NATIONAL INSTITUTES OF HEALTH
NATIONAL CANCER INSTITUTE
SURVEILLANCE, EPIDEMIOLOGY AND END RESULTS (SEER) PROGRAM
BREEZE SESSION
Multiple Primary and Histology Coding Rules—Kidney Rules
February 9, 2007

INTRODUCTION

Welcome to today's Web broadcast on the Kidney rules. This is Steve Peace talking with you today. Today we are going to be discussing the Kidney site-specific 2007 Multiple Primary and Histology Coding Rules as well as the Terms and Definitions that support this particular set of rules. Many of you joining us today have been actively participating in this series of Web broadcasts and I would like to thank you for your continued interest and attention. For those of you who are new to our broadcasts I would like to welcome you. The NCI-SEER Program is very pleased to be able to continue to make these broadcast sessions available to you both through our live Breeze Sessions as well as through the recorded sessions.

Recorded sessions from previous broadcasts are available on the SEER website. Just go to the "Information for Cancer Registrars" area and click on the 2007 Multiple Primary and Histology Coding Rules and you will be directed to the recorded sessions as well as to the area where you can download the rules themselves. The recorded sessions are available to anybody who would like to view and listen to them. They are free of charge and they are available twenty-four hours a day, seven days a week. Transcripts are also available for the hearing impaired.

If you are joining us through the recorded broadcast we would like to welcome you also and are very happy to have you join us after the fact using the special features of the recorded Webcast technology.

Today we have an interesting, approximately one hour presentation of the Kidney rules. We will follow our didactic presentation with instructions on how to access and work through the practicum cases. Antoinette Percy-Laurry will follow with an email announcement inviting everybody to join the Kidney Practicum discussion sometime next week. I believe that's scheduled for Valentine's Day. So be sure to join us to discuss the cases next week.

Today we will go over the general structure and format of the kidney rules. We'll highlight some of the special features of the Kidney Terms and Definitions as well as highlight some of the features of the Kidney Multiple Primary and Histology Coding Rules. This is an open session so you are invited to ask questions as we go along.

As we get started I would like to remind everybody to mute their phones or if you don't have the mute feature on your phone, please exercise your best phone courtesy and please don't put your phone on "Hold" because many of the facilities play music when you place a call on "Hold" and we don't want to interrupt the live or recorded broadcast with music or other recordings. I thank you for that.

I want to begin our discussion today with a little bit of background. When the rules development team, the Histology Committee, with leadership provided by Co-Chairs Carol Johnson and myself began to meet we were faced with the difficult task of developing a standard set of rules for specific cancer sites or site groups for some cases like Head and Neck and some of the Urinary system which we will talk about in our next presentation. The goal was to develop a standard set of rules that registrars could use on a daily basis; that are easy to use and understand and that will result in consistent determination of the number of primary tumors to be abstracted by registrars and consistent and correct histology coding that most appropriately represents the tumor type for each cancer case. We recognized that our old rules had clearly become outdated since they were thirty years old and we knew that we could improve upon them.

SLIDE 1

Kidney presents some unique challenges because, as you know, the kidney and other urinary sites can be confusing if you consider them altogether, particularly if you consider the kidney along with renal pelvis and ureter which has been proved historically. We learned that the best way to approach kidney was to separate the kidney out from the other urinary sites since kidney cancers are almost always glandular in origin or adenocarcinoma. The histologies of tumors in the other urinary sites were almost always **not** adenocarcinoma-- more frequently transitional or squamous cell origin. We also learned that our international colleague, IACR (International Association of Cancer Registries), the WHO, the International Agency for Research on Cancer (IARC) and the European Network of Cancer Registries had come to the same conclusion when they revised the international rules for multiple primary cancers. So, kidney is now separated out from the rest of the urinary system in terms of examining the number of primary tumors and the histology coding for these tumors.

SLIDE TWO

This particular set of rules is pretty straightforward as you will see but we still want to bring some special features and the Terms and Definitions and some special rules to your attention.

The next set of rules that we're going to present after Kidney will be the Other Urinary Sites. That will include Renal Pelvis, Ureter and Bladder as a set of rules instead of just a single site like Kidney.

Now we are ready to get started. You should have a few items for reference during our session today. You should have available to you the Kidney Equivalent Terms and Definitions document, the Kidney Multiple Primary Rules in your choice of format—either text, matrix or flow chart—and the Kidney Histology Coding Rules in your choice of format. I'm going to be using the flowcharts today in my presentation but you can follow along in whichever format you've chosen as each set of rules is identical.

We're going to begin with the Terms and Definitions so if you'll open or pull out the Kidney Terms and Definitions we'll get started.

SLIDE THREE
In the Equivalent Terms and Definitions, you'll notice in the Introduction that the first thing that you see is a little bit of—a couple of paragraphs-- that orient you to the types of tumors that we're going to be looking at in the kidney. Renal cell carcinoma is a group term for glandular carcinomas, adenocarcinomas of the kidney of which approximately 85% of all malignancies of the kidney are made of—the renal cell and specific renal cell subtypes. So the majority of these tumors are renal cell carcinoma, glandular carcinomas of the kidney.

SLIDE FOUR
Transitional cell carcinomas rarely arise in the kidney parenchyma. They are usually found in the upper urinary system in the renal pelvis and then follow down through the rest of the urinary system—through the ureters and into the bladder. So, we are providing instructions throughout and also in the Introduction to inform you that transitional cell carcinomas of the kidney are rare and you only will code transitional cell carcinoma of the kidney when the pathology report confirms that the tumor originated in the parenchyma of the kidney. I think most registrars are pretty alert to this. We are also making sure that we have this information available to new registrars as they start to use these rules and to learn some of the nuances of our coding rules and guidelines.

In the Equivalent Terms and Definitions, equivalent or equal terms, you will notice that *multifocal* and *multicentric* for the purposes of these rules are considered equivalent. Kidney tumors are frequently multifocal or multicentric. You'll also see in the Equivalent or Equal Terms, *renal cell carcinoma (RCC*) and *hypernephroma* which is an obsolete term are equivalent; and of course we carry over with *tumor, mass, lesion* and *neoplasm* being equivalent terms for the purposes of our rules.

If you have your Equivalent Terms and Definitions open or available to you, you'll also see under the Definitions: *carcinoma of the collecting ducts of Bellini* or *collecting duct carcinoma* and there is a nice description there that tells you a little bit about these rare tumors. And there is controversy over whether or not these medullary carcinoma or collecting duct carcinoma are the same or if they're distinctly different histologies. So, you'll see in this definition that we're going to

code medullary carcinoma originating in the kidney to medullary carcinoma so we can differentiate between when the pathologist calls a histology *medullary* or *collecting duct* so we can separate those out.

Also included in the Definitions is a definition for *chromophobe renal cell carcinoma*. About 5% of the renal cell carcinomas are of the *chromophobe* subtype and *chromophobe* means that these tumors are not easily stained; the cytoplasm does not take up the eosin stain very well. So that's one way to distinguish those. About 70% of the renal cell carcinomas are of the *clear cell type* and 10 to 20% are *papillary carcinomas*; they used to be called *chromophil*. *Chromophil carcinoma* is an obsolete term, which is why you don't see it in the Definitions and *chromophil* suggests that these cells take up the eosin stains quite easily so the cells are easily identified. So, that's one way to distinguish between *chromophil* and *chromophobe*.

About 5% of the renal cell carcinomas are identified without a subtype and then we also occasionally will see the Wilms tumor in children, usually between the ages of two and five years.

SLIDE FIVE
If you have your Kidney Equivalent Terms and Definitions open, if you could turn to Table 1. And Table 1 is a display of the Renal Cell Carcinoma and Specific Renal Cell Types. Some people may call those subtypes or variants or different things like that; there are lots of different terms that may be used, but for our purposes we are calling these Renal Cell Carcinoma and Specific Renal Cell Types. You'll notice that renal cell carcinoma, NOS (code 8312) is the non-specific term under which the other types are listed. This Table is a complete listing of the specific renal cell carcinoma types.

SLIDE SIX
Here's a display of that Table. You'll notice some of the terms that I brought to your attention in the Definitions: *papillary* and in parentheses *chromophil* which is the obsolete term; and again those are about 10 to 20% of the renal cell carcinomas*; clear cell renal cell carcinoma* which represents about 70% of the renal cell carcinoma types; *cyst associated* or *cystic* is a small percentage; *chromophobe* is about 5% again; rare tumor—*sarcomatoid*; rare tumor—*collecting duct type*; *granular cell* are also pretty rare and so are *medullary* and so are the *malignant cystic nephromas*. Just a Note here to remind people that *chromophil* and *chromophobe* are different histologies and those will be accounted for in the multiple primary and in the histology coding rules to help you distinguish those particular issues.

What I'd also like to show you is the long-held rule: "Code to the higher ICD-O-3 code," really doesn't work here. Renal cell carcinoma, NOS is coded 8312 and the most common renal cell subtype is 8310. So if we coded all of these to 8312 we would actually be missing a lot of these clear cell subtypes. So that's just one

way of demonstrating that the old rules really don't hold up anymore and that's one of the reasons why we've developed these new sets of rules.

SLIDE SEVEN
We'd also like to bring to your attention—and this is outlined in Table 2—in the Equivalent Terms and Definitions, historically kidney has been grouped with renal pelvis, ureter and other urinary sites. As I outlined in the Introduction, the first few minutes of this session, tumors of the kidney are generally adenocarcinoma (glandular carcinoma). And tumors of the renal pelvis and ureter and other urinary sites are generally transitional cell carcinomas or squamous cell carcinomas. We are now consistent with the international rules in pulling the kidney rules out separate from the renal pelvis and ureter and we have now grouped the renal pelvis, ureter and bladder rules together because histologically and prognostically those tumors are grouped much better and much more representatively together.

[*I have a little note from one of our participants that asked to, "Open the full screen, please." I have been advised by our recording folks that I would not be able to see your notes if I had this on full screen and that's the reason for recording it all; So for notification of the presenter, not to put it on full screen. So I appreciate your comments and your suggestion but there is an actual purpose for my not having this on a full screen. So thank you very much.*]

SLIDE EIGHT
Let's go to the Multiple Primary Rules.

If you pull these up you will notice, first of all, in our headings, in the headings of all the rules, we instruct you through the heading which primary site and sometimes what histologies are to be included in applying the particular rules in this section. For these we are only looking at kidney and we exclude the lymphomas and the leukemias and the Kaposi's sarcomas from this set of rules.

SLIDE NINE
When we go to our first rule, our first set of rules, our first module is: "Unknown if Single or Multiple Tumors." This is the same rule that has been used in all the different sets of multiple primary rules up to this point. And the reason that this module is included is, sometimes the hospital registrar may get an H&P that documents a biopsy in a physician's office; then the patient has another biopsy or resection and the registrar can't really confirm if the patient had a single tumor or multiple tumors. Other times the central registry, when they are trying to do consolidation, they get a path report of a biopsy followed by a hospital report of a resection and the central registry may not be sure if there was a single tumor or multiple tumors. This module, this particular rule, and sometimes there is more than one rule in this section, this rule accommodates whether or not you don't know if you have single or multiple tumors.

SLIDE TEN
The rule is quite simple: “When it is not possible to determine if there is a single tumor or multiple tumors, you opt for a single tumor and you abstract the case as a single primary.” You use this rule only after all information sources have been used. That’s included in the Note. You’ll notice we have a “Notes” section in the text version of the rules, in the flowchart version of the rules and in the matrix version of the rules, you’ll see Notes and they are consistent throughout. When you are using the flowchart version of the rules they are set up such that you’ll be asked a question: “Is it impossible to determine if there is a single tumor or multiple tumors?” And based on your reply, “Yes,” or “No,” you either have a decision or you go to the next set of rules. So if it is impossible to determine if there is a single tumor or multiple tumors you opt for a single primary and you abstract one case. If it is possible to determine, you go to either the Single Tumor or Multiple Tumors module.

SLIDE ELEVEN
The Single Tumor Module is our next module. It is the size of a single rule.

SLIDE TWELVE
Notice that in the Notes: “The tumor is not described as metastasis. Includes combinations of in situ and invasive.” Here are those Notes.

The rule is very simple and sometimes we refer to this as the *Duh rule*: “If there is a single tumor, it is a single primary.” This is sort of the “no nonsense” rule but we have to include it because it’s very important to distinguish these particular situations. Very frequently this will be the only rule that you use and you’re finished determining how many abstracts you have to complete. If you do have multiple tumors, then we have a number of different rules that you have to follow.

SLIDE THIRTEEN
Multiple tumors may be a single primary or they may be multiple primaries. And, again, tumors are not described as metastasis and it does include combinations or in situ and invasive.

SLIDE FOURTEEN
The first rule under the Multiple Tumors [Module] asks the question: “Is the diagnosis Wilms tumor?” If you have bilateral Wilms tumor you have a single primary. If you have multiple Wilms tumor it is a single primary also. Again, these are tumors that arise in children usually between the ages of 2 and 5. They are commonly bilateral even though the Wilms tumor may present months or years apart. So when you have Wilms tumor in both kidneys it is always a single primary.

SLIDE FIFTEEN
On to rule M4: This is our historic two-digit site rule that we have carried through frequently in this set of rules: “Tumors with ICD-O-3 topography codes that are

different at the second and/or third character in the topography code are multiple primaries." A good example of this is if you have a kidney primary and a breast primary. [For] these tumors, the topography is different at the second or third character of the topography code.

SLIDE SIXTEEN
Rule M5 is the laterality rule for kidney. "Are there tumors in both the left kidney and in the right kidney?" If there are, then these are multiple primaries and you will abstract as a single primary when the tumors in one kidney are documented to be metastatic from the other only, which is a very, very rare occurrence. I would like to point out here, and this is something we want to reinforce every time we give instruction on these rules, is that these rules are hierarchical. You follow and ask each question of each rule as you go along. You don't just go and find the rule that you like and use it. You have to ask each question following the next question in a series, one after the next, until you get your answer and then you stop. You don't jump to rule M7 just because you like it. You ask each question one at a time as you go through. This acts as kind of like a gumball bank effect, if you will, where you start your question series with a full gumball bank. Each time you ask a question, some of the gumballs drop out so you have fewer cases from which to ask the next question. This is the way all of these rules are set up. We like to reinforce to everybody that you don't just berry-pick a rule. You follow through each set of rules as you go.

SLIDE SEVENTEEN
Rule M6: "Tumors diagnosed more than three years apart are multiple primaries." So this is our timing rule for kidney. Tumors diagnosed more than three years apart are multiple primaries. So with rule M5-- and I'm going to just bounce a little back and forth here--rule M5 you have pulled out all of the bilateral tumors; rule M6 you've pulled out tumors in a single kidney that are diagnosed more than three years apart. So, see? That gumball bank is getting smaller each time you ask a question.

SLIDE EIGHTEEN
Rule M7 is a rule that you really won't use very much but we've included it because as diagnostic procedures become more and more keenly specific we may be seeing more in situ tumors of the kidney diagnosed as the techniques improve. You will see in situ and invasive tumors more closely diagnosed in time, especially for the other urinary sites that we'll be discussing next time, but for kidney you won't use this rule very often. The purpose of this rule is to ensure that the case is counted as an incident or invasive case when incidence data are analyzed. In situ cancers are not included in incidence rates. So if you have a tumor that is originally diagnosed as in situ and either progresses or develops a new invasive tumor more than 60 days after diagnosis we want to make sure that that's counted as a multiple primary so that invasive case does get included in incidence data when they are analyzed.

There is an additional Note here that says: “Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.” That is something that registrars are still struggling a little bit with. We are not saying that the physician is wrong or incorrect. What we are doing with this rule is ensuring that the case is counted as an incident (invasive) case in the data analysis.

SLIDE NINETEEN

Rule M8 is a specific and specialized rule for kidney. “Is there one tumor with a specific renal cell type and another tumor with a different, specific renal cell type (Table 1)?” [You must reference Table 1 when you are using this.] If you have, and again, we have determined that the tumors are in one kidney and that they are less than 3 years apart in diagnosis. And we have also determined that it’s not in situ and invasive within 60 days so again that gumball bank concept works here. So we’re looking now at what you may frequently see in multifocal, multicentric, multiple tumors in a single kidney where you have one tumor with a specific renal cell type and another tumor with a different specific renal cell type from Table 1. If you have that situation you will abstract these as multiple primaries. A good example here would be if you had a chromophobe carcinoma renal cell carcinoma and a papillary renal cell carcinoma. You would abstract this as two primaries using this particular rule whether, depending upon whether or not, you had already determined whether it was a single or a multiple primary before you got to this rule.

SLIDE TWENTY

Rule M9 looks kind of busy in the question and answer part but it’s actually quite a simple rule. And this rule instructs you to abstract multiple tumors as a single primary when one of the tumors is histologically not diagnosed or cancer/malignant neoplasm, NOS and another is a specific histology. In a situation where one tumor is histologically typed as carcinoma, NOS and the other is a specific carcinoma; in the situation where one tumor is diagnosed as adenocarcinoma NOS and another is a specific type of adenocarcinoma; and finally and probably most frequently, what you will see is when one tumor is a renal cell carcinoma NOS and another tumor in the same kidney is a single renal cell type from Table 1. I would really encourage you and reinforce in you that Notes 1 and 2 from rule M9 are particularly important. They distinguish between what types of qualifiers or what types of adjectives you can use that are used in the description of tumors. And you will notice the specific histology for in situ tumors may be identified as “pattern, architecture, type, subtype, predominantly, with features of, major, or with _____differentiation [whatever fills in that blank].” “Pattern” and “architecture” are terms that are specific for in situ tumors; they can be used and you can only use the terms that are listed in this Note. So other terms are under consideration by the Multiple Primary and Histology Coding Rules Team and the Histology Committee and this may be referenced through the course of additional revisions. However, this list is quite strict and we are trying not to…we are asking folks to apply these Notes quite literally.

SLIDE TWENTY-ONE
Rule M10 is our historic three-digit histology rule where we ask the question: “Do the tumors have ICD-O-3 histology codes that are different at the first, second or third number?” If there is any difference in the first, second or third number, they are multiple primaries. Again, this is after you have already asked all the questions. This rule will very rarely be used because you will have probably identified whether you have a single or multiple primary in a rule preceding rule M10.

SLIDE TWENTY-TWO
Our last multiple primary rule for kidney is a rule that asks: “Does the case not meet any of the above criteria?” If the answer is, “Yes,” it’s a single primary and below here are some examples [they don’t display very well]. The rule M11 examples include: multiple tumors in one kidney that all have the same histology; or an in situ and invasive tumor that are diagnosed within 60 days. And if-- we also have the fall out here that if-- you answered this last question—if you have asked all the questions and you get to rule M11 and you still are answering, “No,” then you need to go back and check your work because you should have already answered that question by the time you get here.

[Are there] any questions about the multiple primary rules for kidney? They are pretty straightforward. They are pretty simple, really. It’s an easy and clean set of rules to use and it’s one that I didn’t really expect a whole lot of questions on. Going once? Okay. Going twice? Let’s move on to the Histology Coding Rules. We’ll give people a chance to pull those out if they’re following on hard copy.

SLIDE TWENTY-THREE
The Histology Coding Rules for Kidney are divided into two separate modules. The first module is a set of rules for “Single Tumors” and it includes seven rules. The second module is for “Multiple Tumors Abstracted as a Single Primar” and there are only six [set] of rules in that module.

SLIDE TWENTY-FOUR
The first rule for kidney histology is, for those of you who have been following along and participating in these Webcasts have already become familiar with this rule.

SLIDE TWENTY-FIVE
“Is there no pathology/cytology specimen or is the pathology/cytology report unavailable?” If that is the situation you can code the histology documented by the physician. You must use this priority order for using those documents to code the histology. The first level of priority is documentation in the medical record that refers to pathologic or cytologic findings. The second listing in the priority is a physician’s reference to the type of cancer/histology in the medical record. And, the third listing in the priority is a CT or MRI scan or this could be expanded to

potentially include PET scans, as well, but these are the clinical diagnostic radiology or other imaging scans. You will find kidney primaries that are not resected because the patient can't undergo resection for other medical problems where you may only have diagnostic imaging diagnosis or you may not have the reports available; you have to use a reference elsewhere in the medical record.

You are to code the specific histology when it's documented. And here is our specific instruction also that you code the histology to 8000 or 8010 as stated by the physician when nothing more specific is documented. [Note 3] We have had that one around for quite a while.

Any questions about rule H1? Okay.

SLIDE TWENTY-SIX
Rule H2 is the rule that you use for abstracting if you only have a specimen from a metastatic site and there is no pathology/cytology specimen from the primary site and this allows you, gives you a provision for coding the histology from the metastatic site. It also instructs you to code the behavior to /3 because, of course, we don't use the /6 behaviors for metastatic sites.

SLIDE TWENTY-SEVEN
H3 is a very simple and straightforward rule: "If you only have one histologic type identified, you code it;" simple, straightforward and clean.

SLIDE TWENTY-EIGHT
Rule H4 is a relatively new concept to registrars and new in the 2007 rules. If the tumor has both invasive and in situ components, you only code the invasive histology. You disregard the in situ component and all the descriptors that go along with the in situ component because the invasive histology is the one that affects the prognosis.

SLIDE TWENTY-NINE
Rule H5 is the rule that instructs you to code the specific histologic type when you have malignant neoplasm and a more specific histology documented; when there is carcinoma NOS and a more specific carcinoma; adenocarcinoma NOS and a more specific adenocarcinoma type; or renal cell carcinoma NOS and one of the specific renal cell types that you can find in Table 1. Again, you have seen this instruction for in situ tumors: You may use "pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation" for in situ. And for the invasive you will see all the things here minus "pattern" and "architecture" which are only allowable when you are coding in situ tumors.

SLIDE THIRTY
Rules H6 and H7 are the last two rules for Kidney [Single Tumor Module]. Rule H6 is an important rule for kidney because you will, on occasion, find this situation where you have two or more specific renal cell carcinoma types that are

described in the pathology report or the single tumor and you are instructed to code adenocarcinoma with mixed subtypes when you see this particular situation. And here is an example: renal cell carcinoma, papillary and clear cell types. You are instructed to code 8255. And, again, you use Table 1 to identify the specific renal cell types.

Our final rule for single tumors is the instruction to—if you haven't gotten an answer before you get to rule H7 and you're still struggling and you don't know how to code this histology yet for the single tumor, the fall out is code the higher ICD-O-3 histology code. We don't expect that you will frequently arrive or use this rule H7 but it is included in the rare case where you have a single tumor and you have not met one of the conditions to instruct you on the action before you got to this particular rule.

This is the end of the instructions for single tumors. You are instructed to code the histology according to the rule that fits the case. Are there any questions for the histology rules for single tumors?

SLIDE THIRTY-ONE
Okay. Let's go on to "Multiple Tumors Abstracted as a Single Primary" Module for the Histology Coding Rules.

SLIDE THIRTY-TWO
You will see in rule H8 the same rule that you saw as H1 for single tumors which asks the question: "Is there no pathology or cytology specimen or is the pathology or cytology report unavailable?" If that is the case you use the histology documented by the physician. And, again, here is the hierarchy for documents that you can use to code the histology.

SLIDE THIRTY-THREE
Rule H9 is identical to the single tumor rule but it's applied to multiple tumors abstracted as a single primary: If you have a specimen from a metastatic site only, you can code the histology from the metastatic site and code the behavior to /3.

SLIDE THIRTY-FOUR
H10 is a very simple rule: "Is only one histologic type identified?" You are instructed to code the histology when only one histologic type is identified.

SLIDE THIRTY-FIVE
Rule H11 is instructions for one tumor that is in situ and another tumor that is invasive or when both tumors are invasive. This is a new rule that is only for the multiple tumors abstracted as a single primary. You are instructed to code the histology of the most invasive tumor. This rule should only be used when the first three numbers of the histology codes are identical. And you are referenced to the Equivalent Terms and Definitions, Tables and Illustrations for the definition of

what “most invasive” includes. If both or all of the histologies are invasive you code the histology of the most invasive tumor. If one tumor is in situ and the other is invasive you code the histology from the invasive tumor.

[Are there] any questions on rule H11?

SLIDE THIRTY-SIX
Okay. We’re coming to the end here, folks. Rule H12 is identical to rule H5 for single tumors which instructs you to code the specific histologic type when you have a diagnosis of cancer or malignant neoplasm and a more specific histology for “Multiple Tumors Abstracted as a Single Primary”; carcinoma NOS and a more specific carcinoma; adenocarcinoma NOS and a more specific adenocarcinoma type; or renal cell carcinoma and one specific renal cell type. Now, again, first you apply the multiple primary rules and determine whether you are abstracting a single primary or multiple primaries. Then you determine whether or not the abstract you are completing is for a *single tumor* or *multiple tumors abstracted as a single primary* and then you follow the rule that fits the situation for your particular case.

Finally, we have the catch-all rule at the end: if you have not answered any of these questions before you get to rule H13 and you have multiple tumors abstracted as a single primary, you are instructed to code the higher ICD-O-3 code.

And that ends the instructions for “Multiple Tumors Abstracted as a Single Primary.” That’s all for the histology coding rules for kidney.

Any questions as we draw our session to a conclusion?

No questions? I told you this was a pretty easy set of rules.

Just once again, Antoinette will be sending out the information for the practicum cases and also you will be getting an announcement for the kidney case practicum sessions. That is still scheduled for Valentine’s Day. If there are no final questions, I will open the floor one more time for questions. Okay. I thank you all for joining us today and have fun doing this set of cases. They are pretty simple.

I appreciate your attention. See you next time. Thank you.