

**DATA STANDARDS AND QUALITY CONTROL
MEMORANDUM
DSQC #2006-01**

CATEGORY: CLARIFICATION
SUBJECT: RESCINDMENT - DSQC MEMORANDUM 2002-08
“Coding Complex Morphologic Diagnoses (revised 8/02)”
EFFECTIVE: For Cases Diagnosed in 2005 and 2006

Effective immediately, DSQC Memorandum 2002-08 “Coding Complex Morphologic Diagnoses,” is rescinded and the rules contained in the document should no longer be applied.

SEER has informed the CCR that the document, “Coding Complex Morphologic Diagnoses” distributed by SEER, is no longer to be used in coding complex and difficult morphology combinations. Instead, SEER is directing registrars to use the SEER Multiple Primaries and Histology Rules from the *SEER Program Coding and Staging Manual 2004*, Fourth Edition. The pages from the *SEER Program Coding and Staging Manual 2004*, pertaining to histology coding are attached.

Please note that on page 2 of this attached document, the terms “architecture” and “pattern” may be used to designate the majority of tumor if written in the College of Pathology (CAP) protocol. Documentation in the pathology text is required indicating that the term originated from the CAP protocol (e.g. as per CAP protocol).

Please apply these multiple primaries and histology rules for all cases diagnosed in 2005 and 2006. Registrars are not expected to go back and apply these rules to cases already abstracted and submitted to the regional registry.

Note: in accordance with the CCR Visual Editing Standards, discrepancies resulting from this new information will not be counted for one month (30 days) after statewide distribution. The Date Completed on the abstract will be the date the visual editor will use to calculate the 30-day time frame.

Histologic Type ICD-O-3

The data item Histologic Type describes the microscopic composition of cells and/or tissue for a specific primary. In the rare instance where there is no tissue pathology, code the histology the medical practitioner uses to describe the tumor. The tumor type or histology is a basis for staging and determination of treatment options. It affects the prognosis and course of the disease.

The *International Classification of Diseases for Oncology*, Third Edition (ICD-O-3) is the standard reference for coding the histology for tumors diagnosed in 2001 and later. Do not record the 'M' that precedes the histology code. Refer to *ICD-O-3* for guidance in coding the histology. See sections *Coding Guidelines for Topography and Morphology*, and *Summary of Principal Rules for Using the ICD-O*, Third Edition.

The histology can be coded only after the determination of multiple primaries has been made.

Synonyms and Equivalent Terms

Mixed, combined, and complex are **usually** used as synonyms when describing histology.

Definitions

Cancer, NOS (8000) and carcinoma, NOS (8010) are not interchangeable.

Carcinoma, NOS (8010) and adenocarcinoma (8140) are interchangeable (See ICD-O-3).

Complex (mixed, combined) histology: The pathologist uses **multiple histologic terms** to describe a tumor. The histologic terms are frequently connected by the word "and" (for example ductal and lobular carcinoma).

Different histology: The first three digits of the ICD-O-3 histology code are different.

Different subtypes: The NOS cell types often have multiple subtypes; for example, scirrhous adenocarcinoma (8143), adenocarcinoma, intestinal type (8144), and linitis plastica (8141) are subtypes of adenocarcinoma, NOS (8140).

Majority of Tumor:

Terms that mean the majority of tumor	Terms that DO NOT mean the majority of tumor
Predominantly	With foci of
With features of	Focus of/focal
Major	Areas of
Type	Elements of
With.....Differentiation*	Component
Pattern (Only if written in College of American Pathologists (CAP) Protocol)**	
Architecture (Only if written in College of American Pathologists (CAP) Protocol)**	

Note: Examples of CAP protocols for specific primary sites may be found on the website – http://www.cap.org/cancerprotocols/protocols_intro.html

Mixed/combined histology: Different cell types in one tumor; terms used interchangeably. In most cases, the terms mixed and combined are used as synonyms; however the term mixed may designate a specific tumor.

Not Otherwise Specified (NOS): “Not Otherwise Specified.”

Same histology: The first three digits of the ICD-O-3 histology code are identical.

Coding Instructions

Refer to “Determining Multiple Primaries” in the first section of this manual to determine the number of primaries. Use all of the information for a single primary to code the histology.

1. If there is no tumor specimen, code the histology described by the medical practitioner.

Example 1: The patient has a CT scan of the brain with a final diagnosis of glioblastoma multiforme (9440). The patient refuses all further workup or treatment. Code the histology to glioblastoma multiforme (9440).

Example 2: If the physician says that the patient has carcinoma, code carcinoma, NOS (8010).

* Effective 1/1/1999 diagnosis

** Effective 1/1/2003 diagnosis

2. Use the histology stated in the **final diagnosis** from the pathology report. Use the pathology from the procedure that resected the majority of the primary tumor.

If a more specific histologic type is definitely described in the microscopic portion of the pathology report or the comment, code the more specific diagnosis.

3. Lymphomas may be classified by the **WHO** Classification, **REAL** system, **Rappaport**, or **Working Formulation**. The WHO Classification is preferred. See page 13 in the ICD-O-3 for a discussion of hematologic malignancies.
4. Cases reported to SEER cannot have a metastatic (/6) behavior code. If the only pathology specimen is from a metastatic site, code the appropriate histology and the malignant behavior code /3. The primary site and its metastatic site(s) have the same basic histology.

Histology Coding Rules for Single Tumor

- The rules are in hierarchical order. Rule 1 has the highest priority.
- Use the rules in priority order.
- Use the first rule that applies to the case. (Do not apply any additional rules.)

1. Code the histology if only one type is mentioned in the pathology report.
2. Code the **invasive histology** when both invasive and in situ tumor are present.

Example: Pathology report reads infiltrating ductal carcinoma and cribriform ductal carcinoma in situ. Code the invasive histology 8500/3.

Exception: If the histology of the invasive component is an 'NOS' term (e.g., carcinoma, adenocarcinoma, melanoma, sarcoma), then code the histology of the specific term associated with the in situ component and an invasive behavior code.

3. Use the **mixed** histology code if one exists

Examples of mixed codes: (This is not a complete list, these are examples only)

8490 Mixed tumor, NOS
9085 Mixed germ cell tumor
8855 Mixed liposarcoma
8990 Mixed mesenchymal sarcoma
8951 Mixed mesodermal tumor

8950 Mixed Mullerian tumor
9362 Mixed pineal tumor
8940 Mixed salivary gland tumor, NOS
9081 Teratocarcinoma, mixed embryonal carcinoma and teratoma

4. Use a **combination** histology code if one exists

Examples of combination codes: (This is not a complete list; these are examples only)

8255 Renal cell carcinoma, mixed clear cell and chromophobe types
8523 Infiltrating duct carcinoma mixed with other types of carcinoma
8524 Infiltrating lobular carcinoma mixed with other types of carcinoma
8560 Adenosquamous carcinoma
8045 Combined small cell carcinoma, combined small cell-large cell

5. Code the **more specific term** when one of the terms is ‘NOS’ and the other is a more specific description of the same histology.

Example 1: Pathology report reads poorly differentiated carcinoma, probably squamous in origin. Code the histology as squamous cell carcinoma rather than the non-specific term “carcinoma.”

Example 2: The pathology report from a nephrectomy reads renal cell carcinoma (8312) (renal cell identifies the affected organ system rather than the histology cell type) in one portion of the report and clear cell carcinoma (8310) (a histologic cell type) in another section of the report. Code clear cell carcinoma (8310); renal cell carcinoma (8312) refers to the renal system rather than the cell type, so renal cell is the less specific code.

6. Code the **majority** of tumor.
a. Based on the pathology report description of the tumor.
b. Based on the use of majority terms. See definition for majority terms.
7. Code the **numerically higher** ICD-O-3 code. This is the rule with the lowest priority and should be used infrequently.

Histology Coding Rules for Multiple Tumors with Different Behaviors in the Same Organ Reported as a Single Primary

Code the histology of the invasive tumor when one lesion is in situ (/2) and the other is invasive (/3).

Example: At mastectomy for removal of a 2 cm invasive ductal carcinoma, an additional 5 cm area of intraductal carcinoma was noted. Code histology and behavior as invasive ductal carcinoma (8500/3).

Histology Coding Rules for Multiple Tumors in Same Organ Reported as a Single Primary

1. Code the histology when multiple tumors have the same histology.
2. Code the histology to adenocarcinoma (8140/_; in situ or invasive) when there is an adenocarcinoma and an adenocarcinoma in a polyp (8210/_ , 8361/_ , 8263/) in the same segment of the colon or rectum.
3. Code the histology to carcinoma (8010/_; in situ or invasive) when there is a carcinoma and carcinoma in a polyp (8210/_) in the same segment of the colon or rectum.
4. Use the **combination** code for the following:
 - a. Bladder: Papillary and urothelial (transitional cell) carcinoma (8130)
 - b. Breast: Paget Disease and duct carcinoma (8541)
 - c. Breast: Duct carcinoma and lobular carcinoma (8522)
 - d. Thyroid: Follicular and papillary carcinoma (8340)
5. Code the more specific term when one *SEER Program Coding and Staging Manual 2004*, Pages 84 – 87 of the terms is ‘NOS’ and the other is a more specific description of the same histology.
6. Code all other multiple tumors with different histologies as multiple primaries.