**Q&A Session**

**V24 Update: ICD-O, Solid Tumor Rules, SSDIs, Surgery Codes**

December 13, 2023

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| # | Question | Answer |
|  | The 2024 rules are out, I am working on a case in 2023. What set do I use? 2023 rules or 2024? | Until 1/1/2024 use the 2023 manuals. On 1/1/2024 and after use the 2023 SPCSM and SEER manuals. Use the 2024 update of the Solid tumor manual and version 3.1 of the SSDI manual. Keep in mind that some of the changes in the manuals won’t be reflected in your software until your software is updated to v24. |
|  | For Solid Tumor Rules, it doesn't matter if the software has been updated to v24... just when you start abstracting cases 1-01-2024 doesn't matter what version of software your using?? | In theory that is correct. Just keep in mind that some of the changes in the 2024 update of the solid tumor manual and 3.1 of the SSDI manual won’t be included in your software until your software is updated to v24. Those types of changes cannot be implemented until your software is updated.  New rules or clarifications to existing rules should be implemented as of 1/1/2024 and apply to all cases diagnosed 2018 forward (unless stated otherwise). |
|  | I thought we used the SSDI manual as it related to our software version. So until we are upgraded to v24, we still use v3.0 if we are on v23 | To some extent that is true. There may be new histology codes, new SSDIs, or new SSDI codes that will not appear in your software until it is upgraded to v24. Those you cannot use until your software is upgraded. |
|  | So for 2007-2022 use rules from 2007 and from 2023 forward use the 2024 tumor rules? | Which manual to use is based on the site and date of diagnosis. See the information found in the solid tumor general instructions--this provides the needed information |
|  | Other sites intro note #2 bullet point 2 says to use the "2023" STM. Based on what Jim just shared should it be "latest version of STM" instead? | If you look at the 2024 update of the STR, Note 2 gives you instructions on what set of rules to use based on the dx year. Starting with the most current version of rules should get you to the appropriate rules.  Note 2: 2007 MPH Other Site Rules and 2018 Solid Tumor Other Site Rules are used based on date of diagnosis.  • Tumors diagnosed 01/01/2007 through 12/31/2022: Use 2007 MPH Rules  • Tumors diagnosed 01/01/2023 and later: Use the 2023 Solid Tumor Rules and Solid Tumor General Instructions  • An original tumor diagnosed before 1/1/2018 and a subsequent tumor diagnosed 1/1/2023 or later in the same primary site: Use the 2023 Solid Tumor Rules and Solid Tumor General Instructions |
|  | Comment: As central registry, we need older manuals to check and code cases that come in late! Need to be able to find them easily. | A revision history of the STR’s is available at <https://seer.cancer.gov/tools/solidtumor/revisions-dec2022.html>  Historical version of the SPCM are available at <https://seer.cancer.gov/tools/codingmanuals/historical.html#1>  Historical versions of the STORE manual are available at  <https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/> |
|  | Please provide additional clarification about new note #5 of rule M10 for breast. Changing behavior and histology on a previously in situ case would create additional inconsistencies across the abstract (for example with Summary Stage). | M10 remains problematic and will likely be revised in 2024. For now, update the cases as needed. Many breast experts feel that the invasive component was present when the in situ neoplasm was found, however, due to current surgical practices, the involved breast tissue is not resected. |
|  | Where can I find a cumulative ICD-O link, that includes ALL updates/revisions, since 2018? Are the word documents on the NAACCR website cumulative? I sincerely miss a book type format, like the old "purple" book. Is there a book format out there somewhere? | Unfortunately, we do not have a book but here is a link to ICDE O 3 Coding Updates https://www.naaccr.org/icdo3/#1582820761130-74100b9f-e677 Keep in mind now you need to start referring to your Solid Tumor Rule Manual for histologies. |
|  | When the STR's are being used for a specific dx year, under the STR section it states to use that particular year. When you mention the contents being cumulative, do we instead use the most recent manual? I don't know why I am just now asking as I have always used the rules for the appropriate dx year. I am confused once again. | If a different set of rules should be used based on dx year, that information will be included in the most current update. |
|  | Are Reportable terms for Histology and the Radiology different? | If you are asking about ambiguous terms, there is no difference between radiology and pathology. |
|  | Software vendors who work with international sites may have been approached by clients re plans to implement ICD-O-4. Is there an estimate of when these changes will come to North America? | ICD O 4 is expected to be released by WHO in early 2024. The standard setters have been discussing when the changes will be adopted. The North American cancer registry community will not adopt these changes for cases diagnosed in 2024. |
|  | The blue books are more constantly being mentioned and used. Should we purchase blue books? Are the blue books online? | The blue books should not be used to assign histology. They may be useful when providing background information but should not be used when abstracting. The Blue Books are the primary reference for pathologists and provide the criteria needed to determine histologic type. They also include newly recognized histologies, current/contemporary terminology, and other information such as anatomical sites the neoplasm occurs in. The Blue Books are the primary resource for the solid tumor rules---we condense the information into the rules as needed. |
|  | could you please go over M10 for breast. From what I understand it is saying that an in situ breast dx and tx we capture the primary BUT if at any time within 5 years an invasive breast in the same side is dx we are to go back and change the original behavior to /3 and leave the dx date for the in situ, Is that a correct understanding? If so all our tx and staging information was based on the original in situ dx. | M10 remains problematic and will likely be revised in 2024. For now, update the cases as needed. Many breast experts feel that the invasive component was present when the in situ neoplasm was found, however, due to current surgical practices, the involved breast tissue is not resected. |
|  | Please clarify: if a pathologist identifies a 2022+ HPV-positive squamous cell carcinoma via p16 testing, for a site NOT in ST Table 5, can code 8085 be used? For example, C311 ethmoid sinus. This combination is listed as valid in both the SEER Site-Type Validation List and the new Cancer PathCHART list. C311 is also listed in the suggested site code range for 8085/3 in ICDO-3.2. 8085/8086 are not limited to Table 5 sites, correct (other than the "non/keratinizing" variants specifically noted in the STM)? Thank you! | No. Codes 8085 and 8086 are valid for the sites listed in H&N Table 5 only, anus, cervix (invasive tumors), vagina, vulva, and penis. For all other sites code SCC or subtype/variant. If required, code HPV status in the appropriate SSDI field. Given the interest in HPV and related malignancies, HPV testing may be done on numerous types of tumors, however, the criteria needed to assign code 8085/8086 is currently specific to only a few sites. |
|  | I wanted to pass along & this might have been stated previously or elsewhere, but the 3 columns for histologies in the STR's are a bit confusing. It's clear when to use column one or column 3. It's what to do with column 2. Do we even use column 2 histologies at all? | Column 2 lists synonyms or related terms to the NOS term in column 1. Not all pathologists use the standard NOS term but may use a synonym. Treat the terms in column 2 as the NOS. All of the terms in column 2 have the SAME ICD-O code as the NOS. |
|  | Is there an error? On website in Malig CNS rules, Table 6 is there an error in Malig CNS Tables? Table 6's title in the Malig CNS rules is: Non-malignant CNS Tumors with Potential of Transforming to Malig behavior. On Pg 33. I don't see the Tbl 6 on your slides with that new row. | I believe these are updates for 2024. |
|  | sorry so you are going to update the STR 2024 with instructions on how to code low grade glioma? | We will initially add the instruction to SINQ. An update to non-malignant CNS rules will come later in 2024. |
|  | Shouldn't Table 9 for Liver & IHBD be only C221? | Yes. A new version of the STR’s have been posted that includes this correction. |
|  | Comment: In the 2024 update, the equivalent terms section has links to jump to the equivalent terms section and histology rules. There is no link to jump to the multiple primary rules. | This has been corrected and the new update posted. |
|  | We are always coding a year behind - in 2024 we are starting our 2023 cases. We would use the 2024 STR update? We were always told to use the manual that corresponds with the year we are coding- So i just want to confirm | As of 1/1/2024 you should be using the 2024 Update of the STR’s for all cases diagnosed 1/1/2018 and later. This update will indicate if a different set of rules should be used based on the dx year. |
|  | Just need to confirm, a cholangiocarcinoma arising in the liver should be coded primary site liver and not intrahepatic bile ducts? That is a big change | That was a typo in the table. A cholangiocarcinoma should NEVER be coded with primary site of liver (C22.0). |
|  | Is the new STR Other Sites Table 9a on the website for 2024? When I try to bring up, it shows 2023. | You may need to scroll down to the page. The 2024 updates is towards the bottom.  <https://seer.cancer.gov/tools/solidtumor/> |
|  | During the SEER Workshop last week, we learned that the PathCHART Site Morphology Validation List exists for cases diagnosed >2024. Can we rely on this for coding primary site and histology, or should we only be using the Solid Tumor Rules? | Use the Solid Tumor Rules. The Cancer PathCHART Site Morphology Validation List is in sync with the Solid Tumor Rules. |
|  | Could you provide an example of M4 in the other sites and its applicability when the patient has a history of acinar adenocarcinoma (or subtype/variant) of the prostate treated with ADVT and or radiation. | Example: Patient diagnosed with prostatic acinar adenocarcinoma of prostate, 1/1/2022. Follow-up TURBT 6/1/203 identified a small cell carcinoma. Abstract the small cell as a new/2nd prostate primary. |
|  | The statement about Cholangiocarcinoma on pg 34 says to code adenocarcinoma unless pathologically confirmed now says "Cases diagnosed before 1/1/23" and per the table 9a, adenocarcinoma on histology or cytology would be coded as 8160/3 now? | The note indicates how to code these cases prior to 2023. Beginning 1/1/2024, some site/type combinations will not pass edits, including adenocarcinoma in liver. |
|  | So just to confirm, if we have a liver biopsy that shows adenoma, but the physicians are calling it a cholangiocarcinoma, we are to code to primary site C22.1 with a histology of 8160/3 cholangiocarcinoma. So, the path does not take priority in this case? | If a liver biopsy states adenocarcinoma but the physicians state cholangiocarcinoma and there is supporting documentation as noted in the criteria column in 9a, code 8160/3 and C221. |
|  | Can we send email later for questions? | i believe they mentioned that you could send questions through ask a SEER Registrar. |
|  | Yes, I do use my STR manual for histologies - but where is there a cumulative list of histologies? ALL available histologies, all in one spot? Is this true of the link above? | We cannot list all possible histologies that could occur in each site/site group. As noted in the rules, the tables are based on WHO and in some sites, C.A.P. protocols. Currently, the ICD-O-3.2 Annotated list provides a cumulative list of histologies. Soon, the CancerPathCHART database search tool will provide this information. |
|  | Sorry I missed what morphology code we should assign for a low-grade glioma? Is it glioma, nos 9380/3 or tumor 8000/1 or 8000/3? | After much consultation with our neuropathology experts, low grade glioma is to be coded as a borderline glioma. Assign code 9380/1 using the Matrix rule. Override the site/type/behavior edit. |
|  | Are the questions that are frequently asked being posted in SINQ? Also, it seems questions being asked thru Ask SEER CTR are not making it into the database so we cannot reference SINQ for our hospitals in our state. | We get about ~100 questions in a week. We cannot move everything over to SINQ. We try to put the most common ones in SINQ. Many of the questions we receive via Ask A SEER Registrar are very specific and may not apply to all cases. |
|  | The response to Neoadj therapy SSDI is not always clear cut by the physician, which is frustrating, I think that's why there might be so many questions. | This is a common problem, which is why this is such a difficult SSDI. |
|  | For the Neoadjuvant SSDI, what if the managing physician just copies and pastes the pathology report in their notes without an actual statement of response? | Common problem, which is frustrating. If that is what the managing physician is doing, then you can use it. Maybe the managing physician knows something that is not documented. |
|  | Where can we find a list of the States that are considered SEER states? | https://seer.cancer.gov/registries/terms.html |
|  | For NET grade, if Mitotic rate is not indicated in the path. Only Gr1 Well Diff is indicated. Can we assign a grade? | G1 is a valid way of documenting grade for NET. If they are stating G1, G2, or G3, chances are they did the Ki-67 and Mitotic rate |
|  | Regarding grade and NETs, it is appropriate to use 9 for the clinical grade when we have a biopsy without any mention of mitotic count or Ki-67? | Yes. Do not be afraid to code 9, it is a valid response. Also, not everything is graded, so don't feel you always have to put something other than a 9. |
|  | Some of our pathologists are stating only NET OR NEC along with the deceiving grade. What do we do? It's maddening. | Code 9. |
|  | Did you say grade for NET is based on Ki-67 test? | It is for the NET Schemas in the GI (does not apply to NET Adrenal Gland). See the grade table for the NET schemas, or the NET chapters in the AJCC chapters |
|  | Assuming the other extra fields will be retiring? | The RX Summ Surg Breast and Rx Summ Recon Breast will still be collected for cases diagnosed 2022 and 2023. They will not be collected for cases diagnosed after 2023. The same information will be collected in different data items. |
|  | When assigning surgical codes and the description in SEER of the procedure does not match the surgical note, how do we code it? For instance, if the surgeon states the patient undergoes a Whipple resection. In the SEER Manual, it describes what organs should be removed but they are not described as removed by the surgeon or identified in the pathology report, is it still coded as a Whipple surgery, or do we down grade the code? | The additional coding instructions in the SEER manual should not conflict with the code definitions in the STORE manual. They should be a clarification. If it appears there is a conflict, send the question to the CAsnwer forum. Let them know there appears to be a conflict. SEER and CoC will attempt to provide a clarification. There are situations where SEER and CoC do not agree on how a procedure should be coded, but these situations are highly unusual. |
|  | What is the difference between Rx Hosp and Rx Summ? | RX Hosp is only coded if the procedure is done at the reporting facility. RX Summ is coded regardless of where the procedure was performed. |
|  | What would the surgery code be for a skin sparing mastectomy with removal of the uninvolved contralateral breast? Would we code the uninvolved breast as surgery of another site? | Assign B320 WITH removal of uninvolved contralateral breast. |
|  | For lung, once in a while they are doing Aliya therapy now (performed during a bronch). We have just been doing as a destruction, nos as wasn't sure how else to code it. | B150 Local tumor destruction, NOS seems like the best code at this time. However, it might be a good idea to send a questions to the CAnswer forum. |