SEER Program Coding and Staging Manual 2018 - Summary of Changes

This table lists the changes in the final 2018 manual by page number made as updates to the draft version.

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 draft version of the 2018 manual.
7	Reportability	Reportable Diagnosis List	Item 1.b.i updated.	Changed AIN III of perianal skin to Squamous intraepithelial neoplasia III of perianal skin.
7	Reportability	Reportable Diagnosis List	Item 1.b.ii updated.	Revised note: ***Note*** : Collection stopped effective with cases diagnosed 01/01/1996 and later. As of the 2018 data submission, cervical in situ carcinoma is no longer required for any diagnosis year. Sequence all cervix in situ cases in the 60-88 range regardless of diagnosis year.
7	Reportability	Reportable Diagnosis List	Item 2.a revised.	Moved notes from 2.d to 2.a.
10	Reportability	Ambiguous Terminology	Exception removed.	**Cytology section** Removed: ***Exception*** : This is a change to previous instructions. The date of a suspicious cytology may be used as the date of diagnosis when a definitive diagnosis follows the suspicious cytology. See Date of Diagnosis for more information.
14	Changing Information on the Abstract	Changing Information on the Abstract	Item 3, Example 5 removed.	Removed: ***Example 5*** : Rectal polyps excised and found to have adenocarcinoma in situ in a tubulovillous adenoma and a tubulovillous adenoma with focal carcinoma in situ. The behavior code is in situ (/2). Eight months later, a rectal polyp is removed and diagnosed as adenocarcinoma with mucinous features, infiltrating into submucosa, seen in a background of tubulovillous adenoma. Change the behavior code to malignant (/3).
18	Section I: Basic Record Identification	SEER Participant	List updated; column added.	Updated list of SEER participants including codes and participant names; added column with two-character abbreviation.
N/A	Section I: Basic Record Identification	Geo Location ID 1970/80/90	Item removed.	
N/A	Section I: Basic Record Identification	Geo Location ID 2000	Item removed.	
N/A	Section I: Basic Record Identification	Geo Location ID 2010	Item removed.	

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64	Section III: Demographic Information	Race 1, 2, 3, 4, 5	Example numbers edited.	Changed coding example numbers for two newly added examples to Example 11 and Example 12.
69	Section III: Demographic Information	Spanish Surname or Origin	Coding Instruction 5 moved to 2.	See manual.
69	Section III: Demographic Information	Spanish Surname or Origin	Coding Instruction 2.a.i added.	2.a.i. Self-reported information takes priority over other sources of information
70	Section III: Demographic Information	Spanish Surname or Origin	Coding Examples added.	See manual.
74	Section III: Demographic Information	Sex	Coding Instruction 1.b edited.	Revised 1.b and added note: ***Note:*** Hermaphrodite is an outdated term.
81	Section IV: Description of this Neoplasm	Date of Diagnosis	Coding Instruction 5 edited.	Removed exception and example from Coding Instruction 5: ***Exception:*** Use the date of the suspicious cytology when the diagnosis is proven by subsequent biopsy. ***Example*** : Cytology suspicious for malignancy 01/12/20108. Diagnosis of carcinoma per biopsy on 02/06/2018. Record 01/12/2018 as the date of diagnosis.
85	Section IV: Description of this Neoplasm	Sequence Number--Central	Code removed.	Removed Code 98 under Non-malignant Tumor as Federally Required based on Diagnosis Year.
86	Section IV: Description of this Neoplasm	Sequence Number--Central	Type of Neoplasm/Sequence Number table, Series 1 edited.	Edited text under All in situ (behavior code 2) to: All in situ (behavior code 2) **excluding** Cervix CIS, CIN III
86	Section IV: Description of this Neoplasm	Sequence Number--Central	Type of Neoplasm/Sequence Number table, Series 2 edited.	Edited text under from Cervix CIS/CIN III: Cervix CIS/CIN III ***Note:*** Submission of cervical carcinoma in situ is no longer required as of 2018 NCI SEER data submission.
86	Section IV: Description of this Neoplasm	Sequence Number--Central	Type of Neoplasm/Sequence Number table, Series 2 edited.	Removed last row in table: Cervix CIS/CIN III Note: Submission of cervical carcinoma in situ is no longer required as of 2018 NCI SEER data submission, code 98.

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87	Section IV: Description of this Neoplasm	Sequence Number--Central	In situ/Malignant Coding Instruction 3 example revised.	Revised Coding Instruction 3, Example 2, b: Removed second bullet from b including note: Reporting cervix in situ was required only before 1996 diagnosis year. ***Note:*** Submission of cervical carcinoma in situ is no longer required as of 2018 NCI SEER data submission. Edited last bullet to remove 'Three' from newly added reportable hematopoietic neoplasms as of 01/01/2010 and removed Example 1 and note, and Example 2 and note.
87	Section IV: Description of this Neoplasm	Sequence Number--Central	Non-Malignant Coding Instruction 6 revised.	Added text to the note in Coding Instruction 6: Sequence all cervix in situ cases in the 60-88 range regardless of diagnosis year.
88	Section IV: Description of this Neoplasm	Primary Site	Coding Instruction 3 revised.	Added Note: Skin cancers overlapping sites in the head and neck ONLY Assign the primary site code for the site where the bulk of the tumor is or where the epicenter is; do not use code C448.
91	Section IV: Description of this Neoplasm	Primary Site	Coding Instruction 14.b revised.	14.b. Use the NOS category for the organ system or the Ill-Defined Sites (C760-C768) if the physician advisor cannot identify a primary site Note: Assign C760 for Occult Head and Neck primaries with positive cervical lymph nodes. Schema Discriminator 1: Occult Head and Neck Lymph Nodes is used to discriminate between these cases and other uses of C760. For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.
91	Section IV: Description of this Neoplasm	Primary Site	Coding instructions and examples added to the Sarcoma section.	Code the organ of origin as the primary site when leiomyosarcoma arises in an organ. Do not code soft tissue as the primary site in this situation. Example 1: Leiomyosarcoma arises in kidney. Code the primary site to kidney (C649). Example 2: Leiomyosarcoma arises in prostate. Code primary site to prostate (C619).

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106	Section IV: Description of this Neoplasm	Grade Post Therapy	Item updated.	Removed text from first sentence: while not required by NCI SEER, it is allowed for collection and transmission for 2018
107	Section IV: Description of this Neoplasm	Tumor Size--Clinical	Code revised.	Removed text (See Instructions for 999 below) from Code 999
110	Section IV: Description of this Neoplasm	Tumor Size--Pathologic	Code revised.	Edited two items under Code 999: The only measurement(s) describes pieces or chips (See #15 below) Not applicable
118	Section V: Stage of Disease at Diagnosis	Lymphovascular Invasion	Spelling of data item updated.	Changed from Lymph-vascular Invasion to Lymphovascular Invasion.
118	Section V: Stage of Disease at Diagnosis	Lymphovascular Invasion	Introductory information added.	Added: LVI is always coded 8 for certain sites (see Coding Instruction #6).
118	Section V: Stage of Disease at Diagnosis	Lymphovascular Invasion	Coding Instruction 1.e revised.	1.e. Assign code 8, Not Applicable for benign/borderline brain and CNS tumors
119	Section V: Stage of Disease at Diagnosis	Lymphovascular Invasion	Coding Instruction 2 revised.	2. Use code 0 when the pathology report indicates that there is no lymphovascular invasion. Assign code 0 for in situ cases.
119	Section V: Stage of Disease at Diagnosis	Lymphovascular Invasion	Coding Instructions 4 and 5 added.	See manual.
121	Section V: Stage of Disease at Diagnosis	Lymphovascular Invasion	Coding Instructions 6 and 8 revised.	Coding Instruction 6, formerly 4, and 8, formerly 6, were edited. See manual. Code 7, formerly 5, is unchanged.
124	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Bone	Coding Instruction 1.b edited.	Changed 'pathologic' to 'pathological' in Coding Instruction 1.b.
124	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Bone	Coding Instruction 1.d revised.	1.d. Code this field for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the following Hematopoietic schemas i. Lymphoma Ocular Adnexa 00710 ii. Lymphoma (excluding CLL/SLL) 00790 iii. Lymphoma (CSS/SLL) 00795 iv. Mycosis Fungoides 00811 v. Primary Cutaneous Lymphoma (excluding MF and SS) 00812

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125	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Bone	Coding Instruction 2.c revised.	2.c. Use code 8 (Not applicable) for the following i. Any case coded to primary site C420, C421, C423, or C424 ii. Plasma Cell Myeloma 00821 iii. Plasma Cell Disorders 00822 iv. HemeRetic 00830 For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.
126	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Brain	Coding Instruction 1.b edited.	Changed 'pathologic' to 'pathological' in Coding Instruction 1.b.
126	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Brain	Coding Instruction 1.d revised.	1.d. Code this field for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the following Hematopoietic schemas i. Lymphoma Ocular Adnexa 00710 ii. Lymphoma (excluding CLL/SLL) 00790 iii. Lymphoma (CSS/SLL) 00795 iv. Mycosis Fungoides 00811 v. Primary Cutaneous Lymphoma (excluding MF and SS) 00812
127	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Brain	Coding Instruction 2.c revised.	2.c. Use code 8 (Not applicable) for the following i. Any case coded to primary site C420, C421, C423, or C424 ii. Plasma Cell Myeloma 00821 iii. Plasma Cell Disorders 00822 iv. HemeRetic 00830 For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.
128	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Liver	Coding Instruction 1.b revised.	Changed 'pathologic' to 'pathological' in Coding Instruction 1.b.
128	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Liver	Coding Instruction 1.d revised.	1.d. Code this field for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the following Hematopoietic schemas i. Lymphoma Ocular Adnexa 00710 ii. Lymphoma (excluding CLL/SLL) 00790 iii. Lymphoma (CSS/SLL) 00795 iv. Mycosis Fungoides 00811 v. Primary Cutaneous Lymphoma (excluding MF and SS) 00812

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129	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Liver	Coding Instruction 2.c revised.	2.c. Use code 8 (Not applicable) for the following i. Any case coded to primary site C420, C421, C423, or C424 ii. Plasma Cell Myeloma 00821 iii. Plasma Cell Disorders 00822 iv. HemeRetic 00830 For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.
130	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Lung	Coding Instruction 1.b revised.	Changed 'pathologic' to 'pathological' in Coding Instruction 1.b.
130	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Lung	Coding Instruction 1.d revised.	1.d. This field should be coded for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the following Hematopoietic schemas i. Lymphoma Ocular Adnexa 00710) ii. Lymphoma (excluding CLL/SLL) 00790) iii. Lymphoma (CSS/SLL) 00795) iv. Mycosis Fungoides 00811) v. Primary Cutaneous Lymphoma (excluding MF and SS) 00812)
131	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Lung	Coding Instruction 2.c revised.	2.c. Use code 8 (Not applicable) for the following i. Any case coded to primary site C420, C421, C423, or C424 ii. Plasma Cell Myeloma 00821 iii. Plasma Cell Disorders 00822 iv. HemeRetic 00830 For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.
132	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Distant Lymph Node(s)	Coding Instruction 1.b revised.	Changed 'pathologic' to 'pathological' in Coding Instruction 1.b.
132	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Distant Lymph Node(s)	Coding Instruction 1.e revised.	1.e. Code this field for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the following Hematopoietic schemas i. Lymphoma Ocular Adnexa 00710 ii. Lymphoma (excluding CLL/SLL) 00790 iii. Lymphoma (CSS/SLL) 00795 iv. Mycosis Fungoides 00811 v. Primary Cutaneous Lymphoma (excluding MF and SS) 00812

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133	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Distant Lymph Node(s)	Coding Instruction 2.c revised.	2.c. Use code 8 (Not applicable) for the following i. Any case coded to primary site C420, C421, C423, or C424 ii. Plasma Cell Myeloma 00821 iii. Plasma Cell Disorders 00822 iv. HemeRetic 00830 For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.
134	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Other	Coding Instruction 1.b revised.	Changed 'pathologic' to 'pathological' in Coding Instruction 1.b.
134	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Other	Coding Instruction 1.d revised.	1.d. Code this field for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the following Hematopoietic schemas i. Lymphoma Ocular Adnexa 00710) ii. Lymphoma (excluding CLL/SLL) 00790) iii. Lymphoma (CSS/SLL) 00795) iv. Mycosis Fungoides 00811)
135	Section V: Stage of Disease at Diagnosis	Mets at Diagnosis--Other	Coding Instruction 2.d revised.	2.d. Use code 8 (Not applicable) for the following i. Any case coded to primary site C420, C421, C423, or C424 ii. Plasma Cell Myeloma 00821 iii. Plasma Cell Disorders 00822 iv. HemeRetic 00830 For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.
149	Section V: Stage of Disease at Diagnosis	First Course of Therapy	Note revised.	***Note:*** Palliative therapy is **part of the first course of therapy only** when it **destroys or modifies cancer tissue.**
157	Section VII: First Course of Therapy	Date of First Surgical Procedure	Introductory information revised.	SEER Central Registries: Collect when available from CoC reporting facilities.
158	Section VII: First Course of Therapy	Date of First Surgical Procedure Flag	Introductory information revised.	SEER Central Registries: Collect when available from CoC reporting facilities.
159	Section VII: First Course of Therapy	Date of Most Definitive Surgical Resection of the Primary Site	Introductory information revised.	SEER Central Registries: Collect when available from CoC reporting facilities.

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Page	Section	Data Item	Change	Notes/Comments
160	Section VII: First Course of Therapy	Date of Most Definitive Surgical Resection of the Primary Site Flag	Introductory information revised.	SEER Central Registries: Collect when available from CoC reporting facilities.
162	Section VII: First Course of Therapy	Surgery of Primary Site	Coding Instruction 10 revised.	10. Code 98 for the following sites/schema unless the case is death certificate only: a. Any case coded to primary site C420, C421, C423, or C424 b. Cervical Lymph Nodes and Unknown Primary 00060 c. Plasma Cell Myeloma 00821 d. Plasma Cell Disorders 00822 e. HemeRetic 00830 f. Ill-defined Other (includes Unknown Primary Site) 99999 i. Excluding Spleen (C422) and C770-C779 (lymph nodes) For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.
163	Section VII: First Course of Therapy	Surgical Margins of the Primary Site	Coding Instruction 7 revised.	7. Assign code 9 a. 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 b. For death certificate only (DCO) cases c. For lymphomas with a lymph node primary site (C770-C779) d. Any case coded to primary site C420, C421, C423, or C424 e. Cervical Lymph Nodes and Unknown Primary 00060 f. Plasma Cell Myeloma 00821 g. Plasma Cell Disorders 00822 h. HemeRetic 00830 i. Ill-Defined Other (includes Unknown primary site) 99999 i. Excluding Spleen (C422)
167	Section VII: First Course of Therapy	Scope of Regional Lymph Node Surgery	Coding Instruction 12 revised.	12. Code 9: The status of regional lymph node evaluation should be known for surgically treated cases (i.e., cases coded 19-90 in the data item Surgery of Primary Site [NAACCR Item #1290]). Review surgically treated cases coded as 9 in Scope of Regional Lymph Node Surgery to confirm the code.

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167	Section VII: First Course of Therapy	Scope of Regional Lymph Node Surgery	Coding Instruction 12 revised (cont'd).	12.a. Assign code 9 for i. Any Schema ID with primary site: C420, C421, C423, C424, C700-C709, C710-C729, C751-C753, C761-C768, C809) ii. Brain 00721 iii. CNS Other 00722 iv. Intracranial Gland 00723 v. Lymphoma (excluding CLL/SLL) (Primary sites C770-C779 only) 00790 vi. Lymphoma (CLL/SLL) (Primary sites C770-C779 only) 00795 vii. Plasma Cell Myeloma 00821 viii. Plasma Cell Disorders (excluding histology 9734/3) 00822 ix. HemeRetic 00830 x. Ill-Defined Other (includes Unknown Primary Site) 99999 1. Excluding Spleen (C422) For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.
169	Section VII: First Course of Therapy	Date of Sentinel Lymph Node Biopsy	Introductory text added.	SEER Central Registries: Collect when available.
169	Section VII: First Course of Therapy	Date of Sentinel Lymph Node Biopsy	Coding Instruction 3 revised.	3. Record the date documented in this data item in the Date of First Surgical Procedure data item [NAACCR Item #1200] when the sentinel lymph node biopsy is the first or only surgical procedure performed
169	Section VII: First Course of Therapy	Date of Sentinel Lymph Node Biopsy	Coding Instruction 4 revised.	4. Record the date of the sentinel lymph node biopsy in this data item and record the date the subsequent regional node dissection was performed in the Date of Regional Lymph Node Dissection data item [NAACCR Item #682] when both a sentinel node biopsy procedure and a subsequent regional node dissection procedure are performed
169	Section VII: First Course of Therapy	Date of Sentinel Lymph Node Biopsy	Coding Instruction 5 added.	5. Record the date of the procedure in both this data item and in the Date of Regional Lymph Node Dissection [NAACCR Item #632] if a sentinel lymph node biopsy is performed in the same procedure as the regional node dissection. The dates should be equal.

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170	Section VII: First Course of Therapy	Date of Sentinel Lymph Node Biopsy Flag	Introductory text revised.	SEER Central Registries: Collect when available from CoC reporting facilities.
171	Section VII: First Course of Therapy	Sentinel Lymph Nodes Examined	Introductory text added.	SEER Central Registries: Collect when available.
171	Section VII: First Course of Therapy	Sentinel Lymph Nodes Examined	Coding Instruction 1 revised.	1. Document the total number of nodes sampled during the sentinel node procedure in this data item when both sentinel and non-sentinel nodes are sampled during the sentinel node biopsy procedure; i.e., record the total number of nodes from the procedure regardless of sentinel node status
171	Section VII: First Course of Therapy	Sentinel Lymph Nodes Examined	Coding Instruction 2 revised.	2. Record the total number of nodes biopsied during the sentinel node biopsy procedure in this data item and record the total number of regional lymph nodes biopsied/dissected (which includes the number of nodes documented in this data item) in Regional Lymph Nodes Examined [NAACCR Item #830] when a. Both a sentinel node biopsy procedure and a subsequent dissection procedure are performed OR b. A sentinel node biopsy procedure is performed during the same procedure as the regional node dissection
171	Section VII: First Course of Therapy	Sentinel Lymph Nodes Examined	Coding Instruction 3 revised.	3. Record the results for the sentinel node biopsy in this data item when an aspiration of sentinel lymph nodes(s) AND a sentinel node biopsy procedure were performed for same patient
171	Section VII: First Course of Therapy	Sentinel Lymph Nodes Examined	Coding Instruction 4 revised.	4. The number of sentinel lymph nodes biopsied will typically be found in the pathology report, radiology reports, or documented by the physician. Determination of the exact number of sentinel lymph nodes examined may require assistance from the managing physician for consistent coding.
172	Section VII: First Course of Therapy	Sentinel Lymph Nodes Positive	Introductory text revised.	This data item is required for breast and cutaneous melanoma cases only.
172	Section VII: First Course of Therapy	Sentinel Lymph Nodes Positive	Introductory text added.	SEER Central Registries: Collect when available.
172	Section VII: First Course of Therapy	Sentinel Lymph Nodes Positive	Code 97 Description updated.	Positive sentinel nodes are documented, but the number is unspecified. For breast ONLY: SLN and RLND occurred during the same procedure

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172	Section VII: First Course of Therapy	Sentinel Lymph Nodes Positive	Coding Instructions 1, 2, 3, 4, 5, and 8 updated.	See manual.
174	Section VII: First Course of Therapy	Date of Regional Lymph Node Dissection	Introductory text added.	SEER Central Registries: Collect when available from CoC reporting facilities.
174	Section VII: First Course of Therapy	Date of Regional Lymph Node Dissection	Coding Instruction 2 updated.	2. 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 [NAACCR Item #832] for breast and melanoma cases when: a. Both a sentinel node biopsy procedure and a subsequent regional node dissection procedure are performed OR b. A sentinel lymph node biopsy is performed in the same procedure as the regional node dissection. The dates should be equal.
174	Section VII: First Course of Therapy	Date of Regional Lymph Node Dissection	Coding Instruction 3 added.	3. Record the date of the regional lymph node dissection in this data item for all cases other than breast and melanoma
175	Section VII: First Course of Therapy	Date of Regional Lymph Node Dissection Flag	Introductory text added.	SEER Central Registries: Collect when available from CoC reporting facilities.
176	Section VII: First Course of Therapy	Regional Nodes Positive	Coding Instruction 2 updated.	Changed 'pathologic' to 'pathological'
176	Section VII: First Course of Therapy	Regional Nodes Positive	Coding Instructions 4.c, 4.d, 5, 6, 7, 8, 10, and 11 updated.	See manual.
179	Section VII: First Course of Therapy	Regional Nodes Examined	Code 99 revised.	Code 99: It is unknown whether nodes are examined; not stated in patient record
179	Section VII: First Course of Therapy	Regional Nodes Examined	Coding Instructions 3, 4, 5, 10, and 11, and 12 updated.	See manual.
182	Section VII: First Course of Therapy	Surgical Procedure of Other Site	Coding Instruction 3.c updated.	3.c. When any surgery is performed for i. Plasma Cell Myeloma 00821 ii. Plasma Cell Disorder 00822 iii. HemeRetic 00830

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Page	Section	Data Item	Change	Notes/Comments
187	Section VII: First Course of Therapy	Date Radiation Started	Introductory text added.	Date radiation started will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the date radiation started may require assistance from the radiation oncologist for consistent coding. 4. There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
187	Section VII: First Course of Therapy	Date Radiation Started	Introductory text revised.	SEER Central Registries: Collect when available from CoC reporting facilities.
187	Section VII: First Course of Therapy	Date Radiation Started	Coding Instruction 4 added.	4. There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
188	Section VII: First Course of Therapy	Date Radiation Started Flag	Introductory text revised.	SEER Central Registries: Collect when available from CoC reporting facilities.
188	Section VII: First Course of Therapy	Date Radiation Started Flag	Codes 10, 11, 12, and 15 updated	Code 10: No information whatsoever can be inferred from this exceptional value (that is, unknown whether any radiation therapy was given) Code 11: No proper value is applicable in this context (e.g., no radiation given) Code 12: A proper value is applicable but not known. This event occurred, but the date is unknown (that is, radiation therapy administered but the date is unknown). Code 15: Information is not available at this time, but it is expected that it will be available later (e.g., radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up)
188	Section VII: First Course of Therapy	Date Radiation Started Flag	Coding Instruction 3 updated.	3. Assign code 11 if radiation was not planned or given as part of the first course of therapy or the initial diagnosis was at autopsy
189	Section VII: First Course of Therapy	Radiation Treatment Modality--Phase I, II, III	Coding Instruction 1 added.	1. Assign code 13, Radioisotopes, NOS, for Radioembolization procedures, e.g., intravascular Yttrium-90

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189	Section VII: First Course of Therapy	Radiation Treatment Modality--Phase I, II, III	Coding for Tumor Embolization deleted.	Deleted the section Coding for Tumor Embolization.
190	Section VII: First Course of Therapy	Radiation External Beam Planning Technique--Phase I, II, III	Data item added.	See manual. This represents three data items.
193	Section VII: First Course of Therapy	Radiation Sequence with Surgery	Coding Instruction 2.a revised	2.a. Assign code 4 when there are at least two 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, surgery to other regional site(s), distant site(s), or distant lymph node(s)
195	Section VII: First Course of Therapy	Reason for No Radiation	Code 2 revised.	Radiation therapy was not administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation, etc.)
195	Section VII: First Course of Therapy	Reason for No Radiation	Coding Instructions 1 and 2 revised.	1. Assign Code 0 if the patient received regional radiation as part of first course of therapy 2. Assign Code 1 if the treatment plan offered multiple alternative treatment options but the patient selected treatment that did not include radiation therapy
196	Section VII: First Course of Therapy	Date Systemic Therapy Started	Introductory text revised.	SEER Central Registries: Collect when available from CoC reporting facilities.
197	Section VII: First Course of Therapy	Date Systemic Therapy Started Flag	Introductory text revised.	SEER Central Registries: Collect when available from CoC reporting facilities.
198	Section VII: First Course of Therapy	Date Chemotherapy Started	Introductory text revised.	SEER Central Registries: Collect when available from CoC reporting facilities.
199	Section VII: First Course of Therapy	Date Chemotherapy Started Flag	Introductory text revised.	SEER Central Registries: Collect when available from CoC reporting facilities.
201	Section VII: First Course of Therapy	Chemotherapy	Coding Instruction 3.a revised.	3.a. This is a continuation of the first course of therapy when the chemotherapeutic agent that is substituted belongs to the same group (alkylating, antimetabolites, natural products, targeted therapy, or other miscellaneous)
206	Section VII: First Course of Therapy	Date Hormone Therapy Started	Introductory text revised.	SEER Central Registries: Collect when available from CoC reporting facilities.

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207	Section VII: First Course of Therapy	Date Hormone Therapy Started Flag	Introductory text revised.	SEER Central Registries: Collect when available from CoC reporting facilities.
211	Section VII: First Course of Therapy	Date Immunotherapy Started	Introductory text revised.	SEER Central Registries: Collect when available from CoC reporting facilities.
212	Section VII: First Course of Therapy	Date Immunotherapy Started Flag	Introductory text revised.	SEER Central Registries: Collect when available from CoC reporting facilities.
221	Section VII: First Course of Therapy	Date Other Treatment Started	Introductory text revised.	SEER Central Registries: Collect when available from CoC reporting facilities.
222	Section VII: First Course of Therapy	Date Other Treatment Started Flag	Introductory text revised.	SEER Central Registries: Collect when available from CoC reporting facilities.
228	Section VIII: Follow Up Information	Date of Last Follow-Up or of Death	Text revised.	Removed: The exception is carcinoma in situ of the cerivx diagnosed on or after 01/01/1996.
232	Section VIII: Follow Up Information	Vital Status	Text revised.	Removed: The exception is carcinoma in situ of the cerivx diagnosed on or after 01/01/1996.
233	Section VIII: Follow Up Information	ICD Code Revision Used for Cause of Death	Text revised.	Removed: The exception is carcinoma in situ of the cerivx diagnosed on or after 01/01/1996.
234	Section VIII: Follow Up Information	Underlying Cause of Death	Coding Instruction for ICD-10, 3 revised.	3. Left justify the codes; if less than four characters, leave the fourth character blank ***Note:*** This is a change from previous instructions.
235	Section VIII: Follow Up Information	Underlying Cause of Death	Example revised.	Malignant neoplasm of thyroid: SEER Code C73
236	Section VIII: Follow Up Information	Type of Follow-Up	Code 3 removed.	Removed code 3: In situ cancer of the cervix uteri only
236	Section VIII: Follow Up Information	Type of Follow-Up	Coding Instruction 1 revised.	1. All cases must be followed annually, including benign and borderline intracranial and CNS tumors diagnosed 01/01/2004 and forward
236	Section VIII: Follow Up Information	Type of Follow-Up	Coding Instruction 2 removed.	Removed Coding Instruction 2 and note: 2. Cases of in situ cancer of the cervix diagnosed on or after 01/01/1996 are not reportable; follow-up is not required Note: Follow-up information should be updated on cases diagnosed before 01/01/1996 when information is available.

This table lists the changes in the final 2018 manual by page number made as updates to the draft version.

Page	Section	Data Item	Change	Notes/Comments
	Appendix B: B1, B2, B3, B4	Country and State Codes	Spelling corrected.	Bosnia and Herzegovina: spelling change Herzogovina to Herzegovina
	Appendix C: Site Specific Coding Modules	Coding Guidelines: Lymphoma	Histology codes modified.	M9590-9699, 9702-9727, 9735, 9737-9738, 9823, 9827
	Appendix C: Site Specific Coding Modules	Coding Guidelines: Lymphoma	Guidelines added.	Surgery codes for lymph nodes exclude these histologies: M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992 Surgery Codes for Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease include C420, C421, C423, C424 (with any histology) or M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992 Assign code 98 for all hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment unless the case is a DCO (Death Certificate Only). Assign 99 for DCOs. Surgical procedures for hematopoietic, reticuloendothelial, immunoproliferative, myeloproliferative primaries are to be recorded using the data item Surgical Procedure of Other Site (NAACCR Item # 1294).
	Appendix C: Site Specific Coding Modules	Coding Guidelines: Melanoma	Reportability section revised	Revised text: As of cases diagnosed January 1, 2018, early or evolving melanoma of any type is not reportable. This includes both invasive and in situ melanomas; early or evolving are not reportable.

SEER Program Coding and Staging Manual 2018 - Summary of Changes

This table lists the changes in the final 2018 manual by page number made as updates to the draft version.

Page	Section	Data Item	Change	Notes/Comments
	Appendix C: Site Specific Coding Modules	Surgery Codes: Breast	Revised SEER Note.	Revised second SEER Note associated with codes 20-24: ***SEER Note:*** Assign code 22 when a patient has a lumpectomy and an additional margin excision during the same procedure. According to the Commission on Cancer, re-excision of the margins intraoperatively during same surgical event does not require additional resources; it is still 22. Subsequent re-excision of lumpectomy margins during separate surgical event requires additional resources: anesthesia, op room, and surgical staff; it qualifies for code 23.
	Appendix C: Site Specific Coding Modules	Surgery Codes: Breast	Note revised	Edited SEER Note associated with code 76 ***SEER Note:*** Assign code 76 for a more extensive bilateral mastectomy. Assign code 0 in Surgical Procedure of Other Site. For a simple bilateral mastectomy, assign code 41 with code 1 in Surgical Procedure of Other Site.
	Appendix E1	Reportable Examples	Example 24 revised	Report the CNS site in which the hemangioma originates. Note: For cavernous sinus hemangioma, report the site as cerebral meninges C700.
	Appendix E2: Non-Reportable Examples	Non-Reportable Examples	Example 35 added	Diagnosis/Condition revised: Early or evolving melanoma, in situ or invasive