**SEER Program Coding and Staging Manual 2021 - Summary of Changes**

This table lists the changes in the 2021 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 additions, deletions, and modifications to the list of major changes made to the 2021 manual including appendices. |
| 2 | Preface | Summary of Changes | Subheading revised. | Changed "Data items deleted" to "Data items removed from manual." |
| 3 | Preface | 2021 Changes | Section added. | See manual. |
| 3, 4 | Preface | Sections | Section headers revised. | Collection and Storage of Dates<br>Transmission Instructions for Dates<br>Also, updated 'field' to 'data item' throughout the manual as appropriate. |
| 6 | Reportability | Reportable Diagnosis List | Item 1.a.revised. | 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 |
| 6 | Reportability | Reportable Diagnosis List | Item 1.a.i added. | 1.a.i. Early or evolving melanoma, in situ and invasive: As of 1/1/2021, early or evolving melanoma in situ, or any other early or evolving melanoma, is reportable. |
| 6 | Reportability | Reportable Diagnosis List | Item 1.a.ii added. | **All** GIST tumors are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2. |
| 6 | Reportability | Reportable Diagnosis List | Item 1.a.iii added. | Nearly all thymomas are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2. The exceptions are<br>• Microscopic thymoma or thymoma, benign (8580/0)<br>• Micronodular thymoma with lymphoid stroma (8580/1)<br>• Ectopic hamartomatous thymoma (8587/0)<br><br>Renumbered subsequent items and removed prior instructions on GIST and thymomas. |
| 6 | Reportability | Reportable Diagnosis List | 1.a.v example heading revised. | ***Examples:*** (Not a complete list. See 1.b.iii for PIN III.) |
| 7 | Reportability | Reportable Diagnosis List | 1.a.v bulleted example edited. | • Squamous intraepithelial neoplasia III (SIN III) excluding cervix (C53_) and skin sites coded to C44_ |
| 7 | Reportability | Reportable Diagnosis List | 1a.vi exception added. | ***Exception:*** The behavior is non-malignant when the primary site is optic nerve (C723). |
| 7 | Reportability | Reportable Diagnosis List | Item on 1.b.i list revised. | Squamous intraepithelial neoplasia III (SIN III) (8077) of skin sites coded to C44_ |

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| 7 | Reportability | Reportable Diagnosis List | Item 1.b.i note revised. | ***Note*** : If the registry collects basal or squamous cell carcinoma of **skin** sites (C440 C449), sequence them in the 60-87 range and do not report to SEER. |
| 7 | Reportability | Reportable Diagnosis List | Item 1.b.ii revised. | **In situ carcinoma of cervix** (/2), any histology, cervical intraepithelial neoplasia (CIN III), or SIN III of the cervix (C530 C539)<br><br>***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. |
| 7 | Reportability | Reportable Diagnosis List | Item 2.a revised (combined with former 2.c). | 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. |
| 8 | Reportability | Reportable Diagnosis List | Item 2.b revised. | Report **Pilocytic/Juvenile astrocytomas**; code the histology and behavior as 9421/3 when the primary site is C71._<br>***Exception*** : The behavior is non-malignant when the primary site is optic nerve (C723). |
| 8 | Reportability | Reportable Diagnosis List | Item 2.c and 2.c.i added. | Formerly not numbered:<br>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<br>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 |
| 9 | Reportability | Documentation of Reportable Diagnoses | Section revised. | Revised Section header and text; formally called Cases Clinically Diagnosed Clinically are Reportable. See manual. |
| 10 | Reportability | Intracranial or CNS Neoplasms | Section terminology revised. | Revised Section header and text; changed wording from brain to intracranial. See manual. |
| 10 | Reportability | Ambiguous Terminology | Cytology section revised. | Added text to first paragraph: Accession the case when a reportable diagnosis is confirmed later. The date of diagnosis is the date of the later confirmation in this situation. |
| 10 | Reportability | Ambiguous Terminology | Cytology section revised. | Added the last paragraph:<br>**Urine** cytology positive for malignancy is reportable. Code the primary site to C689 in the absence of any other information. |

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| Page | Section | Data Item | Change | Notes/Comments |
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| 10 | Reportability | Ambiguous Terminology | Ambiguous Terms for Reportability section revised. | Added: Report cases that use the words on the list or an equivalent word such as “favored” rather than “favor(s).” |
| 11 | Reportability | How to Use Ambiguous Terminology for Case Ascertainment | Item 1.a revised. | If any of the reportable **ambiguous terms precede** a word that is **synonymous** with a reportable in situ or invasive tumor (e.g., cancer, carcinoma, malignant neoplasm, etc.), accession the case. |
| 11 | Reportability | How to Use Ambiguous Terminology for Case Ascertainment | Item 1.b.i.1 example revised. | ***Example*** : Report from the dermatologist is “possible melanoma.” Patient admitted later for unrelated procedure and physician listed history of melanoma. No further information available, no evidence of treatment for melanoma. Give priority to the information from the dermatologist and do not report this case. “Possible” is not a reportable ambiguous term. The later information is less reliable in this case. |
| 12 | Reportability | How to Use Ambiguous Terminology for Case Ascertainment | Item 1.d.i example revised. | ***Example 2*** : CT report states “mass in the right kidney, highly suspicious for renal cell carcinoma.” CT-guided needle biopsy with final diagnosis “Neoplasm suggestive of oncocytoma. A malignant neoplasm cannot be excluded.” Discharged back to the nursing home and no other information is available. Do not accession the case. The suspicious CT finding was biopsied and not proven to be malignant. “Suggestive of” is not a reportable ambiguous term. |
| 12 | Reportability | How to Use Ambiguous Terminology for Case Ascertainment | Item 2.b revised. | **“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 |
| 12, 13 | Reportability | How to Use Ambiguous Terminology for Case Ascertainment | Item 2.c revised. | Accession the case when any of the reportable ambiguous terms precede either the word **“tumor”** or the word **“neoplasm”**<br>**Example:** The mass on the CT scan is consistent with pituitary tumor. Accession the case. |

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| Page | Section | Data Item | Change | Notes/Comments |
|---|---|---|---|---|
| 13 | Reportability | How to Use Ambiguous Terminology for Case Ascertainment | Item 2.d revised. | **"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** |
| 13 | Reportability | How to Use Ambiguous Terminology for Case Ascertainment | 2.f revised. | Use the reportable ambiguous terms when **screening** diagnoses on pathology reports, scans, ultrasounds, and other diagnostic testing other than tumor markers |
| 13 | Reportability | Casefinding Lists | Section moved. | Moved Casefinding Lists to the end of the Reportability section |
| 15 | Changing Information on the Abstract | | Item 4 example dates revised. | **When the date of diagnosis is confirmed in retrospect to be earlier than the original date abstracted**<br><br>***Example*** : Patient has surgery for a benign argentaffin carcinoid (8240/1) of the sigmoid colon in May 2020. In January 2021, the patient is admitted with widespread metastasis consistent with malignant argentaffin carcinoid. The registrar accessions the malignant argentaffin carcinoid as a 2021 diagnosis. Two months later, the pathologist reviews the slides from the May 2020 surgery and concludes that the carcinoid diagnosed in 2020 was malignant. Change the date of diagnosis to May 2020 and histology to 8241 and the behavior code to malignant (/3). |
| 16 | Determining Multiple Primaries | Hematopoietic and Lymphoid Neoplasms | Morphology codes for heme/lymphoid neoplasms upper range updated. | Solid Tumors<br><br>Morphology code (upper range) updated to 9993 (previously 9992) for lymphoma and leukemia in text below table.<br><br>Updated the upper range of morphology codes in additional places in the manual to 9993 for hematopoietic and lymphoid neoplasms in additional places in the manual. |

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| Page | Section | Data Item | Change | Notes/Comments |
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| 16 | Determining Multiple Primaries | Hematopoietic and Lymphoid Neoplasms | Text revised. | Hematopoietic and Lymphoid Neoplasms<br><br>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. |
| N/A | Sections I-VIII | All data items | XML NAACCR ID added. | Added the XML NAACCR ID to all data items. |
| 21 | Section I: Basic Record Identification | Record Type | Code Descriptions edited. | Removed length of record associated with each record type. |
| N/A | Section I: Basic Record Identification | SEER Record Number | Data item removed. | |
| N/A | Section I: Basic Record Identification | SEER Coding System--Original | Data item removed. | |
| N/A | Section I: Basic Record Identification | SEER Coding System--Current | Data item removed. | |
| 23 | Section II: Information Source | Type of Reporting Source | Definition revised. | Stand-alone medical record, second bullet<br>• An independent medical record containing only information from encounters with that specific facility or practice |
| 23 | Section II: Information Source | Type of Reporting Source | Definition revised. | Managed health plan, first bullet<br>• Any practice and/or facility where all of the diagnostic and treatment information is maintained in one unit record |
| 24 | Section II: Information Source | Type of Reporting Source | Definition added. | Unit record<br>• All records for the patient from all departments, clinics, offices, etc. in a single file with the same medical record number |

This table lists the changes in the 2021 manual by page number.

| Page | Section | Data Item | Change | Notes/Comments |
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| 26 | Section II: Information Source | CoC Accredited Flag | Coding instruction 2 added. | **Instructions for Central Cancer Registries**<br>Set the flag to 2 when all incoming records for the consolidated case have the CoC Accredited Flag set to 2 |
| 26 | Section II: Information Source | CoC Accredited Flag | Coding instruction 4 added. | **Instructions for Central Cancer Registries**<br>Set the flag to 2 when incoming records for the consolidated case have the CoC Accredited flag set to 0 and 2 |
| 26 | Section II: Information Source | CoC Accredited Flag | Coding instruction 5 revised. | Flag remains blank for<br>a. DCO cases<br><br>Deleted coding instructions<br>b. Pathologic only cases and<br>c. Autopsy only cases |
| 28 | Section III: Demographic Information | First Name | Introduction edited. | Added: This data item identifies the first name of the patient. First name may also be referred to as given name. |
| 28 | Section III: Demographic Information | First Name | Coding Instruction 2 revised. | Blank spaces, hyphens, and apostrophes are allowed; do not use other punctuation |
| 28 | Section III: Demographic Information | First Name | Coding instruction 4 revised | Record the most current name and update this data item if the first name changes. Enter previous names in the Alias data item (not included in this manual). |
| 28 | Section III: Demographic Information | First Name | Coding instruction 5 added. | Do not record nicknames in First Name<br>a. Record nicknames in the Alias data item (not included in this manual)<br>Example: The patient's nickname is Bill and the first name is William. Record William in First Name. |
| 29 | Section III: Demographic Information | Middle Name | Data item added. | See manual. |
| 30 | Section III: Demographic Information | Last Name | Introduction edited. | Added: This data item identifies the last name of the patient. Last name may also be referred to as surname. |

This table lists the changes in the 2021 manual by page number.

| Page | Section | Data Item | Change | Notes/Comments |
|---|---|---|---|---|
| 30 | Section III: Demographic Information | Last Name | Coding instruction 4 revised. | Record the most current name and update this data item if the last name changes. Enter previous names in the Alias data item (not included in this manual). |
| 31 | Section III: Demographic Information | Birth Surname | Data item added. | See manual. |
| 32 | Section III: Demographic Information | Social Security Number | Data item added. | See manual. |
| 33 | Section III: Demographic Information | Place of Residence | Section name changed. | Changed Section name to Place of Residence and sub-heading now Place of Residence at Diagnosis |
| 35 | Section III: Demographic Information | Address at Diagnosis--Number and Street Address | Data item added. | See manual. |
| 36 | Section III: Demographic Information | Address at Diagnosis--Supplemental | Data item added. | See manual. |
| 37 | Section III: Demographic Information | County | Introduction edited. | Codes for county of residence at the time of diagnosis for each SEER area are listed in Appendix A of this manual. |
| 42 | Section III: Demographic Information | Address at Diagnosis--City | Data item added. | See manual. |
| 44 | Section III: Demographic Information | Address at Diagnosis--Postal Code (ZIP Code) | Data item added. | See manual. |
| N/A | Section III: Demographic Information | Census Tract Poverty Indicator | Data item removed. | |

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| Page | Section | Data Item | Change | Notes/Comments |
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| N/A | Section III: Demographic Information | Rural Urban Continuum 2013 | Data item removed. | |
| N/A | Section III: Demographic Information | Rural Urban Commuting Area--Tract Level 2000 | Data item removed. | |
| N/A | Section III: Demographic Information | Rural Urban Commuting Area--Tract Level 2010 | Data item removed. | |
| N/A | Section III: Demographic Information | Urban Rural Indicator Code--Tract Level 2000 | Data item removed. | |
| N/A | Section III: Demographic Information | Urban Rural Indicator Code--Tract Level 2010 | Data item removed. | |
| 51 | Section III: Demographic Information | Current Address--Number and Street | Data item added. | See manual. |
| 52 | Section III: Demographic Information | Current Address--Supplemental | Data item added. | See manual. |
| 53 | Section III: Demographic Information | Current Address--City | Data item added. | See manual. |
| 54 | Section III: Demographic Information | Current Address--State | Data item added. | See manual. |
| 55 | Section III: Demographic Information | Current Address--Postal Code (ZIP Code) | Data item added. | See manual. |

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| Page | Section | Data Item | Change | Notes/Comments |
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| 56 | Section III: Demographic Information | Telephone | Data item added. | See manual. |
| 64 | Section III: Demographic Information | Age at Diagnosis | Introduction edited. | This data item represents the age of the patient at diagnosis for this cancer or tumor. This data item is tumor specific; i.e., the correct value could be different for each tumor diagnosis for a patient. |
| 66 | Section III: Demographic Information | Race 1, 2, 3, 4, 5 | Coding Instruction 2 revised. | Code race using the highest priority source available according to the list below (a is the highest and c is the lowest) when race is reported differently by two or more sources. Use self-reported information as first priority.<br><br>a. Self-reported race information takes precedence over genetic testing and over information obtained through linkages. Generally, race information is used from linkages when race data is missing or unknown, or to enhance data. Self-reported information is the highest priority for coding race because the race information for the U.S. population comes from census data and that information is self-reported. For national cancer statistics, in order for the numerator (cancer cases) and the denominator (population) to be comparable, use self-reported race information whenever it is available. |
| 67 | Section III: Demographic Information | Race 1, 2, 3, 4, 5 | Coding Instruction 6.b.i added. | A person of Spanish origin may be any race; however, for coding race when there is no further information other than “Hispanic” or “Latino(a),” assign race as White as a last resort instead of coding unknown. |
| 67 | Section III: Demographic Information | Race 1, 2, 3, 4, 5 | Example added. | ***Example*** : Sabrina Fitzsimmons is a Latina. No further information is available. Code race as 01 (White). |
| 68 | Section III: Demographic Information | Race 1, 2, 3, 4, 5 | Coding Instruction 18 revised. | Code the race data items in the order stated when no other priority applies |
| 68 | Section III: Demographic Information | Race 1, 2, 3, 4, 5 | Coding Instruction 19 added. | The race of parents, when known, may be used with caution to determine patient’s race in the absence of other more specific information (see coding examples 5 and 7) |
| N/A | Section III: Demographic Information | Race--NAPIIA | Data item removed. | |

This table lists the changes in the 2021 manual by page number.

| Page | Section | Data Item | Change | Notes/Comments |
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| 71 | Section III: Demographic Information | Spanish Surname or Origin | Introduction edited. | Added sentence: The data item is requested for submission to NAACCR. |
| 71 | Section III: Demographic Information | Spanish Surname or Origin | Code Description edited. | Code 7<br>Spanish surname only (effective with diagnosis on or after 01/01/1994)<br>The only evidence of the person's Hispanic origin is the surname or maiden name (birth surname) and there is no evidence that he/she is not Hispanic. |
| 71 | Section III: Demographic Information | Spanish Surname or Origin | Coding Instruction 2.e revised. | A last name or maiden name (birth surname) found on a list of Hispanic/Spanish names |
| 71 | Section III: Demographic Information | Spanish Surname or Origin | Coding Instruction 4 revised. | Assign code 7 when the only evidence of the patient's Hispanic origin is a surname or maiden name (birth surname) and there is no evidence that the patient is not Hispanic. Code 7 is ordinarily for central registry use only. |
| 72 | Section III: Demographic Information | Spanish Surname or Origin | Coding Examples 2 and 3 edited. | Added (birth surname) in each example following maiden name. See manual. |
| N/A | Section III: Demographic Information | Computed Ethnicity | Data item removed. | |
| N/A | Section III: Demographic Information | Computed Ethnicity Source | Data item removed. | |
| 76 | Section III: Demographic Information | Primary Payer at Diagnosis | Code 60, Medicare/Medicare, NOS definition edited. | Federal government funded insurance generally for persons who are 65 years of age or older, are chronically disabled (social security insurance eligible), or are dialysis patients. Includes Medicare without supplement. Not described in codes 61, 62, or 63. |
| 77 | Section III: Demographic Information | Primary Payer at Diagnosis | Coding Instruction 4.a added. | Code the first insurance mentioned when there is more than one type of insurance specified during the initial diagnosis and/or treatment |

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| Page | Section | Data Item | Change | Notes/Comments |
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| 78 | Section IV: Description of this Neoplasm | First page of section | Introductory paragraph added. | Pathology Reports<br>In general, SEER recommends that information from consult pathology reports be preferred over the original pathology report. This is because consults are usually requested from a more experienced or specialized pathologist/lab and are generally thought to be more accurate. |
| 80 | Section IV: Description of this Neoplasm | Date of Diagnosis | Coding Instruction 1 under Case NOT transmitted to NCI SEER edited. | Case NOT transmitted to NCI SEER<br><br>1. Code the date of diagnosis if known, even when case is not transmitted to SEER for other reasons |
| 81 | Section IV: Description of this Neoplasm | Date of Diagnosis | Coding Instruction 1.a exception added. | ***Exception*** : Do not use the date of diagnosis from a cytology report using ambiguous terminology. See Coding Instruction #5 below. |
| 86 | Section IV: Description of this Neoplasm | Sequence Number--Central | Table: Series 1 item revised. | All in situ (behavior code 2) **excluding** Cervix CIS, CIN III, SIN III of cervix |
| 86 | Section IV: Description of this Neoplasm | Sequence Number--Central | Table: Series 2 examples and note revised. | Non-malignant tumor/benign brain/intracranial<br><br>Cervix CIS/CIN III, SIN III of cervix<br>***Note*** : Submission of in situ cervical cancer is no longer required as of 2018 NCI SEER data submission. |
| 86 | Section IV: Description of this Neoplasm | Sequence Number--Central | Note revised. | ***Note*** : Conversion Guidance<br>Do **not** change the sequence numbers for neoplasms whose histology codes were associated with behavior codes that changed from in situ/malignant to benign/borderline or vice versa during the conversion from ICD-O-2 to ICD-O-3 or the conversion from ICD-O-3 to ICD-O-3.2. |
| 86 | Section IV: Description of this Neoplasm | Sequence Number--Central | Non-malignant Coding Instructions Note revised. | ***Note:*** Sequence all cervix in situ cases in the 60-87 range regardless of diagnosis year.<br>Submission of in situ cervical cancer is no longer required as of 2018 NCI SEER data submission |

This table lists the changes in the 2021 manual by page number.

| Page | Section | Data Item | Change | Notes/Comments |
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| 86 | Section IV: Description of this Neoplasm | Sequence Number--Central | Note under Table revised. | ***Note*** : Conversion Guidance:<br>Do **not** change the sequence numbers for neoplasms whose histology codes were associated with behavior codes that changed from in situ/malignant to benign/borderline or vice versa during the conversion from ICD-O-2 to ICD-O-3 or the conversion from ICD-O-3 to ICD-O-3.2. |
| 87 | Section IV: Description of this Neoplasm | Sequence Number--Central | Coding instructions 1-6 terminology edited. | Non-Malignant Coding Instructions<br>Replaced the term brain with intracranial. |
| 87 | Section IV: Description of this Neoplasm | Sequence Number--Central | Coding Instruction 2.a edited. | The sequence number is 60 when a patient has only one reportable non-malignant tumor. If a tumor has a sequence of 60 and there is another reportable non-malignant tumor, change the sequence number of the first primary from 60 to 61. |
| 87 | Section IV: Description of this Neoplasm | Sequence Number--Central | Note revised. | Non-Malignant Coding Instructions<br>***Note*** : Sequence all cervix in situ cases in the 60-87 range regardless of diagnosis year.<br>Submission of in situ cervical cancer is no longer required as of 2018 NCI SEER data submission. |
| 88 | Section IV: Description of this Neoplasm | Primary Site | Introductory note revised. | ***Note:*** Continue to use ICD-O-3 for assigning topography codes. ICD-O-3.2 did not change any of the topography codes. |
| 88 | Section IV: Description of this Neoplasm | Primary Site | Coding Instructions 2.a-d added | Code the site in which the primary tumor **originated,** even if it extends onto/into an adjacent subsite<br>a. Primary site should always be coded to reflect the site of origin according to the medical opinion on the case. Look for information about where the neoplasm originated. Always code the primary site based on where the tumor arose / site of origin.<br>b. Site of origin may be indicated by terms such as "tumor arose from…," "tumor originated in…," or similar statements<br>c. Site of origin is not necessarily the site of a biopsy<br>d. Tumors may involve many sites. The primary site code should reflect the site where the tumor arose rather than all of the sites of involvement. |

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| 89 | Section IV: Description of this Neoplasm | Primary Site | Coding Instruction 2 example added. | ***Example 6*** : The patient has a left lower lip wedge excision showing invasive squamous cell carcinoma at the mucocutaneous junction. There is no further information in operative report or pathology report regarding the location of this tumor that would indicate this is a skin primary. Assign C001, external lower lip. C001 includes vermilion border of lower lip. Vermilion border is synonymous with mucocutaneous junction. |
| 89 | Section IV: Description of this Neoplasm | Primary Site | Coding instruction 4 revised. | Code the site of the invasive tumor when there is an invasive tumor and also in situ tumor in different subsites of the same anatomic site |
| 89 | Section IV: Description of this Neoplasm | Primary Site | Coding instructions 6, 6.a-6.c revised. | See manual. ICD-O-3 was changed to ICD-O-3.2. |
| 90 | Section IV: Description of this Neoplasm | Primary Site | Coding Instruction 11 revised. | Gastrointestinal Stromal Tumors (GIST): Code the primary site to the location where the GIST originated |
| 90 | Section IV: Description of this Neoplasm | Primary Site | Coding Instruction 13 added. | Assign primary site code C449, skin NOS, for a Merkel cell carcinoma presenting in a nodal or distant metastatic site and site of origin is **unknown**<br><br>Renumbered subsequent instructions to 14 and 15. |
| 90 | Section IV: Description of this Neoplasm | Primary Site | Coding Instruction 14 revised (primary sites added). | Added/edited to coding instruction #14 (formerly #13), list of primary site codes:<br>Ampullary/peri-ampullary, C241<br>Clavicular skin, C445<br>Gastrohepatic ligament, C481<br>Genu of pancreas, C250<br>Interhemispheric fissure (cerebrum), C710<br>Lateral tongue, C023<br>Masticator space, C760<br>Uncinate of pancreas, C250<br><br>Added table column header to Topography Code |

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| 91 | Section IV: Description of this Neoplasm | Primary Site | Coding Instruction 15.b revised. | Added:<br>Occult Tumors of the Head and Neck<br><br>Assign primary site C119 (nasopharynx) for occult head and neck tumors with cervical metastasis in Levels I-VII, and other group lymph nodes positive for Epstein–Barr virus (EBV+) (regardless of p16 status) encoded small RNAs (EBER) identified by in situ hybridization.<br><br>Assign primary site C109 (oropharynx) for occult head and neck tumors with cervical metastasis in Levels I-VII, and other group lymph nodes, p16 positive with histology consistent with HPV-mediated oropharyngeal carcinoma (OPC). |
| 92 | Section IV: Description of this Neoplasm | Primary Site | Subheading revised. | Coding Instructions for Hematopoietic and Lymphoid Neoplasms (9590/3-9993/3) |
| 93 | Section IV: Description of this Neoplasm | Laterality | Coding Instructions 1.a added. | The primary site is not a paired site |
| 93, 94 | Section IV: Description of this Neoplasm | Laterality | Coding Instructions 1.c and 6.b. revised. | Deleted C090-C091 from Laterality coding instructions 1.c and 6.b. |
| 94 | Section IV: Description of this Neoplasm | Laterality | Text moved. | Sites for Which Laterality Codes Must Be Recorded<br><br>Two paragraphs that were below the code/site table moved to the section above the table. |
| 96 | Section IV: Description of this Neoplasm | Diagnostic Confirmation | Coding instruction 2 edited. | Coding Instructions for Solid Tumors<br><br>Change to a higher-priority code, if at **ANY TIME** during the course of disease the patient has a diagnostic confirmation with a **higher priority.** Change to the higher-priority code even when diagnostic confirmation is based on the result of subsequent treatment. |

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| Page | Section | Data Item | Change | Notes/Comments |
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| 97 | Section IV: Description of this Neoplasm | Diagnostic Confirmation | Coding instruction 6 and example edited. | Assign code **5** when the diagnosis of cancer is based on laboratory tests or tumor marker studies that are clinically diagnostic for that specific cancer and there is no other diagnostic work up (e.g., imaging)<br><br>***Example*** : If the workup for a prostate cancer patient is limited to a highly elevated PSA (no DRE and no imaging) and the physician **diagnoses and/or treats** the patient based only on that PSA, code the diagnostic confirmation to 5. |
| 98 | Section IV: Description of this Neoplasm | Diagnostic Confirmation | Table heading revised. | Codes for Hematopoietic and Lymphoid Neoplasms (9590/3-9993/3) |
| 100 | Section IV: Description of this Neoplasm | Histologic Type ICD-O-3 | Introductory (second) paragraph edited. | The current Solid Tumor Rules, the Hematopoietic and Lymphoid Neoplasm Coding Manual, the Hematopoietic and Lymphoid Neoplasm Database, and the International Classification of Diseases for Oncology, Third Edition, Second Revision Morphology (ICD-O-3.2) are the standard references for histology codes. |
| 100 | Section IV: Description of this Neoplasm | Histologic Type ICD-O-3 | Subheading and text revised. | ICD-O-3.2<br>For 2021, standard setters have agreed to implement new histology terms and codes for ICD-O-3 based on the current versions of the *World Health Organization Classification of Tumors* . The update, referred to as ICD-O-3.2, includes comprehensive tables listing histology codes and behavior codes in effect beginning with cases diagnosed in 2021. The new codes, new terms, and codes with changes to behavior are available at https://www.naaccr.org/2021-implementation. |
| 101 | Section IV: Description of this Neoplasm | Behavior Code | Text and example in second paragraph revised. | Metastatic or Non-primary Sites<br><br>Code the behavior as malignant (/3) when malignant metastasis is present. Metastasis could be regional, nodal, or distant.<br><br>***Example*** : Adenocarcinoma in situ with lymph nodes positive for malignancy. Code the behavior as malignant (/3).<br><br>***Exception*** : For in situ breast cancer; code as non-invasive (/2) in the presence of isolated tumor cells or if cells are artifactually displaced from a previous procedure. |

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| Page | Section | Data Item | Change | Notes/Comments |
|---|---|---|---|---|
| 102 | Section IV: Description of this Neoplasm | Behavior Code | Subheading revised. | ICD-O-3.2 Histology/Behavior Code Listing |
| 103 | Section IV: Description of this Neoplasm | Behavior Code | Subheading revised. | Synonyms for In Situ Behavior |
| 105 | Section IV: Description of this Neoplasm | Grade Post Therapy Clin (yc) | Data item added. | See manual. |
| 107 | Section IV: Description of this Neoplasm | Grade Post Therapy Path (yp) | Introductory text revised. | See manual. |
| 108 | Section IV: Description of this Neoplasm | Tumor Size--Clinical | Coding instructions revised. | See manual. |
| 114 | Section IV: Description of this Neoplasm | Tumor Size--Pathologic | Coding instructions revised. | See manual. |
| N/A | Section IV: Description of this Neoplasm | ICD-O-2 Conversion Flag | Data item removed. | |
| 123 | Section V: Stage of Disease at Diagnosis | Extent of Disease Primary Tumor | Introductory text revised. | Extent of Disease Primary Tumor (EOD Primary Tumor) is part of the EOD 2018 data collection system and is used to classify contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs at the time of diagnosis. See also EOD Regional Nodes and EOD Mets. Effective for cases diagnosed 01/01/2018 and later. |
| 124 | Section V: Stage of Disease at Diagnosis | Extent of Disease Regional Nodes | Introductory text revised. | Extent of Disease Regional Nodes (EOD Regional Nodes) is part of the EOD 2018 data collection system and is used to classify the regional lymph nodes involved with cancer at the time of diagnosis. See also EOD Primary Tumor and EOD Mets. Effective for cases diagnosed 01/01/2018 and later. |
| 125 | Section V: Stage of Disease at Diagnosis | Extent of Disease Metastases | Introductory text revised. | Extent of Disease Metastases (EOD Mets) is part of the EOD 2018 data collection system and is used to classify the distant site(s) of metastatic involvement at time of diagnosis. See also EOD Primary Tumor and EOD Regional Nodes. Effective for cases diagnosed 01/01/2018 and later. |

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| 125 | Section V: Stage of Disease at Diagnosis | Extent of Disease Metastases | Code revised. | Code 88<br>Not applicable: Information not collected for this schema<br>Use for these sites only<br>HemeRetic<br>Ill Defined Other (includes unknown primary site)<br>Kaposi Sarcoma<br>Lymphoma<br>Lymphoma-CLL/SLL<br>Plasma Cell Disorder<br>Plasma Cell Myeloma |
| 127 | Section V: Stage of Disease at Diagnosis | Summary Stage 2018 | Introductory text revised. | Summary Stage 2018 stores directly assigned Summary Stage 2018. This data item is effective for cases diagnosed 01/01/2018 and later. Refer to SEER*RSA for additional information. |
| 128 | Section V: Stage of Disease at Diagnosis | Derived Summary Stage 2018 | Introductory text revised. | Derived Summary Stage 2018 is derived using the EOD data collection system (EOD Primary Tumor, EOD Regional Nodes, and EOD Mets) algorithm. Other data items may be included in the derivation process. Effective for cases diagnosed 01/01/2018 and later. |
| 131 | Section VI: Stage-related Data Items | Lymphovascular Invasion | Data item moved. | Data item moved from Section V. Stage of Disease at Diagnosis to Section VI. Stage-related Data Items |
| 131 | Section VI: Stage-related Data Items | Lymphovascular Invasion | Introductory note revised. | ***Note*** : **SEER requires Lymphovascular Invasion (LVI) for penis and testis cases only.** SEER registries may submit LVI for other sites when available. State/central cancer registries may require LVI for sites other than penis and testis. Record 8 for sites other than penis or testis when LVI is not required. LVI is always coded 8 for certain sites (see Coding Instruction #8). |
| 131 | Section VI: Stage-related Data Items | Lymphovascular Invasion | Coding instructions 1-9 revised. | See manual. In addition to revisions, added instruction 8.b. |
| 134 | Section VI: Stage-related Data Items | Mets at Diagnosis data items: Bone, Brain, Liver, Lung, Distant Lymph Nodes, Other | Data items moved. | Data items moved from Section V. Stage of Disease at Diagnosis to Section VI. Stage-related Data Items |

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| 134 | Section VI: Stage-related Data Items | Mets at Diagnosis--Bone | Coding instructions 1.c, 1.d.ii, 1.d.iii, 2.a.ii, and 2.c revised. | See manual. |
| 136 | Section VI: Stage-related Data Items | Mets at Diagnosis--Brain | Coding instructions 1.c, 1.d.ii, 1.d.iii, 2.a.ii, and 2.c revised | See manual. |
| 138 | Section VI: Stage-related Data Items | Mets at Diagnosis--Liver | Coding instructions 1.c, 1.d.ii, 1.d.iii, 2.a.ii, and 2.c revised. | See manual. |
| 140 | Section VI: Stage-related Data Items | Mets at Diagnosis--Lung | Coding instructions 1.c, 1.d.ii, 1.d.iii, 2.a.ii, and 2.c revised. | See manual. |
| 142 | Section VI: Stage-related Data Items | Mets at Diagnosis--Distant Lymph Node(s) | Coding instructions 1.c, 1.e.ii, 1.d.iii, 2.a.ii, and 2.c revised. | See manual. |
| 144 | Section VI: Stage-related Data Items | Mets at Diagnosis--Other | Coding instructions 1.c, 1.d.ii, 1.d.iii, 2.a.ii, and 2.c revised. | See manual. |
| 146 | Section VI: Stage-related Data Items | SEER Site-specific Factor 1 | List of applicable schemas revised. | Revised the list of schemas and schema IDs that apply to this data item. |

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| 146 | Section VI: Stage-related Data Items | SEER Site-specific Factor 1 | Code revised. | Code 9<br>Not documented in medical record<br>HPV test detecting viral DNA and or RNA not assessed, or unknown if assessed |
| 147 | Section VI: Stage-related Data Items | SEER Site-specific Factor 1 | Coding Instruction 6 removed. | Leave blank when no applicable test is performed. |
| 148 | Section VI: Stage-related Data Items | Additional Stage-related Data Items | Schema Discriminator section text revised and tables added. | See manual. Added Tables 2 and 3; edited Table 4 (formerly Table 2). |
| 151 | Section VII: First Course of Therapy | First Course of Therapy/Definition | Definition revised. | Added to Active Surveillance: Also called active monitoring. |
| 152 | Section VII: First Course of Therapy | First Course of Therapy/Treatment Timing | Instruction 1 revised. | 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). |
| 153 | Section VII: First Course of Therapy | First Course of Therapy/Treatment Timing | Coding Instruction 1 revised. | 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. |
| 154 | Section VII: First Course of Therapy | First Course of Therapy/Treatment Timing | Coding Instruction 7.a revised. | 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. |
| 156 | Section VII: First Course of Therapy | Date Therapy Initiated | Coding Instruction 1 revised. | Revised these bullets:<br>• Scope of Regional Lymph Node Surgery (excluding code 1)<br>• Radiation Treatment Modality--Phase I, II, III |
| 156 | Section VII: First Course of Therapy | Date Therapy Initiated | Coding Instruction 3 example dates revised. | ***Example:*** On 01/03/2021, fetus is diagnosed with malignant teratoma. The teratoma is resected in utero on 01/10/2021. Live birth on 04/18/2021. Code the date therapy initiated as January 10, 20218 (20210110). |

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| 158 | Section VII: First Course of Therapy | Date Therapy Initiated Flag | Introductory text added. | This flag may be autogenerated depending on the software in use. |
| 159 | Section VII: First Course of Therapy | Treatment Status | Coding Instruction 1 added. | Assign code 0 when the patient does not receive any treatment<br>a. Scope of Regional Lymph Node Surgery may be coded 0, 1-7, or 9 |
| 159 | Section VII: First Course of Therapy | Treatment Status | Coding Instruction 2 revised. | Assign code 1 when the patient receives treatment collected in any of the following data items<br>a. Surgery of Primary Site<br>b. Surgical Procedure of Other Site<br>c. Radiation Treatment Modality, Phase I, II, III<br>d. Chemotherapy<br>e. Hormone Therapy<br>f. Immunotherapy<br>g. Hematologic Transplant and Endocrine Procedures<br>h. Other Therapy<br><br>Removed Scope of Regional Lymph Node Surgery from list. |
| 159 | Section VII: First Course of Therapy | Treatment Status | Coding Instruction 3 added. | Assign code **2** when there is documentation that the patient is being monitored using **active surveillance/watchful waiting/deferred therapy or other similar options** |
| 160 | Section VII: First Course of Therapy | Date of First Surgical Procedure | Coding Instruction 1 revised. | Record the date of the first/earliest surgery if Surgery of Primary Site, Scope of Regional Lymph Node Surgery (excluding cases coded to 1), or Surgical Procedure of Other Site was recorded as part of the first course of therapy |
| 161 | Section VII: First Course of Therapy | Date of First Surgical Procedure Flag | Introductory text added. | This flag may be autogenerated depending on the software in use. |
| 163 | Section VII: First Course of Therapy | Date of Most Definitive Surgical Resection of the Primary Site Flag | Introductory text added. | This flag may be autogenerated depending on the software in use. |

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| 164 | Section VII: First Course of Therapy | Surgery of Primary Site | Text added. | Added text below code table:<br>Use the **entire operative report** as the primary source document to determine the best surgery of primary site code. The body of the operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the **operative report takes precedence**. |
| 165 | Section VII: First Course of Therapy | Surgery of Primary Site | Coding Instruction 4 Notes revised. | ***Note 1*** : Do **not** code an incisional biopsy as an excisional biopsy when there is macroscopic residual disease.<br><br>***Note 2*** : Shave or punch biopsies are most often diagnostic. Code as a surgical procedure **only** when the entire tumor is removed and margins are clear (meeting the criteria in either 4.a or 4.b above). |
| 165 | Section VII: First Course of Therapy | Surgery of Primary Site | Coding Instruction 4 Example added. | ***Example*** : Shave biopsy performed for a suspicious lesion on the skin of the right arm that has been changing in size and color. The shave biopsy pathology report showed malignant melanoma with only microscopically positive margins. Code the shave biopsy as an excisional biopsy. |
| 165 | Section VII: First Course of Therapy | Surgery of Primary Site | Coding Instruction 5 Example added. | ***Example*** : Left thyroidectomy for suspicious nodules. Path showed papillary carcinoma. Completion thyroidectomy was performed. Code surgery of primary site as total thyroidectomy (50). |
| 165 | Section VII: First Course of Therapy | Surgery of Primary Site | Coding Instruction 10 revised. | Code **98** for the following primary sites **unless** the case is death certificate only (see #12 below)<br>a. Any case coded to C420, C421, C423, C424, C760-C768, or C809 |
| 165 | Section VII: First Course of Therapy | Surgery of Primary Site | Coding Instruction 11 added. | When Surgery of Primary Site is coded **98**<br>a. Code Surgical Margins of the Primary Site (#1320) to 9<br>b. Code Reason for No Surgery of Primary Site (#1340) to 1 |
| 165 | Section VII: First Course of Therapy | Surgery of Primary Site | Coding Instruction 12 revised. | Code **99** for death certificate only (DCO) cases or if patient record does not state whether a surgical procedure of the primary site was performed (i.e., is unknown) |

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| 166 | Section VII: First Course of Therapy | Surgical Margins of the Primary Site | Coding Instruction 7 revised. | Assign code **9**<br>a. When Surgery of Primary Site (#1290) is coded to 98 (not applicable)<br>b. When it is unknown whether a surgical procedure of the primary site was performed or there is no mention in the pathology report or no tissue was sent to pathology<br>c. For any case coded to primary site C420, C421, C423, C424, C760-C768, C770-C779, or C809<br>d. For death certificate only (DCO) cases |
| 168 | Section VII: First Course of Therapy | Scope of Regional Lymph Node Surgery | Coding Instruction 5.a.iii added. | Assume the lymph node that is aspirated is part of the lymph node chain surgically removed and do not include it in the count when its location is **not known** |
| 168 | Section VII: First Course of Therapy | Scope of Regional Lymph Node Surgery | Coding Instruction 7 added. | Assign the appropriate code for **occult head and neck primaries with positive cervical lymph nodes** (schema 00060). Do not default to code 9 for this schema. |
| 169 | Section VII: First Course of Therapy | Scope of Regional Lymph Node Surgery | Coding Instruction 13.a revised. | Assign code **9** for<br>i. Any case coded to primary site: C420, C421, C423, C424, C589, C700-C709, C710-C729, C751-C753, C761-C768, C770-C779, or C809<br>ii. Lymphoma (excluding CLL/SLL) 00790<br>iii. Lymphoma (CLL/SLL) 00795<br>iv. Plasma Cell Disorders (excluding histology 9734/3) 00822 |
| 171 | Section VII: First Course of Therapy | Date of Sentinel Lymph Node Biopsy | Introductory text revised. | **This data item is required for breast and cutaneous melanoma cases only.** |
| 171 | Section VII: First Course of Therapy | Date of Sentinel Lymph Node Biopsy | Coding Instruction 6 added. | Leave this date blank when sentinel lymph node biopsy was attempted, but unsuccessful (e.g. failed to map). Leave this date blank for cases other than breast and cutaneous melanoma. |
| 172 | Section VII: First Course of Therapy | Date of Sentinel Lymph Node Biopsy Flag | Introductory text added. | This flag may be autogenerated depending on the software in use. |
| 172 | Section VII: First Course of Therapy | Date of Sentinel Lymph Node Biopsy Flag | Coding Instruction 3 b. and 3.c added. | b. Sentinel lymph node biopsy was attempted, but unsuccessful (e.g., failed to map)<br>c. Case was not breast or cutaneous melanoma |

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| 173 | Section VII: First Course of Therapy | Sentinel Lymph Nodes Examined | Introductory text added. | This data item may be left blank for cases other than breast and cutaneous melanoma. |
| 174 | Section VII: First Course of Therapy | Sentinel Lymph Nodes Positive | Introductory text added. | This data item may be left blank for cases other than breast and cutaneous melanoma. |
| 176 | Section VII: First Course of Therapy | Date of Regional Lymph Node Dissection | Coding Instruction 2 revised. | Record the date of the regional lymph node dissection in this data item and record the date of the sentinel node biopsy procedure in the Date of Sentinel Lymph Node Biopsy data item [NAACCR Item #832] for breast and cutaneous melanoma cases when |
| 176 | Section VII: First Course of Therapy | Date of Regional Lymph Node Dissection | Coding Instruction 3 revised. | Record the date of the regional lymph node dissection in this data item for all cases other than breast and cutaneous melanoma |
| 176 | Section VII: First Course of Therapy | Date of Regional Lymph Node Dissection | Coding Instruction 4 added. | Leave Date of Regional Lymph Node Dissection blank when only a sentinel lymph node biopsy is performed |
| 177 | Section VII: First Course of Therapy | Date of Regional Lymph Node Dissection Flag | Introductory text added. | This flag may be autogenerated depending on the software in use. |
| 178 | Section VII: First Course of Therapy | Regional Nodes Positive | Coding Instruction 1.a revised. | Include lymph nodes that are regional in the current AJCC Staging Manual or EOD Regional Nodes 2018 |
| 178 | Section VII: First Course of Therapy | Regional Nodes Positive | Coding Instruction 4 revised. | **Nodes positive is cumulative.** Record the total number of regional lymph nodes removed and found to be positive by pathologic examination. Record lymph nodes removed and found to be positive during an autopsy for autopsy-only cases. |
| 179 | Section VII: First Course of Therapy | Regional Nodes Positive | Coding Instruction 5.b revised. | Synoptic report (also known as CAP protocol or pathology report checklist; the consolidated findings on the CAP protocol) |
| 179 | Section VII: First Course of Therapy | Regional Nodes Positive | Coding Instruction 7.a revised. | For all cases **except cutaneous melanoma and Merkel cell** carcinoma of skin |
| 179 | Section VII: First Course of Therapy | Regional Nodes Positive | Coding Instruction 7.b revised. | For cutaneous melanoma and Merkel cell carcinoma of skin |

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| 180 | Section VII: First Course of Therapy | Regional Nodes Positive | Coding Instructions 11.a-11.e revised. | Use code **99** for<br>a. Any case coded to primary site C420, C421, C423, C424, C589, C700-C709, C710-C729, C751-C753, C761-C768, C770-C779, or C809<br>b. Lymphoma (excluding CLL/SLL) 00790<br>c. Lymphoma (CLL/SLL) 00795<br>d. Plasma Cell Disorders (excluding 9734/3) 00822<br>e. Cases with no information about positive regional lymph node |
| 181 | Section VII: First Course of Therapy | Regional Nodes Examined | Coding Instruction 1.a revised. | Include lymph nodes that are regional in the current AJCC Staging Manual or EOD Regional Nodes 2018 |
| 181 | Section VII: First Course of Therapy | Regional Nodes Examined | Coding Instruction 4 revised. | Nodes removed and examined is cumulative. Record the total number of regional lymph nodes removed and examined by the pathologist. Record lymph nodes removed during an autopsy for autopsy-only cases. |
| 182 | Section VII: First Course of Therapy | Regional Nodes Examined | Coding Instruction 5.b revised. | Synoptic report (also known as CAP protocol or pathology report checklist; the consolidated findings on the CAP protocol) |
| 182 | Section VII: First Course of Therapy | Regional Nodes Examined | Coding Instruction 9 revised. | Definition of **"dissection"** (**code 97**). A lymph node "dissection" is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, and lymph node stripping. Removal of lymph nodes during autopsy is a dissection. Use code 97 when more than a limited number of lymph nodes are removed and the number is unknown. |
| 183 | Section VII: First Course of Therapy | Regional Nodes Examined | Coding Instructions 12.a-12.e revised. | Use code **99** for<br>a. Any case coded to primary site C420, C421, C423-C424, C589, C700-C709, C710-C729, C751-C753, C761-C768, C770-C779, or C809<br>b. Lymphoma (excluding CLL/SLL) 00790<br>c. Lymphoma (CLL/SLL) 00795<br>d. Plasma Cell Disorders (excluding 9734/3) 00822<br>e. Cases with no information about the examination of regional lymph nodes |
| 184 | Section VII: First Course of Therapy | Surgical Procedure of Other Site | Coding Instructions moved. | Moved instructions formerly 4 and 5 to 1 and 2. Renumbered subsequent instructions. |

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| 184 | Section VII: First Course of Therapy | Surgical Procedure of Other Site | Coding Instruction 5.b. revised. | When any surgery is performed to remove tumors for any case coded to primary site C420, C421, C423, C424, C760-C768, C770-C779, or C809<br>i. **Excluding** cases coded to the schema Cervical Lymph Nodes and Unknown Primary 00060 |
| 184 | Section VII: First Course of Therapy | Surgical Procedure of Other Site | Coding Instruction 6 revised. | Assign code **2** for sites that are regional. Include sites that are regional in the current AJCC Staging Manual or EOD 2018. |
| 185 | Section VII: First Course of Therapy | Surgical Procedure of Other Site | Coding Instruction 7 revised. | Assign code **4** for sites that are distant. Include sites that are distant in the current AJCC Staging Manual or EOD 2018. |
| 186 | Section VII: First Course of Therapy | Reason for No Surgery of Primary Site | Coding Instruction 2 added. | Assign code **1** when Surgery of Primary Site is coded 98 (not applicable) |
| 186 | Section VII: First Course of Therapy | Reason for No Surgery of Primary Site | Coding Instruction 3 revised. | Assign a code **I** the **range of 1-8** when Surgery of Primary Site is coded 00 |
| 186 | Section VII: First Course of Therapy | Reason for No Surgery of Primary Site | Coding Instruction 3.a.i and note added. | Assign code 1 when<br>i. Primary site is C420, C421, C423, C424, C760-C768, or C809<br>***Note*** : Surgery is not standard treatment for these cases. |
| 187 | Section VII: First Course of Therapy | Reason for No Surgery of Primary Site | Coding Instruction 3.a.iv added. | Surgery was part of the first course of treatment but was cancelled due to complete response to radiation and/or systemic therapy |
| 187 | Section VII: First Course of Therapy | Reason for No Surgery of Primary Site | Coding Instruction 3.c.ii revised. | Makes a blanket statement that he/she refused all treatment when surgery is a customary option according to NCCN guidelines and/or the NCI PDQ for the primary site/histology |
| 189 | Section VII: First Course of Therapy | Date Radiation Started | Coding Instruction 1.a added. | Do **not** record the date of the initial radiation planning session |
| 190 | Section VII: First Course of Therapy | Date Radiation Started Flag | Introductory text added. | This flag may be autogenerated depending on the software in use. |

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| 191 | Section VII: First Course of Therapy | Radiation Treatment Modality--Phase I, II, III | Code added. | Added code and description:<br>98 Radiation therapy administered, but treatment modality is not specified or unknown |
| 191 | Section VII: First Course of Therapy | Radiation Treatment Modality--Phase I, II, III | Code Descriptions edited. | Changed to lower case:<br>10 Brachytherapy, interstitial, LDR<br>11 Brachytherapy, interstitial, HDR<br>14 Radioisotopes, radium-232<br>15 Radioisotopes, strontium-89<br>16 Radioisotopes, strontium-90 |
| 191 | Section VII: First Course of Therapy | Radiation Treatment Modality--Phase I, II, III | Text added. | • Refer to the current STandards for Oncology Registry Entry (STORE) Manual and the CTR Guide to Coding Radiation Therapy Treatment in the STORE |
| 194 | Section VII: First Course of Therapy | Radiation External Beam Planning Technique--Phase I, II, III | Text added. | • Refer to the current STandards for Oncology Registry Entry (STORE) Manual and the CTR Guide to Coding Radiation Therapy Treatment in the STORE |
| 195 | Section VII: First Course of Therapy | Radiation Sequence with Surgery | Introductory text revised. | This data item records the order in which surgery and radiation therapies were administered for those patients who had **both surgery and radiation**. For the purpose of coding the data item Radiation Sequence with Surgery, 'Surgery' is defined as a Surgical Procedure of Primary Site (codes 10-90) or Scope of Regional Lymph Node Surgery (codes 2-7) or Surgical Procedure of Other Site (codes 1-5). |
| 195 | Section VII: First Course of Therapy | Radiation Sequence with Surgery | Coding Instruction 2.a revised. | Assign code 4 when there are at least two courses, 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) |
| 196 | Section VII: First Course of Therapy | Radiation Sequence with Surgery | Coding Instruction 2.b Example 2 #1 and text revised. | Two regional lymph nodes removed<br><br>Code Radiation Sequence with Surgery as 7 (surgery both before and after radiation) because regional lymph node removal is coded in Scope of Regional Lymph Node Surgery. |

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| 199 | Section VII: First Course of Therapy | Date Systemic Therapy Started Flag | Introductory text added. | This flag may be autogenerated depending on the software in use. |
| 200 | Section VII: First Course of Therapy | Date Chemotherapy Started | Coding Instruction 1.a revised. | Code the date that the prescription or physician order was written if date administered unknown |
| 201 | Section VII: First Course of Therapy | Date Chemotherapy Started Flag | Introductory text added. | This flag may be autogenerated depending on the software in use. |
| 203 | Section VII: First Course of Therapy | Chemotherapy | Example 1 revised. | ***Example 1*** : Patient diagnosed with HER2 positive breast cancer December 15, 2020 and was placed on planned Herceptin February 2, 2021. Code Herceptin in the BRM/Immunotherapy data item (as the patient was diagnosed after January 1, 2013). |
| 204 | Section VII: First Course of Therapy | Chemotherapy | Coding Instruction 4 revised and example added. | Code as treatment for both primaries when the patient receives chemotherapy for invasive carcinoma in one breast and also has an invasive or in situ carcinoma in the other breast. Chemotherapy would likely affect both primaries.<br><br>***Example:*** Patient is diagnosed with infiltrating duct carcinoma, stage III, in the right breast and infiltrating duct carcinoma, stage I, in the left breast. Neoadjuvant chemotherapy is administered for the stage III neoplasm in the right breast per the breast surgeon consult, but not for the left breast. Code the chemotherapy on both abstracts for both primaries in this case (simultaneous bilateral breast primaries). |
| 209 | Section VII: First Course of Therapy | Date Hormone Therapy Started Flag | Introductory text added. | This flag may be autogenerated depending on the software in use. |
| 214 | Section VII: First Course of Therapy | Date Immunotherapy Therapy Started Flag | Introductory text added. | This flag may be autogenerated depending on the software in use. |
| 216 | Section VII: First Course of Therapy | Immunotherapy | Example dates revised. | ***Example:*** Patient diagnosed with breast cancer January 5, 2021, and begins receiving Herceptin as part of first course therapy on January 30, 2021. Code the Herceptin in the BRM/Immunotherapy data item. |

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| 219 | Section VII: First Course of Therapy | Hematologic Transplant And Endocrine Procedures | Definition revised. | ***Conditioning:*** High-dose chemotherapy with or without radiation administered prior to transplant such as BMT and stem cells to kill cancer cells. This conditioning also destroys normal bone marrow cells so the normal cells need to be replaced (rescue). The high dose chemotherapy is coded in the Chemotherapy data item and the radiation is coded in the Radiation Treatment Modality--Phase I, II, III data items. |
| 220 | Section VII: First Course of Therapy | Hematologic Transplant And Endocrine Procedures | Coding instruction 3 revised. | Codes **11** (Bone marrow transplant autologous) **and 12** (Bone marrow transplant allogeneic) have priority over code 10 (BMT, NOS) |
| 221 | Section VII: First Course of Therapy | Systemic Treatment/Surgery Sequence | Introductory text revised. | This data item records the sequence of any systemic therapy and surgery given as first course of therapy for those patients who had both systemic therapy and surgery. For the purpose of coding systemic treatment sequence with surgery, 'Surgery' is defined as a Surgical Procedure of Primary Site (codes 10-90) or Scope of Regional Lymph Node Surgery (codes 2-7) or Surgical Procedure of Other Site (codes 1-5). |
| 222 | Section VII: First Course of Therapy | Neoadjuvant Therapy | Data item added. | See manual. |
| 227 | Section VII: First Course of Therapy | Neoadjuvant Therapy--Clinical Response | Data item added. | See manual. |
| 231 | Section VII: First Course of Therapy | Neoadjuvant Therapy--Treatment Effect | Data item added. | See manual. |
| 233 | Section VII: First Course of Therapy | Date Other Treatment Started Flag | Introductory text added. | This flag may be autogenerated depending on the software in use. |
| 234 | Section VII: First Course of Therapy | Other Therapy | Coding instructions reordered. | See manual. Moved instruction formerly 1.b to 1.d. |
| 235 | Section VII: First Course of Therapy | Other Therapy | Coding Instruction 2.d added. | Peptide Receptor Radionuclide Therapy (PRRT)<br><br>Also revised formatting/numbering of coding instructions. |

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| 240 | Section VIII: Follow Up Information | Date of Last Follow-Up or of Death | Coding Instruction 4 revised. | Record the date of death for<br>a. Deceased patients<br>b. Death certificate only (DCO) cases<br>c. Autopsy only cases |
| 242 | Section VIII: Follow Up Information | Date of Last Follow-Up or of Death | Introductory text added. | This flag may be autogenerated depending on the software in use. |
| 243 | Section VIII: Follow Up Information | Vital Status | Coding Instruction 1 revised. | Assign code 0 for<br>a. Deceased patients<br>b. Death certificate only (DCO) cases<br>c. Autopsy only cases |
| N/A | Section VIII: Follow Up Information | Type of Follow-Up | Data item removed. | |
| 247 | Section VIII: Follow Up Information | Survival Data Items | XML NAACCR ID added. | Added table column for XML NAACCR ID; deleted Column # and Length columns. |
| | Appendix A | County Codes | Programs/county codes updated. | See Appendix A for updated county codes for SEER programs. |
| | Appendix B: B1, B2, B3, B4 | Country and State Codes | Country names and codes updated. | See Appendix B for updated country names and codes. |
| | Appendix C: Site Specific Coding Modules | Coding Guidelines: Bladder | Histology section revised. | Over 90% of bladder cancers are urothelial (transitional) cell carcinomas, derived from the uroepithelium. Other types include squamous cell carcinoma (about 2% to 7%) and adenocarcinoma (about 2%). Adenocarcinomas may be of urachal origin or nonurachal origin, with the nonurachal type generally thought to arise from metaplasia of chronically irritated transitional epithelium. Small cell carcinoma, and rarely sarcoma, can also occur. Childhood rhabdomyosarcoma, a type of sarcoma, can form in muscle tissue of the bladder. |

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|---|---|---|---|---|
| | Appendix C: Site Specific Coding Modules | Coding Guidelines: Bladder | Behavior Code section revised. | See manual. |
| | Appendix C: Site Specific Coding Modules | Coding Guidelines: Bones | Histology codes removed. | Removed histology exceptions for consistency with other coding guidelines. |
| | Appendix C: Site Specific Coding Modules | Coding Guidelines: Brain | Histology codes removed. | Removed histology exceptions for consistency with other coding guidelines. |
| | Appendix C: Site Specific Coding Modules | Coding Guidelines: Brain | Reportability section revised. | • Pilocytic astrocytoma/Juvenile astrocytoma, listed as 9421/1 in ICD-O-3.2, is reportable. Record as 9421/3 in the registry.<br>***Exception:*** The behavior is non-malignant (9421/1) when the primary site is optic nerve (C723). |
| | Appendix C: Site Specific Coding Modules | Coding Guidelines: Brain | Histology section revised. | Code low grade neuroepithelial neoplasm to 9413/0 (Dysembryoplastic neuroepithelial tumor). |
| | Appendix C: Site Specific Coding Modules | Coding Guidelines: Brain | Laterality section revised. | Meningioma<br>Assign code **4** (Bilateral involvement, lateral origin unknown; stated to be single primary) when<br>• One meningioma extends to both right and left sides<br>**AND**<br>• It is **not** possible to determine whether the meningioma originated on the left or the right<br><br>Assign code 5 (Midline tumor) when<br>• The meningioma originates in the midline |
| | Appendix C: Site Specific Coding Modules | Coding Guidelines: Lymphoma | Background, Coding Instructions, and Surgery of Primary Site sections revised. | See manual. |

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| | Appendix C: Site Specific Coding Modules | Coding Guidelines: Melanoma | Reportability section revised. | As of cases diagnosed January 1, 2021, early or evolving melanoma of any type is reportable. This includes both invasive and in situ melanomas; early or evolving are reportable. |
| | Appendix C: Site Specific Coding Modules | Surgery Codes (all sites) | Histology codes in header modified. | Revised subheading of exceptions. |
| | Appendix C: Site Specific Coding Modules | Surgery Codes: Bladder | Note revised. | Code 60<br>***SEER Note:*** Use code 71 for cystoprostatectomy. Use code 71 for cystectomy with hysterectomy. |
| | Appendix C: Site Specific Coding Modules | Surgery Codes: Bladder | Note revised. | Code 71<br>***SEER Note:*** Use code 71 for cystoprostatectomy. Use code 71 for cystectomy with hysterectomy. |
| | Appendix C: Site Specific Coding Modules | Surgery Codes: Bladder | Note added. | Code 71<br>***SEER Note:*** If a cystectomy is done and the prostatectomy/hysterectomy is not done, any organs other than the bladder removed during the procedure should be coded in Surgical Procedure of Other Site.<br>If cystectomy is done along with prostatectomy/hysterectomy, all pelvic organs removed during the procedure are included in codes 70-74.<br>Any non-pelvic organs or tissues removed during the procedure should be coded to Surgical Procedure of Other Site (NAACCR # 1294). |
| | Appendix C: Site Specific Coding Modules | Surgery Codes: Breast | Note revised. | Code 30:<br>***SEER Note:*** Code Goldilocks mastectomy in Surgery of Primary Site (NAACCR # 1290). Breast surgery code 30 seems to be the best available choice for "Goldilocks" mastectomy. It is essentially a skin-sparing mastectomy with breast reconstruction. The choice between code 30 and codes in the 40-49 range depends on the extent of the breast removal. Review the operative report carefully and assign the code that best reflects the extent of the breast removal. |
| | Appendix C: Site Specific Coding Modules | Surgery Codes: Colon | Introductory Note added. | ***SEER Note*** : Do not code a colostomy, with no colon tissue removed, as surgery. If colostomy is the only procedure performed, assign surgery code 00. |

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| | Appendix C: Site Specific Coding Modules | Surgery Codes: Colon | Introductory Note added. | ***SEER Note*** : Code circumferential resection margin (CRM) (NAACCR # 3823) when assigning surgery codes 30-80. CRM is not applicable for other surgery codes for this site. |
| | Appendix C: Site Specific Coding Modules | Surgery Codes: Ovary | Notes revised. | Codes 28, 37, 52, and 57<br>***SEER Note:*** Also use code [XX] for current unilateral (salpingo) oophorectomy with previous history of hysterectomy.] |
| | Appendix C: Site Specific Coding Modules | Surgery Codes: Prostate | Code revised. | Code 10<br>Local tumor destruction, NOS |
| | Appendix C: Site Specific Coding Modules | Surgery Codes: Rectosigmoid | Introductory Note added. | ***SEER Note:*** Code circumferential resection margin (CRM) (NAACCR # 3823) when assigning surgery codes 27, 30-80. CRM is not applicable for other surgery codes for this site. |
| | Appendix C: Site Specific Coding Modules | Surgery Codes: Rectum | Introductory Note added. | ***SEER Note:*** Code circumferential resection margin (CRM) (NAACCR # 3823) when assigning surgery codes 27, 30-80. CRM is not applicable for other surgery codes for this site. |
| | Appendix C: Site Specific Coding Modules | Surgery Codes: Skin | Note revised. | Following codes 20-25<br>***SEER Note*** : For Photodynamic therapy (PDT): Assign code 11 if there is no pathology specimen. Assign code 21 if there is a pathology specimen. Codes 20-27 include shave and wedge resection. |
| | Appendix C: Site Specific Coding Modules | Site Specific Codes for Neoadjuvant Therapy Treatment Effect | New Appendix C added. | Added new Appendix C site-specific coding documents for the new Neoadjuvant Therapy--Treatment Effect data item. See manual. |
| | Appendix E1 | Reportable Examples | Example 7 revised. | Microcarcinoid tumors of the stomach<br>Microcarcinoid and carcinoid tumors are reportable. The ICD-O-3.2 histology code is 8240/3. Microcarcinoid is a designation for neuroendocrine tumors of the stomach when they are less than 0.5 cm. in size. Neuroendocrine tumors of the stomach are designated carcinoid when they are 0.5 cm or larger. The term microcarcinoid tumor is not equivalent to carcinoid tumorlet. |
| | Appendix E1 | Reportable Examples | Example deleted. | Former Example 10<br>Gastrointestinal stromal tumor (GIST) with lymph nodes positive for malignancy |

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| | Appendix E1 | Reportable Examples | Example deleted. | Former Example 12<br>Neuroendocrine tumor (/3) and the clinical diagnosis is an insulinoma (/0) |
| | Appendix E1 | Reportable Examples | Example 14 revised. | Liver cases with an LI-RADS category LR-4 or LR-5<br>Report based on the American College of Radiology Liver Imaging Reporting and Data System (LI-RADS) definitions.<br>Use the date of the LR-4 (probable HCC; high probability but not 100% certainty observation is HCC) or LR-5 (definitely HCC; 100% certainty observation is HCC) scan as the date of diagnosis when it is the earliest confirmation of the malignancy.<br>If there is no statement of the LI-RADS score but there is reference that a lesion is in the Organ Procurement and Transplantation Network (OPTN) 5 category, report based on the OPTN class of 5. OPTN class 5 indicates that a nodule meets radiologic criteria for hepatocellular carcinoma. |
| | Appendix E1 | Reportable Examples | Example deleted. | Former Example 17<br>Non-invasive follicular thyroid neoplasm with papillary-like nuclear features |
| | Appendix E1 | Reportable Examples | Example 16 revised. | Assign 8714/3 to malignant PEComa. Some PEComas such as angiomyolipoma and lymphangiomyomatosis have specific ICD-O codes and their malignant counterparts may be coded to 8860/3 and 9174/3, respectively. There are no separate ICD-O codes for other specific PEComas, e.g., clear cell sugar tumor of lung, clear cell myomelanocytic tumor of the falciform ligament, and some unusual clear cell tumors occurring in other organs or for PEComa, NOS. These PEComas may therefore be coded to 8005 as clear cell tumors NOS; in other words, clear cell tumors are not clear cell variants of carcinomas, sarcomas, or other specific tumor type.<br>***Note:*** PEComa is non-specific as to behavior. Unless the pathologist states that it is malignant, the default code is 8005/1 (non-reportable). |
| | Appendix E1 | Reportable Examples | Example deleted. | Former Example 20<br>High grade squamous intraepithelial lesion (HGSIL or HSIL) of the vulva or vagina |
| | Appendix E1 | Reportable Examples | Example 18 revised. | Noninvasive mucinous cystic neoplasm (MCN) of the pancreas with high grade dysplasia<br>For neoplasms of the pancreas, MCN with high grade dysplasia is the preferred term and mucinous cystadenocarcinoma, noninvasive is a related term (8470/2). |

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| | Appendix E1 | Reportable Examples | Example 20 revised. | Report based on the American College of Radiology Prostate Imaging Reporting and Data System (PI-RADS) definitions.<br>PI-RADS categories 4 (high-clinically significant cancer is likely to be present) and 5 (very high-clinically significant cancer is highly likely to be present) are reportable, unless there is other information to the contrary. |
| | Appendix E1 | Reportable Examples | Example 21 added. | As of 1/1/2021, early or evolving melanoma in situ, or any other early or evolving melanoma, is reportable. |
| | Appendix E2 | Non-Reportable Examples | Example deleted. | Former Example 3<br>Lobular intraepithelial neoplasia grade 1 and grade 2 |
| | Appendix E2 | Non-Reportable Examples | Example 3 revised. | High grade squamous intraepithelial lesion (HGSIL or HSIL), carcinoma in situ (CIS), and AIN III (8077) arising in perianal skin (C445)<br>HGSIL or HSIL, CIS, and AIN III arising in perianal **skin** are not reportable. Refer to the Reportability Section of the main manual. |
| | Appendix E2 | Non-Reportable Examples | Example deleted. | Former Example 5<br>Terms "high grade dysplasia" (HGD) and "severe dysplasia" (see also the reportable examples list, Appendix E1) |
| | Appendix E2 | Non-Reportable Examples | Example 6 revised. | Breast cases designated BIRADS 4, 4A, 4B, 4C or BIRADS 5 without any additional information<br>The American College of Radiology defines Category 4 as “Suspicious.” The descriptions in categories 4, 4a, 4b, and 4c are not diagnostic of malignancy. They all represent a percentage of likelihood, the highest being 4c which is greater than 50% but less than 95% likelihood of malignancy. The ACR states "This category is reserved for findings that do not have the classic appearance of malignancy but are sufficiently suspicious to justify a recommendation for biopsy."<br>Category 5 is "Highly Suggestive of Malignancy." "Suggestive" is not reportable ambiguous terminology. ACR states that Category 5 has a "very high probability" of malignancy, but again, it is not diagnostic. |
| | Appendix E2 | Non-Reportable Examples | Example 7 revised. | Lung cases designated "Lung-RADS 4A," 4B, or 4X<br>Lung: Do **not** use the ACR Lung Imaging Reporting and Data System (Lung-RADS™) to determine reportability. Look for reportable terminology from the managing physician or other sources. |
| | Appendix E2 | Non-Reportable Examples | Example 8 revised. | Liver cases based only on an LI-RADS category of LR-3<br>Do not report liver cases based only on an LI-RADS category of LR-3. |

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| | Appendix E2 | Non-Reportable Examples | Example 17 revised. | Mature teratoma of the testis when diagnosed before puberty (benign, 9084/0)<br>Pubescence can take place over a number of years; review history and physical information and do not rely only on age. Do not report mature teratoma when it is not known whether the patient is pre- or post-pubescent. |
| | Appendix E2 | Non-Reportable Examples | Example 19 revised. | Venous angiomas (9122/0)<br>The primary site for venous (hem)angioma arising in the brain is blood vessel (C490). The combination of 9122/0 and C490 is not reportable. This is a venous abnormality. Previously called venous angiomas, these are currently referred to as developmental venous anomalies (DVA). |
| | Appendix E3 | Non-Reportable Examples | Example 20 revised. | Multilocular cystic renal neoplasm of low malignant potential<br>Previously called multilocular cystic renal cell carcinoma, this diagnosis became non-reportable beginning with the new designation in 2016. Refer to the Solid Tumor Coding Rules, Kidney Equivalent Terms and Definitions, for histology/morphology information. |
| | Appendix E4 | Non-Reportable Examples | Example 21 revised. | Lymphangioma of the brain or CNS<br>Lymphangioma is a malformation of the lymphatic system. Even though it has an ICD-O code, do not report it. |