CODING COMPLEX MORPHOLOGIC DIAGNOSES

CODING COMPLEX BREAST HISTOLOGIES
Applying these guidelines in priority order. Use the first guideline that applies and stop.

Single Tumors with Complex Histology

1. If the diagnosis is both lobular and ductal (in situ or invasive or a combination), use code 8522.
Examples: Duct carcinoma and lobular carcinoma in situ -- code as 8522/3.
LCIS and DCIS -- code as 8522/2.

2. If the diagnosis is mixed invasive and in situ, code the invasive diagnosis.
Examples: Ductal carcinoma with extensive cribriforming DCIS -- code as 8500/3
Mucinous carcinoma in a background of ductal carcinoma in situ -- code as 8480/3
Infiltrating ductal carcinoma with DCIS, solid, cribriform and comedo type -- code as ductal carcinoma, 8500/3.

3. Use a combination code if the diagnosis is duct carcinoma or lobular carcinoma mixed with another type of carcinoma.

Examples: Duct carcinoma and tubular carcinoma -- code as 8523/3.
DCIS and cribriform carcinoma in situ -- code as 8523/2

4. Code the specific type if the diagnosis is duct carcinoma, ______ type
Duct carcinoma, predominantly ______
Duct carcinoma with features of ______
Code the stated type (subtype) even if the code is lower than 8500.
Look for the term “type,” “subtype,” or “variant” or terms that indicate the majority of the tumor.
Examples: Duct carcinoma, tubular type -- code as ductal carcinoma, 8211
Duct carcinoma with apocrine features -- code as apocrine carcinoma, 8401/3

5. If the diagnosis includes more than one subtype, use a combination code.
Examples: Duct carcinoma, cribriform and comedo types -- code as 8523/3.
Duct carcinoma in situ, showing both solid and cribriforming subtypes -- code as 8523/2

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CODING COMPLEX MORPHOLOGIC DIAGNOSES

(Continued from page 1)

Separate Tumors of Different Histologies in One Breast

6. If different histologies occur in separate tumors in the same breast, use a combination code if possible and count the case as a single primary.

Examples: LCIS UIQ right breast and duct carcinoma LIO -- code as 8522/3 Paget disease of nipple and intraductal carcinoma, UOQ -- code as 8543/3

HISTOLOGY CODES FOR INVASIVE BREAST CANCERS

Histology code must reflect the invasive tumor; terms include invasion, infiltrating, infiltration

I. Invasive only, single type, no in situ component

- Invasive adenocarcinoma 8140/3
- Invasive ductal (duct) carcinoma 8500/3
- Invasive lobular carcinoma (NOS and subtypes) 8520/3
- Tubular carcinoma 8211/3
- Mucinous (colloid) carcinoma 8480/3
- Medullary carcinoma 8510/3
- Adenoid cystic carcinoma 8200/3
- Intraductal papillary carcinoma with invasion 8503/3
- Apocrine adenocarcinoma 8401/3
- Metaplastic carcinoma 8575/3

II. Invasive only, 2 or more types, no in situ component

- Invasive ductal and lobular 8522/3
- Invasive ductal and mucinous (colloid) 8523/3
- Invasive ductal and tubular 8523/3
- Invasive ductal and cribriform (cribriform also invasive) 8523/3
- Invasive lobular and other types (except ductal) 8524/3

III. Invasive, one type, with DCIS or/and LCIS present

- Invasive ductal and DCIS (loses the DCIS) 8500/3
- Invasive lobular and DCIS 8522/3
- Invasive ductal and LCIS 8522/3
- Invasive lobular and LCIS (loses the LCIS) 8520/3
- Invasive, 2 or more types, with DCIS or/and LCIS
  Code as in category II; the CIS will be lost

HISTOLOGY CODES FOR NON-INVASIVE BREAST CANCERS

No invasion present (DCIS and/or LCIS only)

I. Intraductal (ductal carcinoma in situ, DCIS) only

- DCIS papillary (intraductal papillary) 8503/2
- DCIS micropapillary or clinging 8507/2
- DCIS cribriform 8201/2
- DCIS solid 8230/2
- DCIS comedo 8501/2

II. Intraductal, with one subtype specified

- DCIS papillary (intraductal papillary) 8503/2
- DCIS micropapillary or clinging 8507/2
- DCIS cribriform 8201/2
- DCIS solid 8230/2
- DCIS comedo 8501/2

III. Intraductal, with two or more subtypes specified 8523/2

IV. Intraductal (lobular carcinoma in situ, LCIS) only

- Invasive ductal and LCIS 8522/3
- Both DCIS and LCIS (any DCIS subtypes will be lost) 8522/2

Examples of Complex Breast Diagnoses (coded, with comments)

Assume these examples are single primaries.

8401/3 Core needle breast bx: PD infiltrating ductal carcinoma with apocrine subtype of ductal ca. Code the stated subtype of the invasive component.

8500/3 FNA L breast mass, UIQ: Atypical hyperplasia with clusters suspicious for carcinoma.

Needle localization (L breast, UOQ) followed by exc bx: Scirrhous ductal carcinoma and DCIS (comedo pattern); TS = 1.8 x 2.0 x 2.0 cm; extensive cribriforming noted. Margins of resection are clean.

Code the invasive component.

“Scirrhous” is an adjective meaning “hard” Although it has a code in ICD-O-3, ductal carcinoma is the more precise term. According to our medical advisor, ignore “scirrhous” when it is used in combination with another histologic descriptor. If the term is “scirrhous carcinoma,” code as 8141/3.

8507/3 Infiltrating ductal ca; focal micropapillary invasive pattern and intralymphatic tumor are additional features.

Use the “micropapillary invasive” information to code the more specific term.

8520/3 Infiltrating lobular ca, pleomorphic variant, measuring 5.4 cm.

A pleomorphic variant (subtype) of lobular carcinoma is not the same as pleomorphic carcinoma. Code as lobular carcinoma, NOS.

8522/2 Right breast lumpectomy specimen: Extensive in situ carcinoma with mixed ductal and lobular features and the following characteristics:

1) Two foci suspicious but not definitive for invasion.
2) Solid and cribriform histologic patterns.

Use the guidelines in order. Code the ductal and lobular combination. For coding purposes, any ductal carcinoma subtype should be treated as ductal carcinoma when seen in combination with lobular carcinoma or LCIS.

(Continued on page 5)
The North American Association of Central Cancer Registries' 2003 Implementation Workgroup has completed its task and is pleased to announce the release of the "2003 Implementation Guidelines and Recommendations." In coordination with NAACCR, this document should be available January 9 on the American College of Surgeons Web site at: http://www.facs.org/dept/cancer/coc/standards.html, and will be available from the NAACCR Web site on Monday, January 13, 2003.

The "2003 Implementation Guidelines and Recommendations" were developed by a group that included representatives from the CoC, SEER, NPCR, NCRA, state central cancer registries, and cancer registry software vendors. This collaboration was necessary to ensure that the "Guidelines and Recommendations" were developed to assist all levels of cancer registry activity and to help ease the transition from ROADS to FORDS (NAACCR Version 9.1 to Version 10 standards). The goal of the "Guidelines and Recommendations" is to ensure that data transmission standards are consistently maintained among all facility and central registries and that these standards be implemented in a planned and timely manner.

The CoC understands that cancer registry software providers/developers will likely be able to deliver FORDS compatible software before the end of the second quarter of 2003--this is contingent upon deliverables per the "2003 Implementation Guidelines and Recommendations." Completion of the software updates is dependent on a number of factors including: 1) the release of the "2003 Implementation Guidelines and Recommendations;" 2) revisions to the CoC's conversion rules and computer algorithm which facilitates the ROADS to FORDS transition; and 3) the availability of the necessary Version 10 EDITS metafiles. This delay has been unavoidable and beyond the immediate control of the software providers.

Cases diagnosed on or after 01/01/2003 should be entered into a suspense file until your FORDS compatible software upgrade becomes available. After the ROADS to FORDS conversion is complete, suspended cases can be coded and completed using FORDS. Vendors have been advised to provide training on the software upgrades. State central cancer registries have been advised to distribute their implementation plans and timelines to facility registries and vendors as early as possible.

Inquiries about specific FORDS data items and conversions should be referred to the CoC. Any comments/questions about the "2003 Implementation Guidelines and Recommendations" can be submitted to Andrew Stewart at astewart@facs.org.
Seer Updates

Table 24 Errata
Table 24 replaces ICD-0-3, page 36.

Table 24 in the ICD-O-3 is incorrect. The correct Table 24 is as below:

<table>
<thead>
<tr>
<th>ICD-O-2/-3</th>
<th>Site Groupings</th>
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<tbody>
<tr>
<td>C01</td>
<td>Base of tongue</td>
</tr>
<tr>
<td>C02</td>
<td>Other and unspecified parts of tongue</td>
</tr>
<tr>
<td>C05</td>
<td>Palate</td>
</tr>
<tr>
<td>C06</td>
<td>Other and unspecified parts of mouth</td>
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<tr>
<td>C07</td>
<td>Parotid gland</td>
</tr>
<tr>
<td>C08</td>
<td>Other and unspecified major salivary glands</td>
</tr>
<tr>
<td>C09</td>
<td>Tonsil</td>
</tr>
<tr>
<td>C10</td>
<td>Oropharynx</td>
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<td>C12</td>
<td>Pyriform sinus</td>
</tr>
<tr>
<td>C13</td>
<td>Hypopharynx</td>
</tr>
<tr>
<td>C23</td>
<td>Gallbladder</td>
</tr>
<tr>
<td>C24</td>
<td>Other and unspecified parts of biliary tract</td>
</tr>
<tr>
<td>C30</td>
<td>Nasal cavity and middle ear</td>
</tr>
<tr>
<td>C31</td>
<td>Accessory sinuses</td>
</tr>
<tr>
<td>C33</td>
<td>Trachea</td>
</tr>
<tr>
<td>C34</td>
<td>Bronchus and lung</td>
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<tr>
<td>C37</td>
<td>Thymus</td>
</tr>
<tr>
<td>C38.0</td>
<td>Heart</td>
</tr>
<tr>
<td>C38.1-3</td>
<td>Mediastinum</td>
</tr>
<tr>
<td>C38.8</td>
<td>Overlapping lesion of heart, mediastinum, and pleura</td>
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<tr>
<td>C38.4</td>
<td>Pleura (visceral, parietal, NGS)</td>
</tr>
<tr>
<td>C31</td>
<td>Vulva</td>
</tr>
<tr>
<td>C32</td>
<td>Vagina</td>
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<tr>
<td>C57.7</td>
<td>Other specified female genital organs</td>
</tr>
<tr>
<td>C57.8-9</td>
<td>Unspecified female genital organs</td>
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<tr>
<td>C59</td>
<td>Uterus</td>
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<td>Fallopian tube</td>
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<td>Broad ligament</td>
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<td>Round ligament</td>
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<tr>
<td>C57.3</td>
<td>Parametrium</td>
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<tr>
<td>C57.4</td>
<td>Uterine adnexa</td>
</tr>
<tr>
<td>C60</td>
<td>Penis</td>
</tr>
<tr>
<td>C63</td>
<td>Other and unspecified male genital organs</td>
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<tr>
<td>C64</td>
<td>Kidney</td>
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<tr>
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<td>Renal pelvis</td>
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<td>Ureter</td>
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<td>Other and unspecified urinary organs</td>
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<tr>
<td>C74</td>
<td>Adrenal gland</td>
</tr>
<tr>
<td>C75</td>
<td>Other endocrine glands and related structures</td>
</tr>
</tbody>
</table>

Site/Histo Comparison Table

The new site histo comparison table is available on the SEER Website at:

ICD-O-3 SEER Site/Histology Validation List
(6/14/2001 - updated from 2/9/2001)

The listing is provided in both PDF (*.pdf) and Excel (*.xls) formats. The PDF file is intended as a reference file for ICD-O-3 only. Although based on the 2/9/2001 validation list, it has been stripped of redlining and strikeouts.

Also available an Errata for ICD-0-3 Site/Type Validation List dated 9/16/02

EDUCATION AND TRAINING

2003 CTR EXAM

Application Deadline
February 01, 2003

Examination Date
March 15, 2003

FCDS Incidence Abstracting Workshop
March 26-28, 2003
at the
Double Tree Hotel
Coconut Grove, FL

Registration fee: $100.00

For more information please contact
Mayra Alvarez at 305-243-4603.
8522/2 Excision bx right breast: Ductal carcinoma in situ with the following characteristics:
1) Cribriform and solid subtype.
2) Lobular carcinoma in situ.

Use the guidelines in order. Code the ductal and lobular combination.

8522/2 Left breast core needle bx: ductal carcinoma in situ with the following features:
1) Histologic type: cribriform and solid.
Excisional bx:
1) Lobular carcinoma in situ.
2) Rare microscopic foci of ductal carcinoma in situ with the following features:
   a) Histologic type: cribriform.
   3) Microcalcifications associated with DCIS and LCIS.
Use the guidelines in order. Code the ductal and lobular combination.

8522/2 Stereotactic breast bx: DCIS with the following features:
Pattern: cribriform and solid.
Excision bx: residual ductal carcinoma in situ with the following features:
Histologic type: Solid and cribriform types.
Medial margin: Rare foci reaching minimal criteria for lobular carcinoma in situ. Negative for invasive ca.
Code as ductal and lobular.

8522/3 Infiltrating duct ca with focal lobular features and focal mucinous features. There is cribriform DCIS with focal comedonecrosis adjacent to the infiltrating component.

Use a combination code for the invasive component. Use the first guideline and code the lobular and ductal combination.

8522/3 Right breast excisional biopsy: infiltrating ductal carcinoma with areas of metaplastic carcinoma with associated DCIS, cribriform histologic type and multiple foci of lobular carcinoma in situ.

Code the combination of invasive ductal and lobular in situ. “With areas of” does not constitute a majority of tumor.

8522/3 Left breast mass excision:
1) Infiltrating carcinoma with the following features:
   Histologic type: infiltrating ductal carcinoma of apocrine type.
2) Ductal carcinoma in situ with the following features:
   1) Histologic type: Apocrine cell type with papillary and solid architecture.
   2) Scattered foci of lobular carcinoma in situ.
   Use the combination of ductal and lobular.

8522/3 Ductal and papillary carcinoma with separate foci of lobular ca.

Use the guidelines in order. Use the combination code of ductal and lobular.

8523/3 Exc bx, R breast, UOQ: DCIS, cribriform (comedocarcinoma) and micropapillary, nuclear gr. 3.
Codes as multiple subtypes of DCIS.

8523/2 Stereotactic bx left breast: cribriform ductal carcinoma in situ.
Excisional bx: residual ductal carcinoma in situ, solid type.
Use information from both procedures. Code as multiple subtypes of DCIS.

NOTE: Pre-CTR courses do not provide CE’s to cancer registrars; However, these courses may qualify for RHI education credits. A certificate of attendance will be provided. Forward this information to your HIM department.
DEATH CERTIFICATE NOTIFICATION
FCDS mailed the Death Certificate Request Forms for 2001 the first week of December. All forms were to be returned to FCDS no later than January 15, 2003. The information on the forms was obtained from the official Florida Vital Statistics Death Certificate. Each form identifies a Florida resident who expired with a cancer-related cause of death and does not match with any record already in the FCDS database. **If you have any questions, please contact your Field Coordinator at (305) 243-4600 or 1-800-906-3034.**

PATH LABS
Every anatomic pathology laboratory that reads biopsy and surgical resection specimens collected from patient encounters within the State of Florida MUST electronically submit the specified data for every malignant cancer case. **Specimens read between January 1, 2002 and June 30, 2002 were due to FCDS on December 31, 2002.** Specimen read between July 1, 2002 and December 31, 2002 are due June 30, 2003.