South Carolina Central Cancer Registry
2018 Data Reporting Requirements & Guidelines

NAACCR Version 18
Record Layout and Data Standard Recommendations

New 11/19/19

Please visit SCCCR DHEC Website for Cancer Standards and Reporting, Education and Resources:
https://scdhec.gov/CancerRegistry

NOTE: This document does not replace the SCCCR REPORTING SOURCE MANUAL. This document should be used in conjunction with it. This document may re-state some of its content, and is specifically meant for 2018 reporting guidance. Recent updated 11/19/19 highlighted in yellow

PREFACE

Important Notice to South Carolina Registrars Regarding Abstracting and Reporting 2018 Diagnosed Cases Prior to Release of NAACCRv18 Compliant Software.

In 2018, major changes have occurred for critical items such as stage, grade, site-specific data items, histology coding, and operational changes. Release of the v18 compliant software has experienced extreme delays from the standards setters. These 2018 changes are required to support 2018 case abstracting and reporting requirements to the SCCCR. All the new and revised abstracting and coding tools and resources must be incorporated into the abstracting of all cases reported in 2018.

Due to the large volume of new and revised data items being implemented for 2018, please take note of the following SCCCR Policies:

1. SCCCR will not accept ANY 2018 cases (admit/dx) until January 1, 2019. If there are further delays, you will be notified.

2. SCCCR will not accept 2018 cases in v16 format. All new data items are required to be completed and the SCCCR will monitor unknown values for the new data items.

3. 2018 abstracts may be started in the NAACCR Version 16 (v16) but MUST be completed using NAACCR Version 18 (v18) software.

4. SCCCR recommends facilities document details for the new data items for completion of the abstracts in v18 software with the new codes.

5. The SCCCR requires sufficient TEXT to support all codes, especially the new codes (e.g., HISTOLOGY, GRADE, AJCC & Summary STAGE, ETC.). The TEXT will provide an easy reference for coding cases that require v18 software when it becomes available.

6. The SCCCR recommends to <u>not complete</u> the following data items because new data items are required to collect the information for 2018. The data cannot be converted from v16 fields to v18 fields. These critical items include:
 a) Grade - three new grade items will be collected - clinical, pathological and post-treatment grade

b) AJCC T, N, M, Stage Group and Descriptors - there will be additional categories and a new way to code descriptors

c) Direct Coded Summary Stage 2018

d) Radiation Treatment

e) Site Specific Data Items SSDI 1-25

The South Carolina Central Cancer Registry will be implementing the NAACCR Version 18 (v18) record layout and data standards included in this Guidance Document. The standards are a result of a collaboration between NAACCR, COC, SEER and NPCR. This document should be used as your reference to modify registry software to include the changes in the data requirements when submitting data to SCCCR.

NPCR 2018 new data fields

Item #		Item Name	Note
1506	R	Phase I Radiation Treatment Modality	New
2152	R	CoC Accredited Flag	New
3816	**R**	Brain Molecular Markers	New
3817	**R**	Breslow Tumor Thickness	New
3827	R	Estrogen Receptor Summary	New
3835	R	Fibrosis Score	New
3843	R	Grade Clinical	New
3844	RN	Grade Pathological	New
3845	RN	Grade Post Therapy	New
3855	R	HER2 Overall Summary	New
3890	RS*	Microsatellite Instability (MSI)	New
3911	R	Peritoneal Cytology	New
3915	R	Progesterone Receptor Summary	New
3920	**R**	PSA (Prostatic Specific Antigen) Lab Value	New
3926	R	Schema Discriminator 1	New
3932	R	LDH Pretreatment Lab Value	New

R=Required; R*= Required when available

RS= Required, site-specific

RS* Required, site-specific, when available

D = Derived, site-specific

RN — Implement according to NPCR Stage Transition Plans (for example, for dually funded states capturing EOD18 staging or for collecting CoC facility data)

RH = Required historically (for historical cases)

RH* = Required historically, when available

Table of Contents

SCCCR 2018 Reporting Requirements

(Note: for general SCCCR reporting requirements, refer to the SCCCR Reporting Source Manual)

1. Case Reportability (ICD-0-3) - New terms and Codes effective 1/1/2018

The ICD-O-3 Implementation Task Force has approved new codes, changes in behavior codes, and new terms associated with current codes. These changes reflect updates to the WHO Classifications for Tumors (Blue Books). The new codes, new terms, and codes with changes to behavior are listed in this section.

The 2018 ICD-O-3 Update Guidelines was used to extract the following summary of ICD-O-3 changes for SC registrars. They include comprehensive tables listing all changes to ICD-O-3 effective for cases **diagnosed 1/1/2018 forward.**

The 2018 ICD Coding guidelines also provide background on the project and issues encountered during review of the WHO Classifications of Tumors. Issues not covered in the 2018 update include reportability of GIST and histology codes with terms that include the words “high grade neoplasia” or “high grade dysplasia” or “severe dysplasia” in digestive system sites.

Website Link for 2018 ICD Coding Guidelines:
https://www.naaccr.org/2018-implementation/#Histology

Summary Tables of 2018 ICD-O-3 Changes and Whether Reportable to SCCCR
(ICD-O-3 codes, behaviors and terms are primary site specific)

Status	ICD-O-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
New Term	8010/3	Urachal carcinoma **(C65.9, C66.9, C67. _, C68._)**	**Y**	
New Term	8013/3	Combined large cell neuroendocrine carcinoma **(C34. _, C37.9)**	**Y**	
New code/term	8023/3	Midline carcinoma of children and young adults with NUT rearrangement **(C30.0, C31.9, C34. _)**	**Y**	
New code/term	8023/3	**NUT carcinoma (C30.0, C31.9, C34. _)**	**Y**	

Status	ICD-0-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
New code/term	8023/3	NUT midline (C30.0, C31.9, C34. _)	Y	
New Term	8041/3	High-grade neuroendocrine carcinoma (C54. _, C55.9)	Y	
New Term	8041/3	Neuroendocrine carcinoma, poorly differentiated **(C50. _)**	**Y**	
New Term	8041/3	Small cell carcinoma pulmonary type **(C56.9)**	**Y**	
New Term	8044/3	Small cell carcinoma, hypercalcemic type **(C56.9)**	**Y**	
New code/term	8054/3	Condylomatous carcinoma **(C60.0-C60.2, C60.9)**	**Y**	Cases diagnosed prior to 1/1/2018 use code 8051/3 All other sites use 8051/3 2018 forward
New code/term	8054/3	Warty carcinoma **(C60.0-C60.2, C60.9)**	**Y**	Cases diagnosed prior to 1/1/2018 use code 8051/3 All other sites use 8051/3 2018 forward
Behavior code/term	8071/2	Differentiated penile intraepithelial neoplasia **(C60. _)**	**N**	Not reportable for 2018
Behavior code/term	8071/2	Differentiated-type vulvar intraepithelial neoplasia **(C51. _)**	**N**	Not reportable for 2018
New code/term	8085/3	**Squamous cell carcinoma, HPV-positive (C01.9, C10.2, C10.3, C10.8, C10.9, C31.0–C31.3, C31.9)**	**Y**	
New code/term	8086/3	Squamous cell carcinoma, HPV-negative (C01.9, C10.2, C10.3, C10.8, C10.9, C31.0–C31.3, C31.9)	Y	New code/term

Status	ICD-0-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
New Term	8120/3	Clear cell (glycogen-rich) urothelial carcinoma (C65.9, C66.9, C67. _, C68. _)	Y	New Term
New Term	8120/3	Lipid-rich urothelial carcinoma **(C65.9, C66.9, C67. _, C68. _)**	**Y**	
New Term	8120/3	Microcystic urothelial carcinoma **(C65.9, C66.9, C67. _, C68. _)**	**Y**	
New Term	8120/3	Nested urothelial carcinoma **(C65.9, C66.9, C67. _, C68. _)**	**Y**	
New Term	8120/3	Squamotransitional cell carcinoma **(C53. _)**	**Y**	
New Term	8120/3	Urothelial carcinoma with divergent differentiation **(C65.9, C66.9, C67. _, C68. _)**	**Y**	
New Term	8120/3	Urothelial carcinoma with squamous differentiation **(C65.9, C66.9, C67. _, C68. _)**	**Y**	
New Term	8120/3	Urothelial carcinoma with trophoblastic differentiation **(C65.9, C66.9, C67. _, C68. _)**	**Y**	
New Term	8140/3	Minimally invasive adenocarcinoma, NOS **(C34. _)**	**Y**	
New Term	8140/3	Acinar adenocarcinoma	**Y**	**All sites except C61.9**
New Term	8140/3	Endocervical adenocarcinoma usual type **(C53. _)**	**Y**	

Status	ICD -0-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
New Term	8144/3	Enteric adenocarcinoma (C34.0, C67. _, C65.9, C66.9, C68. _)	Y	
New Term	8144/3	Intestinal-type adenocarcinoma (C30.0, C53. _)	Y	
New Term	8144/3	Mucinous carcinoma, intestinal type **(C53. _)**	**Y**	
New code/term	8158/1	ACTH-producing tumor	**N**	
New code/term	8158/1	**Endocrine tumor, functioning, NOS**	**N**	
New code/term	8163/3	Adenocarcinoma, pancreatobiliary-type **(C24.1)**	**Y**	Cases diagnosed prior to 1/1/2018 use code 8255/3
New code/term	8163/3	**Pancreatobiliary-type carcinoma (C24.1)**	**Y**	Cases diagnosed prior to 1/1/2018 use code 8255/3
New Term	8200/3	Thymic carcinoma with adenoid cystic carcinoma-like features **(C37.9)**	**Y**	
Behavior code/term	8213/3	**Serrated adenocarcinoma (C18.0, C18.2, C18.9, C19.9, C20.9)**	**Y**	
New Term	8246/3	Neuroendocrine tumor, well differentiated **(C50. _)**	**Y**	
Behavior code/term	8250/2	**Adenocarcinoma in situ, non-mucinous (C34. _)**	**Y**	
New Term	8250/3	Lepidic predominant adenocarcinoma **(C34.)**	**Y**	

Status	ICD-0-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
New Term	8253/3	**Invasive mucinous adenocarcinoma (C34. _)**	**Y**	**Important note**: lung primaries ONLY: For cases diagnosed 1/1/2018 forward do not use code 8480 (mucinous adenocarcinoma) for in situ adenocarcinoma, mucinous or invasive mucinous adenocarcinoma.
New Term	8254/3	**Mixed invasive mucinous and non-mucinous adenocarcinoma (C34. _)**	**Y**	
New code/term	8256/3	**Minimally invasive adenocarcinoma, non-mucinous (C34. _)**	**Y**	
New code/term	8257/3	**Minimally invasive adenocarcinoma, mucinous (C34. _)**	**Y**	
New Term	8263/3	Endometrioid adenocarcinoma, villoglandular **(C54. _, C55.9)**	**Y**	
New Term	8263/3	Villoglandular carcinoma **(C53. _)**	**Y**	
New code/term	8265/3	Micropapillary adenocarcinoma **(C34. _)**	**Y**	Cases diagnosed prior to 1/1/2018 use code 8507/3. Code 8265 is not valid for C50._. Use 8507 for micropapillary adenocarcinoma in breast primaries
New code/term	8265/3	**Micropapillary carcinoma, NOS (C18. _, C19.9, C20.9, C34. _)**	**Y**	Cases diagnosed prior to 1/1/2018 use code 8507/3. Code 8265 is not valid for C50._. Use 8507 for micropapillary adenocarcinoma in breast primaries

Status	ICD-0-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
Behavior Code/term	8311/3	Hereditary leiomyomatosis & RCC-associated renal cell carcinoma **(C64.9)**	**Y**	
Behavior code/term	8311/3	MiT family translocation renal cell carcinoma **(C64.9)**	**Y**	
New Term	8312/3	Renal cell carcinoma, unclassified **(C64.9)**	**Y**	
New Term	8316/3	Acquired cystic disease-associated renal cell carcinoma (RCC) **(C64.9)**	**Y**	
New Term	8316/3	Tubulocystic renal cell carcinoma **(C64.9)**	**Y**	
New code/term	8339/3	**Follicular thyroid carcinoma, encapsulated angioinvasive (C73.9)**	**Y**	
New Term	8343/2	Non-invasive encapsulated follicular variant of papillary thyroid carcinoma **(C73.9)**	**Y**	Cases diagnosed 1/1/2017 forward
New Term	8343/2	Non-invasive follicular thyroid neoplasm with papillary-like nuclear features **(C73.9)**	**Y**	Cases diagnosed 1/1/2017 forward
New Term	8343/2	Non-invasive follicular thyroid papillary **(C73.9)**	**Y**	Cases diagnosed 1/1/2017 forward
New Term	8343/3	Encapsulated follicular variant of papillary thyroid carcinoma, NOS **(C73.9)**	**Y**	Cases diagnosed 1/1/2017 forward

Status	ICD-0-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
New Term	8343/3	Invasive encapsulated follicular variant of papillary thyroid carcinoma **(C73.9)**	**Y**	Cases diagnosed 1/1/2017 forward
Behavior code/term	8380/2	Atypical hyperplasia/ Endometrioid intraepithelial neoplasm **(C54._, C55.9)**	**N**	Not reportable for 2018
Behavior Code/term	8441/2	Serous endometrial intraepithelial carcinoma **(C54. _, C55.9)**	**Y**	
Behavior Code/term	8441/2	Serous tubal intraepithelial carcinoma **(C57.0)**	**Y**	
New Term	8453/2	Intraductal papillary mucinous neoplasm with high-grade dysplasia **(C25. _)**	**Y**	
New Term	8453/3	Intraductal papillary mucinous neoplasm (IPMN) with an associated invasive carcinoma **(C25. _)**	**Y**	
Behavior Code/term	8460/2	Non-invasive low grade serous carcinoma **(C56.9)**	**Y**	
Behavior Code/term	8460/2	Serous borderline tumor-micropapillary variant **(C56.9)**	**N**	Not reportable for 2018
New Term	8460/3	Low-grade serous carcinoma **(C48. _, C56.9, C57.0, C57.1–C57.3)**	**Y**	
New Term	8461/3	High-grade serous carcinoma **(C48. _, C56.9, C57.0, C57.1-C57.3)**	**Y**	

Status	ICD-0-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
New Term	8470/3	Mucinous cystic tumor with associated invasive carcinoma **(C25. _)**	**Y**	
New code/term	8474/3	**Seromucinous carcinoma (C56.9)**	**Y**	
New code/term	8480/1	**Low grade appendiceal mucinous neoplasm (C18.1)**	**N**	
New Term	8480/3	Mucinous tubular and spindle cell carcinoma **(C64.9)**	**Y**	
New Term	8482/3	Mucinous carcinoma, gastric type **(C53. _)**	**Y**	
New Term	8500/2	Low grade cribriform cystadenocarcinoma (LGCCC) **(C06.9, C08.9)**	**Y**	
New Term	8500/2	Mammary carcinoma, in situ **(C50. _)**	**Y**	
New Term	8500/2	Non-invasive mammary carcinoma **(C50. _)**	**Y**	
New Term	8500/3	**Invasive carcinoma of no special type (C50. _)**	**Y**	
New Term	8500/3	Invasive carcinoma, NST **(C50. _)**	**Y**	
New Term	8500/3	Invasive mammary carcinoma **(C50. _)**	**Y**	
New Term	8500/3	Salivary duct carcinoma **(C06.9, C08.9)**	**Y**	
New Term	8503/2	Intraductal papilloma with ductal carcinoma in situ **(C50. _)**	**Y**	
New Term	8503/2	Intraductal tubulopapillary neoplasm **(C25. _)**	**Y**	

Status	ICD-0-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
New Term	8503/3	Intracystic papillary neoplasm with associated invasive carcinoma	**Y**	
New Term	8504/2	Encapsulated papillary carcinoma **(C50. _)**	**Y**	
New Term	8504/3	Encapsulated papillary carcinoma with invasion **(C50. _)**	**Y**	
Behavior Code/term	8507/3	**Invasive micropapillary carcinoma (C50. _)**	**Y**	For sites other than C50. _, see 8265/3
New code/term	8509/2	**Solid papillary carcinoma in situ (C50. _)**	**Y**	
New code/term	8509/3	**Solid papillary carcinoma with invasion (C50. _)**	**Y**	
New Term	8510/3	Renal medullary carcinoma **(C64.9)**	**Y**	
New code/term	8519/2	**Pleomorphic lobular carcinoma in situ (C50. _)**	**Y**	ICD-O-3 rule F *DOES NOT APPLY* to code 8519. Invasive pleomorphic lobular carcinoma is coded 8520/3
New Term	8520/2	Intraductal papilloma with lobular carcinoma in situ **(C50. _)**	**Y**	
New Term	8520/3	Invasive lobular carcinoma **(C50. _)**	**Y**	
New Term	8520/3	Invasive lobular carcinoma, alveolar type **(C50. _)**	**Y**	
New Term	8520/3	Invasive lobular carcinoma, solid type **(C50. _)**	**Y**	

Status	ICD-0-3 Morphology	Term	Reportable to SCCCR Y/N	Comments
New Term	8520/3	Invasive lobular carcinoma, tubulolobular variant **(C50. _)**	**Y**	
New Term	8520/3	Pleomorphic lobular carcinoma **(C50. _)**	**Y**	
New Term	8520/3	Tubulolobular carcinoma **(C50. _)**	**Y**	
New Term	8550/3	Acinar cell carcinoma	**Y**	Excludes C61.9- see 8140/3
New Term	8551/3	Acinar adenocarcinoma **(C34. _)**	**Y**	Lung primaries diagnosed prior to 1/1/2018 use code 8550/3 For prostate (all years) see 8140/3
New code/term	8552/3	**Mixed acinar ductal carcinoma**	**Y**	Cases diagnosed prior to 1/1/2018 use code 8523/3
New Term	8570/3	Endometrioid carcinoma with squamous differentiation **(C54. _, C55.9)**	**Y**	
New Term	8570/3	Low grade adenosquamous carcinoma **(C50. _)**	**Y**	
New Term	8571/3	Carcinoma with chondroid differentiation **(C50. _)**	**Y**	
New Term	8571/3	Carcinoma with osseous differentiation **(C50. _)**	**Y**	
New Term	8571/3	Metaplastic carcinoma with chondroid differentiation **(C50. _)**	**Y**	
New Term	8571/3	Metaplastic carcinoma with osseous differentiation **(C50. _)**	**Y**	

Status	ICD-0-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
New Term	8572/3	Acinar adenocarcinoma, sarcomatoid **(C61.9)**	**Y**	
New Term	8572/3	Fibromatosis-like metaplastic carcinoma **(C50. _)**	**Y**	
New Term	8574/3	Adenocarcinoma admixed with neuroendocrine carcinoma **(C53. _)**	**Y**	
New Term	8575/3	Carcinoma with other types mesenchymal differentiation **(C50. _)**	**Y**	
New Term	8575/3	Metaplastic carcinoma of no special type **(C50. _)**	**Y**	
New Term	8575/3	Metaplastic carcinoma with other types mesenchymal differentiation **(C50. _)**	**Y**	
New code/term	8594/1	**Mixed germ cell sex cord-stromal tumor, unclassified (C48.2, C56.9, C57.9)**	**N**	
Behavior code/term	8620/3	Adult granulosa cell tumor **(C56.9 ONLY)**	**N**	Not reportable for 2018 cases
New code/term	8714/3	Malignant perivascular epithelial cell tumor	**Y**	
New code/term	8714/3	**PEComa, malignant**	**Y**	
New code/term	8714/3	Perivascular epithelioid cell tumor, malignant	**Y**	
New Term	8720/3	Meningeal melanoma **(C70. _, C71._)**	**Y**	
New Term	8801/3	Undifferentiated spindle cell sarcoma	**Y**	
New Term	8802/3	Undifferentiated pleomorphic sarcoma	**Y**	

Status	ICD-0-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
New Term	8803/3	Undifferentiated round cell sarcoma	**Y**	
New Term	8805/3	Undifferentiated uterine sarcoma	**Y**	
Behavior Code/term	8811/1	Myxoinflammatory fibroblastic sarcoma (MIFS) **(C49. _)**	**N**	
New Term	8815/0	Solitary fibrous tumor/hemangiopericytoma Grade 1 (CNS) **(C71. _)**	**Y**	Reportable for CNS
Behavior code/term	8815/1	**Solitary fibrous tumor/hemangiopericytoma Grade 2 (CNS) (C71. _)**	**Y**	Reportable for CNS ONLY
Behavior code/Term	8815/3	**Solitary fibrous tumor/hemangiopericytoma Grade 3 (CNS) (C71. _)**	**Y**	
Behavior Code/term	8825/3	**Low-grade myofibroblastic sarcoma (C01.9, C02. _, C06.9, C49._)**	**Y**	
Behavior Code/term	8825/3	**Myofibroblastic sarcoma**	**Y**	
New Term	8830/3	Malignant fibrous histiocytoma (MFH) of bone	**Y**	
New Term	8830/3	Undifferentiated high-grade pleomorphic sarcoma	**Y**	
New Term	8832/3	Fibrosarcomatous dermatofibrosarcoma protuberans	**Y**	
New Term	8840/3	Low-grade fibromyxoid sarcoma	**Y**	
New Term	8840/3	Sclerosing epithelioid fibrosarcoma	**Y**	

Status	ICD-0-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
Behavior Code/term	8842/3	Ossifying fibromyxoid tumor, malignant **(C49. _)**	**Y**	
Behavior Code/term	8842/3	Pulmonary myxoid sarcoma with EWSR1-CREB1 translocation **(C34. _)**	**Y**	
New Term	8912/3	Sclerosing rhabdomyosarcoma	**Y**	
New Term	8933/3	Mullerian adenosarcoma **(C54. _, C55.9)**	**Y**	
New code/term	8975/1	Calcifying nested epithelial stromal tumor **(C22.0)**	**N**	
Behavior Code/term	8983/3	**Adenomyoepithelioma with carcinoma (C50. _)**	**Y**	
New Term	8990/3	Phosphaturic mesenchymal tumor, malignant	**Y**	
New Term	9020/3	Periductal stromal tumor, low grade **(C50. _)**	**Y**	
New code/term	9045/3	**Biphenotypic sinonasal sarcoma (C30.0, C31.0-C31.3, C31.8, C31.9)**	**Y**	
New code/term	9086/3	**Germ cell tumors with associated hematological malignancy (C37.9)**	**Y**	
New Term	9110/3	Adenocarcinoma of rete ovarii **(C56.9)**	**Y**	
Behavior code/term	9133/3	**Epithelioid hemangioendothelioma**	**Y**	
New code/term	9137/3	**Intimal sarcoma**	**Y**	

Status	ICD-0-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
New code/term	9137/3	Pulmonary artery intimal sarcoma	**Y**	
New Term	9187/3	Low-grade central osteosarcoma **(C40. _, C41._)**	**Y**	
New Term	9187/3	Low-grade intramedullary osteosarcoma **(C40. _, C41._)**	**Y**	
New Term	9220/3	Chondrosarcoma grade II/III (grade 2/3)	**Y**	
Behavior Code/term	9302/3	Ghost cell odontogenic carcinoma **(C41.0, C41.1)**	**Y**	
Behavior Code/term	9341/3	Clear cell odontogenic carcinoma **(C41.0, C41.1)**	**Y**	
New Term	9382/3	Anaplastic oligoastrocytoma **(C71. _)**	**Y**	
New Term	9382/3	Oligoastrocytoma, NOS **(C71. _)**	**Y**	
New code/term	9385/3	**Diffuse midline glioma, H3 K27M-mutant (C71._)**	**Y**	
New code/term	9395/3	**Papillary tumor of pineal region (C75.3)**	**Y**	Cases diagnosed prior to 1/1/2018 use code 9361/3
New code/term	9396/3	**Ependymoma, RELA fusion-positive (C71. _)**	**Y**	
New Term	9400/3	Diffuse astrocytoma, IDH-mutant **(C71. _)**	**Y**	
New Term	9400/3	Diffuse astrocytoma, IDH-wildtype **(C71. _)**	**Y**	
New Term	9401/3	Anaplastic astrocytoma, IDH-mutant **(C71. _)**	**Y**	
New Term	9401/3	Anaplastic astrocytoma, IDH-wildtype **(C71. _)**	**Y**	
New Term	9424/3	Anaplastic pleomorphic xanthroastrocytoma **(C71._)**	**Y**	

Status	ICD-0-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
New code/term	9431/1	**Angiocentric glioma (C71._)**	**Y**	Cases diagnosed prior to 1/1/2018 use code 9380/1
New code/term	9432/1	**Pituicytoma (C75.1)**	**Y**	Cases diagnosed prior to 1/1/2018 use code 9380/1
New Term	9440/3	Epithelioid glioblastoma **(C71._)**	**Y**	
New Term	9440/3	Glioblastoma, IDH wildtype **(C71._)**	**Y**	
New code/term	9445/3	**Glioblastoma, IDH-mutant (C71._)**	**Y**	
New Term	9450/3	Oligodendroglioma, IDH-mutant and 1p/19q-codeleted **(C71._)**	**Y**	
New Term	9451/3	Anaplastic oligodendroglioma, IDH-mutant and 1p/19q-codeleted **(C71. _)**	**Y**	
New Term	9470/3	Medulloblastoma, classic	**Y**	
New Term	9471/3	Medulloblastoma, SHH-activated and TP53-wildtype **(C71. _)**	**Y**	
New code/term	9475/3	**Medulloblastoma, WNT-activated (C71. _)**	**Y**	
New code/term	9476/3	**Medulloblastoma, SHH-activated and TP53-mutant (C71. _)**	**Y**	
New code/term	9477/3	Medulloblastoma, group 3 **(C71. _)**	**Y**	
New code/term	9477/3	Medulloblastoma, group 4 **(C71. _)**	**Y**	
New code/term	9477/3	**Medulloblastoma, non-WNT/non-SHH (C71. _)**	**Y**	

Status	ICD-0-3 Morphology Code	Term	Reportable to SCCCR Y/N	Comments
New code/term	9478/3	Embryonal tumor with multilayered rosettes C19MC-altered **(C71. _)**	**Y**	
New code/term	9478/3	**Embryonal tumor with multilayered rosettes, NOS (C71. _)**	**Y**	
New Term	9508/3	CNS Embryonal tumor with rhabdoid features **(C71. _)**	**Y**	
New Term	9508/3	**Embryonal tumor with rhabdoid features (C71._)**	**Y**	
New code/term	9509/1	Diffuse leptomeningeal glioneuronal tumor **(C71. _)**	**Y**	
New code/term	9509/1	**Papillary glioneuronal tumor (C71. _)**	**Y**	Cases diagnosed prior to 1/1/2018 use code 9505/1
New code/term	9509/1	Rosette-forming glioneuronal tumor **(C71. _)**	**Y**	
New code/term	9542/3	**Epithelioid malignant peripheral nerve sheath tumor (C47.0–C47.6, C47.8, C47.9)**	**Y**	
New Term	9560/1	Melanotic schwannoma **(C72.4, C72.5)**	**Y**	
New code/term	9741/1	Indolent systemic mastocytosis	**N**	

2. SCCCR Date Field Requirements 2018

Population-based cancer surveillance is based on accurate dates. The two most important dates for cancer statistics are Date of Diagnosis and the Date of Death. These two dates provide cancer incidence and mortality rates for South Carolina as well as cancer survival statistics. Nothing is any more important than reporting accurate dates!. See the guidelines that follow for how to deal with instances when an exact date may not be available and what is required.

How to code Date of Diagnosis when day, month, or year is unknown

Estimate the date fields according the guidance below. **Always indicate in text that the date was approximated!**

If month, day or year is unknown and cannot be approximated, **the case should not be reported.** SCCCR's will not accept blanks or 9's in the date field for Date of Diagnosis, Date of Birth, or any of the treatment date fields.

SCCCR requirements to estimate unknown dates updated 11/19/19

Estimating the Date of Diagnosis When No Information is Available in the Medical Record

Registrars MUST use every resource available at the reporting facility to determine the best date of diagnosis. In the absence of an exact date of initial diagnosis, you MUST estimate at least the year of diagnosis using your best approximation from the information available in the record. Documentation that the exact date of diagnosis was not available in the medical record MUST be included in a text field. When an exact date of diagnosis is identified after a case has been completed, contact SCCCR.

The date of initial diagnosis is the earliest date this primary reportable neoplasm is diagnosed clinically or microscopically by a recognized medical practitioner, regardless of whether the diagnosis was made at the reporting facility or elsewhere.

The initial diagnosis date may be from a clinical diagnosis or other acceptable diagnostic method; for example, when a radiologist reviews a CT Scan or chest x-ray and the diagnosis is lung cancer or suspicious for lung cancer. When a diagnosis is confirmed later biopsy/resection, the (clinical or other acceptable testing) date of diagnosis remains the date of the initial diagnosis.

Date of Diagnosis Coding Instructions:

1. NEVER LEAVE THE DATE OF DIAGNOSIS BLANK.
2. NEVER ENTER 99/99/9999 FOR DATE OF DIAGNOSIS.

How to Code **Date of Birth** when not stated in record

If the patient age is available only, calculate the year of birth from age and the year of diagnosis (for example, a 60-year-old patient diagnosed in 2010 is calculated to have been born in 1950).

3. SCCCR Edits 2018

The SCCCR requires that all facilities uploading data to the central registry use the state edits metafile. This edits metafile will be sent to all cancer registry software vendors to give them time to update their client's software before the metafile is used in the SCCCR applications to process their cases.

Edit Metafile Name**: NAACCR_v18.smf**

The SCCCR uses the following state-specific edits to perform additional quality control on the data that have been submitted by facilities. **SCCCR requires facilities use these edits within their cancer registry databases prior to uploading their data to the central registry.**

Edit Name	Edit Rationale	Text/Coding Requirements
Prostate Acinar Histology	If Histology is coded 8550/3 this edit flags the record for manual review	8550/3 is not a valid histology for Prostate (C61.9) primaries. Histology should be coded 8140/3 Adenocarcinoma.
Kidney, TCC	If the histology is coded (8120-8131) and the primary site is coded C64.9 Kidney, NOS this edit flags the record for manual review	TCC (8120-8131) is usually found in the upper urinary system and arises in the renal pelvis therefore the record should be coed as primary site C65.9 Renal Pelvis.
Breast, Infiltrating Ductal CA ICDO3	If the Primary Site is coded C50.0 – C50.9 and the Histology is coded 8521 this edit flags the record for manual review	Most of the time histology code 8521 is incorrect. If this code is being used correctly text fields need to be used to document using this code.
Corpus Uteri Combination Histology	If the Primary Site is C54.0 – C54.3 and Histology is coded	Make sure to document in text that the histology is Endometrioid

	8380/3 this edit flags the record for manual review	Adenocarcinoma or Endometrioid Carcinoma, if this isn't the appropriate histology the record should be coded 8323/3 Mixed Cell Adenocarcinoma.

SCCCR Edits 2018, continued

Edit Name	Edit Rationale	Text/Coding Requirements
Date of Diagnosis, Analytic	If Class of Case = 00-30, 40-42, or 99 then the Date of Diagnosis cannot be a partial date	Code complete dates for the Date of Diagnosis, reference Section 2 of this document for the Date of Diagnosis requirements.
Lung Histology	If the Primary Site is C34.0 – C34.9 and the Histology is 8246/3 the record is flagged for manual review to verify the histology is Neuroendocrine carcinoma	Use the text fields to document the specific histology.
Solitary Plasmacytoma of Bone	If Histology is coded 9731/3 Plasmacytoma of bone the record is flagged for manual review to verify the Primary Site is coded to bone (C40.x or C41.x)	Code the primary site to Bone when coding histology 9731/3. Document in text.
Thyroid, Papillary Adenocarcinoma	If Primary Site is C73.9 Thyroid and Histology is coded 8050/3 the record is flagged for manual review	The histology should be coded 8260/3 Papillary Adenocarcinoma of the Thyroid. Document in text.

4. SCCCR 2018 Text Guidelines

The SCCCR requires the submission of text information to validate coded data items. Text is used for quality control purposes to justify codes for various data items. Text is also used to identify errors, determine multiple primaries, and resolve discrepancies in data submitted on the same patient by multiple facilities. CDC NPCR Data Quality requires that documentation accompany all cases sufficient to substantiate the coding of key data items. When the SCCCR is audited each grant cycle by NPCR, they always use text to substantiate codes, and if it is missing, the item is counted against the SCCCR. **There must be text to support codes**.

All cancer registry software must include specific fields that have been designed to record text information. These fields are transmitted to the SCCCR along with the other required data fields when data are electronically submitted.

Recording text information should include but not be limited to the following:

• Record text to support primary site, laterality, histology, grade, stage, and treatment codes.

• Record text to justify any unusual information about the case that could result in potential questions, e.g., record text to support unusual site/histology combinations, such as age/site combinations, gender/site combinations, name/gender combinations, pediatric age.

• Record text to clarify modifications or dates on the abstract.

• If limited information is available in the medical record about a case, utilize the text field to state that limited information was available in the medical record.

• Document dates as M/D/YY

- NCRA Informational Abstracts provide the best practices for documenting text for many sites: http://www.cancerregistryeducation.org/rr

SCCCR Text Guidelines 2018 Table

Field	Instructions	Text to Include
PE	Document information from the history and physical exam	• Date of physical exam • Age, sex, race/ethnicity • History that relates to cancer diagnosis • Palpable lymph nodes • Impression (when stated and pertains to cancer diagnosis) • Date of diagnosis
X-rays & Scans	Document information from all X-rays, scans, and/or other imaging examinations that provide information about diagnosis and staging	• Location, Date(s) and type(s) of X-ray/Scan(s) • Primary site • Histology (if given) • Tumor location, size and staging if stated • Lymph nodes • Record positive and negative clinical findings. Record positive results first • Distant disease or metastasis
Scopes	Document information from endoscopic examinations that provide information for diagnosis, staging and treatment.	• Location, Date(s) of endoscopic exam(s) • Primary site • Histology (if given) • Tumor location • Tumor size • Record site and type of endoscopic biopsy • Record positive and negative clinical findings.
Labs	Document information from laboratory tests other than cytology or histopathology.	• Location, Type of lab test/tissue specimen(s) • Record both positive and negative findings. Record positive test results first. • Information can include tumor markers, serum and urine electrophoresis, special studies, etc. • Date(s) of lab test(s) • Lab tests, tumor markers, and other prognostic factors, including, but not limited to: Breast Cancer – Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu, Prostate Cancer – Prostatic Specific Antigen (PSA),Testicular Cancer – Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH), HPV status
OP	Document all surgical procedures used in staging	• Location, Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived • Observations from surgery • Number of lymph nodes removed • Size of tumor removed • Documentation of residual tumor • Evidence of invasion of surrounding areas • Reason primary site surgery could not be completed

Field	Instructions	Text to Include
Path	Document information from cytology and histopathology reports	• Location, Date(s) of procedure(s) • Anatomic source of specimen • Type of tissue specimen(s) • Tumor type and grade (include all modifying adjectives, predominantly, with features of, with foci of, elements of, etc.) • Tumor size • Extent of tumor spread • Involvement of resection margins • Number of lymph nodes involved and examined • Record both positive and negative findings. Record positive test results first. • Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored
Primary Site	Document information regarding the primary site and laterality of the tumor being reported. •	• State the specific location of the primary site, including subsite. • Include available information on tumor laterality • Source of information (MPH rules, path report, physician statement, etc.)
Histology/GRADE	Document information regarding the histologic type, behavior and grade (differentiation) of the tumor being reported.	• Information on histologic type and behavior • Information on differentiation from scoring systems such as Gleason's Score, Bloom-Richardson Grade, etc. • Source of information (MPH Rules, path report, physician statement, etc.)
Staging	Document information used for staging Example: Clinical Stage: Registrar/Dr Smith Med Onc Consult 2/1/18 cT3 cN0 cM0 Stage grp 2	Justification of clinical and pathologic TNM and Summary Stage, including: Organs involved by direct extension and who staged by: • Size of tumor • Status of margins • Number and sites of positive lymph nodes • Site(s) of distant metastasis
Surgery	Document information regarding surgical treatment.	• Date of each procedure. • Name of physician performing procedure. • Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites. • Lymph nodes removed. • Regional tissues removed. • Metastatic sites. • Facility where each procedure was performed. • Record positive and negative findings. Record positive findings first. • Other treatment information, e.g., planned procedure aborted; unknown if surgery performed

Field	Instructions	Text to Include
Radiation (Beam)	Document information regarding treatment using radiation other than beam radiation.	• Date radiation treatment began • Where treatment was given: at this facility, at another facility • Name of radiation oncologist. • Type(s) of beam radiation, e.g., Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities • Other treatment information, unknown if radiation completed, patient didn't complete last 3 treatments
Radiation (Other)	document information regarding treatment using radiation other than beam radiation.	• Date treatment was started • Name of radiation oncologist • Where treatment was given, e.g., at this facility, at another facility • Type(s) of non-beam radiation, e.g., High Dose rate brachytherapy, seed implant, Radioisotopes (I-131)
Chemo	document information regarding treatment using chemotherapy.	• Date chemotherapy began • Name of physician providing treatment • Where treatment was given, examples: at this facility, at another facility • Type of chemotherapy, example: name of agent(s) or protocol • Other treatment information, example: treatment cycle incomplete, unknown if chemotherapy was given
Hormone	Document information regarding treatment using hormonal treatment	• Name of physician providing treatment • Where treatment was given: at this facility, at another facility • Type of hormone or antihormone: Tamoxifen • Type of endocrine surgery or radiation: orchiectomy • Other treatment information: treatment cycle incomplete; unknown if hormones were given
BRM	Document information regarding treatment using biological response modifiers or immunotherapy.	• Date treatment began • Name of physician providing treatment • Where treatment was given, at this facility, at another facility • Type of BRM agent: Interferon, BCG • BRM procedures: bone marrow transplant, stem cell transplant • Other treatment information: treatment cycle incomplete; unknown if BRM was given

Field	Instructions	Text to Include
Other	Document information regarding treatment that cannot be defined as surgery, radiation or systemic therapy. This includes experimental treatments and blinded clinical trials where the mechanism of the experimental drug is not known.	• Date treatment was started • Name of physician providing treatment • Where treatment was given: at this facility, at another facility • Type of other treatment: blinded clinical trial, hyperthermia • Other treatment information: treatment cycle incomplete; unknown if other treatment was given
Remarks	Document information not documented in another field.	Reason for: SS# unknown, sequence number, justifications for overrides and anything coded unusual.
Place of Diagnosis	Document Facility, physician's office, city, state or country where the diagnosis was made	Complete name of hospital or physician's office where diagnosis occurred.

5. SCCCR Staging Requirements 2018

NPCR discontinued requiring AJCC TNM Staging as of 1/1/2018 cases going forward. The SCCCR will continue to accept TNM staging elements from COC hospitals for 2018 cases.

SEER Summary Stage 2018 is required by the SCCCR for 2018.

SEER Extent of Disease (EOD) is also required by the SCCCR. The thought is that the EOD data elements can be easily completed as they are needed to stage cases using the other staging systems.

6. 2018 SCCCR Staff Contact:

Name	Phone #	Email
Susan Bolick, MSPH, CTR, Deputy Director, Bureau of Health Improvement and Equity	803-898-3001	bolicks@dhec.sc.gov
Deborah Hurley, MSPH Director	803-898-0701	hurleydm@dhec.sc.gov
Michael Castera, CTR Data Quality Manager	803-898-0353	casterma@dhec.sc.gov
Tina Palles, CTR Quality Control Editor: Pee Dee Region	843-777-7818	pallesce@dhec.sc.gov
Kammy Rebl, CTR Education/Training Project Coordinator	843-953-0171	reblkj@dhec.sc.gov
Lynn, Redmon, CTR Quality Control Editor: Upstate Region	864-240-9164	redmonrl@dhec.sc.gov

2018 Reference Manuals and Summary of Requirements

Summary of COC Requirements for Accredited Programs

For all cases diagnosed on or after January 1, 2018, the American College of Surgeons Commission on Cancer (CoC) will require its accredited programs to use Standards for Oncology Registry Entry (STORE); *AJCC Cancer Staging Manual, Eighth Edition* (8th Edition), Site-Specific Data Items (SSDIs) for collection of site-specific information; NAACCR Guidelines for ICD-O-3 Update Implementation; 2018 Solid Tumor Coding Rules; SEER Summary Stage 2018 Manual to assign Summary Stage; most current SEER Hematopoietic and Lymphoid Neoplasm Database and rules; and SEER*RX systemic therapy application. Revisions to CoC reporting requirements for 2018 accommodate the transition from Collaborative Stage Site-Specific Factors to the new SSDI and Grade data items, as well as implementation of new data items for the collection of radiation therapy, information associated with sentinel and regional lymph nodes, and cancer recurrence.

The SCCCR will accept AJCC TNM staging from COC hospitals, however, does not require it for non-hospital cases (path lab or physician office cases). All other requirements are as stated above for the COC accredited hospitals, except that the SCCCR also requires SEER Extent of Disease (EOD) coded data items from all data sources.

7. AJCC TNM Staging Manual, 8th Edition

AJCC 8th Edition significantly expanded and developed by international disease site expert panels, the Eighth Edition AJCC Cancer Staging Manual brings together all the currently available knowledge on staging of cancer at various anatomic sites. In this edition, evidence-based TNM staging is supplemented, as appropriate, by selected molecular markers and newly acquired insights into the molecular underpinnings of cancer. This edition features 12 entirely new staging systems, a wide range of changed or new staging definitions, and a refined emphasis on a personalized-medicine approach. **Effective for all cases diagnosed on or after January 1, 2018 for COC hospitals.**

Highlighted in red are hyperlinks for ordering:

The AJCC Cancer Staging Manual, 8th Edition is available for purchase. The Kindle e-version is available on Amazon.

25% Discount Offered through Springer until 12/31/2018

8. 2018 Site Specific Data Items (SSDI) and Grade

The Grade Coding Instructions and Tables (Grade Manual) is the primary resource for documentation and coding instructions for Grade for cases diagnosed on or after January 1, 2018. Before using the Grade Manual as a coding reference, it is important to review the introductory materials and general instructions of the manual carefully. These reflect several important changes in the collection of Grade data items, including use of AJCC-recommended grade tables where applicable and the introduction of Clinical, Pathological and Post Therapy Grade data items.

To understand how the Grade Tables are organized in the Grade Manual, one must be familiar with the concept of Schema IDs which is described in the SSDI Manual. A particular Grade Table defines the set of applicable codes for a set of schemas and AJCC Chapters. For example, “Grade ID 01 – Clinical Grade Instructions” defines a single set of codes that apply to clinical grade for 23 Schemas/AJCC Chapters. Similar to the SSDI’s, registry software will populate the grade field pick lists for each case with the appropriate grade codes based on the Schema ID, such that once the software is available, the registrar will not have to use the manual to determine which grade codes apply for a particular case.

For registrars who are coding 2018 diagnosed cases before software is available, the Grade Manual provides Grade Table Indexes to assist the registrar in identifying the correct code Tables. These indexes are located at the beginning of the Grade Manual, immediately after the Table of Contents. The first Index provides information sorted in Schema ID # order, which approximates the order of AJCC Chapters, and contains Schema number and name, AJCC Chapter number and name and the Summary Stage Chapter name along with a hyperlink to the appropriate Grade Table. A hyperlink is also provided to return to the Grade Table (Schema ID

order) at the end of the coding instructions for each schema. A second index with similar information and functionality, sorted in alphabetical order by schema name, is also provided. In addition to understanding the concept and structure of the Grade Tables, it is critically important to review all of the general information included in the Manual. Particular attention should be paid to understanding coding instructions for grade tables where both an AJCC-preferred grade system and the generic grade system are allowable codes, coding guidelines for Clinical, Pathological and Post Therapy grade data items and coding instructions for generic grade categories. Thorough understanding of this material will be necessary in order to code the new Grade Data Items accurately.

Hyperlink below to connect via internet version that will always be updated: NAACCR.org All SSDI & Grade 2018 https://apps.naaccr.org/ssdi/list/

The CoC/AJCC and SEER have a broader SSDI Requirements, SCCCR will only monitor data on the 14 SSDI's listed below for analytic cases.

List of 14 Site Specific Data Items (SSDI) Required by SCCCR for 2018

Item Number	Item Name
3816	Brain Molecular Markers
3817	Breslow Tumor Thickness
3827	Estrogen Receptor Summary
3835	Fibrosis Score
3843	Grade Clinical
3844	Grade Pathological
3845	Grade Post Therapy
3855	HER2 Overall Summary
3890	Microsatellite Instability (MSI)
3915	Progesterone Receptor Summary
3920	PSA Lab Value
3926	Schema Discriminator 1
3927	Schema Discriminator 2
3932	LDH Pretreatment Lab Value

SEER Site Specific Factor 1 (SSF-1) is required by SCCCR for 2018

https://www.naaccr.org/SSDI/SSDI-Manual.pdf

2018 SEER Site-Specific Factors 1-6: Currently there is only one site specific factor and it's reserved for capturing information on Human Papilloma Virus (HPV) status. These 2018 SEER Site-Specific factors are not part of the Collaborative Staging Data Collection System and are only for cases diagnosed after 1/1/2018.

Item Number	Item Name
3700	Human Papilloma Virus (HPV) Status

9. STORE 2018 - Standards for Oncology Registry Entry

The STORE replaced the FORDS manual for coding instructions and guidelines, and incorporates all updates to Commission on Cancer (COC) National Cancer Database Data Base (NCDB) standards since the FORDS 2016 revision. **It is effective for cases diagnosed January 1, 2018 and forward.**

Please click on the hyperlink for a copy of 2018 CoC STORE:
https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/store_manual_2018.ashx

10. SEER Summary Stage 2018

Summary Stage is the most basic way of categorizing how far a cancer has spread from its point of origin. The 2018 version of SEER Summary Stage applies to every site and/or histology combination, including lymphomas and leukemias. Summary Stage uses all information available in the medical record, in other words, it is a combination of the most precise clinical and pathological documentation of the extent of disease.

The 2018 Summary Stage Manual chapters consist of a one-digit hierarchical code. In the United States, these chapters will apply to January 1, 2018 diagnoses and forward. It is extremely important to thoroughly read all clinical and pathological documentation, including imaging studies, operative and pathology reports, and the clinician's narrative descriptions of tumor involvement.

Please click on the hyperlink for the most updated internet version:
https://seer.cancer.gov/tools/ssm/

The Registrar Staging Assistant (SEER*RSA) website is intended for use by cancer registrars to help with the following: https://stagingseer.cancer.gov/

For cases diagnosed 2018 and forward:

- Code Extent of Disease (EOD) 2018
- Code Summary Stage 2018 (SS2018)
- Code Site-Specific Data Items (SSDI)
- Code Grade

11. Solid Tumor Rules - Effective for Cases Diagnosed 1/1/2018 and Forward

The 2018 Solid Tumor Rules replace the 2007 Multiple Primary and Histology (MPH) Coding Rules. This revision continues to promote consistent and standardized coding by cancer registrars and coding instructions to ensure accurate data collection**. It is important to note eight site-specific coding modules have been updated for 2018. These site groups are: Benign Brain, Malignant CNS, Breast, Colon, Lung, Head & Neck, Kidney, and Urinary. The remaining two site specific coding modules have not been updated for 2018. These site groups are: Cutaneous Melanoma and Other sites.**

The primary reference for both the 2007 MPH rules and 2018 Solid Tumor Rules are the WHO Classification of Tumors books (blue books). Since 2007, WHO has continued publishing updates to the WHO Classification of Tumors series. As part of each new edition, subject matter experts review current literature and make recommendations regarding current practices in histology terminology and diagnosis. The College of American Pathologists (CAP) has adopted the new histologic terminology and diagnosis criteria into the site-specific 2018 CAP Protocols. The 2018 Solid Tumors Rules have been revised to reflect current CAP and WHO practices.

As part of the revisions to the 2007 MPH rules, the editors and Solid Tumor Committee reviewed issues and questions NCI SEER received since the implementation of the MPH rules. These questions provided valuable information as to what clarifications were needed in the form of additional rules, tables, examples, and notes.

Please click on hyperlink for the most updated internet version:
https://seer.cancer.gov/tools/solidtumor/

2018 Resources Table with Quick Links (11/19/19 updated) This table includes the links for the all required reference manuals. For 2018 abstracting, registrars MUST USE THEIR MANUALS!

Reference Manual / Abstracting Resource	Link to Resource
SCCCR Reporting Source Manual	http://www.dhec.sc.gov/health/docs/cancer/scccr Reporting Source Manual Final 2018 updated.pdf
2019 Case Finding ICD-10-CM Code List Changes	https://seer.cancer.gov/tools/casefinding/
ICD-O-3 Third Edition – purple book	https://seer.cancer.gov/icd-o-3/
ICD-O-3 Third Edition - published errata (two)	https://seer.cancer.gov/icd-o-3/
ICD-O-3 Third Edition - 2007 Updates for Selected Solid Tumors	https://seer.cancer.gov/icd-o-3/
ICD-O-3 Third Edition - 2010 Updates for Hematopoietic and Lymphoid Neoplasms	https://seer.cancer.gov/icd-o-3/
2018 Guidelines for ICD-O-3 Histology Code and Behavior Update	https://seer.cancer.gov/icd-o-3/
2018 Solid Tumor MP/H Coding Rules	https://seer.cancer.gov/tools/solidtumor/
2018 Hematopoietic Database & MPH Rules – web-based version only	http://seer.cancer.gov/seertools/hemelymph/
2018 SEER*Rx – current web version	http://seer.cancer.gov/seertools/seerrx/
2018 Grade Coding Manual, Instructions and Tables	https://apps.naaccr.org/ssdi/list/
2018 Summary Stage Manual	http://seer.cancer.gov/tools/ssm/
AJCC Cancer Staging Manual, 8th ed.	http://www.springer.com/medicine
AJCC Cancer Staging Manual, 8th ed. – errata & breast chapter replacement	https://cancerstaging.org/references-tools/deskreferences/Pages/8EUpdates.aspx#Histology/Topography
AJCC Histology and Topography Code Supplement	https://cancerstaging.org/references-tools/deskreferences/Pages/8EUpdates.aspx#Histology/Topography
2018 Site-Specific Data Items Manual	https://apps.naaccr.org/ssdi/list/
2018 Site/Type Validation Table from SEER	https://seer.cancer.gov/icd-o-3/

CoC STORE Manual - Standards for Oncology Registry Entry	https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals
CTR Guide to Coding Radiation Therapy Treatment in the STORE	https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/case_studies_coding_radiation_treatment.ashx?la=en
SEER*SINQ - Inquiry System	https://seer.cancer.gov/seerinquiry/index.php
CoC Canswer - Inquiry System	http://cancerbulletin.facs.org/forums/
Your State EDITS Metafile – current version	SCCCR Metafile available upon request