SEER PROGRAM CODING and STAGING MANUAL 2021

Just a few of the changes- Please see SPCM for the complete list of summaries of changes.

Reportability Changes (as of, 1/1/2021)

MELANOMA

Early or evolving melanoma, in-situ and invasive

GISTS

All GISTS tumors are reportable and classified as 8936/3 in ICD-0-3.2.

THYMOMAS

Nearly all Thymomas are reportable. The exceptions are:

- Microscopic thymoma or thymoma, benign (8580/0)
- Micronodular thymoma with lymphoid stroma (8580/1)
- Ectopic hamartomatous thymoma (8587/0)

INTRACRANIAL or CNS Neoplasms -revised section header and text; changed wording from brain to intracranial. (see manual).

Report benign and borderline primary intracranial and central nervous system (CNS) tumors with a behavior code of/0 or /1 in ICD-0-3 (effective with cases diagnosed 1/1/2004 to 12/31/2020) or ICD-0-3.2 (effective with cases diagnosed 1/1/2021 and later.

"Neoplasm" and "tumor" *are reportable* terms for intracranial and CNS because they are listed in ICD-0-3.2 with behavior codes of /0 and /1.

"Mass" and "lesion" *are not* reportable terms for intracranial and CNS because they are not listed in ICD-0-3.2 with behavior codes of /0 or /1.

AMBIGUOUS TERMINOLOGY *(as a reminder*: DO NOT accession a case based *ONLY* on a suspicious cytology. Accession cases with cytology diagnoses that are positive for malignant cells")

Cytology section revisions:

Added text to first paragraph: accession the case when a reportable diagnosis is confirmed later. The date of diagnosis is the date of the later confirmation.

Added the last paragraph:

Urine cytology positive for malignancy is reportable. Code the primary site to, C689 in the absence of any other information.

PRIMARY SITE

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

Primary site should always be coded to reflect the site of origin according to the medical opinion on the case. Look for information where the neoplasm originated.

Always code the primary site based on where the tumor arose /site of origin.

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

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

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

Gastrointestional Stromal Tumors (GIST): code the primary site to the location where the GIST originated.

SUMMARY STAGE 2018

Summary Stage 2018 stores directly assigned Summary Stage 2018. This data item is effective for cases diagnosed 1/1/2018 forward. Refer to SEER*RSA for additional information.

LYMPHOVASCULAR INVASION -introductory note revised.

NOTE: SEER requires Lymphovascular Invasion (LVI) for penis and testis cases only.

SCOPE OF REGIONAL LYMPH NODE SURGERY – assume the lymph node that is aspirated is part of the lymph node chain surgically removed and do not include it in the count when location is unknown.

SURGERY CODES

BREAST note revised: CODE 30

SEER NOTE: Use code 30 for "*Goldilocks Mastectomy".* It is essentially a skin-sparing mastectomy with breast reconstruction. The choice between code 30 and codes in 40-49 range depends on the extent of the breast removal. Review the operative report carefully and assign the code that best reflects the extent of the breast removal.

COLON notes added.

SEER NOTE: do not code a colostomy, with no colon tissue removed, as surgery. If colostomy is the only procedure performed, assign surgery code "00".

SEER NOTE: Code circumferential resection margin (CRM) *only* when assigning surgery codes 30-80. CRM is not applicable for other surgery codes for this site.

SEER NOTE: Rectum and Rectosigmoid -Code circumferential resection margin (CRM) *only* when assigning surgery codes 27, 30-80. CRM is not applicable for other surgery codes for these sites.

SKIN- note revised. Following codes 20-25.

SEER NOTE: For Photodynamic therapy (PDT): assign code 11 if there is no pathology specimen. Assign code 21 if there is a pathology specimen. Codes 20-27 include shave and wedge resection.

SUMMARY OF CHANGES COVERED IN THE 2021 ICD-0-3 UPDATE: can be found by accessing this link: (**https://www.naaccr.org/icd03**)

ICD-0

The 2021 ICD-0-3 Update Guidelines includes comprehensive tables listing all changes to ICD-0-3 including new terminology and reportability changes effective for cases diagnosed 1/1/2021 forward. Included in these guidelines are instructions for using the tables together with ICD-0-3.2. Issues not covered in the 2021 update include reportability of histology codes with terms that include "high grade neoplasia", "high grade dysplasia" or "severe dysplasia" in the digestive system sites.

TABLE 1: BEHAVIOR CODE CHANGES-non-reportable to reportable -16 terms and codes that have changed behavior from non-reportable to reportable beginning with cases diagnosed on or after 1/1/2021.

TABLE 2: BEHAVIOR CODES CHANGES -reportable to non-reportable-nine terms and codes that have changed behavior from reportable to non-reportable beginning with cases diagnosed on or after 1/1/2021.

TABLE 3: DELETED CODES- histology terms moved to other ICD-0 codes- ten terms and codes that have been deleted from one ICD-0 code and moved to another code effective with cases diagnosed on or after 1/1/2021.

TABLE 4: CHANGES IN REPORTABLE TERMINOLOGY- this table lists revised preferred terminology for 13 neoplasms in ICD-0-3.2. These neoplasms no longer require "malignant" to be included in the diagnostic term to report the case as malignant (/3).

TABLE 5: NEW TERMS and ICD-0 CODES 12 new terms and ICD-0 codes effective for cases diagnosed on or after 1/1/2021.

From IARC

ICD-O-4 *(Update as of January 25, 2021)*

With the new 5th edition of the Blue Books commencing (it will be completed by mid-2023), it is now the time for the IARC WHO Classification of Tumours Group to start creating new codes. Due to the lack of available codes for new morphological diagnoses in the current 4-digit morphology structure, **it is proposed for the next ICD-O edition (ICD-O-4) that a 5th digit will be added**.

This approach, with the addition of a "0" where there is no need for a more specific code, or other values if needed was chosen for the ease of conversion and consistency with ICD-O-3 (similar to a MOTNAC to ICD-O-1 conversion). Adding an additional digit to the existing four retains the needed consistency, including the possibility to collapse to previous versions, but will likely require minor changes in registry software, notification forms, etc.

As the previous IACR ICD-O Working Group has now concluded its work with ICD-O-3.2, **IACR will establish a new WG with global representation**, with a terms of reference that focuses on the required planning for the implementation of ICD-O-4 in cancer registries worldwide.

2021 / Hematopoietic Database Changes

Several changes in histologies have been incorporated for 2021 based on the *"WHO Classification of Tumors of Hematopoietic and Lymphoid Tissues, Revised 4th edition, Volume 2, 2017"*.

These histologies are part of the ICD-0-3.2 update and are effective for cases diagnosed 2021 and later.

New histologies. These histologies can only be used for cases diagnosed 2021+
Note: In the Hematopoietic database, the "Help me code for diagnosis year" must be 2021 to view information on these histologies
9715/3: Anaplastic large cell lymphoma, ALK-negative/ Breast implant-associated anaplastic large cell lymphoma
9749/3: Erdheim-Chester Disease
9766/3: Lymphomatoid granulomatosis grade 3
9819/3: B-lymphoblastic leukemia/lymphoma, BCR-ALB1 like
9877/3: Acute myeloid leukemia with mutated NPM1
9878/3: Acute myeloid leukemia with biallelic mutation of CEBPA
9879/3: Acute myeloid leukemia with mutated RUNX1
9912/3: Acute myeloid leukemia with BCR-ABL1
9968/3: Myeloid/lymphoid neoplasm with PCM1-JAK2
9993/3: Myelodysplastic syndrome with ring sideroblasts and multilineage dysplasia
Note: Same primaries and transformations were also updated to incorporate the new histologies

The following histologies are now a /1 (instead of a /3) and are no longer reportable starting with 2021 diagnoses
9725/3: Hydroa vacciniforme-like lymphoma (New preferred name: Hydroa vacciniforme-like lymphoproliferative disorder)
Note: See 9725/1 for 2021+
9971/3: Post-transplant lymphoproliferativer disorder (PTLD)
Note: See 9971/1 for 2021+

The following histolog codes and terms are obsolete and have a new code starting with 2021 diagnoses
9826/3: Burkitt Leukemia (for diagnosis 2021+, coded as 9687/3 Burkitt lymphoma with primary site C421)
9991/3: Refractory neutropenia (for diagnosis 2021+, coded as 9980: Myelodysplastic syndrome with single lineage dysplasia)
9992/3: Refractory thrombocytopenia (for diagnosis 2021+, coded as 9980: Myelodysplastic syndrome with single lineage dysplasia)

Change in histology 9751/3
Only Langerhans cell histiocytosis, disseminated is a /3 for 2021+ diagnoses. All other terminology, including Langerhans cell histiocytosis, NOS, is now a /1 (see updated alternate names list when "help me code for diagnosis" is 2021)

The following histologies are new, but are /1 and not reportable. They have been included in the Hematopoietic Database for informational purposes
9591/1: Monoclonal B-cell lymphocytosis, non-CLL type
9673/1: In situ mantle cell neoplasia
9680/1: EBV-positive mucocutaneous ulcer
9695/1: In situ follicular neoplasia
9702/1: Indolent T-cell lymphoproliferative disorder of the gastrointestinal tract
9709/1: Primary cutaneous CD4-positive small/medium T-cell lymphoproliferative disorder (previously listed as an alternate name in 9709/3)
9738/1: HHV8-positive germinotropic lymphoproliferative disorder
9761/1: IgM monoclonal gammopathy of undetermined significance
9823/1: Monoclonal B-cell lymphocytosis, CLL-type

Appendix D: Introduction to Genetic Nomenclature

SEER / SINQ Q & A

Q-20200066

Reportability--Skin: Effective 2021, a cutaneous leiomyosarcoma is a related term for smooth muscle tumor, NOS (8897/1) in ICD-O-3.2. Currently, we have been capturing these as a C44_ (leiomyosarcoma, 8890/3) but the 2019 SEER inquiry states that atypical intradermal smooth muscle neoplasm (AISMN) was previously termed cutaneous leiomyosarcoma. This is not documented on the 2018 ICD-O-3 updates. Should this 2019 case be considered 8897/1 or 8890/3?

A-Cutaneous leiomyosarcoma is reportable for 2019. Code histology to leiomyosarcoma 8890/3.
As of cases diagnosed 1/1/2021, it is no longer reportable based on assignment to 8897/1 in ICD-O-3.2.

Q-20200063

Solid Tumor Rules (2021)/Laterality--Melanoma: Will the table called Site for Which Laterality Code Must Be Recorded be updated in the 2021 SEER Program Coding and Staging Manual as C444 is not included? The 2021 Cutaneous Melanoma Solid Tumor Rules say that C444 requires laterality; it says (new) beside it on the new Solid Tumor Rules for 2021

A-The laterality table in the 2021 SEER manual will not be updated. Please follow the 2021 Cutaneous Melanoma Solid Tumor Rules and assign a laterality for C444.

Q-20200051

Primary site/Unknown and ill-defined site--Melanoma: What is the primary site for a case of metastatic melanoma with an unknown primary site?

A-Code primary site C449. C449 is the default primary site code for melanoma of unknown primary site. C760 should **not** be assigned for this case. Updates will be made to SEER*RSA to remove the melanoma histology codes from the Cervical Lymph Nodes and Unknown Primary Tumors of the Head and Neck schema.

Q-20200058

Surgery of Primary Site/Surgery Codes, NOS--Pancreas: What exactly is an extended pancreatoduodenectomy? Must the entire pancreas be resected to use code 70? What minimal requirements must be met to use code 70? How should a Whipple with cholecystectomy, partial omentectomy, common hepatic excision, portal vein resection, and lymphadenectomy be coded?

A-According to our research, a pancreaticoduodenectomy (PD) includes an en bloc resection of the pancreatic head, the common bile duct, the gallbladder, the duodenum, the upper jejunum, the distal portion of the stomach and the adjacent lymph nodes. The extended PD procedure includes extended lymphadenectomy, extended organ resection, and extended vascular resection and reconstruction.

Code 70 could be assigned without the entire pancreas being resected

A Whipple procedure removes the head of the pancreas, duodenum, stomach and gallbladder and part the common bile duct. The portal vein resection is probably part of the common bile duct excision. If the omentectomy was performed for treatment of this primary, record it in "Surgical Procedure of Other Site." Record the lymphadenectomy in the lymph node data items.

Q-20200055

COVID-19 Abstraction Guidelines

Solid Tumor Rules (2018)/Multiple primaries--Melanoma: Should a case with treatment delayed due to COVID-19 be abstracted as one or two primaries? It is uncertain if the invasive tumor would be a new tumor, or deeper extension/disease progression from the original tumor. See Discussion.

DISCUSSION:

11/18/2019 Left 1st Digit/Thumb Biopsy: Atypical Melanocytic Proliferation consistent with Early Acral Lentiginous Melanoma in situ. Margins Positive. (Not a reportable diagnosis for 2019.)

12/5/2019 Left 1st Digit Shave Biopsies: Malignant Melanoma in situ. Margins Positive.

1/15/2020 Started Aldara (treatment plan: use for ~3 months then Mohs/excision, but due to COVID could not get resection until 7/2020).

7/29/2020 Left Thumb Excision: Residual Melanoma in situ. Margins Positive. Treatment Plan: re-excision.

8/6/2020 Left Thumb Re-Excision: Atypical Lentiginous Melanocytic Proliferation at the 12-2 margin may represent the advancing edge of melanoma in situ. (8/19/2020 Plan to treat the 12-2 margin as positive with in situ: plan for re-excision).

8/20/2020 Left Thumb Re-Excision & Left Nail Plate Excision: Malignant Acral Lentiginous Melanoma with extensive melanoma in situ. Breslow 1.3mm. Margins Positive. Nail plate & bed epithelium with hemorrhage and a mild increase in melanocyte density likely represent melanoma in situ.

9/4/2020 Left thumb partial amputation & Left axillary Sentinel Lymph Node Excision: Residual Malignant Melanoma in situ. 0/3 sentinel nodes positive.

A-Abstract a single primary using the Solid Tumor Rules for melanoma. Report this melanoma as invasive (/3) as documented in the information from 8/20/2020. The treatment delay does not influence the number of primaries to be reported. Registries in SEER regions: Report the COVID-related information as directed in the COVID-19 Abstraction Guidelines, https://seer.cancer.gov/tools/covid-19/

Q-20210025

Primary site--Ovary: What information takes precedence for coding the primary site in cases with high grade serous carcinoma that are clinically called ovarian but on pathology, the pathologist calls the primary site fallopian tube, and the gynecology oncology/managing physician continues to call the cases ovarian. Both the ovary and tube are involved.

A-When the choice is between ovary, fallopian tube, or primary peritoneal, 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. If there is no information about the fallopian tubes, refer to the histology and look at the treatment plans for the patient. If all else fails, you may have to assign C579 as a last resort. Use text fields to document the details.

For additional information, see the CAP GYN protocol, Table 1: Criteria for assignment of primary site in tubo-ovarian serous carcinomas.

Q-20200087

Solid Tumor Rules (2018)/Histology--Thyroid: What is the correct histology code for a micropapillary thyroid carcinoma for cases diagnosed 1/1/2021 and later? See Discussion.

Discussion

The 2021 ICD-O-3.2 Update includes papillary microcarcinoma (8341/3) as the preferred term for thyroid primaries (C739). However, there are multiple SINQ entries instructing registrars not to use code 8341/3 for diagnoses of micropapillary carcinoma of the thyroid (including SINQ 20071076, 20081127, 20110027, 20150023, and 20180008).

SINQ 20150023 specifically indicates: Per the WHO Tumors of Endocrine Organs, for thyroid primaries/cancer only, the term micropapillary does not refer to a specific histologic type. It means that the papillary portion of the tumor is minimal or occult (1 cm or less in diameter) and was found incidentally. WHO does not recognize the code 8341 and classifies papillary microcarcinoma of the thyroid as a variant of papillary thyroid carcinoma and codes histology to 8260. If the primary is thyroid and the pathology states papillary microcarcinoma or micropapillary carcinoma, code 8260 is correct.

Does this clarification apply to cases diagnosed 2021 and later? If WHO feels the term micropapillary still does not refer to a specific histologic type for the thyroid, why is 8341/3 listed as a preferred term for this morphology/site combination? For cases 2021 and later, should a diagnosis of Incidental papillary thyroid microcarcinoma (3 mm) in left lower pole, be coded as 8341/3 per the ICD-O-3.2, or as 8260/3 per clarification in multiple SINQ entries?

This question was prompted from preparing SEER*Educate coding exercises. We will use the answer as a reference in the rationales.

A-Continue to code micropapillary thyroid carcinoma to 8260/3 until instructed otherwise. This coding instruction is based on input from expert endocrine pathologists. This issue will be revisited based on the 4th Ed WHO Endocrine Tumors and updated if needed.

Q-20200023

Solid Tumor Rules (2018) Histolology-Endometrium: Is the histology for a serous carcinoma, high grade endometrial primary 8441/3 (serous carcinoma) or 8461/3(high grade serous carcinoma)? See Discussion.

A-Code histology for this endometrial primary to serous carcinoma 8441/3. Capture “high grade” in the grade field as instructed in the grade coding manual. “High grade serous carcinoma” 8461/3 has specific clinical and histopathologic features found in ovarian tumors.

Corpus Uteri Histology – SINQ Q &A 20180071

Malignant Mixed Mullerian Tumor

Per SINQ Q & A: according to the WHO Classification of Tumors of Female Reproductive Organs, 4th edition, MMMT (8950/3) is now a synonym for carcinosarcoma (8980/3) even though it has a separate ICD-) code. The ICD-0 for MMMT is no longer in the WHO book. Per the subject matter experts, when both terms are used in the diagnosis (carcinosarcoma/MMMT), code the histology to 8980/3. If the ONLY term used is MMMT, assign 8950/3.

THYROID – Change in Reportability

As of January 1, 2021- Non-invasive follicular thyroid neoplasm with papillary-like nuclear features (NIFTP) C739 is no longer reportable for cases diagnosed 1/1/2021 forward.

Code 8349/1 for Non-invasive follicular thyroid neoplasm with papillary-like nuclear features (NIFTP). Term was previously coded to 8343/2.

PROSTATE – GLEASON GRADE and GLEASON SCORE

CONFUSED ABOUT GLEASON SCORE?

Gleason grade (or Pattern): a number from 1 to 5 based on how mutated the cells look under the microscope

Gleason Score: grading at least two areas of the tumor and adding the numbers together, so score of

2 (1+1) to a maximum of 10 (5+5)

Grade Group: putting the Gleason grade and score into one of five groups:

TRADITIONAL GLEASON SCORE	NEW GRADING SYSTEM GROUP 1
GLEASON 3+3=6 Only individual discrete well-formed glands	GRADE 1
GLEASON 3+4=7 Predominantly well-formed glands with a lesser component of poorly-formed/fused/cribiform glands.	GRADE 2
GLEASON 4+3=7 Predominantly poorly-formed/ fused/cribriform glands with a lesser component of well-formed glands.	GRADE 3
GLEASON 4+4=8 Only poorly-formed/fused/cribriform glands or -Predominantly well-formed glands with a lesser component lacking or -Predominantly lacking glands with a lesser component of well-formed glands.	GRADE 4
GLEASON 9-10 Lacks gland formation (or with necrosis) with or without poorly-formed/fused/cribriform gland.	GRADE 5

Connecticut Historical Stage - PROSTATE

The Connecticut Historical Stage covers all cases diagnosed from 1935 forward. The only single stable staging system applicable to over 85 years.

Stage is recorded in the LOCAL/REGIONAL/DISTANT field

Three stages for Prostate:

LOCALIZED: limited to prostate; may include extension through capsule to periprostatic tissue. No extension to adjacent organs. No evidence of metastasis.

REGIONAL: limited to prostate with perineural invasions and/or lymph node metastasis.

DISTANT: extension to adjacent organs, including *seminal vesicle involvement,* and/or

distant lymph nodes or other organs

UNKNOWN, no documentation, no information, death certificate only (DCO).

QC Section….just a few reminders

Accessible lymph nodes vs. Inaccessible lymph nodes:

Accessible lymph nodes: For "accessible" lymph nodes that can be observed, palpated, or examined without instruments, such as the regional nodes for the breast, oral cavity, salivary gland, skin, thyroid, and other organs, look for some description of the regional lymph nodes. **A statement such as "remainder of examination negative" is sufficient to code 000 negative regional lymph nodes.**

> ***Note:*** If there is mention of a clinical evaluation but no mention of positive lymph nodes, assign code 000.

Inaccessible lymph nodes: For certain primary sites, regional lymph nodes are not easily examined by palpation, observation, physical examination, or other clinical methods. These are lymph nodes within body cavities that in most situations cannot be palpated, making them inaccessible. Bladder, colon, corpus uteri, esophagus, kidney, liver, lung, ovary, prostate, and stomach are examples of inaccessible sites (this is not an all-inclusive list). When EOD Primary Tumor is low stage/Localized and standard treatment is done, it is sufficient to code 000 for negative regional lymph nodes.

Insitu tumors (behavior /2:) Code 000 for lymph node involvement.

a. **Note:** Pure in situ tumors (behavior /2) cannot have lymph node mets
    i. For Breast and Thyroid, there are multiple lymph node codes indicating no regional lymph node involvement (depending on whether lymph nodes were pathologically examined or not)

. **In situ tumors with metastatic nodal involvement:** In the event of an in situ tumor with metastatic nodal involvement, assign EOD Primary Tumor as in situ (code 000) and code EOD Regional Nodes appropriately (positive). **This is a change from prior versions of EOD.**

a. **Note:** Behavior would be /3 for these tumors. The primary tumor is in situ; however, there is evidence of an invasive component due to the positive lymph nodes

ACINAR Adenocarcinoma -Prostate

Code 8140 (adenocarcinoma, NOS) for prostate primaries when the diagnosis is Acinar Adenocarcinoma.

LUNG – Mainstem Bronchus

Code to C340 "ONLY" when specifically stated in the operative report and/or documented by a physician. Code to the lobe in which the bronchial tumor is located when stated as

"bronchus".

2021 SSDI'S UPDATES

GENERAL INSTRUCTIONS: TIMING FOR LAB TESTS

- The following sentence removed as a bullet point and is the first criteria for the timing rules for laboratory tests

- All lab values must be done no earlier than approximately three months before diagnosis
  - This statement was removed from the bulleted list
  - This criteria is the first thing that applies
  - This still applies even if further work up is delayed due to COVID

GENERAL INSTRUCTIONS: TIMING FOR LAB TESTS

- Remaining bullets have not been changed

Unless instructions for a specific laboratory test state otherwise, record only tests results obtained

- before any cancer-directed treatment is given (neoadjuvant therapy or surgical), AND
- if multiple lab tests are available, record the highest value

GENERAL INSTRUCTIONS: TIMING FOR LAB TESTS

- Reminder:
  - These instructions are for lab values only (CEA, PSA, etc.)
  - These instructions are not to be used for results based on tissue
    - KRAS, Ki-67, etc.
  - All SSDI's will tell you the source of the information
    - *Example 1:* Note 2: Record the lab value of the highest CEA
    - *Example 2:* Note 5: Results from nodal or metastatic tissue may be used for KRAS
- Note will be added to SSDI manual about this
- http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/103136-ki67-multiple-test

GENERAL INSTRUCTIONS: CONSULTS REPORTS

- If a report is sent out for consult and the results are different than the original reports, record the results from the consult
  - Consults always take priority

- This was confirmed within the surveillance community and with AJCC and CAP
- This applies to Grade as well
  - Documented in the SEER manual, STORE manual, Solid Tumor Rules manual

3823: CIRCUMFERENTIAL RESECTION MARGIN (COLON AND RECTUM)

- Guidelines regarding surgery added to note
  - For Colon primaries, surgery of primary site must be coded as 30-80
    - If surgery of primary site is 00-29, then CRM must be coded as XX.7
    - Edit implemented for cases diagnosed 2021+

- Reminder: If a polypectomy is done, CRM is always XX.7
  - Edit implemented for cases diagnosed 2021+

3823: CIRCUMFERENTIAL RESECTION MARGIN (COLON AND RECTUM)

- Guidelines regarding surgery added to note
  - For Rectal primaries, surgery of primary site must be coded as 27, 30-80
    - If surgery of primary site is 00-26 or 28, then CRM must be coded as XX.7
    - Code 27 includes Transanal resections
    - Edit implemented for cases diagnosed 2021+

3932: LDH LAB VALUE

- Name change
  - Previous name: LDH Pretreatment Lab Value
  - Name was found to be misleading, the "pretreatment" was the problem

- **Note 3: Record the lab value of the highest serum LDH test results documented in the medical record either before or after surgical resection of the primary tumor with or without regional lymph node dissection.** The LDH must be taken prior to systemic (chemo, immunotherapy, hormone), radiation therapy or surgery to a metastatic site. The lab value may be recorded in a lab report, history and physical, or clinical statement in the pathology report.

3922: RESPONSE TO NEOADJUVANT THERAPY (BREAST)

- New Note: For in situ tumors (behavior /2) code 0
- Received confirmation that in situ tumors are not going to have neoadjuvant therapy
  - This does **not** apply to tumors that are invasive during clinical work up, neoadjuvant therapy is done, and the residual tumor is in situ. This would be a /3 tumor
  - Nor does it apply to tumors that are in situ clinically but have positive nodes and have neoadjuvant therapy. These would also be a /3 tumor

HER2 DATA ITEMS (BREAST)

- 3855: HER2 Overall Summary
- New Note: HER2 is not routinely done on pure in situ tumors (/2); however, if you have an in situ tumor and there are HER2 results, go ahead and record it
- Otherwise code 9

3836: FIGO STAGE (ALL GYN SCHEMAS)

- FIGO Stage completely restructured

Current	Revised
01	1
02	1A
10	1C2
24	2B
33	3A11
37	3C
40	4
42	4B

- Update is for all cases diagnosed 2018+
  - New codes cannot be used until your software is updated
- For cases 2018+, all FIGO Stages will be automatically updated during the software update
- The code structure now fits how AJCC documents the FIGO Stage in the AJCC manual

3836: FIGO STAGE (ALL GYN SCHEMAS)

- FIGO Stage completely restructured

Current	Revised
01	1
02	1A
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- The code structure now fits how AJCC documents the FIGO Stage in the AJCC manual

CURRENT SSDI'S WITH NEW SCHEMAS

- The following SSDI's are new for **2021 cases only**
  - 3855: HER2 Overall Summary (Esophagus [both schemas], Stomach)
  - 3863: Ki-67 (NET Ampulla, NET Appendix, NET Colon and Rectum, NET Duodenum, NET Jejunum and Ileum, NET Pancreas, NET Stomach)
- Current Requirement Status (2021)
  - Required by SEER and CoC

As of, 1/1/2021 "COC" and "SEER" are no longer requiring these data items:

HER2 IHC, HER2 ISH, and HER ISH and HIC Status

SSDI'S: CHANGE IN REQUIREMENTS

- CoC and SEER no longer requiring:
  - 3850: HER2 IHC Summary (Breast)
  - 3851: HER2 ISH Dual Probe Copy Number (Breast)
  - 3852: HER2 ISH Dual Probe Ratio (Breast)
  - 3853: HER2 ISH Single Probe Copy Number (Breast)
  - 3854: HER ISH Summary (Breast)
  - 3859: HIV Status (Lymphoma)
- These will no longer be required as 1/1/2021
  - They are still required for cases diagnosed 1/1/2018-12/31/2020

3936: ULCERATION (MELANOMA SKIN)

- **Updated Note 3:** Melanoma ulceration is the absence of an intact epidermis overlying the primary melanoma based upon microscopic (histopathological) examination.
  - Code 1 if any biopsy (punch, shave, excisional, etc.) or wide excision is positive for ulceration in the presence of an underlying melanoma
  - Code 0 if all specimens are negative OR one specimen is negative and the other is unknown
  - Ulceration must be caused by an underlying melanoma. Ulceration caused by trauma from a previous procedure should not be coded as positive for this SSDI

- 2022 update (not in manual at this time)

*Attachment from the Spring 2021 Edition of the TRAC Newsletter


Keeping Connecticut Healthy
DPH
Connecticut Department
of Public Health