Determining Reportability

The following supercedes any previous MCR reportability rules appearing in our manuals. These rules attempt to cover ALL years of case reportability to the MCR, but most specifically refer to diagnoses made beginning in 2003. If there are changes needed in these rules in the future, notification will be sent to reporting facilities and software vendors and replacement pages will be issued for this manual.

The MCR requires reporting facilities to submit all cases seen at that facility with neoplasms classified as invasive or *in situ* in the "Morphology of Neoplasms" section of ICD-O-3* (for cases diagnosed in 2001 and thereafter), ICD-O-2 (for diagnoses made between 1992 and 2000), or ICD-O[-1] (for 1982-1991 diagnoses). (This MCR Manual applies to diagnoses made beginning in 2003, so only ICD-O-3 codes appear here.) If you've changed a listed behavior in an ICD-O book to /**2** or /**3**, that case is also reportable (the "matrix" rule, ICD-O-3 Rule F). The only exceptions to these /**2** and /**3** reportability rules are the site/morphology combinations that follow:

morphology	
8000-8005	malignant neoplasms, NOS, of the skin (C44.0-C44.9)
8010-8046	epithelial carcinomas of the skin (C44.0-C44.9)
8050-8084	papillary and squamous cell carcinomas of the skin (C44.0-C44.9)
8090-8110	basal cell carcinomas of the skin (C44.0-C44.9)

Note: The above morphologies of *any* non-C44 primary site will be reportable to the MCR as of January 1, 2004. For diagnoses made before 2004 SEER phrasing pointed out that these cancers were reportable for skin of the genital sites, and some interpreted this as meaning that they were *only* reportable for these sites.

The MCR requires reporting of all cases with ICD-O behavior codes /**0**, /**1**, /**2** or /**3** of the meninges, brain and central nervous system (C70.0-C72.9) for all diagnosis years beginning in 1982. (There are new data standards for these cases beginning with diagnoses made in 2004.) Remember that non-malignant (/0, /1) diseases must have an ICD-O code to be reportable.

For primary sites C75.1-C75.3 (pituitary and pineal glands and craniopharyngeal duct), only report cases with invasive or *in situ* behavior (/**3**, /**2**) to the MCR when diagnosed before 2004. All ICD-O-3 behaviors (/**0**, /**1**, /**2** or /**3**) for these sites are required when diagnosed beginning in 2004.

* Pilocytic astrocytomas, although appearing in ICD-O-3 as borderline malignancies, are to be coded with /**3** behavior in North America by agreement (9421/**3**).

Beginning with cases diagnosed in 1998, the MCR no longer requires reporting facilities to submit cases of carcinoma *in situ* (CIS) of the uterine cervix (primary site C53._ with histologic type codes 8000-8110 and behavior /**2**). This includes cervical intraepithelial neoplasia, Grade III (CIN III, histology 8077/2), pre-invasive cervical neoplasia, and squamous intraepithelial neoplasia. Invasive carcinomas of the cervix (behavior /**3**) are reportable and must not be overlooked in casefinding. Prostatic intraepithelial neoplasia, Grade III (PIN, histology 8148/2) also became non-reportable to the MCR for diagnoses made beginning in 1998. Please note that SEER has recently clarified the concept of non-reportable CIS of the cervix, now excluding *all* histologies of the cervix with behavior /**2** from reportability (rather than just the simple carcinoma histology range, 8000-8110). This was apparently always SEER's intent so you may begin observing this rule at any time from the present. That is, only invasive cancers of the uterine cervix (behavior /**3** with primary site C53._) are now reportable to the MCR for diagnoses made beginning in 1998.

For diagnoses made between 1998 and 2003 the MCR does not require cases of anal, vaginal or vulvar intraepithelial neoplasia, Grade III (AIN, VAIN, VIN, histology 8077/2) because of uncertainty in the narrative descriptions of these diagnoses. (This "Grade III" does not refer to the histopathologic grade/differentiation; it refers to the highest category of dysplasia in the Bethesda system for non-invasive lesions.) These /**2** terms appear in ICD-O-3 and are reportable to the CDC/NPCR. Therefore the MCR is requiring AIN III, VAIN III and VIN III diagnosed beginning in 2004.

Neoplasms identified only by patient medical history need not be abstracted for the MCR.

Summary of 2003 Reporting Differences Between the MCR and the COC

For diagnoses made beginning in 2003 and 2004 the following differences in reportability exist between the COC and the MCR. (These are the COC reportability rules as the MCR understands them as of December 2003. Always consult COC materials directly if you have questions about what is COC-reportable.) All facilities in Massachusetts are required to report MCR-reportable cases to the central registry regardless of their reportability status from the COC's point of view. The COC does not determine what is reportable to the MCR. If you have any questions about MCR reportability consult the MCR at 617-624-5622.

- Nonanalytic cases of Class 3, 4, 5 and 9 are MCR-reportable but not COC-reportable.
- Brain and other CNS primary sites with any behavior are MCR-reportable; only those with *in situ* or invasive behavior are COC-reportable (until diagnoses made in 2004).
- Invasive recurrence of a disease that was originally *in situ*, diagnosed at least two months after the original diagnosis, is MCR-reportable but not COC-reportable.
- Cases in which the patient receives only transient first-course treatment while temporarily in Massachusetts are MCR-reportable but not COC-reportable.
- Nonanalytic cases of Class 6 and 7 are MCR-optional and not COC-required. You may include these in your regular MCR data submissions; otherwise, send us copies of the pathology reports and we'll follow back to the ordering physician when necessary.

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All other types of diagnosis and case that are COC-reportable are also MCR-reportable for diagnoses made in 2003. For diagnoses made in 2004:

- AIN III, VAIN III and VIN III are MCR-reportable beginning with diagnoses made in 2004 but are not COC-reportable.
- Pituitary and pineal glands and craniopharyngeal duct are added to those brain and other CNS sites reportable to the MCR with any ICD-O-3 behavior when diagnosed beginning in 2004. These will also be NPCR- and COC-reportable beginning with 2004 diagnoses.
- Basal and squamous cell carcinomas of *any* primary site except C44 skin sites are MCR-reportable for diagnoses made as of January 1, 2004. These are also reportable to the COC (beginning with 2003 diagnoses) and the NPCR.

Definition of a Cancer Diagnosis

The MCR collects both pathologic and clinical cancer diagnoses. A patient is considered to have a reportable diagnosis when made by a recognized medical practitioner even if never pathologically confirmed. Usually the medical record clearly presents a cancer diagnosis using specific terms synonymous with cancer, but a physician may not always be certain, nor the recorded language definitive.

The lists on page 14 should be used as a guide in determining reportability. Not every possible form of each term can be listed, so consider variants of the terms to also be included. (For example, "apparent malignancy" is a variant of "apparently malignant".) A *positive pathology report* takes precedence over any other information as evidence of malignancy. If a clinical cancer diagnosis is followed by *negative* pathology, this may mean that the clinical diagnosis was disproven and there is no cancer case to report; but if the patient was treated for this cancer despite negative pathology, report the case because the clinical diagnosis is being upheld; if six months have passed since the negative pathology and a clinician is still using terms diagnostic of cancer, report the case.

Examples: A skin area that was "malignant appearing" is excised and examined pathologically with no cancer found. There is no further treatment. Presume there is no cancer diagnosis to report.

A patient with high PSA tests has a digital rectal exam and the urologist states "probable malignancy". Repeated biopsies fail to find cancer but the patient is treated as if he has prostate cancer. Report the case.

Only MCR-reportable diagnoses are considered here, so a basal cell carcinoma in leg skin diagnosed via one of the "diagnostic" terms does not make the case reportable. There are no special terms for mammography, so apply the lists on p. 14 to all situations (except as noted).

For diagnoses made beginning in 2004, these lists of "malignant" terms are extended to the diagnosis of intracranial/CNS non-malignancies (C70.0-C72.9, C75.1-C75.3 with behaviors /0, /1) and two terms have been added that ONLY apply to such cases. (For example, "apparently a benign brain tumor" and "brain neoplasm" mark reportable 2004 diagnoses.)

page last updated for 2004

Diagnostic of Cancer

A case of cancer has been diagnosed if any of the following terms is used:

- apparently malignant
- appears malignant
- comparable with malignancy
- compatible with malignancy
- consistent with malignancy
- favors malignancy
- malignant appearing
- most likely malignant
- neoplasm *
- presumed malignant
- probable malignancy
- suspect(ed) malignancy
- suspicious of/for malignancy **
- tumor *
- typical of/for malignancy

Not Diagnostic of Cancer

A case is not reportable and a cancer diagnosis has not been made if any of the following terms is used (in the absence of more definitive terminology or better information):

- equivocal (for) malignancy
- malignancy cannot be ruled out
- possible malignancy
- potentially malignant
- questionable malignancy
- rules out malignancy
- suggests malignancy
- worrisome
- any other term that is not a "Diagnostic of Cancer" term (or a variant)

* This term is considered sufficient for a reportable cancer diagnosis **ONLY** for **non-malignant** tumors of the meninges, brain, other CNS, pituitary gland, craniopharyngeal duct and pineal gland **diagnosed beginning in 2004** (primary sites **C70.0-C72.9** and **C75.1-C75.3** with behavior codes /**0** and /**1**). "Neoplasm, NOS" and "tumor, NOS" appear in ICD-O-3 as 8000/1. For non-malignant brain/CNS/intracranial tumors diagnosed before 2004, for malignancies (behavior codes /**2** and /**3**) of any of these primary sites, and for all other primary sites diagnosed in any year, the terms "neoplasm" and "tumor" by themselves are NOT sufficient to identify the diagnosis of a MCR-reportable case.

** If a **cytology** (only) is reported as "suspicious", do not interpret this as a cancer diagnosis. Report the case only if positive pathology or a physician's clinical impression of cancer supports the cytology findings.

Lobular Carcinoma *in Situ* or Neoplasia, Severe Dysplasia, High-Grade Dysplasia

Some physicians do not consider cases of lobular carcinoma *in situ* (LCIS) to be malignancies. Because the histologic type is listed in ICD-O-3 with behavior code **2** (8520/2), the disease is reportable to the MCR. Abstract and submit these to us. Some pathologists now use the WHO classification "lobular neoplasia grade III" rather than LCIS; if your pathologist considers this term equivalent to 8520/2, please report it. The line of transition between dysplasia and outright neoplasm continues to blur. SEER does not consider the terms "severe dysplasia" and "high-grade dysplasia" to be automatically synonymous with truly *in situ* behavior (as of a neoplasm) at this time. Some pathologists and classification systems, however, may be using these terms rather than "*in situ*" to describe non-invasive malignancies. To be consistent with COC/AJCC advice, if you find that a particular pathologist uses "severe dysplasia" or "high-grade dysplasia" to mean "*in situ*" behavior for a reportable case***, report these cases to the MCR as *in situ* malignancies; but do NOT assume that these terms are always synonymous with "*in situ*" behavior unless you are certain. The MCR will decide how to categorize these cases on our data system.

*** For example, a 2004 diagnosis of severe dysplasia of the cervix would not be MCR-reportable even if the pathologist meant *in situ* behavior.

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Identification of the Primary Neoplasm

To ensure the accurate reporting of cancer incidence in Massachusetts, it is essential that the primary neoplasm be identified accurately. The primary neoplasm is the original lesion, as opposed to a tumor that has developed as a result of extension or metastasis.

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 primary-versus-metastatic lesions is often found in pathology reports. The term "secondary" is often used to describe metastatic lesions. The 2007 MP/H rules do not change this distinction between primary and metastatic lesions.

It is important that those recurrences which are reportable to the MCR (invasive recurrences following an *in-situ* tumor after two months) be clearly identified as recurrences (as opposed to progression of the original disease). The site at which the recurrence is found is not necessarily the disease's site of origin; the recurrence's primary site is the primary site of the original non-invasive disease. Beginning with tumors diagnosed in 2007, use the MP/H rules to determine if each new tumor is a new primary. There will no longer be differences between hospital and central registries on reporting recurrences -- any non-metastatic 2007 tumor that is a new primary under the MP/H rules should be reported as a new primary.

Single-Versus-Multiple Primaries

Beginning with tumors diagnosed in 2007, use the rules in the MP/H Manual to determine the number of primaries a patient has. Complete one abstract for each primary.

The old rules for pre-2007 diagnoses follow:

> To ensure consistency, the MCR uses SEER rules and definitions for determining whether lesions are single or multiple primaries. (Facilities with COC approved cancer programs will at times count cases differently than the central registry.) SEER has been reviewing its "counting" rules on a site-by-site basis, but site-specific rule revisions will not be effective until 2007 diagnoses. As formerly stated by SEER (in older SEER manuals):
>
> > ...the determination of how many primary neoplasms a patient has is, of course, a medical decision; but operational rules are needed to ensure consistent reporting by all participants. Basic factors include the site of origin, date of diagnosis, histologic type, behavior of the neoplasm (i.e., benign versus uncertain versus malignant) and laterality....In some neoplasms...one must be careful since different histologic terms are used to describe progressive stages or phases of the same disease process.
>
> *In general*, if there is a difference in the site where the neoplasms originate, then it is fairly easy to determine if they are separate primaries, regardless of dates of detection and histologic differences. Likewise, if there is a major difference in histology, other data such as site and time of detection are not essential to determine the number of primaries.

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Pre-2007 rules continued:

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A separate case report (abstract) must be submitted for each independent primary neoplasm present at the time of abstracting, unless it was previously reported by you. Those recurrences which are required by the MCR may be reported via separate abstracts or by using the Type of First Recurrence and Date of First Recurrence fields. Neoplasms identified only by history need not be abstracted for the MCR.

Definitions and rules governing the determination of single/multiple primaries follow.

General Principle: Report a single or multiple primaries as documented by a physician, remembering that physicians need not adhere to the "counting" rules governing cancer registries. The MCR "counts" tumors on our data system as objectively as we can using SEER rules, but different physicians may wish to record different numbers of tumors for a given patient. If physician determination is absent or unavailable, use the following guidelines.

Definitions Related to Single-Versus-Multiple Primaries

"Site Difference"

For the following, except for combinations of a "_.9 NOS" code with a specific site code from the same group, each topographic subcategory (4 characters, "C###") as delineated in ICD-O-3 is considered to be a separate site:

colon (C18._)
anus and anal canal (C21._)
bones, joints and articular cartilage (C40._, C41._)
skin (C44._) melanomas (8720-8790)
peripheral nerves and autonomic nervous system (C47._)
connective, subcutaneous and other soft tissues (C49._)
non-malignancies of the meninges (except meninges, NOS*) (C70.0 and C70.1 with behaviors /0 and /1)
non-malignancies of the brain (except brain, NOS*) (C71.0-C71.8 with behaviors /0 and /1)
non-malignancies of other CNS sites (except nervous system, NOS*) (C72.0-C72.8 with behaviors /0 and /1)
non-malignancies of the pituitary, craniopharyngeal duct and pineal gland (C75.1-C75.3 with behaviors /0 and /1)

* A combination of a __.9 "NOS" code and a specific primary site with the same first three digits (for example, C71.9 and C71.6) is considered the same site.

Each site grouping shown in Table II.1 (page 17) is considered *one site* when determining single-versus-multiple primaries. These groups were single sites in ICD-O-1, and SEER consistency rules require them to continue to be viewed as single sites. This applies to both invasive and *in-situ* cancers. The MCR believes that laterality should be used in the usual manner for determining multiple primaries in paired sites in Table II.1 -- that is, left kidney and right renal pelvis are not the same site, but left kidney and left renal pelvis are the same site. When circumstances require reporting multiple tumors in Table II.1 site groupings as a single primary, assign the ~~best ICD-O-3 Primary Site Code possible to encompass all the sites involved~~. primary site code (new information from SEER) indicated in the table's right column.

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Pre-2007 rules continued:

Table II.1
ICD-O-3 Codes Considered ONE Primary Site for Determining Single-vs.-Multiple Primaries for Tumors Diagnosed Before 2007

ICD-O-3 Codes	Site Groupings	Assign for a Single Primary
C01 C02	base of tongue other, unspecified parts, tongue	C029 tongue, NOS
C05 C06	palate other, unspecified parts, mouth	C069 mouth, NOS
C07 C08	parotid gland other, unspecified major salivary glands	C089 major salivary gland, NOS
C09 C10	tonsil oropharynx	C109 oropharynx, NOS
C12 C13	pyriform sinus hypopharynx	C139 hypopharynx, NOS
C23 C24	gallbladder other, unspecified parts, 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 C38.0 C38.1-C38.3 C38.8	thymus heart mediastinum overlapping: heart, mediastinum, pleura	C383 mediastinum, NOS
C51 C52 C57.7 C57.8-C57.9	vulva vagina other specified parts, female genital overlapping lesion, female genital tract	C579 female genital, NOS
C56 C57.0 C57.1 C57.2 C57.3 C57.4	ovary fallopian tube broad ligament round ligament parametrium uterine adnexa	When ovary is involved, assign C569 ovary. When only non-ovary sites are involved, assign C579 female genital, NOS.
C60 C63	penis other, unspecified male genital	C639 male genital, NOS
C64 C65 C66 C68	kidney renal pelvis ureter other, unspecified urinary	When kidney is involved, assign C649 kidney. When only non-kidney sites are involved, assign C689 urinary system, NOS.
C74 C75*	adrenal gland other endocrine glands, related structures	C759 endocrine gland, NOS

* The table applies to multiple malignancies. For non-malignancies (behavior /0, /1) of C75.1, C75.2 and C75.3, each of these three primary sites is a separate site for counting non-malignant primaries; do NOT group them with C74._ and the remainder of C75._ for non-malignancies.

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Pre-2007 rules continued:

For all other primary sites, each topographic category (3 characters, "C##") as delineated in ICD-O-3 is considered to be a separate site.

Examples:

- Transverse colon (C18.4) and descending colon (C18.6) are considered separate primary sites.*
- Base of tongue (C01.9) and border of tongue (C02.1) are considered subsites of the tongue and are to be treated as one primary site (C02.9).
- Trigone of bladder (C67.0) and lateral wall of bladder (C67.2) are considered subsites of the bladder and are to be treated as one primary site (C67.9).
- Non-malignancies originating in the cerebral meninges (C70.0) and spinal meninges (C70.1) are considered to be of separate primary sites.
- Non-malignancies originating in meninges, NOS (C70.9) and cerebral meninges (C70.0) are considered to be of the same primary site.
- Malignancies originating in the cerebral and spinal meninges (C70.0, C70.1) are considered to be of the same primary site.

***** Exceptions: colon polyps

1. *Simultaneous* (diagnoses made within 2 months of each other) lesions and polyps in the *same segment* of the colon are a single primary.
2. Polyps may present in more than one segment of the colon. If the diagnosis reads "adenocarcinoma in multiple polyps", it is one primary of the colon, NOS (C18.9).

Familial polyposis is a genetic disease characterized by polyps that increase in numbers and may cover the mucosal surface of the colon. This benign disease usually develops into adenocarcinoma in adenomatous polyposis coli (8220/3) or adenocarcinoma in multiple adenomatous polyps (8221/3).

Patients with the histologies "adenocarcinoma in adenomatous polyposis coli" (8220/3) and "adenocarcinoma in multiple adenomatous polyps" (8221/3) have a different disease process than those patients with frank adenocarcinoma of the colon or typical colon polyps. If multiple segments of the colon, or of the colon and rectosigmoid, or of the colon, rectosigmoid and rectum are involved with adenocarcinoma in adenomatous polyposis coli or adenocarcinoma in multiple adenomatous polyps, it is a single primary. Code the primary site to colon, NOS (C18.9).

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"Histologic Type Difference"

Differences in histologic type refer to differences in the first 3 digits of the morphology code, EXCEPT FOR solid malignant tumors diagnosed beginning in 2007 and lymphatic and hematopoietic diseases and non-malignant intracranial tumors. (See multiple primaries in **Lymphatic and Hematopoietic Diseases** on pages 27-33.)

For all diagnosis years beginning with 2004, non-malignancies (behaviors /0 and /1) of primary sites C70.0-C72.9 and C75.1-C75.3 have special rules using the following histologic type groupings:

Group	**Histologic Type Codes** (/0, /1)
ependymomas	9383, 9394, 9444
neuronal & neuronal-glial neoplasms	9384, 9412, 9413, 9442, 9505, 9506
choroid plexus neoplasms	9390
neurofibromas	9540, 9541, 9550, 9560/0
neurinomatosis	9560/1
neurothekeoma	9562
neuroma	9570
perineurioma	9571

Histologic type codes in the same group (row) above are considered the same histology; assign the more specific histology for a single primary (or simply the earlier diagnosis if neither histology is more specific than the other).

A histologic type code anywhere in the table above and one NOT anywhere in the table above are the same histology if their first 3 digits are the same (usual rule); assign the histology based on multiple/mixed histology rules.

Two histologic type codes NOT anywhere in the table are the same histology if their first 3 digits are the same (usual rule); assign the histology based on multiple/mixed morphology rules.

Note that the codes above are ICD-O-3 codes. If trying to compare a new diagnosis with one made before 2001, convert the original morphology term or code into ICD-O-3 before using the code groups above.

"Simultaneous / Synchronous"

These terms describe diagnoses made within two months of each other.

Note that for non-malignancies (behavior /0, /1) of primary sites C70.0-C72.9 and C75.1-C75.3, there are NO TIME LIMITS involved in their single-vs.-multiple primary rules. Subsequent non-malignancies originating in the "same site" with the "same histologic type" as an earlier one are always considered recurrences (and not reportable to the MCR) for these cases; count only the earliest such diagnosis, and assign the most specific histology.

Pre-2007 rules follow:

Single Primaries

The following are to be considered single primaries:

- A single lesion of *one histologic type* is considered a single primary even if the lesion crosses multiple primary sites.
- A single lesion with *multiple histologic types* is to be considered a single primary.
- A new cancer with the *same histology* as an earlier one, if diagnosed in the **same site** within two months, is considered to be a single primary.
- Multiple lesions of the *same histologic type*, if diagnosed in the **same site** within two months, are to be considered a single primary; further, if one lesion has an *in situ* behavior (/2) and another an invasive behavior (/3), this is still to be considered a single primary whose behavior is invasive (/3). Multifocal tumors are included.

Multiple Primaries

The following are to be considered separate primaries:

- Multiple lesions of the *same histologic type* that occur in **different sites** are considered separate primaries, unless stated to be metastatic or a type of recurrence that is not reportable to the MCR.

  Exception: Kaposi sarcoma (9140/3) is reported only once, even if it occurs in different primary sites. Further details about reporting Kaposi sarcoma appear on pages 21 and 25.

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Pre-2007 rules continued:

- A new cancer of the *same histology* as an earlier one, if diagnosed in the **same site** after two months, should be considered a separate primary unless stated to be metastatic. *Exceptions*:

  Invasive bladder cancers (C67._) with histology codes 8120-8131/3 [transitional cell carcinomas, including (micro)papillary types]: For these, a *single abstract is required for the first lesion only*. Any reappearance of disease in the bladder with histology codes 8120-8131/3 is considered a recurrence, regardless of the time that has passed since the initial diagnosis. If a non-invasive bladder cancer in this histology range is followed by an invasive recurrence after two months, these are considered separate primaries for the MCR (as described in the Note below).

  Invasive prostate adenocarcinomas (C61.9, 8140/3): Record the first of these diagnoses only. Any subsequent diagnosis of this disease is considered a non-reportable recurrence. If PIN III (8148/2) is followed after two months by an invasive prostate cancer, even if stated to be a recurrence, then the second diagnosis is reportable to the MCR even though the PIN III diagnosis is not MCR-reportable. (See the Note below.)

  Kaposi sarcoma (9140/3): Report only the first occurrence as detailed on page 25.

  Non-malignancies (behaviors /0 or /1) of intracranial primary sites (C70.0-C72.9 and C75.1-C75.3): For multiple diagnoses made in the same site with the same histologic type, record only the first diagnosis (regardless of time interval between diagnoses). This is true for all diagnosis years.

Pre-2007 rules continued:

Note: An *in situ* followed by an invasive cancer in the same site* more than two months apart is recorded as two primaries at the MCR even if stated to be a recurrence. Facilities may choose to report the cases in separate abstract records or may use the Type of First Recurrence and Date of First Recurrence fields.

* This is a SEER rule, adopted by the NAACCR Uniform Data Standards Committee, for diagnoses as of January 1, 1995. The ACoS/COC does not want the invasive case sent to them if a physician has called it a recurrence but, as a central registry, the MCR follows SEER rules on this.

For MCR-reportable recurrences, we interpret this rule to mean that the invasive recurrence is not necessarily in the *same* site as the original diagnosis. An invasive local, regional or distant recurrence of a non-invasive cancer is reportable to the MCR if diagnosed after two months. The recurrence need not literally occur "in the same site" for the reporting rule to apply.

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Pre-2007 rules continued:

- Multiple lesions of *different histologic types* within a **single site** are considered separate primaries whether occurring simultaneously or at different times.
  Exceptions:
  - For multiple lesions within a single site occurring within two months, if one lesion is an NOS term (such as carcinoma, NOS; adenocarcinoma, NOS; melanoma, NOS; or sarcoma, NOS) and the second lesion is a more specific related term (such as large cell carcinoma, mucinous adenocarcinoma, nodular melanoma or spindle cell sarcoma), consider this to be a single primary and code the more specific histology. *Exceptions to this Exception*:
    - When an *in situ* or invasive adenocarcinoma arises within the same segment of the colon or rectum as an *in situ* or invasive adenocarcinoma in a polyp (in an adenomatous polyp, villous adenoma or tubulovillous adenoma), then use the less specific code -- (8140/2 or /3). That is, (8140/2 or 8140/3) AND (8210/2 or 8210/3 or 8261/2 or 8261/3 or 8263/2 or 8263/3) in C20.9 or in the *same* colon segment C18.*x* -- assign 8140. Use 8140/2 if there was no invasion; use 8140/3 if any of the tumors was invasive.
    - When an *in situ* or invasive carcinoma (8010/2 or 8010/3) arises within the same segment of the colon or rectum as an *in situ* or invasive carcinoma in an adenomatous polyp (8210/2 or 8210/3), use the less specific code -- (8010/2 or 8010/3). Use /3 if any of the tumors was invasive; use /2 if all were noninvasive.
  - Within each breast, combinations of separate ductal and lobular carcinomas occurring within two months of each other are considered a single primary. Assign the combination histology code 8522/2 or 8522/3. Further details are given on page 24.
  - Certain neoplasms may have multiple tumor foci and multiple histologic types occurring together commonly. When a combination histology code covering the multiple histologies exists, a single primary should be abstracted with that combination code. These multifocal/multi-histologic tumors occur most often in the breast (C50._), bladder (C67._) and thyroid (C73.9). It is almost as if a single cancer were being expressed in multiple places within the primary site in the cell types found in those different places. Examples are ductal and lobular breast carcinomas (combination histologic type code 8522), Paget disease and ductal or intraductal breast carcinomas (8541, 8543), bladder papillary and transitional cell carcinomas (8130), and thyroid papillary and follicular carcinomas (8340).
- Multiple lesions of *different histologic types* in **different sites** are considered separate primaries whether occurring simultaneously or at different times.

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Pre-2007 rules continued:

Paired Organs (Laterality)

Except for malignancies of the "newly paired" CNS primary sites*, each "side" of a paired organ (pages 83-85) is a separate site, but if only *one malignant histologic type* is reported and if **both sides** of a paired site are involved within two months of diagnosis, a determination must be made as to whether the patient has two independent primaries or one (metastatic). If it is determined that there are two independent primaries then two case reports should be sent to the MCR, each with appropriate Laterality and staging.

If it is determined that there is only one primary, then Laterality should be coded according to the side in which the cancer originated and a single case report should be submitted. If it is impossible to tell in which of the pair a single primary originated, Laterality (see page 82) should be coded **4** ("bilateral involvement, side of origin unknown") and a single case report should be submitted.

Exceptions:

- Simultaneous bilateral involvement of the ovaries (C56.9) in which there is only a single histology is to be considered one primary. Laterality is coded based on the side of origin, or with **4** if the side of origin cannot be determined.
- Bilateral retinoblastomas (9510-9513) are always considered a single primary whether occurring simultaneously** or at different times. Laterality is coded **4**.
- Bilateral nephroblastomas (8960, also known as Wilms tumors) are always considered a single primary whether occurring simultaneously** or at different times. Laterality is coded **4**.

** The *FORDS* Manual specifies that these must be simultaneous occurrences, but the MCR is following SEER rules which have been expanded to include non-simultaneous tumors.

If one side of a paired organ is involved by tumor of one histologic type and the other side is involved by a different histologic type, then these are two separate primaries.

* For malignancies (behaviors /2 and /3) of the "newly paired" CNS primary sites (C70.0, C71.0-C71.4, C72.2-C72.5), different lateralities do NOT create separate primary sites. For example, malignancies of the right and left cerebral meninges are of the same site.

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Pre-2007 rules continued:

Breast Duct, Lobular, and Other Carcinomas

A single case report should be prepared for certain combinations of multiple separate carcinomas occurring in the **same breast** within two months of each other, even though they may have different histologies (i.e., a difference in the first three characters of the morphology codes). ICD-O-3 lists the morphology code 8522 for these combinations. If all the tumors are *in situ*, the behavior code should be /2; but if any part of a tumor is invasive, the behavior code must be /3*. Some examples follow:

Multiple simultaneous tumors in the same breast being counted as one primary

- Infiltrating duct carcinoma (8500/3) and lobular carcinoma (8520/3) -- Code as 8522/3.
- Infiltrating duct carcinoma (8500/3) and lobular carcinoma *in situ* (8520/2) -- Code as 8522/3.
- Intraductal carcinoma (8500/2) and lobular carcinoma (8520/3) -- Code as 8522/3.
- Intraductal carcinoma (8500/2) and lobular carcinoma *in situ* (8520/2) -- Code as 8522/2.

SEER has established rules for the use of combination histology codes 8523 (duct mixed with other types of carcinoma) and 8524 (lobular mixed with other types of carcinoma). These two new ICD-O-3 codes should only be used for single tumors of multiple histologic types and should not be used to combine multiple simultaneous tumors in the same breast.

Separate case reports should be sent for a lesion in one breast and an unrelated lesion in the **other breast** having *different histologic types*, whether or not they occur within two months of each other.

Separate case reports should be sent for two lesions in the **same breast** diagnosed more than two months apart. Invasive recurrences diagnosed more than two months after an *in-situ* diagnosis are also reportable as separate primaries (send two case reports to the MCR or use the Type of First Recurrence fields).

* SEER has established this new rule: If there are multiple tumors with different behaviors in the same organ being reported as a single primary, code the histology of the invasive tumor when one lesion is *in situ* and the other is invasive (*SEER Program Coding and Staging Manual 2004*, page 87). However, the breast site-specific coding rules in Appendix C of the SEER Manual demonstrate that the use of 8522 is an exception to this rule (*SEER Program Coding and Staging Manual 2004*, Example 1 on page C-472).

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Pre-2007 rules continued:

(Intra)ductal Carcinoma and Paget Disease

The single morphology code 8543/3 should be used for a combination of intraductal carcinoma (8500/2) and Paget disease of the breast (8540/3). Code 8541/3 should be used for a combination of Paget disease of the breast (8540/3) and duct carcinoma (8500/3).

Kaposi Sarcoma

Kaposi sarcoma (9140/3) is reported only once for a patient (the first diagnosis). Kaposi sarcoma is coded to the site in which it first arises. If Kaposi sarcoma arises in a skin site and another site simultaneously, code to the skin primary site (C44._). If no primary site is stated, code to skin, NOS (C44.9).

Melanomas

The COC counts each skin melanoma as a new primary unless stated to be metastatic, even if diagnosed within two months of each other. Reporting hospitals may follow this rule. At the MCR we follow SEER rules which have no special exceptions for melanomas. For example, a superficial spreading melanoma on the skin of the left arm and a melanoma, NOS diagnosed on the same arm within two months would be coded as two primaries for the COC, but would be one primary (using the more specific histology) at the MCR because they occur in the same primary site.

Behavior Rules for Intracranial / CNS Tumors

The single-vs.-multiple primary rules do not ordinarily refer to behavior because they were originally meant to apply only to malignancies. Continue to apply the standard rules (including determining "same site", "same histologic type" and "simultaneous") to all malignancies except those diagnosed beginning in 2007. For malignant intracranial/CNS tumors diagnosed beginning in 2007, use the MP/H Manual rules.

Intracranial/CNS non-malignancies (C70.0-C72.9, C75.1-C75.3 with behaviors /0, /1) and combinations of malignant and non-malignant tumors require special rules.

For multiple non-malignant lesions beginning with 2004 diagnoses: If the primary sites are different (see page 16), count as separate primaries. If the histologies are different (see page 19), count as separate primaries. If same site and same histology, if the lateralities are on opposite sides (right and left) then count as separate primaries. If same site, same histology, and same laterality (or left side with unknown/midline laterality, or right side with unknown/midline laterality), count as a single primary. These rules apply to any time period between diagnoses.

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For combinations of malignant and non-malignant lesions: A non-malignant tumor followed by a malignant one are separate primaries. A malignant tumor followed by a non-malignant one are separate primaries. These two rules apply even when the sites, histologies and lateralities are the same, and there may be any time period between diagnoses. See also the MP/H Manual for tumors diagnosed beginning in 2007. The MP/H rules (M1, M4) support the continuation of the above rules for combinations of malignant and non-malignant lesions in these primary sites.

If a tumor's behavior transforms from benign to borderline (/0 to/1), do not consider this a new primary. Retain the histology/behavior of the original diagnosis. This is true for diagnoses made beginning in 2004.

If a malignant tumor transforms to a higher WHO grade, do not consider this a new primary. Retain the histology/behavior of the original diagnosis. For malignant tumors diagnosed beginning in 2007, use the MP/H Manual rules.

If a tumor's behavior transforms from benign to malignant and the malignancy is diagnosed in 2007 or later, use the MP/H rules to determine if the malignancy is a new primary.

Deleted: , consider the malignancy to be

Examples: Two benign neoplasms (8000/0) of the right frontal lobe -- count as one primary because the lateralities are the same.

Benign neoplasms of the right and left frontal lobes -- count as separate primaries because they are on opposite sides.

A benign neoplasm of the right frontal lobe, and a benign neoplasm of the frontal lobe (laterality not specified) -- count as a single primary because the lateralities are not opposites.

~~A malignant glioma (9380/3) before or after a subependymoma (9383/1) -- count as separate primaries because one is malignant and other isn't.~~

An anaplastic ganglioglioma (9505/34) before or after a subependymal giant cell astrocytoma (9384/1) -- count as separate primaries because one is malignant and the other isn't.

A patient is diagnosed with a choroid plexus papilloma (9390/0) of the ventricle in 2004 and is treated. Later this patient is found to have a choroid plexus carcinoma (9390/3) in the same area. -- Count as separate primaries because the same disease has transformed from benign to malignant. Rule M4 would apply if the malignant tumor was diagnosed in 2007 or later (count as separate primaries).

(NAACCR announced updates of table on p. 19 2/04) page last updated July 2007

There have been no changes in the rules for determining single/multiple primaries for the lymphatic and hematopoietic diseases as of July 2007. The MP/H Manual rules do not apply to these diseases. Continue to use the "old" rules that follow.

Lymphatic and Hematopoietic Diseases

Table II.2 (pages 30-33) is used to help determine single-vs.-multiple primaries of lymphomas, leukemias and similar diseases. (SEER's fold-out table is identical to the typed Table II.2, except the typed version in this manual labels the rows and columns with histologic type codes only, and the code 9699 is listed numerically as a separate row and column in Table II.2.)

To compare two diagnoses:

1. assign the best ICD-O-3 histologic type code to each;
2. find the code of the first diagnosis in the row headings;
3. find the code of the second diagnosis in the column headings;
4. find the intersection of that row and column;
   - a **S** in the intersection indicates that the two diagnoses are considered parts of the **s**ame disease process, and are a single primary;
   - a **D** in the intersection indicates that they are considered **d**ifferent disease processes and are two separate primaries.

Examples (see page 30):

- first diagnosis -- lymphoma, NOS (9590)
  second diagnosis -- Hodgkin lymphoma, mixed cellularity (9652)
  The **S** at the intersection of row "9590" and column "9650-9667" indicates that this would be considered one primary.
- first diagnosis -- multiple myeloma (9732)
  second diagnosis -- lymphoma, NOS (9590)
  The **D** at the intersection of row "9731-9734" and column "9590" indicates that these would be considered separate primaries.

Rules and Guidelines:

1. Primary site is NOT to be considered in determining single/multiple primaries of these malignancies. Only the histologic types matter.

   Example: A patient has a lymphoma arising in lymph nodes and an extranodal lymphoma. You need to determine the two histologic types and use Table II.2 to determine if these are different diseases; the difference in primary sites is irrelevant.

2. The time interval between diagnoses is NOT to enter into the decision. Two leukemias diagnosed years apart could be considered a single primary.

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3. The sequence (chronologic order) of diagnoses may affect single-versus-multiple primary decisions. Always be careful to look for the earlier diagnosis code down the row labels of the table, and for the more recent diagnosis code across the top column labels.

   Examples: A patient is diagnosed with composite Hodgkin and non-Hodgkin lymphoma (9596) in January 2001, and with lymphoid leukemia (9820) in December 2003. This is a single primary (**S**) (9596), diagnosed in January 2001.

   A patient is diagnosed with lymphoid leukemia (9820) in January 2003, and with composite Hodgkin and NHL (9596) in December 2003. The December diagnosis is a new (**D**) primary.

4. Table II.2 contains only ICD-O-3 codes. It should be used to compare diagnoses made in 2001 and thereafter; it should also be used to compare a diagnosis made before 2001 with one made in 2001 or thereafter. When comparing a pre-2001 diagnosis with a diagnosis made in 2001+, remember to look in the row headings for the best ICD-O-3 code equivalent to the pre-2001 diagnostic term.

   Example: A patient was diagnosed in 1999 with "chronic myelomonocytic leukemia" (ICD-O-2 code 9868, ICD-O-3 code 9945). In 2003 the patient is diagnosed with "myeloid sarcoma" (ICD-O-3 code 9930). Using the ICD-O-3 codes and Table II.2, the intersection of row "9945" and column "9930" contains **S**, so this is a single primary (diagnosed in 1999, so be sure that the ICD-O-2 code 9868 gets assigned to this case).

   When comparing two pre-2001 diagnoses, you should use the old ICD-O-2 version of Table II.2 to decide if these would have been considered the same or different diseases. (See the *ROADS* or Third Edition MCR coding manual for the ICD-O-2 tables.)

5. When two diagnoses are considered to be the same disease process (**S**), and one is an "NOS" term while the other is more specific, assign the more specific diagnosis code to the single primary regardless of the chronological order of the diagnoses.

   Example: first diagnosis -- lymphoma, NOS (9590)
   second diagnosis --Hodgkin lymphoma, mixed cellularity (9652)

   This single primary will have the diagnosis date of the *first* diagnosis and the histologic type code of the *second* diagnosis because the first term is "NOS".

6. "Lymphoma" is a general term for solid malignancies of the lymphoid series of the hematologic diseases. "Leukemia" is a general term for liquid malignancies of the lymphoid or myeloid series. Because so many hematologic diseases can potentially arise as leukemias or lymphomas or both, all such malignancies are assumed to have the potential to appear in both forms.
7. Malignancies of the lymphoid series are to be considered different diseases from those of the myeloid series; and histiocytic malignancies are considered different diseases from those of both the lymphoid and myeloid series.
8. Hodgkin lymphoma is considered to be different from non-Hodgkin lymphoma. Among non-Hodgkin lymphomas, B-cell malignancies are to be considered different diseases from T-cell and NK cell malignancies.

Table II.2: Single ("S") vs. Subsequent ("D") Primaries for Lymphatic and Hematopoietic Diseases

Earlier Diagnosis ↓ ↓ ↓ ↓ ↓ ↓ / Later Dx → → → →	9590	9591	9596	9650 - 9667	9670 - 9671	9673	9675 - 9684	9687	9689	9690 - 9698	9699	9700, 9701
9590	S	S	S	S	S	S	S	S	S	S	S	S
9591	S	S	D	D	S	S	S	S	S	S	S	S
9596	S	S	S	S	S	S	S	S	S	S	S	S
9650 - 9667	S	D	D	S	D	D	D	D	D	D	D	D
9670 - 9671	S	S	D	D	S	D	S	D	D	D	D	D
9673	S	S	D	D	D	S	D	D	D	D	D	D
9675 - 9684	S	S	D	D	S	D	S	S	D	S	D	D
9687	S	S	D	D	D	D	D	S	D	D	D	D
9689	S	S	D	D	D	D	D	D	S	D	S	D
9690 - 9698	S	S	D	D	D	D	S	D	D	S	D	D
9699	S	S	D	D	D	D	D	D	S	D	S	D
9700, 9701	S	S	D	D	D	D	D	D	D	D	D	S
9702 - 9719	S	S	D	D	D	D	D	D	D	D	D	D
9727	S	S	D	D	D	D	D	D	D	D	D	D
9728	S	S	D	D	D	D	D	D	D	D	D	D
9729	S	S	D	D	D	D	D	D	D	D	D	D
9731 - 9734	D	D	D	D	D	D	D	D	D	D	D	D
9740 - 9742	D	D	D	D	D	D	D	D	D	D	D	D
9750 - 9756	D	D	D	D	D	D	D	D	D	D	D	D
9757, 9758	S	S	D	D	D	D	D	D	D	D	D	D
9760	S	S	D	D	S	D	S	D	D	D	D	D
9761	S	S	D	D	S	D	S	D	D	D	D	D
9762	S	S	D	D	D	D	D	D	D	D	D	D
9764	S	S	D	D	D	D	D	D	D	D	D	D
9800, 9801	S	S	D	D	D	D	D	S	D	D	D	D
9805	S	S	D	D	S	S	S	S	S	S	S	S
9820	S	S	D	D	D	D	D	S	D	S	D	S
9823	S	S	D	D	S	D	S	D	D	D	D	D
9826	S	S	D	D	D	D	D	S	D	D	D	D
9827	S	S	D	D	D	D	D	D	D	D	D	D
9832	D	D	D	D	S	D	D	D	D	D	D	D
9833	D	D	D	D	S	D	D	D	D	D	D	D
9834	D	D	D	D	D	D	D	D	D	D	D	D
9835	S	S	D	D	D	D	D	D	D	D	D	D
9836	S	S	D	D	D	D	D	D	D	D	D	D
9837	S	S	D	D	D	D	D	D	D	D	D	D
9840 - 9910	D	D	D	D	D	D	D	D	D	D	D	D
9920	D	D	D	D	D	D	D	D	D	D	D	D
9930	D	D	D	D	D	D	D	D	D	D	D	D
9931	D	D	D	D	D	D	D	D	D	D	D	D
9940	D	D	D	D	D	D	D	D	D	D	D	D
9945	D	D	D	D	D	D	D	D	D	D	D	D
9946	D	D	D	D	D	D	D	D	D	D	D	D
9948	S	S	D	D	D	D	D	D	D	D	D	D
9950	D	D	D	D	D	D	D	D	D	D	D	D
9960	D	D	D	D	D	D	D	D	D	D	D	D
9961	D	D	D	D	D	D	D	D	D	D	D	D
9962	D	D	D	D	D	D	D	D	D	D	D	D
9963	D	D	D	D	D	D	D	D	D	D	D	D
9964	D	D	D	D	D	D	D	D	D	D	D	D
9980 - 9986	D	D	D	D	D	D	D	D	D	D	D	D
9987	D	D	D	D	D	D	D	D	D	D	D	D
9989	D	D	D	D	D	D	D	D	D	D	D	D

Table II.2: Single ("S") vs. Subsequent ("D") Primaries for Lymphatic and Hematopoietic Diseases

Earlier Diagnosis ↓ ↓ ↓ ↓ ↓ / Later Dx → → → →	9702-9719	9727	9728	9729	9731-9734	9740-9742	9750-9756	9757, 9758	9760	9761	9762	9764
9590	S	S	S	S	S	S	S	S	S	S	S	S
9591	S	S	S	S	D	D	D	S	S	S	S	S
9596	S	S	S	S	D	D	D	D	S	S	S	S
9650 - 9667	D	D	D	D	D	D	D	D	D	D	D	D
9670 - 9671	D	D	D	D	D	D	D	D	D	S	D	D
9673	D	D	D	D	D	D	D	D	D	D	D	D
9675 - 9684	D	D	D	D	D	D	D	D	S	S	S	S
9687	D	D	D	D	D	D	D	D	D	D	D	D
9689	D	D	D	D	D	D	D	D	D	D	D	D
9690 - 9698	D	D	D	D	D	D	D	D	D	D	D	D
9699	D	D	D	D	D	D	D	D	D	D	D	D
9700, 9701	D	D	D	D	D	D	D	D	D	D	D	D
9702 - 9719	S	D	D	D	D	D	D	D	S	D	D	D
9727	D	S	S	S	D	D	D	D	D	D	D	D
9728	D	S	S	D	D	D	D	D	D	D	D	D
9729	D	S	D	S	D	D	D	D	D	D	D	D
9731 - 9734	D	D	D	D	S	D	D	D	D	D	D	D
9740 - 9742	D	D	D	D	D	S	D	D	D	D	D	D
9750 - 9756	D	D	D	D	D	D	S	D	D	D	D	D
9757, 9758	D	D	D	D	D	D	D	S	D	D	D	D
9760	D	D	D	D	S	D	D	D	S	S	S	S
9761	D	D	D	D	D	D	D	D	S	S	D	D
9762	D	D	D	D	D	D	D	D	S	D	S	S
9764	D	D	D	D	S	D	D	D	S	D	S	S
9800, 9801	S	S	S	S	D	D	D	D	D	D	D	D
9805	S	S	S	S	D	D	D	D	D	D	D	D
9820	S	S	S	S	D	D	D	D	S	S	S	D
9823	D	D	D	D	D	D	D	D	S	D	D	D
9826	D	D	D	D	D	D	D	D	D	D	D	D
9827	D	D	D	D	D	D	D	D	D	D	D	D
9832	D	D	D	D	D	D	D	D	D	D	D	D
9833	D	D	D	D	D	D	D	D	D	D	D	D
9834	D	D	D	D	D	D	D	D	D	D	D	D
9835	D	S	S	S	D	D	D	D	D	D	D	D
9836	D	S	S	D	D	D	D	D	D	D	D	D
9837	D	S	D	S	D	D	D	D	D	D	D	D
9840 - 9910	D	D	D	D	D	D	D	D	D	D	D	D
9920	D	D	D	D	D	D	D	D	D	D	D	D
9930	D	D	D	D	D	D	D	D	D	D	D	D
9931	D	D	D	D	D	D	D	D	D	D	D	D
9940	D	D	D	D	D	D	D	D	D	D	D	D
9945	D	D	D	D	D	D	D	D	D	D	D	D
9946	D	D	D	D	D	D	D	D	D	D	D	D
9948	S	D	D	D	D	D	D	D	D	D	D	D
9950	D	D	D	D	D	D	D	D	D	D	D	D
9960	D	D	D	D	D	D	D	D	D	D	D	D
9961	D	D	D	D	D	D	D	D	D	D	D	D
9962	D	D	D	D	D	D	D	D	D	D	D	D
9963	D	D	D	D	D	D	D	D	D	D	D	D
9964	D	D	D	D	D	D	D	D	D	D	D	D
9980 - 9986	D	D	D	D	D	D	D	D	D	D	D	D
9987	D	D	D	D	D	D	D	D	D	D	D	D
9989	D	D	D	D	D	D	D	D	D	D	D	D

Table II.2: Single ("S") vs. Subsequent ("D") Primaries for Lymphatic and Hematopoietic Diseases

Earlier Diagnosis ↓↓↓↓ / Later Dx →→→→	9800, 9801	9805	9820	9823	9826	9827	9832	9833	9834	9835	9836	9837	9840-9910	9920
9590	S	S	S	S	S	S	S	S	S	S	S	S	S	S
9591	S	S	S	S	S	S	D	D	D	S	S	S	D	D
9596	S	D	S	S	S	S	D	D	D	S	S	S	D	D
9650 - 9667	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9670 - 9671	D	S	S	S	D	D	S	S	D	D	D	D	D	D
9673	D	S	D	D	D	D	D	D	D	D	D	D	D	D
9675 - 9684	D	S	S	S	D	D	S	S	D	D	D	D	D	D
9687	S	S	S	D	S	D	D	D	D	D	D	D	D	D
9689	D	S	D	D	D	D	D	D	D	D	D	D	D	D
9690 - 9698	D	S	D	D	D	D	D	D	D	D	D	D	D	D
9699	D	S	D	D	D	D	D	D	D	D	D	D	D	D
9700, 9701	D	S	S	D	D	D	D	D	D	D	D	D	D	D
9702 - 9719	D	S	S	D	D	D	D	D	D	D	D	D	D	D
9727	S	S	S	D	D	D	D	D	D	S	S	S	D	D
9728	S	S	S	D	D	D	D	D	D	S	S	D	D	D
9729	S	S	S	D	D	D	D	D	D	S	D	S	D	D
9731 - 9734	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9740 - 9742	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9750 - 9756	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9757, 9758	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9760	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9761	D	D	S	S	D	D	D	D	D	D	D	D	D	D
9762	D	D	S	S	D	D	D	D	D	D	D	D	D	D
9764	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9800, 9801	S	S	S	D	S	S	D	D	D	S	S	S	S	S
9805	S	S	S	S	S	S	S	S	S	S	S	S	S	S
9820	S	S	S	S	S	S	S	S	S	S	S	S	D	D
9823	D	S	S	S	D	D	S	S	D	D	D	D	D	D
9826	S	S	S	D	S	D	D	D	D	D	D	D	D	D
9827	D	S	S	D	D	S	D	D	D	D	D	D	D	D
9832	D	S	S	S	D	D	S	S	S	D	D	D	D	D
9833	D	S	S	S	D	D	S	S	D	D	D	D	D	D
9834	D	S	S	D	D	S	S	D	S	D	D	D	D	D
9835	S	S	S	D	D	D	D	D	D	S	S	S	D	D
9836	S	S	S	D	D	D	D	D	D	S	S	D	D	D
9837	S	S	S	D	D	D	D	D	D	S	D	S	D	D
9840 - 9910	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9920	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9930	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9931	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9940	S	S	D	D	D	D	D	D	D	D	D	D	D	D
9945	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9946	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9948	S	S	S	D	D	D	D	D	D	D	D	D	D	D
9950	S	D	D	D	D	D	D	D	D	D	D	D	D	D
9960	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9961	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9962	S	D	D	D	D	D	D	D	D	D	D	D	S	S
9963	S	D	D	D	D	D	D	D	D	D	D	D	S	S
9964	S	D	D	D	D	D	D	D	D	D	D	D	S	S
9980 - 9986	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9987	S	S	D	D	D	D	D	D	D	D	D	D	S	S
9989	S	S	D	D	D	D	D	D	D	D	D	D	S	S

Table II.2: Single ("S") vs. Subsequent ("D") Primaries for Lymphatic and Hematopoietic Diseases

Earlier Diagnosis ↓↓↓↓ / Later Dx →→→→	9930	9931	9940	9945	9946	9948	9950	9960	9961	9962	9963	9964	9980-9986	9987	9989
9590	S	S	S	S	S	S	D	D	D	D	D	D	D	D	D
9591	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9596	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9650 - 9667	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9670 - 9671	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9673	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9675 - 9684	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9687	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9689	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9690 - 9698	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9699	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9700, 9701	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9702 - 9719	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9727	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9728	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9729	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9731 - 9734	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9740 - 9742	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9750 - 9756	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9757, 9758	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9760	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9761	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9762	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9764	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9800, 9801	S	D	D	S	S	D	D	S	S	D	S	S	D	S	S
9805	S	S	S	S	S	S	D	S	S	D	D	D	S	S	S
9820	D	D	S	D	D	S	D	D	D	D	D	D	D	D	D
9823	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9826	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9827	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9832	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9833	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9834	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9835	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9836	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9837	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
9840 - 9910	S	S	D	S	S	D	D	S	S	S	S	S	D	S	S
9920	S	S	D	S	S	D	D	D	S	D	D	D	D	S	S
9930	S	S	D	S	S	D	D	S	S	S	S	D	D	S	S
9931	S	S	D	S	S	D	D	D	S	D	D	D	D	S	S
9940	D	D	S	D	D	D	D	D	D	D	D	D	D	D	D
9945	S	S	D	S	S	D	D	S	S	D	S	D	D	S	S
9946	S	S	D	S	S	D	D	D	S	D	D	D	D	S	S
9948	D	D	D	D	D	S	D	D	D	D	D	D	D	D	D
9950	D	D	D	D	D	D	S	S	S	D	D	D	D	D	D
9960	S	S	D	S	D	D	D	S	S	S	S	D	D	D	D
9961	S	S	D	S	S	D	D	S	S	S	S	D	D	S	S
9962	S	S	D	S	D	D	D	S	S	S	S	D	D	D	D
9963	S	S	D	S	D	D	D	S	S	S	S	D	D	D	D
9964	S	S	D	S	S	D	D	S	S	D	D	S	D	D	D
9980 - 9986	S	S	D	S	S	D	D	S	S	D	D	D	S	S	S
9987	S	S	D	S	S	D	D	S	S	D	D	D	S	S	S
9989	S	S	D	S	S	D	D	S	S	D	D	D	S	S	S

Differences in Reportability Between ICD-O-2 and ICD-O-3

The year of diagnosis determines coding and other data standards for case reporting.* If a case was first diagnosed before 2001 and was reportable to the MCR under ICD-O-2 coding, then that case is reportable to the MCR regardless of when you abstract and report the case. If a case was first diagnosed before 2001 and was *not* reportable under ICD-O-2 coding, then it is *not* reportable. If a case was first diagnosed in 2001 or thereafter, then its ICD-O-3 coding determines whether or not it is reportable.

Exception: If a hematopoietic disease diagnosed before 2001 transforms (progresses) to a different reportable disease in 2001 or later, abstract the later diagnosis even if *not* a new primary. This ensures registration of the now reportable disease.

Examples: Refractory anemia first diagnosed in 2000 and first seen at your facility in 2002 -- case is *not* reportable because the ICD-O-2 code is 9980/1. Had the case been first diagnosed in 2001, it *would* be reportable.

Serous cystadenoma, borderline malignancy, diagnosed in 2005 -- case is *not* reportable because the ICD-O-3 code is 8442/1. Had the case been diagnosed before 2001, it *would* be reportable.

Chronic myeloproliferative disease first diagnosed before 2001 is *not* reportable because its ICD-O-2 code is 9960/1. The same disease first diagnosed in 2001 *would* be reportable because its ICD-O-3 code is 9960/3.

Myeloproliferative disease, *NOS* (9960/1 in ICD-O-2 and 9975/1 in ICD-O-3) is *not* reportable under either pre-2001 or 2001+ rules.

Myelodysplastic syndrome diagnosed in 1999 transforms to refractory anemia in 2004. The original diagnosis was not reportable under ICD-O-2 rules (9989/1). The second diagnosis is reportable under ICD-O-3 rules (9980/3). Even though the anemia is part of the same disease process (not a new primary), abstract the 2004 diagnosis because the original disease has become something reportable (and note in a narrative that this anemia was originally myelodysplastic syndrome).

Remember that, in North America, SEER ICD-O-3 coding rules state that 9421/1 pilocytic astrocytomas diagnosed in 2001 and thereafter should be reported with the ICD-O-3 morphology code changed to 9421/**3**. Such cases are reportable to the MCR even with the /1 code because of our brain/CNS tumor collection rules, but remember to change the behavior to **3** when reporting histologic type code 9421 (unless the behavior is specified as benign). SEER, the ACoS/COC, NAACCR and CDC/NPCR agree on this practice.

* If the year of diagnosis is unknown to you, try to estimate it. If you cannot estimate the diagnosis year, use the "Date of First Contact" year (the year of your facility's first contact with the patient for this case) to determine which coding rules pertain.

Negative Biopsies

Cases in which a positive cytology is followed by a negative biopsy must be carefully evaluated. The case should not be reported if the biopsy ruled out cancer; if a negative biopsy does *not* rule out cancer, the case is considered cytologically confirmed and it should be reported. (Also see the "suspicious cytology" notes on page 14.)

Consultation-Only Cases and Pathology-Only Cases

Cases seen only for diagnostic or treatment consultation are not reportable to the COC for diagnoses made as of 2003. The MCR made reporting such cases optional since 1995, but we are now discontinuing this practice. Consultation-only cases (that is, the patient came to your facility for *discussions* only) should NOT be submitted to us. We have determined that such cases contribute little to our overall casefinding completeness.

Pathology-only cases are now assigned to Class 7 for diagnoses made beginning in 2003 (see page 113 for Class 7 description). Cases of Class 7 are not required, but if your facility chooses to abstract such cases they should be sent to the MCR along with your regular cases (analytic and nonanalytic). If your hospital registry opts to *not* report Class 7's to us, then you must forward copies of the pathology reports to us and we'll follow back to the ordering physician if we need additional information. The MCR understands that it may be difficult to determine whether a case is truly Class 7 (for example, your pathology department produced a report but you can't tell if your facility had any actual patient contact; the pathology report may represent a second-opinion pathology consultation). The MCR also pursues direct reporting from commercial pathology laboratories and hospital pathology laboratories (rather than through the hospital registry) for pathology-only cases.

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Whenever there is doubt about whether or not to submit a particular case, consult the MCR at 617-624-5622.

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2006 Changes in Cases of Class 0

Beginning with diagnoses made in 2006, the COC has made two changes in their cancer program requirements for Class 0 cases: patients with only a Class 0 case do not need annual follow-up, and physician AJCC (TNM) staging of Class 0 cases is not required. Please note that Class 0 cases must still be accessioned for the COC as before, and the Collaborative Staging "input" fields must still be filled in for Class 0 cases.

These changes have no impact on MCR reporting requirements. We do not require facilities to do annual patient follow-up, and we require no TNM staging for diagnoses made after 2003. We expect no decrease in the number or quality of Class 0 cases reported to the MCR.

page last updated for 2006

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