Exception 1: If the physician treats a patient for a reportable diagnosis in spite of the negative biopsy, report the case.

Exception 2: If enough time has passed that it is reasonable to assume that the physician has seen the negative pathology, but the clinician continues to call this a reportable diagnosis, report the case. A reasonable amount of time would be equal to or greater than 6 months.

The physician, however, may not always be certain, nor the recorded language definitive. The terminology used to describe a reportable diagnosis may be vague or ambiguous. The following lists should be used as a guide in determining reportability.

Ambiguous Terminology

Ambiguous terminology may originate from any source document, such as pathology report, radiology report, or clinical report. If any of the reportable **ambiguous terms precede** a word that is **synonymous** with an in situ or invasive tumor (e.g.: cancer, carcinoma, malignant neoplasm, etc.) or a benign or borderline tumor of the brain, CNS or other intracranial site, the case is reportable. Abstract the case.

Ambiguous terms that are reportable	
Apparent(ly)	Most likely
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect(ed)
Consistent with	Suspicious (for)
Favor(s)	Typical (of)
Malignant appearing	
For site codes C70.0-C72.9; C75.1-C75.3 only	
Neoplasm	Tumor

Ambiguous terms that are not reportable (Do not report cases with a diagnosis based on only these terms)	
Cannot be ruled out	Questionable
Equivocal	Rule(d) out
Possible	Suggests
Potentially malignant	Worrisome

Note*: Do not accession a case based only on suspicious cytology. The case is accessioned if proven by positive cytology or other diagnostic methods including a physician's clinical diagnosis. See the data item Diagnostic Confirmation for methods of diagnosis.*

In Situ Lesion Followed By Invasive Malignancy in the Same Primary Site

For cases diagnosed prior to 2007, a major difference between CoC and SEER reporting rules was the SEER requirement to report, as a new primary, invasive malignancies that occur in the same primary site more than two months after an in situ lesion of the same histologic type, even if the invasive malignancy is stated to be a recurrence. These cases must be reported to the MCR per NPCR requirements. Hospitals with CoC-approved Cancer Programs may not wish to include them in their databases as analytic cases. The MCR suggests that CoC-approved hospitals abstract these cases and submit a copy of the paper abstract to the MCR. Case status may be flagged as "Reviewed/ reportable to central registry", in the hospital's database.

For cases diagnosed on or after January 1, 2007, the new Multiple Primary and Histology Coding Rules will be followed by all standard setters, including the CoC, so there is no need to submit these cases separately.

Analytic and Nonanalytic Cases

Class of case is a Commission on Cancer (CoC) concept that does not directly apply to a central registry; however, it is a convenient way to define the types of cases that must be reported. Although the CoC does not require hospitals to abstract nonanalytic cases, population-based cancer registries, such as the MCR, must collect all cases regardless of place of diagnosis or CoC class of case. The MCR, therefore, requires that nonanalytic cases, which have not been previously reported by your hospital, be abstracted and submitted to the MCR. An abstract is required regardless of whether or not the patient was diagnosed elsewhere previously. Because much of the information regarding initial diagnosis, stage and treatment on such patients is often not available to the reporting hospital, the MCR reporting requirements for nonanalytic cases are less stringent than for analytic cases. Information contained in the medical record should be reported, but it is not necessary to acquire missing information.

Commission on Cancer (CoC) Class of Case Definitions	
Case	**Includes**
Analytic Cases	
Class 0	Diagnosis at the accessioning facility and all of the first course of treatment was performed elsewhere or the decision not to treat was made at another facility. • Patients diagnosed at the accessioning facility who choose to be treated elsewhere. • Patients diagnosed at the accessioning facility who are referred elsewhere for treatment.
Class 1	Diagnosis at the accessioning facility, and all or part of the first course of treatment was performed at the accessioning facility. • Patients diagnosed at the accessioning facility whose treatment plan is either not to treat or watchful waiting. • Patients diagnosed at the accessioning facility who refuse treatment. • Patients diagnosed at the accessioning facility who are not treatable or who were given palliative care only due to age, advanced disease, or other medical conditions. • Patients diagnosed at the accessioning facility for whom it is unknown whether treatment was recommended or administered. • Patients diagnosed at the accessioning facility for whom treatment was recommended, but it is unknown whether it was administered. • Patients diagnosed at a staff physician's office who receive their first course of treatment at the accessioning facility. "Staff physician" refers to any medical staff with admitting privileges at the accessioning facility. • Patients diagnosed at the accessioning facility who received all or part of their first course of treatment in a staff physician's office.
Class 2	• Diagnosis elsewhere, and all or part of the first course of treatment was performed at the accessioning facility. • Diagnosed elsewhere and provided palliative care in lieu of first course treatment, or as part of the first course of treatment, at the accessioning facility.
Nonanalytic Cases	
Class 3	Diagnosis and all of the first course of treatment was performed elsewhere. • Patients treated at the accessioning facility for whom no information on first course of treatment is available. • Patients for whom the accessioning facility developed a treatment plan or provided "second opinion" services, but the diagnosis and treatment was provided elsewhere. • Patients treated for recurrence or progression for a previously diagnosed malignancy.

Commission on Cancer (CoC) Class of Case Definitions	
Class 4	Diagnosis and/or first course of treatment was performed at the accessioning facility prior to the reference date* of the registry. • Patients for whom the accessioning facility manages or treats a recurrence or progression of disease after the reference date. • Patients for whom it is unknown whether the accessioning facility delivered the first course of treatment prior to the reference date.
Class 5	Diagnosed at autopsy. • Prior to autopsy, there was no suspicion or diagnosis of cancer.
Class 6	Diagnosis and all of the first course of treatment was completed by the same staff physician in an office setting. "Staff physician" refers to any medical staff with admitting privileges at the accessioning facility.
Class 7	Pathology report only. Patient does not enter the accessioning facility at any time for diagnosis or treatment. This category excludes cases diagnosed at autopsy.
Class 8	Diagnosis was established by death certificate only. *Used by central registries only*.
Class 9	Unknown. Sufficient detail for determining Class of Case is not stated in patient record. *Used by central registries only*. • Unknown if previously diagnosed. • Unknown if previously treated. • Previously diagnosed, date unknown.

* Reference Date is the start date after which all eligible cases must be included in the registry.

II. IDENTIFICATION OF THE PRIMARY NEOPLASM

General Instructions

To ensure the accurate reporting of cancer incidence in Maine and to stage each cancer properly, it is essential that the primary neoplasm be identified accurately. The primary site, the organ or place in the body where the neoplasm first originated, is always coded. The MCR follows the SEER Program's rules and definitions for determining whether lesions are single or multiple primaries. Basic factors include the site of origin, date of diagnosis, histologic type, behavior of the neoplasm (i.e., benign vs. uncertain vs. malignant) and laterality.

Histology must be taken into account when determining the number of primaries that must be reported. Conversely the number of primaries being reported affect how histology is coded. The two are closely inter-related and cannot be considered separately. This section discusses three major issues: (1) determining multiple primaries for solid malignant tumors; (2) determining multiple primaries for hematopoietic (leukemias and lymphomas) malignancies and (3) determining multiple primaries for non-malignant tumors of the brain and central nervous system and other intracranial sites.

Use the 2007 Multiple Primary and Histology Coding Rules (see page 14 of this manual) to determine the number of primaries to report and for coding histology for solid malignant tumors diagnosed on or after January 1, 2007. For cases diagnoses prior to 2007, follow the rules on pages 14a – 20 of this manual.

The primary neoplasm is the original lesion, as opposed to a tumor that has developed as a result of metastasis or extension. It is particularly important that metastatic lesions be distinguished from the primary lesion. Metastatic lesions are the result of the dissemination of tumor cells from the primary site to a remote part of the body. These new lesions do not represent primary tumors. Information regarding the nature of the primary versus metastatic lesions is most often found in pathology reports. The term "secondary" is often used to describe metastatic lesions.

Note: A separate MCR patient abstract must be submitted for each independent primary neoplasm seen at the reporting hospital. Do not code metastatic site(s) of a tumor; report the primary site. If the primary site cannot be identified, code as unknown primary site (C80.9).

Follow the instructions in the ICD-O-3 section, "Coding Guidelines for Topography and Morphology" to code *Primary Site, Histology, Behavior Code* and *Grade/Differentiation*. For cases diagnosed prior to 2001, the ICD-O-2 coding rules must be used. The instructions for coding primary site are found in the "Topography" section (pp 23-26) of the ICD-O-3 "Coding Guidelines for Topography and Morphology." Use the alphabetic index in ICD-O-3 to assign the most specific site.

Certain histologies represent special circumstances. The following guidelines should be followed for consistent analysis of primary site for lymphomas, Kaposi sarcomas and melanomas.

Lymphoma

- Code lymphomas arising in lymphatic tissue or nodes to the site of origin. The lymphatic sites are Lymph Node(s) C77._, Tonsil C09._, Spleen C42.2, Waldeyer's ring C14.2, and Thymus C37.9.

- Code extralymphatic lymphomas (lymphatic cells in nonlymphatic organs such as intestine or stomach) to the organ of origin (Intestine C26.0, Stomach C16.0–C16.9).

- Code mycosis fungoides and cutaneous lymphomas to Skin (C44._).

- Code to Lymph Nodes, NOS (C77.9) when:

    1) the site of origin is not identified for a lymphoma.

    2) a patient has diffuse lymphoma and a primary site is unknown or not specified.

    3) a lymphoma mass is identified as "retroperitoneal," "inguinal," "mediastinal," or "mesentery," and no specific information is available to indicate what tissue is involved.

    4) bone marrow metastases are present and the primary site of a lymphoma is unknown or not specified.

- Code to Lymph Nodes, Multiple Regions (C77.8) when multiple lymph node chains are involved with disease.

    Note: *Carefully identify the origin of the tumor. Do not code the biopsy site or a metastatic site as the primary site. Lymphoma may be present in both an extranodal organ and one or more lymph node chains. Code the primary site as the extranodal organ or the lymph nodes as directed by the managing physician or physician advisor.*

Kaposi Sarcoma

- Code Kaposi sarcoma to the site in which it arises.

- Code to Skin (C44.9) if Kaposi sarcoma arises simultaneously in the skin and another site or the primary site is not identified.

Melanoma

- Code to Skin, NOS (C44.9) if a patient is diagnosed with metastatic melanoma and the primary site is not identified.

Determining Multiple Primaries: Solid Malignant Tumors
2007 Multiple Primaries and Histology Coding Rules

The 2007 Multiple Primary and Histology (MP/H) coding rules must be used to determine the number of primaries and to code histology for tumors diagnosed on or after January 1, 2007 (including non-analytic cases). They replace all previous multiple primary and histology coding rules. Do not apply the 2007 rules to cases diagnosed prior to 2007. In addition, do not use the 2007 rules to recode cases diagnosed prior to 2007.

The 2007 Multiple Primary and Histology Coding Rules may be downloaded from the SEER website: http://www.seer.cancer.gov/tools/mphrules/download.html.

The new multiple primary rules are still based on the number of tumors, anatomic site, histology, and date of diagnosis of cancer. The major changes are that the new rules are site specific and the time between primary tumors is no longer defined as 2 months.

There are site specific Multiple Primary and Histology coding rules for the following eight site groups, excluding leukemia and lymphoma (M9590-9989) and Kaposi sarcoma (M9140):

- Head and neck [C00.0-C14.8, C30.0-C32.9]
- Colon [C18.0-C18.9]
- Lung [C34.0-C34.9]
- Melanoma of skin [C44.0-C44.9 with Histology 8720-8780]
- Breast [C50.0-C50.9]
- Kidney [C64.9]
- Renal pelvis, ureter and bladder [C65.9, C66.9, C67.0-C67.9, C68.0-C68.9]
- Malignant brain and CNS [C70.0, C70.1, C70.9, C71.0-C71.9, C72.0-72.5, C72.8, C72.9, C75.1-C75.3]

A ninth set of rules covers all other sites (except benign and borderline brain and CNS tumors and hematopoietic malignancies) for solid malignancies. Solid tumors of unknown primary site should also be coded using the *Other Sites* histology coding rules.

Benign and borderline brain and CNS tumors, along with hematopoietic malignancies, are not covered in the 2007 multiple primary and histology coding rules. The pre-existing multiple primary and histology coding rules should be used for benign and borderline brain and CNS tumors and for reportable hematopoietic diseases (see pages 21 & 22 of this manual).

Note: The 2007 rules replace the SEER site grouping table on page 16 of this manual.

Added 01/07

Determining Multiple Primaries: Solid Malignant Tumors

[*SEER Program Coding and Staging Manual 2004* pp. 7-17]

The following rules and definitions apply to tumors diagnosed prior to 2007. Use the 2007 Multiple Primary and Histology Coding Rules for tumors diagnosed on or after January 1, 2007.

Terms:

For the purposes of determining single vs. multiple primaries, the words "**tumor**," "**neoplasm**," "**mass**" and "**lesion**" are used interchangeably in this section. The terms "**original**" and "**initial**" are synonymous.

Definitions:

Focal: Limited to one specific area.

Foci/focus: The starting point of a disease process, a single cell.

Laterality: Describes the right or left side of the body or the right or left of a paired organ, such as the right kidney or the left kidney. **Unilateral** describes a single organ/side. **Bilatera**l describes both organs/sides.

Metachronous tumors: Multiple tumors or lesions that occur greater than two months from the original/initial diagnosis.

Multicentric: A primary tumor with satellites in surrounding tissue.

Multifocal: Multiple tumors arising from two or more locations.

Multiple primaries: Two or more independent primary reportable neoplasms.

Non-synchronous (Metachronous) tumors: Multiple masses or lesions that occur greater than two months after the original/initial diagnosis.

Paired Organ: Two separate organs, a right and a left. For example, right breast and left breast.

Primary site: The anatomic portion of the body where the cancer originated.

Simultaneous tumors: Multiple tumors identified at the time of diagnosis.

Synchronous tumors: Multiple tumors diagnosed within two months of the original/initial diagnosis.

Single primary: One distinctive reportable cancer.

Single tumor: A single lesion. A single tumor may invade regional organs by traveling along the mucosa or extending through the organ wall into regional tissue or organ. A single tumor may have multiple or mixed histologies.

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Same Vs. Different Primary Site Based On ICD-O-3 Topography Code
(tumors diagnosed prior to 2007)

1. **The third numeric digit after the 'C' describes a subsite of the organ; it is not used to define individual (different) sites.**

   Example: C50_ is the code for breast and the third numeric digit, C505 describes a subsite of the breast, the lower-outer quadrant.

   ***Exceptions*:** For the following sites, a difference in the third numeric digit designates a different primary site:

   Colon (C18_)
   Anus and anal canal (C21_)
   Bones, joints, and articular cartilage (C40_- C41_)
   Melanoma of skin (C44_)
   Peripheral nerves and autonomic nervous system (C47_)
   Connective, subcutaneous and other soft tissues (C49_)

   Example: If the patient has a melanoma on the skin of the scalp (C444) and another melanoma on the calf of the right leg (C447), these are two different primary sites because the third numeric digit of the site code is different.

2. **If the first two numeric digits after the C are identical, it is the same site.**

   Example: If there is a tumor in the lower outer quadrant of the right breast (C505) and a separate tumor in the upper outer quadrant of the right breast, (C504), it is the same site.

   Possible exception: There are specific rules for paired organs. See the Multiple Primary Rules.

3. **If there is any difference in the first two numeric digits after the C, it is a different site.**

   Example: Stomach, NOS (C169) and small intestine, NOS (C179) are different sites because the second numeric digit is not identical.

   Exception: **ICD-O-1** and **ICD-O-2/ICD-O-3 groupings**: The second edition of the *International Classification of Diseases for Oncology* (ICD-O-2) split several site codes into categories having differences in the second numeric digit after the C. The second and third edition ICD-O topography codes are identical. The SEER Program continues to use most of the ICD-O-1 subcategory site groupings (See page 16) to prevent artificial changes in site-specific incidence. When the patient has **multiple independent** tumors, any combination of site codes within the same row in the table are the same primary site. Use this table for in situ and/or invasive tumors. (Do not use this table for a single tumor with extension into another site).

SEER Site Grouping Table for Cases Diagnosed prior to 2007*

Refer to the 2007 MP/H Coding Rules for cases diagnosed on or after January 1, 2007
The purpose of this table is to group sites that are treated as a single site when abstracting a case.

ICD-O-3 Code	Site Groupings	Code To
C01 C02	Base of tongue Other and unspecified parts of tongue	C029 Tongue, NOS
C05 C06	Palate Other and unspecified parts of mouth	C069 Mouth, NOS
C07 C08	Parotid gland Other and unspecified major salivary glands	C089 Major salivary glands, NOS
C09 C10	Tonsil Oropharynx	C109 Oropharynx, NOS
C12 C13	Pyriform sinus Hypopharynx	C139 Hypopharynx, NOS
C23 C24	Gallbladder Other and unspecified parts of the biliary tract	C249 Biliary tract, NOS
C30 C31	Nasal cavity and middle ear Accessory sinuses	C319 Accessory sinuses, NOS
C33 C34	Trachea Bronchus and lung	C349 Lung, NOS
C37 C380 C381-3 C388	Thymus Heart Mediastinum Overlapping lesion of heart, mediastinum, and pleura	C383 Mediastinum, NOS
C51 C52 C577 C578-9	Vulva Vagina Other specified female genital organs Unspecified female genital organs	C579 Female genital tract, NOS
C569 C570 C571 C572 C573 C574	Ovary Fallopian tube Broad ligament Round ligament Parametrium Uterine adnexa	Code C569 (ovary) when ovary is one of the involved sites Code C579 (female genital tract, NOS) when only non-ovarian sites are involved.
C60 C63	Penis Other and unspecified male genital organs	C639 Male genital organs, NOS
C64 C65 C66 C68	Kidney Renal pelvis Ureter Other and unspecified urinary organs	Code C649 when one of the involved organs is kidney Code C689 (Urinary system, NOS) when only non-kidney sites are involved
C74 C75	Adrenal gland Other endocrine glands and related structures	C759 Endocrine gland, NOS

** **Note:** This table is not identical to the table in ICD-O-3. Two combinations of sites are listed in the ICD-O-3 but not in the SEER table: C19 (rectosigmoid) and C20 (rectum) and C40 (bones of limbs) and C41 (bonesof other sites). Multiple tumors in the rectosigmoid and rectum are different sites. Multiple tumors in C40 and C41 are different sites.*

Rev 01/07

Same Vs. Different Histology Based On ICD-O-3 Histology Codes

If the first three digits of the ICD-O-3 histology codes are the same, it is the same histology.

> ***Exception:*** The ICD-O-3 histology code for non-small cell carcinoma (8046) is a separate morphology group from the small cell histologies (codes 8040 – 8045). Even though the first three digits are the same, they are different histologies.

Multiple Primary Rules for Single Tumor (tumors diagnosed prior to 2007)

Rule 1: **A single lesion composed of one histologic type is a single primary, even if the lesion crosses site boundaries.**

> ***Example 1:*** A single lesion involving the tongue and floor of mouth is one primary.
>
> ***Example 2*****:** A single, large mucinous adenocarcinoma involving the sigmoid and descending colon segments is one primary.

Rule 2: A single lesion composed of multiple (different) histologic types is a single primary even if it crosses site boundaries.

The most frequent combinations of histologic types are listed in ICD-O-3. For example, combination terms such as "adenosquamous carcinoma (8560/3)" or "small cell-large cell carcinoma (8045/3)" are included. A single lesion composed of mixed or multiple histologies is a single primary.

> ***Example 1:*** A single lesion containing both embryonal cell carcinoma and teratoma is a single primary and would be coded to 9081/3, mixed embryonal carcinoma and teratoma.
>
> ***Example 2:*** A single lesion of the liver composed of neuroendocrine carcinoma (8246/3) and hepatocellular carcinoma (8170/3) is a single primary and would be coded to the more specific histology, neuroendocrine carcinoma (8246/3).

Multiple Primary Rules for Multiple Tumors (tumors diagnosed prior to 2007)

Rule 3a: Simultaneous multiple lesions of the same histologic type within the same site (i.e., multi*focal* tumors in a single organ or site) are a single primary. If one lesion has a behavior code of in situ /2 and the other lesion has a behavior code of malignant /3, this is a single primary whose behavior is malignant /3.

> ***Example 1****:* At nephrectomy, two separate, distinct foci of renal cell carcinoma are found in the specimen, in addition to a 3.5 cm primary renal cell carcinoma. Abstract as one primary.

Example 2: At mastectomy for removal of a 2 cm invasive ductal carcinoma, an additional 5 cm area of intraductal carcinoma was noted. Abstract as one invasive primary.

Rule 3b: If a new cancer of the same histology as an earlier one is diagnosed in the same site within two months, this is a single primary cancer.

Example: Adenocarcinoma in adenomatous polyp (8210) in sigmoid colon was removed by polypectomy in December 2004. At segmental resection in January 2005, an adenocarcinoma in a tubular adenoma (8210) adjacent to the previous polypectomy site was removed. *Count as one primary.*

Rule 4: If both sides of a paired organ are involved with the same histologic type within two months of the initial diagnosis

a. It is one primary if the physician states the tumor in one organ is metastatic from the other.

   i. Code the laterality to the side in which the primary originated.

   ii. Code the laterality as 4 if it is unknown in which side the primary originated.

b. Code as multiple primaries if the physician states these are independent primaries or when there is no physician statement that one is metastatic from the other.

Exception 1: Simultaneous bilateral involvement of the **ovaries** with the same histology is one primary and laterality is coded '4' when it is unknown which ovary was the primary site.

Exception 2: Bilateral **retinoblastomas** are a single primary with laterality of '4'.

Exception 3: Bilateral **Wilms** tumors are always a single primary with laterality of '4.'

Rule 5: If a tumor with the same histology is identified in the same site at least two months after the initial/original diagnosis (metachronous), this is a separate primary.

Exception 1: This is a single primary only when the physician documents that the initial/original tumor gave rise to the later tumor.

Example 1*:* Infiltrating duct carcinoma of the <u>upper outer quadrant</u> of the right breast diagnosed March 2004 and treated with lumpectomy. Previously unidentified mass in <u>lower inner quadrant</u> right breast noted in July 2004 mammogram. This was removed and found to be infiltrating duct carcinoma. Abstract the case as two primaries.

Example 2*:* During the workup for a squamous cell carcinoma of the vocal cord, a second squamous cell carcinoma is discovered in the tonsillar fossa. Abstract as two primaries.

Exception 2: **If an in situ tumor is followed by an invasive cancer in the same site more than two months apart, report as two primaries <u>even if stated to be a recurrence</u>. The invasive primary should be reported with the date of the *invasive* diagnosis.**

Note: The purpose of Exception 2 is to ensure that the case is counted as an incident case (i.e., invasive) when incidence data are analyzed.