Summary of Changes v3.0

This document shows the changes that were made to the SSDI manual and the Grade manual for the SEER*RSA version 3.0 release on August 1, 2022

- **Table 1: New SSDIs, Version 3.0**
- **Table 2: Changes to Schemas**
- **Table 3: Changes to the general instructions, Version 3.0**
- **Table 4: Changes to current SSDIs, Version 3.0**
- **Table 5: Changes to Grade Manual, Version 3.0**

Table 1: New and Retired SSDIs

Data Item # and Description	Schema(s)	Comments
3884: LN Status Femoral-Inguinal, Para-Aortic, Pelvic	Cervix 8th, Cervix V9, Vagina, Vulva	Was retired in v2.1 and replaced with 3 distinct fields. It has been removed from all schemas for v3.0
3956: p16	Anus V9	Applicable for cases diagnosed 2023+
3960: Histologic Subtype	Appendix V9	Applicable for cases diagnosed 2023+
3961: Clinical Margin Width	Melanoma Skin	Applicable for cases diagnosed 2023+

Table 2: Changes to Schemas

Schema	Applicable Years	Comments
Anus Version 9	2023+	AJCC's Anus, Version 9, will be used with 2023+ diagnosis. There are now two EOD Anus schemas in SEER*RSA • Anus 8th: 2018-2022 (Schema ID: 00210) • Anus V9: 2023+ (Schema ID: 09210) Software will automatically take you to the correct Anus schema based on the date of diagnosis Note: For Schema ID 09210 only (2023+), new SSDI: p16 • p16 is not applicable for cases diagnosed 2018-2022
Appendix Version 9	2023+	AJCC's Appendix, Version 9, will be used with 2023+ diagnosis. There are now two EOD Appendix schemas in SEER*RSA • Appendix 8th: 2018-2022 (Schema ID: 00190) • Appendix V9: 2023+ (Schema ID: 09190) Software will automatically take you to the correct Appendix schema based on the date of diagnosis Note: For Schema ID 09190 only (2023+), new SSDI: Histologic Subtype • Histologic subtype is not applicable for cases diagnosed 2018-2022
Brain Version 9	2023+	AJCC's Brain and Spinal Cord, Version 9, will be used with 2023+ diagnosis. There are now two EOD Brain schemas in SEER*RSA • Brain 8th: 2018-2022 (Schema ID: 00721) • Brain V9: 2023+ (Schema ID: 09721) Software will automatically take you to the correct Brain schema based on the date of diagnosis

Schema	Applicable Years	Comments
CNS Other Version 9	2023+	AJCC's Brain and Spinal Cord, Version 9, will be used with 2023+ diagnosis. There are now two Brain schemas in SEER*RSA • CNS Other 8th: 2018-2022 (Schema ID: 00722) • CNS Other: 2023+ (Schema ID: 09722) Software will automatically take you to the correct CNS Other schema based on the date of diagnosis
Intracranial Gland Version 9	2023+	AJCC's Brain and Spinal Cord, Version 9, will be used with 2023+ diagnosis. There are now two Intracranial Gland schemas in SEER*RSA • Intracranial Gland 8th: 2018-2022 (Schema ID: 00723) • Intracranial Gland V9: 2023+ (Schema ID: 09723) Software will automatically take you to the correct CNS Other schema based on the date of diagnosis
Medulloblastoma Version 9	2023+	AJCC's Brain and Spinal Cord, Version 9, will be used with 2023+ diagnosis. For cases diagnosed prior to 2023+, use the appropriate Schema based on primary site 1. Schema ID: 00721: Brain (Primary Sites: C700, C710-C719) 2. Schema ID: 00722: CNS Other (Primary Sites: C701, C709, C720-C729) 3. Schema ID: 00723: Intracranial Gland (Primary Site: C753) Software will automatically take you to the correct schema based on the date of diagnosis

Table 3: Changes to SSDI Manual (General Instructions)

Manual Section	Page	Original Text	Updated Text
General Rules	27	**General Rules versus SSDI specific rules** Unless instructions for a specific tissue test state otherwise, record the highest value (positive versus negative, or actual numerical value) obtained from any tissue based examination (biopsy, surgical resection, bone marrow biopsy). If the SSDI specific coding rules column is yes, then check the SSDI for additional coding instructions	**Priority Order for SSDIs** • Addendums or amendments (corrections that are not incorporated into the initial synoptic report, including CAP Cancer Protocol) • Synoptic report (including CAP Cancer Protocol) • Pathology report: final diagnosis • Physician statement **General Rules versus SSDI specific rules** • Unless instructions for a specific tissue test state otherwise, record the highest value (positive versus negative, or actual numerical value) obtained from any tissue based examination (biopsy, surgical resection, bone marrow biopsy). • If the SSDI specific coding rules column is yes, then check the SSDI for additional coding instructions

Note: The following changes were also done throughout the entire manual as needed, but these changes will have no impact on abstracting

- References to AJCC chapters were changed to refer to AJCC Staging Systems
- References to specific chapters were removed in the Schema ID table
- Text of references to other data items restructured
- For Schema Discriminator 1 [3926], Schema Discriminator 2 [3927]: AJCC chapter references in the validation table were replaced with Schema IDs

Table 4: Changes to current SSDIs

Schema ID Name	Data Item # and Description	Original Text	Updated Text
Head and Neck Schemas: 00060, 00071, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130-00133, 00140	3831: Extranodal Extension Head and Neck Clinical	**Note 6:** Code 7 when • Lymph nodes are determined to be clinically negative • Behavior /2 (in situ)	Note deleted
Head and Neck Schemas:00071, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130-00133, 00140	3831: Extranodal Extension Head and Neck Clinical	Code 7: No regional lymph node involvement during diagnostic workup (cN0)	Code 7: No regional lymph node involvement during diagnostic workup (cN0) Non-invasive neoplasm (behavior /2)
Head and Neck Schemas: 00060, 00071, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130-00133, 00140	3832: Extranodal Extension Head and Neck Pathological	**Note 1:** Physician statement of extranodal extension (ENE) pathologically during a lymph node dissection or physician pathological stage indicating the absence or presence of ENE can be used to code this data item when no other information is available. **Note 2:** Code the status of ENE assessed on histopathological examination of **surgically resected** involved regional lymph node(s). Do	**Note 1:** Physician statement of extranodal extension (ENE) pathologically during a lymph node dissection or physician pathological stage indicating the absence or presence of ENE can be used to code this data item when no other information is available. **Note 2:** Extranodal extension is defined as “the extension of a nodal metastasis through the lymph node capsule into adjacent tissue.” ENE is the preferred terminology. Other names include:

Schema ID Name	Data Item # and Description	Original Text	Updated Text

		not code ENE from a lymph node biopsy (FNA, core, incisional, excisional, sentinel). Do not code ENE for any distant lymph nodes.
		• If codes 0.0-0.9, X.1-X.7 are used, this indicates that the lymph nodes were surgically resected and Scope of Regional Lymph Node Surgery [NAACCR Data Item: 1292] must be 3-7
		
		Note 3: Be aware that the rules for coding ENE for head and neck sites compared to non-head and neck sites are different.
		
		Note 4: Definitions of ENE subtypes and rules:
		• Microscopic ENE [ENE (mi)] is defined as less than or equal to 2 mm.
		• Major ENE [ENE (ma)] is defined as greater than 2 mm.
		• Both ENE (mi) and ENE (ma) qualify as ENE (+) for definition of pN.
		
		Note 5: The measurement of ENE is the distance from the lymph node capsule in millimeters (mm).
			extranodal spread, extracapsular extension, or extracapsular spread.
			• "A regional node extending into a distant structure or organ is categorized as ENE and is not recorded as distant metastatic disease."
			
			Note 3: Code the status of ENE assessed on histopathological examination of **surgically resected** involved regional lymph node(s). Do not code ENE from a lymph node biopsy (FNA, core, incisional, or the absence of ENE from a sentinel). Do not code ENE for any distant lymph nodes. Code the status of ENE based on the following criteria
			▪ Code 0.0
			  ○ Absence of ENE, positive lymph nodes assessed by lymph node dissection
			  ○ 1292: Scope of Regional Lymph Node Surgery must be 3-7
			• Codes 0.1-9.9, X.1, X.2, X.3, X.4 as appropriate for
			  ○ Presence of ENE assessed by Sentinel Lymph Node Biopsy
			  ○ Presence of ENE assessed by lymph node dissection

Schema ID Name	Data Item # and Description	Original Text	Updated Text
			◦ 1292: Scope of Regional Lymph Node Surgery must be 2-7 • Code X.7 as appropriate for ◦ Lymph nodes negative for cancer assessed by Sentinel lymph node biopsy or lymph node dissection ◦ 1292: Scope of Regional Lymph Node Surgery must be 2-7 • Code X.9 Absence of ENE, positive lymph nodes assessed by Sentinel Lymph Node Biopsy ▪ A positive Sentinel Lymph Node biopsy cannot assess the absence of ENE, only the presence of it. This is because there is not enough surrounding tissue in a Sentinel Lymph node biopsy to accurately assess ENE • If codes 0.1-0.9, X.1-X.7 are used, this indicates that the lymph nodes were surgically resected or a

Schema ID Name	Data Item # and Description	Original Text	Updated Text
			Sentinel Lymph Node biopsy was done and Scope of Regional Lymph Node Surgery NAACCR Data Item: 1292] must be 2-7 **Note 4**: Be aware that the rules for coding ENE for head and neck sites compared to non-head and neck sites are different. **Note 5:** Definitions of ENE subtypes and rules: • Microscopic ENE [ENE (mi)] is defined as less than or equal to 2 mm. • Major ENE [ENE (ma)] is defined as greater than 2 mm. • Both ENE (mi) and ENE (ma) qualify as ENE (+) for definition of pN. **Note 6:** The measurement of ENE is the distance from the lymph node capsule in millimeters (mm).
Head and Neck Schemas: 00071, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130-00133, 00140	3832: Extranodal Extension Head and Neck Pathological	Code X.9 Not documented in medical record No surgical resection of regional lymph nodes ENE not assessed pathologically, or unknown if assessed Pathological assessment of lymph nodes not done, or unknown if done	Not documented in medical record No surgical resection of regional lymph nodes Non-invasive neoplasm (behavior /2) ENE not assessed pathologically, or unknown if assessed Pathological assessment of lymph nodes not done, or unknown if done
Head and Neck Schemas:	3883: LN Size	Code 0.0: No involved regional nodes	Code 0.0: No regional lymph node involvement

Schema ID Name	Data Item # and Description	Original Text	Updated Text
00071, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130-00133, 00140, 00150			Non-invasive neoplasm (behavior /2)
Head and Neck Schemas: 00060, 00071, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130-00133, 00140, 00150	3883: LN Size	Code XX.3 Described as “less than 1 centimeter (cm)”	Code XX.3 Described as “less than 1 centimeter (cm)” or “subcentimeter”
00140: Melanoma Head and Neck	3876: LN Head and Neck Levels I-III	Code 0: No involvement in Levels I, II, or III lymph nodes	Code 0: No involvement in Levels I, II, or III lymph nodes Non-invasive neoplasm (behavior /2)
00140: Melanoma Head and Neck	3877: LN Head and Neck Levels IV-V	Code 0: No involvement in Levels IV or VI lymph nodes	Code 0: No involvement in Levels IV or V lymph nodes Non-invasive neoplasm (behavior /2)
00140: Melanoma Head and Neck	3878: LN Head and Neck Levels VI-VII	Code 0: No involvement in Levels VI or VII lymph nodes	Code 0: No involvement in Levels VI or VII lymph nodes Non-invasive neoplasm (behavior /2)
00140: Melanoma Head and Neck	3879: LN Head and Neck Other	Code 0: No involvement in other head and neck lymph nodes	Code 0: No involvement in other head and lymph nodes Non-invasive neoplasm (behavior /2)

Schema ID Name	Data Item # and Description	Original Text	Updated Text
00150: Cutaneous Carcinoma of Head and Neck	3858: High Risk Histologic Features	Code 0: No high risk histologic features	Code 0: No high risk histologic features Non-invasive neoplasm (behavior /2)
00150: Cutaneous Carcinoma of Head and Neck; 00200: Colon and Rectum; 00640: Skin Eyelid; 00690: Lacrimal Gland	3909: Perineural Invasion	Code 0: Perineural invasion not identified/not present	Code 0: Perineural invasion not identified/not present Non-invasive neoplasm (behavior /2)
00161, 00169, 00170: Esophagus and Stomach schemas	3926: Schema Discriminator 1: EsophagusGEJunction (EGJ)/ Stomach		**Complete rewrite of SSDI instructions**

00200: Colon and Rectum	3823: Circumferential Resection Margin	**Note 11**: Code XX.9 when
		• Tumor is in situ only (/2)
		• Checked "Not applicable: Radial or Mesenteric Margin" on CAP Checklist
		• Pathology report describes only distal and proximal margins, or margins, NOS
		    ○ Only specific statements about the CRM are collected in this data item
		• CRM not mentioned in the record
			Note 11: Code XX.9 when
			• Checked "Not applicable: Radial or Mesenteric Margin" on CAP Checklist
			• Pathology report describes only distal and proximal margins, or margins, NOS
			    ○ Only specific statements about the CRM are collected in this data item
			• CRM not mentioned in the record

Schema ID Name	Data Item # and Description	Original Text	Updated Text
00200: Colon and Rectum	3823: Circumferential Resection Margin	XX.9: Not documented in medical record Circumferential or radial resection margin not assessed or unknown if assessed	XX.9: Not documented in medical record Non-invasive neoplasm (behavior /2) Circumferential or radial resection margin not assessed or unknown if assessed •
00200: Colon and Rectum	3890: Microsatellite Instability	**Note 3:** Results from nodal or metastatic tissue may be used for Microsatellite instability	**Note 3:** MSI may be recorded for all stages; however, it is primarily performed for invasive neoplasms. For non-invasive neoplasms (behavior /2), code to 9 if no information available. **Note 4:** Results from nodal or metastatic tissue may be used for Microsatellite instability
00200: Colon and Rectum	3890: Microsatellite Instability	Code 9 Not documented in medical record MSI-indeterminate Microsatellite instability not assessed or unknown if assessed	Code 9 Not documented in medical record MSI-indeterminate MSI-equivocal Microsatellite instability not assessed or unknown if assessed
00220: Liver; 00230: Bile Ducts Intrahepatic	3835: Fibrosis Score	**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 4:** Record the results based on information collected during the initial work-up through the first course surgery, in the absence of neoadjuvant treatment. If multiple histologic assessments of the liver (biopsies or resections) are taken and have conflicting scores, record the highest score. • Information collected after the start of neoadjuvant treatment or primary systemic or radiation

Schema ID Name	Data Item # and Description	Original Text	Updated Text
			therapy may not be used to code this data item.
00290, 00301, 00302, 00310, 00320, 00330, 00340: NET Schemas	3867: Ki-67	**Note 3:** Ki-67 is a marker of cell proliferation. A high value indicates a tumor that is proliferating more rapidly. **Note 4:** Ki-67 results are reported as the percentage cell nuclei that stain positive. As of early 2017, there are no established standards for interpretation of results or for cutoffs for positive and negative.	**Note 3:** Ki-67 is a marker of cell proliferation. A high value indicates a tumor that is proliferating more rapidly. **Note 4:** Results from nodal or metastatic tissue may not be used. • If the only information you have is a Ki-67 from a metastatic site, code to XXX.9 **Note 5:** Ki-67 results are reported as the percentage cell nuclei that stain positive. As of early 2017, there are no established standards for interpretation of results or for cutoffs for positive and negative.

00290, 00301, 00302, 00310, 00320, 00330, 00340: NET Schemas	3867: Ki-67	**Note 7:** A specific value (0.0-100.0) takes priority over XXX.4, XXX.5 or XXX.6. Only use these values when that is the only information available.
		
		• XXX.4, XXX.5 and XXX.6 were added since they are listed on the CAP protocol
			Note 7: A specific value (0.0-100.0) takes priority over XXX.4, XXX.5 or XXX.6. Code the exact percentage when provided. When the exact percentage is not given, including ranges or terms such as “less than” or “greater than” use the range value codes XXX.4, XXX.5, XXX.6.
			• XXX.4, XXX.5 and XXX.6 were added since they are listed on the CAP protocol
			  ○ *Example 1:* Ki-67 stated as less than 1%. Code XXX.4
			  ○ *Example 2:* Ki-67 stated as 5%-10%. Code XXX.5

Schema ID Name	Data Item # and Description	Original Text	Updated Text
			○ *Example 3:* Ki-67 stated as greater than 4%. Code XXX.5 ○ *Example 4:* Ki-67 stated as greater than 30%. Code XXX.6
00360: Lung	3929: Separate Tumor Nodules	Code 0: No separate tumor nodules; single tumor only Separate tumor nodules of same histologic type not identified/not present Intrapulmonary metastasis not identified/not present Multiple nodules described as multiple foci of adenocarcinoma in situ or minimally invasive adenocarcinoma	Code 0: No separate tumor nodules; single tumor only Separate tumor nodules of same histologic type not identified/not present Intrapulmonary metastasis not identified/not present Multiple nodules described as multiple foci of adenocarcinoma in situ or minimally invasive adenocarcinoma Non-invasive neoplasm (behavior /2)
00360: Lung	3937: Visceral and Parietal Pleural Invasion	**Note 2:** Code 0 for in situ (behavior /2) tumors	Note deleted, rest of notes renumbered
00360: Lung	3937: Visceral and Parietal Pleural Invasion	Code 0: No evidence of visceral pleural invasion identified Tumor does not completely traverse the elastic layer of the pleura Stated as PL0	Code 0: No evidence of visceral pleural invasion identified Tumor does not completely traverse the elastic layer of the pleura Stated as PL0 Primary tumor is in situ Non-invasive neoplasm (behavior /2) No evidence of primary tumor
00360: Lung	3938: ALK Rearrangement	**Note 2:** Physician statement of ALK rearrangement for non-small cell carcinoma can be used to code this	**Note 2:** Physician statement of ALK rearrangement for non-small cell carcinoma can be used to code this data item when no other information is available.

Schema ID Name	Data Item # and Description	Original Text	Updated Text
		data item when no other information is available.	• This data item only includes rearrangements. Ignore any amplifications or point mutations
00460: Merkel Cell Skin and 00570: Penis	3830: Extranodal Extension Clin (non-Head and Neck)	**Note 5:** Code 7 when • Lymph nodes are determined to be clinically negative Behavior /2 (in situ)	Note deleted
00460: Merkel Cell Skin and 00570: Penis	3830: Extranodal Extension Clin (non-Head and Neck)	Code 7 No lymph node involvement during diagnostic workup (cN0)	Code 7 No lymph node involvement during diagnostic workup (cN0) Non-invasive neoplasm (behavior /2)
00460: Merkel Cell Skin and 00570: Penis	3833: Extranodal Extension Path (non-Head and Neck)	**Note 4**: Code the status of extranodal extension assessed on the **surgical resection** specimen for the most involved regional lymph node(s). Do not code ENE for any distant nodes. • If codes 0, 1, or 7 are used, this indicates that the lymph nodes were surgically resected and Scope of Regional Lymph Node Surgery [NAACCR Data Item: 1292] must be 3-7	**Note 4**: Code the status of extranodal extension assessed on the **surgical resection** specimen for the most involved regional lymph node(s). Do not code ENE for any distant nodes. Code the status of ENE based on the following criteria ▪ Code 0 ○ Absence of ENE, positive lymph nodes assessed by lymph node dissection ○ 1292: Scope of Regional Lymph Node Surgery must be 3-7 ▪ Code 1 ○ Presence of ENE assessed by Sentinel Lymph Node biopsy ○ Presence of ENE assessed by lymph node dissection

Schema ID Name	Data Item # and Description	Original Text	Updated Text
			○ 1292: Scope of Regional Lymph Node Surgery must be 2-7 ▪ Code 7 ○ Lymph nodes negative for cancer assessed by Sentinel lymph node biopsy or lymph node dissection ○ 1292: Scope of Regional Lymph Node Surgery must be 2-7 ▪ Code 9 ○ Absence of ENE, positive lymph nodes assessed by Sentinel Lymph Node biopsy ▪ A positive Sentinel Lymph Node biopsy cannot assess the absence of ENE, only the presence of it. This is because there is not enough surrounding tissue in a Sentinel Lymph node biopsy to accurately assess ENE ▪ If codes 1 or 7 are used, this indicates that the lymph nodes were surgically resected or a Sentinel Lymph Node biopsy was done and

Schema ID Name	Data Item # and Description	Original Text	Updated Text
			Scope of Regional Lymph Node Surgery [NAACCR Data Item: 1292] must be 2-7
00460: Merkel Cell Skin and 00570: Penis	3833: Extranodal Extension Path (non-Head and Neck)	Code 9 Not documented in medical record No surgical resection of regional lymph nodes Cannot be determined Pathological assessment of lymph nodes not done, or unknown if done Extranodal Extension Pathological not assessed or unknown if assessed	Code 9 Not documented in medical record No surgical resection of regional lymph nodes Non-invasive neoplasm (behavior /2) Cannot be determined Pathological assessment of lymph nodes not done, or unknown if done Extranodal Extension Pathological not assessed or unknown if assessed
00460: Merkel Cell Skin	3918: Profound Immune Suppression	**Note 2:** Per AJCC experts, this data item is limited to the conditions in the table below occurring within two years of the diagnosis of Merkel cell carcinoma.	**Note 2:** Per AJCC experts, this data item is limited to the conditions in the table below occurring within two years of the diagnosis of Merkel cell carcinoma. • For the following conditions, these patients will experience chronic immunosuppression. There are no time limits for these conditions. If a patient has a history (regardless of when diagnosed or treatment status), code as present ○ Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) (Code 1) ○ Solid organ transplant recipient (Code 2) ○ Chronic lymphocytic leukemia (Code 3)

Schema ID Name	Data Item # and Description	Original Text	Updated Text
00470: Melanoma Skin	3817: Breslow Tumor Thickness	Code XX.9 Not documented in medical record Microinvasion; microscopic focus or foci only and no depth given Cannot be determined by pathologist Breslow Tumor Thickness not assessed or unknown if assessed	Code XX.9 Not documented in medical record Microinvasion; microscopic focus or foci only and no depth given Cannot be determined by pathologist Non-invasive neoplasm (behavior /2) Breslow Tumor Thickness not assessed or unknown if assessed
00470: Melanoma Skin	3936: Ulceration	**Note 4:** Code 9 if there is microscopic examination and there is no mention of ulceration. • This instruction **does** apply to in situ tumors	**Note 4:** Code 9 if there is microscopic examination and there is no mention of ulceration. • This instruction **does** apply to non-invasive neoplasms (behavior 2)
00470: Melanoma Skin	3869: LDH Level	**Note 2:** Record this data item based on a blood test performed at diagnosis. In the absence of the lab test, a physician's statement of the exact value or interpretation can be used. Use the highest value available.	**Note 2:** Record the lab value of the highest serum LDH test results documented in the medical record either before or after surgical resection of the primary tumor with or without regional lymph node dissection. The LDH must be taken prior to systemic (chemo, immunotherapy, hormone), radiation therapy or surgery to a metastatic site. The lab value may be recorded in a lab report, history and physical, or clinical statement in the pathology report.
00470: Melanoma Skin	3870: LDH Upper Limits of Normal	**Note 2**: Upper limits of normal for LDH vary widely depending on the lab. Common upper limits can be 200, 250, 618, or other values.	**Note 2:** Record the value of the highest serum LDH test results documented in the medical record either before or after surgical resection of the primary tumor with or without regional lymph node dissection. The LDH must be taken prior to systemic (chemo, immunotherapy, hormone),

Schema ID Name	Data Item # and Description	Original Text	Updated Text
			radiation therapy or surgery to a metastatic site. The lab value may be recorded in a lab report, history and physical, or clinical statement in the pathology report.

00480: Breast	3826: Estrogen Receptor Percent Positive or Range
	3914: Progesterone Receptor Percent Positive or Range
		Note 5: If ER is positive but percentage is unknown, code XX7.
		
		Note 6: Ranges for the codes in this data item are defined in steps of 10 which correspond to the CAP protocol. If a range in a report is given in steps other than those provided in the codes, code to the range that contains the lowest number of the range in the report.
		• *Example 1:* Report says 1-5%. Code R10 (1-10%)
		• *Example 2:* Report says 90-95%. Code R90 (81-90%)
			Note 5: Ranges for the codes in this data item are defined in steps of 10 which correspond to the CAP protocol. If a range in a report is given in steps other than those provided in the R codes, code per the following.
			
			• If the range is less than or equal to 10, then code the appropriate R code based on the lower number
			    o *Example 1:* Report documents 1-5%. Code R10 (1-10%)
			    o *Example 2:* Report documents 25-34%. Code R30 (21-30%)
			• If the range is greater than 10, then code to unknown
			    o *Example 1:* Report documents 10-25%. Code XX9
			    o *Example 2:* Report documents 67-100%. Code XX9
			
			Note 6: If ER is positive but percentage is unknown, code XX7.

Schema ID Name	Data Item # and Description	Original Text	Updated Text
00480: Breast	3828: Estrogen Receptor Total Allred Score 3916: Progesterone Receptor Total Allred Score	**Note 1:** Physician statement of ER (Estrogen Receptor) Total Allred Score can be used to code this data item.	**Note 1:** This SSDI is no longer required by any of the standard setters starting with 2023 diagnoses • For cases diagnosed 2023+, this SSDI may be left blank
00480: Breast	3828: Estrogen Receptor Total Allred Score 3916: Progesterone Receptor Total Allred Score		Code <Blank>.: N/A-Diagnosis year is after 2022
00480: Breast	3894: Multigene Signature Method 3895: Multigene Signature Results	**Note 2:** Multigene signatures or classifiers are assays of a panel of genes from a tumor specimen, intended to provide a quantitative assessment of the likelihood of response to chemotherapy and to evaluate prognosis or the likelihood of future metastasis. • 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)	**Note 2:** Multigene signatures or classifiers are assays of a panel of genes from a tumor specimen, intended to provide a quantitative assessment of the likelihood of response to chemotherapy and to evaluate prognosis or the likelihood of future metastasis. • 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) • Only record tests that are based on gene assays. Don't include other tests which use a multivariate data model to eliminate the need for genetic assays
00480: Breast	3863: Ki-67		**New Note 5**: In cases where there are invasive and in situ components in the

Schema ID Name	Data Item # and Description	Original Text	Updated Text
			primary tumor and Ki-67 is done on both, ignore the in situ results. • If Ki-67 is done on both the in situ and invasive components in the primary tumor, code the Ki-67 value from the invasive component • If in situ and invasive components present and Ki-67 only done on the in situ component in the primary tumor, code unknown
00480: Breast	3922: Response to Neoadjuvant Therapy	Note 2: For in situ tumors (behavior /2), code 0	Note deleted, rest of notes renumbered
00480: Breast	3922: Response to Neoadjuvant Therapy	Code 0 Neoadjuvant therapy not given	Code 0 Neoadjuvant therapy not given Non-invasive neoplasm (behavior /2)
00500: Vulva; 00510: Vagina, 00520: Cervix 8th, 09520: Cervix V9, 09528 Cervix Sarcoma, 00541: Corpus Sarcoma, 00542: Corpus Adenosarcoma 00560: Placenta	3836: FIGO Stage	**Note 1:** Take the highest Federation Internationale de Gynecologie et d'Obstetrique (FIGO) stage documented in the medical record. Do not attempt to code FIGO stage based only on T, N, and M. If FIGO stage is not documented in the medical record, code 99. FIGO stage is not the same as FIGO grade. Only code FIGO stage in this field, do not code FIGO grade. **Note 2:** If a stage group is stated but it does not specify that it is a FIGO stage,	**Note 1:** There must be a statement about FIGO stage from the managing physician in order to code this data item • Do **not** code FIGO stage based on the pathology report • Do **not** code FIGO stage based only on T, N, M • If "FIGO" is not included with a stated stage, then do **not** assume it is a FIGO stage

Schema ID Name	Data Item # and Description	Original Text	Updated Text
		assume that it is a FIGO stage and code it. **Note 3:** If there is more than one FIGO stage provided from the clinical and pathological work up, code the most extensive FIGO stage. **Note 4:** The FIGO stage definitions do not include Stage 0 (Tis). Code 97 for any case that is in situ (/2).	**Note 2:** FIGO stage is not the same thing as FIGO grade. Only code FIGO stage in this field, do not code FIGO grade. • Code FIGO grade in the grade fields **Note 3:** If there is more than one FIGO stage provided from the clinical and pathological work up, code the most extensive FIGO stage. **Note 4:** The FIGO stage definitions do not include Stage 0 (Tis). • Code 97 for any non-invasive neoplasm (behavior /2)
00500: Vulva; 00510: Vagina	3871: LN Assessment Method Femoral-Inguinal	**Note 6:** If there is no mention of femoral-inguinal lymph node involvement in the workup, and the status data item: *LN Status: Femoral Inguinal* does not indicate positive femoral inguinal nodes, code 0	**Note 6:** Code 0 when there is only imaging or a physical exam.
00510: Vagina; Cervix, 8th; 09520: Cervix V9	3872: LN Assessment Method Para-Aortic	**Note 5:** If there is no mention of para-aortic lymph node involvement in the workup, and the status data item: *LN Status: Para-aortic* does not indicate positive para-aortic nodes, code 0	**Note 5:** Code 0 when there is only imaging or a physical exam.
00500: Vulva; 00510: Vagina; Cervix, 8th;	3873: LN Assessment Method Pelvic	**Note 5:** If there is no mention of pelvic lymph node involvement in the workup, and the status data item: *LN*	**Note 5:** Code 0 when there is only imaging or a physical exam.

Schema ID Name	Data Item # and Description	Original Text	Updated Text
09520: Cervix V9		*Status: Pelvic* does not indicate positive pelvic nodes, code 0	
00510: Vagina; Cervix, 8th; 09520: Cervix V9	3874: LN Distant Mediastinal, Scalene	**Note 4:** Code 9 is used when there is no relevant nodal information from diagnostic work up, biopsy or surgical resection documented	**Note 4:** Code 9 when there is no imaging, biopsy, surgical workup, or a physical exam only.
00510: Vagina; Cervix, 8th; 09520: Cervix V9	3875: LN Distant Assessment Method	**Note 3:** The assessment results are recorded in LN Distant: Mediastinal, Scalene [NAACCR Data Item #3975)	**Note 3:** Code 0 when there is only imaging or a physical exam **Note 4:** The assessment results are recorded in LN Distant: Mediastinal, Scalene [NAACCR Data Item #3975)
00500: Vulva; 00510: Vagina; Cervix, 8th; 09520: Cervix V9	3957: LN Status: Pelvic	Code 0 Negative pelvic lymph nodes	Code 0 Negative pelvic lymph nodes Non-invasive neoplasm (behavior /2)
00500: Vulva; 00510: Vagina; Cervix, 8th; 09520: Cervix V9	3957: LN Status: Pelvic	Note 5: If there is no imaging, biopsy or surgical work up, code 9	**Note 5:** Code 9 when there is no imaging, biopsy, surgical workup, or a physical exam only.
00510: Vagina; Cervix, 8th; 09520: Cervix V9	3958: LN Status: Para-aortic	Code 0 Negative pelvic lymph nodes	Code 0 Negative pelvic lymph nodes Non-invasive neoplasm (behavior /2)
00510: Vagina; Cervix, 8th; 09520: Cervix V9	3958: LN Status: Para-aortic	Note 5: If there is no imaging, biopsy or surgical work up, code 9	**Note 5:** Code 9 when there is no imaging, biopsy, surgical workup, or a physical exam only.
00500: Vulva; 00510: Vagina	3959: LN Status: Femoral-Inguinal	Note 5: If there is no imaging, biopsy or surgical work up, code 9	**Note 6:** Code 9 when there is no imaging, biopsy, surgical workup, or a physical exam only.

Schema ID Name	Data Item # and Description	Original Text	Updated Text
00500: Vulva; 00510: Vagina	3959: LN Status: Femoral-Inguinal	Code 0 Negative femoral-inguinal lymph nodes	Code 0 Negative femoral-inguinal lymph nodes Non-invasive neoplasm (behavior /2)
00500: Vulva	3881: Lymph Nodes Laterality	Code 0 No regional lymph node involvement	Code 0 No regional lymph node involvement Non-invasive neoplasm (behavior /2)
00510: Vagina; 00520: Cervix, 8th; 09520: Cervix V9	3875: LN Distant: Mediastinal, Scalene	Code 0 Negative mediastinal and scalene lymph nodes	Code 0 Negative mediastinal and scalene lymph nodes Non-invasive neoplasm (behavior /2)
00530: Corpus Carcinoma and Carcinosarcoma	3836: FIGO Stage	**Note 1:** Take the highest Federation Internationale de Gynecologie et d'Obstetrique (FIGO) stage documented in the medical record. Do not attempt to code FIGO stage based only on T, N, and M. If FIGO stage is not documented in the medical record, code 99. FIGO stage is not the same as FIGO grade. Only code FIGO stage in this field, do not code FIGO grade. **Note 2:** If a stage group is stated but it does not specify that it is a FIGO stage, assume that it is a FIGO stage and code it. **Note 3:** If there is more than one FIGO stage provided from the clinical and pathological work up, code the most extensive FIGO stage.	**Note 1:** There must be a statement about FIGO stage from the managing physician in order to code this data item • Do **not** code FIGO stage based on the pathology report • Do **not** code FIGO stage based only on T, N, M • If "FIGO" is not included with a stated stage, then do **not** assume it is a FIGO stage **Note 2:** FIGO stage is not the same thing as FIGO grade. Only code FIGO stage in this field, do not code FIGO grade. • Code FIGO grade in the grade fields **Note 3:** If there is more than one FIGO stage provided from the clinical and pathological

Schema ID Name	Data Item # and Description	Original Text	Updated Text
		Note 4: The FIGO stage definitions do not include Stage 0 (Tis). Code 97 for any case that is in situ (/2). **Note 5:** For Endometrial intraepithelial carcinoma (EIC) (8380/2) and Serous endometrial intraepithelial carcinoma (SEIC) (8441/2), assign the FIGO stage based on the physician's documentation of FIGO I. • Do not code 97 (in situ) for Endometrial intraepithelial carcinoma (EIC) and Serous endometrial intraepithelial carcinoma (SEIC) since FIGO does not have a Stage 0 • If diagnosis is Endometrial intraepithelial neoplasia (EIN) (8380/2), code 97	work up, code the most extensive FIGO stage. **Note 4:** For Endometrial intraepithelial carcinoma (EIC) (8380/2) and Serous endometrial intraepithelial carcinoma (SEIC) (8441/2), assign the FIGO staged based on the managing physician's documentation of FIGO. (See Note 1) • If FIGO stage for EIC or SEIC is not documented by the managing physician, code unknown (code 99) • Do not code 97 (in situ) for EIC or SEIC since FIGO does not have a Stage 0 • If diagnosis is Endometrial intraepithelial neoplasia (EIN) (8380/2), code 97. **Note 5:** Code 97 for any remaining in situ histologies (/2) since the FIGO stage definitions do not include Stage 0.
00530, 00541, 00542: Corpus Schemas, 00528 Cervix Sarcoma	3899: Number of Examined Para-aortic Nodes	**Note 4:** Code 00 when no lymph nodes are examined by FNA, core biopsy or removal of lymph node(s) (e.g., sentinel lymph node biopsy or lymph node dissection)	**Note 4:** Code 00 when no lymph nodes are examined by FNA, core biopsy or removal of lymph node(s) (e.g., sentinel lymph node biopsy or lymph node dissection) • If a lymph node dissection is done and only pelvic lymph nodes are assessed, or only "nodes" are

Schema ID Name	Data Item # and Description	Original Text	Updated Text
			documented without specifying pelvic or para-aortic, code to 00
00530, 00541, 00542: Corpus Schemas, 00528 Cervix Sarcoma	3900: Number of Examined Pelvic Nodes	**Note 4:** Code 00 when no lymph nodes are examined by FNA, core biopsy or removal of lymph node(s) (e.g., sentinel lymph node biopsy or lymph node dissection)	**Note 4:** Code 00 when no lymph nodes are examined by FNA, core biopsy or removal of lymph node(s) (e.g., sentinel lymph node biopsy or lymph node dissection) • If a lymph node dissection is done and only "nodes" are documented without specifying pelvic or para-aortic, assume they are pelvic
00551, 00552, 00553: Ovary, Primary Peritoneal Carcinoma, Fallopian Tube	3836: FIGO Stage	**Note 1:** Take the highest Federation Internationale de Gynecologie et d'Obstetrique (FIGO) stage documented in the medical record. Do not attempt to code FIGO stage based only on T, N, and M. If FIGO stage is not documented in the medical record, code 99. FIGO stage is not the same as FIGO grade. Only code FIGO stage in this field, do not code FIGO grade. **Note 2:** If a stage group is stated but it does not specify that it is a FIGO stage, assume that it is a FIGO stage and code it. **Note 3:** If there is more than one FIGO stage provided from the clinical and pathological work up, code the most extensive FIGO stage.	**Note 1:** There must be a statement about FIGO stage from the managing physician in order to code this data item • Do **not** code FIGO stage based on the pathology report • Do **not** code FIGO stage based only on T, N, M • If "FIGO" is not included with a stated stage, then do **not** assume it is a FIGO stage **Note 2:** FIGO stage is not the same thing as FIGO grade. Only code FIGO stage in this field, do not code FIGO grade. • Code FIGO grade in the grade fields **Note 3:** If there is more than one FIGO stage provided from the clinical and pathological

Schema ID Name	Data Item # and Description	Original Text	Updated Text
		Note 4: The FIGO stage definitions do not include Stage 0 (Tis). Code 97 for any case that is in situ (/2). **Note 5**: For High-grade (HGSC) serous tubal intraepithelial carcinoma (STIC) (8441/2), assign the FIGO stage based on the physician's documentation of FIGO I. • Do not code 97 (in situ) for high-grade serous tubal intraepithelial carcinoma since FIGO does not have a Stage 0 • If diagnosis is low grade serous intraepithelial carcinoma (LGSC) (8441/2) or serous tubal intraepithelial carcinoma (no grade stated) (8441/2), code 97	work up, code the most extensive FIGO stage. **Note 4:** For High-grade serous carcinoma (HGSC) serous tubal intraepithelial carcinoma (STIC) (8441/2), assign the FIGO stage based on the managing physician's documentation of FIGO. (See Note 1) • If FIGO stage for HGSC or STIC is not documented by the managing physician, code unknown (code 99) • Do not code 97 (in situ) for HGSC or STIC since FIGO does not have a Stage 0 • If diagnosis is low grade serous intraepithelial carcinoma (LGSC) (8441/2) or serous intraepithelial carcinoma (no grade stated) (8441/2), code 97 **Note 5:** Code 97 for any remaining in situ histologies (/2) since the FIGO stage definitions do not include Stage 0
00551, 00552, 00553: Ovary, Primary Peritoneal Carcinoma, Fallopian Tube	3921: Residual Tumor Volume Post Cytoreduction	Code 97 No cytoreductive surgery performed	Code 97 No cytoreductive surgery performed Non-invasive neoplasm (behavior /2)
00580: Prostate	3897: Number of Cores Examined	**Note 2:** Record the number of prostate core biopsies examined from the first	**Note 2:** Record the number of prostate core biopsies examined from the first prostate

Schema ID Name	Data Item # and Description	Original Text	Updated Text
		prostate core biopsy diagnostic for cancer. If the number of cores examined is not specifically documented, code X6.	core biopsy diagnostic for cancer. If the number of cores examined is not specifically documented, code X6. • Information from the first core biopsy is preferred since the physician is usually examining the entire prostate. If a second core biopsy is done, this is usually done on a specified area, so more cores will be found to be positive
00580: Prostate	3898: Number of Cores Positive	**Note 2:** Record the number of positive prostate core biopsies from the first prostate core biopsy diagnostic for cancer. If positive cores are identified and the number of positive cores not specifically documented, code X6.	**Note 2:** Record the number of positive prostate core biopsies from the first prostate core biopsy diagnostic for cancer. If positive cores are identified and the number of positive cores not specifically documented, code X6. • Information from the first core biopsy is preferred since the physician is usually examining the entire prostate. If a second core biopsy is done, this is usually done on a specified area, so more cores will be found to be positive
Soft Tissue Other	3927: Schema Discriminator 2	**Note 5:** Code 9 is used for when there is not enough specific information to determine if the structure is external or internal and is assigned to AJCC 8 edition Chapter 45: Soft Tissue Sarcoma of Unusual Sites and Histologies (Schema ID 00450: Soft Tissue Other).	**Note 5:** Code 9 is used for when there is not enough specific information to determine if the structure is external or internal. These cases are collected in Schema ID 00459: Soft Tissue Other. *Example*: Chest NOS (C493) does not provide enough information in order to determine if it is either an external

Schema ID Name	Data Item # and Description	Original Text	Updated Text
		Example: Chest NOS (C493) does not provide enough information in order to determine if it is either an external structure, on the outer layer or periphery of the body, or an internal structure, in the inner parts of the body	structure, on the outer layer or periphery of the body, or an internal structure, in the inner parts of the body

Changes to Grade Manual, Version 3.0

Note: The following changes were also done throughout the entire manual as needed, but these changes will have no impact on abstracting

- References to AJCC chapters were changed to refer to AJCC Staging Systems
- References to specific chapters were removed in the Grade ID table
- Text of references to other data items restructured

Table 5: Changes to Grade Manual

Grade Table #	Schemas	Original Text	Updated Text
NA	All		General Grade Coding Instructions for Solid Tumors: New Note 4 4. Priority order for grade a. Synoptic report (including CAP protocol) b. Pathology report: Final diagnosis c. Physician statement Remaining notes renumbered
Grade Pathological	All	**Note 6:** Code 9 (unknown) when • Grade from primary site is not documented • No resection of the primary site (see exception in Note 5, Surgical resection, last bullet)	**Note 6:** Code 9 (unknown) when • Grade from primary site is not documented • Surgical resection is done and grade from the primary site is not documented and there is no clinical grade • Surgical resection is done and there is no residual cancer and there is no clinical grade documented • No resection of the primary site (see exception in Note 5, Surgical resection, last bullet) *Note: Note numbers changed will be different depending on schema*

Grade Table #	Schemas	Original Text	Updated Text
Grade Post Therapy Path (yp)	All	**Note 6:** Code 9 (unknown) 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	**Note 6:** Code 9 (unknown) when • Surgical resection is done after neoadjuvant therapy and grade from the primary site is not documented and there is no grade from the post therapy clinical work up • Surgical resection is done after neoadjuvant therapy and there is no residual cancer and there is no grade from the post therapy clinical work up • Grade checked "not applicable" on CAP Protocol (if available) and no other grade information is available *Note: Note numbers changed will be different depending on schema*
9, 10	Heart, Mediastinum, and Pleura; Kaposi Sarcoma; Orbital Sarcoma; Retroperitoneum; Soft Tissue Abdomen and Thoracic; Soft Tissue Head and Neck; Soft Tissue Trunk and Extremities; Soft Tissue Other; Soft Tissue Rare		For all Grade Tables: New Note Added: • Code 1 if stated as "low grade" only New code Added: • H: Stated as "high grade" only
12	Breast: Grade Post Therapy Clinical		New Note 7 (added to other three grade tables, but was missed for this one)

Grade Table #	Schemas	Original Text	Updated Text
	Brain V9, CNS Other V9, Intracranial Gland V9,	Code 2: WHO Grade II: Infiltrative tumors with low proliferative potential with increased risk of recurrence Code 3: WHO Grade III: Tumors with histologic evidence of malignancy, including nuclear atypia and mitotic activity, associated with an aggressive clinical course Code 4: WHO Grade IV: Tumors that are cytologically malignant, mitotically active, and associated with rapid clinical progression and potential for dissemination	**Code 2:** WHO Grade II: Infiltrative tumors with low proliferative potential with increased risk of progression or recurrence **Code 3:** WHO Grade III: Tumors with histologic and/or molecular genetic evidence of malignancy that are associated with an aggressive clinical course **Code 4:** WHO Grade IV: Tumors with histologic and/or molecular genetic evidence of malignancy that are associated with the most aggressive clinical course and shorter overall survival