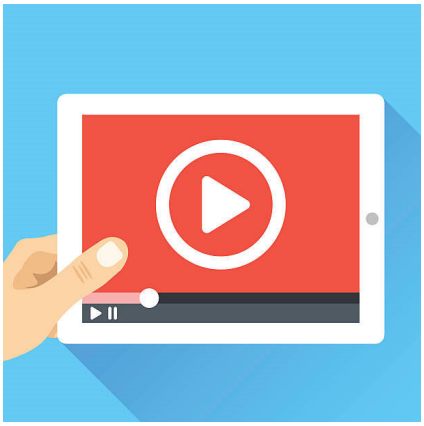


Colon, Rectosigmoid, and Rectum
Primary Site & Histology
Solid Tumor Rules
Effective 2018 dx and forward
2024 Update

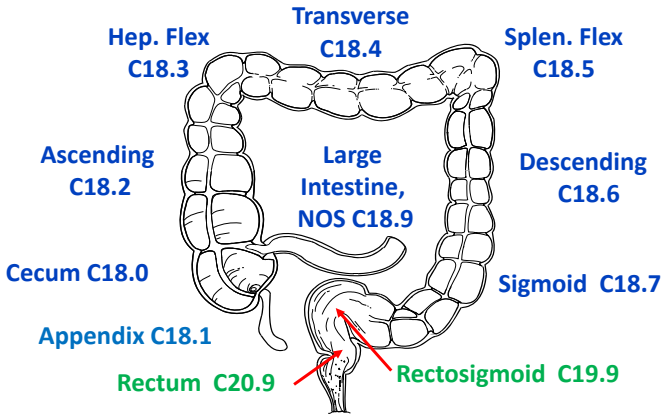
Presented by Lori Somers, RN
SHRI Video Training Series | Iowa Cancer Registry
August 2024

1

1

Colorectal Anatomy

Primary Site ICD-O Codes for Colon and Rectum



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Coding Primary Site for solid tumors

- Code the site the primary tumor originated, even if it extends onto/into adjacent subsite
- Primary site helps software determine which schema to use (as well as date of diagnosis and histology)
- Some sites have specific coding guidelines in Appendix C:

9. See the site-specific coding guidelines in Appendix C for primary site coding guidelines for the following sites

Bladder	Intracranial Glands
Brain/CNS, Benign and Borderline	Kaposi Sarcoma of All Sites
Brain/CNS, Malignant	Lung
Breast	Pancreas
Colon	Rectosigmoid Junction
Esophagus	

3

3

Determining Primary Site: Coding Guidelines

https://seer.cancer.gov/archive/manuals/2023/appendixc.html

Colon, Appendix, Rectosigmoid, Rectum –

Coding Guidelines: Colon (PDF, 94 KB)

Coding Guidelines: Rectosigmoid, Rectum (PDF, 128 KB)

Solid Tumor Rules: Colon, Rectosigmoid, and Rectum (PDF, 1.6 MB)

Surgery Codes

- Colon - (C180-C189) (PDF, 177 KB)
- Rectosigmoid - (C199) (PDF, 212 KB)
- Rectum - (C209) (PDF, 210 KB)

4

4

Determining Primary Site

COLON C180-C189

Coding Guidelines [Appendix C of SEER Manual]

- **Priority Order for Coding Primary Site**

Resected cases

- Operative report with surgeon's description
- Pathology report
- Imaging

Polypectomy or excision without resection

- Endoscopy report
- Pathology report

RECTOSIGMOID JUNCTION C199

Coding Guidelines

- Tumor classified as rectosigmoid when differentiation between rectum and sigmoid not possible.
- Tumor classified as rectal when:
  - Lower margin lies <16 cm from anal verge
    OR
  - Any part of tumor located at least partly within supply of superior rectal artery

5

5

Determining Primary Site

Subsites:

- Code the subsite with the most tumor when the tumor overlaps two subsites.
- Code C188 when both subsites are equally involved

Colonoscopy measurement can be used as indication of tumor location

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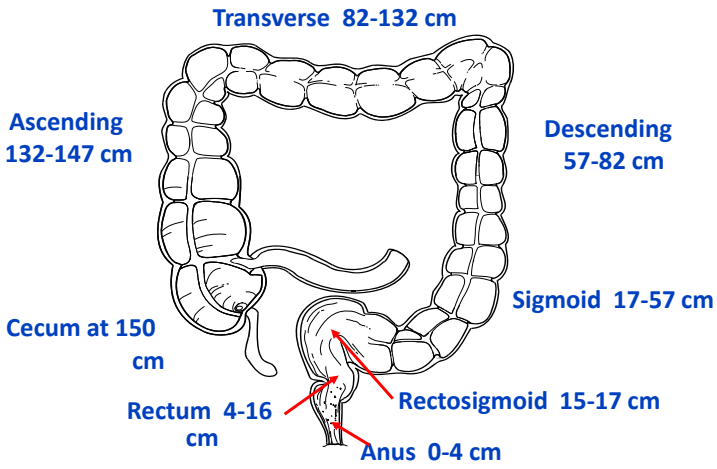
6

Colonoscopy Measurements*



* from anal verge Approximations only.
Source: AJCC Cancer Staging Manual, fifth edition, page 85, 1997.

7

7

USE
Solid Tumor Rule Manual

Effective with cases
1/1/2018 and forward
Updated January 2024

Solid Tumor Rules

Effective with Cases Diagnosed 1/1/2018 and Forward

2024 Update

Editors: Lois Dickie, CTR, NCI SEER
Carol Hahn Johnson, BS, CTR (Retired), Consultant
Suzanne Adams, BS, CTR (IMS, Inc.)
Serban Negoita, MD, PhD, CTR, NCI SEER

Suggested citation: Dickie, L., Johnson, CH., Adams, S., Negoita, S. (December 2023). Solid Tumor Rules. National Cancer Institute, Rockville, MD 20850.

8

8

Review Manual

Introduction specific to Colon
Changes from 2007 MPH Rules
New for 2022
Equivalent or Equal Terms vs Non-equivalent terms
Table 1: Specific Histologies
Table 2: Histologies(Not reportable)
Illustrations
Multiple Primary Rules
Histology Rules

9

9

Introduction

- 98% colon cancers are adenocarcinoma and adenoca subtypes
- Mixed histologies rare
- Terms: NET, NEC, GIST
  - NET (Neuroendocrine tumor) replacing the term carcinoid; some path still uses carcinoid
  - NEC (Neuroendocrine carcinoma) includes small cell, large cell and PD neuroendocrine carcinoma
  - GIST (gastrointestinal stromal tumor) 60% stomach; 30% small intestine
    - About 25% are malig; often difficult to determine behavior

10

10

Changes from 2007 MPH Rules

Effective 1/1/2018 dx and later:

- Code **most specific histology** from biopsy or resection.
  - If discrepancy, code from most representative specimen (greater amt of tumor)
- New multiple primary rules to address anastomotic recurrence
- NET (formerly carcinoid) arising in appendix are reportable 1/1/2015 and forward.
- Rule Clarification: Pseudomyxoma peritonei now has two-tiered classification
  - High grade is malig /3
  - Low grade is NOT malig /1
- Dysplasias /2 behavior but not reportable in U.S.
  - Pathologists often use dysplasia in place of carcinoma in situ. Code CIS only if path states CIS.
- Disregard polyps when coding histology (Adenocarcinoma in adenomatous polyp = 8140)

11

11

New for 2022

Timing Changes

- Rule M7 and M8
- Anastomosis recurrences has changed from 24 to 36 months. Effective 2022 dx forward. (For cases 2018-2021, timing rule remains 24 months)
- LAMN or Low grade appendiceal neoplasm reportable effective 1/1/2022
  - LAMN in situ 8480/2
  - LAMN invasive or malignant 8480/3 based on physician statement of behavior
  - LAMN diagnosed prior to 1/1/2022 are not reportable

12

12

Terminology

- Equivalent Terms
  - 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

- Not Equivalent or Equal
  - Phenotype is not equivalent to subtype/type/variant

13

13

Table 1: Specific Histologies, NOS and Subtypes/Variants

Note 1: Rare histologies may not be listed in table

Note 2: Submit a question to Ask a SEER Registrar when histology code is not found in Table 1, ICD-0 or all updates.

Note 3: Behavior codes are listed when term has only one possible behavior (either /2 or /3)

- If not specified can be /2 or /3

- Columns & Rows

14

14

Colon, Rectosigmoid, and Rectum Equivalent Terms and Definitions
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

James | Jim or Jimmy | Sons of James: Ian, Dan

	Specific and NOS Term and Code	Synonyms for Specific or NOS Term	Subtypes/Variants
1	**Combined small cell carcinoma 8045**	Small cell carcinoma mixed with • Adenocarcinoma **OR** • Neuroendocrine carcinoma **OR** • Any other type of carcinoma/adenocarcinoma	
2	**Gastrinoma 8153**		
3	**Gastrointestinal stromal tumor 8936/3** ***Note:*** See standard setter reportability guidelines.	Gastrointestinal autonomic nerve tumor GANT Gastrointestinal pacemaker cell tumor Gastrointestinal stromal tumor GIST, NOS GIST, malignant Gastrointestinal stromal sarcoma	
4	**Mixed adenoneuroendocrine carcinoma 8244**	Adenocarcinoma ex-goblet cell Adenocarcinoma mixed with high-grade large cell neuroendocrine carcinoma Adenocarcinoma mixed with high-grade small cell neuroendocrine carcinoma MANEC Mixed neuroendocrine carcinoma	Goblet cell adenocarcinoma/Goblet cell carcinoid **8243**
5	**Mixed neuroendocrine non-neuroendocrine neoplasm 8154**	MiNEN	
6	**Neuroendocrine carcinoma 8246**	NEC	Large cell NEC **8013** Small cell NEC **8041**

15

15

Colon, Rectosigmoid, and Rectum Equivalent Terms and Definitions
C180-C189, C199, C209
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Table 2: Histologies <u>Not</u> Reportable for Colon, Rectosigmoid and Rectum

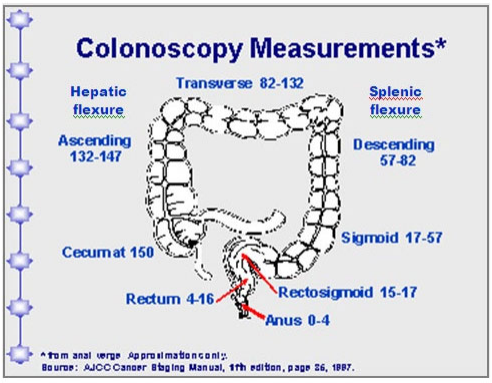
Column 1 lists the **non-reportable** histology term and code for NOS or specific
Column 2 lists the **synonym**(s) for the term
Column 3 lists the **subtype/variant** of the NOS term with the histology code
Column 4 lists the **reason** these histologies are **not reportable**

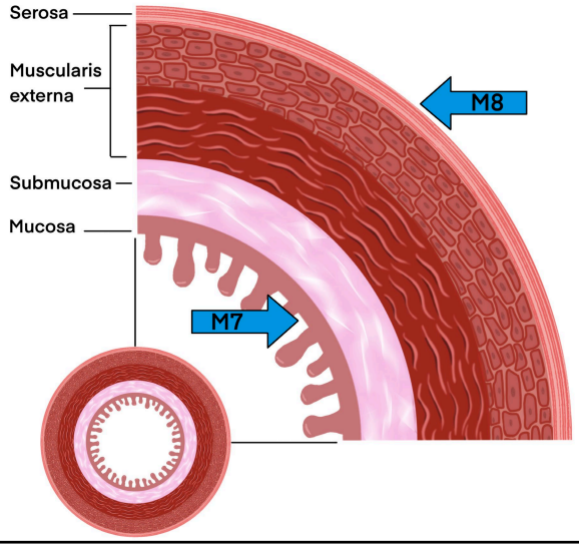
Specific or NOS Term and Code	Synonyms	Subtype/Variant of NOS with Histology Code	Reason not reportable
Adenoma 8140/0 ***Note:*** No malignancy in polyps	Adenoma NOS	Tubular adenoma **8211/0** Tubulovillous adenoma **8263/0** Villous adenoma **8261/0**	Non-malignant
Adenomatous polyp, high grade dysplasia 8210/2			Non-reportable terminology
Cowden-associated polyp No code ***Note:*** No malignancy in polyps	Cowden disease Cowden syndrome Multiple hamartoma syndrome		Non-malignant /no code
Dysplasia, high grade 8148/2 ***Note:*** Colorectal primaries only (C180-C189, C199 and C209)	High-grade dysplasia Intraepithelial neoplasia, high grade		**CURRENTLY NOT REPORTABLE**
Dysplasia, low grade 8148/0* ***Note:*** Colorectal primaries only (C180-C189, C199 and C209)	Intraepithelial neoplasia, low grade		Non-malignant

16

16

Illustrations





17

Multiple Primary Rules

Unknown if single or multiple M1	• Single tumor if unable to determine
Single Tumor M2	• Single tumor is always a single primary
Multiple Tumors M3-M15	• May be a single primary or multiple primaries

18

18

Example Multiple Primary Sites

Example 1: 3/17/2023 Malignant mass found in **transverse colon C18.4,** and another malignant mass found in **descending colon C18.6.**

- **Pathology: Biopsy showed adenocarcinoma (8140) of both lesions.**

- How many primaries?

19

19

Multiple Primary Rules | Multiple Tumors Header

Note 2: Collision tumors

M3 polyposis, FAP

M4 Abstract mult pri when there are separate non-contiguous tumors in sites with ICDO site codes that differ at the second, C**X**xx and or third, Cx**X**x character

Example shows C18.4 and C18.6. Do not stop. YET.

20

20

Multiple Primary Rules | Multiple Tumors Header

- **M5 two or more different** histology subtypes in Table 1, Column 3
- **M6 histology is on** different rows Table 1
- **M7** anastomotic site (mucosa)
- **M8** anastomotic site (serosa)
- **M9** Abstract Multiple primaries when separate non-continuous tumors in ICDO site that differ at 4th character C18X.

  Our Example: C18.4 and C18.6

21

21

Example Multiple cancers

Example 2:

- Patient with Colon cancer in 2000 and on your database with Site: C18.2 **Ascending** colon PD invasive adenocarcinoma, 8140/3 s/p hemicolectomy.
- In 2023 found **to have recurrence at the anastomotic site dx exactly as mucinous adenocarcinoma (8480).**

22

22

Anastomotic Rule

Rule M7 Abstract **multiple primaries**[ii] when a subsequent tumor arises at the **anastomotic** site **AND:**

- One tumor is a **NOS** and the other is a **subtype/variant** of that NOS **OR**
- The subsequent tumor occurs **greater than 36 months** after original tumor resection **OR**
  Note: For cases diagnosed prior to 1/1/2022, the time interval is greater than 24 months.
- The **subsequent** tumor arises in the **mucosa** (see illustration)
  Note: Bullet three does not apply to GIST. GISTs only start in the wall; never in the mucosa.

Example: (For bullet 1: NOS and subtype/variant) The original tumor was adenocarcinoma NOS **8140**. The patient had a hemicolectomy. There was a recurrence at the **anastomotic** site diagnosed exactly as **mucinous** adenocarcinoma **8480.** Mucinous adenocarcinoma is a subtype/variant of the NOS adenocarcinoma, but they are two different histologies. **Code two primaries,** one for the original adenocarcinoma NOS and another for the subsequent anastomotic site mucinous adenocarcinoma.

Note 1: There may or may not be **physician documentation** of anastomotic recurrence. Follow the rules.

Primary site of Tumor 02: C18.2, histology 8480/3

Resource: AJCC Staging Manual, pg 262: If the tumor recurs at the site of surgery, it is anatomically assigned to the proximal segment of the anastomosis (unless that segment is the small intestine, in which case the colonic or rectal segment should be designated as appropriate) and restaged by the TNM Classification.

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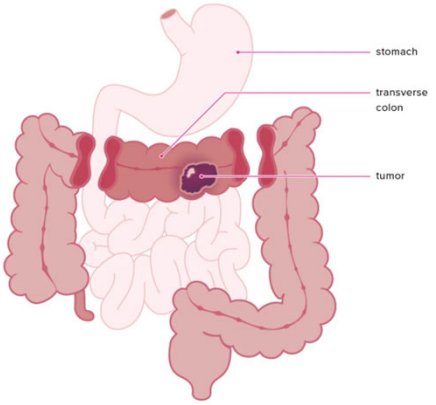
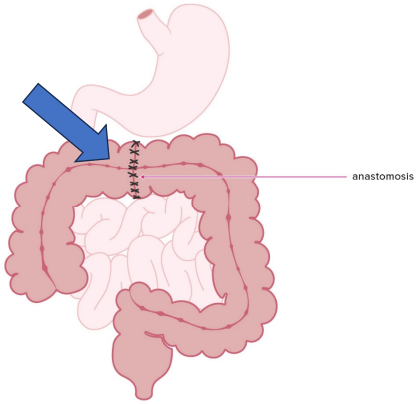
23

Anastomosis

- https://www.healthline.com/health/anastomosis





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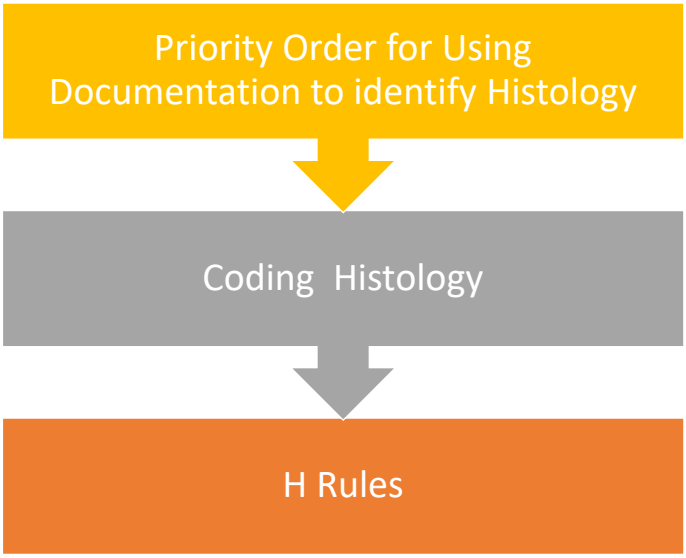
Multiple Primary Rules

- **M10** Timing rule, NED rule for >1 year.
- **M11** Abstract single primary, synchronous tumors, same row Table 1
- **M12** Abstract single primary in situ after invasive
- **M13** Abstract single primary invasive within 60 days of in situ
- **M14** Abstract multiple primary invasive more than 60 days after in situ
- **M15** Abstract single primary when tumor do not meet criteria above

25

25

Coding Histology



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26

Priority Order for Using Documentation

1. Code histology prior to neoadjuvant treatment
   a. Therapy may change histology
   b. Any tumor-related treatment given prior to surgical removal of malignancy

Exception: If initial dx based on histology from FNA, smears, cytology, or from regional or metastatic site and neoadjuvant therapy given followed by resection of primary site which identifies different or specific histology, code histology from the primary site.

27

27

Priority Order for Using Documentation

2. Code histology using the following priority list (for single primaries) and Histology Rules. Code most specific path/tissue from either resection or biopsy

Note 1: Most specific usually subtype/variant

Note 2: Code invasive if in situ and invasive components in single tumor

Note 3: Discrepancy between biopsy and resection (2 distinct different histologies/different rows) code histology from most represented specimen (greater amt of tumor)

28

28

List of hierarchical source documents

1. Tissue or path report from primary site (includes addendums, final, synoptic, CAP)
2. Tissue/path from metastatic site
3. Scan in priority order:
   a. CT
   b. PET
   c. MRI
4. Histology documented by physician when none of above available
   a. Treatment plan
   b. Tumor board
   c. Medical record documents referring to original path, cytology, scans
   d. Physician reference to type of cancer (histology)
5. Cytology (seldom used for colon)

29

29

Coding Histology

Note 1: Priority is to code most specific histology. DO NOT USE BREAST HISTOLOGY CODING RULES FOR THIS SITE.

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

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

30

30

Coding Histology

1. **Code most specific histology or subtype/variant, regardless if described as:**
   - A. **Majority or predominant part of tumor**
   - B. **Minority of tumor**
   - C. **A component**
2. **Code histology described as differentiation or features/features of ONLY when specific code**
3. **Histology described by ambiguous terms ONLY when A or B is true:**
   - A. **The only dx available is one histology described by ambiguous term**
   - B. **There is an NOS and a more specific (subtype/variant) described by ambig term**
     - Term is clinically confirmed by attending OR
     - Treatment based on specific histology described by ambig term
4. **DO NOT CODE**: Architecture; foci; focus; focal or pattern.

31

31

Ambig Terms

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	

32

32

Histology Rules | Single Tumor

- H1 Exactly adenocarcinoma with neuroendocrine differentiation 8574
- H2 Code histology, ignore polyp
- H3 Combined small cell rule
- H4 Mixed mucinous and signet ring cell (need %)
- H5 LAMN & HAMN /2
- H6 Exactly mucinous or 2 histologies and mucinous >50%
- H7 Exactly signet ring cell or 2 histologies and signet ring >50%

33

33

Rule H5

Code LAMN and HAMN 8480/2 when:

- Diagnosis date is 1/1/2022 forward AND
- Behavior is stated to be in situ/non-invasive OR
- Behavior is not indicated (NOS)

If stated as malignant or invasive, continue through rules

34

34

Histology Rules | Single Tumor

- H8 Adenocarcinoma NOS; 2 histologies % unknown or < 50%
- H9 One histology present, use Table 1
- H10 Code invasive when in situ and invasive present in same tumor
- H11 Code subtype/variant when NOS and single subtype/variant based on table 1.

35

35

Histology Rules | Multiple Tumors abstracted as single tumor

- H12 FAP
- H13 FAP not mentioned but at least 2 polyps or <100 polyps identified
- H14 Code invasive when /2 and /3 tumors
- H15 Code the histology when only one histology is present in all tumors.
- H16 code the subtype/variant if NOS and single s/v of that NOS

36

36

- **Example 3**: 5/5/2023 Op Report: Hemicolectomy 5/5/2023 Pathology: A 4.0 cm size MD adenocarcinoma and signet ring cell carcinoma in 45% of tissue of the transverse colon.

M2 Single primary when there is a single tumor
H8 Applies to this case.
Two histologies:
Adenoca and signet ring cell carcinoma
Percentage of signet ring cell documented less than/equal to 50% of tumor
Code 8140 Adenocarcinoma, NOS
Site code C18.4 Transverse Colon

37

37

NET (Carcinoid) cancer

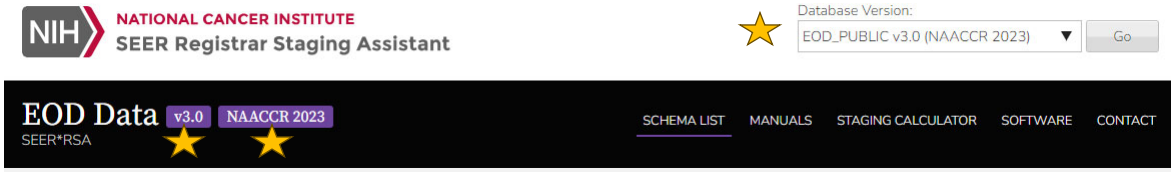
Look for schemas starting with NET

All NET tumors are considered malig, /3.

Effective 2015, carcinoid tumor, NOS of appendix (C18.1) is reportable, 8240/3.

Keep it simple: Code all to /3 unless designated benign.

38



NET Adrenal Gland
NET Ampulla of Vater
NET Appendix
NET Colon and Rectum
NET Duodenum
NET Jejunum and Ileum
NET Pancreas
NET Stomach

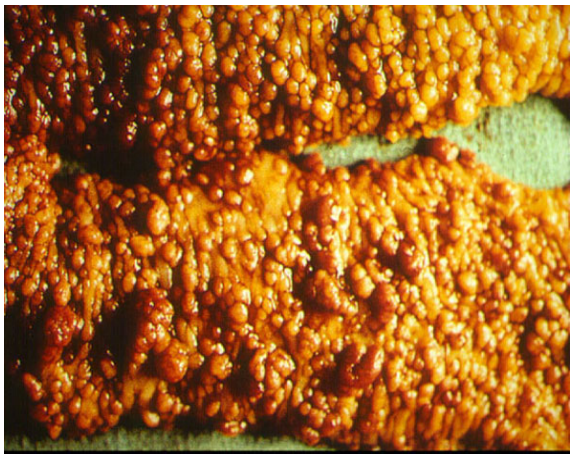
V3.1 is compatible with NAACCR 2024 and should not be used until the 2023 reporting year submissions are complete.

V3.0 is compatible with NAACCR 2023 up through 2023 dx.

39

39

FAP (8220)



- Familial adenomatous polyposis (FAP)
  - also known as familial polyposis coli
    - subtype: Gardner syndrome (with other neoplasms)
  - genetic defect
  - patients have >100 colon polyps (usually thousands); most are tubular adenomas
  - 100% progress to colon carcinoma
  - prophylactic colectomy by age 20-25

Reportable only when cancer in a polyp

Rule M3 single primary

Rule H12 8220

40

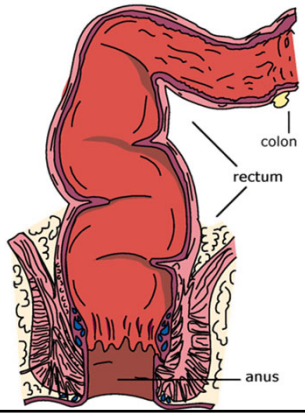
40

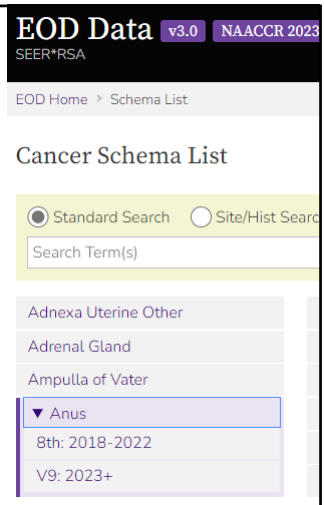
Anus Histology

- **Squamous cell carcinoma** (8070/3)
  - Arises in the anus
- **Cloacogenic** transitional cell carcinoma (8124/3)
  - Arises at anorectal junction

Primary Site :

C21.0 Anus NOS
C21.1 Anal Canal
C21.2 Cloacogenic zone
C21.8 Overlap rectum & anus





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41

Histology Example #4

Pathology: 3-1-23 Left colon resection: **Final DX** = Mass in the splenic flexure MD mucinous adenocarcinoma. Tumor invades through bowel wall. 1 out of 13 mesenteric LNs pos. Stage pT3pN1cM0.

Primary Site C18.5

Histology/behavior: 8480/3

42

42

Primary Site and Morphology Exercises

43

43

Case #1

<u>Final Pathology:</u> 3-1-23 Sigmoid resection: Tumor in sigmoid colon, Infiltrating PD adenocarcinoma with mucinous features. Tumor invades through bowel wall. 1 out of 13 mesenteric LNs pos.	
Primary Site	
Histology/Behavior	

44

44

Case #2

FINAL Pathology: 3-1-23 L colon resection: Tumor in left colon, Infiltrating well diff adenocarcinoma and signet ring cell carcinoma (>75%). Tumor invades through bowel wall. 1 out of 13 mesenteric LNs pos.	
Primary Site	
Histology/Behavior	

45

45

Case #3

Scope: 7/4/2023 Colonoscopy shows tumor 10cm from dentate line. FINAL Pathology: 8/1/23 Rectosigmoid resection: Gross= A 1.5 cm rectal mass showing dysplasia, high grade, intraepithelial neoplasia.	
Primary Site	
Histology/Behavior	

46

46

Case #4

Surgery: 10-10-23 R Hemicolectomy: Adenoma in Hepatic flexure **FINAL Pathology:** 10-10-23 Tubulovillous adenoma at the hepatic flexure with infiltrating mucinous adenocarcinoma, invasion into submucosa. All 10 pericolic LNs negative. Margins free.	
Primary Site	
Histology/Behavior	

47

47

Case #5

Surgery: 10-30-23 Right hemicolectomy: liver palpated WNL. FINAL Pathology: 10-30-23 Right colon, terminal ileum and appendix. DX= Two separate lesions are both mod diff adenoCA; Largest tumor in ascending colon is 3.7cm, infiltrates the muscularis propria and pericolonic fat. Margins negative. 5/14 LNs positive. Second tumor in hepatic flexure is 0.9 cm polyp which invades submucosa. **How many abstracts? _____**	
Primary Site	
Histology/Behavior	

48

48

FORUM SAYS:

- https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/general-instructions/139427-coding-the-grade-when-its-part-of-the-histology
- LAMN is G1 or well diff
- HAMN is G2 or mod diff

49

49

Homework

SEER Solid Tumor Rules on SEER*Edu

- https://educate.fredhutch.org/Identity/Account/Login

- Training | Coding CEs (formerly Practical Application)
  - Select DX 2018-2024 Solid Tumor Rules
    - Colon 2018-2024 Cases 1-5

50

50

Questions

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51

51