2018 Data Changes
Data Item Review &
CCR Collection Requirements

PART 1

Presented by
Donna M. Hansen, CTR
California Cancer Registry

Outline - 2018 Data Changes

Part 1: New Data Items
- CoC Accreditation Flag
- Medicare Beneficiary Identifier (MBI)
- Lymph Node/Sentinel LN Data Fields
- SEER SSF 1 - HPV Status
- Grade 2018
- SSDI 2018
- New Radiation Data Items
- AJCC TNM Categories

CoC Accreditation Flag

CCR Requires from all facilities
- Identifies an analytic cancer case at a facility accredited by the Commission on Cancer (COC)
- Status directly assigned at time of abstraction by someone who has knowledge of the CoC accreditation status
- Codes
  - 0 - Abstract prepared at a facility WITHOUT CoC accreditation of its cancer program
  - 1 - Analytic abstract prepared at facility WITH CoC accreditation (Includes Class of Case 10-22)
  - 2 - Non Analytic abstract prepared at facility WITH CoC accreditation (includes class of case codes 30-43 and 99, plus code 00 which CoC considers analytic but does not require to be staged)
  - Blank – Not applicable; DCO
Medicare Beneficiary Identifier (MBI)

**CCR Requires if information is available**
- Dx Date 2018+
- MBI is a randomly generated 11 character identifier
- Consists of numbers and upper-case letters
- Assigned to patient by Medicare
- Does not include SSN or any personal identifiable information

May leave blank when:
- Information is not available
- Non-Medicare Patient
- Not applicable
- Unknown

---

Sentinel Lymph Node Biopsy & Regional Lymph Node Dissection

New Data Items

---

Sentinel Lymph Nodes & Regional lymph Node Data Items

<table>
<thead>
<tr>
<th>New Data Items</th>
<th>Required Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Sentinel Lymph Node Biopsy</td>
<td>Breast &amp; Cutaneous Melanoma (skin)</td>
</tr>
<tr>
<td>Sentinel Lymph Nodes Positive</td>
<td>Only</td>
</tr>
<tr>
<td>Sentinel Lymph Nodes Examined</td>
<td></td>
</tr>
<tr>
<td>Date of Sentinel Lymph Node Biopsy FLAG</td>
<td></td>
</tr>
<tr>
<td>Date Regional Lymph Node Dissection</td>
<td>All Sites</td>
</tr>
<tr>
<td>Date Regional Lymph Node Dissection FLAG</td>
<td>All Sites</td>
</tr>
</tbody>
</table>
Date of Sentinel Lymph Nodes Biopsy (SLNBx)

- **Record the Date of the Sentinel lymph node(s) biopsy procedure**
  - Do not record the date of:
    - Lymph node aspiration [NOS]
    - Fine needle aspiration [NOS]
    - Fine needle aspiration biopsy [NOS]
    - Core needle biopsy or core biopsy [NOS]
  - **Must be definitively stated as a Sentinel LN procedure**
  - Complete Date Sentinel Lymph Node Flag if software does not auto populate

Sentinel Lymph Nodes Positive

- **Record exact number of Sentinel nodes found positive for metastases**

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>All sentinel nodes examined are negative</td>
</tr>
<tr>
<td>01-90</td>
<td>Sentinel nodes are positive (code exact number of nodes positive)</td>
</tr>
<tr>
<td>95</td>
<td>Positive core biopsy aspiration of sentinel lymph nodes was performed</td>
</tr>
<tr>
<td>97</td>
<td>Positive sentinel nodes are documented, but number is unspecified. For breast only; SLN and RLNO occurred during the same procedure</td>
</tr>
<tr>
<td>98</td>
<td>No sentinel nodes were biopsied</td>
</tr>
<tr>
<td>99</td>
<td>It is unknown whether sentinel nodes are positive; not applicable; not stated in patient record.</td>
</tr>
</tbody>
</table>

Sentinel Lymph Nodes Examined

- **Record total number of LNs sampled during SLNBx (positive & negative)**
  - Includes aspiration of SLNs
  - **Includes all LNs sampled during sentinel procedure** - even those described as not “hot”, “failed to map” or “non sentinel” nodes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>No sentinel nodes examined</td>
</tr>
<tr>
<td>01-90</td>
<td>Sentinel nodes were removed (code exact number of sentinel lymph nodes examined)</td>
</tr>
<tr>
<td>95</td>
<td>No sentinel nodes were removed, but aspiration of sentinel node(s) was performed</td>
</tr>
<tr>
<td>98</td>
<td>Sentinel lymph nodes were biopsied, but the number unknown</td>
</tr>
<tr>
<td>99</td>
<td>It is unknown whether sentinel nodes were examined; not applicable; not stated in patient record.</td>
</tr>
</tbody>
</table>
Date Regional Lymph Node Dissection (RLND)

- **Record the Date non-sentinel Regional Lymph Node Dissection was performed**
  - Applicable for all sites
  - Record the date of the Regional lymph node dissection documented in regional lymph nodes examined.
  - Used to assess date of regional node dissection performed *separate* from a sentinel lymph node biopsy if performed
  - If both a SLNBx (breast or melanoma skin only) and a non-sentinel RLND are performed, record the date of each procedure date in their respective data fields
    - May be same date
    - May be a different date
  - Complete Date RLND Flag if software does not auto populate

Coding Example 1: Sentinel Lymph Nodes

- Left breast 3cm mass on Mammo. 2/1/18 Core biopsy revealed MD invasive ductal ca. SLNbx 2/5/18 revealed 1 blue sentinel LN, with 2 additional non-sentinel LNs without dye uptake. Pathologic exam revealed 0/3 SLNs positive. 2/10/18 lumpectomy performed. No RLND.
  - Total sentinel lymph nodes pos/examined =0 pos/3 examined

<table>
<thead>
<tr>
<th>Status</th>
<th>Data Field Name</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>Date of Sentinel lymph Node Biopsy</td>
<td>02/05/2018</td>
</tr>
<tr>
<td>New</td>
<td>Sentinel Lymph Nodes Positive</td>
<td>00</td>
</tr>
<tr>
<td>New</td>
<td>Sentinel Lymph Nodes Examined</td>
<td>03</td>
</tr>
<tr>
<td>New</td>
<td>Date Regional Lymph Node Dissection</td>
<td>blank</td>
</tr>
<tr>
<td>Current data item</td>
<td>Regional Lymph Nodes Positive</td>
<td>0</td>
</tr>
<tr>
<td>Current data item</td>
<td>Regional Lymph Nodes Examined</td>
<td>3</td>
</tr>
</tbody>
</table>

Coding Example 2: Sentinel Lymph Nodes

- Left breast 3cm mass on Mammo. Core biopsy revealed MD invasive ductal ca. On 2/1/18 lumpectomy with SLNbx performed. 1/1 sentinel lymph node was positive; therefore, surgeon proceeded with an axillary lymph node dissection. Malignancy noted in an additional 2 of 14 axillary lymph nodes.
  - A total of 3/15 lymph nodes were positive for metastases.

<table>
<thead>
<tr>
<th>Status</th>
<th>Data Field Name</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>Date of Sentinel lymph Node Biopsy</td>
<td>02/01/2018</td>
</tr>
<tr>
<td>New</td>
<td>Sentinel Lymph Nodes Positive</td>
<td>01</td>
</tr>
<tr>
<td>New</td>
<td>Sentinel Lymph Nodes Examined</td>
<td>01</td>
</tr>
<tr>
<td>New</td>
<td>Date Regional Lymph Node Dissection</td>
<td>02/01/2018</td>
</tr>
<tr>
<td>Current data item</td>
<td>Regional Lymph Nodes Positive</td>
<td>03</td>
</tr>
<tr>
<td>Current data item</td>
<td>Regional Lymph Nodes Examined</td>
<td>15</td>
</tr>
</tbody>
</table>
Coding Example 3: Date Regional Lymph Node Dissection


<table>
<thead>
<tr>
<th>Status</th>
<th>Data Field Name</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>Date of Sentinel lymph Node Biopsy</td>
<td>blank</td>
</tr>
<tr>
<td>New</td>
<td>Sentinel Lymph Nodes Positive</td>
<td>blank</td>
</tr>
<tr>
<td>New</td>
<td>Sentinel Lymph Nodes Examined</td>
<td>blank</td>
</tr>
<tr>
<td>New</td>
<td>Date Regional Lymph Node Dissection</td>
<td>02/29/2018</td>
</tr>
</tbody>
</table>

Current data item Regional lymph Nodes Positive 04
Current data item Regional lymph Nodes Examined 24

Sentinel Lymph Nodes & Regional lymph Node Data Items

- **Collection Requirements**

<table>
<thead>
<tr>
<th>Data Items</th>
<th>Required Sites</th>
<th>Required by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentinel Lymph Nodes Positive</td>
<td>Breast &amp; Cutaneous Melanoma (skin) Only</td>
<td>X X</td>
</tr>
<tr>
<td>Sentinel Lymph Nodes Examined</td>
<td>All Sites</td>
<td>X</td>
</tr>
<tr>
<td>Date of Sentinel Lymph Node Biopsy</td>
<td>All Sites</td>
<td>X</td>
</tr>
<tr>
<td>Date Regional lymph Node Dissection FLAG</td>
<td>All Sites</td>
<td>X</td>
</tr>
</tbody>
</table>

- See CCR Volume 1 and/or CoC STORE manual for further coding guidelines

SEER SSF1 – HPV Status

Human Papilloma Virus

- CCR Requires from all facilities
SEER Site Specific Factor 1 – HPV Status

- Effective with Date Dx 2018+
- Applicable schemas:
  - Lip and Oral Cavity: C000-C009, C020-C029, C030, C031, C040-C041, C046-C048, C050, C058-C059, C060-C062, C064-C069
  - Oropharynx (p16+): C019, C024, C051-C053, C090-C091, C098-C099, C100, C102-C103, C108-C109, C111
  - Oropharynx (p16-) and Hypopharynx: C019, C024, C051-C053, C090-C091, C098-C099, C100, C102-C103, C108-C109, C111, C120, C130-C132, C138-C139
- Codes 0-7 are hierarchical;
  - 0 is highest, 7 is lowest
  - Use the highest code which applies

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>HPV negative for viral DNA by ISH test</td>
</tr>
<tr>
<td>1</td>
<td>HPV positive for viral DNA by ISH test</td>
</tr>
<tr>
<td>2</td>
<td>HPV negative for viral DNA by PCR test</td>
</tr>
<tr>
<td>3</td>
<td>HPV positive for viral DNA by PCR test</td>
</tr>
<tr>
<td>4</td>
<td>HPV negative by ISH E6/E7 RNA test</td>
</tr>
<tr>
<td>5</td>
<td>HPV positive by ISH E6/E7 RNA test</td>
</tr>
<tr>
<td>6</td>
<td>HPV negative by RT-PCR E6/E7 RNA test</td>
</tr>
<tr>
<td>7</td>
<td>HPV positive by RT-PCR E6/E7 RNA test</td>
</tr>
<tr>
<td>8</td>
<td>HPV status reported in medical records as positive or negative but test type is unknown</td>
</tr>
<tr>
<td>9</td>
<td>Unknown if HPV test detecting viral DNA and or RNA was performed</td>
</tr>
</tbody>
</table>

- Record only HPV status determined by tests designed to detect viral DNA or RNA.
  - Tests such as ISH, PCR, RT-PCR technologies detect the viral DNA or RNA
  - Or, HPV type 16 refers to a virus type and is different from p16 overexpression (p16+)
  - Record results of any HPV testing performed on pathologic specimens including surgical and cytological (cell blocks) tissue from the primary tumor or a metastatic site, including lymph nodes

- Several methods are used for determination of HPV status.
  - Most frequently used test is IHC for p16 expression which is a surrogate marker for HPV infection
- Do Not record the results of IHC p16 over expression [p16+] in this field
- Do Not record results of blood tests or serology
- Leave blank when no applicable test performed

Grade

Clinical
Pathological
Post-therapy
Grade 2018

The following have been discontinued for cases 2018+

- Single grade data item
- SSFs which collected site-specific grades (e.g., Breast, Prostate, Soft Tissue, etc.)
  - Retained for cases 2004-2017
- Cell lineage indicator/grade for hematopoietic and lymphoid neoplasms
  - Exception: Ocular Adnexa Lymphoma AJCC 8th Ed Chapter 71
  - AJCC has a defined grading system for the follicular histologies
  - Applicable primary sites: C441, C690, C695, C696
  - Applicable histologies 9690/3, 9691/3, 9695/3, 9698/3
  - Grade for all other histologies collected in AJCC Chapter 71 coded as 9

Grade 2018 – 3 New Data Items

- Grade Clinical
  - Highest grade from clinical workup – usually from a biopsy or FNA
  - Prior to any treatment (surgical resection or neoadjuvant therapy, etc.)
- Grade Pathological
  - Grade from the surgical resection of the primary tumor or organ
  - OR uses microscopic clinical grade if it was higher then the grade determined from surgical resection (including unknown grade)
  - AND neoadjuvant therapy was NOT administered
- Grade Post-therapy
  - Grade from resection of the tumor or organ AFTER completion of neoadjuvant therapy - only
  - Clinical grade excluded and may never be used to code post-therapy grade

Grade 2018

- AJCC Site-Specific grading systems incorporated into 2018 Grade
- Site specific grading systems are the preferred grade system for that cancer site.
- AJCC preferred grade required to assign AJCC TNM Stage groups for 8 sites
- Many sites - coding options include a combination of
  - Preferred AJCC grade system,
  - CAP protocol special grade,
  - and/or Generic cancer registry grade categories.
- Sites w/o an AJCC recommended grade (14) use historical grade definitions.
- Sites w/o an AJCC Chapter or recommended grade (16) use historical definitions
Grade 2018

- **Grade Codes Restructured**
  - Combination of numeric & alphabetic codes within the same table
  - Codes 1-5, L, H, M, S and 9 represent AJCC recommended grading systems
    - Priority over generic grades (A-E)
  - Code 8 for Hematopoietic neoplasms only
  - Codes A-E represent generic grade categories
  - Each site or groups of sites have a specific grade table
  - Grade assigned for every reportable case

<table>
<thead>
<tr>
<th>Code</th>
<th>Grade Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Grade cannot be assessed; Unknown</td>
</tr>
<tr>
<td>A</td>
<td>Well differentiated</td>
</tr>
<tr>
<td>B</td>
<td>Moderately differentiated</td>
</tr>
<tr>
<td>C</td>
<td>Poorly differentiated</td>
</tr>
<tr>
<td>D</td>
<td>Undifferentiated and anaplastic</td>
</tr>
<tr>
<td>E</td>
<td>Site-specific grade system category</td>
</tr>
<tr>
<td>H</td>
<td>High grade</td>
</tr>
<tr>
<td>L</td>
<td>Low Grade</td>
</tr>
<tr>
<td>M</td>
<td>Site-specific grade system category</td>
</tr>
<tr>
<td>S</td>
<td>Site-specific grade system category</td>
</tr>
<tr>
<td></td>
<td>Blank (Post therapy only)</td>
</tr>
</tbody>
</table>

**Template for a Cancer-Specific Grade Table**

<table>
<thead>
<tr>
<th>Code</th>
<th>Grade Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Site-specific grade system category</td>
</tr>
<tr>
<td>2</td>
<td>Site-specific grade system category</td>
</tr>
<tr>
<td>3</td>
<td>Site-specific grade system category</td>
</tr>
<tr>
<td>4</td>
<td>Site-specific grade system category</td>
</tr>
<tr>
<td>5</td>
<td>Site-specific grade system category</td>
</tr>
</tbody>
</table>

**Grade Table - Breast**

<table>
<thead>
<tr>
<th>Code</th>
<th>Grade Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>G1: Low combined histologic grade (favorable), SBR score of 3-5 points</td>
</tr>
<tr>
<td>2</td>
<td>G2: Intermediate combined histologic grade (moderately favorable), SBR score of 6-7 points</td>
</tr>
<tr>
<td>3</td>
<td>G3: High combined histologic grade (unfavorable), SBR score of 8-9 points</td>
</tr>
<tr>
<td>L</td>
<td>Nuclear Grade I (Low) (in situ only)</td>
</tr>
<tr>
<td>M</td>
<td>Nuclear Grade II (Intermediate) (in situ only)</td>
</tr>
<tr>
<td>H</td>
<td>Nuclear Grade III (High) (in situ only)</td>
</tr>
<tr>
<td>A</td>
<td>Well differentiated</td>
</tr>
<tr>
<td>B</td>
<td>Moderately differentiated</td>
</tr>
<tr>
<td>C</td>
<td>Poorly differentiated</td>
</tr>
<tr>
<td>D</td>
<td>Undifferentiated, anaplastic</td>
</tr>
<tr>
<td>9</td>
<td>Grade cannot be assessed (GX); Unknown</td>
</tr>
</tbody>
</table>

**Priority AJCC Grade for invasive**

- Used when tumor is only in situ
- Used when a more specific grade above was not determined for an invasive ca and path report
- Used these terms for grade

**2018 Grade Tables**

- Appropriate grade table for site derived/selected by registry software
  - Based on Registrar coding
    - Primary Site
    - Histology
    - Schema Discriminator (if applicable)
  - Each Grade table “set” includes a clinical, pathological and post-therapy table along with their respective coding “Notes”
    - Grade codes and coding notes will differ based on primary site/histology
    - Coding notes will differ for each grade data item
      - Clinical, Pathological, Post-therapy
Grade 2018

3 Grade Data Items

• TWO (2) GRADES usually defined per case, sometimes 1, never 3
  • Clinical Grade
    • Most of the time - unless no Dx until surgery
  • Pathological Grade
  • Post-therapy Grade

• Clinical & Pathological Grade may never be blank
• Post-therapy grade can be blank

2018 Grade Manual

➢ Primary resource for documentation and coding instructions
• Important to review the Manual:
  – Organization & Suggestions on how to use
  – General Instructions & General Rules
  – Background and additional information
  – Updates/Revisions to coding Guidelines

➢ Post questions on Grade in the CAnswer Forum
• Periodically review CAnswer Forum
  – Clarifications provided on specific coding situations

• Review general instructions, rules and background info
• Reflects info NOT in software notes
Grade 2018 - Webinar

- See the NAACCR website for a detailed review of the 2018 Grade Coding Rules.

  https://education.naaccr.org/2018-implementation

Site Specific Data Items
**Site Specific Data Item (SSDI)**

- Majority of SSDIs were former SSFs
- 137 SSDIs for 2018
- SSDIs have a specific name (not a number)
  - Example: Prostate CS SSF#2
  - Now SSDI named - Prostatic Specific Antigen (PSA)
- Most New SSDIs needed for AJCC 8th edition stage
- New Code structure
  - Code lengths varies from 1-7 characters
  - Mix of numbers and letters
  - Decimal points included where applicable
- SSDIs may be used for a single schema
  - Example: CRM for colon
- Or SSDIs can be used for multiple sites/chapters/schema when applicable
  - Examples: Perineural Invasion
    - H&N Cutaneous Squamous cell ca
    - Colon and Rectum
    - Eyelid Carcinoma
    - Lacrimal Gland
- Software will select applicable SSDIs for case based on derived schema ID

**Important:**
- If former SSF, updated SSDI may have Revised coding instructions which differ from CS

---

**Site Specific Data Items (SSDI)**

Revised coding instructions from CS for many SSDIs – Examples:

- Kidney and status of adrenal gland involvement
  - Use of Code 0 (neg/not present) requires a statement involvement is *not present* (otherwise coded to 9/unknown)

- Colon and status of Tumor Deposits or Perineural invasion
  - Coded to 9/unknown when pathology does not mention

  ➢ These are changes from CS which allowed registrar to assume negative status for some SSFs when they were not mentioned.

- Some previous definitions moved into the unknown category
  - Example: “Test not done” and “Unknown if test done”
    - Both definitions are included in unknown code 9

---

**SSDI Manual**

- REVIEW the SSDI Manual:
  - Each SSDI has useful background information
  - Additional coding guidelines
  - Updates & Clarifications will be added to SSDI MANUAL - not software

- DO NOT RELY SOLELY ON SOFTWARE CODING NOTES!

- NAACCR custodian of the SSDI Manual
  - [https://apps.naaccr.org/ssdi/list/](https://apps.naaccr.org/ssdi/list/)
SSDI Manual & SSDI Schema – Where are they?

Option 1: **NAACCR**

- **Manual & Schema available on NAACCR website**

- **NAACCR is Custodian of SSDI Manual**: [https://apps.naaccr.org/ssdi/list/](https://apps.naaccr.org/ssdi/list/)

SSDIs included in SEER*RSA Schema

Option 2:

- **SEER*RSA** [https://staging.seer.cancer.gov/](https://staging.seer.cancer.gov/)

- Includes Schemas only
- SSDI Manual not included
- Schemas include codes for EOD/GRADE/Summary Stage & other data items for site

Schema Example in SEER*RSA - Kidney parenchyma

SEER*RSA schema also includes links to other data items plus the SSDIs (which includes grade)
**Site Specific Data Items (SSDI)**

- **CCR Required SSDIs must be collected by all facilities**
  - DX Year 2018 forward
  - Refer to Volume Appendix Q for list of CCR required SSDI(s)

- CCR and CoC facilities may have different collection requirements
  - CoC facilities should Refer to the STORE manual for requirements

---

**Site Specific Data Items (SSDI)**

- **Example # 1 Appendix Q:**

  **Q: Floor of Mouth**

<table>
<thead>
<tr>
<th>AJCC ID</th>
<th>Schema ID</th>
<th>Schema ID Description</th>
<th>Site Codes</th>
<th>Histology Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
<td>00074</td>
<td>Floor of Mouth</td>
<td>0005-0010, 0040-0049</td>
<td>8050-8750, 8962, 0700-0770</td>
</tr>
</tbody>
</table>

  **Standard Setter Requirement**

<table>
<thead>
<tr>
<th>SSDI Name</th>
<th>CCR</th>
<th>CoC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extranodal Extension Head and Neck Clinical</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Extranodal Extension Head and Neck Pathological</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>LN Site</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>SEER Site-Specific Fac 1</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

---

**Site Specific Data Items (SSDI)**

- **Example # 2 Appendix Q:**

  **Q: Breast**

<table>
<thead>
<tr>
<th>AJCC ID</th>
<th>Schema ID</th>
<th>Schema ID Description</th>
<th>Site Codes</th>
<th>Histology Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>48.1, 48.2</td>
<td>00440</td>
<td>Breast</td>
<td>0000-0200, 0050-0059</td>
<td>8000-8700, 8962-8983, 9750-9771</td>
</tr>
<tr>
<td>XX</td>
<td>00440</td>
<td>Breast</td>
<td>0000-0200, 0050-0059</td>
<td>0720-0790</td>
</tr>
</tbody>
</table>

  **Standard Setter Requirement**

<table>
<thead>
<tr>
<th>SSDI Name</th>
<th>CCR</th>
<th>CoC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estrogen Receptor Poor or Negative or Biologic</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Estrogen Receptor Positive or Biologic</td>
<td>CoC Facilities ONLY</td>
<td></td>
</tr>
<tr>
<td>Estrogen Receptor Summary</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Estrogen Receptor Total Assay Score</td>
<td>CoC Facilities ONLY</td>
<td>X</td>
</tr>
<tr>
<td>HER2 IHC Summary</td>
<td>CoC Facilities Non-QC - As Available</td>
<td>X</td>
</tr>
<tr>
<td>HER2 IHC Dual Probe Assay Number</td>
<td>CoC Facilities Non-QC - As Available</td>
<td>X</td>
</tr>
</tbody>
</table>
SSDI Education – Practical Application Tests

SEER*EDUCATE

SSDI 2018 (new material)
- Breast 04-06
- Breast 06-10
- Cervix 05-09
- Colon and Rectum 01-05
- Colon and Rectum 06-10
- Corpus Uteri - Carcinoma and Carcinosarcoma
- Kidney
- Liver
- Lung 01-05
- Lung 06-10
- Melanoma of the Skin 01-05
- Melanoma of the Skin 06-10
- Ovary, Fallopian Tube, and Primary Peritoneal Carcinoma 01-05
- Ovary, Fallopian Tube, and Primary Peritoneal Carcinoma 06-10
- Prostate 01-05
- Prostate 06-10
- Testis

Practical Application Tests Available
- 85 cases in groups of 5
- NCRA CEs approved


Volume 1, VI.3 – VI.3.11

Radiation Therapy

New Data Items
- New Codes
- Database conversion

CoC developed 24 new Radiation data items
- New “Phase” terminology
  - Replaces terms “regional” & “boost”
- 3 Phases can be collected
  - Phase I: Typically initial treatment to primary tumor or tumor bed
  - Phase II-III: Subsequent boost(s) which can occur to tumor bed, LNs, etc., with same or alternate radiation modalities

Phase I-III Radiation Primary Treatment Volume
Phase I-III Radiation to Draining Lymph Nodes
Phase I-III Radiation Treatment Modality
Phase I-III External Beam Radiation Planning Technique
Phase I-III Dose per Fraction
Phase I-III Number of Fractions
Phase I-III Total Dose
Number of Phases Radiation Treatment to this Volume
Radiation Treatment Discontinued Early
Total Dose [all phases combined]
Radiation Primary Treatment Volume

Volume = primary anatomic target

- STORE Codes completely different from FORDS codes
  - Expanded codes capture radiation
    - Primary Tumor or tumor bed
      - Breast- whole, code 40
      - Bladder-whole, code 60
      - Oral pharynx, code 22
    - Or, only to draining lymph nodes for anatomic region
      - Breast/chest wall lymph node regions, code 04
      - Abdominal lymph nodes, code 07
      - Neck lymph node regions, code 01
    - Use codes 01-09 when the LNs are the primary target

Radiation Therapy to Draining Lymph Nodes

- Captures radiation to regional “draining lymph nodes” treated in the same phase as radiation to the primary anatomic site or tumor bed
  - Codes 00-08 are actually the same as found in the Volume codes table – because they are describing the same LN regions
  - Code 88 - Use when radiation to LNs was the primary anatomic target (which you already captured in Primary Radiation Treatment Volume)

Radiation Primary Treatment Volume & Draining lymph nodes

- Example Scenario # 1: Radiation to right breast and lumpectomy site and level II axillary lymph nodes
  - Radiation Primary Treatment Volume Data Item:
    - Code 40 = Whole Breast
    - Whole breast includes treatment direct at all intact breast, which includes tissue either not surgically treated or received lumpectomy or partial mastectomy
  - Radiation to Draining lymph nodes Data Item:
    - Code 04 = Breast/Chest wall lymph node regions
Radiation Primary Treatment Volume & Draining lymph nodes

- Example Scenario #2: Pt s/p right partial mastectomy. Radiation to axillary lymph nodes only (no radiation to breast).
  - Radiation Primary Treatment Volume Data Item:
    - Code =04 Radiation to Breast/Chest wall lymph node regions
      - Code 04 includes axillary, supraclav or intramammary regions
      - Targeted anatomic area “Volume” was only the lymph nodes
  - Radiation to Draining lymph nodes Data Item:
    - Code = 88 Not applicable; Phase 1 Radiation Primary Treatment Volumes is lymph nodes [only]
    - Radiation to draining LNs already coded in “Primary Treatment Volume”

Radiation Modality vs Planning Technique

- Previous (FORDS) “Regional Treatment Modality”:
  - Codes were Mix of treatment modalities, planning techniques and delivery techniques commonly utilized
  - Codes were not mutually exclusive
- New (STORE) Phase I-III “Radiation Treatment Modality” codes
  - Only reflect whether treatment was
    - External beam
    - Brachytherapy
    - Radioisotopes
    - Major subtypes or combinations
  - Modality coded Separately from “Planning Technique”

Radiation Therapy “Modality”

- Former FORDS Radiation Modality codes
- New 2018 STORE Radiation Modality Codes

Codes combination of Modalities, Planning techniques, Delivery techniques

2018 Goal: Separate radiation modality from radiation planning techniques to clarify information with mutually exclusive categories
Radiation External Beam Planning Technique

- New External Beam Radiation Planning Technique

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>No radiation treatment</td>
</tr>
<tr>
<td>01</td>
<td>External beam, NOS</td>
</tr>
<tr>
<td>02</td>
<td>Low energy x-ray/photons therapy</td>
</tr>
<tr>
<td>03</td>
<td>3-D therapy</td>
</tr>
<tr>
<td>04</td>
<td>Conformal or 3-D conformal therapy</td>
</tr>
<tr>
<td>05</td>
<td>Intensity modulated therapy</td>
</tr>
<tr>
<td>06</td>
<td>Stereotactic radiotherapy or radiosurgery, NOS</td>
</tr>
<tr>
<td>07</td>
<td>Stereotactic radiotherapy or radiosurgery, robotic</td>
</tr>
<tr>
<td>08</td>
<td>Stereotactic radiotherapy or radiosurgery, Gamma Knife®</td>
</tr>
<tr>
<td>09</td>
<td>CTV guided online adaptive therapy</td>
</tr>
<tr>
<td>10</td>
<td>MRI guided online adaptive therapy</td>
</tr>
<tr>
<td>88</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Other, NOS</td>
</tr>
<tr>
<td>99</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

- Codes reflect External Beam Planning Technique used to define target treatment area and/or administer the radiation

2018 Radiation Data Items

<table>
<thead>
<tr>
<th>Data Item</th>
<th>CoC facility</th>
<th>Non-CoC facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Diagnosis 1/1/2018+</td>
<td>Required</td>
<td>As Available</td>
</tr>
<tr>
<td>Phase I-III Radiation Primary Treatment Volume</td>
<td>Required</td>
<td>As Available</td>
</tr>
<tr>
<td>Phase I-III Radiation to Draining Lymph Nodes</td>
<td>Required</td>
<td>As Available</td>
</tr>
<tr>
<td>Phase I-III Radiation Treatment Modality</td>
<td>Required</td>
<td>Required Phase I-III</td>
</tr>
<tr>
<td>Phase I-III External Beam Radiation Planning Technique</td>
<td>Required</td>
<td>Required Phase I-III</td>
</tr>
<tr>
<td>Phase I-III Dose per Fraction</td>
<td>Required</td>
<td>As Available</td>
</tr>
<tr>
<td>Phase I-III Number of Fractions</td>
<td>Required</td>
<td>As Available</td>
</tr>
<tr>
<td>Phase I-III Total Dose</td>
<td>Required</td>
<td>As Available</td>
</tr>
<tr>
<td>Number of Phases of Radiation Treatment to this Volume</td>
<td>Required</td>
<td>As Available</td>
</tr>
<tr>
<td>Radiation Treatment Discontinued Early</td>
<td>Required</td>
<td>As Available</td>
</tr>
<tr>
<td>Total Dose (All Phases)</td>
<td>Required</td>
<td>As Available</td>
</tr>
</tbody>
</table>

Radiation Therapy data items

CoC facility Case DX Date 2017 or earlier (& collected in v18 software)

- Code radiation in all the new 2018 radiation fields as appropriate
  - CoC requires radiation coded in the new fields for cases diagnosed in any year
  - CoC database conversion repopulates old radiation data fields with applicable NEW radiation codes
- If date dx prior to 2018, CoC facilities must ALSO code:
  - Radiation Regional RX Modality
  - Radiation RX Summ (directly assigned, software will no longer calculate)
  - Required by NPCR & SEER

Non-CoC 2017 or earlier Cases:

- Code only Radiation Regional RX Modality and Radiation RX Summ
See the NAACCR website for a detailed review of the new Radiation Coding Rules

https://education.naaccr.org/2018-implementation

AJCC TNM 8th edition

- Clinical
- Pathological
- Post-therapy
- Suffixes

AJCC TNM 8th edition

- All new AJCC 8th edition stage data items
  - THREE separate classifications of stage for 2018 - each collected separately

<table>
<thead>
<tr>
<th>Clinical Stage</th>
<th>Pathological Stage</th>
<th>Post therapy Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical T</td>
<td>Pathological T</td>
<td>Post therapy T</td>
</tr>
<tr>
<td>Clinical T suffix</td>
<td>Pathological T suffix</td>
<td>Post therapy T suffix</td>
</tr>
<tr>
<td>Clinical N</td>
<td>Pathological N</td>
<td>Post therapy N</td>
</tr>
<tr>
<td>Clinical N suffix</td>
<td>Pathological N suffix</td>
<td>Post therapy N suffix</td>
</tr>
<tr>
<td>Clinical M</td>
<td>Pathological M</td>
<td>Post therapy M</td>
</tr>
<tr>
<td>Clinical Stage</td>
<td>Pathological Stage</td>
<td>Post therapy Stage</td>
</tr>
</tbody>
</table>

- Field length now 15 characters
  - ypTis(DCIS)
  - pN0(mol+)(sn)
  - cM1b(t)

- 2018 AJCC TNM 8th edition data fields separate from AJCC 7th edition data fields
  - No conversions between 7th and 8th will take place
  - Staging fields may be blank when not applicable for case
**AJCC TNM 8th edition**

- **New Data Items for T suffix**
  - T suffix – indicates multiple tumors or solitary tumor
    - cT suffix
    - pT suffix
    - ypT suffix

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>m</td>
<td>(m)</td>
<td>Multiple synchronous tumors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Or For thyroid differentiated and anaplastic only, Multifocal tumor</td>
</tr>
<tr>
<td>s</td>
<td>(s)</td>
<td>For thyroid differentiated and anaplastic only, Solitary tumor</td>
</tr>
</tbody>
</table>

- Leave field blank if (m) or (s) do not apply to case

**Note:** (m) does not apply to multiple foci of in situ tumors, or mixed invasive and in situ cancer

- **New Data Items for N suffix**
  - N suffix – indicates limited nodal information
    - cN suffix
    - pN suffix
    - ypN suffix

<table>
<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>sn</td>
<td>(sn)</td>
<td>Sentinel node procedure without resection of nodal basin</td>
</tr>
<tr>
<td>f</td>
<td>(f)</td>
<td>FNA or core needle biopsy without resection of nodal basin</td>
</tr>
</tbody>
</table>

- Leave field blank if sentinel node biopsy or FNA was not completed

**Clinical Stage use – part of diagnostic workup**

- cN(sn) or cN(f)

**Pathological Stage use - part of initial surgical Rx**

- pN(sn) or pN(f)

**NOTE:** Suffix NOT used in pN if subsequent completion LND performed at surgery

---

**AJCC TNM 8th edition Webinars**

- Eight Edition Overview
- Introduction & Descriptors
- Major Rule Changes
- Minor Rule Changes
- CAnswer Forum & Staging Questions
- Head & Neck Staging
- Breast Staging

END OF 2018 DATA CHANGES PART 1

Existing Data Items/Revised-Clarified
- Lymphovascular Invasion
- Tumor Size (clinical, pathologic, summary)
- LCIS reportability & staging

Please see Part 2 for review of the following:

Updates
- ICD-O-3
- EOD 2018 & Summary Stage 2018
- SEER 2018 Solid Tumor Rules
- SEER "Heme" & Lymphoid Neoplasm DB
- CoC STORE Manual

CCR Updates
- California Cancer Reporting System Standards, Volume 1-2018: Abstracting and Coding Procedures

Thank you

- Donna M. Hansen, CTR
  Auditor/Education Training Coordinator
  California Cancer Registry
  916-731-2543
  Email: dxhansen@ucdavis.edu