CANCER REPORTING IN CALIFORNIA:
ABSTRACTING AND CODING PROCEDURES
California Cancer Reporting System Standards, Volume I

Changes and Clarifications–22nd Edition
June 2022

Quick Look - Updates to Volume I

New Data Items

VOL I Section #	Data Item	Requirement
III.2.18.2	Tobacco Use Smoking Status	Required, when available
VI.2.4.3	Macroscopic Evaluation of the Mesorectum	Required, CoC only
Appendix Q	Derived Rai Stage	Derived
Appendix Q	p16	Required, CoC only
Appendix Q	LN Status Pelvic	Required, CoC only
Appendix Q	LN Status Para-Aortic	Required, CoC only
Appendix Q	LN Status Femoral-Inguinal	Required, CoC only

Other New Sections/Pages Added

VOL I Section #	Volume I Topic	Reason for Addition
III.2.18.1	Tobacco Use Smokeless and Tobacco Use Other	Separated CCR only from new Tobacco Use Smoking Status data item
Appendix T	Text Documentation Guidelines	New appendix with updated text documentation guidelines

Section/Page Revisions

VOL I Section #	Data Item or Volume I Topic	Reason for Revision
I.1.6	Reporting	Updated reporting requirements
II.1	CCR Reportability Guide - Reportable	2022 requirements, updated terms indicating in-situ behavior
II.2.2	Ambiguous Diagnostic Reportable Terms	Updated coding instructions
II.2.3	Pathology and Consultation Only Cases	Updated coding instructions
III.2.2	Medical Record Number	Updated coding instructions
III.2.10	Race and Ethnicity	Updated guidelines
III.2.10.1	Codes for Race Data Item	Updated code 03 description
III.2.18	Tobacco Use	Expanded Tobacco Use section
III.3.5	Class of Case	Updated example, Class 30 description, added missing codes 36-38
III.3.10	Reporting Facility Referred From	Added coding instruction
IV.1 - IV.1.7	Text - SECTION	Updated coding Instructions/removed guidelines, added link
IV.3	COVID-19	Updated reporting requirements
V.3	ICD-O Morphology-Histology and Behavior	Updated definitions
V.3.1	Histologic Type	Updated coding instructions

V.3.3.1	In-Situ Coding	Updated general and site-specific terms lists indicating in-situ behavior
V.4.1.3	Grade - Post Therapy Clin (yp)	Updated coding instructions
V.4.1.4	Grade - Post Therapy Path (yp)	Updated coding instructions
V.6.1-V.6.6	Mets at Diagnosis - SECTION	Updated coding instructions
V.7	Lymphovascular Invasion	Updated coding instructions and code descriptions
V.8	Terms Indicating In-Situ	Added general and site specific terms
V.9.1	Staging Requirements	Updated Table year to 2022, added to requirement note
V.14	STandards for Oncology Registry Entry (STORE)	Revised introduction
V.14.1	STORE General Information	Revised introduction
VI.1	Definitions and Guidelines - First Course of Treatment	Updated coding instructions; added to CCR expectations
VI.1.1	First Course of Treatment - Special Situations	Updated coding instructions for Treatment-Refused and Treatment-Unknown
VI.1.2	First Course of Treatment - Data Entry	Updated priority order for entering text
VI.2	Surgery Introduction - First Course of Treatment	Updated coding Instructions
VI.3	Radiation Therapy - First Course of Treatment	Updating coding instructions
VI.4	Chemotherapy - First Course of Treatment	Updating coding instructions
VI.5	Hormone (Endocrine) Therapy - First Course of Treatment	Updated coding instructions
VI.6	Immunotherapy (Biological Response Modifier Therapy) - First Course of Treatment	Updated coding instructions
VI.7	Transplant Endocrine - First Course of Treatment	Updated coding instructions
VI.8	Other Therapy - First Course of Treatment	Updated coding instructions
VIII.1	Text-Remarks	Updated coding instructions
Appendix E	Codes for Religion	Added terms and codes
Appendix G	Codes for Casefinding	Removed terms and codes
Appendix K	STORE Surgery Codes	Removed terms and reformatted table
Appendix M	Q-Tips	Revised lists and updated link
Appendix Q	Site-Specific Data Items (SSDIs)	Added and removed codes and terms
Appendix R	Coding Resources	Updated resources
Appendix S	Historical Coding and Staging Manual Requirements for the CCR	Added historical manuals

Items No Longer Required/Pages Deleted

VOL I Section # (HISTORICAL NOW)	**Data Item**	**Requirement**
IV.3.1	NCDB--SARSCoV2--Test	No longer collecting coded field for dx 2022 and forward *
IV.3.2	NCDB--SARSCoV2--Pos	No longer collecting coded field for dx 2022 and forward *
IV.3.3	NCDB--SARSCoV2--Pos Date	No longer collecting coded field for dx 2022 and forward *
IV.3.4	NCDB--SARSCoV2--TX Impact	No longer collecting coded field for dx 2022 and forward *

* No longer collecting the four NCDB coded data items for cases diagnosed in 2022. The CCR will ***only*** continue requirement of COVID-19 using the COVID-19 Abstracting Guidance pdf provided by SEER.

GENERAL CHANGES

Volume I is only presented in PDF format. The web version and self-extracting versions were no longer presented after the 2017 data changes. For historical Volumes, see Archived Volume I - Use case year of diagnosis to determine which Volume I to choose.

All Pages:

- ✓ Updated and confirmed internal and external links.
- ✓ Formatting, grammar, and editing for typos.

Select Pages:

- ✓ Updated all ICD-0 (zero) to ICD-O.
- ✓ "2018" removed from Solid Tumor Rules Manual and Grade Manual.
- ✓ "2018" moved from the beginning of the title to the end of the title for manuals: Extent of Disease (EOD) 2018 and Summary Stage 2018.
- ✓ Updated references to the SEER Hematopoietic and Lymphoid Neoplasm Database to include the Hematopoietic and Lymphoid Neoplasm Coding Manual.
- ✓ Added link to new Appendix T – Text Documentation Guidelines.
- ✓ Removed links to Q-Tips page on website and added a link to Appendix M for a list of Q-Tips that may be related to the specific topic.

SECTION CHANGES

I.1.6 Reporting

- ✓ Cases not reportable list - Removed reference * (no longer applies) for:
  - ➢ Catheter Placement for cancer therapy only
  - ➢ Patients receiving transient care
  - ➢ ****Note:** *Regional Registries may request notification via an alternate reporting mechanism to remain informed of these types of cases.*
- ✓ Revised summary of requirement to include Class 31 as not reportable and to remove "Registry is to notify their Region of Class 31 cases. Additionally, Class 43 is reportable through a CMR." This no longer applies.
- ✓ Non-Analytic Cases, Class 31 changed to not reportable (NR) from Notify. The CCR will no longer require collection of Class 31 cases.
- ✓ In the "Key" for the codes table – Removed Notify – Notify Regional Registry as an option as this reporting method no longer applies to CCR data collection.

II.1 CCR Reportability Guide - Reportable

- ✓ Updated introduction paragraphs to reference the 2022 version of the ICD-O3.2 histology coding changes and combined important reminder note into the introduction paragraph.
- ✓ Updated coding instructions to reference current years.
- ✓ Added "Intraepithelial carcinoma, NOS" to the General Reportable Terms Indicating In-situ Behavior list. This was inadvertently omitted in the previous version of Volume I.
- ✓ Added the following reportable terms to the Site-Specific Terms Indicating In-situ Behavior for 2022 and forward:

- **Appendix** (C181)
  - Low-grade appendiceal mucinous neoplasm (LAMN), 8480/2, dx 01/01/2022 +
  - High grade appendiceal mucinous neoplasm (HAMN) , 8480/2, dx 01/01/2022 +
- **Stomach and Small Intestine** (C160-C166, C168-C169, C170-C173, C178, C179)
  - Intestinal-Type adenoma, high grade, 8144/2, dx 01/01/2022 +
  - Adenomatous polyp, high grade dysplasia, 8210/2, dx 01/01/2022 +
  - Serrated dysplasia, high grade, 8213/2, dx 01/01/2022 +

✓ Added the following reportable terms to reportability list for 2022 and forward.

- **Bones, Joints, and Articular Cartilage** (C40_-C41_)
  - Chondrosarcoma, Grade 1, 9222/1, dx 01/01/2022 +
- **Kidney** (C649)
  - Clear cell papillary renal cell carcinoma, 8323/3, dx 01/01/2022 +

II.2.2 Ambiguous Diagnostic Reportable Terms

✓ Coding instruction change for suspicious cytology - 11th bullet, second square sub-bullet, the coding instruction was changed to:

- "In the absence of a documented physician statement as outlined above, if an FNA "suspicious" for cancer is followed by a definitive procedure such as a tissue biopsy, surgery, scan or other procedure confirming the cancer, the date of the FNA would be the date of diagnosis." Previously, the date of the procedure would be the date of diagnosis.

II.2.3 Pathology and Consultation Only Cases

✓ Separated coding instructions into two bullets, clarifying when and when not to abstract consult only cases:

- Consult Only abstract *required*: If the consulting facility is responsible for treatment decisions or follow-up, an abstract is required.
- Consult Only abstract *not required*: If the consulting facility is confirming a diagnosis made elsewhere, rendering a second opinion, or recommending treatment to be delivered, the regional registry must be notified.

III.2.2 Medical Record Number

✓ Removed the phrase "and should be right justified" in first bullet of coding instructions.

III.2.10 Race and Ethnicity

✓ Updated Guideline #1, Guideline Exception - Added quotations to the terms "Oriental", "Mongolian", and "Asian" to clarify these are not CCR terms, but rather indications of what *may* be encountered in the medical record.

III.2.10.1 Codes for Race Data Item

✓ Code 03 description modified to replace the terms "Aleutian, or Eskimo" with "Alaska Native."

III.2.18 Tobacco Use

✓ Updated from a single page to a section to include subpages (listed below).

✓ Re-wrote page to clearly define standard setter differences and outline CCR Requirements.

- Removed data items:
  - Tobacco Use Cigarette
  - Tobacco Use Other Smoke

- Added Tobacco Use Smoking Status

III.2.18.1 Tobacco Use Smokeless and Tobacco Use, NOS - *New Page*

- ✓ New page provides coding instructions specific to CCR Tobacco Use Smokeless and Tobacco Use, NOS data items that will continue to be collected for cases diagnosed January 1, 2011 and forward.

III.2.18.2 Tobacco Use Smoking Status - *New Page*

- ✓ New page provides coding instructions specific to the new Tobacco Use Smoking Status data item for cases diagnosed January 1, 2022 and forward.

III.3.5 Class of Case

- ✓ Second bullet in introduction – Added sub-bullet to further clarify the CCR requirement status.
- ✓ Third bullet in introduction - Revised example for Class of Case change from non-analytic to analytic.
- ✓ In the codes table:
  - Updated code description for class 30, Example: Consult Only to include the link to (*See Pathology and Consultation Only Cases for exceptions)* to clarify when consultation only cases are reportable as a class 30.
  - Added CCR reportability status to Non-Analytic class 30 series.
  - Added class of case codes to include codes and definitions for classes 36-38 which, were omitted in the 2021 version. No changes to codes or definitions.

III.3.10 Reporting Facility Referred From

- ✓ Added coding instruction below to clarify how to code Facility Referred From, for out of state cases.
  - Code Facility Referred from to 0000999994 UNSPEC NONCAL HOSP, when out of state patient seen at your facility for further workup or treatment.

IV.1 Text - Diagnostic Procedures Performed
IV.1.1 Text - Physical Examination
IV.1.2 Text - X-Rays/Scans
IV.1.3 Text - Scopes
IV.1.4 Text - Laboratory Tests
IV.1.5 Text - Operative Findings
IV.1.6 Text - Pathology Findings
IV.1.7 Text - Staging

- ✓ Rescripted all pages (above) to remove duplicated guidelines from coding instructions. The guidelines indicated in this section were often duplicated between pages, as well as in the stand alone document on the CCR Knowledge Series page called "CCR Text Documentation Guidelines."
  - The CCR Text Documentation Guidelines has been rewritten and is now the new Volume I, Appendix T – Text Documentation Guidelines (see Appendix T below).

IV.3 COVID-19

- ✓ Revised introduction paragraph to document continuation of data collection of COVID-19.
- ✓ Updated guidelines to indicate that the CCR will continue collecting COVID-19 in text fields, using the COVID-19 Abstracting Guidance pdf provided by SEER.

- ✓ Updated link to the COVID-19 Abstracting Guidance pdf.
- ✓ Added guideline for the four NCDB COVID data items:
  - ➢ The CCR will **only** require the collection of the four NCDB COVID-19 data items for cases with a reportable malignancy, diagnosed January 1, 2020 through December 31, 2021.
    - NCDB--SARSCoV2--Test
    - NCDB--SARSCoV2--Pos
    - NCDB--SARSCoV2--Pos Date
    - NCDB--COVID19--TX Impact
- ✓ Added link to the Archived Volume I section so registrars can access the 2021 version of Volume I when abstracting a case diagnosed between January 1, 2020 and December 31, 2021.

IV.3.1 NCDB--SARSCoV2--Test - *Deleted*
IV.3.2 NCDB--SARSCoV2--Pos - *Deleted*
IV.3.3 NCBD--ARSCoV2--Pos Date - *Deleted*
IV.3.4 NCDB--SARSCoV2--TX Impact - *Deleted*

- ✓ No longer collecting the four NCDB coded data items for cases diagnosed in 2022. The CCR will ***only*** continue requirement of COVID-19 using the COVID-19 Abstracting Guidelines provided by SEER.

V.3 ICD-O-Morphology - Histology and Behavior

- ✓ Updated introduction paragraphs to reference the 2022 version of the ICD-O3.2 histology coding changes and combined important reminder note into the introduction paragraph.

V.3.1 Histologic Type

- ✓ Updated resource priority order for ICD-O-3.2.

V.3.3.1 In-Situ Coding

- ✓ Added "Intraepithelial carcinoma, NOS" to the General Reportable Terms Indicating In-situ Behavior list. This was inadvertently omitted in the previous version of Volume I.
- ✓ Added the following reportable terms to the Site-Specific Terms Indicating In-situ Behavior for 2022 and forward:
  - ➢ **Appendix** (C181)
    - Low-grade appendiceal mucinous neoplasm (LAMN), 8480/2, dx 01/01/2022 +
    - High grade appendiceal mucinous neoplasm (HAMN) , 8480/2, dx 01/01/2022 +
  - ➢ **Stomach and Small Intestine** (C160-C166, C168-C169, C170-C173, C178, C179)
    - Intestinal-Type adenoma, high grade, 8144/2, dx 01/01/2022 +
    - Adenomatous polyp, high grade dysplasia, 8210/2, dx 01/01/2022 +
    - Serrated dysplasia, high grade, 8213/2, dx 01/01/2022 +

V.4.1.3 Grade - Post Therapy Clin (yc)

- ✓ Added new coding instruction to "Leave BLANK when:"
  - ➢ Neoadjuvant therapy completed, no microscopic exam done prior to surgery/resection of the primary tumor.

V.4.1.4 Grade - Post Therapy Path (yp)

- ✓ Added new coding instruction to "Leave BLANK when:"
  - ➢ Neoadjuvant therapy completed; surgical resection not done.

V.6.1 Mets at Diagnosis - Bone
V.6.2 Mets at Diagnosis - Brain
V.6.3 Mets at Diagnosis - Liver
V.6.4 Mets at Diagnosis - Lung
V.6.5 Mets at Diagnosis - Distant Lymph Nodes
V.6.6 Mets at Diagnosis - Other

- ✓ Updated coding instructions, bullet 4:
  - ➢ Sub-bullets 2 (00790) and 3 (00795) to remove: (excluding C770-C779, see code 8).
    - Added sub-bullet 6: 00830 HemeRetic (excluding sites C420, C421, C423, C424)
  - ➢ Code 8 - Removed site codes C770-C779 to align with edits.

V.7 Lymphovascular Invasion

- ✓ Added coding instruction (below) as sub-bullet for bullet 2:
  - ➢ Code lymphovascular invasion to codes 0, 2, 3, 4 or 9 for Schema IDs in the following list:
    - 00730 Thyroid
    - 00740 Thyroid Medullary
    - 00760 Renal Gland
- ✓ Updated description for codes 0, 1, 2, 3, and 4. **Bold** indicates the changes.

Code	Description
0	Lymphovascular invasion **stated as** not present (absent)/Not identified
1	Lymphovascular invasion present/identified **(NOT used for thyroid and adrenal)**
2	Lymphatic and small vessel invasion only (L)
	OR
	Lymphatic invasion only (thyroid and adrenal only)
3	Venous (large vessel) invasion only (V)
	OR
	Angioinvasion (thyroid and adrenal only)
4	BOTH lymphatic and small vessel AND venous (large vessel) invasion
OR	
	BOTH lymphatic AND angioinvasion (thyroid and adrenal only)
8	Not Applicable
9	Unknown if lymphovascular invasion present; Indeterminate; not mentioned in path report

V.8 Terms Indicating In-situ for Staging

- ✓ Added "Intraepithelial carcinoma, NOS" to the General Reportable Terms Indicating In-situ Behavior list. This was inadvertently omitted in the previous version of Volume I.
- ✓ Added the following reportable terms to the Site-Specific Terms Indicating In-situ Behavior for 2022 and forward:
  - ➢ **Appendix** (C181)
    - Low-grade appendiceal mucinous neoplasm (LAMN), 8480/2, dx 01/01/2022 +
    - High grade appendiceal mucinous neoplasm (HAMN) , 8480/2, dx 01/01/2022 +
  - ➢ **Stomach and Small Intestine** (C160-C166, C168-C169, C170-C173, C178, C179)
    - Intestinal-Type adenoma, high grade, 8144/2, dx 01/01/2022 +
    - Adenomatous polyp, high grade dysplasia, 8210/2, dx 01/01/2022 +
    - Serrated dysplasia, high grade, 8213/2, dx 01/01/2022 +

V.9.1 Staging Requirements

- ✓ Updated "2018" to "2022" Staging Requirements table end date.
- ✓ Added "cervix" to requirement description for AJCC TNM Cervix 9th version to clarify required for

cervix cases.

V.14 STandards for Oncology Registry Entry (STORE)

- ✓ Updated and revised section introduction paragraph wording, to clarify the STORE Manual is released annually.

V.14.1 STORE General Information

- ✓ Updated section introduction paragraph wording, to clarify the STORE Manual is released annually.

VI.1 Definitions and Guidelines - First Course of Treatment

- ✓ Updated coding instructions between the Definitions and Guidelines page and the subsequent First Course of Treatment specific pages to reduce redundancy between general and specific information.
  - ➢ Removed coding instruction #4 and added it to the First Course of treatment – Special Situations page under: Treatment – Refused section.
  - ➢ Updated the CCR Expectations section:
    - Removed last sentence from first instruction and moved it into to the First Course of Treatment – Data Entry page, in the Priority Order for Entering Text section.
    - Added instruction moved from treatment specific instructions, as this is a general statement across modalities:
      - Treatment given by a physician on the medical staff of a facility should not be recorded as treatment given at that reporting facility, effective with cases diagnosed January 1, 1998 and forward.

VI.1.1 First Course of Treatment - Special Situations

- ✓ Updated coding instructions between the Definitions and Guidelines page and the subsequent First Course of Treatment specific pages to reduce redundancy between general and specific information.
- ✓ Updated entire Treatment - Refused Section and removed modality specific instructions. This section now states:
  - ➢ The first course of therapy is **no treatment** when the patient **refuses** treatment. Code the treatment data items to refused.
    - Keep the refused codes, even if the patient later changes his/her mind and decides to have the prescribed treatment in the following scenario:
      - More than one year after diagnosis, or when there is evidence of disease progression before treatment is implemented.
    - Code 87 in the respective treatment data item if the patient or patient's guardian refuses that modality and record the fact in the text data item.
    - If the patient or patient's guardian refuses surgery to the primary site, enter code 7 in the *Reason for No Surgery* data item.

  Note: Prior to January 1, 2010, referral does not equal a recommendation.
- ✓ Updated Treatment - Unknown section:
  - ➢ Revised wording of last sub-bullet to a more general statement, removing the specific modality.

VI.1.2 First Course of Treatment - Data Entry

- ✓ Updated coding instructions between the Definitions and Guidelines page and the subsequent First Course of Treatment specific pages to reduce redundancy between general and specific information.

- ✓ Updated Priority Order for Entering Text section:
  - ➢ Third bullet - Type of treatment - Added modalities and clarifying statement regarding the need to include all information needed to support codes.
  - ➢ Moved the following instructions from the other First course of Treatment pages:
    - Unknown if treatment given - If it cannot be determined whether an intended therapy was performed, record that it was recommended but is not known if the procedure was administered.
      - For example, record "Chemotherapy recommended; unknown if given."
    - Treatment planned - If the MD has documented a treatment plan, but treatment has not yet been initiated, enter the "planned treatment" specifics in the respective treatment text field, including MD or facility where treatment will be delivered.
    - Treatment delayed - If there is a delay in planned treatment and the treatment has not been initiated, enter the "planned treatment" specifics in the respective treatment text field and the reason for the delay.

VI.2 Surgery Introduction - First Course of Treatment

- ✓ Added coding instructions to clarify entering text for surgery:
  - ➢ In the appropriate text field, enter the following information:
    - Date and name of surgical procedure. Be sure to review the operative report and verify the stated procedure(s) was performed.
    - Avoid recording non-pertinent information such as incidental appendectomy.

VI.2.4.3 Macroscopic Evaluation of the Mesorectum - *New Page*

- ✓ New page provides coding instructions specific to the new Macroscopic Evaluation of the Mesorectum for cases diagnosed January 1, 2022 and forward.

VI.3 Radiation Therapy - First Course of Treatment

- ✓ Added coding instructions for entering radiation text:
  - ➢ In the appropriate text field, enter the following information:
    - Record information for **all** radiation therapy phases in the first Text – Radiation Therapy field.
  - ➢ For each radiation phase, record in chronological order, the following information from the treatment summary to support the radiation data items:
    - Treatment start date
  - ➢ Primary Target Site/Treatment Volume, including radiation to draining lymph nodes
    - E.g. RUL Lung
  - ➢ Treatment modality
    - E.g. Ext Beam 6MV Photons or Intracavitary Brachytherapy, HDR
  - ➢ External Beam Planning Technique
    - E.g. IMRT, Stereotactic radiotherapy
  - ➢ Dose per fraction
    - E.g. 266 cGy
  - ➢ Number of Fractions
    - E.g. 16fx

  For additional information regarding recording text, please see: Appendix T: Text Documentation Guidelines.

VI.4 Chemotherapy - First Course of Treatment

- ✓ Added coding instructions to further clarify the use of SEER Rx*. Revision includes:
  - ➢ Use SEER Rx* to determine if the agent is chemotherapy, hormonal therapy, immunotherapy, or an ancillary agent (non-cancer directed).
    - If a drug regimen is given to the patient, review each agent in SEER Rx* separately.
  - ➢ SEER Rx* indicates in the **Coding** section if the agent should be coded on the abstract. Only include information in text for agents that should be coded.
  - ➢ Read the remarks in SEER Rx* carefully, as some agents should be coded only in specific circumstances (e.g. Prednisone is only coded if part of a drug regimen).
- ✓ Added coding instructions for text documentation, not included in Volume I previously:
  - ➢ Record the following information in the appropriate text field (e.g. Chemotherapy agent recorded in Text-Chemotherapy).
    - Treatment start date
    - Agent(s)
    - Reason for no treatment if systemic therapy would be expected.
      - E.g. Patient co-morbidities
      - E.g. Patient refused recommended treatment

VI.5 Hormone (Endocrine) Therapy - First Course of Treatment

- ✓ Added coding instructions to further clarify the use of SEER Rx*. Revisions include:
  - ➢ Use SEER Rx* to determine if the agent is chemotherapy, hormonal therapy, immunotherapy, or an ancillary agent (non-cancer directed).
    - If a drug regimen is given to the patient, review each agent in SEER Rx* separately.
    - SEER Rx* indicates in the **Coding** section if the agent should be coded on the abstract. Only include information in text for agents that should be coded.
    - Read the remarks in SEER Rx* carefully, as some agents should be coded only in specific circumstances (e.g. Prednisone is only coded if part of a drug regimen).
- ✓ Added coding instructions for text documentation, not included in Volume I previously:
  - ➢ Record the following information in the appropriate text field (e.g. Hormone Therapy recorded in Text-Hormone Therapy).
    - Treatment start date
    - Agent(s)
    - Reason for no treatment if systemic therapy would be expected.
      - E.g. Patient co-morbidities
      - E.g. Patient refused recommended treatment

VI.6 Immunotherapy (Biological Response Modifier Therapy) - First Course of Treatment

- ✓ Added coding instructions to further clarify the use of SEER Rx*. Revisions:
  - ➢ Use SEER Rx* to determine if the agent is chemotherapy, hormonal therapy, immunotherapy, or an ancillary agent (non-cancer directed).
    - If a drug regimen is given to the patient, review each agent in SEER Rx* separately.
    - SEER Rx* indicates in the **Coding** section if the agent should be coded on the abstract. Only include information in text for agents that should be coded.
    - Read the remarks in SEER Rx* carefully, as some agents should be coded only in specific circumstances (e.g. Prednisone is only coded if part of a drug regimen).

- ✓ Added coding instructions for text documentation, not included in Volume I previously:
  - ➢ Record the following information in the appropriate text field (e.g. Immunotherapy agent recorded in Text-Immunotherapy).
    - Treatment start date
    - Agent(s)
    - Reason for no treatment if systemic therapy would be expected.
      - E.g. Patient co-morbidities
      - E.g. Patient refused recommended treatment
  - ➢ Transplant/Endocrine Procedures should be recorded in Text-Immunotherapy since there is no corresponding text field for the Transplant/Endocrine data items. Record:
    - Date of transplant/procedure

VI.7 Transplant/Endocrine - First Course of Treatment

- ✓ Added coding instruction note to clarify where to code Transplant/Endocrine Procedures.

VI.8 Other Therapy - First Course of Treatment

- ✓ Added coding instructions for text documentation, not included in Volume I previously:
  - ➢ In the appropriate text field, enter the following information:
    - Date of therapy
    - Type of therapy. Provide enough information to justify the Other Therapy Code data item.

VIII.1 Text- Remarks

- ✓ Removed items from coding instructions that we determined to be a guideline rather than coding instruction. These have been added to the new Appendix T - Text Documentation Guidelines.
- ✓ Added coding instructions for text documentation, not included in Volume I previously:
  - ➢ Place of Birth – if it differs from race

CHANGES TO APPENDICES

Appendix E - Codes and Religions

- ✓ Code change - Removed code 84 - Islam.
  - ➢ Islam religion is to be coded to 82. The Central Registry will be converting these codes with the v22 data changes.
- ✓ Appendix E1: Codes for Religion - Alphabetical Order
  - ➢ Updated codes not previously shown as two digits.
  - ➢ Updated codes table for terms:
    - Islam to 82 from 84 (see code change above).
  - ➢ Removed terms and codes deemed to be outdated terms for:
    - Mohammedan – code 82
    - Moslem – code 82
- ✓ Appendix E2: Codes for Religion – Code Order
  - ➢ Eastern Religions:
    - Updated code 82 description to remove terms Moslem and Mohammedan
    - Added term Islam to code 82 description

        - Removed code 84 Islam from table (see code change above).
    - Removed terms and codes deemed to be outdated terms for:
        - Mohammedan – code 82
        - Moslem – code 82

Appendix G - Codes for Casefinding

- ✓ Updated with casefinding lists that are effective for cases diagnosed between October 1, 2021 and September 30, 2022.

Appendix K - STORE-Surgery Codes

- ✓ Removed histology code exception from headers of each site page to align with standard setters.
- ✓ Anus:
    - Removed the following codes:
        - 11 and 21 Photodynamic Therapy (PDT)
        - 13 and 23 Cryosurgery
        - 14 and 24 Laser Ablation
        - 25 Laser Excision
    - Updated for codes 10, 12, and 15 and moved it above code 10.
    - Removed "Miles Procedure" from code 60.
- ✓ Bladder:
    - Updated description of code 60 to Complete cystectomy with reconstruction.
- ✓ Brain:
    - Code 10 – Updated SEER Note to include laser interstitial thermal therapy (LITT).
- ✓ Cervix Uteri:
    - Added code 17 – Laser ablation (this was inadvertently omitted in previous versions).
- ✓ Colon:
    - Removed the following codes:
        - 11 and 21 Photodynamic Therapy (PDT)
        - 13 and 23 Cryosurgery
        - 14 and 24 Laser Ablation
        - 25 Laser Excision
    - Updated SEER Note below code 22 to:
        - **SEER Note:** Code 22 above combines 20 Local tumor excision, 26 Polypectomy, NOS, 27 Excisional biopsy, 28 Polypectomy-endoscopic, or 29 Polypectomy-surgical excision WITH 22 Electrocautery.
- ✓ Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease:
    - Removed note regarding list of standard exclusions.
- ✓ Rectosigmoid:
    - Removed the following codes:
        - 11 and 21 Photodynamic Therapy (PDT)
        - 13 and 23 Cryosurgery
        - 14 and 24 Laser Ablation
        - 25 Laser Excision
    - Removed the word "wedge" from code 30.
- ✓ Rectum:
    - Removed the following codes:
        - 11 and 21 Photodynamic Therapy (PDT)
        - 13 and 23 Cryosurgery

- 14 and 24 Laser Ablation
- 25 Laser Excision

- Removed the word "wedge" from code 30.
- Removed “Total mesorectal excision” from code 30.
- Removed “Miles Procedure” from code 50.

Appendix M- Q-Tips

- ✓ Beginning with 2021, CCR Q-Tips have been moved to the CCR learning management system FLccSC. To access your existing FlccSC account or register as a new FLccSC User click here: FLccSC - Fundamental Learning Collaborative for the Cancer Surveillance Community.
  - With the change in location the CCR will be removing the Q-Tips section on the CCR Website.
- ✓ An access link to the FLccSC system has been added as well as instructions for access.
- ✓ Revisions to appendix M have been made to document the Q-Tips published in FLccSC by year.

Appendix Q Site- Specific Data Items (SSDIs)

- ✓ Updated instructions of how to read tables. Specifically, the SSDIs are organized alphabetically by section. This update also includes the same updates to all tables throughout. The intent was to make this section simpler.
- ✓ Removed guidelines for coding 8’s vs 9’s in SSDI’s for CoC vs Non-CoC facilities. This now correlates correctly with edits.
- ✓ Separated Soft Tissue Other into two new schemas (SSDI requirements listed in appropriate sections below).
  - Renamed 00450 Soft Tissue Rare from 00450 Soft Tissue Other
  - New Schema 00459 Soft Tissue Other created
    Note: Soft Tissue Rare now uses the 00450 Schema ID
- ✓ Added *new* Schemas and SSDI requirements to the document:
  - 00528 Cervix Sarcoma (cases diagnosed 2021+), with CCR SSDI requirement

SSDI Name	**CCR**
FIGO Stage	**X**
Number of Examined Para-Aortic Nodes	**X - CoC Facilities ONLY**
Number of Examined Pelvic Nodes	**X - CoC Facilities ONLY**
Number of Positive Para-Aortic Nodes	**X - CoC Facilities ONLY**
umber of Positive Pelvic Nodes	**X - CoC Facilities ONLY**
Peritoneal Cytology	**X**

  - 00450 Soft Tissue Rare (cases diagnosed 2018+), with CCR SSDI requirement

SSDI Name	**CCR**
Bone Invasion	**X**

- ✓ Updated *existing* Schemas and SSDI requirements to the document:
  - Updated Schema ID for Soft Tissue Other to 00459
    - Discriminator 1 added to Schema
    - Discriminator 2 date of requirement revised to 2018+ from 2021+

SSDI Name	**CCR**
Schema Discriminator 1	**X**
Schema Discriminator 2	**X**
Bone Invasion	**X**

- ✓ Added the following *new* SSDIs and requirement date to the appropriate schemas:
  - p16 - 2021+

        - 09520 Cervix 9th
    - LN Status Pelvic - 2018+
        - 00520 Cervix 8th
        - 09520 Cervix 9th
        - 00510 Vagina
        - 00500 Vulva
    - LN Status Para-aortic-2018+
        - 00520 Cervix 8th
        - 09520 Cervix 9th
        - 00510 Vagina
    - LN Status Femoral Inguinal
        - 00510 Vagina
        - 00500 Vulva
- ✓ Removed the following SSDI's from Schemas (these items are being converted for 2018+):
    - LN Assessment Method Femoral Inguinal
        - 00520 Cervix 8th
        - 09520 Cervix 9th
    - LN Assessment Method Para-Aortic
        - 00500 Vulva
    - LN Status Femoral-Inguinal, Para-Aortic, Pelvic
- ✓ LN Status Femoral-Inguinal, Para-Aortic, Pelvic is being replaced by the three new LN Status fields added (see new added SSDIs).
    - 00520 Cervix 8th
    - 09520 Cervix 9th
    - 00510 Vagina
    - 00500 Vulva
- ✓ Added end date to requirement (end 2021) for the appropriate schemas:
    - Primary Sclerosing Cholangitis
        - 00230 Bile Ducts Intrahepatic
        - 00250 Bile Ducts Perihilar
    - Tumor Growth Pattern
        - 00230 Bile Ducts Intrahepatic
- ✓ Renamed the following SSDIs:
    - LDH Level from LDH (Lactate Dehydrogenase) Pretreatment Value
- ✓ Additional Stage-Related Data Items updates:
    - Updated introduction to reflect 2022 data changes
    - Table 3 Updated to 2022 and added 2022 SSDI's
    - Updated Table 4 to include additional stage related SSDIs for 2022.

Appendix R - Coding Resource

- ✓ Added new manuals and updated publication date of revised manuals.

Appendix S - Historical Coding and Staging Manual Requirements for CCR

- ✓ Added manuals that became historical in 2022 to the standard setter lists.

Appendix T - Text Documentation Guidelines - *New Page*

- ✓ New Appendix T - Text Documentation Guidelines has been created. The former document CCR Text Documentation Guidelines was difficult to find on the CCR website. The decision was made

to revise all text instructions within each section and revise the stand alone document and make it an appendix for easier access.