

SEER Program Coding and Staging Manual 2023 - Summary of Changes

This table lists the changes in the 2023 manual by page number.

Page	Section	Data Item	Change	Notes/Comments
1	Preface	Summary of Changes	Listing of major changes updated	Revised the section with the list of major changes including additions, deletions, and modifications made to the 2023 manual and appendices.
3	Preface	2023 Changes	Listing of additional 2023 changes updated	Revised the list of 2023 changes relating to cancer coding and staging.
3	Preface	Collection and Storage of Dates	Text revised	Revised the text regarding collection and storage of dates that refer to the 2023 NAACCR Implementation Guidelines for further information regarding the updated data exchange standard.
3	Preface	Transmission Instructions for Dates	Text revised	Revised text related to format requirements for transmission. Deleted text relating to date flags.
6	Reportability	Reportable Diagnosis List	Items 1.a.i - iv added	Added new reportable diagnoses for 2023: i. High-grade astrocytoma with piloid features (HGAP) (9421/3) as of 01/01/2023 ii. Lymphangiomyomatosis (9174/3) is reportable as of 01/01/2023; the behavior changed from /1 to /3. iii. Mesothelioma in situ (9050/2) is reportable as of 01/01/2023 (new code) iv. Diffuse leptomeningeal glioneuronal tumor (9509/3) is reportable as of 01/01/2023 Subsequent items were renumbered.
6	Reportability	Reportable Diagnosis List	Item 1.a.x revised	Revised the bullet regarding intraepithelial neoplasia, and the list of examples, to include high grade, grade II, and grade III. See manual for the revisions. This was formerly 1.a.vii.
7	Reportability	Reportable Diagnosis List	Item 1.a.viii deleted	Deleted former 1.a.viii: 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).

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7	Reportability	Reportable Diagnosis List	Item 1.a.xiii deleted	Deleted text: Do not report cytology cases with ambiguous terminology (see page 9 for ambiguous terms)
8	Reportability	Reportable Diagnosis List	Item 1.c added	“Carcinomatosis” (8010/9) and “metastatic” tumor or neoplasm (8000/6) indicate malignancy and could be indicative of a reportable neoplasm. Review all of the available information to determine the origin of the carcinomatosis or the origin of the metastases.
8	Reportability	Reportable Diagnosis List	Item 2.b revised	b. Report pilocytic astrocytoma/juvenile pilocytic astrocytoma as 9421/1 for all CNS sites as of 01/01/2023
8	Reportability	Reportable Diagnosis List	Item 2.c added	c. Report diffuse astrocytoma, MYB- or MYBL1-altered and diffuse low-grade glioma, MAPK pathway-altered (9421/1) as of 01/01/2023
8	Reportability	Reportable Diagnosis List	Items 2.d added	d. Report multinodular and vacuolating neuronal tumor (9509/0) as of 01/01/2023
8	Reportability	Reportable Diagnosis List	Items 2.e added	e. Report juvenile xanthogranuloma (9749/1) as of 01/01/2023 (C715 is the most common site)
9	Reportability	Disease Regression	Format changed	Indented the section, Disease Regression, under Diagnosis Prior to Birth.
11	Reportability	Ambiguous Terminology	Text revised	Cytology Changed Note to Note 1 Changed Exception to Note 2
16	Changing Information on the Abstract		Dates in example revised	Updated the dates in #4 example: 4 When the date of diagnosis is confirmed in retrospect to be earlier than the original date abstracted Example: Patient has surgery for a benign argentaffin carcinoid (8240/1) of the sigmoid colon in May 2022. In January 2023, the patient is admitted with widespread metastasis consistent with malignant argentaffin carcinoid. The registrar accessions the malignant argentaffin carcinoid as a 2023 diagnosis. Two months later, the pathologist reviews the slides from the May 2022 surgery and concludes that the carcinoid diagnosed in 2022 was malignant. Change the date of diagnosis to May 2022 and histology to 8241 and the behavior code to malignant (/3).

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17	Determining Multiple Primaries	Hematopoietic and Lymphoid Neoplasms	Text revised	No updates were made to the <i>Hematopoietic and Lymphoid Neoplasm Coding Manual</i> and <i>Database</i> for 2023 cases.
24	Section I: Basic Record Identification	NAACCR Record Version	Code added	Added code 230 and description, 2023 Version 23.
37	Section III: Demographic Information	Place of Residence	Text added	Temporary Residents of SEER Area: Code the residence where the student is living for College students while attending college Exchange students temporarily living in the U.S.
	Section III: Demographic Information	Date of Birth Flag	Data item deleted	Deleted <i>Date of Birth Flag</i> from the manual.
67	Section III: Demographic Information	Race 1, 2, 3, 4, 5	Code Descriptions modified	Modified code descriptions for: Code 02: Black or African American Code 03: American Indian or Alaska Native Code 07: Native Hawaiian Code 13: Cambodian Code 15: Asian Indian, NOS or Pakistani, NOS Code 21: Chamorro Code 32: Papua New Guinean Code 96: Other Asian, including Asian, NOS Code 98 Some other race Code 99: Unknown by patient
68	Section III: Demographic Information	Race 1, 2, 3, 4, 5	Example revised	Updated example in Priorities for Coding Multiple Races section: Example: Patient is described as Japanese and Hawaiian. Code Race 1 as 07 (Native Hawaiian), Race 2 as 05 (Japanese).
69	Section III: Demographic Information	Race 1, 2, 3, 4, 5	Coding Instructions 7, 8, 9, 11, 13, 15 and 16 revised	Modified coding instructions to match revised code descriptions: # 7, 8, 9, 11, 13, 15 (Example 2 and Exception), and 16. Coding Instruction 15 text edited: “deleted from the 2000 Census and Bureau of Vital Statistics” in Appendix D title.

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70	Section III: Demographic Information	Race 1, 2, 3, 4, 5	Coding Examples 4, 6, 8, and 10 and History #8 revised	Modified coding examples and History (#8) to match revised code descriptions.
71	Section III: Demographic Information	Race 1, 2, 3, 4, 5	Coding Examples 13 and 14 added	See manual for examples.
73	Section III: Demographic Information	Spanish Surname or Origin	Note added	Added note to introductory section: Note: Hispanic surname lists are registry-specific.
74	Section III: Demographic Information	Spanish Surname or Origin	Coding Instruction 6 revised	6. Assign code 9 a. For death certificate only (DCO) cases when Spanish/Hispanic origin is unknown b. When there is no written or verbal indication of Spanish origin, the patient declined to answer their Spanish origin, or the patient does not know their Spanish origin Example: The patient's race is white or black, they were born in the United States, their last name is not on a Spanish surname list, and there is no mention of Spanish origin in the patient record.
77	Section III: Demographic Information	Marital Status at Diagnosis	Text revised	Justification for Continued Collection section: Added 'at Diagnosis' to the data item name.
80	Section III: Demographic Information	Tobacco Use Smoking Status	Text revised	Introductory paragraph: Added 'Smoking Status' to the data item name.
80	Section III: Demographic Information	Tobacco Use Smoking Status	Code Description modified	Code 1 Description changed to: Current smoker

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80	Section III: Demographic Information	Tobacco Use Smoking Status	Coding Instruction 3 added	3. Assign code 1 when a. The patient currently smokes OR b. It is known that the patient stopped smoking within 30 days prior to diagnosis. The risks associated with smoking decrease as the time from cessation increases which means a person who stopped smoking within the last 30 days has the same risks as a current smoker. In that instance, assign code 1.
80	Section III: Demographic Information	Tobacco Use Smoking Status	Coding Instruction 4 revised	4. Assign code 2 when the medical record indicates a. "Former smoker" b. Patient has smoked tobacco in the past but does not smoke now Note: If there is evidence in the medical record that the patient quit recently (within 30 days prior to diagnosis), assign code 1, current smoker. The 30 days prior information, if available, is intended to differentiate patients who may have quit recently due to symptoms that lead to a cancer diagnosis.
80	Section III: Demographic Information	Tobacco Use Smoking Status	Coding Instruction 5 added	5. Assign code 3 when a. The patient is noted to have smoked, but the current smoking status is not known b. It is known that the patient "recently" stopped smoking but it is not known how long ago the patient stopped smoking
81	Section III: Demographic Information	Tobacco Use Smoking Status	Coding Instruction 6 revised	6. Assign code 9 when a. The medical record only indicates "No" b. The record has no information about smoking status or history (e.g., pathology report only) c. It is documented that the patient uses or used smokeless or chewing tobacco or e-cigarettes or vapes, but tobacco use is not mentioned
83	Section IV: Description of this Neoplasm	Date of Diagnosis	Transmitting Dates revised	Added 'for year' to second sentence: Transmit only known or estimated year of diagnosis; blanks will not be accepted for year.

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83	Section IV: Description of this Neoplasm	Date of Diagnosis	Common Formats revised	Added asterisk after Year for Blank format; it links to the footnote at the bottom of the page.
83	Section IV: Description of this Neoplasm	Date of Diagnosis	Transmit Instructions revised	Deleted the last sentence in Transmit Instruction #4: The corresponding date flag is not affected (it will remain blank).
85	Section IV: Description of this Neoplasm	Date of Diagnosis	Coding Instruction 1 example dates revised	Example: Area of microcalcifications in breast suspicious for malignancy on 02/13/2023. Biopsy positive for ductal carcinoma on 02/28/2023. The date of diagnosis is 02/13/2023.
85	Section IV: Description of this Neoplasm	Date of Diagnosis	Coding Instruction 3 and example added	Code the date the procedure was done, not the date the specimen was received or read as positive by the pathologist when the date of diagnosis is coded from a pathology report Example: Biopsy was performed on 05/06/2023. The specimen from the biopsy was received and read by the pathologist as positive for cancer on 05/09/2023. The date of diagnosis is 05/06/2023.
85	Section IV: Description of this Neoplasm	Date of Diagnosis	Coding Instruction 4 example 1 dates revised	Example 1: On May 15, 2023, physician states that patient has lung cancer based on clinical findings. The patient has a positive biopsy of the lung in June 3, 2023. The date of diagnosis remains May 15, 2023.
85	Section IV: Description of this Neoplasm	Date of Diagnosis	Coding Instruction 4 Example 2 Note revised	Added 'imaging' prior to procedure. Note: Appendix E in the 2023 SEER Program Manual lists which PI-RADS, BI-RADS, and LI-RADS are reportable versus non-reportable. If reportable, use the date of the imaging procedure as the date of diagnosis when this is the earliest date and there is no information to dispute the imaging findings.
85	Section IV: Description of this Neoplasm	Date of Diagnosis	Coding Instructions 5, 6, and 9 revised	Updated dates in the examples.

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Page	Section	Data Item	Change	Notes/Comments
87	Section IV: Description of this Neoplasm	Date of Diagnosis	Cases Diagnosed Before Birth examples revised	Updated dates in the example.
	Section IV: Description of this Neoplasm	Date of Diagnosis Flag	Data item deleted	Deleted <i>Date of Diagnosis Flag</i> from the manual.
90	Section IV: Description of this Neoplasm	Sequence Number-- Central	Term and footnote removed	Deleted: Juvenile astrocytoma (diagnosis year 2001 and later) from table, Type of Neoplasm/Sequence Number Series; Series 1: In situ/malignant as Federally required. Deleted corresponding footnote: Juvenile astrocytomas should be reported as 9421/1.
91	Section IV: Description of this Neoplasm	Sequence Number-- Central	Coding Instruction 6 example revised	Updated date in the example under Non-Malignant Coding Instructions.
94	Section IV: Description of this Neoplasm	Primary Site	Coding Instruction 9 revised	Added to the list of sites that contain primary site coding guideline in Appendix C: Brain/CNS, Benign and Borderline Brain/CNS, Malignant Intracranial Glands Pancreas
95	Section IV: Description of this Neoplasm	Primary Site	Coding Instruction 15 table revised	Added to the table: Periareolar (breast) (C501) Postauricular region (C444) Preauricular (skin) C443) Prostatic sinus (urethra) (C680)
98	Section IV: Description of this Neoplasm	Laterality	Coding Instruction 1.c revised	Revised coding instruction 1.c that references the table, Sites for Which Laterality Must Be Recorded.
98	Section IV: Description of this Neoplasm	Laterality	Coding Instruction 5.a revised	Added primary site C444 to coding instruction 5.a (Assign code 5 when the tumor originates in the midline).

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99	Section IV: Description of this Neoplasm	Laterality	Coding Instruction 6.b revised	Revised coding instruction 6.b that references the table, Sites for Which Laterality Must Be Recorded.
99	Section IV: Description of this Neoplasm	Laterality	Sites deleted	Deleted sites from the table, Sites for Which Laterality Codes Must Be Recorded C300 Nasal cavity (excluding nasal cartilage, nasal septum) C340 Main bronchus (excluding carina) C413 Rib, clavicle (excluding sternum) C414 Pelvic bones (excluding sacrum, coccyx, symphysis pubis)
	Section IV: Description of this Neoplasm	Morphology	Data item deleted	Deleted <i>Morphology</i> from the manual.
104	Section IV: Description of this Neoplasm	Histologic Type ICD-O-3	Text added	Added under section ICD-O-3.2: Updated dates: See the NAACCR website for additional updates for 2023.
104	Section IV: Description of this Neoplasm	Histologic Type ICD-O-3	Text edited	Added under section Histology Coding for Solid Tumors. Refer to the most current Solid Tumor Rules for histology code changes. 1. Beginning with cases diagnosed 01/01/2022, p16 test results can be used to code squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086). 2. Beginning with cases diagnosed 01/01/2022, non-keratinizing squamous cell carcinoma, HPV positive is coded 8085 for sites listed in Head and Neck Solid Tumor Rules Table 5 only. A diagnosis of non-keratinizing squamous cell carcinoma, NOS is coded 8072. 3. Beginning with cases diagnosed 01/01/2022, keratinizing squamous cell carcinoma, HPV negative is coded 8086 for sites listed in Head and Neck Solid Tumor Rules Table 5 only. A diagnosis of keratinizing squamous cell carcinoma, NOS is coded 8071. 4. Clear cell papillary renal cell carcinoma is coded 8323/3. The 2016 WHO Classification of Tumors of the Urinary System and Male Genital Organs, 4th Edition, reclassified this histology as a /1 because it is low nuclear grade and is now thought to be a neoplasia. This change has not yet been implemented and it remains reportable as behavior /3.

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Page	Section	Data Item	Change	Notes/Comments
114	Section IV: Description of this Neoplasm	Tumor Size-- Clinical	Coding Instruction 4; Notes 2 and 3 added	Note 2: For prostate clinical tumor size, size from an operative report is the highest priority. Use the size from imaging if you do not have a size from an operative report. Note 3: When LEEP is followed by more definitive surgery for a cervical primary, code clinical tumor size based on the LEEP.
116	Section IV: Description of this Neoplasm	Tumor Size-- Clinical	Coding Instruction 23 revised	Assign tumor size for benign and borderline tumors in the schemas Brain, CNS Other, Intracranial Gland, and Medulloblastoma when provided; do not default to 999
117	Section IV: Description of this Neoplasm	Tumor Size-- Clinical	Coding Instruction 25 added	Assign code 999 for calcifications that span given distance. Do not record the size of calcifications as tumor size. If there is no measurement of the mass or tumor, record 999 for clinical tumor size.
120	Section IV: Description of this Neoplasm	Tumor Size-- Pathologic	Coding Instruction 5 example added	Example 2: Anal canal tumor is 2.5 cm from proximal to distal (3.5 cm in circumference). Record tumor size as 035. The circumferential measurement is the largest measurement in this example. In this case, the pathologist usually cuts the anus and rectum open like a tube; the circumference is measured flat.
122	Section IV: Description of this Neoplasm	Tumor Size-- Pathologic	Coding Instruction 21 revised	Assign tumor size for benign and borderline tumors in the schemas Brain, CNS Other, Intracranial Gland, and Medulloblastoma when provided; do not default to 999
122	Section IV: Description of this Neoplasm	Tumor Size-- Pathologic	Coding Instruction 22 format fixed	Indented former 22.d under 22.c; subsequent instructions were renumbered (e.g., 22.d, 22.e, etc.).
132	Section V: Stage of Disease at Diagnosis	Summary Stage 2018	Footnote revised	Applicable for the following Summary Stage 2018 chapters: Brain, CNS Other, Intracranial Gland, Medulloblastoma.
136	Section VI: Stage-related Data Items	Lymphovascular Invasion	Introduction revised	Lymphovascular Invasion indicates whether lymphatic duct or blood vessel invasion is identified in the pathology report.
137	Section VI: Stage-related Data Items	Lymphovascular Invasion	Coding Instruction 7.c added	When there is no residual tumor found after neoadjuvant treatment and there is no LVI on biopsy

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138	Section VI: Stage-related Data Items	Lymphovascular Invasion	Coding Instruction 10.i added	i. Ambiguous terminology is used Example: Assign code 9 for “suspicious LVI.”
150	Section VI: Stage-related Data Items	Mets at Diagnosis--Other	Coding Instruction 1.d Note added	Note: Do not code spleen involvement for Hodgkin lymphoma in <i>Mets at Diagnosis--Other</i> . Spleen involvement is not classified as distant mets for Hodgkin lymphoma in most staging systems.
154	Section VI: Stage-related Data Items	Additional Stage-related Data Items/ SSDIs	Introductory text revised	Revised introductory paragraphs to update information for 2023. See manual.
155	Section VI: Stage-related Data Items	Additional Stage-related Data Items	Table 4 added	Added Table 4: Site-specific Data Items Implemented in 2023. Appendix: Histologic Subtype (Appendix 8480) (3960) Melanoma Skin: Clinical Margin Width (3961) Anus V9 (existing SSDI added to schema): p16 (3956)
155	Section VI: Stage-related Data Items	Additional Stage-related Data Items	Table 5 revised	Table 5 is: Additional Site-specific Data Items Required for Transmission. Removed SSDIs from the table: 3828 Estrogen Receptor Total Allred Score 3884 LN Status Femoral Inguinal, Para Aortic, Pelvic 3916 Progesterone Receptor Total Allred Score
160	Section VII: First Course of Therapy	First Course Therapy Definitions	Definition revised	Surgical procedure: Any surgical procedure coded in the data items <i>Surgery of Primary Site 2023</i> , <i>Scope of Regional Lymph Node Surgery (excluding code 1)</i> , or <i>Surgical Procedure of Other Site</i> .
164	Section VII: First Course of Therapy	Date Therapy Initiated	Coding Instruction 1 bullet revised	Changed <i>Surgery of Primary Site</i> to <i>Surgery of Primary Site 2023</i> . Of note: This was changed throughout the manual.
164	Section VII: First Course of Therapy	Date Therapy Initiated	Coding Instruction 3 example revised	Updated dates in the example.
165	Section VII: First Course of Therapy	Date Therapy Initiated	Coding Instruction 6.a Note added	Leave blank a. When no treatment is given during the first course Note: This includes when a patient dies before treatment is recommended or given.

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Page	Section	Data Item	Change	Notes/Comments
	Section VII: First Course of Therapy	Date Therapy Initiated Flag	Data item deleted	Deleted <i>Date Therapy Initiated Flag</i> from the manual.
167	Section VII: First Course of Therapy	Date of First Surgical Procedure	Introduction revised	Add text to the first introductory paragraph: <i>Date of First Surgical Procedure</i> is the date the first surgery was performed as part of first course of therapy. This is either the date of <i>the Surgery of Primary Site 2023</i> , <i>Sentinel Lymph Node Biopsy</i> , <i>Scope of Regional Lymph Node Surgery</i> (codes 2-7), or <i>Surgical Procedure of Other Site</i> , whichever is earliest.
167	Section VII: First Course of Therapy	Date of First Surgical Procedure	Coding Instruction 5 added	Leave date blank when there is no surgery performed
	Section VII: First Course of Therapy	Date of First Surgical Procedure Flag	Data item deleted	Deleted <i>Date of First Surgical Procedure Flag</i> from the manual.
168	Section VII: First Course of Therapy	Date of Most Definitive Surgical Resection of the Primary Site	Coding Instruction 3 added	Leave date blank when <i>Surgery of Primary Site 2023</i> is coded A000 or B000 (no surgery of primary site performed)
	Section VII: First Course of Therapy	Date of Most Definitive Surgical Resection of the Primary Site Flag	Data item deleted	Deleted <i>Date of Most Definitive Surgical Resection of the Primary Site Flag</i> from the manual.
	Section VII: First Course of Therapy	Surgery of Primary Site	Data item deleted	Deleted <i>Surgery of Primary Site</i> (NAACCR Item #1290) from the manual.
169	Section VII: First Course of Therapy	Surgery of Primary Site 2023	Data item added; codes revised	Added <i>Surgery of Primary Site 2023</i> (NAACCR Item #1291) to the manual. See manual.

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				This data item replaces <i>Surgery of Primary Site</i> (NAACCR Item #1290). The instructions remain the same except as noted in the changes to coding instructions below. Updated surgery codes from the 2-digit format to 4-digit. Of note: Updated surgery codes to the format throughout the manual.
170	Section VII: First Course of Therapy	Surgery of Primary Site 2023	Coding Instruction 6.a added	Assign the code that reflects the cumulative effect of all surgeries to the primary site a. When a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, code the total or final results. Do not rely on registry software to perform this task.
171	Section VII: First Course of Therapy	Surgery of Primary Site 2023	Coding Instruction 14 added	Leave blank for diagnosis years 2003-2022
175	Section VII: First Course of Therapy	Scope of Regional Lymph Node Surgery	Coding Instruction 13.a revised	Deleted 13.a.ii – vi from the list for assigning code 9.
	Section VII: First Course of Therapy	Date of Sentinel Lymph Node Biopsy Flag	Data item deleted	Deleted <i>Date of Sentinel Lymph Node Biopsy Flag</i> from the manual.
179	Section VII: First Course of Therapy	Sentinel Lymph Nodes Positive	Coding Instruction 4.a revised	FOR BREAST ONLY (added sentence at the end of 4.a) a. Use code 97 in this data item and record the total number of positive regional lymph nodes biopsied/dissected (both sentinel and regional) in Regional Nodes Positive (NAACCR Item #820) when a sentinel lymph node biopsy is performed during the same procedure as the regional node dissection. When both are performed during the same procedure, code 97 has priority over the number of positive lymph nodes.
	Section VII: First Course of Therapy	Date of Regional Lymph Node Dissection Flag	Data item deleted	Deleted <i>Date of Regional Lymph Node Dissection Flag</i> from the manual.
184	Section VII: First Course of Therapy	Regional Nodes Positive	Coding Instruction 11.e revised	Deleted: (excluding primary sites C420, C421, C423, C424) from: e. HemeRetic 00830

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187	Section VII: First Course of Therapy	Regional Nodes Examined	Coding Instruction 12.e revised	Deleted: (excluding primary sites C420, C421, C423, C424) from: e. HemeRetic 00830
188	Section VII: First Course of Therapy	Surgical Procedure of Other Site	Coding Instruction 6.a deleted	Revised to: 6. Assign code 1 when a. Any surgery is performed to remove tumors for any case coded to primary site C420, C421, C423, C424, C760-C768, C770-C779, or C809 i. Excluding cases coded to the schema Cervical Lymph Nodes and Unknown Primary 00060
190	Section VII: First Course of Therapy	Reason for No Surgery of Primary Site	Coding Instruction 2 revised	Added second sentence: 2. Assign code 1 when Surgery of Primary Site 2023 is coded A980 or B000 (not applicable). For Autopsy Only cases, see coding instruction #4.
	Section VII: First Course of Therapy	Date Radiation Started Flag	Data item deleted	Deleted <i>Date Radiation Started Flag</i> from the manual.
196	Section VII: First Course of Therapy	Radiation External Beam Planning Technique-- Phase I, II, and III	Text revised	Revised bullets 1 and 4; added bullet 3.
198	Section VII: First Course of Therapy	Radiation Sequence with Surgery	Coding Instruction 2.a revised	Assign code 4 when there are at least two phases, episodes, or fractions of radiation therapy given before and at least two more after surgery to the primary site, scope of regional lymph node surgery (excluding code 1), surgery to other regional site(s), distant site(s), or distant lymph node(s)
	Section VII: First Course of Therapy	Date Systemic Therapy Started Flag	Data item deleted	Deleted <i>Date Systemic Therapy Started Flag</i> from the manual.
	Section VII: First Course of Therapy	Date Chemotherapy Started Flag	Data item deleted	Deleted <i>Date Chemotherapy Started Flag</i> from the manual.

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204	Section VII: First Course of Therapy	Chemotherapy	Dates in example revised	Revised dates in Example 1.
	Section VII: First Course of Therapy	Date Hormone Therapy Started Flag	Data item deleted	Deleted <i>Date Hormone Therapy Started Flag</i> from the manual.
	Section VII: First Course of Therapy	Date Immunotherapy Started Flag	Data item deleted	Deleted <i>Date Immunotherapy Started Flag</i> from the manual.
215	Section VII: First Course of Therapy	Immunotherapy	Dates in example revised	Revised dates in the example.
219	Section VII: First Course of Therapy	Hematologic Transplant And Endocrine Procedures	Coding Instruction 6 Note added	Note: Bilateral oophorectomy is coded 30 when it is performed for hormonal effect for breast, endometrial, vaginal, and other primary cancers.
224	Section VII: First Course of Therapy	Neoadjuvant Therapy	Coding guidelines, text added	Added statement: Document information regarding neoadjuvant therapy in the text remarks field as needed.
224	Section VII: First Course of Therapy	Neoadjuvant Therapy	Coding Instruction 1.a.i added	i. For example, the patient’s only treatment was surgery
229	Section VII: First Course of Therapy	Neoadjuvant Therapy--Clinical Response	Coding Instruction 5 Note 2 added	Note 2: Assign code 3 when the managing/treating physician documents that the patient progressed after neoadjuvant therapy was started even if the neoadjuvant therapy was not completed. Use text fields for documentation.
231	Section VII: First Course of Therapy	Neoadjuvant Therapy-- Treatment Effect	Coding Structure Note 2 added	Note 2: Code 6 includes situations where a treatment effect is noted to be present, but cannot be classified to codes 1-4.

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Page	Section	Data Item	Change	Notes/Comments
	Section VII: First Course of Therapy	Date Other Treatment Started Flag	Data item deleted	Deleted <i>Date Other Treatment Started Flag</i> from the manual.
238	Section VIII: Follow Up Information	Date of Last Cancer (Tumor) Status	Transmit Instructions #3 revised	Deleted last sentence in #3: The corresponding date flag is not affected (it will remain blank).
238	Section VIII: Follow Up Information	Date of Last Cancer (Tumor) Status	Codes and instructions for dates added	Added: Codes for Month Codes for Day Coding Instructions Estimating Dates
	Section VIII: Follow Up Information	Date of Last Cancer (Tumor) Status Flag	Data item deleted	Deleted <i>Date of Last Cancer (Tumor) Status Flag</i> from the manual.
242	Section VIII: Follow Up Information	Recurrence Date--1st	Text revised	Corrected data item name in introductory paragraph.
242	Section VIII: Follow Up Information	Recurrence Date--1st	Transmit Instructions #3 revised	Deleted last sentence in #3: The corresponding date flag is not affected (it will remain blank).
	Section VIII: Follow Up Information	Recurrence Date--1st Flag	Data item deleted	Deleted <i>Recurrence Date--1st Flag</i> from the manual.
246	Section VIII: Follow Up Information	Recurrence Type--1st	Coding Instruction 12 added	Assign code 10 for recurrence of a benign brain tumor.
247	Section VIII: Follow Up Information	Death Clearance Instructions	Text added	There are two SEER requirements that differ from the current NAACCR manual.

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248	Section VIII: Follow Up Information	Date of Last Follow-Up or of Death	Transmit Instruction 3 revised	Deleted last sentence in #3: The corresponding date flag is not affected (it will remain blank).
	Section VIII: Follow Up Information	Date of Last Follow-Up or Death Flag	Data item deleted	Deleted <i>Date of Last Follow-Up or Death Flag</i> from the manual.
256	Section VIII: Follow Up Information	No Patient Contact Flag	Data item added	See manual.
257	Section VIII: Follow Up Information	Reporting Facility Restriction Flag	Data item added	See manual.
259	Section IX: Administrative Codes	Multiple data items	Specific edits used for data items added	See manual beginning page 259 for the following data items: Site/Type Interfield Review Histology/Behavior Interfield Review Age/Site/Histology Interfield Review Sequence Number/Diagnostic Confirmation Interfield Review Site/Histology/Laterality/Sequence Interrecord Review Surgery/Diagnostic Confirmation Interfield Review Type of Reporting Source/Sequence Number Interfield Review Sequence Number/III-Defined Site Interfield Review Leukemia or Lymphoma/Diagnostic Confirmation Interfield Review Over-ride Flag for Site/Behavior (IF39) Over-ride Flag for Site/EOD/Diagnosis Date (IF140) Over-ride Flag for Site/Laterality/EOD (IF41) Over-ride Flag for Site/Laterality/Morphology (IF42) Over-ride Flag for TNM Tis Over-ride Flag for Site/TNM-Stage Group
268	Section IX: Administrative Codes	Over-ride Flag for Name/Sex	Text added	Added sentence to introductory paragraph: Edits do not apply to this data item as registries use this internally and it is not transmitted to SEER.

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Page	Section	Data Item	Change	Notes/Comments
	Appendix A	County Codes	References revised	Updated links in the Reference section.
	Appendix B	Country and State Codes	Minor edits made	Updated links in the Source section. Made editorial changes to the names of countries Côte d'Ivoire, Saint Barthélemy, Yukon
	Appendix C: Site Specific Coding Modules	Coding Guidelines: Bladder	Primary site term added	Added to primary site code C679: Posterolateral wall
	Appendix C: Site Specific Coding Modules	Coding Guidelines: Bones	Laterality list revised	Removed C413 and C414 from the sites where laterality is required.
	Appendix C: Site Specific Coding Modules	Coding Guidelines: Brain/CNS, Benign and Borderline	New guideline added	Created a new Coding Guidelines document specific to Benign Brain based on the former Brain and CNS Coding Guidelines. See manual, Appendix C Coding Guidelines.
	Appendix C: Site Specific Coding Modules	Coding Guidelines: Brain/CNS, Malignant	New guideline added	Created a new Coding Guidelines document specific to Malignant Brain based on the former Brain and CNS Coding Guidelines. See manual, Appendix C Coding Guidelines.
	Appendix C: Site Specific Coding Modules	Coding Guidelines: Breast	Guidance added	Code the primary site to C509 when <ul style="list-style-type: none"> • There are multiple tumors (two or more) in at least two quadrants of the breast • There are multiple tumors (two or more) located together at the 12, 3, 6, or 9-o'clock position on the breast
	Appendix C: Site Specific Coding Modules	Coding Guidelines: Intracranial Glands	New guideline added	See manual, Appendix C Coding Guidelines

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Page	Section	Data Item	Change	Notes/Comments
	Appendix C: Site Specific Coding Modules	Coding Guidelines: Pancreas	New guideline added	See manual, Appendix C Coding Guidelines
	Appendix C: Site Specific Coding Modules	Coding Guidelines: Tongue	New guideline added	See manual, Appendix C Coding Guidelines
	Appendix C: Site Specific Coding Modules	Surgery Codes: All sites	Codes revised	Revised surgery codes for all sites from 2-digits to 4-digits. Codes for all sites begin with the letter A except for skin that begins with the letter B to denote that a significant change was made in codes.
	Appendix C: Site Specific Coding Modules	Surgery Codes: Breast	Guidance revised	<p>Edited text under A400 Total (simple) mastectomy, NOS section A total (simple) mastectomy removes all breast tissue, the nipple, and the areolar complex. An axillary dissection is not done, but sentinel lymph nodes may be removed.</p> <p>For single primaries involving both breasts, use code A760. [SEER Note: Example of single primary with removal of involved contralateral breast-- Inflammatory carcinoma involving both breasts. Bilateral simple mastectomies. Code <i>Surgery of Primary Site 2023</i> (NAACCR #1291) as A760.</p> <p>Deleted text under A500 Modified radical mastectomy section For single primaries only, code removal of involved contralateral breast under the data item Surgical Procedure of Other Site (NAACCR Item #1294)</p>
	Appendix C: Site Specific Coding Modules	Surgery Codes: Colon	Text revised	<p>Edited text to list codes instead of range Any combination of A200, A260, A270, A280, or A290 WITH A220 Electrocautery</p>
	Appendix C: Site Specific Coding Modules	Surgery Codes: Esophagus	Note added	<p>Added note under A800 Esophagectomy, NOS [SEER Note: Code a transhiatal esophagectomy depending on the extent of the esophagectomy. Read all of the operative report and the entire pathology report carefully. If a partial esophagectomy was performed, assign code A300. If a total esophagectomy was performed, assign code A400. If you do not have enough</p>

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				information to determine whether a partial or a total esophagectomy was performed, assign code A800. The transhiatal esophagectomy does not usually include removal of a portion of the stomach, but if a portion of stomach is removed, assign code A520 or A530. If the entire stomach was removed (not likely) assign code A540. Use text fields to record the details.]
	Appendix C: Site Specific Coding Modules	Surgery Codes: Lung	Text moved	Placed statement below A800 Resection of lung, NOS Specimen sent to pathology from surgical events A200–A800
	Appendix C: Site Specific Coding Modules	Surgery Codes: Prostate	Notes added	Added notes under A200 Local tumor excision, NOS section [SEER Note: Assign code A220 for aqua ablation water jet (or other tumor destruction procedure), described on pathology as a TURP, that identified adenocarcinoma as an incidental finding. Use text fields to document the details.] Any combination of A200, A210, A220, or A230 WITH A240 Cryosurgery A250 Laser A260 Hyperthermia [SEER Note: Assign code A250 for Holmium laser enucleation of the prostate when a specimen is sent to pathology.]
	Appendix C: Site Specific Coding Modules	Surgery Codes: Skin	Text added; codes and description revised	Made significant changes to skin surgery codes, descriptions, and text. See Appendix C, Skin Surgery Codes.
	Appendix C: Site Specific Coding Modules	Surgery Codes: Thyroid	Text revised	Revised statement below A800 Thyroidectomy, NOS Specimen sent to pathology from surgical events A200-A800

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	Appendix C: Site Specific Coding Modules	Neoadjuvant Therapy Treatment Effect Site Specific Codes: Breast	Coding instruction 5.b added	Neoadjuvant therapy was completed and the treatment effect in the breast is stated only as “Present”
	Appendix C: Site Specific Coding Modules	Neoadjuvant Therapy Treatment Effect Site Specific Codes: Lymphoma+	Coding instruction 1 revised and 3 added	1. ALWAYS code to 0, no neoadjuvant therapy (not applicable), for the following schemas, except for death certificate only cases (DCO) (see Coding Instruction #3 below) 3. Assign code 9 for DCOs
	Appendix D	Race and Nationality Descriptions	Listing of codes revised	Updated the list of race codes and references/sources. Removed list of American Indian and Alaska Native tribes; provided link to updated information.
	Appendix E1	Reportable Examples	Example 23 added	Intraepithelial neoplasia examples <ul style="list-style-type: none"> • Squamous intraepithelial neoplasia, high grade • High grade squamous intraepithelial lesion (HSIL) • Intraepithelial neoplasia grade II/III; II-III • Squamous dysplasia, high grade for sites other than colon/GI • Anal intraepithelial neoplasia (AIN), grade II • Anal intraepithelial neoplasia (AIN), grade III • Biliary intraepithelial neoplasia, high grade • Conjunctival intraepithelial neoplasia grade III • Penile intraepithelial neoplasia (PeIN), undifferentiated • Squamous intraepithelial neoplasia, grade II • Vaginal intraepithelial neoplasia (VaIN), grade III • Vulvar intraepithelial neoplasia (VIN), grade III • Squamous intraepithelial neoplasia, grade III
	Appendix E1	Reportable Examples	Example 24 added	8380/2 (C54_) <ul style="list-style-type: none"> • Endometrioid intraepithelial neoplasia (EIN)

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				<ul style="list-style-type: none"> Intraepithelial neoplasm of endometrium Atypical hyperplasia of endometrium
	Appendix E1	Reportable Examples	Example 25 added	Pancreatic intraepithelial neoplasia (PanIN III) 8148/2
	Appendix E1	Reportable Examples	Example 26 added	Differentiated Penile Intraepithelial Neoplasia 8071/2
	Appendix E1	Reportable Examples	Example 27 added	Intracholecystic papillary neoplasm (ICPN) with high-grade dysplasia 8503/2 Renumbered subsequent Reportable Non-Malignant Examples.
	Appendix E2	Non-Reportable Examples	Example 33 added	Ecchordosis physaliphora
	Appendix E2	Non-Reportable Examples	Example 34 added	Low to intermediate grade neuroendocrine neoplasm or middle ear adenomatoid tumor (MEANT)
	Appendix E2	Non-Reportable Examples	Example 35 added	Moderate squamous dysplasia and severe squamous dysplasia of lung
	Appendix E2	Non-Reportable Examples	Example 36 added	High grade prostatic intraepithelial neoplasia (PIN)(8148/2)