Kidney Equivalent Terms, Definitions, Tables and Illustrations
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

INTRODUCTION

Renal cell carcinoma (8312) is a group term for glandular (adeno) carcinomas of the kidney. Approximately 85% of all malignancies of the kidney are renal cell and specific renal cell types.

Transitional cell carcinoma rarely arises in the kidney parenchyma (C649). Transitional cell carcinoma found in the upper urinary system usually arises in the renal pelvis (C659). Only code transitional cell carcinoma to kidney in the rare instance when pathology confirms the tumor originated in the parenchyma of the kidney.

Equivalent or Equal Terms

- **Multifocal** and **multicentric**
- **Renal cell carcinoma (RCC)** and **hypernephroma (obsolete term)**
- **Tumor, mass, lesion,** and **neoplasm**

Definitions

Adenocarcinoma with mixed subtypes (8255): A mixture of two or more of the specific renal cell carcinoma types listed in Table 1.

Carcinoma of the collecting ducts of Bellini/collecting duct carcinoma (8319) is a malignant epithelial tumor. There is controversy about the relationship between medullary carcinoma and collecting duct carcinoma; some advocate that there is a relationship, others are not convinced. Genetic studies are ongoing. We will code medullary carcinoma originating in the kidney to 8510 so we can differentiate between the medullary and the collecting duct carcinoma.

Chromophobe RCC (8317) is a rare form of kidney cancer. Chromophobe is a renal carcinoma characterized by large pale cells with prominent membranes.

Clear cell RCC (8310) is the most common type of RCC. Clear cell is composed of clear or eosinophilic cytoplasm. Clear cell is architecturally diverse, with solid alveolar and acinar patterns the most common.

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Cystic: Cystic may be used to describe the gross appearance or it may be used as a morphologic term. Cysts are common in clear cell renal cell carcinomas. Tumors composed completely of cysts are rare.

Medullary carcinoma of the kidney (8510) is a rare tumor almost exclusively associated with sickle cell trait. There is controversy about the relationship between medullary carcinoma and collecting duct carcinoma; some advocate that there is a relationship, others are not convinced. Genetic studies are ongoing. We will code medullary carcinoma originating in the kidney to 8510 so we can differentiate between the medullary and the collecting duct carcinoma.

Most invasive: The tumor with the greatest continuous extension (see focal and foci/focus definitions).
In hierarchical order, the evaluation of least to greatest extension for **kidney** is based on:

- The largest tumor size
- Extension into major veins, adrenal gland, or perinephric tissue.
- Involvement of Gerota's fascia.

Papillary RCC (8260) form finger-like projections. Some doctors call these cancers chromophilic because the cells take up certain dyes making them appear pink. A malignant renal parenchymal tumor with papillary or tubular papillary architecture.

Renal cell carcinoma (RCC) (8312) is the most common type of kidney cancer. Renal cell is a group name that includes several specific types. See Table 1.

Renal sarcoma is a rare disease of the kidney's connective tissues.

Satellite lesion or metastasis: Metastatic lesion within the immediate vicinity of the primary tumor. This is a metastasis, not a separate primary.

Urinary tract: Structures lined by transitional epithelium also known as urothelium

Wilms Tumor/nephroblastoma, NOS (8960) can arise anywhere in the kidney tissue. Wilms tumor typically appears in children between 2-5 years of age.

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Table 1 - Renal cell carcinoma and specific renal cell types

Table Instructions: Use this table to identify specific renal cell carcinoma types.
Note: Renal cell carcinoma, NOS (8312) is the non-specific term under which the specific renal cell carcinoma types are listed. This table **is a complete listing** of specific renal cell carcinoma types.

Column 1: Code	Column 2: Specific Renal Cell Carcinoma Types
8260	Papillary (Chromophil) *
8310	Clear Cell
8316	Cyst associated, cystic
8317	Chromophobe *
8318	Sarcomatoid (Spindle cell)
8319	Collecting duct type (Bellini duct)
8320	Granular cell
8510	Medullary carcinoma, NOS; medullary adenocarcinoma
8959	Malignant cystic nephroma; malignant multilocular cystic nephroma
* ***Note:*** Chromophil and chromophobe are different histologies	

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Table 2 – Changes to Previous SEER Site Grouping Table

Previous to 2007, tumors in the sites below were abstracted as a single primary.

Code	Site Grouping
C64	Kidney
C65	Renal pelvis
C66	Ureter
C68	Other and unspecified urinary organs

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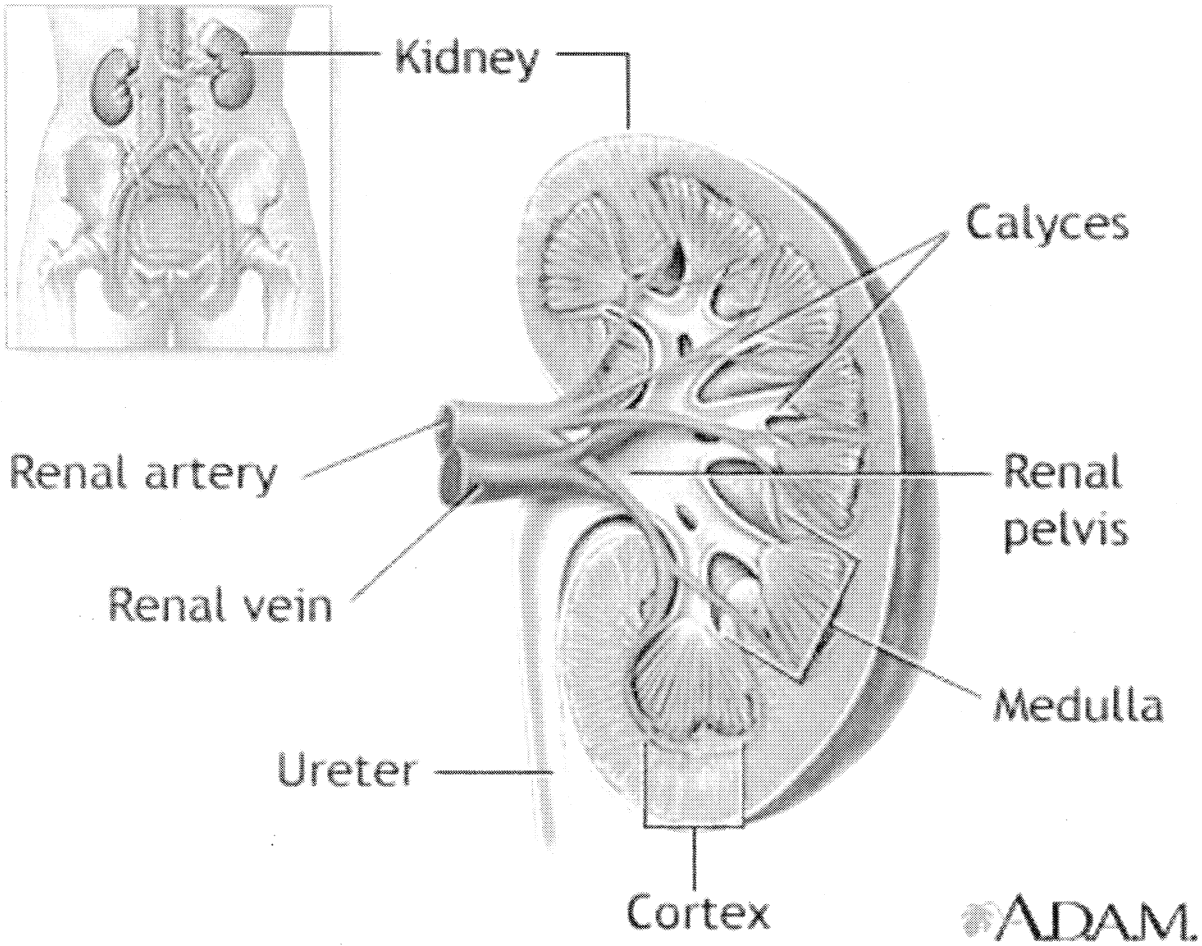

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Kidney Multiple Primary Rules - Text
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

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 tumors.

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 **Wilms tumors** are a single primary. *

Rule M4 Tumors in sites with **ICD-O-3 topography** codes that are **different** at the second (C<u>x</u>xx) and/or third characters (Cx<u>x</u>x) are multiple primaries **

Rule M5 Tumors in **both** the **right kidney and** in the **left kidney** are multiple primaries. **
Note: Abstract as a single primary when the tumors in one kidney are documented to be metastatic from the other kidney.

Kidney Multiple Primary Rules - Text
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

Rule M6 Tumors diagnosed more than **three (3) years apart** are multiple primaries. **

Rule M7 An **invasive** tumor **following** an **in situ** tumor more than 60 days after diagnosis are multiple primaries. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M8 **One** tumor with a specific **renal** cell **type and** another tumor with a **different** specific renal cell **type** are multiple primaries (Table 1). **

Rule M9 Abstract as a single primary * when one tumor is
- **Cancer/malignant neoplasm, NOS** (8000) **and** another is a **specific histology** or
- **Carcinoma, NOS** (8010) **and** the other is a **specific carcinoma** or
- **Adenocarcinoma, NOS (8140) and another is a specific adenocarcinoma or**
- **Renal cell carcinoma, NOS** (8312) and the other is a **single renal cell type** (Table 1)

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 M10 Tumors with **ICD-O-3 histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M11 Tumors that **do not meet any** of the above **criteria** are a single primary.*
Note: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.

*** 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.**
This is the end of instructions for Multiple Tumors.

Rule M11 Examples: The following are examples of cases that use Rule M11. 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: Multiple tumors in one kidney with same histology	**Example 2**: An in situ and invasive tumor diagnosed within 60 days

Kidney Histology Coding Rules – Text
C649
(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 medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT 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 the 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.

Rule H4 Code the **invasive** histologic type when there are invasive and in situ components.

Rule H5 Code the **specific type** 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 one specific adenocarcinoma type or
- Renal cell carcinoma, NOS (8312) and one specific renal cell type

Note 1: Use Table 1 to identify specific renal cell types.

Note 2: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 3: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H6 Code 8255 (adenocarcinoma with mixed subtypes) when there are **two or more specific** renal cell carcinoma types.

Note: Use Table 1 to identify specific renal cell types.

Example: Renal cell carcinoma, papillary and clear cell types. Assign code 8255.

Kidney Histology Coding Rules – Text
C649
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule H7 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 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 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 H9 Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site**.
Note: Code the behavior /3.

Rule H10 Code the histology when only **one histologic type** is identified.

Rule H11 Code the histology of the **most invasive** tumor.
Note 1: This rule should only be used when the first three digits of the histology codes are identical (This is a single primary).
Note 2: See the Kidney Equivalent Terms, Definitions, Tables 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.

Kidney Histology Coding Rules – Text
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(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule H12 Code the **specific type** 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 one specific adenocarcinoma type or
- Renal cell carcinoma, NOS (8312) and one specific renal cell type

Note 1: Use Table 1 to identify specific renal cell types.
Note 2: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation
Note 3: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H13 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.

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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.

Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations
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Papillary tumor: A papillary bladder, ureter, or renal pelvis tumor is a warty growth that is attached to the wall by a stalk.

Papillary and Flat Carcinomas: Urothelial carcinomas may be either flat or papillary. The terms papillary and flat describe the structure or architecture of the tumor, not a specific histologic type. Both are transitional cell/urothelial carcinoma, although there are behavioral differences between the two.

Prostatic Urethra: Adenocarcinoma of the prostatic urethra is usually an extension of adenocarcinoma of the prostate. Transitional cell/urothelial carcinoma in the prostatic urethra may be an extension from the bladder or may be primary in the prostatic urethra. .

Satellite lesion or metastasis: Metastatic lesion within the immediate vicinity of the primary tumor.

Transitional cell carcinoma usually begins in the renal pelvis, not in the kidney. The cancer cells are different from renal cell carcinoma.

Transitional epithelium: A highly expandable epithelium that has a layered appearance with large cube-shaped cells in the relaxed state that transform and stretch into broad and flat cells in the expanded or distended state.

Urinary tract: Structures lined by transitional epithelium also known as urothelium.

Urothelium: The transitional epithelium lining the wall of the bladder, ureter, and renal pelvis, external to the basement membrane.

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)

Table 1 – Urothelial Tumors

Note: Excludes pure squamous carcinoma, glandular (adeno) carcinoma, or other bladder tumor histologies.

Urothelial/Transitional Cell Tumors	Code
With squamous differentiation	8120
With glandular differentiation	
With trophoblastic differentiation	
Nested	
Microcystic	
Transitional cell, NOS	
Papillary carcinoma	8130
Papillary transitional cell	
Micropapillary	8131
Lymphoepithelioma-like	8082
Plasmacytoid	
Sarcomatoid	8122
Giant cell	8031
Undifferentiated	8020

Table 2 – Changes to Previous SEER Site Grouping Table

Previous to 2007, tumors in the sites below were abstracted as a single primary.

Code	Site Grouping
C64	Kidney
C65	Renal pelvis
C66	Ureter
C68	Other and unspecified urinary organs

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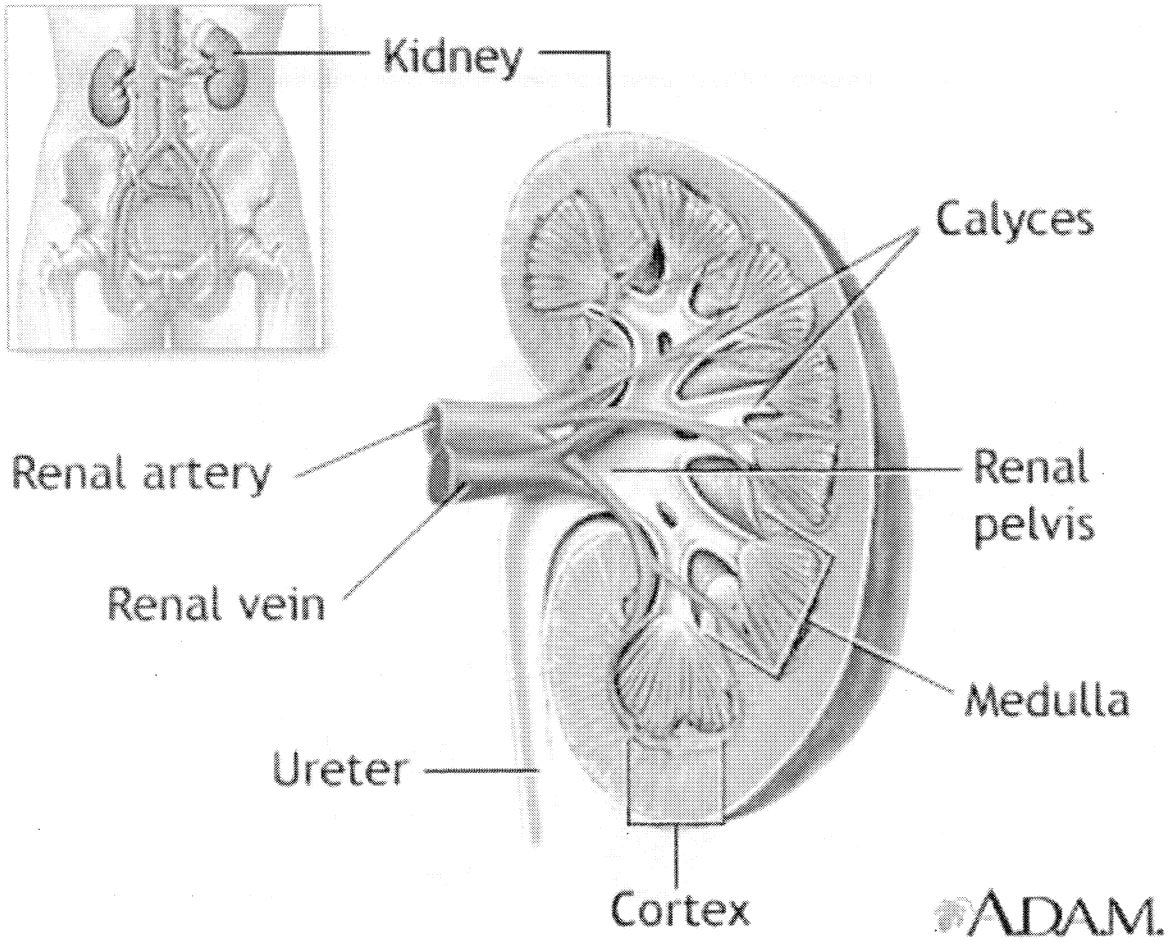

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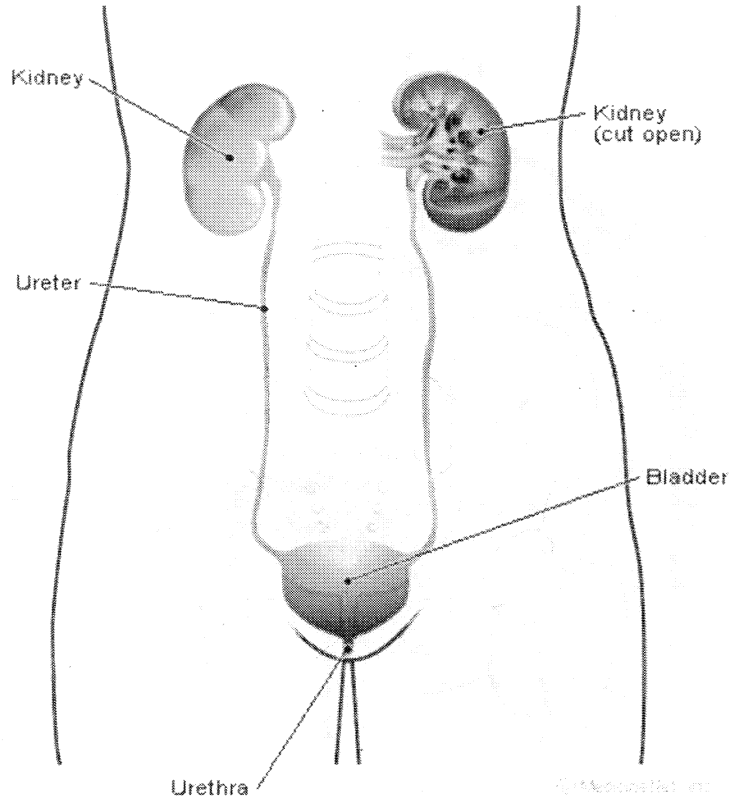

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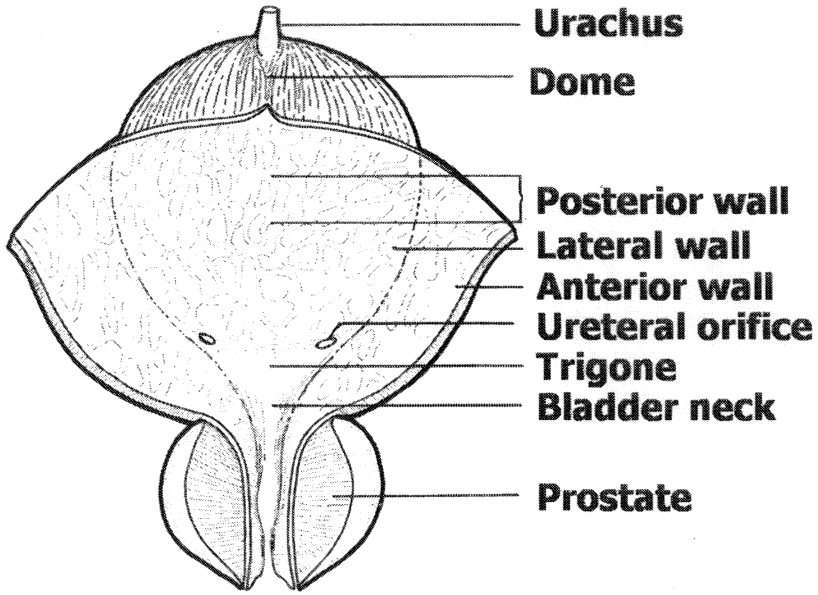

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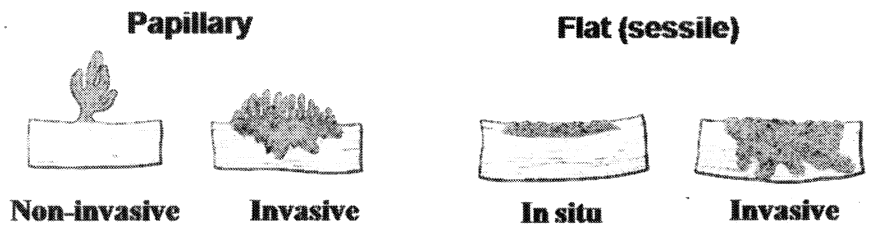

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UNKNOWN IF SINGLE OR MULTIPLE TUMORS

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.

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

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 When no other urinary sites are involved, tumor(s) in the **right renal pelvis AND** tumor(s) in the **left renal pelvis** are multiple primaries. **
Note: Use this rule and abstract as a multiple primary unless documented to be metastatic

Rule M4 When no other urinary sites are involved, tumor(s) in both the **right ureter AND** tumor(s) in the **left ureter** are multiple primaries. **
Note: Use this rule and abstract as a multiple primary unless documented to be metastatic

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Rule M5 An **invasive** tumor **following** a **non-invasive or in situ** tumor more than 60 days after diagnosis is a multiple primary. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease

Rule M6 Bladder tumors with any **combination** of the following histologies: **papillary carcinoma** (8050), **transitional cell carcinoma** (8120-8124), **or papillary transitional cell carcinoma** (8130-8131), are a single primary. *

Rule M7 Tumors diagnosed **more than three (3) years** apart are multiple primaries. **

Rule M8 Urothelial tumors in two or more of the following sites are a single primary* (See Table 1)
- Renal pelvis (C659)
- Ureter(C669)
- Bladder (C670-C679)
- Urethra /prostatic urethra (C680)

Rule M9 Tumors with ICD-O-3 **histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M10 Tumors in sites with ICD-O-3 **topography** codes with **different** second (Cxxx) and/or third characters (Cxxx) are multiple primaries*

Rule M11 Tumors that **do not meet any** of the above **criteria** are a single primary.*
Note: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.

This is the end of instructions for Multiple Tumors.
*** 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.**

Renal Pelvis, Ureter, Bladder, and Other Urinary Histology Coding Rules – Text
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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 or MRI scans

Note 2: Code the specific histology when documented.

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

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

Note: Code the behavior /3.

Rule H3 Code **8120** (transitional cell/urothelial carcinoma) (Table 1 - Code 8120) when there is:
- Pure transitional cell carcinoma or
- Flat (non-papillary) transitional cell carcinoma or
- Transitional cell carcinoma with squamous differentiation or
- Transitional cell carcinoma with glandular differentiation or
- Transitional cell carcinoma with trophoblastic differentiation or
- Nested transitional cell carcinoma or
- Microcystic transitional cell carcinoma

Rule H4 Code **8130** (papillary transitional cell carcinoma) (Table 1 - Code 8130) when there is:
- Papillary carcinoma or
- Papillary transitional cell carcinoma or
- Papillary carcinoma and transitional cell carcinoma

Rule H5 Code the histology when only **one histologic type** is identified

Note : Only code squamous cell carcinoma (8070) when there are no other histologies present (pure squamous cell carcinoma).

Rule H6 Code the invasive histologic type when a single tumor has **invasive and in situ** components.

Renal Pelvis, Ureter, Bladder, and Other Urinary Histology Coding Rules – Text

C659, C669, C670-C679, C680-C689

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

Rule H7 **Code the** most **specific** histologic **term**:

Examples

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma 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 H8 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 H9 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 or MRI scans

Note 2: Code the specific histology when documented.

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

Rule H10 Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Renal Pelvis, Ureter, Bladder, and Other Urinary Histology Coding Rules – Text
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H11 Code **8120** (transitional cell/urothelial carcinoma) (Table 1 – Code 8120) when there is:

- Pure transitional cell carcinoma or
- Flat (non-papillary) transitional cell carcinoma or
- Transitional cell carcinoma with squamous differentiation or
- Transitional cell carcinoma with glandular differentiation or
- Transitional cell carcinoma with trophoblastic differentiation or
- Nested transitional cell carcinoma or
- Microcystic transitional cell carcinoma

Note: Flat transitional cell carcinoma is a more important prognostic indicator than papillary, and is likely to be treated more aggressively.

Rule H12 Code **8130** (papillary transitional cell carcinoma) (Table 1 – Code 8130) when there is:

- Papillary carcinoma or
- Papillary transitional cell carcinoma or
- Papillary carcinoma and transitional cell carcinoma

Rule H13 Code the histology when only **one histologic type** is identified

Note: Only code squamous cell carcinoma (8070) when there are no other histologies present (pure squamous cell carcinoma).

Rule H14 Code the histology of the **most invasive** tumor.

Note: See the Renal Pelvis, Ureter, Bladder and Other Urinary Equivalent Terms, Definitions, Tables 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.

Rule H15 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.

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Benign and Borderline Intracranial and CNS Tumors
Equivalent Terms, Definitions, Charts and Illustrations
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

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

Do not change the behavior code when during the lifetime of the patient when a tumor(s) progresses from a benign /0 to an uncertain whether benign or malignant /1 behavior.

These rules apply to tumors that occur within the cranial vault or within the spinal canal (reportable)

Note: Non-malignant peripheral nerve tumors are not reportable

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

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

Definitions

Benign: ICD-O-3 behavior code of /0.

Borderline: ICD-O-3 behavior code of /1.

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.

Different lateralities: The right side of a site and the left side of a site are different lateralities.

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

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

Invasive: ICD-O-3 behavior code of /3.

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

Benign and Borderline Intracranial and CNS Tumors
Equivalent Terms, Definitions, Charts and Illustrations
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

Meninges: The three membranes that cover the brain and spinal cord. The outside layer is the dura mater and is the most resilient. The center layer is the arachnoid membrane. The thin innermost layer is the pia mater.

Mesencephalon: The region of the brainstem located above the pons.

Nerve sheath: A protective covering around nerves.

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).

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.

Pons: The region of the brainstem located below the mesencephalon and above the medulla oblongata.

Progression of disease: For the purposes of these rules, progression is defined as a change to a more aggressive behavior (Example: a change from /0 to /1).

Spinal Cord: A thick bundle of nerve fibers that runs from the base of the brain to the hip area, running through the spine (vertebrae).

Supratentorial: Tumors located in the sellar or suprasellar region or in other areas of the cerebrum.

Temporal Lobe of the Cerebrum: The region at the lower side of each cerebral hemisphere; contains centers of hearing and memory (located at the sides of the head).

Timing: The amount of time between the original and subsequent tumors is not used to determine multiple primaries because the natural biology of non-malignant tumors is that of expansive, localized growth.

Transformation: The histology of a disease process may change over time.

Table 1 –Paired Sites

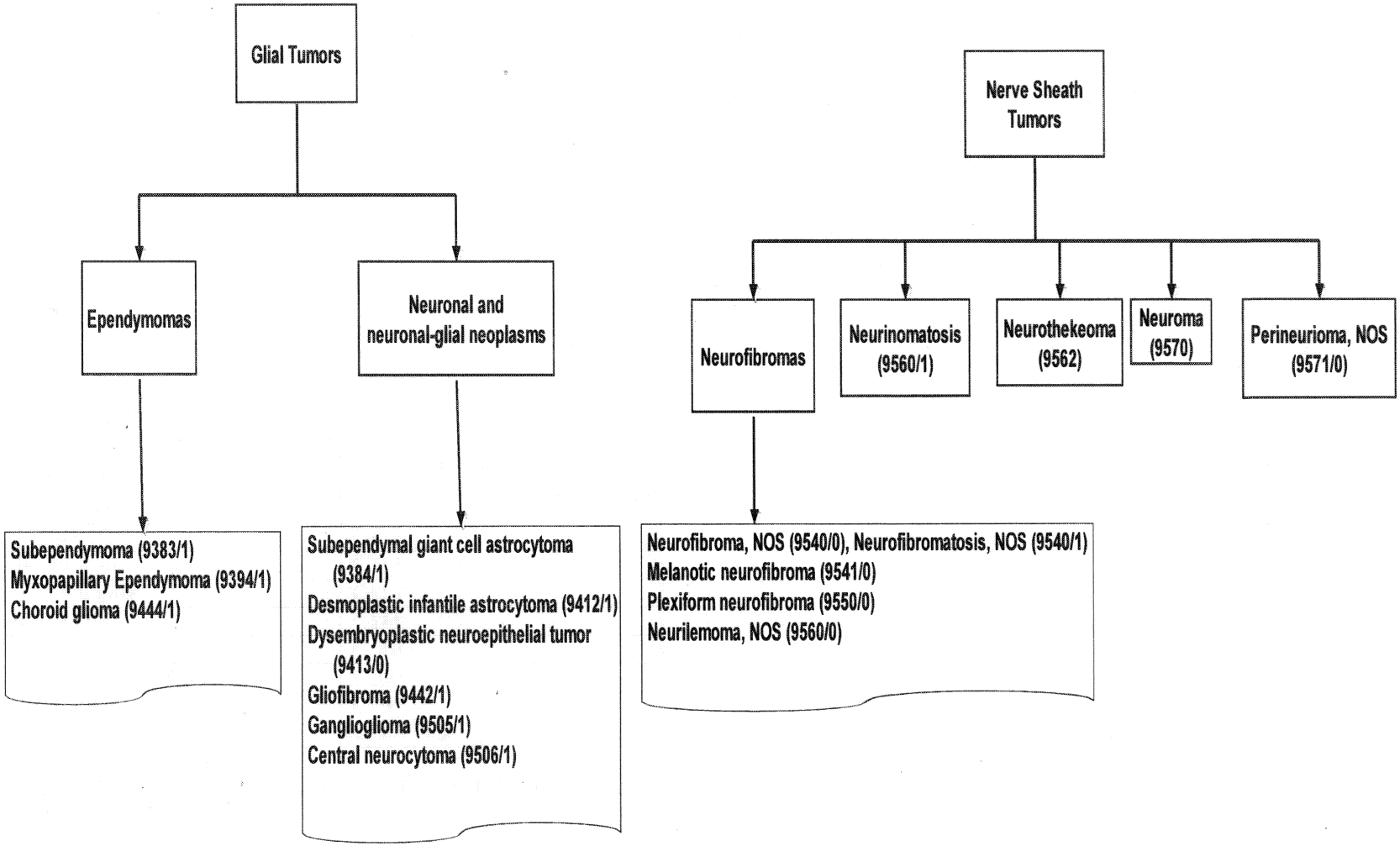
Table Instructions: Use this table to Identify paired sites (Rule M5).

Column 1: Paired Sites	**Column 2: Code**
Cerebral meninges, NOS	C700
Cerebrum	C710
Frontal lobe	C711
Temporal lobe	C712
Parietal lobe	C713
Occipital lobe	C714
Olfactory nerve	C722
Optic nerve	C723
Acoustic nerve	C724
Cranial nerve	C725

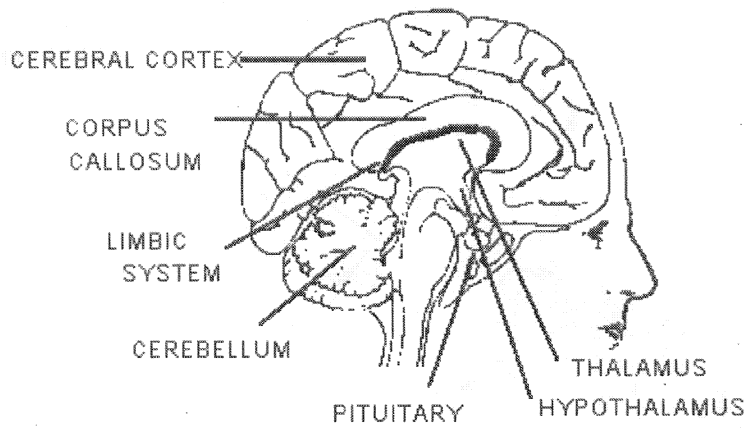
Benign and Borderline Intracranial and CNS Tumors
Equivalent Terms, Definitions, Charts and Illustrations
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

Chart 1: Benign and Borderline Intracranial and CNS Tumors

Note: This chart is based on the *WHO Classification of Tumors* of the Benign Brain. Use this chart to determine multiple primaries and to code histology as instructed in the coding rules.



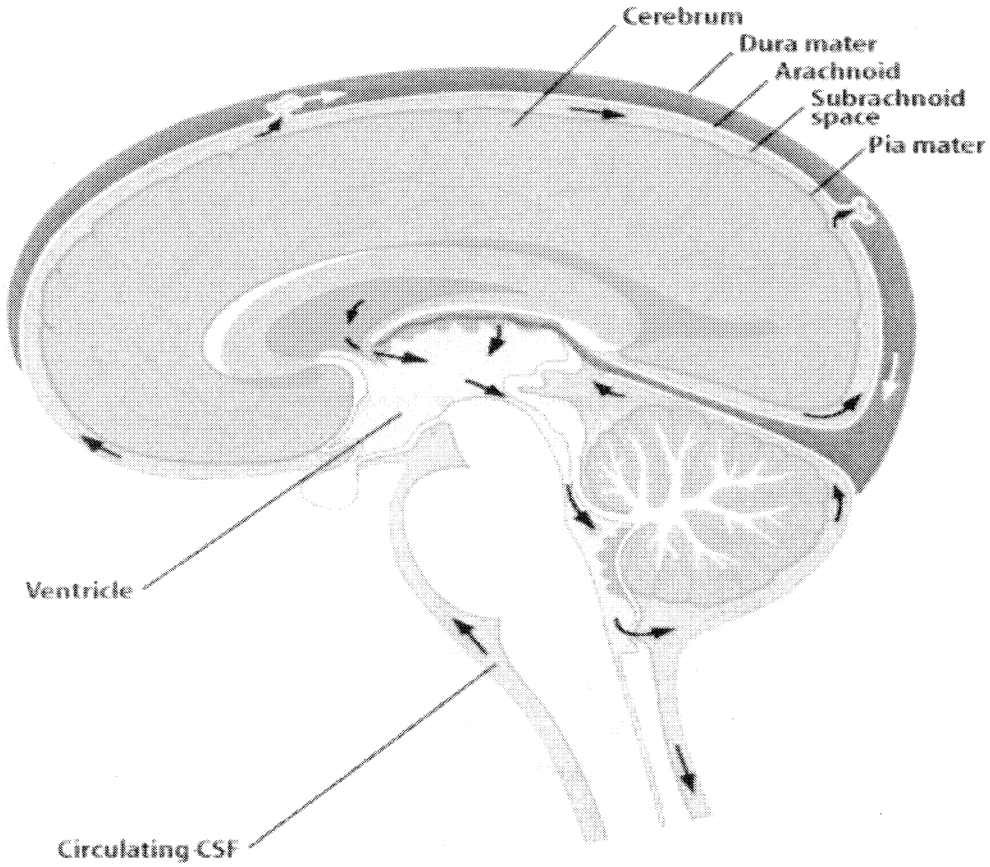
Benign and Borderline Intracranial and CNS Tumors
Equivalent Terms, Definitions, Charts and Illustrations
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753



www.gender.org.uk/ about/07neur/74_brain.htm

Benign and Borderline Intracranial and CNS Tumors
Equivalent Terms, Definitions, Charts and Illustrations
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

Meninges



URL: www.cardioliving.com/consumer/Stroke/Hemorrhagic_Stroke.sht 7/18/03

Benign and Borderline Intracranial and CNS Tumors
Multiple Primary Rules – Text
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

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

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: Tumor not described as metastasis

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: Tumors not described as metastases

Rule M3 An **invasive** brain tumor (/3) **and either** a **benign** brain tumor (/0) **or** an **uncertain/borderline** brain tumor (/1) are always multiple primaries. **

Rule M4 Tumors with ICD-O-3 **topography** codes that are **different** at the second (C**x**xx) and/or third characters (Cx**x**x), or fourth (Cxx**x**) are multiple primaries. **

Rule M5 Tumors on **both sides** (left and right) of a **paired site** (Table 1) are multiple primaries. **

Benign and Borderline Intracranial and CNS Tumors
Multiple Primary Rules – Text
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

Rule M6 An atypical choroid plexus papilloma (9390/1) following a choroid plexus papilloma, NOS (9390/0) is a single primary. *
Note: Do not code progression of disease as multiple primaries.

Rule M7 A neurofibromatosis, NOS (9540/1) following a neurofibroma, NOS (9540/0) is a single primary. *
Note: Do not code progression of disease as multiple primaries.

Rule M8 Tumors with two or more histologic types on the **same branch** in Chart 1 are a single primary. *

Rule M9 Tumors with multiple histologic types on **different branches** in Chart 1 are multiple primaries. **

Rule M10 Tumors with **two or more histologic types** and at least **one** of the histologies **is not listed** in Chart 1 are multiple primaries. **

Rule M11 Tumors with ICD-O-3 **histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **
Note: Use this rule when none of the histology codes are listed in Chart 1.

Rule M12 Tumors that **do not meet any** of the above criteria are a single primary. *
Note: Timing is not used to determine multiple primaries for benign and borderline intracranial and CNS tumors.

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: Tumors in the same site with the same histology (Chart 1) and the same laterality as the original tumor are a single primary.	**Example 2:** Tumors in the same site with the same histology (Chart 1) and it is unknown if laterality is the same as the original tumor are a single primary.
Example 3: Tumors in the same site and same laterality with histology codes not listed in Chart 1 that have the same first three numbers are a single primary.	

**** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**
This is the end of instructions for Multiple Tumors.

Benign and Borderline Intracranial and CNS Tumors
Histology Coding Rules – Text
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

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

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 tumor (histology) in the medical record
- PET, CT or MRI scans

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

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

Rule H3 When there are **multiple histologies** and all histologies are in the **same branch** on Chart 1, code the more specific histology

Rule H4 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 H5 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 tumor (histology) in the medical record
- PET, CT or MRI scans

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

Benign and Borderline Intracranial and CNS Tumors
Histology Coding Rules – Text
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

Rule H6 Code multiple meningiomas of uncertain behavior to 9530/1
Note 1: This is a rare condition that is usually associated with neurofibromatosis type 2 and other genetic disorders
Note 2: Use this code only for meningiomas with uncertain behavior; do not use this code for multiple benign or malignant meningiomas

Rule H7 Code the histology when only **one histologic type** is identified.

Rule H8 Code the histology from the original diagnosis.
Note: Do not change the behavior code when a later tumor(s) shows progression of disease.

Rule H9 When there are **multiple histologies** and all histologies are in the **same branch** on Chart 1, code the more specific histology

Rule H10 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.

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.

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)

PNET (Primitive Neuroectodermal Tumor): A group of malignant central nervous system tumors that includes medulloblastoma, pineoblastoma, ependymoblastoma, retinoblastoma, neuroblastoma, esthesioneuroblastoma, medulloepithelioma and ganglioneuroblastoma. Tumors are composed of primitive, undifferentiated embryonal cell lines and frequently classified according to anatomic location. Also known as central PNET or supratentorial PNET, depending on location of the tumor.

pPNET (peripheral Primitive Neuroectodermal Tumor): These tumors usually occur in the soft tissues of the chest, pelvis, and retroperitoneum and are rarely intracranial. There is known clinical and histological association between pPNET and both extraosseous Ewing sarcoma and peripheral neuroblastoma. Peripheral PNET is clinically and pathologically distinct from central PNET.

Satellite lesion or metastasis: Metastatic lesion within the immediate vicinity of the primary tumor. This is a metastasis, not a separate primary.

Spinal Cord - a thick bundle of nerve fibers that runs from the base of the brain to the hip area, running through the spine (vertebrae).

Supratentorial: Tumors located in the sellar or suprasellar region or in other areas of the cerebrum.

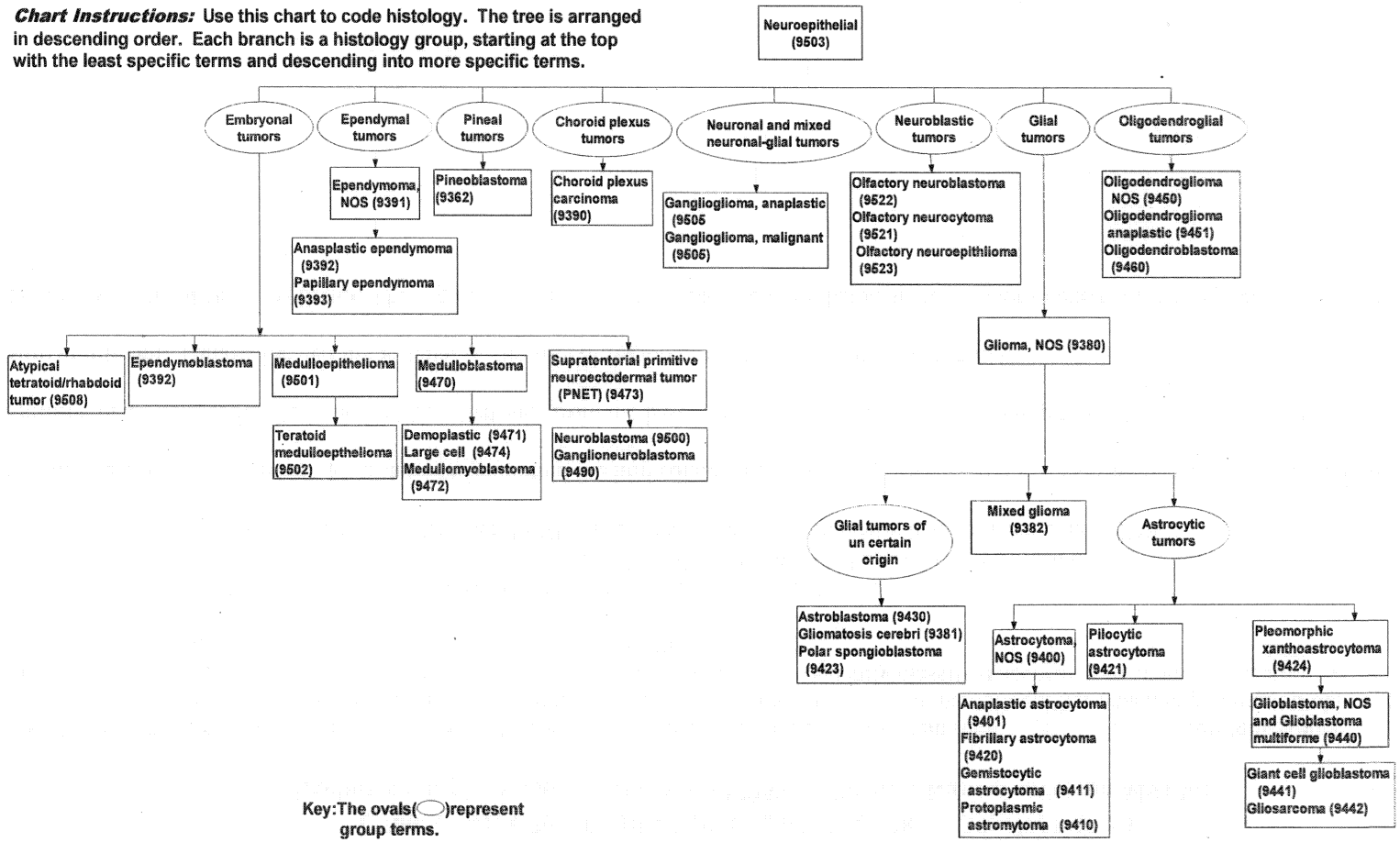
Temporal Lobe of the Cerebrum: The region at the lower side of each cerebral hemisphere; contains centers of hearing and memory (located at the sides of the head).

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)

Chart 1 –Neuroepithelial Malignant Brain and Central Nervous System Tumors

Note: This chart is based on the *WHO Classification of Tumors* of the brain and central nervous system. The chart is **not** a complete listing of histologies that may occur in the brain or central nervous system.

Chart Instructions: **Use this chart to code histology. The tree is arranged in descending order. Each branch is a histology group, starting at the top with the least specific terms and descending into more specific terms.**

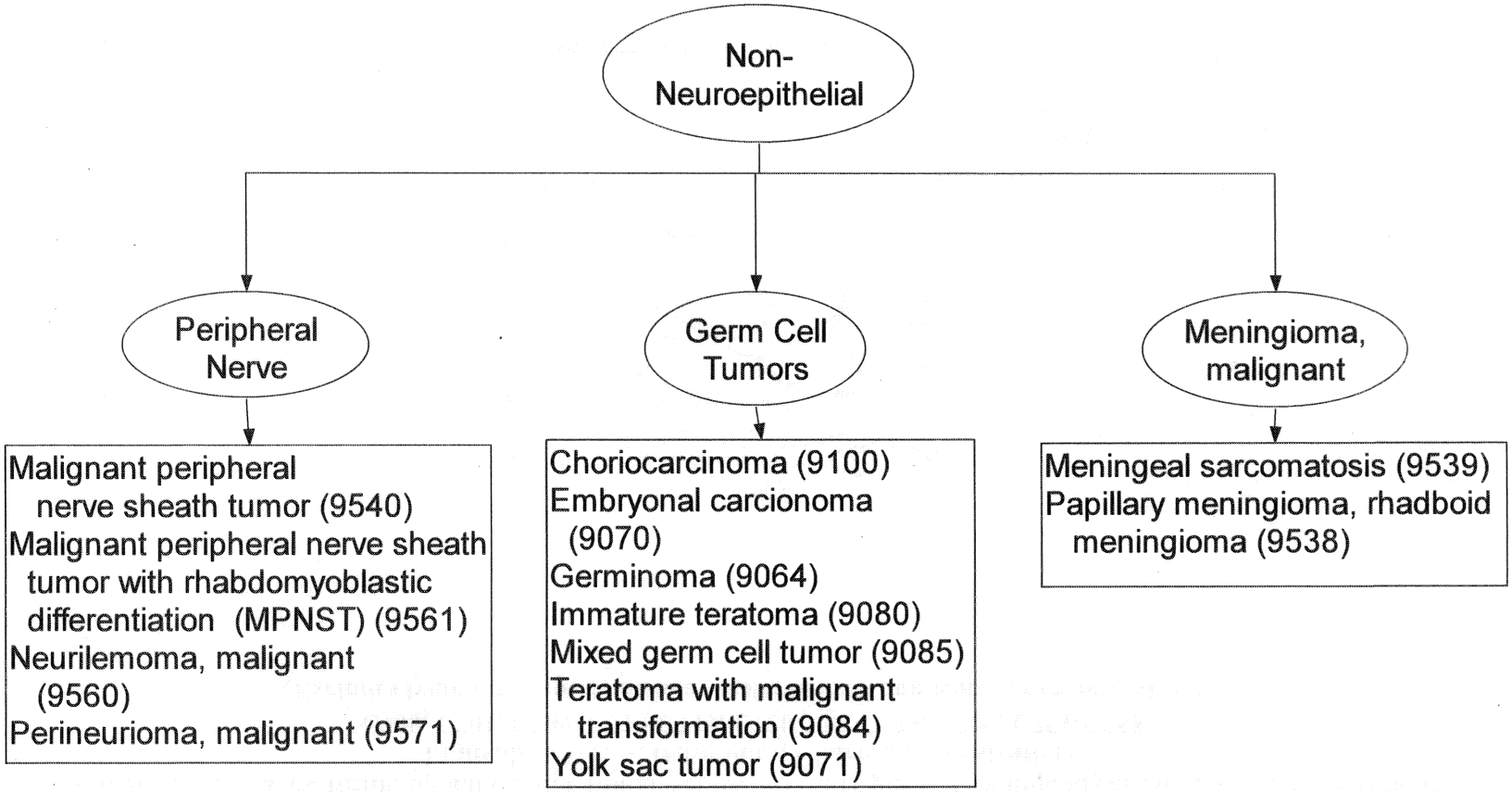


Key:The ovals(◯)represent group terms.

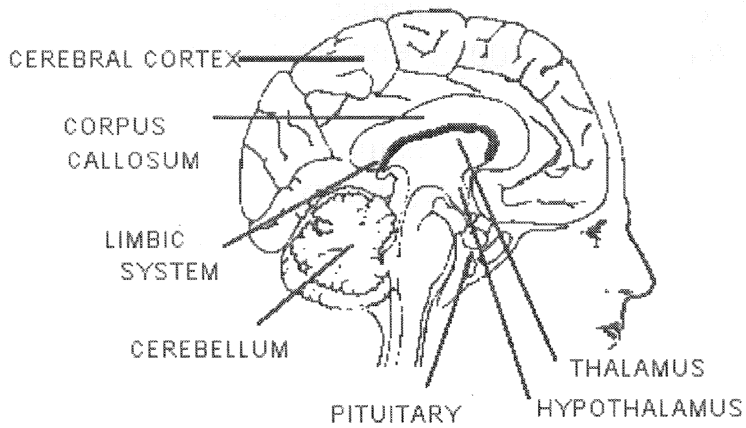
Chart 2 – Non-neuroepithelial Malignant Brain and Central Nervous System Tumors

Chart Instructions: Use this chart to code histology. The tree is arranged in descending order. Each branch is a histology group, starting at the top with the least specific terms and descending into more specific terms.

Note: Chart 2 is based on the *WHO Classification of Tumors* of the brain and central nervous system. This chart is **not** a complete listing of histologies that may occur in the brain or central nervous system.

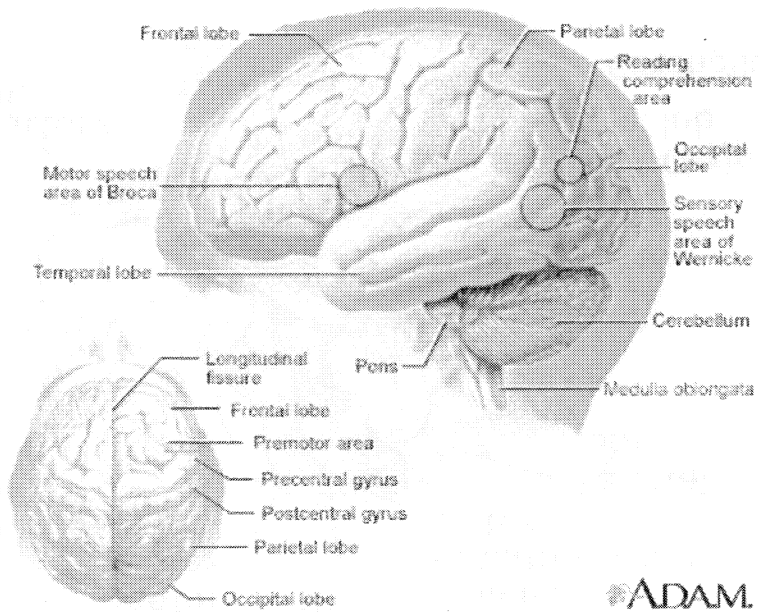


Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland
Equivalent Terms, Definitions, Charts and Illustrations
C700, C701, C709, C710-C719, C720-725, C728, C729, C751-C753
(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

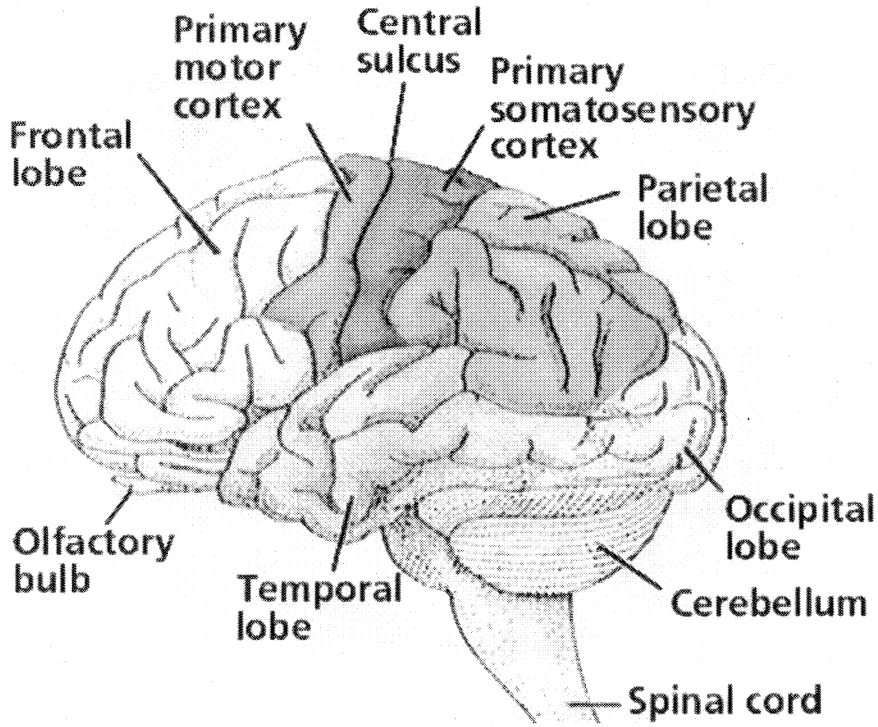


www.gender.org.uk/ about/07neur/74_brain.htm

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)



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)



Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland
Multiple Primary Rules – Text
C700, C701, C709, C710-C719, C720-C725, 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.

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 An **invasive** brain tumor (/3) **and either** a **benign** brain tumor (/0) **or** an **uncertain/borderline** brain tumor (/1) are always multiple primaries. **

Rule M2 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

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

SINGLE TUMOR

Note: Tumor not described as metastasis

Rule M3 A **single tumor** is always a single primary. *
Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

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

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.
Note: Tumors not described as metastases

Rule M4 An **invasive** brain tumor (/3) **and either** a **benign** brain tumor (/0) **or** an **uncertain/borderline** brain tumor (/1) are always multiple primaries. **

Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland Multiple Primary Rules – Text C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753 (Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

Rule M5 Tumors in sites with ICD-O-3 **topography** codes with **different** second (C**x**xx) and/or third characters (Cx**x**x) are multiple primaries.**

Rule M6 A glioblastoma or glioblastoma multiforme (9440) following a glial tumor is a single primary* (See Chart 1)

Rule M7 Tumors with ICD-O-3 histology codes on the **same** branch in Chart 1 or Chart 2 are a single primary.*
Note: Recurrence, progression, or any reappearance of histologies on the same branch in Chart 1 or Chart 2 is always the same disease process.
Example: Patient has an astrocytoma. Ten years later the patient is diagnosed with glioblastoma multiforme. This is a progression or recurrence of the earlier astrocytoma.

Rule M8 Tumors with ICD-O-3 histology codes on **different** branches in Chart 1 or Chart 2 are multiple primaries. **

Rule M9 Tumors with ICD-O-3 **histology** codes that are **different** at the first (**x**xxx), second (x**x**xx) or third (xx**x**x) number are multiple primaries. **

Rule M10 Tumors that **do not meet any** of the above **criteria** are a single primary. *
Note 1: Neither timing nor laterality is used to determine multiple primaries for malignant intracranial and CNS tumors.
Example: The patient is treated for an anaplastic astrocytoma (9401) in the right parietal lobe. Three months later the patient is diagnosed with a separate anaplastic astrocytoma in the left parietal lobe. This is one primary because laterality is not used to determine multiple primary status.
Note 2: Multicentric brain tumors which involve different lobes of the brain that do not meet any of the above criteria are the same disease process.

This is the end of instructions for Multiple Tumors.
*** 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.**

Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland
Histology Coding Rules – Text
C700, C701, C709, C710-C719, C720-C725, 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.

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 or MRI scans

Note 2: Code the specific histology when documented.
Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 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 **9382/3** (mixed glioma) when **at least two** of the following cells and/or differentiation are present:
- Astrocytic
- Oligodendroglial
- Ependymal

Rule H4 Code the histology when only **one histologic type** is identified.

Rule H5 Code the specific type when the diagnosis includes a **non-specific** term **and** a **specific** term or type **on** the **same branch** in Chart 1 or Chart 2.

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.

Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland Histology Coding Rules – Text
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

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 or MRI scans

Note 2: Code the specific histology when documented.

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

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

Note: Code the behavior /3.

Rule H9 Code the histology when only **one histologic type** is identified.

Rule H10 Code the specific type when the diagnosis includes a **non-specific** term **and** a **specific** term or type **on** the **same branch** in Chart 1 or Chart 2.

Rule H11 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.

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

INTRODUCTION

The Other Sites rules cover rectosigmoid, rectum and all sites not included in the site-specific rules.

EQUIVALENT TERMS

Acinar adenocarcinoma, adenocarcinoma (For prostate primaries only)
Adenocarcinoma, glandular carcinoma

DEFINITIONS

Acinar adenocarcinoma of the prostate: The prostate gland is sponge-like consisting primarily of acini or very tiny sacs that produce the fluids for ejaculation. Acinar adenocarcinoma is not a specific histologic type. The term acinar refers to the fact that the adenocarcinoma originates in the prostatic acini. 95% of all prostate cancers are (acinar) adenocarcinoma.

Adenoacanthoma: Adenocarcinoma with squamous metaplasia.

Parametrium: The connective tissue of the pelvic floor extending from the fibrous subserous coat of the supracervical portion of the uterus laterally between the layers of the broad ligament.

Uterine adnexa: The appendages of the uterus, namely the ovaries, fallopian tubes, and ligaments that hold the uterus in place.

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

Table 1 – Paired Organs and Sites with Laterality

Note: This table only includes anatomic sites covered by the Other Sites Rules.

Site Code	Site or Subsite
C384	Pleura
C400	Long bones of upper limb, scapula, and associated joints
C401	Short bones of upper limb and associated joints
C402	Long bones of lower limb and associated joints
C403	Short bones of lower limb and associated joints
C413	Rib, clavicle (excluding sternum)
C414	Pelvic bones (excluding sacrum, coccyx, symphysis pubis)
C441	Skin of the eyelid
C442	Skin of the external ear
C443	Skin of other and unspecific parts of the face (if midline, assign code 9)
C445	Skin of the trunk (if midline, assign code 9)
C446	Skin of upper limb and shoulder
C447	Skin of the lower limb and hip
C471	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C472	Peripheral nerves and autonomic nervous system of the lower limb and hip
C491	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C492	Connective, subcutaneous, and other soft tissues of the lower limb and hip
C569	Ovary
C570	Fallopian tube
C620-C629	Testis
C630	Epididymis
C631	Spermatic cord
C690-C699	Eye and adnexa
C740-C749	Adrenal gland
C754	Carotid body

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 Adenocarcinoma Squamous cell carcinoma	Combined small cell carcinoma	8045
Squamous carcinoma	Basal cell carcinoma	Basosquamous carcinoma	8094
Islet cell Acinar	Exocrine Endocrine	Mixed islet cell and exocrine adenocarcinoma (pancreas)	8154
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 Clear cell Mucinous (colloid) Signet ring Acinar	Adenocarcinoma with mixed subtypes Adenocarcinoma combined with other types of carcinoma	8255
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

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

Table 3 – Changes to Previous SEER Site Grouping Table

Previous to 2007, tumors in sites on the same row were abstracted as a single primary.

Code	Site Groupings
C23	Gallbladder
C24	Other and unspecified parts of the biliary tract
C37	Thymus
C380	Heart
C381-3	Mediastinum
C388	Overlapping lesion of heart, mediastinum, and pleura
C51	Vulva
C52	Vagina
C577	Other specified female genital organs
C578-9	Unspecified female genital organs
C569	Ovary
C570	Fallopian tube
C571	Broad ligament
C572	Round ligament
C573	Parametrium
C574	Uterine adnexa
C60	Penis
C63	Other and unspecified male genital organs
C74	Adrenal gland
C75	Other endocrine glands and related structures

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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 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_)

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

Rule M13 A **frank** in situ or malignant **adenocarcinoma and** an in situ or **malignant** tumor in a **polyp** are a single primary. *

Rule M14 **Multiple** in situ and/or **malignant polyps** are a single primary. *
Note: Includes all combinations of adenomatous, tubular, villous, and tubulovillous adenomas or polyps.

Rule M15 An **invasive** tumor **following** an **in situ** tumor more than 60 days after diagnosis is a multiple primary. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M16 Abstract as a single primary* when one tumor is:

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

Rule M17 Tumors with ICD-O-3 **histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M18 Tumors that **do not meet any** of the above **criteria** are a single primary. *
Note: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.

*** 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.**
This is the end of instructions for Multiple Tumors.

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: IN SITU 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 in the medical record

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 when only **one histologic type** is identified.

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

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

Rule H3 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 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.

Rule H4 **Code the** most **specific** histologic **term** when the diagnosis is:
- Carcinoma in situ, NOS (8010) and a specific in situ carcinoma or
- Squamous cell carcinoma in situ, NOS (8070) and a specific in situ squamous cell carcinoma or
- Adenocarcinoma in situ, NOS (8140) and a specific in situ adenocarcinoma or
- Melanoma in situ, NOS (8720) and a specific in situ melanoma

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.

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

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.

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

Rule H13 **Code the** most **specific** histologic **term.** Examples include:

- 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

Note: 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.

Rule H14 Code papillary carcinoma of the thyroid to papillary adenocarcinoma, NOS (8260).

Rule H15 Code follicular and papillary carcinoma of the thyroid to papillary carcinoma, follicular variant (8340).

Rule H16 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 histologies may be identified as a 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)

Rule H17 Code the histology with the **numerically higher** ICD-O-3 code.

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

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H18 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

- From reports or notes in the medical record that document or reference pathologic or cytologic findings
- From clinician 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 H19 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H20 Code 8140 (adenocarcinoma, NOS) for prostate primaries when the diagnosis is acinar (adeno)carcinoma.

Rule H21 Code 8077/2 (Squamous intraepithelial neoplasia, grade III) for in situ squamous intraepithelial **neoplasia grade III** in sites such as the **vulva** (VIN III) **vagina** (VAIN III), or **anus** (AIN III).

Note 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).

Note 2: This code may be used for reportable-by-agreement cases

Rule H22 Code 8148/2 (Glandular intraepithelial neoplasia grade III) for in situ glandular **intraepithelial neoplasia grade III** in sites such as the **pancreas** (PAIN III).

Note: This code may be used for reportable-by-agreement cases such as intraepithelial neoplasia of the **prostate** (PIN III)

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

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

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

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

Rule H24 Code the histology of the underlying tumor when there is **extramammary Paget disease** and an underlying tumor of the **anus**, **perianal** region, or **vulva**.

Rule H25 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 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.

Rule H26 Code papillary carcinoma of the thyroid to papillary adenocarcinoma, NOS (8260).

Rule H27 Code **follicular** and **papillary** carcinoma of the **thyroid** to papillary carcinoma, follicular variant (8340).

Rule H28 Code the single invasive histology for **combinations** of **invasive** and **in situ.** 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.

Rule H29 **Code the** most **specific** histologic **term.** Examples include:

- 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

Note: 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.

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

Rule H30 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 histologies may be identified as a type, subtype, predominantly, with features of, major, or with ____ differentiation.

Example 1 (multiple specific histologies): Gyn malignancy with mucinous, serous and papillary adenocarcinoma. Code 8323 (mixed cell adenocarcinoma)

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)

Rule H31 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.

IX.
New Data Items

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

Ambiguous Terminology

Item Length: 1
NAACCR Item #: 442
NAACCR Name: Ambiguous Terminology

This data item identifies all cases, including DCO and autopsy only, which are accessioned based only on ambiguous terminology. Registrars are required to collect cases with ambiguous terminology and it is advantageous to be able to identify those cases in the database.

Code	Label	Definition	Time Frame	Examples
0	Conclusive term	There was a conclusive diagnosis within 60 days of the original diagnosis. Case was accessioned based on conclusive terminology. Includes all diagnostic methods such as clinical diagnosis, cytology, pathology, etc.	Within 60 days of the date of initial diagnosis.	1. Adenocarcinoma in TURP chips. 2. Mammogram suspicious for DCIS. Excisional biopsy 1 week later positive for DCIS.
1	Ambiguous term only	The case was accessioned based only on ambiguous terminology. There was no conclusive terminology during the first 60 days following the initial diagnosis. Includes all diagnostic methods except cytology. ***Note:*** Cytology is excluded because registrars are not required to collect cases with ambiguous terms describing a cytology diagnosis.	N/A	1. Chest MRI shows a malignant appearing lesion in the right upper lobe. Patient refused further workup or treatment. 2. Pt with elevated PSA admitted for TRUS. Biopsy. Pathology: Prostatic chips: Consistent with adenocarcinoma. No further information is available
2	Ambiguous term followed by conclusive term	The case was originally assigned a code 1 (was accessioned based only on ambiguous terminology). More than 60 days after the initial diagnosis the information is being updated to show that a conclusive diagnosis was made by any diagnostic method including clinical diagnosis, cytology, pathology, autopsy, etc.	60 days or more after the date of diagnosis	The biopsy of the thyroid reads: most likely thyroid cancer. Three months later a biopsy is positive for papillary follicular cancer. The case would have been coded 1 Ambiguous term only. Change the code to 2 Ambiguous term followed by conclusive term.
9	Unknown term	There is no information about ambiguous terminology..	N/A	.

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

Definitions

Phrase	Definition	Examples
Ambiguous terminology	Terms that have been mandated as reportable when used in a diagnosis. See the reportable list below for a complete listing of those terms. See the 2007 SEER Coding and Staging Manual or the FORDS for detailed instructions on how to use the list.	**Clinical:** a physician's statement that the patient most likely has lung cancer. **Laboratory tests:** A CBC suspicious for leukemia. **Pathology:** A prostate biopsy compatible with adenocarcinoma
Conclusive terminology	A clear and definite statement of cancer. The statement may be from a physician (clinical diagnosis); or may be from a laboratory test, autopsy, cytologic findings, and/or pathology	**Clinical:** a physician's statement that the patient has lung cancer. **Laboratory tests:** A CBC diagnostic of acute leukemia. **Cytologic findings:** A FNA (fine needle aspiration) with findings of infiltrating duct carcinoma of the breast. **Pathology:** A colon biopsy showing adenocarcinoma

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

Ambiguous terms that are reportable
Apparent(ly)
Appears (effective with cases diagnosed 1/1/1998 and later)
Comparable with (effective with cases diagnosed 1/1/1998 and later)
Compatible with (effective with cases diagnosed 1/1/1998 and later)
Consistent with
Favor(s)
Malignant appearing (effective with cases diagnosed 1/1/1998 and later)
Most likely
Presumed
Probable
Suspect(ed)
Suspicious (for)
Typical (of)

Coding Instructions

1. Use **Code 0** when a case is accessioned based on conclusive terminology. The diagnosis includes clear and definite terminology describing the malignancy within 60 days of the original diagnosis.
   Note: Usually the patient undergoes a diagnostic work-up because there is a suspicion of cancer (ambiguous terminology). For example, a mammogram may show calcifications suspicious for intraductal carcinoma; the date of the mammogram is the date of initial diagnosis. When there is a clear and definite diagnosis within 60 days of that mammogram (date of initial diagnosis) such as the pathology from an excisional biopsy showing intraductal carcinoma, assign a code 0.
2. Use **Code 1** when a case is accessioned based on ambiguous terminology and there is no clear and definite terminology used to describe the malignancy within 60 days of the date of initial diagnosis.
   The diagnosis may be from a pathology report, a radiology report, an imaging report, or on the medical record.
3. Use **Code 2** when a case is accessioned based on ambiguous terminology followed by clear and definite terminology more than 60 days after the initial diagnosis.
4. Follow-back to a physician or subsequent readmission (following the initial 60 days period) may eventually confirm cancer (conclusive cancer term more than 60 days after ambiguous term). Assign **Code 2**.
5. Leave this data item blank for cases diagnosed prior to 01/01/2007.

Cases accessioned based on ambiguous terminology (**Code 1**) should be excluded from case selection in research studies. Direct patient contact is not recommended.

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

Date of Conclusive Terminology

Item Length: 8
NAACCR Item #: 443
NAACCR Name: Date of Conclusive Term

For those cases originally accessioned based on ambiguous terminology only, this data item documents the date of a definite statement of malignancy. The abstractor will change the code for the data item "Ambiguous Terminology" from a 1 to a 2 and enter the date that the malignancy was described clearly and definitely in Date of Conclusive Terminology.

Date

Date fields are recorded in the month, day, century, year format (MMDDCCYY) with 99 for unknown month or day and 9999 for unknown year.

Special Codes

00000000	Accessioned based on ambiguous terminology only (Code 1 in data item "Ambiguous Terminology")
88888888	Not applicable. The case was accessioned based on conclusive diagnosis (Code 0 in data item "Ambiguous Terminology")
99999999	Unknown date; unknown if diagnosis was based on ambiguous terminology or conclusive terminology (Code 9 in data item "Ambiguous Terminology"

Leave this field blank for cases diagnosed prior to 01/01/2007.

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
   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.

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

Date of Multiple Tumors

Item Length: 8
NAACCR Item #: 445
NAACCR Name: Date of Multiple Tumors

This data item is used to identify the month, day and year the patient is diagnosed with multiple tumors reported as a single primary. Use the multiple primary rules for that specific site to determine whether the tumors are a single primary or multiple primaries.

Date
Date fields are recorded in the month, day, century, year format (MMDDCCYY) with 99 for unknown month or day and 9999 for unknown year.

Special Codes

00000000	Single tumor
88888888	Information on multiple tumors not collected/not applicable for this site
99999999	Unknown date

Coding Instructions

When multiple tumors are present at diagnosis, record the date of diagnosis.

Example 1: The patient has multiple tumors; a 2 cm infiltrating duct in the LIQ and a 1 cm infiltrating duct carcinoma in the UIQ of the left breast. According to the breast multiple primary rules these tumors are accessioned as a single primary. Enter the date of diagnosis in Date of Multiple Tumors.
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. According to the Bladder, Renal Pelvis, and Ureter multiple primary rules these tumors are accessioned as a single primary. Enter the date of diagnosis in Date if Multiple Tumors.

When subsequent tumor(s) are counted as the same primary.

Example: Patient has an excisional biopsy of a single tumor in the soft palate on January 2, 2007. The pathology shows clear margins. Record 01 in Multiplicity Counter. On July 10, 2007 another tumor is excised from the soft palate. The multiple primary rules for head and neck state that this tumor is the same primary. Change the 01 in Multiplicity Counter to 02 and enter 07102007, the date the second tumor was diagnosed. in Date of Multiple Tumors.

Leave this field blank for cases diagnosed prior to 01/01/2007.

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

Type of Multiple Tumors Reported as One Primary

Item Length: 2
NAACCR Item #: 444
NAACCR Name: Mult Tum Rpt as One Prim

This data item is used to identify the type of multiple tumors that are abstracted as a single primary. Ignore metastatic tumors for this data item.

Code	Code Text	Description	Example(s)
00	Single tumor	All **single tumors.** Includes single tumors with both in situ and invasive components	Code 01 in the Multiplicity Counter
10	Multiple benign	At least two benign tumors in same organ/primary site Use this code for reportable tumors in **intracranial** and **CNS** sites only May be used for reportable by agreement cases	
11	Multiple borderline	At least two borderline tumors in the same organ/primary site Use this code for reportable tumors in **intracranial** and **CNS** sites only May be used for reportable by agreement cases	
12	Benign and borderline	At least one benign **AND** at least one borderline tumors in the same organ/ primary site Use this code for reportable tumors in **intracranial** and **CNS** sites only May be used for reportable by agreement cases	
20	Multiple in situ	At least two in situ tumors in the same organ/primary site	Cystoscopy report documents multiple bladder tumors. Pathology: Flat transitional cell carcinoma of bladder.
30	In situ and invasive	One or more in situ tumor(s) **AND** one or more invasive tumors in the same organ/primary site	

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

Code	Code Text	Description	Example(s)
31	Polyp and adenocarcinoma)	One or more polyps with either • In situ carcinoma or • invasive carcinoma **AND** one or more frank adenocarcinoma(s) in the same segment of colon, rectosigmoid, and/or rectum	
32	FAP with carcinoma	Diagnosis of familial polyposis (FAP) **AND** carcinoma (in situ or invasive) is present in at least one of the polyps	
40	Multiple invasive	At least two invasive tumors in the same organ	
80	Unk in situ or invasive	Multiple tumors present in the same organ/primary site, unknown if in situ or invasive	
88	NA	Information on multiple tumors not collected/not applicable for this site	Leukemia, lymphoma, immunoproliferative diseases, and unknown primaries. All codes 88 in Multiplicity Counter
99	Unk	Unknown	Code 99 in Multiplicity counter, and DCO cases.

Multiple Primary and Histology Coding Rules Project
Roster

Co-Chairs: Carol Johnson, BS, CTR
Steven Peace, BS, CTR

Registry/Organization	Member			
	Last Name	**First Name**	**Credential**	**Status**
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Atlanta	Wilson	Phyllis	MS, CTR	Active
Atlanta	Young	John Lewis	DrPH, CTR	Active
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Cancer Care Nova Scotia	Starratt	Karen		Active
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CDC NPCR	Intlekofer	Ryan	RN, CTR	Active
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Kentucky	Pardee	Reita	CTR	Active
Los Angeles	Conant	Cynthia	CTR	Active
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NAACCR	Havener	Lori	CTR	Active
NCCC	Douglas	Lynda	CTR	Active
NCI SEER	Hankey	Ben	ScD	Active
NCI SEER	Ries	Lynn	MS	Active
NCI SEER	Fritz	April	BA, RHIT, CTR	Active
NCI SEER	Adamo	Peggy	AAS, RHIT, CTR	Active
NCI SEER	Percy-Laurry	Antoinette	MSPH	Active
NCRA	Moats	Pam	RHIT, CTR	Active
New Jersey	Halama	Maria	MD, CTR	Active
New Jersey	Johnson	Linda	CTR	Active
Seattle	Tisdale	Tiffany		Active
Statistics Canada	Friesen	Ingrid	HRT	Active
Statistics Canada	Hamlyn	Elaine	CCHRA (A), CTR	Active
Utah	McFadden	SuAnn	CTR	Active
WHO / AFIP / ICD-O-3 Editor	Sobin	Leslie H	MD	Ad hoc
WHO / UICC / ICD-O-3 Editor	Shanmugaratnam	Kanagaratnam	MD, PhD	Ad hoc

Multiple Primary and Histology Coding Rules Project
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Cancer Site Subcommittees

Cancer Site	Chair	Members	Credential	Registry/Organization
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Brain	Johnson, Carol	All		All
Colon	Johnson, Carol	All		All
Lung	Conant, Cynthia		CTR	Los Angeles
		Scharber, Wendy	RHIT, CTR	Minnesota
		Friesen, Ingrid	HRT	Stats Canada
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		Chen, Amy	MD	Atlanta
		Wilson, Phyllis	MS, CTR	Atlanta
Ovary	Dryer, Cynthia		BA, CTR	Iowa
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		McFadden, SuAnn	CTR	Utah
		Platz, Charles	MD	Iowa
		Scharber, Wendy	RHIT, CTR	Minnesota
Urinary Tract	Nicolin, Patrick			Detroit
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		Fritz, April	BA, RHIT, CTR	NCI SEER
Melanoma	Platz, Charles		MD	Iowa
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Multiple Primary and Histology Coding Rules Project

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		Vance, Katheryne	BA, CTR	Greater California
Education	Fritz, April		BA, RHIT, CTR	NCI SEER
		Intelkoffer, Ryan	RN, CTR	NPCR
		TBA		CoC
		TBA		AJCC
		Vann, Shannon	CTR	NAACCR
		TBA		NCRA
		Friesen, Ingrid	HRT	Statistics Canada
		Platz, Charles	MD	Iowa - specialty only
		Scharber, Wendy	RHIT, CTR	Minnesota

Multiple Primary and Histology Coding Rules Project

Roster

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DEPARTMENT OF STATE HEALTH SERVICES
TEXAS CANCER REGISTRY

CASEFINDING QUICK REFERENCE

CASEFINDING AND REPORTABLE LIST (*Detailed instructions on pages 16–33*)

- Every **inpatient** and/or **outpatient** case with active disease and/or receiving cancer-directed therapy **MUST** be reported to the Department of State Health Services, Texas Cancer Registry (TCR) **regardless of the state or country of residence**.

- Cases of cancer to be reported to the TCR include:

  1) All neoplasms with a behavior code of two or three in the International Classification of Diseases for Oncology (ICD-O) 3rd edition (with certain exceptions); and

  2) All benign and borderline neoplasms of the central nervous system with a morphology term and code listed in ICD-O-3 (includes brain and other CNS neoplasms)

- Obtain a disease index including both inpatient and outpatient admissions after medical records are completed and coded (monthly or quarterly).

- Check the index against a list of cases previously reported to the TCR to identify new cases.

- Complete an abstract for patients found on the disease index with a reportable diagnosis not previously submitted to the TCR. **Patients who have been previously reported to the TCR need to be checked for possible multiple primaries**. Refer to the *Multiple Primaries/Histology Rules (*MP/H) in Appendix O and *Criteria for Determining Multiple Primaries of Lymphatic and Hematopoietic Diseases in* Appendix E for assistance.

- To prevent reporting the same patient with the same primary twice, compare the patient name and primary cancer site from your registry database (accession list or SCL facility data report) to the TCR facility data report. The TCR facility data report lists all the patients a facility has reported to TCR for multiple years.

- Other department logs/records (radiation therapy logs, emergency room logs, oncology unit records, surgery logs, etc.) are to be reviewed in the same manner as the disease index to insure all reportable cases are submitted to the TCR.

- Pathology reports, including all histology, cytology, hematology and autopsy reports, should be reviewed to identify all reportable neoplasms. These should also be reviewed against a list of records submitted to the TCR to avoid reporting duplicates. Check for **multiple primaries** if you find a patient was previously submitted to the TCR.

The following lists are intended to aid the appropriate personnel in creating a disease index with the required reportable neoplasms and ICD-9-CM codes. The reporter should review all inpatient and outpatient admissions with the diagnosis codes listed in the tables.

Reportable Neoplasms:

- Malignant neoplasms (*exclusions noted on page 23 of the Casefinding section of the CRH)*
- Benign and borderline neoplasms of central nervous system
- Carcinoma in-situ (*exclusions noted on page 23 of the Casefinding section of the CRH)*
- Pituitary adenomas diagnosed as of 2003
- Carcinoid, NOS *(excluding appendix, unless stated to be malignant)*
- Pilocytic/juvenile astrocytoma is reportable and should be coded to 9421/3
- Squamous intraepithelial neoplasia grade III of vulva **[VIN]**, vagina **[VAIN]**, and anus **[AIN]** will be reportable **beginning with 2001 cases**.
- Malignant neoplasms of the skin of genital sites are reportable. These sites include: vagina, clitoris, vulva, prepuce, penis, and scrotum.
- Reportable skin tumors such as adnexal carcinomas, carcinomas of the sweat gland, ceruminous gland, and hair follicle, adenocarcinomas, lymphomas, melanomas, sarcomas, and Merkel cell tumor must be reported regardless of site. Any carcinoma arising in a hemorrhoid is reportable since hemorrhoids arise in mucosa, not in skin.

The reporter should review all admissions (inpatient and outpatient) with the following diagnosis codes for reportability:

ICD-9-CM CODES	**DIAGNOSIS (IN PREFERRED ICD-O-3 TERMINOLOGY)**
CODE RANGES	
140.0 - 208.9	Malignant neoplasms
225.0 - 225.9	Benign neoplasms of brain and spinal cord
227.3 - 227.4	Benign neoplasm of pituitary gland, pineal body, and other intracranial endocrine-related structures
230.0 - 234.9	Carcinoma in-situ
237.0 - 237.9	Neoplasms of uncertain behavior (borderline) of endocrine glands and nervous system

The table below lists a sample of codes and is not all-inclusive. The full range of codes must be checked

INDIVIDUAL CODES	
042	AIDS (review records for AIDS-related malignancies)
203.1	Plasma cell leukemia (9733/3)

205.1	Chronic neutrophilic leukemia (9963/3)
227.3	Benign neoplasm of pituitary (body, fossa, gland, lobe)
227.3	Benign neoplasm of craniopharyngeal (duct, pouch)
227.4	Benign neoplasm of pineal (body, gland)
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3) Extramedullary plasmacytoma (9734/3)
238.71	Essential thrombocythemia (9962/3) Essential hemorrhagic thrombocythemia Essential thrombocytosis Idiopathic thrombocythemia Idiopathic hemorrhagic thrombocythemia Primary thrombocythemia Thrombocythemia vera
238.72	Low grade Myelodysplastic syndrome lesions Refractory anemia (RA) (9980/3) Refractory anemia with ringed sideroblasts (RARS) (9982/3) Refractory cytopenia with multilineage dysplasia (RCMD) (9985/3) Refractory cytopenia with multilineage dysplasia and ringed sideroblasts (RCMD-RS) (9985/3)
238.73	High grade Myelodysplastic syndrome lesions Refractory anemia with excess blasts-1 (RAEB-1) (9983/3) Refractory anemia with excess blasts-2 (RAEB-2) (9983/3)
238.74	Myelodysplastic syndrome with 5q deletion (9986/3) Excludes: constitutional 5q deletion (not reportable)
238.75	Myelodysplastic syndrome, unspecified (9985/3, 9989/3)
238.76	Myelofibrosis with myeloid metaplasia (9961/3) Agnogenic myeloid metaplasia Idiopathic myelofibrosis (chronic) Myelosclerosis with myeoloid metaplasia Primary myelofibrosis Excludes: myelofibrosis NOS myelophthisis anemia (not reportable) myeolphihisis (not reportable)
238.79	Other lymphatic and hematopoietic tissues Megakaryocytic myelosclerosis (9961/3) Myeloproliferative disease (chronic) NOS (9960/3) Panmyelosis (acute) (9931/3)
273.2	Gamma heavy chain disease (9762/3)
273.3	Waldenstrom's macroglobulinemia
288.3	Hypereosinophilic syndrome (9964/3)
289.83	Myelofibrosis Myelofibrosis NOS Secondary myelofibrosis

Admissions with the following codes **must** be screened for reportable neoplasms:

ICD-9-CM CODES	**DESCRIPTION**
V07.3	Other prophylactic chemotherapy (screen carefully for miscoded malignancies)
V07.8	Other specified prophylactic measures
V10.0–V10.9	Personal history of malignancy (review these for recurrences, subsequent primaries, subsequent treatment, and diagnosis date)
V58.0	Admission for radiotherapy
V58.11	Admission for chemotherapy
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Radiation therapy follow-up
V67.2	Chemotherapy follow-up
V71.1	Observation for suspected malignant neoplasm
V76.0–V76.9	Special screening for malignant neoplasm
V86.0	Estrogen receptor positive status (ER+) (new code)
V86.1	Estrogen receptor negative (ER-) (new code)

Cases with the following codes should be screened as registry time allows. Check for incorrectly coded malignancies.

ICD-9-CM CODES	DIAGNOSIS TERMINOLOGY
210.0 – 229.9	Benign neoplasms
235.0 – 238.9	Neoplasms of uncertain behavior
239.0 – 239.9	Neoplasms of unspecified behavior
273.9	Unspecified disorder of plasma protein metabolism (screen for potential 273.3 miscodes)

SEER suggests that the following codes be screened as deemed appropriate by the individual reporting facility and as time allows. These are neoplasm related secondary conditions for which there should also be a primary diagnosis of a reportable neoplasm.

ICD-9-CM CODES	DIAGNOSIS TERMINOLOGY
E879.2	Adverse effect of radiation therapy
E930.7	Adverse effect of antineoplastic therapy
E933.1	Adverse effect of immunosuppressive therapy

The following are **exclusions** and **do not** need to be reported to the TCR:

MORPHOLOGY CODES	DESCRIPTION
8000–8005	Neoplasms, malignant, NOS of the skin
8010/2	Carcinoma in-situ of cervix **beginning with 1996 cases**
8010–8046	Epithelial carcinomas of the skin
8050–8084	Papillary and squamous cell carcinomas of the skin **except genital sites**
8077/2	Squamous Intraepithelial Neoplasia, grade III of cervix **beginning with 1996 cases; CIN**
8090–8110	Basal cell carcinomas of the skin **except genital sites**
8148/2	Prostatic Intraepithelial Neoplasia

Non-Reportable Neoplasms

Cases in which the disease is **no longer active** (i.e., leukemia in remission) should only be reported if the patient is still receiving cancer-directed therapy.

Example:

A patient was diagnosed 6 months ago with acute myelocytic leukemia, now in remission, on a maintenance dose of chemotherapy. The patient was admitted for evaluation of neutropenia following the last course of chemotherapy. If this is the first admission to your facility, this patient should be reported because cancer-directed treatment (chemotherapy) is being administered.

Guidelines to Use When a Diagnosis Contains Ambiguous Terms

Diagnostic of Cancer: *apparently, appears, comparable with, compatible with, consistent with, favor(s), malignant appearing, most likely, neoplasm (beginning with 2004 diagnoses and only for C700-C729, C751-C753) presumed, probable, suspect(ed), suspicious (for), tumor (beginning with 2004 diagnosis and only for C700-C729, C751-C753) and typical (of).*

Note: *This list should be used only for determining case reportability. Do not use this list to determine the appropriate histology or stage.*

EXCEPTION: If cytology is reported as "suspicious" do not interpret this as a diagnosis of cancer. Report the case only if there is either a positive biopsy, a physician's clinical impression of cancer supporting the cytology findings, or cancer directed therapy is administered.

Cases to Report Only if Cancer-Directed Therapy is Planned or Given

- Cases diagnosed and/or treated for cancer prior to admission should be reported if there is evidence of

active disease, whether or not diagnostic or therapeutic procedures were performed.

Note: *Stable disease indicates active disease.*

- Cases diagnosed at autopsy, with no suspicion prior to death that the cancer existed, should be reported.
- Abstract cases using the medical record from the first admission (inpatient or outpatient) to your facility with a reportable diagnosis. Use information from subsequent admissions to include all first course treatment information and to supplement documentation.
- Do not report cases diagnosed prior to 1995.
- Do not complete a report for each admission; submit one report per primary tumor.

Examples:

a. A patient is diagnosed with prostate cancer and has several admissions for treatment of the prostate cancer. Only one abstract should be completed.

b. A patient is diagnosed with two separate PRIMARY tumors, such as adenocarcinoma of the prostate and squamous cell carcinoma of the lung. Complete one abstract for the prostate primary and another for the lung.

HELPFUL HINTS:

- **REPORT ALL CASES OF *ACTIVE* CANCER REGARDLESS OF STATE OF RESIDENCE.**
- **REPORT ALL INPATIENTS AND OUTPATIENTS.**
- **DO NOT REPORT BASAL OR SQUAMOUS CELL CARCINOMAS OF THE SKIN (EXCEPT GENITAL SITES).**
- **TO ENSURE CASE ASCERTAINMENT - REVIEW DISEASE INDEX, PATHOLOGY REPORTS, CYTOLOGY, HEMATOLOGY, AND AUTOPSY REPORTS.**
- **REPORT ALL BENIGN AND BORDERLINE NEOPLASMS OF THE CENTRAL NERVOUS SYSTEM.**
- **DO NOT COMPLETE ABSTRACT FOR EACH ADMISSION; ONLY ONE PER PRIMARY TUMOR.**
- **CASES IN WHICH THE DISEASE IS NO LONGER ACTIVE (I.E., LEUKEMIA IN REMISSION) SHOULD ONLY BE REPORTED IF THE PATIENT IS STILL RECEIVING CANCER-DIRECTED THERAPY.**
- **DO NOT REPORT CARCINOMA IN SITU OF CERVIX (ANY HISTOLOGY).**
- **DO NOT REPORT INTRAEPITHELIAL NEOPLASIA OF THE PROSTATE (PIN III).**

DEPARTMENT OF STATE HEALTH SERVICES
TEXAS CANCER REGISTRY

HANDBOOK QUICK REFERENCE SHEET

The Sample Abstract Form can be found in Appendix F in the 2008 CRH.

Data Field 580 DATE OF FIRST CONTACT/ADMIT (MMDDCCYY (page 34): Enter month, day, century and year of the patient's first admission to your facility for diagnosis and/or treatment of this reportable cancer or, if previously diagnosed/treated elsewhere, the date of the first admission to your facility with active cancer or receiving cancer treatment.

Data Field 550 REGISTRY NUMBER (page 35): To be completed only by SCL users or facilities with a cancer registry that maintains an accession register.

Data Field 540 REPORTING FACILITY NUMBER (page 36): Enter 3 digit code assigned by TCR. If you do not know your facility number, contact your regional office or call 1-800-252-8059.

Data Field 500 REPORTING SOURCE (page 36): Enter code for the source documents and/or facility used to abstract the case.

1 - Hospital inpatient; Managed health plans with comprehensive, unified medical records
2 – Radiation Treatment Centers or Medical Oncology Centers (Facility or Private)
3 - Laboratory Only (Facility or Private)
4 - Physician's Office/Private Medical Practitioner
5 - Nursing/Convalescent Home,Hospice
6 - Autopsy Only
7 - Death Certificate Only
8 – Other hospital outpatient units/surgery centers

Note: *Assign codes in priority order: 1, 2, 8, 4, 3, 5, 6 and 7 (if more than one source is used)*

Data Field 2300 MEDICAL RECORD NUMBER (page38): Enter the medical record number (MRN) used for the patient's first admission with a DX of cancer. MRN's less than 11 digits and alpha characters are acceptable. If the MRN is not available (for example, outpatient clinic charts) enter "OP" in this field.

Special Codes:

RT Radiation Therapy department patient without a medical record number
SU One-day surgery clinic patient without a medical record number
UNK Medical Record Number Unknown

Data Field 610 (page 38) **CLASS OF CASE:** Divides data into analytical and non-analytical categories.

Data Field 2230 LAST NAME (page 41): Enter the name of the patient in capital letters. Hyphens, other special characters, and spaces are allowed. **Do not leave blank.**

Data Field 2240 FIRST NAME (page 42): Enter first name of patient in capital letters. Hyphens, other special characters, and spaces are allowed. **Do not leave blank.**

Data Field 2250 MIDDLE NAME (page 43): Enter the middle name of the patient in capital letters. Enter middle initial if full name is unknown. Leave blank if unknown.

Data Field 2390 MAIDEN NAME (page 43): Enter the maiden name of the female patients who are or have been married. Hyphens, other special characters and spaces are allowed. Leave blank if unknown.

Data Field 2280 NAME-ALIAS (page 43): Enter an alternative name or "AKA" used by the patient, if known. If unknown, leave blank

Data Field 2330 STREET ADDRESS (page 44): Enter the number and street of the patient's residence at the time the cancer is diagnosed in 25 characters or less. If address is not known, enter "NO ADDRESS" or "UNKNOWN". DO NOT LEAVE BLANK. Punctuation marks are not allowed in this field. Abbreviate, as needed using standard address abbreviations listed in the *U.S. Postal Service National Zip Code and Post Office Directory* published by the U.S. Postal Service or on the web-site at http://www.usps.com/ncsc/lookups/abbrev.html

Data Field 2335 ADDRESS AT DX SUPPLEMENTAL (page 46): If the name of a facility is provided instead of an address enter the facility name here. If this space is not needed **leave it blank**.

Data Field 70 CITY (page 47): Enter the city of residence at the time the cancer is diagnosed. If no address is known, record "Unknown". **Do not leave blank.**

Data Field 80 STATE (page 47): Enter the two letter abbreviation for state of residence at time of diagnosis. Record US for resident of United States, NOS. If resident of foreign country, other than Mexico (MX) or Canada (CD), record either XX if the country is known or YY if the country is unknown. If no address is known, enter "ZZ".

Data Field 100 ZIP CODE (page 50): Enter patient's zip code at time of diagnosis. If known, enter nine digit extended zip code. If unavailable, refer to National Zip Code Directory or the USPS web site:
http://zip4.usps.com/zip4/welcome.jsp
If resident of foreign country, code all "8's." If address is not available enter "99999".

Data Field 90 FIPS COUNTY CODE: (page 51 & APPENDIX C) Enter the three digit Federal Information Processing Standards code found in Appendix C. Code "998" for out-of-state or foreign residents. If address is not available enter "999".

Data Field 2320 SOCIAL SECURITY NUMBER (page 52): Every resource should be exhausted to obtain social security number. If not available, code all "9's" **as a last resort only**. Take caution to enter the patient's number and not the spouse's number. Dashes and /or slashes are not allowed in this field.

Data Field 240 DATE OF BIRTH (page 53): DOB must be coded. Enter month, day, century, and year of patient's birth. **Unknown date of birth will not be accepted**

Data Field 250 PLACE OF BIRTH (page 54 and Appendix G) Record Patient's place of birth (if available) using the SEER Geo-codes in Appendix G. If the place of birth is unknown, code 999.

Data Field 160 RACE 1 (page 54): Enter the 2 digit code to identify the primary race of the patient.

01 White (includes Mexican, Puerto Rican, Cuban, Arab, and all other Caucasians)

02 Black (African Origin)	12 Hmong	30 Melanesian, NOS
03 American Indian, Aleutian, Eskimo	13 Kampuchean (Cambodian)	31 Fiji Islander
04 Chinese	14 Thai	32 New Guinean
05 Japanese	20 Micronesian, NOS	96 Other Asian including Asian/Oriental NOS
06 Filipino	21 Chamorran	97 Pacific Islander, NOS
07 Hawaiian	22 Guamanian, NOS	98 Other
08 Korean	25 Polynesian, NOS	99 Unknown
09 Asian Indian, Pakistani, Sri Lankan	26 Tahitian	
10 Vietnamese	27 Samoan	
11 Laotian	28 Tongan	

Data Field 161, 162, 163 & 164 RACE 2, RACE 3, RACE 4, & RACE 5 (page 57): If the patient is multi-racial, code all the races using new items (RACE 2) through (RACE 5) Use code "88" for no further race documented.

01 White
88 No further race documented
96 Other Asian and Oriental
97 Pacific Islander, NOS
98 Other
99 Unknown

Data Field 190 SPANISH/HISPANIC ORIGIN (page59): (The list of Spanish/Hispanic surnames is on the TCR website in Appendix M) this code identifies persons of Spanish or Hispanic origin. The information may be coded from the medical record or may be based on Spanish/Hispanic names. **Persons of Spanish or Hispanic origin may be of any race.**

0 Non-Spanish; non Hispanic (includes Portuguese and Brazilian)
1 Mexican (includes Chicano, NOS)
2 Puerto Rican
3 Cuban
4 South Central American (Except Brazil)
5 Other specified Spanish/Hispanic
6 Spanish, NOS; Hispanic, NOS; Latino, NOS
7 Spanish surname only
9 Unknown whether Spanish or not

Data Field 220 SEX (page 60): Enter the code to identify the gender of the patient.

1 Male
2 Female
3 Other (Hermaphrodite)
4 Trans-sexual
9 Not stated/Unknown

Data Field 2680 OTHER PERTINENT INFORMATION (page 61) Document other pertinent information for which adequate or appropriate space has not been provided on the reporting form. Such information may include additional staging or treatment information, history of disease or comments regarding lack of documentation in the medical record. Document the name of the facility that referred the patient or the name of the facility that the patient was referred to in this field. Document age and race of the patient in this field.

Data Field 2460 Physician Managing (page 61): Record the state license number of the physician responsible for the overall management of the patient's care during diagnosis and/or treatment for this cancer. Physician license numbers for Texas can be found at the following web-site: http://www.docboard.org/tx/df/txsearch.htm

Data Field 2470 Physician Follow Up (page 62): Record the state license number of the physician currently responsible for following the patient. Physician license numbers for Texas can be found at the following web-site: http://www.docboard.org/tx/df/txsearch.htm

Data Field 2410 FACILITY REFERRED FROM (page 62): Enter the facility name or the following codes:

Patient not referred 0000000000
Patient referred unknown ID 0099999999
Document the name of the facility and city that referred the patient to your facility under OTHER PERTININT INFORMATION

Data Field 2420 FACILITY REFERRED TO (page 63): Enter the facility name or the following codes:

Patient not referred 0000000000
Patient referred unknown ID 0099999999
Document the name of the facility and the city that the patient was referred to for further care after discharge from your facility under OTHER PERTINENT INFORMATION.

Data Field 560 SEQUENCE NUMBER (page 64): Indicates the chronological sequence of this reportable neoplasm IN THE PATIENT'S LIFETIME. Each PRIMARY tumor is assigned a different number.

Malignant Primaries	**Benign Primaries**
00 One malignant primary only	60 One benign primary only
01 First of multiple malignant primaries	61 First of multiple benign primaries
02 Second of multiple malignant primaries	62 Second of multiple benign primaries
03 Third of multiple malignant primaries	63 Third of multiple benign primaries
99 Unspecified number of malignant primaries	88 Unspecified number of benign primaries

Data Field 2220 OTHER PRIMARY TUMORS (SITE, MORPHOLOGY, AND DATE) (page 66): Complete **if the patient has other reportable tumors during their lifetime.** Record the site, morphology, and date of any other primaries. DO NOT INCLUDE SECONDARY/METASTATIC LESIONS.

Data Field 630 PRIMARY PAYER AT DIAGNOSIS (page 66a) Record the type of insurance reported on the patient's admission page.

01 Not insured
02 Not insured, self pay
10 Insurance, NOS
20 Private Insurance: Managed Care, HMO, PPO
21 Private Insurance: Fee-for-Service
31 Medicaid
35 Medicaid-Administered through a managed care plan
60 Medicare without supplement, Medicare, NOS
61 Medicare with supplement, NOS
62 Medicare-Administered through a managed care plan
63 Medicare with private supplement
64 Medicare with Medicaid eligibility
65 TRICARE
66 Military
67 Veterans Affairs
68 Indian/Public Health Services
99 Insurance status unknown

Data Field 390 DATE OF INITIAL DIAGNOSIS (MMDDCCYY) (page 67): Enter the date of initial diagnosis of this cancer by a recognized medical practitioner **by any method** (for example, a positive finding from a radiology report); regardless of whether the diagnosis was made at this facility or elsewhere. The date of diagnosis for "Death Certificate Only" or "Autopsy Only" is the date of death. For vague dates, estimate month and year. For cases with unknown date of diagnosis code month and year of date of first contact (06992006) and document "Date of dx unknown" in Other Pertinent Information Text Field. This should be used as a last resort after exhausting all available resources. Every effort must be made to obtain date of diagnosis.

Data Field 420, 430 MORPHOLOGY ICD-O-2: TYPE AND BEHAVIOR (page 70): The International Classification of Diseases for Oncology, (ICD-O) 2nd Edition, is to be used for coding and reporting the morphology and behavior of tumors diagnosed before January 01, 2001. **Adequate documentation of tumor cell type must be provided** in the **FINAL DIAGNOSIS** section of the reporting form. Use all pathology reports available; generally tissue from a resection or excision is most representative of the tumor's histology.

Note: *Refer to TCR 2006 Cancer Reporting Handbook, Revised 2007 for cases diagnosed prior to 2007.*

Data Field 522 & 523 MORPHOLOGY ICD-O-3: TYPE AND BEHAVIOR (page 70): The International Classification of Diseases for Oncology, (ICD-O) 3rd Edition is to be used for coding and reporting the morphology and behavior of tumors diagnosed on or after January 01, 2001. **Adequate documentation of tumor cell type must be provided** in the **FINAL DIAGNOSIS** section of the reporting form to support coding. Use all pathology reports available; generally tissue from a resection or excision is most representative of the tumor's histology.

Note: *Refer to Multiple Primary/Histology Rules (MP/H), Appendix O for cases diagnosed on or after 1/1/2007.*

Data Field 400 PRIMARY SITE (page 77)**:** Record the specific topography code from ICD-O. **Adequate documentation must be provided** in the **FINAL DIAGNOSIS** (Data Fields 2590 and 2580) section of the reporting form to support coding.

Data Field 440 GRADE OF TUMOR (page 84)**:** The grade or differentiation of the tumor describes the resemblance of the tumor cells to their normal tissue counterparts. The more undifferentiated the tumor, the greater the incidence of metastases and the more rapid the clinical course. **Do not code the grade of a metastatic site**. If the grade for the primary is unknown enter "9" in this field.

1 Grade I Well differentiated
2 Grade II Moderately differentiated, moderately well differentiated, intermediate differentiation, partially well differentiated, partially differentiated, low grade NOS
3 Grade III Poorly differentiated, moderately undifferentiated, relatively undifferentiated, slightly undifferentiated, medium grade NOS
4 Grade IV Undifferentiated, anaplastic, dedifferentiated, high grade NOS
9 Grade or differentiation not determined, not stated, or not applicable

Codes for T-cell and B-cell designation for lymphomas and leukemia:

5 T-cell, T-precursor
6 B-cell, pre B; B-precursor
7 Null cell; non T-non B (for leukemia only)
8 Natural Killer (NK) cell
9 Grade or differentiation not determined, not stated or not applicable

***For lymphomas, do not code the descriptions "high grade", "low grade", or "intermediate grade" in this field.**

Refer to pages 86-92 of 2008 CRH for specific coding guidelines on grade for Prostate, Breast, Kidney, Astrocytoma, Lymphoma, Leukemia, and Sarcoma primaries.

Coding Grade for Prostate Cases

1. If Gleason's score (2-10) is given:

Gleason's Score	Grading	Code
2, 3, 4	I Well differentiated	1
5, 6	II Moderately differentiated	2
7, 8,9,10	III Poorly differentiated	3

2. If Gleason's Pattern (1-5) is given:

Gleason's Pattern	Grading	Code
1, 2	I Well differentiated	1
3	II Moderately differentiated	2
4, 5	III Poorly Differentiated	3

Data Field 410 LATERALITY (page 93)**:** Enter the code to identify the laterality of a paired site.

0 Not a paired site
1 Right: origin of primary
2 Left: origin of primary
3 Only one side involved, right or left origin not indicated
4 Bilateral involvement, lateral origin unknown: stated to be single primary; includes: both ovaries involved simultaneously with a single histology; bilateral retinoblastoma; bilateral Wilms' tumors
9 Unknown site, paired site, lateral origin unknown; midline tumor

Data Field 2580 & 2590 FINAL DIAGNOSIS- MORPHOLOGY/BEHAVIOR, GRADE, PRIMARY SITE, AND LATERALITY DOCUMENTATION (page 98): Record the morphology/behavior, grade, primary site, and laterality descriptions.

Data Field 490 DIAGNOSTIC CONFIRMATION (page 99) The best method of confirmation throughout the entire course of the disease. All diagnostic reports in the medical record must be reviewed to determine the most definitive method used to confirm the diagnosis of cancer.

MICROSCOPICALLY CONFIRMED

1 Histology -- Microscopic diagnosis based upon tissue specimens from biopsy, frozen section, surgery, and autopsy, of D & C. Positive hematologic findings relative to leukemia are also included. Bone marrow specimens (including aspiration biopsies) are coded as "1".
2 Cytology -- Cytologic diagnosis with no positive histology such as pap smears, bronchial brushings, FNA and peritoneal fluid.
4 Microscopic Confirmation, NOS -- Diagnosis stated to be microscopically confirmed but method not specified.

NOT MICROSCOPICALLY CONFIRMED

5 Laboratory test/marker study -- Clinical diagnosis of cancer based on certain laboratory tests or marker studies.
6 Direct Visualization -- Visualization without microscopic confirmation, i.e., exploratory laparotomy or endoscopy.
7 Radiology/Imaging -- Radiology and other imaging techniques without microscopic confirmation, i.e. CAT scans and MRI.
8 Other (other than 5, 6 or 7) -- Cases diagnosed by clinical methods not mentioned above and for which there were no positive microscopic findings. Physician documented the tumor in the medical record. Refer to ambiguous Terminology List on page 23.

CONFIRMATION UNKNOWN

9 Unknown -- Cases for which it is unknown whether or not microscopically confirmed. Also includes "Death Certificate Only" cases.

Data Field 760 SUMMARY STAGE 1977(page 6): To be used with cases diagnosed/admitted prior to 2001. Summary stage refers to the extent of disease categorized as in-situ, localized, regional, and distant.

0 In Situ
1 Localized
2 Regional direct extension
3 Regional to lymph nodes
4 Regional by both direct extension and regional LN involvement
5 Regional, NOS
7 Distant site(s)/node(s) involved; systemic disease
9 Unknown if extension or metastasis (unstaged, unknown, or unspecified) Death Certificate Only case

*Do not use Code "8" for Summary Stage.

Data Field 759 SUMMARY STAGE 2000(page 6): To be used with cases diagnosed/admitted January 1, 2001 and after. Summary stage refers to the extent of disease categorized as in-situ, localized, regional, and distant.

0 In Situ
1 Localized
2 Regional direct extension
3 Regional lymph nodes involved only
4 Regional by both direct extension and regional LN involvement
5 Regional, NOS
7 Distant site(s)/node(s) involved; systemic disease
9 Unknown if extension or metastasis (unstaged, unknown, or unspecified) Death Certificate Only case

*Do not use Code "8" for Summary Stage.

Data Field 2800 CS TUMOR SIZE (page A-11): Record for cases diagnosed on or after January 1, 2004. Record the largest dimension or diameter of the **primary tumor.** Use the size from the pathology report when there is no radiation or systemic therapy prior to surgery. If the patient receives neoadjuvant therapy record the largest size of

the primary tumor prior to treatment. Always record the size in millimeters. **Documentation in the Summary Stage field is required to support coding**

Data Field 2810 CS EXTENSION (page A-16)**:** Record for cases diagnosed on or after January 1, 2004. Code the farthest extension of the primary tumor. Do not code discontinuous metastases in this field. **Documentation in the Summary Stage field is required to support coding.**

Data Field 2820 CS /TUMOR SIZE/EXT EVAL (page A-18) Identifies how codes for CS TUMOR SIZE and CS EXTENSION were determined based on the diagnostic methods employed **Documentation in the Summary Stage field is required to support coding.**

Data Field 2830 CS LYMPH NODES (page A-15)**:** Record for cases diagnosed on or after January 1, 2004. Identifies the regional lymph nodes involved with the cancer at the time of diagnoses. Record the specific regional lymph node chain farthest from the primary site that is involved by tumor either clinically or pathologically. Information can be obtained from; radiological reports, surgical reports, and pathology reports. If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the farthest involved regional lymph nodes, based on information prior to surgery. **Exception**: In the infrequent event that clinically involved lymph nodes do not respond to neoadjuvant treatment, and are, in fact, more extensively involved at surgery as determined by the pathology report, code the lymph node involvement based on pathology/operative report after surgery. **Documentation in the Summary Stage field is required to support coding.**

Data Field 820 Regional Nodes Positive (page A-23)**:** Enter the number of regional lymph nodes pathologically examined and found to be positive. The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

Use code 99 for sites for which information about the field is unknown or not applicable:

Examples:	Brain	Reticuloendotheliosis	Unknown Primaries
	Leukemia	Lymphoma	

Data Field 830 REGIONAL LYMPH NODES EXAMINED (page A-25) Document and code the number of regional lymph nodes removed. The number of regional lymph nodes removed is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment. If no regional lymph nodes are identified in the pathology report, code 00.

Use code 99 for sites for which information about the field is unknown or not applicable:

Examples:	Brain	Reticuloendotheliosis	Unknown Primaries
	Leukemia	Lymphoma	

Data Field 2850 CS METS AT DIAGNOSIS (page A-28)**:** Record for cases diagnosed on or after January 1, 2004. Identifies the distant site(s) of metastatic involvement at time of diagnosis. Assign the highest applicable code for metastasis at the time of diagnosis. This can be determined clinically or pathologically. Information can be obtained from radiological reports, surgical reports, pathology reports, or physician notes. Metastasis known to have developed after extent of disease was established should not be considered for this field**. Documentation in the Summary Stage field is required to support coding.**

Data Field 2880 CS SITE-SPECIFIC FACTOR 1 (page A-29)**:** Record for cases diagnosed on or after January 1, 2004. *The TCR collects this field for pleura primaries only.* Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival. Limit information to first course of treatment in the absence of disease progression. Information can be obtained from; radiological reports, surgical reports, or pathology reports. **Documentation in the Summary Stage field is required to support coding.**

Data Field 2900 CS SITE-SPECFIC FACTOR 3 (page A-29)**:** Record for cases diagnosed on or after January 1, 2004. *The TCR collects this field for prostate primaries only.* Identifies additional information needed to generate stage, or

prognostic factors that have an effect on stage or survival. Limit information to first course of treatment in the absence of disease progression. Information can be obtained from the prostatectomy pathology report. **Documentation in the Summary Stage field is required to support coding.**

Data Field 2600 SUMMARY STAGE DOCUMENTATION (page 147)**:** Text field for documentation of extent of disease to support coding. Include findings from radiology and pathology reports and descriptions of observations from history and physical and operative reports. Include dates and types of procedures and exams. Document information such as lymph node involvement, extent of invasion, and extension to adjacent organs. Both positive and negative findings that are pertinent to describing the spread of the tumor from the primary site should be recorded. All combined clinical and surgical assessment within **FOUR MONTHS** of diagnosis in the absence of disease progression, which ever is longer, should be documented. These findings may be obtained from diagnostic reports of radiology, endoscopy, surgery, and laboratory tests prior to treatment. Document both the date and the source of the staging information.

Data Field 1292 SCOPE OF REGIONAL LYMPH NODE SURGERY (page 108)**:** Enter the code that defines the removal of regional lymph nodes. If no cancer-directed procedure was performed code (0).

Data Field 1200 RX DATE-SURGERY (MMDDCCYY) (page 110)**:** Document and enter the date of the **first** definitive cancer-directed surgery performed at any facility. If two or more cancer-directed surgeries are performed, enter the date for the first cancer-directed surgery. Do not record all 9's in this field if surgery was rendered as part of first course of treatment.

Data Field 1290 SURGICAL PROCEDURE OF PRIMARY SITE (page 111 & APPENDIX A): Document and code the most definitive first course cancer-directed surgery at any facility. Cancer-directed surgery is an operative procedure that actually removes, excises, or destroys cancer tissue of the primary site. Surgery performed solely for the purpose of establishing a diagnosis/stage (exploratory surgery), the relief of symptoms (bypass surgery), or reconstruction is not considered cancer-directed surgery. Brushings, washings and aspiration of cells are not surgical procedures.

Data Field 1340 REASON FOR NO SURGERY (page 113)**:** If no cancer directed surgery to the primary site was performed record the reason.

0 Surgery of the primary site was performed
1 Not part of the planned first course
2 Not recommended due to patient risk factors
5 Patient died prior to planned or recommended surgery
6 Surgery recommended and unknown why not performed
7 Patient or family refused surgery
8 Surgery recommended, unknown if performed
9 Unknown if surgery recommended or performed

Data Field 1294 RX SUMM-SURG.OTH REG/DIST RX CODE (page 115): Document and code the highest numbered code that describes the surgical resection of Regional/Distant Sites and Distant lymph nodes.

Data Field 1210 DATE RADIATION STARTED (page 116): Document and enter the date radiation began at any facility as part of the first course of treatment. Record all zeros when no radiation therapy is delivered or the cancer was diagnosed at autopsy. Record all 9's when it is unknown whether any radiation therapy was delivered.

Data Field 1570 RADIATION-REGIONAL TREATMENT MODALITY (page 117): Document and code the type of radiation therapy the patient received at any facility as part of the first course of treatment.

Data Field 1380 RX SUMM-SURG/RAD SEQUENCE (page 119)**:** Code the sequence of radiation and surgical procedures given as part of the first course of treatment.

Data Field 3230 DATE SYSTEMIC THERAPY STARTED (page 122)**:** Document and enter the date systemic therapy began at any facility. Systemic therapy includes: chemotherapy, hormonal agents, immunotherapy, bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy. Record all zeros when no systemic therapy was delivered or the cancer was diagnosed at autopsy. Record all 9's when it is unknown if any systemic

therapy was delivered or the case was identified by death certificate only.

Data Field 1390 CHEMOTHERAPY (page 123): Code the type of chemotherapy the patient received as part of the first course of treatment at any facility. Chemotherapy may involve the delivery of one or a combination of chemotherapeutic agents. Code "00" if chemotherapy was not delivered

Data Field 1400 HORMONE THERAPY (HORMONE/STEROID THERAPY) (page 125): Code the type of hormone therapy the patient received as part of the first course of treatment at any facility. Hormonal therapy may involve the delivery of one or a combination of agents. Code "00" if hormone therapy was not delivered

Data Field 1410 IMMUNOTHERAPY (page 127): Code the type of Immunotherapy the patient received as part of the first course of treatment at any facility. Code "00" if Immunotherapy was not delivered.

Data Field 3250 RX SUMM-TRANSPLANT/ENDOCRINE (page 129): Code the type of hematologic transplant and/or endocrine procedures the patient received as part of the first course of treatment at any facility. Code "00" if a transplant or endocrine procedure was not done.

Data Field 1639 RX SUMM—SYSTEMIC SURG SEQ (page 132): Code the administration of systemic therapy in sequence with the first surgery performed, described in the data item **Date of First Surgical Procedure.**

Data Field 1250 DATE OTHER TREATMENT STARTED (page 134): Enter the date other treatment is delivered that is not included in surgery, radiation therapy, and systemic treatment. Record all zeros when no other treatment was delivered or the cancer was diagnosed at autopsy. Record all 9's when it is unknown if other treatment was delivered, or for a death certificate only case.

Data Field 1420 OTHER TREATMENT (page 135): Code the type of "other treatment" the patient received as part of the first course of treatment at any facility. "Other treatment" is designed to modify or control the cancer cells, but is not included in surgery, radiation, or systemic therapy.

Data Fields 2610, 2620, 2630, 2640, 2650, 2660, 2670 TREATMENT DOCUMENTATION (page 137): Text field used to support codes in the treatment fields. Document all planned treatment even if it is unknown if treatment was given. List dates and types of all treatment given, even if it was done at another facility.

Data Field 1750 DATE OF LAST CONTACT OR DEATH (MMDDCCYY) (page 137): Enter the date the patient was last seen at your facility, date of last contact, or date of death. If patient is known to be deceased, but date of death is not available, date of last contact should be recorded in this field. In the "Other Pertinent Information" text area, document the patient is deceased and the date of death is not available.

Data Field 1760 VITAL STATUS (page 138): Patient's vital status as of the date recorded in the "Date of last contact/death" field.

0 Dead
1 Alive

Data Field 2090 DATE ABSTRACTED (MMDDCCYY) (page 138): Record month, day and full year reporting form is completed.

Data Field 570 ABSTRACTOR INITIALS (page 139): Record the initials of the abstractor.

Data Field 50 NAACCR RECORD VERSION (page 139): TCR will automatically code this field.

Purpose: This table contains the data items we collect or previously collected. The Texas Cancer Registry adheres to reporting requirements mandated by the National Programs of Central Registries. Additional data items are required to meet requests from our data users.

Data Item	NAACCR Item Number	Started Collecting	Stopped Collecting
Date of First Contact	580	1995	
Registry Number	550	1995	
Reporting Facility	540	1995	
Reporting Source	500	1995	
Medical Record #	2300	1995	
Class of Case	610	1998	
Last Name	2230	1995	
First Name	2240	1995	
Middle Name	2250	1995	
Maiden Name	2390	1995	
Alias	2280	1995,2006	2003
Street Address	2330	1995	
Address at Dx Supplemental	2335	2006	
City	70	1995	
State	80	1995	
Zip Code	100	1995	
FIPS County Code at DX	90	1995	
Social Security Number	2320	1995	
Date of Birth	240	1995	
Place of Birth	250	1998	
Race 1	160	1995	
Race 2	161	2001	
Race 3	162	2001	
Race 4	163	2001	
Race 5	164	2001	
Spanish/Hispanic Origin	190	1995	
Sex	220	1995	
Other Pertinent Information	2680	1995	
Physician Managing	2460	2006	
Physician Follow Up	2470	2006	
Facility Referred From	2410	2001	
Facility Referred To	2420	2001	
Sequence Number	560	1995	
Other Primary Tumors	2200	1995	
Primary Payer at DX	630	2007	
Date of Initial DX	390	1995	
ICD-O 2 Prior to 2001	420	1995	2001
Behavior prior to 2001	430	1995	2001
ICDO 3 2001 and forward	522	2001	
Behavior 2001 and forward	523	2001	

Primary Site	**400**	**1995**	
Grade of Tumor	**440**	**1995**	
Laterality	**410**	**1995**	
Final DX Morph/Beh/Grade	**2590**	**1995**	
Final DX Primary Site and Laterality	**2580**	**1995**	
Diagnostic Confirmation	**490**	**1995**	
Tumor Size Prior to 2004	**780**	**1998**	**2003**
Summary Stage 1977 for appropriate years	**760**	**1995**	**2000**
Summary Stage 2000 for appropriate years	**759**	**2001**	**2004**
CS Tumor Size 2004 and forward	**2800**	**2004**	
CS Extension	**2810**	**2004**	
CS Tumor Size/EXT Eval	**2820**	**2008**	
CS Lymph Nodes	**2830**	**2004**	
Regional Nodes +	**820**	**1998**	
Regional Nodes Examined	**830**	**1998**	
CS Mets at DX	**2850**	**2004**	
CS Site-Specific Factor 1 Pleura Primaries only	**2880**	**2004**	
CS Site-Specific Factor 3 Prostate Primaries only	**2900**	**2004**	
Summary Stage Documentation	**2600**	**1995**	
RX Summ-Reg LN Examined	**1296**	**2006**	
RX Summ-Scope of Reg LN Surgery	**1292**	**2001**	
RX Date Surgery	**1200**	**1995**	
Surg RX Code	**1290**	**1995**	
Reason for No Surgery	**1340**	**1998,2006**	**2003, current**
RX Summ-Surg Other/Dist RX Code	**1294**	**1998**	
RX Text-Surgery	**2610**	**2004**	
Date Radiation Started	**1210**	**1995**	
Type of RX –Radiation	**1360**	**1998**	**2003**
RAD-Regional RX Modality Code	**1570**	**2003**	
Reason for no Radiation	**1430**	**1998, 2006**	**2003, current**
RX Text-Radiation	**2620, 2630**	**2004**	
RX Summ-Surg/Rad Sequence	**1380**	**2004**	
RX Date-Systemic	**3230**	**2004**	
Chemotherapy Code	**1390**	**1995**	
Reason for no Chemo	**1440**	**1998**	**2003**
RX Text-Chemo	**2640**	**2004**	
Hormone Code	**1400**	**1995**	
Reason for no Hormone	**1450**	**1998**	**2003**
RX Text-Hormone	**2650**	**2004**	
Immunotherapy Code	**1410**	**1995**	
RX Summ-Transplant/Endocrine	**3250**	**2003**	
TX Text-Immunotherapy	**2660**	**2004**	
RX Summ-Systemic/Surg Sequence	**1639**	**2006**	
Date other Treatment Started	**1250**	**1995**	
Other Treatment Code	**1420**	**1995**	
RX Text-Other	**2670**	**2004**	
Date of Last Contact or Death	**1750**	**1995**	
Vital Status	**1760**	**1998**	

Date Abstracted	**2090**	**1995**	
Abstractor Initials	**570**	**1995**	
NAACCR Record Version	**50**	**2003**	

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM

Example Pg Number

SHADED ITEMS WILL BE COMPLETED BY CANCER REGISTRY STAFF	This form MUST be used for all cases diagnosed on or after 2008.
(580) DATE OF FIRST CONTACT: 35 (MMDDYYYY)	(2460) PHYSICIAN MANAGING: 63
(550) REGISTRY NUMBER: 36	(2470) PHYSICIAN FOLLOW UP: 63
(540) REPORTING FACILITY NUMBER: 37	(2410) FACILITY REFERRED FROM: 64
(500) REPORTING SOURCE: 37	(2420) FACILITY REFERRED TO: 65
(2300) MEDICAL RECORD #: 39	(560) SEQUENCE NUMBER: 66
(610) CLASS OF CASE: 39	(2220) OTHER PRIMARY TUMORS: 68 (SITE,MORPHOLOGY, and DATE)
(2230) LAST NAME: 43	
(2240) FIRST NAME: 44	
(2250) MIDDLE NAME: 44	
(2390) MAIDEN NAME: 45	(630) PRIMARY PAYER AT DX: 68
(2280) ALIAS NAME: 45	(390) DATE OF INITIAL DX: 70 (MMDDYYYY)
(2330) STREET ADDRESS: 46	(420, 430) ICD-O-2 MORPH/BEHAVIOR BEFORE 2001: 73
(2335) ADDRESS AT DX SUPPLEMENTAL: 48	(522, 523) ICD-O-3 MORPH/BEHAVIOR DX ON OR AFTER 2001: 73
(70) CITY: 49	(400) PRIMARY SITE: 78
(80) STATE: 49	(440) GRADE OF TUMOR: 84
(100) ZIP CODE: 52	(410) LATERALITY: 93
(90) FIPS COUNTY CODE AT DX: 53	FINAL DIAGNOSIS (2580, 2590)
(2320) SSN: 54	(2590) MORPHOLOGY/BEHAVIOR AND GRADE: 98
(240) DATE OF BIRTH: 55	
(250) PLACE OF BIRTH: 55	
(160) RACE 1: 56	(2580) PRIMARY SITE AND LATERALITY: 98
(161) RACE 2: 59	
(162) RACE 3: 59	
(163) RACE 4: 59	
(164) RACE 5: 59	(490) DIAGNOSTIC CONFIRMATION: 98
(190) SPANISH/HISPANIC ORIGIN: 60	(780) TUMOR SIZE (MM): DX PRIOR TO 2004
(220) SEX: 62	(760) SUMMARY STAGE 1977:
(2680) OTHER PERTINENT INFORMATION: 62	(759) SUMMARY STAGE 2000:

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM

Example Pg Number

(2800) (2004 and >) CS TUMOR SIZE: A-11	(2640) RX TEXT-CHEMO 135
(2810) CS EXTENSION: A-17	
(2820) CS TUMOR SIZE/EXT EVAL:	
(2830) CS LYMPH NODES: A-22	
(820) REGIONAL LYMPH NODES POSITIVE: A-24	(1400) HORMONE CODE: 124
(830) REGIONAL LYMPH NODES EXAMINED: A-26	(2650) RX TEXT-HORMONE 135
(2850) CS METS AT DX: A-29	
(2880) CS SITE-SPECIFIC FACTOR 1: A-30	
(2900) CS SITE-SPECIFIC FACTOR 3: A-30	(1410) IMMUNOTHERAPY CODE: 126
(2600) SUMMARY STAGE DOCUMENTATION: 139	(3250) RX SUMM-TRANSPLANT/ENDOCRINE: 128
	(2660) RX TEXT-IMMUNOTHERAPY 135
FIRST COURSE TREATMENT	(1639) RX SUMM-SYSTEMIC/SURG SEQUENCE: 131
(1292) RX SUMM-SCOPE OF REG LN SURGERY: 108	(1250) DATE OTHER TREATMENT STARTED: 133 (MMDDYYYY)
(1200) RX DATE-SURGERY: 110 (MMDDYYYY)	(1420) OTHER TREATMENT CODE: 134
(1290) SURG RX CODE: 111	(2670) RX TEXT-OTHER 135
(1340) REASON FOR NO SURGERY: 113	
(1294) RX SUMM-SURG OTHER/DIST RX CODE: 114	
(2610) RX TEXT-SURGERY 135	(1750) DATE OF LAST CONTACT OR DEATH: 136 (MMDDYYYY)
	(1760) VITAL STATUS: 137
(1210) DATE RADIATION STARTED: 115 (MMDDYYYY)	(2090) DATE ABSTRACTED: 137 (MMDDYYYY)
(1570) RAD-REGIONAL RX MODALITY CODE: 116	(570) ABSTRACTOR INITIALS: 138
(2620, 2630) RX TEXT-RADIATION 135	(50) NAACCR RECORD VERSION: 11.2
(1380) RX SUMM-SURG/RAD SEQUENCE: 119	FOR CRD USE ONLY
(3230) RX DATE-SYSTEMIC: 121 (MMDDYYYY)	
(1390) CHEMOTHERAPY CODE: 122	

STANDARD TABLES FOR COLLABORATIVE STAGING SCHEMAS

CS TUMOR SIZE

Note: For specific instructions on coding this data field see Appendix A, page 8 of this manual.

Code	Description
000	No mass or tumor found
001-988	001-988 millimeters (code exact size in millimeters)
989	989 millimeters or larger.
990	Microscopic focus or foci only; no size of focus is given.
991	Described as "less than 1 cm"
992	Described as "less than 2 cm," or "greater than 1 cm," or "between 1 cm and 2 cm"
993	Described as "less than 3 cm," or "greater than 2 cm," or "between 2 cm and 3 cm"
994	Described as "less than 4 cm," or "greater than 3 cm," or "between 3 cm and 4 cm"
995	Described as "less than 5 cm," or "greater than 4 cm," or "between 4 cm and 5 cm"
999	Unknown; size not stated; not stated in patient record; Unknown primary

For schemas that do not use tumor size:

Code	Description
888	Not applicable

CS EXTENSION

Note: For specific instructions on coding this data field see Appendix A, page 16 of this manual.

Code	Description	TNM	SS 77	SS 2000
00	In situ; non-invasive	Tis	IS	IS
	SITE/HISTOLOGY SPECIFIC SCHEMA CODES			
80	Further contiguous extension			
95	No evidence of primary tumor	T0	U	U
99	Unknown extension; primary tumor cannot be assessed; not stated in medical record	TX	U	U

CS TUMOR SIZE/EXT EVAL

Note: For specific instructions on coding this data field see Appendix A, page 18 of this manual.

Code	Description	Staging Basis
0	No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.	c
1	No surgical resection done. Evaluation based on endoscopic examination, diagnostic biopsy, including fine needle aspiration biopsy, or other invasive techniques. No autopsy evidence used. ***Does not meet criteria for AJCC pathologic staging.***	c*
2	No surgical resection done, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy)	p
3	Surgical resection performed WITHOUT pre-surgical systemic treatment or radiation **OR** surgical resection performed, unknown if pre-surgical systemic treatment or radiation performed ***Meets criteria for AJCC pathologic staging.*** Evaluation based on evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination of the resected specimen	p
5	Surgical resection performed WITH pre-surgical systemic treatment or radiation; tumor size/extension based on clinical evidence	c
6	Surgical resection performed WITH pre-surgical systemic treatment or radiation, BUT tumor size/extension based on pathologic evidence	y
8	Evidence from autopsy only (tumor was unsuspected or undiagnosed prior to autopsy)	a
9	Unknown if surgical resection done Not assessed; cannot be assessed Unknown if assessed Not documented in patient record ***For sites with no TNM schema:*** not applicable	c

REG LN POSITIVE

Note: For specific instructions on coding this data field see Appendix A, page 23 of this manual.

Code	**Description**
00	All nodes examined are negative.
01-89	1-89 nodes are positive. (Code exact number of nodes positive)
90	90 or more nodes are positive.
95	Positive aspiration of lymph node(s) was performed.
97	Positive nodes are documented, but the number is unspecified.
98	No nodes were examined.
99	It is unknown whether nodes are positive; not applicable; not stated in patient record.

REG NODES EXAMINED

Note: For specific instructions on coding this data field see Appendix A, page 25 of this manual.

Code	Description
00	No nodes were examined.
01-89	1-89 nodes were examined. (Code the exact number of regional lymph nodes examined.)
90	90 or more nodes were examined.
95	No regional nodes were removed, but aspiration of regional nodes was performed.
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated.
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated.
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown.
99	It is unknown whether nodes were examined; not applicable or negative; not stated in patient record.

CS METS AT DX

Note: For specific instructions on coding this data field see Appendix A, page 28 of this manual.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	None	None
10	Distant lymph node(s)	M1	D	D
40	Distant metastases, NOS Distant metastases except distant lymph node(s) code (10) Carcinomatosis	M1	D	D
50	(40) + (10) (Distant lymph node(s) plus other distant metastases)	M1	D	D
99	Unknown; distant metastasis cannot be assessed; not stated in patient record	MX	U	U

TREATMENT STANDARD TABLES

SCOPE OF REGIONAL LYMPH NODE SURGERY

Note: For specific instructions on coding this data field see page 109 of this manual.

CODE	DESCRIPTION	DEFINITION
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1	Biopsy or aspiration of regional lymph nodes, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement.
2	Sentinel lymph node biopsy (only)	Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS	Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel lymph node biopsy.
4	1-3 regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
5	4 or more regional lymph nodes removed	Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated	Code 2 was performed in a single surgical procedure with code 3, 4, or 5. Or code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	Code 2 was followed in a subsequent surgical event by procedure by procedures coded as 3, 4, or 5.
9	Unknown or not applicable	It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

REASON FOR NO SURGERY PRIMARY SITE

Note: For specific instructions on coding this data field see page 115 of this manual.

Code	Definition
0	Surgery of the primary site was performed
1	Surgery of the primary site was not performed because it was not part of the planned first course treatment.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first course of therapy. No reason was noted in the patient record.
7	Surgery of the primary site was not performed: it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient's record
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9	It is unknown whether surgery of the primary site was recommended or performed. Diagnosed at autopsy or death certificate only.

RX SUMM – SURG OTH REG/DIST RX CODE

Note: For specific instructions on coding this data field see page 116 of this manual.

CODE	DESCRIPTION	DEFINITION
0	None	No surgical procedure of non-primary site was performed. Diagnosed at autopsy.
1	Non-primary surgical procedure performed	Non-primary surgical procedure to other site(s), unknown if whether the site(s) is regional or distant.
2	Non-primary surgical procedure to other regional sites	Resection of regional site that is not included in combination surgery codes of the primary site.
3	Non-primary surgical procedure to distant lymph node(s)	Resection of distant lymph node(s).
4	Non-primary surgical procedure to distant sites	Resection of distant site.
5	Combination of codes	Any combination of surgical procedures 2, 3, or 4.
9	Unknown	It is unknown whether any surgical procedure of a non-primary site was performed. Death certificate only.

RADIATION – REGIONAL TREATMENT MODALITY

Note: For specific instructions on coding this data field see page 118 of this manual.

CODE	TYPE	DEFINITION
00	No radiation treatment	Radiation therapy was not administered to the patient.
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. Intracavitary use of these sources is coded to 50 or 51.
23	Photons (2-5 MV)	External beam therapy using a photon-producing machine with beam energy in the range of 2-5 MV.
24	Photons (6-10 MV)	External beam therapy using a photon-producing machine with beam energy in the range of 6-10 MV.
25	Photons (11-19 MV)	External beam therapy using a photon-producing machine with a beam energy in the range of 11-19 MV.
26	Photons (> 19 MV)	External beam therapy using a photon-producing machine with a beam energy more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in medical record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in medical record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in medical record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.

43	Gamma knife	Treatment categorized as using stereotactic technique delivered with a gamma knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, intracavitary, low dose rate (LDR)	Intracavitary (no direct insertion into tissues) radioisotope treatment using LDR applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, intracavitary, high dose rate (HDR)	Intracavitary (no direct insertion into tissues) radioisotope treatment using HDR after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using LDR sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using HDR sources.
55	Radium	Infrequently used for LDR interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	Same as above
80*	Combination modality, specified	Combination of external beam radiation and either radioactive implants or radioisotopes. *This code is to be used *only for cases diagnosed prior to January 1, 2003*
85*	Combination modality, NOS	Combination of radiation treatment modalities not specified in code 80. *This code is to be used *only for cases diagnosed prior to January 1, 2003.*
98	Other, NOS	Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

RX SUMMARY-SURGERY/RADIATION SEQUENCE

Note: For specific instructions on coding this data field see page 121 of this manual.

Code	Label	Definition
0	No radiation therapy and/or surgical procedures	No radiation therapy given; and/or no surgery; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s) , or distant lymph node(s); or no reconstructive surgery. Diagnosed at autopsy
2	Radiation therapy before surgery	Radiation therapy given before surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s)
3	Radiation therapy after surgery	Radiation therapy given after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s)
4	Radiation therapy both before and after surgery	Radiation therapy given before and after any surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph nodes(s).
5	Intraoperative radiation therapy	Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative radiation therapy with other therapy administered before or after surgery	Intraoperative radiation therapy given during surgery to primary site: scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown, but both surgery and radiation were given	Administration of radiation therapy and surgery to primary site, scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record. It is *unknown* if radiation therapy was administered and/or it is *unknown* if surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph node(s) were performed. Death certificate only.

CHEMOTHERAPY

Note: For specific instructions on coding this data field see page 124 of this manual.

CODE	DEFINITION
00	None; chemotherapy was not part of the first course of therapy.
01	Chemotherapy administered as first course of therapy, but the type and number of agents is not documented in the patient record.
02	Single-agent chemotherapy administered as first course of therapy.
03	Multi-agent chemotherapy was delivered as first course of therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors i.e., comorbid conditions, advanced age.
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in the patient record.
87	Chemotherapy was not delivered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

HORMONE THERAPY (HORMONE/STEROID THERAPY)

Note: For specific instructions on coding this data field see page 127 of this manual.

CODE	DEFINITION
00	None; hormone therapy was not part of the planned first course of therapy.
01	Hormone therapy was delivered as first course of therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of treatment. No reason was stated in patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

IMMUNOTHERAPY

Note: For specific instructions on coding this data field see page 129 of this manual.

CODE	DESCRIPTION
00	None, Immunotherapy was not part of the first course of therapy; not customary therapy for this cancer; diagnosed at autopsy only.
01	Immunotherapy administered as first course of therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of treatment. No reason was stated in patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether Immunotherapy agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

RX SUMM – TRANSPLANT/ENDOCRINE

Note: For specific instructions on coding this data field see page 131 of this manual.

CODE	DEFINITION
00	No transplant procedure or endocrine therapy was administered as part of first course of therapy; not customary therapy for this cancer; diagnosed at autopsy only.
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant-autologous.
12	Bone marrow transplant- allogeneic.
20	Stem cell harvest.
30	Endocrine surgery and/or endocrine radiation therapy.
40	Combination of endocrine surgery and/or radiation with a transplant procedure. Combination of codes 30 and 10, 11, 12, or 20).
82	Hematologic transplant and/or endocrine surgery/radiation were not recommended/ administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age.
85	Hematologic transplant and/or endocrine surgery/radiation were not administered because the patient died prior to planned or recommended therapy.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but was not administered as part of first course therapy. No reason was stated in patient record.
87	Hematologic transplant and/or endocrine surgery/radiation were not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hematologic transplant and/or endocrine surgery/radiation were recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation were recommended or administered because it is not documented in the medical record. Death certificate only.

SYSTEMIC /SURGERY SEQUENCE

Note: For specific instructions on coding this data field see page 134 of this manual.

CODES	LABEL	DEFINITION
0	No systemic therapy and/or surgical procedures	No systemic therapy was given: and/or no surgical procedure of primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or no reconstructive surgery was performed. Diagnosed at autopsy
2	Systemic therapy before surgery	Systemic therapy was given before surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
3	Systemic therapy after surgery	Systemic therapy was given after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
4	Systemic therapy both before and after surgery	Systemic therapy was given before and after any surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
5	Intraoperative systemic therapy	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative systemic therapy with other therapy administered before or after surgery	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) with other systemic therapy administered before or after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
9	Sequence unknown	Administration of systemic therapy and surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record. It is unknown if systemic therapy was administered and/or it is unknown if surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed. Death certificate only.

OTHER TREATMENT

Note: For specific instructions on coding this data field see page 136 of this manual.

CODES	TYPE	DEFINITION
0	None	All Cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy.
1	Other	Cancer treatment that cannot be appropriately assigned to specific treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases.
2	Other-Experimental	This code is not defined. It may be used to record participation in facility-based clinical trials.
3	Other-Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other-Unproven	Cancer treatments administered by non-medical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Recommended; unknown if administered	Other treatment was recommended, but is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only.