Primary Site

C670 Trigone of bladder
   Base of bladder
   Floor
   Below interureteric ridge (interureteric crest, or interureteric fold)

C671 Dome of bladder
   Vertex
   Roof
   Vault

C672 Lateral wall of bladder
   Right wall
   Left wall
   Lateral to ureteral orifice
   Sidewall

C673 Anterior wall of bladder

C674 Posterior wall of bladder

C675 Bladder neck
   Vesical neck
   Internal urethral orifice

C676 Ureteric orifice
   Just above ureteric orifice

C677 Urachus
   Mid umbilical ligament

C678 Overlapping lesion of bladder
   Lateral-posterior wall (hyphen)
   Fundus

C679 Bladder, NOS
   Lateral posterior wall (no hyphen)
Priority Order for Coding Subsites

Use the information from reports in the following priority order to code a subsite when the medical record contains conflicting information:

Operative report (TURB)
Pathology report

Multifocal Tumors

Invasive tumor in more than one subsite

Assign site code C679 when the tumor is multifocal (separate tumors in more than one subsite of the bladder).

If the TURB or pathology proves invasive tumor in one subsite and in situ tumor in all other involved subsites, code to the subsite involved with invasive tumor.
**Bladder Wall Pathology**

The bladder wall is composed of three layers. There may be “sub layers” within the major layer of the bladder.

<table>
<thead>
<tr>
<th>Bladder Layer</th>
<th>Sub layer</th>
<th>Synonyms</th>
<th>Staging</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mucosa</td>
<td></td>
<td>Epithelium, transitional epithelium, urothelium, mucosal surface, transitional mucosa</td>
<td>No blood vessels, in situ/noninvasive</td>
<td>First layer on inside of bladder; Lines bladder, ureters, and urethra</td>
</tr>
<tr>
<td>Basement membrane</td>
<td></td>
<td>No invasion of basement membrane is in situ</td>
<td>Invasion/penetration of basement membrane is invasive</td>
<td>Single layer of cells that lies beneath the mucosal layer separating the epithelial layer from the lamina propria</td>
</tr>
<tr>
<td>Submucosa</td>
<td></td>
<td>Submucous coat, lamina propria, areolar connective tissue</td>
<td>Invasive</td>
<td>Areolar connective tissue interlaced with the muscular coat. Contains blood vessels, nerves, and in some regions, glands</td>
</tr>
<tr>
<td>Lamina propria</td>
<td></td>
<td>Submucosa, Suburothelial connective tissue, subepithelial tissue, stroma, muscularis mucosa, transitional epithelium</td>
<td>Invasive</td>
<td></td>
</tr>
<tr>
<td>Muscle</td>
<td>Bladder wall</td>
<td>Muscularis, muscularis propria, muscularis externa, smooth muscle</td>
<td>Invasive</td>
<td></td>
</tr>
</tbody>
</table>

Tumor extends through the bladder wall (invades regional tissue) when the tumor is stated to involve one of the following areas:

**Serosa (Tunica serosa):** The outermost serous coat is a reflection of the peritoneum that covers the superior surface and the upper parts of the lateral surfaces of the urinary bladder. The serosa is part of visceral peritoneum. The serosa is reflected from these bladder surfaces onto the abdominal and pelvic walls.

**Perivesical fat**

**Adventitia:** Some areas of the bladder do not have a serosa. Where there is no serosa, the connective tissue of surrounding structures merges with the connective tissue of the bladder and is called adventitia.
HISTOLOGY

Most bladder cancers are transitional cell carcinomas. Other types include squamous cell carcinoma and adenocarcinoma. Adenocarcinomas tend to occur in the urachus or, frequently, the trigone of the bladder. Other bladder histologic types include sarcoma, lymphoma, and small cell carcinoma. Rhabdomyosarcoma occurs in children.

Behavior Code

Code the behavior as malignant /3, not in situ /2, when
- the only surgery performed is a transurethral resection of the bladder (TURB) documenting that depth of invasion cannot be measured because there is no muscle in the specimen
and
- the physician’s TNM designation is not available

Code the behavior as in situ /2 when the TNM designation is Ta for TURB with no muscle in the specimen.

Grade

**Note:** These guidelines pertain to the data item Grade. Refer to the [Collaborative Stage Data Collection Manual](#) for instructions on coding site-specific factors.

Code grade from the original primary. Do not code grade from recurrence.

Non-invasive papillary urothelial (transitional) carcinoma

- Code grade 1 (well differentiated) for non-invasive papillary urothelial carcinoma, low grade
- Code grade 3 (poorly differentiated) for non-invasive papillary urothelial (transitional) carcinoma, high grade

Urothelial carcinoma in situ

- Code grade 9 for urothelial carcinoma in situ

Invasive Tumors

Three-Grade System (Nuclear Grade)

There are several sites for which a three-grade system is used. The patterns of cell growth are measured on a scale of 1, 2, and 3 (also referred to as low, medium, and high grade). This system measures the proportion of cancer cells that are growing and making new cells and how closely they resemble the cells of the host tissue. Thus, it is similar to a four-grade system, but simply divides the spectrum into three rather than four categories (see conversion table below). The expected outcome is more favorable for lower grades.

---

1 PDQ

2 Clinical Oncology, 8th edition
If a grade is written as 2/3 that means this is a grade 2 of a three-grade system. Do not simply code the numerator. Use the following table to convert the grade to SEER codes.

<table>
<thead>
<tr>
<th>Term</th>
<th>Grade</th>
<th>SEER Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/3, 1/2</td>
<td>Low grade</td>
<td>2</td>
</tr>
<tr>
<td>2/3</td>
<td>Intermediate grade</td>
<td>3</td>
</tr>
<tr>
<td>3/3, 2/2</td>
<td>High grade</td>
<td>4</td>
</tr>
</tbody>
</table>

FIRST COURSE TREATMENT

TREATMENT MODALITIES (most common treatments)

TURB with fulguration
TURB with fulguration followed by intravesical BCG (bacillus Calmette-Guerin) is usually used for patients with multiple tumors or for high-risk patients.
TURB with fulguration followed by intravesical chemotherapy
Photodynamic therapy (PDT) using laser light and chemotherapy
Segmental cystectomy (rare)
Radical cystectomy in patients with extensive or refractory superficial tumor
Internal irradiation (needles, seeds, wires, or catheters placed into or near the tumor) with or without external-beam irradiation
Chemotherapy
Immunotherapy/biologic therapy
Coding Guidelines

BONES, JOINTS, AND ARTICULAR CARTILAGE C400–C419
PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM C470–C479
CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES C490–C499
(Except for M9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9992)

Laterality
Laterality is required for sites C400-C403, C413-C414, C471-C472, and C491-C492.

Three-Grade System (Nuclear Grade)

Note: These guidelines pertain to the data item Grade. Refer to the Collaborative Stage Data Collection Manual for instructions on coding site-specific factors.

Soft tissue sarcomas are evaluated using a three-grade system. The patterns of cell growth are measured on a scale of 1, 2, and 3 (also referred to as low, medium, and high grade). This system measures the proportion of cancer cells that are growing and making new cells and how closely they resemble the cells of the host tissue. Thus, it is similar to a four-grade system, but divides the spectrum into three rather than four categories (see comparison table below). The expected outcome is more favorable for lower grades.

If a grade is written as 2/3 that means this is a grade 2 of a three-grade system. Do not simply code the numerator. Use the following table to convert the grade to SEER codes.

<table>
<thead>
<tr>
<th>Term</th>
<th>Grade</th>
<th>SEER Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/3, 1/2</td>
<td>Low grade</td>
<td>2</td>
</tr>
<tr>
<td>2/3</td>
<td>Intermediate grade</td>
<td>3</td>
</tr>
<tr>
<td>3/3, 2/2</td>
<td>High grade</td>
<td>4</td>
</tr>
</tbody>
</table>

Sarcoma
Sarcomas are graded low, intermediate or high grade by the pathologist. Use the following table to convert these terms to the correct code for the data item Grade.

<table>
<thead>
<tr>
<th>Term</th>
<th>Grade</th>
<th>SEER Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well differentiated</td>
<td>I</td>
<td>1</td>
</tr>
<tr>
<td>Fairly well differentiated</td>
<td>II</td>
<td>2</td>
</tr>
<tr>
<td>Low grade</td>
<td>I-II</td>
<td>2</td>
</tr>
<tr>
<td>Mid differentiated</td>
<td>II</td>
<td>2</td>
</tr>
<tr>
<td>Moderately differentiated</td>
<td>II</td>
<td>2</td>
</tr>
<tr>
<td>Partially differentiated</td>
<td>II</td>
<td>2</td>
</tr>
<tr>
<td>Partially well differentiated</td>
<td>I-II</td>
<td>2</td>
</tr>
<tr>
<td>Partially well differentiated</td>
<td>II</td>
<td>2</td>
</tr>
<tr>
<td>Relatively or generally well differentiated</td>
<td>II</td>
<td>2</td>
</tr>
<tr>
<td>Medium grade, intermediate grade</td>
<td>II-III</td>
<td>3</td>
</tr>
<tr>
<td>Moderately poorly differentiated</td>
<td>III</td>
<td>3</td>
</tr>
<tr>
<td>Moderately undifferentiated</td>
<td>III</td>
<td>3</td>
</tr>
<tr>
<td>Poorly differentiated</td>
<td>III</td>
<td>3</td>
</tr>
<tr>
<td>Relatively poorly differentiated</td>
<td>III</td>
<td>3</td>
</tr>
</tbody>
</table>

Appendix C: Coding Guidelines
<table>
<thead>
<tr>
<th>Term</th>
<th>Grade</th>
<th>SEER Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relatively undifferentiated</td>
<td>III</td>
<td>3</td>
</tr>
<tr>
<td>Slightly differentiated</td>
<td>III</td>
<td>3</td>
</tr>
<tr>
<td>High grade</td>
<td>III-IV</td>
<td>4</td>
</tr>
<tr>
<td>Undifferentiated, anaplastic, not</td>
<td>IV</td>
<td>4</td>
</tr>
<tr>
<td>differentiated</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Coding Guidelines
BRAIN [AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM]
MENINGES C700–C709, BRAIN C710–C719,
SPINAL CORD, CRANIAL NERVES AND
OTHER PARTS OF CENTRAL NERVOUS SYSTEM C720–C729
(Except for M9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9992)

Reportability
Juvenile astrocytoma, listed as 9421/1 in ICD-O-3, is reportable. Record as 9421/3 in the registry.

Grade

Note: These guidelines pertain to the data item Grade. Refer to the Collaborative Stage Data Collection Manual for instructions on coding site-specific factors.

Astrocytoma

Grade astrocytomas (M-9383, 9400, 9401, 9410-9412, 9420, 9421) according to ICD-O-3 rules.

<table>
<thead>
<tr>
<th>Term</th>
<th>Grade</th>
<th>SEER Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well differentiated</td>
<td>Grade I</td>
<td>1</td>
</tr>
<tr>
<td>Intermediate differentiation</td>
<td>Grade II</td>
<td>2</td>
</tr>
<tr>
<td>Poorly differentiated</td>
<td>Grade III</td>
<td>3</td>
</tr>
<tr>
<td>Anaplastic</td>
<td>Grade IV</td>
<td>4</td>
</tr>
</tbody>
</table>

Use the Three-Grade conversion table in the Grade, Differentiation, or Cell Indicator section (page 81) of the General Instructions to code low grade, intermediate grade, and high grade.

Do not record the WHO Grade, Anne/Meay, or Kemohan grades in the grade field
- Record the WHO grade in the appropriate CS data item
- The use of World Health Organization coding of aggressiveness is reserved for assignment of grade for staging.

Do not automatically code glioblastoma multiforme as grade IV
- If no grade is given, code 9 (Cell type not determined, not stated or not applicable)

Always code the Grade, Differentiation field 4 (Grade IV) for anaplastic tumors
- Anaplastic is synonymous with undifferentiated

Code the grade as documented.

Code the Grade, Differentiation field to 9 (Cell type not determined, not stated or not applicable) in the absence of a stated grade on the pathology report.

Laterality

Meningioma
Assign code 4 (Bilateral involvement, lateral origin unknown; stated to be single primary) when
- one meningioma extends to both right and left sides
and
- it is not possible to determine whether the meningioma originated on the left or the right
Primary Site

C500  Nipple (areolar)
   Paget disease without underlying tumor

C501  Central portion of breast (subareolar) area extending 1 cm around areolar complex
   Retroareolar
   Infraareolar
   Next to areola, NOS
   Behind, beneath, under, underneath, next to, above, cephalad to, or below nipple
   Paget disease with underlying tumor
   Lower central

C502  Upper inner quadrant (UIQ) of breast
   Superior medial
   Upper medial
   Superior inner

C503  Lower inner quadrant (LIQ) of breast
   Inferior medial
   Lower medial
   Inferior inner

C504  Upper outer quadrant (UOQ) of breast
   Superior lateral
   Superior outer
   Upper lateral

C505  Lower outer quadrant (LOQ) of breast
   Inferior lateral
   Inferior outer
   Lower lateral

C506  Axillary tail of breast
   Tail of breast, NOS
   Tail of Spence

C508  Overlapping lesion of breast
   Inferior breast, NOS
   Inner breast, NOS
   Lateral breast, NOS
   Lower breast, NOS
   Medial breast, NOS
   Midline breast NOS
   Outer breast NOS
   Superior breast, NOS
   Upper breast, NOS
   3:00, 6:00, 9:00, 12:00 o’clock

Appendix C: Coding Guidelines
C509 Breast, NOS
Entire breast
Multiple tumors in different subsites within breast
Inflammatory without palpable mass
¾ or more of breast involved with tumor
Diffuse (tumor size 998)

**Additional Subsite Descriptors**
The position of the tumor in the breast may be described as the positions on a clock

### O’Clock Positions and Codes

**Quadrants of Breasts**

- **RIGHT BREAST**
  - UIQ
  - C50.4
  - LIQ
  - C50.3
  - LOQ
  - C50.5

- **LEFT BREAST**
  - UIQ
  - C50.2
  - LIQ
  - C50.3
  - LOQ
  - C50.5

### Coding Subsites
Use the information from reports in the following priority order to code a subsite when there is conflicting information:

1. Pathology report
2. Operative report
3. Physical examination
4. Mammogram, ultrasound

Code the subsite with the **invasive** tumor when the pathology report identifies invasive tumor in one subsite and in situ tumor in a different subsite or subsites.

Code the specific quadrant for multifocal tumors all within one quadrant
- Do **not** code C509 (Breast, NOS) in this situation

Code the primary site to C508 when
- there is a single tumor in two or more subsites and the subsite in which the tumor originated is unknown
- there is a single tumor located at the 12, 3, 6, or 9 o’clock position on the breast

Code the primary site to C509 when there are multiple tumors (two or more) in at least two quadrants of the breast.

**Grade**

*Note:* These guidelines pertain to the data item Grade. Refer to the Collaborative Stage Data Collection Manual for instructions on coding site-specific factors for breast cases.

Invasive Carcinoma

The pathologist assigns a numeric value to each of three tumor characteristics: tubule formation, nuclear pleomorphism, and mitotic counts. The three values are added together and the result is a score ranging from 3 to 9. Use the table below to convert scores to SEER code.

Convert Nottingham Histologic Score or BR Grade to SEER Code

**Grade Conversion Table for Invasive Carcinoma**

<table>
<thead>
<tr>
<th>Nottingham Histologic Scores</th>
<th>BR Grade</th>
<th>Nuclear Grade</th>
<th>Terminology</th>
<th>Histologic Grade</th>
<th>SEER Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5</td>
<td>Low</td>
<td>1/3; 1/2</td>
<td>Well differentiated</td>
<td>I, I/III, 1/3</td>
<td>1</td>
</tr>
<tr>
<td>6, 7</td>
<td>Intermediate</td>
<td>2/3</td>
<td>Moderately differentiated</td>
<td>II, II/III, 2/3</td>
<td>2</td>
</tr>
<tr>
<td>8, 9</td>
<td>High</td>
<td>2/2; 3/3</td>
<td>Poorly differentiated</td>
<td>III, III/III, 3/3</td>
<td>3</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>4/4</td>
<td>Undifferentiated/anaplastic</td>
<td>IV, IV/IV, 4/4</td>
<td>4</td>
</tr>
</tbody>
</table>

**Priority Rules for Grading Breast Cancer**

Code the tumor grade using the following priority order:

1. Bloom-Richardson (Nottingham) scores 3-9 converted to grade (see conversion table above)
2. Bloom Richardson grade (low, intermediate, high)
3. Nuclear grade only
4. Terminology
5. Differentiation (well differentiated, moderately differentiated, etc)
6. Histologic grade
7. Grade i, grade ii, grade iii, grade iv
8. Bloom-Richardson (BR)

Nottingham combined histologic grade is also known as Elston-Ellis modification of Scarff-Bloom-Richardson grading system. BR may also be called: modified Bloom-Richardson, Scarff-Bloom-Richardson, SBR grading, BR grading, Elston-Ellis modification of Bloom Richardson score, the Nottingham modification of Bloom Richardson score, Nottingham-Tenovus, or Nottingham grade.

BR may be expressed in scores (range 3-9)

The score is based on three morphologic features of “invasive no-special-type” breast cancers (degree of tubule formation/histologic grade, mitotic activity, nuclear pleomorphism of tumor cells)

Use the preceding table to convert the score into SEER code.
BR may be expressed as a grade (low, intermediate, high)
BR grade is derived from the BR score
For cases diagnosed 1996 and later, use the preceding table to convert the BR grade into SEER code
(Note that the conversion of low, intermediate, and high is different from the conversion used for all other tumors).

DCIS
Ductal carcinoma in situ (DCIS) is not always graded. When DCIS is graded, it is generally divided into three grades: low grade, intermediate grade, and high grade. Use the following table to convert DCIS grade into the SEER code.

DCIS Grade Conversion Table

<table>
<thead>
<tr>
<th>DCIS Grade</th>
<th>Terminology</th>
<th>SEER Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade I</td>
<td>Low</td>
<td>1</td>
</tr>
<tr>
<td>Grade II</td>
<td>Intermediate</td>
<td>2</td>
</tr>
<tr>
<td>Grade III</td>
<td>High</td>
<td>3</td>
</tr>
</tbody>
</table>

Laterality
Laterality must be coded for all subsites.

Breast primary with positive nodes and no breast mass found: Code laterality to the side with the positive nodes
The prognosis of patients with colon cancer is related to the degree of penetration of the tumor through the bowel wall, the presence or absence of nodal involvement, and the presence or absence of distant metastases.

**Primary Site**

**Priority Order for Coding Primary Site**

Use the information from reports in the following priority order to code the primary site when there is conflicting information:

- Resected cases
  - Operative report with surgeon’s description
  - Pathology report
  - Imaging
- Polypectomy or excision without resection
  - Endoscopy report
  - Pathology report

**Subsites**

Code the subsite with the most tumor when the tumor overlaps two subsites.
Code C188 when both subsites are equally involved.

**Grade**

*Note:* These guidelines pertain to the data item Grade. Refer to the Collaborative Stage Data Collection Manual for instructions on coding site-specific factors.

Colon cancer is often graded using a two-grade system; Low Grade (2) or High Grade (4). If the grade is listed as 1/2 or as low grade, convert to a grade 2. If the grade is listed as 2/2 or as high grade, convert to a code 4.

Code the highest grade given.

<table>
<thead>
<tr>
<th>Term</th>
<th>Grade</th>
<th>SEER Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well differentiated</td>
<td>I</td>
<td>1</td>
</tr>
<tr>
<td>Fairly well differentiated</td>
<td>II</td>
<td>2</td>
</tr>
<tr>
<td>Low grade</td>
<td>I-II</td>
<td>2</td>
</tr>
<tr>
<td>Mid differentiated</td>
<td>II</td>
<td>2</td>
</tr>
<tr>
<td>Moderately differentiated</td>
<td>II</td>
<td>2</td>
</tr>
<tr>
<td>Partially differentiated</td>
<td>II</td>
<td>2</td>
</tr>
<tr>
<td>Partially well differentiated</td>
<td>I-II</td>
<td>2</td>
</tr>
<tr>
<td>Partially well differentiated</td>
<td>II</td>
<td>2</td>
</tr>
<tr>
<td>Relatively or generally well differentiated</td>
<td>II</td>
<td>2</td>
</tr>
</tbody>
</table>

This table is consistent with previous information provided in FORDS/ACR Supplement.
<table>
<thead>
<tr>
<th>Term</th>
<th>Grade</th>
<th>SEER Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medium grade, intermediate grade</td>
<td>II-III</td>
<td>3</td>
</tr>
<tr>
<td>Moderately poorly differentiated</td>
<td>III</td>
<td>3</td>
</tr>
<tr>
<td>Moderately undifferentiated</td>
<td>III</td>
<td>3</td>
</tr>
<tr>
<td>Poorly differentiated</td>
<td>III</td>
<td>3</td>
</tr>
<tr>
<td>Relatively poorly differentiated</td>
<td>III</td>
<td>3</td>
</tr>
<tr>
<td>Relatively undifferentiated</td>
<td>III</td>
<td>3</td>
</tr>
<tr>
<td>Slightly differentiated</td>
<td>III</td>
<td>3</td>
</tr>
<tr>
<td>High grade</td>
<td>III-IV</td>
<td>4</td>
</tr>
<tr>
<td>Undifferentiated, anaplastic, not differentiated</td>
<td>IV</td>
<td>4</td>
</tr>
</tbody>
</table>
Laterality

Laterality is required for C649.

Grade

*Note:* These guidelines pertain to the data item Grade. Refer to the Collaborative Stage Data Collection Manual for instructions on coding site-specific factors.

The preferred grading scheme for renal cell carcinoma was developed by Fuhrman et al. Scoring is based on the worst (highest) grade present in the tumor even if only a minor component.

Priority Rules for Coding Grade of Tumor

1. Fuhrman grade
2. Nuclear grade
3. Terminology (well diff, mod diff)
4. Histologic grade (grade 1, grade 2)

These prioritization rules do **not** apply to Wilms tumor (8960).
**Grade**

*Note:* These guidelines pertain to the data item Grade. Refer to the [Collaborative Stage Data Collection Manual](#) for instructions on coding site-specific factors for prostate cases.

**Priority Rules for Grading Prostate Cancer**

Code the tumor grade using the following priority order

1. Gleason score (Use the table to convert Gleason score to the appropriate code)
2. Terminology
   - Differentiation (well differentiated, moderately differentiated, etc)
3. Histologic grade
   - Grade i, grade ii, grade iii, grade iv
4. Nuclear grade only

**Gleason Pattern**

Prostate cancers are commonly graded using Gleason score or pattern. Gleason grading is based on a 5-component system, based on 5 histologic patterns. The pathologist will evaluate the primary pattern (most predominant) and secondary patterns (second most predominant) for the tumor.

*Example:* A Gleason pattern of 2 + 4 means that the primary pattern is 2 and the secondary pattern is 4.

**Gleason Score**

The primary and secondary patterns are added together to create a score. Primary pattern is doubled when there is no secondary pattern. Tertiary pattern is not used to determine Gleason score.

*Example:* If the patterns are 2 + 4, the score is 6.

If the pathology report contains only one number, and that number is less than or equal to 5, it is a pattern. If the pathology report contains only one number, and that number is greater than 5, it is a score. If the pathology report specifies a specific number out of a total of 10, the first number given is the score.

*Example 1:* The pathology report says “Gleason 3/10”. The Gleason’s score would be 3.

*Example 2:* The pathology report states 7(3 + 4). Gleason score is 7. Primary pattern is 3 and secondary pattern is 4.

If there are two numbers other than 10, assume they refer to two patterns. The first number is the primary pattern and the second is the secondary pattern.

*Example:* If the pathology report says “Gleason 3 + 5,” the Gleason score would be 8.

Use the following table to convert Gleason pattern or score into SEER code.
Gleason Conversion Table

<table>
<thead>
<tr>
<th>Gleason Score</th>
<th>Gleason Pattern</th>
<th>Histologic Grade</th>
<th>Terminology</th>
<th>SEER Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>2, 3, 4</td>
<td>1, 2</td>
<td>I</td>
<td>Well differentiated</td>
<td>1</td>
</tr>
<tr>
<td>5, 6</td>
<td>3</td>
<td>II</td>
<td>Moderately differentiated</td>
<td>2</td>
</tr>
<tr>
<td>7, 8, 9, 10</td>
<td>4, 5</td>
<td>III</td>
<td>Poorly differentiated</td>
<td>3</td>
</tr>
</tbody>
</table>

*Note:* Code 7 was moved from Moderately differentiated to Poorly differentiated, effective with cases diagnosed on or after 01/01/2003.
Laterality

Laterality is required for sites C65.9 and C66.9.

Grade

Note: These guidelines pertain to the data item Grade. Refer to the Collaborative Stage Data Collection Manual for instructions on coding site-specific factors.

Urothelial carcinomas are graded as either low grade or high grade according to the WHO/ISUP grading system. The WHO/ISUP grade is captured as a Site Specific Factor in the Collaborative Stage Data Collection System. Do not convert WHO/ISUP grade to the SEER code for grade.

Urothelial Carcinoma
- Low grade
- High grade

Adenocarcinoma and Squamous Cell Carcinoma
- Grade 1 Well differentiated
- Grade 2 Moderately differentiated
- Grade 3 Poorly differentiated
Grade

*Note:* These guidelines pertain to the data item Grade. Refer to the *Collaborative Stage Data Collection Manual* for instructions on coding site-specific factors.

Adenocarcinoma and Squamous Cell Carcinoma
Assign the grade code for adenocarcinoma and squamous cell carcinoma.
- Grade 1 Well differentiated
- Grade 2 Moderately differentiated
- Grade 3 Poorly differentiated

WHO/ISUP Grade
Do not convert WHO/ISUP grade to the SEER code for grade.
- Urothelial carcinomas are graded as either low grade or high grade according to the WHO/ISUP grading system. The WHO/ISUP grade is captured as a Site Specific Factor in the *Collaborative Stage Data Collection System*.

First Course of Therapy

*Do not code Lupron as treatment* for a primary in the prostatic urethra.