This document shows the changes that were made to the SSDI manual and the Grade manual for the SEER*RSA version 3.3 release in October 2025

- Table 1: New SSDIs, Version 3.3
- Table 2: Changes to Schemas, Version 3.3
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Table 1: New SSDIs, Version 3.3

The SSDI manual is now automatically generated from the SEER*API.

- This means that a WORD version of the SSDI manual will no longer be maintained
- This also means that there will be no discrepancies between the online version of the SSDIs and the PDF version of the SSDI manual

Data Item # and Description	Schema(s)	Comments
3890: Microsatellite Instability	00530: Corpus Carcinoma and Carcinosarcoma	MSI has been added to the Corpus Carcinoma and Carcinosarcoma schema for cases diagnosed 2026+.
1176: Spread Through Air Spaces (STAS)	09360: Lung	New SSDI for Version 9, 2026+
1178: Residual Cancer Burden	00480: Breast	New SSDI, effective for 2026+
1179: Residual Cancer Burden Class	00480: Breast	New SSDI, effective for 2026+

Table 2: Changes to Schemas, Version 3.3

Schema	Applicable Years	Comments
Major Salivary Glands Version 9	2026+	AJCC's Major Salivary Glands, Version 9, will be used with 2026+ diagnosis There are now two Major Salivary Gland schemas • Major Salivary Glands 8th: 2018-2025 (Schema ID: 00080) • Major Salivary Glands Version 9: 2026+ (Schema ID: 09081)
Oropharynx HPV-Associated	2026+	AJCC's Oropharynx HPV-Associated, Version 9 will be used with 2026+ diagnosis (previously Oropharynx HPV Mediated (p16+). Name change effective for 2018+) There are now two Oropharynx HPV-Associated schemas • Oropharynx HPV-Associated; 8th 2018-2025 (Schema ID: 00100) • Oropharynx HPV-Associated Version 9: 2026+ (Schema ID: 09100)
Oropharynx HPV-Independent		Name change, previously Oropharynx (p16-), effective for 2018+

Table 3: Changes to current SSDIs, Version 3.3

Schema ID/Name	Data Item # and Description	Original Text	Updated Text
NA	General Instructions Section: Rules for Recording Laboratory Values	Follow the below guidelines for recording laboratory value • All laboratory values must be done no earlier than approximately three months before diagnosis	Follow the below guidelines for recording laboratory value • All laboratory values must be done no earlier than approximately three months before diagnosis ○ ***Notes: Rules for recording PSA have changed in Version 3.3 of the SSDI manual. This rule no longer applies to PSA. Please review the specific rules in the PSA SSDI (Prostate Schema)***
Head and Neck Schemas	3831: Extranodal Extension Head and Neck Clinical 3832: Extranodal Extension Head and Neck Pathological	**Additional Info** **Source documents:** pathology report, imaging reports, physical exam report. **Other names include** ENE, extracapsular extension, ECE, extracapsular extension, ECE, extranodal spread, extracapsular extension, or extracapsular spread • *Note*: ENE is the preferred terminology	**Additional information** **Source documents:** imaging reports, physical exam **Other names include** Extracapsular extension (ECE), extranodal spread (ENS), or extracapsular spread (ECS) *Note*: ENE is the preferred terminology, and includes • **cENE** for clinical ENE • **iENE** for imaging-detected ENE • **pENE** for pathological ENE

Schema ID/Name	Data Item # and Description	Original Text	Updated Text
Head and Neck Schemas	3831: Extranodal Extension Head and Neck Clinical	**Note 2: Clinical assessment criteria** • The assessment for ENE in addition to physical examination may include imaging, biopsy of the regional lymph node, and/or biopsy of tissues surrounding the regional lymph node • Fixed or matted nodes are clinical indications of ENE • Imaging alone is not enough to determine or exclude ENE	**Note 2: Clinical Assessment Criteria** • The assessment for ENE may **include imaging and/or physical examination**. • Biopsy of the regional lymph node or surrounding tissue can be used to confirm the presence of metastatic carcinoma and thus verify the clinical assessment, but cannot be used in isolation to determine ENE during clinical staging • Fixed nodes and/or frank skin involvement are indications of cENE • Matted nodes are indications of iENE • iENE is identified exclusively on imaging • ENE during clinical staging is considered present when cENE and/or iENE are present
Head and Neck Schemas	3831: Extranodal Extension Head and Neck Clinical	**Coding Guidelines** 1) Code 0 when lymph nodes are determined to be clinically positive and physical examination does not indicate any signs of extranodal extension. 2) Code 1 when ENE is unquestionable as determined by physical examination 3) Code 2 when there are positive nodes clinically, ENE is identified by biopsy (microscopically confirmed) 4) Code 4 when there are positive nodes clinically, ENE is identified, but not known how identified	**Coding Guidelines** 1) **Code 0** when lymph nodes are determined to be **clinically positive** and there is **no clinical evidence of ENE** based on physical examination. 2) **Code 1** when there is **definitive (unquestionable) evidence of ENE** as determined by physical examination and/or imaging 3) **Code 2** when there is **definitive (unquestionable) evidence of ENE** as determined by physical examination and/or imaging **and** nodal involvement is microscopically confirmed by biopsy 4) **Code 4** when there is **definitive (unquestionable) evidence of ENE**, but the means of identification is not known

Schema ID/Name	Data Item # and Description	Original Text	Updated Text
Head and Neck Schemas	3831: Extranodal Extension Head and Neck Clinical	**Code 1** Regional lymph node(s) involved, ENE present/identified during diagnostic workup, based on physical exam WITH or WITHOUT imaging	**Code 1** Regional lymph nodes involved, ENE present/identified during diagnostic workup, based on physical examination and/or imaging
Head and Neck Schemas	3832: Extranodal Extension Head and Neck Pathological	**Note 2: Pathological assessment criteria** • Code the status of ENE assessed on histopathologic 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	**Note 2: Pathological assessment criteria** • Code the status of ENE assessed on histopathologic examination of **surgically resected** involved regional lymph node(s) • Includes presence of ENE in a sentinel lymph node • Do not code ENE from a lymph node biopsy (FNA, core, incisional, or the absence of ENE from a sentinel) **Note 3: Regional vs. distant nodes** • Do not code ENE for any distant lymph nodes **Note 4: Minor and Major ENE** • Minor ENE is defined as ≤ 2 mm • Major ENE is defined as > 2 mm • Matted lymph nodes and soft tissue metastases are considered major ENE

Schema ID/Name	Data Item # and Description	Original Text	Updated Text
Head and Neck Schemas	3832: Extranodal Extension Head and Neck Pathological	**Coding Guidelines** **9) Code X.9** Absence of ENE, positive lymph nodes assessed by Sentinel Lymph Nodes Biopsy • i. 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	**Coding Guidelines** **9) Code X.9** when 1) Absence of ENE, positive lymph nodes assessed by Sentinel Lymph Nodes Biopsy **Remaining note removed, moved to Note 2**
Head and Neck Schemas	3883: LN Size	**New note 2**	**Note 2: Criteria for coding LN size** • The metric is the **size of the largest tumor deposit** in the lymph node, not the size of the overall lymph node that is involved. • For larger nodes however, the size of the deposit becomes essentially the size of the overall lymph node as the nodes become almost entirely overtaken with tumor. • Code the size of the largest deposit if pathology reports separately list the size of a deposit and the size of the overall lymph node that the deposit is involving

Schema ID/Name	Data Item # and Description	Original Text	Updated Text
Head and Neck Schemas	3883: LN Size	**Note 2: Clinical vs Pathological size** • If the largest involved node is not examined pathologically, use the clinical node size. • If the same largest involved node (or same level) is examined both clinically and pathologically, record the size of the node from the pathology report, even if it is smaller.	**Note 3: Clinical vs Pathological size** • Code the **clinical node size** when the largest involved node is not examined pathologically. • Code the **pathological node size** when the largest involved node (or same level) is examined clinically and pathologically, even if the pathological size is smaller. • Code the **size of the largest deposit** when the pathology report separately lists the size of a deposit and the size of the overall lymph node that the deposit is involving.
Head and Neck Schemas	3883: LN Size	**Coding Guidelines** 1) Code the largest diameter of any involved regional lymph nodes for head and neck (cervical lymph nodes). The measurement can be pathological, if available, or clinical.	**Coding Guidelines** 1) Code the largest size in millimeters of any involved regional lymph nodes for head and neck (cervical lymph nodes). The measurement can be pathological, if available, or clinical. See note 3. • Record size in millimeters
00100, 09100, Oropharynx HPV-associated; 00111 Oropharynx HPV-Independent	NA		**Name changes** **Oropharynx HPV-mediated now Oropharynx HPV-associated** **Oropharynx (p16-) now Oropharynx HPV-Associated** **Changes applied back to 2018**

Schema ID/Name	Data Item # and Description	Original Text	Updated Text
00100, 09100, Oropharynx HPV-associated; 00111 Oropharynx HPV-Independent	3927: Schema Discriminator 2: Oropharyngeal p16/HPV status	**Description** Staging for oropharyngeal cancers changed in the AJCC 8th edition. Chapter 10 is now for p16+ tumors, while Chapter 11 is for p16- negative tumors or where the p16 is not assessed or unknown. A schema discriminator is necessary to determine the p16 status so that the appropriate chapter/schema is used.	**Description** Staging for oropharyngeal cancers changed in the AJCC 8th edition. Oropharynx was divided into **Oropharynx (HPV-Associated)** (p16+) and **Oropharynx (HPV-Independent)** (p16-) A schema discriminator is necessary to determine the HPV status so that the appropriate protocol/schema is used. There are several methods for determination of HPV status. The most frequent, and preferred test is IHC for p16 expression, which is a surrogate marker for transcriptionally active high-risk HPV. • Other tests that may be used for this data item **in addition to p16 or when p16 is not available** include (but are not limited to): ○ High-risk HPV RNA ISH ○ High-risk HPV DNA ISH • Other tests that may be used for this data item **in addition to p16 include** (but are not limited to): ○ High-risk HPV DNA PCR **High-risk** HPV types include: 16, 18, 26, 31, 33, 34, 35, 39, 45, 51, 52, 53, 56, 58, 59, 66, 68, 70, 73, and 82 **Low-risk (cannot be used to determine HPV status)** HPV types include: 6, 11, 42, 43, and 44

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

00100, 09100, Oropharynx HPV-associated; 00111 Oropharynx HPV-Independent	3927: Schema Discriminator 2: Oropharyngeal p16/HPV status	**Note 2: p16 testing**
		• Only the HPV p16+ test can be used. If another HPV test is done, code 9.
		• 00100: Oropharynx HPV-Mediated (p16+) (see code 2)
		  ○ Used for p16 (+) (positive)
		• 00111: Oropharynx (p16-)
		  ○ p16 expression of weak intensity or limited distribution (see code 1)
		  ○ p16 without an immunostaining performed (see code 9)
			Note 2: p16 testing
			• p16 testing will guide classification of most patients but some will have HPV-specific testing that should be used in conjunction for classification when the pathologist performs it.
			• **00100: Oropharynx (HPV-Associated) (p16+) (see code 2)**
			  ○ p16 positive and it is the only test performed
			  ○ p16 positive when subsequent high-risk HPV-specific testing is performed and is positive
			  ○ p16 equivocal (50-70% staining) when subsequent high-risk HPV-specific testing is performed and is positive
			  ○ p16 not performed but when high-risk HPV-specific testing is positive (High-risk HPV RNA ISH or high-risk HPV DNA ISH when performed alone).
			  ○ High-risk HPV DNA PCR testing if used alone is not reliable to assign HPV status.
			  ○ Stated as **"HPV-associated"** or **"High-risk HPV"**
			• **00111: Oropharynx HPV-Independent (p16-) (see code 1)**
			  ○ p16 negative and it is the only test performed
			  ○ p16 expression of limited (<50%) distribution only
			  ○ p16 positive but when subsequent reliable high-risk HPV-specific testing is performed and is negative (reliable high-risk HPV-specific tests include high-risk HPV RNA ISH and high-risk HPV DNA PCR)
			  ○ **Stated as Oropharynx-Independent**
			• **HPV testing not done or unknown if done (see code 9)**
			  ○ Cases coded as unknown will be included with the Oropharynx HPV-Independent (p16-)schema
			  ○ Stated as **HPV positive** and no indication if it's p16, low risk or high risk
			  ○ Stated as **low risk HPV**

Schema ID/Name	Data Item # and Description	Original Text	Updated Text
00100, 09100, Oropharynx HPV-associated; 00111 Oropharynx HPV-Independent, 00090, Nasopharynx (8th)	3926: Schema Discriminator 1 (Nasopharynx/PharyngealTonsil)		**This Schema Discriminator will no longer be applicable starting with cases diagnosed 1/1/25.** **The Schema Discriminator will not appear in schemas 09090: Nasopharynx, Version 9, or in 09100, Oropharynx-HPV Associated, Version 9** **The Schema Discriminator is still applicable for cases diagnosed 2018-2024**
09360: Lung,v9	PD-L1	**Note 4: Tumor Proportion Score** • PD-L1 is documented by the tumor proportion score. Record the actual Tumor Proportion Score (0.0-100.0) as stated from the pathology report. • An actual tumor proportion score (.1-100.0) takes priority over XXX.2 (Stated as negative), XXX.3 (Stated as low), or XXX.4 (Stated as high/positive)	**Note 4: Tumor Proportion Score** • PD-L1 is documented by the tumor proportion score. Record the actual Tumor Proportion Score (0.0-100.0) as stated from the pathology report. • An actual tumor proportion score (0.1-100.0) takes priority over XXX.2 (Stated as negative), XXX.3 (Stated as low), or XXX.4 (Stated as high/positive) **Note 5: Combined Proportion Score (CPS)** • Do not record the CPS score (0.0-100.0) in this data item. ○ If you have a CPS score WITH an interpretation, record the interpretation. ▪ *Example:* Squamous cell carcinoma: NEGATIVE for PD-L1 Expression, CPS score <1. Record as XXX.2 for negative ○ If you have a CPS score WITHOUT an interpretation, record unknown (XXX.9). ▪ *Example:* Squamous cell carcinoma: PD-L1, CPS score <1. Record as XXX.9 for unknown (interpretation not provided) **Previous Note 5, now note 6**

Schema ID/Name	Data Item # and Description	Original Text	Updated Text
00430: GIST	3865: KIT Gene Immunohistochemistry (IHC)	**Note 2: Results from nodal or metastatic tissue** • May be used for KIT Gene immunohistochemistry	**Note 2: Types of results** • Record results from Immunohistochemistry only. If there are results from DNA sequencing, or some other type of result, code 9 **Note 3: Results from nodal or metastatic tissue** • May be used for KIT Gene immunohistochemistry
00470: Melanoma Skin	3961: Clinical Width Margin	**Note 1: Effective years** • This SSDI is effective for diagnosis years 2021+	**Note 1: Effective years** • This SSDI is effective for diagnosis years 2021+ AND **primary sites C440-C449 only**. For all other primary sites, code XX.9 • See case_identification_guidelines_standard_5_5.pdf (facs.org)
00480: Breast	3255: HER2 Overall Summary	**Note 7: HER2 Positive and Oncotype** • **If the patient is HER2 positive and node negative, a multigene test such as Oncotype Dx may be performed, in which case another HER2 test will be performed. Do not record the results of that test in this field.** • **Record only the results of the test which made the patient eligible to be given the multigene test"**	**Note 7: HER2 Positive and Oncotype** • **In some cases, the Oncotype DX report may include a quantitative HER2 result. However, this value from the Oncotype Dx report should not be recorded in the registry.** • **The HER2 result recorded should be from the combination of IHC and ISH as described for this element.**

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

0058: Prostate	3920: PSA (Prostatic Specific Antigen) Lab Value		**NEW NOTE (Previous note 3 moved to note 4)**
			Note 3: PSA criteria
			• Diagnostic biopsy done
			  ○ Record the last PSA lab value done prior to AND within 3 months of the diagnostic biopsy
			• No diagnostic biopsy done (or unknown if diagnostic biopsy done)
			  ○ Record the last PSA lab value done within 3 months of the date of diagnosis or additional confirmatory testing when no diagnostic biopsy is done, or unknown if diagnostic biopsy done
			• *Note: This is a change in the rules for Version 3.3 of the SSDI manual from the PSA had to be within 3 months and prior to the date of diagnosis AND within 3 months of the diagnostic biopsy*
			  ○ *This change can be applied for cases diagnosed 2018+. There is no recommendation or expectation that registrars will review older cases.*
			• ***Example 1:*** 5/17/25 PSA, 8.5. Date of diagnosis 6/6/25 based on MRI. Patient seeks a second opinion. Returns to physician in November 2025. 11/19/25 PSA, 8.6. 11/21/25 needle core biopsy.
			  ○ Code PSA 8.6 based on the 11/19/25 PSA which was done prior to and within 3 months of the diagnostic biopsy
			• ***Example 2:*** 6/4/25 PSA, 12.7. Additional PSA done 7/5/25, 10.6. Date of Diagnosis on 8/4/25 when the diagnostic biopsy was done.
			  ○ Code PSA 10.6 based on the 7/5/25 PSA since that was the last PSA done prior to and within 3 months of the diagnostic biopsy
			• ***Example 3:*** 4/15/25 PSA, 6.4. 5/2/25 MRI done, which confirms prostate cancer. No diagnostic biopsy done.
			○ Code PSA 6.4 based on the 4/15/25 PSA which was done within 3 months of the date of diagnosis and no diagnostic biopsy was done.

Schema ID/Name	Data Item # and Description	Original Text	Updated Text
00580: Prostate	3920: PSA	**Coding Guidelines** **1)** Record to the nearest tenth in nanograms/milliliter (ng/ml) the last pre-diagnosis PSA lab value prior to diagnostic biopsy of prostate and treatment. 1) **a.** Note: Per the general rules for entering laboratory values, all laboratory values must be done within three months before diagnosis. 2) **b.** The last pre-diagnosis PSA lab value must be done within 3 months prior to the diagnostic biopsy	**Coding Guidelines** 1) Record to the nearest tenth in nanograms/milliliter (ng/ml) the last pre-diagnosis PSA lab value prior to diagnostic biopsy of prostate and treatment ***Note: Sub bullets no longer applicable, new instructions added to new note 3***

Schema ID/Name	Data Item # and Description	Original Text	Updated Text
00580: Prostate	3898: Number of Cores Positive 3897: Number of Cores Examined		**NEW NOTE 4** **Note 4:** If there is a targeted biopsy or a region of interest (ROI) biopsy done, count as 1 core positive/1 core examined, regardless of how many cores are actually taken from the targeted/ROI location. When doing a targeted or ROI biopsy, the region being biopsied is suspected of cancer (usually based on an MRI). Since the area is targeted, there will be many more cores removed. To record all these cores would be inflating the numbers. • ***Example:*** Standard core biopsy done, 2/16 cores positive, targeted biopsy done, 6/8 cores positive. ○ The total cores positive would be 2 + 1 (from the targeted biopsy), and total cores examined would be 16 + 1 (from the targeted biopsy). • If there are multiple targeted or region of interest's biopsies done, count each one as 1/1 cores positive/examined. • *Example:* Standard core biopsy done, 3/8 cores positive. Two targeted biopsies done, one 5/11 cores positive and the other 7/10 cores positive. ○ The total cores positive would be 3 + 2 (for the two targeted biopsies) and total cores examined would be 8 + 2 (for the two targeted biopsies)
00821: Plasma Cell Myeloma	3857: High-Risk Cytogenetics		**New Note 2** **Note 2: Component of R-ISS Stage** • High-risk cytogenetics is part of the Revised International Staging (R-ISS). • **Code 0** if physician states **RISS Stage 1 or 2** and there is no other information

Schema ID/Name	Data Item # and Description	Original Text	Updated Text
00821: Plasma Cell Myeloma	3869: LDH Level	**Note 3: Component of RISS Stage** • LDH level is part of the Revised International Staging (RISS). Use the cut points listed in the table below regardless of the lab's reference range	**Note 3: Component of R-ISS Stage** • LDH level is part of the Revised International Staging (R-ISS). Use the lab's reference range to determine if LDH is normal or elevated • **Code 0** if physician states **RISS Stage 1 or 2** and there is no other information
00821: Plasma Cell Myeloma	3930: Serum Albumin Pretreatment Level	**Additional Information** **Source documents:** laboratory tests (blood only)	**Source documents:** laboratory tests (blood only) • Albumin Blood Test • Preoperative Blood Work • Total Protein and Albumin/Globulin (A/G) Ratio Test • Comprehensive metabolic profile (CMP) • Liver Function Test (LFT)/Hepatic Panel • Nutritional assessment Panels • Renal Function Panel
00821: Plasma Cell Myeloma	3930: Serum Albumin Pretreatment Level		**Added at the end of Note 3** • **Code 1** if physician states **RISS Stage 1** and there is no other information
00821: Plasma Cell Myeloma	3930: Serum Albumin Pretreatment Level	**Note 2:** Record this data item based on a **blood test** performed at diagnosis (pre-treatment). Use the highest value available. ○ Do not use results from a urine test	**Note 2: Pretreatment results only** • Record this data item based on a **blood test** performed at diagnosis (pre-treatment). Use the highest value available. ○ The actual test may not state serum; however, as long as the test results are **based on blood**, they can be used. ○ Albumin results from a **urine test cannot be used** to code this data item.

Schema ID/Name	Data Item # and Description	Original Text	Updated Text
00821: Plasma Cell Myeloma	3931: Serum Beta-2 Microglobulin Pretreatment Level	**Note 3** bullet • LDH level is part of the Revised International Staging (RISS). Use the cut points listed in the table below regardless of the lab's reference range. **(Copy/paste error)**	**Note 3: Component of R-ISS Stage** • Serum Beta-2 Microglobulin is part of the Revised International Staging (R-ISS). • Elevated serum microglobulin is defined as ≥ 5.5 mg/L • Use the cut points listed in the table below regardless of the lab's reference range. ○ **Code 0** if physician states **RISS Stage 1** and there is no other information ○ **Code 2** if physician states **RISS Stage 3** and there is no other information
00830: Heme Retic	3862: JAK2	**Source documents:** clinical laboratory test (whole blood), reference laboratory test; anatomic pathology (polymerase chain reaction test on bone marrow)	**Source documents:** clinical laboratory test (whole blood) *Note: Confirmation that the JAK2 does come from a whole blood test; however, the anatomical pathology will diagnose the specific MPN (histology code)*

Table 4: Changes to Grade Manual, Version 3.3

Grade Table #	Schema(s)	Original Text	Updated Text
07 Grade Clin Grade Path Grade yc Grade yp	NET Schemas	**Note 4 or 5:** Codes 1-3 take priority over codes A-D.	**Note 4 or 5:** Codes 1-3 take priority over codes A-D. • Grades A-D should only be used in the absence of a physician's statement of grade (G1, G2, G3) or no results for Ki-67 or Mitotic Count (See also Note 6) **Note 5 or 6**: Do not code grade based on the following terminology: • Neuroendocrine carcinoma, low grade (8240/3) • Neuroendocrine carcinoma, well differentiated (8240/3) • Neuroendocrine carcinoma, moderately differentiated (8249/3) • Poorly differentiated neuroendocrine carcinoma (8246/3) **Note 6 or 7:** Code grade based on the physician's documentation (G1, G2, G3) OR **in the absence of a physician's statement**, code grade based on the Ki-67 and Mitotic Count. • If a Ki-67 is documented as less than 3, many times the mitotic count is not done. In this situation, the Ki-67 alone is enough to code the grade (G1). • Grades 2 and 3, are either/or for Ki-67 and Mitotic Count. You do not need both the Ki-67 and mitotic Count to assign grade 2 or 3. Remaining notes renumbered