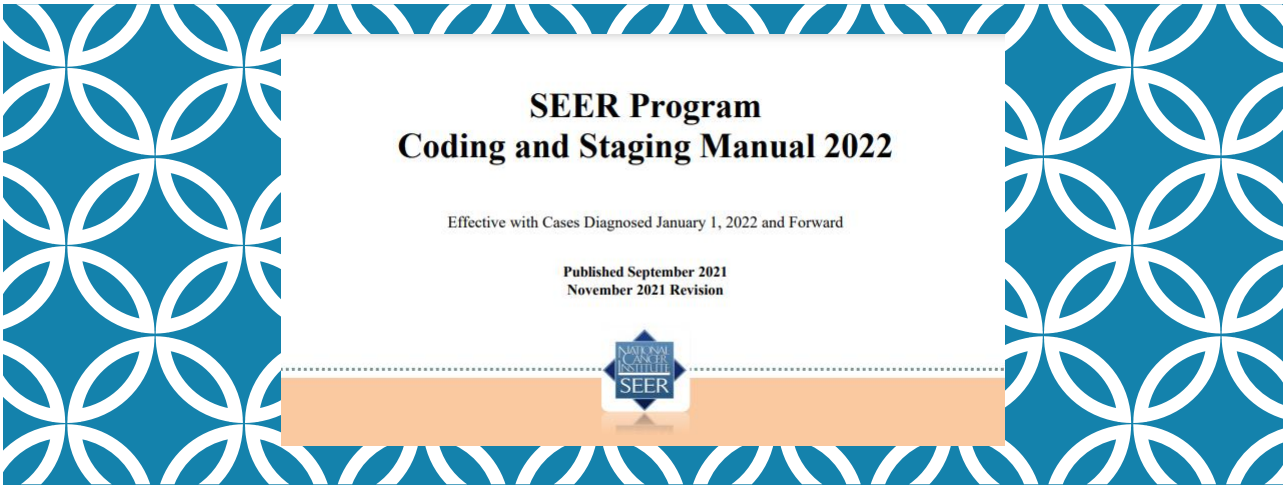

Effective 1/1/2022 diagnosis and forward
Lori Somers, RN
Iowa Cancer Registry
Recorded June 2022
*Links corrected 3/1/2023

2022

1

1

PREFACE: SUMMARY OF CHANGES

https://seer.cancer.gov/archive/manuals/2022/SPCSM_2022_Changelog.pdf [updated 3/1/2023]

Reportability

Date of Diagnosis

Laterality Table

Histology Type ICD-O-3

New SSDIs added for 2022

Data Items Added to manual:

- Section III: Tobacco Use Smoking Status
- Section VI: Macroscopic Evaluation of Mesorectum
- Section VIII: Follow up Information

2

2

PREFACE: SUMMARY OF CHANGES

Appendix C https://seer.cancer.gov/archive/manuals/2022/appendixc.html

- Neoadjuvant Therapy Treatment Effect Site-specific Codes
- Coding Guidelines {Breast, Kidney, Lung, Melanoma, Renal, Urethra}
- Surgery Codes {Anus, Colon, Rectosigmoid, Rectum, Skin}

Appendix E
https://seer.cancer.gov/archive/manuals/2022/SPCSM_2022_Appendix_E.pdf

- E.1 Reportable Examples
- E.2 Non-reportable Examples

3

3

REPORTABILITY

Added reportability and non-reportable terms for 2022

Added equivalent terms for diagnostic of, not diagnostic of, and differential diagnosis

4

4

Page	Section	Change/Comments
6	1a Reportability	i. Clear cell papillary renal cell carcinoma (8323/3) is reportable ii. Low-grade appendiceal mucinous neoplasm (LAMN) is reportable
		Numerous other changes that were effective 1/1/2021. {GIST, Thymomas, evolving melanoma}
7	1b Do Not report	NOT REPORTABLE: {reference Appendix E.2} iv. Colon atypical hyperplasia v. High grade dysplasia in colorectal and esophageal primary sites vi. Adenocarcinoma in situ, HPV assoc (8483/2)(C53)
10	Ambig Terms	Cytology Do **not** accession a case based ONLY on suspicious cytology. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended. Accession the case when a reportable diagnosis is confirmed later. The date of diagnosis is the date of the suspicious cytology. **Exception: This is a change to previous instructions.** The date of a suspicious cytology may be used as the date of diagnosis when a definitive diagnosis follows the suspicious cytology. See Date of Diagnosis for more information.

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5

Page	Section	Change/Comments
11	Ambiguous terms for Reportability	Equivalent to "Diagnostic for" malignancy or reportable diagnosis. **These phrases are reportable when no other information is available.** • Considered to be [malignancy or reportable diagnosis] • Characteristic of [malignancy or reportable diagnosis] • Appears to be a [malignancy or reportable diagnosis] • Most compatible with [malignancy or reportable diagnosis] • Most certainly [malignancy or reportable diagnosis] • In keeping with
		Equivalent to "Not diagnostic for" malignancy or reportable diagnosis. **These phrases are NOT reportable when no other information is available.** • Highly suspicious for, but not diagnostic of [malignancy or reportable diagnosis] • Most compatible with a [non-reportable diagnosis] such as a [reportable diagnosis] • High probability for [malignancy or reportable diagnosis]
		If there is no information to the contrary, report a case described as "malignant until proven otherwise." The patient should have further work up to prove or disprove the findings. When additional information becomes available, update as necessary. Use text fields to describe the details. "Differential diagnoses" is equivalent to differential considerations

6

6

DATE OF DIAGNOSIS

Use date of suspicious cytology when dx is proven by subsequent biopsy, excision or other means

Example:1/12/2022 Suspicious cytology for malignancy. 2/6/2022 Biopsy confirms diagnosis of carcinoma. Date of dx 1/12/2022.

7

7

LATERALITY

Pg 98-99
Laterality Table

C444, skin of scalp and neck, laterality must be recorded for 2022 dx forward

8

8

HISTOLOGY

Page	Section	Change/Comments
104	Section IV: ICDO-3 Histology	Added under section Histology Coding for Solid Tumors: Refer to the most current Solid Tumor Rules for histology code changes. 1. Beginning with cases diagnosed 01/01/2022 forward, p16 test results can be used to code squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086). 2. Beginning 1/1/2022, non-keratinizing squamous cell carcinoma, HPV positive is coded 8085 for sites listed in Head and Neck Solid Tumor Rules Table 5 only. A diagnosis of non-keratinizing squamous cell carcinoma, NOS is coded 8072. 3. Beginning 1/1/2022, keratinizing squamous cell carcinoma, HPV negative is coded 8086 for sites listed in Head and Neck Solid Tumor Rules Table 5 only. A diagnosis of keratinizing squamous cell carcinoma, NOS is coded 8071. 4. Clear cell papillary renal cell carcinoma is coded 8323/3. The 2016 WHO Classification of Tumors of the Urinary System and Male Genital Organs, 4th Edition, has reclassified this histology as a /1 because it is low nuclear grade and is now thought to be a neoplasia. This change has not yet been implemented and it remains reportable as behavior /3

9

9

#344 TOBACCO USE SMOKING STATUS

Patient's past or current use of tobacco (cigarette, cigar, pipe)

Hospital or physician office record

10

10

TOBACCO USE SMOKING STATUS

Code	Description
0	Never smoker
1	Current some day smoker
2	Former smoker
3	Smoker, current status unknown
9	Unknown if ever smoked

11

11

Page	Section	Change/Comments
104	Section IV: Behavior	Code behavior prior to neoadjuvant therapy when given.
113	Section IV: Description of Neoplasm	**Tumor Size Clinical revision**: Clinical classification is composed of diagnostic workup prior to first treatment, including physical examination, imaging, pathological findings (gross description and microscopic measurements most likely from a biopsy that did not remove the entire lesion), and surgical exploration without resection. **Revised Example**: Example: A breast biopsy revealed a 1.3 cm ductal carcinoma. There was no residual carcinoma found in the partial mastectomy specimen. The biopsy removed the whole tumor which makes it an excisional biopsy. Code the clinical tumor size as 999 and the path tumor size as 013.

12

12

Page	Section	Change/Comments
114	Added	3. Use clinical history on a pathology report for **clinical tumor size** when that is the only information available to code clinical tumor size. Use text field to record the details. Subsequent instructions renumbered.
115	Added	9. Do not use endometrial ultrasound reporting endometrial stripe or thickening because this does not represent clinical tumor size
122		Tumor Size Path revision: 20. Assign code 000 when a. No residual tumor is found i. Neoadjuvant therapy has been administered and the resection shows no residual tumor b. Schema is Cervical Lymph Nodes and Unknown Primary 00060 c. EOD Primary Tumor is coded 800 (No evidence of primary tumor) for any schema except for those listed in Coding Instruction 22

13

13

LVI

Pg 136-138

Code descriptions modified for codes 1, 2, 3, and 4.

1) Lymphovascular Invasion Present/Identified (NOT used for thyroid and adrenal)

2) Lymphatic and small vessel invasion only (L) OR
- Lymphatic invasion only (thyroid and adrenal only)

3) Venous (large vessel) invasion only (V) OR
- Angioinvasion (thyroid and adrenal only)

4) BOTH lymphatic and small vessel AND venous (large vessel) invasion OR
- BOTH lymphatic AND angioinvasion (thyroid and adrenal only)

14

14

LVI

Pg 136-138

2. Code lymphovascular invasion to 0, 2, 3, 4, or 9 for the following Schema IDs:

- Thyroid 00730
- Thyroid Medullary 00740
- Adrenal Gland 00760

8. Synonyms: Added vii. Lymphovascular space invasion

9. b. Use Code 8 for non-malignant brain (intracranial) and CNS tumors

15

15

#3950 MACROSCOPIC EVALUATION OF MESORECTUM

Pg 139

New Data Item for Rectal cases only (C209)

- Records whether a **total mesorectal excision (TME)** was performed and the macroscopic evaluation of the completeness of the excision.
- Use information from the pathology report and/or the CAP protocol for codes 10, 20, and 30.
- Neoadjuvant therapy does not alter coding of this data item

16

16

#3950 MACROSCOPIC EVALUATION OF MESORECTUM

Code	Description
00	Patient did not receive TME
10	Incomplete
20	Nearly complete
30	Complete
40	TME performed not specified on pathology report as incomplete, nearly complete, or complete
	TME performed but pathology report not available
	Physician statement that TME performed, no mention of incomplete, nearly complete or complete status
99	Unknown if TME performed
Blank	Site not rectum (C209)

17

17

FOLLOW UP INFORMATION

Pg 246-253 Data items **added:**

#1772 Date of Last Cancer (Tumor) Status

#1770 Cancer Status

#1860 Recurrence Date – 1st: Records date of first recurrence of this tumor

#1880 Recurrence Type – 1st: indicates the type of first recurrence after a period of documented disease-free intermission or remission (pg 253-254 long list of codes)

18

18

FOLLOW UP

#1772 **Date** of Last Cancer (Tumor) Status: Last known cancer status for this tumor

#1770 Cancer **Status**: Presence/absence of clinical evidence of malig or non-malig tumor in #1772.

- Multiple primaries, status may be different for each primary
- Code 1: No indication or evidence of this tumor. Example: Pt in remission for a heme disease.
- Code 2: When there is indication of this tumor. Example: Patient is continuing treatment for this tumor.

19

19

RECURRENCE

#1860 Recurrence Date – 1st: Records date of first recurrence of this tumor

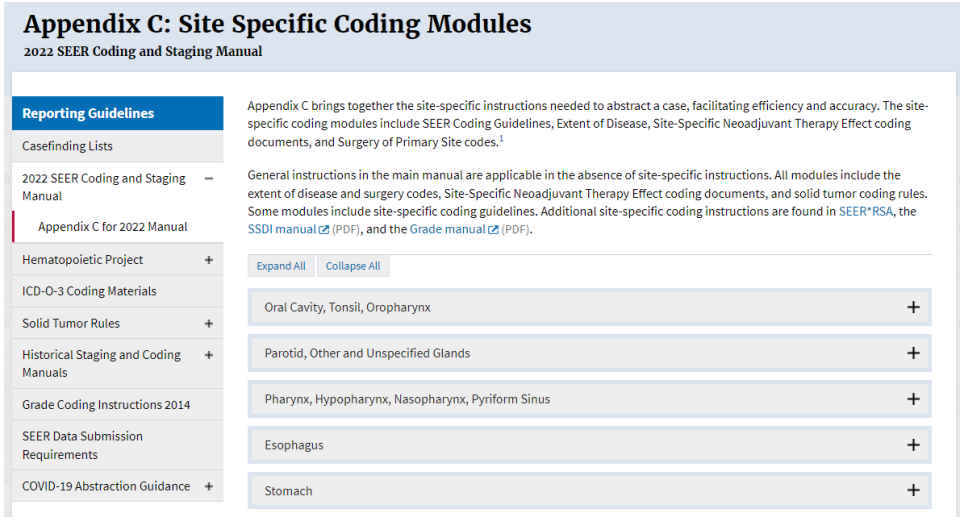
#1880 Recurrence Type – 1st: indicates the type of **first recurrence** after a period of documented disease-free intermission or remission (pg 253-254 long list of codes)

- Do not record subsequent recurrences once a recurrence has been recorded (04-62 or 88)
- Assign highest-numbered response for hierarchical codes 00-70
- Assign code 06, 16, 17, 26, 27, 36, or 46 for recurrence when the tumor was originally diagnosed as in situ. Do not use those codes for any other tumors.
- Assign code 00 for lymphomas or leukemias that are in remission. The patient is in remission when the lymphoma or leukemia is controlled by drugs (e.g., Gleevec for chronic myeloid leukemia).
  - Assign code 59 when patient relapses.
- Code recurrent disease for each tumor when there is more than one primary tumor and the physician is unable to decide which has recurred. If the recurrent primary is identified later, revise the codes appropriately.

20

20

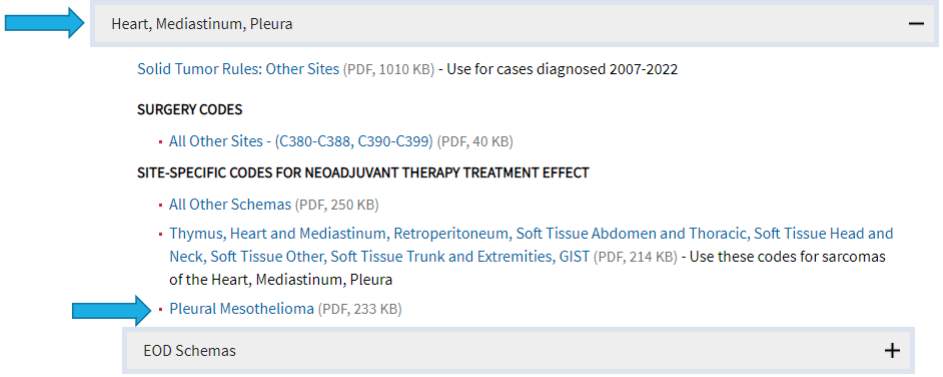
APPENDIX C: CODING MODULES



21

SEER : APPENDIX C

- Added Neoadjuvant therapy treatment effect site-specific codes for pleural mesothelioma



22

*New for 2022 dx

Site-Specific Codes for Neoadjuvant Therapy Treatment Effect

Schema: Pleural Mesothelioma

Neoadjuvant Therapy--Treatment Effect data item [NAACCR # 1634] is related to the Neoadjuvant Therapy data item [NAACCR #1632]. This data item records the findings from the post neoadjuvant therapy surgical pathology report ONLY when surgery is performed after neoadjuvant therapy. This set of codes applies to the Lung schema.

Code	Description
0	Neoadjuvant therapy not given/no known presurgical therapy
1	No residual invasive carcinoma identified Stated as Complete response (CR)
2	Less than or equal to 50% residual viable tumor
3	Greater than 50% of residual viable tumor
4	Residual viable tumor, percentage not stated Stated as partial response
6	Neoadjuvant therapy completed and surgical resection performed, response not documented or unknown Cannot be determined
7	Neoadjuvant therapy completed and planned surgical resection not performed
9	Unknown if neoadjuvant therapy performed Unknown if planned surgical procedure performed after completion of neoadjuvant therapy Death Certificate only (DCO)

For purposes of this data item, **neoadjuvant therapy** is defined as systemic treatment (chemotherapy, endocrine/hormone therapy, targeted therapy, immunotherapy, or biological therapy) and/or radiation therapy given to shrink a tumor before surgical resection.

23

23

CODING GUIDELINES 2022

Colon, Appendix, Rectosigmoid, Rectum –

- Coding Guidelines: Colon (PDF, 29 KB)
- Coding Guidelines: Rectosigmoid, Rectum (PDF, 41 KB)
- Solid Tumor Rules: Colon, Rectosigmoid, and Rectum (PDF, 1.6 MB)

SURGERY CODES

- Colon - (C180-C189) (PDF, 44 KB)
- Rectosigmoid - (C199) (PDF, 44 KB)
- Rectum - (C209) (PDF, 43 KB)

SITE-SPECIFIC CODES FOR NEOADJUVANT THERAPY TREATMENT EFFECT

- Colon and Rectum, Esophagus, Stomach, Anus, Pancreas (PDF, 237 KB)
- Thymus, Heart and Mediastinum, Retroperitoneum, Soft Tissue Abdomen and Thoracic, Soft Tissue Head and Neck, Soft Tissue Other, Soft Tissue Trunk and Extremities, GIST (PDF, 214 KB) - Use these codes for sarcomas of the Colon, Appendix, Rectosigmoid, Rectum

24

24

APPENDIX C: CODING GUIDELINES

- Breast: Coding subsites:
  - Generally, codes C502 - C505 are preferred over C501. Code C501 is preferred over C508. Apply these general guidelines when there is no other way to determine the subsite using the available medical documentation.

- Kidney: Primary Site: Transitional / urothelial cell carcinoma originates in the urethra, bladder, ureters, and renal pelvis. Code the primary site to renal pelvis (C659) when transitional / urothelial cell carcinoma originates in the "kidney."

- Lung: Added to Primary Site C349: Infrahilar area of lung, NOS

25

25

APPENDIX C: CODING GUIDELINES

- Melanoma: Primary Site:
  - Assign C449 for melanoma primary site is unknown and no info suggesting a non-skin site.
  - Assign C809 when the site of origin is unknown and some indication primary site of the melanoma is not skin.

- Renal Pelvis, Ureter: Primary Site: Transitional / urothelial cell carcinoma originates in the urethra, bladder, ureters, and renal pelvis.
  - Code the primary site to renal pelvis (C659) when transitional / urothelial cell carcinoma originates in the "kidney."

- Urethra: Added section
  - Primary Site C680 is the only ICD-O-3 code available for urethra. Assign C680 for penile urethra and for prostatic urethra. Transitional / urothelial cell carcinoma originates in the urethra, bladder, ureters, and renal pelvis. Code the primary site to urethra (C680) when transitional / urothelial cell carcinoma involves the prostate and the urethra.

26

26

APPENDIX C: SURGERY CODES

- Anus: **Removed** codes 11 Photodynamic therapy (PDT), 13 Cryosurgery, 14 Laser, 21 Photodynamic therapy (PDT), 23 Cryosurgery, 24 Laser ablation, 25 Laser excision. **Updated** text following the deleted Local tumor destruction codes: No specimen sent to pathology from surgical events 10, 12, and 15.
- Colon: **Removed** codes 11 Photodynamic therapy (PDT), 13 Cryosurgery, 14 Laser, 21 Photodynamic therapy (PDT), 23 Cryosurgery, 24 Laser ablation, 25 Laser excision. **Updated** text following the deleted Local tumor destruction codes: No specimen sent to pathology from surgical events 10 and 12. **Revised** SEER Note: [SEER Note: Code 22 above combines 20 Local tumor excision, 27 Excisional biopsy, 26 Polypectomy, NOS, 28 Polypectomy-endoscopic, or 29 Polypectomy-surgical excision WITH 22 Electrocautery].

27

27

APPENDIX C: SURGERY CODES

- Rectosigmoid: Removed codes 11 Photodynamic therapy (PDT), 13 Cryosurgery, 14 Laser ablation, 21 Photodynamic therapy (PDT), 23 Cryosurgery, 24 Laser ablation, 25 Laser excision. Updated text following the deleted Local tumor destruction codes; No specimen sent to pathology from surgical events 10 and 12.
- Rectum: Removed codes 11 Photodynamic therapy (PDT), 13 Cryosurgery, 14 Laser, 21 Photodynamic therapy (PDT), 23 Cryosurgery, 24 Laser ablation, 25 Laser excision; revised code 30: Segmental resection; partial proctectomy, NOS. Updated text following the deleted Local tumor destruction codes; No specimen sent to pathology from surgical events 10 and 12.

28

28

APPENDIX C: SURGERY CODES

- Skin: SEER Note: You may take margin information from the operative report if it is missing from the pathology report when assigning the surgery codes for skin. This applies to any skin malignancy for which the skin surgery codes apply.
  - Exception: **Do not apply this to surgery codes 45-47** where specific instructions about microscopic confirmation are included.]

29

29

APPENDIX C: NEOADJUVANT THERAPY

Treatment Effect: Site Specific Codes: ALL

- Revised the note on all Neoadjuvant Therapy--Treatment Effect [#1634] coding guidelines: Note: Neoadjuvant Therapy data item [#1632] coded to 0 or 3.

Treatment Effect: Site Specific Codes: All other Schemas:

- Code 2 Near complete pathological response Present: Single cells or rare small groups of invasive cancer cells
- Code 3 Partial or minimal pathological response Present: Residual invasive cancer with evident tumor regression, but more than single cells or rare small groups of cancer cells

30

30

APPENDIX C: NEOADJUVANT THERAPY

Treatment Effect Site Specific Codes: **Colon and Rectum, Esophagus, Stomach, Anus, Pancreas**

- Corrected description of Code 0: Neoadjuvant therapy not given/no known presurgical therapy

Treatment Effect Site Specific Codes: **Pleural Mesothelioma**

- Added Appendix C, Neoadjuvant Therapy Treatment Effect Site-Specific Codes for Pleural Mesothelioma.

Treatment Effect Site Specific Codes: **Prostate**

- Assign **Code 0**: Example: Patient received a short course of hormone therapy and it is not part of a clinical trial. Exception: If hormone therapy is given as part of a clinical trial, this is coded as neoadjuvant therapy and would not be coded as 0 for treatment effect [see code 3]
- Assign **Code 3**: Note: If hormone therapy is given as part of a clinical trial, this is considered neoadjuvant therapy. Example: Patient has localized prostate cancer and is part of a clinical trial. Three hormonal agents along with two ancillary agents were administered for 3 months, followed by radical prostatectomy that showed treatment effect

31

31

APPENDIX E1: REPORTABLE EXAMPLES

21. Report low-grade appendiceal mucinous neoplasm (LAMN). LAMN is assigned a behavior of /2 or /3 making it reportable.

- LAMNs are slow-growing neoplasms that have the potential for peritoneal spread and can result in patient death. LAMNs demonstrate an interesting biology in that they do not have hematogenous dissemination risk, but risk for appendiceal perforation, which can result in peritoneal dissemination, repeated recurrences after surgery and even death.

32

32

APPENDIX E2: NON-REPORTABLE EXAMPLES

Deleted: Anal intraepithelial neoplasia (AIN) II-III, AIN II/III; Vaginal intraepithelial neoplasia (VAIN) II-III, VAIN II/III; Vulvar intraepithelial neoplasia (VIN) II-III, VIN II/III, etc.

Example 30 Revised: Rathke cleft cyst, also called pars intermedia cyst of the parotid gland, is not reportable; whereas, Rathke pouch tumor is reportable

Example 31 added: Colon atypical hyperplasia – not reportable

Example 32 added: High grade dysplasia in colorectal and esophageal primary sites – not reportable

33

33

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34

34