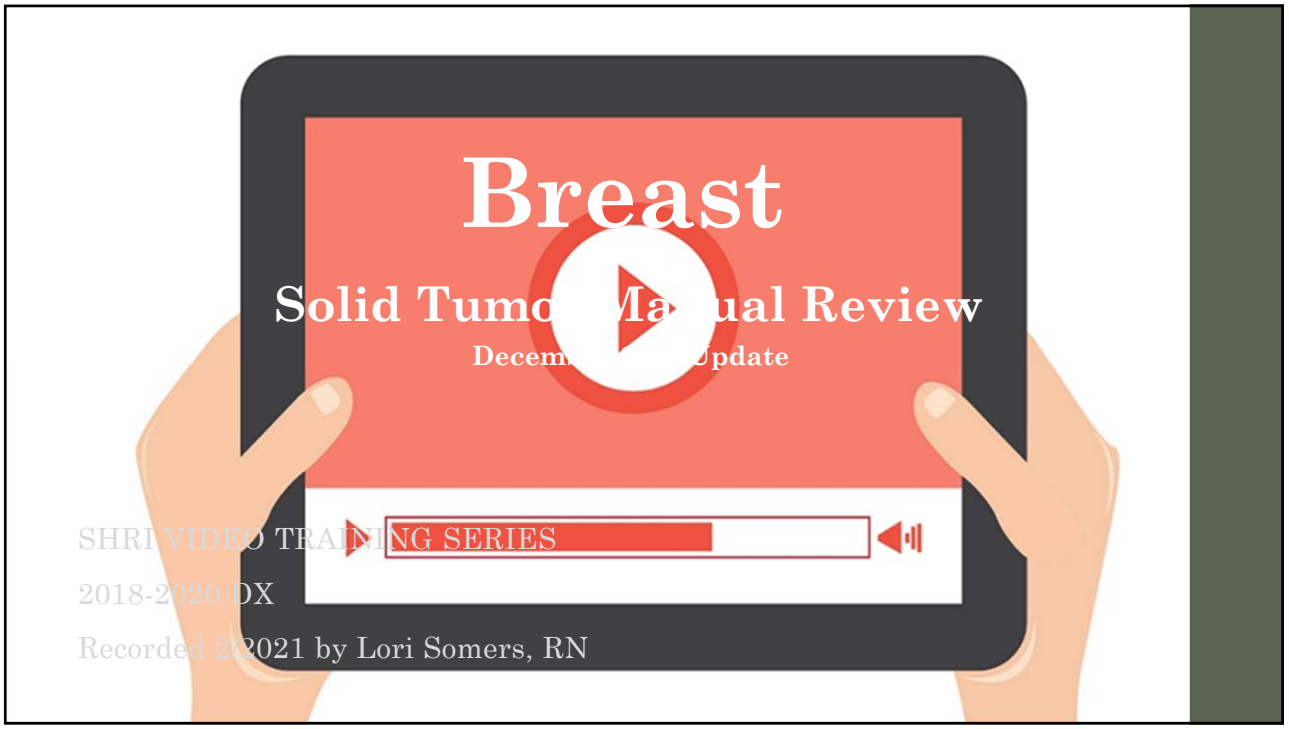

1

How to use…

7. Use the Solid Tumor Rules in the following order:
   - A. For multiple tumors, you must decide whether they are a single or multiple primaries:
     - i. Use the Histology Rules to assign a "working" histology for each tumor.
     - ii. Use Multiple Primary Rules to determine whether the tumors are a single primary or multiple primaries.
     - iii. If a single primary, follow the priority order in #7B.
     - iv. If multiple primaries, follow the priority order in #7B for **EACH** of the separate tumors/primaries.
   - B. For a single tumor or multiple tumors determined to be a single primary:
     - i. General Instructions
     - ii. Equivalent Terms and Definitions
     - iii. Multiple Primary Rules
     - Iv. Histology Rules

Rules are in hierarchical order. Use the first rule that applies and

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Multiple primary rules do not apply to tumors described as metastases.

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Breast changes from 2007 MPH Rules

- 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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Breast changes from 2007 MPH Rules

- 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.
- 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.

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Table 1

- Site Term and Code
- Synonyms
- Refer to the SEER or CoC Manual for a priority list of documents to determine tumor location
- Paget disease without underlying tumor coded to C500
- Paget with underlying tumor code to quadrant of underlying tumor

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Table 2

Combination Histologies

- Specific Histologies, NOS and Subtype/Variants
- Use as directed by rules
- Columns and rows important
- Last resort code – 8522 for mixed histologies
  - Table 2 is used for two histologies. When greater than 2 histo, use last resort code 8522

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Do not use Table 2…

- For tumors with both invasive and in situ behavior [histology rules instruct to code invasive].
- When one of the histologies is described as **differentiation** or **features**.
- When terms are NOS and subtype/variant of that NOS. [see histology rules]

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Table 2

- Per CAP protocol for invasive breast:
  - Invasive carcinoma with ductal and lobular features (mixed type carcinoma) is the term used for ductal mixed with lobular 8522.
  - Exception to H rules that disallow coding 'features'

DO NOT USE 8522:

- When dx carcinoma NST/duct carcinoma with lobular **differentiation** or carcinoma NST/duct carcinoma with lobular **features**.

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Table 3

Specific Histologies, NOS & Subtypes/Variants

- Use as directed by histology rules
- Rare histologies may not be on table
- Table based on WHO 4th Ed breast tumors
- Behavior codes listed if only one possible (/2 or /3). If either possible, behavior code not listed. Code behavior from pathology. [i.e. pleomorphic carcinoma 8022/3]

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"Mets" Rule

Multiple Primary Rules not used for tumor(s) described as mets

- Common metastatic sites for breast:
  - Axillary LNs
  - Bone
  - Brain
  - Chest wall ⟵
  - Skin
  - Distant lymph nodes
  - Liver
  - Lung

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Chest Wall: Mets or recurrence?

- Residual breast tissue in Path report then:
  - New tumor
  - Work through M rules to determine if new primary
- Tumor arose in chest wall stated in Path report:
  - If NO designation of residual breast tissue, this is regional mets and not a new primary

Review gross and micro portion of path report looking for terms residual breast tissue or skeletal/chest wall

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Hormone receptors

- Do not use hormone receptors to determine multiple primaries
  - ER
  - PR
  - HER2

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Multiple Primary Rules

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M Rules

- Note 1: These rules are NOT for tumor described as mets.
- Note 2: Rules are based on date of dx.
  - Tumors dx 2018-2020 use 2018 Solid Tumor Rules
  - If you have orig tumor dx before 2018 and subsequent tumor dx 1/1/2018 or later in same primary site, use 2018 STR

Headers

Unknown if Single or Multiple Tumors: Rule M1 Single

Single Tumor: M2 inflammatory rule or M3 single tumor is a single primary

Multiple Tumors: M4-M18

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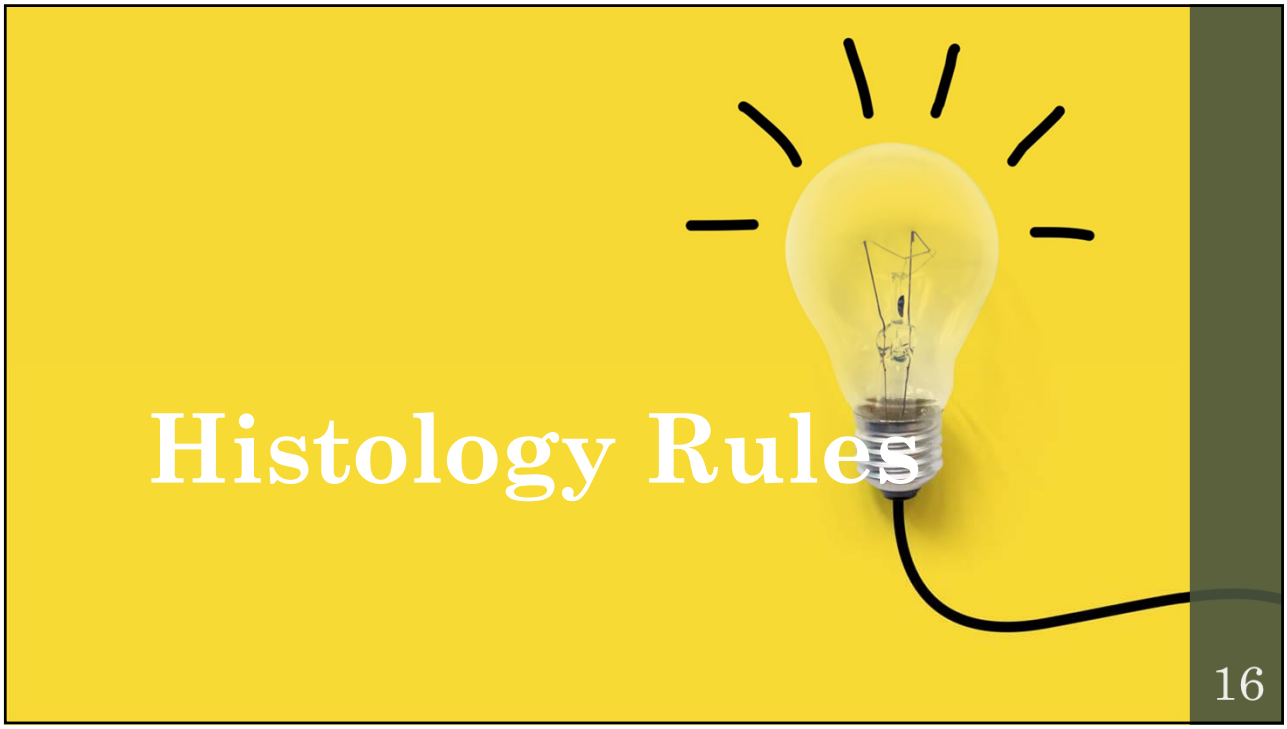

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Histology Rules

- 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 ICDO and all updates. This applies to single and multiple histologies.

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IMPORTANT!!!

Note 1: Rules for coding breast histology are different from histology coding rules for all other sites.

DO NOT USE THESE RULES FOR ANY OTHER SITE 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 Histology Rules.

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Two invasive histologies

- Two histologies within **single** tumor:
  - An NOS and a subtype/variant OR
  - Different histologies

1. **NOS and a s/v**

A. Code s/v (specific) ONLY when documented >90% of tumor

Note: When histology listed as minimal, focus/foci/focal, microscopic then assume other histology comprises >90% of tumor

B. Code the NOS/NST when s/v is documented to be </= to 90% of tumor or % of s/v is unknown/not doc.

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Two invasive histologies

2. **Different Histologies**

A. Code histology which comprises majority of tumor.

Note 1: DOES NOT APPLY to invasive NST/ductal and lobular ca (use 8522/3)

Note 2: Majority may be indicated by terms such as >50%, major, majority, predominantly.

Note 3: Following terms **do not** describe majority of tumor.

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

B. Code a combination code using Table 2 when majority is unknown/not documented.

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Apocrine

- Do not code apocrine carcinoma when the dx specifies apocrine differentiation or features.
- **Apocrine differentiation** is frequently present in:
  - Carcinoma NST/duct carcinoma
    - Subtype/variants of carcinoma NST/duct
  - Lobular carcinoma NOS
    - Pleomorphic lobular CIS

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Ambiguous Terminology

3. Code specific histology when described by ambig term ONLY when A or B is true:
   A. The only diagnosis available is one histology described by ambig term
      - COC and SEER require reporting of cases diagnosed only by ambig terms
      - Case is accessioned based on ambig term and no other info available
   B. There is an NOS histology and a more specific (s/v) described by ambig term
      - Specific histology is clinically confirmed by physician OR
      - Pt is receiving treatment based on specific histology described my ambig term.

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

List of Ambig Terms pg 45

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Important Notes

1. Code histology diagnosed prior to neoadjuvant treatment.
2. Code histology using priority list and histology rules.

Do not change histology in order to make case applicable for staging.

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Priority order to identify histology

1. Tissue or path report from primary site
   A. Addendum
   B. Final dx
   C. CAP
2. Cytology (FNA or nipple discharge)
3. Tissue/path from metastatic site
4. Radiography (not reliable identifying spec histologies)
5. Physician: when none of the above are available.

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Headings for Histology Rules

- Single tumor: In Situ Only
  - H1-H7
- Single Tumor: Invasive and In Situ Components
  - H8: Code the invasive (ignore in situ term)
- Single Tumor: Invasive only
  - H9-H19
- Multiple Tumors abstracted as a Single primary
  - H20-H27

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Case #1

6/8/20 Screening mammo: 2.5 cm progressive retroareolar focal asymmetry on the right.
6/22/20 US Breast: 2.7 cm lobulated predominantly solid mass at 11:00 rt periareolar breast.
Procedures:
6/28/20 US guided Rt breast bx.
7/17/20 Rt breast lumpectomy with Rt SLNB.
7/27/20 Re-excision rt nipple and margins.

Pathology:
6/28/20 Rt breast 11:00 bx: Mucinous (colloid) carcinoma.
7/17/20 Rt breast lumpectomy with Rt SLNB: 35 mm invasive mucinous carcinoma, grade 2. No DCIS. Positive margins. No LVI. 0/1 SLN. pT2N0.
7/27/20 Re-excision of margins: Paget's disease of nipple. Margins neg.

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Answers

Case #1 Paget

Field	Code	Resource/Rule
How Many Primaries		
Primary Site		
Histology		
Primary Site		
Histology		

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Case #2

IMAGING: 2/7/20 Bil mammo: Microcalcifications UOQ LT breast. Mildly enlarged LT axillary LN. LT breast U/S: 13-mm mass 3 o'clock. 2.7-cm enlarged LT Abnl axillary LN, likely adjacent 9-mm Abnl LN. Bx recommended of presumed CA 3 o'clock and mets axillary LN.
2/8/20 Bil breast MRI: LT breast coalescing masses posterior central 6-cm, separate 11-mm enhancing mass 6 o'clock suspicious for CA; tumor extension into nipple, associated dermal involvement. Diffuse skin thickening. At least 5 LT enlarged axillary LNS, largest 3-cm suspicious for mets. RT breast/LN Neg.
2/14/20 MRI brain: Neg.
2/17/20 PET: Known inflammatory CA extends to skin, involves nipple, 1-2 o'clock adjacent skin. Malignant LT axillary LAD 1.8-cm. Additional borderline indeterminate LNS high LT axilla posterior to pectoralis minor muscle. Otherwise Neg.
3/4/20 CT Chest: Known inflammatory breast CA with skin thickening, malignant-appearing enlarged 2.5-cm LT axillary LN.

PROCEDURE: 2/8/20 U/S-guided LT breast BX of 12 o'clock mass noting 2 masses identified NOS; LT axillary LN Bx x1 (not documented as a SLN).
2/9/20 Bx LT nipple skin and of skin below LT nipple.

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Case #2

PATHOLOGY: 2/08/20 LT breast 12 o'clock Bx: Focal high-grade DCIS, tiny foci of invasive ductal type carcinoma Nottingham G2 of 3. LT axilla LN: 1.4-cm mets ducal carcinoma of breast primary. LVI not documented.
2/9/20 LT nipple skin and skin below nipple BX: Benign.
5/30/20 LT breast: Invasive ductal carcinoma residual TS 41-mm G2/3. Pos LVI. Scattered DCIS foci largest 18-mm accounting for 19% of residual tumor. Nipple dermis Pos for focal invasive carcinoma. 1/2 mammary LNS Pos for 3.5 mm mets LT axillary LN dissection: 2/22 Pos for mets; 4 LNs Pos for ITCs up to 1.5-mm. Focal extracapsular LN extension. Treatment effect present in LNS with micromets, ITC's. Medial/lateral skin excision: Neg. Extensive treatment effect.

2/9/20 Onc consult: Bx EW Pos DCIS, foci of invasive ductal carcinoma, Pos LN mets; cutaneous findings of inflammatory breast carcinoma. 2/16/20 Onc F/U: Plan neoadjuvant chemo, surgery, adjuvant RTx/hormone.

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Answers

Case #2 IBC

Field	Code	Resource/Rule
How Many Primaries		
Primary Site		
Histology		
Primary Site		
Histology		

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Case #3

48 YO WHITE FEMALE WHO UNDERWENT SCREENING MAMMO, FOUND TO HAVE SPICULATED MASS UOQ RT BREAST.NO SKIN CHANGES/NIPPLE DISCHARGE.BX PROVED RT BREAST CA.

8-8-20 U/S RT BREAST: IN 3:00 POSITION OF RT BREAST IS AN IRREG SHADOWING MASS WHICH IS CONCERNING FOR MALIG.

8-31/20 MASTECTOMY, WIRE LOCALIZED PARTIAL MASTECTOMY, LATERAL RT BREAST AUTOLOGOUS RECONSTRUCTION, RT AXILLARY SENTINEL LYMPH NODE BIOPSY

8-8-20 RT BREAST U/S GUIDED NEEDLE BX: INV MAMMARY CA W/ LOBULAR FEATURES.NOTTINGHAM GRADE II/III (TUBULES-2, NP-2, MC-1, SCORE-5). SIZE OF INV COMPONENT 1.8cm (MEASURED ON SLIDE).NO LVI.NO DCIS.
8-31-20 RT BREAST PARTIAL MASTECTOMY W/AXILLARY NODE,SLNB: INV CA NST UOQ RT BREAST.GRADE 2(GLANDULAR-3,NP-2,MITOTIC-1,SCORE-6).TUMOR SIZE 21mm.NO DCIS.LCIS PRESENT.NO LVI.MARG NEG.0/3 NODES NEG.0/2 SENTINEL NODES NEG. pT3,pN0

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Answers

- Case #3

Field	Code	Resource/Rule
How Many Primaries		
Primary Site		
Histology		
Primary Site		
Histology		

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Case #4

10-31-19 LT BREAST IMAGE STEREOTACTIC GUIDED BX: INV LOBULAR CA GRADE 2/3.TUMOR INV 10% SUBMITTED TISSUE. LCIS PRESENT W/ SIGNET RINGS AND MICROCALCIFICATIONS.

1-8-20 TOTAL LT MASTECTOMY: INV LOBULAR CA LIQ LT BREAST.NOTTINGHAM GR 3(GLANDULAR-3, NUCLEAR-2, MITOTIC-3, SCORE-8). TUMOR SIZE 22mm. NO DCIS. LCIS PRESENT. NO LVI. MARG NEG. 0/1 SENTINEL NODE NEG. pT1bpN0

10/31/19 INVAS LOBULAR CA, GR 2/3, L BREAST. LCIS, HIGH NUCLEAR GR W/SIGNET RING CELLS & MICROCALCIFICATION.

1/8/20 1 L SENTINEL L/N NEG. INVAS LOBULAR CA, GR 3, L BREAST. 22MM, NOTTINGHAM 8, NO LVI OR DERMAL LVI.PLEOMORPHIC LOBULAR CA IN SITU W/NECROSIS.7MM.MARG NEG. PT2N0.

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Answers

- Case #4

Field	Code	Resource/Rule
How Many Primaries		
Primary Site		
Histology		
Primary Site		
Histology		

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SEER*Educate

–Dx 2018 Solid Tumor Rules

- Breast 1-5

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