

# Solid Tumor Rules

---

NAACCR 2018-2019 WEBINAR SERIES

1



## Q&A

---

Please submit all questions concerning the webinar content through the Q&A panel.

If you have participants watching this webinar at your site, please collect their names and emails

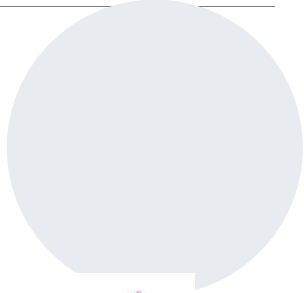
We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.

2



# Fabulous Prizes

---

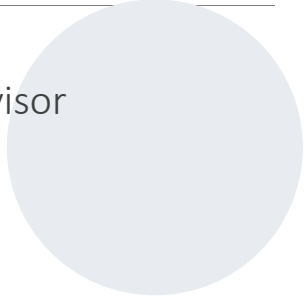


# Guest Speaker

---

Patrick Stevens, CTR

- Training Coordinator / Field Services Supervisor
- New York State Cancer Registry

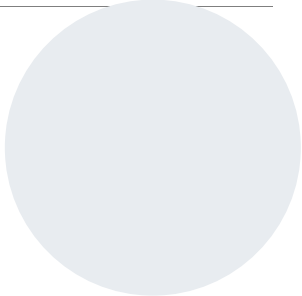


# Agenda


---

## Solid Tumor Rules

- Lung
- Breast



5



# Solid Tumor Rules-Manual

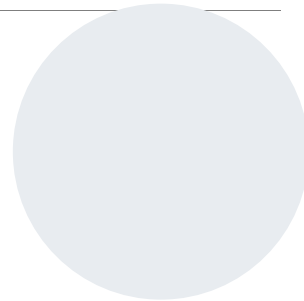
---

6

## Navigating the Manual

---

- Page Navigation Tools
- Bookmarks
- Search function (Ctrl / F)
- Hyperlinks
- Highlighting
- Sticky notes



7



## What's New?

---

### July 2019 Update

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

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

8



## General Equivalent or Equal Terms

---

- “And” and “With” when describing multiple histologies within a single tumor
- **Adenocarcinoma; Carcinoma**
- Simultaneous; At the same time; **Prior to first course treatment**
- Tumor; Mass; Tumor mass; Lesion; Neoplasm; Nodule
  - **Only** to determine multiple primaries
  - **Not** to determine reportability

9



## Do NOT

---

Do NOT use the Solid Tumor Rules to determine:

- Case Reportability
- Stage
- Grade

Do NOT base number of primaries on staging (e.g., how many staging forms are completed)

10



## Timing

---

Abstract multiple primaries when a subsequent tumor is identified following a clinically disease-free period greater than X years after the original diagnosis or last recurrence.

1 year = 365 days  
>365 days = >1 year

Clinically disease-free means no evidence of recurrence on follow-up.

11



## Timing

---

Exception: When pathologist compares slides from current tumor and “original” tumor and documents current tumor is a recurrence of “original” primary.

When there is a recurrence within the prescribed time period the clock is reset to the date of the most recent recurrence.

12



## Ambiguous Terminology

---

Do Not code histology described by ambiguous terminology unless:

- Histology is clinically confirmed by physician
- Patient is treated for stated histology
- Case is accessioned based on ambiguous terminology

13



## Solid Tumor Rules - Lung

---

14

## Rule out Metastases

---

Lungs are one of the most common sites of distant metastases for many other sites.



15

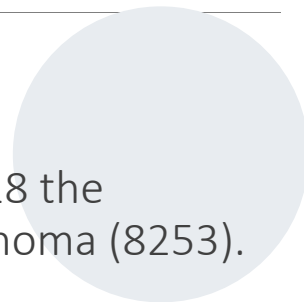


## Changes from 2007 MPH Rules

---

~~Bronchioloalveolar Carcinoma (BAC)~~

For cases diagnosed on or after 1/1/2018 the preferred term is Mucinous Adenocarcinoma (8253).



16





## Changes from 2007 MPH Rules

---

Code the most specific histology from biopsy or resection.

When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen.

17



## Changes from 2007 MPH Rules

---

New terms and codes For Lung Only

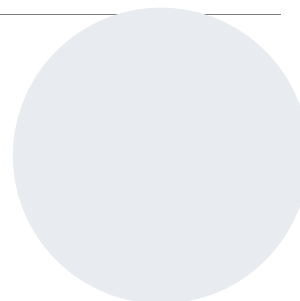
- Mucinous carcinoma/adenocarcinoma
  - 8253/3 when
    - Behavior unknown/not documented
    - Invasive
  - 8257/3 when
    - Microinvasive
    - Minimally invasive
  - 8253/2 when
    - Preinvasive
    - In situ

18



## Changes from 2007 MPH Rules

- New terms and codes For Lung Only
  - Non-mucinous carcinoma/adenocarcinoma
    - 8256/3 when
      - Microinvasive
      - Minimally invasive
    - 8250/2 when
      - Preinvasive
      - In situ



19



## Changes from 2007 MPH Rules

- New terms and codes For Lung Only
  - Adenocarcinomas (CAP Terminology)
    - Adenocarcinoma, acinar predominant 8551
    - Adenocarcinoma, lepidic predominant 8250
    - Adenocarcinoma, micropapillary predominant 8265
    - Adenocarcinoma, papillary predominant 8260
    - Adenocarcinoma, solid predominant 8230



20



## Terms that are NOT Equivalent or Equal

- Bilateral involvement is NOT equivalent to either a single or multiple primaries
- Bronchus is not always equivalent to mainstem bronchus
- Mucinous is NOT equivalent to colloid (Lung only)
- Mucin-producing/mucin-secreting carcinoma 8481 is NOT equivalent to mucinous carcinoma 8253
- Phenotype is not equivalent to subtype/type/variant

21



## Table 1 – Coding Primary Site

Terminology	Laterality	Site Term and Code
Bronchus intermedius Carina Hilus of lung Perihilar	Bilateral	Mainstem bronchus <b>C34.0</b> <i>Note: <b>Bronchus intermedius</b> is the portion of the <b>right mainstem bronchus</b> between the upper lobar bronchus and the origin of the middle and lower lobar bronchi</i>
Lingula of lung	Left	Upper lobe <b>C34.1</b>
Apex Apex of lung Lung apex Pancoast tumor Superior lobar bronchus Upper lobe bronchi	Bilateral	Upper lobe <b>C34.1</b>

22



## Table 2 – Combination/mixed Histology Codes

Do NOT use Table 2:

- For tumors with both invasive and in situ behavior
- When one of the histologies is described as differentiation or features
- When the terms are a NOS and a subtype/variant of that NOS

## Table 2 – Combination/mixed Histology Codes

Required Terms	Combination Histologies and Code
Adenocarcinoma, NOS <p style="text-align: center;"><b>AND</b></p> Squamous cell carcinoma, NOS <i>Note:</i> Diagnosis <b>must be</b> adenocarcinoma NOS and squamous cell carcinoma NOS, <b>NOT</b> any of the <b>subtypes/variants</b> of adenocarcinoma or squamous cell carcinoma.	Adenosquamous carcinoma <b>8560</b>
Giant cell carcinoma <p style="text-align: center;"><b>AND</b></p> Spindle cell carcinoma <i>Note:</i> Sarcomatoid carcinoma is not in the histology table because Sarcomatoid tumors primarily originate in the mediastinum. The combination code is added for the rare occasion when a tumor occurs within the lung.	Sarcomatoid carcinoma <b>8033</b> <i>Note:</i> Both giant cell carcinoma and spindle cell carcinoma are components of sarcomatoid carcinoma. The most accurate code for a combination of giant cell and spindle cell carcinoma is sarcomatoid carcinoma

### Table 3 – Specific Histologies, NOS, and Subtypes/Variants

Specific or NOS Histology Term and Code	Synonym of Specific or NOS	Subtype/Variant of NOS and Code
Adenocarcinoma 8140  <b>Note 1:</b> Mucinous adenocarcinoma for lung only is coded as follows: <ul style="list-style-type: none"> <li>• <b>8253/3*</b> when                             <ul style="list-style-type: none"> <li>○ Behavior unknown/not documented (use staging form to determine behavior when available)</li> <li>○ Invasive</li> </ul> </li> <li>• <b>8257/3*</b> when                             <ul style="list-style-type: none"> <li>○ Microinvasive</li> <li>○ Minimally invasive</li> </ul> </li> <li>• <b>8253/2*</b> when                             <ul style="list-style-type: none"> <li>○ Preinvasive</li> <li>○ In situ</li> </ul> </li> </ul>	Adenocarcinoma NOS Adenocarcinoma in situ <b>8140/2</b> Adenocarcinoma invasive <b>8140/3</b>	Acinar adenocarcinoma/adenocarcinoma, acinar predominant ( <b>for lung only</b> ) <b>8551*</b> Adenoid cystic/adenocystic carcinoma <b>8200</b> Colloid adenocarcinoma <b>8480</b> Fetal adenocarcinoma <b>8333</b> Lepidic adenocarcinoma/adenocarcinoma, lepidic predominant <b>8250/3*</b> Mucinous carcinoma/adenocarcinoma ( <b>for lung only</b> ) in situ <b>8253/2*</b> invasive <b>8253/3*</b> minimally invasive <b>8257/3*</b> microinvasive <b>8257/3*</b> preinvasive <b>8253/2*</b>

## Multiple Primary (M) Rules

## Unknow if Single or Multiple Tumors

---

**M1** Abstract a **single primary** when it is not possible to determine if there is a **single tumor** or **multiple tumors**.

---

### Single Tumor

**M2** Abstract a **single primary** when there is a **single tumor**.

27



## Multiple Tumors

---

**M4** Abstract **multiple primaries** when the patient has a subsequent tumor after being **clinically disease-free** for greater than **three years** after the original diagnosis or last recurrence.

28



## Pop Quiz #1

History of acinar adenocarcinoma diagnosed 4/11/15.  
7/13/18 Chest CT shows a 1.4cm mass in RUL suspicious for malignancy. PET scan: R apical soft tissue density approx. 1.5cm consistent lung ca. R lung biopsy: minute fragments of PD adenocarcinoma, acinar type. Pathologic review of previous slides confirms recurrent acinar adenoca.

How Many Primaries:

M Rule:

Histology(ies):

29



## Pop Quiz #1

History of acinar adenocarcinoma diagnosed 4/11/15.  
7/13/18 Chest CT shows a 1.4cm mass in RUL suspicious for malignancy. PET scan: R apical soft tissue density approx. 1.5cm consistent lung ca. R lung biopsy: minute fragments of PD adenocarcinoma, acinar type. Pathologic review of previous slides confirms recurrent acinar adenoca.

How Many Primaries: 1

M Rule: M14

Histology(ies): Retain code 8550 from 4/11/15 diagnosis

30



## Multiple Tumors

---

**M5** Abstract **multiple primaries** when there is **at least one** tumor that is **small cell carcinoma 8041** or any small cell subtypes/variants and another tumor that is **non-small cell carcinoma 8046** or any non-small cell carcinoma subtypes/variants.

31



## Multiple Tumors

---

**M6** Abstract **multiple primaries** when separate/non-contiguous tumors are two or more **different subtypes/variants** in Column 3, Table 3.

32





## Pop Quiz #2

---

6/18/18: RUL lung biopsy: carcinoid tumor.

2/7/19: RML wedge resection: atypical carcinoid tumor.

How Many Primaries?

M Rule:

Histology(ies):

33



## Pop Quiz #2

---

6/18/18: RUL lung biopsy: carcinoid tumor.

2/7/19: RML wedge resection: atypical carcinoid tumor.

How Many Primaries? 2

M Rule: M6

Histology(ies): 8240 (Carcinoid [Typical]) & 8249 (Atypical carcinoid) – Rule H4 for both

34



## Multiple Tumors

---

**M7** Abstract **single primary** when synchronous, separate/non-contiguous tumors in the same lung are on **the same row** in Table 3.

35



## Multiple Tumors

---

**M8** Abstract **multiple primaries** when separate/non-contiguous tumors are:

- On different rows in Table 3
- A combination code in Table 2 and a code from Table 3

36



## Multiple Tumors

---

M9 Abstract a **single primary** when there are **simultaneous multiple** tumors:

- In **both** lungs (multiple in right and multiple in left) **OR**
- In the **same** lung **OR**
- **Single** tumor in one lung; **multiple** tumors in contralateral lung

37



## Multiple Tumors

---

M10 Abstract a **single primary** when an **in situ** tumor is diagnosed **after** an **invasive** tumor **AND** tumors occur in the same lung.

38



### Pop Quiz #3

---

Two tumors identified in right lung (RUL & RLL). Biopsy of the larger tumor (RLL) is positive for minimally invasive mucinous carcinoma.

How Many Primaries:

M Rule:

Histology(ies):

39



### Pop Quiz #3

---

Two tumors identified in right lung (RUL & RLL). Biopsy of the larger tumor (RLL) is positive for minimally invasive mucinous carcinoma.

How Many Primaries: 1

M Rule: M9

Histology(ies): 8257 (Minimally invasive mucinous adenocarcinoma) – H10

40



## Multiple Tumors

---

**M11** Abstract **multiple primaries** when there is a **single** tumor in **each lung** (one tumor in the right lung and one tumor in the left lung).

41



## Histology (H) Rules

---

42

## Important Notes

---

- Code the histology diagnosed prior to neoadjuvant treatment
- Do not change histology in order to make the case applicable for staging.

43



## Coding Histology

---

Code the **most specific** histology or subtype/variant, regardless of whether it is described as:

- A majority or predominant part of tumor
- The minority of tumor
- A component

44



## Coding Histology

---

Code the histology described as **differentiation** or **features/features of ONLY** when there is a specific ICD-O code for the “NOS with \_\_\_\_\_ features” or “NOS with \_\_\_\_\_ differentiation”.

45



## Coding Histology

---

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

- A. The only diagnosis available is **one histology** term described by ambiguous terminology
- B. There is a **NOS histology** and a **more specific** (subtype/variant) described by ambiguous terminology

46

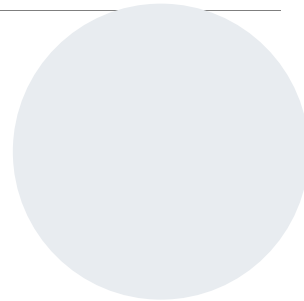


## Coding Histology

---

**DO NOT CODE** histology described as:

- Architecture
- Foci; focus; focal
- Pattern



47

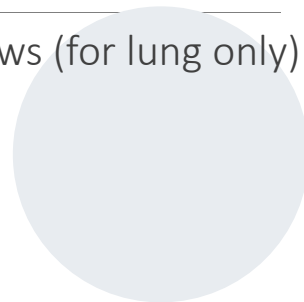


## Histology Rules

---

**H1** Code mucinous adenocarcinoma as follows (for lung only):

- 8253/3 when
  - Behavior unknown/not documented
  - Invasive
- 8257/3 when
  - Microinvasive
  - Minimally invasive
- 8253/2 when
  - Preinvasive
  - In situ



48





## Histology Rules

---

H2 Code non-mucinous adenocarcinoma as follows (for lung only):

- 8256/3 when
  - Microinvasive
  - Minimally invasive
- 8250/2 when
  - Preinvasive
  - In situ

49



## Histology Rules

---

H3 Code the specific histology when the diagnosis is **non-small cell lung carcinoma (NSCLC) consistent with** (or any other ambiguous term) **a specific carcinoma** (such as adenocarcinoma, squamous cell carcinoma, etc.)

50



## Pop Quiz #4

3/16/18: CT Chest reveals large mass in RLL (5cm), and a 3cm LUL nodule. Also noted: left paratracheal and L hilar lymphadenopathy.

3/21/18: RLL needle biopsy: Adenocarcinoma

3/28/18: LUL needle biopsy: Invasive adenocarcinoma, predominantly papillary carcinoma.

How Many Primaries?

M Rule:

Histology(ies):

51



## Pop Quiz #4

3/16/18: CT Chest reveals large mass in RLL (5cm), and a 3cm LUL nodule. Also noted: left paratracheal and L hilar lymphadenopathy.

3/21/18: RLL needle biopsy: Adenocarcinoma

3/28/18: LUL needle biopsy: Invasive adenocarcinoma, predominantly papillary carcinoma.

How Many Primaries? 2

M Rule: M11

Histology(ies): 8140 (Adenocarcinoma, NOS) – H4 & 8260 (Papillary adenocarcinoma) – H6

52



## Histology Rules

H7 Code the histology that comprises the **greatest percentage** of tumor when two or more of the following histologies are present:

- Acinar adenocarcinoma / Adenocarcinoma, acinar predominant 8551
- Lepidic adenocarcinoma / Adenocarcinoma, lepidic predominant 8250
- Micropapillary adenocarcinoma / Adenocarcinoma, micropapillary predominant 8265
- Papillary adenocarcinoma / Adenocarcinoma, papillary predominant 8260
- Solid adenocarcinoma / Adenocarcinoma, solid predominant 8230

53



## Histology Rules

H8 Code a **combination** code when there are multiple histologies **AND**

- The combination is listed in Table 2 in Equivalent Terms and Definitions, the ICD-O and all updates, **OR**
- You received a combination code from Ask a SEER Registrar.

54



## Pop Quiz #5

---

Nodule in RML discovered during routine CXR and confirmed by CT as 1.8cm lesion, suspicious for malignancy. Final Dx. following wedge resection: 1.5cm combined small cell and papillary carcinoma.

How Many Primaries:

M Rule:

Histology(ies):

55



## Pop Quiz #5

---

Nodule in RML discovered during routine CXR and confirmed by CT as 1.8cm lesion, suspicious for malignancy. Final Dx. following wedge resection: 1.5cm combined small cell and papillary carcinoma.

How Many Primaries: 1

M Rule: M2

Histology(ies): 8045 (Combined Small Cell Carcinoma) – H8

56




Questions?

---

57

Solid Tumor Rules-Breast

---



# Tables

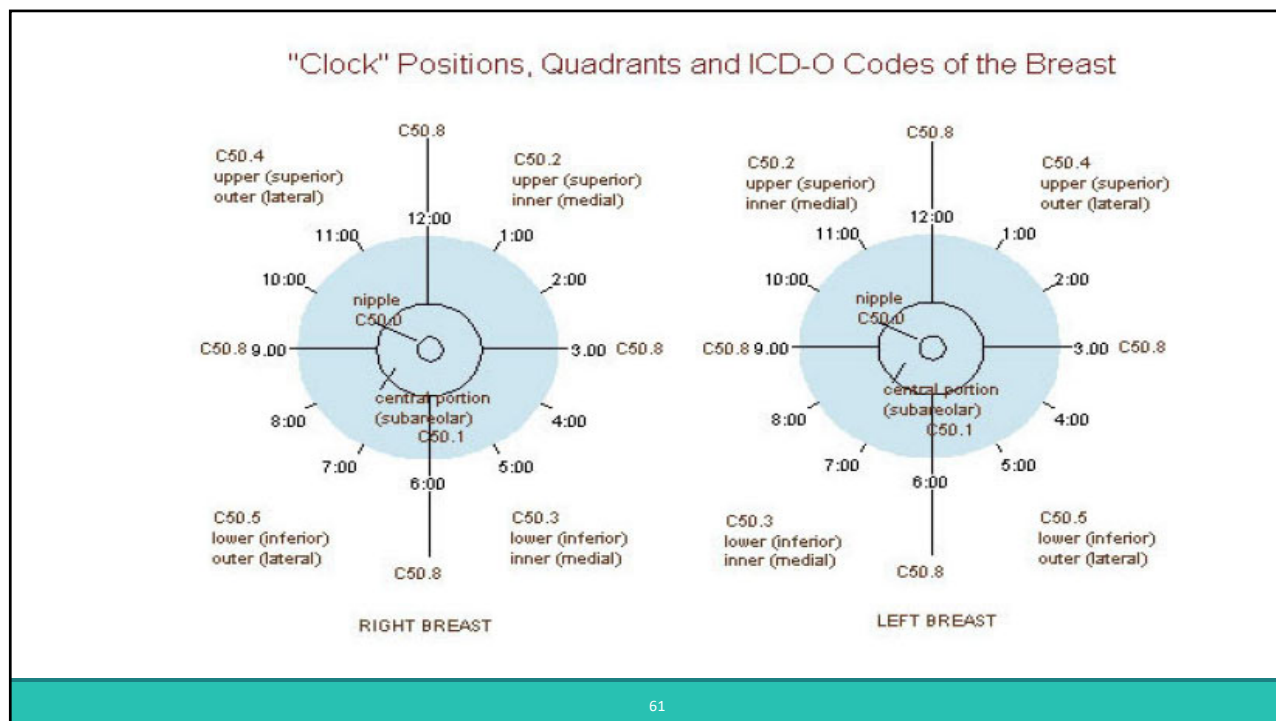
---

TABLE 1: PRIMARY SITE CODES

TABLE 2: HISTOLOGY COMBINATION CODES

TABLE 3: SPECIFIC HISTOLOGIES, NOS/ NST, AND SUBTYPES/VARIANTS

	Terms and Descriptive Language	Site Term and Code
<p><b>Table 1: Primary Site Codes</b></p> <hr/> <p>Includes terms not in the ICD O 3 manual</p>	Areolar Nipple Paget disease <b>without</b> underlying tumor <i>Note:</i> Paget with underlying tumor is coded to the quadrant of breast in which the underlying tumor is located	Nipple <b>C500</b>
	Above nipple Area extending 1 cm around areolar complex Behind the nipple Below the nipple Beneath the nipple Central portion of breast Cephalad to nipple Infra-areolar Lower central Next to areola NOS Next to nipple Retroareolar Subareolar Under the nipple Underneath the nipple	Central portion of breast <b>C501</b>



## Primary Site

### SEER Manual Appendix C

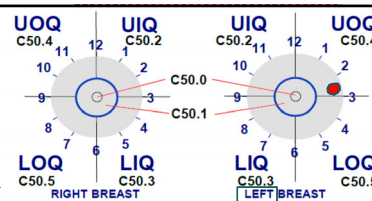
- Code the subsite with the invasive tumor when the pathology report identifies invasive tumor in one subsite and in situ tumor in a different subsite or subsites.
- Code the specific quadrant for multifocal tumors all within one quadrant
- Code the primary site to C508 when:
  - There is a single tumor in two or more subsites and the subsite in which the tumor originated is unknown
  - There is a single tumor located at the 12, 3, 6, or 9 o'clock position on the breast
- Code the primary site to C509 when there are multiple tumors (two or more) in at least two quadrants of the breast.

<https://seer.cancer.gov/manuals/2018/appendixc.html>

## Pop Quiz 6

Assign a primary site to the following

- Single tumor in the left breast at 2:30
  - C50.4 Upper Outer Quadrant
- Right breast inferior lateral quadrant
  - C50.5 Lower Outer Quadrant
- A patient is found to have a large 4cm ductal carcinoma with dermal invasion in the upper outer quadrant of the left breast and a second 1cm ductal carcinoma in the lower outer quadrant.
  - C50.9 Breast NOS



Inferior lateral	Lower outer quadrant of breast C50.5
Inferior outer	
Lower lateral	
Lower outer quadrant (LOQ)	

Code the primary site to C50.9 when there are multiple tumors (two or more) in at least two quadrants of the breast.

63



## Table 2: Histology Combination Codes

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

5. Use the combination codes only when the histologies are in a single tumor OR multiple tumors abstracted as a single primary.

*Note 1:* Do not use Table 2 in the following situations:

- Invasive and in situ.
- One histology is differentiation or features
- When terms are an NOS and a subtype/variant of that NOS.





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

Use Table 3 as directed by the Histology Rules to assign the more common histology codes for breast tumors.

*Note 1:* Some histologies may not be listed in the table. When a histology term is not found, reference ICD-O and all updates.



Row	Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
1	Acinic cell carcinoma 8550	Acinar adenocarcinoma Acinar carcinoma	
2	Adenoid cystic carcinoma (ACC) 8200	ACC Adenocystic basal cell carcinoma Carcinoma adenoides cysticum Cylindromatous carcinoma	
3	Adenomyoepithelioma with carcinoma 8983	AME Malignant AME	
4	Apocrine carcinoma 8401 <i>Note:</i> This is a diagnosis that is <b>EXACTLY</b> apocrine <b>carcinoma</b> , <b>not</b> a carcinoma NST with apocrine <b>features, differentiation, or type.</b>		
5	Carcinoma NST 8500 <i>Note:</i> Cribriform carcinoma may consist of up to 50% tubular formations. The term cribriform/tubular carcinoma is coded as cribriform carcinoma.	Carcinoma of no special type (ductal/NST) Carcinoma/carcinoma NST with choriocarcinomatous features Carcinoma/carcinoma NST with cribriform features Carcinoma/carcinoma NST with melanotic features Carcinoma/carcinoma NST with signet ring cell differentiation DCIS 8500/2 Duct/ductal carcinoma Duct/ductal carcinoma in situ 8500/2 Duct/ductal carcinoma NOS	Carcinoma with osteoclastic-like stromal giant cells 8035 Cribriform carcinoma 8201/3 Pleomorphic carcinoma 8022/3



## Multiple Primary Rules: Multiple Tumors

---

## Single Tumor

---

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

- Multiple quadrants of same breast OR
- Bilateral breasts

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

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

## Multiple Tumors

---

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

- *Note 1:* The rules are hierarchical. This rule only applies when there is a subsequent breast tumor.
- *Note 2:* Clinically disease-free means that there was no evidence of recurrence on follow-up.

69



## M6 and M7

---

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

- Multiple quadrants of same breast OR
- Bilateral breasts

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

- *Note 1:* Physician statement of “bilateral breast cancer” should not be interpreted as meaning a single primary. The term is not used consistently. The literal definition of bilateral is “cancer in both breasts”.
- *Note 2:* When there are multiple tumors in one breast, follow the Multiple Primary Rules to determine if they are single or multiple primaries.
- *Note 3:* The histologies within each breast may be the same or different.



## M8

---

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

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



## M9

---

Abstract multiple primaries when the diagnosis is Paget disease with ~~synchronous~~ underlying tumor which is NOT duct.

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



## M10

---

Abstract a single primary when ~~synchronous/simultaneous~~ multiple tumors are carcinoma NST/duct and lobular.

- Both/all tumors may be a mixture of carcinoma NST/duct and lobular 8522 OR
- One tumor may be duct and another tumor lobular OR
- One tumor may be mixed duct and lobular 8522, the other tumor either duct or lobular
  - *Note 1:* Tumors must be in the same breast.



## Pop Quiz 7

---

A patient is diagnosed in January 2013 with invasive lobular carcinoma in the right breast.

She returns in January of 2019 and is found to have ductal carcinoma in the same breast.

Is the 2019 tumor a subsequent primary?

- Yes per rule M5



## Pop Quiz 8

A patient is diagnosed in January 2013 with invasive lobular carcinoma in the right breast.

- In January of 2015 she was found to have a metastatic axillary lymph node.

She returns in January of 2019 and is found to have ductal carcinoma in the same breast.

Is the 2019 tumor a subsequent primary?

- No per rule M10



## M11

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

DCIS following a diagnosis of:

- DCIS + lobular carcinoma in situ **8522/2 OR**
- DCIS + in situ Paget **8543/2 OR**
- DCIS + Invasive Paget **8543/3 OR**
- DCIS mixed with other in situ **8523/2** (code used for cases diagnosed prior to 1/1/2018)

Invasive carcinoma NST/duct following a diagnosis of:

- Invasive duct + invasive lobular **8522/3 OR**
- Invasive duct + invasive Paget **8541/3 OR**
- Invasive duct + other invasive carcinoma **8523/3**



## M12

Abstract multiple primaries when separate/non-contiguous tumors are two or more different subtypes/variants in Column 3 of Table 3 in the Equivalent Terms and Definitions. Timing is irrelevant.

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

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



## M13

Abstract a single primary when synchronous, separate/non-contiguous tumors are on the same row in Table 3 in the Equivalent Terms and Definitions.

*Note:* The same row means the tumors are:

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



## M14

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

- On different rows in Table 3 in the Equivalent Terms and Definitions
- A combination code in Table 2 and a code from Table 3
  - *Note 1:* Timing is irrelevant. Tumors may be synchronous or non-synchronous.
  - *Note 2:* Each row in the table is a distinctly different histology.
- *Example 1:* Paget disease of the nipple with underlying lobular are multiple primaries.
  - Paget and lobular are on different rows in Table 3.
- *Example 2:* Two tumors right breast.
  - One tumor is invasive mixed duct and lobular 8522/3 (combination code from Table 2)
  - Second tumor is tubular 8211/3 (histology from Table 3).
  - Abstract two primaries: 8522/3 and 8211/3.



## Pop Quiz 9

6/5/2019 Pathology Rt breast:

- Two tumors.
  - UOQ tumor: Metaplastic carcinoma      8575/3
  - LIQ tumor: Carcinosarcoma              8980/3

How many primaries?

- One

Rule:

- M13 Single primary when on the same row in Table 3.





## Pop Quiz 10

6/5/2019 Pathology Rt breast:

- Two tumors.
  - UOQ tumor: Ductal and Lobular carcinoma 8522/3
  - LIQ tumor: Carcinosarcoma 8980/3

How many primaries?

- Two

Rule:

- M14 Multiple primaries when histologies are a combination code in Table 2 and a code from table 3



## Pop Quiz 11

*When comparing a tumor diagnosed prior to 2018 to a tumor diagnosed 2018 or later, assign each tumor a "preliminary" histology using the 2018 STM rules.*

January 3 2016: Mammogram positive for a malignant mass in the upper-outer quadrant of the left breast. The tumor was excised and found to be infiltrating ductal carcinoma with medullary features. The patient refused any additional treatment.

The patient returned on January 6, 2019 and was found to have a new tumor in the same breast. The patient had a modified radical mastectomy and was found to have a 1.5cm medullary carcinoma in the lower out quadrant of the breast.

- Preliminary histology tumor 1 8500/3
- Preliminary histology tumor 2 8510/3

How many primaries?

- Two

Rule:

- M14 Abstract multiple primaries when histologies are on different rows in table 3



## M18

---

Abstract a single primary when none of the previous rules apply.

*Note:* Use this rule as a last resort. Please confirm that you have not overlooked an applicable rule.



## HISTOLOGY RULES

---

---

Rule H2 Code the histology when only one histology is present

- In situ module

Rule H7 Code the invasive histology when both invasive and in situ components are present

- Invasive and in situ

Rule H12 Code the histology when only one histology is present

- Invasive module

85



## Coding Multiple Histologies in a Single Tumor

---



## Coding Multiple Histologies in a Single Tumor

*Note:* The rules for coding breast histology are different from the histology coding rules for all other sites.

DO NOT USE THESE RULES FOR ANY SITE OTHER THAN BREAST.

Two INVASIVE histologies Will be either:

- A NOS AND a subtype/variant OR
- Different histologies (different rows in Table 3 OR different subtypes in Table 3 (Column 3))



## Instructions in Priority Order

### 1. NOS and a subtype/variant

A. Code the **subtype/variant** (specific histology) **ONLY** when documented to be **greater than 90%** of the tumor.

- **Note:** When a histology is listed as “minimal”, “focus/foci/focal”, “microscopic”, you can assume the other histological portion comprises greater than 90% of the tumor.
- **Example:** Patient had an excisional biopsy with a pathologic diagnosis of invasive cribriform carcinoma 8201/3. There was microscopic involvement of one margin. The patient chose to have a total mastectomy.
  - Pathology from the total mastectomy showed minimal residual invasive carcinoma NST 8500/3.

Because the invasive carcinoma NST was minimal, the subtype/variant invasive cribriform carcinoma 8201/3 is assumed to be greater than 90% of the tumor.



## Instructions in Priority Order

1. NOS and a subtype/variant (cont'd)
  - B. Code the NOS/NST when the subtype/variant is documented to be less than or equal to 90% of the tumor OR the percentage of subtype/variant is unknown/not documented.

89



## Instructions in Priority Order Cont'd

2. Different histologies
  - A. Code the histology which comprises the majority of tumor.

*Note 1:* The majority may be indicated by terms such as “greater than 50%”, “major”, “majority” and “predominantly”.

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

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

*\*Note:* A NOS with features or differentiation is a single histology. Go directly to the rules.



## Instructions in Priority Order Cont'd

- B. Code a combination code using Table 2 in the Equivalent Terms and Definitions when the majority is unknown/not documented.



## Code Ambiguous Terminology ONLY When

- Histology is clinically confirmed by a physician (attending, pathologist, oncologist, etc.)
  - *Example 1:* The pathology diagnosis is carcinoma NST consistent with pleomorphic carcinoma. The oncology consult says the patient has pleomorphic carcinoma of the right breast.
  - *This is clinical confirmation of the diagnosis, code pleomorphic carcinoma. The case meets the criteria in bullet 1.*
- Patient is receiving treatment based on the histology described by an ambiguous term
  - *Example 2:* The pathology diagnosis is sarcoma consistent with liposarcoma. The treatment plan says the patient will receive the following treatment for liposarcoma of the breast.
  - Treatment plan confirms liposarcoma; code liposarcoma. The case meets the criteria in bullet 2.



## Ambiguous terminology Cont'd

Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

*Example 3:* Outpatient biopsy says probably apocrine carcinoma. The case is accessioned (entered into the database) as required by both SEER and COC. No further information is available. Code the histology apocrine carcinoma. The case meets the criteria in bullet 3.

*Note:* If the histology described by ambiguous terminology does not meet any of the criteria in bullets 1, 2, or 3, DO NOT CODE the histology.



## Priority Order for Using Documents

### IMPORTANT NOTES

1. Code the histology diagnosed prior to neoadjuvant treatment.
  - *Note 1:* Histology changes do occur following immunotherapy, chemotherapy and radiation therapy.
  - *Note 2:* Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.
2. Code the histology assigned by the physician. Do not change histology in order to make the case applicable to staging.



## Single Tumor: In Situ Only

---



## H2

---

Code the histology when only one histology is present.

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





## H5 and H6

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

Rule H6 Code the histology using Table 2 when there are multiple in situ histologies (2 or more) within a single tumor.

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

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



## Pop Quiz 12

How would the following tumor be coded (single tumor with multiple histologies).

- Ductal carcinoma in situ (8500/2) and medullary carcinoma in situ (8510/2)
  - Ductal carcinoma in situ (8500/2) per rule H5
- Ductal carcinoma in situ (8500/2) and lobular carcinoma in situ (8520/2)
  - DCIS and in situ lobular carcinoma 8522/2 per rule H3
- Lobular carcinoma in situ 8520/2 and papillary ductal carcinoma in situ (8503/2)
  - In situ lobular mixed with other types of in situ carcinoma 8524/2



## Single Tumor: Invasive Only

---



### H9

---

Code the underlying tumor when there is a diagnosis of inflammatory carcinoma.<sup>1</sup>

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

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

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



## H10

---

Code mucinous carcinoma/adenocarcinoma 8480 ONLY when:

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

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

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



## Pop Quiz 13

---

True or False...the following are an NOS/NST histology and a subtype of that NOS/NST histology.

- Acinic cell carcinoma and Apocrine carcinoma
  - False
- Ductal carcinoma and Cribriform carcinoma
  - True
- Carcinoma and ductal carcinoma
  - False
- Carcinoma with signet ring cell features and pleomorphic carcinoma
  - True



## H14

---

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

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



## H15

---

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

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



## H15 Cont'd

### Example 1:

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

### Example 2:

Pathology says the majority of tumor is metaplastic carcinoma with chondroid differentiation 8571/3 and the remainder is metaplastic carcinoma NOS 8575/3.

- Majority simply means greater than 50%, so it is unknown whether or not the subtype/variant is greater than 90% of the tumor.
- Code metaplastic carcinoma NOS 8575/3.

105



## H16

Code the histology that comprises the majority (greater than 50%) of tumor when two histologies are:

- On different rows in Table 3 in the Equivalent Terms and definitions OR
- Different subtypes of the same NOS
  - *Note 1:* The majority may be indicated by terms such as “greater than 50%”, “major”, “majority” and “predominantly”.
  - *Example:* Pathology reads the tumor is predominantly carcinoma NST 8500/3 with areas of tubular carcinoma 8211/3. Code the predominant histology: carcinoma NST 8500/3. Carcinoma NST and tubular carcinoma are on different rows in Table 3, so they are distinctly different histologies.



## H17

---

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

- *Note 2:* The rules are hierarchical, so the tumors are NOT a NOS/NST and a single subtype/variant.
- *Note 3:* The diagnosis may be two subtypes/variants and the pathologist may mention the presence of duct/carcinoma NST. Ignore the mention of carcinoma NST.
- *Note 4:* Do not use a combination code when the second histology is described as features or differentiation unless it is part of the preferred term.



## Multiple Tumors Abstracted as a Single Primary

---

## H19

---

Code Paget disease and ductal carcinoma as follows when:

Pathology specifies Paget disease as invasive /3 OR behavior not documented AND

Underlying tumor is:

- o Invasive carcinoma NST/duct carcinoma 8541/3
- o DCIS 8543/3

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



## H20

---

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



## H22

---

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

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

*Example 1:* Multiple tumors, each with invasive carcinoma NST and in situ lobular carcinoma (LCIS) mixed. Code to invasive carcinoma NST 8500/3.

*Example 2:* One tumor is invasive carcinoma NST and the other is lobular carcinoma in situ (LCIS). Code to invasive carcinoma NST 8500/3.



## H23

---

Code 8522 when carcinoma NST and lobular are present in multiple tumors.

DCIS and in situ lobular 8522/2

Carcinoma NST/duct carcinoma and invasive lobular 8522/3

*Note 2:* One tumor may be carcinoma NST and the other lobular, or all tumors may be a mixture of carcinoma NST and lobular.

*Note 3:* This combination code specifically identifies carcinoma NST and lobular carcinoma. For all other histological combinations, continue through the rules.





## H24

---

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

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

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



## H25

---

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

- *Note 2:* Do not use a combination code when the second histology is described as differentiation or features, unless it is part of the preferred term.
- *Note 4:* Table 2 is used for two histologies. When there are greater than two histologies, use the “last resort” code 8255 because none of the other combinations include greater than two histologies.



Questions?

---

115

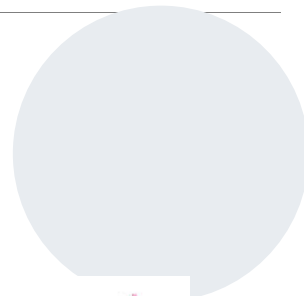
Thank You!!!

---

116

## Fabulous Prize Winners

---



1177



## Coming UP...

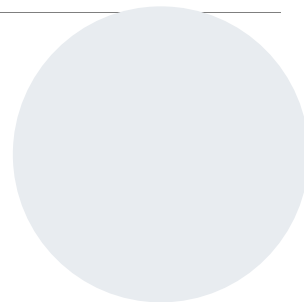
---

Collecting Cancer Data: Coding Pitfalls

- 09/05/2019

Breast

- Guest Presenter: Wilson Apollo, CTR
- 10/3/2019



# CE Certificate Quiz/Survey

---

Phrase

Link

<https://www.surveygizmo.com/s3/5138195/Solid-Tumor-Rules-2019>

