Change Log V1.3- v1.4

This document shows the changes that were made to the SSDI manual and the Grade manual for the SEER*RSA version 1.4 release on (Date TBD).

SSDI Manual Section: General Instructions and Format of SSDIs

Added (at bottom of page)

Death Certificate Only (DCOs) cases

For DCOs, the applicable SSDIs (except for applicable Schema Discriminators) may be blank.

Note: This instruction is for central registries only.

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Data Item #	**Data Item Description**	**Original Text**	**Updated Text**
N/A	General Definitions and Format of SSDI		
3811	Anemia	Note 3: Record this data item based on a blood test (CBC or hematocrit) performed at diagnosis (pre-treatment). In the absence of the lab test, a physician's statement can be used.	**Note 3:** Record this data item based on a blood test (CBC, hemoglobin & hematocrit, H&H) performed at diagnosis (pre-treatment). In the absence of the lab test, a physician's statement can be used.
3812	B Symptoms	**Additional guidelines (part of SSDI manual)** **Note**: This was previously required for staging under the Ann Arbor Staging Classification for Lymphomas. The new Lugano Staging System does not require this for staging.	**Note**: This was previously required for staging under the Ann Arbor Staging Classification for Lymphomas. The new Lugano Staging System does not require this for staging. o **Per AJCC 8th edition:** "The designation A or B is not included in the revised staging of NHL, although clinicians are encouraged to record the presence of these symptoms in the medical record." (pg. 942) o If your physicians no longer record the B symptoms because of this change, code 9
3813	Bilirubin Pretreatment Total Lab Value	**Note 3:** Assay of Bilirubin Pretreatment Total Lab Value includes conjugated (direct) and unconjugated (indirect) bilirubin. Record the **total bilirubin** value for this data item.	**Note 3:** Assay of Bilirubin Pretreatment Total Lab Value includes conjugated (direct) and unconjugated (indirect) bilirubin and total bilirubin values. Record the **total bilirubin** value for this data item.
3831	Extranodal Extension Head and Neck Clinical	**Coding guidelines (2nd bullet)** Code 1 when there are positive nodes clinically, ENE is identified by physical exam or imaging **Note 5: 3rd bullet**	**Coding guidelines (2nd bullet)** Code 1 when there are positive nodes clinically, ENE is identified by physical exam WITH or WITHOUT imaging **Note 5: 3rd bullet: REMOVED**

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		Lymph node biopsy (e.g., FNA, cor, incisional, excisional, sentinel node) confirms ENE. **Note 6**: Code 9 when physical exam is not available AND at least one of the following • No additional information • Statement of lymph node involvement with no information on ENE • Lymph node biopsy (e.g., FNA, core, incisional, excisional, sentinel node) performed and is negative for ENE	**Note 6**: Code 9 when physical exam is not available AND at least one of the following • No additional information • Statement of lymph node involvement with no information on ENE • Lymph node biopsy (e.g., FNA, core, incisional, excisional, sentinel node) performed and is negative for ENE or not stated
3835	Fibrosis Score	**Note 2:** AJCC 8th edition chapter 22 (Liver) and the CAP protocol for Hepatocellular Carcinoma use the term "fibrosis score." Chapter 23 (Intrahepatic Bile Ducts) describes it as "nontumoral hepatic parenchymal fibrosis/cirrhosis." Both AJCC and CAP recommend the Ishak Score system. Ishak uses a scale of 0-6 with 6 indicating cirrhosis. Other pathological scoring systems in use include the Batts-Ludwig system, which uses scores of 0-4, and the METAVIR system which uses scores of F0-F4. **Note 3:** FIB-4 is NOT a pathological fibrosis score of 4. It is a scoring method using the patient's age and relevant lab values to	**<u>Definition</u>** The Fibrosis Score is based on degree of parenchymal fibrosis or cirrhosis of the nontumorous liver as defined in the surgical pathology report. Multiple fibrosis scoring systems have been described for use in pathological evaluation of liver disease. • Ishak system uses a scale of 0-6 with 6 indicating cirrhosis. o Recommended by AJCC and CAP • Batts-Ludwig system uses a score of 0-4, with a score of 3 defined as fibrous septa with architectural distortion but no obvious cirrhosis, and a score of 4 defined as cirrhosis

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		calculate a score. The medical record may show something like "FIB-4 = 3.52." Do not code FIB-4 values in this data item. **Note 4:** AJCC classifies Ishak fibrosis scores 0-4 (none to moderate fibrosis) as F0, and Ishak fibrosis scores 5-6 (cirrhosis/severe fibrosis) as F1. This is not the same as METAVIR score F0 or F1. **Note 5:** If a fibrosis score is stated but the scoring system is not recorded, consult with the physician. If no further information is available, code 9.	o Used most commonly by US pathologists • METAVIR uses scores of F0-F4 o Used mostly in Europe **Additional Information** • **Source documents:** pathology report (biopsy or FNA path report) • **Other names:** Nontumoral hepatic parenchymal fibrosis/cirrhosis (Intrahepatic Bile Duct Tumors) **Note 1:** No change **Note 2:** Previously Note 3 **Note 3:** Previously Note 4 **Note 4:** Record the results based on information collected during the initial work-up. If multiple biopsies are taken and have conflicting scores, use the results from the biopsy closest to the start of treatment. Information collected after the start of treatment may not be used to code this data item. **Note 5**: Code the absence (code 0) or presence (code 1) of fibrosis as documented in the pathology report. **Note 6:** If no score is mentioned, descriptive terms may be used to assign codes 0 and 1 – see specific terms in the table below.

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Data Item #	**Data Item Description**	**Original Text**	**Updated Text**
			Note 7: Previously Note 5
3858	High Risk Histologic Features	**Note 3:** Code 5 if more than one high risk histologic feature is present. **Note 4:** Record the presence of high risk histologic features as documented in the medical record.	**Note 3:** Code the presence or absence of high risk histologic features as documented in the pathology report. **Note 4:** Code 5 if more than one high risk histologic feature is present.
3864	Invasion Beyond Capsule	**Note 4:** Record invasion beyond capsule as documented in the pathology report. Assign code 0 if surgical resection of the primary site is performed, the pathology report is available for review, and invasion beyond capsule is not mentioned.	Note 4 removed Remaining notes renumbered
3866	KRAS	**Note 3:** KRAS analysis is commonly done for patients with metastatic disease. **Note 4:** If KRAS is positive and there is no mention of the mutated codon, or the mutated codon is not specified, code 4.	**Note 3:** KRAS analysis is commonly done for patients with metastatic disease. **Note 4:** Information on **presence** of perineural invasion can be taken from either a biopsy or resection. Absence of perineural invasion can only be taken from a surgical resection pathology report. (This note will be removed in Version 1.5, accidentally included) Note 4 should be: **Note 4:** Results from nodal or metastatic tissue may be used for KRAS. **Note 5:** Record the results of the KRAS from the initial workup (clinical and pathological workup).

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			Note 6: If KRAS is positive and there is no mention of the mutated codon, or the mutated codon is not specified, code 4.
3890	Microsatellite Instability (MSI)	**Note 2:** The microsatellite instability (MSI) test is a genetic test performed on tumor tissue to look for differences in length of certain non-functioning sections of DNA. The differences are caused by problems with the genes that normally repair DNA. A high-positive MSI (MSI-H) result may indicate that the gene repair problem is related to the development of the cancer, and that the patient may have hereditary nonpolyposis colorectal cancer (HNPCC) (also known as Lynch syndrome.) A low-positive or stable MSI result (stable meaning that there are no differences in the lengths) means it is unlikely that the cancer is related to a hereditary condition. **Note 3:** Testing for MSI may be done by immunology or genetic testing. Some laboratories only test for MSI via immunology such as Mismatch Repair (MMR) Protein. Results from immunology will only provide you with positive or negative results and will not specify whether the MSI is low or high. • If the testing was done via immunology, code 9. Only genetic	**Note 2:** The microsatellite instability (MSI) test is a genetic test performed on tumor tissue to look for differences in length of certain non-functioning sections of DNA. The differences are caused by problems with the genes that encode proteins that normally repair certain types of DNA damage. A high proportion of colon cancers arising in patients with hereditary nonpolyposis colorectal cancer (HNPCC) (also known as Lynch syndrome) have high MSI and a smaller percentage of colon cancers not associated with Lynch syndrome have high MSI. Patients with colon cancers with high MSI may be further tested to determine if they have HNPCC. In addition, MSI is a useful prognostic marker in that patients with high MSI colon cancers have better response to surgery and survival. **Note 3:** Testing for MSI may be done by immunology or genetic testing. Only genetic testing results will specify whether the MSI is low or high.

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		testing results will specify whether the MSI is low or high. **Note 4:** In Canada, the following terms are often used • MMR normal (code 0) • MMR abnormal (code 2) **Note 5:** If both tests are done and one or both are positive, code 2. **Note 6:** If all tests done are negative, code 0.	• Some laboratories only test for MSI via an immunologic test for Mismatch Repair (MMR) Protein. Results from immunology will only provide you with positive or negative results and will not specify whether the MSI is low or high. • Results of Mismatch Repair (MMR) may be recorded in this data item - see codes 0 and 2. **Note 4:** If both tests are done and one or both are positive, code 2. **Note 5:** If all tests done are negative, code 0.
3909	Perineural Invasion		**Note 3:** Information on **presence** of perineural invasion can be taken from either a biopsy or resection. Absence of perineural invasion can only be taken from a surgical pathology report.
3926	Schema Discriminator 1: Occult Head and Neck Lymph Nodes	**Note 1:** This schema discriminator is used to discriminate between head and neck tumors with unknown primary site coded as C760. Some situations require that a more specific primary site be assigned. • **Chapter 6: Cervical Lymph Nodes and Unknown Primary Tumors of the Head and Neck**	**Note 1:** This schema discriminator is used to discriminate between head and neck tumors with unknown primary site coded as C760. Some situations require that a more specific primary site be assigned. • **AJCC 8th Chapter 6: Cervical Lymph Nodes and Unknown Primary Tumors of the Head and Neck (Schema ID**

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		Occult head and neck tumor with cervical metastasis in level II/III lymph nodes without a p16 immunostain or with negative results and without an Epstein-Barr virus (EBV) encoded small RNAs (EBER) by in situ hybridization performed or with negative results are staged using Chapter 6 • **Chapter 9: Nasopharynx** Occult head and neck tumors with cervical metastasis in level II/III lymph nodes that is positive for Epstein–Barr virus (EBV+) encoded small RNAs (EBER) identified by in situ hybridization are staged using Chapter 9. Assign primary site C119; do NOT code this discriminator • **Chapter 10: HPV-Mediated (p16+) Oropharyngeal Cancer** Occult head and neck tumors with cervical metastasis in level II/III lymph nodes, p16 positive with histology consistent with HPV-mediated oropharyngeal carcinoma (OPC), should be staged using Chapter 10. Assign primary site	**00060: Cervical Lymph Nodes and Unknown Primary)** Occult head and neck tumor with cervical metastasis in Levels I-VII, and other group lymph nodes without a p16 immunostain or with negative results and without an Epstein-Barr virus (EBV) encoded small RNAs (EBER) by in situ hybridization performed or with negative results are staged using Chapter 6. **Assign primary site C760; code the schema discriminator accordingly.** • **AJCC 8th edition Chapter 9: Nasopharynx (Schema ID 00090: Nasopharynx)** Occult head and neck tumors with cervical metastasis in Levels I-VII, and other group lymph nodes that is positive for Epstein–Barr virus (EBV+) (regardless of p16 status) encoded small RNAs (EBER) identified by in situ hybridization are staged using Chapter 9. **Assign primary site C119; do NOT code this discriminator.** • **AJCC 8th edition Chapter 10: HPV-Mediated (p16+) Oropharyngeal**

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		C109; do NOT code this discriminator • **Ill Defined, Other (Summary Stage only)** If the tumor is not occult or does not have cervical metastasis in level II/III lymph nodes, it is not included in Chapter 6 and will be classified as Ill Defined, Other for Summary Staging **Note 2:** Assign this data item based on physician statement or from lab tests performed at diagnosis (pre-treatment). **Note 3:** If the code determined by available lab tests differs from the physician statement, the physician's statement takes precedence.	**Cancer (Schema ID 00100: Oropharynx HPV-Mediated (p16+))** Occult head and neck tumors with cervical metastasis in Levels I-VII, and other group lymph nodes, p16 positive with histology consistent with HPV-mediated oropharyngeal carcinoma (OPC), should be staged using Chapter 10. **Assign primary site C109; do NOT code this discriminator** • **Ill Defined-Other (Summary Stage only) (Schema ID 99999: Ill-Defined Other)** If the tumor is not occult or does not have cervical metastasis in Levels I-VII, and other group lymph nodes, it is not included in Chapter 6 and will be classified as Ill Defined-Other for Summary Staging **Note 2**: If there is no evidence of the primary tumor, yet the physician "suspects" a specific head and neck subsite, do not assign that primary site, but code C760 (see exceptions for EBV positive or p16 positive cancers.) **Note: Additional information has also been added to the SSDI manual (not included in registry software)**

List of Changes to Grade Manual, version 1.4			
Data Item #	**Data Item Description**	**Original Text**	**Updated Text**
3843, 3844, 3845	Clinical grade, Pathological Grade, Post-therapy grade (Rationale)	For those cases that are eligible for AJCC staging, the recommended grading system is specified in the AJCC Chapter. The AJCC Chapter-specific grading systems (codes 1-5) take priority over the generic grade definitions (codes A-E, L, H, 9). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.	For those cases that are eligible for AJCC staging, the recommended grading system is specified in the AJCC Chapter. The AJCC Chapter-specific grading systems (codes 1-5, H, L, M, S and 9) take priority over the generic grade definitions (codes A-E). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.
3843, 3844, 3845	Clinical grade, Pathological Grade, Post-therapy grade (Allowable formats)	1-5, 8, 9, A, B, C, D, E, L, H, M, S (blank for Grade post-therapy)	1-5, 8, 9, A-E, L, H, M, S (blank for Grade post-therapy)
3843	Clinical grade	**Note (# depends on schema):** If there is only one grade available and it cannot be determined if it is clinical, pathological, or after neo-adjuvant therapy, assign as a clinical grade and code unknown (9) for pathological grade, and blank for post-therapy grade.	**Note (# depends on schema):** If there is only one grade available and it cannot be determined if it is clinical or pathological, assume it is a clinical grade and code appropriately per clinical grade categories for that site, and then code unknown (9) for pathological grade, and blank for post-therapy grade.
3844	Pathological grade	**Note (# depends on schema):** Assign the highest grade from the primary tumor. If the clinical grade is higher than the grade determined during the pathological time frame, use the grade that was identified during the clinical time frame for both the clinical grade and the pathological grade.	**Note (# depends on schema):** Assign the highest grade from the primary tumor. If the clinical grade is the highest grade identified, use the grade that was identified during the clinical time frame for both the clinical grade and the pathological grade. (This follows the AJCC rule that pathological time frame includes all of the clinical time frame

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			information plus information from the resected specimen.) • If a resection is done of a primary tumor and there is no grade documented from the surgical resection, use the grade from the clinical workup • If a resection is done of a primary tumor and there is no residual cancer, use the grade from the clinical workup
3845	Post-therapy grade	**Note (# depends on schema):** Code 9 when • Surgical resection is done after neoadjuvant therapy and grade from primary site is not documented • Grade checked "not applicable" on CAP Protocol (if available) and no other grade information is available	**Note (# depends on schema):** Code 9 when • Surgical resection is done after neoadjuvant therapy and grade from the primary site is not documented • Surgical resection is done after neoadjuvant therapy and there is no residual cancer • Grade checked "not applicable" on CAP Protocol (if available) and no other grade information is available
3843, 3844, 3845	Clinical grade, Pathological Grade, Post-therapy grade (Kidney Renal Pelvis, Bladder, Urethra, Urethra-Prostatic)	**Note 3:** Priority order for codes • Urothelial cancers: use codes L, H and 9 • Adenocarcinomas and Squamous Cell Carcinomas: use codes 1-3, 9	**Note 3:** Priority order for codes • Urothelial cancers: use codes L, H and 9 o If only G1-G3 are documented, code 9 • Adenocarcinomas and Squamous Cell Carcinomas: use codes 1-3, 9 o If only L or H are documented, code 9

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Data Item #	**Data Item Description**	**Original Text**	**Updated Text**
3843	Clinical grade (Prostate)	**None**	**Note 4**: For prostate, a TURP qualifies for a clinical grade only. **Rest of notes renumbered**
3844	Pathological grade (Prostate)	**None**	**Note 4:** For prostate, a TURP does not qualify for surgical resection. A prostatectomy must be performed. **Rest of notes renumbered**
3843	Clinical grade ((Kidney Renal Pelvis, Bladder, Urethra, Urethra-Prostatic)	**None**	**Note 5**: For bladder, a TURB qualifies for a clinical grade only. **Rest of notes renumbered**
3844	Pathological grade ((Kidney Renal Pelvis, Bladder, Urethra, Urethra-Prostatic)	**None**	**Note 5:** For bladder, a TURB does not qualify for surgical resection. A cystectomy, or partial cystectomy, must be performed **Rest of notes renumbered**