2024 Updates: Site Specific Data Items Grade

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IOWA CANCER REGISTRY

DECEMBER 2024

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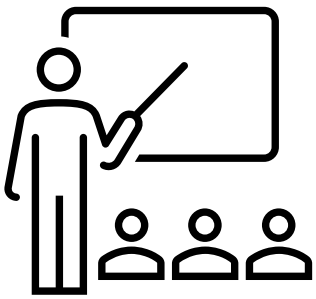
Overview

2024 Major Updates for:

- Site Specific Data Items (SSDI)
- Grade



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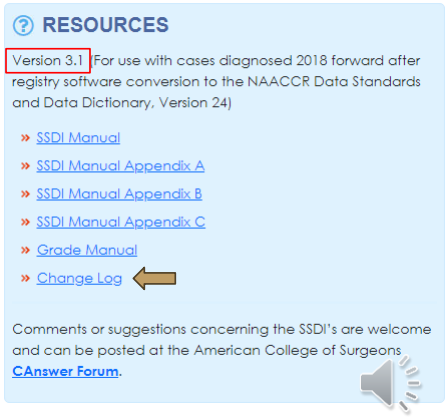
Location of Updates

NAACCR Website

- Central Registry Standards
  - Site Specific Data Items (SSDI)/Grade

https://apps.naaccr.org/ssdi/list/?_gl=1*1nrce0i*_ga*NDk5ODY0NzI3LjE3MzE5NDIwMTA.*_ga_V7J8GWYK5P*MTczMjIyMTIzNC4xMy4wLjE3MzIyMjEyMzQuNjAuMC4w



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2024 UPDATES

Site Specific Data Items (SSDI)

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Site Specific Data Items (SSDI)

Reminders

- It is critical to accurately assign primary site and histology
  - Behavior as well for specific sites
- The above information, along with Schema Discriminator when applicable, defines the following:
  - Schema ID
  - AJCC ID
  - EOD Schema
  - Summary Stage chapter
  - SSDIs
  - Grade
  - Surgery codes

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New Schemas for 2024+

No changes to SSDIs or Grade for these:

- NET Stomach 09290
- NET Duodenum 09301
- NET Ampulla of Vater 09302
- NET Jejunum and Ileum 09310
- NET Appendix 09320
- NET Colon and Rectum 09330
- NET Pancreas 09340

SSDI – p16 required for 2024+

- Vulva 09500
  - Currently collected for Cervix (2021+) and Anus (2023+)

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New SSDI

Brain Primary Tumor Location (Brain 2023+ Schema) – Cases 2024+

- This SSDI distinguishes between the Pons and other subsites with Primary Site code C717
- Information regarding Pons primary site is very important, especially for pediatric brain tumors
- Dangerous site to biopsy or have surgical resection, most of the information will come from imaging or physician's statement

Description	Code
Pons	1
Subsite other than Pons; Multiple subsites in Brain stem listed	2
Not applicable (based on standard setter)	8
Brain Stem, NOS; Unknown subsite of Brain Stem	9
Primary site is **NOT** C717; Diagnosis year prior to 2024	Blank

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Brain Stem Anatomy

Midbrain

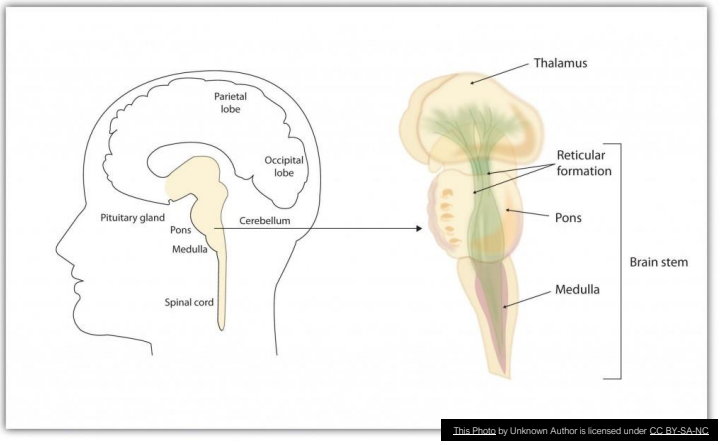
- Most superior portion and acts as a conduit between the forebrain above and pons below

Pons

- Largest portion and located above the medulla and below midbrain
- Group of nerves that function as a connection between the cerebrum and the cerebellum

Medulla Oblongata

- Most inferior portion and houses ascending and descending nerve tracts as well as brain stem nuclei



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New Codes Added

Brain Molecular Markers (2024+)

- New histologies added:
  - **9385/3, 9396/3, 9421/1, 9430/3, 9500/3**
    - **Codes 10-23** can **ONLY** be used **1/1/2024+**
  - **Code 85** (NA due to histology) updated based on new histology codes
    - Histology is ***not***: 9385/3, 9396/3, 9400/3, 9401/3, 9430/3, 9440/3, 9450/3, 9451/3, 9471/3, 9478/3, 9421/1, 9430/3, 9500/3
  - **Code 86** – benign or borderline tumor updated
    - *Excludes 9421/1* (newly included histology)
  - Based on CNS WHO Blue Book updates, released 2022

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Brain Molecular Markers 2024+

Histology	Description	Code
9385/3 (Pediatric-type diffuse low grade gliomas)	Diffuse hemispheric glioma, H3-G34 mutant	10
	Diffuse midline glioma, H3 K27-altered	11
	Diffuse pediatric-type high-grade glioma, H3-wildtype, and IDH-wildtype	12
	Infant-type hemispheric glioma	13
9396/3 (Ependymal Tumors)	Posterior fossa group A (PFA) ependymoma	14
	Posterior fossa group B (PFB) ependymoma	15
	Spinal ependymoma, MYCN-amplified	16
	Supratentorial ependymoma, YAP 1 fusion-positive	17
	Supratentorial ependymoma, ZFTA fusion-positive	18

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Brain Molecular Markers 2024+

Histology	Description	Code
9421/1 (Pilocytic Astrocytoma/Juvenile Pilocytic Astrocytoma)	Diffuse astrocytoma, MYB- or MYBL 1-altered	19
	Diffuse low grade glioma, MAPK pathway-altered	20
9430/3 (Circumscribed Astrocytic Tumor)	Astroblastoma, MN1-altered	21
9500/3 (Other CNS Embryonal Tumor)	CNS Neuroblastoma, FOXR2-activated	22
	CNS Tumor with BCOR internal tandem duplication	23

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SSDI – Updated Notes/Codes

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Updated Notes and Codes

Response to Neoadjuvant Therapy (3922) Breast [schema: 00480]

- Updated Note 2
  - This data item should not be coded based on the pathological, radiological, or imaging findings. **This data item should only be coded based on the managing physician's overall interpretation of the results.**
  - Do not confuse these instructions with the SEER Data Item: Neoadjuvant Therapy-Treatment Effect (#1634)
    - For SEER's data item the field is based on the *pathologic response only* after neoadjuvant therapy.
- Added to **code 9**:
  - Unknown if neoadjuvant therapy done
- *Remember*:
  - If neoadjuvant therapy is not done, that is not going to be documented in the medical record
  - Based on sequence of events (diagnosis, treatment), you can usually determine if neoadjuvant therapy was done or not.

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Updated Notes and Codes

Circumferential Resection Margin (3823) Colon and Rectum [schema: 00200]

- Note 3 updated:
  - For **colon primaries**, surgery of primary site **must be a surgical resection**
    - No surgical resection of primary site (i.e. polypectomy), then **code XX.7**
  - For **rectum primaries**, surgery of primary site must be coded as **excisional biopsy, transanal excision, or surgical resection**
    - For excisional biopsy, transanal procedures*, only the peritonealized portion of the rectum* (upper 1/3) is where you can get the CRM
      - Non-peritonealized portion (below the peritoneal reflection) of rectum is involved or it's unknown if peritonealized portion is involved **code XX.7**
      - If surgery of primary site is not excisional biopsy/transanal excision/surgical resection, **code XX.7**

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Updated Notes and Codes

p16 (3956) Anus [09210] Cervix [09520] Vulva [09500]

- Note 3 updated:
  - This data item must be based on testing results for p16 overexpression.
    - Testing for HPV by DNA, mRNA, or other methods **should not be coded** in this data item.
    - **Do not confuse p16 with HPV**, which is a specific strain of virus. A statement of a patient being HPV positive or negative is not enough to code this data item.

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Schemas: 00528, 00530, 00541, 00542 Cervix Sarcoma and Corpus

SSDI	Note/Code	Update
3899: Number of Examined Para-aortic Nodes *not routinely examined*	Note 4	**Code 00** when no LN are removed (including FNA, core biopsy, SLN Bx, and LND) • If LN are removed and **only pelvic LN** are assessed, or only **"nodes"** are documented – **code 00**
	Code X9	*Removed* "No lymph node dissection performed"
3900: Number of Examined Pelvic Nodes	Note 4	If LN are removed and only **"nodes"** are documented without specifying pelvic or para-aortic, **assume they are pelvic**
	Code X9	*Removed* "No lymph node dissection performed"

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Schemas: 00528, 00530, 00541, 00542 Cervix Sarcoma and Corpus

SSDI	Note/Code	Update
3901: Number of Positive Para-aortic Nodes 3902: Number of Positive Pelvic Nodes	Note 6	**Code X9** if no LN removed: • Only a FNA or core biopsy is done and ***positive***, **code X6** • Only a FNA or core biopsy is done and ***negative***, **code X9**
	Code X9	*Added:* • No lymph nodes removed *Removed*: • No lymph node dissection performed

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Updated Notes and Codes

Invasion Beyond Capsule (3864) Kidney Parenchyma [00600]

- *Note 3:* Perinephric/sinus fat invasion should be confirmed microscopically
  - Synonyms include renal sinus fat, medial invasion
  - Do **not** code invasion of renal hilum
    - If all you have is renal hilum invasion code to 9 (unknown)

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2024 UPDATES

Grade

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Derived Summary Grade

Derived in central registry *ONLY*

- Applied to cases for 2018+
- Based on information already in the cancer registry
- Data items used to derive Summary Grade:
  - Grade Clinical
  - Grade Pathological

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Ranges in Grade

New guideline included in **"General Grade Coding Instructions for Solid Tumors"**

1. Code the grade from the primary tumor only
   a. Do NOT code grade from metastatic tumor or recurrence.
      - In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site
   b. If primary site is unknown, code grade to 9
   c. **If a range is given for a grade (e.g. 1-2 or 2-3), code the higher grade**

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Autopsy Grading

New guideline "General Instruction for the Time Frames for Grade"

- If patient dies and has an **autopsy performed** within the **initial work up and treatment of their cancer** (without signs of progression), the grade from the autopsy can be used
- Include autopsy information from the appropriate timeframe: clinical, pathological, post therapy clin, post therapy path

Note: Do not automatically assign pathological grade based on the autopsy

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Grade Coding Timeframe

Grade Pathological: Diagnosis through 1st course surgery without neoadjuvant Tx

Autopsy – Clinical

Autopsy – Path

Grade Clinical: Diagnosis – biopsy, FNA, imaging, etc.

First course surgery

Adjuvant Therapy

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Post-Therapy Grade Coding Timeframe

Autopsy – Clinical

Grade Clinical: Diagnosis – biopsy, FNA, imaging, etc.

Neoadjuvant Therapy

Autopsy – Post Therapy Clin

Grade Post-therapy Clin

Autopsy – Post Therapy Path

Grade Post-therapy Path

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Autopsy Grade Coding

Example 1

Patient is diagnosed at autopsy.

Autopsy information can't be used to code grade

Example 2

Patient diagnosed prior to death/autopsy.
No treatment administered prior to death/autopsy.

Code Grade Clinical from autopsy findings

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Autopsy Grade Coding

Example 3

Patient diagnosed prior to death/autopsy. Patient has surgical resection and dies soon afterwards. Autopsy performed.

Code Grade Pathological from surgery or autopsy, whichever is higher

Example 4

Patient diagnosed, underwent surgical resection of primary, and subsequently completed all first course treatment prior to death/autopsy. Patient has autopsy.

Autopsy grade can't be used as it was performed following diagnosis and first course treatment

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Grade Coding

Corpus Carcinoma and Carcinosarcoma – Table 13

- *Note 3*: For endometrioid carcinomas **only**
  - If "low grade" is documented **code 2** (FIGO Grade 2)
  - If "high grade" is documented **code 3** (FIGO Grade 3)

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Grade Coding – Table 07

Do **NOT** code grade based on the histology terms below:

- Neuroendocrine carcinoma, low grade (8240/3)
- Neuroendocrine carcinoma, well differentiated (8240/3)
- Neuroendocrine carcinoma, moderately differentiated (8249/3)
- Poorly differentiated neuroendocrine carcinoma (8246/3)

- Ki-67 and Mitotic rate are the preferred grading method
- See CAnswer Forum: https://cancerbulletin.facs.org/forums/node/124336
  - Updated information on the 1/11/24 post

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Grade Coding – Table 07

Neuroendocrine carcinoma, Grade 1 (8240/3)

- Ki-67 less than 3 AND/OR
- Mitotic count less than 2

Note: many times, if Ki-67 is less than 3, mitotic count is not done

Neuroendocrine carcinoma, Grade 2 (8249/3)

- Ki-67 3-20 OR
- Mitotic count 2-20

Neuroendocrine carcinoma, Grade 3 (8249/3)

- Ki-67 >20 OR
- Mitotic count >20

If pathologist gives a stated specific grade and there is no Ki-67 or mitotic rate, then code the stated grade

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Definition	Code
G1: Mitotic less 2 AND Ki-67 less 3	1
G2: Mitotic = 2-20 AND Ki-67 = 3-20	2
G3: Mitotic greater 20 AND Ki-67 greater 20	3
Well Diff	A
Moderately Diff	B
Poorly Diff	C
Undifferentiated; Anaplastic	D
Unknown	9

Grade Coding – Table 07 Example

Neuroendocrine Tumor (NET)

- Appendix: well-differentiated neuroendocrine tumor
  - Histology = 8240/3
  - No Ki-67 or mitotic information
  - What is the correct grade?

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Grade Coding – Table 07 Examples

Well differentiated NET, WHO Grade 2, mitotic rate 1 per 2mm2 and Ki-67 5%

Grade: 2

Neuroendocrine tumor, Grade 1-2, mitotic rate less than 2 per 2mm2 and Ki-67 3%

Grade 2

Duodenum: Well differentiated NET (incidental); Ki67 labeling index: less than 3%

Grade: 1

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Grade Coding – Table 07 Examples

Neuroendocrine carcinoma, well differentiated; Ki-67 2%; no mitotic count information

Grade: 1

Neuroendocrine carcinoma, moderately differentiated; no Ki-67 or mitotic rate information

Grade 9

Poorly differentiated neuroendocrine carcinoma; Mitotic rate: 5 per 2mm2; Ki-67: 15%

Grade: 2

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Questions?

Submit questions to CAnswer Forum:

Site Specific Data Items (SSDI)/Grade 2018

https://cancerbulletin.facs.org/forums/CancerForumHome

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