SSDI's an In-Depth Look

2019-2020 NAACCR WEBINAR SERIES

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Q&A

Please submit all questions concerning the webinar content through the Q&A panel.

If you have participants watching this webinar at your site, please collect their names and emails.

We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.

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Fabulous Prizes

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Guest Presenter

Jennifer Ruhl, Chair SSDI WG
- Public Health Analyst NIH/NCI SEER

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Agenda

Overview

Coding Issues

Changes for 2021

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Overview

Codes and Coding Instructions

Site Specific Data Items (SSDI) and Grade Manual

CAnswer forum

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Codes and Coding Instructions

NAACCR
- https://apps.naaccr.org/ssdi/list/

SEER
- https://staging.seer.cancer.gov/eod_public/list/1.7/

Registry Software

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SSDI and Grade Manual

RESOURCES

- SSDI Manual
- SSDI Manual Appendix A
- SSDI Manual Appendix B
- SSDI Manual Appendix C
- Grade Manual
- Change Log

Listing of all Schema ID's and schema ID info

Listing of Collaborative Stage SSF's, associated AJCC 7th edition chapter, SSDI.

Listing of all SSDI's and associated schema ID

Listing of all changes occurring in the latest update.

Comments or suggestions concerning the SSDI's are welcome and can be posted at the American College of Surgeons **CAnswer Forum.**

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Using the SSDI Manual

Familiarize yourself with the General Instructions!

- Introduction
- Timing
- Definitions and formatting
- Lab values and other measurements
- Schema discriminators
- SSDI's required for stage/EOD derived TNM stage

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Timing for Recording Lab Values

Timing for Recording Laboratory Tests.
All lab values must be done no earlier than approximately three months before diagnosis AND

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

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Rounding Rules

- General rounding rules
  - ALL SSDIs that have a decimal point are recorded to the tenth (1 value after the decimal point)
  - If a value is recorded to the hundredth (2 values after the decimal point), the following rounding rules are applied
    - If digit is 0-4, round down
    - If digit is 5-9, round up

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"Less than" and "Greater than"

- Less than: Record the lab value as one less
- Greater than: Record the lab value as one greater

- Note: One less or one more may refer to a whole number (1), or a decimal (0.1) depending on the code structure of the field

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SSDI Instructions

Organized by site group (similar to AJCC manual)

General

- Related SSDI's may have general instructions (i.e. ER/PR for breast or LN Assessment for Gyn)

Specific

- Each SSDI includes a Description, Rationale, Coding Instructions and Codes
- Some SSDI's also include Definition and Coding Guidelines

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CAnswer Forum

Questions concerning SSDI's and Grade should be sent to the CAnswer forum.

Prior to submitting a question check the following resources

- Codes and coding instructions
- SSDI/Grade manuals
- Previously submitted Canswer Forum questions

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Process for Answering SSDI/Grade Questions

Questions are first reviewed by Jennifer Ruhl

Questions that require additional input are sent to small group…

- AJCC
- CAP
- NAACCR
- Central Registry

Questions help determine what updates should go into the SSDI/Grade manuals

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Process for Answering SSDI/Grade Questions

SSDI: MSI 2018 #1
01-07-19, 12:43 PM

For SSDI: MSI.
Path report states Histologic features of microsatellite instability: present (mucinous features).
IHC for MMR proteins: normal expression (all 4).

Question 1: Pathologist just says microsatellite instability present but not high or low how is that coded?
question 2: microsatellite instability and MMR protein conflict, in this case, microsatellite instability present but MMR proteins are normal which would be code (0)

Tags: None

Quote Flag Like 0

01-08-19, 06:11 AM #2

Per discussion with several members of the SSDI work group, code the MMR as normal.
The MSI stated as "present" cannot be used since this does not indicate whether it is high or low. To record a MSI result, it would need to be stated as low or high.

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SSDI's

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Schema Discriminators

Schema discriminators introduced in 2010 (CSv2)

- Used when primary site and/or histology are not enough to get to right schema

Schema discriminators for 2018

- Schema discriminator 1
- Schema discriminator 2
- Schema discriminator 3 (none for 2018)

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Schema Discriminator 1: Occult Head and Neck Lymph Nodes (Primary site C760 only)

- **AJCC 8th Edition Chapter 6: *Cervical Lymph Nodes and Unknown Primary Tumors of Head and Neck***
- For Chapter 6, the following criteria must be met:
  - Primary site must be C760 (previously assigned C148)
    - Tumor known to originate in head & neck, primary site cannot be determined (T0)
  - Tumor must be occult (meaning tumor mass cannot be found)
    - Equivalent to T0 (no evidence of primary tumor)
  - Positive cervical (head and neck) lymph nodes

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p16 and EBV Status

		EBV		
		Positive	Negative	Unknown
HPV (p16)	Positive	C11.9 Nasopharynx	C10.9 Oropharynx	C10.9 Oropharynx
	Negative	C11.9 Nasopharynx	C76.0 Ill-Defined Site of the Head and Neck	C76.0 Ill-Defined Site of the Head and Neck
	Unknown	C11.9 Nasopharynx	C76.0 Ill-Defined Site of the Head and Neck	C76.0 Ill-Defined Site of the Head and Neck

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C76.0 Ill-Defined Site of the Head and Neck

Schema Discriminator 1:
- 2-5

Use Chapter 6: Cervical Lymph Nodes and Unknown Primary Tumors of the Head and Neck

Code	Description
0	Not Occult
1	Occult, Negative cervical nodes (regional head and neck nodes)
2	Not tested for EBV or p16 in head and neck regional nodes (EBV and p16 both unknown)
3	Unknown EBV, p16 negative in head and neck regional nodes
4	Unknown p16, EBV negative in head and neck regional nodes
5	Negative for both EBV and p16 in head and neck regional nodes
<BLANK>	Not C760, discriminator does not apply Positive p16 in head and neck regional nodes, EBV unknown or negative Assign primary site C109 Positive EBV in head and neck regional nodes, p16 positive, negative, or unknown Assign primary site C119

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Schema Discriminator 1: Esophagus GE Junction

- **AJCC 8th Edition Chapter 16: *Esophagus and GE Junction;* Chapter 17*: Stomach***

Applies when primary site is **C160**
- **Esophagus**: Tumor involving the EGJ with epicenter less than 2 cm into proximal stomach (code 2)
- **Stomach**: No involvement of the EGJ or unknown if involvement of the EGJ AND epicenter at any distance (codes 0, 3, 9)

Code	Description	Disease
0	NO involvement of esophagus or gastroesophageal junction AND epicenter at ANY DISTANCE into the proximal stomach (including distance unknown)	17: Stomach
2	INVOLVEMENT of esophagus or esophagogastric junction (EGJ) AND epicenter LESS THAN OR EQUAL TO 2 cm into the proximal stomach	16 Esophagus AND go to Schema Discriminator 2: Histology Discriminator for 8020/3
3	INVOLVEMENT of esophagus or esophagogastric junction (EGJ) AND epicenter GREATER THAN 2 cm into the proximal stomach	17: Stomach
9	UNKNOWN involvement of esophagus or gastroesophageal junction AND epicenter at ANY DISTANCE into the proximal stomach (including distance unknown)	17: Stomach

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Question

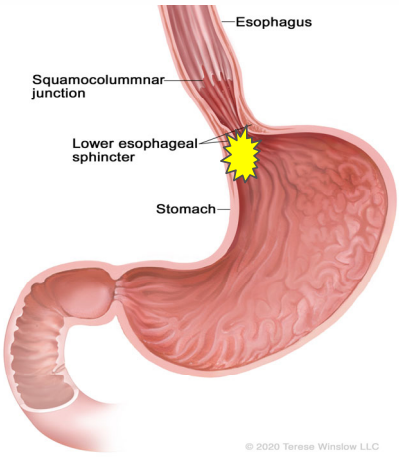
Per PET/CT and Rad Onc, primary site is GEJ.

Pt has hx of bariatric surgery.

EGD described as follows:

- "As we enter a small gastric pouch we see a large mass, ulcerated and friable filling most of the small cavity."
- Epicenter is not stated.

How do we code Schema Discriminator 1: Esophagus GE Junction?



If EGJ is involved but epicenter is not stated, Assign code ***9***

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Questions?

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Problematic SSDI's

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Esophagus and EGJ Tumor Epicenter (Esophagus)

Used for **Squamous Cell Carcinomas** only
- Schema ID 00061: Esophagus (including GE junction) Squamous

Used for pathological staging only

Location is defined by the position of the **epicenter** of the tumor in the esophagus

Code	Description
0	U: Upper (Cervical/Proximal esophagus to lower border of azygos vein)
1	M: Middle (Lower border of azygos vein to lower border of inferior pulmonary vein)
7	L: Lower (Lower border of inferior pulmonary vein to stomach, including gastroesophageal junction)
9	X: Esophagus, NOS Specific location of epicenter not documented in medical record Specific location of epicenter not assessed or unknown if assessed

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Microsatellite Instability (Colon and Rectum)

Form of genetic instability

High MSI an adverse prognostic factor, predicts poor outcome to 5-FU chemotherapy
- Indicator for hereditary nonpolyposis colorectal carcinoma (Lynch syndrome)

Genetic testing for MSI results in stable (code 0), unstable, low (code 1) and unstable, high (code 2)

Immunology testing for Mismatch Repair may also be done
- MMR intact (code 0)
- MMR, lose of nuclei expression (code 2)

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Microsatellite Instability

- Revised note 3: MSI is looking at instability in informative markers
  - Stable (Code 0)
  - Negative (Code 0)
  - MSI-L (Code 1)
  - Unstable, high (Code 2)
  - Unstable, NOS (no designation of high or low) (Code 2)
  - MSI-I (intermediate) (Code 9)

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Microsatellite Instability

- Revised note 4: MMR is looking at expression, or loss of expression of markers (most common: Most common markers are MLH1, MSH2, MSH6, PMS2)
  - No loss of nuclear expression (code 0)
  - Mismatch repair (MMR) intact (code 0)
  - Loss of nuclear expression (code 2)
  - MMR deficient (pMMR or MMR-P) (code 2)

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Fibrosis Score (Liver, Intrahepatic Bile Duct)

The presence of advanced fibrosis/cirrhosis (fibrosis score) is associated with a worse prognosis

Several systems are used to measure the Fibrosis Score
- Ishak Score (recommended by AJCC and CAP)
- METAVIR
- Batt-Ludwig

Can be diagnosed clinically or pathologically

If score is given, but scoring system not mentioned, code 9

Diagnosis of cirrhosis, without score, is enough to code 1

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Fibrosis Score

- Code 0: Must have histological (microscopic confirmation) that fibrosis/cirrhosis **is not** present
- Code 1: Must have histological (microscopic) confirmation that fibrosis/cirrhosis **is** present
- Code 7: Can use for clinical diagnosis ONLY (no microscopic confirmation) of severe fibrosis or cirrhosis

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Separate Tumor Nodules

- New bullet point added **Note 3**
  - In the case of multiple tumor nodules determined to be the same primary, if not all nodules are biopsied, assume they are the same histology

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Separate Tumor Nodules

- Reminder: Just because radiology documents separate tumor nodules, does not mean they are
- Review physician's staging to see if considering the separate tumor nodules to be cancerous (will be at least a T3)
- If not part of physician's staging, then not considering them cancerous

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Separate Tumor Nodules

- CAnswer Forum Post: 02/08/18-Ct chest: RML nodule, 14 mm, 8 mm on 11/22/17, not present 08/04/17. RLL, nodule 8 mm, previous 7mm. Subpleural nodule, medial RLL, nodule 5mm. Few new tiny nodular opacity LLL
- The radiation oncologist staged this case clinical T1b, cN0, cM0, stating "additional right lower lung nodules were stable and nonspecific, but felt to be post-inflammatory"
- Separate Tumor Nodules coded to 0 for none

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Breslow's Depth

- Received confirmation from AJCC and CAP
  - If there are multiple procedures and the pathologist adds the measurements together to get a final Breslow's depth, the registrar can use this
  - However, if the pathologist does not add the measurements, the registrar cannot add them
    - Record the depth from the procedure that has the larger depth documented

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Ulceration

- To code 0 (negative/not present) you MUST have a statement on the path report (or from the managing physician) that ulceration is negative
- This may also be "inferred" from the T category assigned by the physician (see note 1)
  - If a T category assigned with 'a', can infer no ulceration
  - If a T category is assigned with 'b', can infer ulceration

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Ulceration

- If ulceration is not mentioned on the pathology report and there is no T category assigned
  - Code 9 for unknown
- Updated **Note 4:** Code 9 if there is microscopic examination and there is no mention of ulceration
  - This instruction **does** apply to in situ tumors
    - Do not automatically assign 0 (none) for in situ tumors

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LDH Pretreatment Level

- LDH likely done on patients with deep invasive tumor, ulceration/high mitotic rate, or known/suspected metastatic disease
- LDH not likely done for patients with in situ or localized cancers
  - Only skin involved (no invasion of subcutaneous tissue)
  - Negative lymph nodes
  - No clinical evidence of metastatic disease

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LDH Pretreatment Level

- For LDH, "pretreatment" means before
  - Systemic therapy (chemo, immunotherapy, hormone), radiation therapy or surgery to a metastatic site
- Most patients who get LDH lab value have it done AFTER biopsy (punch, shave) FOLLOWED by re-excision
  - LDH lab values that are done after the re-excision may be used

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Multigene Data Items (3894, 3895)

- New bullet to Note 2
  - Only record tests done on tumor tissue that help determine if the cancer is likely to recur. Don't include other tests, such as those that evaluate hereditary mutations that influence a patient's risk of developing cancer (e.g. myRisk, BRCA)

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Oncotype Data Items

- Oncotype Dx Recurrence Score-DCIS
  - If tumor is invasive (/3), code XX6
- Oncotype Dx Risk Level – DCIS
  - If tumor is invasive (/3), code 6
- Oncotype Dx Recurrence Score (Invasive)
  - If tumor is in situ (/2), code XX6
- Oncotype Dx Risk Level (Invasive)
  - If tumor is in situ (/2), code 6

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Ki-67

- Also known as “proliferation index”
- By default a percentage
  - If the % is not documented, treat the number included as being a percentage
- *Example*: Ki-67 3.8
  - Interpreted as 3.8%

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Ki-67

- New note: Results from lymph nodes or metastatic tissue can only be used when there is NO evidence of the primary tumor (T0 for AJCC)
- This same instruction found in ER, PR, HER2

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Invasion Beyond Capsule (3864)

- New bullet to Note 2
  - If **surgical resection** is done and the tumor is "confined to kidney" and staging is based on size, then there has been no invasion through the capsule (no invasion into perinephric fat)
- For AJCC staging, if tumor is T1 or T2, then "invasion beyond capsule" would be 0
  - Invasion beyond capsule is captured in T3a

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Ipsilateral Adrenal Gland Involvement (3861)

- New bullet to Note 2
  - If **surgical resection** is done and tumor is "confined to kidney" and staging is based on size, then there is no involvement of the adrenal gland
  - For AJCC staging, if tumor is T1 or T2, then "ipsilateral adrenal gland involvement" would be 0
  - Ipsilateral Adrenal Gland Involvement is captured in T4

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Major Vein Involvement (3866)

- New bullet to Note 2
  - If **surgical resection** is done and tumor is "confined to kidney" and staging is based on size, then there is no involvement of major veins
  - For AJCC staging, if tumor is T1 or T2, then "major vein involvement" would be 0
  - Major Vein Involvement is captured in T3a or T3b

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Kidney SSDIs

- Surgical resection MUST be done to apply the new bullet under Note 2
  - You cannot apply this new note based on clinical (imaging) findings only (see Note 4)
- If surgical resection is done and the tumor is not confined to the kidney AND there is no mention of the three SSDIs (invasion beyond capsule, ipsilateral adrenal gland involvement, major vein involvement), then Note 6 applies and you code unknown (9)

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Pop Quiz

Patient has a partial nephrectomy and adrenal gland was not removed.

- Histology: Clear cell adenocarcinoma
- Extension: Confined to the kidney
- Adrenal Gland present: no

How is the SSDI for Ipsilateral Adrenal Gland Involvement coded?

- Code 0: There is no involvement of the ipsilateral adrenal gland
- Code 9 when There is no documentation in the medical record Clinical diagnosis only Evaluation of ipsilateral adrenal gland involvement not done or unknown if done

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Sarcomatoid Features (3925)

- **Note 3:** Sarcomatoid features is mostly seen with renal cell carcinoma (all variants); however, if it's seen with other histologies, it can be coded
  - If non-renal cell carcinoma and sarcomatoid features documented, record that in this SSDI
- *Reminder*: Code XX.9 for unknown if surgical pathology report and no mention of Sarcomatoid features
  - Do not assume there are none if not documented

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Lymphocytosis (3885)

Note 5: A physician's statement of **RAI Stage 0-4** means that lymphocytosis is present. If that is the only statement available, code 6

- Lab value unknown, physician states lymphocytosis is present

Note 6: If there is no mention of lymphocytosis, or relevant lab results, code 9

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A Note about the RAI Stage

- RAI stage is used with CLL/SLL
- There are 5 SSDIs associated with the RAI stage (Adenopathy, Anemia, Lymphocytosis, Organomegaly, and Thrombocytopenia)
- There is currently no way to record the actual RAI Stage (0-4)
  - Do not record in the field AJCC Stage Group
- This is different than the Lugano Stage, which is for all lymphomas and is recorded in the field AJCC Stage Group

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S Category Clinical
S Category Pathological (Testis)

"S" category now assigned for those collecting TNM
- 3923: Clinical S for Clinical Stage Group
- 3924: Pathological S for Pathological Stage Group

If "S" category is not documented, registrar may use the results from the individual data items to determine the S category
- Clinical: AFP Range (3808), hCG Range (3849), LDH Range (3868)
- Pathological: AFP Range (3806), hCG Range (3847), LDH Range (3867)

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Brain Molecular Markers (Brain, CNS Other)

- Purpose of data item
  - CBTRUS has requested data item
  - Several brain histology codes have several different terms under the same histology code
- Applies to **malignant** Brain and CNS tumors (C700-C719) WITH the following histologies:
  - 9400/3, 9401/3, 9440/3, 9450/3, 9451/3, 9471/3, 9478/3
- Genetics markers: IDH, 1p/19 q co-deleted, TP53
- Code **85** when not one of the listed histologies
- Code **86** for ALL benign (/0) or borderline (/1) tumors

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RISS Stage (Plasma Cell Myeloma)

Staging classification for Plasma Cell Myeloma (9732/3)

- **4 data items will be collected**
  - **3857**: High Risk Cytogenetics
  - **3869**: LDH Pretreatment Level
  - **3930**: Serum Albumin Pretreatment Level
  - **3931**: Serum Beta-2 Microglobulin Pretreatment Level

- **Note**: At this time, RISS stage cannot be calculated in registry software

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RAI Classification (CLL/SLL)

Staging classification for Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL) (9823/3)

- **5 data items will be collected**
  - **3804:** Adenopathy (absent/present)
  - **3811:** Anemia (HGB <11.0 g/dL OR Hgb >=11.0 g/dL)
  - **3885:** Lymphocytosis (based on absolute lymphocyte count)
  - **3907:** Organomegaly (absent/present)
  - **3933:** Thrombocytopenia (absent/present)

- **Note**: At this time, RAI classification cannot be calculated in registry software

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Questions?

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Grade

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Grade Clinical

- Record the grade of a solid primary tumor before treatment
- Do **not** use information from the pathological timeframe for this data item
- If grade is documented as 1-2, or 2-3, go with the higher grade

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Grade Pathological

- Record the grade of a solid primary tumor that has been surgically resected with no neoadjuvant therapy
- Clinical grade may be assigned if it is higher than the pathological grade (and the behavior is the same)
- If no surgical resection, path grade must be 9
- If there is neoadjuvant therapy, path grade must be 9

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Grade Post Therapy

- If there is no neoadjuvant therapy, leave blank
- Record the grade of a solid primary that has been resected following neoadjuvant therapy
- If post-therapy surgery is done and no grade documented, do **not** use the Clinical grade

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Grade and Behavior

- If tumor is in situ clinically and invasive pathologically, do **not** use the clinical grade in the pathological grade
  - This is because the tumor overall will be invasive
- If tumor is invasive clinically and in situ pathologically
  - Use the clinical grade in the pathological field
  - This is because the tumor overall will be invasive

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Grade-Brain/CNS Other/Intracranial Gland

- Reminder: Grade can be assigned based on imaging for Brain tumors **only**
  - *Example 1:* MRI shows brain mass consistent with Glioblastoma multiforme. Per AJCC Table 72.2, GM is always a code 4.
  - Ex*ample 2:* MRI shows brain mass consistent with meningioma (/0). Per new instructions, code /0's always coded grade 1

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Coding Guidelines for Generic Grade Categories

- Only use when grade codes A-D are in a grade table
- Used for when there is a preferred grading system and the grade documented is using another grading system (usually nuclear grading)

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Coding Guidelines for Generic Grade Categories

- Breast biopsy, SBR grade 2; surgical resection shows low grade
- Clinical grade: Code grade 2 based on the SBR/Nottingham score (preferred grading system)
- Pathological grade: Code grade B based on the “low grade” (use the general grade category table and look for “low grade”

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Coding Guidelines for Generic Grade Categories

- For Breast example
  - Cannot use the clinical grade (based on SBR) in the path grade field since they are different grading systems
  - To use the clinical grade in the path grade field, they must be using the same grading system OR there is no information on the path grade

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Breast Grade

- Grade is behavior dependent
- If behavior is /2
  - Grades must be: L, M, H, or 9 plus generic grade categories A-D
- If behavior is /3
  - Grades must be 1-3, 9, plus generic grade categories A-D

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Recent Clarifications

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ER and PR

- If percent positive is 0.0 or <1% (less than 1%) then
  - Code Negative
- If 1% or greater
  - Code Positive

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Edit Issue

Invasive lobular carcinoma, Grade 1, Nottingham 5/9, ER positive >99% 3+ Allred 8, PR negative <1% weak Allred 2, HER2 1+ negative.

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Grade-Brain/CNS Other/Intracranial Gland

- /0 (Benign) tumors can **always** be coded to 1
  - Edit will be implemented for 2021 forward to enforce this
  - This instruction can be used for 2018 cases forward
- /1 (Borderline) tumors can be either a 1 or 2, so default cannot be implemented
- Both of these confirmed with the CAP Cancer Committee

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Grade-Brain/CNS Other/Intracranial Gland

- For /1 (Borderline) and /3 (Malignant) tumors
  - Use table 72.2 for the default grades for some of the histologies
  - If a histology is not listed in this table and a grade is not provided by the physician, code 9
- You may also use the CAP guidelines: Central Nervous System-Brain/Spinal Cord
- https://www.cap.org/protocols-and-guidelines/cancer-reporting-tools/cancer-protocol-templates#!%40%40%3F_afrLoop%3D1492754601919 56%26_adf.ctrl-state%3Dqlt6qzv6_17

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Questions?

QUIZ

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Future Changes (2021 Updates)

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Lung: Visceral Pleural Invasion

- PL1 and PL2 are no longer relevant (confirmed with CAP and AJCC)
- Codes being restructured
  - PL1 and PL2 now being combined with generic code "invasion of visceral pleural present, NOS"
- Conversion of cases 2018+ will be automatically done
  - No registrar review/input needed
  - Changes will be documented in upcoming change log

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Ovary: Residual Tumor Volume Post Cytoreduction

- Received confirmation that don't need to know if neoadjuvant therapy done or not
- Codes simplified, based only on residual tumor
  - 1 cm or less, greater than 1 cm, or size not stated
- Conversion of cases 2018+ will be automatically done
  - No registrar review/input needed
  - Changes will be documented in upcoming change log

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Field Testing

- New concept implemented by the NAACCR Mid level tactical group
- All new data items proposed (by any standard setter) must go through field testing
- Field testing will be used to pre-test the data item to determine if it is feasible and/or how the proposed instructions work

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Field Testing

- Field Testing being done through the SEER Reliability website
  - This does not mean that the proposed data items will only be required by SEER
  - All standard setters (Canada, CoC, NPCR, SEER) will be using the SEER Reliability website to test new data items
- Please: participate in any upcoming Field Testing
  - CEUs will be available

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Field Test of Potential 2021 Data Items

- About 300 participants
  - 8 proposed new SSDIs
  - New schemas proposed for 4 existing SSDIs
  - Neoadjuvant data items
  - 'yc' data items

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Field Test of Potential 2021 Data Items

- Study results for the SSDIs currently under review
  - At this time, don't know which of these will be implemented and who will require them
- Neoadjuvant data items will be implemented by SEER
  - Unknown at this time if CoC or NPCR will require
- 'yc' data items will be implemented by CoC
  - Specific instructions regarding the 'yc' data items will be coming from AJCC

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Questions?

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Coming UP…

Abstracting and Coding Boot Camp: Cancer Case Scenarios

- 3/05/2020

Melanoma

- Guest Host: Denise Harrison and Louanne Currence
- 04/02/2020

CE Certificate Quiz/Survey

Phrase

Link

- https://www.surveygizmo.com/s3/5311366/SSDI-s-an-IN-Depth-Look-2020

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Thank You!!!