Focus on the Solid Tumor Rules: Breast and Urinary

Presented by
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Solid Tumor Rule Revisions

This presentation outlines updates issued in January 2019, as well as updates which will be released soon.
Introduction

Note 4: For those sites/histologies which have recognized biomarkers, the biomarkers are most frequently used to target treatment. Biomarkers may identify the histologic type. Currently, there are clinical trials being conducted to determine whether these biomarkers can be used to identify multiple primaries. Follow the Multiple Primary Rules; do not code multiple primaries based on biomarkers.
Changes from 2007 MPH Rules

Item 4: The invasive subtype/variant is coded ONLY when it comprises greater than or equal to 90% of the tumor. This change has been implemented in both the WHO and in the CAP protocols.

Equivalent or Equal Terms

- And; with (duct with lobular = duct and lobular)
- Behavior code /2; DCIS, intracystic; intraductal; noninfiltrating; noninvasive; carcinoma in situ
- Carcinoma; adenocarcinoma
- De novo; new tumor; frank (obsolete term)
- Duct; ductal; NST (no special type); carcinoma NST; mammary carcinoma
- Mammary; breast
- Majority; major; predominantly; >50%
- Simultaneous; existing at the same time; concurrent; prior to first course treatment
- Topography; site code
- Tumor; mass; tumor mass; lesion; neoplasm
- Type; subtype; variant
### Table 2 – Combination Codes

<table>
<thead>
<tr>
<th>Required Histology Terms</th>
<th>Histology Combination Term and Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCIS/duct carcinoma/carcinoma NST 8500 AND Lobular carcinoma 8520</td>
<td>Invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma 8522/3 *Note 1: CAP uses the term Invasive carcinoma with ductal and lobular features (“mixed type carcinoma”). *Note 2: Carcinoma NST includes all subtypes/variants of carcinoma NST. DCIS and in situ lobular carcinoma 8522/2 *Note: The lobular carcinoma includes pleomorphic lobular carcinoma in situ 8519/2.</td>
</tr>
</tbody>
</table>

**Note 1:** Both histologies, duct and lobular, must have the same behavior code.

**Note 2:** 8522 is used when:
- Duct AND lobular carcinoma are present in a single tumor OR
- Duct is present in at least one tumor and lobular is present in at least one tumor in the same breast OR
- One tumor is mixed duct and lobular; the other tumor is either duct or lobular OR
- All tumors are mixed duct and lobular

**Example:** One tumor with invasive duct CA in LOQ RT breast; second tumor with invasive lobular in UOQ RT breast

**Note 3:** Do not use 8522 when the diagnosis is carcinoma NST/duct carcinoma with lobular differentiation. See Histology Rules for instructions on coding differentiation.

### Table 3 – Specific Histo, NOS/NST, and Subtypes/Variants

<table>
<thead>
<tr>
<th>Specific and NOS/NST Terms and Code</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metaplastic carcinoma NOS or of no special type (NST) 8575 *Note: Squamous cell carcinomas of the breast are extremely rare. Carefully check the pathology report to verify the squamous cell originated in the breast parenchyma, rather than the skin of the breast.</td>
<td>Invasive mammary carcinoma with matrix production Metaplastic carcinoma, mixed epithelial and mesenchymal type Metaplastic carcinoma with mesenchymal differentiation Metaplastic carcinoma with squamous features Metaplastic carcinoma with other types of mesenchymal differentiation Mixed metaplastic carcinoma</td>
<td>Carcinosarcoma 8980/3 Fibromatosis-like metaplastic carcinoma 8572 Low grade adenosquamous carcinoma 8570 Metaplastic carcinoma spindle-cell type/spindle cell carcinoma 8032 Metaplastic carcinoma with chondroid differentiation with osseous differentiation 8571 Myoepithelial carcinoma 8982 Sarcomatoid carcinoma 8033 Squamous cell carcinoma 8070</td>
</tr>
<tr>
<td>Mucinous carcinoma 8480 *Note 1: This is a diagnosis that is EXACTLY “mucinous carcinoma,” mucinous duct carcinoma, “mucinous DCIS” OR “greater than 95% mucinous.” See Histology Rules *Note 2: Mucinous duct carcinoma is listed on the CAP protocol. It is not recognized by WHO or IARC. Mucinous carcinoma is not a subtype/variant of Carcinoma NST/duct carcinoma.</td>
<td>Colloid carcinoma Mucinous adenocarcinoma Mucoid carcinoma</td>
<td></td>
</tr>
</tbody>
</table>
MULTIPLE PRIMARY RULE UPDATES

Updates to Breast M Rules

No changes to M1-M3

Changes from 8/2018 to 1/2019
- Hierarchy changes for M4-M8
- New M10 with renumbering of 8/2018 M10 – M16
- Clarifications to some rules

Changes from 1/2019 to 4/2019
- New M9 with renumbering of 1/2019 M9 – M17
  Clarifications to some rules
Multiple Tumors: Rules M8- M9

M8 Abstract a **single primary** when the diagnosis is Paget disease with **simultaneous underlying** in situ or invasive CA NST (duct/ductal) or **subtypes of duct**.

– **Note**: If the underlying tumor is any histology other than duct or subtypes of duct, continue through the rules.

M9 Abstract multiple primaries when the diagnosis is Paget disease with underlying tumor which is **NOT duct**.

– **Example**: Paget disease of the nipple with underlying lobular carcinoma are multiple primaries.

(M10) Multiple Tumors: Rule M11

M11 Abstract a **single primary** when a ductal carcinoma occurs after a combination code in the same breast. See the following list:

- DCIS **following** a diagnosis of:
  - DCIS + lobular carcinoma in situ 8522/2 OR
  - DCIS + in situ Paget 8543/2 OR
  - DCIS + invasive Paget 8543/3 OR
  - DCIS mixed with other in situ 8523/2 (code used for cases diagnosed prior to 1/1/2018 : **after** 1/1/2018, use 8500/2)

- Invasive carcinoma NST/duct **following** a diagnosis of:
  - Invasive duct + invasive lobular 8522/3 OR
  - Invasive duct + invasive Paget 8541/3 OR
  - Invasive duct + other invasive carcinoma 8523/3
Multiple Tumors: Rules M12 & M15

(M14)  Abstract multiple primaries when separate/non-contiguous tumors are:

– On different rows in Table 3 in the Equivalent Terms and Definitions
– A combination code in Table 2 and a code from Table 3
  • Timing is irrelevant. Tumors may be synchronous or non-synchronous.
  • Each row in the table is a distinctly different histology.
  • Example 1: Paget disease of the nipple with underlying lobular are multiple primaries. Paget and lobular are on different rows in Table 3.
  • Example 2: Two tumors right breast. One tumor is invasive mixed duct and lobular 8522/3 (combination code from Table 2) and the second tumor is tubular 8211/3 (histology from Table 3). Abstract two primaries: 8522/3 and 8211/3.

HISTOLOGY RULE UPDATES
Coding Multiple Histologies in a Single Tumor

Two Invasive histologies

Two histologies within a single tumor will be either:

- A NOS and a subtype/variant OR
- Different histologies (different rows in Table 3 OR different subtypes in Table 3 Column 3)

NOS and subtype/variant

- Code the subtype/variant (specific histology) **ONLY** when documented to be **greater than or equal to 90%** of the tumor
- Code NST when subtype ≤ 90% or % unknown

*Note: A NOS with features or differentiation is a single histology. Go directly to the rules. (*This means you should NOT be in this section if you have NOS with features or differentiation!!!)

Previous note stated: **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 ICD-O and all updates.**
Ambiguous Terms

Code the histology when described by ambiguous terminology ONLY when:

- Histology is clinically confirmed by a physician (attending, pathologist, oncologist, etc.)
- Pt is receiving Tx based on the histology described by an ambiguous term
- Case is accessioned based on ambiguous terminology and no other histology information is available/documentated

Priority Order for Using Documentation to Identify Histology

IMPORTANT NOTES

   
   *Note 1:* Histology changes do occur following immunotherapy, chemotherapy and radiation therapy.
   
   *Note 2:* Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.

2. Code the histology assigned by the physician using the following priority list and the Histology Rules. Do not change histology in order to make the case applicable to staging.
Priority Order for Using Documentation to Identify Histology

1. Biomarkers
2. Tissue or path report
   – Addendum/comments
   – Final diagnosis/synoptic report
   – CAP protocol
3. Cytology (FNA nipple)
4. Tissue from mets site
5. Radiology – No priority
   – Mammogram
   – Ultrasound
6. Histo documented by physician in med rec
   – Treatment Plan
   – Tumor Board
   – Med record refers to original path, etc.
   – MD reference to histo

Added text to Note 2 under Final diagnosis: The final diagnosis is often the synoptic CAP report.

Single Tumor In Situ Only

New Rules H4 – H6

H4: Code DCIS and in situ Paget 8543/2
H5: Code DCIS 8500/2 when there is a combo of DCIS and any other carcinoma in situ
H6: Code histo using Table 2 when there are ≥2 in situ histologies within a single tumor
   • Lobular and any histology other than DCIS 8524/2
   • ≥2 histologies other than lobular and DCIS 8255/2

(Remaining H rules renumbered)
Introduction

Note 4: For those sites/histologies which have recognized biomarkers, the biomarkers are most frequently used to target treatment. Biomarkers may identify the histologic type. Currently, there are clinical trials being conducted to determine whether these biomarkers can be used to identify multiple primaries. Follow the Multiple Primary Rules; do not code multiple primaries based on biomarkers.

Note: Both papillary and non-papillary urothelial carcinoma urothelial carcinoma and papillary urothelial carcinoma can be in situ /2 or invasive /3. Code the behavior specified in the pathology report.
Equivalent or Equal Terms

- And; with (to describe mult. histos in a single tumor)
- Carcinoma; adenocarcinoma
- Flat TCC; flat UC; UC in situ; noninvasive flat CA; in situ TCC
- Majority; major; predominantly; >50%
- Multifocal/multicentric
- Noninvasive PC; PTCC; Intramucosal PUC
- Noninvasive; cancer that has not spread into muscle may describe either in situ papillary or flat urothelial CA
- PTCC; PUC
- Simultaneous; existing at the same time; concurrent; prior to FCOT
- Topography; site code
- Tumor; mass; lesion; neoplasm
- Type; subtype; variant
- UC; TCC
- Urothelium; epithelium; transitional epithelium

Terms NOT Equivalent or Equal

- Component is ≠ subtype/variant
  - Note: Component is only coded when the pathologist specifies the component as a second carcinoma.
- Noninvasive ≠ papillary urothelial carcinoma or flat urothelial carcinoma
  - Note: Pathologists may use the term noninvasive to describe a tumor which does not invade beyond the subepithelial connective tissue. Both Ta and Tis tumors are technically noninvasive.
Priority for Coding Primary Site

Code **C67.8** when:
- Single tumor of any histology overlaps subsites in bladder **OR**
- Single tumor or discontinuous tumors which are
  - Urothelial CA in situ 8120/2) **AND**
  - Involve(s) ONLY bladder and 1 or both ureters (no other urinary site/organisms involved)

Code **67.9** when: Multiple non-contiguous tumors within bladder **AND** subsite not documented

Code **C68.8** when: Single tumor overlaps 2 urinary sites and site of origin unknown (Renal pelvis and ureter; bladder and urethra; bladder and ureter*)

Code **68.9** when: Multiple discontinuous tumors in multiple organs within urinary system

*Use C67.8 for 8120/2 in bladder and ureter(s)

### Pre-2019 Table 2: Specific Histologies, NOS, and Subtypes/Variants

<table>
<thead>
<tr>
<th>Specific and NOS Histology Codes</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenocarcinoma NOS 8140</td>
<td>Mixed adenocarcinoma</td>
<td>Enteric adenocarcinoma 8144 Mucinous adenocarcinoma 8480</td>
</tr>
<tr>
<td><strong>Note:</strong> Adenocarcinoma and subtypes/variants are listed as subtypes of carcinoma NOS and also as a separate line item in order to provide documentation of all of the subtypes/variants that are specific to adenocarcinoma.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carcinoma NOS 8010</td>
<td>Urachal carcinoma</td>
<td>Adenocarcinoma NOS 8140 Clear cell carcinoma 8310 Endometrioid carcinoma 8380 Enteric adenocarcinoma 8144 Mucinous adenocarcinoma 8480</td>
</tr>
<tr>
<td><strong>Note:</strong> Adenocarcinoma and subtypes/variants are listed as subtypes of carcinoma NOS and also as a separate line item in order to provide documentation of all of the subtypes/variants that are specific to adenocarcinoma.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malignant melanoma 8720/3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 2: Specific Histologies, NOS, and Subtypes/Variants

<table>
<thead>
<tr>
<th>Specific and NOS Histology Codes</th>
<th>Synonyms</th>
<th>Subtypes/Variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenocarcinoma NOS 8140</td>
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<td></td>
</tr>
<tr>
<td>Note: Urachal carcinoma NOS is</td>
<td></td>
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<tr>
<td>coded 8010/3. Urachal adenocarcinoma is coded 8140/3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malignant melanoma 8720/3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malignant perivascular epithelioid cell tumor 8714/3</td>
<td>Malignant PEComa</td>
<td></td>
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<tr>
<td>Sarcoma NOS 8800/3</td>
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<tr>
<td>Note: Rhabdomyosarcoma 8900 is a NOS with a subtype/variant of embryonal rhabdomyosarcoma/sarcoma botryoides 8910/3.</td>
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</tbody>
</table>

Note: Urachal carcinoma NOS is coded 8010/3. Urachal adenocarcinoma is coded 8140/3.

Malignant melanoma 8720/3
Malignant perivascular epithelioid cell tumor 8714/3
Malignant PEComa
Angiosarcoma 9120/3
Chondrosarcoma 9220/3
Leiomyosarcoma 8890/3
Liposarcoma 8850/3
Malignant peripheral nerve sheath tumor (MPNST) 9540/3
Pleomorphic sarcoma 8802/3
Rhabdomyosarcoma 8900/3
Embryonal rhabdomyosarcoma/sarcoma botryoides 8910/3

Updates to Urinary M Rules

<table>
<thead>
<tr>
<th>4/2019</th>
<th>1/2019</th>
<th>1/2019</th>
<th>8/2018</th>
</tr>
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<tbody>
<tr>
<td>M7</td>
<td>M6</td>
<td>NEW M6</td>
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<tr>
<td>M9</td>
<td>M7</td>
<td>M7</td>
<td>M6</td>
</tr>
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<td>M11</td>
<td>NEW M12</td>
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<td>M8</td>
<td>M12</td>
<td>NEW M13</td>
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<td>M14</td>
</tr>
<tr>
<td>M18</td>
<td>M18</td>
<td>M18</td>
<td>M15</td>
</tr>
</tbody>
</table>

No changes to M1-M5

Changes from 8/2018 to 1/2019
- Hierarchy changes
- New M6, M12, and M13
- Clarifications to some rules

Changes from 1/2019 to 4/2019
- Hierarchy changes
- Clarifications to some rules
Multiple Tumors Module

Separate, non-contiguous (S/N-C) tumors are always multiple primaries when:

• In urinary system (Table 1) and non-urinary site
• Non–synchronous tumors other than urothelial carcinoma and urothelial carcinoma subtypes in multiple urinary sites (see M14)

Multiple Tumors: Rules M6 - M7

(M17) M6: Invasive > 60 days after in situ = multiple

(M6) M7: Multiple occurrences of in situ urothelial carcinoma 8120/2 or papillary urothelial carcinoma 8130/2 (excludes micropapillary subtype) of bladder = single
  – Timing doesn’t matter (synchronous or non-synchronous)
  – Papillary urothelial CA8130/2 is the only /2 subtype/variant of 8120/2
  – Abstract a single /2 urothelial bladder tumor per the patient’s lifetime

Example: 1/3/18 TURBT reveals in situ urothelial CA 8120/2; 5/8/19 TURBT reveals noninvasive papillary urothelial CA 8130/2.

Single primary 8120/2 (histo of original tumor)
Multiple Tumors: Rules M8 - M9

(M8) **Non-synchronous** Tumors which are micropapillary urothelial CA 8131/3 and urothelial CA (8120/3 or 8130/3) of the **bladder** = multiple
- New rule for 2019 to capture the incidence of micropapillary
- For synchronous tumors, continue through the rules

(M9) Multiple occurrences of invasive urothelial carcinomas of **bladder** = single
- Multiple occurrences of urothelial
  » Includes urothelial subtypes (except micropapillary)
- Multiple occurrences of micropapillary
- Abstract only 1 invasive urothelial and only 1 micropapillary **bladder** tumor per the patient’s lifetime

Multiple Tumors: Rules M11 & M14

(M8) **M11**: Urothelial CAs in multiple urinary organs = single
- Applies to multifocal/multicentric **urothelial CA** 8120 and ALL subtypes/variants involving 2 or more of the following sites:
  • Renal pelvis; Ureter; Bladder; Urethra
- Excludes non-urothelial CAs and sarcomas
- **Histology for all tumors must be identical**
- **Behavior** doesn’t matter

(M13) **M14**: ICD-O topography code differs at 2nd CXx.x or 3rd CxX.x character = multiple (results in multiple primaries for all histologies other than urothelial)
Multiple Tumors: Rule M16

(M15) **M16**: In situ after invasive in SAME urinary site

OR Are **multifocal/multicentric tumors in multiple urinary sites** = single (the invasive one)

**HISTOLOGY RULE UPDATES**
Priority Order for Using Documentation to Identify Histology, cont’d

IMPORTANT NOTES

   
   **Note 1:** Histology changes do occur following immunotherapy, chemotherapy and radiation therapy.
   
   **Note 2:** Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.

2. Code the histology assigned by the physician using the following priority list and the Histology Rules. Do not change histology in order to make the case applicable to staging.

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Priority Order to Identify Histology

1. Biomarkers
2. Tissue/path from primary site (listed in priority order)
   - Addendum
   - Final dx/synoptic report
   - CAP protocol
3. Cytology (usually urine)
4. Tissue/path from metastatic site

5. Physician documentation (listed in priority order)
   - **Treatment plan**
   - Tumor board
   - Medical record referencing the original pathology, cytology, or scan(s)
   - MD reference to cancer type

6. Scans (no priority order)
   - CT, MRI

Added text to Note 2 under Final diagnosis: **The final diagnosis is often the synoptic CAP report.**
Coding Multiple Histologies

• Code **most specific** histology or subtype/variant regardless of whether it is described as:
  – Majority or predominant part of tumor
  – Minority part of tumor
  – A component

• Code histo described as **differentiation** or **features/features of** ONLY when there is a specific ICD-O code for the “NOS with ____ features” or “NOS with ____ differentiation”
  – **Note 2:** A NOS with features or differentiation is a single histology. Go directly to the rules.

• Code the histology when described by ambiguous terminology ONLY when specified criteria are met

Ambiguous Terms

Code the histology when described by ambiguous terminology ONLY when:

• **Histology is clinically confirmed by a physician** (attending, pathologist, oncologist, etc.)

• **Pt is receiving Tx based on the histology described by an ambiguous term**

• **Case is accessioned based on ambiguous terminology and no other histology information is available/document**
Summary for Coding Histology

<table>
<thead>
<tr>
<th>Urinary</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Biomarkers</td>
<td>1</td>
</tr>
<tr>
<td>Tissue/path from primary</td>
<td>2</td>
</tr>
<tr>
<td>Cytology</td>
<td>3</td>
</tr>
<tr>
<td>Tissue/path from mets</td>
<td>5</td>
</tr>
<tr>
<td>Scans</td>
<td></td>
</tr>
<tr>
<td>MRI; CT</td>
<td>6</td>
</tr>
<tr>
<td>Physician Documentation</td>
<td>4</td>
</tr>
</tbody>
</table>

**Code histology**
- Before neoadjuvant therapy
- **Using priority list & H rules**
- Do not change histo to stage

**Multiple Histologies**
- Code **most specific** histo or subtype/variant **whether described as majority, predominantly, minority, or component**
- Code NOS w/ features or diff. ONLY when there is a specific code
- Use ambiguous terms ONLY when criteria met
- Do NOT code based on pattern architecture, focus/foci/focal

Single Tumor: January 2019 Update to H5

**H5:** Code the histology as follows when there is a mixture of **urothelial carcinoma** AND or WITH:

<table>
<thead>
<tr>
<th>Urothelial plus...</th>
<th>Code</th>
<th>Urothelial plus...</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenocarcinoma</td>
<td>8120</td>
<td>Sarcoma</td>
<td>8800/3</td>
</tr>
<tr>
<td>Enteric adenoca</td>
<td>8120</td>
<td>Angiosarcoma</td>
<td>9120/3</td>
</tr>
<tr>
<td>Mucinous adenoca</td>
<td>8120</td>
<td>Chondrosarcoma</td>
<td>9220/3</td>
</tr>
<tr>
<td>Clear cell CA</td>
<td>8120</td>
<td>Embryonal rhabdomyosarcoma</td>
<td>8910/3</td>
</tr>
<tr>
<td>Endometrioid CA</td>
<td>8120</td>
<td>Leiomyosarcoma</td>
<td>8890/3</td>
</tr>
<tr>
<td>Squamous Cell CA</td>
<td>8120/3</td>
<td>Liposarcoma</td>
<td>8850/3</td>
</tr>
<tr>
<td>Verrucous CA</td>
<td>8120/3</td>
<td>MPNST</td>
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<td>Clear-cell CA</td>
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<td>Pleomorphic sarcoma</td>
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<td>Rhabdomyosarcoma</td>
<td>8900/3</td>
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<tr>
<td></td>
<td></td>
<td>Sarcoma botryoides</td>
<td>8910/3</td>
</tr>
</tbody>
</table>
**Single Tumor: Rule H5**

**H5: Code mixed urothelial carcinomas follows:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8120</td>
<td>Urothelial mixed with</td>
</tr>
<tr>
<td></td>
<td>• AdenoCA or adenoCA subtypes</td>
</tr>
<tr>
<td></td>
<td>• Squamous Cell CA or squamous cell subtypes</td>
</tr>
<tr>
<td>8130</td>
<td>Papillary urothelial mixed with</td>
</tr>
<tr>
<td></td>
<td>• AdenoCA or adenoCA subtypes</td>
</tr>
<tr>
<td></td>
<td>• Squamous Cell CA or squamous cell subtypes</td>
</tr>
<tr>
<td>8131/3</td>
<td>Micropapillary urothelial mixed with</td>
</tr>
<tr>
<td></td>
<td>• AdenoCA or adenoCA subtypes</td>
</tr>
<tr>
<td></td>
<td>• Squamous Cell CA or squamous cell subtypes</td>
</tr>
</tbody>
</table>

**Note:** AdenoCA and subtypes/variants as well as squamous cell CA and subtypes/variants are coded ONLY when pure (not mixed with any other histology).

**Example:** Pathology says majority of tumor is squamous cell CA 8070/3 W/ minority composed of papillary urothelial cell CA 8130/3. Code the papillary urothelial cell carcinoma 8130/3. The squamous cell carcinoma is not pure and cannot be coded.

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**How to Submit Questions**

**Non-SEER Registrars** – Ask a SEER Registrar

[https://seer.cancer.gov/registrars/contact.html](https://seer.cancer.gov/registrars/contact.html)

**SEER Region Registrars** – SINQ System


Include the primary site and select the correct category (2007 MP/H or 2018 STRs)