

Breast Equivalent Terms and Definitions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Introduction

Note 1: Breast includes Nipple C500; Central portion of breast C501; Upper-inner quadrant C502; Lower-inner quadrant C503; Upper-outer quadrant of breast C504; Lower-outer quadrant C505; Axillary tail C506; Overlapping lesion of breast C508; Breast NOS C509.

Note 2: Tables and rules refer to ICD-O rather than ICD-O-3. The version is not specified to allow for updates. Use the currently approved version of ICD-O.

Note 3: 2007 MPH Rules and 2018 Solid Tumor Rules are used based on **date of diagnosis**.

- Tumors diagnosed 01/01/2007 through 12/31/2017: Use 2007 MPH Rules
- Tumors diagnosed 01/01/2018 and later: Use 2018 Solid Tumor Rules
- The original tumor diagnosed before 1/1/2018 and a subsequent tumor diagnosed 1/1/2018 or later in the same primary site: Use the 2018 Solid Tumor Rules

Note 4: For those sites/histologies which have recognized **biomarkers**, the biomarkers are most frequently used to target treatment. Biomarkers may identify the histologic type. Currently, there are clinical trials being conducted to determine whether these biomarkers can be used to identify multiple primaries. Follow the Multiple Primary Rules; do not code multiple primaries based on biomarkers.

Changes from 2007 MPH Rules

These changes are effective with cases diagnosed 1/1/2018 and later.

1. **NST (No Special Type), mammary carcinoma NST, and carcinoma NST** are the new terms for duct or ductal carcinoma. Previously, it was thought that carcinoma originated in the ducts or lobules of the breast, hence the names duct carcinoma and lobular carcinoma. Current thinking is that carcinoma originates in the “terminal duct lobular unit” therefore the preferred term is NST or carcinoma NST.
2. **Mammary carcinoma** is a synonym for carcinoma no special type (NST)/duct carcinoma not otherwise specified (NOS) **8500**. It will **no longer** be coded as carcinoma NOS **8010**.

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3. **DCIS/Carcinoma NST in situ** has a major classification change.
 - A. Subtypes/variant, architecture, pattern, and features **ARE NOT CODED**. The majority of in situ tumors will be coded to **DCIS 8500/2**.
 - B. It is very important to code the grade of all DCIS.
 - i. Code grade as designated in current AJCC Manual, SEER Coding Manual, and COC Coding Manual.
 - ii. The current breast **WHO** edition emphasizes coding the **grade** of tumor rather than the **subtype/variant**.
 - iii. The WHO editions are used internationally by pathologists to keep their nomenclature and histology identification current.
 - iv. Over time, **subtypes/variants** will be diagnosed **less frequently**.
4. The invasive subtype/variant is coded **ONLY** when it comprises **greater than 90%** of the tumor. This change has been implemented in both the WHO and in the CAP protocols.
5. **New codes/terms** are identified by asterisks (*) in the histology table in the Terms and Definitions.
6. Excerpt from the CAP Invasive Breast Protocol (page 17): “A modified list is presented in the protocol based on the most frequent types of invasive carcinomas and terminology that is in widespread usage. The modified list is intended to capture the majority of tumors and reduce the classification of tumors being reported as ‘other.’ The WHO classification is presented for completeness”.

New for 2023

The rules for determining single versus multiple primaries in tumors with carcinoma NST/duct and lobular carcinoma have been revised and now align with ICD-O-3.2. Applicable Histology Rules have also been revised to reflect ICD-O-3.2 histology terminology and corresponding ICD-O codes.

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Equivalent or Equal Terms

These terms can be used interchangeably:

- And; with; (duct **and** lobular is equivalent to duct **with** lobular)
Note: “And” and “with” are used as synonyms when **describing multiple histologies** within a **single tumor**.
- Behavior code /2; DCIS; intraductal; noninfiltrating; noninvasive; carcinoma in situ
- Carcinoma; adenocarcinoma
- De novo; new tumor; frank (obsolete term)
- Duct; ductal; NST (no special type); carcinoma NST; mammary carcinoma
- Mammary; breast
- Simultaneous; synchronous; existing at the same time; concurrent; prior to first course treatment
- Topography; site code
- Tumor; mass; tumor mass; lesion; neoplasm
 - The terms tumor, mass, tumor mass, lesion, and neoplasm are **not** used in a **standard manner** in clinical diagnoses, scans, or consults. **Disregard** the terms unless there is a **physician’s statement** that the term is **malignant/cancer**
 - These terms are used **ONLY** to **determine** multiple primaries
 - **Do not** use these terms for **casefinding** or **determining reportability**
- Type; subtype; variant

Terms that are NOT Equivalent or Equal

These terms are **not equivalent**. There are no casefinding implications.

- **Phenotype** is not equivalent to **subtype/type/variant**
- **Invasive carcinoma, NST with lobular features** is not equivalent to **invasive carcinoma with ductal and lobular features**

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Table 1: Primary Site Codes

Table 1 contains terms used in **mammograms, clinical diagnosis**, and less frequently the **operative and pathology reports** to describe the **location** of the tumor. Find the **term** in Column 1 and use the **site code** in Column 2.

Note: See the **“clock” diagram** at the end of the Equivalent Terms and Definitions for a graphic of the o’clock designations and corresponding **quadrants/subsites** of the breast.

Refer to the **SEER Manual** and **COC Manual** for a **priority list** for using documents such as mammograms, operative reports, and pathology reports to determine the tumor location.

Column 1 includes terms used to describe the **location/site** of the tumor.

Column 2 contains the **site term and code**.

Terms and Descriptive Language	Site Term and Code
Areolar Nipple Paget disease without underlying tumor <i>Note:</i> Paget with underlying tumor is coded to the quadrant of breast in which the underlying tumor is located	Nipple C500

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Terms and Descriptive Language	Site Term and Code
Above nipple Area extending 1 cm around areolar complex Behind the nipple Below the nipple Beneath the nipple Central portion of breast Cephalad to nipple Infra-areolar Lower central Next to areola NOS Next to nipple Retroareolar Subareolar Under the nipple Underneath the nipple	Central portion of breast C501
Superior inner Superior medial Upper inner quadrant (UIQ) Upper medial	Upper inner quadrant of breast C502
Inferior inner Inferior medial Lower inner quadrant (LIQ) Lower medial	Lower inner quadrant of breast C503
Superior lateral Superior outer Upper lateral Upper outer quadrant (UOQ)	Upper outer quadrant of breast C504

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Terms and Descriptive Language	Site Term and Code
Inferior lateral Inferior outer Lower lateral Lower outer quadrant (LOQ)	Lower outer quadrant of breast C505
Axillary tail of breast Tail of breast NOS Tail of Spence	Axillary tail of breast C506
12:00 o'clock 3:00 o'clock 6:00 o'clock 9:00 o'clock Inferior breast NOS Inner breast NOS Lateral breast NOS Lower breast NOS Medial breast NOS Midline breast NOS Outer breast NOS Overlapping lesion of breast Superior breast NOS Upper breast NOS	Overlapping lesion of breast C508 <i>Note:</i> This is a single tumor which overlaps quadrants/subsite .
¾ or more of breast involved with tumor Diffuse (tumor size 998) Entire breast Inflammatory without palpable mass Multiple tumors in different subsites (quadrants) within the same breast	Breast NOS C509 <i>Note:</i> Used for: <ul style="list-style-type: none"> • Non-contiguous multiple tumors in different quadrants/subsites of same breast OR • Unknown/unable to identify in which quadrant/subsite the tumor is located (Example: Outpatient biopsy with no quadrant identified. Patient lost to follow-up.) • Inflammatory carcinoma; diffuse tumor

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Table 2: Histology Combination Codes

Instructions:

1. Use Table 2 when instructed to by the Multiple Primary and Histology Rules.
2. Compare the **terms** in the **diagnosis** (pathology, cytology, radiographic, clinical) to the terms in **Column 1**.
3. When the terms **match**, use the **combination code** listed in **Column 2**.
4. The **last row** in the table is a “**last resort**” code: adenocarcinoma mixed subtypes **8255**.
5. Use the combination codes only when the histologies are in a **single tumor OR multiple tumors** abstracted as a single primary.
6. Mixed histologies may be described as follows:
 - A. A “**combination of**”
 - B. Histology 1 **AND** histology 2
 - C. Histology 1 **WITH** histology 2
 - D. **Mixed** histology 1 and histology 2

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

- For tumors with both **invasive** and **in situ** behavior. The [Histology Rules](#) instruct to code the invasive histology.
- When one of the histologies is described as **differentiation or features**
- When the terms are a **NOS** and a **subtype/variant** of that NOS. See the [Histology Rules](#) for instructions on coding a NOS and a subtype/variant in a single tumor or multiple tumors abstracted as a single primary.

Note 2: Some histologies can be in situ or invasive; others are limited to either /2 or /3 behavior code.

- When a code is **limited to in situ**, /2 will be **added** to the code (both components are in situ)
- When a code is **limited to invasive**, /3 will be **added** to the code (both components are invasive)

Note 3: This table is not a complete listing of histology combinations.

Column 1 contains the required ICD-O histology terms.

Column 2 contains the histology **combination term and code**.

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Required Histology Terms	Histology Combination Term and Code
<p>DCIS/duct carcinoma/carcinoma NST 8500</p> <p style="text-align: center;">AND</p> <p>LCIS/lobular carcinoma 8520 or 8519</p> <p><i>Note 1:</i> Histologies may be a mix of in situ and invasive <i>Note 2:</i> 8522 is used when:</p> <ul style="list-style-type: none"> • Duct and lobular carcinoma are present in a single tumor OR • Duct is present in at least one tumor and lobular present in a least one tumor in the same breast OR • One tumor is mixed duct and lobular; the other tumor in the same breast is either duct or lobular OR • All tumors in the same breast are mixed duct and lobular <p><i>Example:</i> One tumor with invasive duct carcinoma in LOQ RT breast; second tumor with invasive lobular carcinoma in UOQ RT breast</p> <p><i>Note 3:</i> Do not use 8522 when the diagnosis is carcinoma NST/duct carcinoma with lobular differentiation. See Histology Rules for instructions on coding differentiation.</p>	<p>DCIS and in situ lobular carcinoma 8522/2 Note: The lobular includes pleomorphic lobular carcinoma in situ 8519/2</p> <p>Invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma 8522/3 <i>Note 1:</i> CAP uses the term Invasive carcinoma with ductal and lobular features (“mixed type carcinoma”) to indicate both duct and lobular are present. <i>Note 2:</i> This is an exception to the instruction that features are not coded. <i>Note 3:</i> Carcinoma NST includes all subtypes of carcinoma NST <i>Note 4:</i> Lobular carcinoma includes invasive pleomorphic lobular carcinoma</p> <p><u>Additional combinations of duct and lobular coded 8522/3:</u></p> <ul style="list-style-type: none"> • Intraductal and lobular carcinoma (includes invasive pleomorphic lobular carcinoma) • Infiltrating duct and lobular carcinoma in situ (LCIS) • Infiltrating duct and pleomorphic lobular carcinoma in situ • Infiltrating lobular carcinoma and ductal carcinoma in situ (DCIS) <p>Infiltrating pleomorphic lobular carcinoma and ductal carcinoma in situ (DCIS)</p>

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Required Histology Terms	Histology Combination Term and Code
<p>DCIS/duct carcinoma/carcinoma NST OR any ONE subtype/variant of carcinoma NST</p> <p style="text-align: center;">AND</p> <p><u>Any</u> histology in Table 3 with exception of</p> <ul style="list-style-type: none"> • Lobular carcinoma 8520 and pleomorphic lobular carcinoma in situ 8519/2* • Paget disease 8540 <p><i>Note 1:</i> Both histologies must have the same behavior code.</p> <p><i>Note 2:</i> See Table 3 for carcinoma NST/duct carcinoma subtypes/variants.</p> <p><i>Note 3:</i> Do not use combination code for duct with lobular differentiation. This is a synonym for carcinoma NST.</p>	<p>Invasive carcinoma NST/duct mixed with other types of invasive carcinoma 8523/3</p> <p>DCIS mixed with other in situ carcinoma 8500/2 <i>Note:</i> Prior to 2018, DCIS and other in situ was coded 8523/2.</p>
<p>Lobular carcinoma</p> <p style="text-align: center;">AND</p> <p><u>Any</u> histology in Table 3 with exception of</p> <ul style="list-style-type: none"> • Duct carcinoma/carcinoma NST/DCIS (and subtypes/variants) 8500 • Paget disease, in situ and invasive <p><i>Note 1:</i> See Table 3 for carcinoma NST/duct carcinoma subtypes/variants.</p> <p><i>Note 2:</i> This code does not include lobular and Paget disease. See Multiple Primary Rules. Lobular carcinoma and Paget are separate primaries.</p>	<p>Infiltrating lobular mixed with other types of carcinoma 8524/3</p> <p>In situ lobular mixed with other types of in situ carcinoma 8524/2</p>

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Required Histology Terms	Histology Combination Term and Code
<p>Metaplastic carcinoma OR any ONE subtype/variant of metaplastic carcinoma</p> <p style="text-align: center;">AND</p> <p>Duct carcinoma/carcinoma NST OR Lobular carcinoma</p>	<p>Code metaplastic carcinoma 8575 OR Subtype/variant of metaplastic carcinoma</p> <p>Note: Metaplastic carcinoma, NOS and subtypes are almost always mixed with invasive mammary carcinoma, NST and at times lobular carcinoma. These tumors should be coded to metaplastic regardless of percent invasive mammary carcinoma or lobular carcinoma present.</p>
<p>Paget disease</p> <p style="text-align: center;">AND</p> <p>Underlying DCIS</p> <p><i>Note:</i> Paget disease is classified as malignant /3 in the ICD-O. Paget disease is coded as in situ /2 ONLY when the pathology states the Paget disease is in situ.</p>	<p>Paget disease (invasive or behavior not specified) and DCIS/intraductal carcinoma 8543/3</p> <p>Paget disease (specified as in situ) and DCIS/intraductal carcinoma 8543/2</p>
<p>Paget disease</p> <p style="text-align: center;">AND</p> <p>Underlying infiltrating duct carcinoma/carcinoma NST and all subtypes/variants of infiltrating duct/carcinoma NST (must be a /3)</p> <p><i>Note:</i> See Table 3 for subtypes/variants of carcinoma NST/duct carcinoma.</p>	<p>Paget disease and infiltrating duct carcinoma 8541/3</p>

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Required Histology Terms	Histology Combination Term and Code
<p><u>Any</u> two invasive carcinoma NST subtypes/variants (percentage not stated) abstracted as a single primary</p> <p><i>Note 1:</i> The diagnosis may be two subtypes/variants and the pathologist may mention the presence of duct/carcinoma NST. Ignore the mention of carcinoma NST.</p> <p><i>Note 2:</i> See Table 3 for subtypes/variants of carcinoma NST/duct carcinoma.</p>	<p>Adenocarcinoma with mixed subtypes 8255/3</p>

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

Use Table 3 as directed by the [Histology Rules](#) to assign the more common histology codes for breast tumors.

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

Note 2: Submit a question to [Ask a SEER Registrar](#) when the histology is not found in Table 3, ICD-O or all updates.

Note 3: Behavior codes are listed when the term has only one possible behavior (either a /2 or /3). For histologies which may be either /2 or /3, a behavior code is not listed. Code behavior from pathology.

Note 4: Only use the histology code from the table when the diagnosis is **EXACTLY** the term listed.

Column 1 contains specific and NOS histology terms.

- **Specific** histology terms **do not** have **subtypes/variants**
- **NOS** histology terms **do** have **subtypes/variants**.

Column 2 contains **synonyms** for the specific or NOS term. Synonyms have the **same** histology **code** as the specific or NOS term.

Column 3 contains **subtypes/variants** of the **NOS** histology. Subtypes/variants **do not** have the **same** histology code as the NOS term.

Column 3 may contain NOS histologies which are part of a bigger histologic group. For example, sarcoma NOS 8800/3 (column 1) is a generic term which encompasses a number of soft tissue tumors, including rhabdomyosarcoma 8900/3 (column 3).

Rhabdomyosarcoma is also a NOS because it has subtypes/variants. The subtypes/variants are indented under the NOS (rhabdomyosarcoma) in column 3. There is also a note in column 1 which calls attention to the fact that rhabdomyosarcoma has subtypes/variants.

When subtypes/variants are indented under a NOS in Column 3, use coding rules for a NOS and a single subtype/variant. For example, rhabdomyosarcoma **8900/3** and alveolar type rhabdomyosarcoma **8920/3** are a NOS and a subtype/variant, **NOT** two different subtypes.

Table begins on next page

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Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
Acinic cell carcinoma 8550	Acinar adenocarcinoma Acinar carcinoma	
Adenoid cystic carcinoma (ACC) 8200	ACC Adenocystic basal cell carcinoma Carcinoma adenoides cysticum Cylindromatous carcinoma	
Adenomyoepithelioma with carcinoma 8983	AME Malignant AME	
Apocrine carcinoma 8401 <i>Note:</i> This is a diagnosis that is EXACTLY apocrine carcinoma , not a carcinoma NST with apocrine features, differentiation, or type.		
Carcinoma NST 8500 <i>Note:</i> Cribriform carcinoma may consist of up to 50% tubular formations. The term cribriform/tubular carcinoma is coded as cribriform carcinoma.	Carcinoma, NOS Carcinoma of no special type (ductal/NST) Carcinoma/carcinoma NST with choriocarcinomatous features Carcinoma/carcinoma NST with cribriform features Carcinoma/carcinoma NST with melanotic features Carcinoma/carcinoma NST with neuroendocrine features Carcinoma/carcinoma NST with signet ring cell differentiation DCIS 8500/2 DCIS of high nuclear grade 8500/2	Carcinoma with osteoclastic-like stromal giant cells 8035 Cribriform carcinoma/Ductal carcinoma, cribriform type 8201/3 ; Cribriform carcinoma in situ 8201/2 Pleomorphic carcinoma 8022/3 Ductal carcinoma in situ, solid type/intraductal carcinoma, solid type 8230/2 Solid carcinoma/solid adenocarcinoma 8230/3

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Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
	DCIS of intermediate nuclear grade 8500/2 DCIS of low nuclear grade 8500/2 Duct/ductal carcinoma Duct/ductal carcinoma in situ 8500/2 Duct/ductal carcinoma NOS Duct/ductal carcinoma NST (no special type) Duct/ductal carcinoma with apocrine features Duct/ductal carcinoma with apocrine metaplasia Duct/ductal carcinoma with lobular features Duct/ductal carcinoma with micropapillary features Duct/ductal carcinoma with mucin production Duct/ductal carcinoma with neuroendocrine features Duct/ductal carcinoma with squamous metaplasia Infiltrating ductal carcinoma 8500/3 Intraductal carcinoma 8500/2 Invasive carcinoma with medullary features 8500/3 Invasive carcinoma with micropapillary features 8500/3	

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Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
	Invasive carcinoma with neuroendocrine features 8500/3 Invasive carcinoma not otherwise specified (ductal/NOS) 8500/3 Invasive carcinoma NST with metaplastic features 8500/3 Invasive carcinoma NST/duct with medullary features 8500/3 Invasive carcinoma, with signet-ring cell features 8500/3 Invasive carcinoma of no special type (NST) 8500/3 Invasive carcinoma with clear cell (glycogen rich) features 8500/3 Invasive carcinoma, NST 8500/3 Invasive carcinoma, type cannot be determined 8500/3 Invasive mammary carcinoma 8500/3 Invasive mammary carcinoma associated with encysted papillary carcinoma 8500/3 Invasive mammary carcinoma NST with lobular features 8500/3 Invasive mammary carcinoma NST with medullary features 8500/3 Invasive mammary carcinoma NST with mucinous features 8500/3 Invasive mammary carcinoma NST with neuroendocrine features 8500/3	

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Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
	Invasive mammary carcinoma NST with tubulo-lobular variant 8500/3 Invasive mammary carcinoma with apocrine features 8500/3 Invasive mammary carcinoma with cribriform features 8500/3 Invasive mammary carcinoma with tubular features 8500/3 Mammary carcinoma in situ 8500/2 Mammary carcinoma/cancer Non-invasive mammary carcinoma 8500/2	
Glycogen-rich clear cell carcinoma 8315	Glycogen-rich carcinoma	Clear cell carcinoma 8310
Inflammatory carcinoma 8530		
Lipid-rich carcinoma 8314	Lipid-secreting carcinoma	
Lobular carcinoma 8520	Alveolar lobular carcinoma Classic lobular carcinoma Florid lobular carcinoma 8520/2 Intraductal papilloma with lobular carcinoma in situ 8520/2 Invasive lobular carcinoma, alveolar type/variant 8520/3 Invasive lobular carcinoma, solid type 8520/3 Lobular carcinoma in situ 8520/2 Lobular carcinoma with cribriform features	Pleomorphic lobular carcinoma in situ 8519/2* <i>Note:</i> 8519/2 is a new code for in situ /2 tumors only.

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Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
	Mixed lobular carcinoma (lobular carcinoma NOS and one or more variants of lobular carcinoma) Invasive pleomorphic lobular carcinoma 8520/3 Solid lobular carcinoma Tubulolobular carcinoma	
Medullary carcinoma 8510	MC	Medullary carcinoma with lymphoid stroma 8512 Atypical medullary carcinoma (AMC) 8513
Metaplastic carcinoma NOS or of no special type (NST) 8575 <i>Note 1:</i> Squamous cell carcinoma of the breast is extremely rare . Carefully check the pathology report to verify the squamous cell originated in the breast parenchyma, rather than the skin of the breast. <i>Note 2:</i> Metaplastic carcinoma, NOS and subtypes are almost always mixed with invasive mammary carcinoma, NST and at times lobular carcinoma. These tumors should be coded to metaplastic regardless of percent invasive mammary carcinoma or lobular carcinoma present.	Invasive mammary carcinoma with matrix production Metaplastic carcinoma, mixed epithelial and mesenchymal type Metaplastic carcinoma with mesenchymal differentiation Metaplastic carcinoma with squamous features Metaplastic carcinoma with other types of mesenchymal differentiation Mixed metaplastic carcinoma	Carcinosarcoma 8980/3 Fibromatosis-like metaplastic carcinoma 8572 Low grade adenosquamous carcinoma 8560 Metaplastic carcinoma spindle-cell type/spindle cell carcinoma 8032 Metaplastic carcinoma with chondroid differentiation/with osseous differentiation 8571 Myoepithelial carcinoma 8982 Sarcomatoid carcinoma 8033 Squamous cell carcinoma 8070
Mucinous carcinoma 8480	Colloid carcinoma Mucinous adenocarcinoma	

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Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
<p><i>Note 1:</i> This is a diagnosis that is EXACTLY “mucinous carcinoma,” “mucinous duct carcinoma,” “mucinous DCIS” OR “greater than <u>90%</u> mucinous.” See Histology Rules.</p> <p><i>Note 2:</i> Mucinous duct carcinoma is listed on the CAP protocol. It is not recognized by WHO or IARC. Mucinous carcinoma is not a subtype/variant of Carcinoma NST/duct carcinoma.</p>	Mucoid carcinoma	
Mucoepidermoid carcinoma 8430		
Oncocytic carcinoma 8290		
Paget disease of the nipple with no underlying tumor 8540		
Papillary carcinoma 8503	Intraductal papillary carcinoma 8503/2* Intraductal papillary carcinoma with DCIS 8503/2* Intraductal papilloma with ductal carcinoma in situ 8503/2 Invasive ductal papillary carcinoma 8503/3 Invasive papillary carcinoma 8503/3 Papillary carcinoma of breast, NOS 8503/3 Papillary carcinoma non-invasive 8503/2* Papillary ductal carcinoma in situ 8503/2*	Encapsulated papillary carcinoma, NOS/non-infiltrating/intracystic 8504/2 with invasion 8504/3 with invasive carcinoma, NST/invasive duct carcinoma 8504/3 Micropapillary carcinoma 8507* Tall cell carcinoma with reverse polarity 8509/3 Solid papillary carcinoma in situ 8509/2* with invasion 8509/3*

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Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
Phyllodes tumor, malignant 9020/3	Cystosarcoma phyllodes, malignant Periductal stromal tumor, low grade	
Polymorphous carcinoma 8525		
<p>Sarcoma NOS 8800/3</p> <p><i>Note 1:</i> Angiosarcoma 9120/3 is also a NOS with the following subtypes/variants: Lymphangiosarcoma 9170/3 Malignant hemangioendothelioma 9130/3</p> <p><i>Note 2:</i> Rhabdomyosarcoma 8900/3 is also a NOS with the following subtypes/variants: Alveolar type rhabdomyosarcoma 8920/3 Embryonal type rhabdomyosarcoma 8910/3 Pleomorphic rhabdomyosarcoma 8901/3</p> <p><i>Note 3:</i> Angiosarcoma has the following synonyms (they are not subtypes/variants): Epithelioid angiosarcoma Hemangiosarcoma Post radiation angiosarcoma of breast</p>		<p>Angiosarcoma 9120/3 Epithelioid angiosarcoma Hemangiosarcoma Post radiation angiosarcoma of breast Lymphangiosarcoma 9170/3 Malignant hemangioendothelioma 9130/3 Liposarcoma 8850/3 Leiomyosarcoma 8890/3 Osteosarcoma 9180/3 Rhabdomyosarcoma 8900/3 Alveolar type 8920/3 Embryonal type 8910/3 Pleomorphic 8901/3</p>
Sebaceous carcinoma 8410		
Secretory carcinoma 8502	Juvenile breast carcinoma	
Signet ring carcinoma 8490		

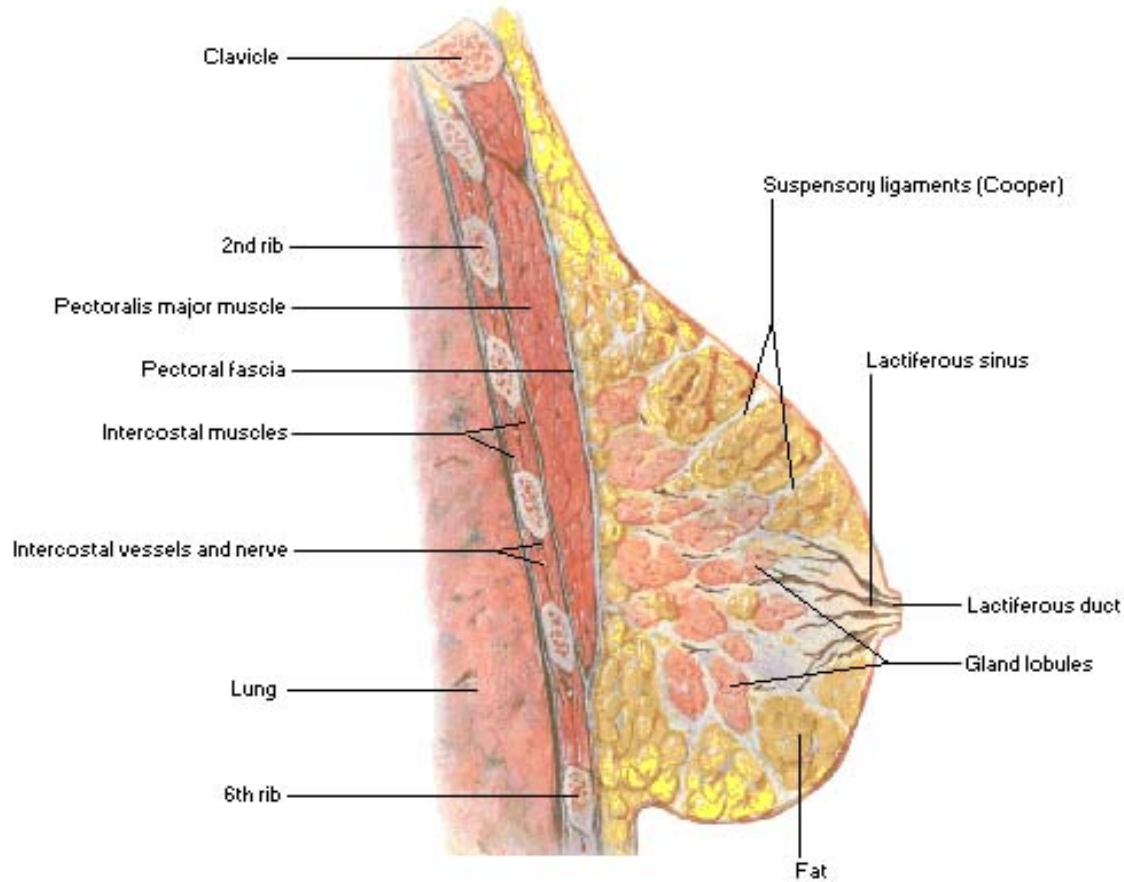
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Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
Small cell carcinoma 8041	Carcinoid tumor of breast Endocrine carcinoma Neuroendocrine carcinoma, poorly differentiated	Carcinoma with neuroendocrine differentiation 8574/3 Neuroendocrine tumor, well-differentiated 8246/3
Tubular carcinoma 8211		

*New codes approved by IARC/WHO Committee for ICD-O

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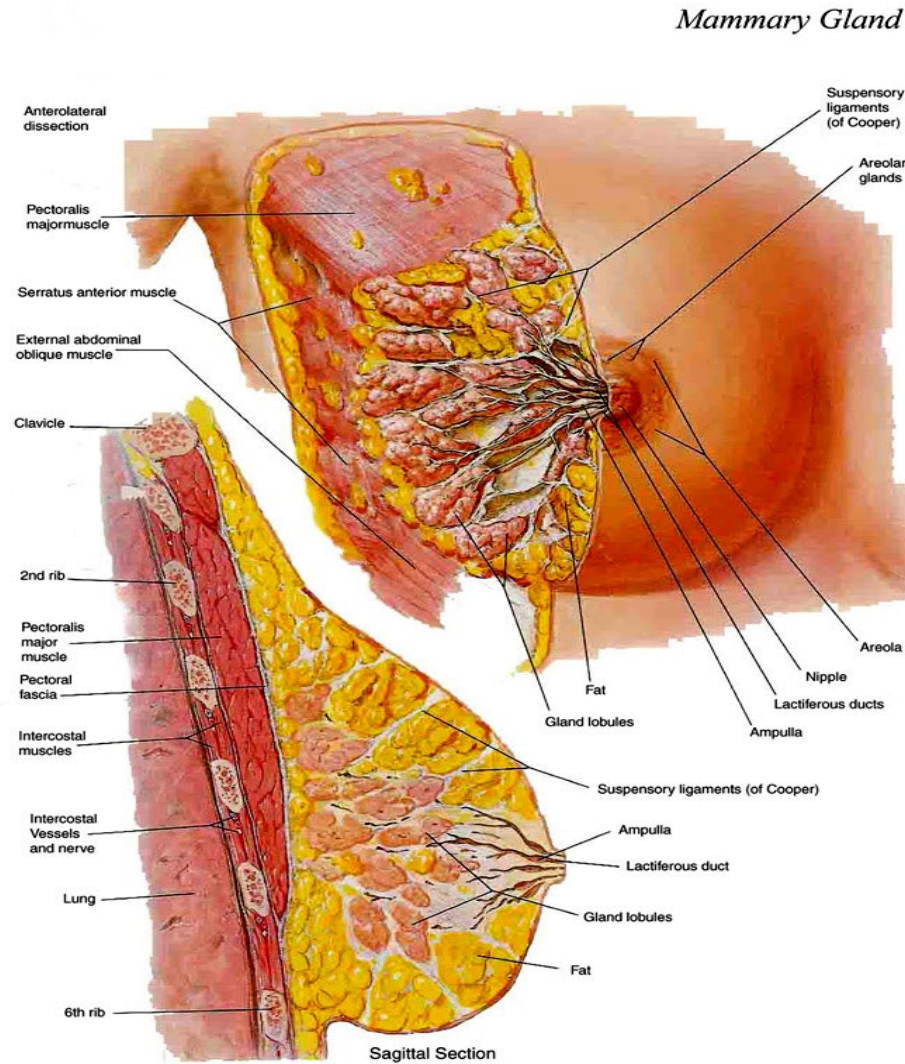
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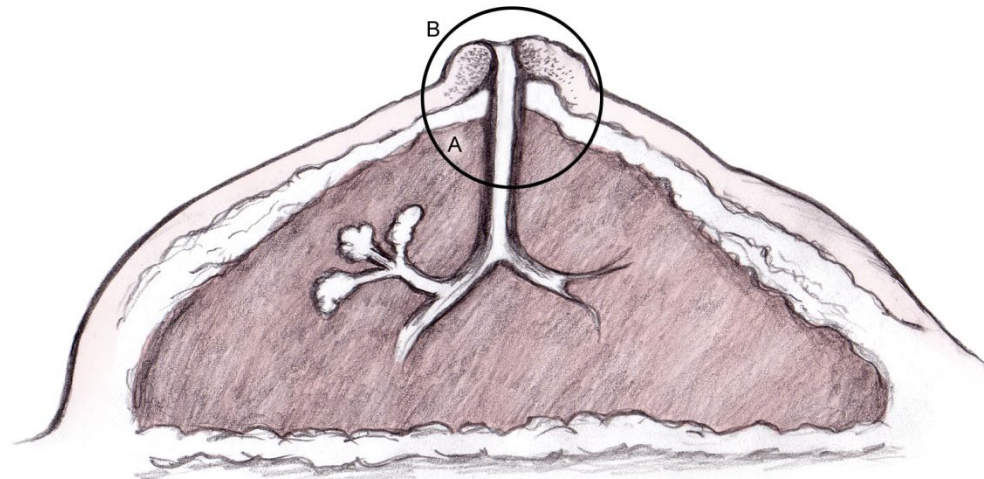
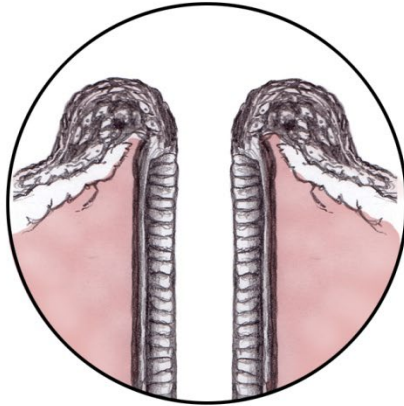


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Atlas of Human Anatomy -- Frank H. Netter

Breast Equivalent Terms and Definitions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

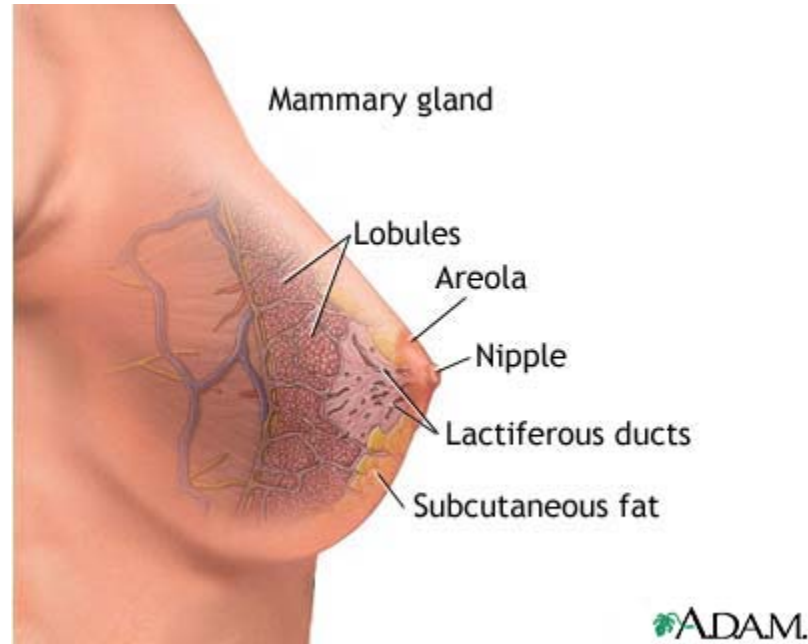


Paget Disease of the nipple. Shows growth pattern of Paget on the pigmented portion of nipple and inside the milk duct opening

Source:

“Image reprinted with permission from eMedicine.com, 2010. Available at: <http://emedicine.medscape.com/article/1101235-overview>”

Breast Equivalent Terms and Definitions
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Breast Equivalent Terms and Definitions
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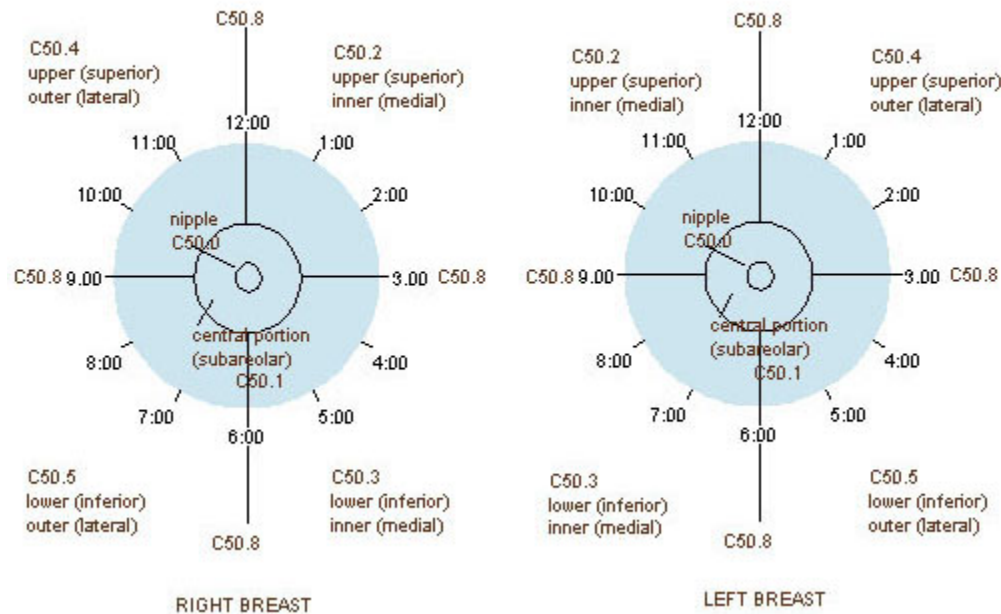
The position of the tumor in the breast may be described as the positions on a clock

The two circles in the graphic are

Innermost circle: Retroareolar (under/behind areola)

Outer circle: Central portion of breast

"Clock" Positions, Quadrants and ICD-O Codes of the Breast



Breast Multiple Primary Rules
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(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Note 1: These rules are **NOT** used for tumor(s) described as metastases. Metastatic tumors include but are not limited to:

- Axillary lymph nodes
- Bone
- Brain
- Chest wall
- Discontinuous involvement of skin of breast
- Distant lymph nodes as identified in Summary Staging Manual
- Liver
- Lung

Note 2: 2007 MPH Rules and 2018 Solid Tumor Rules are used based on **date of diagnosis**.

- Tumors diagnosed 01/01/2007 through 12/31/2017: Use 2007 MPH Rules
- Tumors diagnosed 01/01/2018 and later: Use 2018 Solid Tumor Rules
- The original tumor diagnosed before 1/1/2018 and a subsequent tumor diagnosed 1/1/2018 or later in the same primary site: Use the 2018 Solid Tumor Rules

Unknown if Single or Multiple Tumors

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

Note 1: Use this rule only after all information sources have been exhausted.

Note 2: Examples of cases with minimal information include:

- Death certificate only (DCO)
- Cases for which information is limited to pathology report only
 - o Outpatient biopsy with no follow-up information available
 - o Multiple pathology reports which do not specify whether a single tumor or multiple tumors have been biopsied and/or resected

This is the end of instructions for Unknown if Single or Multiple Tumors

ⁱ Prepare one abstract. Use the [histology rules](#) to assign the appropriate histology code.

Breast Multiple Primary Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Single Tumor

IMPORTANT: If the current tumor was **preceded** by a tumor in the same breast or contralateral breast, go to the **Multiple Tumors module**.

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

- Multiple quadrants of same breast **OR**
- Bilateral breasts

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

Note 1: A single tumor is always a single primary.

Note 2: The tumor may overlap onto or extend into adjacent/contiguous site or subsites/quadrants.

Note 3: The tumor may have in situ and invasive components.

Note 4: The tumor may have two or more histologic components.

This is the end of instructions for Single Tumor

ⁱ Prepare one abstract. Use the [histology rules](#) to assign the appropriate histology code.

Multiple Tumors

Note 1: Multiple tumors may be single primary or multiple primaries.

Note 2: ER, PR, and/or HER2 are not used to determine multiple primaries.

Note 3: A subsequent tumor in the chest wall or surgical scar **without** evidence of residual breast tissue is regional metastasis.

Rule M4 Abstract **multiple primaries**ⁱⁱ when there are **separate, non-contiguous** tumors in sites with ICD-O site codes that **differ** at the second (CXxx) and/or third characters (CxXx).

Note 1: Tumors with site codes that differ at the second or third character are in **different primary sites**; for example, a breast tumor C50x and a colon tumor C18x differ at the second and third character.

Note 2: This rule **does not** include metastases. Metastatic tumors are not used to determine multiple primaries; for example, liver metastases from the breast cancer would not be counted as a second primary.

**Breast Multiple Primary Rules
C500-C506, C508-C509**

(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

- Rule M5** Abstract **multiple primaries**ⁱⁱ when the patient has a subsequent tumor after being **clinically disease-free** for **greater than five years** after the original diagnosis or last recurrence.
Note 1: The rules are hierarchical. This rule **only** applies when there is a **subsequent breast tumor**.
Note 2: **Clinically** disease-free means that there was **no evidence** of recurrence on follow-up.
- Mammograms are NED
 - Scans are NED
- Note 3:* When there is a recurrence less than or equal to five years of diagnosis, the “**clock**” starts over. The time interval is calculated from the **date of last recurrence**. In other words, the patient must have been disease-free for greater than five years from the date of the last recurrence.
- Note 4:* When it is **unknown/not documented** whether the patient had a recurrence, use **date of diagnosis** to compute the time interval.
- Note 5:* The physician may state this is a **recurrence**, meaning the patient had a previous breast tumor and now has another breast tumor. **Follow the rules**; do not attempt to interpret the physician’s statement.
- Note 6:* When a breast resection was done and a subsequent tumor is identified in the remaining chest wall, muscle, or skin AND there was no residual breast tissue identified in the resected specimen, this is a recurrence and not a new primary.
- Rule M6** Abstract a **single primary**ⁱ when there is **inflammatory carcinoma** in:
- Multiple quadrants of same breast **OR**
 - Bilateral breasts
- Rule M7** Abstract **multiple primaries**ⁱⁱ when there is **bilateral** breast cancer (both right and left breast).
Note 1: Physician statement of “bilateral breast cancer” should **not be interpreted** as meaning a single primary. The term is not used consistently. The literal definition of bilateral is “cancer in both breasts”.
Note 2: The histologies within each breast may be the same or different.
- Rule M8** Abstract a **single primary**ⁱ when the diagnosis is **Paget disease with synchronous underlying** in situ or invasive carcinoma NST (duct/ductal) or subtypes of duct.
Note: If the underlying tumor is any histology **other than** duct or subtypes of duct, continue through the rules.
- Rule M9** Abstract **multiple primaries**ⁱⁱ when the diagnosis is **Paget disease with underlying** tumor which is NOT duct.
Example: Paget disease of the nipple with underlying lobular carcinoma are multiple primaries.

**Breast Multiple Primary Rules
C500-C506, C508-C509**

(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M10 Abstract a **single primary**ⁱ when there are multiple tumors of **carcinoma NST/duct and lobular**.

- Both/all tumors may be a mixture of carcinoma NST/duct and lobular 8522 **OR**
- One tumor may be duct and another tumor lobular **OR**
- One tumor may be mixed duct and lobular 8522, the other tumor either duct or lobular

Note 1: Tumors must be in the same breast.

Note 2: Carcinoma NST/duct includes:

- DCIS 8500/2
- Carcinoma NST 8500/3
- Carcinoma with osteoclastic-like stromal giant cells 8035/3 (subtype/variant of carcinoma NST)
- Cribriform carcinoma 8201/3
- Pleomorphic carcinoma 8022/3

Note 3: Lobular carcinoma includes:

- In situ lobular carcinoma 8520/2
- In situ pleomorphic lobular carcinoma 8519/2
- Invasive lobular carcinoma 8520/3
- Invasive pleomorphic lobular carcinoma 8520/3

Note 4: **When a mixture of behaviors is present in carcinoma, NST and lobular carcinoma, follow the H rules to determine the correct histology code.**

Rule M11 Abstract a **single primary**ⁱ when a **ductal** carcinoma occurs **after a combination code** in the same breast. See the following list:

- **DCIS following** a diagnosis of:
 - DCIS + lobular carcinoma in situ 8522/2 **OR**
 - DCIS + in situ Paget 8543/2 **OR**
 - DCIS + Invasive Paget 8543/3 **OR**
 - DCIS mixed with other in situ 8523/2 (code used for cases diagnosed prior to 1/1/2018)
- **Invasive carcinoma NST/duct following** a diagnosis of:
 - Invasive duct + invasive lobular 8522/3 **OR**
 - Invasive duct + invasive Paget 8541/3 **OR**
 - Invasive duct + other invasive carcinoma 8523/3

Breast Multiple Primary Rules C500-C506, C508-C509

(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M12 Abstract **multiple primaries**ⁱⁱ when separate/non-contiguous tumors are two or more **different subtypes/variants** in Column 3 of [Table 3](#) in the Equivalent Terms and Definitions. Timing is irrelevant.

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

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

Rule M13 Abstract a **single primary**ⁱ when **synchronous**, separate/non-contiguous tumors are on the **same row** in [Table 3](#) in the Equivalent Terms and Definitions.

Note: The same row means the tumors are:

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

Rule M14 Abstract **multiple primaries**ⁱⁱ when separate/non-contiguous tumors are:

- On **different rows** in [Table 3](#) in the Equivalent Terms and Definitions
- A combination code in [Table 2](#) and a code from [Table 3](#)

Note 1: Timing is irrelevant. Tumors may be synchronous or non-synchronous.

Note 2: Each row in the table is a distinctly different histology.

Example 1: Paget disease of the nipple with underlying lobular are multiple primaries. Paget and lobular are on different rows in Table 3.

Example 2: Two tumors right breast. One tumor is invasive mixed duct and lobular 8522/3 (combination code from Table 2) and the second tumor is tubular 8211/3 (histology from Table 3). Abstract two primaries: 8522/3 and 8211/3.

Rule M15 Abstract a **single primary**ⁱ (the invasive) when an **in situ** tumor is diagnosed **after** an **invasive** tumor in the same breast.

Note 1: Once the patient has an invasive tumor, the **in situ** is recorded as a **recurrence** for those registrars who collect recurrence data.

Note 2: The rules are **hierarchical**. Only use this rule when none of the previous rules apply.

Note 3: The tumors may be a **NOS** and a **subtype/variant** of that NOS.

**Breast Multiple Primary Rules
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(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule M16 Abstract a **single primary**ⁱ (the invasive) when an **invasive** tumor is diagnosed **less than or equal to 60 days after an in situ** tumor in the same breast.

Note 1: The rules are **hierarchical**. Only use this rule when none of the previous rules apply.

Note 2: The tumors may be a **NOS** and a **subtype/variant** of that NOS.

Note 3: When the case has been abstracted, **change behavior** code on original abstract from /2 to /3.

Note 4: Do **not** change **date of diagnosis**.

Note 5: If the case has already been submitted to the central registry, **report** all changes.

Note 6: The physician **may stage both** tumors because staging and determining multiple primaries are done for different reasons. Staging determines which treatment would be most effective. Determining multiple primaries is done to stabilize the data for the study of epidemiology (long-term studies done on incidence, mortality, and causation of a disease with the goal of reducing or eliminating that disease).

Note 7: See the **COC** and [SEER manuals](#) for instructions on coding **other data items** such as Date of Diagnosis, Accession Year and Sequence Number.

Rule M17 Abstract **multiple primaries**ⁱⁱ when an **invasive** tumor occurs **more than 60 days** after an **in situ** tumor in the same breast.

Note 1: The rules are **hierarchical**. Only use this rule when none of the previous rules apply.

Note 2: Abstract **both** the invasive and in situ tumors.

Note 3: Abstract as multiple primaries even if physician states the invasive tumor is disease recurrence or progression.

Note 4: This rule is based on long-term **epidemiologic** studies of recurrence intervals. The specialty medical experts (SMEs) reviewed and approved these rules. Many of the SMEs were also authors, co-authors, or editors of the **AJCC Staging Manual**.

Rule M18 Abstract a **single primary**ⁱ when none of the previous rules apply.

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

Example: One tumor is invasive carcinoma NST/ductal 8500/3 and a separate non-contiguous tumor in the same breast is DCIS 8500/2. Abstract a single primary: invasive carcinoma NST/ductal 8500/3.

This is the end of instructions for Multiple Tumors.

ⁱ Prepare one abstract. Use the histology rules to assign the appropriate histology code. For registries collecting recurrence data: When a subsequent tumor is “single primary,” record that subsequent tumor as a recurrence.

ⁱⁱ Prepare two or more abstracts. Use the histology rules to assign the appropriate histology code to each case abstracted.

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Note: Only code **differentiation** or **features** when there is a **specific code** for the NOS with differentiation or the NOS with features in [Table 2](#) or [Table 3](#) or the ICD-O and all updates.

Coding Histology

Note 1: The rules for coding breast histology are different from the histology coding rules for all other sites. **DO NOT USE THESE RULES FOR ANY SITE OTHER THAN BREAST.**

Note 2: Only use this section for one or more histologies within a single tumor.

Note 3: Do not use this section in place of the Histology Rules.

Two INVASIVE histologies

Two histologies within a single tumor will be either:

- A NOS and a subtype/variant **OR**
- Different histologies (different rows in Table 3 **OR** different subtypes in Table 3 Column 3 **OR** a combination code from Table 2 and a code from Table 3)

The following instructions are in priority order:

1. NOS and a subtype/variant

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

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

Example: Patient had an excisional biopsy with a pathologic diagnosis of invasive cribriform carcinoma 8201/3. There was microscopic involvement of one margin. The patient chose to have a total mastectomy. Pathology from the total mastectomy showed minimal residual invasive carcinoma NST 8500/3. Because the invasive carcinoma NST was minimal, the subtype/variant invasive cribriform carcinoma 8201/3 is assumed to be greater than 90% of the tumor.

B. Code the **NOS/NST** when the subtype/variant is documented to be **less than or equal to 90%** of the tumor **OR** the percentage of subtype/variant is **unknown/not documented**.

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2. Different histologies

A. Code the histology which comprises the majority of tumor.

Note 1: This instruction **does not apply** to:

- Invasive carcinoma NST/ductal and lobular carcinoma (use the combination code 8522/3).
- Mucinous carcinoma and a different histology (see Histology Rules)
- Metaplastic carcinoma, NOS and subtypes/variants and invasive carcinoma, NST (see Histology Rules)

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

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

*Unless there is an exact ICD-O term that includes “differentiation” or “features”

B. Code a combination code using [Table 2](#) in the Equivalent Terms and Definitions when the majority is unknown/not documented.

Do not code **apocrine carcinoma** when the diagnosis specifies apocrine differentiation or features. **Apocrine differentiation** is frequently present in:

- Carcinoma NST/duct carcinoma
 - o Subtypes/variants of carcinoma NST/duct carcinoma
- Lobular carcinoma NOS
 - o Pleomorphic lobular carcinoma in situ

Ambiguous Terminology

3. Code the specific histology described by **ambiguous terminology** (list follows) **ONLY** when A or B is true:

A. The only diagnosis available is **one histology** term described by ambiguous terminology

- CoC and SEER require reporting of cases diagnosed only by ambiguous terminology

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

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

- B. There is a **NOS histology and a more specific** (subtype/variant) described by ambiguous terminology
- Specific histology is clinically confirmed by a physician (attending, pathologist, oncologist, etc.) **OR**
 - Patient is receiving treatment based on the specific histology described by ambiguous term

Example 1: The pathology diagnosis is carcinoma NST consistent with pleomorphic carcinoma. The oncology consult says the patient has pleomorphic carcinoma of the right breast. This is clinical confirmation of the diagnosis. Code pleomorphic carcinoma. The case meets the criteria in bullet 1.

Example 2: The pathology diagnosis is sarcoma consistent with liposarcoma. The treatment plan says the patient will receive the following treatment for liposarcoma of the breast. Treatment plan confirms liposarcoma. Code liposarcoma. The case meets the criteria in bullet 2.

If the specific histology does not meet the criteria in #3B, then code the NOS histology.

List of Ambiguous Terminology

Apparently	Most likely
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect(ed)
Consistent with	Suspicious (for)
Favor(s)	Typical (of)
Malignant appearing	

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Priority Order for Using Documentation to Identify Histology

IMPORTANT NOTES

1. Code the histology diagnosed **prior to neoadjuvant treatment**.

Note 1: Histology changes do occur following immunotherapy, chemotherapy, hormone, and radiation therapy.

Note 2: Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.

Exception: If the initial diagnosis is based on histology from FNA, smears, cytology, or from a regional or metastatic site, and neoadjuvant treatment is given and followed by resection of primary site which identifies a different or specific histology, code the histology from the primary site. For breast primaries, you cannot determine if histology comprises greater than 90% of the tumor by these diagnostic methods.

2. Code the histology using the following priority list and the Histology Rules. Do not change histology in order to make the case applicable for staging.

Use documentation in the following priority order to identify the histology type(s):

1. **Tissue or pathology report from primary site** (in priority order)
 - A. Addendum(s) and/or comment(s)
 - B. Final diagnosis / synoptic report as required by CAP
 - C. CAP protocol

Note 1: Addendums and comments on the pathology report are given a high priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.

Note 2: The pathologist's diagnosis from the pathology report is always reliable, so the final diagnosis is the second priority. The final diagnosis is often the synoptic CAP report.

Note 3: The CAP protocol is a checklist which:

- Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care.
- Allows physicians to check multiple histologies

2. **Cytology** (nipple discharge or fine needle aspirate (FNA) of primary site)

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3. **Tissue/pathology from a metastatic site**

Note 1: Code the behavior /3.

Note 2: The tissue from a metastatic site often shows **variations** from the primary tumor. When it is the only tissue available, it is more accurate than imaging.

4. **Radiography:** The following list is **not in priority** order because they are not a reliable method for **identifying** specific **histology(ies)**. They are, however, valuable in diagnosing a malignancy.

A. Mammography

B. Ultrasound

C. CT

D. MRI

5. Code the histology **documented** by the physician when none of the above are available. Use the documentation in the following **priority order:**

A. Treatment Plan

B. Documentation from Tumor Board

C. Documentation in the medical record that refers to original pathology, cytology, or scan(s)

D. Physician's **reference** to type of cancer (histology) in the medical record

Note 1: Code the specific histology when documented.

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

Single Tumor: In Situ Only

Note 1: DCIS is often multifocal/multicentric; use this module.

Note 2: Subtypes/variant, architecture, pattern, and features **ARE NOT CODED**. The majority of in situ tumors will be coded to DCIS 8500/2.

Rule H1 Code Paget disease in situ **8540/2** when the diagnosis is **exactly** Paget disease in situ.

Note 1: This is a **de novo** primary of the **nipple** (new tumor) with **no underlying** tumor.

Note 2: Paget is coded as in situ /2 **only** when **pathology documents** in situ behavior.

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Rule H2 Code the histology when only **one histology** is present.

Note 1: Use [Table 3](#) to code histology. New codes, terms, and synonyms are included in **Table 3** and coding errors may occur if the table is not used.

Note 2: When the histology is **not listed** in **Table 3**, use the **ICD-O** and all **updates**.

Note 3: Submit a question to [Ask a SEER Registrar](#) when the histology code is not found in Table 3, ICD-O or all updates.

Rule H3 Code DCIS and in situ lobular carcinoma **8522/2** when DCIS and in situ lobular carcinoma are present.

Note 1: Although the notes preceding the in situ section say most tumors will be coded to DCIS, 8522/2 identifies both DCIS and lobular carcinoma in situ.

Note 2: 8522/2 is the most accurate description of DCIS and lobular carcinoma in situ.

Note 3: 8522/2 includes DCIS and pleomorphic lobular carcinoma in situ.

Rule H4 Code DCIS and in situ Paget **8543/2**.

Note 1: Although the notes preceding the in situ section say most tumors will be coded to DCIS, 8543/2 identifies both DCIS and in situ Paget.

Note 2: 8543/2 is the most accurate description of DCIS and in situ Paget.

Rule H5 Code DCIS **8500/2** when there is a combination of DCIS and any other carcinoma in situ. See [Table 2](#).

Rule H6 Code pleomorphic lobular carcinoma in situ **8519/2** when there is a combination of lobular carcinoma in situ and pleomorphic lobular carcinoma in situ.

Rule H7 Code the histology using [Table 2](#) when there are multiple in situ histologies (2 or more) within a single tumor.

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

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

This is the end of instructions for a Single Tumor: In Situ Only

Code the histology according to the rule that fits the case

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Single Tumor: Invasive and In Situ Components

Rule H8 Code the **invasive** histology when both invasive and in situ components are present (see Notes 2 and 3 for exceptions).

Note 1: Ignore the in situ term.

- This is consistent with the 2007 MPH Rules.

Note 2: The following histologies are exceptions to this rule. When a single tumor has one of the histologies listed, continue through the rules.

- Encapsulated papillary carcinoma with invasion/with invasive carcinoma, NST/invasive duct carcinoma
- Solid papillary carcinoma with invasion

Note 3: When a single tumor has carcinoma NST/duct and lobular with different behaviors, continue through the rules.

This is the end of instructions for a Single Tumor: Invasive and In Situ Components

Code the histology according to the rule that fits the case

Single Tumor: Invasive Only

Rule H9 Code Paget disease **8540/3** when the diagnosis is **exactly** Paget disease.

Note 1: This is a **de novo** primary of the **nipple** (new tumor) with **no underlying** tumor.

Note 2: Paget is coded /3 when:

- Pathology documents invasive behavior **OR**
- Behavior is not documented/unknown

Rule H10 Code the **underlying tumor** when there is a diagnosis of **inflammatory carcinoma**.¹

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

¹ American College of Pathologists: **Protocol for the Examination of Specimens From Patients With Invasive Carcinoma of the Breast: “Inflammatory carcinoma requires the presence of clinical findings of erythema and edema involving at least one-third or more of the skin of the breast”**

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

Note 1: Record the inflammatory carcinoma in **staging** fields.

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

Rule H11 Code mucinous carcinoma/adenocarcinoma **8480 ONLY** when:

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

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

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

Note 3: When a tumor has both mucinous carcinoma and a different histology, and mucinous is less than or equal to 90% of the tumor (or the percentage is not documented), **code the other histology**.

Rule H12 Code the **primary invasive histology** when there is a carcinoma with **signet ring cells OR signet ring cell differentiation**.

Example: Resection pathology diagnosis is invasive lobular carcinoma with signet ring cell differentiation. Code the invasive lobular carcinoma **8520/3**.

Rule H13 Code **metaplastic carcinoma**, NOS, or subtype/variant of metaplastic carcinoma, NOS when **invasive carcinoma, NST OR invasive lobular carcinoma** is present along with the metaplastic carcinoma.

Example: Resection pathology diagnosis is invasive mammary carcinoma, NST with extensive metaplastic carcinoma present. Code metaplastic carcinoma **8575/3**.

Rule H14 Code the histology when only **one histology** is present.

Note 1: Use [Table 3](#) to code histology. New codes, terms, and synonyms are included in **Table 3** and coding errors may occur if the table is not used.

Note 2: When the histology is **not listed** in **Table 3**, use the **ICD-O** and all **updates**.

Note 3: Submit a question to [Ask a SEER Registrar](#) when the histology code is not found in Table 3, ICD-O or all updates.

Rule H15 Code duct carcinoma and lobular carcinoma **8522/3** when the final diagnosis is any of the following:

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(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

- Invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma (includes invasive pleomorphic lobular carcinoma)
- Intraductal and invasive lobular carcinoma (includes invasive pleomorphic lobular carcinoma)
- Infiltrating duct and lobular carcinoma in situ (LCIS)
- Infiltrating duct and pleomorphic lobular carcinoma in situ
- Infiltrating lobular carcinoma and ductal carcinoma in situ (DCIS)
- Infiltrating pleomorphic lobular carcinoma and ductal carcinoma in situ (DCIS)

Note 1: Assign behavior code /3 even when an **in situ** histology is mixed with an **invasive**. This aligns with ICD-O-3.2 and was vetted with specialty matter experts.

Note 2: CAP uses the term **Invasive carcinoma with ductal and lobular features** (“mixed type carcinoma”) as a synonym for duct carcinoma/carcinoma NST AND lobular carcinoma 8522/3.

Note 3: Although the instructions in the “Coding Multiple Histologies in a Single Tumor” section state, “Code the histology that comprises the majority of tumor”, 8522/3 identifies both invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma and is the most accurate description.

Rule H16 Code the **subtype/variant** (specific histology) **ONLY** when there is a NOS/NST and a subtype/variant **AND** the subtype/variant is documented to be **greater than 90%** of the tumor.

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

Note 2: Use [Table 3](#) to identify NOS/NST and subtypes/variants. Examples include the following:

- Carcinoma NST **8500** and a subtype/variant of carcinoma NST
- Glycogen-rich clear cell carcinoma **8315** and a subtype/variant of glycogen-rich clear cell carcinoma
- Lobular carcinoma **8520** and a subtype/variant of lobular carcinoma
- Medullary carcinoma **8510** and a subtype/variant of medullary carcinoma
- Metaplastic carcinoma **8575** and a subtype/variant of metaplastic carcinoma
- Papillary carcinoma **8503** and a subtype/variant of papillary carcinoma
- Sarcoma **8800** and a subtype/variant of sarcoma
- Small cell carcinoma **8041** and a subtype/variant of small cell carcinoma

Note 3: **Do not** code any histology described as **features or differentiation** unless it is part of the preferred term.

Breast Histology Rules C500-C506, C508-C509

(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Example 1: Pathology from excision shows a 1.4 cm tumor and a diagnosis of clear cell carcinoma 8310/3 with a focus of glycogen-rich clear cell carcinoma NOS 8315/3. Because the glycogen-rich clear cell carcinoma NOS is just a focus, more than 90% of the tumor is clear cell carcinoma. Code the subtype/variant: clear cell carcinoma 8310/3.

Example 2: Pathology from an excised tumor says tumor is 95% metaplastic carcinoma spindle cell type 8032/3 and the remainder is metaplastic carcinoma NOS 8575/3. Code the subtype/variant: metaplastic carcinoma spindle cell type 8032/3.

Rule H17 Code the NOS/NST when there is a NOS/NST and a subtype/variant **AND**

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

Example 1: Pathology diagnosis is carcinoma NST 8500/3 and pleomorphic carcinoma 8022/3. The percentage of subtype/variant is unknown. Code the NOS: carcinoma NST 8500/3.

Example 2: Pathology says the majority of tumor is metaplastic carcinoma with chondroid differentiation 8571/3 and the remainder is metaplastic carcinoma NOS 8575/3. Majority simply means greater than 50%, so it is unknown whether or not the subtype/variant is greater than 90% of the tumor. Code metaplastic carcinoma NOS 8575/3.

Rule H18 Code the histology that comprises **greater than 50%** of tumor when **two histologies** are:

- On **different rows** in [Table 3](#) in the Equivalent Terms and definitions **OR**
- **Different subtypes** of the same NOS **OR**
- A **combination code** from [Table 2](#) and a code from [Table 3](#)

Note 1: This rule does not apply to mucinous. See previous rules.

Note 2: The rules are hierarchical, so the tumors are **NOT** a NOS/NST and subtype/variant.

Note 3: If the majority histology is unknown/not documented, continue through the rules.

Example: Pathology reads the tumor is predominantly carcinoma NST 8500/3 with areas of tubular carcinoma 8211/3. Code the predominant histology: carcinoma NST 8500/3. Carcinoma NST and tubular carcinoma are on different rows in Table 3, so they are distinctly different histologies.

**Breast Histology Rules
C500-C506, C508-C509**

(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule H19 Code a **combination code** when there are **two histologies** (two components) within a single tumor and the majority histology is unknown/not documented.

Note 1: Use [Table 2](#) in the Equivalent Terms and Definitions to identify valid combination codes.

Note 2: The rules are hierarchical, so the tumors are **NOT** a NOS/NST and a single subtype/variant.

Note 3: The diagnosis may be two subtypes/variants and the pathologist may mention the presence of duct/carcinoma NST. Ignore the mention of carcinoma NST.

Note 4: **Do not** use a combination code when the second histology is described as **features or differentiation** unless it is part of the preferred term.

Note 5: The histologies may be identified as:

- Mixed histologies
- Combination histologies
- Histology 1 **AND** histology 2
- Histology 1 **WITH** histology 2

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

Code the histology according to the rule that fits the case

Breast Histology Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Multiple Tumors Abstracted as a Single Primary

Note 1: DCIS is often multifocal/multicentric; use the Single Tumor: In Situ module.

Note 2: First use the multiple primary rules to ensure that the multiple tumors are to be abstracted as a single primary.

Rule H20 Code the **underlying tumor** when there is a diagnosis of inflammatory carcinoma²:

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

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

Note 1: Record the inflammatory carcinoma in **staging** fields.

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

Rule H21 Code **Paget disease** and **ductal carcinoma** as follows when:

- Pathology specifies Paget disease as **invasive** /3 **OR** behavior not documented **AND**
- Underlying tumor is:
 - Invasive carcinoma NST/duct carcinoma **8541/3**
 - DCIS **8543/3**

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

Rule H22 Code Paget disease and DCIS **8543/2** when there is Paget disease (specified as **in situ**) with underlying **DCIS**.

Rule H23 Code the histology when only **one histology** is present in **all** tumors.

Note 1: Use [Table 3](#) to code histology. New codes, terms, and synonyms are included in Table 3 and coding errors may occur if the table is not used.

Note 2: When the histology is not listed in **Table 3**, use the ICD-O and all updates.

Note 3: Submit a question to [Ask a SEER Registrar](#) when the histology code is not found in Table 3, ICD-O or all updates.

Breast Histology Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Rule H24 Code the **invasive** histology when there are both invasive and in situ histologies.
Exception: Continue through the rules when there are multiple tumors of ductal and lobular carcinoma with different behaviors.

Rule H25 Code **8522** when carcinoma NST and lobular are present in multiple tumors.

- DCIS and in situ lobular **8522/2**
- DCIS and pleomorphic lobular carcinoma in situ **8522/2**
- Invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma (includes invasive pleomorphic lobular carcinoma) **8522/3**
- Intraductal and invasive lobular carcinoma (includes invasive pleomorphic lobular carcinoma) **8522/3**
- Infiltrating duct and lobular carcinoma in situ (LCIS) **8522/3**
- Infiltrating duct and pleomorphic lobular carcinoma in situ **8522/3**
- Infiltrating lobular carcinoma and ductal carcinoma in situ (DCIS) **8522/3**
- Infiltrating pleomorphic lobular carcinoma and ductal carcinoma in situ (DCIS) **8522/3**

Note 1: Assign behavior code /3 even when an in situ histology is mixed with an invasive. This aligns with ICD-O-3.2 and was vetted with specialty matter experts.

Note 2: CAP uses the term **Invasive carcinoma with ductal and lobular features** (“mixed type carcinoma”) as a synonym for duct carcinoma/carcinoma NST AND lobular carcinoma 8522/3.

Note 3: One tumor may be carcinoma NST and the other lobular, or all tumors may be a mixture of carcinoma NST and lobular.

Note 4: This combination code specifically identifies carcinoma NST and lobular carcinoma. For all other histological combinations, continue through the rules.

Rule H26 Code the **NOS/NST** when there is a NOS/NST and a subtype/variant:

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

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

Rule H27 Code a **combination code** when there are **two histologies** (two components) within all tumors.

Note 1: Use [Table 2](#) in the Equivalent Terms and Definitions to identify valid combination codes.

Note 2: **Do not** use a combination code when the second histology is described as **differentiation or features**, unless it is part of the preferred term.

**Breast Histology Rules
C500-C506, C508-C509**

(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Note 3: The histologies may be identified as:

- Mixed histologies
- Combination histology
- Histology 1 **AND** histology 2
- Histology 1 **WITH** histology 2

Note 4: Table 2 is used for **two** histologies. When there are **greater than two** histologies, use the “last resort” code **8255** because none of the other combinations include greater than two histologies.

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