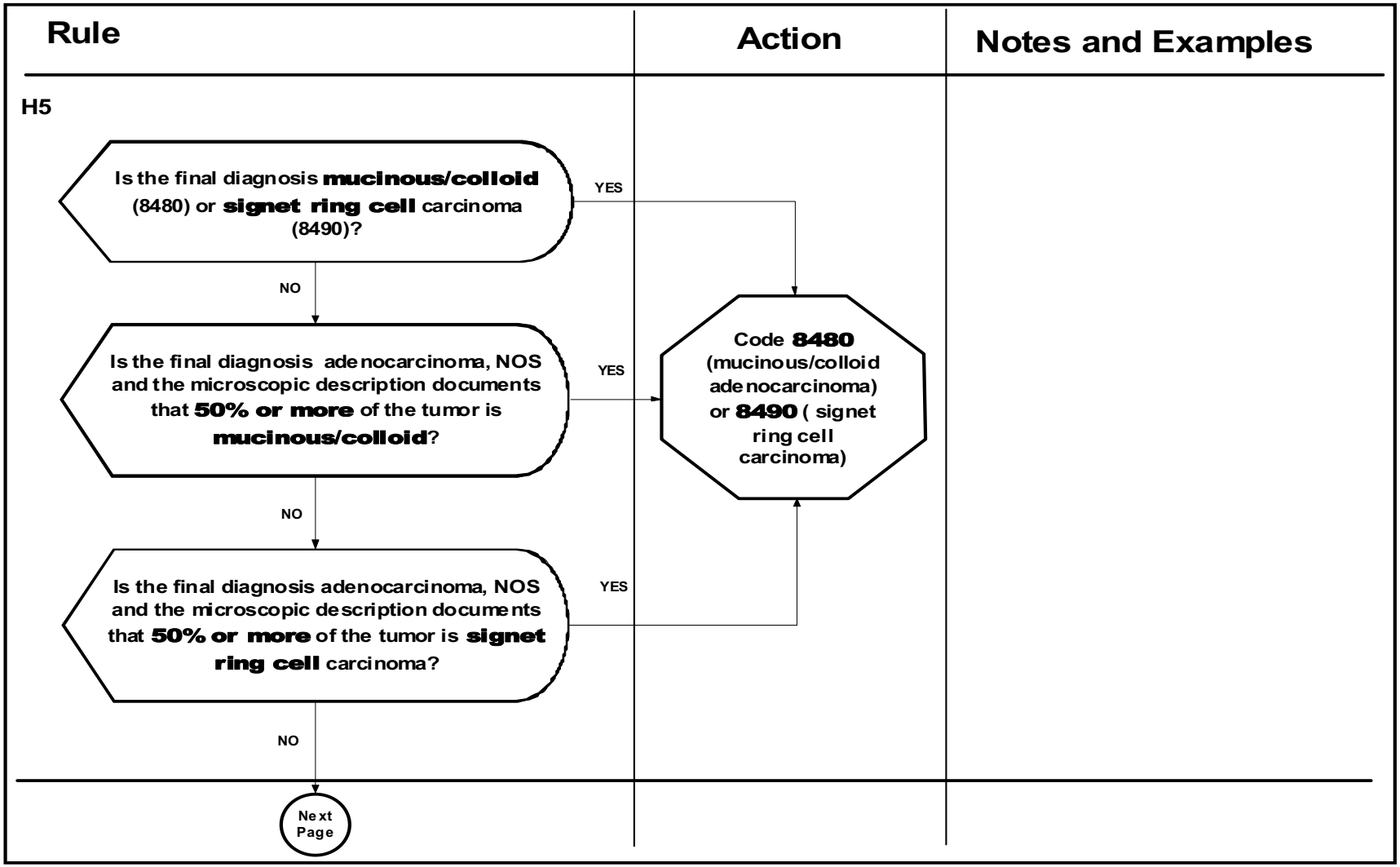
Colon Histo

Colon Histology Coding Rules - Flowchart

(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

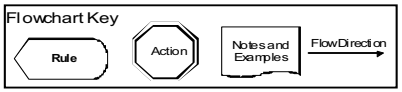
SINGLE TUMOR



Colon Histology Coding Rules - Flowchart

(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

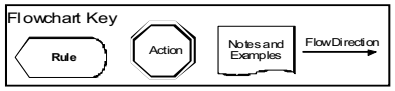
Rule	Action	Notes and Examples
H17 Does the **clinical** history say **familial polyposis** and the final diagnosis on the **pathology report** from resection is adenocarcinoma in adenomatous polyps? YES → Code **8220** (adeno-carcinoma in adenomatous polyposis coli) NO Are there **> 100 polyps** identified in the resected specimen? YES → Code **8220** NO Is the number of polyps not given and the diagnosis is **familial polyposis**? YES → Code **8220** NO		
H18 Are there multiple in situ or malignant polyps present, at least one of which is tubulovillous? YES → Code **8263** (adenocarcinoma in a tubulovillous adenoma) NO		Use this rule only when there are multiple polyps or adenomas. Do not use this rule if there is a frank adenocarcinoma and a malignancy in a single polyp or adenoma.
Next Page		

Colon Histo

Colon Histology Coding Rules - Flowchart

(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule

H19

Are there **> 1 and < = 100** polyps identified in the resected specimen?

YES → Code **8221** (adeno-carcinoma in adenomatous polyps

NO

Are there multiple polyps and the number is not given and **familial polyposis is not mentioned**?

YES → Code **8221** (adeno-carcinoma in adenomatous polyps

NO

H20

Is there a frank adenocarcinoma and a carcinoma in a polyp?

YES → Code the histology of the **most invasive** tumor.

NO

Are there in situ and invasive tumors?

YES → Code the histology of the **most invasive** tumor.

NO

Are there multiple invasive tumors?

YES → Code the histology of the **most invasive** tumor.

NO

Next Page

Action

Code **8221** (adeno-carcinoma in adenomatous polyps

Code the histology of the **most invasive** tumor.

Notes and Examples

Use this rule only when there are multiple polyps. Do not use for a single polyp (adenoma) or for a frank malignancy and a malignancy in a single polyp (adenoma).

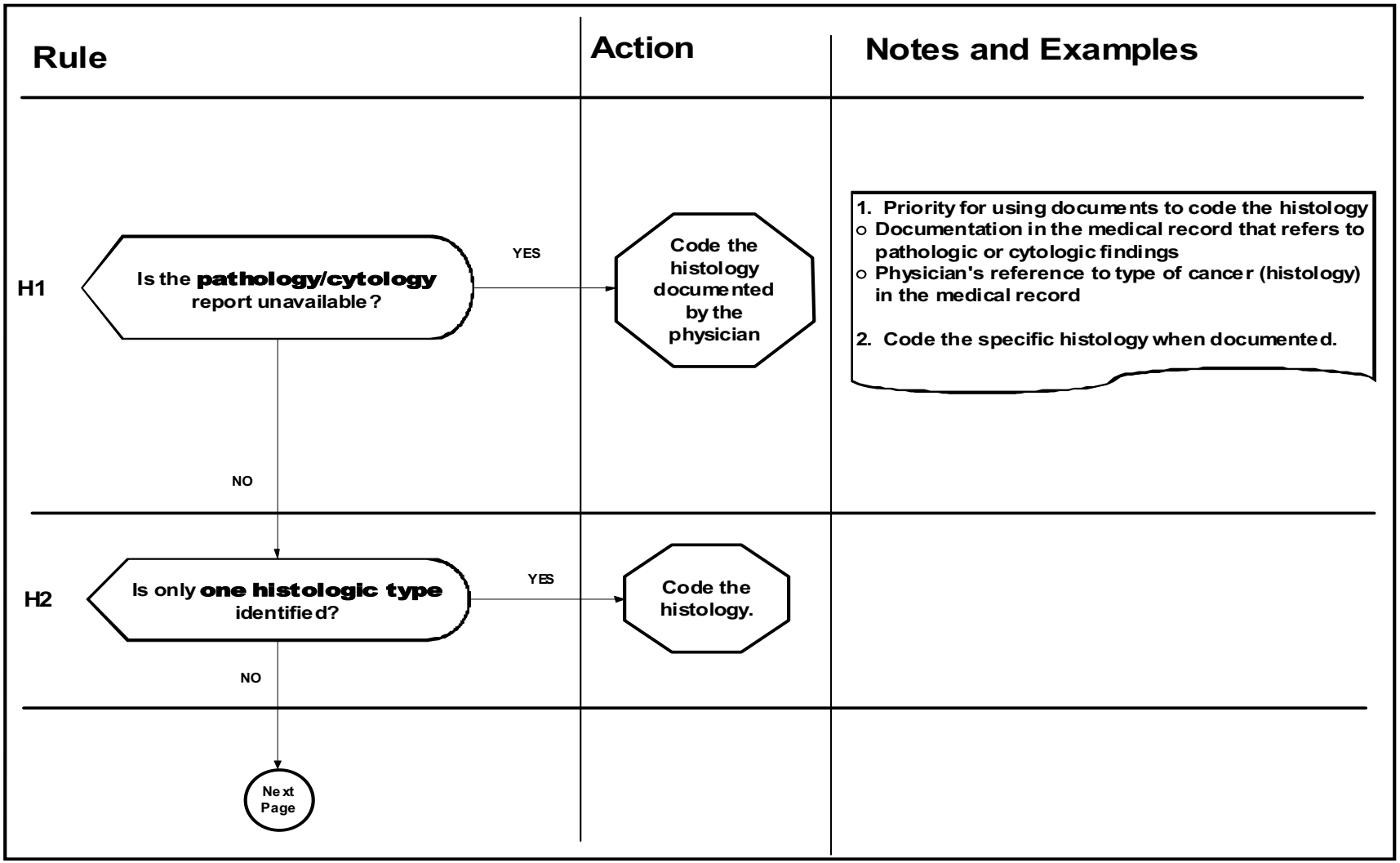
1. See the Colon Equivalent Terms, Definitions and Illustrations for the definition of most invasive.
   - If one tumor is in situ and one is invasive, code the histology from the invasive tumor.
   - If both/all histologies are invasive, code the histology of the most invasive tumor.
2. If tumors are equally invasive, go to the next rule.

Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR: IN SITU CARCINOMA ONLY

(Single Tumor; all parts are in situ)

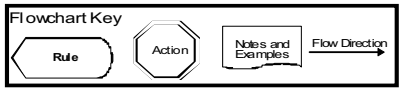


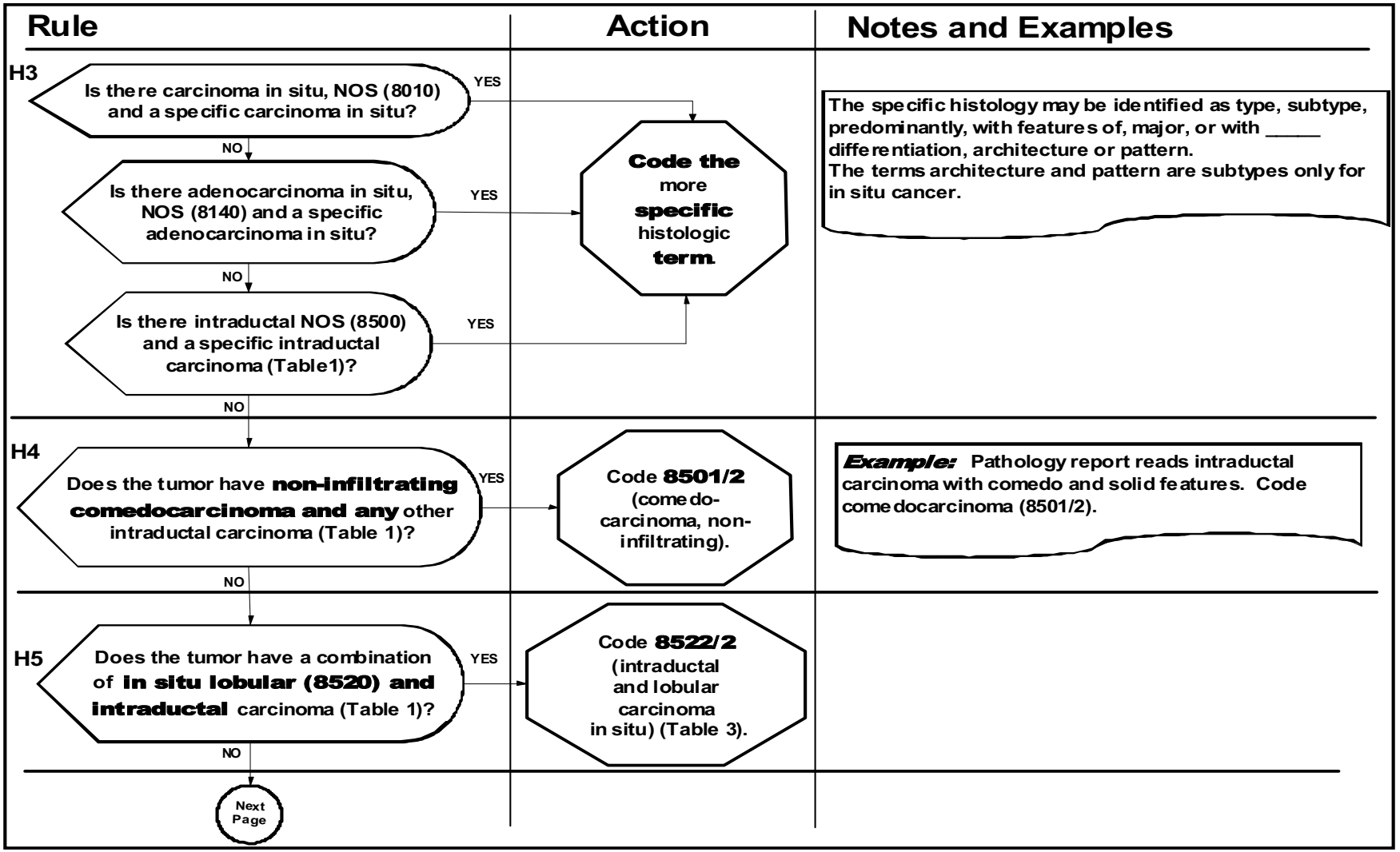
Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR: IN SITU CARCINOMA ONLY

(Single Tumor; all parts are in situ)



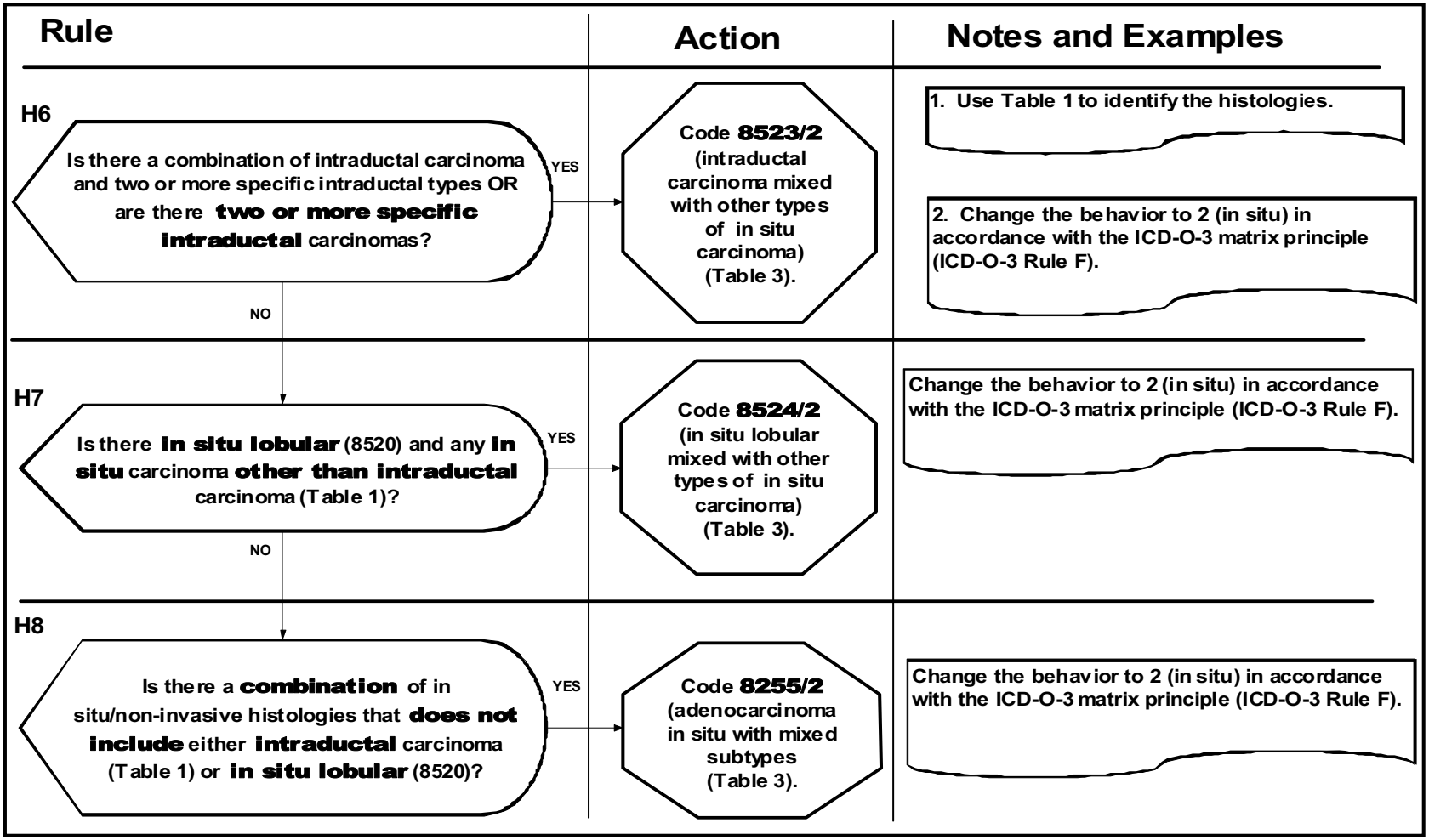


Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR: IN SITU CARCINOMA ONLY

(Single Tumor; all parts are in situ)



Flowchart Key: Rule, Action, Notes and Examples, Flow Direction

This is the end of instructions for Single Tumor: In Situ Carcinoma Only.
Code the histology according to the rule that fits the case.

Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR: INVASIVE AND IN SITU CARCINOMA

(Single Tumor; in situ and invasive components)

Rule	Action	Notes and Examples
H9 Does the tumor have invasive and in situ components? YES	Code the **Invasive** histology.	1. Ignore the in situ terms. 2. This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was the invasive component of the tumor better explains the likely disease course and survival category. Using these new rules, combinations of invasive duct and in situ lobular are coded to invasive duct (8500/3) rather than the combination code for duct and lobular carcinoma (8522/3)
NO ERROR: Confirm Multiple Primary Rule application and then go to H1 - H8 or H10 - H29		

This is the end of instructions for Single Tumor: Invasive and In Situ Carcinoma.
Code the histology according to the rule that fits the case.

Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

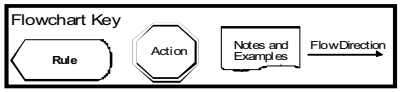
SINGLE TUMOR: INVASIVE CARCINOMA ONLY

(Single Tumor; all parts are invasive)

Rule	Action	Notes and Examples
H14 Is only **one histologic type** identified?	YES → Code the histology.	
NO		
H15 Are there **two or more** specific **duct** carcinomas?	YES → Code the **numerically higher** ICD-O-3 histology code.	Use Table 2 to identify duct carcinomas
NO		
H16 Is there a combination of **lobular** (8520) **and duct** carcinoma (Table 3)?	YES → Code **8522** (duct and lobular).	Use Table 2 to identify duct carcinomas
NO		
Next Page		

Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



SINGLE TUMOR: INVASIVE CARCINOMA ONLY

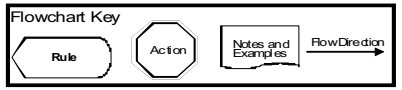
(Single Tumor; all parts are invasive)

Rule	Action	Notes and Examples
H17 Is there a combination of **duct and** any **other** carcinoma (Table 3)? YES	Code **8523** (duct mixed with other types of carcinoma).	1. Use Table 2 to identify duct carcinomas. 2. Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.
NO		
H18 Does the tumor have **lobular** (8520) **and** any **other carcinoma** (Table 3)? YES	Code **8524** (lobular mixed with other types of carcinoma).	Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.
NO		
H19 Are there multiple **histologies** that **do not include duct or lobular** (8520)? YES	Code **8255** (adeno-carcinoma with mixed subtypes) (Table 3).	Use Table 2 to identify duct carcinomas

This is the end of instructions for Single Tumor: Invasive Carcinoma Only.
Code the histology according to the rule that fits the case.

Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

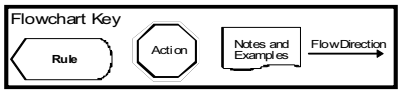


MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule	Action	Notes and Examples
H20 Is there **no pathology/cytology** specimen or is the **pathology/cytology** report unavailable? YES	Code the histology documented by the physician.	1. Priority for using documents to code the histology o Documentation in the medical record that refers to pathologic or cytologic findings o Physician's reference to type of cancer (histology) in the medical record o Mammogram o PET Scan o Ultrasound 2. Code the specific histology when documented. 3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.
NO		
H21 Is the only specimen from a metastatic site? (there is no pathology/cytology specimen from the primary site YES	Code the histology from a metastatic site.	Code the behavior /3.
NO		
H22 Does the final diagnosis of the **pathology** report specifically **state inflammatory carcinoma**? YES	Code **8530** (inflammatory carcinoma).	Record dermal lymphatic invasion in Collaborative Staging.
NO		
Next Page		

Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

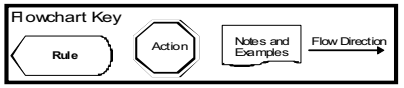


MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule	Action	Notes and Examples
H23 Is only **one histologic type** identified?	YES → Code the histology.	
NO		
H24 Does the pathology report **specifically state** that the Paget disease is **in situ and** the underlying tumor is **intraductal** carcinoma (Table 1)?	YES → Code **8543/2** (in situ Paget disease and intraductal carcinoma (Table 3).	Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).
NO		
H25 Is there **Paget disease and intraductal** carcinoma (Table 3)?	YES → Code **8543/3** (Paget disease and intraductal carcinoma).	*1.* ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3). *2.* Includes both invasive Paget disease and Paget disease with behavior not stated. 3. Use Table 1 to identify intraductal carcinomas.
NO		
H26 Is there **Paget disease and** invasive **duct** carcinoma (Table 3)?	YES → Code **8541/3** (Paget disease and infiltrating duct carcinoma).	*1.* ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3). *2.* Includes both invasive Paget disease and Paget disease with behavior not stated. 3. Use Table 2 to identify duct carcinomas.
NO		
Next Page		

Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

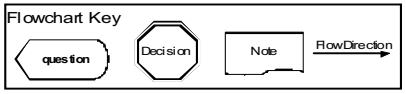
Rule	Action	Notes and Examples
H27 Are there invasive and in situ components?	YES → Code the **invasive** histology.	*1.* Ignore the in situ terms. *2.* This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive lobular and in situ duct carcinoma are coded to invasive lobular (8520/3) rather than the combination code for duct and lobular carcinoma (8522/3)
H28 Is there any combination of lobular (8520) and duct carcinoma (Table 3)?	YES → Code **8522** (duct and lobular).	Use Table 2 to identify duct carcinomas.
H29	NO → Code the **numerically higher** ICD-O-3 histology code.	

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.

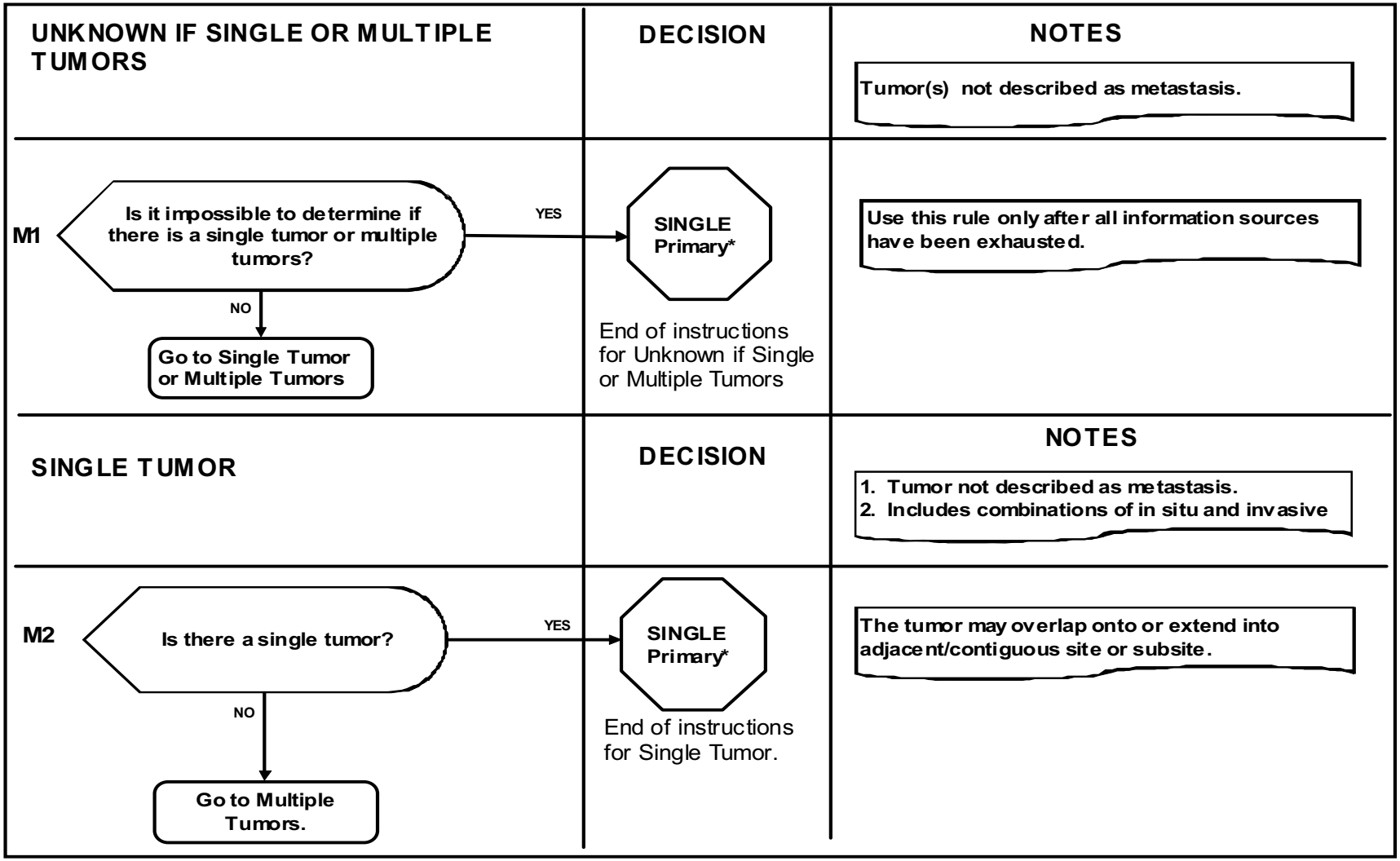
This page left blank

Other Sites Multiple Primary Rules - Flowchart

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

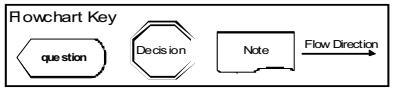


* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

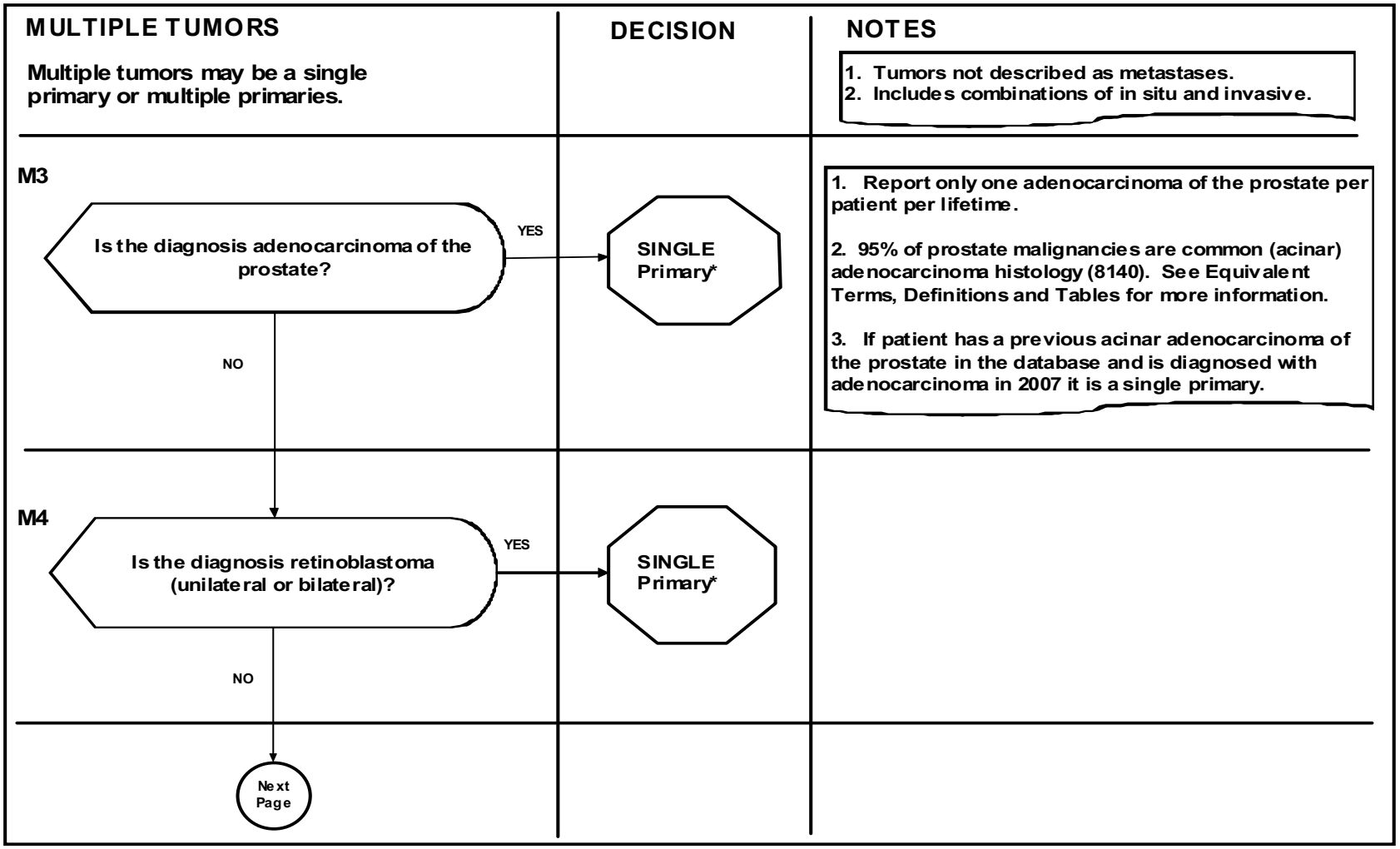


Other Sites Multiple Primary Rules - Flowchart

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

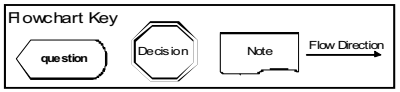


* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

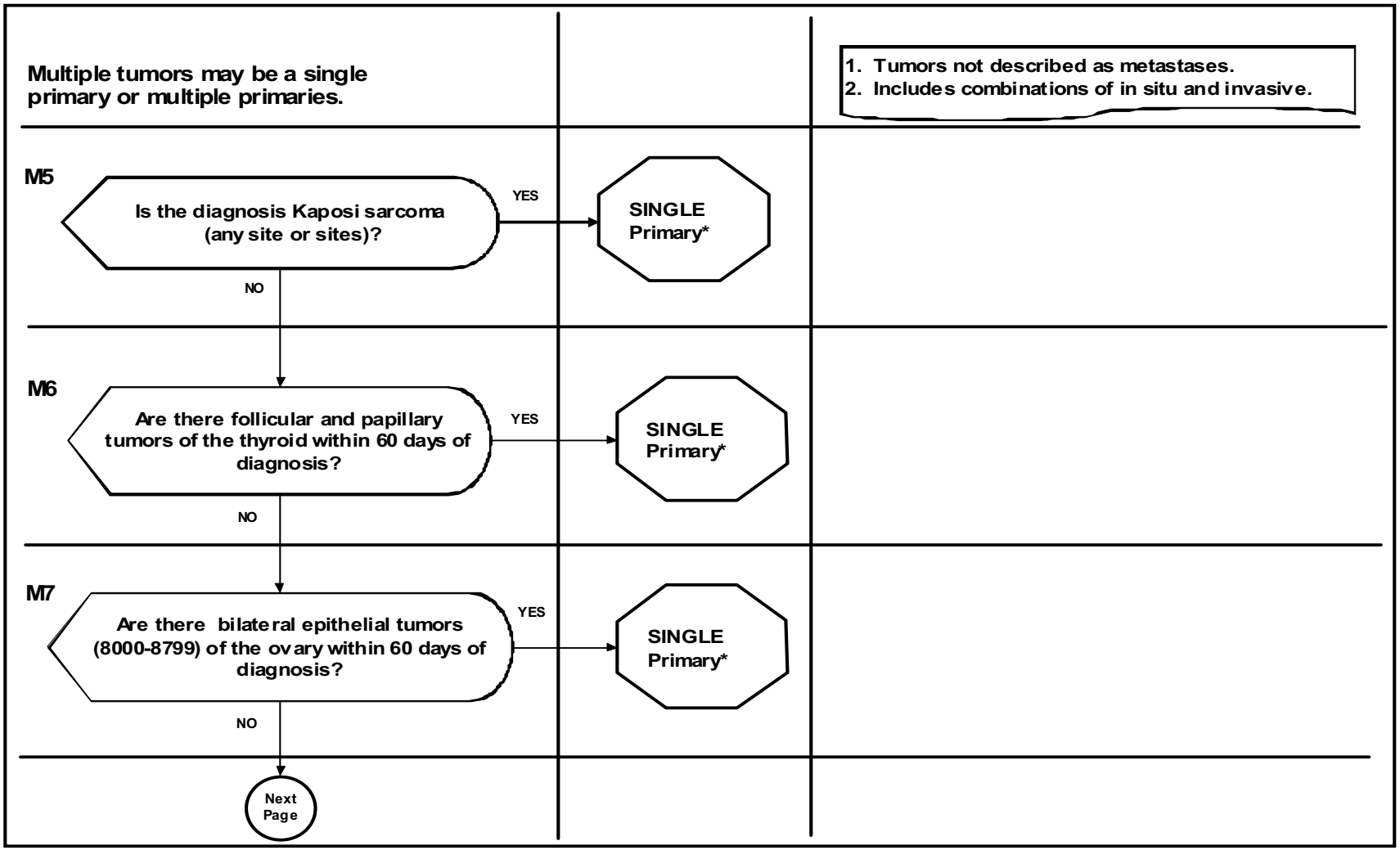


Other Sites Multiple Primary Rules - Flowchart

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)



* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.



Other Sites MP

This page left blank

Other Sites Multiple Primary Rules - Flowchart

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

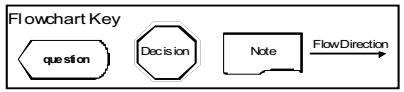
* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

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

MULTIPLE TUMORS, continued	DECISION	NOTES
		1. Tumors not described as metastases. 2. Includes combinations of in situ and invasive.
M8 Are there tumors in both the left and right sides of a paired site (Table 1)?	YES → MULTIPLE Primaries**	Table 1 - Paired Organs and Sites with Laterality
NO		
M9 Is the diagnosis adenocarcinoma in adenomatous polyposis coli (familial polyposis) with one or more malignant polyps?	YES → SINGLE Primary*	Tumors may be present in a single or multiple segments of the colon, rectosigmoid, rectum.
NO		
M10 Are there tumors diagnosed more than one (1) year apart?	YES → MULTIPLE Primaries**	
NO		
Next Page		

Other Sites Multiple Primary Rules - Flowchart

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)



* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

MULTIPLE TUMORS, continued

DECISION

NOTES

1. Tumors not described as metastases.
2. Includes combinations of in situ and invasive.

M11

Are there tumors in sites with ICD-O-3 **topography** codes that are **different** at the second (C**x**xx) and/or third character (Cx**x**x)?

YES → MULTIPLE Primaries**

NO

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: Example 1: A tumor in the cervix C5**3**9 and a tumor in the vulva C5**1**9 have different second characters in their ICD-O-3 topography codes, so they are multiple primaries.

M12

Are there tumors in sites with ICD-O-3 **topography** codes that **differ** at only the **fourth character** (Cxx**x**) and are **in** any one of the following primary sites:

- Anus and anal canal (C21_)
- Bones, joints, and articular cartilage (C40_-C41_)
- Peripheral nerves and autonomic nervous system (C47_)
- Connective subcutaneous and other soft tissues (C49_)
- Skin (C44_)

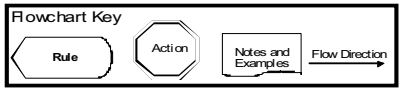
YES → MULTIPLE Primaries**

NO

Next Page

Other Sites Histology Coding Rules - Flowchart

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)



SINGLE TUMOR: INVASIVE ONLY

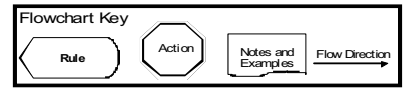
Rule	Action	Notes and Examples
H8 Is there **no pathology/cytology** specimen or is the **pathology/cytology** report unavailable? YES	Code the histology documented by the physician	1. Priority for using documents to code the histology o Documentation in the medical record that refers to pathologic or cytologic findings o Physician's reference to type of cancer (histology) in the medical record o CT, PET or MRI scans 2. Code the specific histology when documented. 3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.
NO		
H9 Is the specimen from a metastatic site? (there is no pathology/cytology specimen from the primary site? YES	Code the histology from a metastatic site.	Code the behavior /3.
NO		
Next Page		

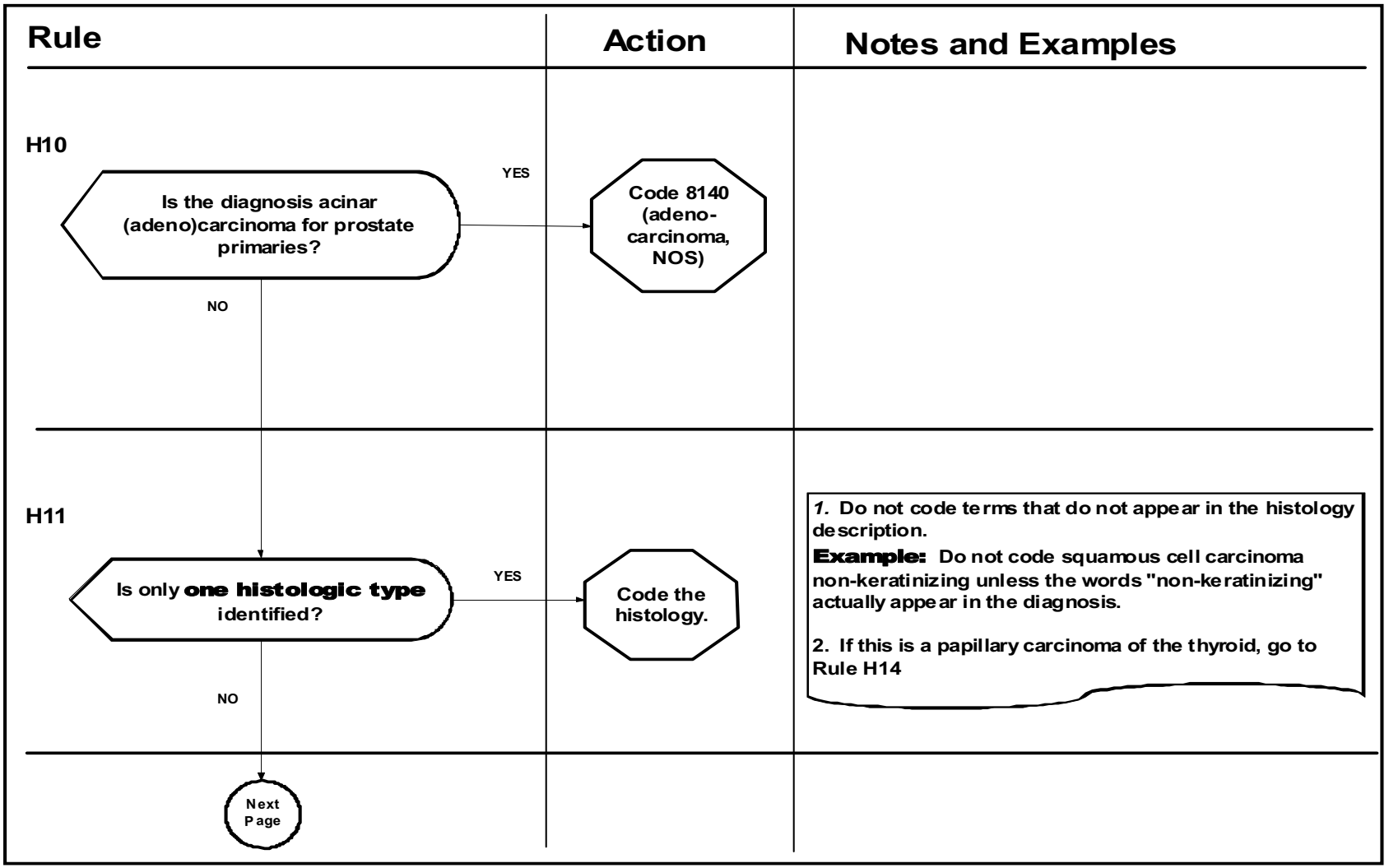
Other Sites Histo

Other Sites Histology Coding Rules - Flowchart

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)

SINGLE TUMOR: INVASIVE ONLY

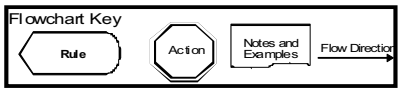




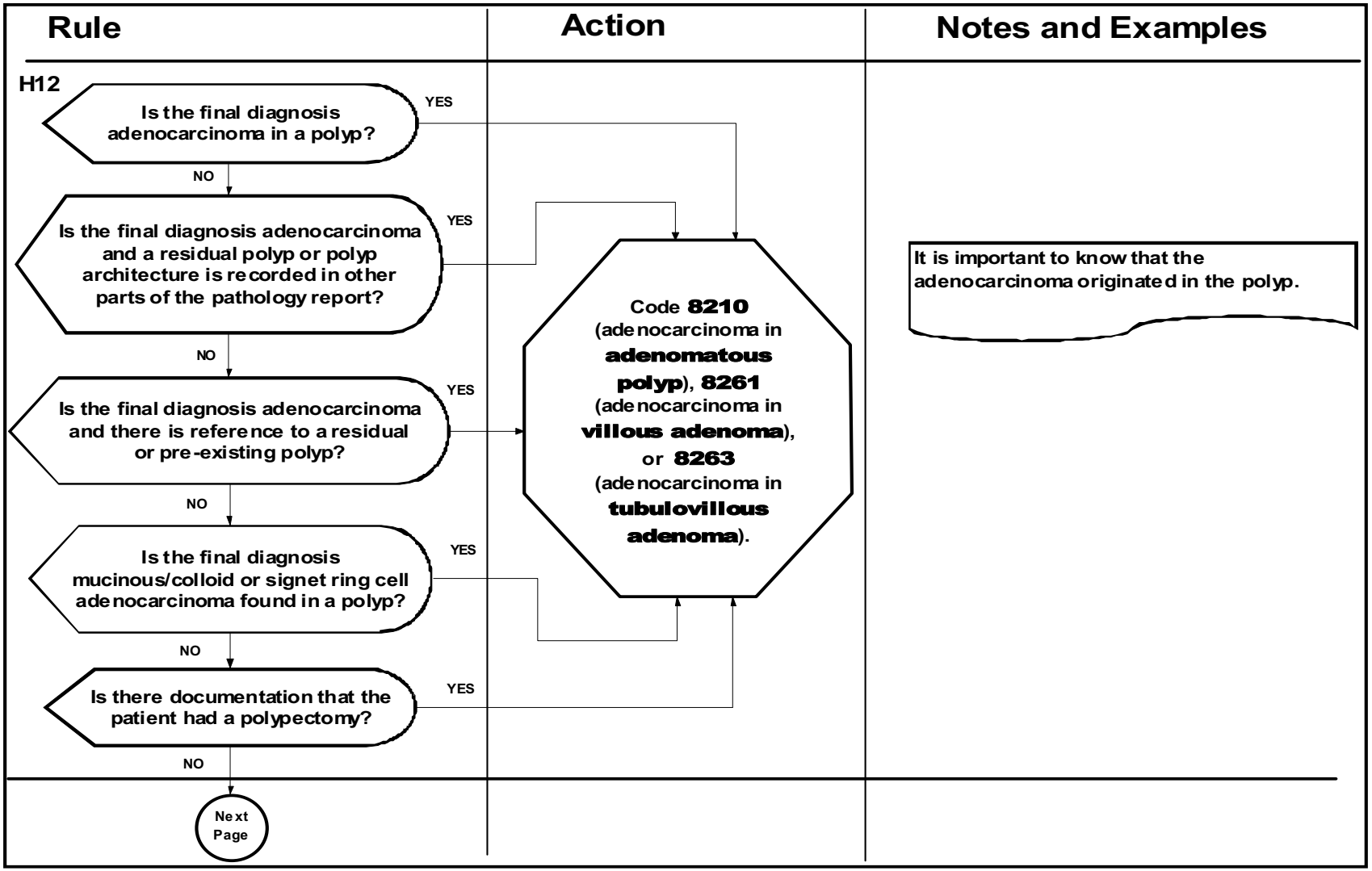
This page left blank

Other Sites Histology Coding Rules - Flowchart

(Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, lymphoma and leukemia)



SINGLE TUMOR: INVASIVE ONLY



Head and Neck Histology Coding Rules – Matrix
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
SINGLE TUMOR					
H1	No pathology/cytology specimen or the pathology/cytology report is not available			***1:*** Priority for using documents to code the histology • Documentation in the medical record that refers to pathologic or cytologic findings • Physician's reference to type of cancer (histology) in the medical record • CT, PET or MRI scans ***2:*** Code the specific histology when documented. ***3:*** Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented	The histology documented by the physician
H2	None from primary site			Code the behavior /3	The histology from metastatic site
H3		One type		***Example:*** Squamous cell carcinoma. Code 8070. Do not code terms that do not appear in the histology description. ***Example:*** Do not code 8072 (squamous cell carcinoma non-keratinizing) unless the words "non-keratinizing" actually appear in the diagnosis	The histology
H4			Invasive and in situ	***Example:*** The final diagnosis is keratinizing squamous cell carcinoma (8071) with areas of squamous cell carcinoma in situ (8070). Code the invasive histologic type, keratinizing squamous cell carcinoma (8071).	The invasive histologic type

Head and Neck Histo

Head and Neck Histology Coding Rules – Matrix
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H5		Multiple histologies all within the same branch on Chart 1. Examples of histologies within same banch: • Cancer/malignant neoplasm, NOS (8000) **and** a more specific histology or • Carcinoma, NOS (8010) **and** a more specific carcinoma or • Squamous cell carcinoma, NOS (8070) **and** a more specific squamous cell carcinoma or • Adenocarcinoma, NOS (8140) **and** a more specific adenocarcinoma or • Melanoma, NOS (8720) **and** a more specific melanoma or • Sarcoma, NOS (8800) **and** a more specific sarcoma		***1.*** The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation. ***2.*** The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation. **Example:** The final diagnosis is squamous cell carcinoma (8070), papillary (8050). Code the specific type, papillary (8050).	The most specific term using Chart 1
H6	None of the above conditions are met				The histology with the numerically higher ICD-O-3 code

Colon Histology Coding Rules – Matrix
C180 – C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
SINGLE TUMOR					
H1	No pathology/cytology specimen or the pathology/cytology report is not available			***1:*** Priority for using documents to code the histology • Documentation in the medical record that refers to pathologic or cytologic findings • Physician's reference to type of cancer (histology) in the medical record • CT, PET or MRI scans ***2:*** Code the specific histology when documented. ***3:*** Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented	The histology documented by the physician
H2	None from primary site			Code the behavior /3	The histology from metastatic site

Colon Histology Coding Rules – Matrix
C180 – C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H3		Intestinal type adenocarcinoma or adenocarcinoma, intestinal type		***1:*** Intestinal type adenocarcinoma usually occurs in the stomach. ***2:*** When a diagnosis of intestinal adenocarcinoma is further described by a specific term such as type, continue to the next rule.	8140 (Adenocarcinoma, NOS)
H4		Final diagnosis: • Adenocarcinoma in a polyp or • Adenocarcinoma **and** a residual polyp or polyp architecture is recorded in other parts of the pathology report or • Adenocarcinoma **and** there is reference to a residual or pre-existing polyp within the medical record or • Mucinous/colloid or signet ring cell adenocarcinoma in a polyp or There is documentation that the patient had a polypectomy		***1:*** It is important to know that the adenocarcinoma originated in a polyp. ***2:*** Code adenocarcinoma in a polyp only when the malignancy is in the residual polyp (adenoma) or references to a pre-existing polyp (adenoma) indicate that the malignancy and the polyp (adenoma) are the same lesion.	8210 (Adenocarcinoma arising in polyp), or 8261 (Adenocarcinoma in a villous adenoma), or 8263 (Adenocarcinoma in a tubulovillous adenoma)
H5		Final diagnosis is: • Mucinous/colloid (8480) or signet ring cell carcinoma (8490) or • Adenocarcinoma, NOS **and** microscopic description documents 50% or more of the tumor is mucinous/colloid or • Adenocarcinoma, NOS **and** microscopic description documents 50% or more of the tumor is signet ring cell carcinoma			8480 (Mucinous/colloid adenocarcinoma) or 8490 (Signet ring cell carcinoma)

Colon Histology Coding Rules – Matrix
C180 – C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY These rules only apply to multiple tumors that are reported as a **single primary**					
H15	No pathology/cytology specimen or the pathology/cytology report is not available			***1:*** Priority for using documents to code the histology • Documentation in the medical record that refers to pathologic or cytologic findings • Physician's reference to type of cancer (histology) in the medical record • CT, PET or MRI scans ***2:*** Code the specific histology when documented ***3:*** Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented	The histology documented by the physician
H16	None from primary site			Code the behavior /3	The histology from a metastatic site

Colon Histo

Colon Histology Coding Rules – Matrix
C180 – C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H17		• Clinical history says familial polyposis and final diagnosis on pathology report from resection is adenocarcinoma in adenomatous polyps, or • > 100 polyps in resected specimen or • Number of polyps is not given but the diagnosis is familial polyposis			8220 (Adenocarcinoma in adenomatous polyposis coli)
H18		Multiple in situ or malignant polyps are present, at least one of which is tubulovillous		Use this rule only when there are multiple polyps or adenomas. Do not use this rule if there is a frank adenocarcinoma and a malignancy in a single polyp or adenoma.	8263 (Adenocarcinoma in a tubulovillous adenoma)
H19		• >1 and <= 100 polyps identified in resected specimen, or • Multiple polyps (adenomas) and the number is not given and familial polyposis is not mentioned		Use this rule only when there are multiple polyps. Do not use for a single polyp (adenoma) or for a frank malignancy and a malignancy in a single polyp (adenoma).	8221 (adenocarcinoma in multiple adenomatous polyps)

Colon Histology Coding Rules – Matrix
C180 – C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H20		• Frank adenocarcinoma and a carcinoma in a polyp, or • In situ and invasive tumors or • Multiple invasive tumors		***1:*** See the Colon Equivalent Terms, Definitions and Illustrations for the definition of most invasive. • One tumor is in situ and one is invasive, code the histology from the invasive tumor. • Both/all histologies are invasive, code the histology of the most invasive tumor. ***2*:** If tumors are equally invasive, go to the next rule	The histology of the most invasive tumor
H21		Final diagnosis: • Adenocarcinoma **and** the microscopic description or surgical gross describes polyps or • Adenocarcinoma **and** there is reference to residual or pre-existing polyps or • Mucinous/colloid or signet ring cell adenocarcinoma in polyps or There is documentation that the patient had a polypectomy		It is important to know that the adenocarcinoma originated in a polyp.	8210 (Adenocarcinoma arising in polyp), or 8261 (Adenocarcinoma in a villous adenoma), or 8263 (Adenocarcinoma in a tubulovillous adenocarcinoma)
H22		One type			The histology

Colon Histo

Colon Histology Coding Rules – Matrix
C180 – C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H23		• Cancer/malignant neoplasm, NOS (8000) and a specific histology or • Carcinoma, NOS (8010) and a specific carcinoma or • Adenocarcinoma, NOS (8140) and a specific adenocarcinoma or • Sarcoma, NOS (8800) and a specific sarcoma (invasive only)		***1:*** The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation ***2:*** The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.	The more specific histologic term
H24	None of the above conditions are met				The histology with the numerically higher ICD-O-3 code

Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
SINGLE TUMOR: IN SITU ONLY (Single tumor; all parts are in situ)					
H1	The pathology/cytology report is not available			***1:*** Priority for using documents to code the histology • Documentation in the medical record that refers to pathologic or cytologic findings • From clinician reference to type of cancer (histology) in the medical record ***2:*** Code the specific histology when documented.	The histology documented by the physician
H2		One type			The histology
H3		• Carcinoma in situ, NOS (8010) and a specific carcinoma in situ or • Adenocarcinoma in situ, NOS (8140) and a specific adenocarcinoma in situ or • Intraductal carcinoma, NOS (8500) and a specific intraductal carcinoma (Table 1)		The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ____ differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.	The more specific histologic term
H4		Non-infiltrating comedocarcinoma and any other intraductal carcinoma (Table 1)		***Example:*** Pathology report reads intraductal carcinoma with comedo and solid features. Code 8501/2 (comedocarcinoma).	**8501/2** (comedocarcinoma, non-infiltrating)
H5		In situ lobular (8520) and intraductal carcinoma (Table 1)			**8522/2** (intraductal carcinoma and lobular carcinoma in situ) **(Table 3)**.

Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H6		• Combination of intraductal carcinoma and two or more specific and two or more specific intraductal types OR • **Two or more specific intraductal** carcinomas		***1:*** Use Table 1 to identify the histologies ***2:*** Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F.)	**8523/2** (intraductal carcinoma mixed with other types of in situ carcinoma) **(Table 3)**.
H7		In situ lobular (8520) and any in situ carcinoma other than intraductal carcinoma (Table 1)		Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F.)	**8524/2** (in situ lobular mixed with other types of in situ carcinoma) **(Table 3)**.
H8		Combination of in situ/non-invasive histologies that does not include either intraductal carcinoma (Table 1) or in situ lobular (8520)		Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F.)	**8255/2** (adenocarcinoma in situ with mixed subtypes) **(Table 3)**.

Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
SINGLE TUMOR: INVASIVE AND IN SITU (Single tumor; in situ and invasive components)					
H9			Invasive and in situ	***1.*** Ignore the in situ terms. ***2.*** This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive duct and in situ lobular are coded to invasive duct (8500/3) rather than the combination code for duct and lobular carcinoma (8522/3).	The invasive histology
SINGLE TUMOR: INVASIVE ONLY (Single tumor; all parts are invasive)					
H10	No pathology/cytology specimen or the pathology/cytology report is not available			***1:*** Priority for using documents to code the histology • Documentation in the medical record that refers to pathologic or cytologic findings • Physician's reference to type of cancer (histology) in the medical record • Mammogram • PET scan • Ultrasound ***2:*** Code the specific histology when documented ***3:*** Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented	The histology documented by the physician
H11	None from primary site			Code the behavior /3	The histology from a metastatic site

Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H12		• Carcinoma, NOS (8010) and a more specific carcinoma or • Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or • Duct carcinoma, NOS (8500) and a more specific duct carcinoma (8022, 8035, 8501-8508) or • Sarcoma, NOS (8800) and a more specific sarcoma		The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation. The terms architecture and pattern are subtypes only for in situ cancer.	The most specific histologic term
H13		Final diagnosis of the pathology report specifically states inflammatory carcinoma		Record dermal lymphatic invasion in Collaborative Staging	**8530** (inflammatory carcinoma)
H14		One type			The histology
H15		Two or more specific duct carcinomas		Use Table 2 to identify duct carcinomas	The histology with the numerically higher ICD-O-3 code
H16		Combination of lobular (8520) and duct carcinoma		Use Table 2 to identify duct carcinomas	**8522** (duct and lobular) (**Table 3)**.
H17		Combination of **duct and** any other carcinoma		***1***: Use Table 2 to identify duct carcinomas ***2***: Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.	**8523** (duct mixed with other types of carcinoma) (**Table 3)**.

Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H18		Lobular (8520) and any other carcinoma		Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2	**8524** (lobular mixed with other types of carcinoma) **(Table 3)**.
H19		Multiple histologies that do not include duct or lobular (8520)		Use Table 2 to identify duct carcinomas	**8255** (adenocarcinoma with mixed subtypes) **(Table 3)**.
MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY					
H20	No pathology/cytology specimen or the pathology/cytology report is not available			***1:*** Priority for using documents to code the histology • Documentation in the medical record that refers to pathologic or cytologic findings • Physician's reference to type of cancer (histology) in the medical record • Mammogram • PET scan • Ultrasound ***2:*** Code the specific histology when documented ***3:*** Code the histology to cancer/malignant neoplasm, NOS (8000) or carcinoma, NOS (8010) as stated by the physician when nothing more specific is documented	The histology documented by the physician
H21	None from primary site			Code the behavior /3	The histology from a metastatic site
H22		Final diagnosis of the pathology report specifically states inflammatory carcinoma		***Note***: Record dermal lymphatic invasion in Collaborative Staging	**8530** (inflammatory carcinoma)
H23		One type			The histology

Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H24		Pathology report specifically states Paget disease is in situ and the underlying tumor is intraductal carcinoma (Table 1)		Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F.)	Code **8543/2** (in situ Paget disease and intraductal carcinoma) **(Table 3)**.
H25		Paget disease and intraductal carcinoma		***1.*** ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3). ***2.*** Includes both invasive Paget disease and Paget disease with behavior not stated. ***3***: Use Table 1 to identify intraductal carcinomas	**8543/3** (Paget disease and intraductal carcinoma) **(Table 3)**.
H26		Paget disease and invasive duct carcinoma		***1.*** ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3). ***2.*** Includes both invasive Paget disease and Paget disease with behavior not stated. ***3***: Use Table 2 to identify duct carcinomas	Code **8541/3** (Paget disease and infiltrating duct carcinoma) **(Table 3).**
H27			Invasive and in situ	***1.*** Ignore the in situ terms. ***2.*** This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive lobular and in situ duct carcinoma are coded to invasive lobular (8520/3) rather than the combination code for duct and lobular carcinoma (8522/3)	The invasive histology

Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H28		Lobular (8520) and duct carcinoma		Use Table 2 to identify duct carcinomas	**8522** (duct and lobular) **(Table 3)**.
H29	None of the conditions are met				The histology with the numerically higher ICD-O-3 code

Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

This page left blank

Other Sites Multiple Primary Rules – Matrix

Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

Rule	Site	Histology	Timing	Behavior	Notes/Examples	Primary
UNKNOWN IF SINGLE OR MULTIPLE TUMORS					Tumor(s) not described as metastasis	
M1					Use this rule only after all information sources have been exhausted.	Single*
SINGLE TUMOR					***1:*** Tumor not described as metastasis ***2:*** Includes combinations of in situ and invasive	
M2	Single				The tumor may overlap onto or extend into adjacent/contiguous site or subsite**.**	Single*
MULTIPLE TUMORS **Multiple tumors may be a single primary or multiple primaries**					***1:*** Tumors not described as metastases ***2:*** Includes combinations of in situ and invasive	
M3	Prostate	Adenocarcinoma			***1:*** Report only one adenocarcinoma of the prostate per patient per lifetime. ***2:*** 95% of prostate malignancies are the common (acinar) adenocarcinoma histology (8140). See Equivalent Terms, Definitions and Tables for more information ***3:*** If patient has a previous acinar adenocarcinoma of the prostate in the database and is diagnosed with adenocarcinoma in 2007 it is a single primary.	Single*
M4	Unilateral or bilateral	Retinoblastoma				Single*
M5	Any site or sites	Kaposi sarcoma				Single*
M6	Thyroid	Follicular and papillary	Within 60 days			Single*

Other Sites MP

Other Sites Multiple Primary Rules – Matrix

Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

Rule	Site	Histology	Timing	Behavior	Notes/Examples	Primary
M7	Bilateral ovary	Epithelial tumors (8000-8799)	Within 60 days of diagnosis			Single*
M8	Both sides of a paired site (Table 1)				Table 1 – Paired Organs and Sites with Laterality	Multiple**
M9		Adenocarcinoma in adenomatous polyposis coli (familial polyposis) with one or more in situ or malignant polyps			Tumors may be present in a single or multiple segments of the colon, rectosigmoid, rectum.	Single*
M10			Diagnosed more than one (1) year apart			Multiple**
M11	Topography codes that are different at the second (C**x**xx) and/or third (Cx**x**x) character				***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	Multiple**
M12	Topography codes that differ only at the fourth (Cxx**x**) character in any one of the following primary sites: • Anus and anal canal C21_) • Bones, joints and articular cartilage (C40_-C41_) • Peripheral nerves and autonomic nervous system (C47_) • Connective tissue and other soft tissues (C49_) • Skin (C44_)					Multiple**

Other Sites Histology Coding Rules – Matrix
Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

Rule	Pathology/Cytology Specimen	Primary Site	Histology	Behavior	Notes and Examples	Code
H10		Prostate	Acinar (adeno)carcinoma			8140 (adenocarcinoma NOS)
H11			One type		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.	The histology
H12			Final diagnosis is: • Adenocarcinoma in a polyp or • Adenocarcinoma **and** a residual polyp or polyp architecture is recorded in other parts of the pathology report or • Adenocarcinoma **and** there is reference to a residual or pre-existing polyp or • Mucinous/colloid or signet ring cell adenocarcinoma in a polyp or There is documentation that the patient had a polypectomy		***1:*** It is important to know that the adenocarcinoma originated in a polyp ***2:*** If this is a papillary carcinoma of the thyroid, go to Rule H14	8210 (adenocarcinoma in adenomatous polyp) or 8261 (adenocarcinoma in villous adenoma) or 8263 (adenocarcinoma in tubulovillous adenoma)

Other Sites Histo

Other Sites Histology Coding Rules – Matrix

Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

Rule	Pathology/Cytology Specimen	Primary Site	Histology	Behavior	Notes and Examples	Code
H13			• Cancer/malignant neoplasm, NOS (8000) **and** a more specific histology or • Carcinoma, NOS (8010) **and** a more specific carcinoma or • Squamous cell carcinoma, NOS (8070) **and** a more specific squamous cell carcinoma or • Adenocarcinoma, NOS (8140) **and** a more specific adenocarcinoma or • Melanoma, NOS (8720) **and** a more specific melanoma or • Sarcoma, NOS (8800) **and** a more specific sarcoma		The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation. The terms architecture and pattern are subtypes only for in situ cancer. ***Example 1:*** Adenocarcinoma, predominantly mucinous. Code mucinous adenocarcinoma (8480). ***Example 2:*** Non-small cell carcinoma, papillary squamous cell. Code papillary squamous cell carcinoma (8052).	The most specific histologic term
H14		Thyroid	Papillary carcinoma			8260 (papillary adenocarcinoma, NOS)
H15		Thyroid	Follicular and papillary carcinoma			8340 (Papillary carcinoma, follicular variant)

Other Sites Histology Coding Rules – Matrix

Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

Rule	Pathology/Cytology Specimen	Primary Site	Histology	Behavior	Notes and Examples	Code
H16			• Multiple specific histologies or • A non-specific histology with multiple specific histologies		The specific histology may be identified as type, subtype, predominantly, with features of, major or with _____ differentiation. ***Example 1 (multiple specific histologies):*** Mucinous and papillary adenocarcinoma. Code 8255 (adenocarcinoma with mixed subtypes). ***Example 2 (multiple specific histologies):*** Combined small cell and squamous cell carcinoma. Code 8045 (combined small cell carcinoma) ***Example 3 (non-specific with multiple specific histologies):*** Adenocarcinoma with papillary and clear cell features. Code 8255 (adenocarcinoma with mixed subtypes)	The appropriate combination code (Table 2)
H17	None of the above conditions are met					The numerically higher ICD-O-3 code

Other Sites Histo

Other Sites Histology Coding Rules – Matrix

Excludes Head and Neck, Colon, Lung, Melanoma, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

Rule	Pathology/Cytology Specimen	Primary Site	Histology	Behavior	Notes and Examples	Code
MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY						
H18	No pathology/cytology specimen or the pathology/cytology report is not available				***1:*** Priority for using documents to code the histology • Documentation in the medical record that refers to pathologic or cytologic findings • Physician's reference to type of cancer (histology) in the medical record • CT, PET or MRI scans ***2:*** Code the specific histology when documented ***3:*** Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented	The histology documented by the physician
H19	None from primary site				Code the behavior /3	The histology from a metastatic site
H20		Prostate	Acinar (adeno)carcinoma			8140 (adenocarcinoma NOS)
H21		Sites such as: Vulva Vagina Anus	Squamous intraepithelial neoplasia grade III such as: • vulva (VIN III) • vagina (VAIN III) • anus (AIN III).	In situ	***1:*** VIN, VAIN, and AIN are squamous cell carcinomas. Code 8077 cannot be used for glandular intraepithelial neoplasia such as prostatic intraepithelial neoplasia (PIN) or pancreatic intraepithelial neoplasia (PAIN). ***2:*** This code may be used for reportable-by-agreement cases	8077/2 (Squamous intraepithelial neoplasia, grade III)

Head and Neck Histology Coding Rules - Text
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

Rule H1 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT, PET, or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H2 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H3 Code the histology when only **one histologic type** is identified.

Example: Squamous cell carcinoma. Code 8070.

Note: Do not code terms that do not appear in the histology description.

Example: Do not code 8072 (squamous cell carcinoma non-keratinizing) unless the words "non-keratinizing" actually appear in the diagnosis.

Rule H4 Code the **invasive** histologic type when a single tumor has invasive and in situ components.

Example: The final diagnosis is keratinizing squamous cell carcinoma (8071) with areas of squamous cell carcinoma in situ (8070). Code the invasive histologic type, keratinizing squamous cell carcinoma (8071).

Head and Neck Histology Coding Rules - Text
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Rule H5 Code the most **specific** histologic term using Chart 1 when there are multiple histologies within the same branch. Examples of histologies within the same branch are:

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Squamous cell carcinoma, NOS (8070) and a more specific squamous carcinoma or
- Adenocarcinoma, NOS(8140) and a more specific adenocarcinoma or
- Melanoma, NOS (8720) and a more specific melanoma or
- Sarcoma, NOS (8800) and a more specific sarcoma

Note 1: The specific histology for **in situ** lesions may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 2: The specific histology for **invasive** lesions may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation

Example: The final diagnosis is squamous cell carcinoma (8070), papillary (8050). Code the specific type, papillary (8050).

Rule H6 Code the histology with the **numerically higher** ICD-O-3 code.

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 H7 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT, PET, or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS), or 8010 (carcinoma, NOS) as stated by the physician when no specific histology is documented.

Rule H8 Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Colon Histology Coding Rules – Text
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

Rule H1 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT, PET or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H2 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H3 Code **8140** (adenocarcinoma, NOS) when pathology describes only **intestinal type adenocarcinoma** or adenocarcinoma, intestinal type.

Note 1: Intestinal type adenocarcinoma usually occurs in the stomach.

Note 2: When a diagnosis of intestinal adenocarcinoma is further described by a specific term such as type, continue to the next rule.

Rule H4 Code **8210** (adenocarcinoma in **adenomatous polyp**), **8261** (adenocarcinoma in **villous adenoma**), or **8263** (adenocarcinoma in **tubulovillous adenoma**) when:
- The final diagnosis is adenocarcinoma in a polyp
- The final diagnosis is adenocarcinoma **and** a residual polyp or polyp architecture is recorded in other parts of the pathology report.
- The final diagnosis is adenocarcinoma **and** there is reference to a residual or pre-existing polyp or
- The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in a polyp or
- There is documentation that the patient had a polypectomy

Note 1: It is important to know that the adenocarcinoma originated in a polyp.

Note 2: Code adenocarcinoma in a polyp only when the malignancy is in the residual polyp (adenoma) or references to a pre-existing polyp (adenoma) indicate that the malignancy and the polyp (adenoma) are the same lesion.

Rule H5 Code **8480** (mucinous/colloid adenocarcinoma) or **8490** (signet ring cell carcinoma) when the final diagnosis is:
- **Mucinous/colloid** (8480) or **signet ring cell** carcinoma (8490) or
- Adenocarcinoma, NOS and the microscopic description documents that **50% or more** of the tumor is **mucinous/colloid** or
- Adenocarcinoma, NOS and the microscopic description documents that **50% or more** of the tumor is **signet ring cell** carcinoma

Colon Histology Coding Rules – Text
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H6 Code **8140** (adenocarcinoma, NOS) when the final diagnosis is **adenocarcinoma** and:

- The microscopic diagnosis states that **less than 50%** of the tumor is **mucinous/colloid** or
- The microscopic diagnosis states that **less than 50%** of the tumor is **signet ring cell** carcinoma or
- The **percentage** of mucinous/colloid or signet ring cell carcinoma is **unknown**

Rule H7 Code **8255** (adenocarcinoma with mixed subtypes) when there is a **combination** of **mucinous/colloid and signet ring cell** carcinoma.

Rule H8 Code **8240** (carcinoid tumor, NOS) when the diagnosis is **neuroendocrine** carcinoma (8246) **and carcinoid tumor** (8240).

Rule H9 Code **8244** (composite carcinoid) when the diagnosis is **adenocarcinoma and carcinoid tumor**.

Rule H10 Code **8245** (adenocarcinoid) when the diagnosis is **exactly** **"adenocarcinoid."**

Rule H11 Code the histology when only **one histologic type** is identified.

Rule H12 Code the invasive histology when both **invasive and in situ** histologies are present.

Rule H13 **Code the** most **specific** histologic **term when** the diagnosis is:

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Sarcoma, NOS (8800) and a more specific sarcoma (invasive only)

Note 1: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 2: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H14 Code the histology with the **numerically higher** ICD-O-3 code.

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

Note: These rules only apply to multiple tumors that are reported as a **single primary**.

Rule H15 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- From CT, PET or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H16 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H17 Code **8220** (adenocarcinoma in adenomatous polyposis coli) when:

- **Clinical** history says **familial polyposis** and final diagnosis on the **pathology report** from resection is **adenocarcinoma in adenomatous polyps** or
- There are **>100 polyps** identified in the resected specimen or
- The number of polyps is not given but the diagnosis is **familial polyposis**

Rule H18 Code **8263** (adenocarcinoma in a tubulovillous adenoma) when multiple in situ or malignant polyps are present, at least one of which is tubulovillous

***Note*:** Use this rule only when there are multiple polyps or adenomas. Do not use this rule if there is a frank adenocarcinoma and a malignancy in a single polyp or adenoma.

Rule H19 Code **8221** (adenocarcinoma in multiple adenomatous polyps) when:

- There are **>1 and <=100 polyps** identified in the resected specimen or
- There are multiple polyps (adenomas) and the number is not given and **familial polyposis** is **not mentioned**

***Note*:** Use this rule only when there are multiple polyps. Do not use for a single polyp (adenoma) or for a frank malignancy and a malignancy in a single polyp (adenoma).

Colon Histology Coding Rules – Text
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H20 Code the histology of the **most invasive** tumor when:

- There is a frank adenocarcinoma and a carcinoma in a polyp or
- There are in situ and invasive tumors or
- There are multiple invasive tumors

Note 1: See the Colon Equivalent Terms, Definitions and Illustrations for the definition of most invasive.

- One tumor is in situ and one is invasive, code the histology from the invasive tumor.
- Both/all histologies are invasive, code the histology of the most invasive tumor.

Note 2: If tumors are equally invasive, go to the next rule

Rule H21 Code **8210** (adenocarcinoma in **adenomatous polyp**), **8261** (adenocarcinoma in **villous adenoma**), or **8263** (adenocarcinoma in **tubulovillous adenoma**) when:

- The final diagnosis is adenocarcinoma **and** the microscopic description or surgical gross describes polyps or
- The final diagnosis is adenocarcinoma **and** there is reference to residual or pre-existing polyps or
- The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in polyps or
- There is documentation that the patient had a polypectomy

Note: It is important to know that the adenocarcinoma originated in a polyp.

Rule H22 Code the histology when only **one histologic type** is identified.

Rule H23 **Code the** more **specific** histologic **term** when the diagnosis is:

- Cancer/malignant neoplasm, NOS (8000) and a specific histology or
- Carcinoma, NOS (8010) and a specific carcinoma or
- Adenocarcinoma, NOS (8140) and a specific adenocarcinoma or
- Sarcoma, NOS (8800) and a specific sarcoma (invasive only)

Note 1: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 2: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H24 Code the histology with the **numerically higher** ICD-O-3 code.

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.

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR: IN SITU CARCINOMA ONLY

(Single Tumor; 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 the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record

Note 2: Code the specific histology when documented.

Rule H2 Code the histology when only **one histologic type** is identified

Rule H3 **Code the** more **specific** histologic **term when** the diagnosis is:
- Carcinoma in situ, NOS (8010) and a specific carcinoma in situ or
- Adenocarcinoma in situ, NOS (8140) and a specific adenocarcinoma in situ or
- Intraductal carcinoma, NOS (8500) and a specific intraductal carcinoma (Table 1)

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, with ___ differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.

Rule H4 Code **8501/2** (comedocarcinoma, non-infiltrating) when there is **non-infiltrating comedocarcinoma and any** other **intraductal** carcinoma (Table 1).
Example: Pathology report reads intraductal carcinoma with comedo and solid features. Code 8501/2 (comedocarcinoma).

Rule H5 Code **8522/2** (intraductal carcinoma and lobular carcinoma in situ) **(Table 3)** when there is a combination of **in situ lobular** (8520) **and intraductal** carcinoma (Table 1).

Rule H6 Code **8523/2** (intraductal carcinoma mixed with other types of in situ carcinoma) **(Table 3**) when there is a combination of intraductal carcinoma and **two** or more specific intraductal types OR there are **two or more specific intraductal** carcinomas.
Note 1: Use Table 1 to identify the histologies
Note2: Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

Rule H7 Code **8524/2** (in situ lobular mixed with other types of in situ carcinoma) **(Table 3**) when there is **in situ lobular** (8520) **and any in situ** carcinoma **other than intraductal** carcinoma (Table 1).
Note: Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H8 Code **8255/2** (adenocarcinoma in situ with mixed subtypes) **(Table 3)** when there is a **combination** of in situ/non-invasive histologies that **does not include** either **intraductal** carcinoma (Table 1) **or in situ lobular** (8520).
Note: Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

This is the end of instructions for a Single Tumor: In Situ Carcinoma Only.
Code the histology according to the rule that fits the case.

SINGLE TUMOR: INVASIVE AND IN SITU CARCINOMA
(Single Tumor; in situ and invasive components)

Rule H9 **Code the invasive histology** when both invasive and in situ components are present.
Note 1: Ignore the in situ terms.
Note 2: This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive duct and in situ lobular are coded to invasive duct (8500/3) rather than the combination code for duct and lobular carcinoma (8522/3).

This is the end of instructions for a Single Tumor: Invasive and In Situ Carcinoma.
Code the histology according to the rule that fits the case.

SINGLE TUMOR: INVASIVE CARCINOMA ONLY
(Single Tumor; all parts are invasive)

Rule H10 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.
Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- Mammogram
- PET scan
- Ultrasound

Note 2: Code the specific histology when documented.
Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H11 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.
Note: Code the behavior /3.

Rule H12 **Code the** most **specific** histologic **term when** the diagnosis is:
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Duct carcinoma, NOS (8500) and a more specific duct carcinoma (8022, 8035, 8501-8508) or
- Sarcoma, NOS (8800) and a more specific sarcoma

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, with ___ differentiation. The terms architecture and pattern are subtypes only for in situ cancer.

Rule H13 Code **8530** (inflammatory carcinoma) only when the final diagnosis of the **pathology** report specifically **states inflammatory carcinoma**.
Note: Record dermal lymphatic invasion in Collaborative Staging

Rule H14 Code the histology when only **one histologic type** is identified.

Rule H15 Code the histology with the numerically **higher ICD-O-3 code** when there are **two or more** specific **duct** carcinomas.
Note: Use Table 2 to identify duct carcinomas

Rule H16 Code **8522** (duct and lobular) when there is a combination of **lobular** (8520) **and duct** carcinoma (**Table 3)**.
Note: Use Table 2 to identify duct carcinomas

Rule H17 Code **8523** (duct mixed with other types of carcinoma) when there is a combination of **duct and** any **other** carcinoma (**Table 3)**.
Note 1: Use Table 2 to identify duct carcinomas
Note 2: Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.

Rule H18 Code **8524** (lobular mixed with other types of carcinoma) when the tumor is **lobular** (8520) **and** any **other carcinoma (Table 3)**.
Note: Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.

Rule H19 Code **8255** (adenocarcinoma with mixed subtypes) **(Table 3)** for multiple **histologies** that **do not include duct or lobular** (8520).
Note: Use Table 2 to identify duct carcinomas

This is the end of instructions for a Single Tumor: Invasive Carcinoma Only.
Code the histology according to the rule that fits the case.

Breast Histo

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H20 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- Mammogram
- PET scan
- Ultrasound

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H21 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H22 Code **8530** (inflammatory carcinoma) only when the final diagnosis of the **pathology** report specifically **states inflammatory carcinoma.**

Note: Record dermal lymphatic invasion in Collaborative Staging

Rule H23 Code the histology when only **one histologic type** is identified.

Rule H24 Code **8543/2** (in situ Paget disease and intraductal carcinoma) **(Table 3)** when the **pathology** report **specifically states** that the **Paget disease** is **in situ and** the **underlying tumor** is **intraductal** carcinoma (Table 1).

Note: Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

Rule H25 Code **8543/3** (Paget disease and intraductal carcinoma) for **Paget disease and intraductal** carcinoma **(Table 3)**

Note 1: ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3).

Note 2: Includes both invasive Paget disease and Paget disease with behavior not stated.

Note 3: Use Table 1 to identify intraductal carcinomass

Rule H26 Code **8541/3** (Paget disease and infiltrating duct carcinoma) for **Paget disease and** invasive **duct** carcinoma **(Table 3)**.

Note 1: ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3).

Note 2: Includes both invasive Paget disease and Paget disease with behavior not stated.

Note 3: Use Table 2 to identify duct carcinomas

Rule H27 Code the invasive histology when **both invasive and in situ** tumors are present.
Note 1: Ignore the in situ terms.
Note 2: This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive lobular and in situ duct carcinoma are coded to invasive lobular (8520/3) rather than the combination code for duct and lobular carcinoma (8522/3).

Rule H28 Code **8522** (duct and lobular) when there is any combination of **lobular** (8520) **and duct** carcinoma **(Table 3)**.
Note: Use Table 2 to identify duct carcinomas

Rule H29 Code the histology with the **numerically higher** ICD-O-3 code.

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.

This page left blank

Other Sites Multiple Primary Rules – Text

Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** tumor **or multiple** tumors, opt for a single tumor and abstract as a single primary. *

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

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Tumors.

SINGLE TUMOR

Note 1: Tumor not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 A **single tumor** is always a single primary. *

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

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Single Tumor.

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.
Note 1: Tumors not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M3 **Adenocarcinoma** of the **prostate** is always a single primary. *

Note 1: Report only one adenocarcinoma of the prostate per patient per lifetime.
Note 2: 95% of prostate malignancies are the common (acinar) adenocarcinoma histology (8140). See Equivalent Terms, Definitions and Tables for more information.
***Note 3*:** If patient has a previous acinar adenocarcinoma of the prostate in the database and is diagnosed with adenocarcinoma in 2007 it is a single primary.

Other Sites MP

Other Sites Multiple Primary Rules – Text

Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemi

Rule M4 **Retinoblastoma** is always a single primary (**unilateral or bilateral**). *

Rule M5 **Kaposi sarcoma** (any site or sites) is always a single primary. *

Rule M6 **Follicular and papillary** tumors in the **thyroid** within 60 days of diagnosis are a single primary. *

Rule M7 **Bilateral epithelial** tumors (8000-8799) of the **ovary** within 60 days are a single primary. *

Rule M8 Tumors on **both sides** (right and left) of a site listed in Table 1 are multiple primaries. **
Note: Table 1 – Paired Organs and Sites with Laterality)

Rule M9 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 the **colon, rectosigmoid, rectum**.

Rule M10 Tumors diagnosed **more than one (1) year** apart are multiple primaries. **

Rule M11 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**60**9 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 M12 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_)
- **Bones, joints, and articular cartilage** (C40_- C41_)
- **Peripheral nerves and autonomic nervous system** (C47_)
- **Connective subcutaneous and other soft tissues** (C49_)
- **Skin** (C44_)

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, with ___ differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.

Rule H5 Code the appropriate combination/mixed code (Table 2) when there are **multiple specific histologies** or when there is a non-specific histology **with multiple specific histologies**

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, with ___ differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.

Rule H6 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for a Single Tumor: In Situ Carcinoma Only.
Code the histology according to the rule that fits the case.

SINGLE TUMOR: INVASIVE AND IN SITU

(Single Tumor; in situ and invasive components)

Rule H7 Code the single invasive histology**. Ignore the in situ** terms.

Note: This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category.

This is the end of instructions for a Single Tumor: Invasive and In Situ Carcinoma.
Code the histology according to the rule that fits the case.

Other Sites Histology Coding Rules – Text

Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

SINGLE TUMOR: INVASIVE ONLY

(Single Tumor; all parts are invasive)

Rule H8 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT, PET, or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H9 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H10 Code 8140 (adenocarcinoma, NOS) for prostate primaries when the diagnosis is acinar (adeno)carcinoma.

Rule H11 Code the histology when only **one histologic type** is identified

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*:** If this is a papillary carcinoma of the thyroid, go to Rule H14

Rule H12 Code **8210** (adenocarcinoma in **adenomatous polyp**), **8261** (adenocarcinoma in **villous adenoma**), or **8263** (adenocarcinoma in **tubulovillous adenoma**) when:

- The final diagnosis is adenocarcinoma in a polyp or
- The final diagnosis is adenocarcinoma and a residual polyp or polyp architecture is recorded in other parts of the pathology report or
- The final diagnosis is adenocarcinoma and there is reference to a residual or pre-existing polyp or
- The final diagnosis is adenocarcinoma mucinous/colloid or signet ring cell adenocarcinoma in a polyp or
- There is documentation that the patient had a polypectomy

Note: It is important to know that the adenocarcinoma originated in a polyp.

New Data Item
Effective with cases diagnosed 1/1/2007

Multiplicity Counter

Item Length: 2
NAACCR Item #: 446
NAACCR Name: Multiplicity Counter

This data item is used to count the number of tumors (multiplicity) reported as a single primary. Do not count metastatic tumors. Use the multiple primary rules for the specific site to determine whether the tumors are a single primary or multiple primaries.

Example 1: The patient has a 2 cm infiltrating duct carcinoma in the LIQ and a 1 cm infiltrating duct carcinoma in the UIQ of the left breast. Accession as a single primary and enter the number 02 in the data item Multiplicity Counter

Example 2: Operative report for TURB mentions multiple bladder tumors. Pathology report: Papillary transitional cell carcinoma present in tissue from bladder neck, dome, and posterior wall. Record 99 (multiple tumors, unknown how many) in Multiplicity Counter.

Example 3: Pathology from colon resection shows a 3 cm adenocarcinoma in the ascending colon. Biopsy of liver shows a solitary metastatic lesion compatible with the colon primary. Record 01 in Multiplicity Counter (do not count the metastatic lesion).

Example 4: Patient has an excisional biopsy of the soft palate. The pathology shows clear margins. Record 01 in the Multiplicity Counter. Within six months another lesion is excised from the soft palate. Use the head and neck multiple primary rules to determine this tumor is not accessioned as a second primary. Change the Multiplicity Counter to code 02 to reflect the fact that there were two separate tumors abstracted as a single primary.

Example 5: CT of chest shows two lesions in the left lung and a single lesion in the right lung. Biopsy of the right lung lesions shows adenocarcinoma. No other workup is done. Using the multiple primary rules for lung, the case is abstracted as a single primary. Enter the number 03 in the data item Multiplicity Counter.

Codes

01 One tumor only
02 Two tumors present
03 Three tumors present
..
..
88 Information on multiple tumors not collected/not applicable for this site
99 Multiple tumors present, unknown how many; unknown if multiple tumors

New Data Item
Effective with cases diagnosed 1/1/2007

Coding Instructions

1. Code the number of tumors being abstracted as a single primary.
2. Do not count metastasis.
3. When there is a tumor or tumors with separate single or multiple foci, ignore/do not count the foci
   a. When the tumor is multifocal or multicentric and the foci of tumor are measured, count them as tumors
   b. When the tumor is multifocal or multicentric and the foci of tumor are not measured, code as 99
4. Use code 01 when
   a. There is a single tumor in the primary site being abstracted
   b. There is a single tumor with separate foci of tumor
5. Use code 88 for:
   a. Leukemia
   b. Lymphoma
   c. Immunoproliferative disease
   d. Unknown primary
6. Use code 99 when
   a. The original pathology report is not available and the documentation does not specify whether there was a single or multiple tumors in the primary site.
   b. The tumor is described as multifocal or multicentric and the number of tumors is not mentioned.
   c. The tumor is described as diffuse.
   d. The operative or pathology report describes multiple tumors but does not give an exact number.
   e. It is unknown if there is a single tumor or multiple tumors and the multiple primary rules instructed you to default to a single tumor.
7. Leave this field blank for cases diagnosed prior to 01/01/2007.