
SEER Program
Coding and Staging Manual 2023
Effective with Cases Diagnosed January 1, 2023 and Forward
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SEER Coding & Staging Manual 2023
MANUAL MANIA
LORI SOMERS, RN
IOWA CANCER REGISTRY
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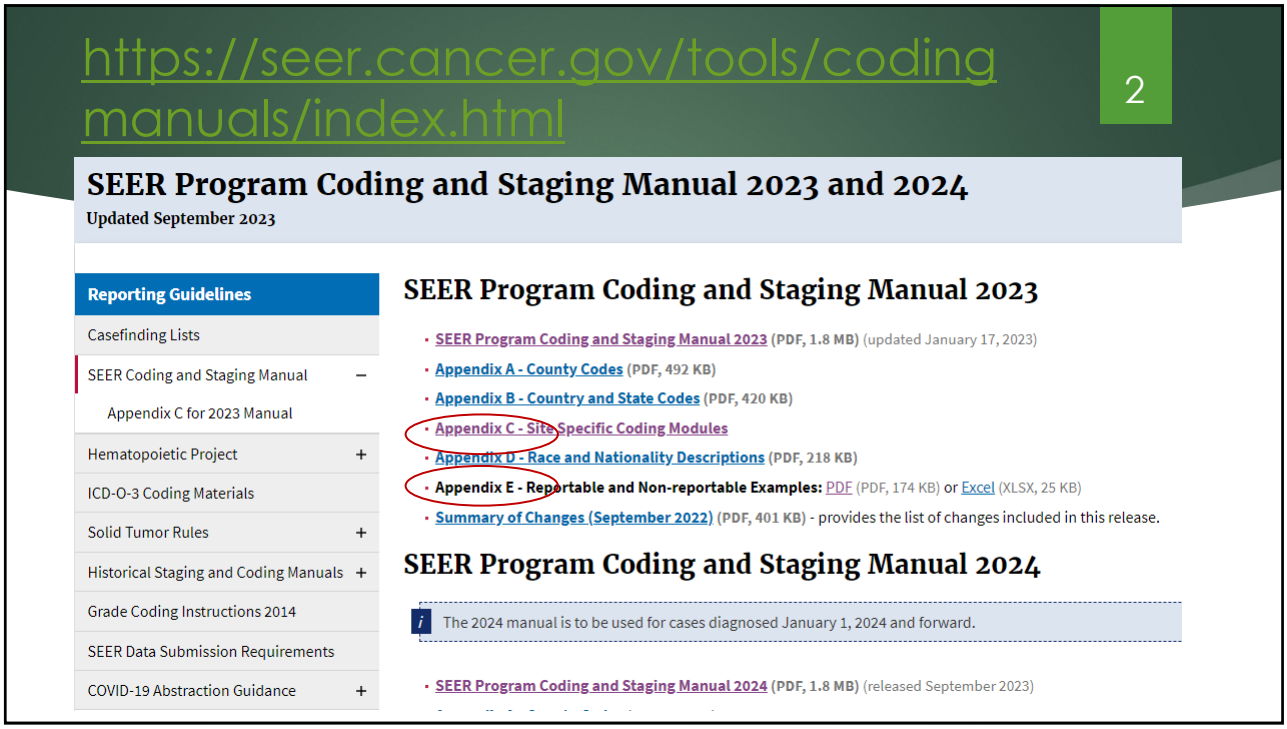
https://seer.cancer.gov/tools/coding manuals/index.html
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SEER Program Coding and Staging Manual 2023 and 2024
Updated September 2023
Reporting Guidelines
Casefinding Lists
SEER Coding and Staging Manual
Appendix C for 2023 Manual
Hematopoietic Project
ICD-O-3 Coding Materials
Solid Tumor Rules
Historical Staging and Coding Manuals
Grade Coding Instructions 2014
SEER Data Submission Requirements
COVID-19 Abstraction Guidance
SEER Program Coding and Staging Manual 2023
SEER Program Coding and Staging Manual 2023 (PDF, 1.8 MB) (updated January 17, 2023)
Appendix A - County Codes (PDF, 492 KB)
Appendix B - Country and State Codes (PDF, 420 KB)
Appendix C - Site-Specific Coding Modules
Appendix D - Race and Nationality Descriptions (PDF, 218 KB)
Appendix E - Reportable and Non-reportable Examples: PDF (PDF, 174 KB) or Excel (XLSX, 25 KB)
Summary of Changes (September 2022) (PDF, 401 KB) - provides the list of changes included in this release.
SEER Program Coding and Staging Manual 2024
The 2024 manual is to be used for cases diagnosed January 1, 2024 and forward.
SEER Program Coding and Staging Manual 2024 (PDF, 1.8 MB) (released September 2023)

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# Reportability

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Cases diagnosed on or after January 1, 1973.
Definition of reportability

- Malignant histologies (invasive /3 and in situ /2)
  - Exceptions
- Benign/non-malignant histologies
  - Neoplasm and tumor are reportable terms for brain & CNS as of 1/1/2004
  - Identified by diagnostic imaging only is reportable
- Cases diagnosed clinically are reportable
  - In the absence of histologic or cytologic confirmation

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# Ambiguous Terminology

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| Do **NOT** | **DO** |
| --- | --- |
| • accession a case based **ONLY** on suspicious cytology | • Accession cases with cytology diagnosis that is positive<br>• **Follow back on cytology cases: Accession case when reportable dx confirmed later. Date of dx is date of suspicious cytology**<br>• Cytology refers to cells in body fluids from aspirations, washings, scrapings and smears. Usually measured in cc or ml. |

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# Ambiguous Terminology

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- Ambiguous terms that ARE reportable (used to determine reportability)
  - apparent(ly) — appears
  - comparable with — compatible with
  - consistent with — favor(s)
  - malignant appearing — most likely
  - presumed — probable
  - suspect(ed) — suspicious (for)
  - typical (of)

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# Ambiguous Phrases

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| Do **NOT use** | **DO use** |
|---|---|
| • Highly suspicious for, but not diagnostic of [*malignancy or reportable disease] | • Considered to be [*malignancy or reportable dx] |
| • Most compatible with a [non-reportable dx] such as [reportable dx] | • Characteristic of [*] |
| • High probability for [malignancy or reportable dx] | • Appears to be a [*] |
| • Differential considerations or differential diagnoses | • Most compatible with [*] |
| | • Most certainly [*] |
| | • In keeping with [*] |

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| | |
|---|---|
| Section III | Demographic info |
| Section IV | Description of neoplasm |
| Section V | Stage of Disease at Dx |
| Section VI | Stage-related items |
| Section VII | First Course Therapy |

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# Description of this Neoplasm

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Date of diagnosis pg 83

- This is the date the reportable neoplasm was first diagnosed
  - NOT the date the patient was admitted to your facility
- Do NOT change the date when a clinical diagnosis is later confirmed by histology or cytology
- Code date of death for autopsy only cases
- Estimating the date of diagnosis

Sequence number: Describes the # and sequence of all reportable tumors

Laterality Table pg 98

Diagnostic confirmation pg 101 [see coding instructions for solid tumors]

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# Description of this Neoplasm

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Primary site pg 92

- Code site of invasive cancer when there is invasive and in situ in different subsites of the same anatomic site
- Always code the site of the primary tumor NOT a metastatic site

Histology – Refer to Solid Tumor Rules

Behavior – note terminology for in situ pg 108

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# Description of this Neoplasm

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Grade (solid tumors ONLY)

- Grade Clinical: Grade before any treatment
- Grade Pathological:  Grade from resection
- Grade Post Therapy Clin (yc)Grade following neoadj therapy
- Grade Post Therapy Path (yp) for 2021 dx and forward

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# Tumor Size - Clinical

2. Document clinical tumor size **before any form of treatment,** in the priority order that follows

**Priority of recording clinical tumor size**

**a. Operative report** from surgical exploration without resection

**b. Imaging-guided tissue biopsy** (i.e., incisional biopsy done under imaging)

i. Do **not** use the size from a core biopsy or needle biopsy for clinical tumor size unless you are confident that the size corresponds to the tumor rather than the size of the specimen obtained. Core biopsies and needle biopsies do not necessarily obtain enough tissue to know the actual tumor size.

***Example***: Prostate biopsy, pathologist states core 1: tumor involves 8 mm of core; core 2: tumor involves 3 mm of core. The sizes reported (8 mm and 3 mm) do not represent the size of the prostate tumor. Look for a tumor size on imaging or elsewhere for this case.

***Note*:** An incisional biopsy that removed the whole tumor is actually an excisional biopsy. Record excisional biopsy tumor size in Tumor Size--Pathologic.

***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.

**c. Diagnostic imaging**

Use the largest size from available diagnostic imaging procedures in no priority order unless the physician specifies the imaging procedure that is most accurate. Examples include: MRI, ultrasound, mammography, CT, PET, x-ray.

**d. Physical exam**

Use in the absence of surgical exploration, imaging from incisional biopsy, and diagnostic imaging. Tumor size from an endoscopy (e.g., colonoscopy) is included under physical exam.

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# Clarification on tumor size

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## Neoadjuvant treatment – how to code Tumor size fields

- Tumor Size Clinical – taken from any clinical information prior to neoadjuvant treatment
- Tumor Size Pathologic – Code 999
- Tumor Size Summary – Code the Tumor size Clinical

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# Stage Related Data Items

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## LVI or Lymphovascular Invasion

- Synonyms include but not limited to:
  - Angiolympatic invasion
  - Blood vessel invasion
  - Lymph vascular emboli
  - Lymphatic invasion
  - Lymphovascular invasion
  - Vascular invasion

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# LVI

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| LVI on pathology report PRIOR to neoadjuvant (preoperative) therapy | LVI on pathology report AFTER neoadjuvant (preoperative) therapy | Code LVI to |
|---|---|---|
| 0 – Not present/Not identified | 0 – Not present/Not identified | 0 – Not present/Not identified |
| 0 – Not present/Not identified | 1 – Present/Identified | 1 – Present/Identified |
| 0 – Not present/Not identified | 9 – Unknown/Indeterminate | 9 – Unknown/Indeterminate |
| 1 – Present/Identified | 0 – Not present/Not identified | 1 – Present/Identified |
| 1 – Present/Identified | 1 – Present/Identified | 1 – Present/Identified |
| 1 – Present/Identified | 9 – Unknown/Indeterminate | 1 – Present/Identified |
| 9 – Unknown/Indeterminate | 0 – Not present/Not identified | 9 – Unknown/Indeterminate |
| 9 – Unknown/Indeterminate | 1 – Present/Identified | 1 – Present/Identified |
| 9 – Unknown/Indeterminate | 9 – Unknown/Indeterminate | 9 – Unknown/Indeterminate |

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# Macroscopic Eval of Mesorectum

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- New field as of 1/1/2022 NACCR Item #3950
- Records if total mesorectal excision (TME) done
- Records macroscopic evaluation of completeness of excision
- Rectal cases only (c20.9)
- Leave blank if site not rectum

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# Macroscopic Eval of Mesorectum

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| 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<br>TME performed but pathology report not available<br>Physician statement that TME performed, no mention of incomplete, nearly complete or complete status |
| 99 | Unknown if TME performed |
| Blank | Site not rectum (C209) |

Source Document: Path report and/or CAP protocol

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# Stage Related Data Items

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Mets at Diagnosis: Discontinous or distant mets, can be clinical or path, can be single or multiple mets, code whether neoadjuvant systemic therapy given or not.

- Bone – do not code bone marrow here
- Brain
- Liver
- Lung – do not include pleural effusion here
- Distant lymph node: Not for regional node involvement
- Other: Bone marrow, pleural nodules, malig pleural or pericardial effusion. Code lymphomas with bone marrow involvement (Stage IV disease). Carcinomatosis.

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# Section VII First Course of Therapy

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Definitions

- Active surveillance (watchful waiting)
  - Watching a patient's condition, giving no treatment unless disease worsens
- Concurrrent therapy
  - Treatment given at the same time as another
- Disease recurrence
  - Solid tumor – see STR manual
- 1st course therapy
  - treatment given after original diagnosis in an attempt to destroy or modify the cancer tissue
- Neoadjuvant
  - Systemic or radiation therapy given prior to surgery to shrink the tumor
- Palliative treatment
  - Treatment that improves quality of life by preventing or relieving suffering
    - Considered part of 1st course when it modifies or destroys cancer tissue

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# First Course of Therapy

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Treatment timing

- First course ends when
  - treatment plan is completed
  - there is disease progression, recurrence or tx failure
  - Or one year after date of diagnosis when there is no documentation of a treatment plan, recurrence or treatment failure

Coding instructions

- Refusal - Multiple primaries

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# First Course of Therapy

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Date therapy initiated

- The start date for any type of treatment for this tumor
- Coding instructions
  - Code date of excisional bx when it is the 1st tx
    - *Code date of incisional bx when further surgery reveals no residual

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# First Course of Therapy

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Surgery of primary site

- See site specific surgery codes Appendix C
- Code the most invasive, extensive or definitive surgery
- Code total removal of primary when a previous procedure removed a portion
- Look for combo codes for en bloc procedures

Source Document: use the entire operative report to determine best surgery of primary site code. Path may be used to compliment info but operative report takes precedence.

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# First Course of Therapy

22

Surgical margins of the primary site

- Describes the final status of surgical margins after resection
- Codes 0-3 & 7-9
- Use margins sections from CAP protocol or micro to identify microscopic findings.

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# Scope of Reg LN Surgery

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- Describes the **procedure** of removal, biopsy or aspiration of regional nodes during any procedure
- Instructions for sentinel lymph node biopsies
  - Additional instructions for breast primaries
- **Op report** takes precedence when determining if a SLNBx or dissection was performed

23

# Date of SLN biopsy

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Date of Sentinel Lymph Node Biopsy

- Required for breast and melanoma cases only
- Record date SLN biopsy only
- Do not record date of FNA, core needle biopsy of LN
- If **BOTH** SLN and subsequent regional LN dissection performed:
  - Record the date of sentinel LN biopsy in this data time.
  - Record the date of the subsequent regional LN dissection in Date of Reg LN Dissection data item.

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# SLN Exam/Pos

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- Sentinel LNs Examined
  - If both SLN and non-SLN sampled during the SLN procedure, document total nodes sampled during the SLN procedure.
- Sentinel LNs Positive
  - Exact number of SLN found to contain mets
- When SLN Bx and Node Dissection performed during **different procedures**
  - Only record the number of positive SLN found during Bx procedure

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# Sentinel Lymph Nodes Positive

- When SLN bx & Node dissection performed during the **same procedure**
  - **Breast only: Code 97**
    - Record total number of **positive** (both SLN & regional) in *Regional Lymph node positive* field
  - **Melanoma only:** Record total number of positive nodes

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# Date of Regional LN Dissection

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Date non-sentinel regional node dissection performed

- If both SLN biopsy and a subsequent regional LN dissection performed:
  - Record the date of the regional LN dissection in this data item
  - Record the SLN biopsy procedure in the date of SLN biopsy

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# Regional Nodes Pos/Exam

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Regional Nodes only

Based on path info only

Nodes pos is cumulative

Site-specific rules for ITCs

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## Surg Proc Other Site

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- Surgical removal of distant LN(s) or other tissue(s) or organ(s) beyond primary site
- Do not code tissue or organs such as an appendix that were removed incidentally, and the organ was not involved with cancer

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## First Course of Therapy

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- Radiation
  - Beam, seeds, radioisotopes
- Chemotherapy
  - Single vs. multiple agents
- Hormone
- Immunotherapy
- Hematologic Transplant and Endocrine Procedures
  - Bone marrow transplants
- Other Experimental

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# Appendix C - Surgery Codes

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- STORE Manual Appendix A
- SEER Manual Appendix C
  - *SEER Notes*

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# Neoadjuvant Therapy

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| NAACCR Item | Field Name | Source of info | Comments |
|---|---|---|---|
| #1632 (pg 229-233) | Neoadjuvant Therapy | Any place in record | Criteria for Neoadjuvant must be met |
| #1633 (pg 234-237) | Neoadjuvant Therapy – Clinical Response | Managing physician must state outcome | Based on the managing/treating physician's interpretation/statement of the response to neoadjuvant therapy, |
| #1634 (pg 238-239) along with Appx C for response codes | Neoadjuvant Therapy – Treatment Effect | Path Report | pathologist's statement of neoadjuvant treatment effect from the surgical pathology report |

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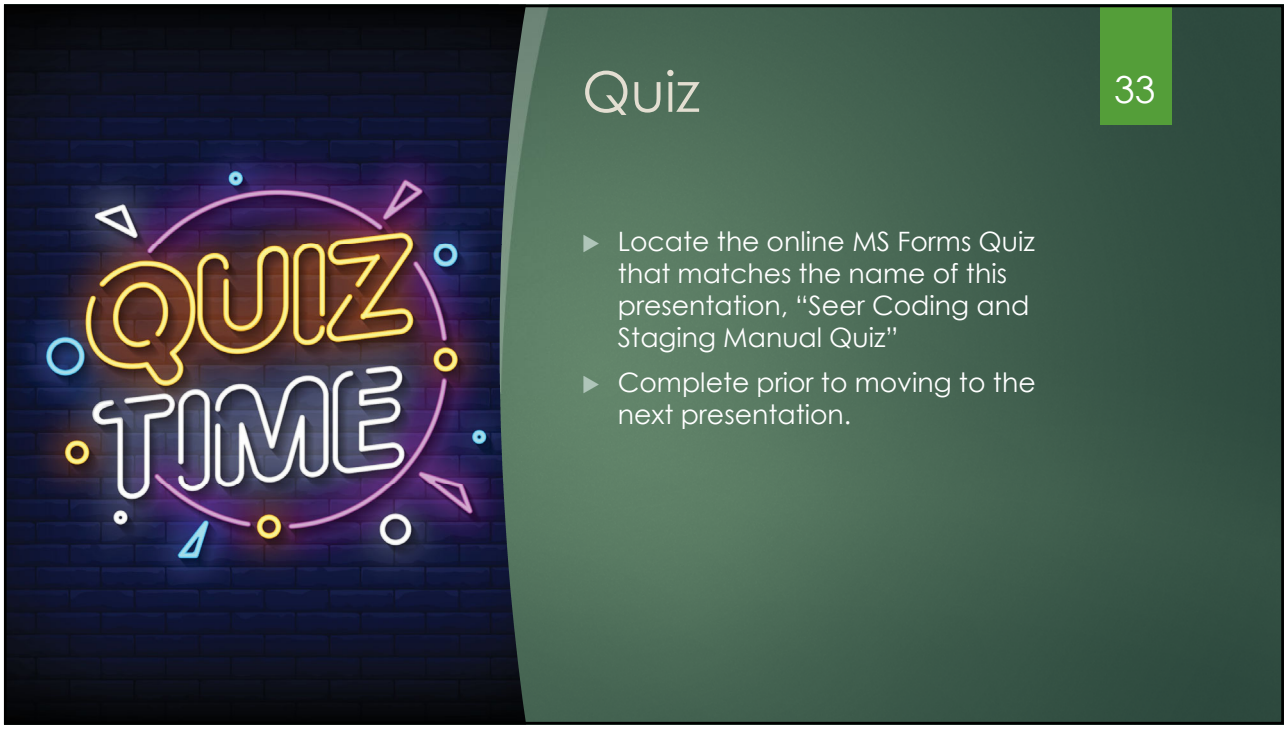


## Quiz

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- Locate the online MS Forms Quiz that matches the name of this presentation, "Seer Coding and Staging Manual Quiz"
- Complete prior to moving to the next presentation.

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## Questions?

lori-somers@uiowa.edu

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