CANCER REPORTING IN CALIFORNIA:
ABSTRACTING AND CODING PROCEDURES
California Cancer Reporting System Standards, Volume I

Changes and Clarifications – 24th Edition
July 2024

Quick Look - Updates to Volume I

New Sections/Data Items

VOL I Section #	Data Item	Requirement
V.3.4	Cancer PathCHART Site-Morphology Combination Standards	N/A
VI.2.4.4	Breast Reconstruction	Required
Appendix Q	Brain Primary Location	Required

Section/Page Revisions

VOL I Section #	Data Item or Volume I Topic	Reason for Revision
I.1.6.2	Abstracting Cancer Data	Added guideline
I.1.8	Cases Diagnosed and Treated Elsewhere	Updated CCR Expectations
II.1	CCR Reportability Guide - Reportable	Updated introduction; updated general and site-specific terms lists indicating in-situ behavior; added 2024 reportability requirements; added instruction to Intracranial and/or Central Nervous System section; added exception Urine Cytology bullet; Errata 2023
II.1.1	CCR Reportability Guide - Non-Reportable or Historically Reportable	Updated prostate and skin histology
II.2.2	Ambiguous Diagnostic Reportable Terms	Added section for Ambiguous Phrases for Reportability and moved coding instruction above into section
II.2.6	Address at Diagnosis	Added Standard Setter Difference
III.2.10	Race and Ethnicity	Updated and added coding instructions
III.2.18.2	Tobacco Use Smoking Status	Updated and added coding instructions
III.3.6	Type of Reporting Source	Added coding instruction
III.3.12.2	Entering Physician NPI Codes	Updated page with NPI coding instructions and codes, Errata 2023
IV.2	Diagnostic Confirmation	Added note for code 7
V.1	Primary Site	Added section for Physician Priority Order for Coding Primary Site for Solid Tumors; added instructions; updated table
V.2	Laterality	Added, revised, and reorganized coding instructions
V.3	ICD-O Morphology - Histology and Behavior	Added 2024 ICD-O-3.2 histology code and behavior changes note
V.3.3	Behavior	Added 2024 ICD-O-3.2 histology code and behavior changes note; added exception; updated code 3 description, Errata 2023
V.3.3.1	In-Situ Coding	Updated general and site-specific terms lists indicating in-situ behavior

V.5	Tumor Size	Updated introduction; removed Tumor Size Clinical and Tumor Size Pathologic
V.5.1	Tumor Size Summary	Renumbered from V.5.3; reordered coding instructions; added new description in table for code 999.
V.7	Lymphovascular Invasion	Added coding instruction for code 8, Errata 2023
V.8	Terms Indicating In-situ for Staging	Updated general and site-specific terms lists indicating in-situ behavior
V.9.1	Staging Requirements	Updated staging requirements
V.11.1.1	EOD – Primary Tumor	Removed coding instruction
V.12.1	SSDI General Information	Removed instruction for rounding rules where exception to rule
V.13	Site-Specific Factor 1	Updated coding instructions and expanded codes to 2 digits (some code changes, see detail section below)
V.15.2	SS2018 Ambiguous Terms for Disease Extension	Separate Possible and Questionable in "Not Involved" in table, Errata 2023
VI.1.2	First Course of Treatment – Data Entry	Added to introduction; added sub-bullet to Date treatment started bullet
VI.1.3.1	Neoadjuvant Therapy	Added coding instruction for code 0
VI.1.3.2	Neoadjuvant Therapy – Clinical Response	Added coding instruction
VI.1.3.3	Neoadjuvant Therapy – Treatment Effect	Updated first sub-bullet of first coding instruction. Add words "of the primary site"
VI.2	Surgery Introduction - First Course of Treatment	Updated sub-bullet of last coding instruction. Added words “(s), including lymph node procedures”
VI.2.4	Surgery of Primary Site 2023	Added notes to coding instructions
VI.2.6	Scope of Regional Lymph Node Surgery	Added to guidelines for text
VI.2.11	Reason for No Surgery of the Primary Site	Updated code descriptions in table
VI.3.3.3	Radiation Treatment Modality – Phases I-III	Updated coding instruction
VI.3.8	Location of Radiation Treatment	Updated code descriptions in table
VI.4.3	Chemotherapy Codes	Updated code descriptions in table
VI.5.3	Hormone Therapy Codes	Added to coding instruction; updated code descriptions in table
VI.6.1	Immunotherapy Agents	Added acronym to term
VI.6.3	Immunotherapy Codes	Added to coding instruction; updated code description in table
VI.7.2	Transplant/Endocrine Procedures Codes	Updated code descriptions in table
VI.8.2	Other Therapy Codes	Removed term from coding table
VIII.1.1	Required Documentation for Data Items – Remarks	Added page back into Volume I, Errata 2023
IX.2.2	Accuracy – Quality Control	Removed VE section and updated audits section
Appendix A	Terms and Definitions	Added Monoclonal Antibodies and description
Appendix C	Codes for Countries	Added and removed codes/terms from alphabetical and code lists
Appendix G	Codes for Casefinding	Updated using SEER casefinding list v24
Appendix I	Common Acceptable Symbols and Abbreviations	Added and removed codes/terms from alphabetical and code lists
Appendix K.2	STORE Surgery Codes for 2023 +	Updated introduction; update the following sites to "B" Codes - Beast, Colon, Lung, Pancreas, and Thyroid

Appendix M	Q-Tips	Added 2023 & 2024 rows to list of Q-Tips
Appendix Q	Site-Specific Data Items (SSDIs)	Added/removed codes/terms, revised required status
Appendix R	Coding Resources	Updated resources
Appendix S	Historical Coding and Staging Manual Requirements for CCR	Added historical manuals
Appendix T	Text Documentation Guidelines	Updated guidelines; updated dates of examples

Items No Longer Required/Pages Deleted

VOL I Section # (HISTORICAL NOW)	**Data Item**	**Requirement**
V.5.1	Tumor Size Clinical	Page deleted, item retired as of 2024
V.5.2	Tumor Size Pathologic	Page deleted, item retired as of 2024

GENERAL CHANGES

Volume I is only presented in PDF format. For historical Volumes, see Archived Volume I - Use case year of diagnosis to determine which Volume I to choose.

All Pages:

- ✓ Added footer containing page number, Volume name, and publication year.
- ✓ Updated and confirmed internal and external links.
- ✓ Formatting, grammar, and editing for typos.

Select Pages:

- ✓ Updated CTR to ODS-C

SECTION CHANGES

I.1.6.2 Abstracting Cancer Data

- ✓ Added guideline: All information about diagnostic workup, staging and treatment should be reported. This includes diagnosis/staging/treatment done elsewhere but documented in the reporting facility medical record.

I.1.8 Cases Diagnosed and Treated Elsewhere

- ✓ Revised CCR Expectations to clarify use of electronic records from outside facilities.
  - ➢ Report all information included in your facility's medical record. If the electronic medical record system used by your facility has the ability to view the medical records from outside facilities, it is not necessary to look for missing information in those outside records, although a facility may choose to do so.
- ✓ Removed two CCR Expectation bullets and replaced it with one that covered both topics.
  - ➢ All information reported must be coded and documented in the appropriate text fields.

II.1 CCR Reportability Guide - Reportable

- ✓ Rewrote introduction to clarify reportability and frequently questioned diagnoses:
  - ➢ **Reportability for cases diagnosed January 1, 2024 and forward is based on ICD-O-3.2 and the associated 2024 update tables.** Please see the *2024 ICD-O-3.2 Implementation Guidelines*. Use of these guidelines are required for determining reportability and accurate coding.
  - ➢ **This section lists reportable diagnoses that are new or are frequently questioned. It also includes diagnostic terms which are not explicitly listed in ICD-O but which SEER has determined are reportable, however, this list is not all inclusive. If a diagnosis is not on this list, do not infer it is not-reportable. Refer to *ICD-O 3.2* as well as the *SEER Program Manual* Reportability section and associated *Appendix E1*.**
  - ➢ When casefinding please follow the above reportability guidelines and California Class of case rules to determine reportability. If you encounter a case where you are uncertain, contact your Regional Registry.
  - ➢ A review of the **SEER Program Manual** and associated **Appendix E1: Reportable Examples** resulted in corrections/additions to this section. These changes can be identified as follow:

- * **Represents Correction** to reportability in Volume I, based on review of the SEER Program Manual. Registries are not required to make changes to previous year cases based on this information.
- ** **Represents Addition of** terms listed in the **2023 or 2024 SEER Program Manual, Appendix E1: Reportable Examples** that have been reportable per ICD-O-3 since 2021. While the CCR will not require registrars to go back and do casefinding procedures for cases prior to 2023 or 2024, if you are still casefinding for previous years and identify these reportable histologies for SEER 2021+, please accession and send cases to the CCR.

✓ Terms added to the General Reportable Terms Indicating In-situ Behavior table:
- Dysplasia, squamous, high grade (excluding cervix)
- ** Glandular intraepithelial neoplasia high grade 8148/2
- Intraductal papillary neoplasm with high grade intraepithelial neoplasia
- Intraepithelial neoplasia:
  - High grade
  - Grade II
  - (excluding: Glandular intraepithelial neoplasia grade II, 8148/0)
- Squamous intraepithelial neoplasia:
  - Grade II (SIN II)

✓ Terms added to the Site-Specific Terms Indicating In-situ Behavior table:
- **Breast** (C500-C509):
  - Lobular intraepithelial neoplasia grade II (LIN II), 8500/2, dx 01/01/2024 +
  - Lobular neoplasia grade II (LN II), 8500/2, dx 01/01/2024 +
- **Endometrium** (C54_) Updated Volume I page based on Errata, 2023:
  - ** Endometrioid intraepithelial neoplasia (EIN), 8380/2, dx 01/01/2021 +
  - ** Intraepithelial neoplasm of endometrium, 8380/2, dx 01/01/2021 +
  - ** Atypical hyperplasia of endometrium, 8380/2, dx 01/01/2021 +
- **Esophagus** (C15_):
  - ** Esophageal squamous intraepithelial neoplasia (dysplasia), high grade, 8077/2, dx 01/01/2021 +
  - ** Esophageal glandular dysplasia (intraepithelial neoplasia), high grade, 8148/2, dx 01/01/2021 +
  - ** Esophageal intraepitelial neoplasia high grade, 8148/2, dx 01/01/2021 +
- **Gallbladder** (C230):
  - ** Biliary intraepithelial neoplasia high grade, 8148/2, dx 01/01/2021 +
- **Larynx** (C320-C329):
  - Laryngeal intraepithelial neoplasia grade II (LIN II), 8077/2, dx 01/01/2024 +
- **Pancreas** (C250-C259):
  - Pancreatic intraepithelial neoplasia grade II (PanIN II), 8500/2, dx 01/01/2024 +
- **Penis** (C600-C609):
  - Penile intraepithelial neoplasia grade II (PeIN II), 8077/2, dx 01/01/2024 +
  - ** Differentiated penile intraepithelial neoplasia (PeIN), 8071/2, dx 01/01/2021 +
- **Stomach and Small Intestine** (C160-C166, C168-C169, C170-C173, C178, C179):
  - Squamous dysplasia, high grade
- **Vulva** (C510-C519):
  - ** Differentiated vulvar intraepithelial neoplasia (VIN), 8071/2, dx 01/01/2021 +

✓ Instruction added to Site-Specific Reportability for Intracranial and/or Central Nervus System section.

- **Neoplasm** and **Tumor** are reportable terms for intracranial and CNS because they are listed in ICD-O with behavior codes of /0 and /1. **"Mass"** and **"Lesion"** are **not** reportable terms as they are not listed in ICD-O.

✓ Exception added to instruction for Site-Specific Reportability for Urine Cytology.
- (except when a subsequent biopsy of a urinary site is negative, do not report).

II.1.1 CCR Reportability Guide - Non-Reportable or Historically Reportable

✓ Terms added to the Non-Reportable or Historically Reportable diagnoses section for:
- Added "high grade" to Prostatic intraepithelial neoplasia
- Added "SIN III" to Squamous intraepithelial neoplasia

II.2.2 Ambiguous Diagnostic Reportable Terms

✓ Added section for Ambiguous Phrases for Reportability and moved first instruction from the coding instructions (above) into this section.

Ambiguous Phrases for Reportability
Ambiguous Phrases Considered as Diagnostic of Cancer

✓ Equivalent to "Diagnostic for" malignancy or reportable diagnosis. These phrases **are reportable** when **no other information is available** or there is no information to the contrary.
- Considered to be [malignancy or reportable diagnosis]
- Characteristic of [malignancy or reportable diagnosis]
- Appears to be a [malignancy or reportable diagnosis]
- Most compatible with [malignancy or reportable diagnosis]
- Most certainly [malignancy or reportable diagnosis]
- In keeping with [malignancy or reportable diagnosis]

✓ Equivalent to "Not diagnostic for" malignancy or reportable diagnosis. These phrases are **NOT reportable** when **no other information is available** or there is no information to the contrary.
- Highly suspicious for, but not diagnostic of [malignancy or reportable diagnosis]
- Most compatible with [non-reportable diagnosis] such as [reportable diagnosis]
- High probability for [malignancy or reportable diagnosis]

✓ Equivalent to "Differential diagnoses."
- Differential considerations

II.2.6 Address at Diagnosis

✓ Added Standard Setter Difference instruction to show difference between CCR and SEER data collection instructions for homeless or transient patients.
- ***Standard Setter Difference:***
- Per SEER guidelines, a homeless or transient patient's address at the time of diagnosis would be coded to the shelter they reside at, or the hospital where diagnosis was confirmed. However, the CCR codes the county at diagnosis, and the rest of the fields as unknown. See the following instructions for CCR coding.

III.2.10 Race and Ethnicity

✓ Updated race coding instruction for coding Native Hawaiian or Other Pacific Islander when described, and no other information is available.

- If record indicates "Native Hawaiian or Other Pacific Islander," look for other descriptions of the patient's race. When no other information is available, assign code 97 – Pacific Islander, NOS.

✓ Added coding instruction for patient described as "Belgian."
- Use code 01, when patient is stated to be "Belgian" and the record indicates "non-hispanic, other race."

III.2.18.2 Tobacco Use Smoking Status

✓ Updated coding instruction to include marijuana and chewing tobacco.

✓ Added coding instructions:
- Past or current use of marijuana, chewing tobacco, e-cigarettes, or vaping devices are **not** to be coded in this data item.
- Code 1 when the record indicates:
  - The patient currently smokes.
  - The record only states "current tobacco use."
  - If there is evidence in the medical record that the patient quit recently (within 30 days prior to diagnosis).
- Code 2 when the record indicates:
  - "Former smoker."
  - "Prior tobacco use."
  - Patient has smoked tobacco in the past but does not smoke now. Patient must have quit 31 or more days prior to cancer diagnosis to be coded as "former smoker".
- Code 3 when the record indicates:
  - Patient is noted to have smoked, but the current status is not known.
  - It is known that the patient "recently" stopped smoking but, it is not known how long ago the patient stopped smoking.
  - It cannot be determined whether the patient currently smokes or formerly smoked.
- Code 9 when:
  - The medical record only indicates "No" for tobacco use.
  - Smoking status is not stated or provided
  - The method (cigarette, pipe, cigar) used cannot be verified in chart
  - The record has no information about smoking status or history.
    Example: Pathology report only.
  - It is documented that the patient uses or used marijuana, chewing tobacco, e-cigarettes, or vaping devices, but tobacco use is not mentioned.
- This item is to be left blank for cases diagnosed prior to January 1, 2022.
- **The CCR requires text documentation to support the tobacco use smoking status code.**

III.3.6 Type of Reporting Source

✓ Added coding instruction for outpatient surgery.
- Surgery for primary cancer performed at a hospital as an outpatient (no overnight stay). Assign code 1 if the hospital is part of a managed health plan with comprehensive, unified medical records – meaning that a single record is maintained for each patient and that record includes all encounters in affiliated locations. Otherwise, assign code 8.

III.3.12.2 Entering Physician NPI Codes

✓ Updated Volume I page based on Errata, 2023. Page corrected to:

III.3.12.2 Entering Physician NPI Codes

The NPI 10-digit number identifies physicians involved in the patients care. Administrative, physician, and service referral reports are based on this item. This data item is required if available by the CCR (if the information is obtainable for abstracting, it is required) for cases diagnosed January 1, 2007 and forward. See *Appendix P* - National Provider Identifier (NPI) codes for further details.

Coding Instructions:

- The *Managing Physician* data item may not be blank.
- Record the 10-digit NPI for the surgeon, radiation oncologist, and/or medical oncologist.
- Additional physicians are designated by their role in the case, i.e. referring, consulting, and other. See *Follow-Up Physician* for further instructions.
- If there is no physician or the physician cannot be determined, leave blank.
- If the managing physician is the same as another physician, (i.e., the medical oncologist) the NPI number must be entered in both places.
- Do not update this item. Once the registry has designated a managing physician, radiation oncologist, and/or medical oncologist for the patient, the information should not be changed or updated even if the patient receives care from another physician.
- NPI may be left blank if diagnosed before January 1, 2007.

Code	Description
(fill spaces)	10-digit NPI number
BLANK	No physician, physician cannot be determined

IV.2 Text - Diagnostic Confirmation

✓ Added note to coding instruction for code 7.

➢ **Note:** Intraductal papillary mucinous neoplasm with high grade dysplasia (8453/2) of the pancreas is reportable based on imaging alone; histologic confirmation is not required.

V.1 Primary Site

✓ Added new section for physician priority order for coding primary site for solid tumors:

Physician Priority Order for Coding Primary Site for Solid Tumors

As a general rule, the surgeon is usually in a better position to determine the site of origin compared to the pathologist. The surgeon sees the tumor in its anatomic location, while the pathologist is often using information given to him/her by the surgeon and looking at a specimen removed from the anatomic landmarks. However, when a pathologist is looking at an entire organ, such as the pancreas, he/she may be able to pinpoint the site of origin within that organ.

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

tumor is located in the "body" vs. the "neck." In this example, we would give preference to the surgeon and assign the code for body of pancreas, C251.

- ✓ Added coding instructions for gyn site decision:
  - ➢ When the choice is between ovary, fallopian tube, or primary peritoneal without designation of the site of origin, any indication of fallopian tube involvement indicates the primary tumor is a tubal primary.
    - Fallopian tube primary carcinomas can be confirmed by reviewing the fallopian tube sections as described on the pathology report to document the presence of either serous tubal intraepithelial carcinoma (STIC) and/or tubal mucosal invasive serous carcinoma.
    - In the absence of fallopian tube involvement, refer to the histology and look at the treatment plans for the patient. If all else fails, assign C579 as a last resort.
    - For additional information, see the CAP GYN protocol, Table 1: Criteria for assignment of primary site in tubo-ovarian serous carcinomas.
- ✓ Updated table for assigning sites in the absence of any additional information.
  - ➢ Added sites:
    - Back of tongue – C019
    - Incisura, incisura angularis – C163
    - Interarytenoid space – C329
    - Intracranial – C719
    - Periareolar (breast) – C501
    - Periclitoral – C511
    - Porta hepatis – C220
    - Postauricular region – C444
    - Perauricular (skin) – C443
    - Prostatic sinus (urethra) – C680
    - True vocal folds – C320
    - Ureterovesical junction (UVJ) – C669
  - ➢ Removed sites:
    - Parapharyngeal space – C490

V.2 Laterality

- ✓ Added, updated, and reordered coding instructions to align with the SEER Program Manual.
  - ➢ Metastatic bilateral involvement is not coded for laterality. If the primary site is unknown (C809) assign code 0. If the primary site is known, continue through the coding instructions to assign the appropriate code.
  - ➢ Code the side where the primary tumor originated:
    - Code 3 if the laterality is not known but the tumor is confined to a single side of the paired organ.
  - ➢ Code 4 is seldom used EXCEPT for the following:
    - Both ovaries involved simultaneously with a **single histology**, or **epithelial histologies** (8000-8799)
    - Diffuse bilateral lung nodules
    - Bilateral retinoblastomas
    - Bilateral Wilms tumors
    - Both breasts when inflammatory carcinoma is bilateral at diagnosis
    - Bilateral involvement at time of diagnosis and lateral origin unknown for a site listed in the table located in *Laterality - Paired Sites* in the next section.

- Code 4 **should not** be used for bilateral primaries for which separate abstracts are prepared or when the side of origin is known, and the tumor has spread to the other side.
  Example: A left ovarian primary with metastases to the right ovary is code 2, rather than code 4.
- Code 5 when the tumor originates in the midline of a paired organ or site listed below:
  - Site code C700, C710-C714, C722-C725, C443, C444, and C445
  - Do not assign code 5 to sites not listed above.

  Example: Patient has an excision of a melanoma located above the umbilicus.
- Code 9 when the neoplasm originated in a paired site and the laterality is unknown **and** there is no statement that only one side of the paired organ is involved.

V.3. ICD-O Morphology – Histology and Behavior

- ✓ Updated to 2024 ICD-O-3.2 code and behavior changes.
  - **2024 ICD-O-3.2 histology code and behavior changes:** Updates include new and revised histology terms, codes, and behaviors for cases diagnosed January 1, 2024 and forward. Please see the *2024 ICD-O-3.2 Implementation Guidelines*. Use of these guidelines are required for determining reportability and accurate coding.
- ✓ Table - Code 3 Description – Revised description to Malignant, Primary Site (includes microinvasion); from Malignant, Primary Site (includes microinvasion **), removing the **. The note does not belong to the Code 3 description.

V.3.3 Behavior

- ✓ Updated to 2024 ICD-O-3.2 code and behavior changes.
  - **2024 ICD-O-3.2 histology code and behavior changes:** Updates include new and revised histology terms, codes, and behaviors for cases diagnosed January 1, 2024 and forward. Please see the *2024 ICD-O-3.2 Implementation Guidelines*. Use of these guidelines are required for determining reportability and accurate coding.
- ✓ Added exception to 3rd coding instruction.
  - Clinical evidence alone is not sufficient to identify behavior as in-situ. A behavior code of /2-in-situ must be based on pathologic examination.
    Exception: Intraductal papillary mucinous neoplasm with high grade dysplasia (8453/2) of the pancreas is reportable based on imaging alone; histologic confirmation is not required.
- ✓ Table - Code 3 Description – Revised description to Malignant, Primary Site (includes microinvasion); from Malignant, Primary Site (includes microinvasion **), removing the **. The note does not belong to the Code 3 description. Updated Volume I page based on Errata, 2023.

V.3.3.1 In-Situ Coding

- ✓ Terms added to the General Reportable Terms Indicating In-situ Behavior table:
  - Dysplasia, squamous, high grade (excluding cervix)
  - Glandular intraepithelial neoplasia high grade 8148/2
  - Intraductal papillary neoplasm with high grade intraepithelial neoplasia
  - Intraepithelial neoplasia:
    - High grade
    - Grade II
    - (excluding: Glandular intraepithelial neoplasia grade II, 8148/0)
  - Squamous intraepithelial neoplasia:

- Grade II (SIN II)

✓ Terms added to the Site-Specific Terms Indicating In-situ Behavior table:

➢ **Breast** (C500-C509):
- Lobular intraepithelial neoplasia grade II (LIN II), 8500/2, dx 01/01/2024 +
- Lobular neoplasia grade II (LN II), 8500/2, dx 01/01/2024 +

➢ **Endometrium** (C54_):
- Endometrioid intraepithelial neoplasia (EIN), 8380/2, dx 01/01/2021 +
- Intraepithelial neoplasm of endometrium, 8380/2, dx 01/01/2021 +
- Atypical hyperplasia of endometrium, 8380/2, dx 01/01/2021 +

➢ **Esophagus** (C15_):
- Esophageal squamous intraepithelial neoplasia (dysplasia), high grade, 8077/2, dx 01/01/2021 +
- Esophageal glandular dysplasia (intraepithelial neoplasia), high grade, 8148/2, dx 01/01/2021 +
- Esophageal intraepitelial neoplasia high grade, 8148/2, dx 01/01/2021 +

➢ **Gallbladder** (C230):
- Biliary intraepithelial neoplasia high grade, 8148/2, dx 01/01/2021 +

➢ **Larynx** (C320-C329):
- Laryngeal intraepithelial neoplasia grade II (LIN II), 8077/2, dx 01/01/2024 +

➢ **Pancreas** (C250-C259):
- Pancreatic intraepithelial neoplasia grade II (PanIN II), 8500/2, dx 01/01/2024 +

➢ **Penis** (C600-C609):
- Penile intraepithelial neoplasia grade II (PeIN II), 8077/2, dx 01/01/2024 +
- Differentiated penile intraepithelial neoplasia (PeIN), 8071/2, dx 01/01/2021 +

➢ **Stomach and Small Intestine** (C160-C166, C168-C169, C170-C173, C178, C179):
- Squamous dysplasia, high grade

➢ **Vulva** (C510-C519):
- Differentiated vulvar intraepithelial neoplasia (VIN), 8071/2, dx 01/01/2021 +

V.3.4 Cancer PathCHART Site-Morphology Combination Standards – *New Page*

✓ Added new page to describe the Cancer Pathology Coding Histology and Registration Terminology (Cancer PathCHART) initiative, the goals, and the use, beginning in 2024. See new page in Volume I for details.

V.5 Tumor Size

✓ Revised introduction to address removal of Tumor Size Clinical and Tumor Size Pathologic Pages.

➢ *Tumor Size Clinical and Tumor Size Pathologic* were collected by the CCR between 2016 and 2023 to capture information on tumor size of the solid, primary tumor at various points in the diagnosis and treatment of the reportable neoplasm. *Tumor Size Summary* was also collected starting in 2016 and will continue to be collected going forward.

➢ **Therefore, in 2024, *Tumor Size-Clinical, Tumor Size-Pathologic* have been removed from the Volume.** See *Archived Volume I* – Use case year of diagnosis to determine which Volume I to choose.

V.5.1 Tumor Size Clinical - *Deleted Page*

✓ Page deleted, data item retired as of 2024.

V.5.2 Tumor Size Pathologic - *Deleted Page*

- ✓ Page deleted, data item retired as of 2024.

V.5.3 Tumor Size Summary - *Renumbered to V.5.1*

- ✓ Page renumbered to V.5.1 from V.5.3 due to deletion of pages V.5.1 and V.5.2 (above).
- ✓ Reorganized instructions to align with the 2024 SEER Program Manual.
- ✓ Table - Code 999 – Added "no excisional biopsy or tumor resection done."

V.7 Lymphovascular Invasion

- ✓ Updated Volume I page based on Errata, 2023 by adding coding instructions for code 8:
  - ➢ Non-malignant brain (intracranial) and CNS tumors.
  - ➢ Not required by standard-setter and the state/central registry is not collecting it.

V.8 Terms Indicating In-Situ for Staging

- ✓ Terms added to the General Terms Indicating In-situ Behavior table:
  - ➢ Dysplasia, squamous, high grade (excluding cervix)
  - ➢ Glandular intraepithelial neoplasia high grade 8148/2
  - ➢ Intraductal papillary neoplasm with high grade intraepithelial neoplasia
  - ➢ Intraepithelial neoplasia:
    - High grade
    - Grade II
    - (excluding: Glandular intraepithelial neoplasia grade II, 8148/0)
  - ➢ Squamous intraepithelial neoplasia:
    - Grade II (SIN II)
- ✓ Terms added to the Site-Specific Terms Indicating In-situ Behavior table:
  - ➢ **Breast** (C500-C509):
    - Lobular intraepithelial neoplasia grade II (LIN II), 8500/2, dx 01/01/2024 +
    - Lobular neoplasia grade II (LN II), 8500/2, dx 01/01/2024 +
  - ➢ **Endometrium** (C54_):
    - Endometrioid intraepithelial neoplasia (EIN), 8380/2, dx 01/01/2021 +
    - Intraepithelial neoplasm of endometrium, 8380/2, dx 01/01/2021 +
    - Atypical hyperplasia of endometrium, 8380/2, dx 01/01/2021 +
  - ➢ **Esophagus** (C15_):
    - Esophageal squamous intraepithelial neoplasia (dysplasia), high grade, 8077/2, dx 01/01/2021 +
    - Esophageal glandular dysplasia (intraepithelial neoplasia), high grade, 8148/2, dx 01/01/2021 +
    - Esophageal intraepitelial neoplasia high grade, 8148/2, dx 01/01/2021 +
  - ➢ **Gallbladder** (C230):
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  - ➢ **Larynx** (C320-C329):
    - Laryngeal intraepithelial neoplasia grade II (LIN II), 8077/2, dx 01/01/2024 +
  - ➢ **Pancreas** (C250-C259):
    - Pancreatic intraepithelial neoplasia grade II (PanIN II), 8500/2, dx 01/01/2024 +
  - ➢ **Penis** (C600-C609):
    - Penile intraepithelial neoplasia grade II (PeIN II), 8077/2, dx 01/01/2024 +
    - Differentiated penile intraepithelial neoplasia (PeIN), 8071/2, dx 01/01/2021 +
  - ➢ **Stomach and Small Intestine** (C160-C166, C168-C169, C170-C173, C178, C179):

- Squamous dysplasia, high grade

➢ **Vulva** (C510-C519):

- Differentiated vulvar intraepithelial neoplasia (VIN), 8071/2, dx 01/01/2021 +

V.9.1 Staging Requirements

✓ Table - Updated AJCC Version 9 Cancer Staging System requirements to include: NET Appendix, NET Colon and Rectum, NET Duodenum and Ampulla of Vater, NET Jejunum and Ileum, NET Pancreas, NET Stomach, and Vulva, for cases diagnosed 2024 +.

V.11.1.1 EOD – Primary Tumor

✓ Removed coding instruction regarding when EOD Primary Tumor is coded to 800,and Tumor Size Clinical and Tumor Size Pathologic are coded to 000 or 999. Tumor Size Clinical and Tumor Size Pathologic have been retired and are no longer collected starting 01/01/2024 forward.

V.12.1 SSDI General Information

✓ Removed rounding instructions with exception for SSDIs: HER2 ISH Single Probe Copy Number, HER2 ISH Dual Probe Copy Number, and HER2 ISH Dual Probe Ratio. These SSDIs have been retired and are no longer collected starting 01/01/2021 forward.

V.13 SEER Site-Specific Factor 1

✓ Updated coding instructions and codes. Codes have been expanded from one digit to two. New section:

Coding Instructions:

- Record the results of 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.
- 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. Other tests (based on ISH, PCR, RT-PCR technologies) detect the viral DNA or RNA.
- HPV-type 16 refers to **virus type** and is **different** from p16 overexpression (p16+).
- Codes 00-51are hierarchical
- Use the highest code that applies (10 is highest, 51 is lowest)
- For cases in the Oropharynx HPV-Mediated (p16+) schema
  - If an additional HPV test is done in addition to p16, code those test results in this data item
  - If no additional HPV test is done, code 11 in this data item (Schema Discriminator 2 coded to 2)
- For cases in the Oropharynx (p16-) schema
  - If an additional HPV test is done in addition to p16, code those test results in this data item
  - If no additional HPV test is done
    - Code 10 in this data item if Schema Discriminator 2 is coded to 1
    - Code 99 in this data item if Schema Discriminator 2 is coded to 9

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

V.15.2 SS2018 Ambiguous Terms for Disease Extension

- ✓ Updated Volume I page based on Errata, 2023.
  - ➢ Table of Terms for non-involvement – Terms "Possible" and "Questionable" separated to two lines.

VI.1.2 First Course of Treatment – Data Entry

- ✓ Added second sentence to introduction.
  - ➢ This includes treatment done elsewhere but documented in the reporting facility patient record.
- ✓ Added sub-bullet to Priority Order for Entering text for Date treatment started.
  - ➢ Treatment dates must be recorded in the FCOT Date fields AND treatment dates MUST ALSO BE DOCUMENTED in the Treatment Text fields. This is a National Program of Cancer Registries (NPCR) requirement.

VI.1.3.1 Neoadjuvant Therapy

- ✓ Added coding instruction to code 0:
  - ➢ When the primary site is unknown and the neoadjuvant therapy is given to treat another site.

VI.1.3.2 Neoadjuvant Therapy – Clinical Response

- ✓ Added coding instruction to code 0:
  - ➢ When the primary site is unknown and the neoadjuvant therapy is given to treat another site.

VI.1.3.3 Neoadjuvant Therapy – Treatment Effect

- ✓ Added to 1st coding instruction, 1st sub-bullet (changes underlined below for clarity):

- Neoadjuvant therapy is defined as systemic treatment (chemotherapy, endocrine/hormone therapy, targeted therapy, immunotherapy, or biological therapy) and/or radiation therapy of the primary site given to shrink the tumor **prior** to surgical resection.

VI.2 Surgery Introduction – First Course of Treatment

- ✓ Added to last coding instruction, sub-bullet (changes underlined below for clarity):
  - Date and name of surgical procedure(s), including lymph node procedures. Be sure to review the operative report and verify the stated procedure(s) was performed.

VI.2.4 Surgery of Primary Site 2023

- ✓ Added note under Excisional Biopsy section, Standard Setter Difference.
  - **Note:** Do **not** code an incisional biopsy as an excisional biopsy when there is macroscopic residual disease.
- ✓ Added note under Code A000 or B000 when, section.
  - **Note:** Codes A000 and B000 exclude all sites and histologies that are coded A980 of B980. (See coding instruction below.)

VI.2.4.4 Breast Reconstruction – *New Page*

- ✓ Added new page for new Breast Reconstruction data items, coding instructions, and codes for cases diagnosed 01/01/2024 and forward. **Note:** The codes for this data item are **NOT** the same as those for the *Surgery of Primary Site 2023*. See new page in Volume I for details.

VI.2.6 Scope of Regional Lymph Node Surgery

- ✓ Added to guidelines for text:
  - Document the type of regional lymph node surgery in Text – Operative Findings and/or Text - Surgery.
    - Provide enough information to support the Scope of Regional Lymph Node Surgery code.
  - For additional information regarding recording text, please see *Appendix T* -Text Documentation Guidelines.

VI.2.11 Reason for No Surgery of the Primary Site

- ✓ Table – Updated descriptions for codes 2, 6, 7, 8, and 9 (only codes with changes listed and changes are underlined for clarity):

Code	Description
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, progression of the tumor prior to planned surgery etc.)
6	Surgery of the primary site was not performed; it was recommended by the patient's physician, but not performed as part of the first course of therapy. No reason was noted in the patient's record
7	Surgery of the primary site was not performed; it was recommended by the patient's physician, but refused by the patient, family member or guardian. The refusal is noted in the patient's record

8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended
9	It is unknown if surgery of the primary site was recommended or performed; Death Certificate Only; diagnosed at autopsy

VI.3.3.3 Radiation Treatment Modality – Phases I-III

- ✓ Added lutetium-77 to coding instruction for code 13.

VI.3.8 Location of Radiation Treatment

- ✓ Updated description for code 2 and 3, changing the word "administered" to "started."

VI.4.3 Chemotherapy Codes

- ✓ Table – Updated descriptions for codes 01, 02, and 82 (only codes with changes listed and changes are underlined for clarity):

Code	Description
01	Chemotherapy administered as first course therapy, but the type and number of agents is not documented in the patient record
02	Single-agent chemotherapy administered as first course therapy
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.)

VI.5.3 Hormone Therapy Codes

- ✓ Added to coding instruction regarding referral to a medical oncologist. Added "(and those coded to 88)."
- ✓ Table – Updated descriptions for codes 00 and 82 (only codes with changes listed and changes are underlined for clarity):

Code	Description
00	None, hormone therapy was not part of the planned first course therapy; not usually administered for this type and/or stage of cancer; diagnosed at autopsy only
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.)

VI.6.1 Immunotherapy Agents

- ✓ Added acronym "(Mabs)" to Monoclonal antibodies.

VI.6.3 Immunotherapy Codes

- ✓ Added to coding instruction regarding referral to a medical oncologist. Added "(and those coded to 88)."
- ✓ Table – Updated descriptions for code 82 (only codes with changes listed and changes are underlined for clarity):

Code	Description

82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., Comorbid conditions, advanced age, progression of tumor prior to administration, etc.)

VI.7.2 Transplant/Endocrine Procedures Codes

- ✓ Table – Updated descriptions for codes 00, 10, 40, 82, 85, 86, 87, 88, and 99 (only codes with changes listed and changes are underlined for clarity):

Code	Description
00	None, transplant procedure or endocrine therapy was not part of the first course therapy; not customary therapy for this cancer; diagnosed at autopsy only
10	Bone marrow transplant, NOS. A bone marrow transplant procedure was administered as first course of therapy, but the type was not specified
30	Endocrine surgery and/or endocrine radiation therapy as first course therapy
40	Combination of transplant procedure with endocrine surgery and/or endocrine radiation (Code 30 in combination with 0, 11, 12, or 20) as first course of therapy
82	Transplant procedure and/or endocrine therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to planned administration, etc.)
85	Transplant procedure and/or endocrine therapy was not administered because the patient died prior to planned or recommended therapy
86	Transplant procedure and/or endocrine therapy was not administered; it was recommended by the patient's physician but was not administered as part of the first course therapy. No reason was noted in the planned or recommended therapy
87	Transplant procedure and/or endocrine therapy were not administered; this treatment was recommended by the patient's physician but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record
88	Transplant procedure and/or endocrine therapy was recommended, but it is unknown if it was administered
99	It is unknown if a transplant procedure or endocrine therapy was recommended or administered because it is not stated in patient record; Death Certificate Only (DCO)

VI.8.2 Other Therapy Codes

- ✓ Removed Peptide Receptor Radionuclide Therapy (PRRT) from code 1 in table to align with the SEER Program Manual. PRRT should be coded as radiation therapy and assigned a radiation treatment modality code in the range 13-16 (radioisotopes).

VIII.1.1 Required Documentation for Data Items - Remarks

- ✓ Page was deleted in Volume I, v2023. Added Volume I page based on Errata, 2023. See page in Volume I for details.

IX.2.2 Accuracy – Quality Control

- ✓ Removed Visual Editing section, per Data Alert – 2024-04 CCR Expectations - Collecting Information for Cases Diagnosed and Treated Elsewhere.
- ✓ Updated Audits section:
  - ➢ Recoding Audits and Focused Audits are performed routinely to evaluate abstracts and determine if codes are accurately reflecting text documentation (and vice versa), to ascertain whether cases have not been reported that should have been, and to identify coding strengths and weaknesses.
    - ▪ Recoding Audits occur once per year and focus on a particular primary site and/or disease.
    - ▪ Focused Audits occur several times per year and are focused on evaluating one data item or a group of related data items.
    - ▪ Both types of audits randomly select cases from different facilities.
  - ➢ Re-Abstracting audits are another method used to assess accuracy . A sample of cases from each facility is re-abstracted by specially trained personnel. The measure used is the number of discrepancies found in related categories of items.

CHANGES TO APPENDICES

Appendix A – Terms and Definitions

- ✓ Added term and definition for Monoclonal Antibodies.
  - ➢ **Monoclonal Antibodies**
    Monoclonal antibodies (Mabs) are produced in a laboratory. The artificial antibodies are used in a variety of ways in systemic therapy and can be chemotherapy, immunotherapy, or ancillary drugs. Some are injected into the patient to seek out and disrupt cancer cell activities. When the monoclonal antibody disrupts tumor growth, it is coded as chemotherapy. Other Mabs are linked to radioisotopes (conjugated monoclonal antibodies). The Mab finds and attaches to the target tumor cells and brings with it the radioisotope that actually kills the tumor cell. The monoclonal antibody itself does nothing to enhance the immune system. Conjugated monoclonal antibodies such as tositumomab (Bexxar) or ibritumomab (Zevalin) are coded to the part of the drug that actually kills the cells, usually radioisotopes. A third function of Mab is to enhance the immune response against the cancer, either by identifying tumor cells that are mimicking normal cells, or by boosting the body's natural defenses that destroy foreign cells. Consult SEER*Rx for the treatment category in which each monoclonal antibody should be coded.

Appendix C – Codes for Countries

- ✓ Revised term/code on alphabetical and code lists:
  - ➢ To Czechia, from Chechia (formerly Czech Republic) – Code CZE
  - ➢ To Netherlands (Kingdom of the), from Netherlands (the) – Code NLD
  - ➢ To Türkiye from Turkey – Code TUR
  - ➢ To Cabo Verde, from Cabo Verde (formerly Cape Verde) – Code CPV

- To Cote d'Ivoire, from Cote d'Ivoire (formerly Ivory Coast) e – Code CIV
- To Eswatini, from Eswatini (formerly Swaziland) – Code SWZ
- To Myanmar, from Myanmar (formerly Burma) – Code MMR

✓ Removed term/code on alphabetical and code lists:
- Term England – Code ENG
- Term Northern Ireland – Code NIR
- Term Scotland – Code SCT
- Term Wales – Code WLS
- Term Yugoslavia – Code YUG

Appendix G – Codes for Casefinding

✓ Updated effective date to:
- Effective for Cases diagnosed between October 1, 2023 and September 30, 2024.

✓ Added N85.02 Endometrial intraepithelial neoplasia [EIN] to the new reportable neoplasms list.

✓ No changes to the supplemental list.

Appendix I – Common Acceptable Symbols and Abbreviations

✓ Moved Guidelines above the section name "I.1 Common Acceptable Symbols and Abbreviations – Word/Term Order.

✓ Added term/coded to alphabetical and code lists:
- Block Numbering Area – Code BNA
- Current Prodedural Terminology (codes) – Code CPT
- Cyclic redundancy code – Code CRC
- Site Specific Factor – Code SSF
- Squamous intraepithelial lesion – Code SIL

✓ Added table for NAACCR Acronyms Used List – See Appendix I for added table.

Appendix K .2 – New STORE-Surgery Codes for 2023 +

✓ Added to the end of the introduction paragraph:
- Revisions will be added annually. Please confirm diagnosis date for the site being coded. **See previous versions of *Volume I, Appendix K.2* when coding sites updated to "B" codes after 2023.**

✓ Added new "B" surgery codes to the following sites: Breast, Colon, Lung, Pancreas and Thyroid, and updated site header to "For cases diagnosed on or after January 1, 2024." See Appendix K.2 for these coding changes.

✓ Moved the instruction "**Any combination of A200, A260, or A270 WITH"** into the correct cell (one cell down from where it was) for the sites: Anus, Bladder, Cervix, Colon, Corpus Uteri, Esophagus, Kidney, Larynx, Oral Cavity, Parotid, Pharynx, Prostate, Rectosigmoid, Rectum, Stomach, and Other Sites.

✓ Removed redundant CCR "***Clarification:*** the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy" from the following sites and codes.
- Bladder - Code A270
- Kidney, Renal Pelvis and Ureter - Codes A200 and A270
- Larynx - Code A270
- Oral Cavity - Code 270
- Stomach - Code A270

Appendix M – Q-Tips

- ✓ Table - Added 2024 row along with the following statement: New Q-Tips will be published throughout the year and will be listed in the CCR Education and Training Quarterly Update data alert.
- ✓ Added list of 2023 Q-Tips published to FLccSC:
  - ➢ Melanoma Skin - NEW Surgery of Primary Site Codes and SSDIs for 2023+
  - ➢ Melanoma Skin - Diagnosis Years 2018 and Forward
  - ➢ Urinary Bladder TURBT and EOD Primary Tumor Coding Reminder
  - ➢ Neoadjuvant Therapy Data Items - Coding Clarifications

Appendix Q – Site-Specific Data Items (SSDIs)

- ✓ New Schemas IDs for 2024+ (Required by CCR), and added an end date for collection of old Schema IDs:
  - ➢ NET Ampulla of Vater
    - Schema ID: 00302 (2018-2023)
      09302 (2024+)
  - ➢ NET Appendix
    - Schema ID: 00320 (2018-2023)
      09320 (2024+)
  - ➢ NET Colon and Rectum
    - Schema ID: 00330 (2018-2023)
      09330 (2024+)
  - ➢ NET Duodenum
    - Schema ID: 00301 (2018-2023)
      09301 (2024+)
  - ➢ NET Jejunum and Ileum
    - Schema ID: 00310 (2018-2023)
      09310 (2024+)
  - ➢ NET Pancreas
    - Schema ID: 00340 (2018-2023)
      09340 (2024+)
  - ➢ NET Stomach
    - Schema ID: 00290 (2018-2023)
      09290 (2024+)
  - ➢ Vulva
    - Schema ID: 00500 (2018-2023)
      09500 (2024+) – Added existing p16 for 2024+
- ✓ Added New SSDI:
  - ➢ Brain – Brain Primary Tumor Location for 2024+
- ✓ Additional Stage-Related Data Items section
  - ➢ Updated introduction with v2024 information.
  - ➢ Added new Table 5, for SSDIs Implemented in 2024.
  - ➢ Table 6 - Renumbered from Table 5 - Site-specific Data Items Required for Transmission
- ✓ Testis - Revised CCR Requirement for AFP Pre-Orchiectomy Lab Value to X (Required) from X-CoC Facilities ONLY. This was missed in the 2022 Data changes. The CCR does not expect registrars to go back and recode these cases as registry software edits should have forced this data item to be completed.

Appendix R – Coding Resources

- ✓ Added new manuals and updated publication date of revised manuals.

Appendix S – Historical Coding and Staging Manual Requirements for CCR

- ✓ Added manuals that became historical in 2024 to the standard setter lists.

Appendix T – Text Documentation Guidelines

- ✓ All examples – Dates updated to 23' or 24'
- ✓ Best Practices for Text Fields section, 3rd bullet - sentence expanded to include "in applicable date fields and text fields."
- ✓ Text – Operative Findings section, 5th bullet "Record" – Added the following guidelines:
  - ➢ Type of regional lymph node procedure(s).
    - ▪ Provide enough information to support Scope of Regional Lymph Node Surgery codes as well as Date of Regional Lymph Node Dissection and Date of Sentinel Lymph Node Biopsy (when applicable).
  - ➢ Example 2 – Added "pelvic LN dissection"
- ✓ Text – Pathology Findings section, 2nd bullet, 9th sub-bullet revised to:
  - ➢ Lymph node involvement stated as number of positive/number examined. Include name of lymph node chain if stated (6/12 Pelvic LN) and/or type of lymph nodes examined (e.g. sentinel vs non-sentinel).
- ✓ First Course of treatment (FCOT) Text Fields section, 1st bullet revised to:
  - ➢ Treatment dates must be recorded in the FCOT Date fields AND treatment dates MUST ALSO BE DOCUMENTED in the Treatment Text fields. This is a National Program of Cancer Registries (NPCR) requirement.
- ✓ Text – Surgery section, 1st bullet, 1st sub-bullet revised to include "including any lymph node procedures."
- ✓ Quality Control section, #7, 2nd sub-bullet revised to:
  - ➢ Are all treatment dates documented in text?