UPDATED VISUAL EDITING GUIDELINES

Diagnosis Year 2018 and Forward
Revised September 2020

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DATA ITEM	DESCRIPTION	REFERENCES
1) County of Residence at Diagnosis	Is the city in the County?	https://tools.usps.com/go/ZipLookupAction!input.action
2) Behavior	o For cases with in situ and invasive behavior is /3 coded? o If the pathology report states behavior is in situ (/2) and the ICD-0-3 histology lists only a malignant (/3) behavior, is the behavior coded to in situ (/2)? o A behavior code of /2 must be pathologic o If the pathology report states behavior is malignant (/3) and the ICD-0-3 histology lists only an in situ (/2) behavior, is the behavior coded to malignant (/3)? o Are the synonyms for in situ (/2) coded? • AIN III (C211) • Behavior code '2' • Bowen disease (not reportable for C440-C449) • Clark level I for melanoma (limited to epithelium) • Confined to epithelium • Hutchinson melanotic freckle, NOS (C44_) • Intracystic, non-infiltrating(carcinoma) • Intraductal (carcinoma) • Intraepidermal, NOS (carcinoma) • Intraepithelial,NOS (carcinoma) • Involvement up to, but not including the basement membrane • Lentigo maligna (C44_) • LIN III (C320-C329) • Lobular, noninfiltrating (C50_) (carcinoma) • Noninfiltrating (carcinoma)	2018 SEER Program Staging and Coding Manual Volume I, Section V.3.3

DATA ITEM	DESCRIPTION	REFERENCES
	• Noninvasive (carcinoma) • No stromal invasion/involvement • Papillary, noninfiltrating or intraductal (carcinoma) • Precancerous melanosis (C44_) • Queyrat erythroplasia (C60_) • SIN III • VAIN III (C529) • VIN III (C52) ▪ Stage 0 (except Paget's disease (8540/3) of breast and colon or rectal tumors confined to the lamina propria **Anus –** Anal Intraepithelial Neoplasia grade III (AIN III), dx 01/01/2001 + High grade squamous intraepithelial invasion (HGSIL or HSIL), dx 01/01/2018 + **Gallbladder** – High grade biliary intraepithelial neoplasia grade III (BiIN III), 01/01/2018 + **Vagina** – Vaginal intraepithelial neoplasia grade III (VAIN III), dx 01/01/1992 + • High grade squamous intraepithelial invasion (HGSIL or HSIL) 01/01/2018 + **Vulva** – Vulvar intraepithelial neoplasia grade III (VIN III), dx 01/01/1992 +; High grade squamous intraepithelial invasion (HGSIL or HSIL) 01/01/2018 + o Is the term microinvasion in the pathology report coded as malignant (/3)? For intracranial and CNS tumors, the WHO grade cannot be used to code behavior.	

DATA ITEM	DESCRIPTION	REFERENCES
3) Race Fields 1-5	o Required on all cases. Cannot be blank, but can be code 99, Unknown. If no information in medical record, a statement documenting no information should be documented in Remarks. o If Race is coded to code 98, Other, is the specific race code documented in Remarks? o Code 98, Other Race, is not to be used if the Face Sheet states “other” or “other race”. If the only information available is these statements, the medical record should be reviewed for a specific race. If no other information is available code 99 should be used. Code 98 should only be used in the event a specified race is identified with no corresponding code. o If there is conflicting Race information, i.e. Last Name vs. Race vs. Place of Birth, is there clarification in Remarks? o Birthplace may be used as one factor to determine race. o If a person’s race is a combination of white and any other race(s), the other race(s) should be coded first and white should be coded as the next race field. o If a person's race is a combination of Hawaiian and any other races, Race 1 should be coded as Hawaiian (07) and the other races coded in Race 2, Race 3, Race 4, and Race 5 as appropriate.	Volume 1, Section III.2.10

DATA ITEM	DESCRIPTION	REFERENCES
4) Spanish/Hispanic Origin	o Is patient name a Spanish Surname? (See Appendix J). o Review Race and Place of Birth. If a female patient is coded to Hispanic, NOS, a statement documenting that patient is Hispanic must be recorded in Remarks. o If patient is coded to Mexican, and Place of Birth is unknown, a statement documenting that patient is Mexican must be recorded in Remarks.	Volume 1, Section III.2.10.2, Appendix J
5) Date of Diagnosis	Does the date reflect the earliest date stating malignancy by a physician, surgeon or dentist using reportable terms (Volume I, II.6.1)? Code the year of admission when there is no basis for estimation	Volume 1, Section III.3.3 and DSQC Memo #2011-04
6) Site/Sub-site	o Is the primary site coded to where the tumor originated, even if it extends into an adjacent sub-site? o Is the code supported by documentation from the physical exam, x-rays, operative and pathology reports? o Is the primary site consistent with the histologic type? o Is the last digit of the primary site code '8' for overlapping sub-site, breast midline tumors and origin unknown and is it documented in the abstract text?	Volume I, Section V.1 2018 SEER Program Coding and Staging Manual, Appendix C, Site Specific Coding Modules o

DATA ITEM	DESCRIPTION	REFERENCES
	o Is the last digit of the primary site coded '9' for single primaries, when multiple tumors arise in different sub-sites of the same anatomic site and point of origin can't be determined? Is it documented in text from operative findings, pathology or other work-up? o For hematopoietic sites, refer to the Hematopoietic Manual and Database for coding histology and determining single or multiple primaries. o For a metastatic melanoma of unknown primary, is the site coded to C44.9 (Skin, NOS)? o If this is a malignant Gastrointestinal Stromal Tumor (GIST), is it coded to the location where the malignant GIST originates? o For a sarcoma of unknown primary, is the site coded to C49.9 (Connective, Subcutaneous and other Soft tissues, NOS)? o For a meningioma, is the site coded to meninges code-C70.0, C70.1 or C70.9?	
7) Diagnostic Confirmation	o Does the code reflect the most conclusive method used to confirm the presence of the cancer being reported? o The lowest numeric number takes precedence when the cancer is confirmed by multiple diagnostic methods. Diagnostic confirmation is NOT limited to the confirmation at the time of diagnosis. o If at ANY TIME during the course of disease the patient has a diagnostic confirmation with a	Volume 1, Section IV.2

DATA ITEM	DESCRIPTION	REFERENCES
	higher priority, change to a lower code. o For cases diagnosed 1/1/2010 and later, code 3 "Positive Histology Plus Positive Immunophenotyping AND/OR Positive Genetic Studies" was added. This code is to be used for hematopoietic and lymphoid neoplasms only (9590/3-9992/3). o Bone marrow aspirations are to be coded 1, Positive Histology. Positive blood count (CBC or peripheral blood) are to be coded to 1, Positive Histology, for leukemia only.	
8) Laterality (Only paired sites listed in Volume I)	o Is Laterality coded using codes **1-9** for all sites listed in Volume I, Section V.2.2 Principal Paired Sites (Laterality Required)**?** o Is Laterality coded for malignant and benign/borderline brain and CNS tumors listed in Volume 1, Section V.2.1? o Is the Laterality code supported by documentation from the physical exam, x-rays, operative and pathology reports? o If the tumor originates in the midline of a paired organ or site, is Laterality coded to 5, midline? o If the laterality is not known but the tumor is confined to a single side of the paired organ, is Laterality coded 3? o Is Laterality coded to 4 – Both sides involved but origin is unknown. Bilateral Simultaneous for the following tumors: 1) Both ovaries involved simultaneously, single histology 2) Diffuse bilateral lung nodules 3) Bilateral retinoblastomas 4) Bilateral Wilms tumors? o If 1) Laterality is unknown AND 2) there is no	Volume I, Section V.2

DATA ITEM	DESCRIPTION	REFERENCES
	statement that only one side of a paired organ is involved, is Laterality coded to 9? o Laterality is coded to 0, Not Paired, for cases with primary site Unknown, C80.9.	
9) Histology – Type (for year of diagnosis)	o Is the histology based on the information from the pathology report? Or in the absence of a report, based on the information from the physician? o Is this a reportable case? o If cytology is reported as "suspicious", do not interpret this as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings. o A cytologically confirmed case with a negative biopsy must be evaluated carefully. If the biopsy rules out the presence of cancer, do not report the case. But if a negative biopsy does not rule out the presence of cancer, the case is considered to be cytologically confirmed and is reportable. o For benign and borderline brain and CNS tumor, is this a reportable histology? o For borderline ovarian tumors, is this a reportable histology? (not reportable 1/1/2016 and forward) For most histologies, refer to the ICD-O-3 manual for the correct codes. o Refer to the 2018 Solid Tumor Coding Manual for instructions on coding histology and determining single or multiple primaries.	Volume 1, Section II.1.6.2 and Section II.1.6.3 Volume 1, Section V.3; V.3.1-V.3.3.7 For Benign and Borderline Brain & CNS tumors, Volume 1, Section II.1.9 & Appendix V ICD-O-3 Manual For Borderline Ovarian tumors- ICD-O-3, Appendix 6 2018 Solid Tumor Coding Manual Hematopoietic and Lymphoid Neoplasms Manual and Database

DATA ITEM	DESCRIPTION	REFERENCES
	o For hematopoietic and lymphoid neoplasms, DO NOT USE ICD-O-3 to code the histology. Refer to the Hematopoietic Manual and Database for coding histology and determining single or multiple primaries. o For Prostate cancers, acinar adenocarcinoma should be coded as adenocarcinoma, NOS, 8140/3, per MPH manual Rule H10. o Cancer; Malignancy, NOS = 8000/3. o Carcinoma = 8010/3. o Colon polyps: Do NOT code to "in a polyp".	
10) Grade Grade – Clinical Grade – Pathological Grade – Post-Neoadjuvant	**Beginning with cases diagnosed in 2018, the definition of grade has been expanded, and classification of grade now varies by tumor site and/or histology. The grading system for a cancer type may have two, three, or four grades. No longer will all grades be converted to a four-grade system**. For solid tumors diagnosed in 2018 and forward, grade will be collected in three different data items, ***Grade Clinical, Grade Pathological, and Grade Post Therapy***, and the codes and coding instructions will depend on the type of cancer. Cell Lineage indicator/grade for hematopoietic lymphoid neoplasms are **NO LONGER COLLECTED** for cases with DX date 2018 forward o If there is evidence of more than one grade of the tumor, the highest grade is recorded,	Grade Coding Instructions and Tables – NAACCR version 1.5 https://www.naaccr.org/SSDI/Grade-Manual.pdf AJCC 8th Edition by Site Volume 1, Section V.4-V.4.1.3 for Solid Tumors & 11.2.5.3 WHO Grade – Benign/Borderline Brain and CNS Tumors STORE Manual

DATA ITEM	DESCRIPTION	REFERENCES
	assuming the recommended grading system was used for both biopsy and resection. AJCC 8th Ed., page 28-29 o WHO Grade-Benign/Borderline Brain and CNS Tumors, Vol 1-g 54 o Grading Brain & Spinal Cord Tumors – AJCC 8th Edition, page 864 ONLY EXCEPTION: Ocular Adnexa Lymphoma AJCC Chapter 71. AJCC has defined a grading system for the follicular histologies. Applicable sites: C441, C690, C695, C696 o Grade for all other histologies collected in AJCC Chapter 71 is coded as 9 o **Grade Clinical** – Record the grade of a solid primary tumor before any treatment, including surgical resection, systemic therapy, radiation therapy or neoadjuvant therapy. Note: Not all surgical procedures are treatment. Examples: Grade determined from a TURBT, TURB, or endoscopic biopsies would be collected as clinical grade o Clinical grade is recorded for cases where a histological (microscopic) exam is done and tissue is available, and grade is recorded. o Includes: FNA, biopsy, needle core biopsy, etc. o Clinical grade must not be blank.	

DATA ITEM	DESCRIPTION	REFERENCES
	o Code the highest grade from the primary tumor assessed during the clinical time frame. o Use Code 9 (unknown) when: o Grade is not documented. o Clinical grade/staging is not applicable. Example: cancer is an incidental finding during surgery for another condition. o Grade checked "not applicable" on CAP Protocol (if available) and no other grade information is available. o If there is only one grade available and it cannot be determined if it is clinical or pathological, assign it as a clinical grade and code unknown (9) for pathological grade, and blank for post-therapy grade. o **Grade Pathological** – Record the grade of a solid primary tumor that has been surgically resected, and patient has NOT had neoadjuvant treatment. The tumor must meet the surgical resection requirements in the AJCC Manual for pathological stage. Pathological grade may include the grade from clinical workup, as all information from diagnosis (clinical staging) through the surgical resection is used for pathological grade. Note: Not all surgical procedures meet the requirements for pathological grade or pathological stage (i.e., TURB or TURP).	

DATA ITEM	DESCRIPTION	REFERENCES
	o Refer to the most current **Grade Coding Instructions and Tables** for coding instructions. Always check the site-specific Pathological Grade tables: (https://apps.naaccr.org/ssdi/list/) for additional information. o Pathological grade is recorded for cases where a surgical resection has been done. o Pathological grade must not be blank. o Assign the highest grade from the primary tumor. Use the grade that was identified during the clinical time frame for both clinical grade and pathological grade if the clinical grade is higher than the grade identified on the surgical resection specimen. Code 9 (unknown) when: o Grade is not documented. No resection of the primary site performed. o Neoadjuvant therapy followed by a resection. See Grade - Post-Therapy. o Clinical case only. See Grade - Clinical. o Grade checked “not applicable” on CAP Protocol (if available) and no other grade information is available. o There is only one grade available and it cannot be determined if it is clinical or pathological.	

DATA ITEM	DESCRIPTION	REFERENCES
	o **Grade Post-Therapy** – Record the grade of a solid primary tumor that has been resected following neoadjuvant therapy. The tumor must meet the surgical resection requirements for yp pathological stage in the AJCC Manual to assign the post-therapy grade. Neoadjuvant therapy must meet applicable guidelines or standards, and not be that given for variable or unconventional reasons as noted in the AJCC Manual. This data item corresponds to the yp staging period only. o Refer to the most current Grade Coding Instructions and Tables for coding instructions. o Always check the site-specific Post-Therapy Grade tables: (https://apps.naaccr.org/ssdi/list/) for additional information. o Leave BLANK when: o No neoadjuvant therapy given. o Clinical or pathological case only. o There is only one grade available and it cannot be determined if it is clinical, pathological, or post-therapy. o Assign the highest grade from the resected primary tumor assessed after the completion of neoadjuvant therapy only. o Clinical grade information may never be used in assigning post-therapy grade	

DATA ITEM	DESCRIPTION	REFERENCES
Cancer Registry Coding of the Cell Indicator or Grade for Hematopoietic and Lymphoid Neoplasms (9590-9992) for cases diagnosed 1/1/2018 and forward: Historically the cell lineage indicator (B-cell, T-cell, Null-cell, NK-cell) was collected in the Grade data item. Cell lineage indicator/grade for hematopoietic and lymphoid neoplasms will no longer be collected. For cases with histologies 9590-9992, the *clinical and pathological* must be coded to "8" and *post therapy* grade must be blank.	o Code 9 (unknown) when: o Surgical resection is done after neoadjuvant therapy and grade is not documented. o Grade checked "not applicable on CAP Protocol (if available) and no other grade information is available.	Grade Coding Instructions and Tables-NAACCR version 1.5 https://www.naaccr.org/SSDI/Grade-Manual.pdf
11) EOD Primary Tumor	**EOD Primary Tumor** Captures contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. **Effective for cases diagnosed January 1, 2018 and later.** o Is the farthest documented extension of the primary tumor coded?	Extent of Disease (EOD) 2018 General Coding Instructions https://seer.cancer.gov/tools/staging/rsa.html EOD Primary Tumor Ambiguous Terminology General Guidelines

DATA ITEM	DESCRIPTION	REFERENCES
	o Did the patient receive neoadjuvant therapy? If so, code extension based on the clinical information unless extension is more extensive post neoadjuvant therapy. o Is all information from pathology, radiology, and PE used to code extension? o Pathology findings take priority over clinical findings. o Imaging takes priority over physical exam o Is the extension code based on contiguous (direct) extension of tumor from the site of origin to the organ/structure/tissue? o Exceptions: for mucinous carcinoma of the appendix, corpus uteri, ovary, fallopian tube and female peritoneum. Discontinuous metastasis is coded in EOD Primary Tumor. o In situ tumors: Assign code 000 for in situ tumors. Exception: For some schemas, e.g., Breast, there may be multiple categories of in situ codes. Use schema-specific instructions and codes. o TNM Information: o T, N, M information may be used to code EOD when it is the only information available. When there is a discrepancy between TNM information and the medical record documentation, use the medical record documentation to assign EOD.	

DATA ITEM	DESCRIPTION	REFERENCES
	o In situ tumors with nodal or metastatic involvement: In the event of an in situ tumor with nodal or metastatic involvement, assign EOD Primary Tumor as in situ and code the EOD Regional Nodes and/or EOD Mets appropriately. **Note: This is a change from previous versions of EOD and Summary Stage.** o Is there ambiguous terminology used to describe extension? o Is the extension code based on using the timing rules? o For prostate cases, code both EOD Primary Tumor (Clinical) and Prostate Pathological Extension. o Are clinically apparent terms and non-apparent terms used appropriately? Tumor, mass, or nodule are apparent terms. o Imaging is not used for clinical EOD unless the physician clearly incorporates imaging into the staging. o Clinical EOD is based on DRE. o Do not use biopsy results for clinical EOD unless they prove extraprostatic extension.	

DATA ITEM	DESCRIPTION	REFERENCES
12) EOD Regional Nodes	**EOD REGIONAL NODES** Identifies the regional lymph nodes involved with cancer at the time of diagnosis. **Effective for cases diagnosed 1/1/2018 and forward.** Involved distant LNS are coded in EOD Mets field. **Ambiguous Terminology:** Are the ambiguous terms used listed in the EOD 2018 manual? This is the list that must be followed. **Terms meaning lymph node involvement**: For solid tumors the terms: fixed or matted, and mass in hilum, mediastinum, retroperitoneum and/or mesentery (with no specific information as to tissue involved) are considered involvement of LNs. Other terms such as: palpable, enlarged, visible swelling, shotty or lymphadenopathy should be ignored unless there is a statement of involvement by the clinician or the patient was treated as though Reg LNS were involved. **In Situ Tumors with metastatic nodal involvement:** o This would usually be coded 000 unless there is proof of positive regional lymph nodes, then code them in EOD Regional lymph nodes and EOD Primary Tumor as in situ (code 000). This is a change from prior versions of EOD. o **TNM Information**: o T, N, M information may be used to code EOD 2018 when it is the only information available. When there is a discrepancy between TNM information	Extent of Disease (EOD) Regional Nodes https://seer.cancer.gov/tools/staging/rsa.html

DATA ITEM	DESCRIPTION	REFERENCES
	and the medical record documentation, use the medical record documentation to assign EOD. Be aware that the lymph node categorized as regional in EOD 2018 are not a direct match for the regional lymph node groups described in previous EOD versions (1977-2003). **Breast Case**—Supraclavicular LNS in EOD 2018 are coded regional LNS. Previous EOD coded as distant. **Isolated Tumor cells (ITCs**) Is the primary site breast, cutaneous melanoma or Merkel Cell CA? ITC information is needed to code this field. Check specific site schema for information on coding this field. In some schemas, ITCs are counted as positive regional nodes, while other schemas count them as negative. **For Colon and Rectum Only**: o Are removed lymph nodes with the colon/rectal resection unnamed? These are presumed to be regional pericolic or perirectal lymph nodes and are included in EOD Regional Nodes 300 (pericolic for sites C180-C189, C199 and perirectal for sites C199 and C209. o **Neoadjuvant therapy:** o Did the patient receive neoadjuvant treatment and post-neoadjuvant surgery shows more extensive lymph node involvement? Code the most extensive lymph node involvement whether it was clinical preoperative or post-neoadjuvant.	

DATA ITEM	DESCRIPTION	REFERENCES
	o **When to use code 800:** o Is it not possible to determine if an involved LN is a regional or distant LN? If not code 800. o Does the resected primary site have unidentified nodes? Code 800. o **When to use code 888**: o Is the primary site Brain, CNS Other, HemeRetic, Ill-Defined Other, Unknown primary site, Intracranial Gland, Lymphoma (excluding Primary Cutaneous Lymphoma and Ocular Adnexal Lymphoma which have separate schemas from Lymphoma), Lymphoma-CLL/SLL, Plasma Cell Myeloma? Use code 888.	
13) EOD Mets	**EOD Mets** Used to classify the distant site(s) of metastatic involvement at the time of diagnosis. **Effective for cases diagnosed January 1, 2018 and later.** Note: Always check site-specific schemas for exceptions and/or additional information. **Document choice of EOD Mets code in text.**	Registrar Staging Assistant (SEER*RSA) https://seer.cancer.gov/tools/staging/rsa.html Volume I, V.15.1

DATA ITEM	DESCRIPTION	REFERENCES
	• Determination of EOD Mets requires only history and physical examination. Imaging of distant organs is not required. In other words, when a case lacks any extensive workup, the registrar can infer that there are no distant metastases based solely on physical exam documentation. • Assign 00 for cases when no information is available (no PE, imaging for pathology): • There is reasonable doubt that the tumor is no longer localized and there is no documentation of distant metastasis • EOD Mets codes are hierarchical with the exception of code 70 • For a few schemas, such as Breast, Lung, Kidney and Ovary, the EOD Mets category may include direct extension of the primary tumor into distant organs or tissues. • Positive pathological findings take priority over clinical findings. • If there is no applicable pathology or the pathology does not show metastasis, code EOD Mets based on clinical findings. Imaging takes precedence over physical examination. • If the patient receives neoadjuvant (preoperative) systemic therapy, code the clinical information description that identifies the most extensive metastasis. If the post-neoadjuvant surgery shows additional or more extensive metastasis, code EOD Mets based on the post-neoadjuvant information.	

DATA ITEM	DESCRIPTION	REFERENCES
	• **Isolated Tumor Cells (ITCs), Circulating Tumor Cells (CTCs), and Disseminated Tumor Cells (DTCs)**: • For breast, code 05 when a biopsy of a distant site shows ITCs, CTCs or DTCs detected by IHC or molecular techniques. For other sites, CTCs, DTCs, and ITCs are coded 00. • If an in situ tumor with metastatic involvement, assign EOD Primary Tumor as in situ (code 000) and code EOD Mets appropriately (positive). **This is a change from prior versions of EOD.** **Code 88 for the following schemas:** • HemeRetic • Ill-Defined Other (includes unknown primary site) • Kaposi Sarcoma • Lymphoma o a) Primary Cutaneous Lymphoma and Ocular Adnexal Lymphoma have separate schemas from Lymphoma. EOD Mets must be coded for those two schemas (88 is not valid) • Lymphoma-CLL/SLL • Plasma Cell Myeloma • Plasmacytomas	

DATA ITEM	DESCRIPTION	REFERENCES
	Code 99 is to be **used ONLY for death certificate only (DCO) cases;** however, assign the appropriate EOD Mets code when specific metastatic information is available on a DCO. • a. When it is unknown if there are distant metastases, code 00 (see rule 1b).	
14) Directly Coded SEER Summary Stage 2018	o **Directly assigned SEER Summary Stage 2018 is required from all facilities starting with cases diagnosed 1/1/2018.** o Use the appropriate primary site staging scheme. o Summary Stage should include all information available within **four months of diagnosis** in the absence of disease progression or upon completion **of surgery(ies)** in first course of treatment, whichever is longer. o Is there documentation on how far the cancer has spread from its point of origin? o Information for Summary Stage from a surgical resection **after neoadjuvant treatment may be used,** but ONLY if the extent of disease is greater than the pre-treatment clinical findings. o If in situ, there must be histologic confirmation. o If unknown primary, stage must be unknown.	2018 SEER Summary Stage Manual https://seer.cancer.gov/tools/ssm/2018-Summary-Stage-Manual.pdf Registrar Staging Assistant (SEER*RSA) https://seer.cancer.gov/tools/staging/rsa.html Volume I, V.15

DATA ITEM	DESCRIPTION	REFERENCES
15) Number of Regional Lymph Nodes Positive/Examined	Records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system. o Is the total number of regional lymph nodes removed and examined by the pathologist correct? o Do all the totals of LN levels examined add up correctly? o Are the correct Collaborative Stage codes used? • 00-No regional LNs examined • 01-89 1-89 regional LNs examined • 90-Ninety or more regional LNs examined • 95-No regional LNs removed, but aspiration or core biopsy of regional LN performed • 96-Regional LNs removed, documented as sampling, # LN NR • 97=Regional LNs removed, documented as a dissection and # LN NR • 98-Regional LNs removed, LN # NR and unknown if dissection or sampling • 99-Unknown, not stated, DCO o Is field coded 99 for appropriate sites and/or histologies or Reporting Facility type? o Does the Scope of LN Surgery code correlate with Regional LN Examined? o Is the Scope of LN Surgery code correct for LNs Examined? o Does the Scope of LN Surgery code correlate with Regional LN Positive?	Volume I, VI.2.6.2 - .3 SEER Program Coding and Staging Manual https://seer.cancer.gov/manuals/2018/SPCSM_2018_maindoc.pdf

DATA ITEM	DESCRIPTION	REFERENCES
	o Is the LN biopsy or FNA coded in Scope of LN Surgery?	
16) Site Specific Data Items (SSDI) Manual	A "SSDI'" is a site-specific data item effective for cases diagnosed 2018 or later. "Site" in this instance is based on the primary site, the AJCC chapter, Summary Stage chapter and the EOD schema. Timing for Recording Laboratory Tests: 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 • no earlier than approximately three months before diagnosis If the only test or tests performed do not meet these criteria, code "test not done" or "unknown if test performed." Each Site-Specific Data Item (SSDI) applies only to selected schemas. SSDI fields should be blank for schemas where they do not apply.	Site Specific Data Item (SSDI) 2018 Manual https://www.naaccr.org/SSDI/SSDI-Manual.pdf?v=1570217758 https://apps.naaccr.org/ssdi/list/ https://seer.cancer.gov/tools/staging/rsa.html
17) SEER Site Specific Factor – Human Papilloma Virus (HPV) This data item only applies to the following sites: • Oropharynx (p16+): C019, C024, C051-C052, C090-C091, C098-	Is the primary site one of the applicable sites for this data item? Is the result obtained from pathological specimens including surgical and cytological tissue from the primary tumor or a metastatic site, including lymph nodes, not blood tests or serology? Is HPV status documented in the text? Is the highest applicable code entered?	SEER Program Coding and Staging Manual 2018, SEER Site-specific Factor 1, page 144. https://seer.cancer.gov/manuals/2018/SPCSM_2018_maindoc.pdf SEER*RSA, EOD Data, Oropharynx (p16-), SEER Site-Specific Factor 1

DATA ITEM	DESCRIPTION	REFERENCES
C099, C100, C102-C103, C108-C109, C111 • Oropharynx (p16-) and Hypopharynx: C019, C024, C051-C052, C090-C091, C098-C099, C100, C102-C103, C108-C109, C111, C129, C130-C132, C138-C139 • Lip and Oral Cavity: C000-C009, C020-C023, C028-C029, C030-C031, C039, C040-C041, C048-(Continued) C049, C050, C058-C059, C060-C062, C068-C069	Is the test based on ISH, PCR, RT-PCR technologies, designed to detect viral DNA or RNA? Confirm that the results of IHC p16 expression was not used to code this field. **Note 1:** This data item is only for HPV status determined by tests designed to detect viral DNA or RNA. Tests based on ISH, PCR, RT-PCR technologies detect the viral DNA or RNA. **Note 2:** Ensure that the results of IHC p16 expression is NOT recorded in this field. HPV-type 16 refers to virus type and is different from p16 overexpression (p16+). **Note 3:** Do not record the results of blood tests or serology.	
18) RX Date Surgery	o Enter the date of surgery performed for each surgical procedure. Procedures for this date field include Surgery of the Primary Site, Scope of Regional Lymph Node Surgery or Surgery of Other Regional/Distant Sites. These must be entered in chronological order.	Volume I, Section VI.2.4.1
19) RX Summ Surgical Margins	After resection of the primary site, the surgical margin status should be coded as it appears in the path report.	VI.2.4.2 Surgical Margins of the Primary Site
20) Surg Prim	Cancer-directed surgery includes most procedures that involve removal of a structure (those with the suffix "ectomy") and such procedures as: • Biopsy, excisional (which has microscopic residual disease or no residual disease)	Volume 1, VI.2.4 Volume 1, Appendix K

DATA ITEM	DESCRIPTION	REFERENCES
	• Biopsy, NOS, that removes all tumor tissue • Chemosurgery (Moh's technique) • Conization • Cryosurgery • Desiccation and Curettage for bladder and skin tumors • Electrocautery • Fulguration for bladder, skin, and rectal neoplasms • Laser therapy • Local excision with removal of cancer tissue (including excisional biopsy but excluding incisional biopsy) • Photocoagulation • Splenectomy for lymphoma or leukemia • Surgery removing metastatic malignant tissue • Transurethral resection (TUR) with removal of tumor tissue of bladder or prostatic tumors. o Do not code pre-surgical embolization of hypervascular tumors with particles, coils or alcohol. These pre-surgical embolizations are typically performed to make the resection of the primary tumor easier. Examples where pre-surgical embolization is used include meningiomas, hemangiomas, paragangliomas, and renal cell metastases in the brain. o For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above.	

DATA ITEM	DESCRIPTION	REFERENCES
	Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is unavailable. o Enter the procedures in chronological order. If more than three surgical, the earliest surgery and the most definitive surgery must be included o Brain primaries: Review codes 40 & 55 to make sure brain lobe is actually removed; Resection of tumor of spinal cord or nerve, verify code 22 is coded	
21) Scope LN Proc	Record the farthest regional lymph node removed regardless of involvement with disease. There is no minimum number of nodes that must be removed. If a regional lymph node was aspirated or biopsied, code regional lymph node(s) removed, NOS (1).	Volume 1, VI.2.6
22) Surg Other Proc	o Code the removal of non-primary site tissue which the surgeon may have suspected to be involved with malignancy even if the pathology was negative. Do not code the incidental removal of tissue for reasons other than malignancy. These procedures are to be entered in chronological order. If no surgery was performed of other regional or distant sites or distant lymph nodes, leave the fields blank. Use code 1 if any surgery is performed to treat tumors of Unknown or Ill-defined Primary sites or for Hematopoietic/Reticuloendothelial/Immunoproliferative disease.	Volume 1, VI.2.8

DATA ITEM	DESCRIPTION	REFERENCES
23) Radiation External Beam Planning Tech	Typically found in Radiation Oncologist's Summary Letter for the first course of treatment. A new phase begins when there is a clinically meaningful change in the target volume, fraction size, modality, or treatment technique.	Volume I, VI.3.3.4 STORE 2018 Manual, pages 287-327 Required by the CCR for cases diagnosed January 1, 2018 and forward. https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/store_manual_2018.ashx
24) Radiation Treatment Modality	o The terms "regional" and "boost" have been replaced with Phase I (initial plan) and Phase II (boost or cone down). o Coding must be supported by text. o Record the date treatment started (not the consult date). o For each phase, record the Radiation Treatment Volume. (This may be the primary site region or metastatic site). If two distinct volumes are radiated, and one of those includes the primary site, record the radiation involving the primary site in all radiation fields. For each phase, record the radiation treatment modality administered: external beam, brachytherapy, a radioisotope as well as their major subtypes, or a combination of modalities. o For each phase, record the radiation planning technique used to administer the radiation.	SEER Program Coding & Staging Manual 2018 Volume I, VI.3 Standard for Oncology Registry Entry (STORE) Manual, pages 285 and 287 https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/store_manual_2018.ashx
25) Reason No Rad	If treatment is not performed, record the reason in the text field. Example: If no radiation was performed, record the reason; such as, patient refused radiation treatment.	Volume I, VI.3.11

DATA ITEM	DESCRIPTION	REFERENCES
26) Rad Sequence	Code the sequence in which radiation and surgical procedures were performed as part of the first course of treatment.	Volume I, 3.8
27) Rad Location of RX Code the sequence in which radiation and surgical procedures were performed as part of the first course of treatment.	Indicate where the procedure was performed, unless it was at the reporting facility.	Volume I, VI.3.11
28) Chemotherapy	o Chemotherapy codes must match treatment text. o Use SEER*Rx to code cases diagnosed 1/1/2005 forward. o Be sure to verify agents are appropriate for site and type and not considered 'ancillary only'. o RX Date – Record date chemotherapy began at any facility as part of first course treatment. Chemotherapy at this Hospital – Do not use code 99 if Class of Case is coded to 00, 30, or 31.	Volume I, VI.4 SEER*Rx – Interactive Antineoplastic Drugs Database http://seer.cancer.gov/tools/seerrx// SEER*Rx Summary of Changes http://seer.cancer.gov/tools/seerrx/revisions.html
29) Hormone Therapy	o Hormone therapy codes must match treatment text. o Use SEER*Rx to code cases diagnosed 1/1/2005 forward. o Record surgery performed for hormonal effect (i.e. castration) and radiation for hormonal effect for breast and prostate cancers only. o If steroids (i.e. Prednisone) are combined with chemotherapy, record their use. o RX Date – Record the date hormone therapy began at any facility as part of first course treatment.	Volume I, Section VI.5 SEER*Rx – Interactive Antineoplastic Drugs Database http://seer.cancer.gov/tools/seerrx//

DATA ITEM	DESCRIPTION	REFERENCES
	Hormone therapy at this hospital – Do not use code 99 if Class of Case is coded 00, 30, or 31.	
30) Immunotherapy (Biological Response Modifier Therapy)	o Immunotherapy codes must match treatment text. o Use SEER*Rx to code cases diagnosed 1/1/2005 forward. o Code as immunotherapy for cases diagnosed 1/1/2012 forward: Donor lymphocyte infusion. o RX Date – Record the date immunotherapy began at any facility as part of first course tx. Immunotherapy at this Hospital – Do not use code 99 if Class of Case is coded 00, 30, or 31.	Volume I, VI.6 SEER*Rx – Interactive Antineoplastic Drugs Database http://seer.cancer.gov/tools/seerrx//
31) Transplant/Endocrine Procedures	o Systemic therapeutic procedures to be coded in this field include: bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy. o Record the date on which the transplant/endocrine procedure took place at any facility o Transplant Endocrine Procedures at this Hospital – Do not use code 99 if Class of Case is coded 00, 30, or 31.	Volume I, Section, VI.7

DATA ITEM	DESCRIPTION	REFERENCES
32) Other Therapy	o Definition: Definitive, cancer-directed treatment that cannot be assigned to any other treatment category. Any experimental drug that cannot be classified elsewhere. Unorthodox and unproven treatment. Double blind clinical trials. o For Newly Reportable Hematopoietic Diseases (NRHD) only, specify in text field and use code 1 "Other Therapy" for the following: • Transfusions/Plasmapheresis • Phlebotomy/Blood Removal • Supportive Care • Aspirin • Observation o For cases diagnosed January 1, 2012 and forward, do not collect blood transfusions for any NRHD. o Collect phlebotomy for polycythemia vera ONLY. o For collecting blood-thinners and/or anti-clotting agents, refer to this section in Volume I as to which diagnoses are applicable. Other Therapy at this Hospital – Do not use code 99 if Class of Case is coded 00, 30, or 31	Volume I, VI.8