2021 UPDATES TO SSDI'S

NAACCR SSDI WORK GROUP
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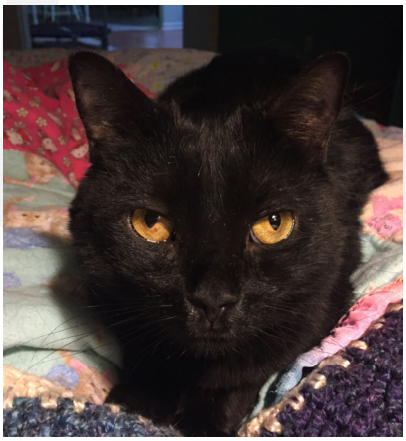

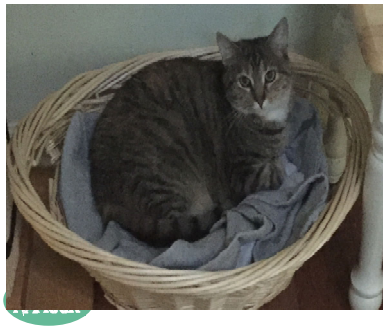

GREETINGS FROM MARYLAND AND MY OFFICE MATES SINCE MARCH 2020

ACKNOWLEDGEMENTS

- NAACCR SSDI Work Group
  - Specifically: Donna Gress (AJCC), Rich Moldwin (CAP), Jim Hofferkamp (NAACCR), Donna Hansen (California) and Liz Ward (co-chair)
- Carolyn Callaghan, Tiffany Janes (Seattle Registry-SEER*Educate)
- Alison Van Dyke (NCI SEER-Pathologist)-liaison to CAP Cancer Committee
- Nicki Schussler (IMS)
- Suzanne Adams (IMS)
- Elaine Collins (NAACCR Contractor)

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VERSION 2.0

- SSDI Manual
  - Appendix A
  - Appendix B
  - Appendix C
- Grade Manual
- Log of changes for SSDI's and Grade

- These can be found on the NAACCR website:

https://apps.naaccr.org/ssdi/list/

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VERSION 2.0 OF SSDI AND GRADE RELEASED

- Both manuals are available on the NAACCR website and SEER*RSA
- Changes/additions of codes or coding instructions will not be in your software until your software is updated
  - Software vendors have everything they need for 2021 to develop their updates
  - Software updates should be available to registries (hospital and central) later this year/beginning of next year
- Version 2.0 manuals can be used prior to the 2021 updates; however, realize that some of the new codes will not be available until your software is updated

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GRADE: VERSION 2.0

- NAACCR webinar on Grade 8/26/2020
  - Developed by SSDI work group members: Donna Hansen, Jim Hofferkamp and Jennifer Ruhl
  - Presented by Jim and Jennifer
- Covered the following
  - Basics
  - Introduction of Grade Post Therapy Clin (yc)
  - Major changes
  - Clarifications
- Recording will be available for free on the NAACCR website

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GENERAL INSTRUCTIONS

GENERAL INSTRUCTIONS: TIMING FOR LAB TESTS

- The following sentence removed as a bullet point and is the first criteria for the timing rules for laboratory tests
- All lab values must be done no earlier than approximately three months before diagnosis
  - This statement was removed from the bulleted list
  - This criteria is the first thing that applies
  - This still applies even if further work up is delayed due to COVID

GENERAL INSTRUCTIONS: TIMING FOR LAB TESTS

- Remaining bullets have not been changed

Unless instructions for a specific laboratory test state otherwise, record only tests results obtained

- before any cancer-directed treatment is given (neoadjuvant therapy or surgical), AND
- if multiple lab tests are available, record the highest value

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GENERAL INSTRUCTIONS: TIMING FOR LAB TESTS

- Reminder:
  - These instructions are for lab values only (CEA, PSA, etc.)
  - These instructions are not to be used for results based on tissue
    - KRAS, Ki-67, etc.
  - All SSDI's will tell you the source of the information
    - ***Example 1:*** **Note 2:** Record the lab value of the highest CEA
    - ***Example 2:*** **Note 5:** Results from nodal or metastatic tissue may be used for KRAS
- Note will be added to SSDI manual about this
- http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/103136-ki67-multiple-test

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GENERAL INSTRUCTIONS: CONSULTS REPORTS

- If a report is sent out for consult and the results are different than the original reports, record the results from the consult
  - Consults always take priority
- This was confirmed within the surveillance community and with AJCC and CAP
- This applies to Grade as well
  - Documented in the SEER manual, STORE manual, Solid Tumor Rules manual

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CANSWER FORUM CLARIFICATIONS ON SSDI'S

3920: PSA (DELAY IN BIOPSY)

- PSA done and elevated. Prostate biopsy planned
- Prostate biopsy delayed due to COVID
- Should registrars record the PSA lab value if more than 3 months prior to diagnostic BX if the procedure was delayed due to the COVID pandemic?

- http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/105556-recording-lab-values-timing-rules-w-covid

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3920: PSA (DELAY IN BIOPSY)

- For **all lab values**
  - Follow the current rules as they are written
  - So, for this case, you would **not** record the PSA lab value
    - Code unknown (XXX.9)
  - The PSA lab value should be recorded in the text portion of your abstract and documented to why it was not coded in the SSDI

- *Note*: For those doing AJCC, you may still assign a stage group without the PSA if the physician documents the stage group

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3936: ULCERATION (MELANOMA SKIN)

- **Updated Note 3:** Melanoma ulceration is the absence of an intact epidermis overlying the primary melanoma based upon microscopic (histopathological) examination.
  - Code 1 if any biopsy (punch, shave, excisional, etc.) or wide excision is positive for ulceration in the presence of an underlying melanoma
  - Code 0 if all specimens are negative OR one specimen is negative and the other is unknown
  - Ulceration must be caused by an underlying melanoma. Ulceration caused by trauma from a previous procedure should not be coded as positive for this SSDI
- 2022 update (not in manual at this time)

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3936: ULCERATION (MELANOMA SKIN)

- Example: 9/2019 Shave bx RT Forehead: MM involving peripheral margin (NOTE: no mention of ulceration by pathologist)

  10/03/19 Re-exc RT Forehead: (NOTE: Re-exc read by the same pathologist who read the shave bx above)

  MICROSCOPIC EXAMINATION:
  Sections show an excision of skin. **There is ulceration and surrounding epithelial hyperplasia associated with fibrosis and mixed inflammation.** There are increased numbers of atypical individual and nested melanocytes to the edge of this area.

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3936: ULCERATION (MELANOMA SKIN)

- The ulceration being described in the pathology report's microscopic examination is not ulceration of the underlying tumor, but ulceration from the previous shave biopsy
- Ulceration would be coded as none for this case (code 0)

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3936: ULCERATION (MELANOMA SKIN)

- In the event that ulceration is **identified** in a biopsy, but not identified in the re-excision, would you code the Ulceration SSDI to "present" (1)? Does the re-excision take priority over the biopsy pathology report for recording this SSDI?
- Per updated instructions: You would code the ulceration as positive based on the biopsy. The fact that this was negative on the wide excision does not change this
- http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/81890-melanoma-ssdi-ulceration

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3840, 3841:GLEASON SCORE (CLINICAL AND PATHOLOGICAL)

- The pathologists at a facility are now recording grade in a section of the pathology report called, "Summary of Core Biopsies." In that summary, the Gleason score provided (the "Summary Score") might actually be lower than the highest grade recorded on one of the individual core biopsies.
- When asked by the registrar about Gleason coding for the two cases below, the pathologist responded that the "Summary" or "Global" score should be used, even if it's lower.
- http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/111522-grade-clinical-gleason

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3840, 3841:GLEASON SCORE (CLINICAL AND PATHOLOGICAL)

- There is no consistency right now in how physicians and pathologist are coding Gleason Score. To ensure consistency in the registry field, you are to continue coding the highest Gleason Score based on the results from the pathology report, even this is different from the Gleason Summary that the pathologist or physician reports.
- Until a final decision is agreed upon and implemented by the groups (GUPS and ISUP), the registry field will not make any changes.

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3922: RESPONSE TO NEOADJUVANT THERAPY (BREAST)

- How do we code the "response to neoadjuvant therapy" in these breast cases with short-term unconventional "neoadjuvant" endocrine therapy due to delayed surgery in light of the COVID-19 pandemic? Do we go by AJCC definition of "neoadjuvant" and code "0" no neoadjuvant therapy given?
- Or is it case-by-case depending on how the pathologist codes it in the synoptic report under "treatment effect"? If pathologist states "no known pre-surgical therapy" then code as 0, but if pathologist indicates there is treatment effect then code the corresponding SSDI code option? (let me know if I should post this in the ask a pathologist forum instead). Thank you!
- http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/107325-breast-ssdi-response-to-neoadjuvant-thearpy-covid-19

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3922: RESPONSE TO NEOADJUVANT THERAPY (BREAST)

- If any type of treatment given prior to surgery does not meet the qualifications for neoadjuvant therapy, you code 0 for no neoadjuvant therapy
- If you are **not** assigning yp values for post therapy staging (based on guidelines from AJCC), then this field would also indicate no neoadjuvant therapy
- You can still have treatment effect from short term hormone treatment, but if the case does not fit the criteria for neoadjuvant therapy, then this field is coded as 0

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3922: RESPONSE TO NEOADJUVANT THERAPY (BREAST)

- Delayed breast surgical treatment due to COVID and the administration of hormones
  - As a reminder, 1-2 months of hormone therapy prior to surgical treatment does **not** qualify for neoadjuvant therapy
  - So, if you have patients that are receiving hormone therapy while waiting on their surgical resection, these will not qualify for post therapy staging
    - This type of therapy is "Bridge Therapy"

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3922: RESPONSE TO NEOADJUVANT THERAPY (BREAST)

- Delayed breast surgical treatment due to COVID and the administration of hormones
  - Pathology report may indicate treatment effect from the hormones
  - This is the pathologist seeing treatment effect on the cells in the specimen
  - Not the same thing as treatment effect for the patient
- This has been confirmed with AJCC
- Applies to all sites, but seeing this most with Breast cancer

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BREAKING NEWS (QUESTION POSTED TODAY)

- Ki-67 is stated to be 5-10%. How should this be recorded? I can't find a rule that applies
- On page 21 of V2.0, it gives us instructions for Less than or greater than. It does not give us instructions when given as a range. Can you please refer me to the rule that would apply for this case please and how should it be coded?
- My thought is 7.5 because it's the mid point but I can't find a rule to apply
- The Less than or greater than can't apply b/c technically you have two values that you could pick from (5.1 or 9.9). If I'm missing something, please let me know!!!

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BREAKING NEWS (QUESTION POSTED TODAY)

- Ki-67 is not a lab value, it is based on tissue examination
- Since Ki-67 does not have specific codes for ranges, use the general instructions for coding less than and greater than. So, code this as 5.1
  - This only applies to those SSDIs that don't have range codes (in other words, don't apply this instruction to ER Percent Positive and PR Percent Positive which have range codes).
- Note: This instruction is not currently in the manual, but we will be adding it for the 2022 update
  - http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/112190-lab-range-ki-67

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CLARIFICATIONS FROM THE 2020 FIELD TEST

ER, PR, HER SUMMARY

- Case Scenario:
  - DCIS only found in primary tumor (no evidence of invasive cancer found in primary tumor)
  - Positive nodal mets, ER, PR and HER2 done on nodal tissue
  - ER, PR, HER2 Summary would all be coded unknown
- Per Note 3: Results from nodal or metastatic tissue may be used **ONLY** when there is no evidence of primary tumor
  - DCIS in the primary IS evidence of the primary tumor

ER, PR, HER SUMMARY

- Some registrars were using Note 4 to code the ER, PR, HER2 since there was evidence of in situ and invasive components
- **Note 4:** In cases where there are invasive and in situ components and ER is done on both, ignore the in situ results.
  - If ER is positive on an in situ component and ER is negative on all tested invasive components, code ER as negative (code 0)
  - If in situ and invasive components present and ER only done on the in situ component, code unknown (code 9)

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ER, PR, HER SUMMARY

- Note 4 applies to the primary tumor ONLY
- Update to this note could be:
- **Note 4:** In cases where there are invasive and in situ components **in the primary tumor** and ER is done on both, ignore the in situ results.
  - If ER is positive on an in situ component and ER is negative on all tested invasive components **in the primary tumor**, code ER as negative (code 0)
  - If in situ and invasive components present and ER only done on the in situ component **in the primary tumor**, code unknown (code 9)
- Note: Wording still needs to be discussed with the SSDI work group

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ER, PR, HER2 SUMMARY

- Comment received: If there are mets in lymph nodes, then the primary tumor is invasive
- This statement is not entirely correct
  - If there is only DCIS in the primary tumor and there are mets in the lymph nodes, then the tumor (or case) is invasive (/3)
  - The primary tumor is still in situ based on the findings
  - The invasive component from the primary tumor was never found, and it would be staged as pTis, N+

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ER, PR, HER2 SUMMARY

- **Note 5:** In cases where there is a single tumor with multiple biopsies and/or surgical resection with different ER results.
  - Use the highest (positive versus negative)
- Reminder: Only use the highest when there is a single tumor, but there are multiple biopsies
- *Example*:
  - Needle core biopsy, invasive ductal adenocarcinoma, ER+, PR+, HER2-
  - Mastectomy, invasive ductal adenocarcinoma, ER+, PR+, HER2+
- Code ER+, PR+, HER2+
  - Use the highest value for all three since there is a single tumor

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ER, PR, HER2 SUMMARY

- **Note 6:** In cases where there are multiple tumors with different ER results, code the results from the largest tumor size (determined either clinically or pathologically) when multiple tumors are present.
  - Do not use specimen size to determine the largest tumor size
- This note is used when you have multiple tumors within the breast that are abstracted as one primary

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ER, PR, HER2 SUMMARY

- Tumor 1 noted to be 0.9 cm, ER negative, PR positive and HER2 negative
  Tumor 2 noted to be 0.7 cm, ER positive, PR positive and HER2 positive
- Per Note 6, use the results from Tumor 1 since that is the larger size:
  - ER: Negative
  - PR: Positive
  - HER2: Negative
- This may not agree with how the physician is treating the patient
  - http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/93658-updated-instructions-for-er-pr-her2-ihc-ish-overall-summary-ssdis (this post addresses some of the concerns when what the registry codes and what the physician documents are not the same)

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FINDINGS FROM FIELD TEST

- We are currently working on reviewing all comments
- Updates to SSDIs may be made based on comments
- Once this work is done, we will update rationale and make all the test cases, answers and rationale available in CAnswer Forum (probably in a PDF)

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2021 UPDATES TO SSDI'S (VERSION 2.0 SSDI MANUAL)

3831: EXTRANODAL HEAD AND NECK CLINICAL

- **New Code 4**: Positive nodes clinically, ENE is identified, but not known how identified
  - Can be used for 2018+ (review of cases already abstracted not required)
  - New codes cannot be used until your software is updated
- Priority given to codes 1 and 2
  - 1: Based on physical exam with or without imaging
  - 2: Based on microscopic examination

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3831: EXTRANODAL HEAD AND NECK CLINICAL

- New Note: Code 7 when
  - Lymph nodes are determined to be clinically negative
  - Behavior /2 (in situ) (new edit implemented for 2021)
- Reminder: In situ tumor (/2) **cannot** have positive lymph nodes
- *Note:* This does not apply to tumors that are invasive clinically and in situ on resection
  - OR in situ tumors that have positive nodes (/3)

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3832: EXTRANODAL HEAD AND NECK PATHOLOGICAL

- Note 2 addition: If codes 0.0-9.9, X.1-X.7 are use, this indicates that the lymph nodes were surgically resected and Scope of Regional Lymph Node Surgery [NAACCR Data Item 1292] must be 3-7
- Scope of Regional Lymph Node Surgery codes 3-7 record the different lymph node procedures
- New edit implemented (2021+)

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3823: CIRCUMFERENTIAL RESECTION MARGIN (COLON AND RECTUM)

- Guidelines regarding surgery added to note
  - For Colon primaries, surgery of primary site must be coded as 30-80
    - If surgery of primary site is 00-29, then CRM must be coded as XX.7
    - Edit implemented for cases diagnosed 2021+
- Reminder: If a polypectomy is done, CRM is always XX.7
  - Edit implemented for cases diagnosed 2021+

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3823: CIRCUMFERENTIAL RESECTION MARGIN (COLON AND RECTUM)

- Guidelines regarding surgery added to note
  - For Rectal primaries, surgery of primary site must be coded as 27, 30-80
    - If surgery of primary site is 00-26 or 28, then CRM must be coded as XX.7
    - Code 27 includes Transanal resections
    - Edit implemented for cases diagnosed 2021+

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3835: FIBROSIS SCORE (LIVER, BILE DUCTS INTRAHEPATIC)

- Added to Code 0: "Any of the following histologically confirmed"
  - To use code 0 you must have a histological confirmation
- Added to Code 1: "Any of the following histologically confirmed"
  - To use code 1 you must have a histological confirmation of fibrosis and/or cirrhosis, probable or definitive; Cirrhosis, NOS
- Code 2: Can be used for a clinical diagnosis (not microscopically confirmed), can be used based on imaging
  - Includes Cirrhosis, probably or definitive; Cirrhosis, NOS

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3937: VISCERAL AND PARIETAL PLEURAL INVASION (LUNG)

- Per recent updates, categories PL1 and PL2 are no longer relevant
- SSDI has been changed to reflect this change
- **Notes modified (note 1 not changed):**
  - **Note 2:** Code 0 for in situ (behavior/2) tumors
  - **Note 3:** A surgical resection must be done to determine if the visceral pleural is involved.
  - **Note 4:** Do not use imaging findings to code this data item
  - **Note 5:** Code 9 when
    - A FNA only is performed. A FNA is not adequate to assess pleural layer invasion
    - Surgical resection of the primary site is performed and there is no mention of visceral and/or parietal pleural invasion

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3937: VISCERAL AND PARIETAL PLEURAL INVASION (LUNG)

- Code 4: Invasion of visceral pleural present, NOS (Stated as PL1 or PL2) (codes 1, 2, and 4 combined)
- Code 5: Tumor invades into or through the parietal pleural OR chest wall (Stated as PL3) (code 3 cases converted)

- No changes done to codes 6, 8, or 9
- Software updates will do automatic conversions for 2018 forward
  - New codes cannot be used until your software is updated

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3937: VISCERAL AND PARIETAL PLEURAL INVASION (LUNG)

Code	Description
0	No evidence of visceral pleural invasion identified Tumor does not completely traverse the elastic layer of the pleura Stated as PL0
4	Invasion of visceral pleura present, NOS Stated as PL1 or PL2
5	Tumor invades into or through the parietal pleura OR chest wall Stated as PL3
6	Tumor extends to pleura, NOS; not stated if visceral or parietal
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record No surgical resection of primary site is performed Visceral Pleural Invasion not assessed or unknown if assessed or cannot be determined

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3932: LDH LAB VALUE

- Name change
  - Previous name: LDH Pretreatment Lab Value
  - Name was found to be misleading, the "pretreatment" was the problem

- **Note 3: Record the lab value of the highest serum LDH test results documented in the medical record either before or after surgical resection of the primary tumor with or without regional lymph node dissection.** The LDH must be taken prior to systemic (chemo, immunotherapy, hormone), radiation therapy or surgery to a metastatic site. The lab value may be recorded in a lab report, history and physical, or clinical statement in the pathology report.

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3922: RESPONSE TO NEOADJUVANT THERAPY (BREAST)

- New Note: For in situ tumors (behavior /2) code 0
- Received confirmation that in situ tumors are not going to have neoadjuvant therapy
  - This does **not** apply to tumors that are invasive during clinical work up, neoadjuvant therapy is done, and the residual tumor is in situ. This would be a /3 tumor
  - Nor does it apply to tumors that are in situ clinically but have positive nodes and have neoadjuvant therapy. These would also be a /3 tumor

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HER2 DATA ITEMS (BREAST)

- 3855: HER2 Overall Summary
- New Note: HER2 is not routinely done on pure in situ tumors (/2); however, if you have an in situ tumor and there are HER2 results, go ahead and record it
- Otherwise code 9

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3836: FIGO STAGE (ALL GYN SCHEMAS)

- FIGO Stage completely restructured

Current	Revised
01	1
02	1A
10	1C2
24	2B
33	3A11
37	3C
40	4
42	4B

- Update is for all cases diagnosed 2018+
  - New codes cannot be used until your software is updated
- For cases 2018+, all FIGO Stages will be automatically updated during the software update
- The code structure now fits how AJCC documents the FIGO Stage in the AJCC manual

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3836: FIGO STAGE (VULVA)

Code	Description
1	FIGO Stage I
1A	FIGO Stage IA
1B	FIGO Stage IB
2	FIGO Stage II
3	FIGO Stage III
3A	FIGO Stage IIIA
3B	FIGO Stage IIIB
3C	FIGO Stage IIIC
4	FIGO Stage IV
4A	FIGO Stage IVA
4B	FIGO Stage IVB
97	Not applicable: Carcinoma in situ (intraepithelial, noninvasive, preinvasive)
98	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 98 will result in an edit error.)
99	Not documented in medical record FIGO stage unknown, not assessed or unknown if assessed

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CORPUS SCHEMAS

- Clarifications added to **SSDI manual only**
  - These will not be found in the online SSDI's or in registry software
  - These will be updated for the 2022 updates
- Affects:
  - 3901: Number of Positive Para-Aortic Nodes
  - 3899: Number of Examined Para-Aortic Nodes
  - 3902: Number of Positive Pelvic Nodes
  - 3900: Number of Examined Pelvic Nodes

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CORPUS SCHEMAS (POSITIVE PARA-AORTIC, PELVIC)

- **Note 5**: Code X9 if no lymph node dissection is performed.
- 8/24/2020: Additional notes added to SSDI manual; however, these are not in the online SSDI's (SEER*RSA or NAACCR).
  - If only a FNA or core biopsy is done and it is **positive**, then code X6
  - If only a FNA or core biopsy is done and it is **negative**, then code X9
  - Codes X9 when no lymph nodes are removed
- *Note: A lymph node dissection is not needed, just that lymph nodes are removed, including an FNA, or sentinel lymph node biopsies, which are starting to be more common in GYN cancers*

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CORPUS SCHEMAS (EXAMINED PARA-AORTIC, PELVIC)

- ~~**Note 3:** For this data item, do not include isolated tumor cells (ITCs).~~
- 8/24/2020: This note has been removed from the SSDI manual; however, it will still be the in online SSDI's (SEER*RSA or NAACCR) until the 2022 updates. The SSDI work group determined that positive ITCs would be counted for the examined lymph node SSDI; however, they are still not counted in the positive lymph node SSDI
- *Note: ITCs are counted as part of Regional Nodes Examined, so they are counted here as well, but they are not counted in positive nodes*

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CORPUS SCHEMAS (EXAMINED PARA-AORTIC, PELVIC)

- ~~**Note 4:** Code X9 if no lymph node dissection is performed.~~
- 8/24/2020: Additional notes added to SSDI manual; however, these are not in online SSDI's (SEER*RSA or NAACCR) until the 2022 updates
- **Note 4:** For the following:
- Code 00 when no lymph nodes are examined by FNA, core biopsy or removal of lymph node(s) (e.g., sentinel lymph node biopsy or lymph node dissection) *(Note: The positive SSDI's would be X9)*
- Code X6 If only an FNA or core biopsy is done
- Code X9 if it's unknown if lymph nodes were removed

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3921: RESIDUAL TUMOR VOLUME POST CYTOREDUCTION

- Applicable schemas: Ovary, Primary Peritoneal Carcinoma, Fallopian Tube

- Determined that codes distinguishing between chemotherapy been given, chemotherapy not been given, or unknown, were not needed
- The only thing that really matters is the residual tumor
  - Residual size 1 centimeter or less
  - Residual size greater than 1 cm
  - Residual size not stated/unknown

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3921: RESIDUAL TUMOR VOLUME POST CYTOREDUCTION

- 50: Residual tumor nodule(s) 1 centimeter (cm or less)
- 60: Residual tumor nodule(s) greater than 1 cm
- 70: Macroscopic residual tumor nodule(s), size not stated

- No changes done to codes 80, 97, 98
- Codes 10-40, 90-93 deleted
- Software updates will do automatic conversions for 2018 forward
  - New codes cannot be used until your software is updated

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3921: RESIDUAL TUMOR VOLUME POST CYTOREDUCTION

Code	Description
00	No gross residual tumor nodules
50	Residual tumor nodule(s) 1 centimeter (cm) or less
60	Residual tumor nodule(s) greater than 1 cm
70	Macroscopic residual tumor, size not stated
80	Procedure described as optimal debulking and size of residual tumor nodule(s) not given
97	No cytoreductive surgery performed
98	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 98 will result in an edit error.)
99	Not documented in medical record Residual tumor status after cytoreductive surgery not assessed or unknown if assessed

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3839/3841: GLEASON PATHOLOGICAL PATTERNS/SCORE (PROSTATE)

- CAnswer Forum question:
  - Does Simple Prostatectomy qualify for Gleason Path SSDI's
  - No, to qualify for the Gleason Path SSDI's (and AJCC Pathological Stage) must have a Radical Prostatectomy
  - The SSDI work group did discuss this but felt that updating the related data items (11) was not needed
    - SEER data supported this, showing that the number of Simple Prostatectomies was very low
    - Note: Simple prostatectomies are usually done for BPH; however, there are times that prostate cancer will be found

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3806, 3847, 3867: TESTIS SSDI'S

- 3806: AFP Post-Orchiectomy Range
  - New Code 5: Post-Orchiectomy alpha fetoprotein (AFP) unknown or not done but pre-orchiectomy AFP was normal
    - Can be used for 2018+ (review of cases already abstracted not required)
    - New codes cannot be used until your software is updated
  - Updated Note 6: Previous instructions states to code 9, now states 5
  - **Note: same changes were made to:**
  - 3847: hCG Post-Orchiectomy Range
  - 3867: LDH Post-Orchiectomy Range

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3924: S CATEGORY PATHOLOGICAL (TESTIS)

- New Code 5: Post-Orchiectomy serum tumor markers unknown or not done but pre-orchiectomy serum tumors markers were normal
  - Can be used for 2018+ (review of cases already abstracted not required)
  - New codes cannot be used until your software is updated
- New Note 6: When all the serum tumor markers are normal pre-orchiectomy and they are not repeated post-orchiectomy, code 5
- Confirmed by AJCC that these types of cases would be a S0

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NEW SSDI'S FOR 2021

3927: SCHEMA DISCRIMINATOR 2: SOFT TISSUE SARCOMA (C473, C475, C493-C495)

- Soft Tissue Sarcomas (C473-C475, C493-C495)
  - ICD-O-3 assigned topography codes for the soft tissue sites (C47, C49) are based on transverse or horizontal plans
  - AJCC 8th edition Soft Tissue Sarcoma chapters 41 and 42 base the eligible sites as either external structures or internal viscera
- In order to make sure that sites were going to the appropriate schema, the Schema Discriminator was developed

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3927: SCHEMA DISCRIMINATOR 2: SOFT TISSUE SARCOMA (C473, C475, C493-C495)

- Code 1: External Structures (Chapter 41: Soft Tissue Trunk & Extremities)
  - Pelvis: includes buttocks, gluteal region, groin, inguinal region, perineum
  - Thorax: axilla, chest wall, infraclavicular region, scapular region
  - Abdomen: abdominal wall, abdominal wall muscle, umbilicus
- Code 2: Internal structures and viscera (sites), NOS (Chapter 42: Soft Tissue Abdomen and Thoracic Visceral Organs)
  - Abdomen: abdominal aorta, celiac artery, inferior vena cava
  - Pelvis: iliac artery, iliac vein
  - Thorax: aorta, internal mammary artery, subclavian artery

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3927: SCHEMA DISCRIMINATOR 2: SOFT TISSUE SARCOMA (C473, C475, C493-C495)

- Code 9: Not specific enough to determine if external or internal (Defaults to Soft Tissue Other schema, not eligible for AJCC staging)
  - Pelvis: lumbosacral plexus, sacral nerve,
  - Thorax: Chest, NOS

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3927: SCHEMA DISCRIMINATOR 2: SOFT TISSUE SARCOMA (C473, C475, C493-C495)

- Schema Discriminator is applicable for cases diagnosed 2018+
- For cases 2018+ forward that have already been abstracted, code 8 (not applicable) will be automatically assigned during the software updates
  - Note: Registrars can go back and recode these cases if they choose to. No one is requiring this review though
- Code 8 may also be used for cases diagnosed 2018-2020 that are abstracted after software update
- Code 8 **cannot** be used for cases diagnosed 2021+

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OTHER NEW SSDI'S

- The following SSDI's are new for **2021 cases only**
  - 3938: ALK Arrangement (Lung)
  - 3939: EGFR Mutational Analysis (Lung)
  - 3940: BRAF Mutational Analysis (Colon and Rectum)
  - 3941: NRAS Mutational Analysis (Colon and Rectum)
  - 3942: CA 19-9 Pre-Tx Lab Value (Pancreas)
- Current Requirement Status (2021)
  - Only required by SEER (CoC and NPCR not requiring; however, CoC hospitals and NPCR only registries may collect them)

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3938: ALK ARRANGEMENT (LUNG)

- "ALK positive cancer describes cancer cells that have a change in the structure of the anaplastic lymphoma kinase (ALK) gene or a higher than normal amount of ALK protein on their surface.
- In normal cells, ALK helps control cell growth. When cancer cells have the changed ALK gene or make too much ALK protein, the cancer cells may grow more quickly.
- Knowing whether a cancer is ALK positive may help plan treatment for advanced non-small cell cancers in the lung."
  - (NCI Dictionary of Cancer Terms https://www.cancer.gov/publications/dictionaries/cancer-terms)
- The presence of the ALK protein predicts a favorable response to therapy with a targeted ALK inhibitor, such as crizotinib or ceritinib (chemotherapy).

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3938: ALK ARRANGEMENT (LUNG)

Code	Description
0	Normal ALK negative Negative for rearrangement, no rearrangement identified, no mutations (somatic) identified, not present, not detected
1	Abnormal Rearrangement identified/detected: EML4-ALK, KIF5B-ALK, TFG-ALK, and/or KLC1-ALK
2	Rearrangement identified/detected: Other ALK Rearrangement not listed in code 1
4	Rearrangement, NOS
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record ALK Rearrangement not assessed or unknown if assessed

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3939: EGFR MUTATIONAL ANALYSIS (LUNG)

- EGFR (epidermal growth factor receptor) is a protein found on certain types of cells that binds to a substance called epidermal growth factor.
- The EGFR protein is involved in cell signaling pathways that control cell division and survival. Sometimes, mutations (changes) in the EGFR gene cause EGFR proteins to be made in higher than normal amounts on some types of cancer cells. This causes cancer cells to divide more rapidly."
  - (NCI Dictionary of Cancer Terms https://www.cancer.gov/publications/dictionaries/cancer-terms)
- The presence of Exon 20 EGFR activating mutations are associated with a resistance to EGFR tyrosine kinase inhibits, such as erlotinib, afatinib, and gefitinib. There is limited data available on response for some of the other uncommon EGFR mutations (other than Exon 20).
  - (CAP Cancer Protocol).

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3939: EGFR MUTATIONAL ANALYSIS (LUNG)

Code	Description
0	Normal EGFR negative, EGFR wild type Negative for mutations, no alterations, no mutations (somatic) identified, not present, not detected
1	Abnormal (mutated)/detected in exon(s) 18, 19, 20, and/or 21
2	Abnormal (mutated)/detected but not in exon(s) 18, 19, 20, and/or 21
4	Abnormal (mutated)/detected, NOS, exon(s) not specified
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record EGFR not assessed or unknown if assessed

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3940: BRAF MUTATIONAL ANALYSIS (COLON AND RECTUM)

- BRAF V600E is a specific mutation (change) in the BRAF gene, which makes a protein that is involved in sending signals in cells and in cell growth.
- This BRAF gene mutation is found in colorectal cancer. It may increase the growth and spread of cancer cells.
- Checking for this BRAF mutation in tumor tissue may help to plan cancer treatment. BRAF (V600E) kinase inhibitor RO5185426 blocks certain proteins made by the mutated BRAF gene, which may help keep cancer cells from growing."
  - (NCI Dictionary of Cancer Terms https://www.cancer.gov/publications/dictionaries/cancer-terms)

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3940: BRAF MUTATIONAL ANALYSIS (COLON AND RECTUM)

Code	Description
0	Normal BRAF negative, BRAF wild type Negative for (somatic) mutations, no alterations, no (somatic) mutations identified, not present, not detected
1	Abnormal (mutated)/detected: BRAF V600E (c.1799T>A) mutation
2	Abnormal (mutated)/detected, but not BRAF V600E (c.1799T>A) mutation
4	Abnormal (mutated), NOS
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record BRAF not assessed or unknown if assessed

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3941: NRAS MUTATIONAL ANALYSIS

- KRAS (NAACCR Data Item # 3866) and NRAS are important signaling intermediates in the growth receptor pathway, which controls cell proliferation and survival.
- Both KRAS and NRAS may be constitutively activated through mutation during colorectal carcinogenesis so that they continuously stimulate cell proliferation and prevent cell death (reference AJCC 8, pg. 266).
- KRAS and NRAS mutations predict poor response to anti-EGFR therapy in patients with metastatic colon cancer.
- AJCC 8 estimates that KRAS may be activated in up to 40% and NRAS in about 7% of colorectal carcinomas.

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3941: NRAS MUTATIONAL ANALYSIS

Code	Description
0	Normal NRAS negative; NRAS wild type Negative for (somatic) mutations, no alterations, no (somatic) mutations identified, not present, not detected
1	Abnormal (mutated)/detected in codon(s) 12, 13, and/or 61
2	Abnormal (mutated)/detected, codon(s) specified but not in codon(s) 12, 13, or 61
4	Abnormal (mutated), NOS, codon(s) not specified
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record NRAS not assessed or unknown if assessed

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3942: CA 19-9 PRE TX LAB VALUE (PANCREAS)

- CA 19-9 is a sialylated Lewis A blood group antigen that is commonly expressed and shed in pancreatic and hepatobiliary disease and in many malignancies, thus is not tumor specific.
- Preoperative CA 19-9 levels in pancreatic cancer patients correlate both with AJCC staging and resectability.
  - NCCN Guidelines Version 3.2019 Pancreatic Adenocarcinoma
- CA 19-9 Pretreatment Lab Value is a strong predictor of resectability in the absence of metastatic disease.

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3942: CA 19-9 PRE TX LAB VALUE (PANCREAS)

Code	Description
0.0	0.0 Units/milliliter (U/ml) exactly
0.1-9999.9	0.1-9999.9 U/ml (Exact value to nearest tenth in U/ml)
XXXX.1	10,000 U/ml or greater
XXXX.7	Test ordered, results not in chart
XXXX.8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code XXXX.8 may result in an edit error.)
XXXX.9	Not documented in medical record CA (Carbohydrate Antigen) 19-9 Pretreatment Lab Value not assessed or unknown if assessed

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CURRENT SSDI'S WITH NEW SCHEMAS

- The following SSDI's are new for **2021 cases only**
  - 3855: HER2 Overall Summary (Esophagus [both schemas], Stomach)
  - 3863: Ki-67 (NET Ampulla, NET Appendix, NET Colon and Rectum, NET Duodenum, NET Jejunum and Ileum, NET Pancreas, NET Stomach)
- Current Requirement Status (2021)
  - Required by SEER and CoC

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CHANGE IN REQUIREMENTS

SSDI'S: CHANGE IN REQUIREMENTS

- CoC and SEER no longer requiring:
  - 3850: HER2 IHC Summary (Breast)
  - 3851: HER2 ISH Dual Probe Copy Number (Breast)
  - 3852: HER2 ISH Dual Probe Ratio (Breast)
  - 3853: HER2 ISH Single Probe Copy Number (Breast)
  - 3854: HER ISH Summary (Breast)
  - 3859: HIV Status (Lymphoma)
- These will no longer be required as 1/1/2021
  - They are still required for cases diagnosed 1/1/2018-12/31/2020

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3919: PROSTATE PATHOLOGIC EXTENSION

- CoC Hospitals:
  - This data item is not required by CoC
  - CoC requirements have been updated to indicate it is not required
  - This data item is only required by registries (hospital and central) in the SEER regions

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COMING SOON: THE SSDI RECODE AND SSDI RECODE MANUAL

THE SSDI RECODE

- This recode takes information collected from the SSF and the SSDI and modifies the data so that it can be looked at over time
- Coding structures between the SSFs and SSDI are different, and sometime the definitions or values available are different
- In order to make sure that everyone is using this data the same, the SSDI recode was developed (by SEER and IMS)

THE SSDI RECODE

- The first variables will be released in SEER*Stat in April 2021
  - ER, PR, HER2, and several other SSDI's where the SSFs were publicly released
- All information for the recodes will be developed into an API, which can be shared with all software vendors and implemented as part of the software updates
- Our goal is to have these recodes become part of the software reports template (2023 updates)

THE SSDI RECODE: BREAST, ER SUMMARY

SSDI Recode #3827 (R)	SSDI Recode Description	SSF #1 Codes	SSDI codes # 3827
0	ER negative	020	0
1	ER positive	010	1
7	Test ordered, results not in chart	997	7
9	Not documented in medical record Cannot be determined (indeterminate) ER (Estrogen Receptor) Summary status not assessed or unknown if assessed	030, 988, 996, 998, 999	9

THE SSDI RECODE

- In the manual, not only will the conversions be shown, but the explanation for how things are grouped will also be available
- Working with NCDB and NPCR in developing this recode manual
- Planned completion date for all SSDI's will be Summer 2022
  - Note: This recode manual will not include any information on the SSFs that did not become SSDI's
- *If you have questions on how to do the SSDI recodes before the information is publicly released, please post in the SSDI CAnswer Forum*

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TOOLS

- SSDI and Grade manuals
  - https://apps.naaccr.org/ssdi/list/1.7
  - https://apps.naaccr.org/ssdi/list/2.0
- SEER*RSA (EOD, Summary Stage, SSDI's, Grade)
  - https://staging.seer.cancer.gov/eod_public/home/1.7/
  - https://staging.seer.cancer.gov/eod_public/home/2.0/

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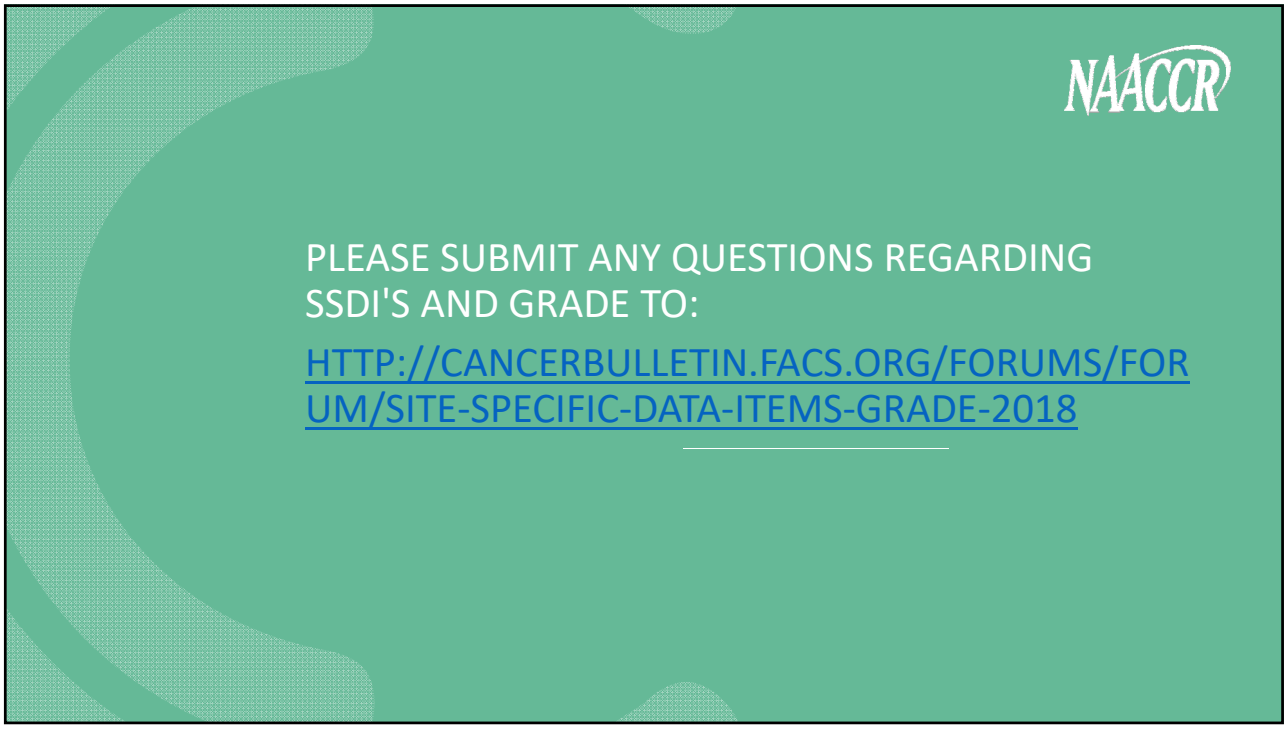
PLEASE SUBMIT ANY QUESTIONS REGARDING SSDI'S AND GRADE TO:
HTTP://CANCERBULLETIN.FACS.ORG/FORUMS/FORUM/SITE-SPECIFIC-DATA-ITEMS-GRADE-2018