Topography Code (ICD-O)

Organization	Field Name	ID	Required
KCR	Topography Code (ICD-O) (Topography)	30080	yes
NAACCR	Primary Site	400	yes

Field Length: 5

Enter the ICD-O 3rd edition Topography code which describes the anatomical site of the patient's primary tumor. This is a five character field. After the "C", enter the three digit code; the decimal point is already in the correct position.

The International Classification of Diseases for Oncology (ICD-O) 3rd edition, represents an extension of Chapter II of the ICD-10 coding reference. ICD-O permits the coding of all neoplasms by topography, morphology, and cell behavior -- providing greater detail than that permitted with ICD-9 or ICD-10 coding schemes.

The structure of the ICD-O reference book contains three major sections:

Topography - A numerical list of anatomic sites adapted from the malignant neoplasms section of Chapter II of ICD-10. The topographic terms have 3-digit code numbers preceded by a "C" which run from C00.0 to C80.9.

Morphology - A numerical list of histologic terms that is a revised and expanded version of the morphology section of The Manual of Tumor Nomenclature and Coding. The ICD-O, 3rd edition includes new histologic types that have come into the literature since 1990. It has revised the Leukemia and Lymphoma sections and now includes several hematopoietic diseases that were previously considered borderline.

Alphabetic Index - A list of anatomic sites, histologic terms and selected tumor-like lesions and conditions.

Resources for Coding Primary Site for Solid Tumors, in priority order

1. Refer to the introductory pages of the International Classification of Diseases for Oncology, 3rd edition, for a more detailed discussion of the differences between ICD-O and ICD-10, as well as for rules governing the appropriate assignment of ICD-O codes. See also **APPENDIX J** for errata and clarifications to ICD-O-3rd edition.

2. SEER Program Manual

a. Including Coding Guidelines in **Appendix C**

3. Solid Tumor Rules

Physician Priority Order for Coding Primary Site for Solid Tumors

As a general rule, the surgeon is usually in a better position to determine the site of origin compared to the pathologist. The surgeon sees the tumor in its anatomic location, while the pathologist is often using information given to him/her by the surgeon and looking at a specimen removed from the anatomic

landmarks. However, when a pathologist is looking at an entire organ, such as the pancreas, he/she may be able to pinpoint the site of origin within that organ.

Example: The surgeon states during a pancreatectomy that the primary site is body of pancreas while the pathologist states in their CAP Synoptic Reports that the primary site is neck of pancreas. In the case of pancreas body vs. neck, the neck is a thin section of the pancreas located between the head and

the body. It may be a matter of opinion whether a tumor is located in the "body" vs. the "neck." In this example, we would give preference to the surgeon and assign the code for body of pancreas, C251.

Coding Instructions for Solid Tumors

See the Coding Guidelines for Topography and Morphology in the introduction of the ICD-O-3 for additional details. Refer also to the current **Solid Tumor Rules** for selected primary site coding instructions.

1. Unless otherwise instructed, use all available information in the medical record to code the site

2. Code the site in which the primary tumor originated, even if it extends onto/into an adjacent subsite

a. Primary site should always be coded to reflect the site of origin according to the medical opinion on the case. Look for information about where the neoplasm originated. Always code the primary site based on where the tumor arose / site of origin.

b. Site of origin may be indicated by terms such as "tumor arose from…," "tumor originated in…," or similar statements

c. Site of origin is not necessarily the site of a biopsy

d. Tumors may involve many sites. The primary site code should reflect the site where the tumor arose rather than all of the sites of involvement.

Example 1: Final diagnosis is adenocarcinoma of the upper lobe of the right lung. Code the topography to lung, upper lobe (C341).

Example 2: The patient has a 4 cm tumor in the right breast. The tumor originated in the upper inner quadrant and extends into the lower inner quadrant. Code the primary site to upper inner quadrant of breast (C502).

Example 3: Patient has a right branchial cleft cyst; the pathology report identifies an adenocarcinoma arising in an ectopic focus of thyroid tissue within the branchial cleft cyst. Thyroidectomy pathology is negative. Code the primary site to branchial cleft (C104).

Example 4: The patient had a total hysterectomy with a bilateral salpingo-oophorectomy ten years ago for non-cancer reasons. She now has widespread cystadenocarcinoma in the peritoneum. Code the primary site to peritoneum, NOS (C482). (The chart may or may not state that the patient has extra-ovarian carcinoma.)

Example 5: Pathology report shows adenocarcinoma arising in a patch of endometriosis on the sigmoid colon. Code the primary site to sigmoid colon (C187), the site in which the cancer originated.

Example 6: The patient has a left lower lip wedge excision showing invasive squamous cell carcinoma at the mucocutaneous junction. There is no further information in operative report or pathology report regarding the location of this tumor that would indicate this is a skin primary. Assign C001, external lower lip. C001 includes vermilion border of lower lip. Vermilion border is synonymous with mucocutaneous junction.

3. Do ***not*** adjust the primary site code to fit staging or any other data items

4. Code the last digit of the primary site code to '8' when a **single tumor overlaps** an adjacent **subsite**(s) of an organ and the **point of origin cannot be determined**

Example: The patient has a primary tumor of the cervicothoracic esophagus and the point of origin is unknown. Code the primary site to C158.

Note: Skin cancers overlapping sites in the head and neck ONLY.

Assign the primary site code for the site where the bulk of the tumor is or where the epicenter is; do **not** use code C448.

5. Code the site of the invasive tumor when there is an invasive tumor and also in situ tumor in different subsites of the same anatomic site

Example 1: Patient has an invasive breast tumor in the upper-outer quadrant of the left breast and in situ tumor in multiple quadrants of the left breast. Code the primary site to C504 (upper outer quadrant of breast).

Example 2: Patient has in situ Paget disease of the right nipple and invasive duct carcinoma of the lower inner quadrant of the right breast. Code the primary site to C503 (lower inner quadrant).

6. Code the last digit of the primary site code to '9' for **single primaries**, when **multiple tumors arise** in **different subsites** of the same anatomic site and the **point of origin cannot be determined**

Example 1: During a transurethral resection of the bladder (TURB), the physician describes multiple papillary tumors in the bladder neck (C675) and the lateral wall of the bladder (C672). Code the primary site as bladder, NOS (C679).

Example 2: Patient has an infiltrating duct tumor in the upper outer quadrant (C504) of the right breast and another infiltrating duct carcinoma in the lower inner (C503) quadrant of the right breast. Code the primary site as breast, NOS (C509).

7. Some histology/behavior terms in ICD-O-3.2 have a **related site code** in parentheses; for example, hepatoma (C220)

a. Code the site as documented in the medical record and ignore the suggested ICD-O-3.2 code when a primary site is specified in the medical record

Example: The path report says "infiltrating duct carcinoma of the head of pancreas." The listing in ICD-O-3.2 is infiltrating duct carcinoma 8500/3 (C50_). Code the primary site to head of pancreas (C250), NOT to breast (C50_) as suggested by the ICD-O-3.2.

b. Use the site code suggested by ICD-O-3.2 when the primary site is the same as the site code suggested or the primary site is unknown

Example 1: The biopsy is positive for hepatoma, and no information is available about the primary site. Code the primary site to liver (C220) as suggested by ICD-O-3.2.

Example 2: Excision of the right axillary nodes reveals metastatic infiltrating duct carcinoma. The right breast is negative. ICD-O-3.2 shows infiltrating duct carcinoma (8500) with a suggested site of breast (C50_). Code the primary site as breast, NOS (C509).

c. Use the site code suggested by ICD-O-3.2 when there is no information available indicating a different primary site

Example: Biopsy of lymph node diagnosed as metastatic non-small cell carcinoma. Patient expired and there is no information available about the primary site. Assign C349 based on the site code suggested in ICD-O-3.2.

8. Code the primary site, not the metastatic site. If a tumor is metastatic and the primary site is unknown, code the primary site as unknown (C809).

a. Code primary site using results of the molecular test CancerTYPE ID only when there is no other information about the primary site. Document in the text that the site is solely based on results from CancerTYPE ID molecular testing.

Note: CancerTYPE ID tests are a standardized molecular method of determining primary site in tumors initially identified in a metastatic site. The use of CancerTYPE ID to determine primary site is not yet a standard practice and has not received FDA clearance.

9. See the site-specific coding guidelines in **SEER Appendix C** for primary site coding guidelines for the following sites:

Anus	Esophagus
Bladder	Intracranial Glands
Brain/CNS, Benign and Borderline	Kaposi Sarcoma of All Sites
Brain/CNS, Malignant	Lung
Breast	Pancreas
Colon	Rectosigmoid Junction

10. See section below for primary site coding guidelines for sarcoma

11. Angiosarcoma

a. Code C422 (spleen) as the primary site for angiosarcoma of spleen

b. Code C50_ (breast) for angiosarcoma of breast. Although angiosarcoma actually originates in the lining of the blood vessels, an angiosarcoma originating in the breast has a poorer prognosis than many other breast tumors.

12. Gastrointestinal Stromal Tumors (GIST): Code the primary site to the location where the GIST originated

13. Transplants

a. Code the primary site to the location of the transplanted organ when a malignancy arises in a transplanted organ, i.e., code the primary site to where the malignancy resides or lies

Example: There is a diagnosis of malignancy in transplanted section of colon serving as esophagus. Code the primary site as esophagus. Document the situation in a text field.

b. For information about organ or tissue transplants, see the section **Determining Multiple Primaries**

c. For additional information about hematopoietic-related transplants, refer to the **Hematopoietic and Lymphoid Neoplasm Coding Manual and Database**

14. Assign primary site code C449, skin NOS, for a Merkel cell carcinoma presenting in a nodal or distant metastatic site and site of origin is **unknown**

15. When the choice is between ovary, fallopian tube, or primary peritoneal without designation of the site of origin, any indication of fallopian tube involvement indicates the primary tumor is a

tubal primary. Fallopian tube primary carcinomas can be confirmed by reviewing the fallopian tube sections as described on the pathology report to document the presence of either serous

tubal intraepithelial carcinoma (STIC) and/or tubal mucosal invasive serous carcinoma. In the absence of fallopian tube involvement, refer to the histology and look at the treatment plans for

the patient. If all else fails, assign C579 as a last resort. For additional information, see the CAP GYN protocol, Table 1: Criteria for assignment of primary site in tubo-ovarian serous carcinomas.

16. In the absence of ***any additional information*** about the primary site, assign the codes listed for these primary sites/histologies

Primary Site/Histology	Topography Code
Ampullary/peri-ampullary	C241
Anal margin	C445
Anal verge	C211
Angle of the stomach	C162
Angular incisura of stomach	C163
Back of tongue	C019
Book-leaf lesion (mouth)	C068

Clavicular skin	C445
Colored / lipstick portion of upper lip	C000
Cutaneous leiomyosarcoma	C44_
Distal conus	C720
Edge of tongue	C021
Frontoparietal (brain)	C718
Gastric angular notch (incisura)	C163
Gastrohepatic ligament	C481
Genu of pancreas	C250
Glossotonsillar sulcus	C109
Incisura, incisura angularis	C163
Infrahilar area of lung	C349
Interarytenoid space	C329
Interhemispheric fissure (cerebrum)	C710
Intracranial	C719
Lateral tongue	C023
Leptomeninges	C709
Masticator space	C760
Melanoma, NOS	C449
Nail bed, thumb	C446
Pancreatobiliary	C269
Parapharyngeal space	C139
Periareolar (breast)	C501
Periclitoral	C511
Perihilar bile duct	C240
Porta hepatis	C220
Postauricular region	C444
Preauricular (skin)	C443
Prostatic sinus (urethra)	C680
Testis, descended post orchiopexy	C621
True vocal folds	C320
Uncinate of pancreas	C250
Ureterovesical junction (UVJ)	C669

17. When the medical record does **not** contain **enough information** to assign a primary

a. Consult a physician advisor to assign the site code

b. Use the NOS category for the organ system or the Ill-Defined Sites (C760-C768) if the physician advisor cannot identify a primary site

c. Occult Tumors of the Head and Neck

i. Assign primary site C119 (nasopharynx) for occult head and neck tumors with cervical lymph node metastasis in Levels I-VII, and other group lymph nodes positive for Epstein–Barr virus (EBV+) (regardless of p16 status) encoded small RNAs (EBER) identified by in situ hybridization

ii. Assign primary site C109 (oropharynx) for occult head and neck tumors with cervical lymph node metastasis in Levels I-VII, and other group lymph nodes, p16 positive with histology consistent with HPV-mediated oropharyngeal carcinoma (OPC)

iii. Assign C760 for Occult Head and Neck primaries with positive cervical lymph nodes. Schema Discriminator 1: Occult Head and Neck Lymph Nodes is used to discriminate between these cases and other uses of C760

For more information about schemas and schema IDs, go to the **SSDI Manual, Appendix A.**

d. Assign the NOS code for the body system when there are two or more possible primary sites documented and all are within the same system

***Example*:** Two possible sites are documented in the GI system such as colon and small intestine; code to the GI tract, NOS (C269). Document the possible primary sites in a text field.

e. Code unknown primary site when there is a physician statement of unknown primary site **ONLY** when **none of the above instructions can be applied**

f. Code Unknown Primary Site (C809) if there is not enough information to assign an NOS or Ill-Defined Site category

Sarcoma

The majority of sarcomas arise in mesenchymal or connective tissues that are located in the musculoskeletal system, which includes the fat, muscles, blood vessels, deep skin tissues, nerves, bones, and cartilage. The default code for sarcomas of unknown primary site is **C499** rather than C809.

Sarcomas may also arise in the walls of hollow organs and in the viscera covering an organ. C**ode the primary site to the organ of origin.**

Example 1: The pathology identifies a carcinosarcoma of the uterine corpus. Code the primary site to corpus uteri (C549).

Example 2: Rhabdomyosarcoma of ethmoid sinus. Code primary site to C311.

Code the organ of origin as the primary site when leiomyosarcoma arises in an organ. Do not code soft tissue as the primary site in this situation.

Example 1: Leiomyosarcoma arises in kidney. Code the primary site to kidney (C649).

Example 2: Leiomyosarcoma arises in prostate. Code primary site to prostate (C619).

Coding Instructions for Hematopoietic and Lymphoid Neoplasms (9590/3-9993/3)

See the **Hematopoietic and Lymphoid Neoplasm Coding Manual and Database** for instructions on coding the primary site for hematopoietic and lymphoid neoplasms.