Florida Cancer Data System

2018 Updates for Neoplasms of the Appendix, Colon, Rectum and GI NETs

1

2018-2019 FCDS WEBCAST SERIES
10/18/2018
STEVEN PEACE, CTR

CDC & Florida DOH Attribution

2

"Funding for this conference was made possible (in part) by the Centers for Disease Control and Prevention. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the US Government."

FCDS would also like to acknowledge the Florida Department of Health for its support of the Florida Cancer Data System, including the development, printing and distribution of materials for the 2018 FCDS Annual Conference and the 2018-2019 FCDS Webcast Series under state contract CODJU. The findings and conclusions in this series are those of the author(s) and do not necessarily represent the official position of the Florida Department of Health.

FLccSC LMS – CEU Quiz –FCDS IDEA

FLccSC
Fundamental Learning Collaborative for the Cancer Surveillance Community

- 2017 - Florida Changed How FCDS Awards CEUs for FCDS Webcasts
- Attendees must take and pass a 3-5 question CEU Quiz to get CEUs
- CEU Awards are Restricted to Attendees with a FLccSC LMS Account
- The CEU Quiz will be posted to FLccSC 1-2 hours after the webcast ends

- Only registered FLccSC Users will be given access to the CEU Quiz
- Florida attendees must have a Florida FLccSC Account to take the Quiz
- South Carolina attendees must have a South Carolina FLccSC Account
- New FLccSC States will follow similar instructions for the CEU Quiz

- Attendees can attend any of the live webcasts without receiving CEUs
- Recorded Sessions are also available for non-FLccSC Users – No CEUs

Let us Help...

4

- Our hearts go out to all affected by the 2017 and 2018 hurricanes and other natural disasters affecting our state and regional area communities. We know many of you are still struggling.
- Each individual, family, community, Parrish, and even neighbors have been increasingly effected by enormous sudden change– you are amazing individuals, small groups and communities.
- We will manage all of these interruptions in our work in stride as we always do...even facing changing rules, instructions, and guidelines. Please let us know if there is something we can do.
- This is the face of the Cancer Registrar/Program Manager

2018 - A Year for Major Changes to Cancer Registry Data Standards

5

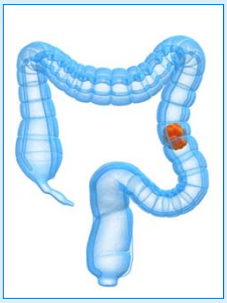
- New ICD-O-3 Histology Code & Behavior Codes
- New Histology Coding Rules and Tools
- New Reportable Cancers
- 2018 Solid Tumor MP/H Rules
- 2018 Hematopoietic MP/H Rules
- Cancer Staging Updates
  - SS2018
  - Grade Coding
  - Site-Specific Data Items
  - AJCC TNM 8th ed.
  - 2018 SEER EOD
- EDITS v18
- STORE Manual
- 2018 FCDS DAM

Harmonization & Interconnectivity with Lots of Moving Parts

Presentation Outline

6

- Introduction to Neoplasms of the Colon & Rectum
- Introduction to Neoplasms of the Appendix and GI NETs
- Anatomy of the Colon and the Rectum
- Colon Cancer Screening Guidelines
- Colon Cancer Diagnostic Workup
- Changes to ICD-O-3 Rules for Colo-Rectal
- Changes to Grade for Colo-Rectal-NET-GIST
- Colon and Rectum MP/H Rules – Important!!
- Anatomic Staging & Site-Specific Data Items
- Biomolecular & Genetic Testing
- Text Documentation
- Practice Cases - Pending
- Questions



http://safetyca.info

Introduction

7

Figure 3. Leading Sites of New Cancer Cases and Deaths – 2018 Estimates

Estimated New Cases

Male			Female		
Prostate	164,690	19%	Breast	266,120	30%
Lung & bronchus	121,680	14%	Lung & bronchus	112,950	13%
Colon & rectum	75,610	9%	Colon & rectum	64,640	7%
Urinary bladder	62,380	7%	Uterine corpus	63,230	7%
Melanoma of the skin	55,150	6%	Thyroid	40,900	5%
Kidney & renal pelvis	42,680	5%	Melanoma of the skin	36,120	4%
Non-Hodgkin lymphoma	41,730	5%	Non-Hodgkin lymphoma	32,950	4%
Oral cavity & pharynx	37,160	4%	Pancreas	26,240	3%
Leukemia	35,030	4%	Leukemia	25,270	3%
Liver & intrahepatic bile duct	30,610	4%	Kidney & renal pelvis	22,660	3%
All sites	856,370	100%	All sites	878,980	100%

Estimated Deaths

Male			Female		
Lung & bronchus	83,550	26%	Lung & bronchus	70,500	25%
Prostate	29,430	9%	Breast	40,920	14%
Colon & rectum	27,390	8%	Colon & rectum	23,240	8%
Pancreas	23,020	7%	Pancreas	21,310	7%
Liver & intrahepatic bile duct	20,540	6%	Ovary	14,070	5%
Leukemia	14,270	4%	Uterine corpus	11,350	4%
Esophagus	12,850	4%	Leukemia	10,100	4%
Urinary bladder	12,520	4%	Liver & intrahepatic bile duct	9,660	3%
Non-Hodgkin lymphoma	11,510	4%	Non-Hodgkin lymphoma	8,400	3%
Kidney & renal pelvis	10,010	3%	Brain & other nervous system	7,340	3%
All sites	323,630	100%	All sites	286,010	100%

Estimates are rounded to the nearest 10, and cases exclude basal cell and squamous cell skin cancers and in situ carcinoma except urinary bladder. Ranking is based on modeled projections and may differ from the most recent observed data.

American Cancer Society – 2018 Cancer Facts & Figures

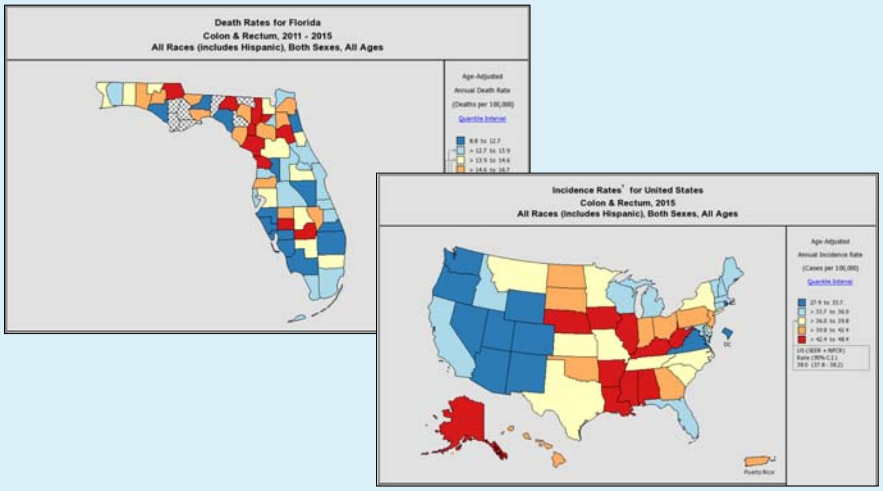
Introduction

8

https://statecancerprofiles.cancer.gov/

Introduction – Incidence

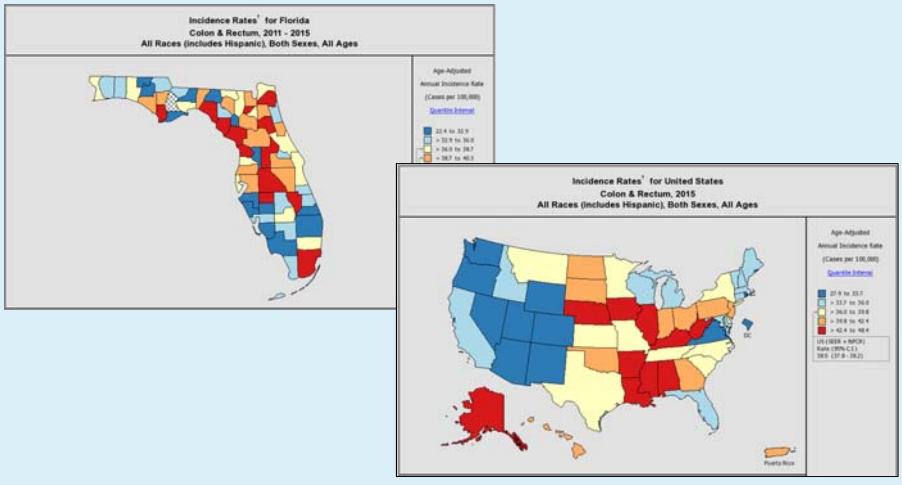
9



https://statecancerprofiles.cancer.gov/

Introduction – Mortality

10

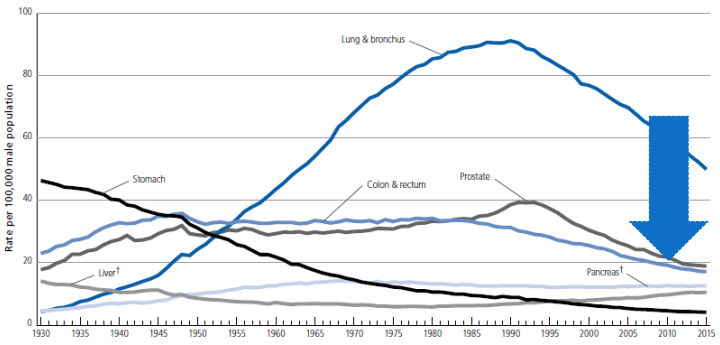


https://statecancerprofiles.cancer.gov/

Introduction – Trends – Male Death

11

Figure 1. Trends in Age-adjusted Cancer Death Rates* by Site, Males, US, 1930-2015



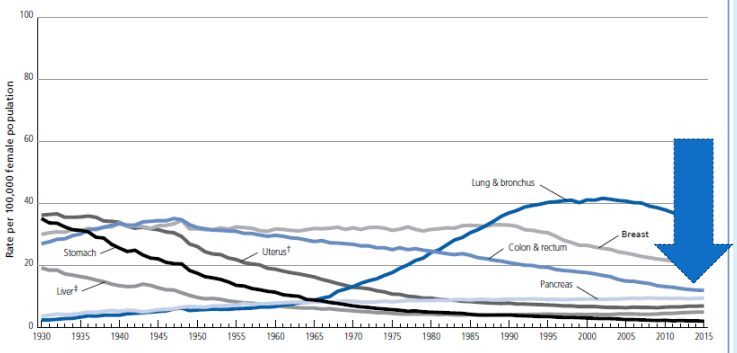
*Age adjusted to the 2000 US standard population. †Mortality rates for pancreatic and liver cancers are increasing.
Note: Due to changes in ICD coding, numerator information has changed over time. Rates for cancers of the liver, lung and bronchus, colon and rectum, and uterus are affected by these coding changes.
Source: US Mortality Volumes 1930 to 1959, US Mortality Data 1960 to 2015, National Center for Health Statistics, Centers for Disease Control and Prevention.

American Cancer Society – 2018 Cancer Facts & Figures

Introduction – Trends – Female Death

12

Figure 2. Trends in Age-adjusted Cancer Death Rates* by Site, Females, US, 1930-2015

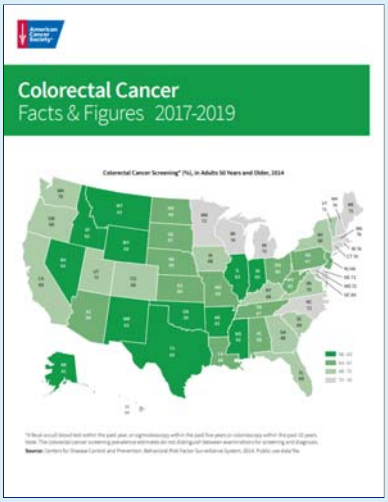


*Age adjusted to the 2000 US standard population. †Uterus refers to uterine cervix and uterine corpus combined. ‡The mortality rate for liver cancer is increasing.
Note: Due to changes in ICD coding, numerator information has changed over time. Rates for cancers of the liver, lung and bronchus, colon and rectum, and uterus are affected by these coding changes.
Source: US Mortality Volumes 1930 to 1959, US Mortality Data 1960 to 2015, National Center for Health Statistics, Centers for Disease Control and Prevention.

American Cancer Society – 2018 Cancer Facts & Figures

Introduction

13

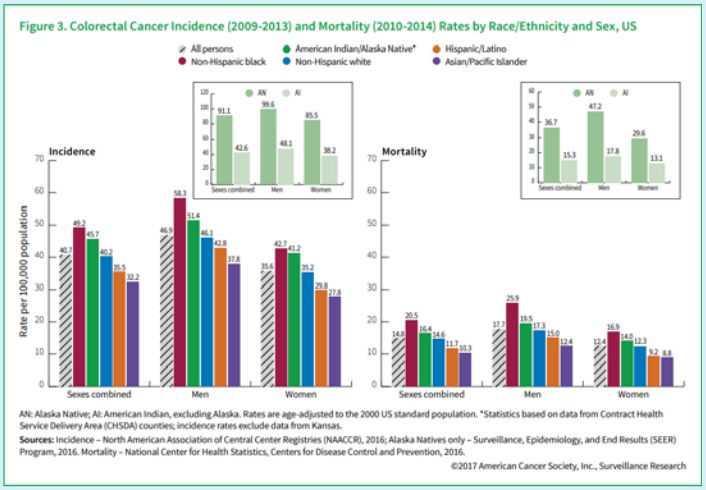


- 1 in every 20 persons will develop colon or rectal cancer in their lifetime.
- **Colorectal cancer is the #3 cause of cancer deaths in the U.S.**
- **Colorectal cancer often begins as a benign growth; a polyp.**
- Adenomas are a type of polyp and are benign tumors of the tissue lining the colon or rectum.
- **Most adenomas are benign.**
- **However, some adenomas have the potential to develop into cancer over the long term.**
- When removed early, polyps are prevented from developing into malignant cancer.

American Cancer Society – Colorectal Cancer Facts & Figures 2017-2019

Introduction – More Trends

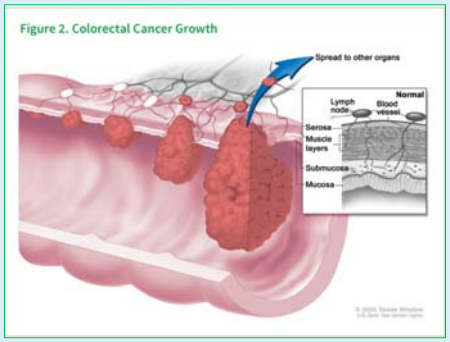
14

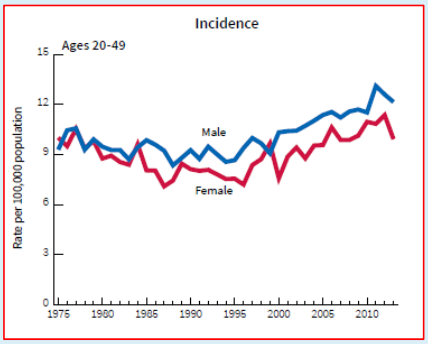


American Cancer Society – Colorectal Cancer Facts & Figures 2017-2019

Introduction

15





American Cancer Society – Colorectal Cancer Facts & Figures 2017-2019

	Benefits	Performance & Complexity*	Limitations	Test Time Interval
Visual Examinations				
Colonoscopy	• Examines entire colon • Can biopsy and remove polyps • Can diagnose other diseases • Required for abnormal results from all other tests	**Performance:** Highest **Complexity:** Highest	• Full bowel cleansing • Can be expensive • Sedation usually needed, necessitating a chaperone to return home • Patient may miss a day of work. • Highest risk of bowel tears or infections compared with other tests	10 years
Computed tomographic colonography (CTC)	• Examines entire colon • Fairly quick • Few complications • No sedation needed • Noninvasive	**Performance:** High (for large polyps) **Complexity:** Intermediate	• Full bowel cleansing • Cannot remove polyps or perform biopsies • Exposure to low-dose radiation • Colonoscopy necessary if positive • Not covered by all insurance plans	5 years
Double-contrast barium enema	• Can usually view entire colon • Few complications • No sedation needed	**Performance:** High (for large polyps) **Complexity:** High	• Full bowel cleansing • Some false-positive test results • Cannot remove polyps or perform biopsies • Exposure to low-dose radiation • Colonoscopy necessary if abnormalities are detected • Very limited availability	5 years
Flexible sigmoidoscopy	• Fairly quick • Few complications • Minimal bowel preparation • Does not require sedation or a specialist	**Performance:** High for rectum & lower one-third of the colon **Complexity:** Intermediate	• Partial bowel cleansing • Views only one-third of colon • Cannot remove large polyps • Small risk of infection or bowel tear • Slightly more effective when combined with annual fecal occult blood testing • Colonoscopy necessary if positive • Limited availability	5 years
Stool Tests (Low-sensitivity stool tests, such as single-sample FOBT done in the doctor's office or toilet bowl tests are not recommended.)				
Fecal immunochemical test (FIT)	• No bowel cleansing or sedation • Performed at home • Low cost • Noninvasive	**Performance:** Intermediate for cancer **Complexity:** Low	• Requires multiple stool samples • Will miss most polyps • May produce false-positive test results • Slightly more effective when combined with a flexible sigmoidoscopy every five years • Colonoscopy necessary if positive	Annual
High-sensitivity guaiac-based fecal occult blood test (gFOBT)	• No bowel cleansing • Performed at home • Low cost • Noninvasive	**Performance:** Intermediate for cancer **Complexity:** Low	• Requires multiple stool samples • Will miss most polyps • May produce false-positive test results • Pre-test dietary limitations • Slightly more effective when combined with a flexible sigmoidoscopy every five years • Colonoscopy necessary if positive	Annual
FIT-DNA test (Cologuard®)	• No bowel cleansing • Can be performed at home • Requires only a single stool sample • Noninvasive	**Performance:** Intermediate for cancer **Complexity:** Low	• Will miss most polyps • More false-positive results than other tests • Higher cost than gFOBT and FIT • Colonoscopy necessary if positive	3 years, per manufacturer's recommendation

*Complexity involves patient preparation, inconvenience, facilities and equipment needed, and patient discomfort.

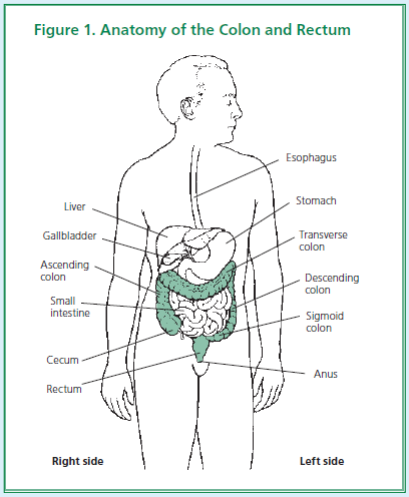
Table 2. Relative Risks for Established Colorectal Cancer Risk Factors

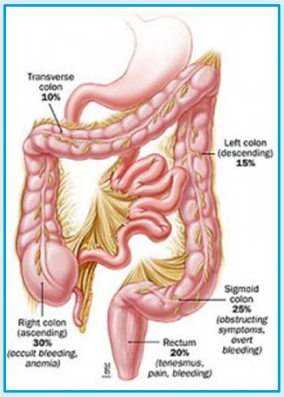
	Relative risk*
Factors that increase risk:	
Heredity and medical history	
Family history	
1 first-degree relative[87]	2.2
More than 1 relative[87]	4.0
Relative with diagnosis before age 45[88]	3.9
Inflammatory bowel disease[81]	1.7
Diabetes[87]	1.3
Behavioral factors	
Alcohol consumption (daily average)[145]	
2-3 drinks	1.2
>3 drinks	1.4
Obesity (body mass index ≥30 kg/m²)[104]	1.3
Red meat consumption (100 g/day)[131]	1.2
Processed meat consumption (50 g/day)[131]	1.2
Smoking (ever vs. never)[126]	1.2
Factors that decrease risk:	
Physical activity (colon)[97]	0.7
Dairy consumption (400 g/day)[119]	0.8
Milk consumption (200 g/day)[119]	0.9

*Relative risk compares the risk of disease among people with a particular "exposure" to the risk among people without that exposure. Relative risk for dietary factors compares the highest with the lowest consumption. If the relative risk is more than 1.0, then risk is higher among exposed than unexposed persons. Relative risks less than 1.0 indicate a protective effect.

Anatomy

17



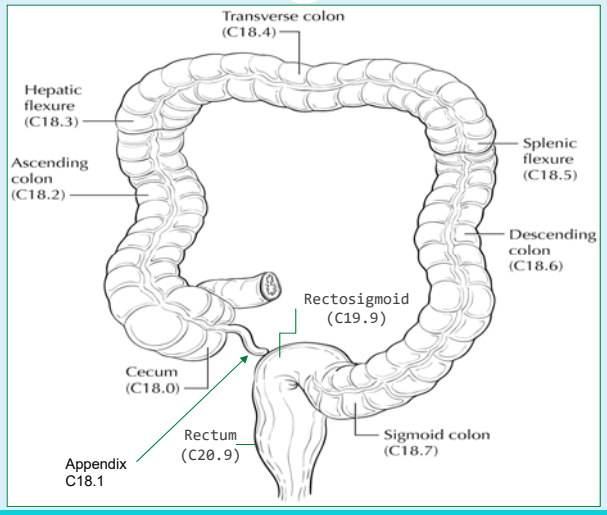


ACS Colorectal Cancer Facts & Figures 2014-2016 and http://fcrc-archives.org

Colon and Rectum

18

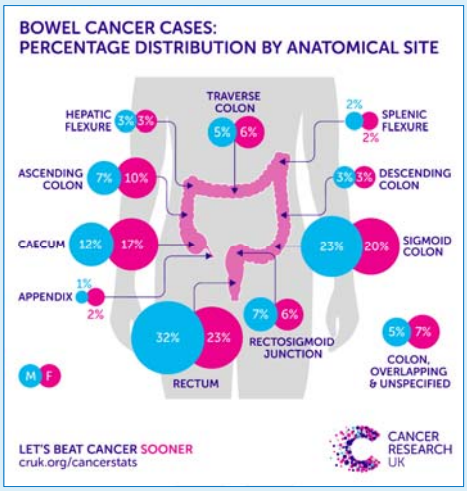
RIGHT COLON



LEFT COLON

Colon and Rectum

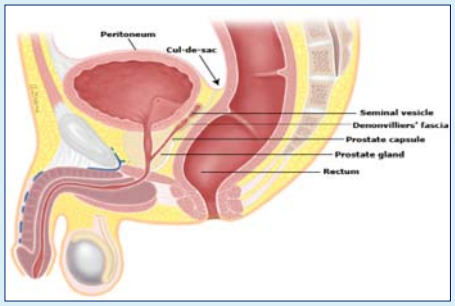
19



https://www.cancerresearchuk.org/health-professional/cancer-statistics/

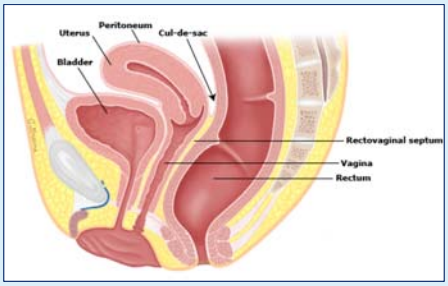
Rectosigmoid and Rectum

20



Male Anatomy

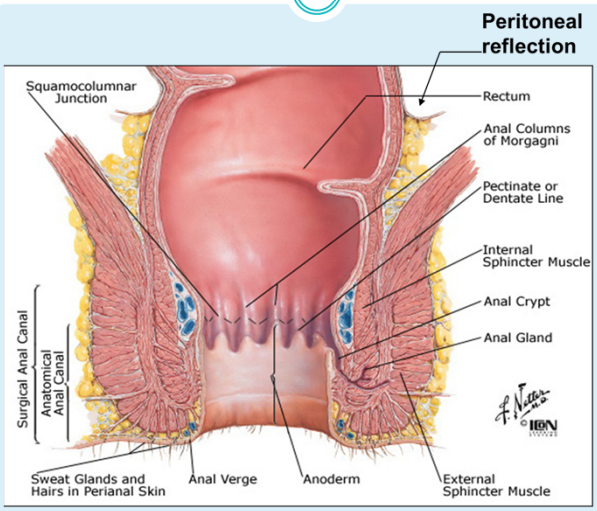
Female Anatomy



http://www.uptodate.com

Rectum – Anorectum – Anus

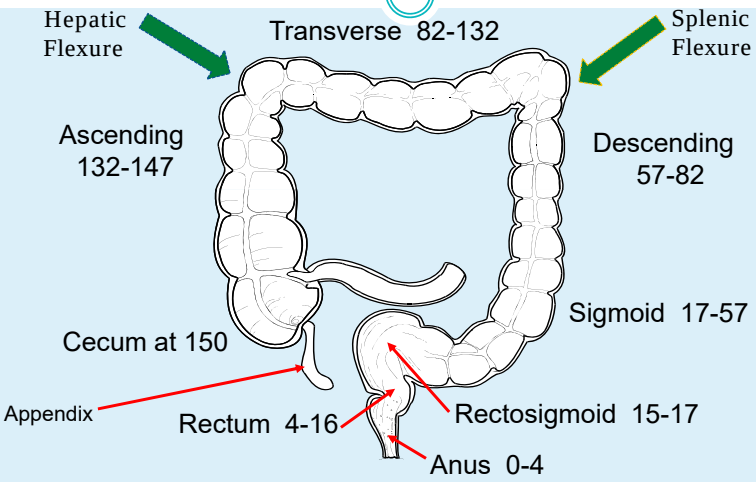
21



http://www.analcancerinfo.ucsf.edu

Colonoscopy Measurements

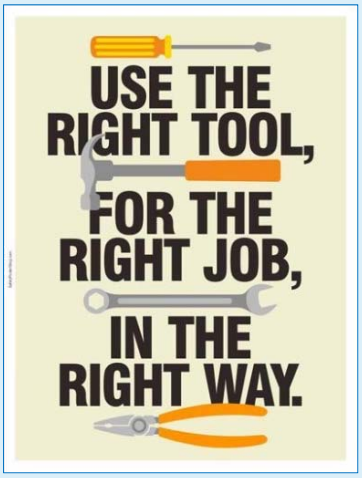
22



Distance from Anal Verge (approximations only)
Adapted from AJCC Cancer Staging Manual

Do I have to use the 2018 Coding Rules?

23



Do NOT Use Old Books or References

24

List of 2018 Required Manuals, Rules & Tools

25

- 2018 FCDS Data Acquisition Manual (2018 FCDS DAM)
- 2018 Cancer Reporting Requirements for Florida
- 2018 Case Finding ICD-10-CM Code List Changes
- ICD-O-3 Third Edition – purple book still is used
- 2018 Guidelines for ICD-O-3 Histology Code and Behavior Update
  - ICD-O-3 New Histology Codes
  - ICD-O-3 Histology/Behavior Code Changes
  - ICD-O-3 Coding for Primary Site and Histology
- 2018 Solid Tumor Coding Rules (formerly MPH Rules for Solid Tumors)
- 2018 Hematopoietic Database & MPH Rules – web-based version only
- 2018 Grade Coding Manual, Instructions and Tables (Grade Manual and Appendices)
- 2018 Summary Stage Manual
- AJCC Cancer Staging Manual, 8th edition – published errata & breast chapter replacement
- 2018 Site-Specific Data Items Manual (SSDI Manual)
- CoC STORE Manual - STandards for Oncology Registry Entry
- SEER*Rx – current web version
- FCDS v.18 EDITS Metafile – current version
- Reference: NAACCR 2018 Implementation Guidelines and Recommendations
- Reference: NAACCR Standards for Cancer Registries Volume II, Data Standards and Data Dictionary, V18, 2018, 21st ed.

Histology

26

WHO ICD-O-3 and 2018 UPDATES

Consensus Change Organizations

World Health Organization
College of American Pathologists
NCI SEER Program
CDC NPCR Program
NAACCR and NCRA
NCCN – Evidence Based Cancer Guidelines
American Joint Committee on Cancer
Commission on Cancer

Histology

27

CAP & Solid Tumor Rules by Site

Consensus Change Organizations

World Health Organization
College of American Pathologists
NCI SEER Program
CDC NPCR Program
NAACCR and NCRA
NCCN – Evidence Based Cancer Guidelines
American Joint Committee on Cancer
Commission on Cancer

Histology

28

Site-Specific Grade and Site Specific Data Items

Consensus Change Organizations

World Health Organization
College of American Pathologists
NCI SEER Program
CDC NPCR Program
NAACCR and NCRA
NCCN – Evidence Based Cancer Guidelines
American Joint Committee on Cancer
Commission on Cancer

Histology – ICD-O-3 Updates

29

- WHO Classification of Neoplasms – 4th ed. – 2010
  - Epithelial Tumors – pre-malignant tumors
  - Serrated Lesions – reclassified to malignant 8213/3 in 2018
  - Carcinomas – conventional adenocarcinoma and subtypes
  - Neuroendocrine Neoplasms – NET G1, G2, small cell neuroendocrine and large cell neuro0endocrine tumors
  - Mesenchymal Tumors – GIST, KS, rare sarcomas
  - Malignant Lymphoma – MALT, mantle cell lymphoma, DLBCL, Burkitt lymphoma, B-cell lymphoma, NOS

High Grade Dysplasia / In-Situ Adeno

30

- Dysplasia is another pre-cancerous condition. It means there's an area in a polyp or in the lining of the colon or rectum where the cells look abnormal, but they don't look like true cancer cells.
- The cancer is in its earliest stage. This stage is also known as carcinoma in situ or intramucosal carcinoma (Tis). It has not grown beyond the inner layer (mucosa) of the colon or rectum.
- The cancer has grown through the muscularis mucosa into the submucosa (T1), and it may also have grown into the muscularis propria (T2). It has not spread to nearby lymph nodes (N0) or to distant sites (M0).cosa) of the colon or rectum. (Invasive localized cancer)

Histology – CAP & Solid Tumor Rules (MP/H)

31

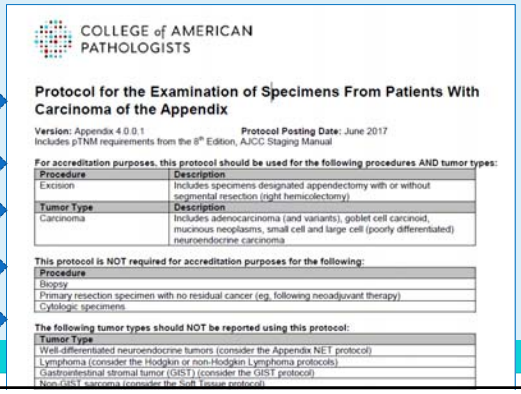
- There were no significant changes in WHO ICD-O-3 New Codes or New Rules – However, there ARE significant changes to the Solid Tumor MP/H Rules for Colon, Rectum, NET, GIST, and coding polyps.
- Many ICD-O-3 Histology Codes will still exist in the software you use and in your printed manuals – but, you are being instructed in the Solid Tumor Rules not to use them.
- EDITS will catch some but not all of these changes.
- Staging will be effected when an 'invalid for staging' histology is used
- ***DO NOT USE CODES - 8210, 8260, 8261, 8262, 8263, 8264***

Histology – CAP Checklist Organization

32

Not All Cancers Have Established CAP Standards

- Carcinoma of the Appendix
- Neuroendocrine (Carcinoid) Tumors of the Appendix
- Primary Carcinoma of the Colon and Rectum
- Neuroendocrine Tumors of the Colon and Rectum



COLLEGE of AMERICAN PATHOLOGISTS

Protocol for the Examination of Specimens From Patients With Carcinoma of the Appendix

Version: Appendix 4.0.0.1 **Protocol Posting Date:** June 2017
Includes pTNM requirements from the 8th Edition, AJCC Staging Manual

For accreditation purposes, this protocol should be used for the following procedures AND tumor types:

Procedure	Description
Excision	Includes specimens designated appendectomy with or without segmental resection (right hemicolectomy)
Tumor Type	**Description**
Carcinoma	Includes adenocarcinoma (and variants), goblet cell carcinoid, mucinous neoplasms, small cell and large cell (poorly differentiated) neuroendocrine carcinoma

This protocol is NOT required for accreditation purposes for the following:

Procedure
Biopsy
Primary resection specimen with no residual cancer (eg, following neoadjuvant therapy)
Cytologic specimens

The following tumor types should NOT be reported using this protocol:

Tumor Type
Well-differentiated neuroendocrine tumors (consider the Appendix NET protocol)
Lymphoma (consider the Hodgkin or non-Hodgkin Lymphoma protocols)
Gastrointestinal stromal tumor (GIST) (consider the GIST protocol)
Non-GIST sarcoma (consider the Soft Tissue protocol)

Histology – CAP & AJCC Chapter

Disease Title	Code	Description	Code Type	Notes
Appendix: Carcinoma	8000	Neoplasm, malignant	Surveillance	Histology is not ideal for clinical use in patient care, as it describes an unspecified or outdated diagnosis. Data collectors may use this code only if there is not enough information in the medical record to document a more specific diagnosis.
Appendix: Carcinoma	8010	Carcinoma, NOS	Surveillance	Histology is not ideal for clinical use in patient care, as it describes an unspecified or outdated diagnosis. Data collectors may use this code only if there is not enough information in the medical record to document a more specific diagnosis.
Appendix: Carcinoma	8013	Large cell neuroendocrine carcinoma (NEC)	Clinical	
Appendix: Carcinoma	8020	Undifferentiated carcinoma	Clinical	
Appendix: Carcinoma	8041	Small cell neuroendocrine carcinoma (NEC)	Clinical	
Appendix: Carcinoma	8070	Squamous cell carcinoma, NOS	Clinical	
Appendix: Carcinoma	8140	Adenocarcinoma	Clinical	
Appendix: Carcinoma	8148	Dysplasia (intraepithelial neoplasia), high	Clinical	
Appendix: Carcinoma	8210	Adenocarcinoma in adenomatous polyp	Surveillance	Histology is not ideal for clinical use in patient care, as it describes an unspecified or outdated diagnosis. Data collectors may use this code only if there is not enough information in the medical record to document a more specific diagnosis.
Appendix: Carcinoma	8243	Goblet cell carcinoid	Clinical	
Appendix: Carcinoma	8244	Mixed adenoneuroendocrine carcinoma	Clinical	
Appendix: Carcinoma	8245	Adenocarcinoid tumor	Surveillance	Histology is not ideal for clinical use in patient care, as it describes an unspecified or outdated diagnosis. Data collectors may use this code only if there is not enough information in the medical record to document a more specific diagnosis.
Appendix: Carcinoma	8246	Neuroendocrine carcinoma (NEC)	Clinical	
Appendix: Carcinoma	8255	Adenocarcinoma with mixed subtypes	Surveillance	Histology is not ideal for clinical use in patient care, as it describes an unspecified or outdated diagnosis. Data collectors may use this code only if there is not enough information in the medical record to document a more specific diagnosis.
Appendix: Carcinoma	8480	Mucinous adenocarcinoma	Clinical	greater than 50% mucinous carcinoma
Appendix: Carcinoma	8481	Mucin-producing adenocarcinoma	Surveillance	Histology is not ideal for clinical use in patient care, as it describes an unspecified or outdated diagnosis. Data collectors may use this code only if there is not enough information in the medical record to document a more specific diagnosis.
Appendix: Carcinoma	8490	Signet ring cell carcinoma	Clinical	greater than 50% signet ring cell
Appendix: Carcinoma	8510	Medullary carcinoma	Clinical	
Appendix: Carcinoma	8560	Adenosquamous carcinoma	Clinical	
Colon and Rectum	8000	Neoplasm, malignant	Surveillance	Histology is not ideal for clinical use in patient care, as it describes an unspecified or outdated diagnosis. Data collectors may use this code only if there is not enough information in the medical record to document a more specific diagnosis.
Colon and Rectum	8010	Carcinoma, NOS	Clinical	

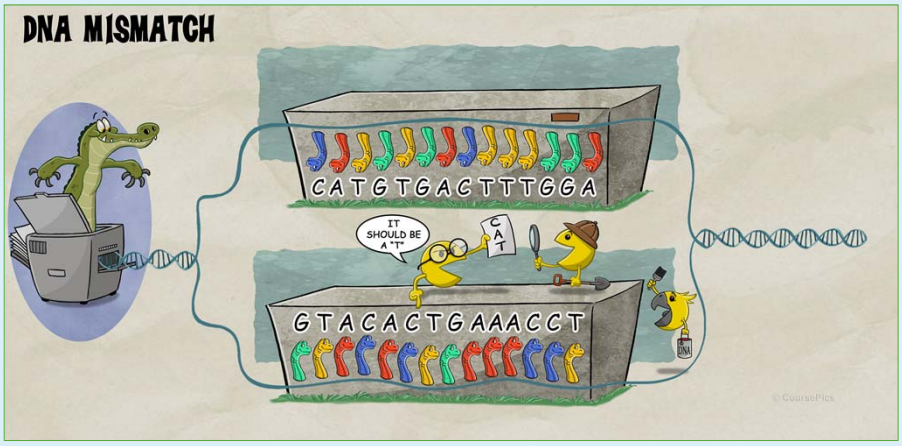
Histology CAP – Biomarker Checklists

34

- Colon and Rectum – none for NET or GIST or other
  - Mismatch Repair Proteins – MLH1, MSH2, MSH6, PMS2
  - Microsatellite Instability (MSI)
  - MLH1 Promoter Methylation Analysis
  - KRAS Mutational Analysis
  - NRAS Mutational Analysis
  - BRAF Expression
  - BRAF V600E Mutational Analysis
  - PIK3CA Mutational Analysis
  - PTEN Mutational Analysis

DNA Mismatch Repair Mechanism

35



Histology CAP – Biomarker Checklists

36

- Multiparameter Gene Expression/Protein Expression Assay

Detect Low Frequency Variants Accurately from Formalin-Compromised DNA

CHR	POS	Gene	Mutation AA	Mutation Type	Expected Frequency (%)	Average (%)
1	115256530	NRAS	Q61K	SNV	12.5	10.4
3	178936091	PI3KCA	E545K	SNV	9.0	7.1
4	55599321	KIT	D816V	SNV	10.0	9.1
7	140453136	BRAF	V600E	SNV	10.5	11.0
12	25398281	KRAS	G13D	SNV	15.0	15.3
12	25398284	KRAS	G12D	SNV	6.0	5.7

Figure 3. The Accel-Amplicon Plus Colorectal Cancer Panel consistently detected validated variants at the expected frequency in replicates from 10 ng of the Horizon Diagnostics Quantitative Multiplex DNA Reference Standard HD200. Variants were called by LoFreq (Genome Institute of Singapore).

FDA-Approved Chemo – No Targeted Tx Yet

37

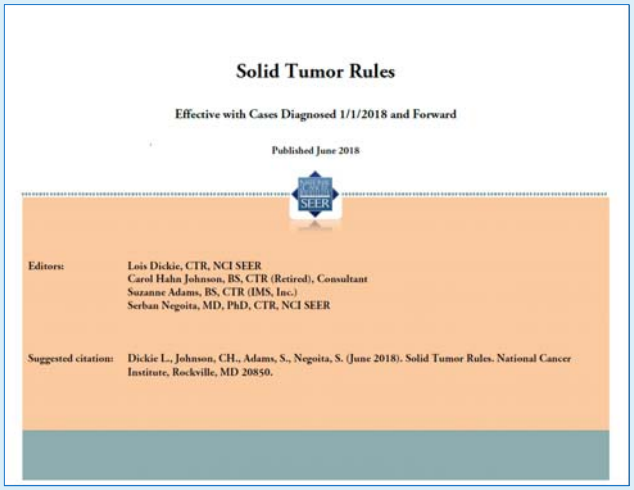
- Capecitabiine (Xeloda)
- 5FU/Leucovorin)
- Oxaliplatin
- Irinotecan
- Trifluridine/Tipiracil
- FOLFOX
- FOLFIRI
- FOLFIRINOX
- CAPEOX
- FLOX

Was more like finding needle in haystack.

Pace has accelerated to a frenzy with more funding for advances in next generation methods, advanced testing, new agents, multi-gene profiles and new technology.

2018 Solid Tumor Rules

38



Solid Tumor Rules

Effective with Cases Diagnosed 1/1/2018 and Forward

Published June 2018

Editors: Lois Dickie, CTR, NCI SEER
Carol Hahn Johnson, BS, CTR (Retired), Consultant
Suzanne Adams, BS, CTR (IMS, Inc.)
Serban Negoita, MD, PhD, CTR, NCI SEER

Suggested citation: Dickie L., Johnson, CH., Adams, S., Negoita, S. (June 2018). Solid Tumor Rules. National Cancer Institute, Rockville, MD 20850.

2018 Solid Tumor Rules

39

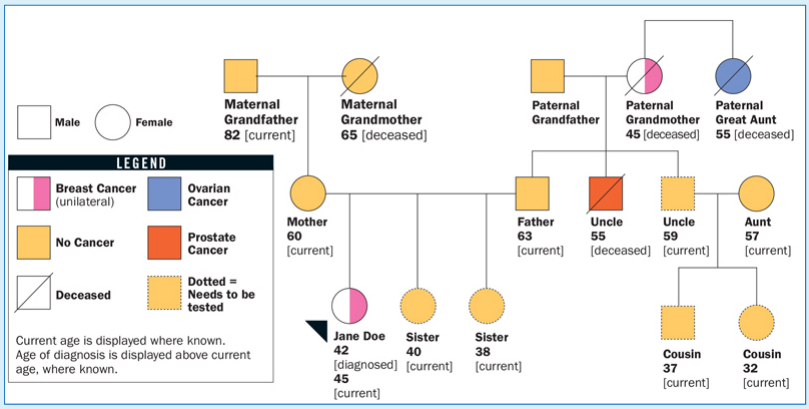
- MOST of the Changes to the Colon/Rectum Rules are HISTOLOGY RULES CHANGES – and they are big.
- Use each set of rules as intended for the sites and/or histology combinations in the header of each module.
- Each set of rules is available only in sentence format.
- There are no logic charts to follow or reference.
- Rules are to be shared to hospital and central registries
- Periodic updates are necessary to maintain methods
- ICD-O-3 is working on ICD-O-3.2 for 2019.
- ICD-O-5 will begin work in 2020.
- ICD-11 is also coming with fewer major changes.
- SEER is planning Training Webinars and Reliability Studies on their website at some time in the future – dates unknown.

MOST PEOPLE ONLY HAVE ONE CANCER

40

Some People or Their Families Have More

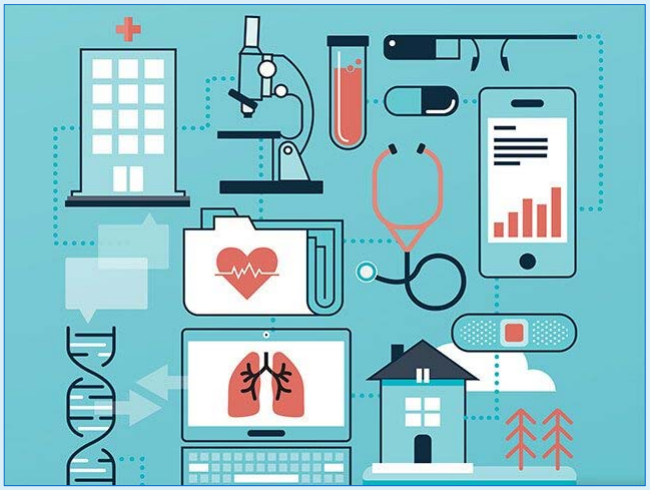
41



https://www.curetoday.com/journey/cancer-guides/at-diagnosis/

Patients are Seen and Treated in Many Places

42



Each Facility Must Report the Cancer/Tx

43

- How do we make sure tumor(s) that these patients tumor(s) or the family member(s) are counted and data are captured in the same manner – not just 'in my registry'.
- We also need to define them the same, code them the same, Quality Check them the same, and use them the same.
- Withhout standards that go far beyond one program or one set of program's goals with people's lives in their hands; but with so many users with different special needs.
- Even our newest and brightest CTR and Candidate CTRs need hands on mentoring – not just training, testing and abstracting – we will need one another for 2018-2019 !!!

2018 Solid Tumor Rules

44

- Introduction
- Changes from 2007 MPH Rules
- Equivalent or Equal Terms
- Terms that are NOT Equivalent or Equal
- Table I: Specific Histologies, NOS and Subtypes Variants
- Table II: Histologies Not Reportable for Colon, Rectosigmoid and Rectum
- Illustrations
- Multiple Primary Rules
- Histology Coding Rules

2018 Solid Tumor Rules - Introduction

45

Introduction

- New terms and codes in these rules are based on the ***WHO Classification of Tumors of the Digestive System*** 2010 edition
- Ninety-eight percent of colon cancers are **adenocarcinoma** and adenocarcinoma **subtypes**
- **Mixed histologies and specific variants or subtypes of adenocarcinoma** other than mucinous/colloid or signet ring cell are **rare**. A less common combination is **mixed adenoneuroendocrine carcinoma (MANEC) 8244** (previously called adenocarcinoma and carcinoid). The new terminology was **originally** proposed for tumors arising from goblet cell carcinoid but with more aggressive adenocarcinoma histology. It was also proposed because **carcinoids** are a subgroup of **neuroendocrine carcinoma**. Pathologists **may still diagnose** adenocarcinoma and carcinoid, adenocarcinoid, or adenocarcinoma and a specific neuroendocrine tumor or adenocarcinoma arising from/with a NET (including specific types of **NET-like goblet cell** carcinoid). Over time, the histologic diagnoses will change to MANEC.
- **De novo (previously called frank) adenocarcinoma** arises in the mucosa of the bowel, not in a polyp

Terms Seen More Frequently: NET, NEC, GIST

- **NET** (neuroendocrine tumor): The term NET is gradually replacing **carcinoid;** however, some pathologists still use the term carcinoid
- **NEC** (neuroendocrine carcinoma): The term NEC includes **small cell neuroendocrine** carcinoma, **large cell neuroendocrine** carcinoma, and **poorly differentiated neuroendocrine** carcinoma
- **GIST** (gastrointestinal stromal tumor):
  - GISTs were originally thought to be smooth muscle tumors but are now thought to originate from the interstitial cells of Cajal, neuro-regulatory cells in the GI tract. Prior to the implementation of an ICD-O-3 histology code for GISTs in **2001**, they were reported as a GI sarcoma, usually **leiomyosarcoma**
  - GISTs are more common in the stomach (60%) and small intestine (30%), but 1-2% occur in the colon and 3% in the rectum
  - About a quarter of gastric GISTs are **malignant**
  - It is often difficult for the pathologist to determine the **behavior** of a GIST

Note 1: Tables and rules refer to **ICD-O rather than ICD-O-3**. The version is not specified to allow for updates. Use the currently approved version of ICD-O.

Note 2: 2007 MPH Rules and 2018 Solid Tumor Rules are used based on **date of diagnosis**.

- Tumors diagnosed 01/01/2007 through 12/31/2017: Use 2007 MPH Rules
- Tumors diagnosed 01/01/2018 and later: Use 2018 Solid Tumor Rules
- The original tumor diagnosed before 1/1/2018 and a subsequent tumor diagnosed 1/1/2018 or later **in the same primary site**: Use the 2018 Solid Tumor Rules.

2018 Solid Tumor Rules

46

Changes from 2007 MPH Rules

These changes are effective with cases diagnosed 1/1/2018 and later.

1. **Rectum** and **Rectosigmoid** are now included with the Colon Rules. In the 2007 MPH Rules, they were included with Other Sites.
2. There are new multiple primary rules which address **anastomotic recurrence.**
3. Neuroendocrine tumors (formerly carcinoid) arising in the appendix are reportable for cases diagnosed 1/1/2015 and forward.
4. **Rule clarification: Pseudomyxoma peritonei** (accumulation of mucin in the abdominal or pelvic cavity) now has a **two-tiered system** (WHO 2010) that classifies pseudomyxoma peritonei as either **high-grade** or **low-grade** (see below). Pseudomyxoma peritonei is usually associated with **mucinous** tumors of the appendix and is rarely associated with ovarian mucinous tumors.
   - **High**-grade pseudomyxoma peritonei is **malignant** /3
   - **Low**-grade pseudomyxoma peritonei is **not malignant** /0
   - See Histology Rules for **coding instructions**
5. There are **dysplasias** which have been assigned an **in situ behavior** code /2 in **WHO** and in **the ICD-O Update**. Despite becoming a /2, they are **not reportable in the US**. They are reportable in Canada.
   A. Dysplasia **was not** collected in the past. If dysplasia is added to the database with the same code as in situ tumors, there will be a **huge upsurge** in the **incidence** of in situ neoplasms.
      - There would be no way to **separate** the dysplasias from the in-situ neoplasms in the database, which would cause problems with surveillance (long-term studies) since the prognosis and probabilities of disease progression are different between an in-situ tumor and a dysplasia
      - **Pathologists frequently use the term "severe dysplasia" or "high grade dysplasia" in place of carcinoma in situ. Code CIS only** if the pathologist expressly states "CIS"
   B. The various agencies are looking for solutions to this issue
6. **Polyps** are now **disregarded** when coding histology. For example, adenocarcinoma in an adenomatous polyp is coded as adenocarcinoma 8140.
7. New codes/terms are identified by asterisks (*) in the histology table in the Terms and Definitions.

2018 Solid Tumor Rules

47

Equivalent or Equal Terms

These terms can be used interchangeably:

- And; with
  Note: "And" and "with" are used as synonyms when **describing multiple histologies** within a **single tumor**.
- Carcinoid; NET; neuroendocrine tumor
- Carcinoma; carcinoma NOS; adenocarcinoma; adenocarcinoma NOS; intestinal type adenocarcinoma **8140**
- De novo; frank adenocarcinoma (obsolete)
- Familial polyposis; familial adenomatous polyposis (FAP) **8220**
- Intramucosal; lateral extension within the mucosal layer of the GI tract
- Invasion through colon wall; extension through colon wall; transmural
  Note: The term "**transmural**" is used to describe **extension through all layers** of the wall, but not past the wall **OR extension through the serosa into the mesentery**. **Read** the **pathology** report carefully.
- Mucinous; mucoid; mucous; colloid
- Neuroendocrine carcinoma; NEC
- Polyp; adenoma; polyp NOS; adenomatous polyp
  Note 1: The term "**polyp**" means projecting from a surface.
  Note 2: There are many kinds of polyps. Most common are **adenomas**, which are part of the adenoma-cancer sequence.
  Note 3: **Other types** of polyps include hyperplastic, juvenile, Peutz-Jeghers and serrated adenoma/polyp.
- Serosa; visceral peritoneum
- Simultaneous; existing at the same time; concurrent; prior to first course treatment
- Site; topography
- Tumor; mass; tumor mass; lesion; neoplasm
  - The terms tumor, mass, tumor mass, lesion, and neoplasm are **not** used in a standard manner in clinical diagnoses, scans, or consults. **Disregard** the terms unless there is a **physician's statement** that the term is malignant/cancer
  - These terms are used **ONLY** to determine multiple primaries
  - **Do not** use these terms for casefinding or determining reportability

2018 Solid Tumor Rules

48

Terms that are NOT Equivalent or Equal

This is a **list of terms** that are **not equivalent**. There are no casefinding implications.

- **Component** is not equivalent to subtype/variant
  Note: Component is **only** coded when the pathologist specifies the component as a second **carcinoma**
- The words "exophytic" and "polypoid" are **not** synonymous with either an adenoma or an adenomatous polyp. The terms "exophytic" and "polypoid" refer to **anything** projecting from the bowel mucosa into the lumen. The lesion may be benign, malignant, or inflammatory
- Polypoid adenocarcinoma is **not equivalent to** adenocarcinoma in a polyp

2018 Solid Tumor Rules

49

Table 1: Specific Histologies, NOS, and Subtypes/Variants

Use Table 1 as directed by the **Histology Rules** to assign the more common histology codes for malignancies found in the colon, rectosigmoid and rectum.

Note 1: Rare histologies may not be listed in the table. When a histology term is not found, reference ICD-O and all updates.
Note 2: Submit a question to Ask a SEER Registrar when the histology code is not found in Table 1, ICD-O or all updates.
Note 3: Behavior codes are listed when the term has only one possible behavior (either a /2 or /3). For histologies which may be either /2 or /3, a behavior code is not listed. Code behavior from pathology.
Note 4: Typical colon, rectal, and appendiceal carcinomas may exhibit **comedo features** or **differentiation**. Comedo describes the tumor appearance rather than a true histologic subtype/variant of adenocarcinoma. Code to adenocarcinoma 8140.

Column 1 contains specific and NOS histology terms.
- **Specific** histology terms **do not** have **subtypes/variants**
- **NOS** histology terms **do** have **subtypes/variants.**

Column 2 contains **synonyms** for the specific or NOS term. Synonyms have the **same** histology **code** as the specific or NOS term.
Column 3 contains **subtypes/variants** of the **NOS** histology. Subtypes/variants **do not** have the **same** histology code as the NOS term.

2018 Solid Tumor Rules

50

Specific and NOS Term and Code	Synonyms for Specific or NOS Term	Subtypes/Variants
Adenocarcinoma 8140 *Note 1:* See Histology Rules for instructions on coding adenocarcinoma **subtypes/variants** arising in a polyp *Note 2:* When the term **intestinal adenocarcinoma** is used to describe a colon primary, it simply means the **appearance** is similar to adenocarcinoma seen in the stomach and is coded to adenocarcinoma NOS **8140**	Adenocarcinoma NOS Adenocarcinoma/carcinoma in a polyp NOS (now coded to 8140) Adenocarcinoma/carcinoma in adenomatous polyp (now coded to 8140) Adenocarcinoma/carcinoma in polypoid adenoma (now coded to 8140) Adenocarcinoma/carcinoma in serrated adenoma (now coded to 8140) Adenocarcinoma and mucinous carcinoma, mucinous documented as less than 50% of tumor OR percentage of mucinous unknown/not documented Adenocarcinoma and signet ring cell carcinoma, percentage of signet ring cell carcinoma documented as less than 50% of tumor OR percentage of signet ring cell carcinoma unknown/not documented Adenocarcinoma/carcinoma in tubular polyp (now coded to 8140) Adenocarcinoma/carcinoma in tubulovillous polyp (now coded to 8140) Adenocarcinoma/carcinoma in villous adenoma (now coded to 8140) Adenocarcinoma in any type of polyp Adenocarcinoma, intestinal type Adenocarcinoma and cribriform carcinoma, percentage of cribriform documented as less than 50% of tumor OR percentage of cribriform carcinoma unknown/not documented	Undifferentiated adenocarcinoma/carcinoma **8020** Adenoid cystic carcinoma **8200** Cribriform comedo-type carcinoma/ adenocarcinoma, cribriform comedo-type **8201*** Diffuse adenocarcinoma/carcinoma **8145** Linitis plastica **8142/3** Medullary adenocarcinoma/carcinoma **8510** Micropapillary carcinoma **8265*** Mucinous/colloid adenocarcinoma/carcinoma **8480** Mucoepidermoid carcinoma **8430** Serrated adenocarcinoma **8213*** Signet ring cell/poorly cohesive adenocarcinoma/carcinoma **8490** Superficial spreading adenocarcinoma **8143** Tubulopapillary carcinoma **8263**

2018 Solid Tumor Rules

51

Single Tumor

Note: **Collision tumors** are counted as **two individual** tumors for the purpose of determining multiple primaries. Collision tumors were originally two **separate** tumors that arose in close proximity. As the tumors increased in size, they merged or overlapped each other. Use the Multiple Tumors module.

Rule M2 Abstract a **single primary**[i] when there is a **single tumor.**
Note 1: A single tumor is always a single primary.
Note 2: The tumor may overlap onto or extend into adjacent/contiguous site or subsites.
Note 3: The tumor may have in situ and invasive components.
Note 4: The tumor may have two or more histologic components.

This is the end of instructions for Single Tumor

2018 Solid Tumor Rules

52

Rule M8 Abstract a **single primary**[i] when a subsequent tumor arises at the **anastomotic** site **AND:**
- The subsequent tumor occurs **less than or equal to 24 months** after original tumor resection **OR**
- The tumor arises in **colon/rectal wall** and/or surrounding tissue; there is **no involvement** of the **mucosa OR**
- The pathologist or clinician documents an **anastomotic recurrence**

Note 1: The physician may stage the subsequent tumor because the depth of invasion determines the second course of treatment.
Note 2: These tumors are a single primary/**recurrence**. Registrars that collect recurrence information should record the information in the recurrence fields.

Rule M10 Abstract **multiple primaries**[ii] when the patient has a subsequent tumor after being **clinically disease-free** for **greater than one year** after the original diagnosis or last recurrence.
Note 1: **Clinically** disease-free means that there was **no evidence** of recurrence on follow-up.
- Colonoscopies are NED
- Scans are NED

Note 2: When there is a recurrence less than or equal to one year of diagnosis, the "**clock**" starts over. The time interval is calculated from the **date of last recurrence.** In other words, the patient must have been **disease-free** for **greater than one** year from the date of the last recurrence.
Note 3: When the first course of treatment was a **polypectomy** only, this rule means there were **no recurrences** for greater than one year.
Note 4: When the first course of treatment was a **colectomy** or **A&P resection**, there were **no anastomotic recurrences** for greater than one year.
Note 5: When it is **unknown/not documented** whether the patient had a recurrence, default to **date of diagnosis** to compute the time interval.
Note 6: The physician may state this is a **recurrence,** meaning the patient had a previous colon tumor and now has another colon tumor. **Follow the rules;** do not attempt to interpret the physician's statement.

2018 Solid Tumor Rules

53

Coding Multiple Histologies

1. **Code** histology when the:
   A. **Exact term is documented OR**
   B. **Histology is described as**
      - Subtype
      - Type
      - Variant
2. **Do not** code the histology when:
   A. The following **modifiers** are used as a descriptor:
      - Architecture
      - Differentiation
        Note: Only **code differentiation** when there is a **specific code** for the NOS with differentiation in Table 1 in the Equivalent Terms and Definitions, **ICD-O** and all **updates**.
      - Features (of)/with features of
        Note: Only **code features** when there is a **specific code** for the NOS with features in Table 1 in the Equivalent Terms and Definitions, **ICD-O** and all **updates.**
      - Foci; focus, focal
      - Major/majority of
        Note: Major/majority describes the greater amount of tumor.
      - Pattern(s)
      - Predominantly
        Note: Predominantly describes the greater amount of tumor.

Example 1: Adenocarcinoma with papillary features is coded 8140/3 (features is ignored).
Example 2: Adenocarcinoma with neuroendocrine differentiation is coded 8574/3 (there is a specific code for adenocarcinoma with neuroendocrine differentiation).

2018 Solid Tumor Rules

54

B. The following **ambiguous terminology** is used as a modifier:
   - Apparently
   - Appears
   - Comparable with
   - Compatible with
   - Consistent with
   - Favor(s)
   - Malignant appearing
   - Most likely
   - Presumed
   - Probable
   - Suspect(ed)
   - Suspicious (for)
   - Typical (of)

Note 1: See SEER Program Manual and COC Manual. **Ambiguous** terminology is used to **determine reportability.**
Note 2: Histology described by ambiguous terminology is coded **ONLY** when a case is accessioned based on ambiguous terminology and no other histology information is available/documented.

2018 Solid Tumor Rules

55

Single Tumor

Rule H1 Code adenocarcinoma with neuroendocrine differentiation **8574** when the final diagnosis is **exactly** "adenocarcinoma with neuroendocrine differentiation".
Note: **Do not** use this code when:
- The diagnosis is any subtype/variant of adenocarcinoma with neuroendocrine differentiation
- Any modifier other than differentiation is used, i.e. adenocarcinoma with neuroendocrine features

Rule H2 Code the **specific histology** and **ignore the polyp** when a carcinoma **originates** in a **polyp.**
Note 1: This is a **change** from the 2007 MPH rules which instructed registrars to use the codes for malignancies in a polyp, such as adenocarcinoma in a polyp **8210.**
Note 2: Sufficient data has been collected to:
- Determine the frequency with which carcinomas arise within polyps
- Establish patient care guidelines for individuals with colon polyps

Example: Colonoscopy with polypectomy finds mucinous adenocarcinoma in the polyp. Code mucinous adenocarcinoma **8480.**

Rule H3 Code combined small cell carcinoma **8045** when the final diagnosis is **small cell** carcinoma **AND any other carcinoma.**
Examples:
- Small cell carcinoma **8041** and adenocarcinoma **8140**
- Small cell carcinoma **8041** and neuroendocrine carcinoma **8246**

Rule H4 Code **mixed mucinous and signet ring cell** as follows:
- Adenocarcinoma with mucinous and signet ring features – code adenocarcinoma **8140**
- Mucinous carcinoma and signet ring cell carcinoma:
  - Mucinous carcinoma documented as **greater than 50%** – code mucinous carcinoma **8480**
  - Signet ring cell carcinoma documented as **greater than 50%** – code signet ring cell carcinoma **8490**
  - Percentage of mucinous carcinoma and signet ring cell carcinoma **unknown/not designated**- code adenocarcinoma mixed subtypes **8255**

2018 Solid Tumor Rules

56

Rule H5 Code adenocarcinoma NOS **8140** when the final diagnosis is:
- Two histologies:
  - Adenocarcinoma and mucinous carcinoma
    - Percentage of mucinous **unknown/not documented**
    - Mucinous documented as less than 50% of tumor
  - Adenocarcinoma and signet ring cell carcinoma
    - Percentage of signet ring **unknown/not documented**
    - Signet ring cell documented as less than 50% of tumor
- Adenocarcinoma in a polyp **OR**
  Note 1: This is a **change** from 2007 MPH rules.
  Note 2: **Sufficient data** has been collected to determine the frequency with which carcinomas arise within polyps as well as establish patient care guidelines for individuals with colon polyps.
- **Exactly** adenocarcinoma **OR**
- **Intestinal** type adenocarcinoma **OR** adenocarcinoma intestinal type (no modifiers or additional histologic terms).
  Note 1: Code **8140 adenocarcinoma NOS** even if pathology says intestinal type adenocarcinoma.
  Note 2: Do **not** use code **8144** adenocarcinoma intestinal type in **colorectal** primaries. Intestinal type adenocarcinoma 8144 is used for tumors which occur in the stomach, head and neck, and specific GYN sites. It is called intestinal because it resembles carcinoma which occurs in the colon, rectosigmoid or rectum.
  Note 3: When a diagnosis of intestinal type adenocarcinoma is **further described** by a **specific term** (such as mucinous intestinal type adenocarcinoma or signet ring cell intestinal type adenocarcinoma), it would be treated as an adenocarcinoma with a **subtype/variant**.

2018 Solid Tumor Rules

57

Rule H6 Code invasive **mucinous** adenocarcinoma **8480** when the diagnosis is any of the following:

- **Exactly** "**mucinous** adenocarcinoma" (no modifiers)
- **High-grade** pseudomyxoma peritonei
- **Invasive** pseudomyxoma peritonei
- **Malignant** pseudomyxoma peritonei

Note 1: Be very **careful** when **determining primary** site; almost all pseudomyxoma peritonei originate in the appendix C181. However, it **can be metastatic** disease from sites such as bowel, ovary, or bladder. Code the primary site as designated by a physician. When the primary site is not designated, code unknown primary **C809** and the histology as mucinous carcinoma **8480.**

Note 2: Report the appendiceal mucinous neoplasm as malignant /3 using the ICD-O matrix principle and the SEER and COC Manuals when the **pathology** from the appendix is **low-grade mucinous** neoplasm (not reportable) **AND**

- The pseudomyxoma peritonei are **high-grade**/invasive/malignant **OR**
- Patient is **treated** for malignant pseudomyxoma peritonei

Note 3: The following are **non-reportable:**

- Appendiceal neoplasm with **low-grade** pseudomyxoma peritonei **AND no treatment**
- **No designation** of high- or low-grade for the appendiceal neoplasm **AND no treatment** for the pseudomyxoma peritonei

2018 Solid Tumor Rules

58

Rule H8 Code the **invasive** histology **when in situ** and **invasive** histologies are present in the **same tumor**

Rule H9 Code the **subtype/variant** when there is a **NOS** and a **single subtype/variant** of that NOS such as the following:

- Adenocarcinoma **8140** and a subtype/variant of adenocarcinoma
- Mixed adenoneuroendocrine carcinoma **8244** and a subtype/variant of mixed adenoneuroendocrine carcinoma
- Neuroendocrine carcinoma **8246** and a subtype/variant of neuroendocrine carcinoma
- Neuroendocrine tumor Grade 1 (G1) **8240** and a subtype/variant of neuroendocrine tumor Grade 1 (G1)
- Sarcoma **8800** and a subtype/variant of sarcoma

Note 1: See Table 1 in the Equivalent Terms and Definitions to find NOS and subtypes/variants.

Note 2: Only code subtypes/variant when pathology gives an **exact diagnosis. Do not** code the subtype/variant when **modified** by terms such as **differentiation, features of, etc., unless** there is a specific code for the histology term with the modifier.

This is the end of instructions for Single Tumor.

2018 Solid Tumor Rules

59

Multiple Tumors Abstracted as a Single Primary

Note: Multiple tumors **must be a single primary** to use this module. See the Multiple Primary Rules to determine whether these tumors are a single primary.

Rule H10 Code adenocarcinoma in familial adenomatous polyposis coli (**FAP**) **8220** when:

- **Clinical** history says the patient has **familial polyposis AND**
  - The **final diagnosis** on the **pathology report** from resection is **adenocarcinoma in FAP OR**
  - There are **greater than 100 polyps** identified in the resected specimen

Note 1: Use this rule **only** when there are **multiple polyps**. **Do not** use for a single polyp (adenoma) or for a de novo (frank) malignancy and a malignancy in a single polyp.
Note 2: Use this rule **ONLY** for adenocarcinoma in **FAP.**
Note 3: The disease process, treatment, and prognosis for F[illegible] not as favorable as a single polyp with adenocarcinoma.

Rule H11 Code adenocarcinoma in multiple adenomatous polyps **8221** when FAP is not mentioned **AND**

- There are at least 2 polyps with adenocarcinoma /2 or /3 **AND**
  - Less than or equal to 100 polyps are identified **OR**
  - The exact number of polyps is unknown/not documented

Note 1: **Do not use** this code for a malignancy in a **single polyp** (adenoma) or for a de novo (frank) malignancy.
Note 2: Use this rule **ONLY** for **adenocarcinoma NOS** in multiple polyps.

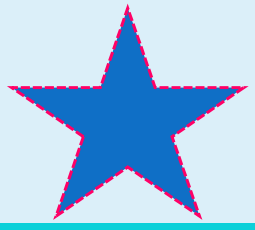
2018 Solid Tumor Rules

60

Rule H14 Code the **subtype/variant** when the diagnosis is a **NOS** and a **single subtype/variant** of that NOS such as the following:

- Adenocarcinoma **8140** and a subtype/variant of adenocarcinoma
- Mixed adenoneuroendocrine carcinoma **8244** and a subtype/variant of mixed adenoneuroendocrine carcinoma
- Neuroendocrine carcinoma **8246** and a subtype/variant of neuroendocrine carcinoma
- Neuroendocrine tumor Grade 1 (G1) **8240** and a subtype/variant of neuroendocrine tumor Grade 1 (G1)
- Sarcoma **8800** and a subtype/variant of sarcoma

Note 1: All tumors may be **mixed** histologies (NOS and a subtype/variant of that NOS) **OR** one tumor may be a **NOS** histology and the other tumor a **subtype/variant** of that NOS.
Note 2: See Table 1 in the Equivalent Terms and Definitions to find NOS and subtypes/variants.
Note 3: Check the Multiple Primary Rules to confirm that the tumors are a single primary.
Note 4: Only code subtypes/variant when pathology gives an **exact diagnosis**. **Do not** code the subtype/variant when **modified** by terms such as **differentiation, features of, etc., unless** there is a specific code for the histology term with the modifier.



Histology - EDITS

61

2018 Site Specific Grade

62

- **Clinical Grade** - the grade of a solid primary tumor before any treatment. Treatment may include surgical resection, systemic therapy, radiation therapy, or neoadjuvant therapy. NOTE: All surgical procedures are not treatment, e.g. TURB and endoscopic biopsies.
- **Pathological Grade** - the grade of a solid primary tumor that has been surgically resected and for which no neoadjuvant therapy was administered. If AJCC pathological staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup, as all information from diagnosis (clinical staging) through the surgical resection is used for pathological staging.
- **Post-Therapy Grade** - the grade of a solid primary tumor that has been resected following neoadjuvant therapy. If AJCC post-therapy staging is being assigned, the tumor must have met the surgical resection requirements for yp in the AJCC manual. Neoadjuvant therapy must meet guidelines or standards, and not be that given for variable or unconventional reasons as noted in the AJCC manual.

2018 Site Specific Grade

63

There are RULES for using this Manual and Menus

- Your Software will direct you – but cannot think for you.
  - This is the GRADE of the PRIMARY TUMOR.
  - DO NOT ASSIGN Grade from a metastatic site – EVER.
  - Clinical Grade Must NEVER BE BLANK
  - Either Pathological **or** Post-Therapy Grade Must BE BLANK
  - Either Pathological **or** Post-Therapy Grade Must BE FILLED
  - There are NOTES that accompany every single Grade Table.
  - DO ASSIGN the highest grade identified from any type of biopsy (FNA, core, excisional, incisional) or resection (partial or complete) of the primary tumor assessed during the clinical time frame
  - If there is only one grade available and it cannot be determined if it is clinical, pathological, or after neo-adjuvant therapy, assign as a clinical grade and code unknown (9) for pathological grade, and blank for post-therapy grade.

Grade - NET

64

Grade ID 07-Clinical Grade Instructions			
Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00290	NET Stomach	29	Neuroendocrine Tumors of the Stomach
00301	NET Duodenum	30	Neuroendocrine Tumors of the Duodenum and Ampulla of Vater
00302	NET Ampulla of Vater	30	Neuroendocrine Tumors of the Duodenum and Ampulla of Vater
00310	NET Jejunum and Ileum	31	Neuroendocrine Tumors of the Jejunum and Ileum
00320	NET Appendix	32	Neuroendocrine Tumors of the Appendix
00330	NET Colon and Rectum	33	Neuroendocrine Tumors of the Colon and Rectum
00340	NET Pancreas	34	Neuroendocrine Tumors of the Pancreas

Code	Grade Description
1	G1: Mitotic count (per 10 HPF) less than 2 AND Ki-67 index (%) less than 3
2	G2: Mitotic count (per 10 HPF) equal 2-20 OR Ki-67 index (%) equal 3-20
3	G3: Mitotic count (per 10 HPF) greater than 20 OR Ki-67 index (%) greater than 20
A	Well differentiated
B	Moderately differentiated
C	Poorly differentiated
D	Undifferentiated, anaplastic
9	Grade cannot be assessed (GX); Unknown

Grade - GIST

65

Grade ID 11-Clinical Grade Instructions

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00430	GIST	43.1	Gastrointestinal Stromal Tumor: Gastric and Omental
		43.2	Gastrointestinal Stromal Tumor: Small Intestinal, Esophageal, Colorectal, Mesenteric, and Peritoneal GIST

Code	Grade Description
L	Low: 5 or fewer mitoses per 5 square mm
H	High: Over 5 mitoses per 5 square mm
A	Well differentiated
B	Moderately differentiated
C	Poorly differentiated
D	Undifferentiated, anaplastic
9	Grade cannot be assessed; Unknown

Grade – Colon and Rectum

66

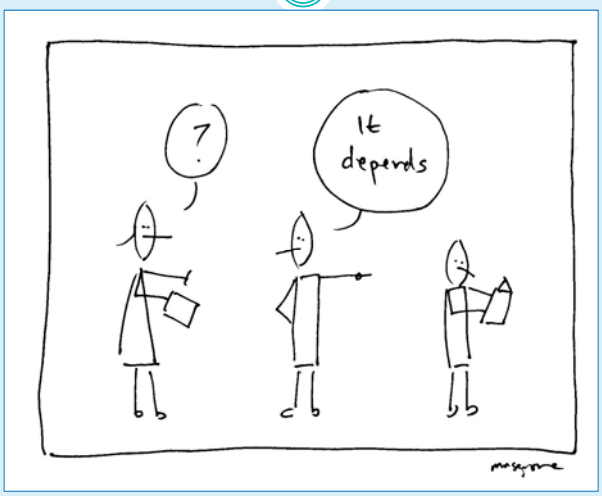
Grade ID 02-Clinical Grade Instructions

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00111	Oropharynx (p16-)	11.1	Oropharynx (p16-)
00112	Hypopharynx	11.2	Hypopharynx
00150	Cutaneous Squamous Cell Carcinoma of Head and Neck	15	Cutaneous Squamous Cell Carcinoma of the Head and Neck
00180	Small Intestine	18	Small Intestine
00200	Colon and Rectum	20	Colon and Rectum
00220	Liver	22	Liver
00360	Lung	36	Lung
00370	Pleura	37	Malignant Pleural Mesothelioma
00640	Skin of Eyelid	64	Eyelid Carcinoma
00650	Conjunctiva	65	Conjunctival Carcinoma

Code	Grade Description
1	G1: Well differentiated
2	G2: Moderately differentiated
3	G3: Poorly differentiated
4	G4: Undifferentiated
9	Grade cannot be assessed (GX); Unknown

Grade – Appendix

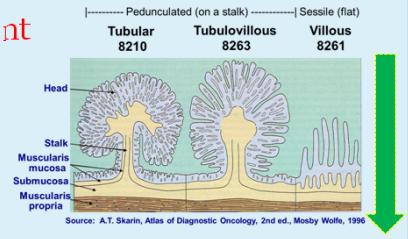
67



Polyps and Colon Cancer

68

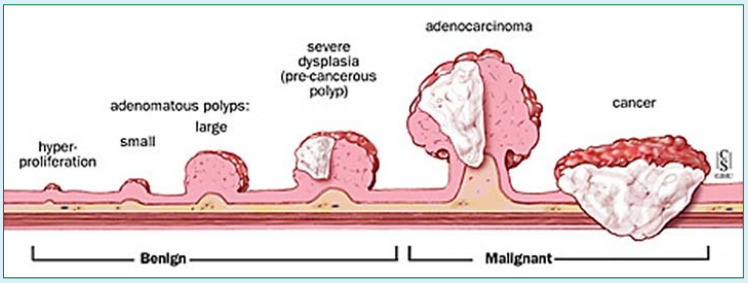
- 95-98% of colon cancers - adenocarcinoma
  - Most originate in polyps or adenomas – DO NOT CODE POLYPS !!!!
  - 10% of all adenomas develop into adenocarcinoma
  - **DO NOT USE 8210, 8260, 8261, 8263, 8264 for C18.0-C20.9**
- Types of adenoma – still important
  - Tubular
  - Villous
  - Tubulo-villous
- Process takes up to 10 years



- De Novo Cancers – mucinous, signet ring > 50% production
  - >10% of all colon ca are mucinous (>50% mucin production)
  - <1% of all colon ca are signet ring cell (>50% signet rings)

Polyps and Colon Cancer

69

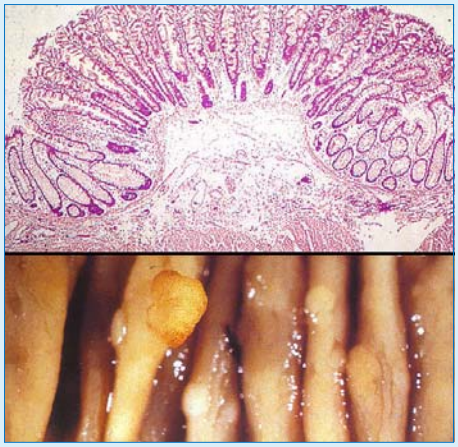


DO NOT USE 8210, 8260, 8261, 8263, 8264 for C18.0-C20.9

http://hopkinscoloncancercenter.org

Polyps and Colon Cancer

70



HYPERPLASTIC POLYP – NO CA

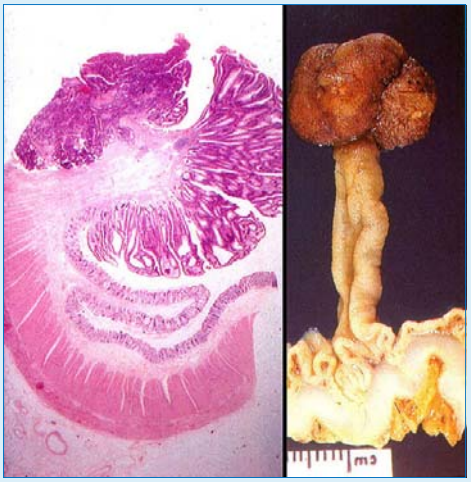
SMALL REACTIVE POLYP

NOT PRE-CANCEROUS

http://www.pathology.pitt.edu/lectures/gi/colon-a/14.htm

Polyps and Colon Cancer

71



TUBULAR ADENOMA

OFTEN BENIGN

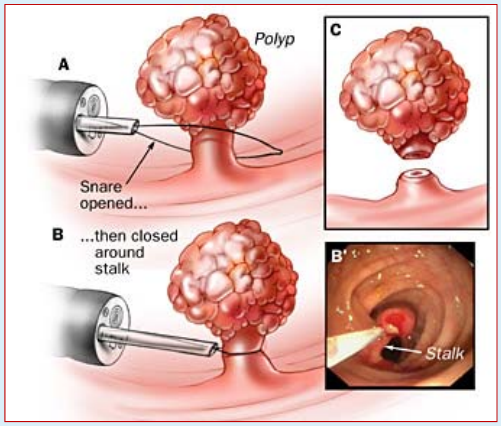
>10% MAY CONTAIN a NON-INVASIVE or INVASIVE CANCER

POLYP REMOVAL WILL PREVENT COLON CANCER

http://www.pathology.pitt.edu/lectures/gi/colon-a/16.htm

Polyps and Colon Cancer

72



http://hopkinscoloncancercenter.org

Polyps and Colon Cancer

73

SESSILE VILLOUS and TUBULO-VILLOUS ADENOMA

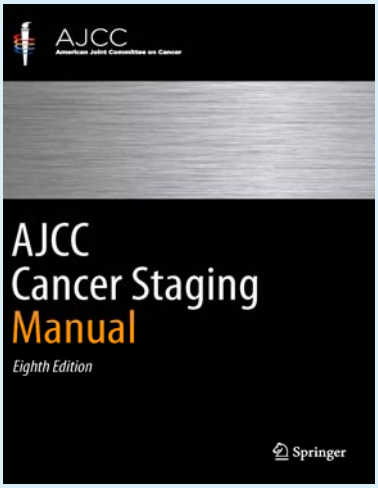
MORE OFTEN CONTAIN INVASIVE CANCER

POLYP REMOVAL MAY NOT REMOVE ALL CANCER

http://www.pathology.pitt.edu/lectures/gi/colon-a/17.htm

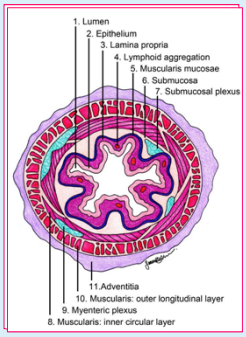
Anatomic Staging – Colon and Rectum

74

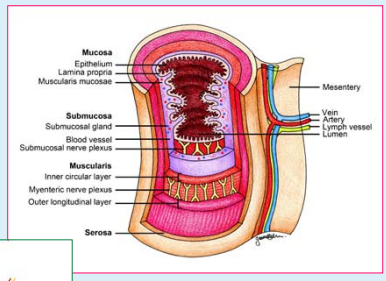


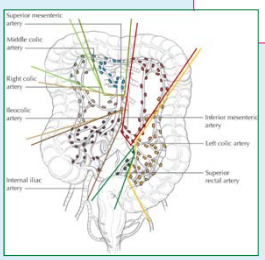
Comparing SS2018 to TNM – Same Anatomy

75



- ✓ Size of Tumor
- ✓ Wall Extension
- ✓ Regional Nodes
- ✓ Distant Nodes
- ✓ Distant Sites
- ✓ Some SSDIs
- ✓ Most SSDIs Not for Staging but Tumor Characteristics





SS2018 – mixed stage/limited detail EOD – mixed stage/mod detail/can convert to mixed stage TNM/SS2018 AJCC TNM – strict rules for clinical, pathological and post-treatment stage and slightly more detail than EOD/SS

There is considerably more to AJCC TNM and UICC TNM in terms of standard language and shared definitions – key!

https://www.memorangapp.com/flashcards/29623/Histology+week1/

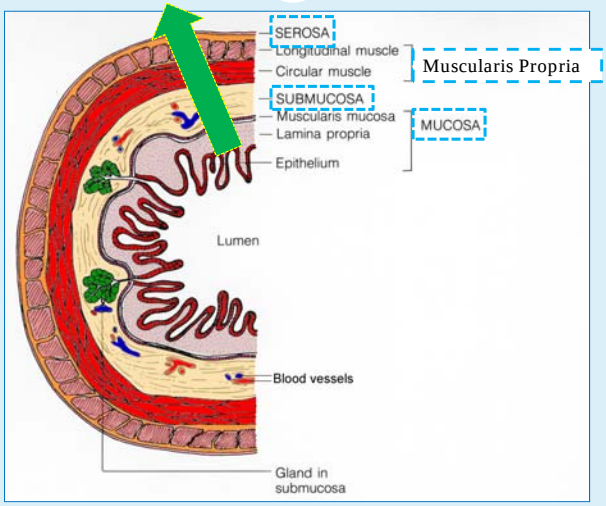
Simplify Staging Parameters

76

- Combined Clinical and Pathological for SS2018 Staging
- Clinical (Pre-Tx) Stage is Critical for Rectal, Breast, Liver Cancers
- Primary Tumor Grade Important for NET/GIST
- Typical Colon/Rectal Cancers – Adenocarcinoma, NOS
  - (in-situ or local) Intramucosal Spread (“T”)
  - (local) Depth of Invasion into Wall (“T”)
  - (local or regional) Depth of Invasion thru Wall (“T”)
  - Number of Lymph Nodes Examined (“N”)
  - Number of Lymph Nodes Positive (“N”) – (regional) if any + nodes
  - (regional) Extranodal Tumor Deposits (“N”)
  - Status of Resection Margins
  - Lymph-Vascular Invasion (LVI)
  - (distant) Metastatic Sites (“M”)

Layers of Colon Wall

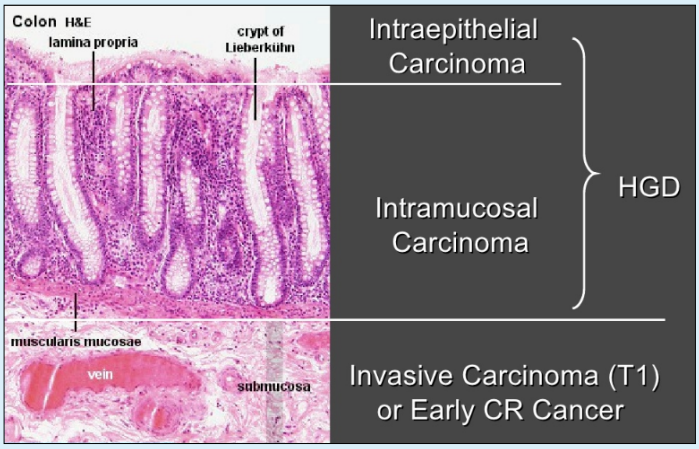
77



http://www.mannisjournals.com.au/images

Intramucosal Colon Cancer

78



Source: http://www.slideshare.net/giaffa/petruzziello

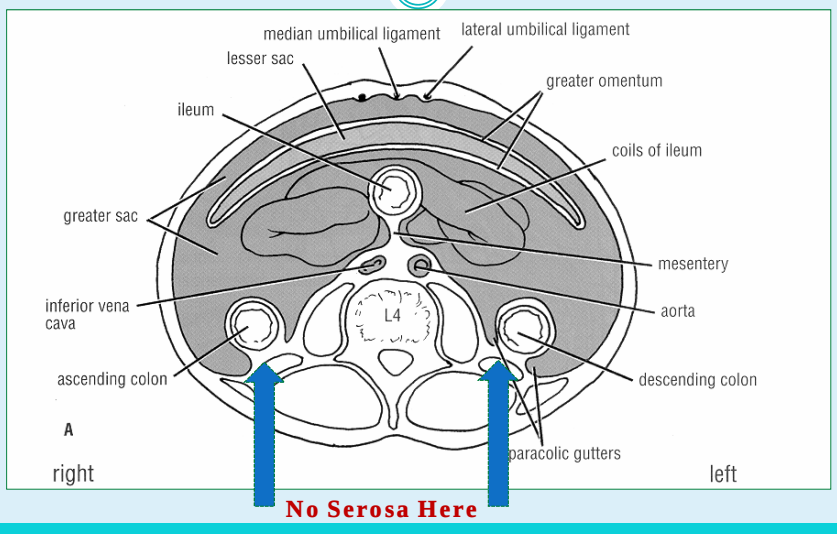
"Non-Peritonealized" Surface

79

- The serosa acts as barrier for tumors that begin on inside surface of the colon and invade down into the mucosa and through the wall of the colon (the serosa).
- Some colon surfaces have no serosa at the exterior surface (around the hollow organ)
- When there is no serosa – you lose a natural barrier that helps contain the colon cancer
- Non-Peritonealized Surfaces in Colon-Rectum:
  - Rectum – no serosa in rectum below peritoneal reflection
  - Descending Colon – no serosa covering posterior surfaces
  - Ascending Colon – no serosa covering posterior surfaces

"Non-Peritonealized" Surface

80



Clinical Anatomy for Medical Students, 5th Edition, Richard S. Snell. Little, Brown and Company, 1995.

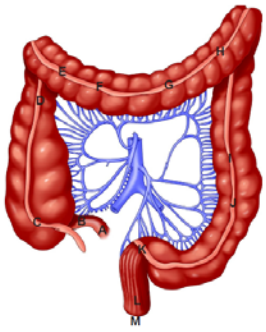
Surgical Resection

81

DEFINITIONS OF COMMON COLORECTAL RESECTIONS

The extent of colorectal resection depends on the location of the tumor, any underlying condition (eg, inflammatory bowel disease, hereditary syndrome), and the vascular supply to the colorectum.

Definitions of common colorectal resections are as follows:[1]



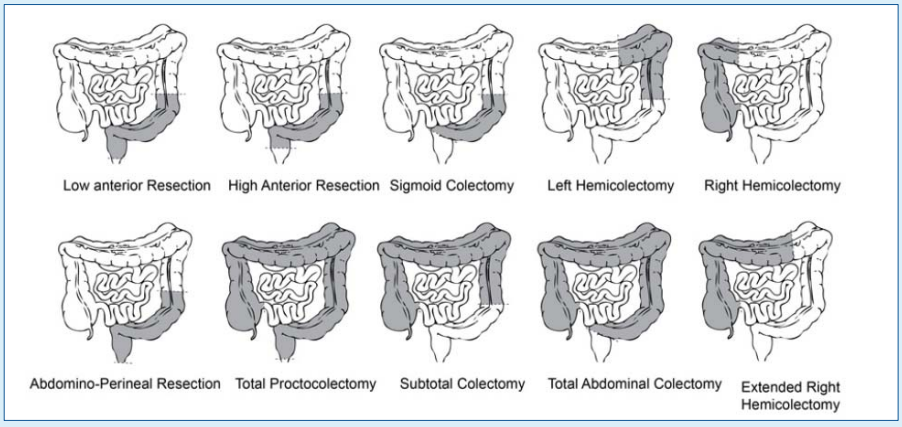
A through C	Ileocecectomy
A through F	Right hemicolectomy
A through G, H or I	Extended right hemicolectomy
E through I	Transverse colectomy
G through K	Left hemicolectomy
F through I	Extended left hemicolectomy
J through K	Sigmoid colectomy
A through K	Total colectomy
I through L	Low anterior resection with sphincter preservation
I through M	Abdominoperineal resection without sphincter preservation
A through M	Total proctocolectomy

[1]Adapted and reprinted with permission from Bullard KM and Rothenberger DA. (2005). Colon, Rectum, and Anus. In Brunicardi C (Ed.) Schwartz's Principles of Surgery, 8th Edition, page 1069. McGraw Hill: New York, NY.

NCCN Guidelines – Colorectal Cancer Screening

Surgical Resection

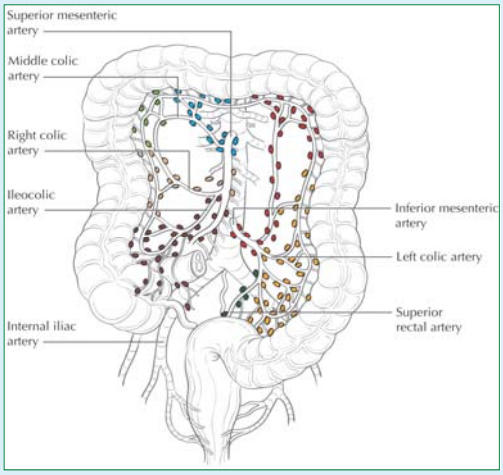
82



https://www.bcm.edu/healthcare/care-centers/general-surgery/procedures/colon-resection

Lymphatics of Colon / Rectum

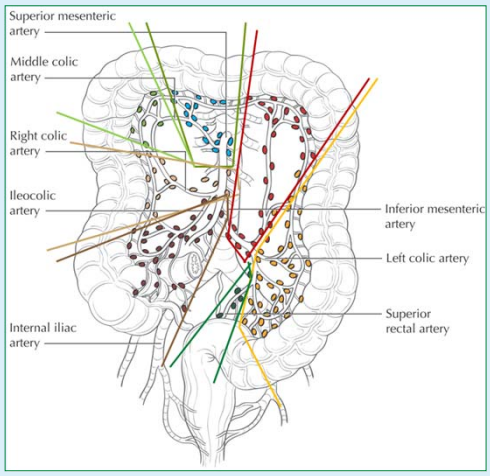
83



AJCC Image - The regional lymph nodes of the colon and rectum are colored by anatomic location.

Lymphatics of Colon / Rectum

84

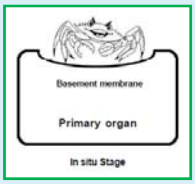


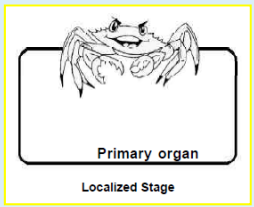
Modified AJCC Image - The regional lymph nodes of the colon and rectum are colored by anatomic location.

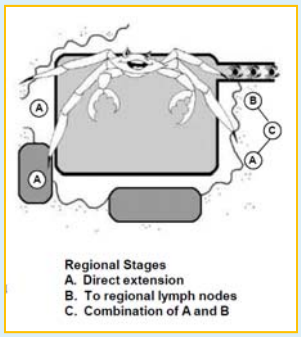
2018 SEER Summary Stage – USE IT .

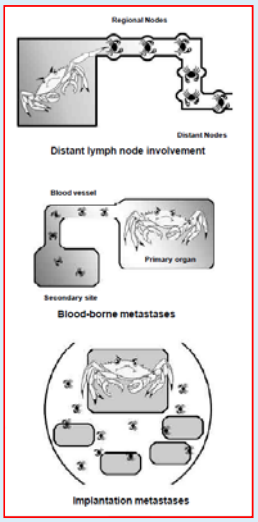
85

SS2018 and earlier editions *may* appear to be a crude anatomic cancer staging system – it is the same pie sliced differently is all.









Source: SEER Summary Staging Manual 2018

SEER Summary Stage – 2018

86

- Use All Information – history, clinical, imaging, labs, biopsy, resection, physician notes – use all info avail.

DIGESTIVE AND HEPATOBILIARY SYSTEMS

DIGESTIVE SYSTEM SITES

Below is information about the subsites of the colon

- The *ascending colon*, measuring 15 to 20 cm, begins with the *cecum*, a 6 to 9 cm pouch that arises at the proximal segment of the right colon at the end of the terminal ileum. It is covered with a visceral peritoneum (serosa) and measures 15 to 20 cm. The ascending colon ends at the *hepatic flexure*, which transitions the ascending colon into the *transverse colon*, passing just inferior to the liver and anterior to the duodenum.
- The *transverse colon*, measuring 18 to 22 cm long, is completely intraperitoneal and supported on a mesentery that is attached to the pancreas. Anteriorly the serosa is continuous with the gastrocolic ligament. The transverse colon ends at the *splenic flexure*, which transitions into the *descending colon*.
- The *descending colon*, measuring 10 to 15 cm long, passes interiorly to the spleen and anterior to the tail of the pancreas. The posterior aspect lacks serosa and is in direct contact with the retroperitoneum.
- The *sigmoid colon*, measuring 15 to 20 cm long, is completely intraperitoneal with a mesentery that develops at the medial border of the left psoas major muscle and extends to the *rectum*. The transition from the sigmoid colon to the rectum is marked by the fusion of the taenia of the sigmoid colon to the circumferential muscle of the rectum.
- The *rectum*, measuring 12 to 16 cm, is covered by peritoneum in front and on both sides.

SEER Summary Stage – 2018

87

SUMMARY STAGE 2018 CHAPTERS

The Summary Stage site-specific chapters are based on historical staging, Summary Stage 2000 and the AJCC 8th Edition. Some of the AJCC 8th edition chapters were divided to line up with historical Summary Stage chapters.

SS Chapter	EOD Schema	AJCC Chap. No	AJCC Chapter Name
Adnexa Uterine Other	Adnexa Uterine Other	N/A	N/A
Adrenal Gland (including NET)	Adrenal Gland	76	Adrenal Cortical Carcinoma
Adrenal Gland (including NET)	NET Adrenal Gland	77	Adrenal-Neuroendocrine Tumors
Ampulla Vater (including NET)	Ampulla Vater	27	Ampulla of Vater
Ampulla Vater (including NET)	NET Ampulla of Vater	30	Neuroendocrine Tumors of the Duodenum and Ampulla of Vater
Anus	Anus	21	Anus
Appendix (including NET)	Appendix	19	Appendix-Carcinoma
Appendix (including NET)	NET Appendix	32	Neuroendocrine Tumors of the Appendix
Biliary Other	Biliary Other	N/A	N/A
Bladder	Bladder	62	Urinary Bladder
Bone	Bone Appendicular Skeleton	38	Bone
Bone	Bone Pelvis	38	Bone
Bone	Bone Spine	38	Bone
Brain	Brain	72	Brain and Spinal Cord
Breast	Breast	48	Breast
Buccal Mucosa	Buccal Mucosa	7	Lip and Oral Cavity
Cervical Lymph Nodes and Unknown Primary	Cervical Lymph Nodes and Unknown Primary Tumor of The Head and Neck	6	Cervical Lymph Nodes and Unknown Primary Tumors of Head and Neck
Cervix	Cervix	52	Cervix Uteri
CNS Other	CNS Other	72	Brain and Spinal Cord
Colon and Rectum (including NET)	Colon and Rectum	20	Colon and Rectum
Colon and Rectum (including NET)	NET Colon and Rectum	33	Neuroendocrine Tumors of the Colon and Rectum

SEER Summary Stage – 2018

88

APPENDIX

8000-8700, 8720-8790, 9700-9701

C181
C181 Appendix

Note 1: The following sources were used in the development of this chapter

- SEER Extent of Disease 1988: Codes and Coding Instructions (3rd Edition, 1998) (https://seer.cancer.gov/archive/manuals/EOD10Dig.3rd.pdf)
- SEER Summary Staging Manual-2000: Codes and Coding Instructions (https://seer.cancer.gov/tools/ssm/)
- Collaborative Stage Data Collection System, version 02.05: https://cancerstaging.org/cstage/Pages/default.aspx
- Chapter 19 *Appendix – Carcinoma*, in the AJCC Cancer Staging Manual, Eighth Edition (2017) published by Springer International Publishing. Used with permission of the American College of Surgeons, Chicago, Illinois.
- Chapter 32 *Neuroendocrine Tumors of the Appendix*, in the AJCC Cancer Staging Manual, Eighth Edition (2017) published by Springer International Publishing. Used with permission of the American College of Surgeons, Chicago, Illinois.

Note 2: See the following chapters for the listed histologies

- 8710-8714, 8800-8934, 8940-9137, 9141-9582: *Soft Tissue*
- 8935-8936: *GIST*
- 9140: *Kaposi Sarcoma*

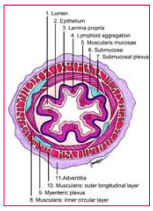
SEER Summary Stage – 2018

89

COLON AND RECTUM

8000-8700, 8720-8790, 9700-9701

C180, C182-C189, C199, C209
C180 Cecum
C182 Ascending colon
C183 Hepatic flexure of colon
C184 Transverse colon
C185 Splenic flexure of colon
C186 Descending colon
C187 Sigmoid colon
C188 Overlapping lesion of colon
C189 Colon, NOS
C199 Rectosigmoid junction
C209 Rectum, NOS



Note 1: The following sources were used in the development of this chapter

- SEER Extent of Disease 1988: Codes and Coding Instructions (3rd Edition, 1998) (https://seer.cancer.gov/archive/manuals/EOD10Dig.3rd.pdf)
- SEER Summary Staging Manual-2000: Codes and Coding Instructions (https://seer.cancer.gov/tools/ssm/)
- Collaborative Stage Data Collection System, version 02.05: https://cancerstaging.org/cstage/Pages/default.aspx
- Chapter 20 *Colon and Rectum*, in the AJCC Cancer Staging Manual, Eighth Edition (2017) published by Springer International Publishing. Used with permission of the American College of Surgeons, Chicago, Illinois.
- Chapter 33 *Neuroendocrine Tumors of the Colon and Rectum*, in the AJCC Cancer Staging Manual, Eighth Edition (2017) published by Springer International Publishing. Used with permission of the American College of Surgeons, Chicago, Illinois.

Note 2: See the following chapters for the listed histologies:

- 8710-8714, 8800-8934, 8940-9137, 9141-9582: *Soft Tissue*
- 8935-8936: *GIST*
- 9140: *Kaposi Sarcoma*

Note 3: Code 0 (behavior code 2) includes cancer cells confined within the glandular basement membrane (intraepithelial), or described as in situ.

Note 4: For the following, AJCC 8th edition stages these as in situ tumors. SS2018 stages these as localized (behavior code 3)

- Intramucosal, NOS
- Lamina propria

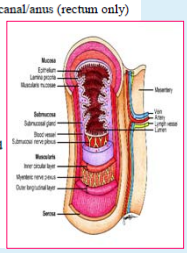
Note 5: Ignore intraluminal extension to adjacent se[illegible]t(s) of colon/rectum or to the ileum from the cecum; code depth of invasion or extraco[illegible]spread as indicated.

Note 6: Tumor that is adherent to other organs or structures, macroscopically, is co[illegible]s regional (code 2) or distant (code 7). However, if no tumor is present in the adhesi[illegible]microscopically, the classification should be coded to localized (code 1) or regio[illegible]de 2).

Note 7: Tumors characterized by involvement of the serosal surface (visceral peritoneum) by direct extension or perforation in which the tumor cells are continuous with the serosal surface through inflammation are coded to regional (code 2).

1 Localized only (localized, NOS)

- Confined to colon, rectum, rectosigmoid, NOS
- Extension through wall, NOS
- Intraluminal extension to colon and/or anal canal/anus (rectum only)
- Invasion of
  - Intramucosal, NOS
  - Lamina propria
  - Mucosa, NOS
  - Muscularis mucosae
  - Muscularis, NOS
  - Muscularis propria
  - Submucosa (superficial invasion)
- Non-peritonealized pericolic tissues invaded
- Perimuscular tissue invaded
- Polyp (head, stalk, NOS)
- Subserosal tissue/(sub)serosal fat invaded
- Transmural, NOS
- Wall, NOS

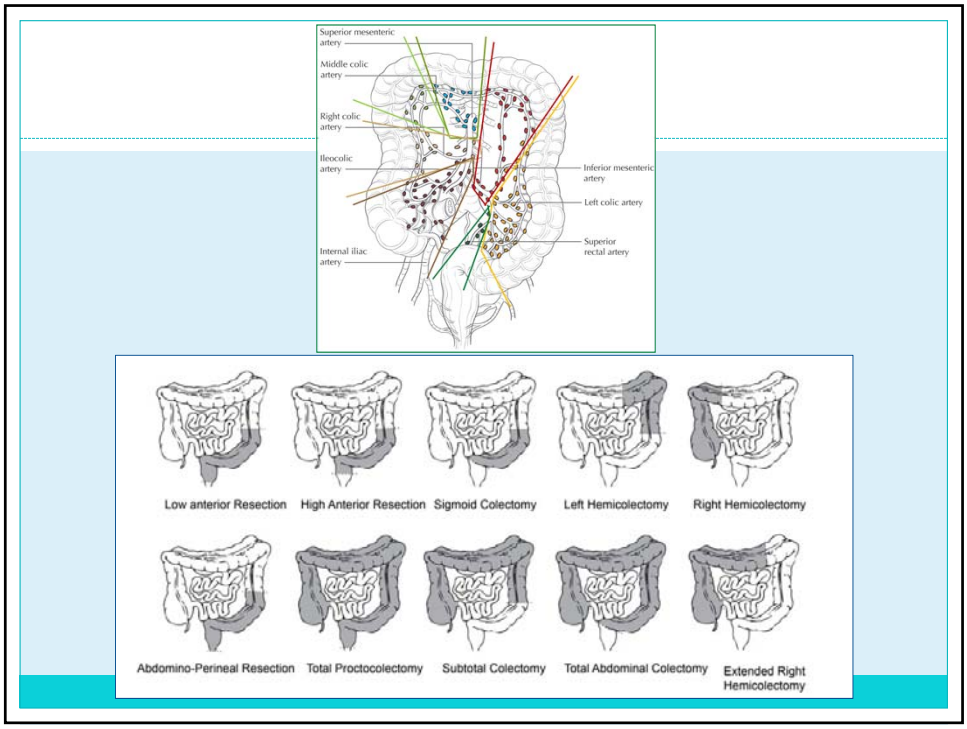


SEER Summary Stage – 2018

90

3 Regional lymph node(s) involved only

- All sites
  - Colic, NOS
  - Epicolic (adjacent to bowel wall)
  - Mesenteric, NOS
  - Mesocolic, NOS
  - Paracolic
  - Pericolic
  - Tumor deposits (TD) in the subserosa, mesentery, mesorectal or nonperitonealized pericolic or perirectal tissues WITHOUT regional nodal metastasis
  - Regional lymph node(s), NOS
    - Lymph node(s), NOS
- Cecum (C180)
  - Cecal, NOS
    - Anterior cecal (prececal)
    - Posterior cecal (retrocecal)
  - Colic (right)
  - Ileocolic
  - Periappendiceal
- Ascending colon (C182)
  - Colic (middle-right branch, right)
  - Ileocolic
- Hepatic flexure (C183)
  - Colic (middle, right)
  - Ileocolic
- Transverse colon (C184)
  - Colic (middle)
- Splenic flexure (C185)
  - Colic (left, middle)
  - Mesenteric (inferior)
- Descending colon (C186)
  - Colic (left)
  - Mesenteric (inferior)
  - Sigmoid
- Sigmoid colon (C187)
  - Colic (left)
  - Mesenteric (inferior)
  - Rectal (superior) (hemorrhoidal)
  - Rectosigmoid
  - Sigmoid (sigmoidal) (sigmoid mesenteric)
  - Superior rectal (hemorrhoidal)
- Rectosigmoid (C199)
  - Hemorrhoidal (middle, superior)
  - Mesenteric (inferior)
  - Mesorectal
  - Pericolic
  - Perirectal
  - Rectal (middle, superior)
  - Sigmoid (mesenteric)
- Rectum (C209)
  - Hemorrhoidal (middle, superior)
  - Iliac (internal) (hypogastric) (obturator)
  - Mesenteric (inferior)
  - Mesorectal
  - Perirectal
  - Rectal (inferior)
  - Sacral, NOS
    - Lateral sacral (laterosacral)
    - Middle sacral (promontorial) (Gerota's node)
    - Presacral
  - Sigmoidal (sigmoid mesenteric)



"Tumor Deposits"

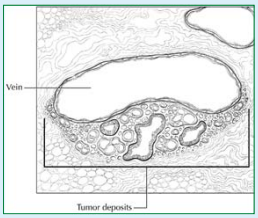
92

- Definition
  - Separate tumor nodules or tumor deposits of malignant cells in perirectal or pericolic fat with no evidence of lymph node tissue
- Found in primary lymphatic drainage area
- Other names
  - Peri-tumoral deposits, satellite nodules, discontinuous extramural extension, or malignant tumor foci
- N1c = Specific TNM "N" Code for tumor nodule or deposit(s) in the subserosa, mesentery, or non-peritonealized pericolic or perirectal tissues without regional nodal metastasis.

"Tumor Deposits"

93

- Mesenteric
- Pericolonic
- Perirectal
- Subserosa
- All Regional Lymph Nodes Negative
- Deposits + LNs



- N1c = Tumor deposit(s) in the subserosa, mesentery, or nonperitonealized pericolic or perirectal tissues without regional nodal metastasis.

SEER Summary Stage – 2018

94

7 Distant site(s)/lymph node(s) involved

- Distant site(s) (including further contiguous extension)
  - All sites
    - Adrenal (suprarenal) gland
    - Bladder
    - Diaphragm
    - Fallopian tube
    - Fistula to skin
    - Gallbladder
    - Other segment(s) of colon via serosa
    - Ovary(ies)
    - Uterus
  - Cecum (C180)
    - Kidney, right
    - Liver
    - Ureter, right
  - Transverse colon and flexures (C183-C185)
    - Ureter
  - Sigmoid colon (C187)
    - Cul de sac (rectouterine pouch)
    - Ureter
  - Rectosigmoid (C199)
    - Bladder
    - Colon via serosa
    - Fallopian tube
    - Ovary
    - Prostate
    - Skeletal muscles of pelvic floor
    - Ureter
    - Vagina
  - Rectum (C209)
    - Bladder (for females only)
    - Bone(s) of pelvis
    - Cervix
    - Perineum, perianal skin
    - Sacral plexus
    - Sacrum
    - Ureter
    - Urethra
    - Uterus
- Distant lymph node(s), NOS
  - Colon
    - Iliac (common, external)
    - Inferior mesenteric (cecum, ascending colon, hepatic flexure, transverse colon)
    - Para-aortic
    - Retroperitoneal
    - Superior mesenteric
  - Rectosigmoid/Rectum
    - Colic (left) (cecum)
    - Hemorrhoidal, inferior (rectosigmoid)
    - Iliac (common, external)
    - Internal iliac (hypogastric), NOS (rectosigmoid)
    - Obturator (rectosigmoid)
    - Rectal, inferior (rectosigmoid)
    - Superior mesenteric
- Distant metastasis, NOS
  - Carcinomatosis
  - Peritoneal surface metastasis (peritoneum)
  - Distant metastasis WITH or WITHOUT distant lymph node(s)

Site Specific Data Items

95

Site-Specific Data Item (SSDI) Manual

Effective with Cases Diagnosed 1/1/2018 and Forward

Published May 2018

Editors: Jennifer Ruhl, MSHCA, RHIT, CCS, CTR, NCI SEER
Jim Hofferkamp, CTR, NAACCR
Elizabeth Ward, PhD, Consultant to NAACCR

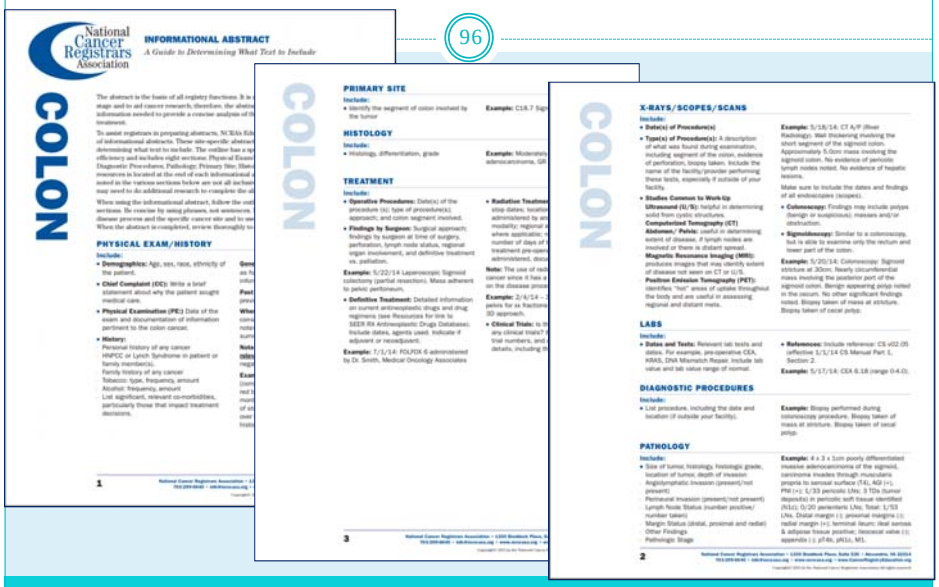
Suggested Citation: Ruhl J, Ward E, Hofferkamp J, et al. (March 2018). Site-Specific Data Item (SSDI) Manual. NAACCR, Springfield, IL 62704-4194

Funding for this project was made possible in part by a contract with Federal funds from the National Cancer Institute, National Institutes of Health and Department of Health & Human Services under Contract number HHSN261201400004 / HHSN261100002. Additionals, funding for this project was made possible in part by a cooperative agreement with Federal funds from the Centers for Disease Control and Prevention Cooperative Agreement number 5NU58DP004817. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NCI and CDC. The NAACCR Board of Directors adopted these standards in February 2018.

00320: NET Appendix	32: Neuroendocrine Tumors of the Appendix	No SSDIs defined for this Schema ID
00330: NET Colon and Rectum	33: Neuroendocrine Tumors of the Colon and Rectum	No SSDIs defined for this Schema ID

Text Documentation

96



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

COLON

PHYSICAL EXAM/HISTORY

PRIMARY SITE

HISTOLOGY

TREATMENT

X-RAYS/SCOPES/SCANS

LABS

DIAGNOSTIC PROCEDURES

PATHOLOGY

http://www.cancerregistryeducation.org

Staging Practice

97

References

98

- Cancer Epidemiology, Oxford University Press
- American Cancer Society – www.acs.org
  - Cancer Facts and Figures 2018
  - Colorectal Cancer Facts and Figures 2017-2020
- American Joint Committee on Cancer
  - www.cancerstaging.org
- SEER Summary Staging Manual 2018
  - https://seer.cancer.gov/tools/ssm/
- 2018 Grade Coding Manual
  - www.naaccr.org
- 2018 Site Specific Data Items Manual
  - www.naaccr.org
- 2018 Solid tumor Rules
  - https://seer.cancer.gov/tools.ssm/
- www.medicinenet.com/colon_cancer
- NCCN Treatment Guidelines 2017 or 2018 – www.nccn.org

Thank you

99