2024 ICD-O-3 Updates

For 2024, no major changes have been identified during review of the *5th Editions WHO Urinary and Male Genital Tumors*. Majority of changes for 2024 are new related terms for existing codes, five new ICD-O codes, four reportable, one non-reportable, and one histology that has changed behaviors and is reportable from Jan 1, 2024 forward.

34 new preferred or alternative terms for existing ICD-O-3 histologies have been added and 11 are non-reportable.

1 ICD-O-3 code and term changed behavior from /1 to /3.

HPV related Squamous Cell Carcinoma codes are valid for C60._ Other Male Genital Organs and C63.2 Scrotum.

WHERE CAN THE 2024 ICD-O-3 UPDATED TABLES BE FOUND?

- These documents are posted to the NAACCR web site at: https://www.naaccr.org/icdo3/
- Email blasts from the standard setters will also include updates and links to the tables.

ICD O 3 Coding Updates

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ICD-O-3 IMPLEMENTATION GUIDELINES

ICD O 2024 | Previous Guidelines

These documents address the implementation of ICD-O-3 for cases diagnosed on or after January 1, 2024.

ICD O 3.2 Implementation Documents for implementation in 2024

- 2024 ICD O 3.2 Coding Guidelines – 8/2/23
- 2024 ICD O 3.2 Table 1 Numeric – 8/2/23
- 2024 ICD O 3.2 Table 2 Alpha Table – 1/30/24 *(Behavior corrected for TFE3-rearranged RCC (C64.9) and TFE3-rearranged RCC. Corrected from 8311/1 to 8311/3).*

WHO IARC ICD-O-3.2

- WHO IARC ICD-O-3.2 Excel Table 1/1/2021 *(1/1/2021 is when North American registries adopted 3.2 for use)*

Annotated Histology List

- Annotated Histology List Description and Disclaimer 7/29/21
- Annotated Histology List – 11/27/23 (corrected misspelling for terms associated with 9500/3, 9505/0 and 9738/1. No other changes)

Alignment with the Cancer PathCHART initiative

- **The Cancer PathCHART initiative involves a substantial, multifaceted review process of histology and behavior codes (and associated terminology) by tumor site that includes expert pathologists and tumor registrars. The results of these in-depth reviews are incorporated into the Cancer PathCHART database, and serve as all-new, single source of truth standards for tumor site, histology, and behavior coding across all standard setters.**

- **The 2024 Cancer PathCHART ICD-O-3 Site Morphology Validation List, output directly from the Cancer PathCHART database, is a comprehensive table that replaces both the ICD-O-3 SEER Site/Histology Validation List, as well as the list of impossible site and histology combinations included in the Primary Site, Morphology-Imposs ICDO3 (SEER IF38) edit. The 2024 Cancer PathCHART ICD-O-3 Site Morphology Validation List is aligned with these 2024 ICD O Guidelines.**

How to use Tables 1(numeric) and 2(alphabetic)

Column Name	Description
ICD-O-3 Morphology Code	Lists code number and behavior
Term	Histology name per WHO. Preferred terms are indicated in **BOLD** font
Required SEER (Y/N)	Indicates if the histology is reportable or non-reportable to SEER
Required NPCR (Y/N)	Indicates if the histology is reportable or non-reportable to NPCR
Required CoC (Y/N)	Indicates if the histology is reportable or non-reportable to CoC
Required CCCR (Y/N)	Indicates if the histology is reportable or non-reportable to CCCR
Remarks	Provides information related to the ICD-O code and identifies it as a new ICD-O code, new term, or change to behavior. Coding instructions, if applicable, are also noted in this column

Table 1: 2024 ICD-O-3.2 Update (Alpha)

- Codes/terms listed *alphabetically*
- Only new terminology to existing ICD-O-3.2 codes are included in the 2024 ICD-O Implementation guidelines and documentation. Terms are those listed in WHO Blue Books
- Update based on 5th Ed Classification of Urinary and Male Genital Tumors

ICD-O Code	Term	Required SEER	Required NPCR	Required CoC	Required CCCR	Remarks
8147/3	Adenoid cystic (basal cell) carcinoma **(C61.9)**	Y	Y	Y	Y	Related term
8860/0	Angiomyolipoma with epithelial cysts	N	N	N	N	New term. Not reportable
8960/1	Cellular congenital mesoblastic nephroma	N	N	N	N	New term. Not reportable
8960/1	Classic congenital mesoblastic nephroma	N	N	N	N	New term. Not reportable
8120/3	Conventional urothelial carcinoma	Y	Y	Y	Y	New term
9085/3	Diffuse embryoma	Y	Y	Y	Y	Related term
8311/3	ELOC (formerly TCEB1)mutated RCC **(C64.9)**	Y	Y	Y	Y	New term
8311/3	Eosinophilic solid and cystic RCC **(C64.9)**	Y	Y	Y	Y	New term
8311/3	Fumarate hydratase-deficient RCC ALK-rearranged RCC **(C64.9)**	Y	Y	Y	Y	New term
9070/2	Intratubular embryonal carcinoma	Y	Y	Y	Y	New term and behavior
9061/2	Intratubular seminoma	Y	Y	Y	Y	New term and behavior
9080/2	Intratubular teratoma	Y	Y	Y	Y	New term and behavior
9061/2	Intratubular trophoblast	Y	Y	Y	Y	New term and behavior
9071/2	Intratubular yolk-sac tumor	Y	Y	Y	Y	New term and behavior
8120/3	Large nested urothelial carcinoma	Y	Y	Y	Y	New term
8130/2	Low-grade papillary urothelial carcinoma with an inverted growth pattern	Y	Y	Y	Y	New term
8960/1	Mixed congenital mesoblastic nephroma	Y	Y	Y	Y	New term. Not reportable
9085/3	Mixed teratoma and yolk-sac tumor	Y	Y	Y	Y	Related term
8590/0	Myoid gonadal stromal tumor	N	N	N	N	Related term. Not reportable
8361/1	Non-functioning juxtaglomerular cell tumor	N	N	N	N	New term and behavior. Not reportable

8130/2	Non-invasive high-grade papillary urothelial carcinoma with an inverted growth pattern	Y	Y	Y	Y	New term
8130/2	Non-invasive papillary urothelial carcinoma, high-grade	Y	Y	Y	Y	New term
8130/2	Non-invasive papillary urothelial carcinoma, low-grade	Y	Y	Y	Y	New term
8860/0	Oncocytic angiomyolipoma	Y	Y	Y	Y	New term. Not reportable
8967/0	Ossifying renal tumor of infancy	N	N	N	N	New term. Not reportable
9104/3	Placental site trophoblastic tumor of testis	Y	Y	Y	Y	Behavior change from /1 to /3. Reportable for cases DX 1/1/2024 forward-Testis ONLY
8122/3	Plasmacytoid urothelial carcinoma	Y	Y	Y	Y	Related term
8020/3	Poorly differentiated urothelial carcinoma	Y	Y	Y	Y	Related term
8140/3	Prostatic intraepithelial-like carcinoma (C61.9)	Y	Y	Y	Y	Related term
8070/3	Pure squamous carcinoma of urothelial tract	Y	Y	Y	Y	New term
8510/3	Renal medullary carcinoma (C64.9)	Y	Y	Y	Y	New term
9061/3	Seminoma with syncytiotrophoblastic cells	Y	Y	Y	Y	Related term
8510/3	SMARCB1-deficent dedifferentiated RCC of other specific subtypes (C64.9)	Y	Y	Y	Y	New term
8510/3	SMARCB1-deficient medullary-like RCC (C64.9)	Y	Y	Y	Y	New term
8510/3	SMARCB1-deficient undifferentiated RCC, NOS (C64.9)	Y	Y	Y	Y	New term
9063/3	Spermatocytic tumor with sarcomatous differentiation	Y	Y	Y	Y	Related term
8085/3	Squamous cell carcinoma, HPV-associated	Y	Y	Y	Y	Valid for C60._ (Other Male Genital Organs); C63.2 (Scrotum) beginning 1/1/2024 p16 is a valid test to determine HPV status and can be used to code HPV associated and HPV independent histologies

8086/3	Squamous cell carcinoma, HPV-independent	Y	Y	Y	Y	Valid for C60._ (Other Male Genital Organs); C63.2 (Scrotum) beginning 1/1/2024 p16 is a valid test to determine HPV status and can be used to code HPV associated and HPV independent histologies
8311/3	T(6;11)RCC **(C64.9)**	Y	Y	Y	Y	New term
9080/3	Teratoma, postpubertal-type	Y	Y	Y	Y	New preferred term
8311/3	TFEB-altered RCC **(C64.9)**	Y	Y	Y	Y	New term
8311/3	TFE3-rearranged RCC **(C64.9)**	Y	Y	Y	Y	New term
8120/3	Tubular and microcystic urothelial carcinoma	Y	Y	Y	Y	New term
8260/0	Tubulopapillary adenoma	N	N	N	N	New term. Not reportable
8311/3	Xp11 translocation RCC **(C64.9)**	Y	Y	Y	Y	New term

High Grade Dysplasia of Esophagus

Reportable for cases diagnosed Jan 1, 2024 & forward

20240025	Update to the current manual/Reportability--Esophagus: Is high grade dysplasia of the esophagus reportable? The 2024 Seer Program Manual, page 21, has an example that states it is not reportable. See Discussion.	Example 4: Esophageal biopsy with diagnosis of "focal areas suspicious for adenocarcinoma in situ." Diagnosis on partial esophagectomy specimen "with foci of high grade dysplasia; no invasive carcinoma identified." Do not accession the case. The esophagectomy proved that the suspicious biopsy result was false. Appendix E2 #32 of the SEER Manual states high grade dysplasia in site **other than** stomach, small intestines, and esophageal primary sites are not reportable. Does this mean high grade dysplasia is reportable for esophagus primaries?	High grade dysplasia of the esophagus is reportable. The example will be corrected in the next edition of the SEER manual.
20240021	Solid Tumor Rules/Reportability/Histology--Digestive Sites: Is a diagnosis of "high grade dysplasia" (not specified to be squamous or glandular) reportable for esophagus, stomach, and small intestine for cases diagnosed beginning in 2024? If so, how should histology be coded? See Discussion.	SEER Program Coding and Staging Manual indicates high grade dysplasia of esophagus, stomach, and small intestine are reportable. The ICD-O-3.2 does not include "high grade dysplasia" as equivalent to "high grade squamous dysplasia." If reportable, would high grade dysplasia (NOS) that originates in the stomach and small intestine default to 8148/2, while esophageal high grade dysplasia (NOS) default to 8077/2?	Report these high grade dysplasia of the following organs as stated below. **Stomach:** Assign code 8148/2 glandular intraepithelial neoplasia, high grade using the Other Sites Solid Tumor Rules, Table 6: Stomach Histologies and as described in the WHO Classification of Digestive Tumors, 5th edition. **Small intestine and Esophagus:** Assign code 8148/2 glandular intraepithelial neoplasia, high grade, using the Other Sites Solid Tumor Rules, Other Sites Histology Rules, Rule H4/H26. The following note is listed for both of these rules. Note: This list may not include all reportable neoplasms for 8148/2. See SEER Program Coding and Staging Manual or STORE manual for reportable neoplasms The Other Sites Solid Tumor Rules, Table 5: Esophagus Histologies and Table 7: Small Intestine and Ampulla of Vater Histologies will be updated to reflect this code as time

“Severe Dysplasia” / “High Grade Dysplasia” Reportability

Jan 1, 2024 and forward

REPORTABLE

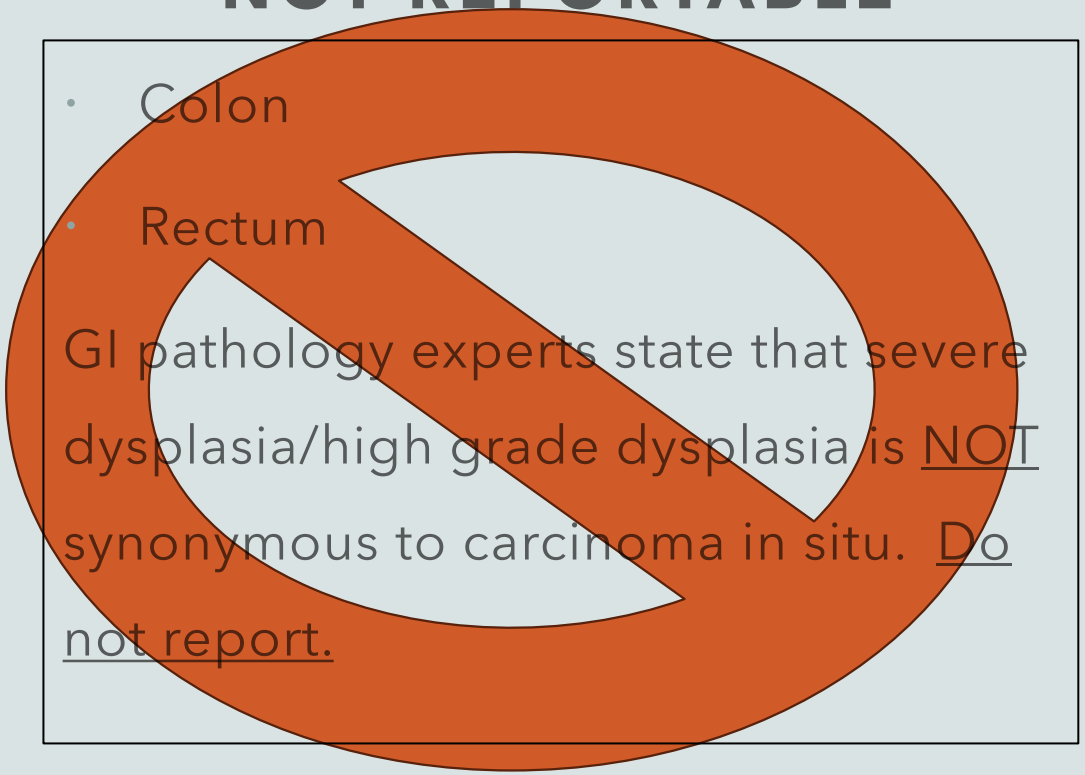
- Esophagus
- Stomach
- Small intestines

GI pathology experts state that severe dysplasia/high grade dysplasia is synonymous for carcinoma in situ.

NOT REPORTABLE

- Colon
- Rectum

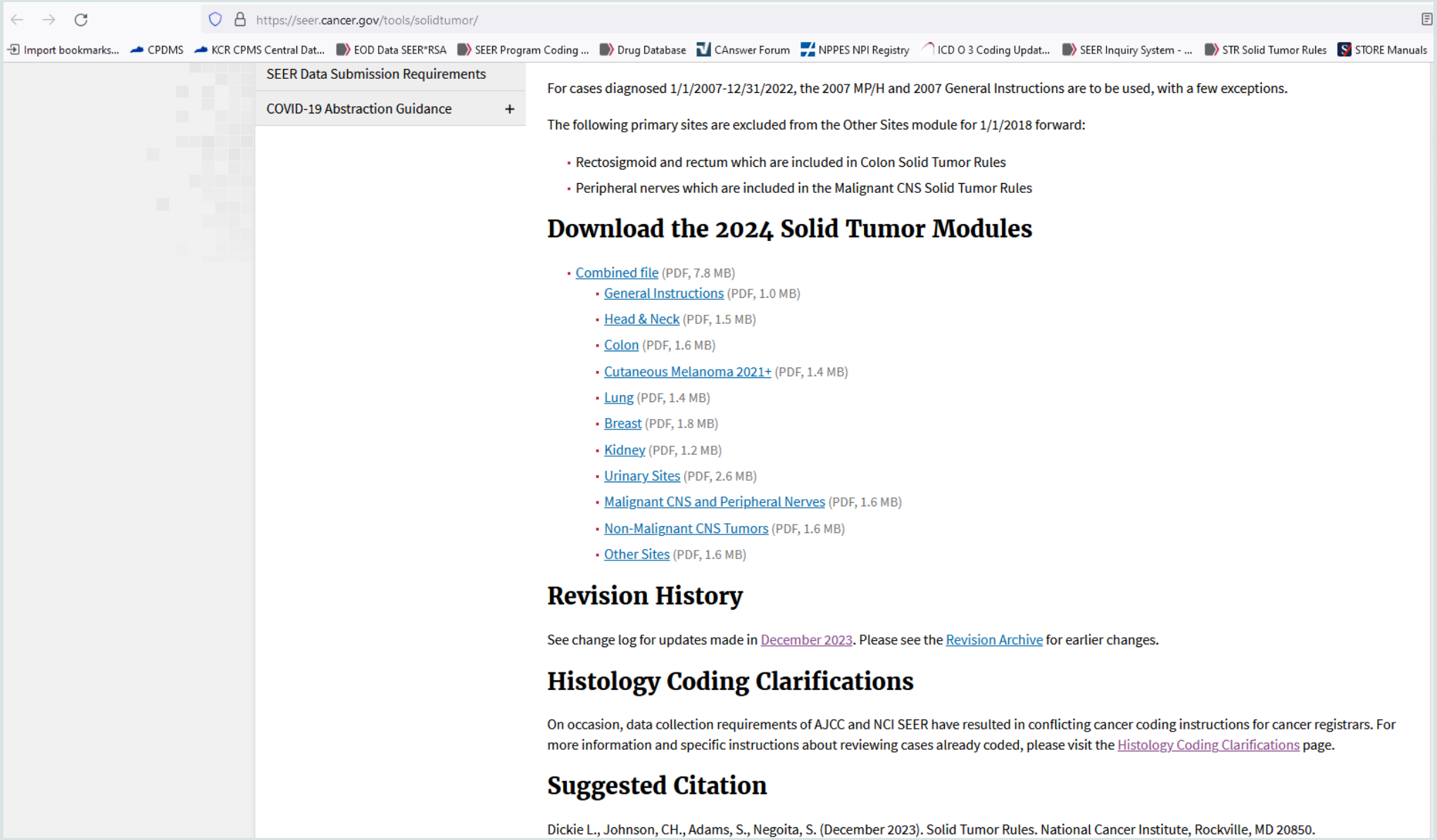
GI pathology experts state that severe dysplasia/high grade dysplasia is NOT synonymous to carcinoma in situ. Do not report.



Questions?

2024
Solid Tumor
Rules Updates

https://seer.cancer.gov/tools/solidtumor/



Reminder: The contents in the Solid Tumor Rules are *cumulative*.

When abstracting a case diagnosed after 1/1/2018 use the most current Solid Tumor Rules manual. You can start using 2024 Solid Tumor Rules immediately.

Terms and/or rules which are diagnostic date specific are noted in each update.

DISCLAIMER

The following is <u>not</u> a full or extensive list of the Solid Tumor Rules 2024 changes or updates.

Please refer to the specific Solid Tumor Rule for any changes when you prepare to abstract each case.


Breast

Breast Histology Rules
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Priority Order for Using Documentation to Identify Histology

IMPORTANT NOTES

1. Code the histology diagnosed **prior to neoadjuvant treatment.**
   Note 1: Histology changes do occur following immunotherapy, chemotherapy, hormone, and radiation therapy.
   Note 2: Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.

Exception: If the initial diagnosis is based on histology from FNA, core biopsy, smears, cytology, or from a regional or metastatic site, and neoadjuvant treatment is given and followed by resection of primary site which identifies a different or specific histology, code the histology from the primary site. For breast primaries, you cannot determine if histology comprises greater than 90% of the tumor by these diagnostic methods.

Example 1: Patient presents with a 5.0 cm right breast mass and solitary liver met. Biopsy of the liver proved metastatic triple negative ductal carcinoma [8500/3] (biopsy of breast mass was not performed). Patient was started on NAC therapy and repeat PET Scan noted complete resolution of liver met. Patient was brought to surgery for a total mastectomy and SLN. The surgical path noted 2.5 cm residual Invasive Pleomorphic Carcinoma. Update histology to 8022/3 Invasive Pleomorphic Carcinoma.

Example 2: Patient presents with left inflammatory breast cancer. A skin punch biopsy is performed and positive for Infiltrating duct and lobular carcinoma [8522/3]. Patient received NAC followed by a LMRM. Final diagnosis shows Invasive Lobular Carcinoma. Update histology to 8520/3 Invasive Lobular Carcinoma based on primary tumor. NOTE: There is no direct skin extension of primary tumor.

NOTE: PRIMARY SITE WAS NOT ORIGINALLY BIOPSIED IN EITHER OF THESE EXAMPLES.

Table 3 (page 14): Solid Carcinoma/Solid Adenocarcinoma of the breast should be coded to 8500/3 starting 1/1/2024.

Breast Equivalent Terms and Definitions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
Acinic cell carcinoma 8550	Acinar adenocarcinoma Acinar carcinoma	
Adenoid cystic carcinoma (ACC) 8200	ACC Adenocystic basal cell carcinoma Carcinoma adenoides cysticum Cylindromatous carcinoma	
Adenomyoepithelioma with carcinoma 8983	AME Malignant AME	
Apocrine carcinoma 8401 *Note:* This is a diagnosis that is **EXACTLY** apocrine **carcinoma**, **not** a carcinoma NST with apocrine **features**, **differentiation**, or **type.**		
Carcinoma NST 8500 *Note*: Cribriform carcinoma may consist of up to 50% tubular formations. The term cribriform/tubular carcinoma is coded as cribriform carcinoma.	Carcinoma, NOS Carcinoma of no special type (ductal/NST) Carcinoma/carcinoma NST with choriocarcinomatous features Carcinoma/carcinoma NST with cribriform features Carcinoma/carcinoma NST with melanotic features Carcinoma/carcinoma NST with neuroendocrine features Carcinoma/carcinoma NST with signet ring cell differentiation DCIS **8500/2** DCIS of high nuclear grade **8500/2**	Carcinoma with osteoclastic-like stromal giant cells **8035** Cribriform carcinoma/Ductal carcinoma, cribriform type **8201/3;** Cribriform carcinoma in situ **8201/2** Pleomorphic carcinoma **8022/3** Ductal carcinoma in situ, solid type/intraductal carcinoma, solid type **8230/2** Solid carcinoma/solid adenocarcinoma **8230/3 ++(cases diagnosed prior to 1/1/2024 only)**

Table 3 (page 18): Metaplastic Carcinoma Spindle Cell Type/Spindle Cell Carcinoma is now a synonym for Metaplastic Carcinoma and should be coded to 8575/3 starting 1/1/2024.

Breast Equivalent Terms and Definitions
C500-C506, C508-C509
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
Medullary carcinoma 8510	MC	Atypical medullary carcinoma (AMC) **8513**
Metaplastic carcinoma NOS or of no special type (NST) 8575 *Note 1*: Squamous cell carcinoma of the breast is **extremely rare.** Carefully **check** the **pathology** report to verify the squamous cell originated in the breast parenchyma, rather than the skin of the breast. *Note 2:* Metaplastic carcinoma, NOS and subtypes are almost always mixed with invasive mammary carcinoma, NST and at times lobular carcinoma. These tumors should be coded to metaplastic regardless of percent invasive mammary carcinoma or lobular carcinoma present.	Invasive mammary carcinoma with matrix production Metaplastic carcinoma, mixed epithelial and mesenchymal type Metaplastic carcinoma with mesenchymal differentiation Metaplastic carcinoma with squamous features Metaplastic carcinoma with other types of mesenchymal differentiation Mixed metaplastic carcinoma Metaplastic carcinoma spindle- cell type/spindle cell carcinoma ++**(cases diagnosed 1/1/2024 forward)**	Carcinosarcoma **8980/3** Fibromatosis-like metaplastic carcinoma **8572** Low grade adenosquamous carcinoma **8560** Metaplastic carcinoma spindle-cell type/spindle cell carcinoma **8032 ++(cases diagnosed prior to 1/1/2024)** Metaplastic carcinoma with chondroid differentiation/with osseous differentiation **8571** Myoepithelial carcinoma **8982** Squamous cell carcinoma **8070**

Diagnosed before 1/1/2024, code to 8032/3
Diagnosed AFTER 1/1/2024, code to 8575/3

Malignant CNS

New 'M' rule: M4 (including Note 1).

Note 1: Glioma NOS is considered an umbrella term. Additional testing should be performed to identify mutations and biomarkers that would provide a definitive histology type. A diagnosis of Glioma NOS 9380/3 is not recommended and may be used only when additional tests were inconclusive.

Malignant CNS and Peripheral Nerves Multiple Primary Rules
C470-C479, C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Single Tumor

IMPORTANT: The **major difference** between **M5** and **M6** is:
M5: No resection as first course of treatment **AND** when the same tumor is subsequently **resected**, **pathology proves malignant** behavior
M6: Tumor resected as first course of treatment. Subsequent tumor (**recurrence** or **de novo**) is **malignant**

Rule M2 Abstract a **single primary**[i] when there is a **single tumor**.
Note 1: A single tumor is always a single primary.
Note 2: The tumor **may overlap onto** or **extend** into **adjacent**/contiguous site or subsites.
Note 3: The tumor may have two or more histologic components.
Note 4: A glioblastoma multiforme 9440 (GBM) diagnosed in residual tumor, regardless of timing, is not a new primary

Rule M3 Abstract a **single primary**[i] when a neoplasm is **originally diagnosed** as an **oligodendroglioma** and subsequently **recurs** in residual tumor tissue with **different features** such as a densely cellular tumor with pseudo palisading necrosis.
Note 1: The pathology may state that the recurrence "looks like" or "has the appearance of" a glioblastoma multiforme (GBM). This is not a true GBM.
Note 2: Record as a recurrence for those registrars who collect recurrence data.

Rule M4 Abstract a **single primary**[i] when a neoplasm is originally diagnosed as **Glioma, NOS** and subsequently recurs in residual tumor with a more specific histology.
Note 1: Glioma, NOS is considered an umbrella term. Additional testing should be performed to identify mutations and biomarkers that would provide a definitive histology type. A diagnosis of glioma, NOS is not recommended and may be used only when additional tests were inconclusive.
Note 2: If a specific histology is diagnosed in residual tumor or additional testing provides a definitive histology, edit the original abstract as follows:
- Do not change the date of diagnosis
- For cases that have been abstracted, update the ICD-O code based on the new findings
- Report all data changes for cases which have been submitted to the central registry

Note 3: There is no time requirement.

Other Sites

New Table (page 37 & 38): 9a Guidelines for Assigning Primary Site for Liver and Intrahepatic Bile Duct.

Site of biopsy or cytology	Pathology or cytology diagnosis
Liver C220 or Intrahepatic bile ducts C221	Hepatocellular carcinoma
Liver C220	Combined hepatocellular carcinoma and cholangiocarcinoma

Table 9a: Guidelines for Assigning Primary Site for Liver and Intrahepatic Bile Duct

C220 Liver; hepatic, NOS
C221 Intrahepatic bile duct; biliary canaliculus; cholangiole

Guidelines for assigning primary sites for liver and intrahepatic bile duct neoplasms based on histology and other criteria are included in the newly added Table 9a. The criteria for coding liver (C220) versus intrahepatic bile duct (C221) is based on Cancer PathCHART Specialty Matter Expert review. The experts have determined adenocarcinoma and subtypes of adenocarcinoma cannot be primary to liver and therefore are biologically impossible. This table may be applied to cases diagnosed 2023 forward.

Column 1 contains the site of the biopsy specimen and/or cytology specimen
Column 2 contains the histology diagnosis as stated by the pathologist
Column 3 contains the criteria required to assign primary site based on Cancer PathCHART Specialty Matter Expert review
Column 4 contains the primary site and histology to be assigned

Site of biopsy or cytology	Pathology or cytology diagnosis	Criteria	Primary Site/ Histology
Liver C220	Adenocarcinoma Adenocarcinoma subtypes/variants	Supporting documentation such as scans, lab tests, or definitive clinical diagnosis of intrahepatic bile duct primary and/or definitive diagnosis of cholangiocarcinoma	**C221** **8160/3**
Liver C220	Adenocarcinoma Adenocarcinoma, subtypes/variants	No documentation supporting the primary site of intrahepatic bile duct is available in the medical record. This includes scans, lab tests or definitive clinical diagnosis. Liver is a common metastatic site for other neoplasms such as breast, lung, and colon. Code unknown primary site C809 when a primary site is not indicated in the pathology report or medical record.	**C809** **8140/3**

Jump to Multiple Primary Rules
Jump to Histology Coding Rules

Table 16 list the more common histologies for uterine corpus
C540 Isthmus uteri; lower uterine segment
C541 Endometrium; endometrial gland; endometrial stroma
C542 Myometrium
C543 Fundus uteri
C548 Overlapping lesion of corpus uteri
C549 Corpus uteri; body of uterus
C559 Uterus, NOS

Specific and NOS Terms and Code
Mixed cell adenocarcinoma **8323** *Note 1:* Mixed cell adenocarcinoma is comprised of endometrial carcinoma with two distinct histological types, in which one component is either serous or clear cell. Excludes dedifferentiated carcinoma and carcinosarcoma. *Note 2:* Mixed cell adenocarcinoma 8323/2 or 8323/3 have been designated biologically impossible for **myometrium (C542)** per Cancer PathCHART review.
Mucinous carcinoma, NOS **8480** *Note:* Mucinous carcinoma, NOS 8480/3 and 8480/3 have been designated biologically impossible for **Myometrium (C542)** per Cancer PathCHART review.
Neuroendocrine carcinoma NOS **8246/3** *Note*: Neuroendocrine carcinoma NOS 8246/3 has been designated biologically impossible for **Myometrium (C542)** per Cancer PathCHART review.

Several tables in the STR Other Sites modules include more than one site or site group. The tables are based on WHO Classifications of Tumors books unless otherwise noted. The Cancer PathCHART review determined that some histologies are valid for specific sites only and not for all sites within a site group. The valid C-code will be in **bold** next to the histology(ies) in applicable tables. Coding these histologies to a site *other than the one(s) noted* have been determined to be biologically impossible and **will not pass edits**.
(Example: Table 16: Uterine Corpus Histologies, page 57)

Remember:

This is not an exhaustive list of changes to the rules.

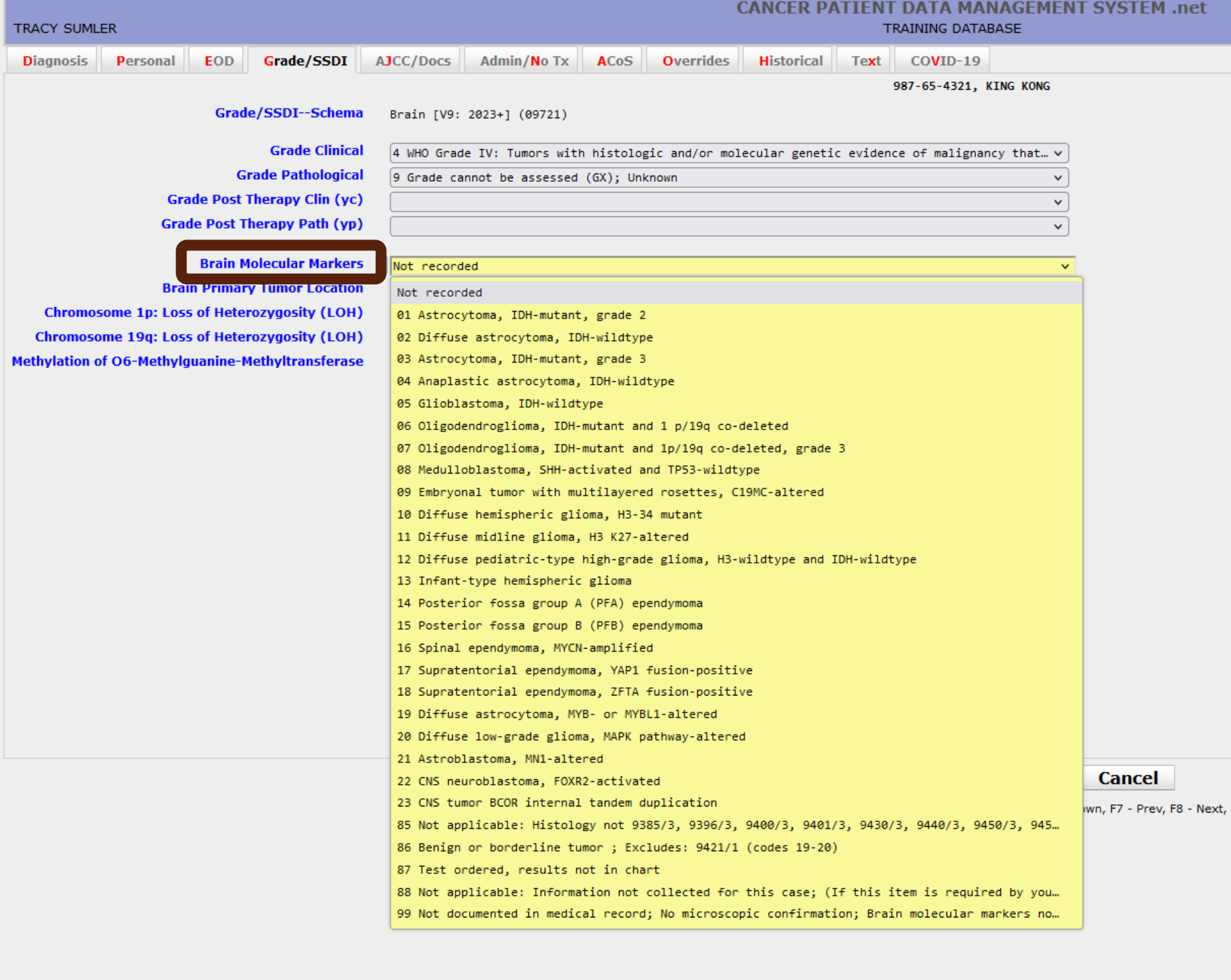
Conclusion:

Review the 2024 Solid Tumor Rules every time you begin to abstract a case!

Questions?

Site Specific Data Items (SSDI)

New codes added to Brain Molecular Markers (Brain & CNS Other schema).



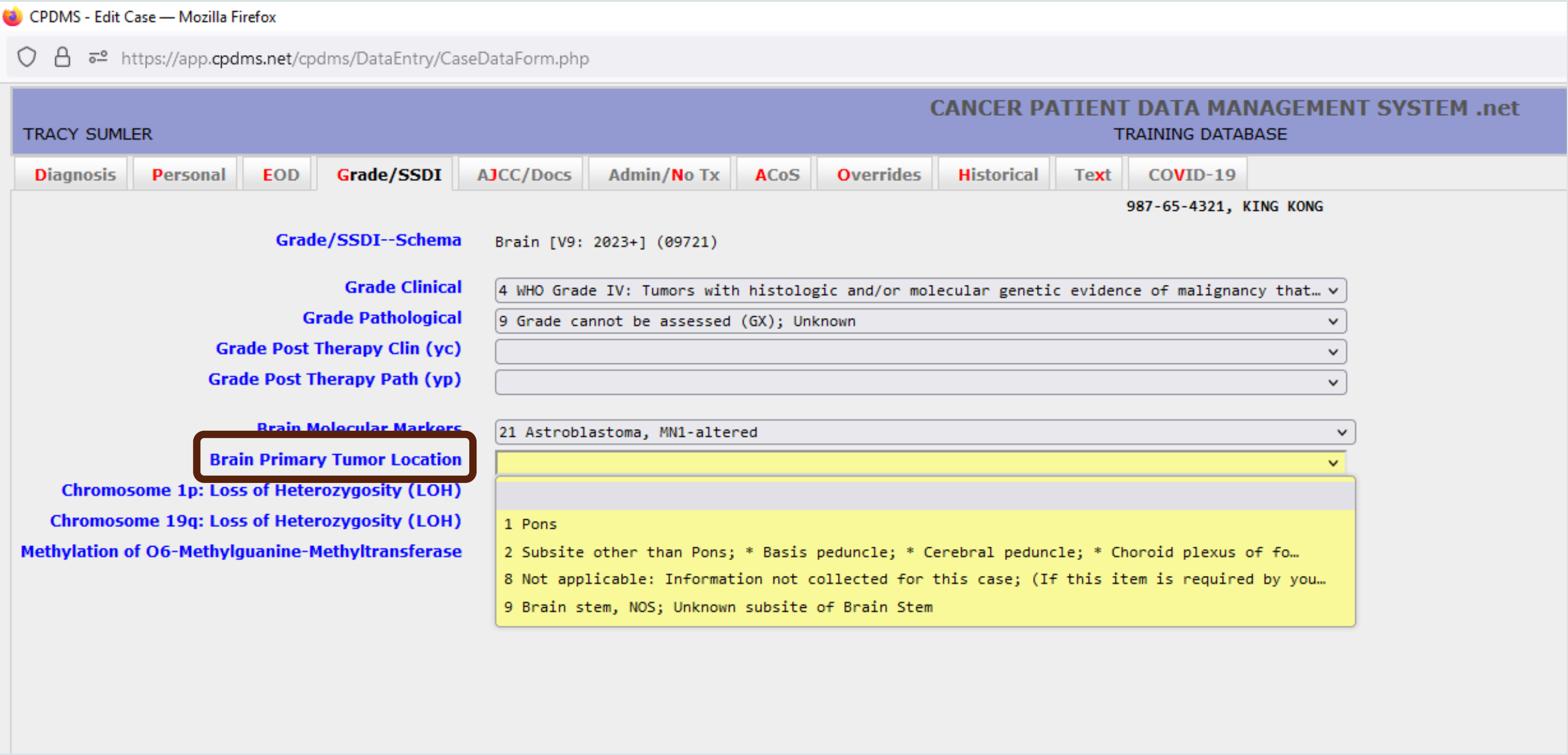
New codes added to Brain Molecular Markers (Brain & CNS Other schema).

- Codes 10-23 added for cases diagnosed 1/1/2024 forward.

Code	ICD-O-3 Code	ICD-O-3 Description
01	9400/3	Astrocytoma, IDH-mutant, grade 2
02	9400/3	Diffuse astrocytoma, IDH-wildtype
03	9401/3	Astrocytoma, IDH-mutant, grade 3
04	9401/3	Anaplastic astrocytoma, IDH-wildtype
05	9440/3	Glioblastoma, IDH-wildtype
06	9450/3	Oligodendroglioma, IDH-mutant and 1 p/19q co-deleted
07	9451/3	Oligodendroglioma, IDH-mutant and 1p/19q co-deleted, grade 3
08	9471/3	Medulloblastoma, SHH-activated and TP53-wildtype
09	9478/3	Embryonal tumor with multilayered rosettes, C19MC-altered
10	9385/3	Diffuse hemispheric glioma, H3-G34 mutant
11	9385/3	Diffuse midline glioma, H3 K27-altered
12	9385/3	Diffuse pediatric-type high-grade glioma, H3-wildtype, and IDH-wildtype
13	9385/3	Infant-type hemispheric glioma

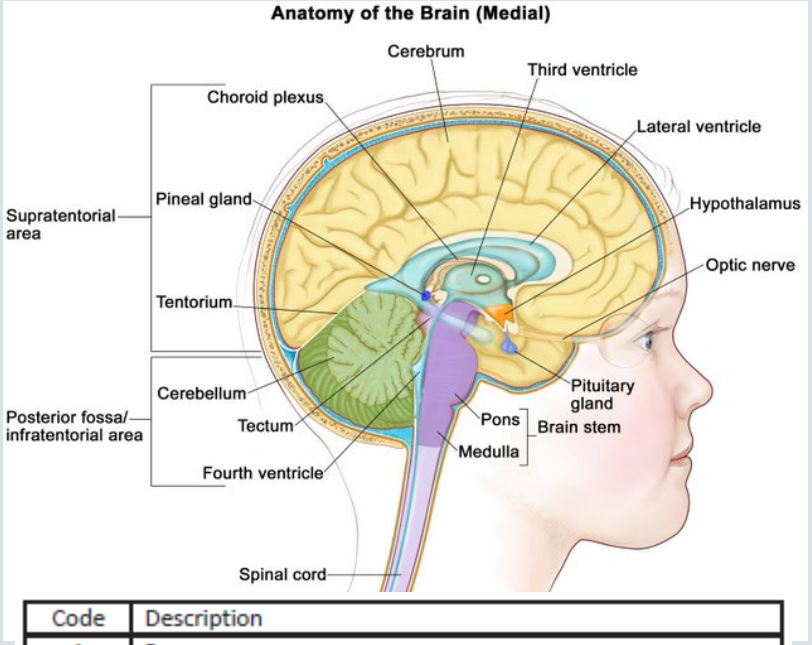
Code	ICD-O-3 Code	ICD-O-3 Description
14	9396/3	Posterior fossa group A (PFA) ependymoma
15	9396/3	Posterior fossa group B (PFB) ependymoma
16	9396/3	Spinal ependymoma, MYCN-amplified
17	9396/3	Supratentorial ependymoma, YAP1 fusion-positive
18	9396/3	Supratentorial ependymoma, ZFTA fusion-positive
19	9421/1	Diffuse astrocytoma, MYB- or MYBL1-altered
20	9421/1	Diffuse low-grade glioma, MAPK pathway-altered
21	9430/3	Astroblastoma, MN1-altered
22	9500/3	CNS neuroblastoma, FOXR2-activated
23	9500/3	CNS tumor with *BCOR* internal tandem duplication
85	NA	Not applicable: Histology not 9385/3, 9396/3, 9400/3, 9401/3, 9430/3, 9440/3, 9450/3, 9451/3, 9471/3, 9478/3, 9421/1, 9430/3, 9500/3
86	NA	Benign or borderline tumor Excludes: 9421/1 (codes 19-20)
87	NA	Test ordered, results not in chart
88	NA	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 88 will result in an edit error.)
99	NA	Not documented in medical record No microscopic confirmation Brain molecular markers not assessed or unknown if assessed

New SSDI for 2024+ Brain



New SSDI for 2024+ Brain

- **NAACCR item#3964: Brain primary tumor location.**
- A data items is needed to distinguish between the Pons and all other subsites within the brain stem (C71.7).
- The pons site is the 3rd most common site for pediatric brain tumors and there is currently no way to identify tumors that occur in this site. Surgery and needle biopsies are too dangerous and extremely rare, so the best information will come from radiology reports or physician notes.
- **Code the site in which the tumor arises.**



Code	Description
1	Pons
2	Subsite other than Pons • Basis peduncle • Cerebral peduncle • Choroid plexus of fourth ventricle • Fourth ventricle, NOS • Infratentorial brain, NOS • Medulla oblongata • Midbrain • Olive • Pyramid

Code	Description
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 88 will result in an edit error.)
9	Brain stem, NOS Unknown subsite of Brain Stem
<Blank>	Primary Site is NOT C717 Diagnosis year is prior to 2024

TRACY SUMLER

CANCER PATIENT DATA MANAGEMENT SYSTEM .net

TRAINING DATABASE

Diagnosis | Personal | EOD | Grade/SSDI | AJCC/Docs | Admin/No Tx | ACoS | Overrides | Historical | Text | COVID-19

987-65-4321, KING KONG

Diagnosed in 2024+

Grade/SSDI--Schema Oropharynx HPV-Mediated (p16+) (00100)

Grade Clinical A Well differentiated

Grade Pathological 9 Grade cannot be assessed; Unknown

Grade Post Therapy Clin (yc)

Grade Post Therapy Path (yp)

Extranodal Extension Head and Neck Clinical 7 No lymph node involvement during diagnostic workup (cN0); Non-invasive neoplasm (behavior…

Extranodal Extension Head and Neck Pathological X.7

LN Size 0.0

SEER SSF1 (HPV Status) Not recorded

- Not recorded
- 10 HPV negative by p16 test
- 11 HPV positive by p16 test
- 20 HPV negative for viral DNA by ISH test
- 21 HPV positive for viral DNA by ISH test
- 30 HPV negative for viral DNA by PCR test
- 31 HPV positive for viral DNA by PCR test
- 40 HPV negative by ISH E6/E7 RNA test
- 41 HPV positive by ISH E6/E7 RNA test
- 50 HPV negative by RT-PCR E6/E7 RNA test
- 51 HPV positive by RT-PCR E6/E7 RNA test
- 70 HPV status reported in medical records as negative, but test type is unknown
- 71 HPV status reported in medical records as positive, but test type is unknown
- 97 Test done, results not in chart
- 99 Not documented in medical record; HPV test not done, not assessed, or unknown if assessed

Update to Head & Neck Human Papilloma Virus (HPV) Status "SEER SSF 1"

- Data item change from a one-digit field to a two-digit field and additional instructions have been added.
- Use SEER*RSA or SEER Manual for revised coding instructions and codes.

https://seer.cancer.gov/tools/codingmanuals/

			tnSize		
SEER_SSF1: SEER Site-Specific Fact 1	99	No	NAACCR #3700 seerSiteSpecificFact1		None

Human Papilloma Virus (HPV) Status

Notes

Note 1: There is evidence that human papilloma virus (HPV) plays a role in the pathogenesis of some cancers. HPV testing may be performed for prognostic purposes; testing may also be performed on metastatic sites to aid in determination of the primary site.

Note 2: Record the results of any HPV testing performed on pathological 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.

Note 3: There are several methods for determination of HPV status. The most frequently used test is IHC for p16 expression which is surrogate marker for HPV infection. **Do not record the results of IHC p16 expression in this field.** The rest of the tests (based on ISH, PCR, RT-PCR technologies) detect the viral DNA or RNA. **This data item is only for HPV status determined by tests designed to detect viral DNA or RNA.**

Note 4: HPV-type 16 refers to virus type and is different from p16 overexpression (p16+).

Note 5: Codes 0-7 are hierarchical; use the highest code that applies.

2024+ changes

Code	Description
10	HPV negative by p16 test
11	HPV positive by p16 test
20	HPV negative for viral DNA by ISH test
21	HPV positive for viral DNA by ISH test
30	HPV negative for viral DNA by PCR test
31	HPV positive for viral DNA by PCR test
40	HPV negative by ISH E6/E7 RNA test
41	HPV positive by ISH E6/E7 RNA test
50	HPV negative by RT-PCR E6/E7 RNA test
51	HPV positive by RT-PCR E6/E7 RNA test
70	HPV status reported in medical records as negative, but test type is unknown
71	HPV status reported in medical records as positive, but test type is unknown
97	Test done, results not in chart
99	Not documented in medical record HPV test not done, not assessed, or unknown if assessed

Human Papilloma Virus (HPV) Status

Notes

Note 1: There is evidence that human papilloma virus (HPV) plays a role in the pathogenesis of some cancers. HPV testing may be performed for prognostic purposes; testing may also be performed on metastatic sites to aid in determination of the primary site.

Note 2: Record the results of any HPV testing performed on pathological 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.

Note 3: There are several methods for determination of HPV status. The most frequently used test is IHC for p16 expression which is surrogate marker for HPV infection. **Do not record the results of IHC p16 expression in this field.** The rest of the tests (based on ISH, PCR, RT-PCR technologies) detect the viral DNA or RNA. **This data item is only for HPV status determined by tests designed to detect viral DNA or RNA.**

Note 4: HPV-type 16 refers to virus type and is different from p16 overexpression (p16+).

Note 5: Codes 0-7 are hierarchical; use the highest code that applies.

DIAGNOSED 2018 - 2023

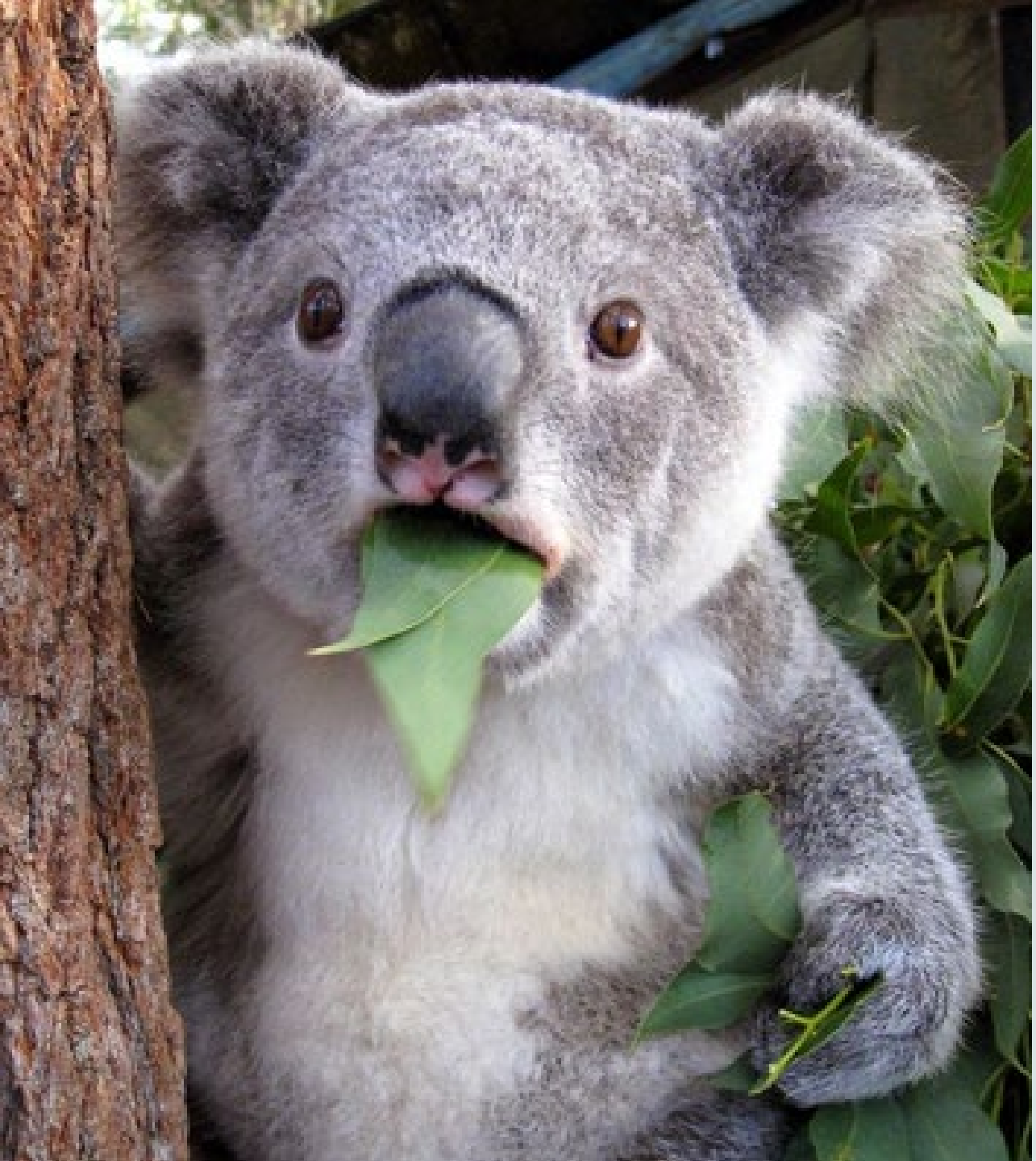
Code	Description
0	HPV negative for viral DNA by ISH test
1	HPV positive for viral DNA by ISH test
2	HPV negative for viral DNA by PCR test
3	HPV positive for viral DNA by PCR test
4	HPV negative by ISH E6/E7 RNA test
5	HPV positive by ISH E6/E7 RNA test
6	HPV negative by RT-PCR E6/E7 RNA test
7	HPV 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	Not documented in medical record HPV test detecting viral DNA and or RNA not assessed, or unknown if assessed

DIAGNOSED IN 2024+

Code	Description
10	HPV negative by p16 test
11	HPV positive by p16 test
20	HPV negative for viral DNA by ISH test
21	HPV positive for viral DNA by ISH test
30	HPV negative for viral DNA by PCR test
31	HPV positive for viral DNA by PCR test
40	HPV negative by ISH E6/E7 RNA test
41	HPV positive by ISH E6/E7 RNA test
50	HPV negative by RT-PCR E6/E7 RNA test
51	HPV positive by RT-PCR E6/E7 RNA test
70	HPV status reported in medical records as negative, but test type is unknown
71	HPV status reported in medical records as positive, but test type is unknown
97	Test done, results not in chart
99	Not documented in medical record HPV test not done, not assessed, or unknown if assessed

7 new AJCC 9th Edition Chapters were released for cases diagnosed 1/1/24 and after. The schemas for these 7 sites have been updated to align with the new 9th Edition changes.

- **Vulva**
  - ***p16 will be required for vulva***
- **NET Ampulla of Vater**
- **NET Appendix**
- **NET Colon and Rectum**
- **NET Duodenum**
- **NET Jejunum and Ileum**
- **NET Pancreas**
- **NET Stomach**



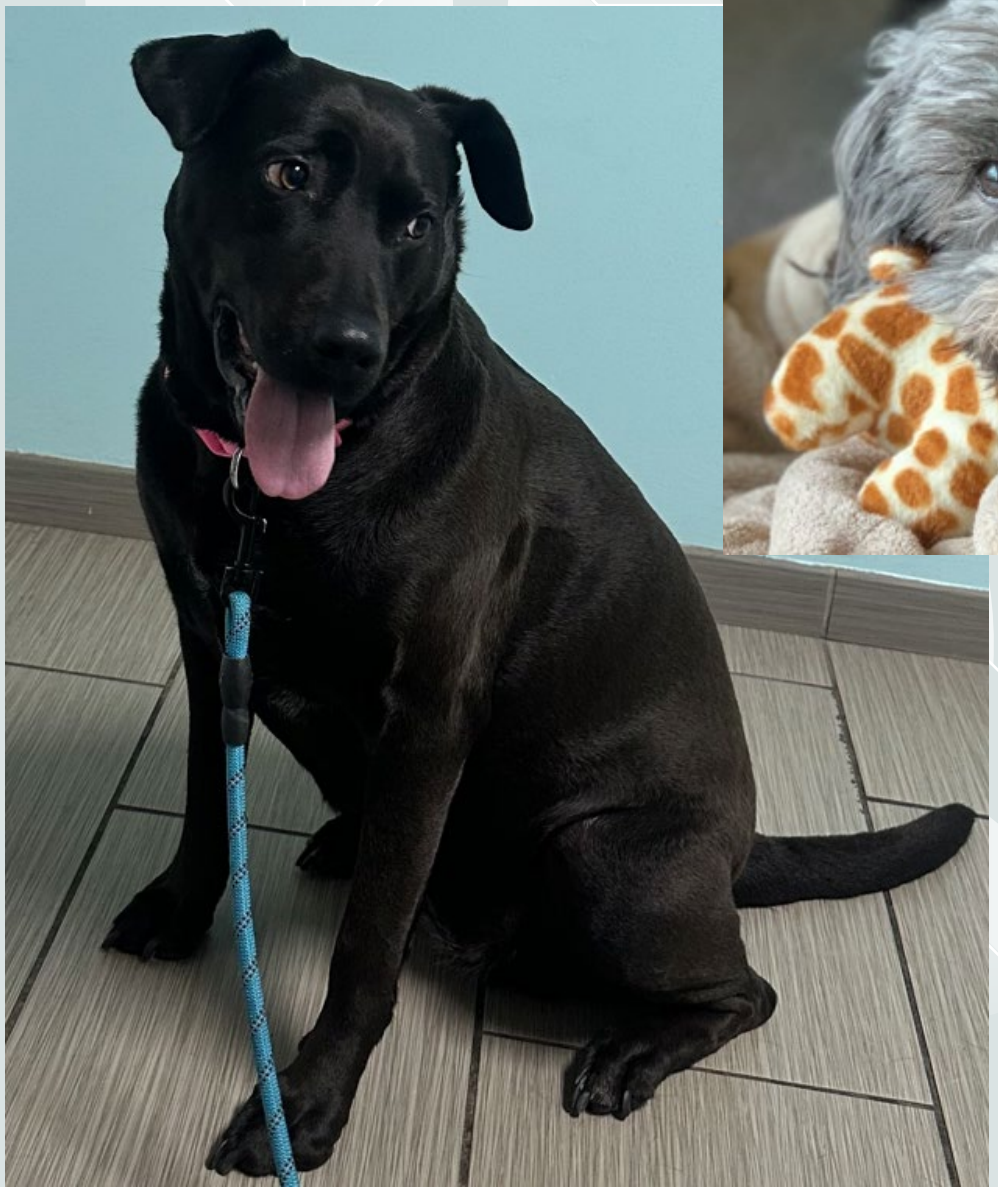
2024 Grade Updates

Clarification added: Ranges in Grade

- **If a range is given for a grade (example: 1-2 or 2-3), code the *higher* grade.**
- **Reminder! Grade can only be collected from the primary tumor. Do not code grade from a metastatic lymph node, distant metastatic site or recurrence. In the rare instance that the tumor extends contiguously to an adjacent structure/site AND the primary site is not available, code the grade from the contiguous site.**

Hematopoietic and Lymphoid Neoplasms Manual & Database

NO CHANGES IN 2024!



Thank you

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