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Breast Multiple Primary and Histology Coding Rules Breeze Session
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Introduction

This is Steve Peace talking with you this afternoon. I am very happy to be here today to present the 2007 Breast Multiple Primary and Histology Coding Rules as well as the Terms and Definitions that are used to support this particular set of rules. SEER has already hosted several earlier sessions covering an introduction to the 2007 Multiple Primary and Histology Coding Rules and the General Instructions that go with the new rules—now, these aren't the General Rules but the General Instructions that I am talking about. The Other Sites Rules will come on a later broadcast sometime in January 2007. We have had a session on the Lung Rules and a follow-up session covering the case practicum for lung. We have also had a session on the colon rules with a follow-up session covering the case practicum for colon.

We are very excited to be able to continue to make these broadcast sessions available to you both through our live Breeze Sessions as well as through our recorded sessions that are now available on the MP/H Rules homepage which can be located with a link on the main SEER website. And, of course, these are free of charge to anybody who wants to view them 24 hours a day, 7 days a week. If you are joining us through the recorded broadcast we would like to welcome you and are very happy to have you join us after the fact using the special features of this new technology.

This will be an interesting, approximately one hour presentation of the breast rules. We will follow today with instructions on how to access and work the practicum cases for breast and then with information about the broadcast session when we will have a discussion about those breast practicum cases. That will be available through a recorded playback broadcast also.

This will be about an hour today and we may or may not go over an hour. We are going to try and keep it to an hour. I want to talk a little bit about what we are going to have time to do. We will be able to go over some of the general format and structure by providing you examples and walking through the breast rules, highlighting some of the special features of the breast Terms and Definitions. I won't go over every page and every comment but you won't want me to either because I would just read the details to you and my voice is not Casey Cassum or Howard Stern and you would be asleep in about ten minutes.

I will use some of our time to explain and correct some of the long-held misconceptions about how we have been coding breast cancers. That is one of the things that is definitely going to lead us all to doing our job better at

representing the cases that we are abstracting in a more correct and consistent manner which is the overall intent of the new set of rules. We will go over special features of the breast multiple primary rules and the breast histology rules. We are available to answer questions as we go along.

(I would like to remind everybody of phone courtesy and encourage people to make sure that their phones are on mute except when they are asking questions). You are encouraged to ask questions as they come up but I believe that by the end of our broadcast today you will have had your questions sufficiently answered.

So, let's go ahead and get started. I want to start this particular session with a little bit of background. When the rules development team—the Histology Committee—under the leadership of Carol Johnson and then later under the Co-chairs of Carol Johnson and myself, when we first began to meet we were faced with a difficult task of developing a standard set of rules for specific cancer sites. This was really difficult especially when we started to look at breast. We recognized that our old rules had clearly become outdated since they were now [at that time] thirty years old and we knew we could improve upon them. But we still had to retain some of the long-standing elements so we could compare our data for these cancer sites and histologic types over fairly long periods of time, otherwise the data that we have been collecting for thirty years would really not be....we would have a difficult time making sense of it and using it. So we couldn't have just cut and run with a new set of rules. We had to take into account the long-held and familiar concepts and then also make some corrections and modifications along the way.

I can assure you this was no small task, especially for breast cancer where we had a wide and varied use of pathologic terms, ambiguous terms and, of course, multiple terms used by pathologists in different ways across different parts of the country. We had pathologists and clinicians using sometimes-different terms to describe the same things and we still had to recognize that our understanding of breast cancer is evolving and we had to try and build that in as an evolutionary part of the new rules. So we had to build in some areas for potential growth.

The rules I am going to be sharing with you today represent a huge step in improving the consistency and the compatibility of how breast cancers will be understood, abstracted and coded by cancer registrars across the U.S. and Canada, specifically in terms of determining the appropriate number of primary cancers to abstract as a case and then correctly coding the histology for each case abstract and hopefully all this without undoing the many years of data that we have been collecting and coding for the past thirty plus years.

We will have some new concepts that I will be presenting today. Some of them we already know and recognize and some of them the even the more seasoned and experienced registrars may not completely understand or agree with

immediately and it's my job to try and explain these changes to you and to help you use the rules correctly so we can really have correct and reliable case abstracting and coding.

I am excited to be able to present these rules to you today so let's get started.

Slide 1

I would like to remind everybody that you were instructed to print out a few items in preparation for our session today. You should have available to you the Breast Equivalent Terms and Definitions document, the Breast Multiple Primary Rules in your choice of the three formats--either the text, the matrix or the flow chart-- and the Breast Histology Rules in your choice of format.

Slide 2

We are going to be starting with the Terms and Definitions so you can pull these out. As we go along I would like to remind folks that these rules have been developed with input from specialty pathologists who specialize in breast cancers, with the Commission on Cancer's Breast Disease Site Team and with the ICD-O-3 Editors. We have met and communicated with these folks as the rules have been developed. These rules have been approved, and provided feedback from and eventually approved through the Commission on Cancer's Quality Improvement Committee. I just like to give you a little bit of background on that; so let's get going.

Slide 3

Starting with the Equivalent Terms and Definitions and some Illustrations, of course, that we have included with the different sets of site-specific rules. I would like to highlight in the Equivalent Terms that this statement is used for the histology rules only. This Equivalent Terms is for the histology rules only and don't use it for case ascertainment or for any other data item. What I am trying to emphasize here is to make sure that when we look at these site-specific sets of [Equivalent] Terms and Definitions, they are only to be used with the multiple primary and histology rules. You don't apply them to other registry duties like determining whether or not a case is reportable and those types of things.

Under the Equivalent Terms and Definitions you will notice that "and" and "with" that are used in the histology rules are equivalent terms; "duct" and "ductal;" "mammary" and "breast," etc. down the line.

Slide 4

We also have some equivalent terms for "mucinous" and "colloid" which I think most folks are already familiar with. "NOS" and "NST:" that NST is probably something new to registrars. In the literature in breast cancer, NST is a description of "no specific type" when you are referring to duct carcinoma or mammary carcinoma; it's not necessarily duct. In the Equivalent Terms we also

would like to point out that “tumor, mass, lesion and neoplasm” are all considered equivalent terms for purposes of these rules.

We do have listed a lot of definitions which I am not going to have time to talk with you a lot about today but I would like to point out that if you have questions about things, for example, ductular carcinoma or inflammatory breast carcinoma, Paget Disease, Phyllodes tumor or cystosarcoma phyllodes we have offered some definitions that can be used as reference for you while you are using these rules.

Slide 5

Next, I would like to bring your attention to Table 1. Table 1 is an important table for our rules. Although this is not a complete list of every possible intraductal carcinoma it does include the usual histologies that you will abstract. This is Table 1-- Intraductal and Specific Intraductal Carcinomas. These should all appear reasonably familiar to you. I would like to point out that if a certain histologic type appears only on Table 1 and does not appear on Table 2, which we will be showing you next, it is not impossible for the histology to occur as invasive but it is much, much less likely. We will see what I mean by that as we go along.

Slide 6

Here is the display of the content of Table 1. You'll notice the histologic types, subtypes of intraductal carcinoma are listed here. They should be fairly familiar to you. Table 2. ..Let me go back to Table 1 for just a second. When we are looking at Table 1, when we are looking at the intraductal carcinomas, what I would like to point out is that many of these descriptions are describing architecture of cells and what they look like architecturally. Cribriform is a lacy or a sieve-like pattern of cells. Solid cells fill the ducts in solid sheets; papillary is another architectural feature. So I would like to point out that frequently when we are looking at non-invasive cancers, the terms that are used to describe these non-invasive cancers are describing architectures or patterns of cells differently than when we start to look at the invasive cancers.

Slide 7

I would like to also point out that intracystic carcinoma or intracystic papillary carcinoma as it is sometimes referred to is a variant of intraductal. It is used to describe encysted forms of papillary carcinoma. You will code behavior for these as in situ unless the histology is specifically described as invasive intracystic carcinoma, which is a rare occurrence.

As before, Table 2 is not a complete list of all the invasive duct carcinomas but it will cover the histologies that are routinely abstracted. And, again, histologies that appear on Table 2 can occur with in situ behavior but not all of them are particularly likely to, as you will see.

Slide 8

Here is our first look at Table 2. Note that the table lists Duct carcinoma, NOS and specific duct carcinomas. They are all included here. This is the list of invasive tumors and these don't necessarily fit with our long-held 3-digit histology rule, 850 remember? All of these would have been considered the same type of duct carcinoma but we have a couple of invasive duct subtypes that are included in this table that we wouldn't have previously recognized as duct carcinoma: pleomorphic carcinoma and carcinoma with osteoclast-like giant cells. You might not see these very frequently but they are in the group of duct carcinomas. Pleomorphic carcinoma is a specific duct carcinoma type. It is a rare variant of high-grade duct carcinoma, NOS. It is very important. So when you see these you don't automatically code to a higher code like so many of us have become accustomed to; this is much more important to document than the fact that it is a duct carcinoma; pleomorphic carcinoma is much more important to document.

Slide 9

I would like to bring you to Table 3, which is our Table of Combination Codes for Breast Cancer. This is a two-page table. It is to be used with some specific histology rules in the breast section and you are using this table to select combination histology codes. This, of course, does replace the old combination and complex morphology document that was put together a number of years back; this Combination Code Table does replace that as do all of these rules replace any previously existing rules. We would like to stress that the combination and mixed codes are used for multiple histologies in a single tumor. That is kind of new to a lot of folks. We are looking at a single tumor for using these mixed and combination codes. If you are looking at two or more tumors with different histologies then the rules, as you will see as we go along, will specifically mention those histologies under Multiple Tumors and give you specific guidance and instruction on how to code those.

Slide 10

Here is the first part of our table and the way that you use this table is: First of all you look in column 1 and look for your "required histology." Then you look at column 2; this is the "combined with histology." Or, you may perhaps see a "combination term" that describes this combination here [column 3]. And, of course, the code is at the end [column 4]. I will give you a better example here on the next page, on the next slide. Let me go back one second. This asterisk right here-- you don't see it on the slide because it is at the bottom of the table. But the asterisk denotes that this is rarely used for breast cancer—this 8255/3, adenocarcinoma with mixed subtypes. We noticed an increasing number of folks were starting to use this combination code so we specifically want to identify this as rarely used for breast cancer. And, that is what that asterisk will indicate for this particular table. We did include it in the table because it came to our attention that it may be used for certain cases and we wanted to make sure that we included it in this particular table.

Slide 11

For combination code 8523/2 we had a great deal of conversation back and forth with the Breast Disease Site Team of the Commission on Cancer and the ICO-3 Editors about using this particular code for intraductal carcinoma mixed with other types. The ICD-O-3 Editors were very hesitant to allow us to use the behavior of 2 for this particular code. In the ICD-O-3 you will only see this code listed with a behavior of 3. You will only see 8523/3, I believe. What we have come to learn is, the ICD-O-3 Editors created this code to describe invasive ductal mixed with other types of carcinoma and did not originally intend for us to use it to code multiple intraductal subtypes for histology. We'll talk about that more when we get to the histology rules but this was a compromise that we reached with the ICD-O-3 Editors. And I guess we browbeat them enough that registrars were using this code already as it is for this purpose and they agreed that we could use it for this purpose as well because we were specific in these rules on how it should be used.

Slide 12

This is again how we use this table: Column 1, the "Required Histology:" The pathology report must say infiltrating duct and something else, we use this particular code and we will talk about that a little bit more as we get into the histology rules.

Slide 13

Here is an entry for infiltrating lobular combined with duct carcinoma; infiltrating lobular mixed with other types of carcinoma. Notice that these are for invasive carcinomas only. There is a "Note" here and we are going to talk about this as we get into the rules as we go along about how we are going to use that.

Slide 14

The same entries for Paget Disease and infiltrating duct 8541; Paget Disease and intraductal, 8543 with a behavior of 3. And I have some Notes that we will talk about for Paget Disease when we get to the coding the histology of those.

Are there any questions about the Terms and Definitions before we move onto the Multiple Primary Rules? Okay.

Slide 15

If you would pull out your Multiple Primary Rules-- whatever format you have decided to follow; any of the formats will do. They have the same information, they are just laid out somewhat differently so you can use whichever format is easiest for you to use.

Slide 16

As with all of our Multiple Primary Rules, the very first rule represents the first module that you use in the Multiple Primary Rules. What I would like to start out with is, first of all, telling you that there are three modules for the breast multiple

primary rules. There is the first module that is used when you don't know if you have a single or multiple tumors; you don't have the information or it is unclear. The second module is for single tumors and the third module is for multiple tumors. Most of the time in most of our experience about 90% of the breast cancers that we encounter in our registry will be single tumors. So many of these rules have been developed to address only a small percentage of the cases that we actually encounter. Most of our cases are single tumors and this is a very easy rule.

Slide 17

We start out every section with the module on "Unknown if Single or Multiple Tumors" with a very simple rule: When it is not possible to determine if there is a single tumor or multiple tumors, you opt for a single tumor and you abstract as a single primary. Now, I am displaying the flowchart [format] of the rules; you may be following these in the text or in the matrix [formats of the] rules. You'll notice that the content is the same.

There are Notes to distinguish that the tumors are not described as metastasis so we are looking at primary tumors, not metastatic disease. In this particular rule we also have a "Note" saying to use this rule only after all information sources have been exhausted. If it is possible to determine if there is a single or multiple tumors then you go on to the next rule. These rules are hierarchical. You go to the first rule that applies to your particular case and if you get a "Yes," answer, that's your answer and you stop.

Slide 18

Our rules for single tumors...

Slide 19

You'll notice that M2, inflammatory carcinoma, is a new rule for registrars. This same rule is repeated in the multiple tumors section. Basically this particular rule tells you, instructs you, if you have a diagnosis of inflammatory carcinoma in one or both breasts, it is a single primary. The tumor may overlap onto or extend into adjacent or contiguous sites or subsites but if it is inflammatory carcinoma, it is a single primary.

There is another rule [M3] in the module for single tumors. If there is a single tumor, it is a single primary. That is what we often refer to as the "Duh rule," but we had to include it so new registrars who may be using these rules, would know what to do if we just had a single tumor so they did agree to put that in.

Slide 20

If you have multiple tumors, then we're going to go on to the Multiple Tumors Rules.

Slide 21

The first rule [M4] under “Multiple Tumors” is a very familiar rule that basically says a tumor in the breast and a separate tumor in another site, for example, colon or lung or something like that, as long as it is not a metastasis, is a multiple primary. So if you would have a colon primary and a breast primary, for example. Again, that is a very simple rule, but we had to include it to make sure that nothing was overlooked.

Slide 22

Rule M5: It's a very interesting rule. This is a default timing rule that is used to decide if a second tumor in the breast is a new primary or a recurrence. The SEER database has over half a million cases of breast cancer. Only .004% of these cases recurred between two months and five years in the same breast with the same histology. So, what we are looking at is a very small percentage of cases where there is an occurrence of breast tumor in the same breast less than five years apart. So rule M5 distinguishes if the tumors are diagnosed more than 5 years apart automatically they are multiple primaries.

Slide 23

Rule M6: This particular rule is repeated for inflammatory breast carcinoma. Remember, even if it is in both breasts, it is a single primary.

Slide 24

Rule M7: Once again, I would like to point out that we are going through a hierarchy. If you have already gotten an answer to your decision in one of the previous rules you will never even get to use Rule M7. You would have already made your decision based on a previous rule. This rule is a long-standing rule that if you have a tumor in each breast you have multiple primaries. Notice that we do have a “Note” here to make sure that we have clarified that lobular carcinoma in both breasts—often referred to as a “mirror image”—is a multiple primary. Okay?

Slide 25

Rule M8: If we have an invasive tumor following a diagnosis of an in situ tumor more than 60 days after diagnosis, we have multiple primaries. What I would like to try and illustrate to you is: These rules work as kind of a gumball machine. All of the rules before it –Rule M7, Rule M6, Rule M5—all of these are taking gumballs out of this bank of possible decisions whether it's a multiple primary or a single primary. By the time we get to Rule M8 we have already taken out all the inflammatories; we have taken out all of the tumors that are in both the right breast and the left breast; we have already taken out all of the single tumors; we have already taken out all of the tumors that are diagnosed greater than 5 years apart. So we are continually making decisions on a fewer and fewer number of cases. So, the likelihood of using some of these rules as we get higher and higher in the rules chain becomes less and less frequent.

The purpose of this particular rule, M8, if there is an invasive tumor following an in situ tumor more than 60 days after the diagnosis is to ensure that the case is counted as an incident, invasive case when incidence data are analyzed. If a breast tumor is diagnosed as in situ it is not counted in the incidence case count or in the incidence rate; invasive tumors *are* counted. So if we have a situation where we have invasive and in situ tumor that now is in the same breast because Rule M7 that has already limited us to work in the same breast, then we want to make sure that we have multiple primaries if they are diagnosed greater than 60 days apart even if the medical record or the physician states that this is recurrence or progression of disease. That is new to a lot of registrars and there has been resistance and hesitation about discounting or passing by what a physician may state. Now, earlier in the first Breeze presentation there was discussion of how physicians use the term “recurrence” in many, many ways. This is a situation where for purposes of counting tumors, we want to make sure that physicians’ use of the term “recurrence” does not keep you from abstracting a separate primary. We want two primaries in this particular situation.

Slide 26

Rules M9, M10 and M11 are multiple tumors that are familiar to us in the breast; that we have used for historical reasons and kept for historical reasons. When we see, for example, duct and Paget Disease in the same breast it is a single primary; lobular and intraductal or duct—single primary; and if there are multiple intraductal and/or duct carcinomas again we are talking about the same breast, and we have already used that sieve, that gumball bank analogy to look at these; these are all to be abstracted as single primaries even if they are separate tumors. Many of these are historic rules and we have kept those rules to ensure consistency and reliability over time.

Slide 27

Rule M12: Now a lot of you are familiar with this particular rule. If there is a difference in one of the first three digits of the histology code—the ICD-O-3 histology code—then these are multiple tumors. Now notice the number of this rule: this is Rule M12. That’s nearly the very end of our rule set. Don’t jump to Rule M12 because you like it. Make sure that you use the rules previous to this and opt out to whichever decision is made in the earlier rules. But this is in the rare case that none of the above rules have been already applied, where you have multiple tumors in the breast—these would be in the same breast—and they are not combinations of duct and Paget, not lobular and duct, not multiple duct, not invasive or in situ, not tumors in each breast and so on; that’s when you can use this long standing rule that says if there is a difference in the 3-digit histology you code them—abstract these cases—as multiple primaries.

Slide 28

And finally, we come to our final rule [M13]. This says if you have gotten to this rule and you have not met any of the above criteria, abstract the case as a single

primary. This is the default rule and we don't expect people—registrars—will ever really get to use this rule but we built it into the system to make sure. We do have some Examples (Sorry this doesn't appear quite clear on the presentation for the Rule M13 Examples) but we want to reassure the abstractor that for any of these types of cases, for example, multicentric lobular carcinoma in the same breast, that you are going to abstract these as a single primary. So, we have given you some examples of how you may arrive at this particular rule.

[Are there] any questions about the multiple primary rules?

Questions

Question 1

I have a question... [“Sure”]...on M9, 10 and 11 where you've got multiple tumors in the same breast and it is a single primary? [Yes; *that is correct*] I was looking at a case the other day where there was a tumor in different quadrants in the same breast and same histology and the physician called it two primaries and I looked on the ACOS INR and on there was a question regarding that and it said it was revised in September 06. It said that normally that would be a single primary but if the physician said it was two we should code it as two primaries. What should we do with that case?

Response to Question 1

I would be happy to clarify that. In that case, you code this as a single primary and these rules do take effect January 1, 2007. The response on the INR was using the historic rules and it was an exception in the historic rules with clarification by the INR system. In the new set of rules we would abstract this as a single primary and what you do to indicate that you have multiple invasive duct tumors in the same breast, you use the new data item—the Multiplicity Counter—to indicate how many tumors were abstracted as a single primary for this particular case. So you would put the number “2” in the Multiplicity Counter to indicate that you had two tumors, same histology, in the same breast. Outstanding question. Thank you very much.

[Are there] any other questions? [Thank you] Okay.

Slide 29

We are going to move on to the histology rules. I am not doing that great with time but we will take the time that we need. I would like to first of all point out that the histology rules for breast are extensive. There are a total of 29 rules. Now, don't let that frighten you. You will never use more than 10 rules on one case. There are four Modules in the Breast Histology Coding Rules. The first thing you do is decide if you have a single tumor or multiple tumors. When you have a single tumor, you then must determine whether the tumor is entirely in situ or if you have a combination of in situ and invasive in the single tumor, or if that single tumor only has invasive disease. The first set of rules applies to “Single Tumor—In Situ Only”. The second set of rules will be for a “Single Tumor With In Situ and

Invasive” components. The third set of rules will apply for “Single Tumors [that are] Invasive Only” and the fourth module or the fourth set of rules will apply to “Multiple Tumors [that you] Abstract[ed] as a Single Primary” based on your decision from the multiple primary rules. Okay?

It takes a few cases to start to navigate the breast rules because they are modularized in such a way, but in our testing what we have determined is that after about 3-5 cases registrars become comfortable with using the rules and understand them quite well and can follow through the cases pretty easily.

Slide 30

We are going to start our Breast Histology Rules. Again, it is a single tumor and it is in situ only.

Slide 31

Our first rule which is a common default rule says when the abstractor does not have access to the pathology report or a cytology report he can code the histology that is documented by the physician. You can notice that the wording here is slightly different from some later rules but since Rule H1 is just for in situ tumors there must be histologic confirmation that it is in situ to code it as in situ. So, very rarely are you going to have a situation where you don't have the path or cytology, hopefully, but it's a default rule to use in the meantime.

Slide 32

This is another very simplistic rule: If you have one histologic type in your final diagnosis of the path report, you code that histology. Again, there are “Notes” and instructions in the General Instructions that tell you: “Code only from the final diagnosis.” Don't go hunting through the microscopic description or the gross or anywhere else for a whole host of terms. You are not “term matching” anymore. What we are looking for is what is listed in the final diagnosis to code our histology. Rule H2: Again, this is a single tumor, in situ only. If you have one histologic type of in situ breast cancer, code the histology.

Slide 33

Rule H3 is a version of the old rule that we used to use that instructed you that if you have a non-specific term and a specific term you code the more specific. So, this is the same basic rule as that. It says, for example, if you have a diagnosis of carcinoma in situ and a specific carcinoma in situ you code the more specific. Pay special attention to the “Note” for this particular rule: “The specific histology may be identified as--using the terms-- type, subtype, predominantly, with features of, major, or with _____ differentiation.” And here are the terms “architecture” and “pattern.” You are only going to see those terms listed for the non-invasive or in situ rules. This is very important for you to keep an eye on that. If you come across a descriptor that is not listed here when you are trying to determine histology, you don't use it. You only use the terms that are in this list. If you have the term “adenocarcinoma in situ” and a specific adenocarcinoma in

situ of the breast, you code the specific term. And, again, here we have our reference to Table 1: If there is an intraductal NOS and a specific intraductal carcinoma, referencing our Table 1 that is included in the Terms and Definitions, then you code the more specific histologic type.

Slide 34

Rule H4 is a very, very important rule: Does the tumor have non-infiltrating [again, we are in the in situ group, single tumors] So, if we have “features of” comedocarcinoma and any other intraductal carcinoma from Table 1, you code the comedo carcinoma. This is a new rule for registrars. Comedocarcinoma is a distinct and more important type or subtype of intraductal carcinoma so we are going to raise those to the top of the heap. Again, we are using that gumball bank analogy. So, we are pulling all of the comedos out at the beginning.

Slide 35

[Rule H5] If we have a single tumor in situ only with a combination of in situ lobular and intraductal from Table 1 (it can be any of the intraductals listed in Table 1) then you use the code 8522/2—intraductal and lobular carcinoma in situ.

Slide 36

If you have a combination of intraductal carcinoma and one or more specific intraductal types or if there are two or more intraductal carcinomas from Table 1, you can use the code 8523/2. And, again, this is the compromise rule that we arrived at with the approval of the ICD-O-3 Editors and the Commission on Cancer’s Breast Site Team. We recognize that registrars have been using this code for this purpose for the past few years and we recognize that up to 14% of the in situ tumors are coded using this particular rule or this particular code. So, we recognized that and went to bat for registrars and we got to agree on this particular rule and using that code.

Slide 37

Rule H7 states that if there is in situ lobular and in situ [carcinoma] other than intraductal carcinoma, you code 8524/2—in situ lobular mixed with other types of in situ carcinoma because you have already taken out some of the intraductals before.

Slide 38

Rule H8 is used for combinations of histologies that are not lobular or intraductal. This is the adenocarcinoma in situ with mixed subtypes. Very rarely will you use a combination code as it says in the Table. This rule here is how you code those.

[Are there] any questions about the “Single Tumor-- In Situ Only” rules? All right.

Questions

Question 1

Steve, I have one. When we are looking at Rules H3 and H6: If we had a scenario where we did have an intraductal plus a more specific intraductal type, Rule H3 would tell us to code it to the more specific intraductal type found on Table 1, right? "Yes." Now, Rule H6 seems to be a bit repetitive where it is also saying if there is a combination of intraductal and one or more specific intraductal types.

Response to Question 1

That actually is not the case. And I will go ahead and clarify that. They are very different. They appear in the hierarchy differently and that is part of the key to the answer to this question. Rule H3 [unfortunately, I can't place them both on the screen at the same time but] these are not referring to combinations per se. These are referring to descriptions of an NOS term like intraductal carcinoma and there is a further descriptor that says "comedo" or "cribriform intraductal carcinoma," or something like that. Rule H6 on the other hand-- in order to get to Rule H6 you first have to apply Rule H4 which will take out the comedo combinations; Rule H5 which will take out the lobular and ductal combinations and then you can go to Rule H6. So, you have already removed most of those other common combinations. So, here is when you can start to look at those multiple types of intraductal carcinoma that are not lobular and duct and that are not comedo and duct. So, for example, if you have a single tumor that says "in situ carcinoma, papillary and cribriform," or, you know, sometimes you see a whole list of descriptors for non-invasive breast cancers; that's what this rule is used for. Does that help?

Question 1a

Just to clarify: In order to use H3, it would be something like intraductal carcinoma with papillary architecture?

Response to Question 1a

Yes, yes. *Exactly. Okay.*

Slide 39

Now we are going to talk about the rule—and there actually is only one rule and it is very new to registrars—for a single tumor that has invasive and in situ breast cancer; single tumor, invasive and in situ.

Slide 40

You will only code the invasive histology. Period. You ignore the in situ terms. This is a change from the previous histology coding rules and it is different than the ICD-O-3 rules, but has been passed through the ICD-O-3 Editors. This change was made in collaboration with the ICD-O-3 Editors. The consensus was the invasive component better explains the likely disease course and the survival category. So using these new rules, combinations of invasive duct and in situ

lobular will be coded only to invasive duct. You don't code the combination any longer. So we have to "un-think" the way we have been coding some of our combined invasive and in situ tumors. You ignore the in situ term; You code the invasive histology only.

It is interesting in some of the beta testing and in some of the early questions and answers we had many registrars try to tell us that they didn't like this rule. They thought it was wrong until we offered the explanation and the rationale that the invasive component explains the disease course and the survival category; then things started to make sense. Even if the invasive component is an NOS term like invasive duct with in situ cribriform you only code the invasive duct, NOS. Code the invasive histology only.

[Are there] any questions about that rule? All right.

Slide 41

Now we are going to talk about the rules for "Single Tumor—Invasive Only." There are ten rules in this section. The "Single Tumor—Invasive Only" and "Single Tumor—In Situ Only" are going to be the rules you will use most of the time. So, we are only looking at invasive [in this module] and we are looking at a single tumor.

Slide 42

This rule should familiar to you by now [H10]: If there is no pathology or cytology specimen, you can code the histology documented by the physician. This is Rule H10. We do now have a priority list for using documents from the medical record. It gives the order of preference of using these documents to code histology. We also have in the "Notes" for this particular rule that [when] you code histology 8000 (malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented. There is nothing new about this; this is "old hat."

Slide 43

Rule H11: If you only have a specimen from a metastatic site, you can code the histology from the metastatic site and you code a behavior of 3. This is a long-standing ICD-O-3 rule and you will notice that we did not include it in the in situ rules. Why is that? Because the in situ tumor is not going to metastasize without reporting another primary.

Slide 44

Rule H12 is again a variation on the "Code the more specific term rule." This is the one we just talked about briefly for the intraductal. If you have a diagnosis of duct carcinoma and a more specific duct carcinoma, you code the more specific term. We also included sarcomas here because you occasionally will find sarcomas in the breast. I would like to point out also that the terms "architecture"

and “pattern” are not in our list here because those are subtypes only for in situ cancers.

Slide 45

Rule H13: This is a very important rule for registrars to understand. Inflammatory carcinoma is a clinical diagnosis. The clinical appearance of inflammatory carcinoma is coded in the Collaborative Staging extension field. The clinical appearance of inflammatory carcinoma is **never** coded in the histology. Along the way we first had a rule to not code inflammatory carcinoma at all in the histology field. We backed off from that a little bit because occasionally we will see inflammatory carcinoma in the final diagnosis. But the final diagnosis must specifically state “inflammatory carcinoma” or you cannot code inflammatory carcinoma in histology. You will document it in the stage and extension fields—the Collaborative Staging extension fields—but you don’t code it in the histology field. And there is a “Note” here that says: Record dermal lymphatic invasion in Collaborative Staging and don’t presume that there is a diagnosis of inflammatory carcinoma. Again, you are coding only from the final diagnosis, you don’t go looking for this in the microscopic.

Slide 45

Rule H14 is our very simple rule: If you have one histologic type, you code the histology.

Slide 46

Rule H15: If you have two or more specific duct carcinomas from Table 2, you code the numerically higher ICD-O-3 code. You will find occasionally that you will have more than one duct carcinoma from that Table but not that often.

Slide 47

[Rule H16] These again are single tumors. If you have a combination of lobular and duct, you code 8522 (duct and lobular). You can use any of the duct carcinoma types that are listed in Table 2 so duct carcinoma here is used in a very general sense. This is why there is not a specific code behind it.

Question

Steve, can I ask a question back to inflammatory carcinoma? [“Sure”] If you had a final diagnosis that states carcinoma and a comment that says consistent with inflammatory carcinoma, could you then go to the Multiple Primary Histology instructions--the histologic type ICD-O-3 and the priority order for using the documents?

Response

You actually don’t have to use the priority order.

Okay, because Rule 1b Note 1 says you can use the information from the addenda and comments. So, therefore, in that situation, would you code inflammatory carcinoma?

Yes and I actually appreciate the question and the comment. I overlooked mentioning that you can use comments and addenda to clarify a diagnosis. And in the situation you just described, it does clarify that diagnosis. [Okay. Thank you.] In that particular instance, you could code and you should code, inflammatory carcinoma because the comment clarified the final diagnosis.

Slide 49

Rule H17 is the combination code for duct carcinoma mixed with other types of carcinoma. Now, notice that the “other types of carcinoma” excludes lobular and any of the duct carcinomas listed on Table 1 or Table 2. The way, again, the hierarchy of these rules works is, before you get to Rule H17 you would have already coded the combinations of duct and lobular or multiple types of duct carcinoma. So, by the time you get to use Rule H17 you would have excluded lobular carcinomas and you would have excluded the multiple duct carcinomas so you won’t use this code very frequently.

Slide 50

Rule H18 is again an even more rarely used combination code. This is the combination of lobular and other carcinoma. So that includes lobular and includes the duct carcinomas. So this is a very rarely used code.

Slide 51

An even more rarely used code would be 8255—the combination code of adenocarcinoma with mixed subtypes [H19]. At one point in time we had a rule that said: “Don’t ever use this code,” but we had to back off a little bit because we were given an example of a rare occurrence of when you could have this. So these are multiple histologies that are not duct and not lobular.

Are there any questions on the “Single Tumor” rules? Okay. We are right at about an hour so I think we are going to go about ten more minutes at the most and we will be able to complete these today so I appreciate a little bit of your extra time here and we will complete these in a little bit longer than an hour.

Slide 52

The final module of the breast histology rules is to be used in the rare event, relatively rare event, where you have multiple tumors that are abstracted as a single primary. Now, again, how do you know you have multiple tumors that you are abstracting as a single primary? You determine this by using the Multiple Primary Rules. So, if your Multiple Primary Rules said that you have multiple tumors and [the rules] tell you to abstract them as a single primary, that is the only time when we use this last set of rules. Okay?

Slide 53

This is the same default rule [H20] that we had before: If you don't have the pathology report or the cytology report, you code the histology documented by the physician. And, again, here is the hierarchy. I am not going to read that.

Slide 54

Rule H21 is the same rule used in the Single Tumor [module]. If the specimen is only from a metastatic site, you can code the histology from the metastatic site and code behavior as /3.

Slide 55

Here again is our rule [H22] about inflammatory carcinoma. If the final diagnosis of the pathology report specifically states "inflammatory carcinoma" and, again, back to it can have been clarified in an addenda or a comment, but not from a consultation that's by the medical oncologist or anything like that. We are talking about comments and addenda that are part of the pathology report only. So the final diagnosis on the path report or a comment or addenda from the path report specifically states inflammatory carcinoma, then you can code inflammatory carcinoma. Normally, you will only document the inflammatory carcinoma in the Collaborative Staging and you will not code it in histology.

Slide 56

This is our very simple rule again [H23]. If you have multiple tumors that are abstracted as a single primary and they all have the same histology you just code that histology.

Slide 57

This is a new concept and a new rule for folks, Rule H24. The pathology report specifically states that Paget Disease is in situ and the underlying tumor is intraductal carcinoma, then you can code 8543 with a behavior of 2 using the old matrix principle from the ICD-O-3, which is Rule F in ICD-O-3. In the United States there is a lot of discussion; it is not only in the United States but across the globe, about whether or not Paget Disease when it is seen with ductal carcinoma in situ or invasive, whether it should be looked at as invasive or in situ disease (the Paget's component). In ICD-O-3 Paget Disease is generally regarded as invasive Paget. So, if the pathology report specifically states that the Paget is in situ and the underlying tumor is intraductal, then you can --using the matrix principle--change the behavior for the code 8543 to a behavior of 2 and use that code. But it has to specifically say this in the path report.

Slide 58

Most of the time it won't say that; it will just say "Paget Disease and intraductal" and that's when you use Rule H25 and you use the code 8543 with the behavior of 3 to code this particular histology. And, here in the "Notes" explains what I just tried to convey: "ICD-O-3 classifies all mammary Paget Disease as a malignant

process with a malignant behavior of /3.” So, this includes both invasive Paget Disease and Paget Disease with behavior of “9” (not stated); then you can use Table 1 to identify any of the intraductal carcinoma.

Slide 59

Here we have Paget Disease and invasive duct carcinoma [H26]. There is a specific code for invasive duct carcinoma with Paget Disease that’s separate from non-invasive duct carcinoma. And, again, these are the same “Notes” that we just talked about in Rule H25.

Slide 60

For Rule H27: Are there invasive and in situ components in these multiple tumors? Same rule: Code the invasive histology. Ignore the in situ terms with the same explanation that we provided earlier that this decision was made in conjunction with communications and agreements by the ICD-O-3 Editors and that the reasoning is: The invasive component better explains the disease course and the survival category.

Slide 61

Rule H28 is for combinations of lobular and duct carcinoma. And, you use the code 8522 for duct and lobular combinations. And, finally, our very last rule for “Multiple Tumors Abstracted as a Single Primary: Code the numerically higher ICD-O-3 code. I don’t expect any registrar in a one to five year period will ever get to use this particular rule. But it’s stuck in there just in case, just in case.

Slide 62

I would like to acknowledge and thank the members of the Multiple Primary and Histology Task Force that includes representatives from SEER, NPCR, the Commission on Cancer, AJCC, the National Cancer Institute, CDC, National Cancer Institute of Canada and the Canadian Cancer Registries, the National Cancer Registrars Association and the North American Association of Central Cancer Registries. A lot, *a lot of time* and effort went into developing these breast rules and I would like to acknowledge everyone for their involvement and input into these particular rules.

I do have a question that asks: “Please address how you code something if it says, ‘with focal _____differentiation.’” Let me try and explain this question a little bit more before I answer it. If you have a histology that includes a description that says “duct carcinoma with focal pleomorphic carcinoma or pleomorphic differentiation,” the “with _____differentiation” is to be coded whether it is focal or not, as I understand it. Joanne, I recognize that you have asked this question. I will follow up on the answer to this and we will add it to our “Frequently Asked Questions” because I think that that’s an excellent question to add to our FAQs that we will be posting in the near future on the Multiple Primary and Histology Coding Rules website for registrars’ access; so they have access to a lot of the questions that have been asked.

“Thanks, Steve.”

I would like to get a clear, precise answer with a rationale rather than answer it here on this call and potentially miss something. Please allow me to make sure that we fully answer the question.

For the Live Breeze participants: You will receive an email notification with a link in the next couple of days to link you to the cases. You may already have received it; I am not sure. Antoinette?

I will be sending it out right after the end of your session.

Okay. Perfect.

For those of you who are joining us on the recorded session: there will be instructions on the website that tell you how to access and use the cases. And there will be a follow-up Breeze Session describing questions and answers and how these practice cases are to be used. We have a follow-up Breeze Session on December 15 at 1 PM Eastern Time; that's one week from today at the same time. And, I would like to go ahead and open it up. We have gone a little bit over today but I would like to open it up our session if we have any final questions or any additional questions before we go today.

Did I answer all of your questions? Well, great.

I would like to thank everybody for joining us today. And, we appreciate the opportunity to bring you these new rules. We hope you appreciate the time and effort that have gone into developing these rules and we hope that they are going to really help registrars in making the decision to determine whether or not you need to do a single abstract or multiple abstracts and how to better code histology. We are hoping that we will improve consistency across the registries of how to code tumors and we appreciate your attention today. On that note, we sign off. Thank you very much.

