2018 Coding Manuals: SEER and STORE 2018

KCR 2018 SPRING TRAINING

Summary of changes

Extent of Disease and Summary Stage
- Extent of Disease data items are now required by SEER
- Summary Stage 2018 is a revised and updated version of Summary Stage 2000

Site Specific Data Items are individual variables formerly collected in the CS SSFs. They are in a new section called Stage Related Data Items.

SEER SSF1: HPV status for Oropharynx (p16+), Oropharynx p16- and Hypopharynx, and Lip and Oral Cavity (only collected by SEER)

The Solid Tumor Rules Manual replaces the former MP/H Manual

Reportable and Non-reportable examples added in SEER Appendix E

Ambiguous Terminology clarification: References of Last Resort added

Summary of changes (continued)

Tumor Grade replaced with three Grade data items:
- Grade Clinical, Grade Pathological, Grade Post-therapy
- Grade will now be site specific

First Course Therapy – data items added in Case Data
- Date of Sentinel Lymph Node Biopsy (breast and melanoma)
- Sentinel Lymph Nodes Examined (breast and melanoma)
- Sentinel Lymph Nodes Positive (breast and melanoma)
- Date of Regional Lymph Node Dissection

Summary of changes (continued)

Radiation-Phase I, II, III (conversion available)
- Radiation Treatment Modality (COC and SEER)
- External Beam Planning Technique (COC only)
- Primary Treatment Volume (COC only)
- Radiation to Draining Lymph Nodes (COC only)
- Dose per Fraction (COC only)
- Number of Fractions (COC only)

Summary of changes (continued)

Radiation Treatment (page 1)
- Number of Rad Phases to this Volume (COC only)
- Rad Tx Discontinued Early (COC only)
- Total Dose across all phases (COC only)

Follow up – new data item
- Date of Last Cancer Status

Existing data items - revised

Spanish Surname or Origin

Sex

Other Therapy

Appendices modified

Appendix C Breast Surgery Codes

Appendix C Skin Surgery Codes

Details of the 2018 changes

Ambiguous terminology

Clarification from COC STORE Manual

When abstracting, registrars are to use the "Ambiguous Terms at Diagnosis" list with respect to case reportability, and the "Ambiguous Terms Describing Tumor Spread" list with respect to tumor spread for staging purposes.

The first and foremost resource for the registrar for questionable cases is the physician who diagnosed and/or staged the tumor. The ideal approach to abstracting situations when the medical record is not clear is to follow up with the physician. If the physician is not available, the medical record, and any other pertinent reports should be read closely for the required information. The purpose of the Ambiguous Terminology lists is so that in the case where wording in the patient record is ambiguous with respect to reportability or tumor spread and no further information is available from any resource, registrars will make consistent decisions. When there is a clear statement of malignancy or tumor spread, they should not refer to the Ambiguous Terminology lists. Registrars should only rely on these lists when the situation is not clear and the case cannot be discussed with the appropriate physician/pathologist.

Sex – coding instructions added

Assign code **3** for
- a. Intersexed (persons with sex chromosome abnormalities)
- b. Hermaphrodite

Codes 5 and 6 may be used for cases diagnosed prior to 2015

Codes 5 and 6 have priority over codes 1 and 2

Assign code **5** for transsexuals who are natally male or transsexuals with primary site of C600-C639

Assign code **6** for transsexuals who are natally female or transsexuals with primary site of C510-C589.

Assign code **4** for transsexuals with unknown natal sex and primary site is not C510-C589 or C600-C639

Spanish origin – added coding instructions

Assign code **6** when there is more than one ethnicity/origin (multiple codes), such as Mexican (code 1) and Dominican Republic (code 8). There is no hierarchy among the codes 1-5 or 8.

Portuguese, Brazilians, and Filipinos are not presumed to be Spanish or non-Spanish
- a. Assign code **7** when the patient is Portuguese, Brazilian, or Filipino and their name appears on a Hispanic surname list
- b. Assign code **0** when the patient is Portuguese, Brazilian, or Filipino and their name does NOT appear on a Hispanic surname list

Use all information to determine the Spanish/Hispanic Origin including Birthplace, information about life history or language spoken, maiden name, etc.

Other therapy

These changes will be covered in the changes to the Hematopoietic Manual

New Stage-related Data Items

Site Specific Data Items (SSDI) – covered in Spring Training EOD section

SEER Site Specific Factor 1 – HPV status, for these AJCC schemas only:

Lip and Oral Cavity, Oropharynx (p16+), and Oropharynx (p16-) and Hypopharynx

Grade Clinical

Grade Pathological

Grade Post Therapy

New Stage Related Data Items

SEER Site Specific Factor 1 – HPV status

Code	Description
0	HPV negative for viral DNA by ISH test
1	HPV positive for viral DNA by ISH test
2	HPV negative for viral DNA by PCR test
3	HPV positive for viral DNA by PCR test
4	HPV negative by ISH E6/E7 RNA test
5	HPV positive by ISH E6/E7 RNA test
6	HPV negative by RT-PCR E6/E7 RNA test
7	HPV positive by RT-PCR E6/E7 RNA test
8	HPV status reported in medical records as positive or negative but test type is unknown
9	Unknown if HPV test detecting viral DNA and or RNA was performed

New Stage Related Data Items

SEER Site Specific Factor 1 – HPV status

Coding Instructions

Codes 0-7 are hierarchical; use the highest code that applies (0 is highest, 7 is lowest)

This data item is only for HPV status determined by tests designed to detect viral DNA or RNA. Tests based on ISH, PCR, RT-PCR technologies detect the viral DNA or RNA.

Do not record the results of IHC p16 expression in this field

a. There are several methods for determination of HPV status. The most frequently used test is IHC for p16 expression which is a surrogate marker for HPV infection and is **not** to be recorded in this field.

b. HPV-type 16 refers to a virus type and is different from p16 overexpression (p16+). Record the results of any HPV testing performed on pathologic specimens including surgical and cytological (from cell blocks) tissue from the primary tumor or a metastatic site, including lymph nodes

Do not record the results of blood tests or serology

New Grade Data Items and Manual

Beginning with cases diagnosed in 2018, the definition of grade has been expanded, and classification of grade now varies by tumor site and/or histology.

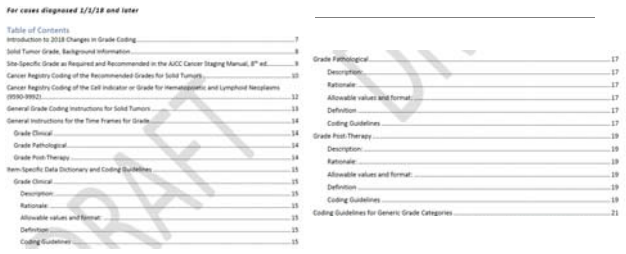
Grade will no longer be collected for Hematopoietic and Lymphoid Neoplasms.

The recommended AJCC grade is required to assign stage group (clinical, pathological and post-therapy) for certain tumors. If the recommended AJCC grade is not available, use the generic cancer registry grade categories.

For solid tumors diagnosed 2018 and forward, grade will be collected in three different data items, Grade Clinical, Grade Pathological, and Grade Post-Therapy, and the codes and coding instructions will depend on the type of cancer.

For AJCC chapters for which there is no recommended grading system (for example, chapter 47, Melanoma of the Skin) or for sites for which there is no applicable AJCC chapter (for example, Trachea), the generic cancer registry grade categories used historically will still apply and will be used for all three grade fields.

Grade Coding Manual



For cases diagnosed 1/1/18 and later

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Grade - Example

Code	Grade Description
1	G1: Low combined histologic grade (favorable), SBR score of 3–5 points
2	G2: Intermediate combined histologic grade (moderately favorable); SBR score of 6–7 points
3	G3: High combined histologic grade (unfavorable); SBR score of 8–9 points
L	Nuclear Grade I (Low) (in situ only)
M	Nuclear Grade II (Intermediate) (in situ only)
H	Nuclear Grade III (High) (in situ only)
A	Well differentiated
B	Moderately differentiated
C	Poorly differentiated
D	Undifferentiated, anaplastic
9	Grade cannot be assessed (GX); Unknown

New Lymph Node Data Items – case level

Surgery data

- Date of Sentinel Lymph Node Biopsy (breast and melanoma)
- Sentinel Lymph Nodes Examined (breast and melanoma)
- Sentinel Lymph Nodes Positive (breast and melanoma)
- Date of Regional Lymph Node Dissection

New Therapy Data Items

Number of Phases of Rad Tx to this Volume (COC only)
Rad Tx Discontinued Early (COC only)
Total Dose (COC only)

Radiation Treatment --Phase I, II, III (conversion available)
Radiation Treatment Volume
Radiation to Draining Lymph Nodes
Radiation Treatment Modality
Radiation External Beam Planning Technique
Dose per Fraction
Number of Fractions
Total Dose for Phase

Date SLN Biopsy – Breast and Melanoma

Records the date of the sentinel lymph node(s) biopsy procedure. This data item is required for cases diagnosed 01/01/2018 and later.
This data item is required for breast and melanoma cases only.

SLN Examined – Breast and Melanoma

Records the total number of lymph nodes sampled during the sentinel node biopsy and examined by the pathologist. This data item is required for cases diagnosed 01/01/2018 and later. This data item is required for breast and melanoma cases only.

Code	Description
00	No sentinel nodes were examined
01-90	Sentinel nodes were examined (code the exact number of sentinel lymph nodes examined)
95	No sentinel nodes were removed, but aspiration of sentinel node(s) was performed
98	Sentinel lymph nodes were biopsied, but the number is unknown
99	It is unknown whether sentinel nodes were examined; not stated in patient record

SLN Positive – Breast and Melanoma

Records the exact number of sentinel lymph nodes biopsied by the pathologist and found to contain metastases. This data item is required for cases diagnosed 01/01/2018 and later. **This data item is required for breast and melanoma cases only.**

Code	Description
00	All sentinel nodes examined are negative
01-90	Sentinel nodes are positive (code exact number of nodes positive)
95	Positive aspiration of sentinel lymph node(s) was performed
97	Positive sentinel nodes are documented, but the number is unspecified; For breast ONLY: SLN and RLND occurred during the same procedure
98	No sentinel nodes were biopsied
99	It is unknown whether sentinel nodes are positive; not applicable; not stated in patient record

Date Regional LN dissection

Records the date non-sentinel regional node dissection was performed. This data item is required for cases diagnosed 01/01/2018 and later.

Radiation Modality - Phase I, II, III

Phase I, II, and III identify the radiation modality administered during the first, second, and third phase, respectively, of radiation treatment delivered during the first course of treatment.

Code Description
00 No Radiation Treatment
01 External beam, NOS
02 External beam, photons
03 External beam, protons
04 External beam, electrons
05 External beam, neutrons
06 External beam, carbon ions

Code Description
07 Brachytherapy, NOS
08 Brachytherapy, intracavitary, LDR
09 Brachytherapy, intracavitary, HDR
10 Brachytherapy, Interstitial, LDR
11 Brachytherapy, Interstitial, HDR
12 Brachytherapy, electronic
13 Radioisotopes, NOS
14 Radioisotopes, Radium-232
15 Radioisotopes, Strontium-89
16 Radioisotopes, Strontium-90
99 Treatment radiation modality unknown

Radiation External Beam Planning Technique – Phase I, II, or III

Identifies the external beam radiation planning technique used to administer a phase of radiation treatment during the first course of treatment. This data item is required for CoC-accredited facilities as of 01/01/2018.

Code	Description
00	No radiation treatment
01	External beam, NOS
02	Low energy x-ray/photon therapy
03	2-D therapy
04	Conformal or 3-D conformal therapy
05	Intensity modulated therapy
06	Stereotactic radiotherapy or radiosurgery, NOS
07	Stereotactic radiotherapy or radiosurgery, robotic.
08	Stereotactic radiotherapy or radiosurgery, Gamma Knife®
09	CT-guided online adaptive therapy
10	MR-guided online adaptive therapy
88	Not Applicable
98	Other, NOS
99	Unknown

Radiation Primary Treatment Volume – Phase I, II, or III

Identifies the primary treatment volume or primary anatomic target treated during the first phase of radiation therapy during the first course of treatment. This data item is required for CoC-accredited facilities as of 01/01/2018.

00	No radiation treatment	24	Sinuses/Nasal tract	57	Biliary tree or gallbladder	82	Shoulder
01	Neck lymph node regions	25	Parotid or other salivary glands	58	Pancreas or hepatopancreatic ampulla	83	Ribs
02	Thoracic lymph node regions	26	Thyroid	59	Abdomen (NOS)	84	Hip
03	Neck and thoracic lymph node regions	29	Head and neck (NOS)	60	Bladder - whole	85	Pelvic bones
04	Breast/ Chestwall lymph node regions	30	Lung or bronchus	61	Bladder - partial	86	Pelvis (NOS, non-visceral)
05	Abdominal lymph nodes	31	Mesothelium	62	Kidney	88	Extremity bone, NOS
06	Pelvic lymph nodes	32	Thymus	63	Ureter	90	Skin
07	Abdominal and pelvic lymph nodes	39	Chest/lung (NOS)	64	Prostate - whole	91	Soft tissue
09	Lymph node region, NOS	40	Breast - whole	65	Prostate - partial	92	Hemibody
10	Eye/orbit/optic nerve	41	Breast - partial	66	Urethra	93	Whole body
11	Pituitary	42	Chest wall	67	Penis	94	Mantle, mini-mantle (obsolete after 2017)
12	Brain	50	Esophagus	68	Testicle or scrotum	95	Lower extended field (obsolete after 2017)
13	Brain (Limited)	51	Stomach	70	Ovaries or fallopian tubes	96	Inverted Y (obsolete after 2017)
14	Spinal cord	52	Small bowel	71	Uterus or Cervix	97	Invalid historical FORDS value
20	Nasopharynx	53	Colon	72	Vagina	98	Other
21	Oral Cavity	54	Rectum	73	Vulva	99	Unknown
22	Oropharynx	55	Anus	80	Skull		
23	Larynx (glottis) or hypopharynx	56	Liver	81	Spine/vertebral bodies		

Radiation to Draining Lymph Nodes – Phase I, II, or III

Identifies the draining lymph nodes treated (if any) during a phase of radiation therapy delivered to the patient during the first course of treatment. This data item is required for CoC-accredited facilities as of 01/01/2018.

Code	Description
00	No radiation treatment
01	Neck lymph node regions
02	Thoracic lymph node regions
03	Neck and thoracic lymph node regions
04	Breast/Chest wall lymph node regions
05	Abdominal lymph nodes
06	Pelvic lymph nodes
07	Abdominal and pelvic lymph nodes
08	Lymph node region, NOS
88	Not applicable; Phase I Radiation Primary Treatment Volume is lymph nodes
99	Unknown if any radiation treatment to draining lymph nodes; Unknown if radiation treatment administered

Dose Per Fraction – Phase I, II, or III

Records the dose per fraction (treatment session) delivered to the patient a particular phase of radiation during the first course of treatment. The unit of measure is centiGray (cGy). This data item is required for CoC-accredited facilities as of 01/01/2018.

Code	Description
00000	Radiation therapy was not administered
00001-99997	Record the actual Phase I dose delivered in cGy
99998	Not applicable, brachytherapy or radioisotopes administered to the patient
99999	Regional radiation therapy was administered but dose is unknown, it is unknown whether radiation therapy was administered. Death Certificate only.

Number of Fractions – Phase I, II, or III

Records the total number of fractions (treatment sessions) delivered to the patient in the phase of radiation during the first course of treatment. This data item is required for CoC-accredited facilities as of 01/01/2018.

Code	Description
000	Radiation therapy was not administered to the patient.
001-998	Number of fractions administered to the patient during the first phase of radiation therapy.
999	Phase I Radiation therapy was administered, but the number of fractions is unknown; It is unknown whether radiation therapy was administered.

Phase Total Dose – Phase I, II, or III

Identifies the total radiation dose delivered to the patient in a phase of radiation treatment during the first course of treatment. The unit of measure is centiGray (cGy). This data item is required for CoC-accredited facilities as of 01/01/2018.

Code	Description
000000	No therapy administered
000001-999997	Record the actual total dose delivered in cGy
999998	Not applicable, radioisotopes administered to the patient
999999	Radiation therapy was administered, but the dose is unknown; it is unknown whether radiation therapy was administered

Number of Rad Phases to this Volume

Identifies the total number of phases administered to the patient during the first course of treatment. A "phase" consists of one or more consecutive treatments delivered to the same anatomic volume with no change in the treatment technique. This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later.

Code	Description
00	No radiation treatment
01	1 phase
02	2 phases
03	3 phases
04	4 or more phases
99	Unknown number of phases; Unknown if radiation therapy administered

Radiation Treatment Discontinued Early

This field is used to identify patients/tumors whose radiation treatment course was discontinued earlier than initially planned. That is the patients/tumors received fewer treatment fractions (sessions) than originally intended by the treating physician. This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later.

Code	Description
00	No radiation treatment
01	Radiation treatment completed as prescribed
02	Radiation treatment discontinued early – toxicity
03	Radiation treatment discontinued early - contraindicated due to other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation etc.)
04	Radiation treatment discontinued early – patient decision
05	Radiation discontinued early – family decision
06	Radiation discontinued early – patient expired
07	Radiation discontinued early – reason not documented
99	Unknown if radiation treatment discontinued; Unknown whether radiation therapy administered

Total Dose – All Phases

Identifies the total radiation dose delivered to the patient in all phases of radiation treatment during the first course of treatment. The unit of measure is centiGray (cGy). This data item is required for CoC-accredited facilities as of 01/01/2018.

Code	Description
000000	No therapy administered
000001-999997	Record the actual total dose delivered in cGy
999998	Not applicable, radioisotopes administered to the patient
999999	Radiation therapy was administered, but the dose is unknown; it is unknown whether radiation therapy was administered

Revised Breast surgery codes

Revised Skin surgery codes

New Follow up Data Item

Date of Last Cancer (Tumor) Status

This data item documents the date of last cancer (tumor status) of the patient's malignant or non-malignant reportable tumor. This data item is required for cases diagnosed 01/01/2018 and later.

Other new and revised data items

Patient Level – Date of Last Contact will now be a patient level field

Case Level – Date of Last Cancer Status will be a new Follow up data item

Calculated items: Derived EOD T, N, M and EOD Stage Group

Derived Summary Stage 2018

AJCC Schema ID

RQRS NCDB Submission Flag

SEER Appendix E.1: Reportable examples

#	Diagnosis/Condition	Notes
1	Atypical fibroxanthoma (superficial malignant fibrous histiocytoma)	The information in parentheses provides more detail and confirms a reportable malignancy.
2	Positive histology from needle biopsy followed by negative resection	This case is reportable based on positive needle biopsy.
3	Biopsy-proven squamous cell carcinoma of the nipple with a subsequent areolar resection showing foreign body granulomatous reaction to suture material and no evidence of residual malignancy in the nipple epidermis	This case is reportable based on the fact that 'no residual malignancy found' in the later specimen does not disprove the malignancy diagnosed by the biopsy.
…	And more examples …	

SEER Appendix E.2: Non-reportable examples

#	Diagnosis/Condition	Notes
1	Sclerosing hemangioma of the lung with multiple regional lymph nodes involved with sclerosing hemangioma.	The lymph node involvement is non-malignant. According to the WHO Classification of Lung Tumours, sclerosing hemangioma "behaves in a clinically benign fashion…Reported cases with hilar or mediastinal lymph node involvement do not have a worse prognosis."
2	Anal (AIN) II-III, AIN II/III, Vaginal (VAIN) II-III, VAIN II/III, Vulvar (VIN) II-III, VIN II/III, intraepithelial neoplasia	Intraepithelial neoplasia (8077/2 and 8148/2) must be unequivocally stated as **Grade III** to be reportable.
3	Lobular intraepithelial neoplasia grade 1 and grade 2	Not reportable
…	More examples….	