2025 SSDI/Grade

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Iowa Cancer Registry Annual Updates

April 2025

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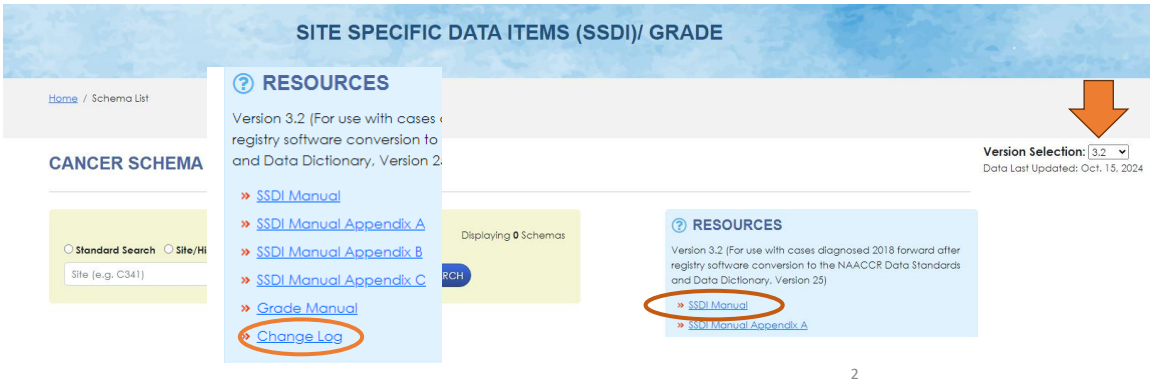
SSDI v3.2

- Current SSDI Manual is found on the NAACCR website:

https://apps.naaccr.org/ssdi/list/?_gl=1*os2bpr*_ga*NDk5ODY0NzI3LjE3MzE5NDIwMTA.*_ga_V7J8GWYK5P*MTc0MzcwNzQyMS45Ni4wLjE3NDM3MDc0MjEuNjAuMC4w



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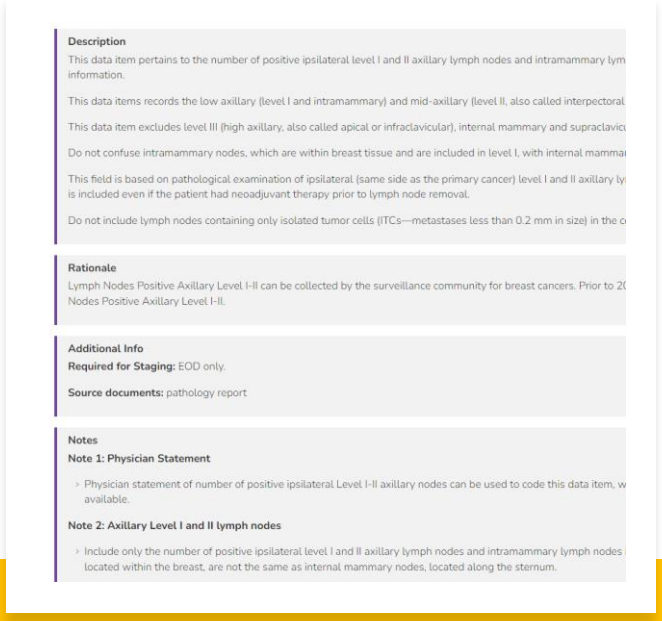

Description

This data item pertains to the number of positive ipsilateral level I and II axillary lymph nodes and intramammary lym information.

This data items records the low axillary (level I and intramammary) and mid-axillary (level II, also called interpectoral

This data item excludes level III (high axillary, also called apical or infraclavicular), internal mammary and supraclavic

Do not confuse intramammary nodes, which are within breast tissue and are included in level I, with internal mamma

This field is based on pathological examination of ipsilateral (same side as the primary cancer) level I and II axillary ly is included even if the patient had neoadjuvant therapy prior to lymph node removal.

Do not include lymph nodes containing only isolated tumor cells (ITCs—metastases less than 0.2 mm in size) in the c

Rationale

Lymph Nodes Positive Axillary Level I-II can be collected by the surveillance community for breast cancers. Prior to 2(Nodes Positive Axillary Level I-II.

Additional Info

Required for Staging: EOD only.

Source documents: pathology report

Notes

Note 1: Physician Statement

- Physician statement of number of positive ipsilateral Level I-II axillary nodes can be used to code this data item, w available.

Note 2: Axillary Level I and II lymph nodes

- Include only the number of positive ipsilateral level I and II axillary lymph nodes and intramammary lymph nodes located within the breast, are not the same as internal mammary nodes, located along the sternum.

General Instruction Updates

- Alignment between SEER*RSA and SSDI manual
  - V3.2 in SEER*RSA and SSDI will now have the same information
  - Notes
    - Reformatted – each note will have a short header
    - Many SSDI formats were changed but **NOT** the content and not included in change log

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NEW SSDIs

PD-L1

PTLD

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NEW SSDI

- **Lung** – **PD-L1**
  - Effective for cases **diagnosed 2025+**
  - Physician statement can be used if no other information
  - Primary Source: Pathology Report or Lung Biomarker Report
    - **Document the tumor proportion score** (0.0-100.0)
    - **Actual score takes priority** over:
      - XXX.2 – stated as negative
      - XXX.3 – stated as low
      - XXX.4 – stated as positive
  - **Neoadjuvant Therapy**:
    - If administered report assay from tumor specimen prior to neoadjuvant tx
    - If there is no pre-treatment results report the post-treatment findings

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PD-L1 Codes

Description	Code
No PD-L1 expression; Tumor Proportion score = 0%	**0.0**
0.1-100.0 PD-L1 expression; Tumor Proportion score = 0.1%-100.0%	**0.1 – 100.0**
PD-L1 expression absent **AND** Tumor Proportion score stated negative	**XXX.2**
PD-L1 expression present **AND** Tumor Proportion score stated as low	**XXX.3**
PD-L1 expression present **AND** Tumor Proportion score stated as high/positive	**XXX.4**
Test ordered, results not in chart	**XXX.7**
Not documented in the record; No microscopic confirmation of tumor; PD-L1 can't be determined, not assessed, or unknown if assessed	**XXX.9**

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NEW SSDI

- **Post Transplant Lymphoproliferative Disorder** (PTLD)
  - **Applies to schemas**:
    - 00790 Lymphoma
    - 00795 Lymphoma CLL/SLL
    - 00812 Primary Cutaneous Lymphomas (exclude Mycosis Fungoides)
    - 00821 Plasma Cell Myeloma
    - 00822 Plasma Cell Disorders
  - **Effective 2025+**

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Types of PTLD

- **Polymorphic PTLD**
  - PTLD by itself, no accompanying lymphoma, plasmacytoma, or other type of Hematopoietic neoplasm
  - This type is **NOT** collected as an SSDI
  - This is a reportable cancer – **9971/3** (2025+)
- **Monomorphic PTLD** ★
  - Most common and is associated with a malignant hematopoietic neoplasm
    - Most common, but not limited to, DLBCL and Burkitt lymphoma
- **Classic Hodgkin lymphoma-PTLD type** ★
  - Reed-Sternberg cells which are associated w/ Hodgkin Lymphoma are present
- **PTLD, NOS** ★
  - Used when only PTLD is documented and there is no mention of monomorphic or Hodgkin like type
  - Also used for **Burkitt-like PTLD**

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PTLD Coding

Code - 0	Code 1	Code 2	Code 4
• No mention of PTLD on path report or in the chart	• Path report describes monomorphic PTLD w/ lymphoma	• Path report describes Classic Hodgkin lymphoma-PTLD type	• Path report describes Burkitt like PTLD or doesn't specify what type of PTLD

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PTLD - Examples

Example 1

Path report: staining supports the diagnosis of PTLD, monomorphic type, EBV+ diffuse large b-cell lymphoma (non-germinal center)

Histology:

9680/3

SSDI - PTLD:

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Example 2

Right inguinal LN biopsy: CD20+ polymorphic PTLD

Histology:

9971/3

SSDI – PTLD:

N/A

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Changes to Schemas

Lung
Nasopharynx
Pleura Mesothelioma
Thymus
Soft Tissue Abdomen/Thoracic

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Schema Changes - Updates

Site	Schema	Applicable Years	Notes
Lung	00360	2018-2024	
	09360	2025+	AJCC lung v9 Histology 8982 (Myoepithelioma carcinoma) **ADDED**
Nasopharynx	00090	2018-2024	
	09090	2025+	AJCC Nasopharynx v9
Pleura Mesothelioma	00370	2018-2024	
	09370	2025+	AJCC Pleura Mesothelioma v9
Thymus	00350	2018-2024	
	09350	2025+	AJCC Thymus v9 Histology 8980 (Carcinosarcoma) **ADDED**
Soft Tissue Abdomen/Thoracic	00421	2025+	Primary Site C340-C349, histology *8982 removed* Pimary Site C379, histology *8980 removed*

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Changes to Current SSDIs

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Brain v9

- Coding Guidelines:
  - ***NEW*** Note:
    - **Code 86** for benign (/0) or borderline (/1) tumor
      - Includes microscopic or non-microscopic confirmed cases
      - *EXCEPTION*:
        - Histology 9421/1
          - See codes 19 & 20 when microscopic confirmed
          - If 19-20 don't apply or not microscopically confirmed – code 99

Edit if abstracted in v24

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Prostate

- **Number of Cores Positive/Examined**
  - *Note 2*: **Priority Order**
    - **Final Diagnosis**
      - If the core biopsy path report contains a summary of the number of cores positive use the summary provided
      - Do **NOT** include cores of other areas like seminal vesicles
    - **Gross Description**
      - Can be used to code this data item when the final diagnosis is not available and gross provides the actual number of cores and not pieces, chips, fragments, etc.
    - **Physician Statement** (see *Note 1*)

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Prostate – NEW Notes

- **Gleason Patterns Pathological**
  - *Note 7*: **Active Surveillance, then Radical Prostatectomy**
    - **Code X9** when first course treatment is active surveillance, but a radical prostatectomy is done later due to dz progression or patient changed their mind

- **Gleason Score Pathological and Gleason Tertiary Pattern**
  - *Note 5*: **Active Surveillance, then Radical Prostatectomy**
    - **Code X9** when first course treatment is active surveillance, but a radical prostatectomy is done later due to dz progression or patient changed their mind

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Other Updates:

- **Colon/Rectum**
  - BRAF Mutational Analysis
    - ***New* Code 3**
      - Abnormal (mutated)/detected, KIAA549-BRAF
- **Lung**
  - Visceral and Parietal Pleura Invasion
    - *Note 2*: Criteria for Coding
      - *EXCEPTION:*
        - In situ tumors (/2) can be coded 0 based on biopsy or surgical resection

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Other Updates:

- **Melanoma Skin**
  - Clinical Margin Width:
    - If a range is listed, code the lower range
      - *Example*: Clinical margin width documted as 1-1.2cm, code 1cm
- **Melanoma Iris, Choroid, and Ciliary Body**
  - Chromosome 3 status
    - **Added**: Loss of BAP1 expression

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Grade Manual v3.2

Updates 2025+

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Clinical & Path 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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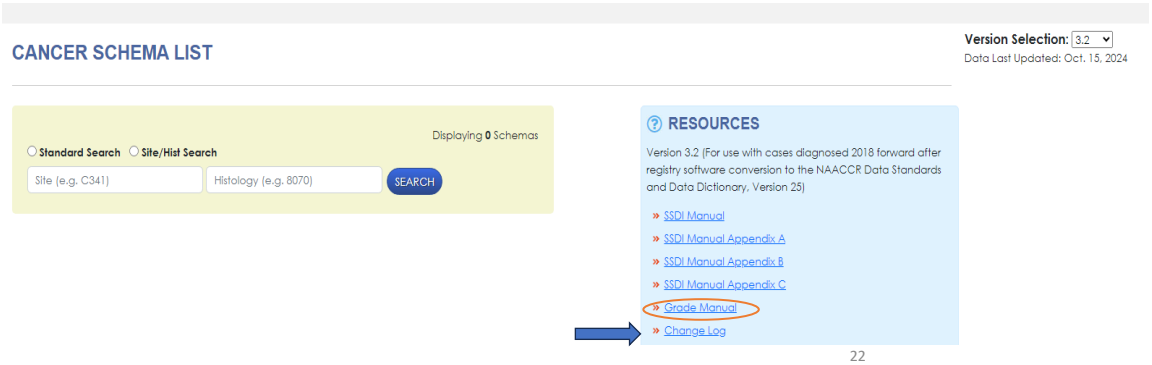
Grade Manual v3.2

SSDI and Grade Manual – NAACCR site:

https://apps.naaccr.org/ssdi/list/?_gl=1*1t8r1xq*_ga*NDk5ODY0NzI3LjE3MzE5NDIwMTA.*_ga_V7J8GWYK5P*MTc0NDA1NjQwMS45Ny4wLjE3NDQwNTY0MDEuNjAuMC4w



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NEW Table

Pleural Mesothelioma Table 27 (2025+)

Grade Description	Code
Nuclear Grade 1 *WITH* or *WITHOUT* necrosis **OR** Nuclear Grade 2 *WITHOUT* necrosis	**L**
Nuclear Grade 2 WITH necrosis **OR** Nuclear Grade 3 WITH or WITHOUT necrosis	**H**
Grade cannot be assessed; Unknown	**9**

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Breast – Grade Table 12

Timeframe	Note	Description
Post-Therapy Clinical (yc)	***Note 4***	2 Major grading systems used for breast and based on behavior: • Invasive: Nottingham grade/score • Based on 3 components: tubule formulation, nuclear pleomorphism, and mitotic count
Post-Therapy Path (yp)	***Note 5***	
Post-Therapy Clinical (yc)	***Note 6***	"Grade 1, 2, or 3" stated for invasive cancer and **NO** further information, **assume this is the Nottingham grade** • "Well diff, Mod diff, Poorly diff, low, med, high" use grades **Generic Grade Categories A-D** Do **NOT** use L, M, or H for invasive tumors
Post-Therapy Path (yp)	***Note 7***	
Post-Therapy Clinical (yc)	***Note 6***	In Situ tumors the preferred grading system is based on a 3 grade Nuclear system: • Low (**L**) (Nuclear grade 1) • Intermediate (**M**) (Nuclear grade 2) • High (**H**) (Nuclear grade 3) If pathologist states **Nottingham grade for in-situ tumor they are documenting the nuclear grade** – code L, M, or H Do **NOT** use grades 1, 2, or 3 for in situ tumors
Post-Therapy Path (yp)	***Note 8***	

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Other Updates…

- **Appendix** – Table 06
  - Clinical; Grade Post-Therapy Clinical = *Note 4*
  - Pathological; Grade Post-Therapy Path = *Note 5*
    - Assign **Grade 1 for LAMN** tumors
    - Assign **Grade 2 for HAMN** tumors

    Note: This was confirmed by AJCC physician experts

- **Cervix Sarcoma/Corpus Carcinoma & Carcinosarcoma/Corpus Sarcoma** – Table 13
  - Clinical; Grade Post-Therapy Clinical = *Note 3*
  - Pathological; Grade Post-Therapy Path = *Note 4*
    - For endometroid carcinomas **ONLY**
      - "**Low grade**" = code **2** (FIGO Grade 2)
      - "**High grade**" = code **3** (FIGO Grade 3)

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Case Scenarios

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Lung SSDI

Biomarker	Method	Analyte	Result	Therapeutic Assoc
PD-L1 (22c3)	IHC	Protein	Positive, TPS: 10%	Benefit – prembrolizumab
PD-L1 (28-8)	IHC	Protein	Positive, 1+, 5%	Benefit – nivolumab/Ipilimumab combo
PD-L1 (SP263)	IHC	Protein	Positive, TC: 1+ 10%	Benefit – atezolizumab (adjuvant)

What is the correct code for this lung cancer PD-L1 SSDI?

Code: 10.0
We code based on the Tumor Proportion Score (TPS)

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)

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Lung SSDI

Results from a PD-L1 report:

PD-L1 IHC 22C3 pharmDX –

Tumor Proportion Score (TPS)*: <1%

Expression level: Negative for PD-L1 expression (TPS less than 1%)

What is the correct code this lung cancer PD-L1 SSDI?

Code: 0.9
Based on general instructions recording values when "less than" are used
SSDI Manual, pg. 22

Recording values when "less than," "greater than," and "or least" are used

Record the value as **one less** than stated when a value is reported as "less than X," and as **one more** than stated when a value is reported as "more than X" or "at least." **One less** or **one more** may refer to a whole number (1), or a decimal (0.1), depending on the code structure of the field.

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PTLD

Bone Marrow biopsy: monomorphic post-transplant lymphoproliferative disorder (plasma cell myeloma), EBV negative. Monoclonal kappa plasmacytosis (estimated 20% by CD138 IHC)

What is the correct histology?

9732/3
Plasma cell myeloma

How would you code SSDI PTLD?

PTLD data item: 1
Monomorphic PTLD w/ a specified histology

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PTLD

Per physician, Stage IIA (bulk) PTLD – Hodgkin-like morphology, intermediate risk

What is the correct histology?

9650/3
Classic Hodgkin Lymphoma

How would you code SSDI PTLD?

PTLD data item: 2
PTLD, Hodgkin like

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Brain Molecular Marker

Cerebellar vermis resection: Pilocytic astrocytoma, CNS WHO grade 1; ngs: p.Gln22Lys and p.Leu19Phe in KRAS gene; Negative MYB, MYBL1

Physician note: KRAS Q22K and L19F mutations are not common for this type of tumor but do involve the pathway that is often altered for pilocytic astrocytoma. The genetic alteration does not change the plan for imaging surveillance.

How should we code Brain Molecular Marker?

A. 19 – Diffuse astrocytoma, MYB or MYBL1 altered
B. 86 – Borderline/Benign tumor
C. 99 – Not documented in medical record; unknown

May encounter an edit until registry software and edits updated to v25

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Breast Grade

Right UOQ breast, breast: DCIS, Nottingham Grade 2

Right UOQ, lumpectomy: Invasive ductal carcinoma, poorly differentiated

What is the clinical grade?

M – DCIS Nott Grade 2
You can't use codes 1, 2, or 3 for in situ tumors
Note 7: if Nottingham grade is stating the nuclear grade and code L, M, or H appropriately

What is the pathological grade?

C – IDC, Poorly Diff
Note 6: For invasive tumors use Generic Grades A-D as appropriate when it uses the "differentiation" for grade

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Endometrioid Grade

Endometrium biopsy: low grade endometrioid carcinoma

TAH/BSO: endometrioid carcinoma, FIGO grade 1

What is clinical grade?

Code: 2
Biopsy has "low grade", *Note 4* states code 2

What is pathologic grade?

Code: 2
Note 7: Code pathologic grade from clinical grade when clinical is higher grade

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Questions?

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