Q&A Session for V23 Update: ICD O, Solid Tumor Rules, SSDI

January 11, 2023

#	Question	Answer
1.	Just to confirm - we always use the latest version of the STM when abstracting? For example, abstracting 2021 diagnosis in calendar year 2023, would use the Dec 2022 version of the STM following the rules w/in that applies to 2021 diagnosis year?	Yes, use the most current version. Any rules that are date based will be noted in the updated version.
2.	Will the new H Rule for mixed melanomas continue to be updated if additional mixed melanoma tumors are submitted?	Yes. I'll continue to compile the combinations not included in the current rule and update yearly.
3.	F/U clarification to question - except for melanoma & other sites would use the section(s) of previous versions of STM or MP/H manual for specific diagnosis year.	Use the current version applicable for each site
4.	Where do we find the Solid Tumor Change Log?	See the Revision Log at the bottom of the page below. https://seer.cancer.gov/tools/solidtumor/
5.	In the new General Instructions, it states "Once a patient has been diagnosed with metastatic disease, whether at diagnosis or later, they will never be NED. " What if we have a physician that states the patient is NED?	If the patient had only one metastatic tumor which was resected for example, then they would be NED. But if there were distant lymph nodes, they are unlikely to be NED.
6.	If the most specific histology is on the specimen post neoadjuvant treatment versus pre-adjuvant specimen, which would you code? would you code?	Code the pre neo-adj histology unless the initial diagnosis was made by cytology, FNA or from a regional or distant site.
7.	If you end up with 2 different prostate histologies. Would that be abstracted as two primaries of prostate?	Yes, provided they were separate tumors.
8.	Is it correct to use the most recently published version of the Solid Tumor Manual for all cases, as long as we follow the dx-year specific instructions in each module? (meaning we don't have to worry about finding prior versions of the manual to code 2020, 2021, etc cases?)	Yes. Rules that are date based will be noted in the updated version.
9.	Question on the Other Sites timing rule in regards to AIN, VAIN, VIN etc…., since this condition more often than not recurs in	I've initiated a request to revisit timing for these neoplasms and make then similar to bladder---one per patient per lifetime.

	these patients should each positive Bx over a year be considered a new primary or a recurrence...normally Tx entails surveillance	
10.	Lois, will the highlighted notes in STR be in the actual manual or are these just your notes?	there are just in the handouts that we have. Not in the SEER manual. You can highlight the manual
11.	I noted on SEER site for 2023 SEER coding and staging manual the Appendix C does not have the current Other Sites pdf. Has it not been updated yet?	I'll notify our database support team to update this.
12.	Using adenocarcinoma, these intrahepatic bile duct cancers cannot be AJCC staged.	Histology has priority over clinical diagnosis. Consult with GI experts indicated that the term cholangiocarcinoma should be used to indicate carcinoma/adenocarcinoma in the bile ducts rather than specific histologic type.
13.	Will you please discuss the HPV related histologies for cervix that are discussed on p. 12 in the 2023 Implementation Guidelines that indicate they are reportable for 2021 and the instructions to review and recode the cases? There is a link on p.12 to click on for section 13.4 for instructions for manually reviewing and when you click on it, it takes you to section 14.4 where recommendations are given for reviewing and recoding. Will these histologies be required for 2021?	You can use the new codes 8085/8086 for these sites diagnosed 2021 forward. SEER is not requiring their registries to review previously abstracted cases and change the histology.
14.	If the most specific histology is on the specimen post neoadjuvant treatment versus pre-adjuvant specimen, which would you code? would you code?	The only time you may code the post-treatment histology is when the original diagnosis was made by cytology, FNA, smears or from a regional or metastatic site. This is noted in the H rules, “Priority Order for Using Documents to Identify Histology”.
15.	Many of us still have our "purple books" ICD-O-3. With all the changes 2018+ we should only use the ICD lists and the STM, right?	It's best to use the current ICD-O version (3.2) and any ICD-O updates rather than ICD-O-3 or 3.1 with the exception of the C-codes. ICD-O-3 includes WHO 3rd editions. ICD-O-3.2 includes addendums to 3rd Editions and ICD-O-3.2 is current up to 4th Editions. Each version is more current. The next edition of ICD-O will include 5th Editions.

16.	Is there only one update for STR per year? If we download the rules, can we be sure they are the most current for the data year?	The solid tumor rules will be updated once per year unless a major error is identified that impacts surveillance, then an update would be released.
17.	Recoding projects for any of these? specifically pilocytic astrocytomas	At this time, the standard setters do not require these cases be recoded to /1.
18.	In Prostate cancer, I have seen several cases in which the Path report will have Acinar Adenocarcinoma followed by Adenocarcinoma: Ductal carcinoma. What would be the correct code?	Beginning 1/1/2023, if the diagnosis is based on core biopsies/TURP only, then the rules tell you to code 8140. The ductal component must comprise greater than 50% of the tumor to be coded. Per our expert GU pathologists, this means the prostate must be resected to accurately determine this.
19.	Can you please explain how we would use the annotated site/histology list on the NAACCR website and is it updated for v23 codes?	The annotated ICD-O table includes ICD-O-3.2 AND all updates that are released by the NAACCR ICD-O Update work group. This means the annotated list is the most current and includes all new terms, codes, etc. identified in WHO Classifications of Tumors published after the creation of ICD-O-3.2.
20.	Just to confirm: No changes need to be made to 9421/3 cases diagnosed prior to 2023?	Correct. You do not need to re-code cases diagnosed prior to 1/1/2023.
21.	Why are other sites still clumped into other sites and not have individual chapters for each site?	The original multiple primary rules were developed by WHO/ICD-O committee. The US standard setters identified the need to expand the rules to meet surveillance needs. Developing the 2007 MPH rules was a major undertaking and involved many disciplines and field testing. Because of the scope of the project, it was decided to create specific modules for the sites which made up the majority of cases. The rest fell into Other. When updating to solid tumor format, much of the resources originally assigned to the project were re-assigned to other "more important" projects. This resulted in a drastic cut in resources. Currently, there is only one person working on the ST rules (me). I have expert resources that contribute. This did not allow for new modules to be created. This will change beginning 2024 as I will create at least two new site-specific modules.

22.	Is there any way to download these manuals for hospital shared registry where we log in remotely and get a new desktop daily?	You could download on to a jump drive for each person. Make sure to update yearly or when a new version is releases. This way, the manuals travel with the registrars. Fyi...we are referring to the Solid Tumor Manual, SSDI Manual, and other freely available manuals. We are not referring to the AJCC manual. Please contact AJCC with questions concerning sharing of the AJCC manual.
23.	In the future, for the Solid Tumor Rules, Other Sites, will there be guidance included for determining primary site included for some of these sites, such as GYN with High Grade Serous Carcinoma?	Yes, I have initiated conversations with GYN path experts and others to revise the M rules for ovarian and fallopian tube tumors.
24.	When I look on the SEER Appendix C site for 2023, the other section still shows the 2007-2022 one. https://seer.cancer.gov/manuals/2023/appendixc.html Will this be updated to show the 2023 one for the main appendix C page?	I'll let the website team know so it can be updated.
25.	Why in the SSDI Appendix A v3.0 was the tables which defines the specific primary site(s) and/or histology(ies) combinations which are eligible for AJCC staging removed? They were a great resource as to what the AJCC ID should be (AJCC ID=XX or an actual AJCC ID).	AJCC ID information can only be provided by AJCC. At the beginning of this appendix, there is a note that addresses this and who you need to contact to get that information.
26.	Lois did you say we can begin to use the new breast histology rule now for H15? or just applicable for 2023 moving forward	You can use the "new" breast rules for cases DX'd 1/1/2018 forward.
27.	Are there plans for the 09 AJCC books to be in print? and possibly when?	That is a question for AJCC!
28.	In SEER SINQ, there is a button beside the Q&A named "add to report" so we have a listing of all the questions we have searched. It saves time having to re-search the same thing. Does CAnswer have a function similar to this?	CAnswer Forum does not have a similar function.
29.	Can someone comment on the RADS changes. There are multiple questions in the forum and the latest comments state	This is still under discussion.

	they will not be commenting further until Standard Setters meet and come to a consensus. Specifically, can any rads be used as a dx date if later confirmed by histology? IE: could a BIRADS 0-3 MMG be used as the dx date after a positive bx, or is it only certain RADS?	
30.	Lois, if I have multiple soft tissue sarcomas and multiple liver tumors (and the patient has been disease free for more than a year), should we add these to our registry as new primaries? (This question is similar to the AIN II question about multiple primaries). Thanks!	I've included these questions to my growing list of site-specific timing updates for our experts to review. I think it's time to record occurrences of subsequent tumors rather than add new primaries.
31.	For FIGO, if the physician completes an electronic AJCC Staging form, there is a FIGO Stage next to the selected TNMs fields, would we be able to use those for the FIGO SSDI?	Yes, you would be able to use this.
32.	Do we keep coding Allred Scores for 2021 & 2022 cases?	Yes, you need to keep coding it for 2021 and 2022
33.	Is there a time limit PRIOR to diagnosis that LDH can be used. If LDH lab value is available from awhile before diagnosis, can it be used?	Follow the general instructions for SSDIs, especially for lab values. They must be available within 3 months of diagnosis.
34.	Is there a time frame for how far after the surgery you can record the LDH? If LDH was 2 months after surgery, would you use it?	Only if it is done within the initial diagnosis and workup and systemic therapy hasn't been done. See General Rules for SSDIs: all SSDI's must be collected within the initial diagnosis and treatment.
35.	Our Gyn oncs state that they only use FIGO stage (Never TNM stage) and that we can assume it is FIGO stage even though it is not documented with "FIGO" in the EMR. Would it be okay to make this assumption for GYN Oncologist and code FIGO stage?	As long as this is documented somewhere in your policy and procedure manual, you may use it. This would have to be done for each facility.
36.	Is the addendum dx or dx comment included with the Pathology Report: Final Diagnosis priority for the Grade priority?	An addendum would take priority to the pathology report.
37.	Can the Grade updates be used for all previous years from 2018 forward or just for 1/2023 forward	They can be used for 2018 forward. For the new code “H” in the soft tissue schemas, this can only be used after your 2023 software updates are implemented

38.	Is there any way to get the SSDI section on CAnswer forum separated out by site?	Excellent suggestion. Followed up with CoC, who manages the forum, and they are open to setting up the SSDI forum like this. Once we get the different categories, the current questions will be moved. This process will take several months though.
39.	Our pathology reports include the FIGO stage. With the new rules, we should not use that, correct?	According to the instructions we are getting from AJCC, you cannot take the FIGO stage from the pathology report, it must come from the managing physician: See updated notes for Version 3.0
40.	Will CAnswer Forum include numbers for reference citations for each inquiry, so that citations can be searched on more easily?	There are reference numbers in the CAnswer Forum posts. Please contact CAnswer Forum "HELP" for assistance on how to find these.
41.	If path report specifically states "FIGO STAGE", can that be used?	According the instructions we are getting from AJCC, you cannot take the FIGO stage from the pathology report, it must come from the managing physician: Per the updated 3.0 notes, you cannot take the FIGO stage from the pathology report.
42.	More of a comment than a question, but they need to make it easier to find where to submit a question to Cancer Forum. A button on the home page would be the best!	There are buttons on CAnswer Forum for each of the different forums. It's at the very top of the page and goes across (left to right).
43.	RX hosp means it was done at your facility, RX summ means it was done, regardless of where, right?	That is a good general explanation of the difference.
44.	What is the code for a patient who has an endoscopic mucosal resection of a rectal adenoca	It seems like the best code for that procedure would be 27 (A270) excisional biopsy.
45.	Sorry, I was referring to Prostatectomy cases. However, the percentage of each Acinar Adenoca vs. Ductal Ca is not given. As per Pathology, Adenocarcinoma and Ductal Carcinoma fall under the same umbrella. We as Registrars know this, but to code the most correct one.	Pathologists may not be used to provide percentages yet. But that's an issue with CAP. Other sites Table 3 see row "Mixed acinar-ductal adenocarcinoma. It instructs you to assign code 8552/3 when the percentages are not stated.
46.	Is this the best way to make the difference between Acinar Adenoca and Ductal Ca -the percentage?	It is the responsibility of the pathologist to indicate percentages which they are likely to do. Don't try to figure this yourself. Assign the mixed acinar-ductal code.

47.	How do you tell the difference between a punch bx and a needle/core bx?	The response below comes from a participant. *A punch biopsy is done with a punch biopsy tool, which produces a small round piece of tissue. A needle core biopsy is done with a large Tumey Needle. The punch biopsy is a larger sample.*
48.	Does this mean that for 2023 shave bx are not considered dx and staging procedures? Did I understand correctly?	That is correct.
49.	When we see a patient at our hospital for a wide excision of a melanoma, who previously had a shave biopsy, what surgical code should we use if the shave biopsy was done elsewhere.	B520-Shave Biopsy followed by wide excision would be used for both RX Hosp and RX Surg fields.
50.	If tumor dx 2022, first surg 2022, second surg 2023 how does that work out? Will the surgery field be determined by date of dx or date of most def surg?	Always code based on rules in effect for the year the case was **diagnosed**. The new codes only apply for cases diagnosed 2023 and later.
51.	Melanoma- How do you code Clinical Margin value when wide excision shows no remaining disease?	The residual disease does not influence the code. Clinical margin width is coded based on a statement from the physician prior to surgery. If physician states they are going to take a 2cm margin, code clinical margin width as 2.0.
52.	How do these changes to the melanoma Surgery codes effect the Operative Standards for Melanoma for CoC facilities? Surgeons have to document the margins in an Operative Template starting 2022.	The changes are directly related to the operative standards for melanoma and were approved by the same physicians that helped develop the CoC operative standards for melanoma.
53.	Will only certain surgery codes apply for the margins? Meaning, does it have to be a wide excision or above to code something other than XX9?	Correct. XX.9 for is assigned to Clinical Margin Width unless surgery of primary site is B500-B540.
54.	To Lois Dickie. I'm not sure if any project takes precedence over improving the manuals registrars use. The manuals are ground zero.	Agree. We're fortunate to have experts in different disciplines to consult with, BUT, they often have tunnel vision and are not always aware of real world practices. Hopefully the ST rules help. We (the CTR's at NCI SEER) fight to limit new data items or other changes that may impact workloads but have no impact on surveillance.
55.	Question about example about melanoma: I often see cases where shave bx has extension to margin but physician notes no	For cases diagnosed prior to 2023, the margin status dictates whether the procedure is coded as a diagnostic staging

	visible residual on exam and wide-excision path shows NO RESIDUAL. Wouldn't that shave be coded as surgery since it was only microscopic margins per STORE? (Do not code excisional biopsies with clear or microscopic margins in this data item - dx stg procedure. Use the data item Surgical Procedure of Primary Site [1290] to code these procedures.)	procedure or as a surgical procedure. Starting with cases diagnosed in 2023, a shave biopsy is always coded using the surgery of primary site field. The margin status does not determine which field to use.
56.	What if the surgeon just says, "wide excision"?	A "wide excision" as defined in the surgery codes means the patient has a previous excision of the tumor and has returned for a "wide excision" to ensure negative margins. If it is obvious the patient has not had a previous excision of the tumor, the procedure would be codes as a B200 Excisional biopsy.
57.	Clinical Margin Width is in centimeters instead of millimeters?	That is correct. A clinical margin width of 2cm would be coded 2.0. Remember, the margin width is coming from the surgeon not from the pathologist.
58.	Is any excision following a shave/punch bx considered 'wide excision' or do we need that terminology specifically documented?	Below is the definition under code B500. As long as the procedure falls within the parameters described in the code definition, it can be assigned a code in the B500 series. Be sure not to code a procedure such as a MOHS in this series. *B500 Biopsy (NOS) of primary tumor followed wide excision of the lesion; Wide Excision NOS, Re-excision*
59.	Will these melanoma shave bx surgery codes also be 1st course treatment date?	That is my understanding.
60.	Isn't the use of "Clinical Margin Width" confusing, because WLE are usually for treatment and not just diagnostic?	"Clinical margin width" is the term in the CoC Operative Standards (5.5). You do bring up a good point. The word "clinical" is used differently here than it is with AJCC staging.
61.	Would be great if registrars had a "hot line" to call with questions during their workday :)	That would be great! However, due to the sheer volume of questions that come in every day, that is probably not going to happen.
62.	Might be an unrelated question, Will CoC accredit a Cancer hospital outside the U.S? I know they currently do not- is it a	I don't know! I did a quick search and did not find any. I know of many Canadian registrars with the CTR credentials.

	possibility in the future? How to start this conversation with CoC ?	https://www.facs.org/hospital-and-facilities/?searchTerm=&address=canada&page=1
63.	Will you state or show where to take the test for CE's	
64.	I have never been able to get into the Seer Inquiry system as it always states that my email does not work?	Try Google Chrome as the search engine. For SINQ, anyone can search for the database but only designated staff from a SEER registry can submit questions. https://seer.cancer.gov/seer-inquiry/inquiry-search/
65.	Does the LDH for melanoma SSDI need to be a standalone LDH test, or can it be part of a lipid panel?	As long as it's LDH, it doesn't matter if it's stand alone or part of a lipid panel.