NATIONAL INSTITUTES OF HEALTH
NATIONAL CANCER INSTITUTE
SURVEILLANCE, EPIDEMIOLOGY AND END RESULTS (SEER) PROGRAM
Colon Multiple Primary and Histology Coding Rules Breeze Session
November 29, 2006

Slide 1
Hello everybody and welcome to the Breeze Session on the colon rules. My name is Peggy Adamo and I'll be guiding you through this session. We are taking turns and today is my turn. You should see in front of you the first slide which says, "MP/H Task Force and Multiple Primary Rules and Histology Coding Rules 2007, Colon."

Slide 2
The first document that you should have available to you is the colon "Equivalent Terms, Definitions and Illustrations." I just want to point out a couple of things from that document. The first is that we want you to notice that only 10-15% of adenocarcinomas should be coded mucinous. In the past we have been over coding mucinous adenocarcinomas. These new rules will correct that process. Also, notice that mucinous and colloid are not synonymous with mucin-producing or mucin-secreting.

Slide 3
The next thing we want you to notice from the Equivalent Terms and Definitions is that in colon there are very few mixed histologies. The only common ones you will see are: mucinous/colloid and signet ring. Other mixed histologies are rare for colon.

Slide 4
So the code 8255, which is adenocarcinoma with mixed subtypes, is going to be used rarely for colon primaries. There is another code that we want to point out to you 8144 which is adenocarcinoma, intestinal type. That is a form of stomach cancer and our rules are saying, "Do not use this code when the tumor arises in the colon."

Slide 5
That brings us to the multiple primary rules. Please take out your multiple primary rules for colon. There are three formats. Choose the one that you would like to use. This presentation will be using the matrix format.

Slide 6
There are three modules within the multiple primary rules. The first module is titled: "Unknown if Single or Multiple Tumors." Each of the three modules are independent of one another and should not to be used together for the same case.

Slide 7
The first rule in the first module is rule M1. This says if it is unknown if you have a single or multiple tumors in your case you default (this is a default rule) to a single tumor. You only want to use this rule after all information sources have been exhausted. This is a default. We really mean that; it is not to be used first and foremost. It should be used as a last resort. I also want to point out to you that for the purposes of this presentation the matrix format has been condensed to fit on these slides. This is the only rule you will see in that first module: "Unknown if Single or Multiple Tumors."

Slide 8
Then we move on to the second module, which is "Single Tumor." If your case consists of a single tumor you go directly to this Single Tumor Module.

Slide 9
The first rule there is M2. It says if you have a single tumor, you have a single primary. It doesn't matter how large that single tumor is or how many regions it involves, if it is a single tumor, it is a single primary. Notice the two "Notes," numbers one and two there. We say that the tumor is not a metastasis (Note 1) and that the tumor may include combinations of in situ and invasive (Note 2). The key thing here is that it is a single tumor.

Slide 10
The third module is the Multiple Tumors Module. If your case consists of more than one tumor you will come directly to this module and start the process here.

Slide 11
You start by looking at rule M3. M3 says that if you have adenocarcinoma in adenomatous polyposis (or familial polyposis) with one or more malignant polyps you have a single primary. We have a "Note" that points out that if these tumors are present in multiple segments of the colon or in a single segment of the colon you still have a single primary. This is a special rule for familial polyposis; it will be a single primary.

Slide 12
In this rule [M4] and as in our previous rules for the colon, as you recall, tumors in different segments of the colon are multiple primaries. So this rule says sites with topography codes that are different at the second, third or fourth character are multiple primaries. So what we are saying here is: if you have tumors in different parts of the colon you automatically have a multiple primary. This rule also covers situations where, if you have a tumor in the colon and a separate tumor in another site, you definitely have multiple primaries there as well.

Slide 13
The next rule [M5] is: "Tumors diagnosed more than one (1) year apart are multiple primaries." This one-year timing is based on information we collected

from the SEER database. There were 248,519 colon cases in the entire SEER database. The number of second tumors with the same histology within the same segment of the colon within one year was less than 0.02%--a very small number. So, this one-year timeframe has been very well tested and will not change incidence whatsoever. So this is the rule for colon: multiple tumors diagnosed more than one year apart are multiple primaries.

Slide 14

The next multiple primary rule under Multiple Tumors is M6 and this is a special rule for an invasive tumor following an in situ tumor. When you have that situation more than 60 days after the first diagnosis you have a multiple primary. What this does is make sure that incidence counts are based on invasive cases only with very few exceptions. The reason for this rule is that we want survival based on invasive disease not in situ disease. We don't want survival time affected by the time between an in situ and an invasive. This rule will take a little bit of getting used to for people outside of SEER registries. It has been in place in SEER registries for quite a while. To restate that: if it is more than 60 days after the diagnosis and you have an invasive tumor following an in situ tumor, they are multiple primaries.

Slide 15

The next rule is M7. This is the same as it was previously. If you have a frank or *de novo* adenocarcinoma, which means it is arising in the colon wall without the presence of a polyp, and you also have an in situ or a malignant polyp, it is a single primary. Remember, these would be in the same segment of the colon. You would have already excluded all the cases that are in different segments of the colon using the earlier rules. By the time you get down here they are in the same segment of the colon and the timeframe is less than a year. Again, frank adenocarcinoma—malignant or in situ and an in situ or malignant tumor in a polyp in the same segment of the colon is a single primary.

Slide 16

The next rule is M8. You might recognize this rule as "the NOS and a more specific rule"—coding the more specific type which is basically the same as it was before but the instructions here are intended to be much clearer. So, if you have a cancer or a malignant neoplasm, not otherwise specified (NOS) and something else that is more specific, i.e. a more specific histology, that's a single primary. If you have a carcinoma not otherwise specified (NOS) and a specific carcinoma you have a single primary. If you have a case that has adenocarcinoma and another specific type of adenocarcinoma, you have a single primary. Or, if you have a sarcoma and then a specific type of sarcoma in the same case, you have a single primary. Remember, again, you are within one year and in the same segment of the colon.

Slide 17
The next rule takes you to polyps: “Multiple in situ and/or malignant polyps are a single primary.” This includes all combinations of adenomatous, tubular, villous and tubulovillous adenomas or polyps. So, any selection of those types of polyps would be a single primary. Remember, again, this is in the same segment of the colon because that rule has already passed and within a year.

Slide 18
Rule M10: This has not changed either from previous rules. What we are saying here is when you have tumors with histology codes that are different at the first, second or third number you have a multiple primary. This is your same histology rule: different histologies are different primaries. We define “different” very clearly here: different at the first, second or third number = multiple primary.

Slide 19
The next rule for multiple primary determination is that [M11] if you have not found a rule in any of the previous ten rules that fits your case, default to a single primary. This rule takes care of a lot of situations so that we didn’t have to write multiple rules talking about these conditions being single primaries. If the case didn’t meet the criteria for any of the previous rules, it is a single primary. Notice Notes 1 and 2: These are intended to reassure you as the abstractor that you are in the right place; that you came to the right rule; that none of the other ones fit and you are in the right place. Those “Notes” don’t cover every situation but we feel that these are two situations that will come up a lot. You have come to the right choice; you can be secure in your choice and it is a single primary. There are eleven rules. Most of them are in the Multiple Tumors Module. The other two Modules only have one rule apiece so they are very straightforward. As you can see, if you have a single tumor you are going to default to a single primary and that will take care of that situation.

Slide 20
We will transition now to the Histology Rules for Colon. If you want to take out your histology rules, any of the three formats that you choose are fine. This presentation will be using the matrix format.

Slide 21
In the histology rules we have two modules. We have the Single Tumor Module and then later on we will show you the Multiple Tumors Module. We don’t have a module similar to the one in the multiple primary rules for “Unknown Whether Single or Multiple Tumors” because you have already made that decision by the time you get to the histology rules. You make your multiple primary/single primary decision first, and then you bring that case to the histology rules and code the histology. If you chose the Single Tumor Module in the multiple primary rules, you will continue with that default here. You are going to know whether you have a single tumor or multiple tumors by the time you get to the histology rules. So starting with “Single Tumor” [Module]

Slide 22
The first rule you encounter [H1] when you get to the histology talks about what you do if you don't have a pathology report or a cytology report or a pathology specimen or a cytology specimen. This rule tells you if you have that situation, you code the histology documented by the physician. The rule establishes a priority order for sources to code the histology. The priority starts with documentation in the medical record that refers to pathologic or cytologic findings—that's your first priority; followed by the physician's reference to the type of cancer or histology in the medical record; followed by the mention of histology on a scan—CT, PET or MRI. You code the specific histology whenever it is documented. And, lastly, if the histology is not documented you can code 8000 for cancer/malignant neoplasm, NOS or 8010 --carcinoma, NOS—when it is stated by the physician when nothing more specific is documented. This rule is intended to cover the cases where you either don't have a pathology or cytology specimen or the report is not available to you. Some of you more experienced registrars might be thinking this is rather basic, but the rules have to be meaningful to all registrars including the very, very new ones. So, keep that in mind as we go through some of these.

Slide 23
The next rule [H2] tells you what to do to code histology when you do not have a specimen from the primary site; the specimen may only be from a metastatic site. This rule appears in all site-specific rules and that is why it is here in colon although it will be fairly rare to have this situation for a colon primary. Should it arrive and you do not have a specimen from the primary site, you can code the histology from a metastatic site when you have a specimen from a metastatic site. The "Note" there is just a reminder to code the behavior /3 in this situation, even though you are coding from a metastatic site to get the histology your behavior would still be /3.

Slide 24
The next rule [H3] talks about intestinal type adenocarcinoma or adenocarcinoma, intestinal type. If you should happen to see this diagnosis for a colon primary, this rule instructs you to code 8140 (adenocarcinoma, NOS). As we talked about before with the Terms and Definitions, intestinal adenocarcinoma is a stomach histology, not a colon histology so that is why this rule is here. This will get you to the right code.

Slide 25
The next rule [H4] talks about adenocarcinoma in a polyp. The rule is intended to capture the fact that the adenocarcinoma started in a polyp. So, if you have a case with a final diagnosis of adenocarcinoma in a polyp you code 8210, 8261 or 8263 depending upon what type of polyp it was. All three of those codes reflect the fact that your adenocarcinoma originated in a polyp. If you have a final diagnosis of adenocarcinoma and residual polyp or polyp architecture is recorded

anywhere else in the pathology report, you would also assign one of those three codes: 8210, 8261 or 8263 depending upon the type of polyp. So, again that is a final diagnosis of adenocarcinoma, then mention of a polyp or residual polyp or polyp architecture somewhere else on the path report. Another situation where you could use this rule is a final diagnosis of adenocarcinoma and reference to a residual or pre-existing polyp within the medical record; that is outside the path report. So, your final pathologic diagnosis is adenocarcinoma but somewhere else in the record—maybe a scan or an oscopy –you see that there was a pre-existing polyp. This rule would instruct you to code 8210, 8261 or 8263 depending upon what type of polyp it was. This rule also instructs you that if your final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in a polyp, you would also assign 8210, 8261 or 8263. That is mucinous/colloid or signet ring cell adenocarcinoma in a polyp. The last statement in this rule says if you have documentation that the patient had a polypectomy then you would code 8210, 8261 or 8263 depending upon the type of polyp. The whole point of this rule is to capture the fact that the adenocarcinoma originated in a polyp; any reference to a polyp trumps everything else. Evidence of the polyp may come from the final diagnosis, the microscopic description or the gross description. Obtaining polyp information is a specific exception to the general histology-coding rule about taking information only from the final diagnosis. There are some very specific exceptions here about finding the polyp information in other parts of the pathology report or in other parts of the medical record.

Slide 26

The next rule [H5] talks about: When do you code 8480 or 8490? [Code] 8480 is mucinous or colloid adenocarcinoma and 8490 is signet ring cell. When do you assign those two codes? You assign them when your final diagnosis is: mucinous or colloid (8480) or when your final diagnosis is signet ring cell carcinoma (8490); if that's your final diagnosis you assign the appropriate code—8480 or 8490. You can also assign one of those two codes when your final diagnosis is adenocarcinoma, NOS and the microscopic description documents that 50% or more of the tumor is mucinous or colloid; or 50% or more of the tumor is signet ring cell carcinoma. So you can either assign 8480 or 8490 based on the final diagnosis or based on the final diagnosis and a clear statement in the microscopic description that 50% or more of the tumor is mucinous/colloid or signet ring; that's when you *do* use those codes.

Slide 27

Now, what if you don't have the situation? If you don't have that situation you will probably end up coding 8140, adenocarcinoma, NOS and rule H6 tells you when the criteria is not going to fit the codes 8480 or 8490 and that is: If your final diagnosis is adenocarcinoma and the microscopic description states that less than 50% of the tumor if mucinous or colloid, or less than 50% of the tumor is signet ring then you do not assign 8480 or 8490, you code 8140. The other situation could be that your final diagnosis is adenocarcinoma and the percentage of mucinous/colloid or signet ring cell is unknown. If you have that

situation, you code 8140. If the path report doesn't specify the percentage, you code 8140. So we are really trying to get away from over coding the mucinous/colloid and the signet ring. This rule was written just for that purpose.

Slide 28
The next rule is H7. This is talking about combination codes for colon and the only time you are going to use a combination code for colon is when you have a combination of mucinous/colloid and signet ring cell carcinoma. If that should occur in your case, you are going to code 8255, adenocarcinoma with mixed subtypes. This is probably pretty rare. I don't think you will see it too much, but if you do, here's the rule.

Slide 29
The next rule [H8] talks about when to assign the code 8240, carcinoid tumor, NOS. The rule gives you some very specific guidelines about when to assign that code. Your histology must be neuroendocrine carcinoma and carcinoid tumor. If that is the histology on your pathology report you are going to assign 8240. Carcinoid tumor is a specific type of neuroendocrine carcinoma. When the pathology report mentions neuroendocrine and carcinoid, code the more specific histology, which is carcinoid.

Slide 30
The next rule [H9] talks about another often misunderstood code, so we put this rule in to help clarify when to use 8244, composite carcinoid. The histology must say: "Adenocarcinoma and carcinoid tumor." Then you assign 8244, composite carcinoid. That is the only histology applicable to this code: adenocarcinoma and carcinoid tumor.

Slide 31
The next rule [H10] talks about yet another code that was confusing to a lot of people and needed some clarification and that is 8245, which is adenocarcinoid. The histology in order to assign 8245, the histology must be "exactly adenocarcinoid." You only assign code 8245 when the final diagnosis of the pathology report says exactly adenocarcinoid. Just to reiterate why these rules are here, H9 and H10 give specific guidelines for using these codes because we have had a lot of questions about them. The rules are intended to clarify them and to provide consistent coding from here on out for these codes.

Slide 32
H11 has to be here. If you only have one histologic type, you code that histology. The perfect example for colon is adenocarcinoma. If that is your diagnosis, that's what you code. This rule covers all those situations that we miss because we don't see them very much any more. When there is only one histologic type in the final diagnosis—if there is one histologic type—you code it.

Slide 33
H12 tells you that if your tumor has a histology that is invasive and a histology that is in situ you code the invasive histologic type. This is different from what you have done before. The invasive histology is the one that will affect survival and govern treatment; by coding the invasive type the case will be placed in the correct analysis group. And, yes, we do mean that even if the in situ portion is more specific, we want you to code the invasive portion. The in situ portion is not the histology that impacts survival and treatment. You may feel funny about coding the invasive histologic type especially if it is less specific than the in situ type but this rule should make you feel okay about doing that. Code the invasive type.

Slide 34
Rule H13 tells you to code the more specific histologic term. This is a version of the previous not-otherwise-specified and a more specific rule. You have to be careful to code the more specific only when the two terms are directly related, for example: cancer/malignant neoplasm, not-otherwise specified and a more specific histology—anything pretty much is going to be more specific than cancer/malignant neoplasm, NOS so you would code the more specific. Another example is a carcinoma, NOS and then something more specific, another carcinoma that is more specific—those are related. They are both carcinoma; you code the more specific carcinoma; adenocarcinoma, NOS and a more specific adenocarcinoma—those are related, they are both adenocarcinoma. You code the more specific adenocarcinoma. Lastly, is sarcoma, NOS and a more specific sarcoma—those are both related, they are both sarcoma—so you code the more specific sarcoma. The “Note” there-- “invasive only”-- means that sarcomas will only be invasive. The Notes: Note 1 says “the specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with _____differentiation.” So, when you are looking for the more specific type, and it is an in situ case, the more specific type might be identified by any of those words. Note 2 tells you that “the specific histology for an invasive tumor may be identified as type, subtype, predominantly, with features of, major, or with _____differentiation.” The difference there is that there are two words, *architecture* and *pattern* that can be used to identify the more specific in situ type but are not applicable to invasive types. So, the gist of this rule is to code the most specific histologic term and making sure that the terms are related, e.g. they are both adenocarcinomas or they are both carcinomas, etc.

Slide 35
H14 is the last histology rule in the Single Tumor section for colon and it’s the default rule for any cases that the previous thirteen rules did not apply to. If you get to this rule and you don’t know which histology code to assign, you code the histology with the numerically higher ICD-O-3 code. This is a last resort rule. We like to go to it first because it is easy. Apparently, too many of us were doing that. So, we put this rule out for a reason. It’s a last resort. Make sure that none of the

previous rules apply to your case before you resort to coding the histology with the higher ICD-O-3 number. So, that takes us through the histology rules for colon when there is a single tumor.

Slide 36
The next module for histology coding is: “Multiple Tumors Abstracted as a Single Primary.” The cases for which you would be coming to this section are the cases when you went through the multiple primary decisions, you came up with a case that has multiple tumors but is going to be a single primary. So these are the cases for which you would come to this part of the histology coding rules.

Slide 37
The first rule in this section is very similar to the corresponding rule in the Single Tumor section. It tells you how to handle a situation where you don’t have a pathology or a cytology specimen or your pathology or cytology report is not available. The instructions are the same. You code the histology documented by the physician and the priority order for using documents to code that histology is the same here as it was in the previous rule, which was H1. The only difference here is that you are coding multiple tumors as a single primary instead of a single tumor.

Slide 38
The next rule [H16] is also the same as its corresponding rule in the Single Tumor section. If you have a situation where you do not have a specimen from the primary site, you may code the histology from a metastatic site. Remember that the behavior is a /3, malignant. That is the same as rule H2 which is in the Single Tumor section.

Slide 39
Rule H17 tells you what to do if you have a clinical history of familial polyposis and the final diagnosis on the path report from the resection is adenocarcinoma in adenomatous polyps. This rule is telling you what the criteria are for assigning code 8220, adenocarcinoma in adenomatous polyposis coli. The criteria are, as listed here in your “Histology” column: clinical history that says familial polyposis and the final diagnosis on the pathology report from the resection is adenocarcinoma in adenomatous polyps. That’s one way you can get to code 8220. Another way is if you have greater than 100 polyps in the resected specimen, then you can code 8220. The third way that you can get to code 8220 is if the number of polyps is not mentioned but the diagnosis is familial polyposis. So, this rule gives you three criteria that can be used to assign code 8220.

Slide 40
Rule H18 tells you when to use code 8263, which is adenocarcinoma in a tubulovillous adenoma. The criterion for that code is: “Multiple in situ or malignant polyps are present, at least one of them [which] is tubulovillous.” They don’t all have to be tubulovillous but if you have at least one that is tubulovillous, you

assign 8263. The reason for that is that tubulovillous polyps have the worst prognosis. We want to capture that fact when a tubulovillous polyp is present among multiple malignant polyps, the code should reflect the tubulovillous. So, if even one of them is tubulovillous, assign code 8263.

Slide 41
The next rule [H19] gives you guidelines on when to code 8221, which is adenocarcinoma in multiple adenomatous polyps. The guidelines are: If you have less than or exactly 100 polyps in a resected specimen, you can code 8221, adenocarcinoma in multiple adenomatous polyps. Or, if you have multiple polyps and the number of polyps is not given **and** familial polyposis is not mentioned. So, multiple polyps, number unknown and there is no mention at all of familial polyposis code 8221, adenocarcinoma in multiple polyps. This rule H19 and the rule about familial polyposis are intended to clarify those two codes. There were a lot of questions about the difference between 8221 and 8220 so these two rules-- H17 and rule H19-- clarify that decision making process. They give you specific instructions and then you will know which code is most appropriate depending upon your case.

Slide 42
H20 tells you to code the histology of the most invasive tumor. The situations that might happen are that: you have a frank adenocarcinoma and a carcinoma in a polyp, or you have an in situ and an invasive tumor, or you have multiple invasive tumors. If any one of those situations applies to your case, you code the histology of the most invasive tumor. This is similar to rule H12, which is in the Single Tumor Module, which tells you to code the invasive if you have invasive and in situ. This one is written slightly different because it applies to multiple tumors. There is a definition of “most invasive” in the [Colon Equivalent] Terms and Definitions. If you have a question about which one is the most invasive, you go to the Colon Equivalent Terms and Definitions document and refer to that definition and apply it to your case. If one tumor is in situ and one is invasive, you code the histology from the invasive tumor. If all of the histologies are invasive, you code the histology from the most invasive. If the tumors are equally invasive, you go to the next rule; that rule is H21.

Slide 43
This rule [H21] is the multiple tumor equivalent of rule H4 which is in the Single Tumor Section and it’s the same idea: if there is any mention of a polyp, we want to capture that fact in the code. So, if your final diagnosis is adenocarcinoma and the microscopic description or surgical gross describes a polyp, you assign 8210, 8261 or 8263 depending on the type of polyp. If your situation is that your final diagnosis is adenocarcinoma and there is reference to a residual or pre-existing polyp you also assign one of those three codes depending upon the type of polyp. If your situation is mucinous/colloid or signet ring cell adenocarcinoma in the final diagnosis in a polyp then you code 8210, 8261 or 8263 depending upon the type of polyp. Lastly, if there is any documentation that the patient had a

polypectomy you want to assign one of those codes reflecting the fact that adenocarcinoma originated in a polyp.

Slide 44
The next rule is H22. This is the same as H11 in the Single Tumor section: If you have one histologic type, you code that histology. It's very simple.

Slide 45
The next rule is H23, which is the NOS and the more specific rule. Again, it is just the same as its single tumor counterpart, which is [rule] H13 and what we are saying here is code the more specific histology. If you have two histologic terms, for example, a carcinoma, NOS and a more specific carcinoma or a specific carcinoma, you code the more specific term. The Notes and Examples explain what terms can be applied to in situ; what terms can be applied to invasive and they are the same as we discussed before. The difference between those two "Notes" is that the terms *architecture* and *pattern* can be used to find a specific histology for in situ but they do not apply to invasive.

Slide 46
The last rule is H24. If your situation of "multiple tumors abstracted as a single primary" was not covered by any of the previous rules, your last resort is to code the histology with the numerically higher ICD-O-3 code. As I told you before, this really is a last resort. We made this rule the very last one on purpose. It is only here in case nothing else applies. Hopefully, you won't be using this rule very often.

That is the last histology rule and the end of the presentation.