ICD-O
Solid Tumor Rules
Heme/Lymph
2025 Updates

IOWA CANCER REGISTRY ANNUAL UPDATES

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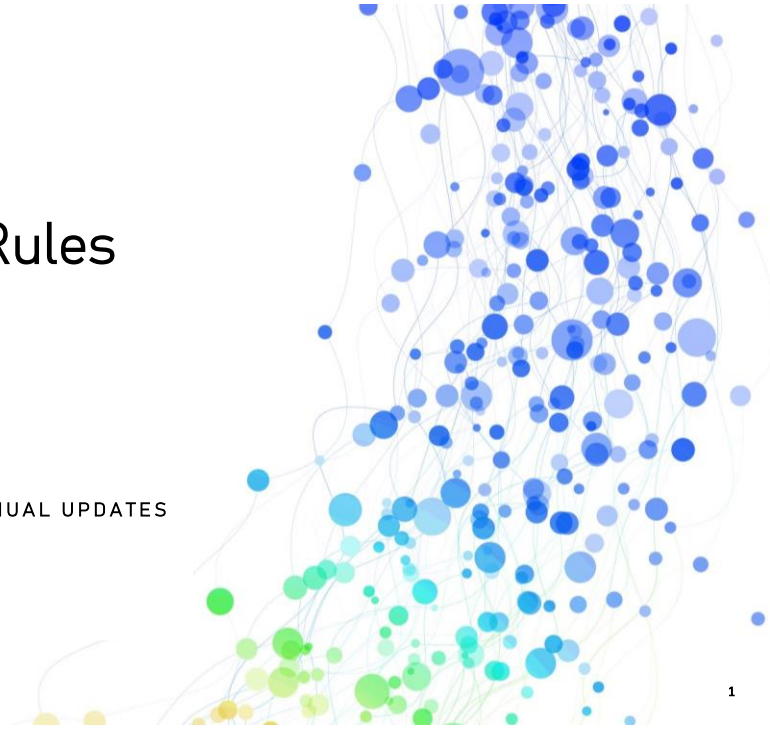
APRIL 2025



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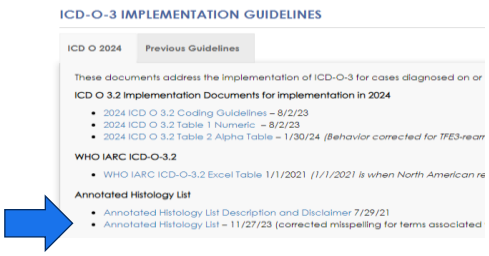
ICD-O

There are **NO** updates for ICD-O for 2025!!!

Continue to use ICD-O updates from 2024



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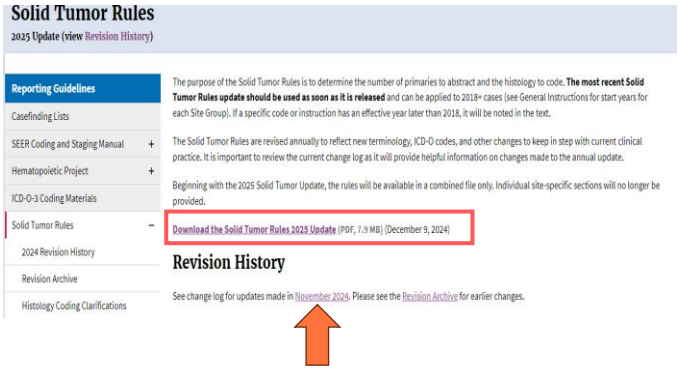
Solid Tumor Rules

- Use the latest manual as soon as it is release don't wait for a specific diagnosis year
- **Download the STR Manual** – don't use from the site
- Consolidated Manual
- **READ** the changes!
  - Revision History – Nov. 2024

https://seer.cancer.gov/tools/solidtumor/



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Changes Across All Sites

- "2007 MPH rules" = **MPH rules**
- "2018 Solid Tumor Rules" = **Solid Tumor Rules**
- "WHO 2010" = **5th edition**
- "Site-Specific Modules" = **Site groups**
- Changes from 2007 MPH Rules sections removed
- "New for _____" sections removed or moved to introduction
- Note about coding histology from most representative specimen moved to H rules
- **Coding Histology Section**: #3B bullet 1: "Pathologist" replaced by "Surgeon"

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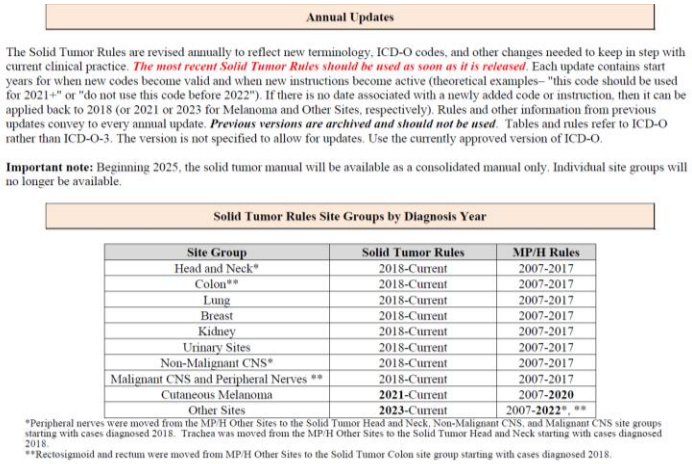
General Instructions



Annual Updates

The Solid Tumor Rules are revised annually to reflect new terminology, ICD-O codes, and other changes needed to keep in step with current clinical practice. ***The most recent Solid Tumor Rules should be used as soon as it is released.*** Each update contains start years for when new codes become valid and when new instructions become active (theoretical examples– "this code should be used for 2021+" or "do not use this code before 2022"). If there is no date associated with a newly added code or instruction, then it can be applied back to 2018 (or 2021 or 2023 for Melanoma and Other Sites, respectively). Rules and other information from previous updates convey to every annual update. ***Previous versions are archived and should not be used.*** 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.

Important note: Beginning 2025, the solid tumor manual will be available as a consolidated manual only. Individual site groups will no longer be available.

Solid Tumor Rules Site Groups by Diagnosis Year

Site Group	Solid Tumor Rules	MP/H Rules
Head and Neck*	2018-Current	2007-2017
Colon**	2018-Current	2007-2017
Lung	2018-Current	2007-2017
Breast	2018-Current	2007-2017
Kidney	2018-Current	2007-2017
Urinary Sites	2018-Current	2007-2017
Non-Malignant CNS*	2018-Current	2007-2017
Malignant CNS and Peripheral Nerves **	2018-Current	2007-2017
Cutaneous Melanoma	**2021**-Current	2007-**2020**
Other Sites	**2023**-Current	2007-**2022***, **

*Peripheral nerves were moved from the MP/H Other Sites to the Solid Tumor Head and Neck, Non-Malignant CNS, and Malignant CNS site groups starting with cases diagnosed 2018. Trachea was moved from the MP/H Other Sites to the Solid Tumor Head and Neck starting with cases diagnosed 2018.
**Rectosigmoid and rectum were moved from MP/H Other Sites to the Solid Tumor Colon site group starting with cases diagnosed 2018.

- NEW Sections Added:
  - Cancer PathCHART Site-Morphology Combination Standards
  - Annual Updates
  - Solid Tumor Rules Site Groups by Diagnosis Year

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How to Navigate the STR

The following functions will help you maneuver within site groups:

- Navigating between hyperlinks –
  - Use the PREVIOUS VIEW button to return to your starting point
    - Enable this button:
      - Right click on the toolbar
      - Select Show Page Navigation Tools
      - Click Previous View (left-pointing arrow will appear on the toolbar)
- Bookmarks –
  - In the left panel, use the bookmarks to quickly jump between sections and subsections
    - Click [+] to expand a bookmark level, showing all sub-levels
    - Click [-] to collapse a bookmark level, showing a main level

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How to Navigate the STR

Footer Links –

- Links in the footer of every page that go to the first page of other sections within a site group

Search Function –

- Press CTRL+F will display a search box
- Enter the desired search term and press ENTER or NEXT
  - Multiple occurrences of the term:
    - Use NEXT button to view consecutive occurrences of the term
    - Use PREVIOUS button to go back to the most recently viewed term

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How to Navigate the STR

Adobe Reader/Acrobat Updates

- Be sure to keep your version of Adobe up to date
- The previous functions may not work on outdated versions

For full performance on mobile operating systems,

- It is recommended that you download the free Adobe Reader app

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Using the STR

Purpose of STR is to determine multiple primaries and code histology ONLY!

Not used to determine reportability, casefinding, stage, or tumor grade

Staging systems are not used to determine the number of primaries or histology

Tumors diagnosed in different years?

Use the later diagnosis year to determine which set of rules to use

- Lung cancer diagnosed in 2015 and another in in 2018 – use STR
- Cutaneous melanoma diagnosed in 2013 and another in 2022 – use 2021 Cutaneous Melanoma Rules (STR)

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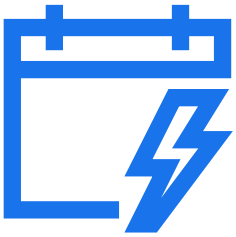

Timing Rules

- Timing rule is included in the Multiple Primary Rules
  - Timing is different by site
  - **One year** = One calendar year
  - **Less than one year** = less than one calendar year
  - **More than one year** = more than one calendar year
- **Clinically-disease free** – No evidence of recurrence on follow-up
  - Recurrence less than or equal to X year of diagnosis the clock starts over
    - Calculate timing rule based on date of last recurrence
  - Recurrence unknown/not documented use date of diagnosis to calculate
- ***Exception***: pathologist compares slides from subsequent tumor to original and documents the subsequent tumor is a recurrence of the previous primary
  - **NEVER** abstract multiple primaries based **ONLY** on a physician's statement of "recurrence" or "recurrent"

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Multiple Primary Rules

- Choose the appropriate module:
  - Unknown if Single or Multiple
  - Single Tumor
  - Multiple Tumors
- Rules are hierarchical within each module – use the first rule that applies and STOP
  - Have a working histology as you begin to walk through the rules
  - Notes and Example are included w/ some of the rules to highlight key points or to add clarity to the rules
- Rule states
  - Single Primary – one abstract
  - Multiple Primaries – two or more abstracts

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Histology Rules

Two Sections:

- Single Tumor
- Multiple Tumor Abstracted as a Single Primary
  - Within each section rules are hierarchical, use first rule that applies and STOP!

Code histology prior to neoadjuvant therapy

- See specific site groups for exceptions to this rule

Do NOT code a histology just to make the case applicable for staging

Follow Histology Coding Instructions in site specific groups

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Site Group Updates

COLON
H&N
LUNG
NON-MALIGNANT CNS
URINARY

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Colon

Multiple Primary Rules:

- Synchronous = tumors existing at the same time; concurrent; prior to first course treatment, simultaneous
- Separate/non-contiguous tumors = arise independently of each other

M Rule – Multiple Tumors

- M3 – Abstract a **Single Tumor** when
  - Adenocarcinoma in situ and/or invasive in at least one polyp **AND**
    - Clinical diagnosis of FAP **OR**
    - More than 100 polyps documented (no FAP diagnosed) **OR**
    - NEW Referred to as polyps carpeting the bowel, small bowel, intestines, etc.

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Colon

Coding Histology Instructions

- Number 4 – Do **NOT** code histology when described as:
  - NEW Phenotype added to list

Single Tumor

- **H5** – LAMN/HAMN 8480/2
  - NEW *Note 4* added:
    - If the pathologist states the LAMN as T3 or T4, continue through the rules

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Head & Neck

Multiple updates to the histology tables

Multiple Tumors

- **M3** – Abstract **Multiple primaries** when there are separate/non-contiguous tumors in and two of the following sites:
  - **Aortic body C755 AND Carotid body C754**

NEW Histology Rules:

- Single Tumor: **H4**
- Multiple Tumors Abstract as Single Primary: **H8**
  - Diagnosis is carcinoma ex pleomorphic adenoma **AND** histologic type of the malignant component is provided, **code the malignant component**
    - ***Note 1***: Carcinoma ex pleomorphic adenoma primarily occurs in the parotid gland, submandibular gland, and salivary gland. Use **Table 6** to code histology
    - ***Note 2***: When the dx is carcinoma ex pleomorphic adenoma, NOS and no other histologic type, **code 8941**

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Lung

- Multiple Tumors
  - M5 – Abstract **Multiple Primaries** when
    - At least one tumor with:
      - NEC or subtype/variant OR
      - NET or subtype/variant
    - AND another tumor with non-small cell carcinoma subtype/variant
  - M9 – Abstract **Single Primary** when there are simultaneous multiple tumors:
    - Both lungs (multiple R and L) OR
    - In SAME lung OR
    - Single tumor one lung; multiple in the other lung

Rule Rewritten

Added

EXCEPTION: Do not apply this rule if:

- Pathology from a biopsy/resection proves tumors are different histologies (see previous rules)
- Attending, oncologist, or pulmonologist state unequivocally that the tumors are different primaries
  - Unequivocal = no ambiguous terms such as "probable" are used in the statement

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Lung

New Notes!!

- Histology Rules – **New** Notes Added
  - Code histology when only one is present
    - H4 – Single Tumor
      - *Note 5*: When histology is carcinoma in situ, NOS, code 8010/3
    - H13 – Multiple Tumors Abstract as Single
      - *Note 4*: When histology is carcinoma in situ NOS, code 8010/3
  - Code adenocarcinoma mixed subtypes 8255
    - H9 – Single Tumor
      - *Note 3*: Cancer PathCHART has determined that 8255 is "unlikely" histology for lung primary sites. If 8255 is appropriate code per the histology rules, override inter-field edit 25 (IF25)
    - H16 – Multiple Tumors Abstract as Single
      - Code appropriate combination code when all tumors have multiple histologies
      - *Note 2*: Cancer PathCHART has determined that 8255 is "unlikely" histology for lung primary sites. If 8255 is appropriate code per the histology rules, override inter-field edit 25 (IF25)

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Malignant CNS

New Note

- Multiple Tumors
  - M11 – Single Primary
    - Separate, non-contiguous tumors are Glioma, NOS and a subtype/variant of Glioma NOS

      Note 1: Glioma, NOS is considered an umbrella term; additional testing should be performed to identify mutations and biomarkers that would provide a definitive type. A diagnosis of glioma, NOS is not recommended and may be used only when additional tests were inconclusive.

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Non-Malignant CNS

New Rules

- **NEW** Rules for low-grade glioma NOS and more specific histology
  - Single Tumor: M5
    - Abstract **single primary** – original diagnosis as low-grade glioma and subsequently recurs in residual tumor w/ a more specific histology
      - ***Note 1***: Low-grade glioma is considered an umbrella term or non-specific diagnosis, primarily seen on imaging. Often the patient is actively followed with scans and surgical intervention delayed or not recommended that would provide a definitive histology type. A diagnosis of low-grade glioma is not recommended and may be used when the diagnosis is based on imaging and/or additional tests as inconclusive.
      - ***Note 2***: If a specific histology is diagnosed in residual tumor or additional testing provides a definitive histology, edit the original abstract as follows:
        - Do not change date of diagnosis
        - Cases already abstracted, update the ICD-O code based on new findings
        - Report all data changes for cases which have been submitted to the central registry
      - ***Note 3***: Timing Irrelevant
  - Multiple Tumors: M13
    - Abstract **single primary** – separate/non-contiguous tumors are Glioma NOS and subtype/variant of Glioma NOS
      - ***Note:*** Low-grade glioma is considered an umbrella term or non-specific diagnosis, primarily seen on imaging. Often the patient is actively followed with scans and surgical intervention delayed or not recommended that would provide a definitive histology type. A diagnosis of low-grade glioma is not recommended and may be used when the diagnosis is based on imaging and/or additional tests as inconclusive.

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Urinary

Updated Rules

- Multiple Tumors
  - M8 – Micropapillary urothelial carcinoma AND urothelial carcinoma is multiple primaries now applies to ALL urinary sites
  - M11 – Abstract single primary when there are urothelial carcinomas in multiple urinary organs, ***exception*** added for micropapillary urothelial carcinoma
  - M12 – Separate/non-contiguous tumor two or more different subtype/variant is multiple primaries
    - *Note 2*: Rule does not apply to urothelial subtypes in the bladder (see previous rules)

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Urinary

- Histology Coding
  - Single Tumor – H4 Updated
    - Code mixed cell carcinoma 8045 when final diagnosis small cell neuroendocrine mixed with any other type of carcinoma (does not apply to sarcoma) – *Reference to small cell carcinoma subtype/variants removed*
  - **NEW** Rules
    - Single Tumor – H5
    - Multiple Tumors Abstract as Single – H11
      - Code combine large cell carcinoma 8013 when the final diagnosis for all tumors is large cell neuroendocrine carcinoma and any other type of carcinoma (doesn't apply to sarcoma)

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Case Scenario 1

3/2/25 25yr old SWF with history of FAP. She is here for screening colonoscopy. Previous biopsies and polypectomies have been benign.

3/2/25 Colonoscopy: polyps present in ascending colon and sigmoid. These were resected endoscopically

3/2/25 Ascending colon, polypectomy: adenocarcinoma in situ; Sigmoid colon, polypectomy: poorly differentiated adenocarcinoma with focal invasion

How many primaries?

A. Multiple – Rule M4
B. Single – Rule M3

Patient has a diagnosis of FAP.
There are 2 polyps with adenocarcinoma
Primary Site: C189

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Case Scenario 2

1/15/25 56yr old patient with several weeks of enlarging and painful salivary gland. This is palpable and need a biopsy.

1/20/25 Salivary gland biopsy: salivary duct carcinoma ex pleomorphic adenoma

What is the correct histology code?

A. Carcinoma ex pleomorphic adenoma – 8941/3
B. Carcinoma 8010/3
C. Duct Carcinoma 8500/3
D. Cystadenocarcinoma 8440/3

Single Tumor –
H4 – code the histologic type of the malignant component

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Case Scenario 3

4/4/25 54yr old patient with chronic non-productive cough for 3 months, thought to be residual from a viral infection; patient has a history of smoking (1ppd x 15yr), quit 2 years ago

4/4/25 Chest x-ray: consolidation and abnormal appearing nodule in the peripheral RUL

4/9/25 CT Chest: 1.3cm RUL nodule suspicious for malignancy, no abnormal LN or other concerns; biopsy recommended

4/14/25 RUL biopsy: carcinoma in situ

What is the correct histology?

A. Carcinoma in situ 8010/2
B. Carcinoma NOS 8010/3
C. Adenocarcinoma in situ 8140/2
D. Adenocarcinoma NOS 8140/3

Single Tumor
Per H4 – code the histology if only one is present
Note 5: For CIS code 8010/3, not 8010/2

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Case Scenario 4

2/5/25 35yr old female with history right frontal lobe glioma diagnosed in 2020, now with increasing headaches, nausea, and vertigo. Need to re-evaluate the glioma and possible biopsy. She underwent Gamma Knife radiation in 2020.

2/14/25 MRI Brain: increased size of the low-grade glioma in the right frontal lobe, concern for possible progression

2/27/25 Stereotactic brain biopsy R frontal lobe: Oligodendroglioma, 1p/19q-codeleted

2020 case is in your registry

Is the 2025 case new?

A. Yes, based on Rule M7

B. No, based on Rule M11

Multiple Tumors –
Rule M11 Abstract a single primary when separate tumors are Glioma NOS and a Subtype/Variant of Glioma

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Case Scenario 5

1/15/25 Patient has a history of high-grade papillary urothelial carcinoma of the right renal pelvis diagnosed and had partial nephrectomy in 2023. Now, has hematuria and left flank pain.

1/15/25 CT A/P: 1.1cm mass in left ureter noted and is suspicious for malignancy

1/16/25 Ureterscopy: mass noted in the distal end of left ureter and biopsied

1/17/25 L ureter biopsy: small cell neuroendocrine carcinoma?

2023 RP case is in your registry

Is the 2025 case new?

A. Yes, based on rule M12

B. No, based on M11

Multiple Tumors –
Per M12 Abstract multiple primaries when separate tumors 2+ different s/v

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Heme/Lymph Updates

PTLD

HHV8-POSITIVE DLBCL

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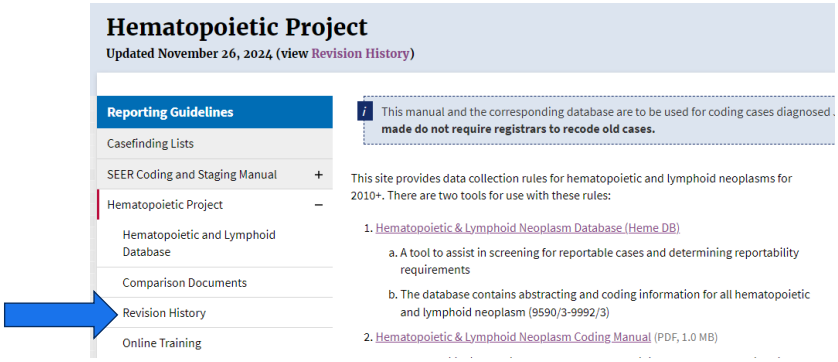
Where to find the updates….



HTTPS://SEER.CANCER.GOV/TOOLS/HEME/

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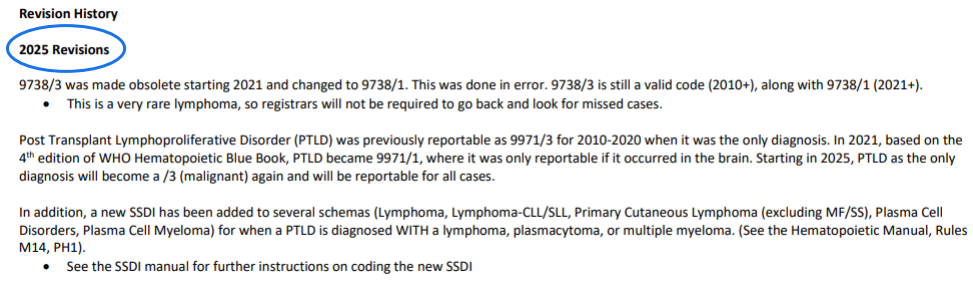
Where to find the updates…

- Heme/Lymph Manual, *page 8*



Revision History

2025 Revisions

9738/3 was made obsolete starting 2021 and changed to 9738/1. This was done in error. 9738/3 is still a valid code (2010+), along with 9738/1 (2021+).

- This is a very rare lymphoma, so registrars will not be required to go back and look for missed cases.

Post Transplant Lymphoproliferative Disorder (PTLD) was previously reportable as 9971/3 for 2010-2020 when it was the only diagnosis. In 2021, based on the 4th edition of WHO Hematopoietic Blue Book, PTLD became 9971/1, where it was only reportable if it occurred in the brain. Starting in 2025, PTLD as the only diagnosis will become a /3 (malignant) again and will be reportable for all cases.

In addition, a new SSDI has been added to several schemas (Lymphoma, Lymphoma-CLL/SLL, Primary Cutaneous Lymphoma (excluding MF/SS), Plasma Cell Disorders, Plasma Cell Myeloma) for when a PTLD is diagnosed WITH a lymphoma, plasmacytoma, or multiple myeloma. (See the Hematopoietic Manual, Rules M14, PH1).

- See the SSDI manual for further instructions on coding the new SSDI

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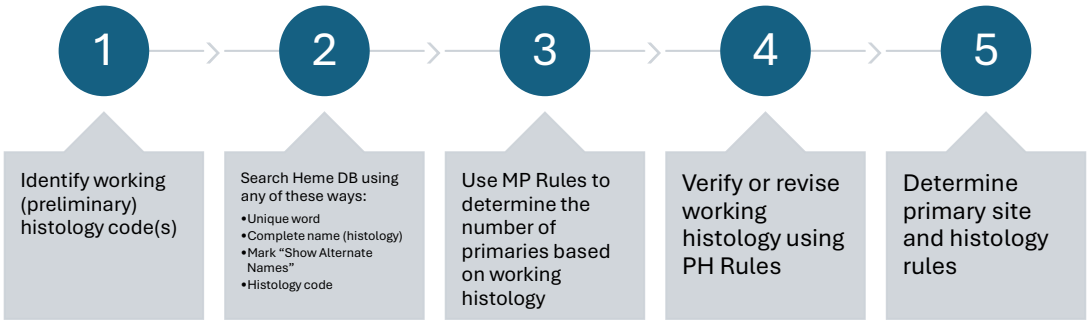
Steps for Using Heme DB and Manual



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Ambiguous Term

- "Consistent with" is historically and currently considered ambiguous terminology
  - Becoming the standard of reporting Heme diagnoses

- For Heme Neoplasms **ONLY**
  - "Consistent with" is a definitive diagnosis
  - This is **NOT** an ambiguous term

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2025 Reportability Updates

- HHV8-positive diffuse large B-cell lymphoma **9738/3**
  - Inadvertently made obsolete in 2021
  - This is a very rare lymphoma
  - It should have stayed reportable and is to be collected moving forward (2010+)
    - No need to go back and look for possible missed cases

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Types of PTLD

SSDI

- **Polymorphic PTLD** Reportable Histology
  - PTLD by itself, no accompanying lymphoma, plasmacytoma, or other type of Hematopoietic neoplasm
- **Monomorphic PTLD**
  - Most common and is associated with a malignant hematopoietic neoplasm
    - Most common, but not limited to, DLBCL and Burkitt lymphoma
- **Classic Hodgkin lymphoma-PTLD type**
  - Reed-Sternberg cells which are associated w/ Hodgkin Lymphoma are present
- **PTLD, NOS**
  - Used when only PTLD is documented and there is no mention of monomorphic or Hodgkin like type
  - Also used for **Burkitt-like PTLD**

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2025 Reportability Updates

- Post Transplant Lymphoproliferative Disorder (PTLD) **9971/3**
  - **NOT** in conjunction with:
    - Lymphoma
    - CLL/SLL
    - Plasma cell disorders
    - Plasma cell myeloma
    - Primary cutaneous lymphoma

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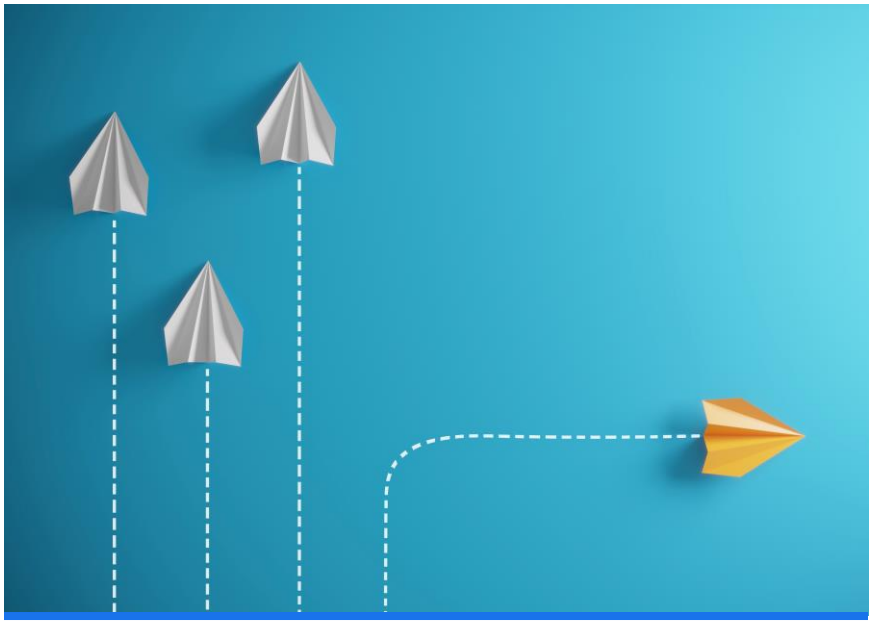

Thank you!

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