Wisconsin Cancer Reporting System **Reporting Manual**

Updated for 2021 Diagnoses

Wisconsin Cancer Reporting System
Office of Health Informatics
Division of Public Health
Department of Health Services

WISCONSIN DEPARTMENT *of* HEALTH SERVICES

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Contents

Overview

The primary purpose of this WCRS Coding Manual is to assist Wisconsin cancer reporters in reporting cancer cases to the Wisconsin Cancer Reporting System (WCRS), as mandated by Wis. Stat. § 255.04, Cancer Reporting.

Since the passage of Public Law 102-515 Cancer Registries Amendment Act by the 102nd Congress in October 1992, there has been a tremendous effort by all national agencies collecting cancer data to unify and standardize data sets. With the establishment of the National Program of Cancer Registries (NPCR) in 1994, all central registries funded by the Centers for Disease Control and Prevention (CDC) through NPCR are required to follow stringent data management procedures; provide training for state personnel and hospital/clinic reporting staff; publish an annual report; and conduct casefinding and re-abstracting audits at randomly selected facilities.

Although WCRS began receiving CDC/NPCR funding in 1995, the Wisconsin Legislature had already established the registry in 1976; therefore, our index year is 1976. WCRS collects data that are compliant with required NPCR data elements; meet standard requirements designated by the North American Association of Central Cancer Registries (NAACCR) for incidence reporting and endorsed by CDC; and assist WCRS staff when assessing data quality. WCRS also uses the data to provide useful feedback to submitting facilities for quality assurance activities and administrative purposes.

What Is the Wisconsin Cancer Reporting System (WCRS)?

The Wisconsin Cancer Reporting System (WCRS) collects and processes information on cancer cases in Wisconsin. In addition, WCRS provides data and produces reports on cancer incidence and mortality statewide and other geographic areas in Wisconsin, by gender, anatomic site (e.g. breast, lung, colon, and prostate) and stage of disease.

One of the oldest cancer registries in the country, WCRS has been collecting information on Wisconsin residents with cancer for over 40 years. The first state mandate requiring hospitals and physicians to report cancer cases was passed in 1976 by the Wisconsin State Legislature. WCRS began collecting data from Southeast Wisconsin that year. In 1978, WCRS began collecting data statewide.

In 1995, WCRS began receiving funding from CDC through a cooperative agreement under the Cancer Registries Amendment Act. These funds have permitted WCRS to make improvements in the collection and processing of data, such as increasing the number and quality of data elements collected on each cancer patient, consistent with standards of NPCR. Also through this agreement, WCRS began applying national standard edits to cancer cases. Since 1995, WCRS data have been available on public use query sites, provided to researchers, and submitted annually to CDC and standard setters.

In 2004, per the Benign Brain Tumor Cancer Registries Amendment Act, WCRS began collecting data on brain and nervous system tumors classified as benign or uncertain behavior. While these won't metastasize beyond the tissue they originated, they are treated aggressively as if they were malignant, which is one of the main reasons those cases are reported.

Why Report to WCRS?

Submission of data is mandated under Wis. Stat. § 255.04, Cancer Reporting.

WCRS is a population-based cancer registry responsible for collection of demographic, diagnostic, and treatment information on patients with active cancer disease that was diagnosed or treated at hospitals, laboratories and physicians throughout Wisconsin. In determining case reportability, WCRS follows rules of the Surveillance, Epidemiology and End Results (SEER) Program of the National Cancer Institute (NCI). Data items are based on fields required or recommended by the National Program of Cancer Registries (NPCR) for central registries. Additional fields are required for quality assurance.

WCRS collects a variety of information that can be used for research, public health planning, and evaluation. Because the data are population-based, it can be used to monitor incidence patterns in the state.

Data collected by WCRS are used to:

- Determine cancer rates and trends
- Prepare health policy and planning
- Conduct research in epidemiological studies, including case-control studies
- Evaluate cancer control interventions
- Identify and target high-risk populations
- Respond to public concerns regarding perceived excesses of cancer

WCRS plays an important role in research to identify causes of cancer. Researchers have used the data to identify cancer patients who could be interviewed about possible exposures they had before being diagnosed with cancer. These responses can then be compared to interview responses of people without cancer to determine whether there were different exposures.

Who Reports to WCRS

By law, all Wisconsin hospitals, laboratories and physicians in certain settings must report information concerning any person diagnosed as having cancer or a precancerous condition to WCRS, as mandated by Wis. Stat. § 255.04, Cancer Reporting.

> ***Note*:** Physicians in the following settings are required to report: Radiation Treatment Centers, Ambulatory Surgery Centers, Nursing Homes, Hospice Centers, Clinics, Private Offices, and Diagnostic and Treatment Centers.

A facility may be small or large, and the extent of information submitted varies depending on facility size, services available to the patient, and reporting methods for each facility. Some facilities have their own cancer registries, while others have limited registries or no registry and only provide the minimum data required by Wisconsin law.

In addition to in-state facility submissions, WCRS has established formal agreements with many states and territories to exchange information regarding cancer patients.

What Information Is Collected About Patients with Cancer?

In 1976, when WCRS started collecting data, only a minimal amount of information about the patient and tumor was collected. Over the years, as the population ages and knowledge about the disease increases, along with continued research, the volume of cancer cases has increased and the amount of data collected for each case has expanded. Data can be divided into two major types: information pertaining to the disease process and socio-demographic information about the patient. If a person is diagnosed with more than one type of cancer in his/her lifetime, the same information is collected for each new unique tumor.

Examples of Disease-process information:

- Anatomic site of the tumor, such as *breast*, *lung*, or *lymph nodes*.
- Stage of disease at the time of diagnosis
- Cancer cell type, such as *leukemia*, *melanoma*, and *osteosarcoma*.
- Type of first course treatment rendered to destroy the tumor

Examples of Socio-demographic information:

- Sex
- Age at diagnosis
- Race
- Address at diagnosis
- Occupation
- Place of birth
- Ethnicity

File Retention

There is no statute governing how long reporting facilities must keep cancer case abstracts or files. However, WCRS recommends retaining them for at least seven years.

How Are Cancer Reports Submitted to WCRS and Processed?

Electronic data must be sent using the NAACCR Version 21 layout. Electronic cancer reporting is required. WCRS uses a secure internet application called Web Plus for data submissions. Contact WCRS to obtain a Web Plus account. ***Note*:** Web Plus passwords expire every six months.

Once WCRS receives the uploaded files, they are processed through a series of computerized and manual operations before the files can be used for analysis.

WCRS data is multiple-source reporting to ensure statewide coverage and completeness because patients are often seen at more than one facility for diagnosis, treatment, or follow up. On average, 1.6 reports are received for each primary tumor diagnosed.

- WCRS monitors the number of cases submitted by each facility and the total number of cases for a given diagnosis year. Completed cases should be submitted to WCRS within six months

of date of diagnosis, or date of initial contact if diagnosed elsewhere.

- Breast cancer cases should be submitted to WCRS within 12 months of date of diagnosis or date of initial contact if diagnosed elsewhere (breast cancer treatment and sometimes staging information are often not complete within the six month time frame).

WCRS requires the following submission schedule to maintain timeliness:

Annual Caseload	Schedule
More than 500	Monthly
Less than 500	Monthly or quarterly

Timely Reporting Calendar		Timely Reporting Calendar for Breast Cases	
Month Case Dx/Seen	**Month Case Due**	**Month Case Dx/Seen**	**Month Case Due**
January	July	January	December
February	August	February	January
March	September	March	February
April	October	April	March
May	November	May	April
June	December	June	May
July	January	July	June
August	February	August	July
September	March	September	August
October	April	October	September
November	May	November	October
December	June	December	November

What Is the Death Certificate Only Process?

Data collection on Death Clearance Only cases is mandated by Wisconsin Statutes and is in compliance with all HIPAA requirements. A DCO case means the only source of information about the cancer was from the death certificate. This process of follow-up on death cases to identify missed cases is required by CDC. WCRS begins the Death Certificate Only process once most of the data for the most recent diagnosis year are received and processed.

When the Wisconsin Vital Records Section receives death certificates, an underlying cause of death (UCOD) is assigned based on the causes of death listed. Up to 20 conditions can be factored in the determination of the UCOD, including history of cancer, which can be listed regardless of whether the person died as a direct result of the cancer. For example, if the decedent died from pneumonia but was diagnosed with prostate cancer two years prior, the cancer is listed as a significant condition on the death certificate.

Each year WCRS links the death file to the WCRS database to identify persons in the database who have died and adds the date and UCOD to the record. In instances when no person match is found, or when the type of cancer on the death certificate is different from that recorded in the WCRS database, the result is a Death Certificate Only (DCO), meaning the cancer was listed on the death certificate but WCRS does not have a record of that cancer. WCRS is required to follow-back with the hospital, physician, or coroner listed on the death certificate to request information on the cancer diagnosis. If a DCO is proven not to be reportable to WCRS (the patient was actually a resident of another state when diagnosed, for example) the DCO is deleted. When a full abstract is provided for a missed case the case is no longer considered a DCO and the abstract is added to the database as a complete case.

DCO process improves the completeness of data and identifies missing data submissions or facilities that need to improve their casefinding routines. If a facility receives many DCOs it probably means that there was a failed file submission or your casefinding routine is not catching all of the reportable cancers and needs to be updated. WCRS cannot use solely the information on the death certificate because it does not provide the true year of diagnosis, stage of disease, histology, treatment provided, and other information.

Are There Measures of Quality Applied to the Cancer Registry?

Three national indicators measure the quality of cancer reporting:

1. Percentage of cases reported by death certificates only (DCO)
2. Percentage of cases confirmed microscopically
3. Percentage of cases with nonspecific diagnoses

The number of DCO cases indicates the completeness of casefinding within a facility. The number of microscopically confirmed cases and the number with nonspecific diagnoses (unknown primary site, subsite or cell type) measure the accuracy of the information provided. A high percent of cases without microscopic confirmation or with nonspecific diagnoses can indicate inadequate medical record abstracting and reporting, or that the diagnostic work-ups were not as complete as they could have been.

WCRS uses the indicators below, along with the national indicators, to also measure data quality and identify areas for improved reporting from facilities:

- Percent of cases reported with only a PO Box for the street address
- Cases with an unknown stage at diagnosis
- Cases with an unknown maiden name
- Cases with an unknown race

WCRS uses the following measures to calculate timeliness of cases submitted:

- Percent of cases received within six months
- Percent of cases received within nine months
- Percent of cases received within 12 months
- Percent of cases received after 12 months

WCRS measures the completeness of cases submitted by diagnosis year against the estimated annual caseload for each facility:

- 100% of annual estimated caseload submitted
- 95% of annual estimated caseload submitted
- 90% of annual estimated caseload submitted
- Less than 90% of annual estimated caseload submitted

WCRS provides Feedback Summary Reports to reporting facilities that focuses on timeliness, completeness and select data quality indicators, as mentioned above.

How Does WCRS Protect Privacy?

Per Wisconsin Statute 255.04(3), “Any information reported to the department under sub. (1) or (5) which could identify any individual who is the subject of the report or the person submitting the report shall be confidential and may not be disclosed by the department.”

WCRS policy identifies the following required data items as confidential:

- Patient name
- Street address
- Date of birth
- Social security number
- Patient medical record number
- Cancer registry patient accession number (assigned by facility)
- Name of physician
- Date of death
- Death Certificate Number

WCRS policy identifies the following combinations of data items as potentially identifying, based on the combined number of items and the geographic size of the area being analyzed:

- Age
- Race
- Sex
- Year of diagnosis
- Cancer site
- Cancer cell type
- Geographic area

Policies and procedures are in place to protect patient’s privacy. Access to WCRS work areas is restricted and WCRS employees sign confidentiality agreements and conduct annual training on handling confidential information. Statute and policies govern the release of data to outside investigators. All research studies involving data with patient identifiers must comply with Wisconsin Statute, Chapter 255.04(3)(c),(8),(9) and (10) and be approved by the Division of Public Health’s Data Governance Board. Individual-level data without identifiers for small geographic areas are also protected by data release policies. Statistics for areas smaller than the county level are only released when there are enough cases in the area to guard against revealing confidential information about an individual. When there are fewer than six cases of a particular type of cancer in small area the exact number of cases is not revealed.

The Health Insurance Portability and Accountability Act (HIPAA) allows reporting of identifiable cancer data to public health entities. Because WCRS is a public health authority, HIPAA allows your facility to report cancer incidence data in compliance with Wisconsin Statute, Chapter 255.04 and Administrative Rule DHS 124.05(3)(h). Written informed consent from each cancer patient reported to public health entities is not required under HIPAA, nor is a Business Associate Agreement required; rather, facilities must document that reporting has occurred.

What Kind of Data Does WCRS Release?

De-identified data are submitted annually to CDC NAACCR for registry certification and publication in Cancer in North America. Registries whose data meet established criteria for timeliness, accuracy and completeness are recognized as NAACCR-Certified registries. WCRS is recognized as a NAACCR Gold-Certified Registry. WCRS submits de-identified data to CDC for inclusion in the United States Cancer Surveillance annual publication and is recognized as a Registry of Excellence. CDC provides de-identified Wisconsin data to national and international organizations for use in public use data query systems and publications.

WCRS data are available on the Division of Public Health's Wisconsin Interactive Statistics on Health (WISH) website at https://www.dhs.wisconsin.gov/wish/cancer/index.htm and the Cancer-Rates.info site, https://cancer-rates.info/wi/. Data can be filtered by cancer incidence, mortality, stage of disease at the time of diagnosis, and geographic location.

Periodically, WCRS produces exclusive reports and collaborative reports that include more detailed data than are available online. These are on the WCRS website at https://www.dhs.wisconsin.gov/wcrs/data-pubs.htm.

WCRS releases confidential data to qualified researchers when all statutory requirements have been met and the Data Governance Board has approved the request. More details on how to apply are available at: https://www.dhs.wisconsin.gov/wcrs/researcherinfo.htm.

Determining Reportability for State Reporting

Definition of Reportable: Meets the criteria for inclusion in a registry. Reportable cases are cases that the registry is required to collect and report. Reporting requirements WCRS are established by the National Program of Cancer Registries (NPCR). A “Reportable List” includes all diagnoses to be reported by WCRS by the registry to NPCR.

Reportable List

1. Cases diagnosed on or after January 1, 1976, for hospitals, or on or after January 1, 1992, for all nonhospital reporting entities such as clinics and physician offices.

2. Patients whose residence at diagnosis is in Wisconsin or **anywhere else**. WCRS has data exchange agreements with 45 states and two U.S. territories. These states provide WCRS with reports on Wisconsin residents and we provide them reports on their residents. Interstate data exchange is an NPCR requirement.

3. **Malignant Histologies (In Situ and Invasive)**

    a. Report all histologies with a **behavior code** of **/2 or /3** in the ICD-O- Third Edition, Second Revision Morphology (**ICD-O-3.2**), except as noted in section 1.b. below.

        i. Early or evolving melanoma, in situ and invasive: As of 01/01/2021, early or evolving melanoma in situ, or any other early or evolving melanoma, is reportable.

        ii. **All** GIST tumors are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2.

        iii. Nearly all thymomas are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2. The exceptions are:

            - Microscopic thymoma or thymoma, benign (8580/0)
            - Micronodular thymoma with lymphoid stroma (8580/1)
            - Ectopic hamartomatous thymoma (8587/0)

        iv. Carcinoid, NOS of the appendix is reportable. As of 01/01/2015, the ICD-O-3 behavior code changed from /1 to /3.

        v. The following diagnoses **are reportable** (not a complete list).

            - Lobular carcinoma in situ (LCIS) of breast
            - Intraepithelial neoplasia, grade III
              Examples: (Not a complete list)
                - Anal intraepithelial neoplasia III (AIN III) of the anus or anal canal (C210-C211)
                - High grade biliary intraepithelial neoplasia (BiIN III) of the

gallbladder (C239)
- Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)
- Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast (C500-C509)
- Pancreatic intraepithelial neoplasia (PanIN III) (C250-C259)
- Penile intraepithelial neoplasia, grade III (PeIN III) (C600-C609)
- Squamous intraepithelial neoplasia III (SIN III) excluding cervix (C53_) and skin sites coded to C44_
- Vaginal intraepithelial neoplasia III (VAIN III) (C529)
- Vulvar intraepithelial neoplasia III (VIN III) (C510-C519)

vi. Report Pilocytic/Juvenile astrocytomas; code the histology and behavior as 9421/3.

- ***Exception*****:** The behavior is non-malignant when the primary site is optic nerve (C723).

vii. Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high grade dysplasia is reportable. For neoplasms of the pancreas, the term MCN with high grade dysplasia replaces the term mucinous cystadenocarcinoma, non-invasive.

viii. Mature teratoma of the testes in adults is malignant and reportable as 9080/3.

ix. **Urine** cytology positive for malignancy is reportable for diagnoses in 2013 and forward.

- ***Exception*****:** When a subsequent biopsy of a urinary site is negative, do not report
- Code the primary site to C689 in the absence of any other information
- Do not implement new/additional casefinding methods to capture these cases
- Do **not** report cytology cases with ambiguous terminology

b. Do **not** report (Exceptions to reporting requirements).

i. **Skin** primary (C440-C449) with any of the following histologies.

- Malignant neoplasm (8000-8005)
- Epithelial carcinoma (8010-8046)
- Papillary and squamous cell carcinoma (8050-8084)
- Squamous intraepithelial neoplasia III (SIN III) (8077) of skin sites coded to C44_
- Basal cell carcinoma (8090-8110)

- ***Exception***: Basal cell carcinomas (histology codes 8090 – 8110) and squamous cell cancers (8050 – 8084) that originate in the following mucoepidermoid sites:

Cases That Must Be Reported to WCRS		
Site	ICD-O-3 Site Code	ICD-10 Code
Lip	C00.0-C00.9	C00.0 – C00.9
Anus	C21.0	C21.0
Vulva	C51.0-C51.9	C51.0 - C51.9
Vagina	C52.9	C52
Penis	C60.0- C60.9	C60.0 – C60.9
Scrotum	C63.2	C63.2

ii. **In situ** carcinoma of **cervix** (/2), any histology, cervical intraepithelial neoplasia (**CIN III**), or SIN III of the cervix (C530-C539).

- ***Note*:** Collection stopped effective with cases diagnosed 01/01/1996 and later. As of the 2018 data submission, cervical in situ cancer is no longer required for any diagnosis year. Sequence all cervix in situ cases in the 60-87 range regardless of diagnosis year.

iii. Prostatic intraepithelial neoplasia (PIN III) (C619).

- ***Note*:** Collection **stopped** effective with cases diagnosed 01/01/2001 and later.

4. **Benign/Non-Malignant Histologies**

a. Report **benign** and **borderline** primary **intracranial** and **central nervous system** (**CNS)** tumors with a behavior code of /0 or /1 in ICD-O-3 (effective with cases diagnosed 01/01/2004 to 12/31/2020) or ICD-O-3.2 (effective with cases diagnosed 01/01/2021 and later). See the table below for the specific sites.

i. ***Note 1:*** Benign and borderline tumors of the cranial bones (C410) are **not reportable**.

ii. ***Note 2:*** Benign and borderline tumors of the peripheral nerves (C47_) are **not reportable**.

b. Report **Pilocytic/Juvenile astrocytomas**; code the histology and behavior as 9421/3 when the primary site is C71_ .

i. ***Exception*:** The behavior is non-malignant when the primary site is optic nerve (C723).

c. **Neoplasm and tumor** are reportable terms for intracranial and CNS because they are listed in ICD-O-3.2 with behavior codes of /0 and /1.

i. **"Mass"** and "**lesion"** are **not** reportable terms for intracranial and CNS because they are **not** listed in ICD-O-3.2 with behavior codes of /0 or /1.

Documentation of Reportable Diagnoses

A reportable diagnosis made by a recognized medical practitioner may appear on a variety of medical documentation including but not limited to:

- Pathology report
- Cytology report
- Imaging report
- Discharge diagnosis
- History and physical
- Other parts of medical record
- Death certificate
- Autopsy Report

Clinically Diagnosed Cases

Cases diagnosed clinically are reportable. In the absence of a histologic or cytologic confirmation of a reportable neoplasm, accession a case based on the clinical diagnosis (when a recognized medical practitioner says the patient has a cancer, carcinoma, malignant neoplasm, or reportable neoplasm). A clinical diagnosis may be recorded in the discharge diagnosis on the face sheet or other parts of the medical record.

Note: A pathology report normally takes precedence over a clinical diagnosis. If the patient has a negative biopsy, the case would not be reported.

Exceptions

1. Patient receives treatment for cancer. Report the case.
    a. ***Note***: Standard treatments for cancer may be given for non-malignant conditions. Follow back with the physician to clarify if needed.
2. It has been six months or longer since the negative biopsy, and the physician continues to call this a reportable disease. Report the case.

Intracranial or CNS Neoplasms

An intracranial or a CNS neoplasm identified only by diagnostic imaging is reportable.

- **"Neoplasm"** and "**tumor"** are reportable terms for brain and CNS because they are listed in ICD-O-3 with behavior codes of /0 and /1.
- **"Mass"** and "**lesion"** are **not** reportable terms for brain and CNS because they are not listed in ICD-O-3 with behavior codes of /0 or /1.

Cytology

Cytology refers to the microscopic examination of cells in body fluids obtained from aspirations, washings, scrapings, and smears; usually a function of the pathology department.

IMPORTANT: Report cases with cytology diagnoses that are positive for malignant cells.

Urine cytology positive for malignancy is reportable. Code the primary site to C689 in the absence of any other information.

Do **not** report a case based ONLY on suspicious cytology. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended. Report the case when a reportable diagnosis is confirmed later. The date of diagnosis is the date of the later confirmation in this situation.

Note: "Suspicious cytology" means any cytology report diagnosis that uses an ambiguous term, including ambiguous terms that are listed as reportable in this manual.

Hematopoietic and Lymphoid Neoplasms

The Hematopoietic and Lymphoid Database is a tool to assist in screening for reportable cases and determining reportability requirements. The tool must be used to determine case reportability. See the Reportability Instructions in the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database.

When a Patient is seen by a Clinic and a Hospital

Ordinarily when a patient is seen by one or more freestanding clinics or physician offices and by one or more hospital, each facility will independently report the case. In each case, the date of initial diagnosis will be the same for each reporting facility. Here are some examples.

- If a patient is diagnosed by a freestanding clinic and sent to a hospital for treatment, the hospital will report the case. The clinic only needs to report the case if it also provided some definitive, first-course treatment.

- If a patient is diagnosed by a freestanding clinic and the patient is NOT referred to a Wisconsin hospital, the clinic must report the case even if the clinic does not treat the patient.

- If a clinic diagnoses a case, sends the patient to the hospital for surgery, but the clinic provides chemotherapy, radiotherapy or any non-surgical cancer-directed therapy before or following the surgery, both the clinic and the hospital will report the case. The criterion requiring clinic reporting is that it provided some of the first- course treatment.

- If a hospital 1) diagnosed a case OR 2) provided first-course treatment OR 3) saw the patient for a non-cancer issue BUT the medical record indicated the patient has active cancer, it must report the case. Any follow-up clinic visits are not reportable by the clinic unless it provides first-course treatment.

- If a hospital or clinic sees a patient with active disease that is metastases or a recurrence, the

original primary IS reportable under the conditions above if the original primary had not been reported by the facility when it was first diagnosed.

In many Wisconsin communities, larger health systems and hospitals routinely abstract cancer cases diagnosed or treated at their affiliated local freestanding clinics and physician offices (or those in geographic proximity) through a formal or informal arrangement with those facilities. This often occurs between facilities that share the same electronic health record system. The following situations apply:

- The facility having its cases reported routinely by another facility IS responsible for reporting any required cases not completed by the reporting facility.
- The reporting facility must report the first-course treatment provided by all facilities, not just the treatment provided at the reporting facility's location.
- The facilities must maintain accurate, current updates on these reporting agreements and send notification via email or fax to WCRS when first initiated or changes are made.

What to Report: Additional Hospital-Only Requirements

- All active primary cancers.
- Patients who die at your facility with active cancer, even if they were not diagnosed nor treated at your facility.
- Patients that received initial diagnosis and first-course therapy at another facility, but are now seen at your facility for diagnosis and/or treatment of recurrent or metastatic disease.

***Example 1*:** Patient was originally diagnosed with prostate cancer in 2006 at another facility and is admitted to your facility in 2015 with a questionable chest x-ray. A biopsy shows metastatic adenocarcinoma consistent with a prostate primary. This case is reportable. Report all information you have on the original prostate cancer diagnosis, staging and treatment.

Example 2: Patient with a history of breast cancer diagnosed and treated elsewhere five years ago is admitted to your facility's ER for a broken hip. The patient was not diagnosed with a recurrence or treated for her breast cancer during this admission. This case is not reportable.

Note: Report all available information regarding the original diagnosis, stage at diagnosis and the original first-course treatment, if available. Do not provide information on the recurrence or metastatic treatment.

What to Report: Additional Nonhospital-Only Requirements

- Patients treated at your facility
- Patients clinically diagnosed at your facility but not treated at your facility are only reportable when the patient is **not** referred to a Wisconsin hospital.

Note: For reportable cases which your facility did not diagnose and/or treat – WCRS is aware that

a facility may not have enough information to enter specific codes for treatment or staging besides 'unknown' or 'not available in chart' but could document additional information, as stated by physicians or otherwise noted in the chart, in appropriate text fields. These types of cases are required by central cancer registries. It is a 'catchment' requirement to cover instances when the facility diagnosing or treating the patient does not report the case as required.

Differences between Hospital and Nonhospital Reporting Requirements

Item	Hospital	Non-Hospital
Diagnosis Date	Diagnosed 1976 and forward	Required: 1992 and forward. Accepted: 1976 and forward
Coverage*	All patients for which a medical record is created regardless of residence (WCRS requires out of state cases to be reported)	Patients of clinics or physician offices whose records are not maintained with a hospital's inpatient records
Reportable Cases By Nature of Care	Diagnosed and/or treated by the hospital **-- or –** Admitted for ***any reason*** with ***active*** cancer (including diagnosis, treatment, palliative care, terminal care, care for noncancerous condition)	Clinic provided definitive, first-course cancer treatment **-- or –** Diagnosed at clinic but treatment **NOT** provided at clinic AND patient **NOT** referred to a Wisconsin hospital within 2 months following diagnosis

*Coverage maintains the emphasis on hospital reporting, and supplements hospital reports with clinic reports for the types of cancers only seen in an outpatient setting or the clinic first-course treatment not provided and/or reported by a hospital.

Cases Non-Reportable to WCRS

- Patients who have a history of cancer but no diagnosis or treatment at your facility.
- Records, slides or patients seen only in consultation to confirm a diagnosis where no chart is created in your facility. If a chart is created, it is reportable.
- Pathology cases that are consultative readings of slides submitted from outside facilities.
    - ***Exception***: If the outside facility is an out-of-state facility or pathology laboratory, the case is reportable.
- Metastatic sites or recurrences of a primary cancer that was already reported by your facility.
- Patients diagnosed before 1976.

Ambiguous Terminology

The contents of this section are adapted from the SEER Program Coding and Staging Manual. (Adamo, Groves, Dickie, & Ruhl, 2020)

Ambiguous terminology may originate in any source document, such as a pathology report, radiology report, or clinical report. The terms listed below are reportable when they are used with a term such as cancer, carcinoma, and sarcoma.

Reportable malignancies are stated by a recognized medical practitioner. The medical record usually presents the diagnosis clearly; however, physicians sometimes use vague or ambiguous terms to describe a tumor when its behavior is uncertain.

Cytology
Do **not** accession a case based ONLY on **suspicious** cytology. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended. Accession the case when a reportable diagnosis is confirmed later. The date of diagnosis is the date of the later confirmation in this situation.

Note: "Suspicious cytology" means any cytology report diagnosis that uses an ambiguous term, including ambiguous terms that are listed as reportable in this manual.

Cytology refers to the microscopic examination of cells in body fluids obtained from aspirations, washings, scrapings, and smears; usually a function of the pathology department.

IMPORTANT: Report cases with cytology diagnoses that are positive for malignant cells.

Urine cytology positive for malignancy is reportable. Code the primary site to C689 in the absence of any other information.

Ambiguous Terms for Reportability
***Note*:** Ambiguous terms not listed below are not reportable.

- Apparent(ly)
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Malignant appearing
- Most likely
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- Typical (of)

Report cases that use the words on the list or an equivalent word such as "favored" rather than "favor(s)." Do not substitute synonyms such as "supposed" for presumed or "equal" for comparable. Do not substitute "likely" for "most likely."

There may be ambiguous terms preceded by a modifier, such as "mildly" suspicious. In general, ignore modifiers or other adjectives and accept the reportable ambiguous term.

Ambiguous Terminology Lists: References of Last Resort

The first and foremost resource for the registrar for questionable cases is the physician who diagnosed and/or staged the tumor. The ideal way to approach abstracting situations when the medical record is not clear is to follow up with the physician. If the physician is not available, the medical record, and any other pertinent reports (e.g., pathology, etc.) should be read closely for the required information. The purpose of the Ambiguous Terminology lists is so that in the case where wording in the patient record is ambiguous with respect to reportability or tumor spread and no further information is available from any resource, registrars will make consistent decisions. When there is a clear statement of malignancy or tumor spread (i.e., the registrar can determine malignancy or tumor spread from the resources available), they should not refer to the Ambiguous Terminology lists. Registrars should only rely on these lists when the situation is not clear and the case cannot be discussed with the appropriate physician/pathologist.

Note: Refer to *How to Use Ambiguous Terminology for Case Ascertainment* in the SEER Program Coding and Staging Manual.

Additional Ambiguous Terminology Guidelines for Hematopoietic and Lymphoid Neoplasms

- Do not report the case when biopsy or physician's statement confirms a non-reportable condition or proves the ambiguous diagnosis is wrong.
    - ***Example***: CT scan shows enlarged lymph nodes suspicious for lymphoma. Subsequent biopsies of the lymph nodes thought to be involved with a neoplasm are negative for malignancy. Do not report the case. The pathology is more reliable than the scan; the negative biopsy proves that the ambiguous diagnosis was wrong.
- Do not report cases diagnosed only by ambiguous cytology (cytology diagnosis preceded by ambiguous term).
    - ***Example***: Parotid ultrasound guided FNA states "consistent with non-Hodgkin's lymphoma." Case diagnosed based on cytology/fine needle aspiration (FNA) preceded by ambiguous terminology (consistent with). Do not report this case based on ambiguous cytology.
- Report the case when the patient is treated for a reportable neoplasm.
    - ***Note 1:*** Report the case even if the diagnostic tests are inconclusive, equivocal, or negative.
    - ***Note 2***: For treatment information see the National Cancer Institute's Physicians' Data Query (PDQ) website at: http://www.cancer.gov/cancertopics/pdq or the SEER*Rx Antineoplastic Drugs Database
- Report the case when a reportable diagnosis appears in any text or report described as a Definitive Diagnostic Method in the Hematopoietic database. Search the Hematopoietic Database to determine case reportability.
    - ***Note***: Definitive diagnostic methods differ depending upon the histology. See the Hematopoietic Database for details: https://seer.cancer.gov/seertools/hemelymph

Casefinding Techniques

The contents of this section are adapted from the SEER Program Coding and Staging Manual. (Adamo, Groves, Dickie, & Ruhl, 2020)

Casefinding (case ascertainment) is the process of identifying all reportable cases through review of source documents and case listings. Casefinding covers a range of cases that need to be assessed to determine whether or not they are reportable.

IMPORTANT: A casefinding list is not the same as a reportable list. Casefinding lists are intended for searching a variety of cases so you don't miss any reportable cases.

WCRS requires casefinding for the Comprehensive ICD-10-CM Casefinding Code list for Reportable Tumors. WCRS recommends that facilities review cases from the Supplemental list ICD-10-CM. Casefinding Code lists in pdf and Excel format are located on the SEER website: https://seer.cancer.gov/tools/casefinding/

Use the casefinding lists to screen prospective cases and identify cases for inclusion in theregistry. Include all casefinding sources when searching for reportable cases.

Casefinding Sources:

- Inpatient/Outpatient Admission/Discharge Documents
- Pathology/Cytology Pathology Reports
- Surgery Logs/Schedules
- Radiology
- Nuclear Medicine
- Radiation Therapy Logs
- Chemotherapy Outpatient Logs
- Emergency Room Records
- Autopsy Reports
- Pain Clinic Logs

It is essential to include review of the disease index, which is usually provided by Health Information Management (HIM) or Medical Records Departments. Other tracking tools such as medical and radiation oncology clinic logs help ensure that all reportable cases are identified.

It is advisable to form an alliance with staff from HIM, radiation oncology and pathology departments to develop a systematic method to receive necessary information from them.

IMPORTANT: Never rely solely on the pathology department to provide reportable cases. Doing so excludes cases that the facility has no diagnostic tissue reports. Cases diagnosed elsewhere but treated at your facility and those diagnosed radiographically or clinically, without tissue confirmation would be missed during casefinding.

Modification Records

The change/correction procedure ensures that the most accurate information is available to users by enabling reporting facilities to provide updated or corrected information to WCRS after the original case has been transmitted. The information originally collected on the abstract should be changed or modified under the following circumstances:

- To correct coding or abstracting errors (for example, errors found during quality control activities).
- When clarifications or rule changes retroactively affect data item code.
- When better information is available later.
- When the date of diagnosis is confirmed in retrospect to be earlier than the original date abstracted.

  Example 1*:* Consults from specialty labs, pathology report addenda or comments or other information have been added to the chart after the registrar abstracted the information may contain valuable information. Whenever these later reports give better information about the histology, grade of tumor, primary site, etc., change the codes to reflect the better information.

  Example 2**:** At the time a case was reported to WCRS, the primary site was *unknown*. On a subsequent admission several months later, the primary site was documented as upper lobe of the left lung. **Submit an update** to revise the primary site, laterality and any information that may have become available.

Submission of Modification Records

- Changes to specific reporting fields below should be submitted to WCRS.
  - Name
  - Address at diagnosis
  - Race/Ethnicity
  - Sex
  - Birthdate
  - Social Security number
  - Date of diagnosis
  - Primary site or Laterality
  - Morphology, behavior, grade
  - Diagnostic confirmation
  - Summary Stage
  - Type and date of first course definitive treatment
- Do not submit changes as a regular new report.
- Use the ‘M’ NAACCR electronic record layout.
  - Contact your vendor for specific instructions on submitting changes using the M layout.

Determining Multiple Primaries

Now that you have learned how to determine if a case is reportable, you must next determine if the case is a single or a multiple primary. Use the 2018 Solid Tumor coding rules to determine the number of primaries to abstract and the histology to code for cases diagnosed January 1, 2018 and forward.

The 2007 Multiple Primary and Histology (MPH) Coding Rules have been revised and are now referred to as 2018 Solid Tumor Rules. The 2007 Multiple Primary and Histology Coding Rules were developed to promote consistent and standardized coding by cancer registrars and the 2018 Solid Tumor Rules continue to provide coding instructions to ensure accurate data collection.

IMPORTANT: For complete Solid Tumor Rules see: https://seer.cancer.gov/tools/solidtumor/.
To determine multiple primaries for hematopoietic cancers such as lymphoma and leukemia,use the hematopoietic website at: https://seer.cancer.gov/seertools/hemelymph/

Solid Tumors

- Apply the general instructions and site-specific instructions for determining multiple primaries in the current Solid Tumor Rules.
- Apply the site-specific multiple primary rules in the current Solid Tumor Rules.

The General rules do not apply to hematopoietic primaries (lymphoma and leukemia) of any site or to the reportable benign or borderline intracranial or CNS tumors. The head and neck, colon, rectosigmoid and rectum, breast, kidney, urinary sites, and malignant CNS and peripheral nerves rules exclude lymphoma and leukemia (M9590-M9993) and Kaposi sarcoma (M9140). All other sites rules exclude lymphoma and leukemia (M9590-M9993).

Hematopoietic and Lymphoid Neoplasms

Updates to the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database have been made for 2021 cases. The updates reflect changes based on ICD-O-3.2. Apply the Multiple Primary Rules in the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database.

Transplants

Transplanted organs or tissue may originate from

a. Organs or tissue from the patient's own body (called autograft) or
b. Another human donor (homograft or allograft)

Accession a new primary in the transplanted organ as you would any new primary, applying the current Solid Tumor Rules. Code the primary site to the location of the transplanted organ, i.e., code the malignancy where it resides/lies.

Multiple Primaries and Histologies for Solid Tumors

The contents of this section are adapted from the Solid Tumor Rules (Dickie, Johnson, Adams, & Negoita, 2020)

2018 Solid Tumor Rules - What You Need to Know

(Excludes lymphoma and leukemia M9590 – M9992)

IMPORTANT: There are specific instructions preceding each set of histology rules that define terms which may be used to code histology as well as terms which may not be used to code histology. These changes are in accordance with current WHO and CAP guidelines.

Eight site groups have been revised for 2018. The 2018 General Instructions apply to the revised sites listed below:

- Head & Neck
- Colon (includes rectosigmoid and rectum for cases diagnosed 1/1/2018 forward)
- Lung
- Breast
- Kidney
- Urinary sites
- Non-malignant CNS
- Malignant CNS and Peripheral Nerves

One site group has been updated for 2021. For cases diagnosed January 1, 2021 and later, the 2018 General Instructions apply to the following revised site listed below:

- Cutaneous Melanoma (Published November 2020)

The 2007 Multiple Primary & Histology rules and the 2007 General Instructions are to be used for cases diagnosed 1/1/2007 to 12/31/2021 for the following site group:

- Other Sites
    - Primary sites excluded are:
        - Rectosigmoid and rectum which are included in 2018 Colon rules
        - Peripheral nerves which are included in 2018 Malignant Brain rules
    - Other Sites rules will be revised for 2021 to 2022 implementation. The Solid Tumor Task Force has identified the need to expand the rules to include GYN, soft tissue, thyroid as well as other site-specific solid tumors.

General Equivalent or Equal Terms

The contents of this section are adapted from the Solid Tumor Rules (Dickie, Johnson, Adams, & Negoita, 2020)

These terms can be used interchangeably:

- And; with
    - Note: “And” and “with” are used as synonyms when describing multiple histologies within a single tumor.
- Adenocarcinoma; glandular carcinoma; carcinoma
- De novo; new tumor; frank (obsolete term)
- Multicentric; multifocal
- Simultaneous; synchronous; at the same time; prior to first course treatment
- Topography; site code
- Tumor; mass; tumor mass; lesion; neoplasm; nodule
    - The terms tumor, mass, tumor mass, lesion, neoplasm and nodule 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
- Type; subtype; variant

General Instructions: How to Use the Solid Tumor Rules

The contents of this section are adapted from the Solid Tumor Rules (Dickie, Johnson, Adams, & Negoita, 2020)

Note: The rules do not apply to hematopoietic primaries (lymphoma and leukemia) of any site. Use the Hematopoietic & Lymphoid Neoplasm Coding Manual and Database for histologies M9590-M9992.

1. The **purpose** of these rules is to determine **multiple primaries** and to code **histology ONLY**. The Solid Tumor Rules are **not used** to determine case reportability, casefinding, stage, or tumor grade. For instructions on coding grade, stage, SSDIs, and treatment, please refer to the appropriate manuals.

2. Staging systems are **not used** to determine the number of primaries or histology.

3. Use the following site-specific rules for tumors diagnosed 1/1/2018 and forward:

    a. Malignant CNS and Peripheral Nerves
    b. Non-Malignant CNS
    c. Breast
    d. Colon
    e. Head and neck
    f. Kidney
    g. Lung
    h. Urinary sites

4. Use the following site-specific rules for tumors diagnosed 1/1/2021 forward:
    a. Cutaneous Melanoma
5. Use the following site-specific rules for tumors diagnosed 1/1/2007 through 12/31/2021:
    a. Other Sites (not updated for 2018) for solid tumors which occur in primary sites not covered by the site-specific rules.
6. 2007 MPH Rules. 2018 Solid Tumor Rules, and 2021 Cutaneous Melanoma rules are used based on **date of diagnosis**. See the site-specific rules for instruction on which rules to use.
    a. Tumors diagnosed 01/01/2007 through 12/31/2017: Use 2007 MPH Rules.
    b. Tumors diagnosed 01/01/2018 and later: Use 2018 Solid Tumor Rules (with exceptions in #4).
    c. An 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.
    d. A melanoma diagnosed before 1/1/2021 and a subsequent melanoma diagnosed 1/1/2021 or later: Use the 2021 Cutaneous Melanoma Rules.
7. Use the Solid Tumor Rules in the following order:
    a. For multiple tumors, you must decide whether they are a single or multiple primaries:
        i. Use the Histology Rules to assign a “working” histology for each tumor.
        ii. Use Multiple Primary Rules to determine whether the tumors are a single primary or multiple primaries.
        iii. If a single primary, follow the priority order in #7B.
        iv. If multiple primaries, follow the priority order in #7B for **EACH** of the separate tumors/primaries.
    b. For a single tumor or multiple tumors determined to be a single primary:
        i. General Instructions
        ii. Equivalent Terms and Definitions
        iii. Multiple Primary Rules
        iv. Histology Rules
8. The Solid Tumor Rules are available in text format.
9. ***Note*****s** and ***examples*** are included with some of the rules to highlight key points or to add clarity to the rules.

Note: Rules are in **hierarchical** order within each module. Use the first rule that applies and **STOP.**

General Instructions: How to Use the Multiple Primaries Rules

The contents of this section are adapted from the Solid Tumor Rules (Dickie, Johnson, Adams, & Negoita, 2020)

Note: Multiple Primary Rules do NOT apply to tumors described as metastases.

Each Multiple Primary Rule section begins with a note that reads, “These rules are NOT used for tumor(s) described as metastases.” This means that a tumor in a metastatic site is not counted when deciding which module to use in the Multiple Primary Rules (Unknown if Single or Multiple Tumors, Single Tumor or Multiple Tumors).

1. To choose the appropriate module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors), determine the **number of tumors**.
    a. Do not count **metastatic** lesions when determining which module to use.
    b. When the number of tumors is **unknown/not documented**, use the “Unknown if Single or Multiple Tumors” module.
        i. When there is a tumor or tumors with separate microscopic foci, ignore the microscopic foci.
    c. When the patient has a **single tumor**, use the “Single Tumor” module.
    d. When the patient has **multiple tumors**, use the “Multiple Tumors” module.
2. When the rules return a **single** primary, prepare one abstract.
3. When the rules return **multiple** primaries, prepare two or more abstracts.
4. For those sites/histologies which have recognized **biomarkers**, the biomarkers frequently identify the histologic type. Currently, there are clinical trials being conducted to determine whether these biomarkers can be used to identify multiple primaries. Follow the Multiple Primary Rules; do not code multiple primaries based on biomarkers.
5. Do not use physician staging to determine multiple primaries.

General Instructions: Timing Rules

The contents of this section are adapted from the Solid Tumor Rules (Dickie, Johnson, Adams, & Negoita, 2020)

Each Solid Tumor site group includes timing rules in the Multiple Primary Rules. It is important to remember that timing rules differ by site. Examples of timing rules include:

- Abstract **multiple primaries** when the patient has a subsequent tumor after being **clinically disease-free** for **greater than X years** after the original diagnosis or last recurrence.
- Abstract a **single primary** (the invasive) when an **invasive** tumor is diagnosed **less than or equal to 60** days **after** an **in-situ** tumor.

One year = 365 days
***Example*:** A tumor diagnosed 1/1/2018 and second tumor diagnosed 1/1/2019 occur exactly one year apart.

Less than one year = Less than 365 days

More than one year = 366 days or more
***Example*:** A tumor diagnosed 1/1/2018 and second tumor diagnosed 1/2/2019 occur more than one year apart.

- **Clinically disease-free** means that there was **no evidence** of recurrence on follow-up.
- When there is a recurrence less than or equal to X years 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 X years from the date of the last recurrence.
- When it is **unknown/not documented** whether the patient had a recurrence, default to **date of diagnosis** to compute the time interval.
- Use the Multiple Primary Rules as written to determine whether a subsequent tumor is a new primary or a recurrence. The **ONLY *Exception*** is when a **pathologist compares slides** from the subsequent tumor to the "original" tumor and documents the subsequent tumor is a recurrence of the previous primary. Never code multiple primaries based only on a physician's statement of "recurrence" or "recurrent".
- No evidence of disease (NED) means complete response to treatment.

General Instructions: Histologic Type ICD-O-3

The contents of this section are adapted from the Solid Tumor Rules (Dickie, Johnson, Adams, & Negoita, 2020)

The data item Histologic Type ICD-O-3 describes the microscopic composition of cells and/or tissue for a specific primary. The tumor type or histology is a basis for staging and determination of treatment options. Histology affects treatment decisions, prognosis and course of the disease.

The *International Classification of Diseases for Oncology*, Third Edition (ICD-O-3) is the standard reference for histology codes for tumors diagnosed in 2001 and later. See sections *Coding Guidelines for Topography and Morphology* and *Summary of Principal Rules for Using the ICD-O*, Third Edition for guidance in using the ICD-O-3.

Important Information for Coding Histologic Type for Cases Diagnosed 1/1/2018 Forward

The North American Association of Central Registries (NAACCR) have released the 2018 Guidelines for ICD-O-3 Histology Code and Behavior Update effective for cases diagnosed 1/1/2018 forward and 2021 Guidelines for ICD-O-3 Histology Code and Behavior Update effective for cases diagnosed 1/1/2021 forward.

The updates include:

- New ICD-O codes
- Changes in behaviors for existing ICD-O codes
- New preferred terminology

The Solid Tumor Editors recommend coding histology using:

- The 2018 Solid Tumor Rules
- The 2021 Cutaneous Melanoma Solid Tumor Rules
- Updated ICD-O histology codes and terms which can be found at: https://seer.cancer.gov/icd-o-3/
- The ICD-O-3.2

When a histology code cannot be identified using the above recommendations, submit a question to Ask a SEER Registrar.

General Instructions: How to Use the Histology Rules

The contents of this section are adapted from the Solid Tumor Rules (Dickie, Johnson, Adams, & Negoita, 2020)

***Note 1*: Do not use these rules to determine case reportability**.

***Note 2*:** Refer to the How to Use the Solid Tumor Rules for instructions on the order in which to use the rules.

1. Rules are divided into two sections: Single Tumor and Multiple Tumors Abstracted as a Single Primary.
    - Each section is a complete set of rules.
    - Within each section, the rules are hierarchical. Use the first rule that applies and **STOP**. Do not continue through the rules.
2. Code the histology diagnosis prior to **neoadjuvant** therapy. Neoadjuvant therapy can change the histological profile of the tumor. **See site-specific modules for *Exception*s to this rule.**
3. Code the histology assigned by the physician. **Do not change histology** in order to make the case applicable for **staging**.
4. A list of terms which can be used and terms which cannot be used to code histology precede each set of histology rules.
5. Code a histology when described by ambiguous terminology **ONLY** when:
    - Histology is clinically confirmed by a physician (attending, pathologist, oncologist, etc.)
    - Patient is treated for the histology described by an ambiguous term
    - Case is accessioned (added to your database) based on a single histology described by ambiguous terminology and no other histology information is available/documented
    - ***Note***: If the histology described by ambiguous terminology does not meet any of the criteria in bullets 1, 2, or 3, **DO NOT CODE** the histology.

Ambiguous Terminology for Solid Tumor Histology

IMPORTANT: Ambiguous terminology to determine histology for Solid Tumor Rules is NOT the same as ambiguous terminology used to determine reportability.

- Apparently
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Malignant appearing
- Most likely
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- Typical (of)

General Instructions: Priority Order for Using Documentation to Code Histology

The contents of this section are adapted from the Solid Tumor Rules (Dickie, Johnson, Adams, & Negoita, 2020)

For each site, priorities include tissue/histology, cytology, radiography/scans, and physician diagnoses, and biomarkers. **You must use the priority order that precedes the histology rules for each site.**

- Priority order will differ by site. Tissue pathology (and/or biomarkers, if applicable) always takes precedence.
- The specific types of radiography/scans also differ by site.

Which document to use when there is conflicting information between the final diagnosis, synoptic report, or CAP protocol:

When there are discrepancies between the final diagnosis and synoptic report, use the document that provides the more specific histology. This will likely be found in the synoptic report. The CAP Protocol should be used only when a final diagnosis or synoptic report are not available. Definitions for CAP Protocol, final diagnosis, and synoptic report can be found in the Definitions section of the SEER Coding and Staging Manual 2021.

Multiple Primary and Histology for Hematopoietic and Lymphoid Neoplasms

The SEER Hematopoietic Project site provides data collection rules for hematopoietic and lymphoid neoplasms for 2010+. There are two tools for use with these rules:

1. Hematopoietic & Lymphoid Neoplasm Database (Heme DB)
    a. A tool to assist in screening for reportable cases and determining reportability requirements.
    b. The database contains abstracting and coding information for all hematopoietic and lymphoid neoplasm (9590/3-9992/3).
2. Hematopoietic & Lymphoid Neoplasm Coding Manual
    a. Reportability instructions and rules for determining the number of primaries, the primary site and histology, and the cell lineage or phenotype.

These rules are for cancer registries and are not followed by physicians. Follow the rules stated in the manual and abstract the number of primaries based on the rules. This may, or may not, agree with what the physician indicates in the patient record. However, physician interpretation can sometimes factor into determining reportability, diagnostic confirmation, or primary site; this is addressed in the specific coding instructions for those sections.

Note: For lymphomas, leukemia and other hematopoietic malignancies, primary site and timing are not applicable for determining single or multiple primaries – histology becomes the determining factor.

Steps in Priority Order for Using the Hematopoietic and Lymphoid Neoplasm Database and Coding Manual

The contents of this section are adapted from the Hematopoietic and Lymphoid Neoplasm Coding Manual (Ruhl, Adamo, Dickie, & Negoita, 2020).

Follow each step in the order listed

1. Identify the working (preliminary) **histology code(s)**
    a. Search the Heme DB using any of the methods below
        i. Search using a **unique word** in the diagnosis; for example, “precursor” if the diagnosis is precursor acute lymphoblastic leukemia
            1. Avoid searching on general terms such as “leukemia” or “lymphoma.” This type of search will return too many results.
        ii. Search on the **complete name** (diagnosis). For example, “acute myelomonocytic leukemia”. Two different results will appear:

1. 107 neoplasms match any term. The words may appear in any part of the entry (alternate names, abstractor notes, transformations, etc.)

2. 10 neoplasms match all terms. This is when all three words occur together

iii. You can also search on **abbreviations** such as AMML for acute myelomonocytic leukemia, DLBCL for diffuse large B-cell lymphoma, or AML for acute myeloid leukemia.

b. "Show Alternate Names": This box appears under the Search box. If this box is checked, the results will include an additional column that shows where alternate names include the words being search.

c. Search on histology code if desired, i.e., 9867/3.

d. When multiple results are displayed, click on the desired term (e.g. acute myelomonocytic leukemia) to display the record.

Examples of Searches		
Search	**Example**	**Notes**
Unique word in diagnosis	"precursor"	If diagnosis is precursor acute lymphoblastic leukemia
Complete name (diagnosis)	"acute myelomonocytic leukemia"	The number of matched terms will be much smaller than just searching on "leukemia". Results displayed will have all three words in the histology name. The words may appear inany part of the entry (alternative names, abstractor notes, transformations, etc.
Abbreviations	AMML	Acute myelomonocytic leukemia
Histology code	9867/3	Code search display's: Acute myelomonocyticleukemia

2. Use the Multiple Primary Rules to determine the number **of primaries** using the working histology code(s).

   a. Start with rule M1, move through the rules in consecutive order and stop at the first rule that applies. The M rule references in the Heme DB are to be used as a guide only.

   b. Use the Hematopoietic Multiple Primaries Calculator in the Heme DB **only** when instructed by the rules in the Hematopoietic Manual.

3. Verify or revise the working histology code(s) using the Primary Site and Histology (PH) Rules.

   a. When the PH rules lead you to a different histology code, enter that code in the Heme DB search box and display the record for that histology.

   b. The PH rules referenced in the Heme DB are the most common rule(s) used to code Primary Site and Histology for the selected histology. More than one Module/PH Rule may be needed to code Primary Site and Histology.

4. Determine **primary site using the Primary Site and Histology Rules in the Hematopoietic and Lymphoid Neoplasm Coding Manual**

    a. See Primary Site Coding Instructions.

    b. For certain histologies, only one primary site code is displayed in the Heme DB.

        i. The primary site code displayed under **Primary Site(s)** is the **only** site code to be used for that histology.

        ii. All leukemia, myelodysplastic syndromes and chronic myeloproliferative diseases are assigned primary site bone marrow C421. There are no exceptions. This rule was implemented in ICD-O-2 in 1992.

    c. When there is no primary site code listed under **Primary Site(s)** in the Heme DB

        i. Review the **Primary Site Text** field for common primary sites or other primary site instructions and rules.

        ii. Search the Hematopoietic Manual and/or database to find applicable modules.

        iii. Read the **Abstractor Notes** to find other information regarding sites of involvement for stages II, III, and IV lymphomas. Use the **Abstractor Notes** to confirm that the **site/histology combination indicated by the involvement documented in the medical record is probable**. You may also seek a physician's help in determining the primary site.

    ***Note*:** The PH rules in the manual are organized in Modules

    - Use Modules 1-9 (PH1-PH31) to help determine primary site and histology.
    - Modules 1-6 are histology specific.
    - Module 7: All lymphomas, extraosseous plasmacytomas, histiocytic and dendritic cell neoplasms, mast cell sarcoma, heavy chain disease, myeloid sarcoma and post-transplant lymphoproliferative disease (PTLD).
    - Module 8: All hematopoietic neoplasms (NOS and more specified histologies).
    - Module 9: All hematopoietic neoplasms.

5. Determine the grade **(applicable only for cases diagnosed 2010-2017)**

    Note: *Grade is no longer collected for cases diagnosed 1/1/2018 and forward.*

    a. See the Grade field in the Heme DB
    b. See the Grade rules in the manual when grade cannot be coded using the Heme DB

IMPORTANT: For cases with histologies 9590/3-9992/3, the clinical and pathological grade must be coded the "not applicable" grade (code 8), while Post Therapy Clin (yc) and Post Therapy Path (yp) should default to blank. ***Exception***: Grade is still coded for Lymphoma Ocular Adnexa cases diagnosed in any year.

First Course of Therapy

Treatment or therapy for cancer should modify, control, remove, or destroy cancer tissue (cancer-directed treatment). Therapy can be used to treat cancer tissue in a primary or metastatic site(s), regardless of the patient's response to that treatment. The first course of therapy should include all cancer-directed treatments indicated in the initial treatment plan and delivered to the patient after the initial diagnosis of cancer. Multiple modalities of treatment may be included, and therapy may include regimens of a year or more. WCRS requires facilities to report the first course therapy/ treatment provided at that facility or any other facility if the information is available in the medical chart.

The treatment plan specifies the types of cancer-directed therapies proposed to eliminate or control the patient's disease. Treatment intentions may be found in discharge summaries, consultations, and outpatient records. All cancer-directed therapies (surgery, radiation, chemotherapy, hormone therapy, immunotherapy, transplant/endocrine or other therapy) documented in the physician treatment plan and administered are considered first-course therapy.

***Note 1*:** Make sure you enter first-course treatment only in the standard software treatment fields. Do not report subsequent treatment (for a class 32, as an example) in those fields. Subsequent treatment can be 1) recorded in the treatment text fields or 2) entered in specific second course treatment fields that your software vendor may make available to you. (WCRS Abstract Plus software does not have any subsequent or second- course treatment fields.)

***Note 2*:** Surgical diagnostic and staging procedures such as biopsies, thoracentesis, and bypasses do not modify or destroy cancer cells. Surgical procedures that aspirate, biopsy or remove regional lymph nodes to diagnose and/or stage disease are to be entered in Scope of Regional Lymph Node Surgery, not in the Primary Site Surgery field.

Note 3: No treatment: No treatment is considered a treatment option and may represent the first course of therapy. Reason for no treatment should be entered in the appropriate treatment field.

If there is no treatment plan and:

a. No other treatment guidelines are established, evaluate the therapy and the time it began in relation to the diagnosis date. If the therapy is a part of an established protocol or within accepted guidelines for the disease, consider it part of the first course of therapy.

b. No established protocol or management guidelines are established, and not physician counsel is available, use the following principle: Initial treatment must begin within four months of the date of the initial diagnosis.

Site-specific surgery codes are available in the Standards for Oncology Registry Entry (STORE) manual, Appendix A:
https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/store_manual_2021.ashx

The SEER RX web site contains drug classifications by specific treatment category (hormone, chemotherapy, etc.): https://seer.cancer.gov/seertools/seerrx/.

First Course of Therapy for Solid Tumors

The contents of this section are adapted from the SEER Program Coding and Staging Manual (Adamo, Groves, Dickie, & Ruhl, 2020)

Note: **First course of therapy:** All treatments administered to the patient after the original diagnosis of cancer in an attempt to destroy or modify the cancer tissue.

Definitions

Active surveillance: A treatment plan that involves closely watching a patient's condition but not giving any treatment unless there are changes in test results that show the condition is getting worse. Active surveillance may be used to avoid or delay the need for treatments such as radiation therapy or surgery, which can cause side effects or other problems.

Concurrent therapy: A treatment that is given at the same time as another.

- ***Example***: Chemotherapy and radiation therapy

Hospice: A program that provides special care for people who are near the end of life and for their families, either at home, in freestanding facilities, or within hospitals. Hospice care may include treatment that destroys or modifies cancer tissue. If performed as part of the first course, treatment that destroys or modifies cancer tissue is collected when given in a hospice setting. "Hospice, NOS" is not specific enough to be included as first course treatment.

Neoadjuvant therapy: Systemic therapy or radiation therapy given prior to surgery to shrink the tumor.

Palliative treatment: The World Health Organization describes palliative care as treatment that improves the quality of life by preventing or relieving suffering.

- ***Note 1*:** Palliative therapy **is part of the first course of therapy only when it destroys or modifies cancer tissue.**
- ***Example*:** The patient was diagnosed with stage IV cancer of the prostate with painful bone metastases. The patient starts radiation treatment intended to shrink the tumor in the bone and relieve the intense pain. The radiation treatments are palliative because they relieve the bone pain; the radiation is also first course of therapy because it destroys proliferating cancer tissue.
- ***Note 2*:** Procedures performed to palliate or alleviate symptoms may include surgery, radiation, systemic therapy and/or other pain management therapy; types of therapy that can also be considered first–course, cancer-directed treatment in other situations. If the therapy is used for palliative purposes only, the palliative treatment itself is **NOT** reportable to WCRS (but the case still is reportable - refer to Chapter 1 for rules on reportable case determination.

Watchful waiting: Closely watching a patient's condition but not giving treatment unless symptoms appear or change. Watchful waiting is sometimes used in conditions that progress slowly. It is also used when the risks of treatment are greater than the possible benefits. During watchful waiting, patients may be given certain tests and exams.

Treatment Timing

The contents of this section are adapted from the SEER Program Coding and Staging Manual (Adamo, Groves, Dickie, & Ruhl, 2020)

Use the following instructions **in hierarchical order**

1. Use the **documented** first course of therapy (treatment plan) from the medical record. First course of therapy ends when the treatment plan is **completed** no matter how long it takes to complete the plan unless there is documentation of disease progression, recurrence, or treatment failure (see #2 below).

    a. ***Example:*** Hormonal therapy (e.g., Tamoxifen) after surgery, radiation, and chemotherapy. First course ends when hormonal therapy is completed, even if this takes years, unless there is documentation of disease progression, recurrence, or treatment failure (see #2 below).

2. First course of therapy ends when there is documentation of **disease progression, recurrence, or treatment failure**.

    a. ***Example 1:*** The documented treatment plan for sarcoma is pre-operative (neoadjuvant) chemotherapy, followed by surgery, then radiation or chemotherapy depending upon the pathology from surgery. Scans show the tumor is not regressing after pre-operative chemotherapy. Plans for surgery are cancelled, radiation was not administered, and a different type of chemotherapy is started. Code only the first chemotherapy as first course. Do **not** code the second chemotherapy as first course because it is administered after documented treatment failure.

    b. ***Example 2:*** The documented treatment plan for a patient with locally advanced breast cancer includes mastectomy, chemotherapy, radiation to the chest wall and axilla, and hormone therapy. The patient has the mastectomy and completes chemotherapy. During the course of radiation therapy, the liver enzymes are rising. Workup proves liver metastases. The physician stops the radiation and does not continue with hormone therapy (the treatment plan is altered). The patient is placed on a clinical trial to receive Herceptin for metastatic breast cancer. Code the mastectomy, chemotherapy, and radiation as first course of treatment. Do not code the Herceptin as first course of therapy because it is administered after documented disease progression.

3. When there is **no documentation** of a treatment plan or progression, recurrence or a treatment failure, first course of therapy ends one year after the date of diagnosis. **Any treatment given after one year is second course of therapy in the absence of a documented treatment plan or a standard of treatment**.

Coding Instructions

The contents of this section are adapted from the SEER Program Coding and Staging Manual (Adamo, Groves, Dickie, & Ruhl, 2020)

1. Code all treatment data items to 0 or 00 (Not done) when the physician opts for **active surveillance, deferred therapy, expectant management, or watchful waiting.** When the disease progresses or the patient becomes symptomatic, any prescribed treatment is second course.
    a. Code Treatment Status (RX Summ--Treatment Status) to 2
2. Code the treatment as first course of therapy if the patient refuses treatment but changes his/her mind and **the prescribed treatment is implemented less than one year** from the date of diagnosis, AND there is no evidence of disease progression.
3. The first course of therapy is **no treatmen**t when the patient **refuses** all treatment. Code all treatment data items to Refused.
    a. Keep the refused codes even if the patient later changes his/her mind and decides to have the prescribed treatment.
        i. more than one year after diagnosis, or
        ii. when there is evidence of disease progression before treatment is implemented
4. Code all treatment that was started and administered, whether completed or not. Document treatment discontinuation in text fields.
    a. ***Example:*** The patient completed only the first dose of a planned 30-day chemotherapy regimen. Code chemotherapy as administered.
5. Code the treatment on each abstract when a patient has multiple primaries and the treatment given for one primary also affects/treats another primary.
    a. ***Example 1:*** The patient had prostate and bladder cancer. The bladder cancer was treated with a TURB. The prostate cancer was treated with radiation to the prostate and pelvis. The pelvic radiation includes the regional lymph nodes for the bladder. Code the radiation as treatment for both the bladder and prostate cases.
    b. ***Example 2:*** The patient had a hysterectomy for ovarian cancer. The pathology report reveals a previously unsuspected microinvasive cancer of the cervix. Code the hysterectomy as surgical treatment for both the ovarian and cervix primaries.
6. Code the treatments only for the site that is affected when a patient has multiple primaries and the treatment affects only one of the primaries.
    a. ***Example:*** The patient has colon and tonsil primaries. The colon cancer is treated with a hemicolectomy and the tonsil primary is treated with radiation to the tonsil and regional nodes. Do not code the radiation for the colon. Do not code the hemicolectomy for the tonsil.

7. Code the treatment given as first course even if the correct primary is identified later when a patient is diagnosed with an unknown primary.

    a. ***Example:*** The patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Code the chemotherapy as first course of treatment.

        i. Do not code treatment as first course when it is added to the plan after the primary site is discovered. This is a change in the treatment plan.

        ii. ***Example:*** The patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Hormonal treatment is started. Code the chemotherapy as first course of treatment. The hormone therapy is second course because it was not part of the initial treatment plan.

For information regarding first course of therapy for hematopoietic and lymphoid neoplasms, refer to the NCI SEER Hematopoietic and Lymphoid Neoplasm Coding Manual.

First Course of Therapy for Hematopoietic and Lymphoid Neoplasms

The contents of this section are adapted from the Hematopoietic and Lymphoid Neoplasm Coding Manual (Ruhl, Adamo, Dickie, & Negoita, 2020).

Some treatments for reportable hematopoietic diseases, such as transfusions, phlebotomy, and aspirin administration, do not meet the usual standard criteria for and definition of definitive treatment. Please refer to the SEER Hematopoietic and Lymphoid Neoplasm Database to look up the appropriate reportable treatments for these diseases. The website lists the standard treatments on each disease page: https://seer.cancer.gov/seertools/hemelymph/.

Treatment varies by the type of hematopoietic neoplasm. Lymphomas can be treated with surgery (extranodal or nodal), chemotherapy, and radiation, while leukemias are often treated with chemotherapy and bone marrow transplants. In addition, immunotherapy (biologic response modifiers) and hormones are frequently used to treat hematopoietic neoplasms. Also, for many of these diseases, the principal treatment is either supportive care, observation, or another type of treatment that does not meet the usual definition of treatment that "modifies, controls, removes or destroys proliferating cancer tissue."

Coding Instructions

1. When there is only one neoplasm (one primary), use the documented first course of therapy (treatment plan) from the medical record. First course of therapy ends when the treatment plan is completed, no matter how long it takes to complete the plan.

2. Chronic neoplasm followed by an acute neoplasm.

    a. The presence/absence of treatment DOES NOT affect the number of primaries when a chronic neoplasm transforms to an acute neoplasm.

    b. ***Example:*** Patient diagnosed in 2000 with follicular lymphoma. Patient refused treatment. Patient returns in 2014 with DLBCL. Abstract the DLBCL as a second primary even though there was no treatment for the follicular lymphoma.

    c. First course of treatment for the chronic neoplasm may or may not be completed when the chronic neoplasm transforms to the acute neoplasm.

3. Acute neoplasm followed by a chronic neoplasm

    a. The presence/absence of treatment DOES impact the determination of the number of primaries when the acute neoplasm reverts to a chronic neoplasm (see Rules M12 and M13).

    b. The planned first course of therapy may not have been completed when a biopsy/pathologic specimen shows only chronic neoplasm after an initial diagnosis of an acute neoplasm.

    c. The patient may have completed the first course of treatment and have been cancer

free (clinically, no evidence of the acute neoplasm) for an interim when diagnosed with the chronic neoplasm.

d. The patient may not have been cancer free, but completed the first course of treatment and biopsy/pathology shows only chronic neoplasm.

4. Code the treatment on both abstracts when a patient has multiple primaries and the treatment given for one primary also affects/treats the other primary.

    a. ***Example***: Patient is diagnosed in May 2014 with both multiple myeloma (9732/3) and mantle cell lymphoma (9673/3), which are separate primaries per rule M15. The oncologist states she began Velcade chemotherapy for the lymphoma. Velcade would affect both primaries, so it should be coded on both abstracts.

Leukemia

For patients with a diagnosis of leukemia, the first course of therapy includes all cancer- directed treatments and planned therapies during or after the initial diagnosis of leukemia. All remission-inducing or maintenance cancer-directed therapy is recorded as the first course, including radiation to the central nervous system. The multiple modalities of therapy for the treatment of leukemia may involve a year or more.

Example 1**:** If the patient has an adverse reaction, the regimen may be changed and a new drug introduced. If the new chemotherapy drug(s) is in the same group as the initial therapy (anti-metabolite, alkylating agent, etc.) it is considered continuation of the first course of treatment. If the drug(s) is not in the same group, it is no longer the first course of therapy. Additionally, if the patient fails to respond to treatment and the regimen is changed, it is no longer first course of treatment.

Example 2**:** Physician plans a regimen of Adriamycin/Cytoxan. The patient does not respond and disease progresses so the treatment plan is changed to Methotrexate/5FU. The treatment becomes subsequent (and no longer reportable to WCRS) because the planned first course of treatment failed.

Reporting Phlebotomy, Blood-Thinners/Anti-Clotting Medications, and Transfusions as Other Therapy

- Do not collect blood transfusions (whole blood, platelets, etc.) as treatment. Blood transfusions are widely used to treat anemia and it is not possible to collect this procedure in a meaningful way.
- Collect phlebotomy for polycythemia vera (9950/3) ONLY.
- Collect blood-thinners and/or anti-clotting agents for essential thrombocythemia (9962/3) ONLY.

Donor Leukocyte Infusions

The use of donor leukocyte infusions for treatment of hematopoietic neoplasms, specifically leukemia’s, is increasing. Abstract as immunotherapy when a reportable hematopoietic neoplasm is treated with donor leukocyte infusion, even if it is not listed in the treatment section of the Hematopoietic database for the specific neoplasm.

Grade

The contents of this section are adapted from Grade Coding Instructions and Tables in the Grade Manual (Ruhl, J; Ward, E; Hofferkamp, J, et. al, 2020)

The Grade Coding Instructions and Tables (Grade Manual) is the primary resource for documentation and coding instructions for Solid Tumor 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 Grade Clinical, Grade Pathological, and Grade Post Therapy Clin (yc) and Grade Post Therapy Path (yp) data items.

- Grade Post Therapy Clin (yc) was added in 2021, and Grade Post Therapy Grade was changed to Grade Post Therapy Path (yp)

In addition to understanding the concept and structure of the Grade Tables, it is critically important to review all of 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 Grade Clinical, Grade Pathological, Grade Post Therapy Clin (yc) and Grade Post Therapy Path (yp) data items and coding instructions for generic grade categories. Thorough understanding of this material will be necessary in order to code the new Grade Data Items accurately.

Individual site-specific Grade tables for Solid Tumors are available in Schema ID order and in Alphabetical order of Schema ID name/,and located in the Grade Coding Instructions and Tables in the Grade Manual.

Note 1: Beginning with cases diagnosed in 2018, the definition of grade has been expanded, and classification of grade now varies by tumor site and/or histology. The grading system for a cancer type may have two, three, or four grades. No longer will all grades be converted to a four-grade system.

Note 2: For cases diagnosed 1/1/2018, Grade is no longer applicable for Hematopoietic neoplasms.

> ***Exception***: Grade is still coded for Lymphoma Ocular Adnexa cases diagnosed in any year (see the Grade Manual for further instructions on coding grade).

Cancer Registry Coding of the Recommended Grades for Solid Tumors

The contents of this section are adapted from Grade Coding Instructions and Tables in the Grade Manual (Ruhl, J; Ward, E; Hofferkamp, J, et. al, 2020)

For solid tumors diagnosed 2018 and forward, grade will be collected in three different data items, Grade Clinical, Grade Pathological, and Grade Post Therapy, and the codes and coding instructions will depend on the type of cancer. In 2021, Grade Post Therapy was changed to Grade Post Therapy Path (yp) and Grade Post Therapy Clin (yc) was added.

The tables for grade have been re-structured for 2018. There may be a combination of numeric and alphabetic codes within the same table, according to this template.

Template for the Cancer-Specific Grade Table	
Code	Grade Description
1	Site-specific grade system category
2	Site-specific grade system category
3	Site-specific grade system category
4	Site-specific grade system category
5	Site-specific grade system category
8	Not applicable (Hematopoietic neoplasms only)
9	Grade cannot be assessed; Unknown
A	Well differentiated
B	Moderately differentiated
C	Poorly differentiated
D	Undifferentiated and anaplastic
E	Site-specific grade system category
Code	Grade Description
H	High grade
L	Low grade
M	Site-specific grade system category
S	Site-specific grade system category
Blank	(Post therapy only)

Codes 1-5, H, L, M, S, and 9 all represent AJCC recommended grading systems.

Categories L and H are applicable for the AJCC recommended grading systems of “low grade” and “high grade” for those cancers for which these are used (e.g. urinary cancers with urothelial histologies). It also includes M for intermediate grade to be used with L and H for breast in situ cancers. S is utilized for sarcomatous overgrowth in corpus uteri adenosarcoma, an AJCC registry data collection variable.

Codes A-E are the generic grade categories (definitions) that have been used by the cancer surveillance community for many years. Although many AJCC chapters continue to use the traditional grade terms, codes A-E are not available for all cancers and many of the chapters now use a three-grade system, instead of the four grade system.

General Grade Coding Instructions for Solid Tumors

The contents of this section are adapted from Grade Coding Instructions and Tables in the Grade Manual (Ruhl, J; Ward, E; Hofferkamp, J, et. al, 2020)

Listed below are general guidelines for coding all four new grade data items.

1. Code the grade from the primary tumor only.
    a. Do **NOT** code grade based on metastatic tumor or recurrence. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site.
    b. If primary site is unknown, code grade to 9.
2. If there is more than one grade available for an individual grade data item (i.e. within the same time frame).
    a. Priority goes to the recommended AJCC grade listed in the applicable AJCC chapter.
        i. If none of the specified grades are from the recommended AJCC grade system, record the highest grade per applicable alternate grade categories for that site.
    b. If there is no recommended AJCC grade for a particular site, code the highest grade per the applicable grade categories for that site.
3. In situ and/or combined in situ/invasive components:
    a. If a grade is given for an in situ tumor, code it. Do **NOT** code grade for dysplasia such as high-grade dysplasia.
    b. If there are both in situ and invasive components, code only the grade for the invasive portion even if its grade is unknown.
4. Systemic treatment and radiation can alter a tumor's grade. Therefore, it is important to code clinical grade based on information prior to neoadjuvant therapy even if grade is unknown during the clinical timeframe. Grade can now be collected in grade post therapy clinical (yc) when grade is available after neoadjuvant therapy and prior to surgical resection and grade post therapy pathological (yp) cases when grade is available from post neoadjuvant surgery.
5. If a case is sent out for consult and the grade results are different than the original case, record the results from the consult.
    a. ***Example 1*:** Patient had biopsy done at a facility which showed a moderately differentiated tumor. Slides were sent out for consult and their review showed a well differentiated tumor.
        i. Record the well differentiated grade based on the consult

General Instructions for the Time Frames for Grade

The contents of this section are adapted from Grade Coding Instructions and Tables in the Grade Manual (Ruhl, J; Ward, E; Hofferkamp, J, et. al, 2020)

There are four grade data items which reflect the points in time in the patient's care when grade may be assessed.

Grade Clinical
For the Grade Clinical data item, record the grade of a solid primary tumor before any treatment. Treatment may include surgical resection, systemic therapy, radiation therapy, or neoadjuvant therapy. All surgical procedures are not treatment, e.g. TURB and endoscopic biopsies.

Grade Post Therapy Clin (yc)
This data item was introduced for cases diagnosed 1/1/2021. For cases diagnosed 2018-2020, this field can be left blank.

For the Grade Post Therapy Clin (yc) data item, record the grade of a solid primary tumor that has been microscopically sampled following neoadjuvant therapy or primary systemic/radiation therapy. If AJCC staging is being assigned, the tumor must have met the neoadjuvant therapy or primary systemic/radiation therapy requirements in the AJCC manual or according to national treatment guidelines.

Grade Pathological
For the Grade Pathological data item, record 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.

Grade Post Therapy Path (yp)
For the Grade Post Therapy Path (yp) data item, record the grade of a solid primary tumor that has been resected following neoadjuvant therapy. If AJCC post therapy path 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 have been given for variable or unconventional reasons as noted in the AJCC manual.

This may include the grade from the post-therapy clinical workup (yc), as all information from the completion of neoadjuvant therapy (post-therapy clinical (yc)) through the surgical resection is used for post-therapy grade (yp).

Grade obtained prior to neoadjuvant therapy (clinical grade obtained during the initial workup) cannot be used after the initiation of neoadjuvant therapy and thus cannot be used to record Grade Post therapy Path (yp).

This data item corresponds to the yp staging period only.

Grade for Hematopoietic and Lymphoid Neoplasms

The contents of this section are adapted from Grade Coding Instructions and Tables in the Grade Manual (Ruhl, J; Ward, E; Hofferkamp, J, et. al, 2020)

Historically the cell lineage indicator (B-cell, T-cell, Null cell, NK-cell) was collected in the Grade data item. Cell lineage indicator/grade for hematopoietic and lymphoid neoplasms will no longer be collected for cases diagnosed 1/1/2018 and forward.

Note: The Lymphoma Ocular Adnexa chapter in the AJCC manual has a defined grading system for the follicular histologies. Grade is to be assigned to these according to the Lymphoma Ocular Adnexa chapter, chapter 71. The primary sites and follicular histologies included in chapter 71 are as follows.

- Applicable primary sites: C441, C690, C695, C696
- Applicable histologies: 9690/3, 9691/3, 9695/3, 9698/3
- Grade for all other histologies collected in the Lymphoma Ocular Adnexa chapter will be coded to 9

For cases with histologies 9590/3-9992/3, the clinical and pathological must be coded to ‘8’ and post therapy clin and path grades must be blank.

Reference Materials and Websites

SEER

Main Coding Website: https://seer.cancer.gov/registrars/

SEER Program Coding and Staging Manual:
https://seer.cancer.gov/tools/codingmanuals/index.html

SEER Summary Stage 2018 Manual: https://seer.cancer.gov/tools/ssm/

Solid Tumor Rules: https://seer.cancer.gov/tools/solidtumor/
Use this manual to determine the number of reports needed to complete each case.

Hematopoietic and Lymphoid Neoplasm Coding Manual and Database:
https://seer.cancer.gov/tools/heme/
Use the Manual Instructions and rules for determining the number of primaries, primary site, histology, and the cell lineage or phenotype. Use the database to assist in screening for reportable cases and determining reportability requirements. Site contains abstracting and coding information of all hematopoietic and lymphoid neoplasms (9590/3- 9992/3).

SEER*Rx - Interactive Antineoplastic Drugs Database:
http://www.seer.cancer.gov/seertools/seerrx/
One-step lookup for coding oncology drug and regimen treatment categories.

Glossary for Registrars: https://seer.cancer.gov/seertools/glossary/
Features definitions for terms used by cancer registrars. Includes information on where the term is uses, as well as any applicable alternative names, abstractor notes, histology and primary sites.

SEER*Educate: https://educate.fredhutch.org/LandingPage.aspx
Free online training platform tailored specifically for cancer registry professionals to improve technical skills through applied testing on the latest coding guidelines and concepts

SEER Inquiry System (SINQ): https://seer.cancer.gov/seerinquiry/index.php
Site for a searchable collection of questions on coding cancer cases, specific to solid tumor rules (primary site and histology), hematopoietic cancers, SEER summary stage.

Ask a SEER Registrar: https://seer.cancer.gov/registrars/contact.html
Site for members of cancer registrar community to submit questions about coding cancer cases or about the materials for registrars distributed through the SEER site. Use only if the question you want to ask was not already answered in SINQ.

NAACCR

NAACCR Data Standards and Data Dictionary:
https://www.naaccr.org/data-standards-data-dictionary/

Grade Coding Instructions and Tables:
https://www.naaccr.org/wp-content/uploads/2021/01/Grade-Manual_v-2.01-1.pdf?v=1614209296
Primary resource for documentation and coding instructions for Grade.

Site-Specific Data Item (SSDI) Manual:
https://www.naaccr.org/SSDI/SSDI-Manual.pdf?v=1527608547
Primary resource for documentation and coding instructions for site-specific data items introduced in 2018.

Recommended Abbreviations for Abstractors to Use in Text Fields:
http://datadictionary.naaccr.org/default.aspx?c=17&Version=21
Consist of two main lists of about 600 word/terms and their recommended abbreviations/symbols, as well as a special table of context-sensitive abbreviations.

Other Resources

Site-Specific Surgery Codes:
https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/store_manual_2018.ashx
From this site, scroll down the left column and select Appendix B – site-specific surgery codes.

STORE Manual: https://www.facs.org/quality-programs/cancer/ncdb/call-for-data/cocmanuals
Commission on Cancer, National Cancer Database Data Standards

2018 ICD-O-3 Coding Guidelines and Coding Tables:
https://www.naaccr.org/implementation-guidelines/#ICDO3
Address implementation of updated histology terms and codes for cases diagnosed on or after January 1, 2018.

International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3):
http://www.iacr.com.fr/index.php?option=com_content&view=category&layout=blog&id=100&Itemid=577
This is the definitive classification of neoplasms and is used to describe the topography, morphology, malignant behavior and grade of all neoplasms.

CAnswer Forum: https://cancerbulletin.facs.org/forums/help
Site for a searchable collection of questions on coding cancer cases, specific to AJCC TNM staging, grade and SSDIs. New questions can be submitted on this site.

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Madison WI 53701-2659

Express Courier Address
Wisconsin Cancer Reporting System
1 W. Wilson Street, Room 118
Madison WI 53703

Web Plus Portal: https://webplus.wisconsin.gov/logonen.aspx
WCRS Email Address: DHSWCRSdata@dhs.wisconsin.gov
WCRS Fax Number: 608-266-2431
WCRS Website: www.dhs.wisconsin.gov/wcrs/index.htm
WCRS Reporter Web Page: https://www.dhs.wisconsin.gov/wcrs/reporterinfo/announcements.htm

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