The Top 5 Cancer Sites

The Ins, Outs, and In betweens

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RegistryPartners

DATA ABSTRACTION | REGISTRY MANAGEMENT | CONSULTING

Objectives

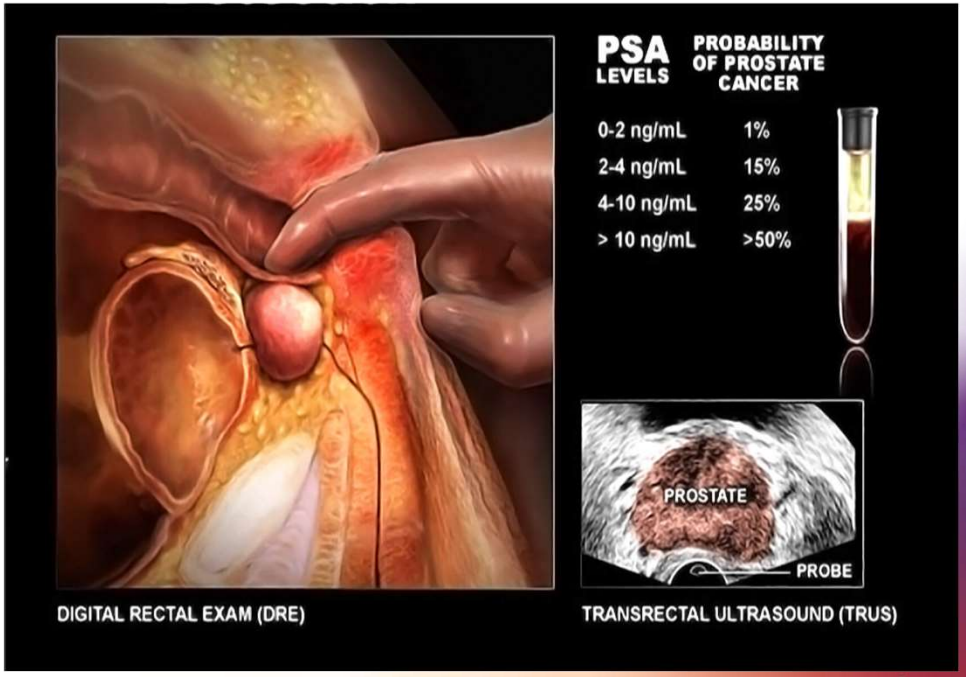
- Review common coding errors for the top 5 primary sites (Prostate, Colon, Lung, Bladder, and Breast) with instruction and rationale for choosing the correct answers.

- Review site-specific grade, SSDI, AJCC, and SEER staging coding rules while providing clarity with case examples.

- Test abstractor knowledge and provide insight on utilizing registry resources to select correct coding answers.

Prostate

- PSA
- Digital Rectal Exam (DRE)
  - gold standard for prostate cancer
  - Used to determine cT
- Transrectal Ultrasound (TRUS)



Prostate

Patient with elevated PSA. Prostate Bx: Adenoca, Gleason 3+3=6 in 1/12 cores. Presents for surgery consult. No digital rectal exam found documented in consult note. Limited info available from surgeon.

How would you code cT?

a) cTx

b) cT blank

American College of Surgeons YouTube, AJCC Presentation on X vs. Blank

- Blank: Unknown to registrar
- X: Physician's perspective; known for certain DRE was not done

Prostate

Patient presents with elevated PSA and clinical exam reveals negative DRE
Prostate bx: adenocarcinoma in rt and lt lobes, Gleason 3+4=7 in 3/12 cores

How would you code cT?

a) **cT1c, Tumor identified by needle bx found in one or both sides, but not palpable**
b) **cT2a, Tumor involves ½ of one side or less**
c) **cT2b, Tumor involves greater than ½ of one side but not both sides**
d) **cT2c, Tumor involves both sides**

Prostate

Patient presented with elevated PSA and subsequent DRE revealed multiple nodules in the prostate. Prostate bx: adenocarcinoma in rt and lt lobes, Gleason 4+3=7 in 4/12 cores

How would you code cT?

a) cT1c, Tumor identified by needle bx found in one or both sides, not palpable

b) cT2a, Palpable tumor involves ½ of one side

c) cT2, Palpable tumor confined to prostate

d) cT2c, Palpable tumor involves both sides

Prostate

Prostate Biopsy: Adenoca. Gleason 3+3=6, Gr Group 1
Simple Prostatectomy: Adenoca, Gleason 3+4=7, Gr Group 2

How would you code the Pathologic Grade?

a) **Grade 1**

b) **Grade 2**

c) **Grade 9**

Simple Prostatectomy is coded as a surgery, but does not qualify for pathologic grade, as grade coding rules follow AJCC rules for staging; Capsule is still intact and therefore qualifies for clinical stage and grade only.

Prostate

3/15/24 PSA 8.2
4/17/24 PSA 6.6

5/1/24 Prostate bx: positive for adenoca

How would you code the pre-treatment PSA?

a) 8.2

b) 6.6

c) XXX.9 PSA not assessed or unknown

Per SSDI manual: Record the *last pre-diagnosis PSA lab value* prior to diagnostic biopsy of prostate and initiation of treatment in nanograms per milliliter (ng/ml) in the range 0.1 (.1 ng/ml) to 999.9 (999.9 ng/ml).

Note: This is a change from CSv2, where the instructions stated to code the highest PSA value within 3 months prior to diagnostic biopsy

Prostate

Patient underwent radical prostatectomy followed by radiation to prostate bed.

How would you code the Phase I Radiation Primary Treatment Volume?

a) 65, partial prostate

b) 86, pelvis

c) 64, whole prostate

STORE p. 242
Code to the primary anatomic structure after site removal when the surgical bed is targeted.

Exception – breast

Colon

Colonoscopy: fungating tumor **@ 130cm**, suspicious for colonic adenoca

CT Abd: There is distention and thickening noted in the **ascending colon**

EUS: There is a 4cm tumor extending from the **hepatic flexure into the ascending colon**

Operative Report: **Hepatic flexure** tumor is noted

Right Hemicolectomy Path report: 4.6cm, poorly diff adenoca in the **ascending colon, involving the hepatic flexure.**

How would you code the primary site?

a) C18.3, Hepatic Flexure

b) C18.2, Ascending Colon

c) C18.8, Overlapping tumor

d) C18.9, Colon, NOS

Priority Order for Coding Primary Site-Colon

Resected cases

- Operative report with surgeon's description
- Pathology report
- Imaging

Polypectomy or excision without resection

- Endoscopic Report
- Pathology Report

Subsites

- When tumor involves more than one subsite, ***code to the subsite that includes most of the tumor.***
- Tumor overlaps 2 subsites equally, code to C18.8 Overlapping lesion
- **Multiple tumors** in multiple subsites determined to be a single primary, code to **C18.9** Colon, NOS.

Colon

4/1/24 Colonoscopy: Cecal Mass, biopsy obtained

4/3/24 Biopsy path report: Adenocarcinoma

4/15/24 Resection path report: Adenocarcinoma with Mucinous and Signet Ring Cell Features

How would you code the histology?

a) **8140/3 Adenocarcinoma, NOS**

b) **8480/3 Mucinous Adenoca**

c) **8255/3 Adenocarcinoma, Mixed**

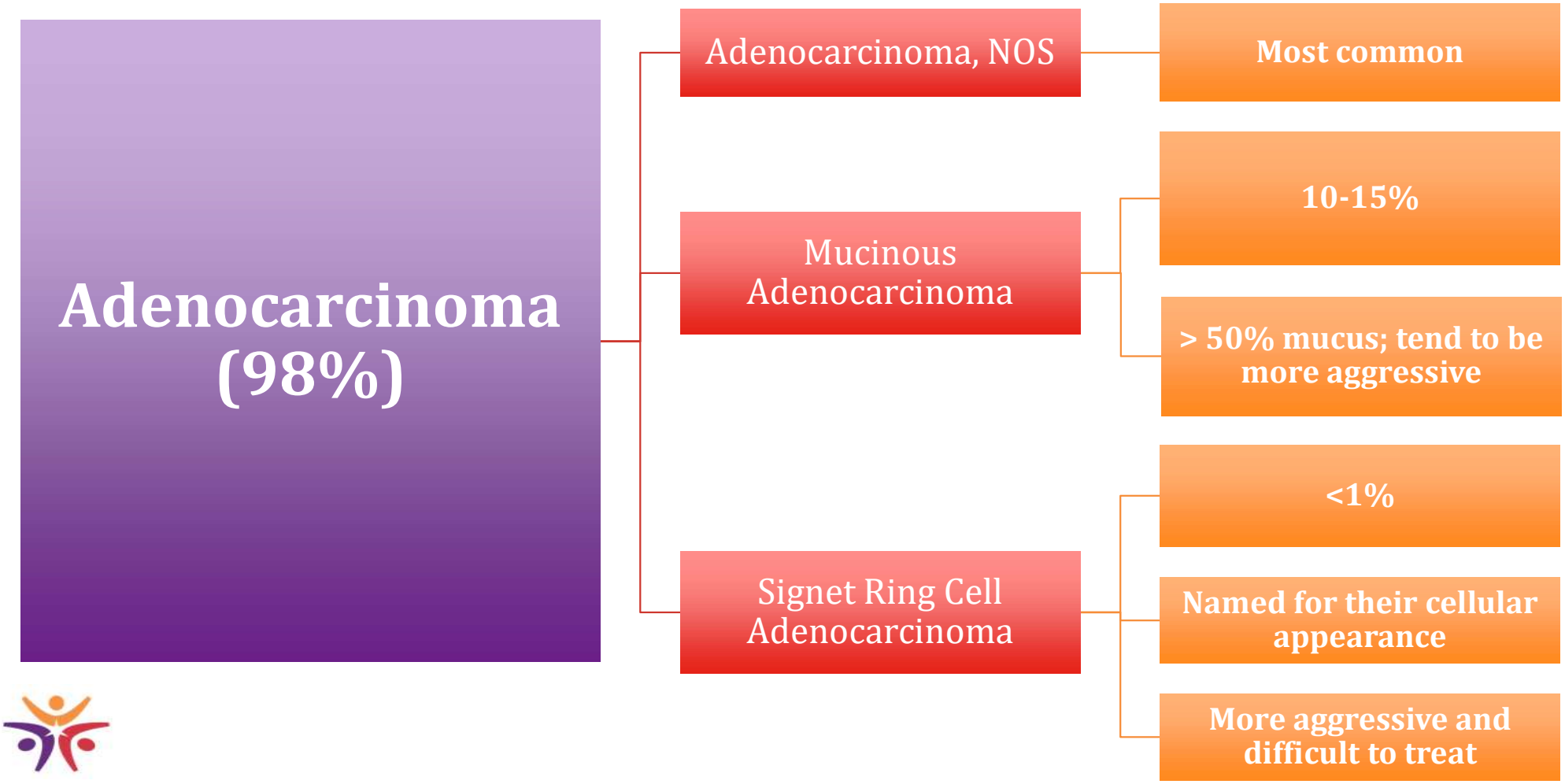
d) **8490/3 Signet Ring Cell Carcinoma**

Rule H4 Code **mixed mucinous and signet ring cell** as follows:

- Adenocarcinoma with mucinous and signet ring features – code adenocarcinoma **8140**
- Mucinous carcinoma and signet ring cell carcinoma:
  - Mucinous carcinoma documented as **greater than 50%** – code mucinous carcinoma **8480**
  - Signet ring cell carcinoma documented as **greater than 50%** – code signet ring cell carcinoma **8490**
  - Percentage of mucinous carcinoma and signet ring cell carcinoma **unknown/not designated**- code adenocarcinoma mixed subtypes **8255**

Note: This rule is for mucinous carcinoma and signet ring cell carcinoma in a single tumor. For mucinous adenocarcinoma mixed with another histology OR signet ring cell carcinoma mixed with another histology proceed through the rules.

Most Common Colon Histologies



Colon

Patient had polypectomy on 1/17/24 which showed intramucosal adenocarcinoma with no evidence of lymph node metastasis or evidence of distant metastasis on workup.

How would you code pT?

a) pTis, In situ
b) pT1, Tumor invades submucosa

AJCC Definition of Tis (pg. 256): lesions confined to mucosa in which cells invade the lamina propria and may involve but not penetrate muscularis propria (intramucosal carcinoma)

Colon

Mucosa

- Made up of the epithelium, basement membrane, and lamina propria
  - **Epithelium**: Single layer of simple columnar cells that contains no blood vessels or lymphatics
  - **Basement Membrane**: Thin sheet of extracellular matrix that supports cells
  - **Lamina propria**: Connective tissue that lies beneath basement membrane and separates the epithelial cells from the muscularis mucosa; Supports blood vessels, nerves, and lymphatics

Muscularis Mucosa

- Thin layer of smooth muscle fibers

Submucosa

- Thick layer of connective tissue that contains blood vessels and lymphatics

Muscularis Propria

- Double layer of muscle tissue that constitutes colon wall

Subserosa

- Fat and flesh tissues between the muscularis and serosa
- Sometimes referred to as subserosal fat or pericolic fat

Serosa

- Also called the mesothelium and visceral peritoneum
- Part of the visceral peritoneum

SEER Appendix C 2023

Colon

Patient had polypectomy on 1/17/24 which showed intramucosal adenocarcinoma with no evidence of lymph node metastasis or evidence of distant metastasis on workup.

How would you code SEER Summary Stage?

a. 0, In situ

b. 1, Localized

Note 4: For the following, AJCC 8th edition stages these as in situ tumors. SS2018 stages these as localized (behavior code 3)

- Intramucosal, NOS
- Lamina propria
- Mucosa, NOS
- Confined to, but not through muscularis mucosa

Histology will be coded to 8140/3

Colon

Hemicolectomy path report: Adenocarcinoma, mod differentiated, tumor 5cm from radial margin.

How would you code the SSDI CRM?

a) XX.9 unknown, not assessed

b) 5.0

c) 50.0

CRM synonyms: *radial* margin, soft tissue margin, mesenteric (mesocolon) (mesorectal) margin, or circumferential radial margin.

Record in mm to the nearest tenth. If given in cm, multiply by 10.

5 cm = 5x10 = 50.0mm

Colon

Cecum Biopsy: Adenocarcinoma, poorly differentiated. LVI (+). No perineural invasion.

How would you code the SSDI Perineural Invasion?

a) 0, Perineural invasion not identified/not present
b) 1, Perineural invasion identified/present
c) 9, Perineural invasion not assessed or unknown if assessed

Note 3: **Absence of PNI** can only be taken from a **surgical** resection path report

Colon

Cecum Biopsy: Adenocarcinoma, poorly differentiated. LVI (+). Perineural invasion present.

How would you code the SSDI Perineural Invasion?

a) 0, Perineural invasion not identified/not present

b) 1, Perineural invasion identified/present

c) 9, Perineural invasion not assessed or unknown if assessed

Note 3: Presence of PNI can be taken from **either bx or resection specimen.**

SSDI: Perineural Invasion

Source Document

- Pathology Report
- Must be microscopically confirmed

Presence of PNI

- Can be taken from **biopsy or resection**

Absence of PNI

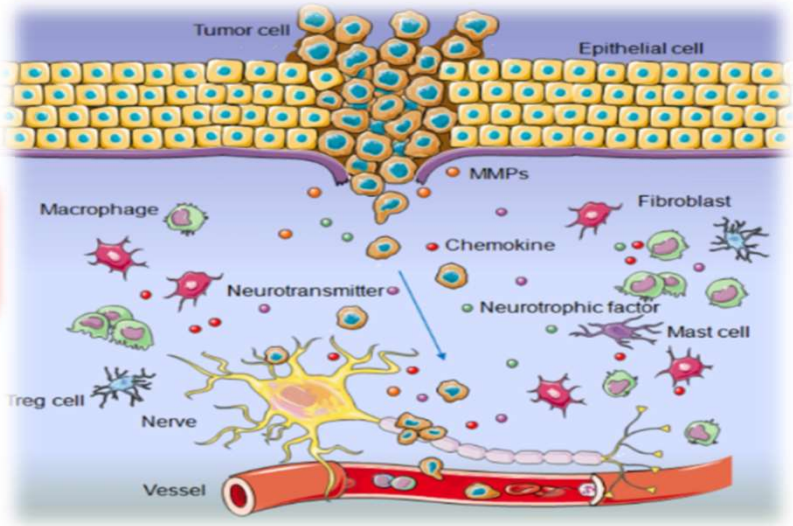
- Can only be taken from **surgical resection only**

Non-invasive /2

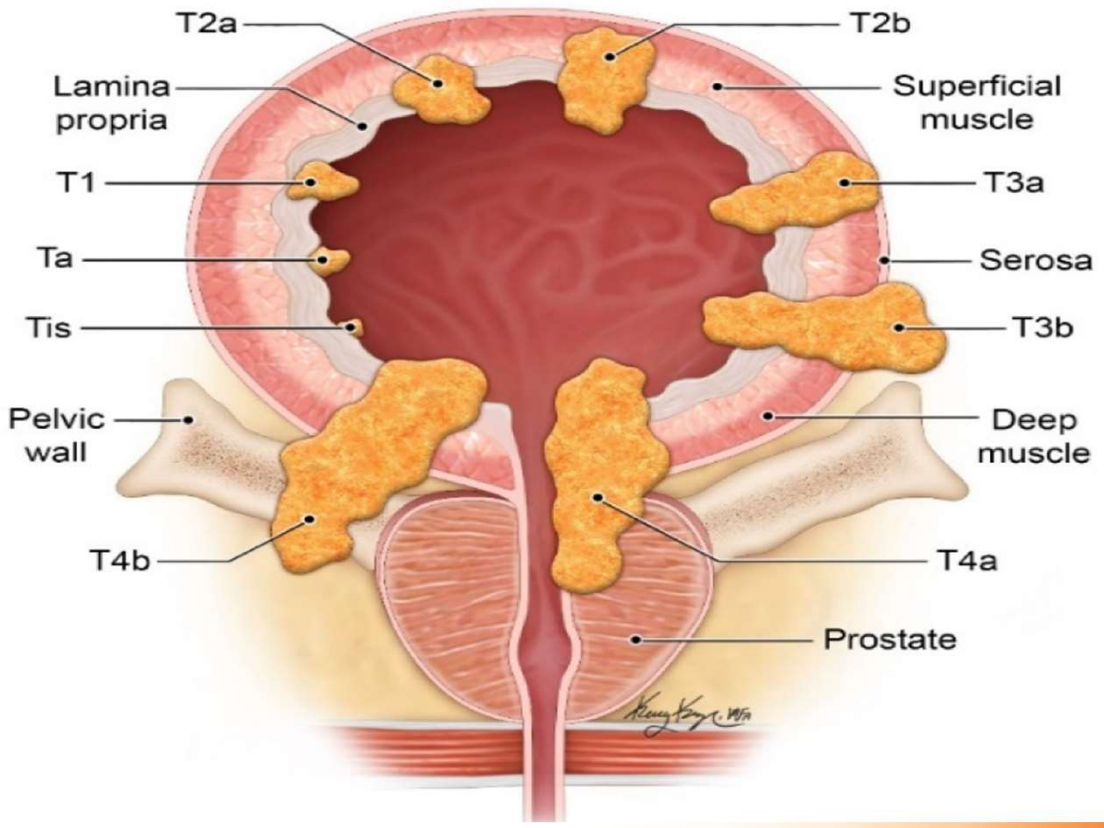
- Code 0

Perineural Invasion (PNI)

- Tumor cells encroaching on nerves
- Negative prognostic factor; predicts outcomes; recurrence
- Decreased survival



Bladder


T2a
T2b
Lamina propria
Superficial muscle
T1
T3a
Ta
Serosa
Tis
T3b
Pelvic wall
Deep muscle
T4b
T4a
Prostate

Bladder

Patient presents on 4/17/24 with gross hematuria and has TURB with electrocautery to tumor bed to eliminate residual tumor.

How would you code the surgery?

a) A120 Electrocautery; fulguration
b) A270 Excisional biopsy
c) A220 Electrocautery

A200 Local tumor excision, NOS
A260 Polypectomy
A270 Excisional biopsy
[***SEER Note:*** Code TURB as A270.]

Any combination of A200, A260, or A270 WITH
A210 Photodynamic therapy (PDT)
A220 Electrocautery
A230 Cryosurgery
A240 Laser ablation

❖ **Note: be sure to read the Op note carefully to determine whether the electrocautery was used on the tumor bed or just to stop the bleeding**

❖ **Use code A270 if the electrocautery was for <u>hemostasis only</u>**

Bladder

65 y/o male underwent a radical cystoprostatectomy with ileal conduit 5/15/2024.

How would you code the surgery?

a) **A610 Radical cystectomy PLUS ileal conduit**
b) **A710 Radical cystectomy including anterior exenteration**

Bladder

SEER

Appendix C

A710 Radical cystectomy including anterior exenteration

[***SEER Note:*** Use code A710 for cystoprostatectomy. Use code A710 for cystectomy with hysterectomy.]

[***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* (NAACCR #1294).

If cystectomy is done along with prostatectomy/hysterectomy, all pelvic organs removed during the procedure are included in codes A700-A740.

Any non-pelvic organs or tissues removed during the procedure should be coded to *Surgical Procedure of Other Site* (NAACCR #1294).]

For females, includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra. For males, includes removal of the prostate. When a procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code A600-A640).

STORE

Appendix A

A710 Radical cystectomy including anterior exenteration

For females, includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra. For males, includes removal of the prostate. When a procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code A600-A640).

Bladder

Bladder TURB is performed at 4/24/24. Path: Urothelial Carcinoma, LG. No mention of margins.

How would you code the surgical margins?

a) 7, Margins not evaluable

b) 9, Margins unknown

- Per STORE, record the margin status as it appears **in the path report.**
- Code 7 if the path report indicates the **margins could not be assessed/indeterminate.**
- Code 9 if the path report **makes no mention of margins**.

Bladder

2/16/2024 TURB path report: Non-invasive papillary urothelial carcinoma.

How would you code cT?

a) **cTa, Non-invasive papillary carcinoma**
b) **cTis, Carcinoma in situ**

Bladder

2/16/2024 TURB path report: Low grade, non-invasive urothelial carcinoma. Tumor Configuration: Papillary. pTa.

How would you code the histology?

a) 8120/2 Urothelial Carcinoma in situ

b) 8130/2 Papillary Urothelial Carcinoma, non-invasive

Per STR, do not code histology described as Architecture, Configuration, Foci, Focus, Focal, Pattern.

Bladder

Patient has a TURB on 3/13/24
Op note: 0.6cm bladder tumor on trigone of bladder, a 1cm tumor on posterior wall, and a 1.4cm tumor on the dome of the bladder. All 3 were resected and fulgurated for hemostasis.
Path report: non-invasive urothelial cell carcinoma for all the resected tumors.
How would you code the clinical T suffix?

a) (m) multiple tumors
b) Blank

AJCC Chapter, page 12:
The (m) suffix applies to multiple *invasive cancers*. It is not applicable for multiple foci of an in situ or for a mixed invasive and in situ cancer.

Lung

Patient presents with a RUL Bronchus mass that measures 1.5cm

Biopsy path report: adenocarcinoma.

How would you code the primary site?

a. C34.1 RUL Lung

b. C34.0 Mainstem Bronchus

Bronchus vs. Mainstem Bronchus		
Mainstem Bronchus Bronchus Intermedius	Bilateral	C34.0
Superior lobar bronchus Upper lobe bronchi	Bilateral	C34.1
Middle lobe bronchi	Right	C34.2
Lower lobar bronchus Lower lobe bronchi Lower lobe segmental bronchi	Bilateral	C34.3
Bronchus, NOS	Bilateral	C34.9

Lung

Patient presents with a 1.5cm Lingula mass

Biopsy path report: adenocarcinoma

How would you code laterality?

a) 9, Unknown

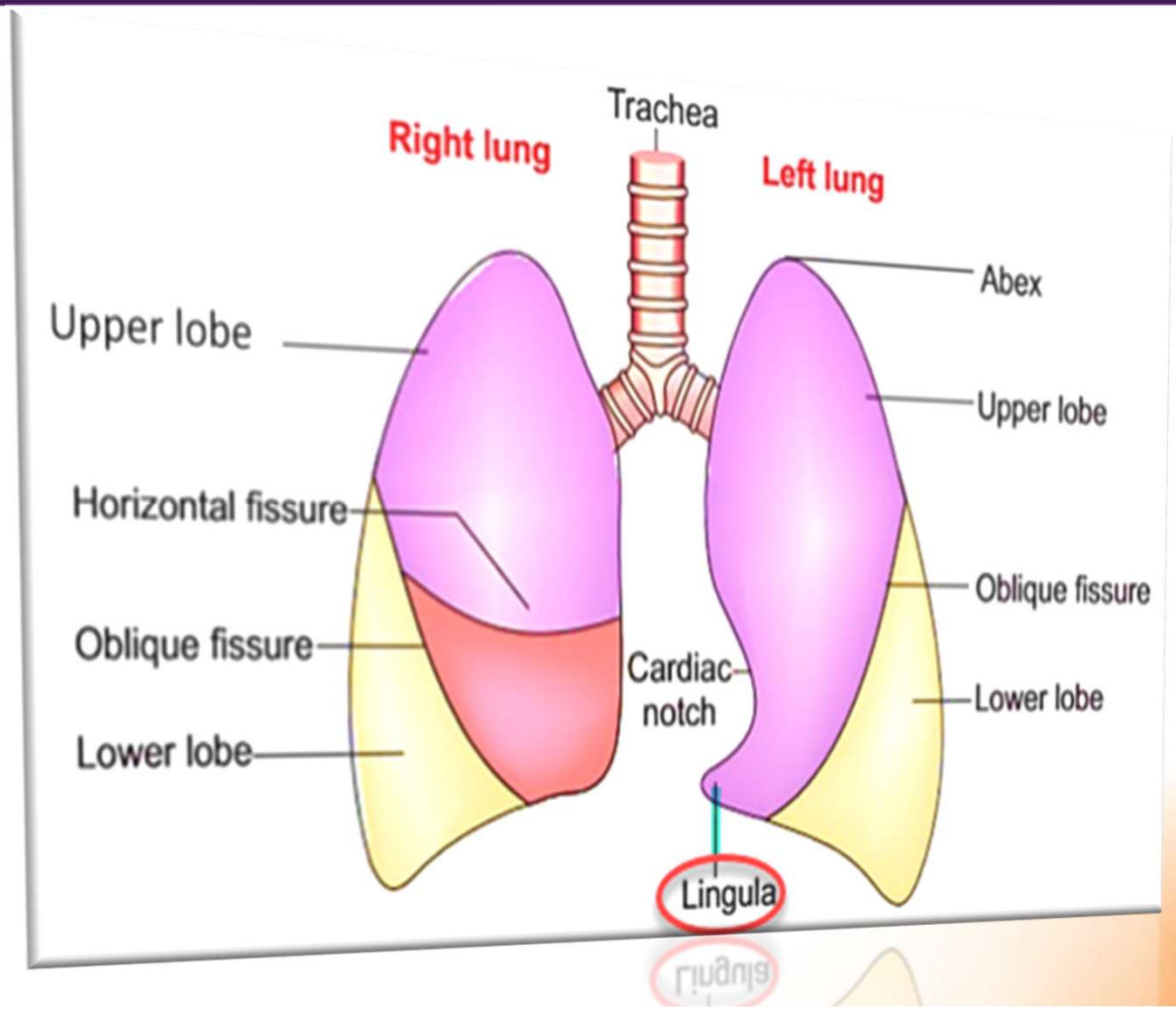
b) 4, Bilateral

c) 2, Left

d) 1, Right

Site Terminology		
Hilum Hilus Hilar Perihilar	Bilateral	C34.0
Lingula	Left	C34.1
Apex Pancoast Tumors	Bilateral	C34.1
Extending up to hilum Extending down to the hilar region Suprahilar	Bilateral	C34.9

Lung


Trachea
Right lung
Left lung
Upper lobe
Horizontal fissure
Oblique fissure
Lower lobe
Abex
Upper lobe
Oblique fissure
Cardiac notch
Lower lobe
Lingula

Lung

CT notes a Pancoast Tumor on the rt side

How would you code the primary site?

a) C34.0, Main Bronchus
b) C34.1, Upper Lobe, Lung
c) C34.9, Lung, NOS
d) N/A; Not reportable

Site Terminology		
Hilum Hilus Hilar Perihilar	Bilateral	C34.0
Lingula	Left	C34.1
Apex Pancoast Tumors	Bilateral	C34.1
Extending up to hilum	Bilateral	C34.9

Pancoast tumor is a lung cancer in the upper-most segment of the lung that directly invades the brachial plexus (nerve bundles) of the neck, causing pain. It is by definition malignant. Code the date of diagnosis from the imaging report when a Pancoast tumor is identified on imaging prior to biopsy.

Lung

Patient presents with a LUL mass

Biopsy path report: carcinoma with a small cell component

How would you code the histology?

a. **8000/3 Carcinoma, NOS**

b. **8140/3 Adenocarcinoma, NOS**

c. **8041/3 Small Cell Carcinoma**

Terms that are **NOT** Equivalent

bilateral ≠ single or multiple primaries

**must use the rules to determine number of primaries*

bronchus ≠ mainstem bronchus

**code mainstem bronchus when reported on Op note. If only bronchus noted, code to the lobe in which the bronchial tumor is located*

Component ≠ subtype/variant/type

Mucin producing/mucin secreting ≠ mucinous carcinoma (*lung only)

Lung

Patient presented with multiple foci of adenocarcinoma with lepidic features involving the RUL and RML

How would you code the SSDI Separate Tumor Nodules?

a) **1 Separate tumor nodules of same histologic type in ipsilateral lung, same lobe**

b) **0 No separate tumor nodules**

c) **2 Separate tumor nodules of same histologic type in ipsilateral lung, different lobe**

Lung

Note 3: For this item, only code separate tumor nodules of the same histologic type as the primary tumor, also referred to as intrapulmonary metastases.

- In the case of multiple tumor nodules determined to be the same primary, if not all nodules are biopsied, assume they are the same histology

Note 4: Other situations that display multiple lesions are NOT coded in this item. Assign code 0 if the multiple lesions belong to one of these other situations. Refer to the AJCC Staging System Lung for standardized and precise definitions of the situations which aren't separate tumor nodules. They are

- second primary tumors, also called synchronous primary tumors (not the same histology as the primary tumor)
- multifocal lung adenocarcinoma with ground glass/lepidic features
- diffuse pneumonic adenocarcinoma

Note 5: "Synchronous" describes the appearance in time compared to the primary tumor. Do not code this item based solely on the word "synchronous". If separate nodules are described as "metachronous," the nodules may be evidence of progression of disease in which case they would not be coded here.

Lung

2.5cm RUL mass w/o distant metastasis noted on clinical workup

Resection path report: adenocarcinoma w/ positive supraclavicular LN

How would you code the SEER Summary Stage?

a) 2, Regional by direct extension

b) 3, Regional to Lymph Nodes

c) 7, Distant

SEER: Distant Lymph Nodes Lung

Contralateral or Bilateral

- Bronchial
- Carinal
- Hilar
- Mediastinal
- Periesophageal
- Pericardial
- Precarinal
- Pretracheal

Ipsilateral OR Contralateral

- Cervical
- Scalene
- **Supraclavicular**

Lung

Pt has Lobectomy with LN Dissection. No distant metastasis noted on clinical workup.

Resection path report: adenocarcinoma, 2.5cm in RUL, 0/7 mediastinal LNs positive, 1/1 supraclavicular LN positive.

How would you code the pathological TNM?

a. **pT1c, pN3, cM0**

b. **pT1c, pNX, pM1**

c. **pT1c, pN0, pM1**

Standard Setter Staging Disagreements

	AJCC	No Mets Involved	SEER
Adjacent Rib; Rib	T3	Stage 3A-3C	Distant
Heart; Visceral pericardium	T3	Stage 3A-3C	Distant
Inferior vena cava	T4	Stage 3A-3C	Distant
Separate tumor nodules, different lobe	T4	Stage 3A-3C	Distant
Ipsilateral Scalene lymph nodes	N3	Stage 3B-3C	Distant
Contralateral mediastinal, hilar, scalene	N3	Stage 3B-3C	Distant
Supraclavicular lymph nodes	N3	Stage 3B-3C	Distant

Lung

Patient presents with 3.4cm RUL lung mass and CT reveals no LAD

RUL biopsy path report: Squamous cell carcinoma

PET: Lytic lesions in rt ulna

Rt ulna biopsy: metastatic Squamous cell carcinoma

How would you code the pathological TNM?

a. **pT blank, pN blank, cM1a**

b. **pT blank, pN blank, pM1a**

c. **cT2a, cN0, pM1a**

d. **cT2a, pNX, pM1a**

Breast

5/10/2024 Needle Bx Rt UOQ Breast: IDC, gr 2

ER+ 98%, PR+ 10-25%, Her2- by IHC, ki67 20-30%

How would you code Estrogen % positive?

a) R99 (91-100%)
b) 98
c) 098

How would you code Progesterone % positive?

a) R10 (1-10%)
b) R20 (11-20%)
c) XX9
d) 11

How would you code ki67?

a) 20.1
b) 30
c) 21
d) 20

Breast

ER/PR are reported in both a range and an actual %

Code the Actual %

ER/PR % less than 1%

Code 000 (Negative)

Ki67

When given in a range, code 0.1 higher than the lower number.

Example ki67 10-20%
Code 10.1

ER/PR reported in range outside of those listed in R10-R99

Range is **less than or equal** to **10**:
Record R Code **range** based on **lowest number**

Example: ER 90-100%.
Code **R90** (81-90%)

ER/PR reported in range outside of those listed in R10-R99

Range is **greater than 10**, code to **unknown**.

Example: PR 67-100%.
Code XX9

Breast

1/15/2024 Needle Bx Lt UOQ, Breast: atypical ductal hyperplasia (ADH)

03/07/2024 Lt Breast Partial Mastectomy: invasive ductal carcinoma

How would you code the surgery?

a) **B200 Partial mastectomy; less than total mastectomy; lumpectomy, segmental mastectomy, quadrantectomy, tylectomy, with or without nipple resection**

b) **B210 Excisional breast biopsy - Diagnostic excision, no pre-operative biopsy proven diagnosis of cancer**

c) **B215 Excisional breast biopsy, for atypia**

Scenario	2023	2024
No biopsy Partial Mastectomy	A200 Partial Mastectomy, NOS less than total mastectomy, NOS	B210 Excisional breast biopsy – Diagnostic Excision, no pre-operative biopsy proven diagnosis of cancer Note: Use code B210 when a surgeon removes the (positive) mass and there was no biopsy (either core or FNA) done prior to the mass being removed. An excisional biopsy can occur when the nodule was previously not expected to be cancer
Needle Biopsy positive for atypia then Partial Mastectomy	A200 Partial Mastectomy, NOS less than total mastectomy, NOS	B215 Excisional breast biopsy, for atypia Note: Use code B215 when patient has a biopsy that shows atypical ductal hyperplasia (ADH), an excision is then performed, and pathology shows in situ or invasive cancer. The excisional breast biopsy for ADH diagnosed the cancer, not the core biopsy. An excisional breast biopsy removes the entire tumor and/or leaves only microscopic margins. This surgical code was added for situations where atypia tissue is excised and found to be reportable. Approx. 10-15% of excised atypia are cancer and reportable
Needle Biopsy positive or FNA positive for Ductal Carcinoma then Partial Mastectomy	A200 Partial Mastectomy, NOS less than total mastectomy, NOS	B200 Partial Mastectomy; less than total mastectomy; lumpectomy; segmental mastectomy; quadrantectomy; tylectomy, with or without nipple resection Note: Use code B200 when there is a previous positive biopsy (either core or FNA

Breast

01/01/2024 Lt UOQ Breast Needle Bx: infiltrating ductal carcinoma

02/01/2024 Lt *modified radical mastectomy* without removal of uninvolved contralateral breast and SLN Bx (at your facility)

How would you code this surgery?

a) **B610 Total simple mastectomy without removal of uninvolved contralateral breast**

b) **B710 Radical mastectomy without removal of uninvolved contralateral breast**

Breast

B600 Total (simple) mastectomy
- B610 WITHOUT removal of uninvolved contralateral breast
- B620 WITH removal of uninvolved contralateral breast

Note: A total (simple) mastectomy removes all breast tissue, the nipple, areolar complex, and breast skin. It is performed with and without sentinel node biopsy or ALND.

Use code B600, B610, B620 if patient had a modified radical mastectomy.

B700 Radical mastectomy, NOS
- B710 WITHOUT removal of uninvolved contralateral breast
- B720 WITH removal of uninvolved contralateral breast
- B760 Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma

A radical mastectomy removes all breast tissue, the nipple areolar complex, breast skin, and pectoralis muscle. It is performed with level l-III ALND.

Breast

1/1/24 LT Breast Core Bx: infiltrating ductal carcinoma, Nottingham Grade 2

2/1/24 Lumpectomy with SLN Bx: Gr 2, IDC, 0/2 SLNs positive

How would you assign EOD Regional Nodes?

a. 000

b. 070

070- pathologic assessment only. No regional lymph node involvement pathologically (lymph nodes removed and pathologically negative) WITHOUT ITCs or ITC testing unknown

Breast

Patient diagnosed with IDC of the rt breast had a mammogram and U/S of the axilla which showed a suspicious axillary LN. FNA performed and path was negative for malignancy.

How would you code this procedure?

a) **Surgical and Diagnostic Staging Procedure, Code 01: Biospy of site other than primary**
b) **Scope of Regional LN Surgery, Code 1: Biopsy or aspiration of RLN**
c) **This biopsy procedure would not be coded since the results were negative**

Breast

STORE:

The scope of regional lymph node surgery is collected ***for each surgical*** event even if surgery of the primary site was not performed.

Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item.

Key Takeaways

- Use all your resources!
- AJCC and SEER don't always agree. Be sure you're using the correct rules for each field.
- Check your **SEER Appendix C for surgery codes**, as SEER includes notes that the STORE manual usually does not.
- Create an Excel Spreadsheet/Google Sheet or One Note for abstracting reminders by site. This is an easy way to keep information organized and accessible for efficiency.

Thank You!

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