**Race Coding Updates**

**Update to Current Manual (2024)/Race**

For the Example #15 under Race Coding Examples in the 2024 SEER manual, *could coding these as 97 result in an under-reporting of Native Hawaiians?*

**What race code should be used in a situation where the only available information is “Native Hawaiian/Pacific Islander?”**

**Answer**

Change to current instructions. We will update this example in the next edition of the manual. The new example will instruct registrars to look for other descriptions of the patient’s race. When no other information is available, assign 07, Native Hawaiian, in Race 1 and assign 97, Pacific Islander, NOS in Race 2. Begin following this new instruction now.

[SEER SINQ 20240039](#)

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**How is Race coded when stated as Hispanic and there is no other information?**

There appears to be discrepant information in the 2024 (and prior) SEER manual regarding race coding when the patient is described only as Hispanic/Latina.

**[SEER Manual] page 78 tells us to Code as 01 (White) when:**

| b. | There is a statement that the patient is Hispanic or Latino(a) and no further information is available. A person of Spanish origin may be any race; however, for coding race when there is no further information other than “Hispanic” or “Latino(a),” assign race as White as a last resort instead of coding unknown. However, Appendix D, under “Other Race descriptions,” [states] that "If no further information is available, code as 99 Unknown." The list includes "Hispanic."

**Answer**

Assign code 01 (White) for Hispanic when there is no additional information. It is listed in the 2024 SEER Manual, Race Coding Instruction 6.b.i. and in Appendix D for code 01. We will remove Hispanic from the list in Appendix D under code 99 in the next version of the manual.

[SEER SINQ 20240036](#)

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**Melanoma Surgery Coding Updates for 2023+**

- Margins are no longer incorporated into the surgery codes. This is captured separately in the SSDI for 2023+ Clinical Margin Width.

**Excisional, Shave, Punch, Elliptical Biopsies are ALWAYS coded as surgery.**

- Assign biopsy procedures to Surgical Diagnostic and Staging Procedures ONLY when there is a small specimen of tissue taken from the melanoma tumor such as a needle or core biopsy.

- Assign the surgery code based on the description of the procedure. **Priority Order for assigning surgery code:**
  1. Operative report
  2. Statement from a physician
  3. Description of the surgical procedure on a pathology report
  4. Results of the pathology report

**Lymphoma Primary Site Coding Tips**

- Do not assume that the lymphoma originated in the biopsied lymph node chain.

- Remember providers will usually biopsy the most accessible lymph nodes or other involved tissues.

- **Always look for lymphadenopathy on the PET/CT and follow the rules in the HP manual for assigning primary site.**

**2024 Fall Virtual SEER Workshop**

**Advanced Topics for Registry Professionals**

September 24-26, 2024

Registration is through NCRA. Workshop exercises are posted on SEER Educate. Complete by August 15, 2024.

**NAACCR Boot Camp 2024 Webinar**

**SEER SINQ 20240036**

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**SEER SINQ 20240039**

Questions can be sent to your facility’s NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email. The information provided here is correct as the distribution date of the newsletter. **Always check your manuals!**
**Cancer PathCHART Site-Morphology Combination Standards**

The 2024 Cancer PathCHART ICD-O-3 Site Morphology Validation List (CPC SMVL), output directly from the Cancer PathCHART database, is a comprehensive table that replaces both the ICD-O-3 SEER Site/Histology Validation List and the list of impossible site and histology combinations included in the Primary Site, Morphology-ImpSSSSEER IF38) edit.

The downloadable list can be found at https://seer.cancer.gov/cancerpathchart/products.html.

**Cancer PathCHART SVML Search Tool:**
For January 2024 implementation, a webtool is now available on the Cancer PathCHART website that will allow searches for tumor topography, histology, and behavior codes and terms and whether the site-morphology combinations are biologically valid, impossible, or unlikely.

**SEER Program Coding and Staging Manual 2024**
**Cancer PathCHART Search Tool**

**Looking for ICD-10-CM Codes for Intraepithelial neoplasia???
Check out SEER SINQ 20240020**

**Behavior Coding for Intracranial and CNS Tumors**
Intracranial and CNS tumors with behavior codes 0 (benign) and 1 (borderline malignancy) are reportable beginning with January 1, 2004 diagnoses.

Code the behavior from CT scan, Magnetic Resonance Imaging (MRI), or Positron Emission Tomography (PET) report when there is no tissue diagnosis (pathology or cytology report). **Code the behavior listed on the scan. Do not use the WHO grade to code behavior.**

**SEER Program Coding and Staging Manual 2024**

**Question:**
Breast: Is ductal carcinoma in situ (DCIS), solid type coded as 8500/2 or 8230/2?

In the NAACCR Coding Pitfalls 2023 webinar, the example of DCIS, solid type is given. The webinar advised us to code 8230/2 (ductal carcinoma in situ, solid type). When going through the beginning of the solid tumor rules in the Changes from 2007 MPH Rules section it states "DCIS/Carcinoma NST in situ has a major classification change. Subtypes/variant, architecture, pattern, and features ARE NOT CODED. The majority of in situ tumors will be coded to DCIS 8500/2." In the equivalent or equal terms section it lists "Type, subtype, variant" can be used interchangeably.

Since the example has it listed as ductal carcinoma in situ, solid "type," would we code 8500/2 or 8230/2?

**Answer:**
Assign 8230/2 (ductal carcinoma in situ, solid type/intraductal carcinoma, solid type) using Breast Solid Tumor Rules Table 3 as instructed in Rule H2 for in situ tumors. The carcinoma, NST row lists this histology in the subtype/variant column 3.

Coding histology for in situ breast tumor differs from invasive. While the majority of in situ breast primaries will be coded to DCIS 8500/2, there are others that are listed in Table 3 that should be coded according to the specific histology. Some codes have the word subtype or type as part of their histologic term so these can be coded based on the histologic term as listed in the table. We suggest you routinely review the histology tables to see if a term is listed.

**SEER SINQ 20240015**

Submission recommendations for the reporting year:
**All 2023 records submitted by July 1, 2024.**

Check out new shorts on FlccSC!!
Address at Diagnosis Race

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Histology coding for Digestive Sites:

SEER Program Coding and Staging Manual indicates high grade dysplasia of esophagus, stomach, and small intestine are reportable. The ICD-O-3.2 does not include “high grade dysplasia” as equivalent to “high grade squamous dysplasia.”

What is the correct histology code for “high grade dysplasia” (not specified to be squamous or glandular) for esophagus, stomach, and small intestine for cases diagnosed beginning in 2024?

According to SEER Sinq 20240021, the correct histology for “high grade dysplasia NOS” (not specified to be squamous or glandular) that originates in the stomach, small intestine, and esophagus is:

**Stomach:** Assign code 8148/2 glandular intraepithelial neoplasia, high grade using the Other Sites Solid Tumor Rules, Table 6: Stomach Histologies and as described in the WHO Classification of Digestive Tumors, 5th edition.

**Small intestine and Esophagus:** Assign code 8148/2 glandular intraepithelial neoplasia, high grade, using the Other Sites Solid Tumor Rules, Other Sites Histology Rules, Rule H4/H26. The following note is listed for both of these rules.

*Note: This list may not include all reportable neoplasms for 8148/2. See SEER Program Coding and Staging Manual or STORE manual for reportable neoplasms.

SEER Sinq 20240021

**Recurrence**

When there is a recurrence less than or equal to \( X \) years of diagnosis, the “clock” starts over.

- The time interval is calculated from the date of last recurrence.
- The patient must have been disease-free for greater than \( X \) years from the date of the last recurrence.
- When it is unknown/not documented whether the patient had a recurrence, default to date of diagnosis to compute the time interval.
- The **ONLY exception** is when a pathologist compares slides from the subsequent tumor to the “original” tumor and documents the subsequent tumor is a recurrence of the previous primary.

**Never code multiple primaries based only on a physician’s statement of “recurrence” or “recurrent”**.

**What cancer should be reported to NJSCR?**

Both analytic and non-analytic cases with active disease are required to be reported to the NJSCR.

Patients diagnosed elsewhere and admitted for additional work-up and/or treatment, cancer-directed or non-cancer-directed must be reported.

Patients with a clinical diagnosis of cancer which was based on clinical judgment only must be reported.

*Patients with a history of cancer with active disease must be reported.*

Consult-only cases are reportable. A consult may be done to confirm a diagnosis or treatment plan.

Private outpatient specimens are reportable. These specimens are submitted from a physician's office to be read by the hospital pathologist and the patient is not registered as an inpatient or outpatient at the hospital.

*Check out the 2024 NJSCR Program Manual for more information.*

Use the Multiple Primary Rules as written to determine whether a subsequent tumor is a new primary or a recurrence.

See full definition of Recurrence in the Solid Tumor Rules General Instructions

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Hormone Therapy Coding for Thyroid Primaries

**Code Hormone Therapy as 01** for follicular and/or papillary thyroid cancer when thyroid hormone therapy is given.

*Example: Levothyroxine, Synthroid*

*Do not code replacement therapy as treatment unless the tumor is papillary and/or follicular.*

The thyroid gland produces hormones that influence essentially every organ, tissue and cell in the body. When the thyroid is partially or totally removed, it is no longer able to secrete these essential hormones and the patient is placed on hormone replacement therapy.

**Check out SEER Manual Diagnostic Coding Section for more information and full list of notes!**

**Diagnostic Confirmation Coding for Solid Tumors**

- These codes are in priority order; code 1 had the highest priority.
- *Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple methods.*
- Change to a higher-priority code, if at **any time during the course of disease** the patient has a diagnostic confirmation with a higher priority.
- *Example: Benign brain tumor diagnosed on MRI. Assign diagnostic confirmation code 7. Patient later becomes symptomatic and the tumor is surgically removed. Change the diagnostic confirmation code to 1.*

**Check out SEER Manual Diagnostic Coding Section for more information and full list of notes!**

**Question:**

Head & Neck: How is histology coded for laryngeal intraepithelial neoplasia II-III (LIN II or LIN III)? See Discussion.

Laryngeal intraepithelial neoplasia II-III is not included in the ICD-O-3.2 and, while the SEER Program Coding and Staging Manual (SPCSM) confirms this is reportable, neither the SPCSM nor the Solid Tumor Rules Manual provide the specific histology to use for LIN II or LIN III. Should this be coded as 8077/2 since this is most like a high grade squamous dysplasia?

**Answer:**

Assign histology code, 8077/2 (squamous intraepithelial neoplasia, high grade) for LIN III and for LIN II. ICD-O-3.2 lists squamous intraepithelial neoplasia, grade II and grade III as 8077/2 indicating it is reportable, ICD-O-3.2 does not list every site-specific type of intraepithelial neoplasia. Check the SEER manual for reportable and non-reportable examples.
## Radiation Coding: Breast Phase I-II-III Radiation Primary Treatment Volume

**NAACCR Coding Pitfalls 2023 Webinar**

**If the breast AND lymph nodes are being treated**

Code the Primary Treatment Volume to Breast (codes 40 and 41) and Breast/chest wall lymph nodes (code 04) in radiation to Draining Lymph Nodes.

### Code 40 (Breast-whole)
Patients who had whole breast radiation after a lumpectomy or partial mastectomy

### Code 41 (Breast-partial)
Patients who had partial radiation after a lumpectomy

### Code 42 (Chest wall)
Patients who received radiation after mastectomy

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**Melanoma SSDI Clinical Margin Width**

This SSDI is effective for diagnosis year 2023+

**Code the peripheral surgical margins from the operative report from a wide excision.**

- Do not use the pathology report to code this data item.
- Margins from wide excision-measured from the edge of the lesion or the prior excision scar to the peripheral margin of the specimen, do not use deep margin
- Do not add margins together
- If multiple wide excisions are performed, code the clinical margin width from the procedure with the largest margin.

**Order of priority:**
1. Operative Note
2. Physician statement in medical record

Record stated margin in centimeters. Include decimal point. Example: 0.5 cm - 0.5

Physician statement of clinical margin width can be used to code this data item when no other information is available, or the available information is ambiguous.

**Discussion:**

This patient does not have a previous diagnosis of prostate adenocarcinoma nor a previous history of androgen-deprivation therapy. Does the logic in the Other Sites Solid Tumor Rules (STRs) noted in SINQ 20200052 still apply? This SINQ confirms a diagnosis of mixed prostatic adenocarcinoma and small cell neuroendocrine carcinoma is 8045. This matches the STRs instructions for Rule H21 and Table 2 (Mixed and Combination Codes), row 1. Row 1 indicates a mixed small cell carcinoma and adenocarcinoma is combined small cell carcinoma (8045). For a patient without previous treatment, is this the correct mixed histology code?

**Answer:**

Code histology as combined small cell carcinoma (8045) based on the Other Sites Solid Tumor Rules, May 2023 Update, Table 2, Mixed and Combination Codes, for this mixed histology prostate carcinoma consisting of adenocarcinoma and small cell neuroendocrine carcinoma regardless of treatment status. This is similar to SINQ 20200052 that applies to one tumor with mixed histologies.


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### EOD and SS2018 Version 9 Update

AJCC released version 9 for NET (excluding Adrenal Gland) and Vulva diseases which will be effective for cases diagnosed 1/1/2024 or later. There are now 2 schemas for each. SEER*RSA has been updated to reflect these changes.

The Registrar Staging Assistant (SEER*RSA) website is intended for use by cancer registrars to help with diagnosis 2018 and forward coding:

- Extent of Disease (EOD) 2018
- Summary Stage 2018 (SS2018)
- Site-Specific Data Items
- Grade

Current sites that have both AJCC 8th Edition and version 9 coding guidelines include: Anus, Appendix, Brain, Cervix, CNS Other, Intracranial Gland, NET tumors, Vulva

### Breast Histology Coding

Mammary carcinoma is a synonym for carcinoma no special type (NST)/duct carcinoma not otherwise specified (NOS) use **code 8500.**

Invasive carcinoma, NST with lobular features is not equivalent to invasive carcinoma with ductal and lobular features.

**Invasive mammary carcinoma NST with lobular features use code 8500/3**

**Breast Solid Tumor Rules**

### Coding Guidelines for Bladder

Use the information from reports in the following priority order to code a subsite when the medical record contains conflicting information:

- Operative report (TURB)
- Pathology report
- Multifocal Tumors

#### Coding Bladder subsites

**C679** Assign when there are multifocal tumors all of the same behavior in more than one subsite of the bladder and the specific subsite of origin is not known.

**C678** Assign when:

- A single tumor of any histology overlaps subsites of the bladder
- A single tumor or non-contiguous tumors which are:
  - Urothelial carcinoma in situ 8120/2 **AND** involves only bladder and one or both ureters (no other urinary sites involved) **Note:** Overlapping non-invasive tumors of the bladder and ureter almost always originate in the bladder

**C688** Assign when a single tumor overlaps two urinary sites and the origin is unknown/not documented

If the TURB or pathology proves invasive tumor in one subsite and in situ tumor in all other involved subsites, code to the subsite involved with invasive tumor.

### Questions

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