South Carolina Central Cancer Registry
2021 Data Reporting Requirements & Guidelines

NAACCR Version 21
Record Layout and Data Standard Recommendations

Revised 01/11/2021

Please visit SCCCR DHEC Website for Cancer Standards and Reporting, Education and Resources:
https://scdhec.gov/CancerRegistry

NOTE: This document does not replace the SCCCR REPORTING SOURCE MANUAL. This document should be used in conjunction with it. This document may re-state some of its content and is specifically meant for 2021 reporting guidance. Recent updated 01/11/2021 highlighted in yellow

PREFACE

Important Notice to South Carolina Registrars Regarding Abstracting and Reporting 2021 Diagnosed Cases Prior to Release of NAACCRv21 Compliant Software.

The extensive changes for 2021 include twenty-six new data items, twenty-five revised items, and eighteen retired reserved data items. Additionally, we will be adopting the implementation of ICD-O-3.2 as well as the 2021 revisions to the Site-Specific Prognostic Data Items, Solid Tumor Rules, 2018 SEER Summary Stage, 2018 SEER EOD, 2018 SEER Grade Manuals, as well as the Commission on Cancer's STORE Manual (formerly named FORDS). All the 2021 data changes are requirements from national standard setting agencies and were not initiated by the South Carolina Central Cancer Registry.

Reporting facilities in South Carolina should direct any corrections, comments, and suggestions regarding this document to Connie Boone (boonecr@dhec.sc.gov). If individuals or facilities that are not part of the South Carolina reporting system need copies of the reporting manual, they may download the PDF from the South Carolina Central Cancer Registry website: https://scdhec.gov/health-professionals/electronic-health-records-meaningful-use/cancer-registry-data-standards
To open PDF click on the SCCCR Reporting Manual link.

1. SCCCR will not accept ANY 2021 cases (admit/dx) until April 2021. If there are further delays, you will be notified.

2. SCCCR will not accept 2021 cases in v18 format. All new data items are required to be completed and the SCCCR will monitor unknown values for the new data items.

3. 2021 abstracts may be started in the NAACCR Version 18 (v18) but MUST be completed using NAACCR Version 21 (v21) software.

4. SCCCR recommends facilities document details for the new data items for completion of the abstracts in v21 software with the new codes.

5. The SCCCR requires sufficient TEXT to support all codes, especially the new codes (e.g., HISTOLOGY, GRADE, AJCC & Summary STAGE, ETC.). The TEXT will provide an easy reference for coding cases that require v21 software when it becomes available.

6. The SCCCR recommends to not complete the following data items because new data items are required to collect the information for 2021. The data cannot be converted from v18 fields to v21 fields. These critical items include:
a) AJCC TNM Post Therapy Clin (yc) items

b) Neoadjuvant Therapy – clinical response, treatment effect

c) COVID 19 fields

d) SSDI Items: NRAS, BRAF, EGFR, ALK Rearrangement, CA 19-9 pre-treatment

When you have questions please send the SCCCR an email explaining your problem or phone the SCCCR. That is why we are here. Managers – You should allow your abstractors to contact the SCCCR when they need assistance. That is our job. Please remember the SCCCR is here to be used as a resource and to support your team.

Thank you for your continued commitment to ensure that the SCCCR data is of the highest quality. The data you provide remains the cornerstone of the South Carolina Cancer Registry.

Connie Boone, BSPH, AAS, CTR
Quality Control Manager/ETC

Table of Contents

SCCCR 2021 Reporting Requirements

(Note: for general SCCCR reporting requirements, refer to the SCCCR Reporting Source Manual)

SECTION 1: Case Reportability (ICD-0-3.2) - New terms and Codes effective 1/1/2021. Please see the 2021 ICD-O-3.2 – Coding Tables.

The ICD-O-3 Implementation Task Force has approved new codes, changes in behavior codes, and new terms associated with current codes. These changes reflect updates to the WHO Classifications for Tumors (Blue Books). The new codes, new terms, and codes with changes to behavior are listed in this section.

The 2021 ICD-O-3 Update Guidelines includes comprehensive tables listing all changes to ICD-O-3 including new terminology and reportability changes effective for cases diagnosed 1/1/2021 forward. Included in these guidelines are instructions for using the tables together with ICD-O-3.2. The guidelines also provide background on the project and issues encountered during review of the WHO 4th Edition Classifications of Tumors book series. Issues not covered in the 2021 update include reportability of histology codes with terms that include the words “high grade neoplasia” or “high grade dysplasia” or “severe dysplasia” in digestive system sites.

***IMPORTANT REMINDER:**

Please check the 2021 ICD-O-3 Update Table 6 or 7 first to determine if the histology is listed. If the histology is not included in the update, then review ICD-O-3.2 and/or Hematopoietic and Lymphoid Database and/or Solid Tumor Rules (MP/H).

Currently in ICD-O-3, when a topography (C code) is listed in parentheses next to the morphology term, it indicates morphology is most common to that site. It may occur in other sites as well. Many of the new codes, terms, and behaviors listed in this update are site-specific and may not apply to all sites. Applicable C codes will be noted next to the term in bold font. These site- and histology-specific combinations will not be added to the “Impossible combination” edit. However, if a site other than the one listed with the morphology code is assigned, the result will be an edit requiring review.

Website Link for 2021 ICD Coding Guidelines:
https://www.naaccr.org/icdo3/

Summary Tables of 2021 ICD-O-3.2 Changes and Whether Reportable to SCCCR
(ICD-O-3.2 codes, behaviors and terms are primary site specific)

Action	ICD-O-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
New Term	8151/3	Insulinoma	**Y**	Prior to 2021 these histologies were reportable only when the pathologist included "malignant" in the diagnosis term.
New Term	8152/3	Glucagonoma	**Y**	Prior to 2021 these histologies were reportable only when the pathologist included "malignant" in the diagnosis term.
New Term	8153/3	Gastrinoma	**Y**	Prior to 2021 these histologies were reportable only when the pathologist included "malignant" in the diagnosis term.
New code/term	8155/3	VIPoma	**Y**	Prior to 2021 these histologies were reportable only when the pathologist included "malignant" in the diagnosis term.

Action	ICD-0-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
New Term	8156/3	Somatostatinoma	**Y**	Prior to 2021 these histologies were reportable only when the pathologist included "malignant" in the diagnosis term.
New Term	8580/3	Thymoma, NOS (C37.9) Metaplastic thymoma (C37.9) Sclerosing thymoma (C34. _) Intrapulmonary thymoma C34. _)	**Y**	Prior to 2021 these histologies were reportable only when the pathologist included "malignant" in the diagnosis term.
New Term	8581/3	Type A thymoma including atypical variant (C37.9)	**Y**	Prior to 2021 these histologies were reportable only when the pathologist included "malignant" in the diagnosis term.

New Term	8582/3	Type AB thymoma (C37.9)	**Y**	Prior to 2021 these histologies were reportable only when the pathologist included "malignant" in the diagnosis term.
New Term	8583/3	Type B1 thymoma (C37.9)	**Y**	Prior to 2021 these histologies were reportable only when the pathologist included "malignant" in the diagnosis term.
New Term	8584/3	Type B2 thymoma (C37.9)	**Y**	Prior to 2021 these histologies were reportable only when the pathologist included "malignant" in the diagnosis term.
New Term	8585/3	Type B3 thymoma (C37.9) Thymoma, atypical (C37.9) Thymoma, epithelial (C37.9)	**Y**	Prior to 2021 these histologies were reportable only when the pathologist included "malignant" in the diagnosis term.
New Term	8693/3	Paraganglioma	**Y**	Prior to 2021 these histologies were reportable only when the pathologist included "malignant" in the diagnosis term.
New Term	8700/3	Differentiated-type vulvar intraepithelial neoplasia **(C51. _)**	**Y**	Prior to 2021 these histologies were reportable only when the pathologist included "malignant" in the diagnosis term.
New code/term Synonym	8273/3	Pituitary blastoma Embryoma	**Y**	
New code/term	9749/3	Erdhiem-Chester Disease	**Y**	

Status	ICD-0-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
New code/term	9766/3	Lymphomatoid granulomatosis, grade 3	Y	
New code/term	9819/3	B-lymphocytic leukemia/lymphoma, BCR-ABL1-like	**Y**	

New code/term	9877/3	Acute myeloid leukemia with mutated NPM1	**Y**	
New code/term	9878/3	Acute myeloid leukemia with biallelic mutations of CEBPA	**Y**	
New code/term	9879/3	Acute myeloid leukemia with mutated RUNX1	**Y**	
New code/term	9912/3	Acute myeloid leukemia with BCR-ABL1	**Y**	
New code/term	9968/3	Myeloid/lymphoid neoplasms with PCM1-JAK2	**Y**	
New code/term	9993/3	Myelodysplastic syndrome with ring sideroblasts and multilineage dysplasia	**Y**	
New code/term	9715/3	Anaplastic large cell lymphoma ALK-negative Breast implant-associated anaplastic large cell lymphoma	**Y**	
New code/term	8349/1	Non-invasive follicular thyroid neoplasm with papillary-like nuclear features (NIFTP) C73.9)	**N**	**This term was previously coded to 8343/2. The new code and behavior will make this non-reportable**

Action	ICD -0-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
New behavior	8077/2	Squamous intraepithelial neoplasia, grade II	**N**	Change from /0 **Excludes cervix** Refer to standard setter and/or state guidelines for further reportability guidelines
New behavior	8150/3	Pancreatic endocrine tumor, NOS (C25.4) Islet cell adenoma (C25.4) Islet cell adenomatosis (C25.4) Nesidioblastoma (C25.4) Islet cell tumor, NOS (C25.4)	**Y**	Change from /1 Change from /0 Change from /0 Change from /0 Change from /1
New code/term	8158/3	ACTH-producing tumor Endocrine tumor, functioning, NOS	**Y**	Change from /1

New code/term	8380/2	Endometrioid intraepithelial neoplasia (C54.1)	**N**	
New behavior code	8408/3	Aggressive digital papillary adenoma (C44. _)	**Y**	Change from behavior /1
New behavior/term	8452/3	Solid pseudopapillary neoplasm of pancreas	**Y**	Change from /1
New behavior/term	8620/3	Granulosa cell tumor, adult type (C56.9)	Y	Reportable for cases diagnosed 1/1/2021 forward
New behavior/term	8690/3	Middle ear paraganglioma (C30.1, C755.5))	Y	Change from /1
New behavior code	8691/3	Aortic body tumor (C75.5)	Y	Change from/1
New behavior/term	8692/3	Carotid body paraganglioma (C75.4)	Y	Change from/1
New behavior code	8693/3	Extra-adrenal paraganglioma, NOS Nonchromaffin paraganglioma, NOS Chemodectoma Composite paraganglioma Laryngeal paraganglioma Vagal paraganglioma	Y	Change from/1

Status	**ICD-0-3 Morphology Code**	**Term**	**Reportable to SCCCR Y/N**	**Comments**
New behavior	8700/3	Pheochromocytoma, NOS (74.1)	Y	Change from /0
New behavior code	8936/3	Gastrointestinal autonomic nerve tumor GANT Gastrointestinal pacemaker cell tumor	Y	Change from /1
New behavior/term	9505/0	Multinodular and vascolating neuronal tumor (MVNT) (C71.2)	Y	
New behavior/term	9766/3	Lymphomatoid granulomatosis, grade 3	Y	

Table 2: New behavior codes (Non-reportable neoplasms)

WHO has changed behavior codes for the following terms which result in reportable neoplasms becoming non-reportable beginning with cases diagnosed 1/1/2021. Continue reporting these cases when diagnosed prior to 1/1/2021.

Action	ICD-O Code	Term/Site	Comments
New behavior	8832/1	Dermatofibrosarcoma protuberans, NOS (C44. _) Dermatofibrosarcoma, NOS (C44. _)	Change from /3
New behavior	8833/1	Pigmented dermatofibrosarcoma protuberans (C44. _) Bednar tumor (C44. _)	Change from /3
New behavior code (***for specific sites only)***	9080/1	Immature teratoma of the lung (C34. _) Immature teratoma of thymus (C37.9) Immature teratoma of thyroid (C73.9)	Change from behavior /3 for the histology/site combination will make these terms non-reportable
New behavior code	9709/1	Primary cutaneous CD4-positive small/medium T-cell lymphoma (C44. _)	Change from /3
New behavior code	9718/1	Primary cutaneous CD30+ T cell lymphoproliferative disorder (C44. _) Lymphoid papulosis (C44. _)	Change for /3
New behavior/term	9725/1	Hydroa vacciniforme-like lymphoproliferative disorder	Change from /3.
New behavior code	9751/1	Langerhans cell histiocytosis, NOS Langerhans cell histiocytosis, monostotic Langerhans cell histiocytosis, polystotic	Change from /3
New behavior	9971/1	Polymorphic Post Transplant Lymphoproliferative Disorder (PTLD)	Change from /3
New behavior & term	8335/1	Follicular tumor of uncertain malignant potential (C73.0) Preferred term Follicular carcinoma, encapsulated (C73.9)	Change from /3

Table 3: Deleted ICD-O codes in ICD-O-3.2

ICD-O-3/3.1 Code/behavior	Term(s)	ICD-O-3.2 code (1/1/2021)	Comments
8471/3	Papillary mucinous cystadenocarcinoma (C56.9) Papillary pseudomucinous cystadenocarcinoma (C56.9)	8470/3	Cases diagnosed ***prior*** to 1/1/2021 use code 8471/3 Cases diagnosed 1/1/2021 forward use code 8470/3
9150/3	Hemangiopericytoma, malignant	8815/3	Cases diagnosed ***prior*** to 1/1/2021 use code 9150/3 Cases diagnosed 1/1/2021 forward use code 8815/3
9260/3	Ewing sarcoma	9364/3	1/1/2021 forward Ewing sarcoma is the preferred term for 9364/3 and is no longer coded to 9260/3. Cases DX'd prior to 1/1/2021 should be coded to 9260/3
9670/3	Malignant lymphoma, small B lymphocytic, NOS *(see also M-9823/3)* Malignant lymphoma, lymphocytic, diffuse, NOS Malignant lymphoma, lymphocytic, NOS Malignant lymphoma, lymphocytic, well differentiated, diffuse Malignant lymphoma, small cell diffuse Malignant lymphoma, small cell, NOS Malignant lymphoma, small lymphocytic, diffuse Malignant lymphoma, small lymphocytic, NOS	9823/3	Cases diagnosed ***prior*** to 1/1/2021 use code 9670/3 Cases diagnosed 1/1/2021 forward use code 9823/3
9728/3	Precursor B-cell lymphoblastic lymphoma *(see also M-9836/3)*	9811/3	Cases diagnosed ***prior*** to 1/1/2021 use code 9728/3 Cases diagnosed 1/1/2021 forward use code 9811/3
9729/3	Precursor T-cell lymphoblastic lymphoma *(see also M-9837/3)*	9837/3	Cases diagnosed ***prior*** to 1/1/2021 use code 9729/3 Cases diagnosed 1/1/2021 forward use code 9837/3
9826/3	Burkitt cell leukemia *(see also M-9687/3)* Acute leukemia, Burkitt type [obs]	9687/3	Cases diagnosed ***prior*** to 1/1/2021 use code 9826/3 Cases diagnosed 1/1/2021 forward use code 9687/3

	Acute lymphoblastic leukemia, mature B-cell type B-ALL [obs] FAB L3 [obs]		
9836/3	Precursor B-cell lymphoblastic leukemia *(see also M-9728/3)* c-ALL Common ALL Common precursor B ALL Pre-B ALL Pre-pre-B ALL Pro-B ALL	9811/3	Cases diagnosed ***prior*** to 1/1/2021 use code 9836/3 Cases diagnosed 1/1/2021 forward use code 9811/3
9991/3	Refractory neutropenia	9980/3	Cases diagnosed ***prior*** to 1/1/2021 use code 9991/3 Cases diagnosed 1/1/2021 forward use code 9980/3
9992/3	Refractory thrombocytopenia	9980/3	Cases diagnosed ***prior*** to 1/1/2021 use code 9992/3 Cases diagnosed 1/1/2021 forward use code 9980/3

Per ICD-O-3.2, several ICD-O codes have been removed and the histologies moved to other codes. The comment column provides coding instructions for cases diagnosed prior to 1/1/2021 and 1/1/2021 forward. This table lists only ***reportable*** neoplasms.

Table 4: Changes in reportable terminology

(*) WHO has revised preferred terminology for these neoplasms and no longer requires "malignant" to be used in the term to code behavior of /3

Action	ICD-O Code	Term/Site	Comments
New term	8151/3	Insulinoma	**(*)**
New term	8152/3	Glucagonoma	**(*)**
New term	8153/3	Gastrinoma	**(*)**
New term	8155/3	VIPoma	**(*)**
New term	8156/3	Somatostatinoma	**(*)**
New term	8580/3	Thymoma, NOS (C37.9) Metaplastic thymoma **(C37.9)** Sclerosing thymoma (C34. _) Intrapulmonary thymoma C34. _)	**(*)**
New term	8581/3	Type A thymoma including atypical variant **(C37.9)**	**(*)**
New term	8582/3	Type AB thymoma **(C37.9)**	**(*)**
New term	8583/3	Type B1 thymoma **(C37.9)**	**(*)**
New term	8584/3	Type B2 thymoma **(C37.9)**	**(*)**
New term	8585/3	Type B3 thymoma **(C37.9)** Thymoma, atypical **(C37.9)** Thymoma, epithelial **(C37.9)**	**(*)**
New Pref term	8693/3	Paraganglioma	**(*)**
New term	8700/3	Pheochromocytoma	**(*)**

(*) prior to 1/1/2021, these histologies were reportable only when the pathologist included "malignant" in the diagnosis term. Example: thymoma, malignant or malignant thymoma. WHO as dropped malignant from the reportable term. All the neoplasms listed are reportable as /3 unless stated to be benign

Table 5: New Terms and ICD-O codes

Action	ICD-O Code	Term/site	Comment
New code/term Synonym	8273/3	Pituitary blastoma Embryoma	
New code/term	9749/3	Erdhiem-Chester Disease	
New code/term	9766/3	Lymphomatoid granulomatosis, grade 3	
New code/term	9819/3	B-lymphocytic leukemia/lymphoma, BCR-ABL1-like	
New code/term	9877/3	Acute myeloid leukemia with mutated NPM1	
New code/term	9878/3	Acute myeloid leukemia with biallelic mutations of CEBPA	
New code/term	9879/3	Acute myeloid leukemia with mutated RUNX1	
New code/term	9912/3	Acute myeloid leukemia with BCR-ABL1	
New code/term	9968/3	Myeloid/lymphoid neoplasms with PCM1-JAK2	
New code/term	9993/3	Myelodysplastic syndrome with ring sideroblasts and multilineage dysplasia	
New code/term	9715/3	Anaplastic large cell lymphoma ALK-negative Breast implant-associated anaplastic large cell lymphoma	
New code/term	8349/1	Non-invasive follicular thyroid neoplasm with papillary-like nuclear features (NIFTP) C73.9) Non-invasive FTP (C73.9)	**This term was previously coded to 8343/2. The new code and behavior will make this non-reportable**

NPCR 2021 new data items

Item #		Item Name	Note
2232	R	Name – Birth Surname	New
1068	R*	Grade Post Therapy Clin (yc)	New
3845	R*	Grade Post Therapy Path (yp)	New
1021	RN	AJCC TNM Post Therapy Path (yp)T	New
1022	RN	AJCC TNM Post Therapy Path (yp) N	New
1023	RN	AJCC TNM Post Therapy Path (yp) M	New
1024	RN	AJCC TNM Post Therapy Path (yp) Stage Group	New
1033	RN	AJCC TNM Post Therapy Path (yp) T Suffix	New
1036	RN	AJCC TNM Post Therapy Path (yp) N Suffix	New
1062	RN	AJCC TNM Post Therapy Clin (yc) T	New
1063	RN	AJCC TNM Post Therapy Clin (yc) T Suffix	New
1064	RN	AJCC TNM Post Therapy Clin (yc) N	New
1065	RN	AJCC TNM Post Therapy Clin (yc) N Suffix	New
1066	RN	AJCC TNM Post Therapy Clin (yc) M	New
1067	RN	AJCC TNM Post Therapy Clin (yc) Stage Group	New
3943	RN	NCDB--SARSCoV2--Test	New
3944	RN	NCDB--SARSCoV2--Pos	New

3945	RN	NCDB--SARSCoV2--Pos Date	New
3946	RN	NCDB--COVID19--Tx Impact	New
2232	R	Name – Birth Surname	New
1068	R*	Grade Post Therapy Clin (yc)	New
3845	R*	Grade Post Therapy Path (yp)	New
1021	RN	AJCC TNM Post Therapy Path (yp)T	New
1022	RN	AJCC TNM Post Therapy Path (yp) N	New

R=Required; R*= Required when available
RS= Required, site-specific
RS* Required, site-specific, when available
D = Derived, site-specific
RN Implement according to NPCR Stage Transition Plans (for example, for dually funded states capturing EOD18 staging or for collecting CoC facility data)
RH = Required historically (for historical cases)
RH* = Required historically, when available

Section 2: SCCCR Date Field Requirements 2021

Population-based cancer surveillance is based on accurate dates. The two most important dates for cancer statistics are Date of Diagnosis and the Date of Death. These two dates provide cancer incidence and mortality rates for South Carolina as well as cancer survival statistics. Nothing is any more important than reporting accurate dates! See the guidelines that follow for how to deal with instances when an exact date may not be available and what is required.

How to code Date of Diagnosis when day, month, or year is unknown

Estimate the date fields according to the guidance below. **Always indicate in text that the date was approximated!**

SCCCR will not accept blanks or 9's in the date field for Date of Diagnosis, Date of Birth, or any of the treatment date fields.

SCCCR requirements to estimate unknown dates updated 11/19/19

Estimating the Date of Diagnosis When No Information is Available in the Medical Record

Registrars MUST use every resource available at the reporting facility to determine the best date of diagnosis. In the absence of an exact date of initial diagnosis, you MUST estimate at least the year of diagnosis using your best approximation from the information available in the record. Documentation that the exact date of diagnosis was not available in the medical record MUST be included in a text field. When an exact date of diagnosis is identified after a case has been completed, contact SCCCR.

The date of initial diagnosis is the earliest date this primary reportable neoplasm is diagnosed clinically or microscopically by a recognized medical practitioner, regardless of whether the diagnosis was made at the reporting facility or elsewhere.

The initial diagnosis date may be from a clinical diagnosis or other acceptable diagnostic method; for example, when a radiologist reviews a CT Scan or chest x-ray and the diagnosis is lung cancer or suspicious for lung cancer. When a diagnosis is confirmed later biopsy/resection, the (clinical or other acceptable testing) date of diagnosis remains the date of the initial diagnosis.

Date of Diagnosis Coding Instructions:

1. NEVER LEAVE THE DATE OF DIAGNOSIS BLANK.
2. NEVER ENTER 99/99/9999 FOR DATE OF DIAGNOSIS.
3. NEVER ENTER 00/00/0000 FOR DATE OF DIAGNOSIS

How to Code **Date of Birth** when not stated in record

If the patient age is available only, calculate the year of birth from age and the year of diagnosis (for example, a 60-year-old patient diagnosed in 2010 is calculated to have been born in 1950).

SECTION 3 - SCCCR Edits 2021

The SCCCR requires that all facilities uploading data to the central registry use the state edits metafile. This edits metafile will be sent to all cancer registry software vendors to give them time to update their client's software before the metafile is used in the SCCCR applications to process their cases.

Edit Metafile Name**: SC_v21A_20201011.smf**

The SCCCR uses the following state-specific edits to perform additional quality control on the data that have been submitted by facilities. **SCCCR requires facilities use these edits within their cancer registry databases prior to uploading their data to the central registry.**

Edit Name	Edit Rationale	Text/Coding Requirements
Date of Initial Rx SEER	Date field cannot be empty with noted exceptions	Date of Initial Rx SEER – This date should be left blank when: • When no treatment is given during the first course • When Treatment Status is coded 2, Active surveillance/watchful waiting • When it is known the patient had first course therapy, but it is impossible to estimate the date • When it is unknown whether the patient had treatment • For DCO (death certificate only) cases when the date is unknown and cannot be estimated • Autopsy only cases You can find more information on this topic: https://seer.cancer.gov/archive/manuals/2018/SPCSM_2018_maindoc.pdf
EOD Primary Tumor		This must reflect the extension of the tumor within the pathology report. This should also reflect localized or more extension in the SEER Summary Stage. This will be considered an edit that needs to be rectified prior to submission. Exception: prostate is based on clinical findings only.
EOD Nodes		This must reflect the extension to nodes or no extension to nodes. This should also reflect in the SEER Summary Stage.

EOD Mets		This must reflect whether there is metastatic disease. This should also reflect in the SEER Summary Stage.
Primary Site/ Histology	If the histology code is 8046 and the primary site code is 34.0 – 34.9, this edit flags the record for manual review	Non-small cell carcinoma is coded as 8046/3 as a last resort.
Tx > 240+ days	This edit flags the record for manual review	The text should determine why there was a delay in treatment or if the initial plan spanned over 6+ months.
State of Death	This edit flags the record for review	Access to the death certificate can provide the state of death. Internet search engines may also assist in finding the state of death with patient obituary.
Clinical Stage Group		If there is not enough information to determine the stage, this data item should be coded as 99.
Path Stage Group		If there is not enough information to determine the stage, this data item should be coded as 99.
Lymphovascular Invasion		Histologic types 9590 - 9992 must be coded as 8
Serous Carcinoma/ Ovary	Histology 8460 & 8461 will generate a warning.	If histology states this is low grade serous carcinoma, histology should be coded to 8460. If histology state this is high grade serous carcinoma, histology should be coded to 8461.
Meningioma	C70.9 will generate a warning	Determination of cerebral or spinal meninges should be made. Primary site text should state whether this is C70.0 or C70.1.
Empty Text Box		There should be no text field left blank. If you do not have the information for that field state that the information is not available. If this text field does not apply, none or n/a should be entered.

SECTION 4 SCCCR 2021 Text Guidelines

The SCCCR requires the submission of text information to validate coded data items. Text is used for quality control purposes to justify codes for various data items. Text is also used to identify errors, determine multiple primaries, and resolve discrepancies in data submitted on the same patient by multiple facilities. CDC NPCR Data Quality requires that documentation accompany all cases sufficient to substantiate the coding of key data items. When the SCCCR is audited each grant cycle by NPCR, they always use text to substantiate codes, and if it is missing, the item is counted against the SCCCR. **There must be text to support codes**.

All cancer registry software must include specific fields that have been designed to record text information. These fields are transmitted to the SCCCR along with the other required data fields when data are electronically submitted.

Recording text information should include but not be limited to the following:

• Record text to support primary site, laterality, histology, grade, stage, and treatment codes.

• Record text to justify any unusual information about the case that could result in potential questions, e.g., record text to support unusual site/histology combinations, such as age/site combinations, gender/site combinations, name/gender combinations, pediatric age.

• Record text to clarify modifications or dates on the abstract.

• If limited information is available in the medical record about a case, utilize the text field to state that limited information was available in the medical record.

• Document dates as M/D/YY

- SCCCR will no longer allow any text field to remain blank. If the information is not available or does not apply that will need to be communicated in the appropriate text field.

- NCRA Informational Abstracts provide the best practices for documenting text for many sites: http://www.cancerregistryeducation.org/rr

SCCCR Text Guidelines 2021 Table

Field	Instructions	Text to Include
PE	Document information from the history and physical exam	• Date of physical exam • Age, sex, race/ethnicity • History that relates to cancer diagnosis • Palpable lymph nodes • Impression (when stated and pertains to cancer diagnosis) • Date of diagnosis
X-rays & Scans	Document information from all X-rays, scans, and/or other imaging examinations that provide information about diagnosis and staging	• Location, Date(s), and type(s) of X-ray/Scan(s) • Primary site • Histology (if given) • Tumor location, size and staging if stated • Lymph nodes • Record positive and negative clinical findings. Record positive results first • Distant disease or metastasis
Scopes	Document information from endoscopic examinations that provide information for diagnosis, staging and treatment.	• Location, Date(s) of endoscopic exam(s) • Primary site • Histology (if given) • Tumor location • Tumor size • Record site and type of endoscopic biopsy • Record positive and negative clinical findings.
Labs	Document information from laboratory tests other than cytology or histopathology.	• Location, Type of lab test/tissue specimen(s) • Record both positive and negative findings. Record positive test results first. • Information can include tumor markers, serum and urine electrophoresis, special studies, etc. • Date(s) of lab test(s) • Lab tests, tumor markers, and other prognostic factors, including, but not limited to: Prostate Cancer – Prostatic Specific Antigen (PSA), Testicular Cancer – Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH), HPV status Breast Cancer – Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu, is exempt from positive results before negative results.
OP	Document all surgical procedures used in staging	• Location, Dates, and descriptions of biopsies and all other surgical procedures from which staging information was derived • Observations from surgery

Field	Instructions	Text to Include
		• Number of lymph nodes removed • Size of tumor removed • Documentation of residual tumor • Evidence of invasion of surrounding areas • Reason primary site surgery could not be completed

Field	Instructions	Text to Include
Path	Document information from cytology and histopathology reports	• Location, Date(s) of procedure(s) • Anatomic source of specimen • Type of tissue specimen(s) • Tumor type and grade (include all modifying adjectives, predominantly, with features of, with foci of, elements of, etc.) • Tumor size • Extent of tumor spread • Involvement of resection margins • Number of lymph nodes involved and examined • Record both positive and negative findings. Record positive test results first. • Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored
Primary Site	Document information regarding the primary site and laterality of the tumor being reported. •	• State the specific location of the primary site, including subsite. • Include available information on tumor laterality • Source of information (MPH rules, path report, physician statement, etc.)
Histology /Grade	Document information regarding the histologic type, behavior, and grade (differentiation) of the tumor being reported.	• Information on histologic type and behavior • Information on differentiation from scoring systems such as Gleason's Score, Bloom-Richardson Grade, etc. • Source of information (MPH Rules, path report, physician statement, etc.)
Staging	Document information used for staging Example: Clinical Stage: Registrar/Dr Smith Med Onc Consult 2/1/18 cT3 cN0 cM0 Stage grp 2	Justification of clinical and pathologic TNM and Summary Stage, including: Organs involved by direct extension and who staged by: • Size of tumor • Status of margins • Number and sites of positive lymph nodes • Site(s) of distant metastasis

Surgery	Document information regarding surgical treatment.	• Date of each procedure. • Name of physician performing procedure. • Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites. • Lymph nodes removed. • Regional tissues removed. • Metastatic sites. • Facility where each procedure was performed. • Record positive and negative findings. Record positive findings first. • Other treatment information, e.g., planned procedure aborted; unknown if surgery performed

Field	Instructions	Text to Include
Radiation (Beam)	Document information regarding treatment using radiation other than beam radiation.	• Date radiation treatment began • Where treatment was given at this facility, at another facility • Name of radiation oncologist. • Type(s) of beam radiation, e.g., Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities • Other treatment information, unknown if radiation completed, patient didn't complete last 3 treatments
Radiation (Other)	document information regarding treatment using radiation other than beam radiation.	• Date treatment was started • Name of radiation oncologist • Where treatment was given, e.g., at this facility, at another facility • Type(s) of non-beam radiation, e.g., High Dose rate brachytherapy, seed implant, Radioisotopes (I-131)
Chemo	document information regarding treatment using chemotherapy.	• Date chemotherapy began • Name of physician providing treatment • Where treatment was given, examples: at this facility, at another facility • Type of chemotherapy, example: name of agent(s) or protocol • Other treatment information, example: treatment cycle

		incomplete, unknown if chemotherapy was given
Hormone	Document information regarding treatment using hormonal treatment	• Name of physician providing treatment • Where treatment was given at this facility, at another facility • Type of hormone or antihormone: Tamoxifen • Type of endocrine surgery or radiation: orchiectomy • Other treatment information: treatment cycle incomplete; unknown if hormones were given
BRM	Document information regarding treatment using biological response modifiers or immunotherapy.	• Date treatment began • Name of physician providing treatment • Where treatment was given, at this facility, at another facility • Type of BRM agent: Interferon, BCG • BRM procedures: bone marrow transplant, stem cell transplant • Other treatment information: treatment cycle incomplete; unknown if BRM was given

Field	Instructions	Text to Include
Other	Document information regarding treatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments and blinded clinical trials where the mechanism of the experimental drug is not known.	• Date treatment was started • Name of physician providing treatment • Where treatment was given at this facility, at another facility • Type of other treatment: blinded clinical trial, hyperthermia • Other treatment information: treatment cycle incomplete; unknown if other treatment was given
Remarks	Document information not documented in another field.	Reason for: SS# unknown, sequence number, justifications for overrides and anything coded unusual.
Place of Diagnosis	Document Facility, physician's office, city, state, or country where the diagnosis was made	Complete name of hospital or physician's office where diagnosis occurred.

SECTION 5 SCCCR Staging Requirements 2021

NPCR discontinued requiring AJCC TNM Staging as of 1/1/2018 cases going forward. The SCCCR will continue to accept TNM staging elements from CoC hospitals for 2018 cases.

SEER Summary Stage 2018 is required by the SCCCR for 2018 and forward.

SEER Extent of Disease (EOD) is also required by the SCCCR. The thought is that the EOD data elements can be easily completed as they are needed to stage cases using the other staging systems.

Guidelines:

Methods commonly used to determine stage are the American Joint Committee on Cancer (AJCC) TNM staging system, SEER Summary Stage, SEER Extent of Disease, Site-Specific Data Items, and Collaborative Stage:

AJCC TNM: Used in the clinical setting by physicians to define spread of disease to make appropriate treatment decisions, determine prognosis, and measure end results. Refer to the most current AJCC Cancer Staging Manual for coding instructions.

SEER Summary Stage: Used by Epidemiologists and researchers where cases are grouped into standardized and simplified broad categories to ensure consistent definitions over time. Refer to the most current SEER Summary Stage 2018 Manual for coding instructions.

SEER Extent of Disease: Reflects a combination of clinical and pathologic information. Permits staging of all cancer types. Allows calculation of a combined “best” stage. Refer to the most current SEER Extent of Disease General Instructions for coding.

Site-Specific Data Items: Consist of additional prognostic factors or schema discriminators, which are cancer site-specific. Some are used in combination with staging systems variables to determine or derive a stage.

Refer to the most current Site-Specific Data Items Manual for coding instructions.

AJCC TNM Cervix 9th Version Required from CoC facilities only, for cases diagnosed 2021 +
SEER 2018 Extent of Disease (EOD) Directly Coded Required from ALL facilities for cases diagnosed 2018 +
Summary Stage 2018 Directly Coded Required from ALL facilities for cases diagnosed 2018 +

SECTION 6 2021 SCCCR Staff Contact:

Name	Phone #	Email
Deborah Hurley, MSPH Director	803-898-0701	hurleydm@dhec.sc.gov
Michael Castera, CTR Data Quality Manager	803-898-0353	casterma@dhec.sc.gov
Kammy Rebl, CTR Data Collection Manager	843-953-0171	reblkj@dhec.sc.gov
Connie Boone, BSPH, AAS, CTR Quality Control Manager/ETC	843-898-0985	boonecr@dhec.sc.gov

2021 Reference Manuals and Summary of Requirements

Summary of CoC Requirements for Accredited Programs

For all cases diagnosed on or after January 1, 2018, the American College of Surgeons Commission on Cancer (CoC) will require its accredited programs to use Standards for Oncology Registry Entry (STORE); *AJCC Cancer Staging Manual, Eighth Edition* (8th Edition), Site-Specific Data Items (SSDIs) for collection of site-specific information; NAACCR Guidelines for ICD-O-3 Update Implementation; 2018 Solid Tumor Coding Rules; SEER Summary Stage 2018 Manual to assign Summary Stage; most current SEER Hematopoietic and Lymphoid Neoplasm Database and rules; and SEER*RX systemic therapy application. Revisions to CoC reporting requirements for 2018 accommodate the transition from Collaborative Stage Site-Specific Factors to the new SSDI and Grade data items, as well as implementation of new data items for the collection of radiation therapy, information associated with sentinel and regional lymph nodes, and cancer recurrence.

The SCCCR will accept AJCC TNM staging from CoC hospitals, however, does not require it for non-hospital cases (path lab or physician office cases). All other requirements are as stated above for the CoC accredited hospitals, except that the SCCCR also requires SEER Extent of Disease (EOD) coded data items from all data sources.

SECTION 7 AJCC TNM Staging Manual, 8th Edition

In 2021, AJCC has started rolling updates with the release of Cervix 9th version. AJCC Staging is required by CoC-accredited facilities for all cases diagnosed January 1, 2018 and forward.

Guidelines:

•

Refer to the most current AJCC Cancer Staging Manual for specific disease site chapters and staging instructions.

•

AJCC Cancer Staging questions should be directed to the CAnswer Forum at: http://cancerbulletin.facs.org/forums.

•

There were errata released in February 2021 for AJCC 8TH EDITION.

SECTION 8 Site Specific Data Items (SSDI) and Grade

The Grade Coding Instructions and Tables (Grade Manual) is the primary resource for documentation and coding instructions for Grade for cases diagnosed on or after January 1, 2018. Before using the Grade Manual as a coding reference, it is important to review the introductory materials and general instructions of the manual carefully. These reflect several important changes in the collection of Grade data items, including use of AJCC-recommended grade tables where applicable and the introduction of Clinical, Pathological and Post Therapy Grade data items.

To understand how the Grade Tables are organized in the Grade Manual, one must be familiar with the concept of Schema IDs which is described in the SSDI Manual. A particular Grade Table defines the set of applicable codes for a set of schemas and AJCC Chapters. For example, “Grade ID 01 – Clinical Grade Instructions” defines a single set of codes that apply to clinical grade for 23 Schemas/AJCC Chapters. Similar to the SSDI’s, registry software will populate the grade field pick lists for each case with the appropriate grade codes based on the Schema ID, such that once the software is available, the registrar will not have to use the manual to determine which grade codes apply for a particular case.

For registrars who are coding 2021 diagnosed cases before software is available, the Grade Manual provides Grade Table Indexes to assist the registrar in identifying the correct code Tables. These indexes are located at the beginning of the Grade Manual, immediately after the Table of Contents. The first Index provides information sorted in Schema ID # order, which approximates the order of AJCC Chapters, and contains Schema number and name, AJCC Chapter number and name and the Summary Stage Chapter name along with a hyperlink to the appropriate Grade Table. A hyperlink is also provided to return to the Grade Table (Schema ID order) at the end of the coding instructions for each schema. A second index with similar information and functionality, sorted in alphabetical order by schema name, is also provided. In addition to understanding the concept and structure of the Grade Tables, it is critically important to review all the general information included in the Manual. Particular attention should be paid to understanding coding instructions for grade tables where both an AJCC-preferred grade system and the generic grade system are allowable codes, coding guidelines for Clinical, Pathological and Post Therapy grade data items and coding instructions for generic grade categories. Thorough understanding of this material will be necessary to code the new Grade Data Items accurately.

Hyperlink below to connect via internet version that will always be updated: NAACCR.org All SSDI & Grade 2018 2.0 https://www.naaccr.org/wp-content/uploads/2020/09/Version-2.0-Changes-for-SSDI-and-Grade-Manuals.5.18-1.pdf?v=1612385147

List of 22 Site Specific Data Items (SSDI) Required by SCCCR for 2021

Item Number	Item Name
3855	HER2 Overall Summary
3863	Ki-67
3927	Schema Discriminator 2 – Soft Tissue Sarcomas (C473, C475, C493-C495)
3938	ALK Rearrangement
3939	EGFR Mutational Analysis
3940	BRAF Mutational Analysis

3941	NRAS Mutational Analysis
3942	CA 19-9 PreTx Lab Value
3816	Brain Molecular Markers
3817	Breslow Tumor Thickness
3827	Estrogen Receptor Summary
3835	Fibrosis Score
3843	Grade Clinical
3844	Grade Pathological
3845	Grade Post Therapy
3855	HER2 Overall Summary
3890	Microsatellite Instability (MSI)
3915	Progesterone Receptor Summary
3920	PSA Lab Value
3926	Schema Discriminator 1
3927	Schema Discriminator 2
3932	LDH Pretreatment Lab Value

2021 Changes to SSDI Manual (General Instructions)

Manual Section	Page	Original Text	Updated Text
Timing for Recording Laboratory Tests	16	**Timing for Recording Laboratory Tests**: Unless instructions for a specific laboratory test state otherwise, record only test results obtained • Before any cancer-directed treatment is given (neoadjuvant therapy or surgical), AND • No earlier than approximately three months before diagnosis AND • If multiple lab tests are available, record the highest value	All lab values must be done no earlier than approximately three months before diagnosis AND Unless instructions for a specific lab test state otherwise, record only test results obtained • Before any cancer-directed treatment is given (neoadjuvant therapy or surgical), AND • If multiple lab tests are available, record the highest value.
Consult Reports	17		**New Section**

			If a report is sent out for consult and the results are different than the original report, record the results from the consult Example 1: Patient had biopsy done at a facility with a Gleason Score of 4+4=8. Slides were sent out for consult and their review showed Gleason Score 4+3=7. • Record the Gleason score of 4+3=7 based on the consult. Example 2: Original pathology report states ER and PR positive. Slides were sent out for consult and their review showed ER and PR negative. • Record ER and PR as negative Example 3: Breast pathology report states Grade 3, ER 95% strong on outside pathology. Patient presents at facility for treatment and the slides from the outside facility are reviewed, with the results of Grade 2, ER 80% intermediate. • Record Grade 2 and ER 80% intermediate

Schema ID Name	Data Item# and Description	Original Text	Updated Text
00060-00150: Head and Neck Cancer	3831: Extra nodal Extension Head and Neck Clinical-Coding guidelines (SSDI manual only)		Code 4 when there are positive nodes clinically, ENE is identified, but not known how identified
00060-00150: Head and Neck Cancer	3831: Extra nodal Extension Head and Neck Clinical		New code 4 Regional lymph nodes involved, ENE present/identified, unknown how identified
00060-00150: Head and Neck Cancer	3831: Extra nodal Extension Head and Neck Clinical	Note 4: Code 0 when lymph nodes are determined to be positive and physical examination does not indicate any signs of extra nodal extension	Note 4: Code 0 when lymph nodes are determined to be clinically positive and physical examination does not indicate any signs of extra nodal extension

00060-00150: Head and Neck Cancer	3831: Extra nodal Extension Head and Neck Clinical	Note 6: Code 9 when physical exam is not available AND at least one of the following	Note 6: Code 7 when • Lymph nodes are determined to be clinically negative • Behavior /2 (in situ) Note 7: Code 9 when physical exam is not available AND at least one of the following
00060-00150: Head and Neck Cancer	3832: Extra nodal Extension Head and Neck Pathological	Note 2: Code the status of ENE assessed on histopathological examination of surgically resected involved regional lymph node(s). Do not code ENE from a lymph node biopsy (FNA, core, incisional, excisional, sentinel). Do not code ENE for any distant lymph nodes.	**Note 2:** Code the status of ENE assessed on histopathological examination of surgically resected involved regional lymph node(s). Do not code ENE from a lymph node biopsy (FNA, core, incisional, excisional, sentinel). Do not code ENE for any distant lymph nodes. • If codes 0.0-9.9, X.1-X.7 are used, this indicates that the lymph nodes were surgically resected and Scope of Regional Lymph Node Surgery • [NAACCR Data Item: 1292] must be 3-7
00060, 00140: Cervical Lymph Nodes and Unknown Primary, Melanoma Head and Neck	3877: Lymph Nodes Head and Neck Levels IV-V	Note 3: Code the presence or absence of lymph node involvement for Levels IV-V For more information on Levels IV-V lymph nodes, see AJCC 8th edition, Chapter 5: Staging Head and Neck Cancers, Table 5.1	**Note 3:** Code the presence or absence of lymph node involvement for Levels IV-V For more information on Levels IV-V lymph nodes, see AJCC 8th edition, Chapter 5: Staging

		Note 4: Pathological information takes priority over clinical.	Head and Neck Cancers, Table 5.1 **Note 4:** If lymph nodes are described only as "supraclavicular," try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. • If the specific level cannot be determined, or is documented as supraclavicular with no further information, code them as Level V nodes **Note 5:** Pathological information takes priority over clinical
00161, 00169 Esophagus	Schema Discriminator 1: Esophagus/GE Junction/Stomach		**New note** **Note 2:** The CAP protocol uses "midpoint" instead of "epicenter."
00161: Esophagus (including GE junction) Squamous	3829: Esophagus and EGJ Tumor Epicenter		**New Note** **Note 6:** If primary site is C159 (Esophagus, NOS), code 9.
00200: Colon and Rectum	3823: Circumferential Resection Margin	**Note 2:** Tumor involvement of the circumferential resection margin or radial resection margin appears to be a strong prognostic factor for local or systemic recurrences and survival after surgery. **Note 3:** The CRM may be referred to as • Circumferential radial margin • Circumferential resection margin	**Note 3:** There are 4 KRAS codons that are commonly mutated in colorectal cancers. This SSDI does not record the actual mutation, but instead records the codon or codon group that contains the mutation. If a specific KRAS mutation is reported, its codon may be

		• Mesenteric (mesocolon) margin • Radial margin • Soft tissue margin **Note 4:** According to the AJCC 8th edition, "the CRM is the distance in millimeters between the deepest point of tumor invasion in the primary cancer and the margin of resection in the retroperitoneum or mesentery." **Note 5:** The CRM may be referred to as • Circumferential radial margin • Circumferential resection margin • Mesenteric (mesocolon) margin • Radial margin Soft tissue margin	identified from the following list of common KRAS mutations grouped by codon. Codon 12 • Gly12Asp (GGT>GAT) • Gly12Val (GGT>GTT) • Gly12Cys (GGT>TGT) • Gly12Ser (GGT>AGT) • Gly12Ala (GGT>GCT) • Gly12 Arg (GGT>CGT) • Codon 12 mutation, not otherwise specified Codon 13 • Gly13Asp (GGC>GAC) • Gly13Arg (GGC>CGC) • Gly13Cys (GGC>TGC) • Gly13Ala (GGC>GCC) • Gly13Val (GGC>GTC) • Codon 13 mutation, not otherwise specified **Codon 61** • Gln61Leu (CAA>CTA) • Gln61His (CAA>CAC) • Codon 61 mutation, not otherwise specified

			Codon 146 • Ala146Thr (G436A) (GCA>ACA) • Codon 146 mutation, not otherwise specified **Note 4:** KRAS analysis is commonly done for patients with metastatic disease.
00200: Colon and Rectum	3866: KRAS		**Note 8:** Code 9 when • Insufficient amount of tissue available to perform test • No microscopic confirmation of tumor • KRAS not ordered or not done, or unknown if ordered or done
00200: Colon and Rectum	3866: KRAS	Code 0: Normal (wild type) Negative for mutations	Code 0: Normal KRAS negative, KRAS wild type Negative for (somatic) mutations, no alterations, no (somatic) mutations identified, not present, not detected
00200: Colon and Rectum	3890: Microsatellite Instability (MSI)	Note 4 MMR deficient (pMMR or MMR-p) (code 2)	Note 4 MMR deficient (dMMR or MMR-D) (code 2)
00200: Colon and Rectum	3890: Microsatellite Instability (MSI)	Code 0 Microsatellite instability (MSI) stable; microsatellite stable (MSS); negative, NOS AND/OR Mismatch repair (MMR) intact, no loss of nuclear expression of MMR proteins	Code 0 Microsatellite instability (MSI) stable. microsatellite stable (MSS); negative, NOS AND/OR Mismatch repair (MMR) intact, no loss of nuclear expression of MMR proteins MMR proficient (pMMR or MMR-P)

00200: Colon and Rectum	3890: Microsatellite Instability (MSI)	Code 2 MSI unstable high (MSI-H) AND/OR MMR-D (loss of nuclear expression of one or more MMR proteins, MMR protein deficient)	Code 2 MSI unstable high (MSI-H) AND/OR MMR deficient (dMMR or MMR-D), loss of nuclear expression of one or more MMR proteins

SECTION 9 STORE 2018 - Standards for Oncology Registry Entry

The STORE replaced the FORDS manual for coding instructions and guidelines, and incorporates all updates to Commission on Cancer (COC) National Cancer Database Data Base (NCDB) standards since the FORDS 2016 revision. **It is effective for cases diagnosed January 1, 2018 and forward.**

STORE General Information

The American College of Surgeons Cancer (ACS), Commission on Cancer (CoC) released the Standards for Oncology Registry Entry (STORE) in August 2018. The STORE Manual is required for CoC Accredited facilities for cases diagnosed January 1, 2018 and forward. If non-CoC facilities are collecting data items outlined in the STORE Manual as available, then the STORE Manual should be referenced for coding instructions, particularly in the event coding clarification is not included in Volume I for those data items.

Please click on the hyperlink for a copy of 2018 CoC STORE:
https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/store_manual_2021.ashx

STORE Manual questions should be directed to the CAnswer Forum at:
http://cancerbulletin.facs.org/forums.

SECTION 10 SEER Summary Stage 2021

Summary Stage is the most basic way of categorizing how far a cancer has spread from its point of origin. The 2021 version of SEER Summary Stage applies to every site and/or histology combination, including lymphomas and leukemias. Summary Stage uses all information available in the medical record, in other words, it is a combination of the most precise clinical and pathological documentation of the extent of disease.

The 2018 Summary Stage Manual chapters consist of a one-digit hierarchical code. In the United States, these chapters will apply to January 1, 2018 diagnoses and forward. It is extremely important to thoroughly read all clinical and pathological documentation, including imaging studies, operative and pathology reports, and the clinician's narrative descriptions of tumor involvement.

Please click on the hyperlink for the most updated internet version:
https://seer.cancer.gov/tools/ssm/

The Registrar Staging Assistant (SEER*RSA) website is intended for use by cancer registrars to help with the following: https://stagingseer.cancer.gov/

For cases diagnosed 2018 and forward:

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

SECTION 11 Solid Tumor Rules - Effective for Cases Diagnosed 1/1/2018 and Forward

The 2018 Solid Tumor Rules replace the 2007 Multiple Primary and Histology (MPH) Coding Rules. This revision continues to promote consistent and standardized coding by cancer registrars and coding instructions to ensure accurate data collection**. It is important to note seven site-specific coding modules have been updated for 2021. These site groups are: Urinary, Colon, Head and Neck, Malignant CNS, Non-Malignant CNS, Breast & Lung. The remaining two site specific coding modules have not been updated for 2018. These site groups are: Cutaneous Melanoma and Other sites.**

The primary reference for both the 2007 MPH rules and 2018 Solid Tumor Rules are the WHO Classification of Tumors books (blue books). Since 2007, WHO has continued publishing updates to the WHO Classification of Tumors series. As part of each new edition, subject matter experts review current literature and make recommendations regarding current practices in histology terminology and diagnosis. The College of American Pathologists (CAP) has adopted the new histologic terminology and diagnosis criteria into the site-specific 2021 CAP Protocols. The 2018 Solid Tumors Rules have been revised to reflect current CAP and WHO practices. Just as a reminder there were revisions made for 2021+ cases.

As part of the revisions to the 2007 MPH rules, the editors and Solid Tumor Committee reviewed issues and questions NCI SEER received since the implementation of the MPH rules. These questions provided valuable information as to what clarifications were needed in the form of additional rules, tables, examples, and notes.

Please click on hyperlink for the most updated internet version:
https://seer.cancer.gov/tools/solidtumor/

2021 Resources Table with Quick Links (2/3/2021 updated) This table includes the links for the all required reference manuals. For 2018 and forward abstracting, registrars MUST USE THEIR MANUALS!

Reference Manual / Abstracting Resource	Link to Resource
SCCCR Reporting Source Manual	http://www.dhec.sc.gov/health/docs/cancer/scccr Reporting Source Manual Final 2018 updated.pdf
2020 Case Finding ICD-10-CM Code List Changes	https://seer.cancer.gov/tools/casefinding/
ICD-O-3 Third Edition – purple book	https://seer.cancer.gov/icd-o-3/
ICD-O-3 Third Edition - published errata (two)	https://seer.cancer.gov/icd-o-3/
ICD-O-3 Third Edition - 2007 Updates for Selected Solid Tumors	https://seer.cancer.gov/icd-o-3/
ICD-O-3 Third Edition - 2010 Updates for Hematopoietic and Lymphoid Neoplasms	https://seer.cancer.gov/icd-o-3/
2021 Guidelines for ICD-O-3 Histology Code and Behavior Update	https://seer.cancer.gov/icd-o-3/
SEER Program Coding and Staging Manual 2021	https://seer.cancer.gov/manuals/2021/SPCSM_2021_MainDoc.pdf
2018 Solid Tumor MP/H Coding Rules	https://seer.cancer.gov/tools/solidtumor/
2018 Hematopoietic Database & MPH Rules – web-based version only	http://seer.cancer.gov/seertools/hemelymph/
2018 SEER*Rx – current web version	http://seer.cancer.gov/seertools/seerrx/
2018 Grade Coding Manual, Instructions and Tables	https://apps.naaccr.org/ssdi/list/
2018 Summary Stage Manual	http://seer.cancer.gov/tools/ssm/
AJCC Cancer Staging Manual, 8th ed.	http://www.springer.com/medicine
AJCC Cervix uteri Protocol for Cancer, Version 9	https://www.amazon.com/AJCC-Cancer-Staging-System-Documentation-ebook/dp/B08LQZZMN8/ref=sr_1_2?dchild=1&keywords=AJCC&qid=1612386111&s=digital-text&sr=1-2
AJCC Cancer Staging Manual, 8th ed. – errata & breast chapter replacement	https://cancerstaging.org/references-tools/deskreferences/Pages/8EUpdates.aspx#Histology/Topography
AJCC Histology and Topography Code Supplement	https://cancerstaging.org/references-tools/deskreferences/Pages/8EUpdates.aspx#Histology/Topography
2018 Site-Specific Data Items Manual	https://apps.naaccr.org/ssdi/list/1.7

2021 Site-Specific Data Items/Grade	https://apps.naaccr.org/ssdi/list/2.0
2018 Site/Type Validation Table from SEER	https://seer.cancer.gov/icd-o-3/
CoC STORE Manual - Standards for Oncology Registry Entry	https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/store_manual_2021.ashx
CTR Guide to Coding Radiation Therapy Treatment in the STORE	https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/case_studies_coding_radiation_treatment.ashx?la=en
SEER*SINQ - Inquiry System	https://seer.cancer.gov/seerinquiry/index.php
CoC Canswer - Inquiry System	http://cancerbulletin.facs.org/forums/
Your State EDITS Metafile – current version	SCCCR Metafile available upon request